Praise for the Second Edition

“Every clinical social worker, nurse specialist, and physician should read this book. A landmark achievement—this is the first comprehensive book to examine domestic violence from a multicultural perspective. This brilliantly written and all-inclusive resource provides new clinical knowledge and practice wisdom to alleviate the emotional pain and trauma of battered women and their children. I have been searching for a book like this for years, especially when I was consultant to the U.S. Army Surgeon General.”

—Jesse J. Harris, PhD, BCD, ACSW
Professor and Dean
School of Social Work
University of Maryland
Colonel Retired

“This volume provides the step-by-step answers and solutions on how to detect, assess, and treat battered women in trauma, acute crisis, and emergency situations. Professor Roberts’s timely volume provides concrete solutions and a nonjudgmental approach to a major societal and public health problem. If you are planning to purchase only one book on interpersonal violence this year, this is the essential book to purchase.”

—Karil S. Klingbeil, MSW, ACSW
Director, Department of Social Work
Harborview Medical Center, Clinical Associate Professor
University of Washington, School of Social Work

“As the former Chair of the National Research Council’s Panel of Research on Violence Against Women, I applaud this second edition . . . . It includes valuable adult abuse protocols, treatment models, and techniques on how to intervene effectively with women and children
in violent homes. . . . I am particularly impressed with the breadth and depth of the topics covered ranging from emergency department triage teams to primary care settings, to group therapy, to shelter for abused women and their at-risk children. This is the first book of major importance that emphasizes the growing alliance between clinical nurse specialists and clinical social workers. . . . This volume is extremely well written, insightful, and thoroughly up-to-date—a must read for all clinicians.”

—From the Foreword by Ann W. Burgess, RN, CS, DNSc, FAAN
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THIS 3RD EDITION IS DEDICATED TO ALL SURVIVORS AND THEIR FAMILIES, DOMESTIC VIOLENCE ADVOCATES AND CLINICIANS SPECIALIZING IN DOMESTIC VIOLENCE INTERVENTION.

This book is dedicated in loving memory to my parents, Harry and Evelyn, whose love, faith, unconditional acceptance, and family values instilled in me the fervent belief that all women and children should be cherished and treated with compassion. Since my adolescence I have been inspired by my mother’s quiet fighting spirit, resilience, and altruistic nature as she survived 17 years after having been diagnosed with breast cancer. This is my 34th book; it could not have been completed without the compassion and perseverance my parents instilled in me.

To Beverly, my wife of 35 years, whose love, altruism, and intellectual stimulation provide me with balance and focus.

This book is also dedicated to the many nurses, social workers, and counselors who provide essential health care, social services, and clinical intervention to battered women and their vulnerable children. The lives of thousands of chronically battered women in life-threatening situations are saved each year, because of the commitment of these nurses and social workers.
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I am honored that I was invited to write the Foreword to the third edition of *Battered Women and Their Families*. As an educator with nearly 30 years experience and as the long-standing dean of the School of Social Work at the University of Texas at Austin, I am in a good position to recognize a classic textbook on family violence. My university and faculty members have received national acclaim for their leadership in the domestic violence field; the first National Domestic Violence Hotline was established in consult with the University of Texas at Austin in 1996 (this was a collaboration between the Texas Council on Family Violence and our School of Social Work, with an initial $1 million grant from the U.S. Dept. of Health and Human Services).*

Dr. Roberts has thoroughly revised and updated the third edition of *Battered Women and Their Families*, and the result is a comprehensive new work that retains revisions of the best chapters from the second edition while incorporating 12 new chapters. More than 60% of this edition contains new and valuable material.

This important book provides an exceptionally well-written, up-to-date, and informative text that will rapidly become indispensable to all social work and counseling students as well as to clinicians committed to helping battered women and their children. This volume explores the vital role of social workers, crisis counselors, nurses, and domestic violence advocates in promoting safety, survival skills, recovery, and social functioning to battered women and their children. It provides in-depth and up-to-date coverage of the frontiers, policy changes, innovative programs, treatment

*In the spring of 2006, Senator Joseph Biden Jr. (sponsor of the Violence Against Women Act) proudly announced that after 10 years in operation, the 24-hour National Domestic Violence Hotline had received 1.5 million calls for help.*
modalities, and evidence-based practices related to battered women and their children.

Among social workers, nurses, public health officials, and physicians, there is increasing recognition of the prevalence of woman battering. A substantial proportion of women across social strata experience intimate partner abuse and violence. The lifetime prevalence of abuse against women is estimated at a shocking rate of one in every four women. Fortunately, during the past 3 decades, a continuum of individual, group, and family services for battered women has become a major priority among federal and state governmental agencies as well as nonprofit social service agencies. Over the years, we have learned that woman battering is a harmful and life-threatening social problem in all age groups, all races, all religions, and all socioeconomic groups.

- We have learned that some women are battered for a short time and are able to end the relationship before the violence escalates in frequency and intensity. Some women are battered intermittently for several years, and some women are chronically battered for many years.
- We have learned that most battered women are intelligent, articulate, and hardworking but are stuck with or addicted to (or both) hostile and abusive intimate partners.
- We have learned from clinical research that 25% to 60% of battered women meet the diagnostic criteria for depression, acute stress disorder, substance abuse, panic disorder, generalized anxiety disorder, posttraumatic stress disorder, or a comorbid combination of these disorders.
- We have learned that the children of battered women suffer acute crisis episodes and trauma but can be helped by play therapists, child and adolescent clinicians, and trauma-focused therapists.
- We have learned that problem solving, motivational interviewing, cognitive–behavioral, and crisis intervention counseling can facilitate crisis stabilization as well as recovery.
- We have learned that these entrapped women can permanently leave the batterer and recover from mental health and medical disorders with help from experienced clinicians.

These and many other challenges, problems, intervention strategies, assessment and treatment methods, and empowerment ap-
proaches are documented in this book by one of the most brilliant clinical researchers in North America today—Dr. Albert R. Roberts—together with the highly experienced chapter authors.

This book will help readers learn about the most effective policies, programs, and intervention strategies for helping battered women and their families escape an abusive relationship and improve their quality of life. This book provides the knowledge base, assessment and treatment guidelines, and evidence-based clinical protocols that are critically needed by every clinician and advocate working in the domestic violence field. Sadly, there are still many women who remain trapped in violent relationships, and for numerous reasons they are unable to seek help. Therefore, we must continue the necessary education and outreach—to both boys and girls, both men and women, beginning in childhood—to underscore the most basic principle that all forms of violence in personal relationships are prohibited. *This is the most practical, evidence-based, inspirational, and well-written book on family violence that I have read in the past 10 years. Every social worker, counselor, nurse, and domestic violence advocate should read this book.*

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Intimate partner violence, also known as family violence, domestic violence, dating violence, and spouse abuse, is all too pervasive around the world. In fact, domestic violence continues to be one of the most life-threatening and traumatic family and public health problems in all societies. Recent estimates have indicated that a woman is battered by a current or former intimate partner every 9 seconds. Intimate partner violence has no geographic boundaries and is prevalent among all age groups, races, sex, and socioeconomic groups.

