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**BATTERING AND THE CLIENT: IMPLICATIONS
FOR THE REHABILITATION COUNSELOR**

A Thesis
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts
in
Rehabilitation Counseling

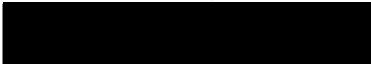
by
Paul Castillo

June 1995


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ABSTRACT

The possibility there are clients who are battered presenting themselves for vocational services without the battering relationship being identified or addressed was explored. A review of literature was conducted to understand the dynamics of battering, the scope of the problem, possible identifying characteristics of the client who is battered, and suggested intervention strategies. Implications were drawn as to the influence early identification will have upon the formulation and successful completion of the Individualized Written Rehabilitation Plan. Future areas of research were discussed.

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INTRODUCTION

BATTERING AND THE CLIENT: IMPLICATIONS FOR THE REHABILITATION COUNSELOR

The lack of counselor interaction with significant others of a client has a historical basis. The subject of concern to the vocational rehabilitation counselor has been, and continues to be, the individual with a disability and the vocational implications of the disability. The Vocational Rehabilitation Act of 1920 was in direct response to the social and vocational needs of servicemen with severe disabilities. The Americans with Disabilities Act of 1990 continues the focus on the individual with disabilities. Family is mentioned in the context that an employer may not discriminate against the family member because of their association to the person with disabilities. The lack of interaction between the family and the counselor is surprising in that current curricular texts focus on the family as an integral part of the assessment process (Power, 1991; Rubin & Roessler, 1987).

Power (1991) suggests that one of the main reasons behind the lack of interaction between the counselor and the significant others of the client is that the interaction is not encouraged by most state and private rehabilitation agencies. Two studies released in 1993 would lend support to this conclusion. One thousand twenty five rehabilitation counselors who were renewing their certification were sur-

veyed regarding knowledge areas currently used in the workplace. The grouping of knowledge areas most rehabilitation counselors identified as perceived as moderately low importance was family counseling (Szymanski, Linkowski, Leahy, Diamond, & Thoreson, 1993). When human resource development needs of certified rehabilitation counselors were identified, group and family issues had relatively low importance ratings (Szymanski, Linkowski, Leahy, Diamond, & Thoreson, 1993b).

Rehabilitation counselors are expected to manage a comprehensive medical, psychological, and vocational evaluation of the client. Current curricular texts emphasize an accurate assessment of the client is integral to the formulation and successful completion of the Individualized Written Rehabilitation Plan (IWRP). Part of the assessment process is to include the significant others of the client, identifying how they interact with the client (Power, 1991; Rubin & Roessler, 1987).

Rehabilitation literature exploring the implications of working with a client who is battered is virtually nonexistent. This paper proposes to examine current literature on battering, recommend methods of identifying the client, draw implications affecting the Individualized Written Rehabilitation Plan, and suggest possible interventions.

DOMESTIC VIOLENCE

The term "domestic violence" is much more encompassing than wife battering. It includes all forms of violence between intimates. This would include spousal abuse, child abuse, elder abuse, and same gender couples abuse. There are sub-categories such as husband battering, wife battering, and marital rape. The focus of this paper is sub-category of the person who is/has been battered.

The Attorney General's Task Force emphasized that battering is a major source of injury to women in America (National Crime Survey, 1982). "Battering" is defined as a syndrome of control and increased entrapment characterized by a history of physical and mental abuse by the significant other (Stark & Flitcraft, 1991). Among the group that is battered there are individuals who are "serially battered." Serial battering consists of being assaulted monthly, and in some circumstances, weekly (Klaus & Rand, 1984). Due to the repetition of assault and the attendant physical and psychological consequences, it is proposed that this particular group is the highest at risk to require the services of the rehabilitation counselor.

Not all persons who are in a domestically violent relationship are necessarily battered. Straus (1979) operationalized "violence" through the use of the Conflict Tactics Scale. Only the last eight of the 18-item scale reflect the use of physical violence. Although the fre-

quency of assault in the last 12 months is noted, the instrument is not structured in such a manner as to ask is there a regular pattern to the assaults. Battering is contingent on a regular or frequent physical assault. A person might identify themselves in a domestically violent relationship even if they only experienced one of the physically violent acts in the last 12 months.

THE ETIOLOGY OF BATTERING

The number of theories regarding the etiology of battering is extensive. The list of theories can be divided into sociocultural theories which deal with cultural values and beliefs that foster the existence of battering; interpersonal theories which are concerned with the interactions between people; and intrapersonal theories that focus on the individual's characteristics which place them at risk to being battered (Van Hasselt, Morrison, Bellack, & Heresen, 1988).

Sociological Theories

The Patriarchal Society

The domestic violence movement was founded by feminists, shaped by their ideology. Wife abuse is not viewed as the problem of the individual but as an issue of power and control. The patriarchal society, through institutionalized structures, maintains the disproportionate power over resources. This is done in order to keep women in a subservient position to men. It creates an environment that

emphasizes male dominance and aggression at the expense of victimizing women and children (Davis, 1988; Pfouts & Renz, 1981; Dobash & Dobash, 1979; Martin, 1976; Pizzey, 1974).

Resource Theory

Blood & Wolfe (1960) view power as the potential ability of one member of a family influencing the behavior of the other. A resource is anything that will help the members of the family satisfy needs or meet goals. Balance of power in the family will be in the favor of the spouse that can contribute the greatest resources. External social structures further socialize the individual within the family to accept that husbands win power by virtue of their bringing greater resources to the marriage than the wife. O'Brien (1971) suggests that in family situations where the male has been traditionally regarded as having a higher status ascribed, but who fails to bring the resources into the relationship, may resort to physical violence to maintain dominance.

