Battered Women: Stages of Change and Other Treatment Models That Instigate and Sustain Leaving

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This article incorporates a cognitive problem-solving intervention model in a case report of a chronically abused woman from Roberts’ continuum of the extent and chronicity level of women battering. It depicts Prochaska and DiClemente’s stages of change and Roberts’ crisis intervention model in the progressive movement from living in a battering situation to leaving the relationship and becoming independent. By attempting to understand the nature of the battering experience and how women cope on a daily basis, insights can be illuminated into their survival skills and the strengths that are utilized to make the decision to leave, act upon, and sustain that goal. In addition, the application of the cognitive problem-solving intervention model to the battering experience of clients can assist practitioners in developing treatment assessments and strategies that intend to motivate their clients to move towards freedom of choice, disengagement, and empowerment. [Brief Treatment and Crisis Intervention 3:83–98 (2003)]

KEY WORDS: battered women, stages of change, domestic violence, crisis intervention, cognitive therapy, problem solving.

Despite severe physical and emotional traumas inflicted by batterers, there continues to be a measure of suspicion and questions of culpability addressed to the target of the aggression. Queries like, “Why does she put up with that?” and “Why does she stay?” continue to haunt the battered woman and demonstrate a pervasive reversal of condemnation—from the perpetrator to the victim. The implication is “that the battered woman’s behavior is problematic, rather than that of their abusive partners” (Ferraro, 1997, p. 124). This ego-deflating and incriminating element can serve to keep a woman trapped in a situation that she may view as being incapable of ending herself, and even one that is justified due to her own faults and imperfections. It is a classic incriminating spin of “blaming the victim” that women must defend against—one that serves to justify violence and the status quo in a violence-prone society.

Yet we know that women do attempt to end assaultive relationships and many do leave, often putting themselves at great risk. Roberts
(2002) relates that no single characteristic defines the potential for leaving the batterer. However, staying in the relationship may be more likely when a group or cluster of personal and situational characteristics can be identified. Many are based on psychosocial variables, duration of the battering, and levels of violence against women. By attempting to understand the nature of the battering and how women cope, we can also glean some insights into their survival skills and the strengths that are utilized to make the decision to leave, act upon, and sustain that goal.

With his prolific research and writings, Roberts has greatly contributed to the knowledge base of domestic violence. His formulation of a seven-stage crisis intervention model (Roberts, 2000) and different levels (a continuum) of the severity of battering that women persevere through time (Roberts, 2002) can provide a therapeutic direction towards identifying coping skills needed to upset the status quo, thereby freeing these women from the torment they experience. In his study of 501 battered women who left their batterers, we can derive an indication of not only the extent and chronicity of the battering episodes, the demographic characteristics of these women, and the means of ending the relationships, but also can extrapolate varying stages of change (Prochaska & DiClemente, 1982; Prochaska & Prochaska, 2002) that eventually result in the leaving/escape phenomenon. By identifying these stages, practitioners can develop treatment assessments and strategies to be used at each phase of potential movement towards disengagement and empowerment.

The stages of change have been aptly described by Brown (1997) in her article on battered women, and Petrocelli’s (2002) integration of the stages in the counseling process. Expanding on their work, this article will examine the stages’ goals and tasks, Roberts’ crisis intervention model and severity continuum, and a cognitive problem-solving practice model that is detailed in a case report of the battering and leaving experience.

The Stages of Change

Prochaska, Norcross, and DiClemente (1994) remarked, “[W]e can exert some power over the course of our own lives. . . . [A]ny activity that you initiate to help modify your thinking, feeling, or behavior is a change process” (pp. 13, 25). This empowering stance was introduced in the hallmark work of Prochaska and DiClemente (1982) that was heralded as a paradigm shift, confronting the staunchly held beliefs about the rigidity of maladaptive behaviors. Initially researched on smokers who quit on their own (without treatment), the transtheoretical change model and its stages of change have been applied to drug cessation, weight reduction, and other problematic behaviors and conditions. From the data collections, themes of change were noted within six active stage categories titled precontemplation, contemplation, determination/preparation, action, maintenance, and termination.

Precontemplation

During this period, the battered woman tends to minimize or deny the source, extent, and consequences of the problem, refraining from viewing her partner in a realistic light. She may be defensive if anyone suggests or suspects something is wrong, trying to hide or rationalize the remnants of bruises that others may see, much to their concern and dismay. She accommodates herself to the situation, constantly hoping that by pleasing her spouse/partner and improving her behavior, he will “change his ways.” The excuses and promises that it will never happen again, and intermittent “honeymoon stages”
provide a faulty sense of optimism that the abusive behaviors are under control and will not be repeated. At the same time, there is an invasive apprehensiveness in her daily routine—one that lies just beneath the surface and threatens the vulnerable state of stability and security.

