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LOYOLA UNIVERSITY CHICAGO

HOW COUNSELING HELPS: AN IN-DEPTH LOOK AT DOMESTIC VIOLENCE
COUNSELING

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE
OF DOCTOR OF PHILOSOPHY

PROGRAM IN SOCIAL WORK

BY

SONYA V. CRABTREE-NELSON

CHICAGO, IL

AUGUST, 2010

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ACKNOWLEDGEMENTS

I would like to thank family and friends for their support and belief in me, even when I didn't always believe in myself. Without them, this would not have been possible. My husband and partner, Eric—you kept me going. Your love, support, technical assistance, and babysitting services allowed me the time and space to complete this journey. I also want to thank my son, Clayton. Even though you don't know it yet, your arrival solidified my resolve to dig in and complete this undertaking.

My deepest appreciation goes to my friends near and far who listened to and encouraged me in every step of the process, especially Valerie; our shared venting sessions, whether while running, drinking coffee, or talking on the phone, helped me to be in the moment and not get buried in the details. My friends and colleagues, Ann and Jennifer; your support and humor day in and day out meant the world to me. I also want to thank Sonja. Without your generous gift of babysitting my son, I would never have completed this in the timeframe I set for myself. I owe you so much. Lastly, words cannot capture the immense gratitude I have for my friendship with two of my cohort classmates, Carol and Mauricio. You were the two people who truly knew what I was going through and always were there to listen and encourage me. Your friendship rejuvenates me.

I want to say a special word of thanks to my mentor, Fred Steffen. You pushed, listened, and encouraged me with a belief in me that was energizing. I owe so much of my success over these five years to your support. Thank you.

I would also like to thank my dissertation committee members: Marta Lundy, Susan Grossman, and Terri Kilbane. I am honored to have had the opportunity to work so closely with the three of you; such experts in the field of domestic violence. I truly have learned so much during these past five years. Terri, all roads do lead to Rome. I hope our paths cross there again. Susan, you have an ability to teach and calm me all at the same time. That is priceless. Marta, the opportunity I have had to work with you both on this project as well as on the shelter study research project have taught me so much. Your combination of support and challenging pushed me to create something I didn't know I was capable of. Thank you.

This dissertation project was supported by an Advanced Doctoral Fellowship, which was awarded by the Graduate School at Loyola University Chicago. I also benefitted from being selected to participate in the pilot year of the Graduate Undergraduate Mentor Project, also sponsored by the Graduate School. Both of these awards allowed me to take the time to focus on completing this dissertation. Brittany, I am so thankful we were paired together for the mentor project. Your hours of assistance on this were invaluable.

Lastly, I would like to thank my colleagues at Between Friends as well as the greater domestic violence community in Chicago. You were with me from the beginning of this journey. I cannot thank you all enough, especially Carrie, Kathy, and my former

supervisor Yesenia; you not only supported me, you connected me with others in the domestic violence community. My deepest thanks. The work that all of you do inspires me and keeps me motivated.

In memory of my father, Eugene Clayton Crabtree, whose love, pride, and belief in my ability to do whatever I set my mind to sustained me through this process.

In honor of my husband and partner, Eric, whose sense of humor and unfaltering belief in me helped to make this dream a reality.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	iii
LIST OF TABLES	x
LIST OF FIGURES	xi
ABSTRACT	xii
CHAPTER ONE: INTRODUCTION	1
Research Problem	1
Issues Related to Domestic Violence Shelters and Agencies	2
Purpose	8
Methodology	9
Importance of the Study for the Field of Domestic Violence	12
Implications for Clinical Social Work Profession	13
CHAPTER TWO: REVIEW OF THE LITERATURE	16
Demographic Characteristics of Intimate Partner Violence	16
Sequelae of Domestic Violence	20
Interventions Utilized by Counselors with Survivors of IPV	24
Overview of Services	24
Effectiveness of Interventions with Survivors of IPV	28
Voices of the Survivors in Shaping Service Delivery	31
CHAPTER THREE: METHODOLOGY	36
Design	36
Delimitations and Limitations	38
Population and Sample	41
Main Concepts and Variables	43
Measures and Instruments	44
Pilot Study	52
Ethical Considerations	53
Data Collection Procedures	55
The Researcher's Role	58
Data Management Strategies	59
Data Analysis	60
Researcher's Resources and Skills	62
CHAPTER FOUR: RESEARCH FINDINGS	64
Survivors	64
Characteristics of the Participants	65

Quantitative Results	71
Qualitative Results	78
Counselors	87
Characteristics of the Participants	88
Quantitative Results	89
Open-Ended Items	95
Summary	101
CHAPTER FIVE: ANALYSIS, DISCUSSION AND SUGGESTIONS FOR FUTURE RESEARCH	102
Discussion	102
Analysis of Survivor and Counselor Data	103
Importance of Relationship	105
Knowledge of Domestic Violence	110
Interventions	113
Summary of the Mixed-Methods Analysis	120
Implications for Social Work Practice	122
Implications for Social Work Education	122
Suggestions for Future Research	123
Conclusion	127
APPENDIX A: WEB-BASED SURVEY COVER LETTER	129
APPENDIX B: LETTERS OF COOPERATION	131
APPENDIX C: RESEARCH FLYER	136
APPENDIX D: SURVIVOR INTERVIEW QUESTIONS	139
APPENDIX E: SURVIVOR DEMOGRAPHIC SURVEY	142
APPENDIX F: TRAUMA SYMPTOM INVENTORY (TSI)	146
APPENDIX G: SCALE TO ASSESS THERAPEUTIC RELATIONSHIPS IN COMMUNITY MENTAL HEALTH CARE (STAR – P)	151
APPENDIX H: COUNSELOR WEB-BASED SURVEY	154
APPENDIX I: COUNSELOR CONSENT FORM	161
APPENDIX J: SURVIVOR CONSENT FORM	164
APPENDIX K: IRB APPROVAL LETTER	168

APPENDIX L: CONFIDENTIALITY AGREEMENT FOR TRANSCRIPTIONIST	171
BIBLIOGRAPHY	173
VITA	184

LIST OF TABLES

TABLE	PAGE
1. Prevalence of Depression, Anxiety, PTSD, and Physical Symptoms among Women Who Have Experienced IPV	22
2. Trauma Symptoms Inventory (TSI): Reliability Scores for the Sub- and Reliability Scales of the TSI	48
3. STAR Table: Reliability Scores for the Subscales of the STAR	50
4. Survivor Demographic Information	66
5. Trauma Symptoms Inventory (TSI): Average Scores for the Sub- and Reliability Scales of the TSI	72
6. TSI Critical Item Frequency Table	74
7. STAR Table	76
8. Trees or Emergent Themes from Qualitative Interview	79
9. Theoretical Orientation of Domestic Violence Counselors	91
10. Interventions Identified as Most Important by DV Counselors: Ranked from Most to Least Important	92
11. Number of Counselors and Frequency with Which They Use Various Interventions and Techniques	94
12. Comparison of Most Frequently Listed Counselor Interventions from Quantitative	98
13. Translation of the Data into a Model for Working with Survivors of Domestic Violence	126

LIST OF FIGURES

FIGURE	PAGE
1. Embedded Mixed-Methods Design (Large Qual; Small Quan)	37
2. Embedded Mixed-Methods Design (Large Quan; Small Qual)	37

ABSTRACT

Intimate partner violence (IPV) is currently described by trauma researchers as a social epidemic (Briere & Jordan, 2004)¹. The array of domestic violence services we currently have in the United States were started 30 years ago by women victims assisting other women. Currently, the services we have for victims of IPV are largely unchanged and the literature lacks information on what is helpful to victims of IPV in a domestic violence counseling setting. The research points to the fact that women seeking domestic violence counseling experience an array of physical and mental health sequelae as a result of the violence. This study utilized a mixed-methods embedded design to explore the counseling services at domestic violence agencies from the points of view of both counselors and clients. The study looked at the interventions offered and their perceived helpfulness as well as the trauma symptomatology of survivors of IPV and the relationship factors between counselors and their clients. Three main categories emerged from the survivor and counselor data as important in domestic violence counseling: importance of the relationship, counselor's knowledge of domestic violence, and the specific interventions used.

¹ Briere, J. & Jordan, C. E. (2004). Violence against women: Outcome complexity and implications for assessment and treatment. *Journal of Interpersonal Violence, 19*, 1252-1276.

CHAPTER ONE

INTRODUCTION

Research Problem

Survivors of domestic violence are a stigmatized and marginalized population that can benefit from further research which addresses what is actually helpful to the survivors in a counseling relationship. It is interesting to note that the roots of the domestic violence movement (DV), sometimes referred to as intimate partner violence (IPV), began with women survivors helping other women get to safety and begin to heal (Berry, 2000). One would think that with a foundation based on empowerment, the domestic violence field would continue to look to the survivors for information on what is most helpful to them in the counseling relationship. According to the literature, that has not always been the case (Burke, Denison, Gielen, McDonnell, & O'Campo, 2004; Chang et al. (2005); Dienemann, Glass, Hanson, & Lunsford, 2007; Hage, 2006; Lundy & Grossman, 2001; Shamai, 2000). There is little information that looks at the way survivors of IPV experience counseling and the meaning that is attached to the experience. The few studies that have been done often focus on shelter services and the advocate – client relationship (Black, 2003; Davis, Hagen, & Early, 1994) and on counselors' and clients' views regarding specific intervention approaches with battered women (Burke et al., 2004; Dienemann, et al., 2007; Shurman & Rodriguez, 2006). There is a need for additional research that explores, with both survivors and counselors,

what is helpful about the counseling received at agencies that serve survivors of domestic violence. Further, there is a question about whether the field of domestic violence agrees on what constitutes the best counseling approach for survivors of domestic violence and whether this has been updated to meet the complex needs of those currently seeking counseling at domestic violence agencies. The literature states that the women who seek counseling at domestic violence agencies may have suffered abuse as children or have been witness to domestic violence (Zosky, 1999; Van der Kolk & Courtois, 2005). This means that the women utilizing the counseling services at domestic violence agencies may present with an array of issues related to complex trauma and not only the effects of the current domestic violence incident.

Issues Related to Domestic Violence Shelters and Agencies

Lack of Literature

One issue raised due to the lack of literature on the topic of domestic violence counseling, is that domestic violence programs likely differ on what constitutes the best approach for counseling with survivors of IPV. This leads to survivors of domestic violence, who are seeking counseling services from domestic violence agencies, not knowing what to fully expect from counseling. Each counseling program, while agreeing on the fundamental principles of empowerment and feminism, may differ greatly on many other aspects of counseling. This can have the result of women with similar presenting problems receiving dramatically different services depending on the agency utilized. Unfortunately, there is currently a lack of research to guide us as to what specific

approaches are used and which of these approaches is better suited to the clients seeking the service.

Limited Knowledge from Survivors' Experiences in DV Counseling

Another issue is that there is limited knowledge regarding a woman's experience in domestic violence counseling and what has been helpful to her. A recent study by Hague & Mullender (2006), where 112 survivors of IPV in the United Kingdom were interviewed, found that the majority of them felt that their experiences and needs were largely overlooked by service providers who were shaping policies and services (p. 573). Of the few studies looking at the women's experience, several key counseling elements emerged as important: (1) a relationship with a counselor; (2) the right to be someone with legitimate feelings; (3) a safe space to discuss the violence; and (4) group counseling for support and shared stories (Burke et al., 2004; Grauwiler, 2008; Shamai, 2000). Hague & Mullender's (2006) study emphasized that women who had received domestic violence services wanted to have a voice in shaping policy and concrete service provision, but largely felt that there was no opportunity to do so.

DV Survivors' Complex Trauma Histories

Additionally, in order to address the issue of counseling services for survivors of IPV, further research is needed that looks at the complex trauma histories and symptoms of the women seeking counseling at domestic violence agencies. Throughout the past several decades, women seeking services at domestic violence agencies have had a growing number of complex trauma symptoms and corresponding mental health issues that have recently been identified and documented (Warshaw, Gugenheim, Moroney, &

Barnes, 2003). These findings may lead agency administration and staff to reconsider the type and array of services offered to survivors of IPV.

More recent literature exists on this topic and it highlights a group of women with complex physical and mental health issues resulting from the abuse (Campbell, Martin, Moracco, Manganello, & Macy, 2006; Macy, Nurius, Kernic, & Holt, 2005; Shurman & Rodriguez, 2006; Warshaw, Moroney, & Barnes, 2003). The complex needs of those seeking domestic violence counseling is partially explained by a study that found women cope through informal means as long as possible and thus have severe problems by the time they seek formal help (Macy et al., 2005). The specific health and mental health issues found were: moderate depression (Macy et al., 2005; Shurman and Rodriguez, 2006); moderate to severe anxiety (Shurman and Rodriguez, 2006); post traumatic stress disorder (Humphreys, 2003; Jackson, Petretic-Jackson, & Witte, 2002; Petretic-Jackson, Witte, & Jackson, 2002); substance abuse issues; and overall lower levels of physical health (Campbell, et al., 2006; Macy et al., 2005). These studies point to the multifaceted needs of women seeking help from domestic violence counseling.

In addition, DV counseling takes place within a relationship between the client and counselor. A critical element described in the literature when working with complex trauma is the primacy of the therapeutic relationship (Briere, 2006; Dutton, 1992; Van der Kolk & Courtois, 2005). There is little research that identifies and describes this critical relationship and how it is implemented in DV work, and even less on the survivors' perspective of the meaning and utility of this relationship.

Context of Services

In addition to exploring the needs of survivors of IPV, it is important to understand the context of services within the domestic violence movement. An in-depth look at the root of the domestic violence movement helps to understand the current agency differences regarding the interventions utilized. The domestic violence field was founded on the cornerstones of feminism and empowerment. The primary model of intervention was women survivors helping other survivors (Berry, 2000; Wilson, 1997). This has largely been a byproduct of the desire to ensure that victims of IPV were no longer blamed for the violence done to them, and was precluded by a belief that DV is largely used as a means of social control by a patriarchal society. The emphasis turned away from victim blaming and toward interventions that did not pathologize (Hamby, 1998).

Domestic Violence at a Crossroads

Currently, domestic violence agencies appear to be at somewhat of a crossroads in terms of the type of counseling services that are provided to survivors. The research states that domestic violence counseling varies widely as to theoretical frameworks and interventions utilized (Howard, Riger, Campbell, & Wasco, 2003). Some agencies appear to want to move forward to embrace a paradigm that allows for intrapsychic work which addresses issues such as prior childhood abuse and trauma recovery (Burke et al., 2004; Dienemann et al., 2007; Hage, 2006) and other complex psychological needs that often stem from abuse, e.g. depression, anxiety, and PTSD (Edmunds, Peterson, & Underwood, 2002; Shurman & Rodriguez, 2006; Walker, 1993). Others adhere to the

idea of a focus on the present situation of the client, using empowerment counseling, and traditional supportive group counseling (Lutze & Symons, 2003; Mills, 1996; Shamai, 2000). The lack of research guiding counselors and agencies on what constitutes the best approach in domestic violence counseling perpetuates the bifurcation among agency practices and may create a wider system problem.

Differing Models for Mental Health

Many domestic violence programs still make a distinction that the counselors should not engage in intrapsychic therapy, but rather provide domestic violence counseling. Historically, the fundamental differences between therapy and domestic violence counseling are as follows: in domestic violence counseling the focus is primarily on the present, focusing on safety, empowerment, advocacy, support, options, and societal influences for abuse (Dutton, 1992; Herman, 1992; Lutze & Symons, 2003). Traditional mental health therapy that is based on the medical model is focused on gaining an understanding of the symptoms expressed by the victim, e.g., depression, substance abuse, trauma, anxiety, through intrapsychic assessment and interventions (Austrian, 1998; Kerlin & Brandell, 1997; Meyer, 1993). Although a simplified description, the medical model approach understands that symptomatology is from life-long difficulties that most likely are a result of early childhood problems (Kerlin & Brandell, 1997; Payne, 1997). Perhaps the greatest difficulty, for counselors working with survivors of IPV, with accepting the medical model is that mental health workers have traditionally overlooked the symptoms of depression and anxiety as relevant to the experience of domestic violence. Instead, survivors' symptoms have often been

explained to be due to the long-term illness of the woman and as a partial explanation for the response to violence in her life (Kerlin & Brandell, 1997). This is a critical difference in the models. Both of these approaches will be addressed further in the literature review section.

It is becoming clear that there continues to be a lack of literature surrounding the counseling experience of women survivors of IPV who seek counseling at domestic violence agencies with non-affiliated shelters. Important aspects in need of further research are as follows: a women's experience in domestic violence counseling, the complex trauma histories and symptomatology of the women, and interventions used at domestic violence agencies as well as their perceived effectiveness. All of this is important and needs to be considered in the current and historical context of domestic violence agencies. This study will address the aforementioned issues.

In order to begin to understand and meet the current needs of survivors of IPV who seek counseling at domestic violence agencies, further research needs to be done. Specific information that appears lacking in the literature is: 1) what interventions do counselors at domestic violence agencies identify that they utilize most and what is their perception on what is most helpful; 2) what aspects of the intervention are helpful to those experiencing it; 3) what is the trauma symptomatology of survivors seeking counseling from domestic violence agencies; and 4) what are the relationship factors between the counselor and survivors that each identify as helpful. This study intends to begin to answer these questions.

Purpose

This study is important because there is a lack of information on what is helpful for survivors in the domestic violence counseling setting (Grauwiler, 2008; Hague & Mullender, 2006; Hamilton & Coates, 1993). This is important to survivors of IPV, the counselors providing the service, and the domestic violence agencies where the counseling is occurring as well as policy makers and funding organization, and the social work profession as a whole. It is relevant for those in the domestic violence field to know what types of counseling are being done, and what aspects of it are identified by both survivors and counselors as most helpful. Further, it is essential to their work to know the characteristics of the trauma histories of those currently seeking counseling at domestic violence agencies. By doing this, we hope to learn about the trajectory of needs and services that may be most effective for clients. We hope to learn what survivors and counselors wish they would have explored in counseling. In addition, this study may find that certain therapeutic interventions work with many women survivors or it may find that each woman is an individual and in need of different theories and intervention. Either of these findings would be extremely helpful to counselors and administrators at domestic violence agencies as well as to social work and other mental health professionals.

The ontological assumption in this study about intimate partner violence is that it is a societal problem that often gets reframed to look like a family or individual problem. Because of this, it is important to look at the issue of intimate partner violence and domestic violence counseling from various vantage points, using methodology that

triangulates the data, a process for examining findings that will be discussed in greater detail in the Methods section of this proposal. Another ontological assumption held by this study is that given the opportunity, survivors of IPV are the experts on their lives and what is most helpful to them. Professionals can partner with survivors in order to bring about both individual and societal change, but it is the survivors' voice that is primary in the counseling. That is why this study will look for input from both domestic violence counselors as well as survivors of IPV who have received domestic violence counseling. Similarly, my epistemological assumptions are that in order to understand what interventions work best with survivors of IPV, we need to ask survivors. We can't assume that because empowerment has always been a cornerstone of interventions with survivors (Berry, 2000; Black, 2003; Simon, 1994) that it is the best method. We need to hear what works, why, and in what context.

Methodology

Research Questions

Due to the mixed-methods design of this study, data for the research questions was collected using both quantitative instruments, open-ended questions, and qualitative interviews. The reason for choosing a mixed-method design and the delineation of where and how the data was collected is described below. However, at this point the specific research questions will be identified for clarification.

Data collected from the domestic violence counselors is used to explore the following research questions: 1) what interventions do counselors at domestic violence agencies identify that they utilize most and what is their perception on what is most

helpful; 2) what are the relationship factors between the counselor and survivors that each identify as helpful. Data collected from the domestic violence survivors is used to explore these additional research questions: (1) what aspects of the intervention are helpful to those experiencing it; (2) what is the trauma symptomatology of survivors seeking counseling from domestic violence agencies; (3) and what are the relationship factors between the counselor and survivors that each identify as helpful.

Research Plan

The study is a mixed-methods exploration of what therapeutic interventions are used in counseling with survivors of IPV and in what ways counselors and survivors perceive them as helpful. The reason for an exploratory design was that the variables were unknown and needed to emerge from the mixed-method data collection. This was done by collecting interview and survey data from 10 survivors as well as from 30 counselors. The counselors were asked primarily survey data, with six open-ended questions for them to complete. Data were collected using a purposive sample of women who received counseling and counselors who provided counseling at domestic violence agencies without affiliated shelters in the Chicago metropolitan area.

Survivors

In addition to the qualitative interview, survivors were given the Trauma Symptom Inventory (TSI) (Briere, 1996), a 100-item questionnaire that utilizes 10 subscales on mental health functioning, e.g., anxiety/irritability, depression, in order to further confirm and clarify the research questions. The TSI was used to discover the trauma symptomatology of those seeking counseling from domestic violence agencies.

The Scale to Assess Therapeutic Relationships in Community Mental Health Care (STAR), a 12 number item instrument, was utilized (McGuire-Snieckus, McCabe, Catty, Hansson, & Priebe, 2007) to study the relationship factors between the counselor and survivor. The version for clients, the STAR – P was given to survivors.

In-depth interviews were used to gather data from the survivor participants. The qualitative interview asked the main question, “What therapeutic interventions are used in counseling with survivors of intimate partner violence and are these interventions experienced as helpful?” Follow up questions included, “What do survivors of IPV identify as the most helpful aspects of counseling?”, “What do survivors wish they had discussed in counseling, but didn’t?”, “Is it common for survivors of IPV to receive counseling assistance from several social service agencies simultaneously?”.

Counselors

Counselors were given a web-based survey instrument to complete. It answered the question, “What interventions do counselors most commonly use in counseling with survivors of intimate partner violence and are these interventions experienced as helpful?”. The survey also included six open ended questions: (1) “There are many difficult client situations that counselors at domestic violence agencies deal with (clients with difficulties related to immigration status, clients with mental health issues, etc.). What is the most difficult client situation you deal with as a counselor?”, (2) “When you deal with this type of difficult client situation, what theories do you draw upon the most?”, (3) “What interventions do you find most helpful in those situations?”, (4) “What do you think are similarities and differences among counselors at domestic violence

agencies in regards to training, education, and theoretical orientation?”, (5) “What do you wish you could address with your clients, but have not?”, and (6)) “Tell me about a time when your beliefs about what is important in counseling has conflicted with the parameters of your setting (i.e. length of counseling, individual verses group counseling, etc.)”.

Importance of the Study for the Field of Domestic Violence

The field of domestic violence will benefit from this study by informing counselors, domestic violence agencies, and policy makers about what survivors of IPV report as the most helpful aspects of counseling. The study provides a forum to identify the symptomatology of women seeking help from domestic violence agencies outside of shelter services. It also looks at what services can respond to their specific needs. Studies in the past have either compiled all domestic violence services together or looked at specific clinical models and their affect on counseling. This study collected information from women at non-shelter based domestic violence agencies

This study aimed to give survivors of IPV who were utilizing counseling services an opportunity to inform domestic violence service providers on what each perceived was needed and helpful. The domestic violence movement has been around for approximately three decades (Berry, 2000; Wilson, 1997). It is possible that either the demographics or needs of those seeking counseling from domestic violence agencies have changed over the years. Due to the phenomenological nature of this study, the women were able to tell service providers what they needed and what was most helpful to them.

The current literature is not clear about what constitutes the best approach for domestic violence counseling agencies. As stated earlier, some researchers posit a focus on the present situation of the survivor, utilizing empowerment counseling (Lutze & Symons, 2003; Mills, 1996; Shamai, 2000), while others advocate for a more intrapsychic or trauma informed approach (Burke et al., 2004; Dienemann et al., 2007; Hage, 2006). This bifurcation among agency practices creates a wider system problem, which this study aimed to address. This study obtained information from both survivors and counselors in an attempt to see what services were being provided, to whom were they provided, and what aspects of the service provision were most helpful.

Implications for Clinical Social Work Profession

The paths of the social work profession and the domestic violence movement appear to be quite similar, often following parallel tracks that are aware of and work toward the elimination of oppression and discrimination. Specifically, in the history of social work, and in the formation of the domestic violence movement, there was and continues to be an emphasis on social justice and empowerment for marginalized and often stigmatized populations. Just as the social work profession has grown to incorporate a myriad of models, theories and scenarios for working with different populations and problem areas (Bentley & Walsh, 2006; Hepworth & Larson, 2002) so too, the domestic violence field seems to be growing to fit the complex needs of survivors of domestic violence. This study serves to benefit both the profession of social work and the field of domestic violence.

While the benefits to the field of domestic violence may appear more readily apparent, the social work profession will also benefit from an increased understanding of how survivors of IPV experience the counseling relationship and what they find helpful. The study will also benefit the social work profession by increasing the understanding of the type of counseling that is provided at domestic violence agencies. This understanding will benefit both instructors at colleges of social work as well as LCSW supervisors. It may be that social workers can be leaders in the field of domestic violence as social workers have a rich history of looking at both the person in society as well as the person's intrapsychic issues (Dorfman, 1998; Goldstein, Miehl, & Ringel, 2009; Hamilton, 1951; Meyer, 1993). This partnering between the domestic violence field and the social work profession appears to be a strong natural collaboration. The values of the domestic violence field fit almost seamlessly with the social work ethics of social welfare, public participation, public emergencies, and social and political action (for a delineation of the overlap, see; Brandell, 1997; National Association of Social Workers, Code of Ethics, 1996; ICADV Mission and Vision statements, 2008).

The social work profession has a rich history that can lend itself to support and further the domestic violence field. In 1996, Mills promoted the use of postmodern social work theory with battered women. The theory states that the power and control of a woman's actions reside in the woman, not in the caregiver. Mills went on to say that we must not make assumptions that we know how a battered woman feels or can understand the conflicting loyalties that she is experiencing. This ability to meet the needs of each person as an individual closely mirrors the social work concept of beginning where the

client is (Goldstein, 1996). The counselor, by not making assumptions, could provide short term, traditional domestic violence counseling or longer psychotherapy, depending on the needs of the client.