Subculture of Violence Thesis

Wolfgang & Ferracuti (1967, 1982) suggest that coexisting with the main American culture there are subcultures oriented towards violence. The subculture defines values, beliefs and norms according to the patterns of socialization and reinforcement particular to the subculture. Situations that the mainstream culture would deem resolvable through other means may require the subculture member to react in a

violent manner. Failure to act in such a manner may even bring ridicule to the subculture member. Relationships within the family nurture and reinforce socialization towards these normative beliefs.

Interpersonal Theories

Social Learning Theory

The social learning theory can be divided into two components learning that goes on before the battering relationship and that which transpires while in the relationship. Both components involve the direct interaction of family members influencing each other through modeling, reinforcement, and coercion.

There exists a consistent correlation in domestic violence research that individuals who have experienced or witnessed interparental violence in their childhood have a greater likelihood to be involved in a violent relationship than individuals who have experienced little or no violence (Straus, Gelles, & Steinmetz, 1980; Davis, 1987; Gayford, 1975). According to the modeling theory, witnessing violent or aggressive models provides an opportunity in acquiring and reproducing similar behaviors (Bandura, 1977). Role modeling may be gender specific. This may explain why males tend to act out in an aggressive manner while the response of their partner may be modeled after the family of origin, the woman acting in an avoidant, passive, non-help-seeking manner.

Behavioral psychologists have long recognized that intermittent reinforcement produces the greatest impact in molding behavior. The third stage of Walker's (1979) cycle of abuse is characterized by the batterer's profound remorse and an attempt to reestablish the loving relationship prior to the violent episode. Meanwhile, the batterer is being reinforced to continue or increase the behavior that results in the submission or control of the abused partner (Star, 1980).

Family Systems

Investigators Murray Straus, Richard Gelles, and Suzanne Steinmetz were among the first to attempt to gather empirical data regarding violence in the families. Their influence is such that their results and interpretations continue to fuel research and debate within the field of domestic violence (Schwartz & DeKeseredy, 1993).

Straus (1973) used the general systems theory, as applied to sociology (Buckley, 1967), with the goal of having a dynamic and comprehensive framework explaining family violence. A general understanding of the theory's components is necessary before proceeding to its application to family violence.

The general systems theory examines the individual components of a system as defined by the overview of the sum of all the interrelationships and interactions. Systems have set boundaries which separate it from the environment.

Each system is composed of subsystems that, as the larger systems of which they are part, have their own boundaries, organization, and patterns of interaction (Nichols & Everett, 1986). Few systems are completely open or closed to influence or interaction with the environment. The system is goal oriented. Feedback generates how the system proceeds towards its goal. Progress towards the goal is controlled by positive and negative feedback. Negative feedback indicates to the system it has reached some predetermined maximum output towards the goal and should stop or reduce its efforts. This tends to push the system towards stability or homeostasis. Positive feedback tells the system that continued or greater effort is needed.

The family is a system. The subsystems are its members, individually and in sum of all collective interactions. The family is organized so that what one member does affects the other, family violence is not the result of individual pathology but is the result of the product of the entire system (Weitzman & Dreen, 1982). Power and control within the family can be viewed as hierarchical. The socialization of the family or individual can be oriented toward the retention of power in the male. When pressures are placed on the system threatening this goal, violence may be a possible reaction. This is especially true when this course of action is modeled in the home of origin. The pressures can be environmental, interpersonal, or intra-

personal. Stress creates positive feedback, indicating that goal is being threatened. Given the reinforcement of successful use of violence in achieving the goal of control, the desired goal is again reached through violence. Negative feedback prevents the immediate escalation to violence as long as the system's goal of control remains at an acceptable level.

Intrapersonal Theories

Learned Helplessness

Women in battering relationships can arrive at a state of hopelessness, thinking there is nothing that they or anyone else can do. People suffering from learned helplessness (Seligman, 1975) are most likely to choose the behaviors that have the highest chance of predicting the outcome in the known environment. Escape, although seemingly an alternative to the outsider, would plunge the person who is battered into the unknown (Walker, 1989). The unknown is especially threatening due to necessity of risking. The idea of risking in a situation that is uncontrollable, when already in a situation over which the individual has little control, seems to the person who is battered as giving up what control they have left.

Post Traumatic Stress Syndrome

Psychological symptoms developed during regular exposure to repeated, unexpected, and severe abuse continue to affect the person long after the original trauma. The

person may feel essentially helpless, lacking the power to change the situation. According to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSMIV) a person experiencing domestic battering may exhibit:

"change from the individual's previous personality, impaired social relationships, social withdrawal, self-destructive or impulsive behavior, hostility, shame, despair, hopelessness, or a sense of feeling constantly threatened. There may be increased risk of phobias such as agoraphobia, social phobia, or specific phobias. The client may exhibit Panic Disorder, Major Depressive Disorder, Obsessive-Compulsive Disorder, or Substance Abuse Related Disorders" (p.425).

The Cycle of Violence

Walker (1987) examined 1600 incidents of violence. The cycle of abuse was present in two-thirds of the relationships. The cycle of violence (Walker,1979) is divided into three phases: The tension building stage, the acute battering incident, and the tranquil, loving, or at least nonviolent, phase.