Within the context of this stage, traumatic bonding becomes pronounced. Dutton (1992b) reported that this emotional connection is rooted during the early phase of the relationship, often before the abuse begins. Intermittent expressions of concern/reinforcement and violence intensify the attachment/traumatic bonding (Barnett, 2001; Saunders & Edelson, 1999). With increasing forced isolation, a dependency on the batterer grows, reducing the potential for constructive change and leaving the relationship. Concurrently, a demoralized and shattered sense of self-esteem and self-worth, accentuated by a feeling of responsibility and self-blame for the assaults, are noted. “If I had not spoken up and argued, if I had only done something differently, it never would have happened.” Through the development of learned helplessness (Walker, 1994), the woman eventually accepts that the battering cannot be controlled no matter what she does, resulting in feelings of powerlessness, helplessness, and hopelessness.

Consequential emotional responses of depression and anxiety can be extremely debilitating. “Psychic numbing,” an avoidance response that functions to deny or minimize an awareness of the traumatic experience and its aftermath, may occur (Dutton, 1992b). Alternatives to living in this manner are cognitively unrecognized. Nevertheless, the seeds of change are being gradually sown. A primary treatment goal and task in this stage is to raise doubt about maintaining the current situation by providing information about the critical nature of abuse and increasing an awareness of the personal risks involved in continuing the relationship, if nothing changes.

**Contemplation**

Ambivalence marks this stage, that is, “simultaneously (or in rapid alternation) experiencing reasons for concern and for unconcern, motivations to change and to continue unchanged” (Miller & Rollnick, 1991, p. 16). The cognitive dissonance between a loving and uncaring/abusive relationship begins to grow, accentuated by the batterer’s inconsistent behaviors. As the abuse continues, denial and its adaptive mechanisms weaken. Escalation of the violence and its severity initiates a realization of the potential lethality and lack of personal safety. Ferraro (1997) related that during this stage of ambivalence, fighting back may be a defensive tactic, as self-protection becomes a vital need. However, it is generally not effective and often results in escalating the violence and resultant injuries. The first effort at leaving may be attempted, but is usually not permanent.

A goal in this stage is to reduce the ambivalence and cognitive dissonance through a reasoned evaluation of the battering relationship, leading to making a conscious decision to change. The decisive task that generally precedes the transition to the next stage of determination/preparation to creating a change is conducting a cost-benefit analysis (the weighing of the costs and benefits or pros and cons of remaining versus leaving—a treatment focus in the contemplation stage). The disadvantages of “going it alone” can be disarming and overwhelming, including economic insecurity and the possibility of not obtaining gainful employment to support herself and her children; lacking supports and other resources can also undermine an active move to the next stage of change. The batterer’s terrorist tactics may immobilize the woman, placing her in a “no win” situation. If she stays, she is at risk; if she leaves, she can be stalked, harassed, and pursued with death threats. Harm to her children is also a reality of major concern. At
this point of desperation, she may find that the choice of escaping may be the only viable option to survival. A *decisional balance chart* can illuminate positive aspects of leaving, which may hold aspects of risk, but compared to the alternative, holds more promise for safety and freedom from terror and bodily harm (Table 1).

**Determination/Preparation**

The goal at this stage is to determine the best course of action and prepare to carry it out. Ambivalence may still be evident, but this diminishes with each bout of terrorism and brutality. Awareness of these events, with no essential modification of the batterer’s actions, reduces thoughts of staying and increases the commitment to change. A decision is made to leave, and strategies are formulated that are most suitable to personal needs and circumstances. Putting money away in a safe place to assist with the escape and getting started again in a different location; collecting phone numbers and addresses of supports and resources to contact at the crucial time of need; finding the location of a shelter for women (and their children, if needed); and checking into alternative housing, legal aid services, adequate transportation, and day care are some preparation tasks to consider. Women with greater amounts of resources, options, and supports are in a better position to leave, being able to utilize various sources of safety, protection, and independent living, while developing further plans to maintain the change.

