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The domestic violence survivor assessment: a tool for counseling women in intimate partner violence relationships

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Abstract

Seeking to end violence and distress in their relationship is the goal of women abused by intimate partners. The theoretical framework guiding development of the domestic violence survivor assessment (DVSA) was Landenburger's theory of entrapment and recovery. Social context and need to balance care for others and herself influence women's decision-making about abuse. The DVSA was developed collaboratively between researchers and counselors to gain a deeper understanding of battered women's cognitive states in order to assist them during counseling to effectively resolve the dilemma of their abusive relationships while experiencing personal growth. Five states are identified which a woman may experience on 11 issues concurrently at the personal, relationship or social context levels. Research to validate the DVSA and suggestions on use with women desiring to preserve their relationship or preserve their self or preserve the resolution of change is described. Using the DVSA for assessment, intervention and measuring intermediate outcomes is delineated. © 2002 Elsevier Science Ireland Ltd. All rights reserved.

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A deeper understanding of women survivors' reasoning processes for achieving non-violence in their lives and the concurrent cognitive states, they commonly hold about their life situation can be revealed through use of the domestic violence survivor assessment (DVSA). This instrument was developed to guide counseling using the theory of entrapment and recovery [1]. A feminist perspective of valuing active listening to the voices of survivors to guide the development of assessments, interventions, and outcomes was used in its development [2]. This is an alternative to the traditional approach of basing assessments and interventions on the observations of professionals [3,4].

The current "gold standard" for evaluating interventions for women experiencing domestic violence is usually thought to be permanent cessation of violence through leaving the relationship. Conversely, this has been described as victim blaming, since she cannot control his behavior and to leave is not necessarily to end the violence [5]. In developing instruments for assessing battered women, we acknowledge that no one instrument can fully capture the complexity of any woman's life. Our goal was to develop a theoretically and scientifically valid instrument to: (1) guide battered women and their counselors in their search for a deeper understanding of women's lives as they traverse the decision-making process of seeking safety and non-violence, and (2) provide measures of intermediate goals to demonstrate the effectiveness of counseling interventions.

1. Background

Many researchers have explored the process of change that women experience when resolving abusive relationships. We reviewed qualitative research on the meanings women attach to the journey of change to safe lives as the basis for guiding our instrument development.

Changes in a woman's behavior are propelled or constrained by the meaning she attaches to her experiences. Understanding the meaning of any relationship becomes more complex as one begins to include the social context of children, families of origin of both partners, friendship networks including neighbors, co-workers, and relatives. Often a woman's ability to discern meaning and make decisions to protect her is mitigated by the intensity of

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the abusive relationship and the low level of interaction with others outside the relationship. Isolation may be due to such conditions as: frequent moves, living in a rural area, jealous isolation enforced by the abuser, and/or being an immigrant. This highlights the importance of both individual influencing factors and the social nature of this problem. Personal values, community, religious and family norms, and resources of sanctuary and sanctions impact both her and his behavior.

Her stage of moral development also shapes the meaning an abused woman gives to experiences and decisions regarding the relationship. Gilligan [6] described, in her research, how moral development in women evolves through resolution of conflicts between caring for herself and others in her life. She identified three levels of moral development as women grew from a child's selfishness of individual survival, to the recognition of responsibility for the good of self-sacrifice for the care of others, and finally to a morality of non-violence to balance caring for self with caring for others. Belknap [7], in listening to battered women describe the decisions in their lives, repeatedly heard them describe moral choices. Women described moving from "the good of self-sacrifice" to "balancing caring for self with care for others" in telling of first deciding to remain in the relationship to meet the needs for their children to have a two-parent home and economic security and later deciding to leave to secure her own safety and end the harm the children receive from living in a home where they witness intimate partner violence [8]. In other cases, women report first staying to care for "the little boy who needs help" in her violent partner, sacrificing her need for safety, to later deciding his need for care is less important than her need for safety [7]. Thus, personal growth often accompanies ending abuse [9].