Tension Building Phase

This phase is one in which the stress level of the batterer is beginning to mount. There is verbal and psychological abuse. It can proceed to minor battering such as pinching, pushing, and slapping with the hand open. The person who will be battered attempts to control the environment, hoping to keep the batterer calm. If the batterer has identified part of the environment as producing stress, such as the friends or family of the partner, the partner may choose to isolate themselves. This is also referred to as

social battering.

As the cycle becomes more familiar to both partners, anxiety increases as both partners recognize that a violent episode is imminent. Not knowing what will cause it nor when it will happen may encourage the person who will be battered to provoke the batterer into the violent act in an attempt to get to the loving stage.

Acute Battering Incidence

The batterer feels the inner tension build to the point that there is a loss of control. The violent act may be precipitated for any number of reasons. The batterer may initiate a confrontation in order to feel justified in dealing with the situation in a physical manner. The level of violence that is used by the batterer in the beginning is rarely life threatening. It may be pushing, slapping, or kicking. There is a correlation that as the cycle becomes more ingrained in the relationship, the level of violence starts to increase. Each couple is unique as far as the time frame and increase in the intensity levels of violence.

Tranquil, Loving, or At Least Not Violent Stage

The batterer has initiated the violent act and feels relief from the motivating stress. Being very remorseful in the beginning of the battering relationship, the batterer can promise that it is an isolated incident that will not reoccur. The batterer may shower the partner with gifts and loving attention. This phase has also been referred to as

the "honeymoon phase." The batterer may revert to the caring individual the partner fell in love with originally. The partner forgives the batterer and all seemingly proceeds well until the violent incident happens again.

As the cycle becomes more regularized in the relationship several things happen. The time of the honeymoon period decreases, as the tension building phases become more and more frequent. The batterer, faced with the failure of keeping the promise to stop, begins to increasingly blame the partner for causing the situation. The person being battered, having looked forward to the honeymoon period, begins to be satisfied with the simple lack of violence. Each time the cycle of abuse is repeated the person who is battered becomes increasingly disoriented, losing self-awareness, self-esteem, and the sense of control. They decrease their social contact, blaming themselves for their condition. The fear of what might happen if they leave the abusive relationship competes with the false sense that they at least know what to expect in the current situation. This denial of lost control and inability to predict what will precipitate the battering is bolstered by the intermittent times of kindness and loving experienced after the violent episode. The perception of the ability to leave and not return to the abusive party is systematically destroyed (Walker, 1979).

Incidence

There are several problems inherent in attempting to give an accurate number to the incidence of battering. Samples may not be representative of the entire range of battered women. Women seeking intervention, such as in a shelter, usually are associated with a certain level of violence suffered and limited material resources (Okun, 1986; Gelles, 1980). Conclusions of many early studies were based on post-hoc explanations and failed to have control comparison groups. No attempt was made in earlier studies to operationalize abuse or violence. It greatly depended on the labeling by the authorities when the individual became publically known. This technique produced a systematic bias including confounding variables and lack of generalizability. The majority of cases have only dealt with women which may reflect gender bias (Gelles, 1980).

An accurate picture of the incidence of battering is complicated by the under reporting to identifying agencies. The sub-category of persons who are battered have often been subsumed into larger categories. The National Crime Survey (1982) estimated that a third of the incidences of domestic violence were reported by the authorities as rape, robbery, or assault. Studies are based upon the reporting of the person who is battered and rarely is it done in conjunction with the battering partner (Okun, 1986).

Patients rarely volunteer that they have been abused by

their spouse. Yet when asked direct questions about the reason for the injury, the person who is battered has been open to answering affirmatively to being assaulted (Goldberg & Tomlanovich, 1984). The medical staff of an emergency room at the Medical College of Pennsylvania identified 5.6% of its cases as the results of abuse. Trained in protocol that was sensitive to identifying causes due to physical abuse, the staff raised the percent of cases identified from the original 5.6% to 30% (McLeer & Anwar, 1987). The failure to identify ongoing abuse may be also due to the reluctance of health care professionals to become involved (Henderson, 1992).

Reported prevalence ranges from 3.8% of American women having had at least one violent incident in the last 12 months (National Crime Survey, 1982; Straus, Gelles, & Steinmetz, 1980) to more than 70% of couples in therapy (Barling, O'Leary, Jouriles, Vivian, & Macewen, 1987). Stark and Flitcraft (1995) point out that these surveys used only married women. Their figures indicate the greatest number of women are assaulted when single, separated, or divorced, making the estimate higher. They believe a more accurate figure is 20% of the general population. This figure is close to estimated cases identified in emergency rooms 22% (Stark & Flitcraft, 1991; Goldberg & Tomlanovich, 1984). The National Crime Survey (1982) found that 32% of those assaulted by their domestic partner were assaulted

again within six months. Klaus & Rand (1984) estimate 25% to 30% of women who are battered suffer serial victimization, many being beaten weekly.

Husband battering is a subcategory whose legitimacy is contested by the feminist movement (Schwartz & DeKeseredy, 1993; Stark & Flitcraft, 1991; Dobash & Dobash, 1979). When size and strength are taken in consideration, men are usually larger and stronger than their partner. In a situation where physical blows were to be exchanged the smaller, weaker opponent would be at a disadvantage. This is supported by data gathered by Straus & Gelles (1990). The population investigated was normed in comparison to a like population except for the history of assault. When comparing the genders in the category of having sustained one or more severe assaults, 7.3 % of the women required medical attention versus 1% of the men. Nineteen percent of the women in this category took time off work against 10% of the men. Women had a higher rate (23%) of being bedridden for one or more days than men (14.5%). Women reported psychosomatic complaints 43.9%, men 25.9%. Women reported feeling stressed 61% while men reported 33.9%. Women experienced feelings of depression at the rate of 58.3% while men indicated depression at 29.8%.