**Action**

Taking action means confronting trepidations and fortifying efforts and goals of change. The prospect of leaving, with potentially dangerous repercussions, inevitably provokes fear and apprehensions, but the alternative at this stage can be more frightening and disabling. Having considered the options and made a rational decision to leave, energy is now directed towards the goal of carrying out strategies that will protect the woman (and her children) in the ultimate objective of safety and protection from continued assaults. Tasks/strategies can include going to a shelter, calling on relatives or friends for help, and obtaining a restraining order. Police intervention, which may have been required previously to counter attacks, can now be a means of keeping the batterer at bay. Unfortunately, even these efforts might not eliminate the danger, for an obsessed partner will return. His dependency needs and the desire for power and control are relentless and consuming. Yet once a woman takes action steps, personal strengths and survival skills are tapped, reinforcing the motivation to end the abuse and escape the battering relationship.

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**TABLE 1. Decisional Balance Chart**

<table>
<thead>
<tr>
<th>Disadvantages of Leaving</th>
<th>Advantages of Leaving</th>
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<tbody>
<tr>
<td>Fear of making it alone</td>
<td>Feelings of empowerment (self efficacy, confidence, respect)</td>
</tr>
<tr>
<td></td>
<td>Improved self image</td>
</tr>
<tr>
<td></td>
<td>Improved coping, decision-making, problem-solving skills</td>
</tr>
<tr>
<td>Financial insecurity</td>
<td>Greater opportunities for advancement</td>
</tr>
<tr>
<td></td>
<td>Renewed hope for a better life</td>
</tr>
<tr>
<td>Fear of stalking/increasing abuse</td>
<td>Only survival/safety option left for my children and myself</td>
</tr>
<tr>
<td></td>
<td>Breaking the intergenerational cycle of violence</td>
</tr>
</tbody>
</table>
Drug use by either the perpetrator or victim must always be a consideration when assessing the severity of battering. It can impede planning and taking action to leave the relationship, when chemicals are used to self-medicate and cope with the stress, pain, and suffering. Dutton (1992b) commented that this behavior “interfere[s] with the battered woman’s attempts to gain control over her own life, may be dangerous to others (e.g., her children), or produce negative effects (e.g., drug or alcohol addiction, arrest, loss of children to social services” (p. 126). In order to activate the tasks of rescue and leaving, cognitive processes must be clear of drugs that can impair and dull thinking, judgment, and coordination. The prospect of an addiction can add another entrapment that defies personal control and weakens the search and acquisition of a meaningful existence. For those women who have used drugs with their partners (and may have been introduced and supplied by them), the chances of escape and remaining independent are markedly reduced, as the compelling nature of the drug takes precedence over a way out of the relationship.

**Maintenance**

Understandably, Miller and Rollnick (1991) explained, “Making a change, however, does not guarantee that the change will be maintained” (p. 17). That is precisely why the goal of this stage is to prevent a relapse to returning to the perpetrator of the horrific abuse. In the case of the battered woman, there are enormous obstacles to preventing this relapse, which in this context would lead to reestablishing the relationship. Ferraro (1997) reported that generally between five and seven attempts to leave are made, before finally being successful. Many women return after departing from a shelter or other locations of escape. Various reasons have been given for this action, including “fear, continuing emotional involvement, desire to keep the family together, and lack of viable alternatives” (p. 133), and as previously cited, an addiction to drugs that weakens fortitude, goal commitments, and resolve.

Also to be considered is the threat of impending death and incapacitating injuries if found. These fears become overpowering as time passes. No matter where the woman goes or hides, thoughts of being found create nightmares, intense trepidations, and emotional turmoil. Post-traumatic stress symptoms (e.g., anxiety-producing assault flashbacks and hypervigilance), as well as pervasive grief reactions over losses (e.g., reminders of positive aspects of the relationship, former economic security), exaggerate the vulnerability to goal commitment. These events make it difficult for some women to sustain a lasting change. Nevertheless, many women do indeed make and carry out strategies to maintain the separation, eventually moving toward the final stage of termination. The utilization of treatment resources and ongoing supportive structures can be crucial elements in alleviating troubling symptoms and coping with the marked changes this stage presents. With each step in this journey, a reaffirming of the self becomes more apparent.

**Termination**

If termination of the battering experience can be achieved, an empowering grasp of self-efficacy, self-confidence, and a positive self-image can emerge. Women come to believe that their actions/behaviors have made a positive difference in their lives. The relief of being unburdened confirms the favorable aspects of change. Yet the aftermath of the harrowing experience may linger interminably, and despite its subtle effects, they may feel an attachment to the partner left behind. Even the perpetrator’s death may not sever this bond. But a new life can be
sought if needed resources and opportunities are available to counter this lingering emotional connection—e.g., earning a satisfactory income, suitable housing and other basic necessities, legal assistance and protection, and enduring supports. Investing in trusting relationships and social networks takes time, patience, and effort, as with the seeking of satisfying goals and career choices.

