Discovering Strengths and Competencies in Female Domestic Violence Survivors: An Application of Roberts’ Continuum of the Duration and Severity of Woman Battering

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This paper describes a solution-focused approach for treating domestic violence female survivors and discusses the implications of Roberts’ Continuum of Duration and Severity of Women Battering for therapists and researchers working within a solution-focused frame. Building on a strengths perspective, a solution-focused approach holds a person accountable for solutions instead of focusing on problems. The ultimate goal of the therapy is to provide a therapeutic context for domestic violence female survivors to rediscover and reconnect with their own resourcefulness in resisting, avoiding, escaping, and fighting against the abuse, develop a vision of a life free of violence, and empower women to re-experience their personal power in bringing positive changes to their lives. [Brief Treatment and Crisis Intervention 7:102–114 (2007)]

KEY WORDS: domestic violence female survivors, solution-focused brief therapy, strengths perspective, continuum of the duration and severity of woman battering.

Based on the data from a carefully designed study of 501 battered women, Dr. Roberts developed the Continuum of the Duration and Chronicity of Women Battering. The Continuum provides therapists with a useful tool for identifying and assessing lethality issues in treating battered women. For a detailed description of the five levels of the woman battering continuum—short term, intermediate, intermittent long term, chronic with a discernable pattern, and homicidal—see Ending Intimate Abuse: Practical Guidance and Survival Strategies (Roberts & Roberts, 2005). Such a relatively new classificatory scheme also echoes the concern of some helping professionals who recognize battered women as a heterogeneous group with diverse experiences unique to their own individual and social context (e.g., Dutton, 1996). Treatment based on one predominant vision of battered women’s experience and what is best for them runs the danger of decontextualization, thereby reducing the effectiveness and appropriateness of treatment to the individual woman.

The Continuum implies a diversity of battered women’s experience and their life situations. Such recognition has important implications for assessment, treatment, and research with this population. Besides assisting
helping professionals to focus their attention on those women who are at a high risk for severe abuse so that appropriate services can be provided, such a continuum also captures the experience of those women who appear to be at the beginning trajectory of an abusive cycle (Roberts & Roberts, 2005). An understanding of their experience will have useful implications for early detection as well as early prevention. In other words, what may be helpful to protect a woman from an abusive cycle at its beginning stage so that the battering can be ended without being exacerbated both in its severity and chronicity.

This paper describes a solution-focused approach for treating female domestic violence survivors and discusses the implication of the Continuum to therapists and researchers working within a solution-focused frame. Solution-focused therapy is based on building on each person’s hidden strengths and competencies, rather than using a deficit or pathology model. In individual and group treatment settings, such an approach focus’s on what clients can do rather than on what they cannot do. The focus is on clients’ successes in dealing with their domestic violence problems and how to notice and build on small attainable goals. The important first step to optimize the success of solution-focused treatment is based on the practitioner’s ability to recognize and respect clients’ strengths, sometimes more than clients respect themselves. This approach has been supported by numerous clinical observations on how clients discover partial and complete solutions more quickly if the focus is on their strengths, abilities, and accomplishments (Berg & Dolan, 2001). A solution-focused approach for the treatment of domestic violence is a relatively new approach developed in the late 1980s. Such an approach has been used for individual treatment for victims (Dolan, 1994), crisis intervention (Greene, Lee, Trask, & Rheinscheld, 2005), couple treatment (Johnson & Goldman, 1996; Lipchik, 1991; Lipchik & Kubicki, 1996), and group treatment for domestic violence offenders (Lee, Sebold, & Uken, 2003; Uken & Sebold, 1996) with encouraging outcomes.