While these figures do not prove nor disprove that males can also be battered it does lead one to the conclusion that women are more vulnerable to the consequences,

both physical and psychological, of physical abuse. If there is a higher number of women reporting physical and emotional complaints associated with battering it would seem to imply that there is also a greater number of women who are reaching the more intense levels of violence associated with a cycle of violence that has been ongoing.

The question still remains whether individuals who are battered are of sufficient number to impact the caseload of the rehabilitation counselor. Is it a sufficiently large number to warrant the time of the rehabilitation counselor to familiarize themselves with this population?

A very crude estimate can be made using different surveys to get a range of values. It was originally proposed that the consumer in a battering relationship would be at a high risk for rehabilitation services, especially those that are serially battered, due to the repetitive exposure to injury and increasing intensity of violence. This proposal fits within the dynamics of the cycle of abuse (Walker, 1978). The population demographics were taken from the 114th edition of The Statistical Abstract of the United States, 1994. The emergency room information was drawn from a national survey done in 1992 for the National Center for Health Statistics (McCaig, 1992). Twenty-two percent of females, in first-time emergency-room visits, were identified in the study of Goldberg & Tomlanovich (1984) appearing in The Journal of the American Medical Association. Stark

and Flitcraft (1991) identified a similar percentage in their study.

The United States Department of Health and Human Services compiled a national survey of medical care in emergency departments for the year 1992 (McCaig, 1994). Demographics of urgent and unurgent visits was tabulated. Nonurgent care is defined as, "Patient does not require attention immediately or within a few hours" (p12). The definition given to urgent care is:

"A patient visit in which the patient requires immediate attention for an acute illness or injury that threatens life or function and where delay would be harmful to the patient" (p12).

There were a total of 89.8 million urgent and unurgent visits made to emergency rooms. Of the 89,796,000 urgent and nonurgent visits made 84,095,000 visits were first time visits, approximately 93.7%.

The study of Golberg & Tomlanovich (1984) used the information gathered from ages 15-64. Females in this age group accounted for 11,724,000 urgent visits. Using the first time visit percentage (93.7%), there were approximately 10,985,388 women seen for the first time. If 22% are attributable to causes of abuse, it meant 2,416,783 urgent visits by women were due to abuse. Walker (1980) found 66% of her sample to have been participating in the cycle of violence, that would result in 1,595,077 women in the cycle of violence. Serial battering would impact 25% (Klaus & Rand, 1984). There would be 398,769 women in the greatest

risk category of repeated and more serious violence.

Using the U.S. Census of 1990, 3.8% (Gelles, Straus, & Steinmetz, 1979; National Crime Survey, 1982) of the female married population results in approximately 3,138,838 women being violently abused, at least once, in the last 12 months. Of these, 66% are in the cycle of abuse, 2,071,633. If 25% are being serially battered, the number is 517,908 in the category of the highest risk to be a consumer of rehabilitation services in the future.

If 20% of all women 15-64 were abused by an intimate, as suggested by Stark and Flitcraft (1991), then 16,520,200 were abused. Of these, 66% are in the cycle of violence or 10,903,332 and those serially battered number 2,725,833.

There are between 517,908 and 2,725,833 women who can potentially impact the caseloads of rehabilitation counselors at a national level. There is no way at this time to determine how much of an impact current rehabilitation cases due to abuse have on the caseload of the rehabilitation counselor. Yet it would be safe to assume that any percentage, no matter how low, has a definite effect on the counselor's time and the dwindling available resources.

The Batterer

Some mention should be made in reference to the batterer in the relationship. The counselor should be prepared for possible behavior patterns that can impact the client who is participating in a battering relationship. The

earlier studies on the batterer tended to treat them as a homogeneous group. Current studies reflect at least three sub-groups of batterers.

Characteristics of the Batterer

The characteristics of the batterer are relatively consistent when described in earlier literature. The batterer has poor self esteem and a negative self image, although he may appear in public as successful, self-confident and charming. The batterer is generally possessive, jealous, and highly intrusive, especially in the affairs of the partner. They keep their mates under surveillance, calling home repeatedly. They often take their lunch hour at home. In some cases they will actually lock their partner in the house. The couple may go through a period of "social battering," where the partner who is battered is alienated from their support group such as friends and family. They are extremely dependent on their partner. Ten percent of batterers commit suicide when they lose their mate. (Walker, 1979).

Assaulters externalize blame, confuse roles, displace anger, and exhibit poor impulse control (Star, 1980). They have been raised in violent homes, have difficulty communicating, relating, and are isolated from social support systems.

The study of Holtzworth-Munroe & Stuart (1994) divide male batterers into three subtypes, family only directed

violence, dysphoric/borderline, and generally violent/anti-social. Previous research literature was compiled and a general description of each group was compiled. One general finding that crossed all three groups was in the area of attachment behavior (Dutton, Saunders, Starzomski, & Bartholomew, 1994). When any of these three groups is presented with issues involving threats to their relationship, they report more anger and have less competent responses than nonviolent husbands. Batterers are more preoccupied with, and dependent on, their wives than the nonviolent spouse.