Roberts’ Seven-Stage Crisis Intervention Model and Battering Severity Continuum

The crisis intervention model (Roberts, 2000) provides pertinent guidelines to follow in the crucial period of early crisis resolution (Figure 1). Divided into seven stages, the model details hierarchical assessment and intervention activities that aim to subdue a crisis so that strength-oriented, empowering cognitive and independent functioning can be achieved.

Stage 1 details a risk assessment screening plan that examines imminent danger and potential lethality measures. Stage 2 initiates relationship building, based on trust and rapport, which will facilitate entry into the next phase (Stage 3). During this stage (problem identification and definition), the severity and duration of precipitating events that led to help-seeking are examined. Stage 4 employs therapeutic skills (e.g., active listening, empathy, reflecting and summarizing disclosures) to explore clients’ feelings and emotions. Stage 5 assesses previously developed coping mechanisms, both adaptive and maladaptive, that forged reactions to crisis events. From this data, alternative coping methods that tap into client strengths are introduced, laying the foundation for empowering cognitive problem solving. Stage 6 formulates an action plan that involves incorporating rational cognitive functioning, goal setting, and taking steps to develop and implement problem solutions toward crisis resolution. The final phase, Stage 7, affords the opportunity to examine and reinforce progress made. Acknowledging the importance of maintaining these positive changes, follow-up sessions are mutually planned and agreed upon.

Five levels of duration and severity of battering (Roberts, 2002) have been developed from a statewide research study of battered women in pertinent locations—“prisons, shelters, police departments, and the community” (p. 68). This continuum typology’s usefulness, as a clinical diagnostic and risk indicator, is significant in identifying the level of subjective danger before more extensive injuries and even death might occur. With this vital information, mental health and criminal justice practitioners can intervene, with the aim of preventing further violence and harm, while empowering battered women to gain freedom from further pain and suffering.

From level 1+ (short-term victims) to level 5+ (homicidal), the battering experience is described from both duration and severity perspectives. Psychosocial variables of descriptive levels provide additional descriptive indicators for risk assessments. Table 2 delineates the major significant points to consider in each level of the continuum.

The Cognitive Problem-Solving Practice Model

Cognitive problem-solving treatment serves to reinforce and fortify the gains made through crisis intervention that provided a foundation for problem solving and empowerment. Yet we know that vulnerability remains; return to the nightmarish existence is not uncommon. Therefore the client would benefit greatly with continued help in sustaining previous advances made, while reinforcing positive behavioral and emotional change. A continuity of supportive
environmental resources should be recognized and tapped. This treatment approach is a natural progression to Roberts’ crisis intervention model, complementing its cognitive problem-solving emphasis on positive change (refer to Roberts & Burman, 1998, for a more detailed discussion).

To demonstrate the usefulness of the practice model, this article will concentrate on the case of Naomi, a severely battered woman whose traumatic experiences and efforts toward leaving her husband were previously cited in the Handbook of Domestic Violence Intervention Strategies (Roberts, 2002, pp. 74–75). The severity and duration of her abuse place her in level 4+ of Roberts’ continuum typology (i.e., a regu-
<table>
<thead>
<tr>
<th>Characteristics</th>
<th>1+ Short-term, n = 94</th>
<th>2+ Intermediate, n = 104</th>
<th>3+ Intermittent long-term, n = 38</th>
<th>4+ Chronic and predictable, n = 160</th>
<th>5+ Homicidal, n = 105</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration</td>
<td>Less than 1 year (dating relationship) mild to moderate intensity</td>
<td>Several months to 2 years (cohabiting or married); moderate to severe injuries</td>
<td>Severe and intense violent episode without warning; long periods without violence, then another violent episode; married with children</td>
<td>Severe repetitive incidents; frequent, predictable pattern; violence often precipitated by alcohol or polydrug abuse; married with children</td>
<td>Violence escalates to murder/manslaughter precipitated by explicit death threats and life-threatening injuries (cohabiting or married)</td>
</tr>
<tr>
<td>Severity level</td>
<td>1–3 incidents</td>
<td>3–15 incidents</td>
<td>4–30 incidents</td>
<td>Usually several hundred violent acts per woman</td>
<td>Numerous violent and severe acts per woman</td>
</tr>
<tr>
<td>Psychosocial variables</td>
<td>Usually middle-class and steady dating relationship (severity, e.g., push, shove, and sometimes severe beating; woman leaves after first or second physically abusive act; caring support system, e.g., parents or police)</td>
<td>Usually middle-class and recently married or living together (severity, e.g., punch, kick, chokehold, or severe beating; woman leaves due to bruises or injury; caring support system, e.g., new boyfriend or parents)</td>
<td>Usually upper-middle or upper social class, staying together for the children or status/prestige of wealthy husband (woman stays until children grow up and leave home; no alternative support system)</td>
<td>Usually lower socio-economic or middle class, often devout Catholic with school-age children at home (abuse continues until husband is arrested, is hospitalized, or dies: husband is blue-collar, skilled or semiskilled)</td>
<td>Usually lower socio-economic class, high long-term unemployment, limited education (majority of battered women dropped out of high school; woman usually suffers from PTSD and BWS)</td>
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lar pattern of chronic and severe battering). The category includes the majority of women in the research study, and therefore can be a focal point to illuminate pertinent strategic coping methods and problem-solving skills instigated toward terminating battering relationships. Generally, unlike the short-term, intermediate, and intermediate long-term categories of battering, the violence directed at chronically battered women is predictably a discernable pattern and often precipitated by alcohol or polydrug abuse. Extent of the injuries may vary, but become more extreme and debilitating with the passage of time. Heightened consideration must be given to safety precautions, alleviating emotional distress, improving coping skills, developing and implementing action plans, and addressing other pressing concerns and issues that might arise during the treatment process.