Simon (1994) advocates for the pairing of clinical social work with survivors of domestic violence. She states that the social worker can help the client create and maintain a sense of self worth that allows the woman to continue to meet or alter the demands made upon her. Simon goes on to suggest that empowerment based social workers can bring to light various ways in which a client's strengths contribute to the survival, development, and sustenance in the face of difficulty or trauma. The social work concept of the person-in-environment (Coady & Lehmann, 2008; Hamilton, 1951) is also a cornerstone to working with survivors of IPV.

CHAPTER TWO

REVIEW OF THE LITERATURE

Demographic Characteristics of Intimate Partner Violence

Intimate partner violence has become a burgeoning social issue for research for just over thirty years. It has even been described by some trauma researchers as a societal epidemic (Briere & Jordan, 2004). Accurate statistics regarding the prevalence of IPV remain a challenge to compile due to the fact that the majority of violence among intimate partners is never reported to the police or other social service agencies. Historically, IPV has been thought of as a private family matter, rather than a crime, greatly reducing the likelihood of formal reporting or help seeking. The power and control dynamics within IPV also influence the likelihood that abuse will not be reported due to shame and fear experienced by the survivors.

The findings of reports and studies on the prevalence of IPV often appear to differ slightly. One of the largest studies of IPV completed by the medical profession found that one in every twenty women experienced violence in the previous year and one out of every five women experienced IPV in their adult life (McCauley, et al., 1995). The researchers conducting this study went on to find that additionally, one out of every three women had experienced violence as either a child or adult (1995). A study by Tjaden and Thoennes (2000) that analyzed the National Violence Against Women data, found that approximately 1.5 million women in the United States experience sexual or physical

violence from a current or former intimate partner each year. However, a study that looked at the Surgeon General's statistics from a public health study found that two to four million women in the United States are physically abused each year (Nuvello, Rosenberg, Saltzman, & Shosky, 1992), while more recent statistics estimate over five million intimate partner victimizations occur annually, resulting in over two million injuries and almost 1,300 deaths (Centers for Disease Control and Prevention, CDC, 2003).

The literature also shows that IPV is usually a combination of numerous forms of violence with the coexistence of psychological, physical, and sexual violence against women abused by their partners being extremely high. Ellsberg adds that 94% of women who experienced physical abuse also reported verbal and emotional abuse, while 36% of women experienced sexual abuse while being beaten (1997). Evidence suggests that physical and sexual violence often occur in the same relationship, placing battered women at an increased risk for partner rape (Howard, Riger, Campbell, & Wasco, 2003). A survey of women's health done by the Commonwealth Fund in 1998, found that almost 20% of women in the U.S. experience physical assault, 20% experience rape, and 35% experience IPV (Plichta & Falik, 2001). These forms of violence are often intermingled as the earlier study by Ellsberg points out.

What the studies agree upon is that IPV is a serious matter affecting the lives of many women in the United States. Although research suggests that abuse rates differ little by race, education level, and ethnicity, women have more to fear from family members, especially intimate partners, than from strangers (Collins et al., 1999). The

U.S. Department of Justice (1995) found that 39% of violent crimes were committed by a family member with 58% perpetrated by a spouse or ex-spouse. The National Family Violence Surveys of 1975 and 1985 as well as the National Longitudinal Couples Survey of 1995, found that, “One of five U.S. couples are affected by intimate partner violence” (Martin et al., 2008, p. 131). Additionally, a review of three different studies showed that 30-60% of murdered women in the U.S. are killed by a current or former intimate partner (Kellermann & Mercy, 1992; Moracco, Runyan, & Butts, 1998; Violence Policy Center, 2000). The National Crime Victimization Survey corroborates these studies as it estimates that one third of all murdered women in the United States were killed by an intimate partner (Rennison & Welchans, 2000). IPV remains a relatively common source of both fatal and nonfatal injuries to women in the United States (Thompson, Saltzman, & Johnson, 2003).

Researchers are also beginning to look at the link between exposure to IPV in childhood as a predictor of male perpetration and female victimization in intimate relationships. Although childhood exposure to IPV in the familial home is less a predictor of female victimization as it is male perpetration (O’Leary, 1988), children’s exposure to IPV between parents increased the risk of IPV victimization significantly more than if the woman had been subject to physical victimization as a child (Kantor & Jasinski, 1998; O’Keefe, 1998; Vatnar, & Bjorkly, 2008). Vatnar, and Bjorkly (2008) studied a sample of 157 help-seeking women who were victims of IPV and found that women who had been childhood victims of sexual abuse in their families of origin were at an almost 25 times greater risk for IPV than those who were not sexually abused.

One large-scale study found a pattern as to the occurrence of IPV. Vazquez, Stohr, and Purkis found that the monthly incidence rates of reported IPV were higher during the summer months, with July having the highest rate of reported IPV (2005). Their study, that included seven years of data, also found that the first day of each month and the weekends consistently included more incidents of IPV than any other day of the month or week. Of these times, incidents were more pronounced during the evening hours. This was hypothesized as due in part to the following issues; greater alcohol consumption, increased irritability, both partners home from work, and the children put to bed. Certain holidays were found to correlate with higher rates of IPV. These included New Year's Eve, New Year's Day, Superbowl Sunday, Memorial Day, and Independence Day; while other holidays had the lowest rates of reported IPV. These holidays included Valentine's Day, Thanksgiving, and Christmas Day. The holidays with the highest rates of IPV are linked to higher testosterone levels, which have been linked to heightened rates of violence (Vazquez, Stohr, & Purkis, 2005). Ironically, Vatnar and Bjorkly (2008) found that in 75% of the cases they looked at, neither the perpetrator nor the victim had consumed alcohol at the time of the abuse.

The literature is clear that women suffer from IPV at alarming rates. The rates of IPV in the general population are a challenge to decipher due to the fact that statistics can only be gathered on women who either report the crime or seek help from a doctor or helping professional. However, the information we do have is enough to cause alarm and show a need for a further understanding of how to assist women survivors of IPV.

Sequelae of Domestic Violence

Many women who have experienced domestic violence may later experience physical and mental health complications (Martin et al., 2008; Perez & Johnson, 2008; Shurman & Rodriguez, 2006; Walker, 2000). There are a growing number of studies that are addressing the affects of IPV on women. These can be complicated to compile as many of them study slightly different aspects of IPV and its psychological effects. The studies also differ as to the instruments used, the sample utilized (women receiving services at domestic violence agencies or at health clinics), and the time when the women experienced IPV (currently, within the last year, within their adult lives). What the studies agree on is that women who have experienced IPV are at a greater risk than the average woman of suffering from numerous psychological and physical ailments. Women who have experienced IPV in their adult lives have higher rates of depression than the average public (Leiner, Compton, Houry, & Kaslow, 2008; Macy et al., 2005; McCauley, et al., 1995; Rodriguez et al., 2008; Sato-DiLorenzo & Sharps, 2007; Shurman & Rodriguez, 2006); moderate to severe anxiety (McCauley, et al., 1995; Sato-DiLorenzo & Sharps, 2007; Shurman and Rodriguez, 2006); post traumatic stress disorder (Humphreys, 2003; Krause, Kaltman, Goodman, & Dutton, 2006; Jackson, et al., 2002; Leiner et al., 2008; Perez & Johnson, 2008; Petretic-Jackson, et al., 2002; Rodriguez et al., 2008; Sato-DiLorenzo & Sharps, 2007); clinically elevated anger (Shurman & Rodriguez, 2006); substance abuse issues; and overall lower levels of physical health (Humphreys, 2003; Macy et al., 2005; Martin et al., 2008; McCauley, et

al., 1995; Sagrestano, Carroll, Rodriguez, & Nuwayhid, 2004). Domestic violence also often interferes with women's employment and education (Tolman & Rosen, 2001).

Though the focus of this study is on a large Midwest city in the United States, studies done elsewhere in the world confirm the effects of IPV are not limited to our country. One study compiled research done around the world that looked at rates of physical violence perpetrated by male intimate partners against female partners. They found between 10%-56% of women were affected by physical IPV at least once in their lifetimes (Ludermir, Schraiber, D'Oliveira, Franca-Junior, & Jansen, 2008). A multi-country study by the World Health Organization (WHO) found high rates of IPV committed against women by their domestic partners (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006).

The effects of IPV are also similar around the world. A study of 2,118 women in Brazil found that women who have been abused psychologically, physically, or sexually have been found to have a 40.2% chance of having a mental disorder (Ludermir, et al., 2008). A similar study in Spain found that in their sample of 298, abused women scored higher for depression and anxiety than the average public (Calvete, Corral, & Estevez, 2008). A comparison study done in Canada also supported these findings by showing that women who were abused suffered increased levels of depression and lower self esteem than those not abused (Orava, et al., 1996). Finally, a recent large global study that included 10 countries done by the World Health Organization (WHO) on violence against women found that IPV causes anxiety, depression, and suicidal thoughts among

women (Garcia-Morena, et al., 2006). The psychological effects of IPV are great and they are consistent across most of the world.

Table: 1

Prevalence of Depression, Anxiety, PTSD, and Physical Symptoms Among Women Who Have Experienced IPV

Citation	Sample	Depression	Anxiety	PTSD	Physical Symptoms	Other
Calvete et al., 2008	N=298 women in Spain who were abused (sample from victim services and women's organizations)	Increased depression	Increased anxiety			
Garcia-Morena, et al., 2006	N=approximately 1500 families per country with 10 countries participating	Increased depression	Increased anxiety			Suicidal thoughts
Humphreys, 2003	N= 50 women in dv shelter			Increased ptsd	Increased injuries	Increased psychological distress
Krause et al, 2006	N=405 women receiving services from dv agencies			Increased ptsd		
Leiner et al, 2008	N=323 women from an emergency department who experience IPV	Increased depression		Increased ptsd		Increased suicidal ideation
Ludermir, et al., 2008	N=2118 women in Brazil					Women abused had 40.2% chance of a mental disorder
Macy et al, 2005	N=448 women who filed police report or order of protection	Increased depression			Low levels of physical health	Lack of social relationships
Martin et al, 2008	N=1,761 women who experienced IPV				Poor physical health	Poor mental health and functional limitations

Table 1: Prevalence of Depression, Anxiety, PTSD, and Physical Symptoms among Women Who Have Experienced IPV (continued)

McCauley et al, 1995	N=108 women who had experienced violence in last year	Increased depression	Increased anxiety		Physical symptoms and somatization	Increased substance use and low self esteem
Orava et al., 1996	N=21 abused women and 18 comparison women in Canada	Increased depression				Low self esteem
Perez & Johnson, 2008	N=320 women from health centers who experienced IPV.			Increased ptsd		
Rodriguez et al, 2008	N=92 women from prenatal clinics	Increased depression		Increased ptsd		
Sangrestano et al, 2004	N=188 women from health care center who experience IPV				Adverse physical outcomes	Adverse psychological outcomes and decreased social support
Sato-DiLorenzo & Sharps, 2007	N=177 women from a dv shelter	Increased depression	Increased anxiety	Increased ptsd symptoms		
Shurman & Rodriguez, 2006	N=85 women from dv shelters & transitional housing	Increased depression	Increased anxiety			Clinically elevated anger

The literature points to a need to further explore the trauma symptomatology of women seeking counseling from domestic violence agencies. More recent literature exists on this topic and it highlights a group of women with complex physical and mental health issues resulting from the abuse (Campbell, Martin, Moracco, Manganello, & Macy, 2006; Macy, Nurius, Kernic, & Holt, 2005; Shurman & Rodriguez, 2006; Warshaw, Moroney, et al., 2003). The complex needs of those seeking domestic violence counseling is partially explained by studies that found women cope through informal means as long as possible and thus have severe problems by the time they seek

formal help (Macy et al., 2005; Sagrestano, et al., 2004). These studies highlight the fact that women who actually report the abuse in their lives are under a great deal of psychological and physical stress. They also are not currently receiving adequate levels of social support. This explains their need to reach out for assistance from professionals (doctors, social workers, etc.). This is echoed by the Domestic Violence and Mental Health Policy Initiative in Chicago which has stated that we are seeing more women with complex needs seek out services for IPV due to the fact that women with adequate supports and resources are now able to find other means of assistance in our society (Warshaw, Gugenheim, et al., 2003).

Interventions Utilized by Counselors with Survivors of IPV

During the 1990's several authors and researchers sought to review the past 20 years of work with survivors of IPV. The authors appear to differ in their opinion as to which approaches are best for survivors of IPV. However, the authors do clearly lay out the trends in services for survivors of IPV from the 1970's through the 1990's. This section of the literature review will focus on the compiled findings of the above mentioned authors. It will then highlight the research that has been done since 2000. However, since the turn of the century few authors have critiqued counseling services that are specifically being offered to survivors of IPV; instead, the research often appears to be included under the umbrella of trauma.

Overview of Services

Interventions for female victims of IPV gained attention in the 1970's when domestic violence became recognized as a social problem (Berry, 2000; Hamby, 1998;

Wilson, 1997). Early interventions were apt to fall into one of two frames: either a traditional medical model/psychiatric viewpoint or a newly formed grassroots shelter movement (Hamby, 1998). Hamby goes on to explain that early medical models often focused on masochistic behaviors of the victims. In reaction to this perceived focus on pathology, interventions with victims at shelters tended more toward issues of social control and safety.

Services for victims of IPV have not changed dramatically in the 30 years since their inception. Most services are arranged around community-based shelter interventions (Hamby, 1998), including safety planning, legal advocacy, and group counseling (Hamby, 1998; Tutty & Rothery, 2002; Zweig & Burt, 2007). Tutty and Rothery (2002) point out that even when services for victims of IPV are offered for those not seeking shelter, the services tend to be similar, crisis intervention, options planning, safety, legal advocacy and group counseling. Although research suggests victims experience depression, anxiety, and post-traumatic stress disorder as well as other problems, many domestic violence programs lack the resources to respond to mental health needs (Warshaw, Gugenheim, et al., 2003). Most of the groups offered for survivors of IPV can be classified as support or psychoeducational groups (Hamby, 2008; Tutty & Rothery, 2002). The groups are led by professionals or other trained volunteers and focus on group members supporting and teaching their peers.

Many researchers and experts in the field of IPV state that the current approach at shelters and many other community-based programs is the best approach. Tutty and Rothery (2002) cite research by 10 different studies that support the modality of group

counseling for survivors of IPV (p. 398). These studies argue that since the symptoms of anxiety and depression are often a result of post-traumatic stress disorder, the women survivors of IPV do not generally require more in-depth therapy in order to heal and recover. Two authors compiled research that showed many in the field of domestic violence believe that traditional medical model psychotherapy often re-victimizes the women and pathologizes the symptoms incurred from the abuse (Giles-Sims, 1998; Hamby, 1998).

However, there is also research to support the fact that at times the psychological needs of victims of IPV have been neglected in the service community; perhaps partially due to the desire to focus mainly on social control and to refrain from pathologizing victims. Hamby states that the psychological needs of many women victims are often great (1998) and that to ignore them or inadequately address them in counseling does a disservice to the women. Lenore Walker (1994) and Mary Ann Dutton (1992) are two authors whose books focus on treating the psychological needs of victims of IPV. Both are highly regarded in the field of mental health and DV. Dutton's (1992) book utilizes a mental health treatment philosophy that addresses protection, choices, and healing from the effects of post-traumatic stress. Her approach is one that utilizes a feminist framework, viewing the victim's coping strategies from a strengths based perspective. She relies primarily on cognitive-behavioral and supportive interventions. Walker's (1994) book also describes an approach that is grounded in feminist and trauma therapy principles while utilizing cognitive-behavioral techniques. Walker, however, also

describes the importance of exploring intrapsychic problems of survivors when necessary.

The relationship between the survivor and the counselor has been relatively unexplored in the domestic violence literature. However, it has been researched in the mental health community and underscored as an important element in treatment intervention. Lambert (2004) put together a collection of writings that talk extensively about the importance of relationship between a therapist and client. Other researchers echoed the opinion that a respectful, trusting relationship is pertinent to a productive counseling process (Horvath & Symonds, 1991; Norcross, 2002). Thus most researchers in the mental health field agree, despite their varied therapeutic orientations, that the relationship between client and counselor is important to the therapeutic work (Greenberg, 2002; Safran & Muran, 2000) and an actual mechanism of therapeutic change (Hill & Knox, 2009).

The research done by the Domestic Violence and Mental Health Policy Initiative in Chicago, supports the idea that there is a need to blend the core principles of domestic violence counseling with a mental health treatment philosophy in order to meet the needs of many survivors of IPV (Warshaw, 1996). Warshaw invites people to consider a new perspective on work with survivors of IPV. She states that work with survivors does not always fit either the traditional shelter paradigm for counseling or the traditional medical model. The surfacing of trauma theory has begun to bridge the gaps in these two models (Warshaw, Gugenheim, et al., 2003). Trauma theory can provide a framework as well as the needed client advocacy. It is important to look at the individual needs of the woman

in order to compile a treatment plan that works for her. Warshaw goes so far as to state that if clinicians fail to do this they may inadvertently ignore the psychological needs of a woman in their care. Conversely, if clinicians stick to a strict psychodynamic framework, they may find it difficult to play an active role in planning for the woman's safety and in exploring her possible options (1996, p. 88).

The Handbook of Domestic Violence Intervention Strategies by Albert Roberts (2002) compiles numerous chapters on current treatment approaches with survivors of IPV. The book echoes the stance that survivors need a treatment approach that includes the necessary crisis intervention strategies as well as elements to deal with the post-traumatic effects of the abuse. Two chapters in particular advocate for the following clinical interventions with survivors of IPV: Intervention goals should be appropriate to an individual's needs, clinicians should develop and use a conceptual framework to guide their treatment, a contextual perspective must guide intervention, clinicians must engage in self-monitoring of their attitudes, beliefs, and behaviors, and the impact of clinical intervention must be monitored (Jackson, Petretic-Jackson, & Witte, 2002; Petretic-Jackson, Witte, & Jackson, 2002).

Effectiveness of Interventions with Survivors of IPV

A review of the literature illustrates that few researchers have looked at the effectiveness of counseling interventions with survivors of IPV. What is clear is research continues to be done on various aspects of IPV, however, most of these works are not looking at specific counseling interventions and few of them ask the women their experience or perception of the counseling they received.

Current research studies with survivors of IPV demonstrate that the women benefited in some way from the services they received at domestic violence agencies, but do not discuss specific interventions utilized or the background of the counselors providing the service (Cattaneo, Stuewig, Goodman, Kaltman, and Dutton, 2007; Howard et al., 2003; Shamai, 2000; Zweig & Burt, 2007). Cattaneo et al. (2007), looked at 406 women who had received domestic violence services (criminal court, dv shelter, or order of protection) and found that women's use of services declined over the year if no new violence took place. Due to this, they argue that domestic violence services should be prepared to offer an array of services at one location instead of referring women to other locations for future legal help, therapy, and psychiatric services (p. 476). The study by Howard et al. (2003) found that of the 500 women in their study, all displayed higher well-being scores after counseling at a domestic violence agency. Zweig and Burt (2007) administered a large study that included 1509 women who sought assistance from domestic violence or sexual assault agencies. They found that the services were perceived as helpful when staff had a positive attitude and when collaboration with other agencies occurred or the agency was able to assist with several issues at once (p. 1171). A qualitative study by Shamai (2000) had similar findings. Other studies that address IPV look at aspects of coping or resilience in women who experienced abuse and sought assistance from domestic violence agencies (Bauman, Haaga, & Dutton, 2008; Hage, 2006; Humphreys, 2003; Sabina & Tindale, 2008). Women were found to be very resilient in the face of adversity. Bauman et al. (2008) conducted quantitative interviews with 406 women and found that women benefited from their spirituality, emotional

expression, problem solving, and social support. This confirms what Hage (2006) discovered in the 10 qualitative interviews she conducted where it was discussed that having one supportive person in their lives (formal or informal) was helpful and could create change. One study even looked at a culturally specific approach one domestic violence agency utilized (Gillum, 2008). Gillum found that the 14 women interviewed felt that the culturally specific components of the program were helpful and led them to feel satisfied with the services in ways they had not been at prior agencies.

The literature points to one model of intervention with survivors of IPV that has been reviewed by several researchers, it describes women moving through a process of change in their decision making when leaving an abusive relationship (Burke, et al., 2004; Burke, Gielen, McDonnell, O'Campo, & Maman, 2001; Chang et al., 2006; Liang, Goodman, Tummala-Narra, & Weintraub, 2005; Shurman & Rodriguez, 2006). Most of the authors specifically refer to the stages of change model or transtheoretical model of change (TM) when discussing this process (Burke, et al., 2004; Burke, et al., 2001; Chang et al., 2006; Shurman & Rodriguez, 2006). Three of the studies support the use of the TM for assessment and intervention in counseling with survivors of IPV (Burke, et al., 2004; Burke, et al., 2001; Shurman & Rodriguez, 2006) and one study supports the same concept, but does not utilize the TM model specifically (Liang et al., 2005). Only one research study was found that states that the TM was not an effective intervention due to the fact that women move back and forth within the stages of change and therefore the structured model was not a good fit (Chang et al., 2006). Instead they proposed counselors must be ready to offer various interventions to women at one time (i.e., safety

planning and domestic violence information) due to urgency even if she is not at the appropriate stage in her process (Chang et al., 2006, p. 337). That way if she does not continue with services, she still benefitted from the domestic violence information.

One research article looked at the effectiveness of individual counseling at a domestic violence shelter and discussed the clinical orientation and background of the counselors at the agency (McNamara, Tamanini, & Pelletier, 2008). This study was the only one that specifically addressed the interventions used, the training of the counselors, and the satisfaction and benefit to the women utilizing services. The study specifically looked at the effectiveness of counseling through pre and post-test measures with 119 women at a domestic violence shelter. The counselors were all Master's level clinicians who identified a feminist orientation with interventions that included cognitive behavioral, existential, solution focused and systems (McNamara et al., 2008, p. 133). It was found that 68.3% of the women experienced clinically meaningful change in 3 sessions (p. 134) and that 93% of the women were highly satisfied with services (p. 135).

Voices of the Survivors in Shaping Service Delivery

As stated earlier, the few studies that look at the survivors' experience found several key counseling elements stated as important: the relationship with the counselor, the right to be someone with legitimate feelings, safe space to discuss the violence, group counseling for support and shared stories, and a broad spectrum of service delivery at one location (Burke et al., 2001; Shamai, 2000; Zweig & Burt, 2007). Other studies found that women who had received domestic violence services wanted to have a voice in shaping policy and concrete service provision, but largely felt that there was no

opportunity to do so (Grauwiler, 2008; Hague & Mullender, 2006; Hamilton & Coates, 1993).

It is interesting to note that in a field where the service delivery was founded on women survivors of IPV informing, creating, and delivering the services, a review of the literature shows that few studies specifically ask survivors what they find to be helpful or effective in service delivery.

In one of the few studies that set out to determine what was helpful to women survivors from their own point of view, Zweig and Burt (2007) found that, “women who felt they were listened to by agency staff and who had a greater sense of control when working with domestic violence agencies found services to be more helpful across all service types” (p. 1171). The authors went on to note that the women in their sample listed safety, child advocacy, emotional support, legal advocacy, and individual advocacy as extremely important. The importance of a sense of control and of feeling heard could be explained by the lack of control the women had experienced in the abusive relationship. Additionally, a study by Bauman, et al. (2008) found that women perceived prayer and spirituality, increased independence, and empowerment to be the most effective strategies in assisting them through the process of leaving and healing from abusive partners. Hague & Mullender (2006) agreed that spirituality is important to survivors and that it is also beneficial for survivors to have their strengths affirmed and their experiences validated.

A qualitative study by Shama (2000) underscores a lot of the prior listed sentiments. The women in his study found the most helpful aspect of counseling was,

“the discovery and recognition of the right to be someone with legitimate feelings, thoughts, and desires” (p. 90). The women went on to describe that this experience was facilitated by the space and time they were given in counseling as well as the experience that the social workers were attuned and attentive to them. The women also described a reduction in the guilt and shame they had due to a nonjudgmental attitude of the counselors (Shamai, 2000).

A research study by Hamilton and Coates (1993) looked at the perceived helpfulness of different professionals who were contacted by survivors of IPV as well as which interventions were perceived as most helpful. The data were compiled from the responses of 270 women who completed the study surveys. The authors found that social workers were contacted the most for problems related to physical, emotional, and sexual abuse and that the women generally viewed social workers as helpful. Women listed several responses as most helpful in their interactions with helping professionals. These included, “listening respectfully, believing my story, helping me see my strengths, helping me see how I’d been losing self-confidence, asking if I was physically hurt, helping me see the danger to my children and myself, letting me know that I am not alone, and recognizing the impact the abuse had on me,” (p. 319-320). Unhelpful responses were, “advice giving, not informing me of other agencies or professional services, suggestions the couple get counseling together, going along with the woman’s minimization of the situations, questioning her story, and denying the impact it had on her life,” (p. 321).

A recent, qualitative study by Grauwiler (2008) had similar results. Grauwiler interviewed 10 women survivors of IPV who took part in services provided by a non-shelter based domestic violence program. The women shared that they felt domestic violence hotlines and 311 were often ill-informed regarding referrals to domestic violence counseling agencies for women not seeking shelter. The majority of the women also expressed dissatisfaction both with the helping system's emphasis on leaving the abusive situation and with the system's inability to hold their partner's accountable for the abuse. Conversely, the women all expressed extreme satisfaction with the non-shelter based domestic violence agency where they received individual and group counseling. The women specifically cited the supportive groups and positive, strengths-based nature of the staff at the agency to be helpful. They also said that they benefited greatly from learning ways to navigate the relationship with their abusive ex-partner surrounding continued contact related to shared parenting.