Family Only Batterers

This group has the best marriages. They express a greater marital satisfaction, having more stable and less conflictual relationships. They are more committed to their marriage and are less likely to have affairs. They are overly dependent on their wives but exhibit the fewest attachment problems. This group feels the greatest remorse after the violent situation and is most apt to seek help. The family only batterer is least likely to impulsively engage in antisocial activities such as criminal behavior, substance abuse, and the use of alcohol/drugs at the time of the violent episode. They have the most liberal attitudes of the three groups towards sex roles. They are the least likely to have a positive attitude towards the use of violence.

Dysphoric/Borderline Batterers

These men view their wives as part of themselves, an extension of them. They are pathologically dependent on their wives. They experience high levels of relationship strife, marital dissatisfaction, jealousy, and ambivalence about their relationship. This group has conservative views of the sex roles. Information on the level of remorse, impulsivity, and the use of violence by this group was not definitive.

Generally Violent/Antisocial Batterers

Marital problems within this group are an ongoing problem. The men in this group are narcissistic and self-centered in close relationships, viewing their wives as objects. They generally feel little remorse over the violent episode, blaming the battered spouse. This group is the highest at risk to impulsively act out in antisocial behaviors. They lack social skills in both the marital and nonmarital situations, using violence to resolve any situation. They have rigid attitudes towards sex roles. They have a positive attitude towards the use of violence, feeling that it is justified in a wide set of circumstances. They use violence as a regular coping mechanism.

IDENTIFICATION OF THE CLIENT WHO HAS BEEN BATTERED

Characteristics ascribed to the client who is battered are dependent on the ideological stance of the investigator. The construction of the questionnaire or survey may be done in such a manner to insure that the subject is not seen as deviant from the general population. Okun (1986) found that residents in a shelter apparently did not differ from adult American women in the general prevalence of violence in their family of upbringing. While Davis (1988) found that many shelter residents are victims of childhood sexual and physical abuse and have a history of prolonged abusive relationships (Davis, 1988). Thirty-four percent of domestic violence victims stated the presence of a prior abusive relationship (Goldberg & Tomlanovich, 1984).

The ideal situation would be for the rehabilitation counselor to work with the injured client during the convalescence and transition the individual into the vocational rehabilitation. The reality is, at least in the California Department of Rehabilitation, that many rehabilitation counselors see the client only after they are medically stable and ready to seek employment.

The rehabilitation counselor often depends on the medical records of the client to give a history of the disability. Therefore the report of the attending physician may assist the counselor in making an accurate assessment of physical, emotional and/or psychological potential of the

client to plan and complete successfully an IWRP.

If the client is involved in a battering relationship and suffers a serious injury, the emergency physician is the most likely professional to first identify the battering situation. Research by Rounsaville & Weissman (1978) confirmed that a great number of trauma patients seen in emergency departments were assaulted by a significant other. Spousal assault may be the single most common cause of injury bringing more women to emergency rooms than the combined injuries of auto accidents, rapes, and muggings (Stark & Flitcraft, 1991). It has been estimated that up to one third of all women using the emergency room for a wide array of injuries are there as a result of battering (Moss & Taylor, 1991; McLeer & Anwar, 1987).

PHYSICAL INJURIES THAT MAY BE AN INDICATION OF ABUSE

The rehabilitation counselor may be able to detect a consumer that has been/is being battered by examining the medical records of the patient. Multiple injuries, injuries to the head, neck, breasts, abdomen, perineum, and rape are areas of concern. Battered women are 13 times more likely to be injured in these areas than nonbattered women. Much of the abuse in the relationship is of a sexual nature. Consumers may complain about old injuries that are causing headaches or non-specific pain. Areas particularly affected are the back, neck, or ribs. Other complaints resulting from living in a stressful environment are dysphagia, hyper-

ventilation, and sleeping disorders (Chez, 1994; Stark & Flitcraft, 1991).

Drug or alcohol abuse may be present. There may be a frequent use or dependence on sleep medication or minor tranquilizers. Forty percent to 50% of all female alcoholism seen in the emergency medical and psychiatric services may be precipitated by abuse. Persons who are battered request pain medication more often than any other service (Goldberg & Tomlanovich, 1984).

Persistent gynecological complaints, dyspareunia, or a history of self-induced, therapeutic or spontaneous abortions may indicate an ongoing abusive relationship. Women who are battered are three times more likely to be injured during pregnancy. Twenty-three percent of pregnant women report abuse (Helton, McFarlane, & Anderson, 1987). Battering is present in two-thirds of the suicide attempts made by pregnant women. The woman who is battered is 15 times more likely than the nonbattered woman to suffer a miscarriage (Stark & Flitcraft, 1995; Henderson & Erickson, 1994). A high risk group are clients who are being divorced or separated during their pregnancy. According to Stark & Flitcraft (1991) 25% of all obstetrical patients are in abusive relationships.

PSYCHOLOGICAL ISSUES

Twenty-five percent of women utilizing psychiatric emergency services have had a history of domestic violence.

Compared to nonbattered mental health clients they have a higher incidence of being diagnosed with situational or personality disorders. They may exhibit impaired self esteem (Stark & Flitcraft, 1991).

The woman who is battered (26% of the population) accounts for 42% of all traumatic attempts and is significantly more likely to attempt suicide more than once (20% vs. 8%). Eighty-five percent of these women are seen in the hospital for at least one abusive injury before the suicide attempt. Over one-third of the women who are battered and attempt suicide are seen at the hospital for an abuse-related injury or complaint the same day as their attempt (Stark, Flitcraft, & Fraiser, 1979). The underestimation of the seriousness of problems facing the person who is being battered is addressed by Drake (1982):

"Survivors of violence often report being victimized twice--once by their abuser, and once by the staff in the health care facility they visit"
(p43).