1.1. Theoretical framework

The theoretical framework of entrapment and recovery of women who leave abusive relationships [1,10] is based on two studies as well as Landenburger's ongoing clinical work with battered women. The first study interviewed 30 women who were in or had recently left abusive relationships using a semi-structured interview guide to explore the experience of being abused [1,10]. A model of a process of entrapment and loss of self-followed by recovery of self was identified through constant comparative analysis. The second longitudinal study of 70 women, recruited from a shelter, focused on the choices and factors that enhanced or retarded a woman leaving and recovering from an abusive relationship [10]. The women attended focus groups of 7–10 participants for 10 months answering open-ended questions on how they were restructuring their lives. A subset of 10 women had extensive interviews initially and at 3 and 6 months on how they were restructuring their lives. From these studies, Landenburger posited four phases of leaving an abusive relationship. The *binding* phase incorporates the initial development of the relationship, the beginnings of abuse, and her initial reactions to abuse. *Enduring* encompasses the period when a woman recognizes that abuse is occurring, but remains committed to the relationship and tries to control the violence and focus on the good aspects of the relationship. During this time, she also begins to feel "sucked dry" and entrapped and that she must leave in order to survive. She also experiences a loss of self and feelings of worthlessness. A woman enters *disengaging* when she begins to identify with other abused women, more actively seeks help, and rejects those who encourage her to stay. She may also experience reemergence of self-needs. At times balancing this with the need to care for others is overwhelming and frightening. *Recovering*, the last phase, begins when she permanently leaves and continues until she gains a new balance and meaning in her life. Leaving does not necessarily end the violence as he may harass, stalk, intimidate, or physically abuse her after she has left. Recovery is more complex if she has children with ongoing issues of custody and child support.

Landenburger [10] emphasizes that her theoretical framework is not to be interpreted as a linear measure of change. Women are struggling to interpret meaning and make decisions within a context of mixed messages regarding the violence by her perpetrator, family, and community. This results in a skewed reality. Change is complex, and concurrently includes the levels of self, the relationship, and her family and community. She may be in different phases for different levels at once, but change is cumulative and visible over time.

1.2. Research supporting the theoretical framework

Most of the studies on the process of women changing their lives to end the violence are cross-sectional, retrospective, descriptive investigations of women in shelters or from the community who have left abusive relationships [1,9,11–17]. The majority of these studies used primarily white samples, but there was at least a significant proportion of African–American women in two of the studies [14,17].

From these studies, five had a theoretical analysis describing states associated with change leading to the woman leaving the abusive, intimate male partner [1,12,13,16,17]. Some studies combined two states that others separated and each used different labels, but there was general agreement that a process of change that included identifiable states characterized abusive relationships. Across the five studies, the identified states reflected a process of: (1) confusion by the woman when violence enters the relationship; (2) minimization of abuse and commitment to the relationship by both partners; (3) the woman committed to enduring while recognizing negative costs and emotional abuse by the male partner; (4) the woman seriously considering her options to end the violence; (5) the woman determined to end the violence with opposition by the man; (6) the woman leaving, determined not to go back and the man actively opposing the change; and (7) the woman viewing abuse

Table 1
Women survivors' cognitive states concerning themselves and intimate abusive relationships

Authors[a]	Cognitive States of Women Survivors						
	Violence enters relationship and it continues	**Abuse continues: She is committed**	**Abuse continues: She endures but begins to question violence**	**Abuse continues: She seriously considers how to end violence**	**Abuse continues She leaves with intent of ending relationship**	**Abuser may stalk and/or harass She begins new life**	**Abuse and relationship is in her past**
Wuest Merrit-Grey	Counter Act Abuse			Break Free		Not Going Back	Moving On
Mills	Enter Violent Relationship	Manage the Violence	Expeience Loss of Self	Re-evaluate Relationship	Leave		
Landenburger	Binding		Enduring	Disengaging		Recovery	
Fishwick	Sustained Personal Integrity		Jeopardized Personal Integrity	Erosion of Personal Integrity		Reclaimed Integrity	
Moss, Petula Halstead	Being in Enduring		Being in Recognizing	Being in Becoming	Getting Out	(With children never over)	Going On
Brown[b]	Precontemplation		Contempla-tion	Prepare	Action	Maintenance	

[a] See Reference List for Citations.
[b] Theoretical application of the transtheoretical model of change to domestic violence relationships.

as in her past. The change to living without violence was not a linear progression, and in many cases, the first several attempts to leave were followed by returning discouraged, but also with new insights on what challenges she will face when she finally leaves [18]. Table 1 summarizes the similarities of the states identified in the five studies and the transtheoretical theory of change [1,12,13,16,17,19].