In November 2005, the World Health Organization in Geneva, Switzerland, completed the largest international study ever on domestic violence in 10 countries, including Bangladesh, Brazil, Ethiopia, Japan, Peru, Namibia, and Thailand. Approximately 24,000 participants were interviewed by phone, and the findings clearly indicate the huge number of domestic violence incidents and related injuries—especially head, neck, and face injuries and miscarriages—that occur as a direct result of woman-battering incidents. Also noted was the lack of routine domestic violence screening in hospital emergency rooms, maternity units, medical-surgery units, and trauma centers. These women need help from skilled professionals who understand the emotional and physical impact of battering and who can implement effective crisis assessment and time-limited intervention on a 24–7 basis through well-coordinated social service and medical delivery systems.

During the 9 years since the second edition of this book was written, significant changes have taken place. As a result, I have recruited 12 new chapters and thorough revisions of the other chapters. The most important changes at both the federal and state levels have been the enactment of specific legislation responsive to the legal, social
service, and mental health needs of battered women, including vulnerable immigrant women. Legislation without a major appropriation of funds attached to it is usually doomed to fail. In sharp contrast, the federal Violence Against Women Act has provided the necessary funding to state and local domestic violence coalitions for such critically important services as training domestic violence advocates, police, and court staff, expanding emergency shelters for battered women, crisis intervention hotlines, clinical and mental health interventions for battered women, legal advocacy programs, transitional housing services, specialized technologically advanced domestic violence courts, electronic pendants and other security devices to aid battered women, and digital cameras for police and emergency room staff to document the extent of injuries.

In this book, my author team—28 nurses, social workers, and criminologists and I—has documented the latest trends, intervention strategies, and treatment programs for battered women and their children. We focus on the following:

- The various levels of woman battering and methods of permanently ending the battering relationship
- Lethality assessment, safety plans, and Roberts’s Seven-Stage Crisis Intervention Model
- The national survey of the structure and functions of 107 shelters for battered women and their children
- The stress–crisis–trauma continuum with battered women
- Applying the stages of change model and motivational interviewing techniques
- Strengths perspective and solution-focused therapy
- Cognitive problem-solving treatment
- Trauma and crisis recovery for children in shelters
- Battered women in imminent danger and ecologically based crisis intervention
- The strengths as well as the dangers of conjoint couples therapy
- Emerging roles for the emergency room social worker and nurse in the United Kingdom and the United States
- Health care issues, policies, and treatment programs for battered women
- Overcoming the challenges of poverty combined with domestic violence
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- Same-sex domestic violence myths, facts, correlates, and treatment strategies
- Global issues in elder abuse and mistreatment
- Substance abuse and domestic violence
- Use of the culturagram in understanding immigrant women affected by domestic violence
- Assessment, treatment, and empowerment strategies with Chinese and Latino battered women
- Legal advocacy and court-based justice centers

The primary emphasis of this book is on the nuclear family, and the violence found behind closed doors within that unit. This is a handbook about family violence from the perspective of intergenerational linkages—including traumatized and often abused children of battered women, adolescent abuse, woman battering, the intersection of child abuse and spouse abuse, and elder abuse. It also focuses on cross-cultural issues, patterns, and intervention programs with family violence. Unlike most books on domestic violence, this volume provides step-by-step guidelines and practical applications of crisis intervention and other time-limited treatment approaches with battered women and their children. Because we are in the 21st century with managed care cost cutting and major health insurance restrictions looming over our clients and patients, the time-limited clinical strategies and programs examined in this book are of paramount importance.

In 1994, President Bill Clinton signed the landmark Violence Against Women Act (VAWA I) into law. This resulted in the establishment of the first federal Violence Against Women office in Washington, D.C.; funding of major grant programs (e.g., STOP—Services, Training, Officers, and Prosecutors grants); and coordination of state and local services to battered women and their children throughout the United States. President Clinton stated that:

Domestic violence—the enemy from within—is a national tragedy that calls all of us to action. . . . Our homes should be places of solace and comfort, not violence and pain. The only place worse than being attacked in your own home is feeling trapped with nowhere to turn for help. That is why in February of 1996 we launched a 24-hour, seven day a week, toll-free hot-
line which is helping direct women to get the help they need, including counseling, shelters, and law enforcement.

President George W. Bush is also highly committed to reducing domestic violence, and by January 2006, he had signed the Violence Against Women Act III and increased the five-year appropriation to $3.9 billion for fiscal years 2005–2010. With VAWA III, the U.S. Congress has developed a single set of definitions and conditions for all grantees. Thus, most programs will now be required to serve “adult and youth victims” of domestic violence, date abuse, sexual assault, and stalking. The third iteration of VAWA creates new prevention and intervention programs for child witnesses of domestic violence; funding to conduct outreach and education programs to youths focusing on dating violence and stalking; funding to the nonabusing parent or caretaker in domestic violence homes; funding to facilitate cross-training and collaboration between the child welfare and domestic violence systems; changes in immigration law to protect battered immigrants’ children from threats of deportation relating to abuse; hiring victim assistants by law enforcement agencies to ensure adequate triage of cases, especially for persons battered by partners who are law enforcement officers; improving housing opportunities for battered women and their children and providing culturally appropriate resources for battered Native American women from tribal nations; amending substantive laws to child custody, visitation, and support; and engaging men and youth in community-based domestic violence prevention programs.

As mentioned in the previous two editions of this book, most other books on family and domestic violence examine the plight of the battered woman as an entity separate from her family. The overriding purpose of this book is to focus on the need for therapeutic intervention for all members of the violent family. The wide range of social service delivery issues, treatment techniques, court-based interventions, and research findings discussed in this book go beyond monolithic approaches to understanding woman battering. Throughout this book, case illustrations, assessment protocols, programmatic issues, and effective intervention strategies are presented.

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The National Coalition Against Domestic Violence (NCADV) is to be congratulated for their nationwide efforts to educate legislators and the general public about the critical survival and safety needs
of battered women and their children. In addition, NCADV provides free two-page fact sheets on its Web site focusing on domestic violence issues and topics related to violence against women such as Human Trafficking Facts, Economic Abuse Facts, or Elder Abuse Facts. For further information on state and local domestic violence hotlines and services, contact the National Domestic Violence Hotline: (800) 799-SAFE (7233).