Any psychiatric or psychological diagnosis that can be associated with Post Traumatic Stress Syndrome Disorder and not have a defined causal agent, can be a possible sign of a person who has been battered in the past, particularly those conditions or disorders, such as depression, anxiety, Panic Disorder or Agoraphobia.

SOCIAL ISSUES

Women who are separated or divorced from a spouse are at a higher risk of violence than those who are married.

The rate of simple and aggravated assault by relatives is more than ten times greater for divorced or separated than it is for married or widowed persons (National Crime Survey, 1989). The relationship with separation and the more severe forms of violence, such as the use of weapons, demonstrates the great physical risk the consumer who is battered takes in their attempt to end the abusive relationship (Okun, 1986). Even shelter residents are likely to experience new violence (Davis, 1988; Bowker, 1983).

The conclusion that battering occurs more often in the lower socioeconomic groups has been partially due to the demographics of the samples reviewed (Gelles, 1980). Women with resources are more apt to terminate the battering relationship (Okun, 1986; Aguirre, 1985). The probability of wives returning to the abusive relationship increases greatly if the husband is the sole source of support. In fact, financial dependence almost always insures return (Aguirre, 1985). If after a short stay, alternate housing is not available, an estimated 20% to 50% return to their assailant (Davis, 1988). If social battering has occurred the client may find themselves unable to depend on any part of their former social support system. There is the possibility that the batterer has isolated the person by moving them away from the social support system. Seventy percent of women who are battered and attempted suicide were single, separated, or divorced (Stark & Flitcraft, 1995). Clients

who are non-English, monolingual, immigrants from a strong patriarchal society may be at a high risk to experience domestic abuse.

Battering occurs across cultural, socioeconomic, and age groups (Walker, 1979). Therefore the counselor should not limit their scope of concern to only disadvantaged individuals that may have medical or psychological factors indicating partner violence.

SUMMARY CHECKLIST FOR COUNSELORS

The following questions are based upon the statistical information supplied within this paper. They are not all encompassing of the characteristics of the person who is battered. The greater number of affirmative answers may indicate the client is being/has been battered. The use of partner and significant other is interchangeable.

- 1) Does the client belong to a patriarchal culture?
- 2) Has the client more education than their partner?
- 3) Has the client usually had a better paying job?
- 4) Was there abuse in the family of origin?
- 5) Does the client have equal input on family decisions?
- 6) Must the partner always be consulted before decisions?
- 7) Does the client feel in control of their life?
- 8) Does the client self-blame or have low self esteem?
- 9) Does the client excuse the actions of the partner?

- 10) Is the client isolated from a social support network?
- 11) Has there been a history of work absences?
- 12) Are there repeated visits to health care providers?
- 13) Are physical complaints thought to be psychogenic?
- 14) Are there complaints of non-specific pain?
- 15) Is there drug or alcohol dependence or abuse?
- 16) Is there a history of pain medication usage?
- 17) Is there use of sleep medication or tranquilizers?
- 18) Is there a history of gynecological complaints?
- 19) Is there a history of abortions or miscarriages?
- 20) Is the client single, separated, or divorced?
- 21) Is the client currently pregnant?
- 22) Has the client attempted or thought of suicide?
- 23) Are there any symptoms of Post Traumatic Stress?
- 24) Does the client have access to family resources?
- 25) Have there been other abusive relationships?

VOCATIONAL IMPLICATIONS

Consumers that have participated in battering relationships will not be necessarily identified as coming from a shelter. Shelters are not equipped to deal with medical problems. Many require the resident to be sufficiently able bodied to do their share of chores in the shelter. Many shelters have policies that exclude drug or alcohol addictions (Davis, 1988). Therefore, the counselor may have to depend on their assessment procedures to identify the con-

sumer who is/has been in a battering relationship.

The vocational implications, once the client is identified, depend on several factors. Is the client still in a battering situation? Primary consideration must be given first, to the safety and security of the client. Given that the person presents for rehabilitations services indicates that there has been an injury of serious and enduring nature, or the individual is exhibiting the psychological effects of ongoing abuse which cause an impediment to employment. The injuries may have been sustained in a previous relationship, but the client may have formed another relationship of abuse (Goldberg & Tomlanovich, 1984). The rehabilitation counselor needs to establish the intensity and occurrence of the last incident of abuse in order to have some idea if the safety of the client will be compromised by the IWRP. If the IWRP is seen as a threat by the batterer in increasing the independence of the client, the batterer may attempt to sabotage the rehabilitation process. The client may miss appointments, no call, no show. This may be due to a last minute intervention by the batterer as "needing the family car." It may be associated with the embarrassment of visible signs of abuse. Or simply, the client may be not allowed out of the house. Are there children involved in the relationship? The person is often controlled by the batterer by using the care, needs, or safety of the children as the reason the client cannot make

appointments, look for a job, or work particular hours. This becomes especially evident when the client makes excuses for their partner's lack of childcare when he comes home from work and is available to watch their children. Such an excuse might be, "He's so tired and nervous when he gets home, how can I ask him to watch the kids while I work."