These studies have revealed the dynamics of intimate partner violence and offered deeper understanding of how difficult it is to end violence against women in our society. Yet, weaknesses of this design are the reliance on recall and the underlying assumption that leaving is necessary to end intimate partner violence. Other studies were descriptive, prospective, and longitudinal [5,11,20–22]. These studies had more ethnically heterogeneous samples and demonstrated that the distress in the relationship and the abuse were two different issues in the minds of the women. Some of the women in these studies report resolving the distress in the relationship through controlling or eliminating the abuse and maintaining the relationship and others by leaving the relationship. The means described for maintaining the relationship included: negotiating with the abuser, making the abuse more visible and more likely to be sanctioned, sanctions by family or friends, and/or police arrest leading to court sanctions (often including mandated attendance at a abuser intervention program), and voluntary counseling. Other studies have shown police arrest alone is a deterrent to future abuse by men who are otherwise law abiding [23].

2. Domestic violence survivor assessment (DVSA)

Working with three community-based agencies to develop and implement outcomes for their women's domestic violence counseling programs, a need to develop an assessment tool that could be used on admission and discharge to guide interventions and measure outcomes was identified. The agencies were the family violence programs of one rural and one suburban office of United Family Services of Central Maryland and the third was the Counseling and Outreach Department of House of Ruth of Baltimore. All three offered individual counseling, structured and open-ended support groups and related services for referral such as hotlines, shelter and victim assistance with the justice system. The instrument needed to be simple to use, quick to complete, yet still reflect the complexity of women's lives, and her intermediate progress toward ending violence. Advocates with baccalaureate degrees and training in domestic violence by the organization did intake at all three agencies; counseling was done by social workers. A tool for women coming either for counseling or shelter was desired.

Using Landenburger's theoretical framework as a guide, Dienemann and Campbell collaborated with the staff and administrators to develop a tool that was scientifically sound and administratively feasible. The agencies had agreed to five specific goals they had for women clients. They were: (1) increase effectiveness of survivors' safety practices, (2) increase survivors' knowledge of the "healthiness" of the relationship (or lack thereof), (3) increase the effectiveness

of survivors' coping skills with life situations, (4) rebuild survivors' self-identity; increase survivors' self-sufficiency, and (5) decrease survivors' trauma and stress symptoms. It was agreed that most of the clients' personal objectives and the myriad approaches used by the counselors for interventions were in agreement with these five overreaching goals.

The staff had observed changes in women as they worked with them over time and strongly believed that leaving was not a valid measure of ending abuse or recovering from abuse. After the researchers provided an overview, they chose the theory of entrapment and recovery as a framework. With the researchers' guidance, they decided to make adaptations to fit their practice wisdom. These included: (1) focusing on the period after abuse enters an intimate relationship; (2) incorporating the concepts of considering and preparing for change from the transtheoretical theory of change [24]; and (3) recognizing that resolution through the partner changing, as well as the woman leaving, is possible. The phases were described as states, to avoid the implication that all women simultaneously move sequentially on all levels to resolve their dilemma of abuse. The five states are: *committed to continuing* which includes the later aspects of binding after the violence has entered the relationship, but before she defines it as abusive. *Committed but questioning* which equates to the enduring phase. The disengaging phase is split into *considering and preparing for change* when she accepts the label of abused and actively seeks and tries options and *breaks away or partner changes* when she first remains away or soon after he responds to sanctions and ends the violence. *Establishes a new life—apart or together* equates to the recovery phase in Landenburger's model. The staff and researchers named these states. For example, staff suggested not using the term "recovery" due to its association with addictions treatment.

The researchers reviewed the literature and found that issues often encountered by battered women across all phases of decision-making had been independently studied by Smith et al. [25,26] and by Ferraro and Johnson [15]. Using these issues and Landenburger's levels of self, relationship, and social context as a guide, we defined five issues about the relationship which were to be measured across the state continuum and also could measure achievement of the overreaching goals mentioned above. The issues were the woman's assessment of: (1) causes of abuse, (2) how she tries to manage her partner's abuse, (3) love she feels and isolation she experiences, (4) views of the relationship and her options, and (5) how her friends and family see the relationship. The first two relate to goal one for safety and the next three relate to goal two for knowledge of the healthiness of the relationship.