**Predominant Treatment for Female Domestic Violence Victims**

The predominant treatment approaches for female victims owe largely to the contribution of feminist activists, scholars, and practitioners who have been the force behind the Battered Women’s Movement in the United States. These feminist activists, scholars, and practitioners have significantly contributed to our understanding of the suffering of female victims as well as their treatment (Petretic-Jackson & Jackson, 1996). Feminist social critics of domestic violence focus on how cultural beliefs about sex roles and the resulting institutional arrangements contribute to and maintain gender inequality and the oppression of women by men (Gondolf, 1988; Martin, 1976; Warrior, 1976). Feminist psychologists further examine the psychological vicious cycle in which many female victims find themselves entangled. Walker (1984, 1994) employs the concept of “learned helplessness” (Seligman, 1975) and the “cycle of violence” to explain the battered woman syndrome. Mary Ann Dutton elaborates on the psychological mechanism of traumatic bonding that maintains the plight of female survivors (Dutton & Painter, 1993). Based on a feminist analysis of the social and psychological roots maintaining the cycle of domestic violence, the current predominant paradigm of treatment is to separate the spouses; remove the woman from the abusive union and empower her through therapy, education, and advocacy; and legally punish the abusers and resocialize them through psychoeducational groups.
A Solution-Focused Approach for Treating Female Domestic Violence Victims

Solution-focused therapy was originally developed at the Brief Family Therapy Center in Milwaukee, WI, by Insoo Kim Berg, Steve de Shazer, and their associates. “Doing what works” is the basic tenet that guides the practice of solving problems and finding solutions (Berg & De Jong, 1996). Consistent with the widely accepted goals in the treatment of female victims as proposed by feminist therapists Dutton (1992) and Walker (1994), the overall goals of a solution-focused approach in the treatment of female survivors are stopping violence, establishing safety, empowerment, and healing. A solution-focused approach, however, adopts different assumptions and methods in assisting female survivors to achieve these ends. Instead of building the treatment strategies upon an understanding of the problem of violence, solution-focused approach suggests an alternative view of change—that positive change in clients can occur by focusing on solutions, strengths, and competencies instead of focusing on problems, deficits, and pathology (Berg & De Jong, 1996; Greene et al., 2005; Lee, 1997).

In interviewing with clients, solution-focused therapists emphasize engaging in solution-talk over problem-talk. The focus on solution-talk to achieve change is based on a systems perspective (Bateson, 1979), social constructivism, and a belief in the resources, potentials, and capacities inherent in human beings (de Shazer, 1988). Social systems are constantly changing; no system is totally static with no fluctuations and movement. Even though it is well-documented that many female victims demonstrate learned helplessness (Walker, 1994), have negative “distorted” beliefs about their self-worth, ability to survive on their own, and responsibility for the abuse (Webb, 1992), there must be times, however brief they may be, when a female survivor feels a little bit better about herself or better able to resist, avoid, and fight against violence. The task for the therapist is to first assist the female victim to be curious about fluctuations in her life and then to notice, identify, amplify, sustain, and reinforce these exceptions to the violent times regardless of how small and/or infrequent they may be. Once clients are engaged in exception behaviors, they are on the way to realizing a more satisfying life that excludes violence in intimate relationships.

Influenced by social constructivism, solution-focused therapy further assumes that solutions are a result of how an individual has developed his or her views/beliefs/assumptions about reality (world view). One’s construction of reality affects his or her future behaviors (Greene et al., 2005). A major emphasis in solution-focused therapy is a future orientation. “The future exists in our anticipation of how it will be” (Cade & O’Hanlon, 1993, p. 109). The future orientation of solution-focused therapy is particularly relevant for female survivors who, all too often, are stuck in an abusive relationship. Overwhelmed by the fear of violence accompanied by the feeling of powerlessness and helplessness, many of them become paralyzed and withdrawn. By therapeutically moving clients away from the past mishappenings, encouraging clients to visualize a future without violence in intimate relationships, directing their attention to helpful things that they are doing in realizing the desired change, and emphasizing their strengths and resourcefulness no matter how small or insignificant they seem to be, solution-focused therapy becomes a validating process that helps clients to coconstruct a violence-free reality and rediscover the resources they have to achieve that end. Such a violence-free reality may involve staying in and changing the relationship with
her partner or leaving the relationship permanently, something that heretofore she has not been able to do.