An interesting study by Gillum (2008), which was cited earlier, discusses the perceived helpfulness of a culturally-specific approach to working with survivors of IPV. This further underscores the importance of being aware not only of the specific needs of survivors of IPV, but of differing cultures and individuals. The 14 women in the sample explained that they experienced the staff, who culturally represented the clients they served, as understanding them and this allowed them to open up in ways they had not in prior counseling experiences.

Lastly, there are several research articles that begin to point to women survivors of IPV experiencing counseling services at domestic violence agencies as more

supportive and helpful than the counseling received at traditional counseling or mental health agencies (Grauwiler, 2008; Hage, 2006; McNamara et al., 2008). This information, along with the studies that encourage a collaborative approach or spectrum of services for survivors of IPV, point to the importance of domestic violence agencies that continue to meet the growing needs of survivors of IPV.

CHAPTER THREE

METHODOLOGY

There is a quote by Schon (Fitzgerald & Rasheed, 1998) that likens research to a varied wilderness landscape:

In the varied topography of professional practice, there is a high hard ground where practitioners can make effective use of research-based theory and technique and there is a swampy lowland where situations are confusing messes incapable of technical solution. The difficulty is that the problems of the high ground, however great their technical interest, are often relatively unimportant to clients and the larger society, while in the swamp are the problems of greatest human concern. (p. 200)

This statement rings true for the conceptualization of this research study.

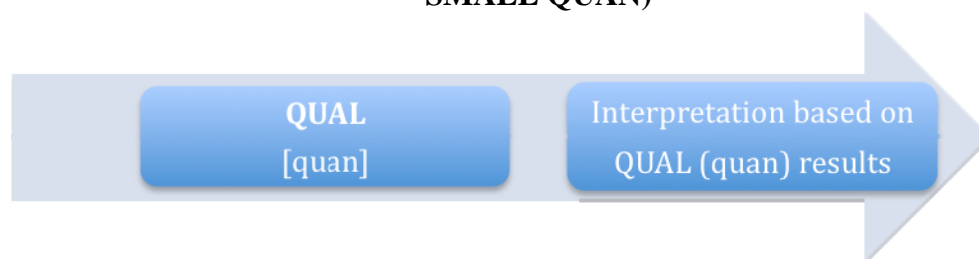
Sometimes what looks like the most straightforward and clearest path may not have the most value. This study grounds itself in the middle of the “swampy” issue of domestic violence counseling and looks at it from various vantage points to really see what would be most useful and beneficial to clients, the social work profession, and to the larger society in terms of research.

Design

This study is a mixed-methods exploration of the interventions that are used in counseling with survivors of IPV and the ways in which counselors and survivors perceive them as helpful. The specific design is an embedded design. Since the study entails both the use of an interview and standardized instruments with survivors and a web-based survey with counselors there are two different aspects of the embedded

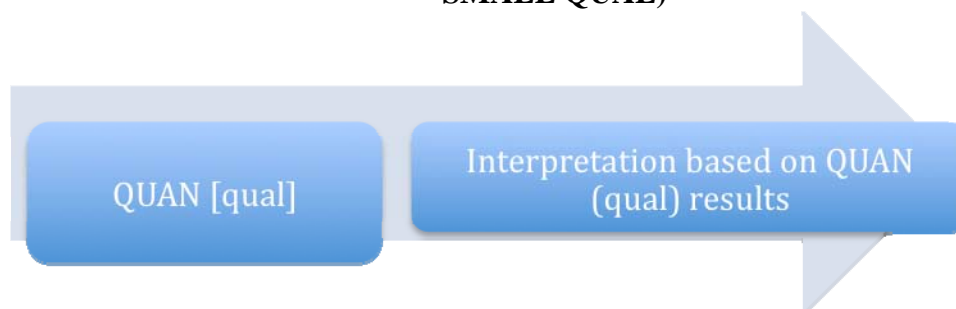
design. The survivor portion of the study has the quantitative data imbedded in the qualitative data. This is done because a single, qualitative data design would not be sufficient to answer the questions in this research study. By embedding the quantitative data within the qualitative, the quantitative data plays a supplemental role in the overall design. This is often done in an exploratory phenomenology design (Creswell & Clark, 2007). The following figure illustrates the mixed-methods embedded design (Creswell & Clark, 2007, p. 68).

FIGURE 1: EMBEDDED MIXED-METHODS DESIGN (LARGE QUAL; SMALL QUAN)



The counselor portion of the study, the web-based survey consists primarily of quantitative questions with six open-ended items. This means that the qualitative data is embedded in the quantitative data. The qualitative data exist to further describe and explain the quantitative data.

FIGURE 2: EMBEDDED MIXED-METHODS DESIGN (LARGE QUAN; SMALL QUAL)



The reason for an exploratory design is that many of the key variables were unknown and therefore needed to emerge from the mixed-method data collection. Variables then emerged through the use of the data collection methods, which included surveys and interviews. The counselors were asked to complete a structured survey that included six open-ended questions. A semi-structured, qualitative interview was conducted with survivors and they were also asked to complete two standardized scales in order to quantitatively assess trauma and their relationship with their counselor. Data were collected using a purposive sample of women who had received counseling and counselors who had provided counseling at domestic violence agencies without affiliated shelters in the Chicago metropolitan area. The counselors completed the survey via Opinio, a web-based software program.

Delimitations and Limitations

This study addresses the counseling experiences of female survivors of IPV who have received counseling at domestic violence counseling agencies independent of shelter services. The domestic violence agencies included in this study were from the greater metropolitan Chicago area. As a consequence of Chicago being the only region in which the study was conducted, it cannot be generalized to the country, rural areas, or to other metropolitan areas.

The study utilized a convenience sample. Due to the fact that the study took place in the greater Chicago metropolitan area with a purposive sample, the information gathered is specific to the subjects experience in their specific location at this specific time. The sample includes a small number of counselors and survivors, which further

means that the information gathered is not generalizable to all domestic violence agencies.

This study utilizes a mixed-method design. This methodology allowed for a better understanding of the information gathered than either quantitative or qualitative methods could have if either were utilized on its own (Creswell & Clark, 2007). Quantitative and qualitative research methods have been said to have weaknesses when done in isolation. For example, people have argued that quantitative research leaves out the critical element of the participant's voice; whereas qualitative research hinges largely on the interviewing experience of the researcher and encompasses that person's biases. Mixed methods research can mitigate the weaknesses of each by utilizing them in combination.

A mixed method design allows the researcher to utilize both qualitative and quantitative means to address the research problem. This allows for the utilization of inductive and deductive problem solving. Practically put, there is opportunity to collect data and match the data with a rich description of narrative used by the participants.

There are weaknesses to the utilization of a mixed-method design. One is that the researcher needs to be trained in both quantitative and qualitative forms of inquiry (Creswell & Clark, 2007). Another is that the time commitment is larger to gather both forms of data from participants and to describe it in a clear manner that showcases how the two forms of inquiry combined to showcase the research problem. It appears that in the case of the research questions asked in this study, the benefits from a mixed-method form of inquiry outweighed the negatives.

This study utilized a phenomenological method of inquiry in the qualitative interview. Phenomenology focuses on one's lived experience in language form and utilizes those experiences to develop a worldview (Marshall & Rossman, 2006; Rudestam & Newton, 2007). There are several weaknesses of the qualitative aspects of the design for this study. Several of them hinge on the fact that the researcher is utilized as an instrument of data collection. This means that this researcher had to be careful of the biases that were brought to the design. To combat this, qualitative inquiry builds in various ways to bracket the researcher's bias as well as discuss any preconceptions prior to the interviews. Another weakness of an exploratory study is that large, quantitative studies are still often seen as having more impact. This is because larger, quasi-experimental studies have been historically viewed as having the ability to measure reality against an objective known (Anastas, 1999, p. 57).

One way this study worked to counter the inherent biases was to triangulate the data. The study triangulated the data in two ways; first, by surveying counselors who provided counseling at domestic violence agencies as well as survivors who received counseling. The second was by administering both qualitative interview questions and quantitative surveys. By securing data from two sources and in two modalities, the researcher was able to analyze data from various aspects thus reducing the likelihood that the findings were impacted by researcher bias.

External validity in qualitative designs refers to the transferability of the findings to other settings (Johnson, 1997; Rudestam & Newton, 2007, p. 113). Rudestam and Newton (2007) state that the thick description obtained in qualitative studies are generally

detailed enough to allow for transferability to others settings (p. 113). Anastas (1999) states that if other studies do not obtain the same results the difference can still be understood by comparing the situations under which each set of research took place. External validity in the quantitative design generally refers to the researcher drawing meaningful inferences from the results to a population (Creswell & Clark, 2007, p. 133). However, due to the small, exploratory nature of this study, neither the quantitative nor qualitative results will be generalizable to a larger population.

Population and Sample

This study utilized a convenience sample. A convenience sample was selected not to approximate representativeness or to generalize, but because it met the study selection criteria and was easy to access (Anastas, 1999, p. 286). Participants were selected who met both inclusionary and exclusionary criteria (Rudestam & Newton, 2007).

Inclusion and exclusion criteria for survivors of IPV were as follows: 1) received counseling services in the state of Illinois from domestic violence agencies while not housed in a domestic violence shelter, 2) did not receive counseling services from Between Friends (formerly Friends of Battered Women and Their Children) while this researcher was employed by the agency, 3) received a minimum of two sessions of counseling, 4) were female, and 5) spoke English.

Inclusion and exclusion criteria for counselors at domestic violence agencies included: 1) currently employed as a counselor or doing a counseling internship at a domestic violence agency in the Chicago area, 2) provided counseling (individual, group,

or family) to survivors of IPV who do not reside in a shelter, and 3) not employed by Between Friends. For the purposes of this study, a counselor includes anyone at a domestic violence agency who is the role of counselor that has provided domestic violence counseling to survivors of IPV. I spoke with female counselors (the majority, if not all, counselors are female).

The study sought to obtain interviews from 30 counselors and 10 survivors of IPV in the Chicago metro area. The convenience sample looked for female survivors of domestic violence due to the fact that most domestic violence counseling is provided to female survivors since women make up the majority of reported domestic violence victims (Lundy & Grossman, 2001). For the purposes of this sample, victims of IPV are defined as people using services for the problem of violence perpetrated by one intimate partner against another and includes psychological aggression, physical assault, and sexual coercion (Burke, et al., 2004).

To obtain counselors for the survey, The Chicago Metropolitan Battered Women's Network (CMBWN) agreed to send out an email to their member organizations. This email asked agencies to forward the web-based counselor survey link to all domestic violence counselors at their agencies who saw clients who were not in shelter currently. The email cover letter is provided in Appendix A. To obtain client interviews, this researcher contacted domestic violence agencies to ask them to agree to inform clients about the research. Those who consented were asked to write a letter of cooperation stating their agreement to do this. The letter of cooperation can be found in Appendix B. Once the letter was received and approved by the Institutional Review

Board, agencies posted the research flyers and informed clients about the research. The clients then contacted this researcher directly to schedule the interviews. Research flyers are listed in Appendix C.

The client interviews took place at domestic violence agencies in Chicago and the surrounding suburbs, in the state of Illinois, which provide domestic violence counseling independent of shelter services. The rationale for excluding shelter services is that much of the existing research has been conducted on domestic violence shelter services and the clients who utilize those services (Black, 2003; Davis, Hagen, & Early, 1994). Instead of repeating this, the hope was to gain an increased understanding regarding the experience of current domestic violence counseling. By looking at counseling services independent of shelter services, the study avoided a clouding of the service delivery issue. For example, a client may have thought of her shelter advocate as a counselor and this would not capture the counseling service that this study aimed to address.

Main Concepts and Variables

This study looked at both main concepts and several variables. The main concepts related to the survivors include: *the nature of the therapeutic experience, the aspects of that experience which are viewed as helpful, the nature of the therapeutic relationship, and the aspects of that relationship which are helpful*. These were assessed using semi-structured interviews and the STAR. The pre-set variables related to the survivors include the extent of trauma as measured by the TSI scores and aspects of counselor-client relationship as measured by the STAR).

The main concepts related to the counselors include: *interventions utilized, perceived helpfulness, and theoretical orientation*. These were assessed using the survey and open-ended items.

There are also several terms used in this study. They are defined as follows:

Intimate partner violence (IPV). Violence perpetrated by one intimate partner against another and includes psychological aggression, physical assault, and sexual coercion (Burke, et al., 2004).

Domestic violence counseling. Conceptually, this has been recognized as counseling received at a domestic violence agency. It includes a present focus that addresses the client's IPV. Domestic violence counseling historically utilizes an empowerment and feminist framework as well as supportive individual and group counseling. The focus is current functioning and an understanding of the survivors IPV issues, using assessment and intervention skills.

Mental health therapy. This has been conceptually defined as, therapy sought from an agency or individual outside of a domestic violence agency. Traditionally, mental health therapy is focused on diagnosis and treatment. The therapist often understands the clients' symptoms as resulting from long-term mental illness, e.g., depression, anxiety, personality disorder, or early attachment problems.

Measures and Instruments

The following section addresses the credibility of qualitative research in general and then goes on to discuss the specific instruments used in this study. The instruments are described and their reliability and validity information is given, when appropriate.

The credibility in qualitative methods is generally understood as the, “extent to which the investigator’s constructions are empirically grounded in those of the participants” (Rudestam & Newton, 2007, p. 113). Since the study utilized in-depth interviews with the survivors, there should have been an extremely high propensity for measuring the concepts intended to be measured, thus strengthening the credibility (Anastas, 1999, p. 57). This is due to the fact that the researcher is able to ask the questions directly and in-person, clarifying when appropriate, in order to obtain information that was intended.

To increase the credibility of the findings, the survivor research participants were checked in with throughout the interview to ensure that both researcher and participant understood the meaning of the question asked or the answer given. The potential limitations in qualitative interviews mainly reside with the role of the researcher being included in the research boundary. This was countered by triangulation of the data as well as a continued awareness of the potential bias of the study. The method of interviewing both survivors and counselors assists in obtaining more than one perspective on the experience of domestic violence counseling.

Survivors

In-depth Interview. In-depth, phenomenological interviews were used to gather data from the survivor participants. The interview questions were composed by the researcher. They were then reviewed and revised based on feedback from classmates in a research course as well as by Loyola faculty who are experienced in doing research in the field of domestic violence. The qualitative interview addressed the main research

question, “What therapeutic interventions are used in counseling with survivors of intimate partner violence and are these interventions experienced as helpful?” Specific interview questions included, “What do survivors of IPV identify as the most helpful aspects of counseling?”, “What do survivors wish they had discussed in counseling, but didn’t?”, “Is it common for survivors of IPV to receive counseling assistance from several social service agencies simultaneously?” The survivor interview questions can be found in Appendix D.

Demographic Questionnaire. In addition to the in-depth, semi-structured qualitative interview, demographic information (Appendix E) was collected about each woman that included her abuse experience and relationship to the abuser as well as her lifetime counseling experience. The brief, demographic questionnaire was developed by this researcher. The information gathered was used to create a richer description of the women who participated in the interviews.

Trauma Symptom Inventory. Survivors were given the Trauma Symptom Inventory (TSI) (See Appendix F; Briere, 1996), in order to further confirm and clarify the research questions regarding the trauma symptomatology of survivors of IPV who are seeking counseling at domestic violence agencies. The assumption was that women seeking counseling at domestic violence agencies currently have a wide range of trauma symptoms. The TSI is an, “evaluation of acute and chronic posttraumatic symptomatology, including the effects of rape, spouse abuse, physical assault, combat experiences, major accidents, and natural disasters, as well as the lasting sequelae of childhood abuse and other early traumatic events” (Briere, 2004, p. 1). It is a 100-item

questionnaire that utilizes 10 clinical subscales on mental health functioning, e.g., anxiety/irritability, and depression. Each symptom item is rated on its frequency of occurrence over the prior six months using a 4-point score from never to often (Briere, 2004, p.1). It differs from most trauma measures in that the TSI also contains three validity scales: response level (RL), atypical response (ATR), and inconsistent response (INC) (Briere, 1995). The 10 clinical scales of the TSI are internally consistent and exhibit “reasonable convergent, predictive, and incremental validity”(p.3). The TSI scales predicted PTSD status in over 90% of cases when tested in a standardization subsample (p.3).

The TSI has shown itself to be a reliable and valid instrument for testing traumatic symptomatology. The TSI was first analyzed for internal consistency. Reliability coefficients for the final version of the TSI clinical scales ranged from .74 to .91; while the alpha coefficients for the validity scales (RL, ATR, and INC) were .80, .75, and .51 (Briere, p. 34). The TSI was also tested for construct validity, which is a test to see if the scale follows a behavior that theory states it should (p. 36). The TSI did well on this in that four trauma types studied (adult interpersonal violence, adult disaster, childhood interpersonal violence, and childhood disaster) were all associated with elevated TSI scores (p. 38). The clinical scales also tested positive for convergent and discriminate validity (p. 41). The TSI was shown to identify psychological distress associated with interpersonal victimization above and beyond that done by other trauma scales which lends itself to good incremental validity (p.43). Incremental validity is defined as the increase in predictive validity attributable to a test (p.43) and is concerned with whether

a measure accounts for more variance in a relevant variable than is accounted for already by another instrument (p.43).

As mentioned earlier, the measure has three validity scales and ten clinical scales. The validity scales of the TSI are: response level (RL), atypical response (ATR), and inconsistent response (INC). The clinical scales are: anxious arousal (AA), depression (D), anger/irritability (AI), intrusive experiences (IE), defensive avoidance (DA), Dissociation (DIS), sexual concerns (SC), dysfunctional sexual behavior (DSB), impaired self-reference (ISR), and tension reduction behavior (TRB). Table 2 provides reliability information for the TSI results for this study.

Table 2
Trauma Symptom Inventory (TSI)
Reliability Scores for the Sub- and Reliability Scales of the TSI

	Cronbachs Alpha	Standard Deviation	Minimum Score	Maximum Score	Number of Items
Response Level (RL)	NA	.756	.00	2.00	10
Atypical Response (ATR)	.841	3.41841	.00	10.00	6
Inconsistent Response (INC)	.771	3.592	1.00	12.00	10
Anxious Arousal (AA)	.878	6.01189	7.00	24.00	8
Depression (D)	.935	6.879	1.00	24.00	8
Anger/Irritability (AI)	.887	6.113	6.00	24.00	9
Intrusive Experiences (IE)	.884	5.765	3.00	22.00	8
Defensive Avoidance (DA)	.767	5.187	7.00	24.00	8
Dissociation (DIS)	.875	7.064	4.00	25.00	9
Sexual Concerns (SC)	.896	5.711	1.00	17.00	8
Dysfunctional Sexual Behavior (DSB)	.704	4.315	.00	12.00	8

Table 2: Trauma Symptom Inventory (TSI): Reliability Scores for the Sub- and Reliability Scales of the TSI (continued)

Impaired Self-Reference (ISR)	.464	3.988	8.00	21.00	9
New ISR	.694	4.451	6.00	20.00	8
Tension Reduction Behavior (TRB)	.697	3.714	1.00	11.00	7
New TRB	.734	3.369	1.00	10.00	6

Cronbach's alphas for most scales were between .704 and .935, with most falling around .88. Two exceptions were the RL scale, which counts the number of positive symptoms and doesn't quite scale like the other sub-scales, and the ISR. The TRB also had a low alpha (.697). To address problems with these last two scales, this researcher dropped problematic items in order to increase the reliability of the findings. For the ISR, survey item number ninety-four (being easily influenced by others) was dropped and the New ISR was run. For the TRB, survey item number seventy-eight (trying to keep from being alone) was dropped and the New TRB was run. Furthermore, in calculating the Cronbach's alphas for the ATR, the SC, the DSB scales items were dropped automatically by SPSS due to the component variables having zero variance. This was also done for the TRB and New TRB scales.

Scale to Assess Therapeutic Relationships in Community Mental Health Care.

The Scale to Assess Therapeutic Relationships in Community Mental Health Care (STAR), a 12 item instrument, was utilized (McGuire-Snieckus, McCabe, Catty, Hansson, & Priebe, 2007) to study the relationship factors between the counselor and survivor. STAR is a specifically developed, brief scale to assess therapeutic relationships

in community psychiatry. The version for clients, the STAR – P (Appendix G) was given to survivors.

The new patient (STAR-P) has 12 items comprising three subscales: positive collaboration and positive clinician input as well as non-supportive clinician input. Test–retest reliability was $r=0.76$ for STAR-P (McGuire-Snieckus, McCabe, Catty, Hansson, & Priebe, 2007). The factorial structure of the new scale was confirmed with a good fit.

The STAR usually takes five minutes to complete and can be scored for the total scale and subscales.

The STAR was completed by all seven survivor participants. The STAR consists of three subscales; positive collaboration (items 2, 3, 5, 6, 8, and 11), positive clinician input (items 1, 10, and 12), and non-supportive clinician input (items 4, 7, and 9).

Table 3

**STAR Table
Reliability Scores for the Subscales of the STAR**

	Cronbach's Alpha	Standard Deviation	Minimum	Maximum
Total Score	.802	2.449	41	48
Positive Collaboration	.772	1.813	19	24
Star 1 (My clinician speaks with me about my personal goals and thoughts about treatment)	x	.488	3	4
Star 10 (My clinician seems to like me regardless of what I do or say)	x	.378	3	4

Table 3: STAR Table: Reliability Scores for Subscales of the STAR (continued)

Star 12 (I believe my clinician has an understanding of what my experiences have meant to me)	x	.378	3	4
New Star 4 (I believe my clinician withholds the truth from me)	x	-	4	4
New Star 7 (My clinician is stern with me when I speak about things that are important to me and my situation)	x	-	4	4
New Star 9 (My clinician is impatient with me)	x	-	4	4

Items 4, 7, and 9 are labeled new as these scales were reversed to obtain the correct score. As one can see from the table, most respondents scored similarly on the survey so there was little variance on many items. Due to this result, and the fact that the positive and negative clinical support sub-scales had so few items, a reliability analysis was not done for these two sub-scales

Counselors

Counselors were given a 29-item, on-line survey through Opinion (see Appendix H) that asks questions related to their education and experience. Since there is no existing instrument for obtaining the specific data needed to answer the research question, a non-standardized instrument was developed. This instrument was reviewed by two research methods professors at Loyola University Chicago, the author's research

methods classmates, and domestic violence counselors at Between Friends, an agency where this author was employed. Consequently, the instrument underwent several revisions based on feedback from these groups.

The survey asks questions about the types of interventions utilized in counseling which ones the counselor perceives are most helpful to clients. This addresses the research question, “What interventions do counselors most commonly use in counseling with survivors of intimate partner violence and are these interventions experienced as helpful?”

The survey also asks six open-ended questions: (1) “There are many difficult client situations that counselors at domestic violence agencies deal with (clients with difficulties related to immigration status, clients with mental health issues, etc.). What is the most difficult client situation you deal with as a counselor?”, (2) “When you deal with this type of difficult client situation, what theories do you draw upon the most?”, (3) “What interventions do you find most helpful in those situations?”, (4) “What do you think are similarities and differences among counselors at domestic violence agencies in regards to training, education, and theoretical orientation?”, (5) “What do you wish you could address with your clients, but have not?”, and (6) “Tell me about a time when your beliefs about what is important in counseling have conflicted with the parameters of your setting (i.e. length of counseling, individual verses group counseling, etc.)”.

Pilot Study

A pilot study was done once approval was obtained from the Institutional Review Board (IRB). Between Friends, a domestic violence agency in Chicago, agreed to

participate in the pilot study. The survivors were former clients of Between Friends who are now in a group at the agency called Ambassadors. They are clients who desire to give back to the agency and community through advocacy, education, and research. The counselors were interns and master's level clinicians who are currently providing counseling to survivors of domestic violence. The pilot study helped to ensure that the instruments were testing what was intended to be tested and that the qualitative interview captured what was intended. The feedback from the survivor pilot interviews was that it was important to ensure that the clients completing the interviews were currently in counseling as the TSI may trigger some difficult memories. This became part of the criteria for the interviews. Secondly, a probing question was added to the semi-structured interview that asked the survivor about the initial appointment or assessment. It was intended to find out whether the initial appointment had met the clients needs. The feedback from the counselor survey related to typos and word order in some of the questions. All of the feedback was incorporated into the final documents.

Ethical Considerations

An overarching ethical concern in any study is maintaining the confidentiality of all study participants. This study ensured, through clear informed consent agreements, that each participant understood how their privacy would be protected and how the data would be utilized (Anastas, 1999). See Appendices I and J for both the counselor and survivor consent forms respectively. The interview items, survey instruments, consent forms and all necessary attachments were submitted to the Institutional Review Board

(IRB) for approval. A letter from the IRB indicating their approval for the research project is provided in Appendix K.

Survivor Participants

As mentioned earlier, one issue that needed to be addressed was that survivors of IPV may have been worried that their counseling services hinged on their participation in the study. This was countered by addressing the issue explicitly in the consent forms. While going over the consent forms, it was highlighted to survivors that their counseling services would not be affected in anyway by their participation in this study. It was explained that this meant that their participation or what was said in the interview did not affect any of the counseling services they received. This issue was discussed with domestic violence agencies as this researcher worked with sites in order to gather consent for their agreement of involvement in the research. It was clarified that a client's lack of participation would not impact services.

There was also a need to ensure that the participants were not re-traumatized by participating in the study. Their current physical and emotional safety was considered, especially due to the in-depth interviews surrounding a sensitive topic. First, all survivors were in counseling at the time of the research which was seen as a protective factor should any distress occur; second, survivors were encouraged to follow-up with their counselors if they felt distress as a result of the interview; and lastly, survivors were supplied the number for the Illinois Domestic Violence 24-hour crisis hotline if they needed to speak to someone after the interview. Of the seven survivors interviewed, none of them appeared to be unduly upset by any aspects of the interview.