Naomi’s Experience

Leaving her husband was initiated after a desperate period of crisis following a severe battering that culminated seven years of terror and incapacitating injuries. Naomi entered a shelter with her child, attended a battered women’s support group and received counseling that motivated her readiness to change. Roberts’ seven-stage crisis intervention model helped to identify recurring problems of violence and harassment that put her at greater risk with the passage of time. It also assisted in contemplating options and devising a viable action plan. The stages of change raised doubts about her husband’s willingness and capabilities to alter his abusive behaviors and reinforced the need to sever emotional and physical ties that kept her captive in the relationship. After realistically weighing the costs and benefits of staying with her husband, Naomi became determined to take safety precautions and carried out her course of action. Having accomplished these tasks, she shortly thereafter sought additional treatment to maintain the gains made. She realized that her current situation was precarious and was fearful of faltering in her resolve to terminate the relationship. This began the next phase of Naomi’s journey towards empowerment and independence.

Treatment: A Cognitive, Problem-Solving Model

Consistent with intervention protocols, the initial engagement of the client in a trusting and rapport-building relationship is critical to establishing compliance and willingness to participate fully in treatment. Acknowledging Naomi’s significant changes to date, the mutually agreed-upon treatment plan was geared to preventing relapse, monitoring safety activities, and improving/developing new problem-solving coping skills geared to satisfying and healthy functioning. It was necessary to take a general history, type and severity of assaults and injuries experienced, and problems that emerged since leaving her husband, in order to design and implement the treatment plan.

Problem-solving steps included (a) a general, lethal, and mental health assessment, (b) problem identification and implications, (c) goal setting and contracting, (d) implementation of interventions, (e) termination and referrals, and (f) an evaluation of the effectiveness of interventions.

A General Background Assessment

The following data was derived from a preliminary interview with Naomi, placing her in the category of a chronically abused woman (Level 4):

**Demographics.** Thirty-four-year-old single parent with one child; high school graduate;
worked for the same company for 14 years as a customer service representative.

Abuse history. Father was an abuser; chronically abused by her husband for 7 years (mostly without warning).

Abuse injuries. Broken nose; bruises all over body; eye swollen from punches (three different occasions); punched in mouth; choked several times; faked passing out after being strangled (attempt to avoid being killed).

Seeking help. Attended a shelter and support group for battered women, after which she made the decision to leave her husband; obtained a court restraining order.

A Lethality and Mental Health Assessment

The predictable nature of the repetitive cycle of abuse over a 7-year period and the mode and extent of the injuries acquired must alert to the potential for lethality. It can be surmised that if Naomi had not escaped from this situation, the abuse would have escalated to this magnitude. Yet the mental health assessment exhibits an overlying emotional attachment/grief over losses and emerging post-traumatic stress symptoms, including emotional/psychic numbing, flashbacks, reexperiencing the trauma, hypervigilance, insomnia, inability to concentrate, anxiety, and depression. These symptoms are often debilitating and can readily deplete her energy and the positive changes made.