The Family Violence Department of the National Council of Juvenile and Family Court Judges Association is also to be congratulated for their important annual publications, which are extremely helpful to legislators, magistrates, attorneys, legal advocates, domestic violence advocates, and educators. For example, each year I have received a monograph titled *Family Violence Legislative Update*. These useful monographs are made possible through funding from the U.S. Department of Health and Human Services and the Conrad N. Hilton Foundation. Volume 11 was completed in the summer of 2006 and provides a state-by-state update of family violence-related statutes, including new additions, deletions, and amended statutes.
SECTION I

Overview, Stages of Change, Crisis Intervention, and Time-Limited Treatment
Overview and New Directions for Intervening on Behalf of Battered Women

Albert R. Roberts

This chapter begins with a discussion of the experiences and dilemmas battered women encounter; the scope of this prevalent social and public health problem; the barriers to seeking help; the myths and realities about battering; medical, criminal justice, and human costs; and the 23 warning signs of a batterer. Then the key findings are provided of a study of 501 battered women, which led to a continuum of the five levels of woman battering. The concluding portions of this chapter focus on practice implications and applying each stage of Roberts’s Seven-Stage Crisis Intervention Model (R-SSCIM).

Every 9 seconds a woman is battered by her current or former intimate partner somewhere in the United States. Each year, it is estimated that 8.7 million women are physically abused by a male partner, and about 2 million of these women are victims of severe violence (Roberts & Roberts, 2005). Social workers, nurses, and counselors must make assessments and treatment plans to help women to permanently leave the battering relationships. The overriding goal of all domestic violence advocates and clinicians is to reduce and stop the pain and suffering, severe and permanent injuries, as well as domestic violence-related homicides.
Domestic violence is a global public health and criminal justice problem that has enormous consequences for the health and well-being of millions of women and children throughout the world. On November 24, 2005, the World Health Organization (WHO) in Geneva, Switzerland, published the key findings of the largest international study of domestic violence ever completed. The study findings are based on interviews with over 24,000 women residing in urban and rural areas in 10 countries, including Brazil, Ethiopia, Japan, Peru, Samoa, Serbia, and Thailand. The study indicated that women are at a much greater risk from violence in their homes than on the street. One-quarter to one-half of all female victims of physical assault by their husbands and partners stated that they had sustained physical injuries as a result of the battering. More than 20% of the women who reported physical violence in this study said they had never told anyone about the abuse prior to the interview. Despite serious medical consequences of domestic violence, a very small percentage ever sought help from health care providers or the police. Instead, those who sought help only reached out to neighbors and extended family members. Also, significant was the finding in most countries studied that 4% to 12% of the pregnant women interviewed in the random sample said that they were beaten during pregnancy by the unborn child’s father. One-half of them reported they had been punched or kicked in the abdomen. The conclusions of this landmark study are that domestic violence by husbands and other intimate partners is still largely hidden around the world, and it is critically important for policy makers and public health officials to address the health and human costs, and for each country to develop national plans, policies, and programs for the elimination and prevention of violence against women and children.

CASE SCENARIOS

Case 1: Cathy

Cathy was a 24-year-old college graduate whose childhood and adolescence had been quite normal. She grew up in a two-parent home, the oldest of three children. Upon entering high school, she had feelings of inadequacy that are not uncommon for adolescent girls. During her
junior and senior years in high school, she had a couple of boyfriends, but the relationships were not serious. During her freshman year in college, when she was living in the dormitory, she met Bryan, a college junior, at a fraternity party, and there was an immediate mutual attraction. Bryan was one of the most popular guys in the fraternity, and, initially, Cathy felt lucky that he was attracted to her. In the spring, when they had been dating for several months, Cathy told Bryan she wanted to work for the summer at a beach resort that was located approximately 85 miles away from the college. Bryan needed to take summer school classes and continue his part-time job near the campus, and he did not want Cathy to be so far away. Their disagreement over this issue turned into a raging argument that ended when Bryan grabbed Cathy’s shoulders, shook her very hard, and punched her in the face. Cathy then called the police. When they arrived, they took Bryan to another room to calm him down, and they called the paramedics because Cathy’s nose was bleeding. The paramedics took her to the hospital, where she was treated for a broken nose. When the police asked Cathy if she wanted to press charges, she said no, because she didn’t want Bryan to get into trouble. (Roberts and Roberts, 2005)

Case 2: Julia

Julia was married to Steve, and she put her career on hold to raise their two daughters. Julia and Steve were married for almost 2 years when he first began abusing her. They always fought about their financial difficulties, and at times, Steve would get so mad that he would punch and kick her. Occasionally, the fights were so severe that Julia would call the police. When they arrived at the scene, they took Steve into a separate room to interview him, while the paramedics treated Julia, who usually had minor cuts and bruises.

The police department received calls from Julia once or twice a month, and sometimes they would arrest Steve, but Julia never pressed any charges or sought a restraining order.

One day, after a check bounced, Julia came home to find Steve furious after receiving a letter from the bank. Steve pushed her down the stairs and beat her with a baseball bat. Julia suffered a broken leg, broken ribs, and a concussion. After a long and painful recovery, Julia filed for a divorce.
Case 3: Cynthia

Cynthia was married to Anthony the summer after they both graduated from a small college in Arizona. They were both 22 years of age. Cynthia was a third-grade teacher and her husband worked as a mechanic. After she graduated, she immediately got a job as a teacher with a starting salary of $40,000 a year. This was much more than her husband earned as a mechanic. Anthony first began hitting Cynthia a few months after they were married, when he went out with his buddies and got drunk. When Anthony lost his job 2 years after their marriage, he became even more violent, due to his increased drinking and difficulty accepting Cynthia as the “breadwinner.” After 2 1/2 years of marriage, Cynthia filed for divorce. Anthony began stalking Cynthia in order to get her back and he ignored the restraining order that Cynthia filed. When Anthony realized he was losing Cynthia to another man, his anger reached a new extreme. After leaving school one afternoon as Cynthia approached her car, Anthony pulled out a shotgun and murdered her. He then used the same gun to kill himself.

BARRIERS TO SEEKING HELP

Many women are ashamed of being abused and are not comfortable with the idea of others knowing about their abuse. Although some may seek emergency medical treatment after an abusive incident, because of embarrassment or fears of retaliation by their abusive partners, women may lie or avoid questioning from doctors and nurses who treat them. Many of these women may want to escape from their dangerous battering environments as soon as they feel it is safe to do so, and by not talking about it they seem to remove themselves from the situation for the moment even if it means reliving it at a later time. The following four cases from the author’s research files describe what typically happens in emergency rooms through the voices of battered women.