Lastly, all participation was voluntary with the ability for the participant to withdraw at any point in the process. The participants were compensated for their time with a \$15 Target gift card.

Counselor Participants

Previous research into this issue has indicated that some domestic violence counselors maybe reluctant to discuss their counseling interventions (M. Lundy, personal communication, March 21, 2006). This may stem directly from the current controversy regarding best practice in counseling services for survivors of IPV. The study attempted to overcome this by educating counselors on the purpose and techniques utilized in the study. Counselors were assured that the purpose of the study was to obtain information that allows survivors to give voice to their experience in counseling. They were informed that this researcher has experience in domestic violence counseling and thus would be equipped to conduct the interviews with sensitivity for the survivors and the subject matter.

Similar to the survivors, the counselor participants were ensured that the study was voluntary and they were able to withdraw from participation (end or close the survey link) at any time. This was outlined in the consent forms.

Data Collection Procedures

Domestic violence agencies were contacted via email by the Chicago Metropolitan Battered Women's Network (The Network) - see attached letter from cooperating agency (Appendix B). The email included information regarding the study purpose and nature of their participation (counselors to complete a web-based survey –

which can be accessed via a link in the email). Domestic violence agencies were contacted directly by this researcher regarding the referral of clients for the research. Letters of agreement were obtained for all agencies that decided to inform clients about the study. A protocol was established for referral: (1) Clients were told by their counselors about the fliers in the waiting room that described the research project; (2) Clients who had seen and read the fliers and who were interested could contact the researcher directly; (3) The interviews occurred at the counseling sites. Clients from three agencies participated in the interviews. It is not possible to know how many agencies participated in the counselor surveys. Compensation was given to survivor clients for their time. Counselors did not receive gift cards due to the fact they were taking the interview anonymously online.

Although the nature of the phenomenological interview is to be loosely structured and flexible (Marshall & Rossman, 2006, p. 104; Rudestam & Newton, 2007, p. 109), this study had several questions that it set out to ask the participants. The researcher utilized follow up probes in addition to the set questions. As a component of phenomenological interviewing, this researcher wrote up a full description of her experience as a domestic violence counselor. This was done prior to conducting the interviews. This phase of the research process or epoch (Marshall & Rossman, 2006, p. 105) served to bracket this researcher's experience from those of the interviewees. This assisted in ensuring that the researchers own bias of her counseling experience did not cloud her interpretation of the data.

Survivors –Qualitative Data

The qualitative data was collected by in-depth, semi-structured phenomenological interviews. The interviews were audio recorded in order to ensure that the participants' views were accurately captured, thus increasing the credibility of the study (Rudestam & Newton, 2007, p. 113). The audio-tapes were then transcribed into text by an undergraduate social work student who was paid for her time (see Appendix L for the confidentiality agreement).

To further increase credibility, notes were taken during the interviews that captured the researcher's observations at the time. This method of data collection allowed for the themes to unfold naturally with the least amount of intrusion from the researcher's own biases or assumptions. The text from the audio-tapes was then read through while reviewing the field notes in order to capture the non-verbal meanings along with the text. The information recorded on all tapes and written records was coded to insure that identities remained confidential. Tapes were kept in a locked cabinet to ensure that no one was able to access them without permission.

Survivors-Quantitative Data

The quantitative instruments were in paper format. The researcher gave a copy to the participant and read the questions out loud. This ensured that the participant was not restricted from answering if her reading skills did not allow her to understand the form. The participants' answers were marked on the paper form and entered into the computer at a later date.

A journal or audit trail (Rudestam & Newton, 2007, p. 114) was kept during the entire research process outlining the decisions made and why they were made. This allowed for anyone to review what was done and reach the same conclusions. The audit trail also illuminated the potential bias inherent in the study.

Counselors-Qualitative and Quantitative

The surveys for the counselors contained both the quantitative and qualitative data questions. The surveys were conducted utilizing the software package Opinio, which Loyola licenses and which has passed IRB protocol. The hope was that this would increase the likelihood that counselors would complete the surveys as a growing number of professionals spend a great deal of time at their computers. It is often seen as more efficient than paper surveys. It also promoted the anonymity of the respondent. The counselors were assured that their name and agency would not be linked to the information shared. As stated earlier, the Opinio survey link was sent to agencies through the CMBWN's member list. It was then forwarded on to all counselors at the domestic violence agencies that receive the email.

The Researcher's Role

In a phenomenological study, the researcher is a part of the research boundary. As part of the research boundary, the researcher could be seen as an intervening agent that could skew the study. To temper this, the study utilized triangulation as well as peer debriefing (Padgett, 2003; Rudestam & Newton, 2007, p. 114-115).

Triangulation occurred, as noted through the process of obtaining information from counselors as well as survivors. It was also implemented through the researcher

utilizing a process recording during the interview in order to note nonverbal communication of the participant and reactions of the researcher.

By utilizing peer debriefing, this study asked for peer reviewers to question the data collection, analysis, and interpretation in order to keep the researcher honest and on track (Rudestam & Newton, 2007, p. 115). This researcher also utilized two peer reviewers during the coding of the data to ensure that another colleague would agree with the themes and meanings that were extracted from the data.

The bracketing of the researcher's experience and potential bias, as mentioned in the measures and instrumentation section, assist in controlling for bias. The bias in this study is that there are many therapeutic interventions, not only those traditionally utilized by domestic violence agencies, which have a helpful effect in work with survivors of IPV. The study might have found a split among counselors working with survivors of IPV and what they find to be helpful. This study held the belief that many counselors would state that they adhered strictly to a feminist or empowerment model while others might have admitted to integrating other therapeutic techniques.

Data Management Strategies

The proper management of the data is important both for organizational reasons as well as for maintaining confidentiality of all participants. The data were coded and organized in a way that ensured retrieval of the data as well as confidentiality of all participants.

Some data organization came prior to data collection, such as deciding to label each survivor interview with identification numbers one through 10. Other forms of

organization began with data analysis. This included deciding how to assign codes and memos to texts in order to promote clarity and easy retrieval.

All identifying data was stored in a locked file cabinet in the home office of the researcher. The research log that was kept by the researcher was also kept in the locked file, ensuring that no one had access other than this researcher.

Data Analysis

A descriptive analysis approach was utilized in this study. This involved constructing meaning or an explanation about what was going on for survivors in the counseling relationship (Creswell & Clark, 2007). Descriptive research is used in qualitative methods to generate statements about the phenomena being studied. This was done in this study through narrative descriptions that were supported by aggregate, numerical data.

A concurrent form of data analysis was used due to the mixed-method embedded design. There were two main stages for the analysis (Creswell & Clark, 2007). In the first stage, initial data analysis was done for the qualitative and quantitative data. These are discussed further under the qualitative and quantitative subheadings. It involves, coding, theme development for qualitative data and descriptive analysis for quantitative data. The second stage involved the merging of the two data sets so that, “the supportive dataset can reinforce or refute the results of the primary dataset” (Creswell & Clark, 2007, p. 136). Lastly, comparisons were made between the two data sets through tables and discussion. The themes that emerged from the qualitative data were compared with the descriptive, quantitative data.

Qualitative Interviews

Once the taped interviews were transcribed, the software package, NVivo, was utilized to assist in the analysis of the data. Since this was a phenomenological study, the data were analyzed utilizing a phenomenological data reduction approach. This included the full disclosure, in writing, of the researcher's experience of phenomenon and then the following steps as outlined in Rudestam and Newton (2007):

1. Review each statement for how well it describes the experience.
2. Record all relevant statements.
3. Remove all statements that are redundant or overlap with others, leaving the key meaning units of the experience.
4. Organize the invariant meaning units into themes.
5. Coalesce the themes into a description of the textures of the experience and augment the description with quotations from the text.
6. Using your imagination and taking multiple perspectives to find possible meanings in the text, construct a description of the structures of your experience.
7. Create a textual-structural description of the meanings and essences of your experience (p. 183).

There are some difficulties with this type of data analysis. One is the need to avoid provincialism, which would be a tendency to interpret the participants' behavior in a way that made sense to the researcher (Anastas, 1999). To avoid this, peer review was utilized to ensure that another researcher would come to the same conclusions. The avoidance of any hasty conclusions was also monitored. For example, this would include seeing all the data through certain categorical lenses and then fitting any additional data

into those categories. This was avoided by having colleagues code and categorize some of the interviews to see if they came up with the same themes and categories.

Quantitative Data

The analysis of the quantitative survey data was largely descriptive in nature. Scores on the TSI and STAR surveys were computed for individuals participating in the interviews. SPSS software was used to analyze the data. The role of the TSI is to assist in describing the trauma symptomatology of the survivor participants; whereas the STAR allows for a better description of the relationship factors between counselors and survivors in the counseling relationship.

Researcher's Resources and Skills

This researcher is a Master's level social worker with a clinical licensure. The master's degree was obtained in 1998, thus allowing for ten years of clinical work with clients. The client populations worked with have included teenagers in the child welfare system as well as women and children seeking domestic violence services. In both settings, the issue of family violence and IPV were present.

Due to the clinical nature of this researcher's work experience, due attention was given to the meaning in peoples' narratives including their non-verbal communication. Both of these were important while taking field notes. The research courses at Loyola University Chicago prepared this researcher for the data collection and analyzing phase of the study. This researcher also had an opportunity to work as a research assistant on a research project with three Loyola Faculty members. That experience gave this

researcher an opportunity to gain experience in qualitative and quantitative data collection. It also gave her experience in data management and analysis.

CHAPTER FOUR

RESEARCH FINDINGS

The first section of the chapter will describe the findings for the survivor's portion of the study. This includes the qualitative interview questions about their counseling experience and the quantitative survey findings about trauma symptoms and their relationship with the counselor. The second section of this chapter will describe the findings for the counselors, which entails a quantitative exploration of their work with survivors, including several open-ended questions.

Survivors

In-depth, semi-structured interviews were conducted with survivors of domestic violence who received counseling at domestic violence agencies and were not currently residing in domestic violence shelters. The clients and the researcher were introduced either directly by telephone or through the domestic violence counselor to set up the interview.

Two instruments and a brief demographic questionnaire were used during the semi-structured interviews with survivors of domestic violence. The purpose of the questionnaires was to collect the characteristics of those participating in the study as well as to answer two of the four research questions. The Trauma Symptom Inventory (TSI) was used to answer the research question, "What is the trauma symptomatology of survivors seeking counseling from domestic violence agencies?"; while the Scale to

Assess Therapeutic Relationships in Community Mental Health Care (STAR) was used to help answer the research question, “What are the relationship factors between the counselor and survivors that each identify as helpful?”. Appendices F and G provide information about the TSI and the STAR.

The qualitative portion of the interview, developed by Crabtree-Nelson (2008), included a semi-structured interview that had initial guiding questions. The interview was designed to answer critical questions about each participant’s perception of the therapeutic relationship, e.g., “what aspects of the intervention are helpful to those experiencing it?” and, “What are the relationship factors between the counselor and survivor that each identify as helpful?”. (The complete list of interview questions is provided in Appendix D.)

Characteristics of the Participants

Seven survivors completed interviews for this research project. While the project originally aimed to interview ten survivors, two factors contributed to the final number of seven participants. The first factor, which will be discussed further in the final chapter, was the budget constraints that affected all domestic violence agencies in the state of Illinois in 2009. The other factor is that upon reviewing the interviews, saturation of the data was reached with the seven interviews conducted.

Table 4**Survivor Demographic Information**

	Age	Education	Employment	Marital Status
Survivor 1	44	High School Graduate	Homemaker	Married
Survivor 2	40	College Graduate	Homemaker	Married
Survivor 3	25	Some College	Full-time	Separated
Survivor 4	33	College Graduate	Full-time	Separated
Survivor 5	42	College Graduate	Unemployed	Separated
Survivor 6	38	College Graduate	Part-time	Never Married
Survivor 7	42	Some College	Part-time	Separated

Of the seven survivor participants, five were born in the United States; four of these five were Caucasian. The countries of origin for the other two survivors included Japan and Mexico. The mean age of the participants was thirty-eight with four of the seven graduating from college, two receiving some college, and one receiving her high school diploma. Four of the women reported working full or part-time, two reported being homemakers, and one listed herself as unemployed. Two of the survivors were currently married, while the rest reported that they were separated from their boyfriends or husbands with all but one of the women having children. Three of the seven women reported prior relationships that had been abusive. The following vignettes attempt to give the reader a greater understanding of the survivors that participated in the study. The TSI critical items in the vignettes are further described in Table 6.

Survivor One: Survivor one was a married White woman in her early 40s. She had been in counseling for about three years at her current agency and has also been in mental health counseling in the past. Survivor one scored in the clinical range, according

to Briere's (1996) TSI T-scores, on two clinical sub-scales. These included the Anxious Arousal (AA) and Intrusive Experiences (IE). Her score on the Impaired-Self Reference (ISR) sub-scale was on the cusp of the clinical range. She also scored one critical item as often (a 3 on a scale that ranged from 0 to 3). This was item 19 "thoughts or fantasies about hurting someone". She stated that she did not have any intention of actually hurting her husband, but at times she fantasized that she would when he was calling her names in front of her two children.

Survivor Two: Survivor two was a married Asian woman in her 40s. She had been in domestic violence counseling for a couple years at her current agency. She stated she had also been in mental health therapy with several different counselors in the past. She admitted that her current counseling situation was the first time she had felt comfortable enough to open up in counseling. Survivor two did not score in the clinical range on any of the clinical sub-scales. She talked about the importance of domestic violence for normalizing her experience and educating her about domestic violence. Survivor two also stressed the value of having a bicultural counselor as she was able to understand the nuances that culture norms can play when dealing with domestic violence. She scored one critical item a 1 on a scale of 0 (never) to 3 (often). The item (item – 90) was "Feeling like life wasn't worth living". She stated that she had no desire to harm herself and truly benefitted from the positive nature of her counselor.

Survivor Three: Survivor three was a Latino woman in her 20s who was currently separated from her husband. She had been in domestic violence counseling for two years and credited her counselor and the agency with helping her connect with pro

bono legal services that have allowed her to follow through with the divorce process. She said that she viewed counseling as a place that helped her to move on with her life.

Survivor three scored in the clinical range on the TSI sub-scale Anger/Irritability (AI).

She also scored four critical items on the TSI. These were: item 19, “Thoughts or fantasies about hurting someone”, item 25, “Threatening or attempting suicide”, item 30, “Wishing you were dead”, and item 90, “Feeling like life wasn’t worth living”. She scored each one a one (see Table 4) on a scale of 0 (never) to 3 (often). She stated that she had these feelings awhile back when she still wanted to get back together with her husband. However, she stated that she has been able to work through these issues with her counselor.

Survivor Four: Survivor four was a Latino woman in her 30s who was currently separated from her husband. She had been in domestic violence counseling for approximately eight months and was pleased with how quickly she was able to get in for counseling once she called. She stated her counselor helped her to understand that she was not the problem in the relationship; that she did not cause her husband to become violent towards her. Survivor four did not score in the clinical range on any of the TSI clinical sub-scales nor did she mark any of the critical items higher than a zero. Survivor four mentioned that the agency assisted her by connecting her to numerous helpful resources, mainly legal services to assist with a divorce. She stated that finding a counselor who spoke Spanish and understood domestic violence has been important for her.

Survivor Five: Survivor five was a white woman in her 40s who was currently separated from her husband. She had been in domestic violence counseling for approximately nine months and stated she had utilized mental health therapy in the past. She stated that she received both emotional support as well as concrete service help and referrals from the domestic violence agency. Survivor five shared that her counselor's knowledge of domestic violence as well as the area resources for survivors were invaluable to her. Survivor five scored in the clinical range on the TSI sub-scale Intrusive Experiences (IE). She also scored on the following critical items: 19 "Thoughts or fantasies about hurting someone" (scored a one on a zero to three scale), 30 "Wishing you were dead", and 90 "Feeling like life wasn't worth living" (both scored a two on a zero to three scale). She opted to leave 92 "Seeing people from the spirit world" blank.

Survivor Six: Survivor six was a white woman in her 30s who had left her boyfriend. She had been in domestic violence counseling approximately one month and stated that she had been in mental health therapy in the past. She stated that she appreciated the fact that nothing she said shocked her domestic violence counselor. Survivor six believed that her counselor understood her and her situation in a way that no one else had. She felt this helped her to move on. Survivor six scored in the clinical range on the TSI sub-scales of Anger Irritability (AI) and Dissociation (DIS). She also scored a one on a zero to three scale for four critical items on the TSI: item 19 "Thoughts or fantasies about hurting someone", item 28 "Getting into trouble because of sex", item 30 "Wishing you were dead", and item 58 "Getting into trouble because of your

drinking”. Survivor six stated that the month of counseling had already helped her and she was looking forward to future individual and group counseling.

Survivor Seven: Survivor seven was a white woman in her 40s. She had been in domestic violence counseling for approximately two months and had been in mental health therapy in the past. Survivor seven reported being separated from her current husband. She described the domestic violence counseling agency as a place that felt safe for her; where she could be herself and not have to pretend. Survivor seven scored in the clinical range on nine of the TSI’s clinical sub-scales: Anxious Arousal (AA), Depression (D), Anger/Irritability (AI), Intrusive Experiences (IE), Defensive Avoidance (DA), Dissociation (DIS), Sexual Concerns (SC), Impaired self-reference (ISR), and Tension Reduction Behavior (TRB). However, she also scored high on the atypical response scale (ATR), which could indicate an over-endorsement of all items. Survivor seven scored a two on two TSI critical items: item 19 “Thoughts and fantasies about hurting someone” and item 65 “Hearing someone talk to you who wasn’t really there”. She also scored a three on two other TSI critical items: item 30 “Wishing you were dead” and item 90 “Feeling like life wasn’t worth living”. When this researcher talked with her about these critical items, survivor seven assured the researcher that she was feeling better since being in counseling but that the past six months had held some difficult moments for her.

Quantitative Results

Trauma Symptom Inventory

The TSI, a one hundred-item survey instrument to assess trauma was completed by all seven of the survivor Participants. One person was missing values on two items of the instrument while two people were missing values on one item. In order to not lose the value, mean substitution was utilized for the missing items. The items where mean substitution was used were TSI36, TSI37, TSI79, and TSI 92.

The TSI does not generate a DSM-IV diagnosis, but is intended to evaluate the relative level of various forms of posttraumatic distress (Briere, 1996). The measure has three validity scales and ten clinical scales. There are twelve critical items. The validity scales of the TSI are: response level (RL), atypical response (ATR), and inconsistent response (INC). The clinical scales are: anxious arousal (AA), depression (D), anger/irritability (AI), intrusive experiences (IE), defensive avoidance (DA), Dissociation (DIS), sexual concerns (SC), dysfunctional sexual behavior (DSB), impaired self-reference (ISR), and tension reduction behavior (TRB). Table 5 provides information on the sub- and reliability scales for the TSI results for this study.

Table 5
Trauma Symptom Inventory (TSI)
Average Scores for the Sub- and Reliability Scales of the TSI

	Mean	Minimum Score	Maximum Score	Number of Items
Validity & Reliability Scales:				
Response Level (RL)	.286	.00	2.00	10
Atypical Response (ATR)	3.0471	.00	10.00	6
Inconsistent Response (INC)	4.714	1.00	12.00	10
Clinical Sub-scales:				
Anxious Arousal (AA)	13.857	7.00	24.00	8
Depression (D)	13.000	1.00	24.00	8
Anger/Irritability (AI)	15.476	6.00	24.00	9
Intrusive Experiences (IE)	13.286	3.00	22.00	8
Defensive Avoidance (DA)	14.286	7.00	24.00	8
Dissociation (DIS)	11.714	4.00	25.00	9
Sexual Concerns (SC)	5.429	1.00	17.00	8
Dysfunctional Sexual Behavior (DSB)	4.239	.00	12.00	8
Impaired Self-Reference (ISR)	13.714	8.00	21.00	9
New ISR	12.143	6.00	20.00	8
Tension Reduction Behavior (TRB)	5.381	1.00	11.00	7
New TRB	3.953	1.00	10.00	6

The means for the TSI validity and reliability scales ranged from .286 (RL) to 4.714 (INC). This falls within the normal range for these three scales. Since these scales judge the validity and reliability of the respondents' answers, high scores may have indicated invalid profiles. The means for the clinical sub-scales ranged from 3.953 (New TRB) to 15.476 (AI). The next highest clinical score (DA) had a mean of 14.286 with three of the scales having mean scores around 13 (AA – 13.857, IE – 13.286, and D –

130). The New ISR (12.143) and the DIS (11.714) followed. While the SC (5.429) and the DSB (4.239) were lower.

When the mean scores are converted to T scores (Briere, 1996), none of the means fell within the clinical range for the TSI, although scales that scored means of 13-15 were close to clinical range. Some individual respondents did have scores that qualified in the clinical range.

When the individual TSI scores were analyzed for the seven survivors, five of the seven women had a least one clinical subscale score that was in the clinically significant range. Three women had heightened scores on the Anger/Irritability (AI), Intrusive Experiences (IE), and the Dissociation (DIS) scales, although not the same three women. Two survivors also scored in the clinical range on the clinical sub-scale, Anxious Arousal (AA). Three women had more than one clinically significant subscale. This may be an indicator of greater trauma symptomatology, which could be the circumstance of many survivors had there been a larger sample. One survivor had heightened scores on three other scales; Depression (D), Defensive Avoidance (DA), and Impaired Self Reference (ISR). However, this respondent scored high on the Atypical Response (ATR) validity scale, which may reflect a generalized over-endorsement of all items. Due to the clinically significant scores of the women individually, the trauma symptomatology of women seeking domestic violence counseling cannot be taken lightly.

The TSI includes twelve critical items that include behaviors such as fantasies about hurting someone, getting into trouble due to one's sexual behavior, and substance

abuse. Table 6 depicts how these items were scored by the seven respondents in terms of the number of individuals with scores in each response category.

Table 6
TSI Critical Item Frequency Table

Names of Scores	Never			Often
Values of Scores	0	1	2	3
Item 19 Thoughts/fantasies of hurting someone else	2	3	1	1
Item 25 Threatening or attempting suicide	6	1	0	0
Item 28 Getting into trouble because of sex	6	1	0	0
Item 30 Wishing you were dead	3	2	1	1
Item 40 Using drugs other than marijuana	7	0	0	0
Item 48 Intentionally hurting yourself (scratching, cutting, or burning)	7	0	0	0
Item 50 Sexual fantasies about being dominated or overpowered	7	0	0	0
Item 58 Getting into trouble because of your drinking	6	0	1	0
Item 65 Hearing someone talk to you who wasn't really there	6	0	1	0
Item 90 Feeling like life wasn't worth living	3	2	1	1
Item 92 Seeing people from the spirit world	7	0	0	0
Item 99 Thinking that someone was reading your mind	7	0	0	0

The items that received the highest scores were 19 (thoughts/fantasies of hurting someone else), 30 (wishing you were dead) and 90 (feeling like life wasn't worth living). Items 58 (getting into trouble because of your drinking) and 65 (hearing someone talk to you who wasn't really there) had two respondents rate these as "two" on a scale of zero to three. Items 25 (threatening or attempting suicide) and 28 (getting into trouble because of sex) followed with each having one respondent score the item with a "one". The remaining items: 40 (using drugs other than marijuana), 48 (intentionally hurting yourself - scratching, cutting, or burning), 50 (sexual fantasies about being dominated or overpowered), 92 (Seeing people from the spirit world), and 99 (thinking that someone was reading your mind) were all scored as zero by all respondents. The elevated scoring for items 19, 30, and 90 indicate a heightened response to trauma for some of the respondents. It is important to keep in mind that respondents are asked to answer the question for their feelings over the previous six months. Although the time frame was broad, suggesting that the items might have been relevant at some earlier point in time, nonetheless, That being said, this researcher took time to talk with each participant who scored above zero on these items to evaluate that she was not currently suicidal and that she was planning to continue in counseling. All seven respondents confirmed this.

It is also important to note that only one of the seven respondents scored zero on all critical items. This person stated that she had been in counseling for eight months and was currently separated from her husband. It could be that these factors contributed to how she felt over the past six months.

Scale to Assess Therapeutic Relationships in Community mental Health Care

The STAR, a twelve-item survey instrument to assess the relationship between the survivor and her counselor was completed by all seven survivor participants. The STAR consists of three subscales; positive collaboration (items 2, 3, 5, 6, 8, and 11), positive clinician input (items 1, 10, and 12), and non-supportive clinician input (items 4, 7, and 9).

Table 7

STAR Table

	Mean	Minimum	Maximum
Total Score	46.00	41	48
Positive Collaboration	22.57	19	24
Star 1 (My clinician speaks with me about my personal goals and thoughts about treatment)	3.71	3	4
Star 10 (My clinician seems to like me regardless of what I do or say)	3.86	3	4
Star 12 (I believe my clinician has an understanding of what my experiences have meant to me)	3.86	3	4
New Star 4 (I believe my clinician withholds the truth from me)	0	0	0
New Star 7 (My clinician is stern with me when I speak about things that are important to me and my situation)	0	0	0
New Star 9 (My clinician is impatient with me)	0	0	0

Items 4, 7, and 9 are labeled new as these scales were reversed to obtain the correct score. As one can see from the table, most respondents scored similarly on the survey so there was little variance on many items. What came across in this survey

instrument was that the seven participants all indicated a positive relationship with their counselor by scoring high for positive collaboration (mean of 22.57) and positive clinician input (Star 1, 10, and 12 with a mean range of 3.71-3.86 for each item on a 4 point scale). None of the respondents indicated a lack of support from her counselor (items 4, 7, and 9); all scored these items as 0.