Problem Identification and Implications

From the assessments conducted, several problem areas should be targeted in treatment:

1. Recurrent emotional distress and symptoms of post-traumatic stress disorder that surface periodically.
2. Recurrent fears of the batterer’s retribution/return (safety considerations).
3. Inability to maintain changes and potential relapse (return to the battering relationship).
4. Lack of a wide network of stable social supports and necessary community resources.

Interventions

Planned clinical procedures are designed to focus on the presenting problems, in order to produce meaningful behavioral and emotional changes to support treatment goals. A clearly defined, step-by-step format can follow this design:

problem → objective → intervention → goal.

Problem 1 Recurrent emotional distress and symptoms of post-traumatic stress disorder (PTSD) that surface periodically.

Objective 1 Client will utilize group and individual therapy to address the emotional distress.

Interventions Homework assignment: Read checklist of cognitive distortions from the Feeling Good Handbook (Burns, 1989, p. 96).

1. Make a list of five recent times you experienced emotional distress.
2. List cognitive distortions you experienced during these times of distress.
3. Discuss this list during group therapy and individual therapy for feedback.
4. Develop five rational responses (realistic thoughts) that will address these feelings of emotional distress.

Objective 2 Client’s symptoms related to emotional distress and PTSD will be alleviated with the aid of medications (if medically indicated).
**Interventions**

1. Referrals will be made for testing of anxiety-related symptoms.
2. Depending on test results, antidepressant and anti-anxiety medications may be prescribed.

**Goals**

1. To develop problem-solving and cognitive/behavioral coping skills through cognitive restructuring and other techniques to relieve the emotional distress and maintain the change process.
2. To stabilize medically and relieve anxiety-related signs and symptoms.

**Problem 2** Recurrent fears of the batterer’s retribution/return (safety considerations).

**Objective 1** Client will add new precautionary measures to the safety plan devised at the shelter with the assistance of therapy feedback and the book, *A Woman Like You: The Face of Domestic Violence* (Anderson, 1997).

**Objective 2** Client’s fears will subside after safety plan has been updated, with reassurance from peers in the battered woman’s group.

**Interventions**

1. Client will review her safety plan and discuss it in therapy sessions.
2. Client will obtain 10 more safety measures from feedback and the assigned book, to combine with the original plan.

**Goal** To empower the client to develop a safety plan that will have the effect of counteracting potential repetition of assaultive behaviors.

**Problem 3** Inability to maintain changes and potential relapse (return to the battering relationship).

**Objective** Client will utilize therapy groups and individual counseling to identify strategies that affirm the gains made by her decision to leave the battering relationship.

**Interventions**

1. Identify five danger signs that may provoke a potential relapse and return to the abusive relationship. Discuss these in treatment sessions.
2. Detail five treatment strategies that will maintain positive changes accomplished and discuss the possible outcomes in treatment sessions to obtain constructive feedback.

**Goal** To successfully complete the maintenance stage of change by improving coping skills; experiencing a sense of self-efficacy, self-confidence, and empowerment; and guarding against falling back to self-defeating behaviors and thought processes.

**Problem 4** Lack of a wide network of stable social supports and necessary community resources.

**Objective** Client will obtain lists of social supports and community resources from social service departments and personal/associate contacts to secure safety and will look into opportunities for advancement and healthy living.

**Interventions**

1. Identify suitable community resources from United Way and other agency resources.
2. Note potential supports and resources from churches, schools, and media outlets.
3. List five desirable goals and opportunities that will be of interest, will be manageable, and have potential for success.

**Goal** To develop and maintain supportive structures and resources that can be tapped when...
needed in order to sustain efforts toward independent living arrangements.

**Contract/Informal Agreement on the Number of Sessions**

It is expected that the initial contract will specify 12–15 sessions, with more to be included if needed. An ongoing assessment and mutual agreement may alter the actual number of sessions and responsibilities/tasks.

**Implementation of the Cognitive, Problem-Solving Model**

Naomi has thus far made courageous strides in escaping a potentially dangerous situation, but her resolve and actions remain uncertain. After leaving her husband, she and her child went to a shelter where they found safety, compassion, and vital services (e.g., counseling, community referral sources). They then moved in with a friend from work who was unknown to Naomi’s husband. Realizing this was temporary, she had to formulate ideas and decisions about the future. During this period, fears of retribution from her husband and emotional reactions to past experiences created havoc in her daily routine. She considered moving away, but felt immobilized by having to make it on her own without the security of her long-held job. She began to have second thoughts about the decision to leave her spouse, as recurrent favorable memories were interspersed with the negative aspects of the relationship. The emotional attachment had not been severed, as she grieved the loss of the only man she had loved so intimately.