Following such a view is also the belief that the client is the only “knower” and the “expert” of their unique experiences, realities, and aspirations (Cantwell & Holmes, 1994). Because individual experiences and realities are unique, there is no one “optimal” solution for female victims or one “best” treatment approach to this inherently heterogeneous population. Consequently, from a solution-focused perspective, clients define the goals for their treatment and they fully “own” the work for a more satisfactory life.

The collaborative orientation of a solution-focused approach is particularly appropriate for female victims because of the emphasis on self-motivation. Oftentimes, it is not uncommon for shelter workers to spend hours educating women about their rights and helping them obtain needed resources but only to find them returning to their abusive partners for reasons ranging from being coerced, financial dependency, and/or still loving their partners (Johnson, 1992). The solution-focused approach does not make any assumptions about what is best for clients, nor does it educate them as to what is the right way. Echoing the concerns of other therapists who argue for a contextualized or phenomenological approach in treatment (Dutton, 1996; Eisikovits & Buchbinder, 1996), solution-focused therapists believe in the uniqueness of each client’s experience. Solution is an individual’s construction and has to come from within.

From such a perspective, therapy becomes a validating and collaborative process in which female survivors are continuously facilitated in discovering, connecting with, and amplifying life goals appropriate to their unique life context as well as their own resourcefulness for achieving their goals. Through the empowering process that fosters an internal locus of control and a positive sense of self in female survivors, we believe that clients will become more aware of their needs and resources. Consequently, there is a higher likelihood for them to develop a viable solution that is appropriate to their needs and life context. From this perspective, client’s self-determination is supported. The woman may decide to stay with or leave her partner. In case she wants to stay in the relationship, the therapist will advocate for a violence-free relationship. Couple therapy becomes a viable choice of treatment if the client desires, and the couple meet the safety criteria for couple treatment (see Lipchik & Kubicki, 1996, p. 70, for details of the criteria).

**Solution-Focused Interventions**

Solution-focused therapy views language as the medium through which personal meanings are expressed and constructed. By its symbolic quality, language enables people not only to describe and organize their experience but also to relabel and reframe their experience in a way that creates an alternative, more beneficial reality (Eisikovits & Buchbinder, 1996). Solution-focused intervention, therefore, is a dialog between the therapist and the client in which the therapist asks questions that help the client to think differently about her situation and engage in a solution-building process (de Shazer, 1994). In the treatment of female survivors, the therapist uses different questions to assist clients to construct solution patterns that do not subject them to violence and abuse in intimate relationships.

**Exception questions** inquire about times when the problem is either absent, less intense, or dealt with in a manner that is acceptable to the client (de Shazer, 1985). In treating female survivors, exception questions can focus on the times when the client is better able to protect herself and to resist, avoid, escape, and fight against violence. “When was the last time that
Bill might have hit you but you managed to protect yourself?” “How did you decide to call the police instead of letting him continue to hit you?” When the client desires to leave the relationship but is ambivalent about it, exception questions can be used to support the client’s decision. “When was the last time that you might have gone back to Bill but you didn’t?” “How were you able to do that?” “What has been helpful to remind you not to go back to that relationship again?” “When have there been times in the past that you were able to get out of and stay out of a bad relationship? How were you able to do that?”

Solution-focused therapy is goal oriented, and clients define their goals. Outcome questions are commonly used to assist clients in establishing goals for themselves (Greene et al., 2005). Outcome questions ask clients to state goals in the positive rather than in the negative; that is, the presence of something rather than the absence of something. A widely used format is the “miracle question”:

Suppose that after our meeting today you go home and go to bed. While you are sleeping a miracle happens and your problem is suddenly solved, like magic. The problem is gone. Because you were sleeping, you don’t know that a miracle happened, but when you wake up tomorrow morning, you will be different. How will you know a miracle happened? What will be the first small sign that tells you that a miracle has happened and the problem is resolved (Berg & Miller, 1992, p. 359).