The STAR assessed three specific subscales. The first, *positive collaboration*, included items 2 (My clinician and I are open with one another), 3 (My clinician and I share a trusting relationship), 5 (My clinician and I share an honest relationship), 6 (My clinician and I work towards mutually agreed upon goals), 8 (My clinician and I have established an understanding of the kind of changes that would be good for me), and 11 (We agree on what is important for me to work on). The minimum score on this subscale by a survivor was 19 out of 24 or 79%; while the maximum score by a survivor was 24 out of 24 or 100%. Of the seven survivors all scored these items either a 3 (often) or 4 (always), except for one item by one survivor. One survivor responded “sometimes” to the statement “my clinician and I have established an understanding of the kind of changes that would be good for me”.

The next subscale, *positive clinician input*, included items 1 (My clinician speaks with me about my personal goals and thoughts about treatment), 10 (My clinician seems to like me regardless of what I do or say), and 12 (I believe my clinician has an understanding of what my experiences have meant to me). The minimum score on this sub-scale by a survivor was 10 out of 12 or 83%; while the maximum score was 12 out of

12 or 100%. Of the seven survivors all scored these items either a 3 (often) or a 4 (always).

The last subscale, *non-supportive clinician input*, included items 4 (I believe my clinician withholds the truth from me), 7 (my clinician is stern with me when I speak about things that are important to me and my situation), and 9 (my clinician is impatient with me). All survivors scored this the same, indicating that their clinician never withholds the truth, is stern, or impatient. Based on the findings from these three subscales, it appears that the seven survivors who participated in this study felt a strong rapport with their counselor. In fact, most survivors indicated a relationship that was both trusting and honest as well as productive and goal oriented.

Qualitative Results

Coding Methods

A combination of manual and electronic methods was used to organize and analyze data generated from the seven interviews. First, transcribed interviews were manually coded. Next, interview transcriptions were imported into NVivo, a computer-assisted qualitative data analysis software package, and organized into categories (referred to as “nodes” in NVivo). Second-level coding involved organizing the nodes into themes, referred to in NVivo as “trees.” Three trees were identified: Helpful Aspects of Interventions, Relational Factors, and Knowledge of Domestic Violence. The trees and the nodes organized into each are listed below in Table 8.

Table 8

Trees or Emergent Themes from Qualitative Interviews

Tree Nodes (Themes)		
Name	Sources (Survivor Interviews)	Reference (Number of times the node or theme was mentioned across all seven interviews)
<u>Helpful Aspects of Interventions</u>		
1. Challenging	3	5
2. Concrete Suggestions	4	13
3. Emotional Support	4	6
4. Psychoeducation	5	7
5. Normalizing	4	4
6. Goal Planning	1	2
7. Cultural Competence	3	5
<u>Relational Factors</u>		
1. Bilingual/Bicultural	3	5
2. Comfort Level	6	9
3. Non-Judgmental	6	8
4. Positive Transference (to counselor)	4	6
5. Positive Transference to Agency	5	11
6. Miscellaneous relational factors	4	10
<u>Knowledge of Domestic Violence</u>		
1. Community Resources	6	10
2. Safety Plan	2	3
3. Cycle of Violence	1	1
4. Clear definition of DV	3	3
5. General DV information (effects on children, tactics of abuser).	5	7

Two colleagues, one a doctoral student and one a current Ph.D. in Social Work were asked to code the responses based on these categories. Minor coding revisions were made following their reviews, but overall there was agreement with the categories generated. While coding the qualitative data, ideas related to aspects of the counselors' knowledge of domestic violence and their understanding of the experience of the survivor kept emerging. Originally, this researcher attempted to simply place these aspects or nodes under different themes (Psychoeducation under Helpful Interventions). However, through discussion with the previously mentioned colleagues, it became clear that Knowledge of Domestic Violence needed its own theme in addition to aspects of it (psychoeducation, normalizing) being included under the other themes. The more the data was analyzed, the more it became apparent that the coding categories are not mutually exclusive. In-fact, various quotes could be coded several different ways. At times, aspects of one survivor idea were placed into two different coding categories. For example, the following quote could be placed in both "normalizing", under the theme of "helpful interventions" and in "community resources" under the theme "knowledge of domestic violence":

Well, she is good at thinking about different possibilities and presenting those, and because she is aware of a lot of services that are available she can talk about them...and because of talking with lots of clients, she has a lot of stories that she can relate to my situation and make parallels that are helpful.

Instead of viewing this overlap in categories and themes as troubling or confusing, this researcher believes it underscores the complexity of domestic violence counseling that these seven women experienced firsthand. Thus, the following themes

are not intended to be mutually exclusive. Instead, they capture the richness of the lived experience of the survivors in domestic violence counseling.

Data from each of the themes/trees is presented below.

Helpful Aspects of Interventions

Seven coding categories were identified as helpful aspects of interventions used during domestic violence counseling, and all were included under this theme. Of the seven categories, three were mentioned by the greatest number of survivors and were referenced most often: (1) Concrete Suggestions, (2) Psychoeducation, and (3) Emotional Support.

Concrete suggestions are something that domestic violence counselors often give to their clients. Concrete suggestions are generally intended to both educate about domestic violence as well as offer safety planning and referrals. The following excerpts are indicative of the importance that the survivors placed on concrete suggestions given by their counselors:

Well, she is good at thinking about different possibilities and presenting those, and because she is aware of a lot of services that are available she can talk about them...and because of talking with lots of clients, she has a lot of stories that she can relate to my situation, and make parallels that are helpful.

How she taught me that it [son's aggressive behavior] was learned behavior, and, and um, just everything that he did, and that and all the, like the still all the emotional abuse my husband does, and, and um, and she did always make sure I had a safe...what is it called? A safe plan.

Psychoeducation was the next most referenced characteristic of intervention with five of the seven survivors mentioning it as an important feature of their counseling.

Psychoeducation is a cornerstone of domestic violence counseling. It often includes describing the cycle of violence as well as common tactics that are used by abusive partners. The following quotations highlight the contribution of this intervention for survivors:

I have learned a lot of stuff that I did not know [about] domestic violence...like a cycle of violence. I thought I was special but not really. I was looking at my situation and then learning about it was an eye-opener.

It's very educational from here. Much more so than where I have been before (mental health therapy). Where I have been before it's like okay this was my experience, this is what I need to talk about. Here I am being shown and explained things, which is good for me because I didn't have a clear definition of what domestic violence is. People would say to me, well is he abusive? And I would say, well not really, not abuse abuse and so here I am getting a great amount of education on what I have experienced and it's extremely helpful.

The next most often referenced category (six times by four survivors) was Emotional Support. The following excerpts illustrate the importance of emotional support for these women:

A lot of times I would go away, um, just thinking about, ya know, she made me feel better about myself, that I am, um, ya know, that I am a good person, ya know, where a lot of times I wouldn't feel like I was, even though my friends would tell me that I was.

When I am on the outside, um, I have to be, I have to be put together and serious to just go on, and I am trying to run my own business and trying not to fall apart, and in a lot of situations I have to be professional or just seem like everything is okay. And here, I don't have to do that. It's not expected of me, and I think they would look at me like what's her problem if I wasn't falling apart every few minutes...so I have a safe place here where I can just be the person who went through a really horrible trauma, and that's what I mean about being real, like I don't have to be a person who puts on a face to go to work.

The four remaining categories of interventions identified under the theme of Helpful Aspects of Intervention, are listed in descending order of occurrence:

Normalizing, Cultural Competence, Challenging, and Goal Planning.

The importance of normalizing is expressed by the following excerpt:

I was living in my husband house and in my husband house it was violence domestic (sic) and when I come here, I received information about I am not the problem, but the problem is he...we need to stop the circle (sic) for no more...I now understand about my dignity.

Cultural competence was referenced by three of the survivors as important;

She [counselor] has (sic) more open-minded about having the different culture background so she understand the way, where I come from. That's the key that I have and that's the one thing that I couldn't find in the other [mental health agency].

When inquired as to whether they were asked uncomfortable questions by the counselor, three survivors talked about the importance of the challenging questions:

Yes it does [help me] because sometimes I am so numb from the present situation, so I am not, I cannot, honor the situation myself. And then she asks me the very surprising questions that make me think about it.

Lastly, goal planning was viewed as particularly helpful by one survivor:

The counseling is very important. It is protective. It has changed my...my focus and because I was...my mind was closed...and here she is really helping to open my mind to talk about what the different options for me are.

Relational Factors

Six categories were organized under the theme of relational factors. Comfort level, non-judgmental, and positive transference to the agency were the three categories

referenced most often by the most women. The following quotations highlight what women described regarding their comfort level with their counselors:

Well, the reason I liked this place so much was that...the counselor was like...the first counselor I could be very relaxed with.

I am feeling good because I am having someone to talk about things with. I have coworkers at my work, but it's not the confidentiality, and with the...with [counselor's name], I am feeling comfortable and I can talk with her about my feelings and about my life, my problems. So it is a big help for me.

Well, they give me a space here where I can cry, where I can be real, where I can be me.

Non-judgmental is the next most cited category. Six women mentioned it and it was referenced eight times. The following describes the importance of experiencing the lack of judgment around an issue that continues to hold a great deal of stigma in our society.

She tries to encourage me without the criticizing.

I guess just that she seems well-versed in domestic violence and the impact I guess. It's very non-judgmental. I would say that.

Another category cited for a total of 11 times by five women is positive transference to the agency. This category was not at all expected but emerged from the data. The women not only discussed their positive experience with domestic violence counseling and their counselors, but also their feelings about the domestic violence agencies where they received counseling:

It was a lot of paperwork [at the initial appointment], but I was also told that I did not have to answer all of the questions. I mean you don't know what type of place you are walking into, and it's personal information, and I liked the vibe that I got here a lot.

This may seem strange, but it's not just my counselor. It's like people are happy to see me. Which sounds odd, but they seem like, 'oh, here she is'. It's great. Just a genuine...it's just supportive and yeah, and cheerful. It's odd I don't know how else to say it. I mean we aren't here to party obviously, but they make me feel like I belong here so that's important.

The following three categories, Miscellaneous Relational Factors, Positive Transference to Counselor, and Bilingual/Bicultural were also important to the survivors. Various words were used to describe the counselors' care and relationship to the survivors (miscellaneous relational factors). Phrasing that was used includes:

I guess if I could elaborate I would say that she is very intelligent, friendly, and knowledgeable so all of that together are very beneficial in what she is able to do for people, and the help she provides to people.

I don't know. I tend to be so very negative...aspects of life and stuff...and she tries to keep it positive.

Her sense of humor [laughs]. Makes it [counseling] very good.

Positive transference to the counselor was another category that emerged from the interviews:

Sometimes I hear her voice in my head. I always say...well, I guess I shouldn't say this, that I, I don't think I would take another counselor.

It's just been really organized, very well-organized and an overall positive experience. The people who run the group...just do an excellent job.

Lastly, the category of bilingual/bicultural was mentioned by three of the seven women as important to their experience. One woman mentioned that even though they spoke mainly English in the sessions, she knew she could always elaborate with a Spanish word or phrase and that her counselor would understand. She stated she couldn't

go to a monolingual counselor and feel the same. Another mentioned the cultural background:

I guess that she has understanding of my background, that's the first thing.

Knowledge of Domestic Violence

This theme was originally placed under the other two themes. However, upon further review and discussion with the researcher's aforementioned colleagues, it emerged as its own theme due to the prevalence with which it was mentioned by the survivors and the degree that it permeated most of what they discussed. Six women mentioned the importance of their counselors having a great deal of knowledge about domestic violence. It was referenced a total of 24 times. The following details the importance of having counselors who were knowledgeable about domestic violence:

And I guess, I felt like everything that I had said seemed very expected or maybe textbook or understood, which I had not experienced that...and it has been about 2-3 weeks since the incident that brought me here and most people were in shock. So, it was good to have somebody that saw it as expected. Sort of normal...I don't know how to explain it.

After I was coming here I can't imagine why I was ever seeing the other counselor. Because she...it was more of the domestic issues, more, much more...not so much telling you what to do, but it was just understood. Whereas we didn't really touch on it [domestic violence] with the other one [mental health therapist].

In addition, specific types of information about domestic violence that was provided by the DV counselors was identified by different survivors as particularly illuminating. Specifically, survivors described this explicit information as helping them to understand their circumstances and the options that were available to them, e.g., Community resources, Cycle of violence, Safety planning, Definition of abuse, and

General domestic violence information. The following quote illustrates the importance of a clear definition of domestic violence when receiving counseling:

Here I am being shown and explained things, which is good for me because I didn't have a clear definition of what domestic violence is. People would say to me, well is he abusive? And I would say, well not really, not abuse abuse, and so here I am getting a great amount of education on what I have experienced and it's extremely helpful.

Another survivor underscores the importance of learning the effects of domestic violence on children. This was something she had not been aware of prior to counseling. Based on this information, she made different choices for her family.

I was living in my husband house...and in my husband house it was violence domestic...and when I come here, I received information about I am not the problem, but the problem is he, and if I keep my son with violence domestic around ..he... it's not good.. and we need to protect... stop the circle [cycle] for no more, and I understand about my dignity.

Counselors

A 29-item survey was used to assess which interventions counselors at domestic violence agencies utilize most, and to determine which interventions they believed were most helpful. The web-based survey was sent via the Chicago Metropolitan Battered Women's Network (CMBWN) to their member list. A letter, along with a link to the survey was sent by electronic mail inviting CMBWN members to participate in this phase of the research study. The results to the 29 questions are described in the following section. The quantitative survey, including its open-ended questions helped to answer the research question, "What interventions do counselors at domestic violence agencies identify that they utilize most and what is their perception on what is most helpful?". The

open-ended questions also addressed the following research question, “What are the relationship factors between the counselor and survivor that each identify as helpful?”.

Characteristics of the Participants

Fifty counselors opened the link to the web-based survey, but some questions were answered by as few as 13 people. The partial responses are included in this analysis. Questions one and two of the survey were used to screen out counselors who did not conform to the protocol for the study. Specifically, these were counselors who were either not employed at a domestic violence agency or were providing counseling with survivors who currently resided in a shelter. This study sought to survey counselors who provide domestic violence counseling to survivors who are not currently in a domestic violence shelter.

Questions three through seven asked specific questions about the education of the counselors. Regarding education level, 13 counselors stated they had their master’s degree. Of those, 11 counselors stated they had either their Licensed Clinical Social Work (LCSW) or Licensed Clinical Professional Counselor (LCPC) state licensure. Five counselors stated they had their bachelor’s degree and two were master’s level interns. Eight counselors checked “other” and wrote in their status: BA student, DV advocate, Licensed Professional Counselor (LPC), and Illinois Certified Domestic Violence Counselor (ICDVP). When further asked about their educational background, the thirty-two counselors (N=32) were broken down into social work (11), counseling (8), psychology (6), human services (1), and other (criminal justice, philosophy, and biology) (6). Thirty-one of the 32 had been through the domestic violence 40-hour training and

12 had their ICDVP certification. The median number of years that counselors had been practicing was four with the range between 1 month (one of the interns) and 20 years.

There were three demographic questions in the survey. Questions 27 through 29 asked the counselors to describe their gender, ethnicity, and age. Twenty-three counselors responded to the question of gender (all female) and ethnicity. The ethnic breakdown of the 23 respondents was as follows: Caucasian (48%; n=11), African-American (13%; n=3), Latino American (22%; n=5), Asian American (13%; n=3), and Asian (4%; n=1). The average age of counselor respondents was 37 years (n = 22), with a range from 25 to 60. There was a decline in the number of respondents by the end of the survey. This could be attributed to several explanations: (1) the last several questions were overlooked or not noticed; (2) counselors felt nervous about providing too much identifying information; (3) due to the pervasive pattern of protecting women survivors from the intrusions of mental health and legal scrutiny, counselors may have developed a pattern of declining information.

Quantitative Results

Five questions, numbers eight – twelve, asked counselors about the type of counseling services they provided. For question eight, individuals could choose more than one answer. Thirty-one of the 68 responses provided (45.6%), from the 32 individuals who responded, indicated that they provided counseling to adult survivors of domestic violence (45.59%; n= 31 responses). Twenty-two percent (n=15 responses) related to providing counseling to children and adolescents who experienced domestic violence in their home; while 19% (n=13 responses) pertained to counseling adolescents

who were in violent dating relationships. Lastly, 7.35% (n=5 responses) reported that they provided counseling to batterers² and 5.88% provided counseling to other (n=4 responses). The counselors who checked “other” wrote in prevention, children of child sexual abuse, and substance abuse counseling.

One question, number nine, asked counselors to identify which therapeutic modalities they most frequently used with domestic violence survivors. Individuals could select more than one option. Of the four different modalities (individual, group, family, or other counseling) listed as options for counselors to choose (N = 32), 43% of the 65 responses provided (n = 28 responses) endorsed the provision of individual counseling. Forty percent (n = 26 responses) pertained to the provision of group counseling. This indicates that these two modalities were reported as the most often conducted and were utilized almost equally with survivors. Interestingly, family counseling was utilized far less (13.85%; n = 9 responses). Two respondents stated they utilized other modalities, and listed specifically, parent child psychotherapy and crisis counseling.

Question ten (see table nine) was an open-ended response category, which asked counselors to choose from a list of alternatives the guiding theory or overarching theoretical principles used by their agency. They were instructed to mark all that applied. In total, 94 responses were provided. Empowerment Theory (29%; n = 27 responses) was the responses provided most often; while Strength’s Perspective (19%; n = 18 responses), Trauma Theory (16%; n = 15 responses), Feminist Theory (13%; n = 12 responses) and

² For the purpose of this study, the term “batterers” refers to the abusive partner of domestic violence victims.

Relational Theory (12%; n = 11 responses) were also endorsed numerous times by the 32 respondents who answered this item. Cognitive Behavioral Theory (7.45%; n = 7 responses) and the Ecological model (3.19%; n = 3 responses) were also selected by several counselors as overarching theories used by their agency. One counselor responded that she did not know her agency's overarching principles or guiding theories.

Table 9

Theoretical Orientations of Domestic Violence Counselors³

Choices	Number of Responses	Relative Frequency
Feminist Theory	12	12.77%
Empowerment Theory	27	28.72%
Trauma Theory	15	15.96%
Cognitive-Behavioral Theory (CBT)	7	7.45%
Strengths Perspective	18	19.15%
Ecological Model	3	3.19%
Relational Theory	11	11.7%
Uncertain of what principles or theories Guide my agency	1	1.06%
Sum	94	100%

Item number 11 asked counselors to rank order the interventions listed in order of importance for work with survivors of domestic violence. Table Ten further depicts the order that counselors ranked the interventions.

³ Respondents could give more than one answer so the N represents the number of responses, not respondents. Twenty-one of the 32 respondents for this item gave more than one answer.

Table 10
Interventions Identified as Most Important by DV Counselors
Ranked from Most to Least Important

Intervention	Minimum rank	Maximum rank	Rank Score	N
Safety Planning	1	8	2.60	30
Empathy	1	10	2.93	30
DV Education	1	7	3.00	30
Use of Relationship as a healing agent of change	1	11	5.03	30
Trauma Informed Practice	1	10	5.38	29
Group	2	10	6.23	30
Connecting past experiences to current issues	3	10	6.30	30
Child Parent psychotherapy	3	10	7.00	29
Cognitive-Behavioral Theory (CBT)	3	10	7.67	30
Other	1	11	8.22	9
Dialectical-Behavioral Theory (DBT)	7	11	9.45	29

The results were somewhat varied, with the majority of counselors ranking safety planning (2.60), empathy (2.93), and domestic violence education (3.00) as the most important with a range of one being most important and 11 being least. The three that received the lowest rank were DBT (9.45), CBT (7.67), and Child Parent Psychotherapy (7.00). The interventions that scored in the mid-range of utilization and thus were listed as neither most or least important were: use of relationship (5.03), trauma-informed practice (5.38), group (6.23), and connecting past to present (6.3). Nine counselors stated that other interventions were used. The two listed were universality and feminist theory, but without further delineation of a specific intervention.

The counselor respondents were mostly consistent in their response to item number 12 which asked which three interventions they used most often with survivors of domestic violence. A total of 31 counselors answered this question for a total number of 93 responses. Of the nine choices listed, domestic violence education was cited by most of the 31 counselors who responded as an often used intervention (29%; n = 27 responses). Empathy and safety planning were each listed by (18.28%; n = 17 responses) respondents as one of the three most often used interventions with survivors of domestic violence. Least used interventions were Child Parent psychotherapy (1.08%; n = 1 response) and CBT (2.15%; n = 2 responses). Once again, the interventions listed as neither most or least used were; use of relationship (9.68%; n = 9 responses), trauma-informed practice (8.60%; n = 8 responses), group (5.38%; n = 5 responses), and connecting the past to the present (7.53%; n = 7 responses). Domestic violence education, empathy and safety planning were thus indicated as the top three important interventions used with survivors. However, question 11 which asked counselors to rank the interventions by order of importance listed the top three intervention as: 1) Safety Planning, 2) Empathy, and 3) DV Education; while question 12 which asked counselors to mark the three interventions they used most often listed the top three in a different order. Domestic Violence Education was by far the most often intervention listed with Safety Planning and Empathy equal in the responses they received for second most often used interventions.

Questions 13 through 19 (N=28) asked counselors to list the frequency with which they utilized various interventions and techniques with survivors of domestic violence.

Table 11

Number of Counselors and Frequency with Which They Use Various Interventions and Techniques

	Number of Counselors									
Intervention	(1) Hardly Ever	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10) Almost Always
Safety Plans	0	0	0	1	1	2	5	6	3	10
DV Education	0	0	0	1	1	3	1	3	5	14
Support	0	0	0	1	0	1	1	1	0	24
Encourage Group	1	0	1	0	1	3	5	5	0	12
Effects of Childhood Experiences on Present	1	0	0	1	4	3	5	5	2	7
Discussion of abusive adult relationships	0	0	0	1	0	2	1	10	5	9
Concrete Services (referrals, monetary assistance, resources)	1	0	3	1	1	5	2	4	4	7

The above table shows how the counselors ranked the frequency with which they used the listed interventions. When the interventions are looked at for what is used “almost always”, there are several that stand out from the others. The three identified as

most often used are support (24 of the 28 counselor's answering this question or 85.7% indicated that they used this intervention almost always), domestic violence education (50% of all those responding), and encouraging group (42.9% of responding counselors). The other interventions, in order of frequency of use are: safety plans (35.7%), discussion of abusive adult relationships (32.1% indicated they used this intervention almost always), and discussion of effects of childhood experiences on present and concrete services (both had seven of the 28 respondents or 25% indicate that they used this intervention almost always).

Question 20 asked counselors how many sessions are typical for counseling with adult survivors. Twenty-five counselors answered this question. The range of answers was from three sessions (n=2) to "as many as needed for therapeutic healing (n=1). The mean number of sessions listed was 14; while the median number was 12.

Open-Ended Items

Questions 21 through 26 were open-ended questions that related to the clinical work conducted by the counselor. They were intended to inform the research questions for this study.

Question 21 asked, "There are many difficult client situations that counselors at domestic violence agencies deal with (clients with difficulties related to immigration status, clients with mental health issues, etc.). What is the most difficult client situation you deal with as a counselor?". Twenty-five counselors answered this question. The responses varied and often included several difficulties. Of the 25 responses, six (24%) listed mental health issues as the most difficult client situation.

Assisting a client w/ domestic violence issues whose mental illness made it very difficult to develop a rapport, set goals or stay on task.

Client's difficulty with intense feelings of shame. While for some of my clients a variety of clinical symptoms are present, the overwhelming number of clients experience shame as a daily emotional response to abusive relationships, either current or in the past.

Issues related to immigration, including a lack of services in the client's native language was often cited as a difficult client situation (32% of 25 responses related to this theme). The following highlights some of the counselor responses.

Immigration, cultural issues (stigma of single mother, marriage is forever in the Latino community) and unemployment.

No support system, no job skills, limited English proficiency, no financial support, cultural barriers (does not understand the need for counseling).

The other large category was related to a lack of services (housing, legal, employment) for clients (28% of all responses). Other comments that emerged related to issues affecting elders, LGBTQ clients, and those clients involved with the Department of Child and Family Services.

Question 22 followed up by asking the counselors, "When you deal with this type of difficult client situation, what theories do you draw upon the most?". Twenty counselors answered this question. The responses appeared to fall into the following categories with some counselors listing more than one theory; strengths-based (35%), concrete service planning (safety planning, dv education, referrals and linkage to other needed services not provided by the domestic violence agency – 25%), empowerment (20%), relational (15%), eclectic (10%), and none (10%).

Question 23 further asked, “What interventions do you find most helpful in those situations?” Twenty-one counselors responded to this question with several of them listing more than one intervention. The answers fell into the following categories: Support for client, which includes empathy, validation, and empowerment (57% of all responses); Concrete service planning, which includes referrals and safety planning (33% of all responses); domestic violence education (19% of all responses); goal setting (10% of all responses); and unsure or none (10% of all responses).

The following table attempts to compare and contrast the interventions and theoretical frameworks that counselors stated they used most frequently in counseling with survivors of domestic violence. The first column depicts the responses to the quantitative survey questions previously discussed in tables 6, 7, and 8. The second column showcases the responses to the open-ended questions number 22 and 23. The purpose of asking both closed and open-ended questions regarding interventions was to allow counselors to demonstrate both how they intellectually think about their work as well as how they apply the intellectual knowledge to an actual case. The open-ended query also allowed for the counselors to list interventions that this researcher was not aware of.

Table 12

Comparison of Most Frequently Listed Counselor Interventions from Quantitative Versus Qualitative Analysis

	Interventions				
Rank order	Item 11	Item 12	Items 13-19	22	Item 23
1	Safety Planning	DV Education	Support	Strengths-based	Support
2	Empathy	Empathy (tied with Safety Planning)	DV Education	Concrete Service Planning	Concrete service planning
3	DV Education	Safety Planning (tied with Empathy)	Encouraging Group	Empowerment	DV Education
4	Use of Relationship	Use of Relationship	Safety Plans	Relational Theory	Goal Setting
5	Trauma-Informed Practice	Trauma-Informed Practice	Discussion of Abusive Adult Relationships	Eclectic	Unsure

The top five interventions listed, both quantitatively and qualitatively are shown in the above table. The table highlights the fact that the counselors, quite consistently, emphasized domestic violence education as something important they did with clients. In all five questions it was listed as one of the top three interventions used.