Case 1

One night the battered woman in this case was accused of cheating on her spouse. He then started pushing her around; this led to her being pushed down the stairs after some verbal abuse. Her fall resulted in a
broken leg and fractured nose. When she was brought to the hospital emergency room, to avoid questioning, she lied and said she fell down the stairs. In reflecting on the incident, she told an interviewer:

Well, when my time came around to be seen by the doctor they called me into the room and asked me what happened. I told them that I fell. The nurse made a face like “yeah right” and they fixed my nose and leg and gave me crutches and aspirin and sent my ass home.

Case 2

In the evening when this woman’s husband came home, he found that no dinner was prepared. This made him angry and he started verbally abusing his wife. He then picked up a frying pan and hit her face with it. She sustained a broken nose and cheekbone, and fractured jawbone from this incident of abuse. At the hospital where the woman required reconstructive surgery, the nurses and doctors kept asking questions, but she told them to just “fix me and send me home,” and after that they did just that.

All these stupid doctors and nurses came and asked me the same questions over and over again that really annoyed me. . . .

Case 3

In this case, the victim was confronted with a death threat by her husband, who was wielding a knife. The woman ran out of their house across the main street in their town, and her husband chased her down, threw her to the ground where he choked her, and subsequently slammed her head into the concrete. She had suffered a concussion and went to the emergency room (ER), where she was medically examined. She did not want to talk about her abuse because she did not like getting advice from strangers, so they sent her home without calling the police.

[The doctors and nurses] examined me and gave me medication and they sent me home. I didn’t really want to talk about [my abuse] so we didn’t. They didn’t give me any phone numbers or anything. I don’t
like strangers giving me advice—who are they to tell me how to run my life—I’d rather talk to my friends about it.

**Case 4**

During this victim’s pregnancy, the husband kicked and punched her in the stomach; it seemed like he was trying to kill the baby she was carrying. He was convinced the baby was not his. This woman almost suffered a miscarriage and went to the hospital to get it checked out. She felt the nurses were sweet but could not understand the situation she was in.

When I was pregnant I thought that I was going to lose my daughter, but they were able to save her. A nurse told me that I shouldn’t be with a man who would cause me and my baby such harm. She was sweet, but she didn’t understand I had nowhere else to go.

Women from the author’s chronically abused group are oftentimes sent to the hospital for different injuries ranging from bruises to broken bones. Many of these women choose not to report the battering to ER staff, consequently neglecting themselves of services. In their minds, they are avoiding retaliation and future abuse from their battering partner. To avoid being questioned on the topic of abuse, women may forget the sequence of events prior to the abuse, blame themselves, or outright lie to the health care provider. In some cases they shut down when confronted with the topic, and in other cases they altogether push the health care provider away from giving advice on abusive relationships.

Abused women may change their stories to keep professionals at a distance. Case 1 was about a victim who lied about her abuse. She merely claimed that she sustained the injury by falling down a flight of stairs because of her clumsiness. This type of lying pushes the doctor away. If the doctor still suspects abuse despite the woman’s story, he or she may hesitate to help the victim because they perceive her as not receptive to advice about intimate abuse.

Many of these women feel that the nurses and doctors who confront them with the advice may not understand or do not really care about their situation. The victim in Case 4 did not feel as though the nurses and doctors could help her. She said that they could not relate
and really understand her situation. This prevented her from getting
advice on how to break the chain of violence that plagued her.

In some cases, especially when abuse is not as obvious, health care
providers may be the ones who choose not to bring up the subject
of abuse. Another woman in the study claimed that when she went
to the hospital, nurses and doctors treated her injuries but asked no
questions and sent her on her way. She felt the health care providers
may have fixed her injuries but did very little to heal her.

Many women also experience shame for being abused and want to
avoid the negative stigma that accompanies victims of intimate abuse.
In these cases, victims are likely going to try to do whatever it takes
to avoid situations that make them vulnerable to others knowing
their pain. Some of these women may not even go to the hospital
to avoid this situation. This was especially true for one woman who
was a nurse and was adamant about treating her own injuries to
avoid going to the emergency room. Regardless of the severity of
the injury, many women are hesitant to let health care providers
or outsiders see their vulnerable abused side. Unfortunately, their
inability of letting others into this horrifying secret world often leads
them to be quietly trapped in their abusive environments with no
readily available means of escape.

**MYTHS AND FACTS**

1. **Myth:** Woman battering is a problem only in the lower socio-
   economic class. **Fact:** Woman battering takes place in all social
classes, religions, races, and ethnic groups. There is a large hidden
group of battered women living in highly affluent suburbs through-
out the United States. Neighbors rarely hear the violence because
some of the battered women are living on 1-, 2-, and 3-acre estates.
Although woman battering occurs in all socioeconomic classes, it is re-
ported to be more visible and prevalent in the lowest socioeconomic
groups.

2. **Myth:** Woman battering is not a significant problem because
most incidents are in the form of a slap or a push that does not
cause serious medical injuries. **Fact:** Woman battering is a very seri-
ous problem that places victims at risk of medical injuries as well as
homicide. Many cases of domestic violence result in life-threatening
injuries and/or lethal consequences. The most frequent site of
domestic violence injuries is the head, neck, or face of the battered women (Roberts & Kim, 2005).

3. **Myth:** The police never arrest the batterer because they view domestic violence calls as a private matter. **Fact:** As of 2001, all states have implemented “warrantless” arrest policies, and mandated domestic violence police training, specialized police domestic violence units, collaborative community police and prosecutor response teams, enhanced technology, and collaboration between victim advocates and police to enhance victim safety and offender accountability. The landmark U.S. Supreme Court case of the mid-1980s—Tracy Thurman vs. the city of Torrington, Connecticut—served notice to police departments nationwide to rapidly respond to domestic violence calls as any other crime in which the victim and perpetrator did not know each other. It was a catalyst for the development of mandatory arrest laws.

4. **Myth:** It is extremely rare for a battered woman to be homeless. **Fact:** Domestic violence is one of the primary causes of homelessness among women.

5. **Myth:** Temporary restraining orders and protective orders rarely are effective in stopping the battering. **Fact:** In recent years, family, criminal, and specialized domestic violence courts have instituted major institutional reforms including technology enhancement, automated case-tracking systems, and more victim protection of confidentiality rights. It has been documented that many thousands of women are being helped and having their legal rights protected by court orders. New innovations include around-the-clock methods of issuing temporary restraining orders and providing a pro bono attorney 24 hours a day, 7 days a week (Keilitz, 2002; Lutz, 2002).