Next we identified six issues related to her as an individual. These were: (1) how she accesses help and available resources, (2) her feelings, (3) her self-identity, (4) her self-sufficiency, (5) her mental health, and (6) her response to physical injuries resulting from her abuse. The first two related to the goal of increasing the effectiveness of coping skills, the second two to self-identity and self-sufficiency, and the last two to decreasing trauma and stress symptoms. Five additional issues were identified which were later dropped or integrated into other issues as described in the following sections.

Initially, this information was organized in a grid with five columns for the five cognitive states and 16 rows for the 16 issues relevant to battered women's lives. Phrases and statements by battered women quoted in research publications and the staff's experiences were gathered and entered to richly describe women across the continuum. Thus, each issue had five cells across the continuum from committed and continuing to establishes a new life—apart or together with descriptive phrases and statements. After five iterations of review and critique by the staff and researchers, the grid was reduced from 16 to 11 issues. The grid form was then compressed into short phrases in order to reduce the form to one page for ease of administration as shown in Table 2.

The critiques were led by the primary researcher (Dienemann) at staff meetings and followed up by facsimile summaries of decisions. These were validated at staff meetings and communicated by the administrator to the researcher. As the researcher rotated visits to each site, she would review the decisions and feedback from the other agencies gained between visits. The staff participating included six social workers with 5–10 years experience working with domestic violence and four intake counselors with 1–3 years of experience in the field. The three agencies differed by population served: inner city, suburban, and rural areas with the ethnicity of the inner city and suburban clients primarily African–American and White European and the rural women primarily White European. Researchers triangulated critiques based on practice wisdom with published research findings.

Instructions for the DVSA ask clinicians after an intake interview, to complete the form from the woman's perspective by marking the cell for each issue that best represented the state the woman reported experiencing. If a woman had made statements that fit two adjacent states, the clinician could mark two cells. Clinicians are to leave blank rows for issues where they do not think the woman articulated enough information or if the woman's story does not focus in one or two adjacent states on that issue.

2.1. Pilot study of DVSA clinician form

A pilot study was undertaken by asking for assessment of three clients by three social workers at each agency with the original 16-item form before integration. A total of 20 forms were received for analysis. Feedback indicated the DVSA was easy to understand, quick to complete, and provided a valuable holistic viewpoint. For example, it helped staff summarize the multiple problems women experience during a crisis and visually display issues where she needed assistance and issues she was resolving. It also provided a way for staff to add or modify information as, over time, women gained trust and disclosed more. Staff saw the DVSA as a

Table 2
Domestic violence survivor assessment form

INTAKE DATE: ________________ NAME OF INTERVIEWER____________________ NAME OF CLIENT_____________________________

Issues about the relationship……………

Causes of abusive incidents?	Denies & excuses abuse. May accept blame by partner.	Questions self blame Vague talk rela. ending. Looks for logic in causes of incidents.	Rejects self blame. Continues to make excuses to others, but realizes he chooses to abuse.	Partner is accountable abuse. Assesses safety – partner change or time to leave	Intends violence past. If left, avoids partner. If together Monitors partner for change.
Managing Partner Abuse	Sees partner control as trade off for good in relationship	Placates, feeling trapped. Asks partner to get help	Realizes cannot prevent partner abuse. Tries to avoid abuse by sleep, work, etc.	Abuse must end. Makes and acts on plans for own safety.	Learns new ways to relate to new/changed partners. If left, makes excuses to avoid abuser.
Love & Isolation	Tries to love enough. Keeps abuse secret.	Loves & "Gives 2nd Chance" Shame is secret. Tries to not think about abuse.	Ambivalent losing home, partner, dreams. Begins to identify with survivors.	Embarrassed. Yearns for what may have been. Plans and acts to avoid danger.	If left, reminds self why; feels void, nostalgia for love & loss. If apart or together builds support network.
Views Relationship and Options	Positive overall. No need for options. Violence temporary.	Reflects on good and bad, overall OK. Try change self, dreads abuse	Ambivalent. Tries options to help partner change &/or tries leaving for 1-2 nights. .	Determined abuse must end. Willing "to do what it takes" over time to become safe	If she leaves, partner may plead, stalk, harass. Regardless, has learned to weigh options.
How my friends/ family see relationship	Fears stigma of failure in relationship.	Remains "for the family, or status, or children" Does not want partner humiliated.	Struggles own loyalty and rising sense injustice. Thinks what is too much?	Partner does not deserve loyalty. For many there is a precipitating crisis.	Feels justified in leaving or monitoring partner's change with some lingering guilt.