Concrete service planning, safety planning, and empathy and support are also mentioned in both. Use of relationship or Relational Theory was listed in both closed and open-ended questions as something important in working with survivors. One interesting note is that encouraging group was mentioned as the third most utilized intervention in questions 13-19. However, it does not make the top five interventions used in any of the

other closed or open-ended questions that asked counselors about their interventions with survivors.

The following question, item number 24, asked counselors to speculate on the similarities and differences among counselors at domestic violence agencies in regards to training, education, and theoretical orientation. Twenty counselors answered this question. The majority of the answers were consistent in the similarities and differences mentioned. Similarities in counselors included; having the 40-hour domestic violence training that is required by the state of Illinois in order to work at domestic violence agencies: having and showing empathy for the clients; theoretical base that includes strengths, empowerment, or feminist background; and a passion for the work. Differences cited mainly included a reference to the educational level (bachelors or masters degree), clinical training, and clinical supervision. An example of what was said follows;

I think the similarities among the domestic violence counselors is that all have a framework where they usually understand the dynamic of domestic violence, know about safety planning, and are able to educate clients in terms of domestic violence issues related to children, court and OP in general terms. The difference among DV counselors is how deep some counselors are able to go in the counseling sessions with their clients due to their educational background. Some counselors have education in areas that are not related to human behavior, others have a bachelor degree versus others who have a master (sic) degree. I think that there is more probability that someone with a master (sic) degree has the skills to use frameworks, theories, and some clinical skills and perspectives someone with less training won't have. I also think that one of the differences among counselors is that some are more culturally competent than others.

40 hour training is not enough. Short-term crisis work is important but long term work is necessary in order for clients to understand their

situation in order not to repeat. Master level therapists are necessary in order to do this type of work.

Other counselors mentioned that much of the domestic violence training is Hetero-normative and thus not applicable to the LGBTQ population. Another counselor stated that she thought most counselors had to have their master's degree in order to do counseling with survivors.

The next question, number 25, relates to the insight of counselors for the work that they do and their vision for their clients, specifically asking counselors to describe what they wished they could address with clients but that they had not included in their work. Fourteen counselors stated that they had addressed everything they wanted to with clients. The remaining 10 who answered the question gave an array of answers. The most often referenced item was deeper therapeutic work including transference/counter-transference issues, more examination of how the past affects the future, further work related to the effects of sexual abuse, and addressing the issue of being a survivor or a victim. The other issues mentioned included substance abuse, future relationships, spiritual needs, family work, and group work.

The final open-ended question was, "Tell me about a time when your beliefs about what is important in counseling have conflicted with the parameters of your setting (i.e. length of counseling, individual verses group counseling, etc.)." Only 13 counselors answered this question. Of those 13, five counselors stated there was no conflict. Five counselors stated that their agencies needed additional resources in order to provide the services they felt were needed (long-term trauma work, legal resources, group services,

children's counseling and translation services). Other counselors listed the following conflicts: (1) need for psychoeducational groups versus support groups, (2) confidentiality related to clients involved in the DCFS system, and (3) a need for more social justice work.

Summary

An embedded mixed-methods design was used to explore the counseling experience of survivors of domestic violence and begin to identify interventions that were perceived as helpful by both counselors and survivors. This study interviewed seven survivors and had as many as 50 counselors open the web-based survey. However, the majority of questions were answered by 29-30 counselors with some questions answered by as few as 13 counselors. Many similar themes were identified by both survivors and counselors as helpful aspects of counseling. Some of these themes served to confirm information that currently exists in the literature. However, information was also gathered that serves to build upon the already existing body of knowledge.

CHAPTER FIVE

ANALYSIS, DISCUSSION AND SUGGESTIONS FOR FUTURE RESEARCH

Discussion

It is important to discuss the context of the data collection. The state of the economy was an issue that largely impacted this research study. The Illinois budget problems in 2009 led to a loss of funding for numerous social service agencies across the state. Many domestic violence agencies and programs were impacted. Some of them closed entirely while many others dramatically reduced programs and cut staff. The timing of this reduction coincided with data collection for this study. In many ways it curtailed the collection of data due to the loss of programs and staff as well as the stress that many agencies were under in the summer of 2009 related to concern about the unknown impact of the budget cuts and to future potential cuts in funding (ICADV Impact of Cuts – Cash Flow Problems, 2010). Several agencies that had previously agreed to inform staff and clients about the research decided to withdraw from participation. This influenced the number of respondents for both the web-based counselor survey and the survivor interviews. However, due to the exploratory nature of this study, the intent was not to generalize to the larger population. The information gathered serves to both support prior research detailed in the literature review and point to areas in need of further study. The agencies that chose to participate in the study,

despite the budgetary crisis, may have done so because of their interest in the topic, which may have biased the results.

Despite the budgetary crisis, it is important to note that the web-based counselor survey was opened by 50 people with between 27 to 32 counselors responding to most questions. As the study hoped to hear from 30 counselors, this goal was met. The intent of the study was to have 10 completed survivor interviews. It is believed that budget cutbacks may have contributed to the lower number of survivor respondents (seven). This is due to the fact that fewer agencies chose to participate and inform clients about the research opportunity due to the budgetary stress and cutbacks that many agencies experienced during the summer of 2009. It is also possible that concern over the confidentiality and anonymity of survivors by domestic violence agencies further contributed to the difficulty in obtaining survivor interviews.

Due to the purposive nature of the sample, the information gathered is specific to the subjects experience in their specific location at this specific time. The demographics of the women in the study are not, nor were they intended to be generalizable to the larger domestic violence community. A new study with a larger sample would be needed in order to make those connections.

Analysis of Survivor and Counselor Data

The intent of the research study, an exploratory mixed-methods design, was to gather information on women's experiences in domestic violence counseling, the trauma symptomatology of the women, the relationship factors in the counseling relationship, and the interventions used at domestic violence agencies as well as their perceived

effectiveness. Data was gathered from both domestic violence counselors and survivors of domestic violence in order to best capture this information. It is important to note the trauma symptomatology of survivors of domestic violence, as it is a partial guide to counselors in the work that they do. However, whether or not all counselors use a trauma questionnaire or checklist was not determined by this study. The trauma symptomatology of the seven survivors interviewed was not clinically significant in the sample as a whole. This may have been due to the small sample size, the mental health of the women who chose to participate in the study, and the fact that all but two of the women had been in domestic violence counseling for eight months or longer. The literature points to trauma symptomatology decreasing while in domestic violence counseling (Howard et al., 2003; Zweig & Burt, 2007). The original intent of the study was to interview survivors who were earlier in their counseling process. However, the budget crisis, which impacted agency involvement, also influenced the survivor sample as noted above. It also made it more difficult to obtain survivors in general so further limiting the available pool of survivors.

Three key areas emerged from the quantitative and qualitative data as important to both survivors and counselors, albeit in varying degrees: relationship, knowledge of domestic violence, and interventions. While these categories are not mutually exclusive, they create a framework in which to discuss the findings of this study. These three categories will be discussed further in the following section. Each component will be looked at and discussed with special attention paid to see how the concepts converged

and diverged for survivors and counselors. The ways in which the literature was supported or built upon will also be discussed.

Importance of Relationship

Although historically in process and outcome research about therapy, the importance of the therapeutic relationship has been well established (Bergin & Garfield, 1993; Lambert, 2004) it has not been examined as a factor within the counseling relationship in domestic violence. This study had as one purpose to explore how counselors and survivors describe the counseling relationship as one of several factors important to learn about regarding the provision of services for survivors. The relationship between counselors and survivors was examined from various vantage points. The survivor instrument, the STAR, the survivor interview, and the web-based counselor interview all were used to better understand the counseling relationship. The analysis of the data discovered numerous relational factors that are central, yet often overlooked, aspects of the domestic violence counselor – survivor relationship.

Convergence and Divergence between Survivor and Counselor Data

There were more areas of divergence than convergence with regard to the relational themes of the data. For example, the survivors highlighted many relational aspects as important in their interviews. Specifically stated, survivors benefitted from bilingual/bicultural counselors, a comfort level that was cultivated by their counselor, and the non-judgmental attitude of counselors. All of these helped to foster a positive transference to their counselors and to the agency where they sought counseling. The STAR also underscored the fact that all seven survivors scored the relationship with their

counselors highly on two sub-scales: positive collaboration and positive clinician input. None of the survivors interviewed indicated that they felt a lack of support from their counselor. The counselors did not highlight the relational aspects of their work with survivors to the same extent. As the previous chapter indicated, the counselors listed the relationship or Relational Theory as an intervention or theory they drew upon. However, the relationship was never in the top three interventions used. In fact, it usually fell to the rank of fourth most utilized intervention by the counselors in this study. This potentially means that the counselors did not put as much weight on the relationship as the survivors did. Conversely, it could mean that the elements of relationship highlighted by the survivors are intrinsically part of the therapeutic rapport for the counselors and thus not highlighted separately. The following discussion highlights some of the relational themes that were highlighted by survivors as central to their counseling experience. The views of the counselors are woven into the dialogue.

Bilingual/Bicultural. Three of the seven survivors interviewed stated that it was important to have a counselor who was bilingual or bicultural, and described the ease they felt when describing their experiences in their language of origin. They felt that such counselors had an increased understanding of the cultural aspects of the abuse and the healing process. One survivor described the difference in having a counselor who was also an immigrant to the United States verses someone who was Caucasian and native to the U.S.:

She [current immigrant counselor] has [sic] more open-minded about having the different culture [sic] background so she understand the way, where I come from, that's the key that I have and that's the one thing that I couldn't find in the other [counseling agency].

While the counselors also expressed a concern for immigration issues when asked about difficult client situations that they dealt with, they did not underscore the importance of bilingual/bicultural counselors in the same way. Some stated that they had observed a lack of services in the clients' language while another counselor expressed frustration that she often had to do translating for other staff at her agency.

Nonjudgmental Attitude. Six of the seven survivors underscored the importance of their counselors' nonjudgmental attitude. This was not mentioned or highlighted by the counselors, most likely due to the fact that a nonjudgmental attitude is a cornerstone of good counseling practice. However, this aspect was critical to survivors in this study for fostering the counseling relationship.

She didn't ever tell me to leave my husband, where a lot of your friends do is tell you that.

She's not bossy. I mean she doesn't say you have to do this or you have to do that. It's a better way to do it.

Comfort and Positive Transference to the Agency. Positive transference to the agency was described by five of the seven survivors as something that was very important to them in the counseling process. One woman eloquently stated it in the following manner:

Just knowing that I have a space to come to that is good. It's probably the best aspect about it for me because I am out there trying to gain control, trying to put one foot in front of the other. So if I can have a place, a safe place to be able to say okay I'm really upset right now...it's...[helpful].

Six survivors also discussed their feeling of comfort with their domestic violence counselor while discussing such a difficult and painful topic. Three of the women stated

this was different from previous counseling at mental health organizations. The following quotes help capture their sentiments:

She [domestic violence counselor] was the first one that I could totally, you know, was easy to open up to.

It [mental health therapy] didn't really make it comfortable to discuss, you know, it was just at the time I didn't know because I had never been to counseling before.

The fact that counselors did not explicitly highlight the importance of ensuring a safe space could be due to the universal tenet of therapy that the counseling space is one of safety. This is further discussed in the literature section below.

Mutually Agreed Upon Goals. The sub-scales, *positive collaboration* and *positive clinician input*, from the STAR, both contain items that underscored the counselor and survivor working on agreed upon goals. Survivors in the study felt that their counselors understood what was important to them and worked together towards mutually agreed upon goals. These were important aspects of the working relationship brought out on the STAR. Counselors also spoke to the issue of goals on one of the open-ended questions in the counselor survey. When asked what interventions they would use when they encountered difficult client situations, 10% of the responses listed goal planning as important. That counselors viewed this as an intervention and survivors viewed this as an aspect of the relationship is an ongoing difference that emerged throughout the study.

Connection to the Literature

The literature review pointed to relational aspects of the domestic violence counseling experience as important or helpful (Burke et al., 2001; Shamai, 2000; Zweig & Burt, 2007). The literature on mental health has also underscored the importance of

relationship in therapeutic intervention (Greenberg, 2002; Hill & Knox, 2009; Horvath & Symonds, 1991; Lambert, 2004; Norcross, 2002). Shamai's (2000) qualitative study found that the survivors appreciated the nonjudgmental attitude of the counselors at the domestic violence agency. This was echoed in the findings from the survivor interview. Six of the seven women in this study described the nonjudgmental attitude of their counselor as something that was helpful in the counseling process. A culturally-specific approach was described as helpful (Gillum, 2008) when working with survivors of IPV. This was also viewed as an important relational aspect by three of the seven survivors in this study.

Positive transference to an agency was not cited in the literature specifically for work with survivors of domestic violence. The literature does, however, discuss the importance for survivors to have a safe space to come to and discuss the violence (Burke et al., 2001; Shamai, 2000; Zweig & Burt, 2007). The women, in the study by Shamai went on to describe that their positive experience was facilitated by the space as well as the time they were given in counseling (2000).

Other relational themes mentioned included counselors sense of humor, listening skills, positive attitude, and her passion and genuine interest in the survivor. Some of these factors were also described in a previously mentioned study by Hamilton and Coates (1993) where women listed useful interactions with helping professionals including; "listening respectfully, believing my story, helping me see my strengths, and letting me know I am not alone".

Knowledge of Domestic Violence

Knowledge of domestic violence was cited overwhelmingly by both counselors and survivors of domestic violence as something that was important to the counseling process above and beyond relational factors or specific interventions alone. This is not surprising given that the field of domestic violence counseling largely began due to the fact that mental health counselors did not have the knowledge of domestic violence necessary to adequately meet the needs of survivors of domestic violence. There is a working assumption in the field of domestic violence that the specific knowledge counselors have regarding domestic violence is something that is extremely important to the survivors seeking services. This study did not specifically set out to explore the knowledge of domestic violence that counselors possess. However, it emerged from the data obtained in both the survivor interviews and the counselor surveys as central to the counseling experience. The following section showcases how this study brought to light the specific aspects of the knowledge of domestic violence that counselors possess and survivors find helpful.

Convergence and Divergence between Survivor and Counselor Data

Counselors and survivors concurred in their opinions on the importance of knowledge of domestic violence for the domestic violence counseling experience. Survivors described the importance of their counselors possessing knowledge of domestic violence to such a large extent that it was coded as its own category, when originally it was thought that it would be a sub-category. Six of the seven survivors overtly listed it as something important or helpful to them in the counseling process. Sub-categories under

knowledge of domestic violence for the survivor interview included community resources, safety planning, cycle of violence, definition of dv, and general dv information. However, as stated earlier, the themes and categories from the survivor interview were not mutually exclusive. For example, the sub-category, psychoeducation is listed under interventions but also fits under knowledge of domestic violence.

Psychoeducation. Psychoeducational interventions are possible due to the knowledge base that counselors have regarding domestic violence. This category, listed under the theme of “helpful interventions”, was mentioned by five survivors as important in their counseling experience.

Counselors also underscored the importance of their knowledge of domestic violence and psychoeducation as central to the help they offered survivors. Since it is suggested that knowledge of domestic violence and domestic violence services are something that separates domestic violence counselors from most mental health therapists, it will be imperative to study this further in order to see if this knowledge base is consistently highlighted by survivors as helpful to them in the healing process. The following quotes showcase the importance that survivors in this study placed on their counselors’ possessing a knowledge and understanding of dv:

I think about the process for me, because I wasn’t aware...and it’s very educational from here. Much more so than where I have been before [mental health agency]. Where I have been before it’s like okay this was my experience, this is what I need to talk about. Here I am being shown and explained things, which is good for me because I didn’t have a clear definition of what domestic violence is.

Well she [counselor] is good at thinking about different possibilities and presenting those, and because she is aware of a lot of services that are available she can talk about them...and because of talking with lots of

clients, she has a lot of stories that she can relate to my situation, and make parallels that are helpful.

Counselors also valued their knowledge of domestic violence. Many counselors listed domestic violence education as something important they did with clients. In all five questions from the counselor survey (both quantitative and open-ended) regarding interventions used, domestic violence education, was listed as one of the top three interventions used (see Table 12).

Community Resources and Concrete Service Planning. Both survivors and counselors listed knowledge of community resources and appropriate referrals as central to the counseling experience. Survivors stressed the importance of their counselor knowing the resources available to them as victims of domestic violence. Specifically, six of the seven survivors mentioned the importance of appropriate referrals to needed services that the domestic violence agency didn't provide but either knew of or had connections with. These referrals generally included legal referrals and counseling services for their children who had witnessed domestic violence in the home. Counselors also stressed concrete service planning and safety planning as valuable interventions they did with survivors. When the counseling interventions were compared (see Table 12), counselors listed concrete service planning or safety planning in the top two of important interventions for counseling with survivors of dv in four out of the five questions regarding interventions.

Connection with the Literature

While no studies were found that explicitly addressed knowledge of domestic violence as an important element for survivors in domestic violence counseling; several

research articles reviewed pointed to women survivors of IPV experiencing counseling services at domestic violence agencies as more supportive and helpful than traditional counseling or mental health agencies (Grauwiler, 2008; Hage, 2006; McNamara et al., 2008). This may be due to numerous factors, including knowledge of domestic violence. Other researchers describe domestic violence counseling as largely psychoeducational (Hamby, 2008; Tutty & Rothery, 2002). Tutty and Rothery (2002) point out that services for survivors of domestic violence tend to safety planning and legal advocacy. The studies mentioned did not survey survivors to see if this was valuable or helpful. This study supports and adds to the literature by lending a voice to the survivor in regards to aspects of the knowledge of domestic violence that counselors use and survivors find helpful in the counseling relationship.

Interventions

Many interventions used by domestic violence counselors have been written about and discussed in the literature for the past 30 years. One of the goals of this study was to look at the interventions that counselors used and survivors found helpful in the counseling relationship. Historically, domestic violence counselors have utilized various interventions in counseling; often including crisis intervention, options planning, safety, legal advocacy and group counseling (Tutty & Rothery, 2002). This study discovered that while many of these interventions continue to be utilized, some counselors have broadened their repertoire to include other intervention strategies. This study gathered information on counseling interventions used through the counselor web-based survey as well as the survivor interview. While the survivors did not know the names of specific

interventions utilized, they were often able to describe the techniques used by their counselor. Various intervention strategies that were highlighted by survivors and counselors are included in the next section.

Convergence and Divergence between Survivor and Counselor.

Comments about counselor interventions made by survivors and counselors both converged and diverged in this study. This may have been due to the fact that counselors were able to specifically describe the interventions they utilized in counseling while survivors described aspects of what was helpful to them in their counseling experience. Another reason that different interventions are stressed may be due to the fact that certain interventions are so ingrained in domestic violence counselors that they were not mentioned. Lastly, it may be that survivors in this study perceived the helpfulness of some interventions differently than counselors imagined they would. The data from both counselors and survivors clearly described several often-used interventions that were experienced as helpful by survivors. Survivors also described aspects of interventions that they perceived as helpful that were not emphasized by counselors in this study.

Emotional Support. Emotional support was communicated as a helpful aspect of counseling by both counselors and survivors. Counselors described empathy, support, and empowerment as some of the top-most intervention techniques that were helpful to them in their clinical work with survivors of domestic violence. In fact, these three interventions consistently were placed in the top three of interventions used in counseling by counselors in the web-based survey (see Table 12). The theme of emotional support was echoed by the survivors who expressed that emotional support from the counselor

was one of the most helpful aspects of counseling to them. One survivor described it in the following manner:

A lot of times I would go away, um, just thinking about, ya know, she made me feel better about myself, that I am, um, ya know, that that's, I am a good person, ya know. Where a lot of times I wouldn't feel like I was even though my friends would tell me that I was.

Concrete Suggestions. Both counselors and survivors listed concrete suggestions such as safety planning, referrals, and assistance with resources and planning as helpful interventions. This emergent theme is an area with a great deal of overlap with that of community resources and concrete service planning under the category knowledge of domestic violence. However, it is placed under the theme of intervention as well due to the fact that concrete suggestions such as safety planning and referrals are thought of and used as specific intervention techniques by counselors in domestic violence counseling. As stated under the category, knowledge of dv, counselors consistently list safety planning and concrete service planning as important interventions they utilize with survivors (see Table 12). Similarly, four of the seven survivors described the use of concrete suggestions as a helpful intervention used by their counselor while two of the seven survivors specifically recalled the benefits of safety planning with their counselors.

Challenging. Challenging emerged unexpectedly under the category of helpful interventions. This was not described by counselors but was emphatically mentioned by three of the seven survivors in their interviews. Survivors were questioned if they had ever been expected to answer uncomfortable questions by their counselor. Three of them stated that they had been and that it had been instrumental in helping them to think differently about their situation. Survivors described this dynamic in the following ways:

Yes, there are some things like let's say, I don't want to hear...but again like I said, it made me think, okay maybe she's right, but I mean let's say maybe sometimes maybe I don't agree with what she said, but maybe it makes me think about it...like maybe it's not right or maybe I can do it differently. But no, nothing [was asked] that has made me feel really uncomfortable.

Yeah, yeah...that [being asked difficult questions] that was very helpful. She always surprised me. Yeah, made me think about it.

Counselors were not explicitly asked whether they challenged clients during the counseling process on the web-based survey. Since this emerged from the data with a small sample, it would be beneficial to follow-up with a group of counselors and a larger sample of survivors to see what was said about challenging interventions. The idea of challenging clients might be a more natural fit with traditional mental health therapy than with the empowerment model of domestic violence counseling. However, this would need to be explored further.

Normalizing. The category of normalizing is another area of divergence as it emerged from the survivor interviews but not the counselor survey. However, it may be that counselors have internalized the skill of normalizing a survivors experience to such an extent that they did not mention it explicitly. Normalizing is also connected closely with the theme of knowledge of domestic violence and the interventions of emotional support and empowerment. Four of the seven survivors specifically cited powerful moments in counseling when their counselor helped them to understand that they were not alone in their experience. This appears to be an aspect of the counseling that was unique and especially helpful for the survivors as they dealt with the abuse in their lives:

and I guess, I felt like everything that I had said seemed very expected or maybe textbook or understood which I had not experienced that...and it

has been about two to three weeks since the incident that brought me here and most people were in shock so it was good to have somebody that saw it as expected sort of ...or normal...I don't really know how to explain it.

Cultural Competence. Cultural competence is an aspect of intervention that overlaps with the previously mentioned theme of bilingual/bicultural under the category of relational factors. Once again, it is important to note that, three survivors stressed how importance it was to them that their counselor was either bicultural or possessed a level of cultural competence that allowed them to feel comfortable and understood. One's culture or religion can bring an array of confounding factors into the abusive relationship. Survivors in this study were appreciative that their counselors were able to understand those factors in order to better assist them with healing and navigating the abusive relationship. Although counselors did not speak to this directly, it was not specifically asked in the counselor survey.

Connection with the Literature

The literature reviewed for this study did discuss various therapeutic interventions historically used by counselors for domestic violence counseling. Many of these were similar to the interventions highlighted by the counselors and survivors in this study. Specifically, the importance of emotional support for survivors is addressed as an often used and important intervention tool (Grauwiler, 2008; Zweig & Burt, 2007). Additionally, a study by Hage (2006) specifically highlights a group of 10 women survivors who discussed the importance of having at least one emotionally supportive person (formal or informal) in their lives in order to heal and create change.

The literature also addressed the use of safety planning as well as referrals and connection to additional resources such as legal aid or housing options. These are cornerstones of domestic violence counseling and have been identified as beneficial by counselors and survivors in the current literature (Grauwiler, 2008; Hamby, 1998; Tutty & Rothery, 2002; Zweig & Burt, 2007).

The literature reviewed for this study did not speak directly to the aspect of challenging in counseling with survivors of domestic violence. However, the research that may fit most closely with this concept are studies done by the Domestic Violence and Mental Health Policy Initiative in Chicago (Warshaw, 1996; Warshaw, Gugenheim et al., 2003; Warshaw, Moroney, et al., 2003). As mentioned previously, the research conducted by this group speaks to the need to blend the core principles of domestic violence counseling with a mental health treatment philosophy in order to meet the needs of many survivors of IPV (Warshaw, 1996). Warshaw goes on to suggest that trauma theory begins to bridge the gaps between traditional domestic violence counseling and the mental health model (Warshaw, Gugenheim, et al., 2003).

While the intervention of normalizing the experience of the survivor was not directly addressed in the literature, two studies with survivors listed aspects of counseling interventions that are similar and may have captured the essence of normalizing the survivors' experience. One study specifically cited the fact that survivors found the non-judgmental attitude of their counselors as beneficial (Shamai, 2000). Another study (Hamilton & Coates, 1993) surveyed 270 women and found that survivors generally

viewed social workers as helpful when they, listened respectfully, believed the survivor's story, and helped the survivor see that she was not alone".

Cultural competence was cited as important to survivors in domestic violence counseling in a study by Gillum (2008) where a culturally specific approach was found to be beneficial when working with survivors of domestic violence. This was echoed in the sentiments of three of the seven survivors in this study.

In conclusion, there are some specific and important aspects of the counseling experience between the counselor and survivor that were perceived as helpful by counselors and survivors. These aspects can be grouped under the areas of relationship, knowledge of domestic violence, and interventions. Relational themes perceived as helpful included a non-judgmental attitude, mutually agreed upon goals, a sense of comfort and positive transference to the agency as well as a counselor who was bilingual or bicultural for those who were of a cultural background other than Caucasian. The importance of the domestic violence counselor possessing knowledge of domestic violence was underscored as integral to the counseling relationship for survivors. Specific themes under the category knowledge of domestic violence included psychoeducation and knowledge of community resources as well as concrete service planning and safety planning. Lastly, the study discovered specific interventions used by counselors in counseling with survivors of domestic violence. Specific helpful interactions that emerged from the data included the ability to normalize the situation and offer concrete suggestions as well as offering emotional support and some challenging

questions. It was also important for survivors that their counselor be culturally competent while shaping and providing interventions.