Therapy was sought to alleviate distressing symptoms and, as Naomi expressed, to “gain guidance before making a move that I might regret.” She was obviously struggling against an impulsive action, attempting to control her emotions and behaviors by cognitively weighing the pros and cons of any decision she might make (as she had done in a previous stage of change). Her inner strength had gotten her out of a hazardous relationship, but she was now feeling vulnerable. Due to the acute nature of post-traumatic symptoms and difficulty maintaining the changes she had made, treatment was to focus on these issues concurrently. In addition to reaffirming Naomi’s positive changes, relapse prevention would be prominent in the plan to maintain her progress and help move ahead with her goals.

An assessment of her safety precautions, current emotional stability, and coping skills was conducted in order to ascertain an appropriate individualized treatment and action plan. Various scales were helpful in measuring the degree of symptom severity: the PTSD Diagnostic Stress Scale (Foa, Cashman, Jaycox, & Perry, 1997), the Beck Depression Inventory II (Beck, Steer, & Brown, 1996), and the Beck Hopelessness Scale (Beck, Weissman, Lester, & Trexler, 1974). The Response to Violence Inventory (Dutton, 1992a) assessed coping strategies in reaction to battering incidents; open-ended interviews enumerated safety precautions taken in the past and continued to the current time.

A contract was agreed upon that Naomi would not return to her husband while in treatment (a period of 3 to 4 months), and if a personal decision were made to do so, she would discuss the advantages and disadvantages in a session. She realized the choice was hers to make, but rationally and not under duress. In the meantime, a therapeutic relationship was being established, based on mutual rapport and trust.

**Cognitive Restructuring.** It was important to point out, reaffirm, and have Naomi cognitively examine the reasons she left her husband, and the determination, strengths, and resourcefulness she exhibited while taking the necessary action steps to do so. Although many trepida-
tions and other emotions were evident during this process, she willfully and forcefully set and followed through with her goal. Finding meaning in these actions was critical, in order to strengthen her commitment to change the status quo and take control of her life. Many problem-solving skills were in place, but she needed positive reinforcement to internalize the empowering gains already made by her own efforts.

Many factors, previously cited, jeopardize the maintenance stage of change. Among these are also intrusive, self-defeating thoughts (e.g., “I can’t make it alone”) that relate the feelings of hopelessness and powerlessness endemic in the battered woman’s experience. Through reflective listening, reframing negativity, and reality testing, Naomi was coached to monitor, challenge, and modify these beliefs and thought patterns that created troublesome and unsettling emotions. Assertiveness training and positive self-talk in the form of affirmations added to her repertoire of coping skills. She was also reminded that her lengthy work record and advancement were evidence that she had the capability of surviving autonomously and independently, while making significant strides in protecting herself and her child.

The lingering attachment bonds posed another difficulty to overcome. She was challenged to provide indications that her needs and expectations were being met in the relationship. The betrayal of trust and dreams of a happy and secure marriage could not be justified; positive feelings that were developed earlier, before the advent of the abuse, had changed to fear and disillusionment. When reconstructing events, she concluded that what she had considered love was a developing unhealthy dependency. The caring and concern for her husband was not returned in kind; therefore, her self-esteem and self-worth diminished.

Naomi adamantly acknowledged that had she stayed, she might be dead by now. This was demonstrated by the last choking scene in which she felt compelled to “fake passing out” to stop the strangling resulting from her husband’s rage. He had been drinking heavily during this episode and many others. Naomi had always blamed the alcohol or even her own provocation for these transgressions, but through recall and logic, was able to admit that “he beat me relentlessly, even when he was sober and no matter what I did or said.” Exploring these events provided a new perspective to ponder. Soon she realized that he was responsible for his behavior; the desire for control and power over her was the source of the aggression, and undoubtedly would continue if she returned.