The important task is to assist clients to think in terms of small, observable, and concrete behaviors so they can notice any small positive changes that make a difference in their situation (de Shazer, 1985). To expand the miracle picture, the therapist can ask questions such as: “What do you think has to be different for a small part of the miracle to start happening?” “Suppose there are times when a small part of it has already happened, what is different?” “When are there times when the miracle happens just a little bit?” “What will have to happen for that to happen more often?” Other examples of outcome questions are as follows: “If I run into you a year later and by that time you are no longer in an abusive relationship, how will I know that you are different? What will you be like then?” “Six months down the road, what do you want yourself (and your children) to be like?”

Coping questions help clients to recognize their resources in times of turmoil. Coping questions ask clients to talk about how they manage to survive and cope with the problems. Examples are as follows: “What keeps you going despite the terrible situation?” “Looking at your situation, I’m amazed why things aren’t worse? What are you doing (or other family members doing) to keep it from getting worse? How has that been helpful? What else will be helpful?” In counseling female survivors, therapists have to be careful about focusing questions on how the women cope with the abuse because those questions may potentially collude with and, therefore, run the danger of reinforcing the abuse. Coping questions, however, are extremely useful to support a client’s decision to have an independent life. “Life in a shelter is never easy. How do you (and your children) cope with the changes?” “How do you cope with . . . (changes) and still hold on to your decision to leave Bill and be on your own?”

The scaling question asks clients to rank their situation and/or goal on a 1–10 scale (Berg, 1994). Usually, 1 represents the worst scenario that could possibly be and 10 is the most desirable outcome. Scaling questions provide a simple tool for clients to quantify and evaluate their situation and progress so that they establish clear indicators of change for themselves (Berg, 1994; Greene, 1989). Scaling questions
are found to be useful in helping clients rate the intensity of the problems, their goals, their confidence of and motivation to change, and their progress.

Relationship questions ask clients how their significant others are reacting to their problem situation and solution finding progress (Berg, 1994). The establishment of multiple indicators of change facilitates clients in developing a clear vision of a desired future appropriate to their real-life context. Examples are as follows: “What will your child (friend, therapist etc.) notice that is different about you when you are no longer in an abusive relationship (or Bill is no longer violent)?”, “On a 1 to 10 scale, how would your child (friend, therapist etc.) rank your ability to say 'no' to Bill’s attempt to get you back?”

The solution-focused approach also uses task assignments (de Shazer & Molnar, 1984; Kral & Kowalski, 1989) to help clients identify exception behaviors to the problem for which they are encouraged to “do more of what works.” For clients who focus on the perceived stability of their problematic pattern and fail to identify any exceptions, an observation task is given instead: “Between now and next time we meet, we (I) want you to observe, so that you can tell us (me) next time, what happens in your (life, marriage, family, or relationship) that you want to continue to have happen” (de Shazer & Molnar, 1984, p. 298). Again, the focus is on the presence of desired changes, not on the absence of undesirable behaviors. In sum, solution-focused techniques encourage clients to be curious about their behaviors and potentials and identify, expand, amplify, and reinforce solution-oriented behaviors.

Assessing Lethality and Mental Health Status

Despite a treatment focus on strengths, resources, solutions, and a deliberate de-emphasis on problem-talk, solution-focused therapists have made theoretical adjustments in terms of assessing lethality and mental health status when treating female victims. Therapists taking a solution-focused approach do not abdicate responsibility for keeping the victim safe and attending to signals that may contribute to the possibility of further abuse (Lipchik & Kubicki, 1996). The therapist, therefore, pursues information about the extent of violence as perceived by the clients—what causes the violence, how frequent and intense it is, where the responsibility lies for the conflict, etc. (Lipchik, 1991). She/he also assesses symptoms indicating drug and alcohol abuse or psychiatric problems—issues that may be associated with the occurrence of abuse and complicate the help-seeking efforts of the women.