Summary of the Mixed-Methods Analysis

The intent of this dissertation research study was to explore the counseling experience of survivors of IPV who receive services from domestic violence agencies while not residing in shelter. It was thought that identifying ways domestic violence counseling interventions are currently helpful to survivors would be beneficial to agencies as they seek to provide quality services to survivors of IPV. Another goal of this study was to provide information on the trauma symptomatology of the women who seek counseling at domestic violence agencies as current research suggests they are a group of women who often suffer from a myriad of physical and mental health related issues (Campbell, Martin, Moracco, Manganello, & Macy, 2006; Macy, Nurius, Kernic, & Holt, 2005; Shurman & Rodriguez, 2006; Warshaw, Moroney, et al., 2003). Lastly, the study explored the relationship between domestic violence counselors and survivors in order to begin to describe the nature and healing elements of this specific therapeutic connection.

This mixed methods study has made important first steps toward these goals. Through the use of both interview and survey data, information was gathered that supports the literature about the importance of specific aspects of the therapeutic relationship between domestic violence counselors and survivors for healing. Specifically, data in this study confirmed the significance of the pairing of specific therapeutic relational aspects and a rich knowledge of domestic violence as intervention

tools for domestic violence counseling. It also underscored the magnitude that cultural competency can play in the counseling relationship in addition to the importance of receiving counseling in one's primary language.

Numerous findings of this study added to the current body of knowledge yet also call for further study. The first of these is the concept of the counseling space being one of safety and healing, which will need to be explored further to fully understand its significance for the vulnerable population. Other significant contributions that will benefit from further study include the importance both counselors and survivors placed on the counselors possessing an understanding of domestic violence and the referrals networks that are important to someone currently struggling in an abusive relationship. Lastly, further research that looks at the trauma symptomatology of survivors and how this influences what they perceive as helpful, would be beneficial, especially with a larger client sample.

Challenges existed in this study, largely related to the State of Illinois budget crisis that occurred in 2009. This impacted the number of agencies that partnered with this study, decreasing the number of staff who provided services and would have been available to participate, thus resulting in lower than expected numbers for both survivor interviews and counseling web-based surveys. In the future, more agencies may be willing to participate in future studies as a means to showcase the importance of their services.

Implications for Social Work Practice

Results from this study can be helpful to social workers by increasing their competency and understanding related to counseling with survivors of domestic violence. Specifically, social workers can take a leadership role in educating domestic violence agencies and counselors. The research findings point to the importance of domestic violence counselors having a precise set of intervention tools. These tools appear to work best when they are based on a supportive and non-judgmental relationship with the survivor and include a mix of interventions and information that are specific to the domestic violence community. Social workers can work with the domestic violence community on developing and honing a specific protocol and training for its clinical workers.

Implications for Social Work Education

The Council on Social Work Education (CSWE) Educational Policy and Accreditation Standards stresses the importance of the field of social work promoting: human and community well-being, a quest for social justice, prevention of conditions that limit human rights, and the enhancement of the quality of life for all persons (Council on Social Work Education, 2010). Infusing information about domestic violence counseling into courses would help to advance these four accreditation standards. The field of domestic violence has long embraced the concepts in these social work standards. The domestic violence movement started as a social justice action that aimed to promote human well-being and quality of life to woman who had been living with violence in a society that largely chose to ignore what was occurring. By infusing information about

the history of domestic violence as well as current counseling protocol, schools of social work will not only advance their accreditation standards, they will be partnering with the domestic violence community for the betterment of survivors of domestic violence.

Suggestions for Future Research

Although this study provides valuable information regarding what is helpful to survivors in domestic violence counseling, more study needs to be done on this topic. Survivors would ultimately benefit from studies where the scope was both broadened and constricted.

First, it would be beneficial to do a study with a larger sample. It would be interesting to go back to the agencies that were already involved in the study as well as to reach out to the agencies that stated they could not participate this past year due to the budget crisis. The timing of the future research could be thus that the data collection would not be occurring during the budget planning time, so that agencies would not be in the midst of flux.

The larger sample would be beneficial to further look at the trauma symptomatology of survivors who seek counseling at domestic violence agencies. To this end, it would also be advantageous to try to recruit more participants who are early on in their counseling process (two to four months). The literature points to a group of women with complex physical and mental health needs (Campbell, Martin, Moracco, Manganello, & Macy, 2006; Macy, Nurius, Kernic, & Holt, 2005; Shurman & Rodriguez, 2006; Warshaw, Moroney, et al., 2003). With that being the case, it is important that the

research better understand the intersection between survivors' mental health needs and the training and competency of domestic violence counselors.

It would also be beneficial to further look at the various relational intervention aspects that arose in this study. Specifically, it would be interesting to look at the issue of positive transference to the agency and its impact on the referral process. For instance, several counselors in the study stated that they were not able to see clients for as many sessions as they would like. It would be interesting to see if clients followed up with therapeutic referrals that were given. It may be that when clients have a strong positive transference to an agency that it is more beneficial for them to continue in the needed services at the agency they are already connected to. The literature points to the fact that women do not always follow up with referrals to other agencies over the course of a years time when new violence does not occur (Cattaneo et al., 2007). This lends itself to the argument that domestic violence agencies may best meet their clients' needs if they are able to offer an array of services at one location instead of referring women to other locations for therapeutic needs.

Third, it would be interesting to further explore both the intersection of relationship, knowledge of domestic violence, and aspects of relationship cited in this study by survivors as most helpful. These could be used as variables in a larger study to see if they remained relevant when a larger sample was used. This could be done on either a state or national scale.

Lastly, the data points to the presumption that domestic violence counselors utilize a specific, yet not fully described, model of counseling intervention. This model

appears to draw on various theories and intervention strategies yet generally contains the key elements of empathy/support, domestic violence knowledge/education, concrete services, and relational elements. Both counselors and survivors mentioned these four intervention strategies as an important part of the counseling process. Since this study was intended as a beginning in the exploration of the counseling process, future research is needed that will further map out the intervention model for counseling with survivors of domestic violence. The following table begins to demonstrate the idea of a model with the data that emerged from this study.

Table 13

Translation of the Data into a Model for Working with Survivors of Domestic Violence

Knowledge	Interventions	Relationship
Cycle of Violence	Psychoeducation, Empathy	Explore when to use, how much to say. Offer support as new aspects of relationship are discovered.
Safety Planning	Concrete Suggestions, Emotional Support, Goal Planning, Strengths	Work with client to create a plan to increase her emotional and physical safety. Emotional support is needed as it is difficult to face how vulnerable one has been. Build upon her strengths.
Community Resources/Referrals	Referrals and linkage	Connect client to services while assuring her she is not being placed with another agency for support.
Clear definition of domestic violence	Psychoeducation, Normalizing, Challenging	Discuss aspects of emotional, physical, sexual, and financial abuse. Normalize her experience and support her through this process of new discovery and planning.
General domestic violence information	Psychoeducation, Normalizing, Goal Planning	Help client fully realize the impact of domestic violence on her life and that of her family. Assist her in planning for the future.

While only a beginning, the table illustrates what emerged from the data for both counselors and survivors. This demonstrates a conceptualization of a counseling model for survivors of domestic violence. Further research can assist in understanding how knowledge, interventions, and relationship work together to create a specific model that, the data suggests, is being utilized by domestic violence counselors, albeit in a less formalized manner. In theory, this would allow mental health therapists to be better

trained to provide quality domestic violence counseling to those in their practice who are in abusive relationships.

Conclusion

An exploratory mixed methods design, in which qualitative and quantitative data were gathered from survivors and counselors, was used to study and identify interventions that are helpful for survivors of domestic violence who are in domestic violence counseling while not residing in a domestic violence shelter. Equal importance was given to both the quantitative web-based counselor survey with included open-ended questions and the survivor interviews that consisted of survey instruments and a semi-structured interview.

Further study is needed in order to better understand the trauma symptomatology of survivors who seek counseling at domestic violence agencies. It is also important to better recognize how agencies can provide a therapeutic space and service that best meets the current needs of those seeking assistance and counseling for problems related to domestic violence.

Similar themes were identified from data in the counselor and survivor surveys and interviews. Respondents stressed the importance of specific relational aspects of counseling, counselors' knowledge of domestic violence, and specific interventions as helpful in the domestic violence counseling process. Specifically highlighted were a nonjudgmental attitude, normalizing of the experience, knowledge of community resources and referrals, emotional support, concrete suggestions, and the ability to challenge in the counseling space. Also important were the safety and feel of the space

where the counseling is occurring. Lastly, both stressed the importance of bilingual and bicultural counselors in order to best meet the needs of the clients. Due to these findings, it will be important to further explore the specific interventions and techniques that are unique to domestic violence counseling. Emerging from the data is the idea that there is a precise technique to domestic violence counseling that can be researched, taught, and practiced in a manner that will assist survivors in healing from the trauma they endured.

APPENDIX A:
WEB-BASED SURVEY COVER LETTER

APPENDIX A:

WEB-BASED COVER LETTER

Dear Clinical Director,

As a doctoral student at Loyola University Chicago School of Social Work, I am conducting research on the experience of domestic violence counseling and what counselors and clients identify are the most helpful aspects. While more research is currently being done in the field of domestic violence, the counseling experience of women who receive counseling while not currently in a shelter is largely unexplored. I hope to better understand the aspects of counseling that both counselors and clients identify as helpful, as well as explore the relational factors between the counselor and client, which most research identifies as positive. I believe this information can inform our practices at domestic violence agencies as well as help to advocate for funding and our clients' needs on the policy level.

To this end, I invite you and your counseling staff to:

Respond to a Chicago-Area , online survey of domestic violence counseling. The survey asks questions regarding your education and experience, the types of counseling you provide, the theories that guide you in counseling, and what types of interventions you utilize most and believe to be the most helpful. To access the survey, click on the link listed at the end of this letter. The survey is for everyone at your agency who is providing counseling to clients who do not currently reside in shelter. *Please complete this survey, if appropriate to your position and forward it on to all counselors at your agency who provide counseling to clients not currently in shelters.*

Answers to survey items will remain strictly anonymous; in fact, I ensure both individual and institutional anonymity. All responses to this web-based survey are managed and maintained through the Opinio computer software program, the license for which is owned by Loyola University Chicago. The anonymity of responses is insured through this program. Email addresses and Internet Protocol addresses are separated from the survey responses in the Opinio database, and thus cannot be identified by the researcher. Consequently, I ask you to answer these questions honestly.

The Chicago Metropolitan Battered Women's Network's involvement in the project is limited to distributing this information. The Network believes that by lending their support in this way, the response rate by domestic violence agencies and counselors will increase. The Network does not have access to any of the raw data from the study.

Please set aside approximately 15 minutes at your convenience to take the counselor survey. I believe that your participation will help produce valuable insights into domestic violence counseling and how it is helpful.

Thank you for your time and participation.

To begin the survey, click the link below. If that does not work, please copy and paste it into your browser.

<https://surveys.luc.edu/opinio6/s?s=10556>

Sonya Crabtree-Nelson, LCSW

APPENDIX B:
LETTERS OF COOPERATION

APPENDIX B:
LETTERS OF COOPERATION



CHICAGO METROPOLITAN
BATTERED WOMEN'S NETWORK

203 N. Wabash Ave, Suite 2323 | PHONE: (312)
Chicago, Illinois 60601 | FAX: (312) 751
www.batteredwomensnetwork.org | TTY: (312) 751

February 24, 2009

Institutional Review Board
Loyola University
Chicago, IL 60611

To IRB Review Committee,

The Chicago Metropolitan Battered Women's Network (The Network) is a collaborative membership organization that improves the lives of battered women, their children, and others impacted by domestic violence by leading public policy and advocacy efforts; providing education and raising public awareness; and connecting members of the community to direct service providers. The Network supports Sonya Crabtree-Nelson, Doctoral Student at Loyola University Chicago, in her work on *How Counseling Helps: An In-Depth Look at Domestic Violence Counseling*.

The Network's involvement in the project is limited to the sending out of Ms. Crabtree-Nelson's project information, including the Opinion survey link for counselors. This way, area domestic violence agencies can contact Ms. Crabtree-Nelson if they are interested in connecting their clients with her research project. Counselors will be able to complete the on-line survey at their convenience.

The Network is willing to email the member agencies with the above research project information. We believe that by lending agency support in this way, the response rate by domestic violence agencies and counselors will increase.

Ms. Crabtree-Nelson has agreed to acknowledge The Network in all written reports of her research, as well as any presentations made regarding the project. If you need any further information I can be reached at 312-750-0730.

Sincerely,


Dawn Dalton
Executive Director



September 23, 2009

Institutional Review Board
Loyola University
Chicago, IL 60611

To IRB Review Committee,

Between Friends is an agency that improves the lives of battered women, their children, and others impacted by domestic violence. Between Friends supports Sonya Crabtree-Nelson, Doctoral Student at Loyola University Chicago in her work on *How Counseling Helps: An In-Depth Look at Domestic Violence Counseling*.

Between Friends' involvement in the project includes: 1) requesting that counselors inform their clients about the flyers in the lobby concerning the research 2) making flyers available in the lobby where clients can read them, and 3) providing space for the Investigator to meet with participants (if the participants choose to meet at the agency). Between Friends understands that clients will contact Ms. Crabtree-Nelson directly if they are interested in volunteering for the research study and that they will be compensated for their volunteer time with a \$15 Target gift card.

Between Friends is willing to provide the above mentioned support to the research project *How Counseling Helps: An in-Depth Look at Domestic Violence Counseling*.

Sincerely,

Kathy Doherty, LCSW
Executive Director

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14th District
The Honorable Carol Roman
Former Illinois State Senator, 7th District
The Honorable Jan Schakowsky
United States Congress,
9th Congressional District
Cary Steinback
Executive Director,
Chicago Low Income Housing Trust Fund
Terrill L. Stumpf
Director, Center for Whole Health,
Fourth Presbyterian Church
Larry Sullredin
Cook County Commissioner, 13th District
Lali Watt
Board Member Emeritus
Trustee, Village of Wilmette
Michele Weldon
Assistant Professor, Northwestern
University, Medill School of Journalism
Rhonda Woodard
Vice-President Product Operations,
Allstate Insurance Company
Member of Illinois Coalition Against
Domestic Violence, Community Shares
of Illinois and the Chicago Metropolitan
Battered Women's Network

NORTH CENTER

Metropolitan Family Services
150 years of amazing strength

July 15, 2009

Institutional Review Board
Loyola University
Chicago, IL 60611

To IRB Review Committee,

Metropolitan Family Services is an agency that improves the lives of battered women, their children, and others impacted by domestic violence by providing early intervention services for survivors of partner abuse and their children. The program also offers legal services and services to teens and children who have witnessed domestic violence. Staff provides outreach, education, counseling, safety planning, information and referral and case management. Metropolitan Family Services supports Sonya Crabtree-Nelson, Doctoral Student at Loyola University Chicago in her work on *How Counseling Helps: An In-Depth Look at Domestic Violence Counseling*.

Metropolitan Family Services involvement in the project includes: 1) requesting that counselors inform their clients about the flyers in the lobby concerning the research 2) making flyers available in the lobby where clients can read them, and 3) providing space for the Investigator to meet with participants (if the participants choose to meet at the agency). Metropolitan Family Services understands that clients will contact Ms. Crabtree-Nelson directly if they are interested in volunteering for the research study and that they will be compensated for their volunteer time with a \$15 Target gift card.

Metropolitan Family Services is willing to provide the above mentioned support to the research project *How Counseling Helps: An in-Depth Look at Domestic Violence Counseling*.

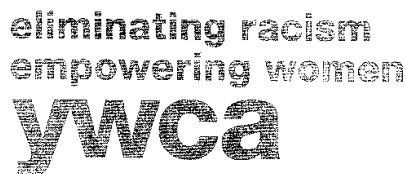
Sincerely,



A. Fernando Freire, LCSW
Program Manager

3249 N. Central Ave. Chicago, IL 60634

773.371.3700 phone 773.282.6698 fax
metrofamily.org



ywca evanston/north shore
1215 Church Street | Evanston, Illinois 60201
(847) 864-8445 | Fax (847) 864-8498

August 25, 2009

Institutional Review Board
Loyola University
Chicago, IL 60611

To IRB Review Committee,

YWCA Evanston North Shore is an agency that improves the lives of battered women, their children, and others impacted by domestic violence by providing a number of services including: crisis intervention; housing and community-based services; legal advocacy; and violence prevention. YWCA Evanston North Shore supports Sonya Crabtree-Nelson, Doctoral Student at Loyola University Chicago in her work on *How Counseling Helps: An In-Depth Look at Domestic Violence Counseling*.

YWCA Evanston North Shore's involvement in the project includes: 1) requesting that counselors inform their clients about the research 2) making flyers available where clients can read them, and 3) providing space for the Investigator to meet with participants (if the participants choose to meet at the agency). YWCA Evanston North Shore understands that clients will contact Ms. Crabtree-Nelson directly if they are interested in volunteering for the research study and that they will be compensated for their volunteer time with a \$15 Target gift card.

YWCA Evanston North Shore is willing to provide the above mentioned support to the research project *How Counseling Helps: An in-Depth Look at Domestic Violence Counseling*.

Sincerely,

A handwritten signature in cursive script, appearing to read "Tina White".

Tina White, MSW
YWCA Evanston North Shore

APPENDIX C:
RESEARCH FLYER

APPENDIX C:

RESEARCH FLYER

Counseling Research Study

Are you currently receiving domestic violence counseling? Do you currently reside somewhere other than a domestic violence shelter? If so, you may be eligible to participate in this study.

Study name: “How counseling helps: An In-Depth Look at Domestic Violence Counseling”.

Purpose: To learn more about the counseling relationship between survivors of interpersonal violence and counselors at domestic violence agencies. The intent is to find out what is helpful for survivors in domestic violence counseling.

Why you: You are being asked to participate because you have received counseling services from a domestic violence agency and I am interested in your opinion about your experience of the services.

In order to participate you need to:

- 1) Be currently receiving counseling services in the state of Illinois from a domestic violence agency while not housed in a domestic violence shelter,
- 2) Not have received counseling services from Between Friends (formerly Friends of Battered Women and Their Children) while this researcher was employed by the agency (11/04-9/18/09),
- 3) Have received a minimum of two sessions of counseling,
- 4) Be female, and
- 5) Speak English.

What will be done with the information: The information will be used to gain an understanding of what is helpful in domestic violence counseling. This information can then be used to inform counseling practices.

Confidentiality: All information given in the interview is completely confidential. Your counselor or the agency you receive counseling services at will not have access to the information you give in the interview. Your decision to participate or not will not affect your services at the agency in any way.

Compensation: Your time is extremely important. Because of that you will receive a \$15 Target gift card for the time you will spend in the interview (approximately 45 minutes to 1 hour).

What to expect: The entire interview should take 45 minutes to 1 hour. Sample questions include: Why did you initially seek counseling services here?, What have you found to be the most helpful?, What have you found different about counseling here versus your other counseling/therapy experiences? You will be asked to participate in a semi-structured, audio-taped interview as well as 1 brief demographic questionnaire and 2 survey instruments.

What to do if interested: Please contact me, Sonya Crabtree-Nelson, LCSW 847-804-7264 (confidential cell phone). We can arrange a time and place to meet that is convenient to you. Thank you for considering this project.

APPENDIX D:
SURVIVOR INTERVIEW QUESTIONS

APPENDIX D:**SURVIVOR INTERVIEW QUESTIONS****Interview Guide for Survivors of Intimate Partner Violence**

As this is a phenomenological interview in an exploratory study, there will be some preplanned questions. However, I will largely allow the survivor to have the role of expert and guide me to an increased understanding of the counselor – survivor relationship and what is helpful in counseling.

How long have you been coming to this agency for counseling?

Why did you initially seek counseling services here?

Do you remember what you did for an initial appointment or assessment? Do you recall what types of forms you filled out and what things they asked about?

What types of services do you receive here? (Probe for individual, group, or family counseling; case management, referrals, etc.. Find out if there are services they desire that they have not received)

What have you found to be the most helpful? Probe for aspects of the services and the way they are delivered.

Have you ever received counseling or therapy somewhere else? (Probe for where and what type of services were received)

What have you found different about counseling here verses your other counseling/therapy experiences? (Only ask if they have other experiences of counseling or therapy. Probe for different experiences in different settings such as mental health vs. this agency or other domestic violence agencies vs. this one)

Are you currently receiving services from another agency?

What do you like most about your counselor? (Probe for qualities and aspects of counseling)

What do you find most helpful about your counselor? (Probe for relationship, concrete items, etc.)

Are there things you wish you could discuss in counseling, but haven't? (Probe for why they haven't and what these things are, such as past childhood abuse, past abusive experiences, mental health issues, etc.)

Are there things you have been asked to discuss, but haven't wanted to talk about? (Probe for what these are and why they didn't want to talk about it)

APPENDIX E:
SURVIVOR DEMOGRAPHIC SURVEY

APPENDIX E:**SURVIVOR DEMOGRAPHIC SURVEY**

THE FIRST SET OF QUESTIONS I AM GOING TO ASK YOU FOCUS ON SOME BASIC INFORMATION ABOUT YOU AND YOUR SITUATION.

1. What is your Age: _____

2a. What is your Race: (please circle your response.)

- a. Asian American
- b. African America
- c. Caucasian
- d. Native American
- e. Biracial (please describe _____)

2b. Are you Hispanic:

Yes No

2c. What is your ethnic heritage?

(Please be specific: Pakistani, Polish, Lebanese, Ghanaian, etc.)

3a. Were you born in the U.S.?

Yes No

3b. If not, where were you born?

4. What is your Marital Status?

- a. Never married
- b. Currently married
- c. Divorced
- d. Separated
- e. Widowed
- f. Common law

g. Other: _____

5. What is your highest level of education?

- a. Less than high school
- b. High school graduate/GED
- c. Technical school/some college
- d. College graduate
- e. Completed grad school

Comments: _____

HOUSEHOLD INCOME

(SHOW THE INCOME CHART TO THE RESPONDENT)

6. In the last year, what was the category of income for your household?

_____ a. none	_____ b. Under \$5,000
_____ c. \$5,000 TO \$14,999	_____ d. \$15,000 TO \$24,999
_____ e. \$25,000 TO \$34,999	_____ f. \$35,000 TO \$49,999
_____ g. 50, 000 to 74,999	_____ h. \$75,000 and above
_____ i. I don't know	

7. How many adults contribute to family income?

8. Are you currently... ?

- a. employed full-time
- b. employed part-time
- c. unemployed
- d. homemaker/do not work outside house

11. Parental status:

a. How many children do you have:

b. How many of your children live with you at home?

RELATIONSHIP HISTORY

12a. What is your relationship with the current (or most recent) abuser?

- a. Current Husband
- b. Former Husband
- c. Current Boyfriend

- d. Former Boyfriend
- e. Current Girlfriend
- f. Former Girlfriend
- g. Parent
- h. Sibling
- i. Other _____

12b. What is the gender of abuser ?

(male=1, female=2, other=3)

12c. Have you had other relationships that became abusive before this one?

Yes No

12d. If yes, how many? _____

APPENDIX F:
TRAUMA SYMPTOM INVENTORY (TSI)

APPENDIX F:

TRAUMA SYMPTOM INVENTORY (TSI)

THE FOLLOWING SERIES OF QUESTIONS ARE ABOUT SPECIFIC FEELINGS, THOUGHTS, AND/OR BEHAVIORS THAT YOU MAY HAVE HAD IN THE LAST 6 MONTHS, PLEASE TRY TO REMEMBER TO THE BEST OF YOUR ABILITY.

PLEASE CIRCLE THE NUMBER THAT CORRESPONDS WITH YOUR EXPERIENCE.