6. **Myth:** All batterers are psychotic, and no treatment can change their violent habits. **Fact:** The majority of men who assault women can be helped. The main types of intervention are arrest, psychoeducational groups, and court-mandated group counseling. Research on over 1,200 batterers documented that mandatory arrest had a deterrent effect among abusers who were employed, White, and married. In Milwaukee, arrests for men who were minorities and unemployed led to an increase in battering (Roberts & Roberts, 2005).

7. **Myth:** Elder abuse is neither prevalent nor dangerous. **Fact:** More than 1.5 million older persons may be victims of abuse by their aging spouses as well as by their adult children. We can expect a sharp increase in elder abuse due to baby-boom children reaching retirement age and retiring within the next 5 years.
8. **Myth:** Children who have witnessed repeated acts of violence by their father against their mother do not need to participate in a specialized counseling program. **Fact:** Several studies have demonstrated that long-lasting harm and trauma to children result from exposure to violence between their parents. These child witnesses to their mothers being battered exhibit a range of adjustment and anxiety disorders. Boys who witness their mother being assaulted have a greater likelihood of becoming an abuser.

9. **Myth:** Although many battered women suffer severe beatings for years, only a handful experience symptoms of posttraumatic stress disorder (PTSD). **Fact:** Clinical studies of battered women revealed an association between extent and intensity of battering experiences and severity of PTSD (Robertiello, 2006).

10. **Myth:** Battered women who remain in a violent relationship do so because they are masochistic. **Fact:** Most battered women who stay in abusive relationships do so because of economic need, intermittent reinforcement and traumatic bonding, learned helplessness, the fear that the abuser will hunt them down and kill them if they leave, fear that leaving and moving will be a disruption for the children, and fear that they may lose custody permanently.

11. **Myth:** There are no marginalized and throwaway battered women or no women with serious mental health disorders, AIDS, PTSD, polydrug abuse, and/or developmental disabilities. **Fact:** Many thousands of battered women suffer from all of these. Recently, several model programs have been developed to provide them with legal advocacy and legal representation, medical or mental health treatment, and many community support systems.

12. **Myth:** Alcohol abuse and/or alcoholism causes men to assault their partners. **Fact:** The majority of batterers are not alcoholics, and the overwhelming majority of men classified as high-level or binge drinkers do not abuse their partners. Alcohol is used as an excuse, not a cause, for battering. Removing the alcohol does not cure the abusive personality.

The previously cited myths permeate the public’s view of battered women. The false beliefs can be particularly detrimental when endorsed by women in abusive relationships whose belief in these myths may create excuses for the abuse or prevent them from taking steps to get out of abusive situations. Social workers and medical professionals should be cognizant that these myths are widely believed in our
culture and should work to educate women and men of the actual facts.

23 WARNING SIGNS OF A POTENTIALLY ABUSIVE PARTNER

For professionals who are likely to come in contact with battered women and for women entering new relationships, it is helpful to be aware of common indicators of potentially abusive relationship dynamics. The next section identifies 23 warning signs or red flags (Roberts & Roberts, 2005) useful for all women and practitioners.

1. Abuser is extremely jealous and overly possessive of his date and has intense fear of being cheated on.
2. Abuser intimidates and instills fear in his date by raising a fist or kicking or mutilating a pet.
3. Abuser exhibits poor impulse control or explosive anger.
4. Most of abuser’s desires need immediate response.
5. Abuser repeatedly violates his girlfriend’s personal boundaries.
6. Abuser tries to dominate her by telling her what to wear.
7. Abuser uses extreme control tactics, such as monitoring the mileage on her car.
8. Abuser attacks the self-confidence of the partner (name-calling).
9. Abuser is emotionally dependent (wants her to spend her time just with him).
10. Abuser becomes hostile after binge drinking.
11. Abuser never takes responsibility for the role he played in the problem.
12. He cannot control his anger.
13. Abuser has poor communication skills.
14. Abuser has a history of having abused a previous girlfriend.
15. Abuser often was on college or high school sports team where violence was emphasized.
16. In a fit of anger sparked by jealousy or disagreement with his date, he threatens to hit, slap, or punch her.
17. He has a generational history of interpersonal violence among father or other familial male role models in which he was
beaten as a child or he observed his father/stepfather beating his mother.

18. He is demanding, overly aggressive, frequently rough, and/or sometimes sadistic during sexual activity.

19. He escalates intimidating and potentially assaultive behavioral patterns when his partner is pregnant.

20. He exerts coercive control by threatening and then attempting homicide or suicide when the woman attempts to leave the relationship.

21. He exhibits a narcissistic personality disorder.

22. He exhibits an avoidant depressive personality disorder.

23. He exhibits a borderline personality disorder and is highly impulsive, self-punitive, sexually abusive, moody, resentful, and tense.

**PREVALENCE AND COSTS**

Each year, approximately 8.7 million women are victims of intimate partner violence (Roberts, 2002; Roberts & Roberts, 2005). Every 9 seconds somewhere in the United States, a woman is battered by her current or former intimate partner. Violence among current and former intimate partners has been found to be highly prevalent in American society. Two national studies have provided methodologically rigorous national estimates of the prevalence of women battering. The Tjaden and Thoennes (2000) national violence against women survey was based on a national representative sample of 8,000 women and 8,000 men 18 years of age and older. The report from the National Violence Against Women (NVAW) survey indicated that almost 25% of the women surveyed and 7.6% of the men surveyed stated in the telephone interviews that they were raped and/or physically battered by a spouse, cohabiting partner, or date during their lifetime; and 1.5% of the women surveyed indicated that they were physically abused or raped by an intimate partner during the previous 12-month period. These estimates are probably low because of the problem of underreporting. Many battered women do not make criminal complaints and/or minimize the abuse or are in denial. Each year for the past 20 years, approximately 1.5 million to 2 million women have needed emergency medical attention as a result of domestic violence (Roberts, 1998; Straus, 1986). Annual estimates indicate that
approximately 2,000 battered women are killed by their abusive partners, and the majority of these homicides take place after the victim has tried to leave, separate from, or divorce their batterer. In addition, 1,250 chronically battered women have killed their mates each year as a result of explicit terroristic or death threats, PTSD, and/or recurring nightmares or intrusive thoughts of their own death at the hands of the batterer (Browne, 1987; Cascardi, O’Leary, and Lawrence, 1993; Federal Bureau of Investigation [FBI], 2003; Roberts, 2002; Walker, 1984).

The aftermath of domestic violence assaults has a destructive impact on the battered woman and her children. Carlson (1996) estimated that each year more than 10 million children witness woman battering in the privacy of their own homes. The impact of growing up in a violent home often results in an intergenerational cycle of violence. See chapter 9 in this book for detailed descriptions of treatment plans to help traumatized children of battered women.