In assessing lethality, we especially pay attention to the safety of the women and suicidal risk for them. Because of the trauma that has happened to the victims, one-half of all battered women have considered suicide and one-fourth of all suicide attempts are directly related to abuse (Geffner & Pagelow, 1990). Solution-focused therapists, however, take a solution-oriented approach in assessing lethality. We avoid asking clients problem-oriented questions such as, “Have you consider killing yourself?” or “How likely will Bill beat you again?” Instead, we focus the conversation on how the client will know that she is safe and has a good life.

The “safety scale”—a variation of the scaling question—is an extremely useful and simple technique in assessing lethality (Johnson & Goldman, 1996). The safety scale asks the woman and other family members how safe they feel in their household, with a 10 meaning completely safe and a 1 representing a complete lack of safety. The safety scale quickly helps the client and the therapist realize the extent of safety as experienced by the client. The therapist continues to ask the client to think about
“What needs to happen for you to know that you (and your children) are safe?” “What can you (or her partner, shelter workers) do differently so that by tomorrow you can move from a 3 to a 4 on the safety scale?” The focus on a brief time dimension helps the client develop concrete, specific ideas relevant to the immediacy of the situation. “On a scale of 1 to 10, how confident (motivated) are you that you can keep doing . . . (behaviors suggested by the client) so that you and your children can be safe?”

The dialog around the safety scale gives the therapist some ideas about how active the client plans to do things to resist, avoid, escape, and fight against the violence. Such information also has an implication for the client’s desire to live. If the client cannot respond to those questions; has no plan for tomorrow; and is obviously depressed, emotional, and overwhelmed, the therapist has to pursue more intensely a mental status examination of depression and suicidal risk (Roberts & Dziegielewski, 1995).

In sum, a solution-focused therapist begins the therapeutic process by understanding the client’s unique experience of her life situation and battering experience. She/he orients the client to a solution-focused frame by letting her know that the focus of therapy is to assist her to find solutions for her concerns. In understanding a client’s construction of her situation, the therapist at the same time asks solution-oriented questions to assess lethality and mental health status of the client. Using outcome questions, the therapist assists the client to establish concrete, observable, specific goals that are stated as desirable behaviors. Through the therapeutic dialog, the therapist continuously asks exception, outcome, coping, relationship, and scaling questions to assist the client to construct an alternative reality that does not contain violence in intimate relationships. The therapist compliments the client on any of her positive, beneficial, behaviors and suggestions that are conducive to her self-defined goals. The ultimate goal of the therapy is to empower the client by helping her rediscover her own resourcefulness in resisting, avoiding, escaping, and fighting against the abuse; develop a vision of a life free of violence; and empower a woman who has been experiencing learned helplessness to reconnect with her potential to achieve a more satisfying life for herself and/or her children.

Implications of Roberts’ Continuum of Duration and Chronicity of Woman Battering for Treatment Using a Solution-Focused Approach

Roberts’ conceptualization of a continuum for assessing the duration and chronicity of woman’s battering experience is very helpful because oftentimes these clinical situations are complex and multifaceted. Because the duration and chronicity of battering experiences strongly influence a woman’s strategic responses to the abuse and her environment, they may indicate different therapeutic challenges and issues in the assessment and treatment of female victims (Roberts & Roberts, 2005). Hence, the Continuum can provide a useful reference for the therapist to fine-tune the therapeutic dialog in joining with the client and providing appropriate treatment relevant to the client’s unique situation.

Using the Continuum in a manner consistent with a solution-focused approach, however, requires some modification. The idea of using a continuum is consistent with the solution-focused technique of the scaling question that assists clients to gauge their problems, goals, and other dimensions of their experience. In addition, the focus on duration and chronicity as two important dimensions of the battering experience provides useful guidelines for a
solution-focused therapist to assist clients in gauging their current situation. On the other hand, a solution-focused therapist believes that any classification of a client’s situation has to be self-anchored. Because both problems and solutions are a clients’ construction, any presupposed understanding of clients’ situations or categorizing clients may run the risk of overriding the clients’ perception of their situation.