Issues about the individual ………………

Access sup-port/resource	Little, sees others as not understanding.	Generalized mistrust. Afraid one can help. Seeks respite.	Hints to others of abuse, seeks support & help. Fears reprisal	Persistently seeks and sorts out who is and is not helpful	Negotiates with multiple sources. At times overwhelmed. More trust
Feelings	Avoids/denies own negative feelings.	Avoids all feelings to protect self. Numb, overwhelmed.	Able to name feelings. Fear and anxiety prominent.	May put feelings on hold as deals with other issues.	If leaves, acknowledges loss and grief. Continues to feel and anxious
Self identity	Sees relationship as self Unassertive to partner.	Loss of self is OK sacrifice for relationship. Partner needs her.	Struggles to regain lost identity. Feels guilty & mixed up. Labels self as abused.	Negative about abuser. Acts on own needs. Vacillates guilt and anger.	Self identity becomes clear. Sees negative and positives in abuser and relationship. Less anger.
Self Sufficient	Cannot imagine. Alone would be frightening.	Considers possibility. Anxious about being lonely.	Sets goals & takes first steps. Questions fears of separation.	Acts to meet goals. Tests tolerance of being alone.	Works to be self sufficient. Anticipates needed support & uses.
Mental Health	Stressed. Possibly depressed & confused. May have PTSD.	Stressed, depressed, anxious. May dislike self. If PTSD, worsens.	High anxiety, panic attacks. Fantasies murder. Fears is crazy. If PTSD, intolerable.	Senses can gain control of "out of control" feelings. If PTSD, causes higher stress	Grief rises, then recedes. Lower self esteem slowly improves. If PTSD, also rises, then recedes.
Medical Care for Injuries from DV	Ignores, denies injuries when with others. Treats own injuries.	Tolerates lack of medical treatment to keep partner. Treats own injuries.	May delay seeking medical treatment, but does receive. May not tell partner.	Seeks medical treatment as soon as safe. May not tell partner.	Seeks medical treatment as needed. May or may not have ongoing health problems from DV.
	Committed to Continuing	**Committed, but Questioning**	**Considers Abuse and Options**	**Breaks Away or Partner Curtails Abusiveness**	**Establishes a New Life - Apart or Together**

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useful tool to remind them of the usual range of women's problems, to systematically record new issues, as they became visible, and to validate change at time of discharge.

None of the 20 women assessed had marked cells in only one vertical column (state). Six women had cells marked only in two adjacent columns. Five had all, but one or two cells marked in two adjacent columns. The last four had one dominant column with no pattern in the remaining marked cells. Staff believed these patterns were reflective of the women they assessed and the issues they were facing. They recognized that when a woman had one or two cells marked in an earlier state of change than the others, it was a valuable guide to where she was ''stuck'' and needed assistance in counseling to move forward.

Analysis of the clusters of marked cells indicated three primary groups. One was women who primarily expressed commitment for *preservation of the relationship*. Clinicians stated these women often sought temporary shelter or information on how to preserve their families and minimized discussion of the violence in the relationship. They interpreted the violence as not representative of the relationship or a temporary problem due to an issue in the perpetrator's life. A second group was women who sought counseling or shelter for *preservation of the self*. This pattern had marks clustered in the three center columns. The clinicians described these survivors as viewing themselves as abused, concerned for their own safety and well being and with shifting ambivalence about their relationship with the abuser. They often came sporadically for counseling or repeatedly to shelter. They described them as working through their options and moving toward resolution. The last group sought *preservation of the resolution*. Their marks clustered in the two right-hand columns. These women had worked out some resolution to curtail the violence in their relationship and sought services to support restructuring their lives. In the pilot study, all of the women in this group had left the relationship and came regularly to a support group or were in shelter for a sustained period.