The client may present an idealized version of the significant other's support of their pursuit of gainful employment. It may even be predicated upon financial need. The client may be very invested in obtaining employment as it may afford an opportunity to be in control of their environment. It may be the only socialization outside the home the person has. If the individual is no longer in a battering relationship, what are the circumstances surrounding the separation? Has the consumer relocated away from the batterer? Are there geographical constrictions in the job search, such as location of the batterer's employment or places of frequency? Is there a restraining order? Has job harassment by the batterer caused job loss?

How total has the control of resources been in the relationship? The client may present themselves as having little or no previous job experience. They may lack a driver's license or their own car. Documents that establish identification, such as social security cards, may have been locked up by the batterer "for safe keeping." The purchase of clothing may be strictly controlled by the batterer, even

to the point of buying the clothing for the person. The client may have little or no resources of their own.

If the client has children and is separated from the abusive relationship, how will childcare be managed? Will the potential earnings of the employment be of sufficient quantity to pay for childcare and still leave enough for daily living expenses?

The primary disability may be a consequence of abuse. If the addiction is in remission or the depression stabilized, how long will the client remain so, if the precipitating cause is still ongoing? If the person feels helpless or useless, and this is being reinforced at home, how will the rehabilitation counselor address these feelings? How will the client react to being asked to risk becoming involved in a training program or new vocational direction? How will the demands of timely decisions regarding vocational direction impact a client who has a limited amount of energy due to depression or grief over the loss of their relationship?

INTERVENTION

The client who is battered and has incurred disability may have feelings of denial and grief (Chez, 1994; Stewart, 1994; Turner & Shapiro, 1986). Faced with the possible loss of an idealized relationship, marital role, emotional and financial security, the person who is battered often retreats into a state of denial, refusing to acknowledge the reality of their situation (Turner & Shapiro, 1986). Stewart (1994) suggests that denial may be destructive. Part of the mechanism of denial may be not seeking medical attention immediately. This can have very negative consequences to the person especially if the injuries are not visible. A concussion from a headblow or a skull fracture may not be visible but can have long-term effects on the person's physical and mental capacities. The person in denial may fail to realize the long-term effects of the disability.

The common interventions that are suggested are rapport building through accurate empathy, unconditional positive regard, and confrontive interactions. In describing the necessity of understanding the inner world of the client, Stewart (1994) touches upon issues that are central to the client who is battered and in denial.

"Rehabilitation counselors need to know their clients' inner world well enough to determine if the appropriate empathetic layer involves issues of reality, fears of destructive relationships and abandonment with loss of self, or personality disorganization and loss of self-other boundaries" (p13).

The end of an intimate relationship is a stressful situation. Grief over the loss of the significant other can manifest itself in a person ending an abusive relationship. Russell & Uhleman (1994) conclude that appropriate counselor interventions involve providing information regarding the grieving process. Perhaps just as important to the counselor is recognizing the client may not be ready or able to make decisions beyond that of ending the abusive relationship. There may be several stages the person goes through in leaving or losing a significant relationship. The first stage may be one in which the person has little energy to make basic decisions, requiring assistance even with survival necessities. The second stage is where the energy level increases to take care of survival necessities, but little energy is left over to make life decisions or changes. The third stage encompasses the person beginning to use energy in making life decisions and changes. The rehabilitation counselor needs to be sensitive in which stage the client finds themselves. Supportive services may be required in the initial interaction between the rehabilitation counselor and the client prior to any attempt to identify suitable vocational goals. The energy state of the client may be at such a level that any choice of vocation would not only be premature but also lessen the chance of successful IWRP completion.

The primary goal of intervention is empowerment (Chez,

1994; Emner, 1991). The objective of empowerment is providing the information, social support, and encouraging increased self-awareness allowing the client who is battered to become emotionally and financially independent of the batterer. The psychoeducational approach, as outlined by Hardley and Guerny (1989) deals with empowering the individual or family by teaching them skills that the person will be able to apply to the home life, as well as in the vocational setting. It focuses on the acquisition of positive, self enhancing, behavior rather the elimination of negative behaviors. Instead of being the victim of circumstance and dependent on others, the client is seen with skills and encouraged to be an agent of their own self-change. The rehabilitation plan should focus on capitalizing on assets rather than eliminating or accommodating deficits. The rehabilitation counselor can enhance the sense of personal accomplishment of the client by doing less for an encouraging the client to do more on their own. Coaching, teaching, problem solving, and consulting with the client can be done in support of the client, rather than the counselor taking the role of leading the client through the process of rehabilitation.

The expectation of success is engendered by the counselor when the helping relationship is devoid of victimizing language or disabling language (Patterson, 1988). People with disabilities are often highlighted in their portrayal

of the media as helpless or heroic (National Institute on Disability and Rehabilitation Research, 1991). The promotion of the victim concept is especially used as an emotional motivating component in fund raising (Lynch & Thomas, 1994). Fund raising is an activity in which the shelter movement, due to irregular funding, is necessarily invested. It, however, does not emphasize the potential for independence or the individuality of each person. Rehabilitation professionals may unintentionally reinforce the victim concept by the use of disabling language in the counseling environment.

Counseling strategies should include validating the consumer's disclosures, education of the dynamics of abuse, assessing the current level of danger, and assisting in the formulation of a safety plan, referrals and advocacy (Stark & Flitcraft, 1995). Developing a safety plan includes the access to documents that validate identification and eligibility for assistance, access to transportation, extra keys, emergency phone numbers, emergency money, a safe place to go for the night, a packed suitcase, perhaps kept at a neighbor's, children's necessities, a plan of escape with a safe place in mind (Chez, 1994).