[TSI] In the last 6 months, how often have you experienced:

QUESTIONS	NEVER.....OFTEN			
1. Nightmares or bad dreams	0	1	2	3
2. Trying to forget about a bad time in your life	0	1	2	3
3. Irritability	0	1	2	3
4. Stopping yourself from thinking about the past	0	1	2	3
5. Getting angry about something that wasn't very important	0	1	2	3
6. Feeling empty inside	0	1	2	3
7. Sadness	0	1	2	3
8. Flashbacks (sudden memories or images of upsetting things)	0	1	2	3
9. Not being satisfied with your sex life	0	1	2	3
10. Feeling like you were outside of your body	0	1	2	3
11. Lower back pain	0	1	2	3
12. Sudden disturbing memories when you were not expecting them	0	1	2	3
13. Want to cry	0	1	2	3
14. Not feeling happy	0	1	2	3
15. Becoming angry for little or no reason	0	1	2	3
16. Feeling like you don't know who you really are	0	1	2	3
17. Feeling depressed	0	1	2	3
18. Having sex with someone you hardly knew	0	1	2	3
19. Thoughts or fantasies about hurting someone	0	1	2	3
20. Your mind going blank	0	1	2	3

21. Fainting	0	1	2	3
22. Periods of trembling or shaking	0	1	2	3
23. Pushing painful memories out of your mind	0	1	2	3
24. Not understanding, why you did something	0	1	2	3
[TSI] In the last 6 months, how often have you experienced	NEVER.....OFTEN			
25. Threatening or attempting suicide	0	1	2	3
26. Feeling like you were watching yourself from far away	0	1	2	3
27. Feeling tense or "on edge"	0	1	2	3
28. Getting into trouble because of sex	0	1	2	3
29. Not feeling like your real self	0	1	2	3
30. Wishing you were dead	0	1	2	3
31. Worrying about things	0	1	2	3
32. Not being sure of what you want in life	0	1	2	3
33. Bad thoughts or feelings during sex	0	1	2	3
34. Being easily annoyed by other people	0	1	2	3
35. Starting arguments or picking fights to get your anger out	0	1	2	3
36. Having sex or being sexual to keep from feeling lonely or sad	0	1	2	3
37. Getting angry when you didn't want to	0	1	2	3
38. Not being able to feel your emotions	0	1	2	3
39. Confusion about your sexual feelings	0	1	2	3
40. Using drugs other than marijuana	0	1	2	3
41. Feeling jumpy	0	1	2	3
42. Absent-mindedness	0	1	2	3
43. Feeling paralyzed for minutes at a time	0	1	2	3
44. Needing other people to tell you what to do	0	1	2	3
45. Yelling or telling people off when you felt you shouldn't have	0	1	2	3
46. Flirting or "coming on" to someone to get attention	0	1	2	3
47. Sexual thoughts or feelings when you thought you shouldn't have them	0	1	2	3
48. Intentionally hurting yourself (for example, by scratching, cutting, or burning) even though you	0	1	2	3

weren't trying to commit suicide				
49. Aches and pains	0	1	2	3
50. Sexual fantasies about being dominated or overpowered	0	1	2	3
51. High anxiety	0	1	2	3
52. Problems in your sexual relations with another person	0	1	2	3
53. Wishing you had more money	0	1	2	3
[TSI] In the last 6 months, how often have you experienced:	NEVER.....OFTEN			
54. Nervousness	0	1	2	3
55. Getting confused about what you thought or believed	0	1	2	3
56. Feeling tired	0	1	2	3
57. Feeling mad or angry inside	0	1	2	3
58. Getting into trouble because of your drinking	0	1	2	3
59. Staying away from certain people or places because they reminded you of something	0	1	2	3
60. One side of your body going numb	0	1	2	3
61. Wishing you could stop thinking about sex	0	1	2	3
62. Suddenly remembering something upsetting from your past	0	1	2	3
63. Wanting to hit someone or something	0	1	2	3
64. Feeling hopeless.	0	1	2	3
65. Hearing someone talk to you who wasn't really there	0	1	2	3
66. Suddenly being reminded of something bad	0	1	2	3
67. Trying to block out certain memories	0	1	2	3
68. Sexual problems	0	1	2	3
69. Using sex to feel powerful or important	0	1	2	3
70. Violent dreams	0	1	2	3
71. Acting "sexy" even though you didn't really want sex	0	1	2	3
72. Just for a moment, seeing or hearing something upsetting that happened earlier in your life	0	1	2	3
73. Using sex to get love or attention	0	1	2	3
74. Frightening or upsetting thoughts popping into your mind	0	1	2	3

75.	Getting your own feelings mixed up with someone else's	0	1	2	3
76.	Wanting to have sex with someone who you knew was bad for you	0	1	2	3
77.	Feeling ashamed about your sexual feelings or behavior	0	1	2	3
78.	Trying to keep from being alone	0	1	2	3
79.	Losing your sense of taste	0	1	2	3
80.	Your feelings or thoughts changing when you were with other people	0	1	2	3
81.	Having sex that had to be kept a secret from other people	0	1	2	3
82.	Worrying that someone is trying to steal your ideas	0	1	2	3
83.	Not letting yourself feel bad about the past	0	1	2	3
[TSI] In the last 6 months, how often have you experienced:		NEVER.....OFTEN			
84.	Feeling like things weren't real	0	1	2	3
85.	Feeling like you were in a dream	0	1	2	3
86.	Not eating or sleeping for 2 or more days	0	1	2	3
87.	Trying not to have any feelings about something that once hurt you	0	1	2	3
88.	Daydreaming	0	1	2	3
89.	Trying not to think or talk about things in your life that were painful	0	1	2	3
90.	Feeling like life wasn't worth living	0	1	2	3
91.	Being startled or frightened by sudden noises	0	1	2	3
92.	Seeing people from the spirit world	0	1	2	3
93.	Trouble controlling your temper	0	1	2	3
94.	Being easily influenced by others	0	1	2	3
95.	Wishing you didn't have any sexual feelings	0	1	2	3
96.	Wanting to set fire to a public building	0	1	2	3
97.	Feeling afraid you might die or be injured	0	1	2	3
98.	Feeling so depressed that you avoided people	0	1	2	3
99.	Thinking that someone was reading your mind	0	1	2	3
100.	Feeling worthless	0	1	2	3

APPENDIX G:
SCALE TO ASSESS THERAPEUTIC RELATIONSHIPS IN COMMUNITY
MENTAL HEALTH CARE (STAR – P)

APPENDIX G:**SCALE TO ASSESS THERAPEUTIC RELATIONSHIPS IN COMMUNITY
MENTAL HEALTH CARE (STAR – P)**

	Never	Rarely	Sometimes	Often	Always
1. My clinician speaks with me about my personal goals and thoughts about treatment.	0	1	2	3	4
2. My clinician and I are open with one another	0	1	2	3	4
3. My clinician and I share a trusting relationship	0	1	2	3	4
4. I believe my clinician withholds the truth from me.	0	1	2	3	4
5. My clinician and I share an honest relationship	0	1	2	3	4
6. My clinician and I work towards mutually agreed upon goals.	0	1	2	3	4
7. My clinician is stern with me when I speak about things that are important to me and my situation.	0	1	2	3	4
8. My clinician and I have established an understanding of the kind of changes that would be good for me.	0	1	2	3	4
9. My clinician is impatient with me.	0	1	2	3	4
10. My clinician seems to like me regardless of what I do or say.	0	1	2	3	4
11. We agree on what is important for me to work on.	0	1	2	3	4

12. I believe my clinician has an understanding of what my experiences have meant to me.	0	1	2	3	4
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APPENDIX H:
COUNSELOR WEB-BASED SURVEY

APPENDIX H:**COUNSELOR WEB-BASED SURVEY**

THIS IS A SURVEY ON DOMESTIC VIOLENCE COUNSELING. PLEASE ANSWER EACH QUESTION TO THE BEST OF YOUR ABILITY.

This survey aims to capture the breadth of counseling services provided to survivors of domestic violence as well as what you feel is most helpful.

1. I am currently employed as a counselor at a domestic violence agency.

☐ Yes

☐ No (*Please describe the setting in which you practice domestic violence counseling*)

2. I provide counseling for clients who do not currently reside in a shelter.

Yes

No (*If you answered "no", the survey program will direct you to the end. Thank you.*)

3. I am a : (*please check all that apply*)

☐ Ph.D.

☐ LCSW

☐ LCPC

☐ MSW or MA

☐ BSW or BA

☐ BSW Intern

☐ MSW Intern

Other: _____

4. My highest degree is in:

☐ Social Work

☐ Psychology

☐ Counseling

☐ Human Services

☐ Other: _____

5. I have been through the domestic violence 40 hour training.

☐ Yes

☐ No

6. I am an Illinois Certified Domestic Violence Professional (ICDVP).

- ☐ Yes
☐ No

7. I have been a counselor at a domestic violence agency for: _____ years**8. While at a domestic violence agency, I have provided counseling for (please check all that apply):**

- ☐ Adult survivors of domestic violence
☐ Children/Adolescents of domestic violence survivors
☐ Adolescents in violent dating relationships
☐ Batterers
☐ Other: _____

9. I provide (please check all that apply):

- ☐ individual counseling
☐ group counseling
☐ family counseling
☐ other: _____

10. My agency's guiding theory or overarching principle is based on: (check all that apply)

- ☐ Feminist Theory
☐ Empowerment Theory
☐ Trauma Theory
☐ CBT
☐ Strengths Perspective
☐ Ecological Model
☐ Relational Theory
☐ Connections Model
☐ DBT
☐ Other: _____
☐ Uncertain what principles or theories guide my agency

11. Of the following interventions, rank order the interventions with 1 being the intervention you find most important with survivors of domestic violence and 9 being the least?

- ☐ Empathy
☐ DV Education
☐ Safety Planning
☐ Use of relationship as a healing agent of change
☐ Connecting past experiences to current issues (past child abuse to current relational issues)

CBT
 Parent/Child psychotherapy
 Trauma-informed practice
 DBT
 Group as an intervention
 Other: _____

12. Of the following interventions, which 3 do you use most often with survivors of domestic violence?

- ☐ Empathy
☐ DV Education
☐ Safety Planning
☐ Use of relationship as a healing agent of change
☐ Connecting past experiences to current issues (past child abuse to current relational issues)

CBT
 Parent/Child psychotherapy
 Trauma-informed practice
 DBT
 Group as an intervention
 Other: _____

13. I spend time in the counseling session conducting safety planning with clients:

1-----2-----3-----4-----5-----6-----7-----8-----9-----10
 Hardly Almost
 Ever Always

14. I spend time in counseling sessions providing information on domestic violence (cycle of violence, power and control dynamics, information on how domestic violence affects children):

1-----2-----3-----4-----5-----6-----7-----8-----9-----10
 Hardly Almost
 Ever Always

15. I spend time in sessions offering support to my clients as a counseling technique:

1-----2-----3-----4-----5-----6-----7-----8-----9-----10
 Hardly Almost
 Ever Always

16. I encourage and offer opportunities for my clients to receive support from other survivors in a group setting:

1-----2-----3-----4-----5-----6-----7-----8-----9-----10
 Hardly Almost
 Ever Always

17. I spend time in session discussing the effects of clients' childhood experiences (domestic violence or abuse):

1-----2-----3-----4-----5-----6-----7-----8-----9-----10
 Hardly Almost
 Ever Always

18. I spend time in session discussing my clients' abusive relationships that they have had as adults:

1-----2-----3-----4-----5-----6-----7-----8-----9-----10
 Hardly Almost
 Ever Always

19. I spend time in session providing concrete services (referrals, monetary assistance, etc.) to my clients:

1-----2-----3-----4-----5-----6-----7-----8-----9-----10
 Hardly Almost
 Ever Always

20. Average number of counseling sessions that clients attend:

☐ 1
 3
 5
 8
 12
 16
 20

21. There are many difficult client situations that counselors at domestic violence agencies deal with (clients with difficulties related to immigration status, clients with mental health issues, etc.). What is the most difficult client situation you deal with as a counselor ?

22. When you deal with this type of difficult client situation, what theories do you draw upon the most?

23. What interventions do you find most helpful in those situations?

24. What do you think are similarities and differences among counselors at domestic violence agencies in regards to training, education, and theoretical orientation?

25. What do you wish you could address with your clients, but have not?

N/A I have addressed everything I wanted to with clients.

26. Tell me about a time when your beliefs about what is important in counseling have conflicted with the parameters of your setting (i.e. length of counseling, individual verses group counseling, etc.).

PLEASE TELL US A LITTLE ABOUT YOURSELF.

27. I am:

- ☐ Male
- ☐ Female

28. I am:

- ☐ Caucasian
- ☐ African American
- ☐ Latino American
- ☐ Asian American
- ☐ Native American
- ☐ Biracial
- ☐ Other: _____

29. My age is: _____

THANK YOU FOR YOUR TIME!

APPENDIX I:
COUNSELOR CONSENT FORM

APPENDIX I:
COUNSELOR CONSENT FORM

Project Title: How Counseling Helps: An In-Depth Look at Domestic Violence Counseling

Researcher: Sonya Crabtree-Nelson, LCSW

Faculty Sponsor: Dr. Marta Lundy, Ph.D.

Introduction:

You are being asked to participate in a dissertation research project being conducted by Sonya Crabtree-Nelson, LCSW, under the supervision of Dr. Marta Lundy, Ph.D., in the Department of Social Work at Loyola University Chicago. You received information on this survey forwarded to you by your agency contact for the Chicago Metropolitan Battered Women's Network (the Network), which has agreed to forward information about this study to domestic violence agencies on its member list. They will not have access to any of the raw data from the study. You are being asked to participate because you have provided counseling services to non-shelter residents at a domestic violence agency. If you do not provide counseling services please forward this to a counselor at your agency who provides such services.

Purpose:

The purpose of this study is to learn more about the counseling relationship between survivors of interpersonal violence and counselors at domestic violence agencies. The intent is to find out what is helpful in domestic violence counseling. The researcher will be surveying people who have received counseling at domestic violence agencies as well as counselors at these agencies.

Procedures:

If you agree to be in this study, you will be asked to participate in a survey where you will be asked questions about your experience in counseling survivors of interpersonal violence, techniques or theories you utilize in your work, what counseling services you provide at your agency and what counseling services you refer out for, and what you find to be the most helpful aspects of counseling with survivors. The survey has 22 questions and will take approximately 15 minutes to complete.

Risks:

There are no foreseeable risks involved in participating in this research survey beyond

those experienced in everyday life.

Benefits:

There are no direct benefits to the participants. However, the study is beneficial in that it is looking at what survivors find helpful in counseling at domestic violence agencies as well as what techniques counselors are utilizing in the counseling relationship. The study results will be shared with agencies, funding bodies, and counselors so that survivors of domestic violence can be helped in ways that they have identified as most helpful to them. The counselors who participate will also know that they were able to directly impact current research on domestic violence services.

Anonymity:

All responses to this web-based survey are managed and maintained through the Opinio computer software program, the license for which is owned by Loyola University Chicago. The anonymity of responses is insured through this program. Email addresses and Internet Protocol addresses are separated from the survey responses in the Opinio database, and thus cannot be identified by the researcher. If you complete this anonymous survey and submit it, the researcher will be unable to extract anonymous data from the database should you wish it to be withdrawn. Confidentiality will be maintained to the degree permitted by the technology used. No absolute guarantees can be made regarding the confidentiality of electronic data.

Voluntary Participation:

Participation in this study is voluntary. If you do not want to be in this study, you do not have to participate. Even if you decide to participate, you are free not to answer any question or to terminate the online survey at any time without penalty.

Contacts and Questions:

If you have questions about this research study, please feel free to contact Sonya Crabtree-Nelson at 773-274-5232 ext. 11 (office) or Dr. Marta Lundy @ 312-915-7007. If you have questions about your rights as a research participant, you may contact the Compliance Manager in Loyola's Office of Research Services at 773-508-2689.

By completing the survey you are agreeing to participate in the research

APPENDIX J:
SURVIVOR CONSENT FORM

APPENDIX J:**SURVIVOR CONSENT FORM**

Project Title: How Counseling Helps: An In-Depth Look at Domestic Violence Counseling

Researcher: Sonya Crabtree-Nelson, LCSW

Faculty Sponsor: Dr. Marta Lundy, Ph.D.

Introduction:

You are being asked to participate in a dissertation research project being conducted by Sonya Crabtree-Nelson, LCSW, under the supervision of Dr. Marta Lundy, Ph.D. in the Department of Social Work at Loyola University Chicago.

You are being asked to participate because you are: 1) Currently receiving counseling services in the state of Illinois from a domestic violence agency while not housed in a domestic violence shelter, 2) Did not receive counseling services from Between Friends (formerly Friends of Battered Women and Their Children) while this researcher was employed by the agency (11/04-present), 3) Have received a minimum of two sessions of counseling, 4) Are female, and 5) Speak English.

Please read this form carefully and ask any questions you may have before deciding whether to participate in the study.

Purpose:

The purpose of this study is to learn more about the counseling relationship between survivors of interpersonal violence and counselors at domestic violence agencies. The intent is to find out what is helpful for survivors in non-shelter based domestic violence counseling. The researcher will be interviewing people who have received counseling at domestic violence agencies as well as counselors at these agencies.

Procedures:

If you agree to be in this study, you will be asked to participate in an interview where you will be asked questions about your counseling experiences, why you decided to utilize domestic violence counseling, and what you find helpful in counseling. You will also be asked to complete 3 survey tools. The first is a brief demographic questionnaire, where you are asked some background information such as your age and marital status. The next set of questions is about the feelings and sensations you may have experienced due to the trauma you experienced. You will be asked to answer a number of sensitive questions such as how often you have thought about suicide, how often you engage in risky sexual behaviors, as well as your drug and alcohol usage. These questions are asked in order to help determine the impact that the trauma has had on your life. The third is a brief survey that asks about your relationship with your counselor. The interview will take place at the counseling agency, the researcher's office or at another

mutually agreed upon location. It will take approximately one hour, depending on your situation. The interview will be audiotaped.

Risks:

The foreseeable risks in this study are that it may be uncomfortable to discuss some of the aspects of counseling with a researcher. The interview may touch on information that brings emotional discomfort. You are encouraged to talk with your counselor after the interview if you become distressed. You will also be given the number to the Illinois Domestic Violence Hotline. If you cannot complete the interview, please let the researcher know and the interview can be stopped without penalty.

Benefits:

There are no direct benefits to the participants. However, the study is beneficial in that it is looking at what survivors find helpful in counseling at domestic violence agencies as well as what techniques counselors are utilizing in the counseling relationship. Studies show that survivors would like a voice in the services being offered. The combined, de-identified study results will be shared with agencies, funding bodies, and counselors so that survivors of domestic violence can be helped in ways that they have identified as most helpful to them.

Compensation:

Each counseling interview participant will receive a \$15 gift certificate to Target to compensate for the time spent in the interview. If at any point during the interview or after the interview you decide you do not want to be included in the study, you are still able to keep the \$15 gift certificate.

Confidentiality:

- The audio tapes of the interview will be stored in a locked file cabinet in the researcher's office. After the research project is completed, all the audiotapes will be erased.
- To ensure your confidentiality all interview consent forms will be kept in a separate locked storage cabinet, to which only the researcher has access. Your name and identity will not be used in the work; pseudonyms will be used in all writings, publications or presentations to further protect your confidentiality.
- Each interview will be assigned a client id number and this will be used instead of the client name. The researcher will not record participant's names on the questionnaires.
- A paid transcriptionist will be transcribing the audiotapes. Participant names will not be recorded in the transcripts.
- As the researcher is a licensed social worker and thus a mandated reporter, she is required to report any child and/or elder abuse or neglect that is disclosed.

Voluntary Participation:

Participation in this study is voluntary. If you do not want to be in this study, you do not have to participate. Even if you decide to participate, you are free not to answer any question or to withdraw from participation at any time without penalty. Your decision to participate will not have any affect on your current counseling services.

Contacts and Questions:

If you have questions about this research study, please feel free to contact Sonya Crabtree-Nelson at 773-274-5232 ext. 11(office) or Dr. Marta Lundy @ 312-915-7007.

If you have questions about your rights as a research participant, you may contact the Compliance Manager in Loyola's Office of Research Services at 773-508-2689.

Statement of Consent:

Your signature below indicates that you have read and understood the information provided above, have had an opportunity to ask questions, and agree to participate in this research study. You will be given a copy of this form for your records.

I agree to participate in this study.

Participant's Signature

Date

Researcher's Signature

Date

I agree to have this interview audiotaped.

Participant's Signature

Date

Researcher's Signature

Date

APPENDIX K:
IRB APPROVAL LETTERS

APPENDIX K:

IRB APPROVAL LETTERS



Research Services
Institutional Review Board for The Protection of Human Subjects
Lakeside
Lake Shore Campus
1032 W. Sheridan Road | Chicago, Illinois 60660

October 12, 2009

Dear Ms. Sonya Crabtree-Nelson,

Thank you for requesting approval of an amendment to IRB file #74168, entitled: How Counseling Helps: an In-Depth Look at Domestic Violence Counseling. The IRB has reviewed your Amendment via Expedited Review. After careful examination of the materials you have submitted, the IRB has approved the submitted change(s) in your research project as described in your application through the end of the current approval period for the project. The IRB has approved the final version of the consent form(s). Official stamped version(s) are attached to the email you received. Please make copies of the IRB approved consent form(s) for use in obtaining consent from participants.

At the end of this approval period, you will receive a renewal notice stating that approval of your project is about to expire. This notice will give you detailed instructions for submitting a renewal application. If you do not submit a renewal application prior to June 14, 2010, your approval will automatically lapse and your project will be suspended. When a project is suspended, no more research or writing regarding human subjects may be done until the project is reevaluated and re-approved. I recommend that you respond to these annual renewals in a complete and timely fashion.

This review procedure, administered by the IRB itself, in no way absolves you personally from your obligation to inform the IRB in writing if you propose to make any changes in aspects of your work that involve the participation of human subjects. The sole exception to this requirement is in the case of a decision not to pursue the project—that is, not to use the research instruments, procedures, or populations originally approved. Researchers are respectfully reminded that the University's willingness to support or defend its employees in legal cases that may arise from their use of human subjects is dependent upon those employees' conformity with University policies regarding IRB approval for their work.

Thank you very much for your continued cooperation. If you have questions please feel free to contact me at (773) 508-3018.

Dr. Raymond H. Dye, Jr.
Chair, Institutional Review Board

CC: Dr. Marta Lundy -Social Work



Research Services
Institutional Review Board for The Protection of Human Subjects
Lakeside
Lake Shore Campus
 1032 W. Sheridan Road | Chicago, Illinois 60660

June 15, 2009

Dear Ms. Sonya Crabtree-Nelson,

Thank you for submitting the research project entitled: How Counseling Helps: an In-Depth Look at Domestic Violence Counseling, for review by the Institutional Review Board for the Protection of Human Subjects. After careful examination of the materials you submitted, we have approved this project as described for a period of one year. The IRB has approved the final version of the consent form(s). Official stamped version(s) are attached to the email you received. Please make copies of the IRB approved consent form(s) for use in obtaining consent from participants.

Approximately eleven months from your initial review date, you will receive a renewal notice stating that approval of your project is about to expire. This notice will give you detailed instructions for submitting a renewal application. If you do not submit a renewal application prior to June 14, 2010, your approval will automatically lapse and your project will be suspended. When a project is suspended, no more research or writing regarding human subjects may be done until the project is reevaluated and re-approved. I recommend that you respond to these annual renewals in a complete and timely fashion.

This review procedure, administered by the IRB, in no way absolves you, the researcher, from the obligation to immediately inform the IRB in writing if you would like to change aspects of your approved project (please consult our website for specific instructions). You, the researcher, are respectfully reminded that the University's ability to support its researchers in litigation is dependent upon conformity with continuing approval for their work. Should you have questions regarding this letter or general procedures, please contact the Compliance Manager at (773) 508-2689. Kindly quote File #74168 if this project is specifically involved.

Thank you for your careful attention to this process.

Dr. Raymond H. Dye, Jr.
 Chair, Institutional Review Board

CC: Dr. Marta Lundy -Social Work

APPENDIX L:
CONFIDENTIALITY AGREEMENT FOR TRANSCRIPTIONIST

Appendix L:**Confidentiality Agreement for
Transcriptionist****Transcriptionist Confidentiality Agreement**

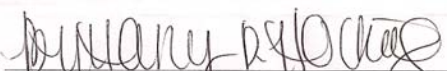
Dissertation Project
Sonya Crabtree-Nelson, LCSW
Doctoral Program: School of Social Work
Dissertation Director: Dr. Marta Lundy, Ph.D.

Title: How Counseling Helps: An In-Depth Look at Domestic Violence Counseling

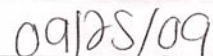
Confidentiality Agreement

In serving as transcriber for the counselor interviews, I agree to respect the confidentiality of all information shared in the process of this study. I agree to not discuss the transcripts with anyone other than the researcher.

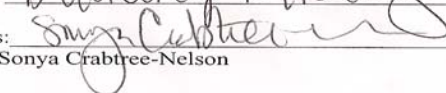
Signed: _____



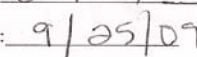
Date: _____



Witness: _____


Sonya Crabtree-Nelson

Date: _____



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Zweig, J. M. & Burt, M. R. (2007). Predicting women's perceptions of domestic violence and sexual assault agency helpfulness: What matters to program clients? *Violence Against Women*, 13(11), 1149-1178.

VITA

Sonya V. Crabtree-Nelson was born in Milwaukee, Wisconsin and raised in various small towns across the state. She is a licensed clinical social worker with over 10 years of experience in working with individuals and families affected by trauma. Before attending Loyola University Chicago, she attended Wartburg College, where she graduated Summa Cum Laude with a Baccalaureate Degree in Social Work in 1995. She also completed her graduate studies at Jane Addams School of Social Work at the University of Illinois at Chicago, where she received a Master's Degree in Social Work in 1998.

Sonya has extensive experience working with women and children who are survivors of domestic violence. She has received advanced training in Child Parent Psychotherapy, as well as advanced domestic violence training. In addition to providing consultation and supervision to Master's level therapists who are studying for their licensure, Sonya is currently an Adjunct Professor in the Social Work and Sociology Department at Concordia University in River Forest, IL.

Sonya is a member of the National Association of Social Workers and is an Illinois Certified Domestic Violence Professional. While at Loyola, Sonya was awarded the Advanced Doctoral Fellowship from the Graduate School for the 2009-2010 academic year. She was also awarded a fellowship opportunity to participate in the

Graduate Undergraduate Mentor Program through Loyola's Graduate School for the summer of 2009.

Sonya has made numerous presentations on topics related to clinical work with survivors of domestic violence. Most recently, Sonya gave a presentation titled "An In-Depth Look at Domestic Violence Counseling" at Loyola University Chicago's Graduate School Interdisciplinary Research Symposium in April 2010 where she received an award for her presentation. She also presented a paper, "How Counseling Helps: Exploring Domestic Violence Counseling" at the National Association of Social Workers, IL Chapter's conference in September 2009. Sonya co-authored a paper titled "Shelter and Service Receipt for Victims of Domestic Violence in Illinois", published in the *Journal of Interpersonal Violence*.

DISSERTATION APPROVAL SHEET

The dissertation submitted by Sonya V. Crabtree-Nelson has been read and approved by the following committee:

Marta Lundy, Ph.D., LCSW, Director
Professor of Social Work
Loyola University Chicago

Susan Grossman, Ph.D.
Professor of Social Work
Loyola University Chicago

Teresa Kilbane, Ph.D.
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The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

Date

Director's Signature