Stark and Flitcraft (1988) have indicated that the impact of the battered women syndrome results in subsequent high rates of medical problems, mental disorders, miscarriages, abortions, alcohol and drug abuse, increased risks of rape, and suicide attempts. More recently, Hamberger and Phelan (2004) reviewed 14 studies to determine the prevalence of spousal abuse among patients presenting at family medicine and internal medicine clinics, and found that health-related problems from physical abuse ranged from 13% to 46% of patients.

It has been estimated that approximately $4.1 billion has been spent annually for medical care and mental health treatment, and almost $1.8 billion on lost productivity related to morbidity and premature mortality of battered women (NCIPC, 2003). This does not take into account the fact that hospital and physician fees are rising considerably every year. Any estimate of the costs of intimate partner violence should also include the intangible costs of pain and suffering to the battered women themselves and PTSD and other serious disorders of the children of chronically battered women. Any realistic estimate of overall domestic violence costs should also include advocacy and direct service costs of $3.3 billion that was allocated through the Violence Against Women Act-II for the years 2000 to 2005 as well as county and city criminal justice processing related costs including law enforcement, prosecution, and court costs. Therefore, an annual
cost estimate of $10 billion for intimate partner violence in the United States may well be a very low estimate.

Because domestic violence frequently results in serious medical injuries, in addition to calculating criminal justice costs, it is important to include estimates of average and total hospital costs. Domestic violence is the number one cause of emergency room visits by women (Roberts and Roberts, 2005, p. 4). Estimating average hospital costs for a battered woman can be quite challenging and complex. Injuries can range from broken bones and bruises to mental illnesses. According to a national economic study conducted within the health sector, Max et al. (2004) estimated the prevalence and medical costs of domestic violence in terms of ER visits, outpatient visits, inpatient hospitalizations, physician visits, dental visits, ambulance/paramedic costs, and physical therapy visit costs. This economic analysis found that for intimate partner assault victims, the average cost per woman for medical care was $4,247.10 (Max et al., 2004).

Case 3, Cynthia, is an exception to the other two cases because it is a case of domestic violence that resulted in homicide. Therefore, not only should the total hospital costs be calculated, but also the largest cost estimates, those due to absenteeism and lost wages, should be computed. There is an assumption that most people work until the age of 66. If a batterer kills his 23-year-old wife or ex-wife, her salary must be multiplied by the number of years to age 66.

Cathy’s short-term case is the least serious of the three. Her incident involved only one hospital visit, and no overnight admission was necessary. She suffered a broken nose, and the only fee charged was the standard emergency room fee of $760. An additional $195 was added to her total for cost of stitches. Her total hospital cost was approximately $955.

Julia’s case involves more medical attention. Julia suffered a broken leg, a concussion, and broken ribs when her husband threw her down the stairs. She was admitted to the hospital for a total of 2 days and charged $760 for the emergency room fee, $2,320 for skull x-rays and an MRI due to possible head and traumatic brain injuries, $150 for the chest film and broken ribs, and $125 for sutures. She was also charged $500 per day for admission costs. Her total equaled $4,355.

Cynthia’s case is the most complex and involves the calculation of additional costs not estimated for Cathy or Julia. Within a 2-year period, Cynthia visited the emergency room a total of eight times.
Each visit required an overnight stay and admission into the hospital. The initial emergency room fee for her eight visits totaled $4,880 for a 2-year period. Costs for x-rays, chest films, and sutures totaled $2,430. Admission costs totaled $5,100. Cynthia’s total hospital costs for a 2-year period were estimated to be $12,410.

We also must compute Cynthia’s costs due to lost wages. Cynthia died at the age of 23. At that time, she was earning an annual salary of $40,000. Individuals typically work until the age of 66, so Cynthia lost 43 years of wages. Forty-three years multiplied by her salary of $40,000 totals $1,720,000 ($1.72 million) in lost wages. If we factor in 32% in fringe benefits each year and a cost-of-living increase in annual salary each year of approximately 4.5%, then the lost productivity total is estimated at $4.25 million.

In addition, it is necessary to also calculate lost wages due to a lengthy recovery period. On average, if there are only 4 million domestic violence cases per year, and each case costs the victim on average about $6,000, the average number of sick days directly resulting from domestic violence is 28 days per year (4 million cases × $6,000 per case = $24 billion) per year in lost wages.

CONTINUUM OF THE DURATION AND SEVERITY OF WOMAN BATTERING BASED ON 501 CASES

The next section of this chapter summarizes the findings of a 7-year study of domestic violence that included over 500 in-depth interviews with battered women survivors. The author presents a qualitative analysis that compares chronically battered women with women who ended the battering relationship relatively quickly. A model for effective crisis intervention is proposed. It involves implications for police-based domestic violence units, 24-hour crisis hotlines, crisis intervention units at local mental health centers, and court-mandated batterers group treatment programs.

The continuum the author developed focuses on circumstances, situations, and the nature and extent of battering relationships. Interview points include checking onset, duration, and severity of injuries. Particular attention was paid to critical incidents and turning points where the victim either tried to leave the batterer or there was a lethal outcome; in the sample 105 women killed their partners. From the
data collected, the author developed a classification schema based on duration and chronicity. It is based on the common themes extracted in a content analysis of the interviews.

The 501 women who participated in the study were comprised of four subsamples. These came from a state women’s prison, two shelters for battered women, three suburban police departments, and a modified snowball sample. A 39-page standardized interview schedule was developed and pretested. The findings indicated a significant correlation among a low level of education, a chronic pattern of battering, PTSD, explicit death threats, and battered women who kill in self-defense.

The literature explaining the reluctance of women to leave their abusive husbands is inconclusive. There is no single characteristic that determines a woman’s potential for leaving the batterer (Astin, Lawrence, & Foy, 1993; Roberts, 1996, 2002). Rather, it is a group or cluster of personal and situational characteristics taken together that can provide significant indicators of the battered woman staying in the relationship.

**Methodology**

*Constructing the Sample:* The study sample came from four sources:

1. Battered women who have killed their partners were found at a large state women’s prison in the northeastern part of the United States \(N = 105\).
2. Three police departments \(N = 105\).
3. Three shelters for battered women \(N = 105\).
4. A convenience subsample of 186 formerly abused women was drawn by inviting 30 graduate students in two sections of the author’s MSW Family Violence course, and 15 criminal justice honor students to locate and interview one to three friends, neighbors, or relatives who had been battered during the past 4 years. This type of convenience subsample is also known as a modified snowball sample (Roberts, 2002).