Regarding women with multiple abusive relationships, the staff suggested asking the woman which relationship, she viewed as most relevant at this time. They also agreed that sometimes a woman's story changed as she gained trust and revealed more about her life over time. Two social workers suggested that the DVSA should be ''finalized'' after a second visit. All social workers agreed that having the intake advocates complete as much of the DVSA as possible at intake was very helpful in assisting them to focus discussion for initial visits.

Inter-rater reliability among seven social workers and nine advocates was tested at a retreat for all three agencies. The staff all read the same case scenario and independently rated the case using the DVSA. Agreement on the 16 issues varied from 43.75 to 81.25%. Discussion followed regarding why the differences were found. Differences in rating were attributed to: (1) disagreement about if the case had sufficient information to rate all the issues, (2) difficulty remembering to assess from the woman's point of view and not the staff's experience with many women, and (3) semantics with the tool itself. Changes in wording were recommended and revisions made. A sheet to guide use and remind the clinician to assess from the woman's point of view was made. For future training on use of the tool, the staff recommended a role play of an assessment interview due to the difficulty assessing from a written case scenario and it would more closely simulate how they use the DVSA.

2.2. Preliminary research findings

The DVSA is currently being tested at three hospitals and two domestic violence community-based programs that participated in the development of the tool. The rural and urban agencies have individual counseling and ongoing support groups for women who call and request services. The three hospitals have full time advocates and universal screening. One hospital is urban, one suburban, and one rural. Only the urban hospital and urban agency have a substantial number of African–American or other minority patients. Women are asked after disclosing domestic violence and meeting with the counselor if they will consent to participate in the study. For those who consent, the clinician completes the DVSA after the interview and seals it in an envelope for analysis by the researcher. Eighty-seven clients have been assessed by clinicians using the DVSA. The marked cells are analyzed for patterns of preservation of the relationship, preservation of self, or preservation of resolution. A standard of eight marked cells for the 11 issues must fall within the pattern for identification. When adjacent cells are marked, both are eligible for pattern identification. Only 11.5% of the 87 clients had no identified pattern. Preservation of relationship was identified in 7.6%; preservation of self was identified in 41.3%, and preservation of resolution in 34.8%. The most frequently omitted items (due to clinicians deciding they had insufficient information for rating) were mental health and response to injuries from DV. Clinicians report that most of the women consenting to participate attend an ongoing support group or individual counseling or are in-patients.

3. Counseling and intermediate outcomes

3.1. Target population to serve

The DVSA completed on intake at the community program was reported as useful for systematic review of issues many battered women face and a guide for the initiation of counseling. The providers/advocates at the hospitals report more complete information is provided by women who are in-patients or returning to the ambulatory clinics or domestic violence support program. Women in crisis seen in the emergency department are often unable to focus globally on their life situation at that time.

3.2. Practice implications for interventions

The DVSA is designed for use with women who have disclosed intimate partner violence through screening or through seeking counseling or shelter. As more hospitals and ambulatory services offer advocate counseling when women screen positive for abuse, the DVSA is one tool to assist the clinician to holistically review issues that many battered women face. With women who are in crisis, the counselor may use the DVSA to identify areas that are not marked to further explore when she is seen again at a follow-up visit. The guide for using the form includes sample open-ended questions to use in assessment to address these issues. For these women, the DVSA is a summary to use after an interview, not a form to ask a client to complete.

When working with a woman who is not presently in crisis, the counselor and client may jointly complete the DVSA. This exploration of her relationship and issues related to self-care will act as a means to assist her to gain a deeper understanding of the issues she is facing and that leaving or curtailing the violence is just one decision she must make. Clinicians report the DVSA provides a useful starting point for asking the woman what she will find helpful at this time and affirming that much of what she is experiencing is similar to other women's experiences. As with all IPV clients, the counselor must be vigilant for child abuse and inform the client of local laws for reporting abuse.