A solution-focused therapist will use the Continuum in the following modified manner. Instead of classifying clients’ battering experience, the therapist integrates the ideas underlying the Continuum and presents them as a scaling question. Besides gauging the duration and chronicity of the battering experience, such a scale can be used to assist clients in establishing desired outcome goals. To assess the duration of the battering experience, the therapist asks the female survivors, “On a 1 to 10 scale, with a 1 meaning that the battering seems to be forever and a 10 meaning that there is no battering, where will you put yourself on the scale?” (duration of battering) “Where would you like to be?” (outcome goal). Likewise, to assess the chronicity of the battering experience, the therapist asks the female victim, “On a 1 to 10 scale, with a 1 meaning that the battering is at its worst, and a 10 meaning that the battering is almost non-existing, where will you put yourself on the scale?” “Where would you like to be?” Although still using the idea of a continuum and the dimensions of duration and chronicity of the battering experience, the present scale is self-anchored based on the client’s description and uses a 1–10 scale. Such characteristics are consistent with the scaling question as used in a solution-focused approach.

Case Application

Using the case scenarios provided by Dr. Roberts, the following discussion focuses on how solution-focused therapy might be modified for women who differentially rate themselves on a self-anchored scale of the duration and chronicity of battering experience.

The Case of Josephine (intermediate abuse). In response to the modified self-anchored scale, Josephine may represent those clients who give a 7 or 8 for both the duration and chronicity of the abuse. Based on the description, Josephine is well-educated, generally resourceful, financially independent, but stays in the abusive relationship because of “love” (Roberts & Roberts, 2005). Because of her general resourcefulness, she may have a higher likelihood to discover exception behavior that will make a difference in her life. It may be easier for Josephine to come up with a vision of life without violence and reconnect with resources that she has to make the “miracle” happen. In terms of constructing homework assignments, it is also more likely that she can identify exception behaviors to the problem for which she is encouraged to do more of what works. Hence, for women like Josephine, the use of exception and outcome questions and action-oriented homework assignments will be especially appropriate to their situation and potentials.

The Case of Arlene (intermittent/long-term abuse). In response to the modified self-anchored scale, Arlene may represent those clients who give themselves a 5 or 6 for the chronicity of the abuse and a 2 or 3 for the length of the abuse. Using the case of Arlene as an example, she is educated although highly dependent on and bonded to the abuser as a result of economic, emotional, and/or religious reasons. The long-term nature of the abuse and the fact that she still stays in the relationship may implicate a stronger sense of helplessness and passivity in her. Because a sense of helplessness is also associated with depression, there may be a higher likelihood for Arlene to be
depressed as well. With such an understanding of the client’s situation, a solution-focused therapist will be alerted to several clinical issues.

In terms of assessing lethality and mental health status, the therapist may pursue more intensely signals that may implicate the presence of depression and its influence on the client’s life. Referral for psychiatric treatment may be appropriate for some clients.

Because of the long-term nature of the abuse, Arlene is likely to feel helpless and passive in face of the violence. She might also develop distorted negative beliefs on how to cope with the situation (Roberts & Roberts, 2005). One common clinical trap for many therapists treating clients like Arlene is to first take a rescuing stance and overfunction for them in order to save them from the abuse. The rescuing effort may include educating them about their rights, persuading them to leave the abusive situation, and providing the required tangible support for her to end the abuse. As a result of unsuccessful attempts to convince the client to leave the relationship, many therapists may feel frustrated and give up on or blame the client (Petretic-Jackson & Jackson, 1996). Neither the rescuing stance nor the giving up stance is helpful because the dynamics involved exactly reinforce the feeling of helplessness, passivity, and failure in these women—stances that cannot empower the already powerless clients.