Focus on Emotional Distress. Coping with debilitating memories of past abuses was facilitated by having Naomi recall accounts of the assaults in a manner in which the original anxiety and other debilitating emotions could now be controlled and subdued in a recognizably safe environment, without fears of being revictimized. Relaxation and stress management training preceded this endeavor so she could pace the emerging emotions to her level of tolerance. Homework assignments were constructed to practice these relaxation techniques, while simultaneously disqualifying the force of disabling fears that often erupted spontaneously. The aim of these activities was to decrease emotional reactions to trauma reminders by increasing her power and control over them. It was important to have her understand the essence of post-traumatic symptoms as reflections of past painful and fear-evoking experiences that could be reduced and systematically desensitized when examining them in another context, under differing circumstances. Antidepressant medication (Prozac) was initially prescribed, while monitoring closely for mood stabilization and potential side effects. Similar to other treatment modalities, assertiveness training, positive self-talk, and affirmations had a positive effect in reducing the debilitating effects of emotional distress.
Grief work encompassed the many losses Naomi experienced—the relationship with her husband, her home and security, and her sense of self that she once valued. She had to come to terms with the reality of what the relationship had become in contrast to what she had hoped for, in order to let go of it. And she had to regain self-respect and confidence in herself as a vital, productive woman, unencumbered by self-blame and guilt. To accomplish these realms, the sense of loss and subsequent emotions had to be realized, accepted, and expressed, thereby acknowledging and comprehending the normality of the pain and confusion that accompanies grief. This also included the anger related to the unjustified abuses and betrayal that may or may not have been recognized. To establish a renewed identity, forged by improved self-esteem and acceptance of self, she was helped to make sense of her experiences—how they had a significant effect on her beliefs, values, attitudes, and actions; her subsequent choices and decisions; and the direction her life took. Passing through this process, as well as other tasks of rehabilitation, would enable her to grow and fully develop to move in another direction—towards self-actualization and empowerment in reinvesting herself in social ties and new goals.

Fears of retaliation by her husband required a realistic outlook of her safety options. Naomi soon recognized that she could not control her husband’s impulsive behaviors and followed through with protective alternatives available—obtaining another restraining order and inquiring about an arrest if the order was not honored; identifying people to call in case of an emergency; hiding money and a suitcase with necessary items in a secure place; and making sure transportation was readily available, if needed. She was aware that with the predictability and chronicity of the abuse, there was no guarantee that her husband would not attempt to find her and reenact the assaults and harassment. Nevertheless, she was not ready to relocate, but knew that this (along with changing names) might be the only viable alternative available to safeguarding herself and her child. A positive aspect for her to consider was the ability to find suitable work and income, based on her many years of employment, responsibilities, and promotions. Throughout treatment, efforts were made to activate supportive structures and increase social networks. In addition, continuous involvement in a battered woman’s therapy and support group provided helpful feedback, reassurance, role modeling, and guidance.

**Termination and Evaluation**

Treatment was terminated with the agreement that follow-up contacts would be made, so that any problems and safety concerns could be immediately addressed. Naomi continued to show progress in stabilizing emotionally and maintaining her goals of independent living and securing social supports. Referrals for community resources were made available, as needed. In the event that she decided to move out of state, she was assured that assistance would be forthcoming in finding employment, housing, a school for her child, and financial, legal, therapeutic, and supportive aid.

Fortune (2002, p. 458) cites several criteria that would determine the ending of therapeutic services. Those of significance to Naomi’s treatment experience include:

- Meeting goals set by the client or practitioner.
- Improved behavior and intrapsychic functioning for the client.
- The client expresses readiness to terminate.

**Conclusion**

Cognitive therapy methods and problem solving are incorporated to enhance current coping ca-
pacities and decision-making that can be generalized to many other problematic situations and interpersonal transactions. The development of functional behavioral, emotional, and environmental changes are paramount to its goals, utilizing various strategies that are formulated by assessing individual needs and resources. In working with a battered woman, a crisis intervention approach is inevitably a first step in assuring safety with stabilization, initial problem solving, and the exploration of alternative options that will culminate in meaningful action plans. Like the cognitive problem-solving model, crisis intervention necessitates a cognitive restructuring of perceptions, beliefs, and attitudes that empowers decision-making towards change. Prescribed and closely monitored psychotropic medications may be recommended, after evaluating the presenting symptoms. If the woman has been self-medicating with alcohol and other drugs, an assessment should be made to determine the amount, frequency, and duration of use. Substance abuse treatment may be necessary if abuse or dependency is suspected.

Cognitive problem solving can be utilized in every stage of change. It exemplifies new modes of learning, with a reality/strong-oriented focus that reinforces survival and actualization skills. Toward these objectives, self-defeating thoughts and beliefs that restrain rational decisions are challenged so that constructive problem solving can be facilitated. Separating emotional choice-making from rational, cognitively planned actions can mean the difference between enduring victimization and potential death versus survival, a better quality of life, and breaking the generational cycle of violence. For many women, particularly those in the severely chronically battered group who experience years of escalating abuse, leaving the relationship on a permanent basis may be the only recourse. For as Ferraro (1997) reminds us when considering survival and freedom from continued harassment and abuse: “the most realistic strategy . . . is for women to leave and begin new lives” (p. 138).

References