The final sample of 501 battered women consisting of the four waves of subsamples comes very close to the author’s plan of sampling
battered women from different educational, income levels, and racial backgrounds. The results of this exploratory and qualitative study indicate that the duration and severity of battering varies at different levels of chronicity.

Limitations. The four subsamples of battered women all came from New Jersey. Thus, the findings are not general to all battered women. Although the study sample was carefully selected, there is always some small amount of sampling error.

All of the interviewers were college seniors or graduate students. Each interviewer received 30 hours of training on interviewing skills and qualitative research on women battering. The training included role-playing and practice interviews. The woman battering questionnaire was prepared, pretested, and modified. It consisted of a 39-page standardized interview schedule to guide the interviews.

Findings

The 501 battered women had three experiences in common: 1) They had experienced one or more incidents of physical battering by their partners; 2) jealous rages, insults, and emotional abuse; and 3) over one-fifth of the victims received terroristic or death threats from their abusive partner. Some of the women were hit a few times and got out of the abusive relationship quickly. These were primarily high school or college students that were not living with the abusive boyfriend. Others were assaulted intermittently over a period of several months to 2 years before leaving the batterer and filing for divorce. The largest group of the women endured chronic abuse for many years before permanently ending the relationship. The extent and degree of chronicity of battering is plotted on a five-level continuum (Figure 1.1).

Duration and Severity Level of Woman-Battering Continuum

As an outgrowth of the author’s study, five categories of woman battering were identified based on the duration and severity of the abuse and demographic and psychosocial variables (see Figure 1.1).
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| **Short-Term**  
(*N = 94*) | **Intermediate**  
(*N = 104*) | **Intermittent Long-Term**  
(*N = 38*) | **Chronic and Predictable**  
(*N = 160*) | **Homicidal**  
(*N = 105*) |
| Less than 1 year (dating relationship for a few weeks or several months); mild to moderate intensity; usually high school or college students | Several months to 2 years (cohabiting or recently married); moderate to severe injuries | Severe and intense violent episode without warning; long periods without violence, then another violent episode; married with children | Severe repetitive incidents; frequent, predictable pattern; violence often precipitated by alcohol or polydrug abuse; married with children | Violence escalates to homicide, murder precipitated by explicit death threats and life-threatening injuries (cohabiting or married); weapons in home |
| 1–3 incidents | 3–15 incidents | 4–30 incidents | Usually several hundred violent acts per woman | Numerous violent and severe acts per woman |

**Psycho-social variables and the 5-level women-battering continuum**

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<td>Usually middle-class and steady dating relationship (severity, e.g., push, shove, and sometimes hit with large object; woman leaves after first, second, or third physically abusive act; caring support system, e.g., parents or police)</td>
<td>Usually middle-class and recently married or living together (severity, e.g., punch, kick, chokehold, or severe beating; woman leaves due to bruises or injury; caring support system, e.g., new boyfriend or parents)</td>
<td>Usually upper-middle or upper social class, staying together for children or status/prestige of wealthy husband (woman stays until children grow up and leave home; no alternative support system)</td>
<td>Usually lower socioeconomic or middle-class, often devout Catholic with school-age children at home (abuse continues until husband is arrested, is hospitalized, or dies; husband is blue-collar, skilled or semiskilled)</td>
<td>Usually lower socioeconomic class, high long-term unemployment, limited education; majority of battered women dropped out of high school; woman usually suffers from PTSD, traumatic bonding, or Battered Woman Syndrome</td>
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**FIGURE 1.1 Duration and severity level of woman-battering continuum.**

Source: Copyright © Albert R. Roberts (2002). Reprinted by permission.
**Level 1.** Short Term: Less than 1 year dating, one to three incidents, usually middle class, and steady dating relationship. Woman leaves after first or second physically abusive act, caring support system (parents).

**Level 2.** Intermediate: Several months to 2 years (cohabiting or married), moderate to severe injuries, 3–15 incidents. Usually middle class and recently married or living together.

**Level 3.** Intermittent Long-Term: Severe and intense violent episode without warning, long periods without violence, then another violent episode. Married with children. Four to 30 incidents. Usually upper middle class, staying together for sake of children and wealth and prestige of husband.

**Level 4.** Chronic and Predictable: Severe repetitive incidents, frequent predictable pattern, violence often precipitated by alcohol or polydrug abuse, married with children. Usually several hundred violent acts per woman. Usually lower class or middle class.

**Level 4.5.** Subset of Chronic With a Discernible Pattern: Mutual combat; 1–25 years.

**Level 5.** Homicidal: Violence escalates to murder/manslaughter precipitated by specific death threats, sleep disturbances, and life-threatening injuries. Numerous violent and severe acts per woman. Usually lower class, high long-term unemployment and low level of educational attainment.

**Level 1+, Short-Term Victims.** The level and duration of abuse experienced by short-term abused women was determined from interviews with 94 battered women who reported experiencing one to three misdemeanor abusive incidents by their boyfriend or partner. Most of the victims were high school or college students in a steady dating relationship. The overwhelming majority of the women were not living with the abuser. The abusive acts could usually be classified in the mild to moderate range of severity, for example, pushing, slapping, and punching with no broken bones or permanent injuries. Most of these women were between 16 and 25 years of age, and ended the relationship with the help of a parent or older brother. Short-term victims generally seek help from their parents and sometimes call the police to obtain a temporary protective order. Most of the women in this level were middle class (Roberts & Roberts, 2005).
**Level 2+, Intermediate.** The level and duration of women battering in this category ranged from 3 to 15 incidents over a period of several months to 2 years. The 104 battered women in this category were usually living with the abuser in either a cohabiting or a marital relationship. None of the women in this level had children. The women ended the relationship with the help of the police, a family member, or a friend after a severe battering incident. Many of the women had sustained severe injuries such as a broken jaw, stitches, and broken ribs, or a concussion. These women often obtained a restraining order and moved out to a safer residence. Most of the women in this level were middle class (Roberts, 2002).

**Level 3+, Intermittent/Long-Term.** The intensity of each incident is usually severe, and the duration of battering is 5 to 40 years. Most women in this category are economically and socially dependent on their husbands. In addition, they are often religious and would not divorce for that reason. They are nurturing and caring mothers and want to keep the family together for the sake of the children. There may be no physical violence for several months, and then because of pressures (e.g., at his job), the husband vents his anger and frustration at his wife by beating her. Most of these 38 women are middle or upper class, and rarely go to the hospital. When they go to their family physician for treatment, they have an excuse for the causation of the injury (e.g., accident-prone).