One major therapeutic challenge under such circumstances is how to join with the client without either overfunctioning for her or giving up on her. The therapist adhering to a solution-focused perspective understands clearly that any viable solution for the client has to come from within in order for the client to feel empowered and develop an internal locus of control. Therefore, the therapist does not give in to the urge to quickly find a normative solution for the client. The therapist stays focused on assisting the client to rediscover her own resources no matter how small or meager they seem to be. The process may be slow and tedious, although the therapist is persistent and patient with the client in the process of coconstructing a solution picture that excludes violence in an intimate relationship. Instead of rushing to ask exception questions, the therapist may need to take more time to listen to the client’s story. Coping questions may be more appropriate at the beginning of the therapy in view of the negativity of these clients. The client may need more time and probing to establish goals that are appropriate to her needs and situation. Because the abuse is long term, the client may develop a rigid perspective toward the permanency of the situation. As such, it is important to assist the client to first be curious about any small improvement in her situation before helping her to identify exceptions. The observation task (de Shazer & Molnar, 1984), therefore, may be more appropriate than action-oriented homework assignments to direct the client’s attention to desirable behaviors and changes in her life.

Finally, if the client verbalizes her desire to stay in the relationship, the solution-focused therapist will want to assess the appropriateness of couple treatment for her situation.

The Case of Naomi (chronic and severe abuse with a regular pattern). In response to the modified self-anchored scale, Naomi may represent those clients who give themselves a 2 or 3 for both the duration and chronicity of the abuse. Using the case of Naomi as an example, she suffers severe and regular abuse, comes from a low socioeconomic class, has low self-esteem, and is struggling with addiction problems (Roberts & Roberts, 2005). As such, Naomi might find her partner’s violence as only one of the oppressors in her life (Davidson & Jenkins, 1989). Such characteristics present another clinical issue, namely, how to stay focused on solutions and not be overwhelmed in face of the multiplicity of problems.
The keys in handling such a challenge may be for the therapist to firmly believe in the potentials of human beings; to demonstrate curiosity about the client’s ability so that she may begin to be curious about her own ability and resources to live a more satisfying life without violence; to stay focused on goal-oriented behaviors no matter how small they may be; to lavishly compliment the client on any successes and positive behaviors; to respect the client’s pace in achieving her goals; and to provide appropriate assistance (e.g., tangible assistance, information) upon the client’s request. Because of the social disadvantages experienced by women like Naomi, they probably need more tangible assistance to end the violence and/or to start a violence-free life. However, it is important for the therapist “to lead from a step behind” (Cantwell & Holmes, 1994), that is, to act as a facilitator and let the client discover and decide for herself her goals and needs. If the client decides to leave the abusive situation, the therapeutic dialog can focus on how she refrains from returning to the abuser and how she successfully copes with the major changes in her life.

In terms of assessment, the therapist may pursue more intensely the extent of violence and the issue of safety both in terms of homicidal and suicidal risk. It is also important to understand the effects of alcohol or drug addiction on the pattern of abuse and the help-seeking effort of the woman. Such an understanding should be followed up with appropriate assistance as requested by the client. It is, however, imperative that the assessment be conducted within a solution-oriented frame.

Although solution-focused therapy does not rely on any diagnostic instruments in its treatment process, the concepts underlying the development of the Continuum are embedded in the scaling question that can be used to obtain relevant information for treatment. Still adhering to fundamental solution-focused techniques, the tone of the therapeutic process can be fine-tuned to adjust to the unique battering experience of the client.

**Implications of Roberts’ Continuum of Duration and Chronicity of Woman Battering for Research From a Solution-Focused Frame**

As suggested by Petretic-Jackson and Jackson (1996), an empirically based understanding of assessment and treatment issues related to battered women is relatively meager. Further, because of the tendency to define battered women primarily by their battering experience, variation among battered women as a group and their differential responses to different treatment approaches have not been carefully investigated. The Continuum provides a useful typology to study the effectiveness and appropriateness of different treatment approaches with women experiencing different intensities of battering. Likewise, it can be used to examine the differential responses of women’s partners to different strategies for ending violence, such as the arresting policy, restraining order, and mandated treatment for male batterers.