Counselors who recognize that a woman is motivated to *preserve the relationship* should focus on assisting her to understand the cycle of violence [27], to overcome the shame of being a victim, and identify patterns in her relationship that are disruptive to her life. Asking to hear her story and being fully present are essential approaches. Often, no one has believed her when she mentions the violence or they have minimized its importance. Emphasis is on expressing concern for her safety and the counselor creating an atmosphere that clearly welcomes her to return no matter what she decides to do at this time. She may not accept the counselor's naming the violence as abuse or assertions that no one deserves abuse, but she will hear it and remember it later. The frustration for the counselor is that they may not see this client again and have the satisfaction of knowing how she resolves her dilemma.

When counseling a woman demonstrating a *preservation of self-pattern*, the counselor should reinforce her awareness of the increased danger she is now facing. Tools such as Campbell's danger assessment [28], Parker et al.'s safety checklist [29], and/or safety planning guides help identify risks and potential actions to become safer. Information and referral to inform her of her legal rights, police and court sanctions, and victim assistance programs in her locality are timely. The counselor should have informally investigated the experiences of other battered women using these services in case they have a history of unresponsiveness. It is vital that counselors acknowledge that the woman is the expert on how and when to resolve her dilemma and express respect for her autonomy. Women often report that counselors become negative if they return later for assistance and have not left their partners [30].

Counselors should validate with the client her mixed feelings about her partner and the losses that leaving or external sanctions would bring. The DVSA may be helpful as a starting point for this discussion. Many women express ongoing moral conflicts between her personal needs and the needs of her partner, children, and extended family. These conflicts and the added tensions associated with her partner's resistance to her attempts to curtail the violence may result in her experiencing increased symptoms of trauma and stress. Assessment of depression and symptoms of post-traumatic stress syndrome (PTSD) should be done and appropriate referrals made if indicated. Teaching stress management techniques are helpful. Counselors should also be alert to her mentioning health problems that may be consequences of sexual assault or repeated physical assault that may need medical follow-up [31].

Many of these women do come for follow-up or are repeatedly identified in screening. Attendance at open-ended support groups or individualized counseling may be sporadic, but continuing. For women returning, another approach is to encourage her to envision how she will restructure her life when she achieves resolution. Many women also need support as they go through the process of identifying which services and individuals will or will not be helpful and support ending the violence. If she has children, plans for obtaining custody and the children's recovery as witnesses to violence are needed. Appropriate referrals for job training or other social services may also be needed.

When counseling a client, who reports a *preservation of resolution pattern*, interventions should support her working through her feelings and assist her to rebuild competencies. Often support groups are very helpful for women to share successes and hardships of restructuring their lives. This is often much more difficult than women had realized before the change. Many are surprised to find some friends and family unwilling to hear her story or share her future. One new issue that arises for many women who have left an abusive partner is how to choose new partners who will not be abusive.

For women participating in individual counseling, the DVSA can be helpful to clarify issues where the client is being restrained in her progress. This is also a time when counselors should probe for sexual abuse by the intimate partner. For many women post-resolution is a time when they will reveal sexual abuse that they have been too ashamed to discuss earlier. Acknowledging that forced sex, being forced to do sexual practices that are undesired, and marital rape are widespread problems for abused women can be very supportive. Reiterating that abuse is not deserved, that it is her right to give or withhold permission for sexual acts, and that the perpetrator is responsible for his actions are all also supportive. Exploring how this experience is shaping all her current relationships often provides valuable insights and behavioral changes.

3.3. Intermediate outcomes

Intermediate outcomes demonstrate progress in treatment during the period of counseling [32]. A counselor using the DVSA records initial assessments, periodic assessments at standard time periods, and at discharge. Notes regarding factors influencing her decision-making and life events creating crises should be recorded. Evaluators should avoid statements that promote linear progress as a standard or blame survivors for not changing their partner's behavior.

One agency uses the DVSA at intake, quarterly report, and discharge. Counselors report the forms are feasible, but results are still in the pilot phase. Computer scanning of forms for data entry is the next step to support evaluation.

4. Conclusion

Counselors are most helpful when they directly discuss the violence and unconditionally accept the client's definition of the situation [30]. The client's perceptions are the reality in which she lives. The DVSA is designed to capture her reality and assist counselors to guide her to more deeply understand what she is experiencing, that it is abusive and harmful to her and her children, and that options exist which can transform her life. The goal is empowerment that is as complex as the woman's circumstances and may be a slow and uneven process, but is still achievable and measurable.

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