REFERRAL FOR THERAPEUTIC INTERVENTION

Appropriate referral to a therapist or family counselor depends on matching the needs of the consumer to the ideology of the therapist. A feminist counselor would be at odds

with conjoint therapy. For the last two decades the treatment model used in many family service agencies has been based on the systems theory. Based on the assumption that victims are seen as part of the dysfunctional interaction of the couple. The violence in the relationship is a sequential interaction where both the batterer and the victim contribute to the escalation of stress that precipitates the violent act. It is unacceptable to the feminist that the victim is in any way responsible for precipitating the violence. The batterer should be made responsible for his violence, regardless of provocation. Men should not be allowed to think they can be absolved of any part of their responsibility so long as they can blame a woman (Schwartz & DeKeseredy, 1993; Harris, Savage, Jones, & Brooke, 1988).

Of particular concern to the counselor is the fact that the client may not consider separation or divorce as an alternative. This is especially true if there is a great cultural stigma, such as a religious injunction, that affects the client. Dr. Lenore Walker, whose studies have been referred to in this paper, is nationally recognized as a feminist and expert on domestic violence. Dr. Walker's quotation taken from her book Terrifying Love: Why Battered Women Kill and How Society Responds (1987) reflects how a feminist therapist might look upon the person who is battered and their relationship:

"It is my professional opinion the best hope for the battered woman to stop the violence is to end

the relationship altogether" (p46).

CONCLUSIONS

The historical development of rehabilitation counseling has focused the interaction of the counselor almost exclusively on the individual with the disability. Current studies reflecting practicing counselors' rating of the importance of family counseling theory indicate a perception of moderately low importance (Szymanski et al., 1993). Describing future areas of continued need for human resource development, counselors again rated family issues as of low importance (Szymanski et al., 1993b). This is surprising in that current curricular texts reinforce the importance of including the significant others of the client in order to make an accurate assessment of the individual (Power, 1991; Rubin & Rossler, 1987).

An examination of the etiology of domestic violence produces a pattern of interaction between the batterer and the person who is battered. Walker (1979) identifies a correlation that the longer the couple is in the cycle of violence, the greater intensity and occurrence of violence. The serially battered, those that are assaulted no less than monthly, comprise 25% of women who are battered (Klaus & Rand, 1984). It is this sub-group of persons who are battered that is at the highest risk of becoming consumers of rehabilitation services. The most conservative estimate of individuals in this category is 398,769 and reflects only those individuals requiring emergency room services. This

estimate does not include men who have been battered. Nor can it take into account incidences of assault that are treated by personal physicians, go untreated, or unreported. If Stark and Flitcraft (1991) estimate that 20% of all women between the ages of 16-64 are in battering relationships, the persons in the highest risk category rises to 2,725,833. A moderate percentage of either figure would impact the caseload of rehabilitation counselors.

Facile identification of the client who has been/is in a battering relationship is complicated by several factors which include resistance on the client's part to report the cause of injury or the lack of identification by treating physician (Stark & Flitcraft, 1991). If the rehabilitation counselor hopes to identify the client who has been in a battering relationship from past records, there are physical and psychiatric/psychological patterns of injury and behaviors that may serve as indicators of being battered.

Identification of the client who has been/is being battered is critical in the formation of the IWRP and in its successful completion. Although the client may be medically stable, the recency of the relationship may impact the client's abilities to make decisions (Russel & Uhleman, 1994). The emotional or physical state of the client may be compromised if they are still in a battering relationship. The ability of the client to follow through with appointments may be beyond their ability to control. Rather than

place the blame on their significant other, the client may become self-blaming. If the counselor is unaware of the dynamics ongoing in the home, it could be possible to categorize the client as uncooperative or ambivalent towards their rehabilitation plans.

The vocational implications are dependent upon the circumstances of the client and their relationship to the batterer. Even if the client is no longer in the battering relationship that caused the injury, they may be in another abusive relationship (Goldberg & Tomlanovich, 1984). If not in an abusive relationship there may be geographical restrictions placed by a restraining order or concern for personal safety that precludes the individual from job searching in a particular area. The client may have limited resources requiring additional referrals by the rehabilitation counselor to supportive services.

For the rehabilitation counselor to be ignorant of the client who has been battered is the same as to be ignorant of the etiology of the disability of any client. It may not fit into the feminist ideology to identify the client whose disability is directly the result of abuse in reference to the home environment (Schwartz & DeKeseredy, 1993). Yet if the rehabilitation counselor is to be able to make an accurate assessment of the client and their strengths, it must involve both supportive and non-supportive relationships with significant others (Power, 1991). The persistent use

of victimizing terminology by the feminist movement in referring to clients who have been battered, so as to place the blame completely on the male batterer (Schwartz & DeKeseredy, 1993; Walker, 1980; Dobash & Dobash, 1979; Martin, 1976; Prizzey, 1974) may serve only to undermine the empowerment of the client (Patterson, 1988).

FUTURE AREAS OF RESEARCH

Future areas of research should include the establishment of an assessment protocol by rehabilitation counselors that includes a component that helps identify a consumer that has been battered. Current caseloads could be examined using factors that may indicate past/current battering. Surveys could be taken of clients who are identified as having been battered to see, considering their circumstances, whether the best combination of services were offered.

The attitude of practicing counselors, considering the current low importance of family services, must be addressed through additional research. This research will hopefully indicate the importance of understanding the impact the significant other has upon the client who has been battered.

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