Specific to a solution-focused approach, the Continuum has implications for several research questions. Currently, because of the emphasis on accountability and treatment effectiveness in a managed care context, it is imperative for therapists to establish outcome effectiveness of the approach. It is useful to examine the effectiveness of specific solution-focused intervention techniques with women at different levels of the Continuum. In other words, do all intervention techniques work equally well with women across all levels? If not, what specific techniques work better with women at which level? Such information helps therapists to refine their skills and increase treatment effectiveness.
Other questions examine the theoretical assumptions of solution-focused therapy. Solution-focused therapy assumes a solution is an individual’s construction which does not necessarily correspond to the presenting problems (de Shazer, 1985). Further, because change is constant in any system, a person will discover exception behaviors (clues for solution) regardless of the severity of the problems. Hence, such an approach should be effective across different problems and different client populations. In addition, more severe problems do not necessarily require longer and/or more complex treatment. By examining the outcome effectiveness and the duration of solution-focused therapy with women situated at different levels of the Continuum, this classificatory scheme can be used to examine the validity of such theoretical claims of its effectiveness regardless of problems.

The Continuum also has important implications for investigating the use of couple treatment in solution-focused therapy. Different from feminist perspectives that largely exclude couple therapy in the treatment of female survivors, a solution-focused approach views couple therapy as a viable solution (Johnson & Goldman, 1996; Lipchik, 1991; Lipchik & Kubicki, 1996). However, such a decision about therapy choice has to be carefully made due to the woman’s safety and well-being in the potentially abusive relationship. A useful research question is to examine the effectiveness of couple therapy with women situated at different levels of the Continuum. In other words, will women at a certain level of the Continuum benefit from couple treatment more than women at some other levels? Will the partners of women who suffer long-term, severe, battering (e.g., Level 3 and up) be less likely to take responsibility for violence and less cooperative with couple treatment? Together with research findings about typologies of batterers, the findings of such inquiry will make the decision about appropriateness for couple’s treatment much easier and safer (Lipchik & Kubicki, 1996).

The Continuum will also be useful for comparative studies of the effectiveness between a solution-focused approach and other approaches such as crisis intervention models (Dziegielewski, Resnick, & Krause, 1996; Greene et al., 2005; Roberts & Dziegielewski, 1995), cognitive-behavioral approaches (Dutton, 1992), and survivor therapy (Walker, 1994) for women at different levels on the Continuum. The above discussion focuses on the implication of the Continuum in its present form to do research from a solution-focused frame. Going beyond the premise of the Continuum that is problem oriented, a “Solution Identification Scale” for female victims can be developed (Dolan, 1991). Consistent with the philosophy of a solution-focused approach, such a scale will consist of items that ask respondents to self-report their strengths, competencies, and solutions regarding their efforts to attain a violence-free life. Instead of focusing on the problem and assessing lethality issues, the Solution Identification Scale will assess the ability of the female victim to say “no” to violence and to say “yes” to a more satisfying life. By asking a client to self-discover and identify their potentials, such an instrument can be a useful intervention in itself. The Solution Identification Scale, therefore, uses the language of “solutions and strengths” in both its formulation and its approach to conduct research.

Conclusion

Significant progress has been made regarding treatment for female victims since the inception of the Battered Women’s Movement in the 1970s. Although people increasingly recognize the heterogeneity of female survivors who live in diverse social and individual context, the current treatment paradigm is still very much
dominated by the perception that defines battered women only by their experience of battering and a singular—often a helpless and passive—response to it. The development of Continuum provides a useful reference for us to refine our assessment and treatment strategies based on an understanding of clients’ unique battering experiences and their life contexts. In the age of accountability, the Continuum also provides a useful scheme for researchers to examine the interactive effects between the intensity of battering experience and treatment responses. Such inquiries will be helpful for mental health professionals to increase and establish outcome effectiveness of any treatment approaches treating female domestic violence victims.

A solution-focused approach for treating female victims is part of the pluralistic, societal effort to develop pragmatic solutions to empower women against male violence in intimate relationships. Although a solution-focused approach uses the language and symbols of solutions and strengths while the Continuum is more problem focused, the Continuum has direct implications for investigating some important research questions specific to a solution-focused approach. In addition, the ideas underlying the development of Roberts’ Continuum have indirect implications both for treatment and the development of a “Solution Identification Scale” for female survivors.

References

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