**Level 4+, Chronic and Severe With a Regular Pattern.** The duration of battering was 5 to 35 years, with the intensity of the violence increasing over the years. The 160 battered women who comprised this category all reported a discernible pattern of abuse during the recent past (e.g., every weekend, every other weekend, and/or every Friday night). Many of the batterers (68%) had serious drinking problems including binge drinking, drunkenness, and blackouts. However, about three-fourths battered their partners when they were sober. After many years, especially when the children are grown and out of the house, the battering becomes more extreme, more predictable and includes the use of weapons, forced anal and genital sex, and generalized death threats. The injuries for these victims are extensive and include sprains, fractures, broken bones, numerous stitches, and head injuries, that require treatment in the hospital emergency room (Roberts & Kim, 2005; Roberts & Roberts, 2005).
Level 4.5, Subset of Chronic With a Discernible Pattern-Mutual Combat. Twenty-four (24) of the 160 Level 4 cases fit the mutual combat category. This mutual combat and chronic category sometimes leads to dual arrests, and at other times the police arrest the partner who appears to have the lesser injuries. The level of violence was usually severe, and the duration of woman battering in this category lasted from 1 to 25 years. The study identified two types of mutual combat. In the first type, the man was the primary aggressor and initiated a violent act such as punching the woman, and she retaliated (e.g., slapping or punching him back). He then retaliated more violently by beating her severely. In the second type of mutual combat, the woman retaliates for physical or emotional abuse and uses a weapon (typically a knife) to get back at him. The 10 battered women in this category had either a chronic alcohol problem or a drug problem, or a history of violent aggressive acts in adolescence (e.g., cutting another girl, boy, or adult with a knife). In 14 of the 24 cases, both the abusive male and the female had a drug problem. Generally, there are severe injuries to one or both parties. Most of the women in this level were lower class. Many of these couples separate after a few years.

Level 5+, Homicidal. The duration of the battering relationship in this category is generally 8 years or longer, although the range is 2 years to 35 years. The majority of these women are usually in a common-law relationship (cohabiting for 7 years or longer), a marital relationship, or recently divorced. The overwhelming majority (59.2%) of these women lacked a high school education and the skills to earn a decent income on their own (Roberts, 2002). Almost half (47.6%) of the homicidal battered women had been on public assistance for many years during the battering episodes (Roberts, 2002).

The 105 women in this category began at Level 2, and usually escalated to either Level 4 or Level 5 for several years, after which the death threats became more explicit and lethal. Also in a number of cases, the victim had finally left the abuser and obtained a restraining order, which he violated. Many of the women in this category suffered from PTSD, nightmares, and insomnia; and some had attempted suicide. A smaller group of the homicidal women indicated that at the time they killed their batterer, they were delusional or hallucinating due to heavy use of LSD, methamphetamines, cocaine, or other drugs. The most significant finding
related to the homicidal battered woman is that the overwhelming majority (65.7%) of the women received specific lethal death threats in which the batterer specified the method, time, and/or location of their demise.

**PRACTICE IMPLICATIONS**

Interventions and treatment plans should be geared to the type of abuse pattern detected. The short-term and intermediate patterns of abuse may be more amenable to crisis intervention, brief psychotherapy, support groups, and restraining orders. Crisis intervention can bolster the survivor’s self-confidence, as well as suggest new coping and safety skills that can facilitate a permanent end to the battering relationship. The prognosis for the chronic/long-term category, whether it be intermittent or a weekly pattern of battering, is much more guarded. The chronic recidivist cases are frequently put into a life-threatening situation. However, when there are specific death threats and a loaded handgun in the house, even the short-term and intermediate battering cases can also escalate to a *code blue—life and death situation*.

In chronic cases, the human suffering, degradation, and emotional and physical pain sometimes end in permanent injuries to the victim, or in the death of the batterer or the battered woman. At other times, the chronically battered woman temporarily escapes to a shelter, a relative’s home, or the police precinct. In many of the chronic cases, the victim returns to the batterer or is dragged back to the violent home. Finally, a small but growing number of chronically battered women leave the batterer and stay free of violence because they are empowered through a support group and counseling, legal advocacy, an out-of-state relative or friend who provides temporary housing, or the death of the batterer due to a drug overdose, cirrhosis of the liver, or other terminal illnesses. The final section of this chapter applies a structured and sequential crisis intervention model developed by the author.

**ROBERTS’S SEVEN-STAGE CRISIS INTERVENTION MODEL**

The Seven-Stage Crisis Intervention Model (Figure 1.2; Roberts, 2000, 2005; Roberts & Roberts, 2005) includes the following stages.
FIGURE 1.2 Roberts’s Seven-Stage Crisis Intervention Model.

It is important to note that Stages 1 and 2 need to take place simultaneously, immediately on making contact with the battered woman.

Stage 1. Assessing Lethality: Assess whether caller is in any current danger and consider future safety concerns in treatment planning and referral. Maintain active communication with the client.
Evaluating issues: severity of crisis, client’s current emotional state, immediate psychosocial needs, and level of the client’s current coping skills

Stage 2. Establishing Rapport and Communication: Active listening and empathic communication skills are essential in establishing rapport and engagement of the client.

Stage 3. Identifying the Major Problems: Crisis worker should help the client prioritize the most important problems or impacts by identifying these problems in terms of how they affect the survivor’s current status. First priority of this stage is meeting the basic needs of emotional and physical health and safety.


Stage 5. Exploring Possible Alternatives: Crisis workers help clients recognize and explore a variety of alternatives such as situational supports, coping skills, and positive and rational thinking patterns.

Stage 6. Formulating an Action Plan: Crisis worker must help the client look at both the short-term and long-range impacts in planning intervention. Main goals are to help the client achieve an appropriate level of functioning and maintain adaptive coping skills and resources.

Stage 7. Follow-Up Measures: Help determine whether these results from the last stage have been maintained or if more work needs to be done. At this stage, four tasks of crisis resolution should have been addressed: physical safety and survival, venting and expressing feelings, cognitive mastery, and interpersonal adjustments.

The crisis intervention model will now be specifically applied to domestic violence.

Stage 1. Assessing Lethality: Assessment in this model is ongoing and critical to effective intervention at all stages, beginning with an assessment of the lethality and safety issues for the battered women. With victims of family violence, it is important to assess whether the caller is in any current danger and to consider future safety concerns in treatment planning and referral. In addition to determining lethality and the need for emergency intervention, it is
crucial to maintain active communication with the client, either by phone or in person, while emergency procedures are being initiated.

To plan and conduct a comprehensive assessment, the crisis counselor needs to evaluate the following issues: (a) the severity of the crisis, (b) the client’s current emotional state, (c) immediate psychosocial and safety needs, and (d) level of client’s current coping skills and resources. In the initial contact, assessment of the client’s past or pre-crisis level of functioning and coping skills is useful; however, past history should not be a focus of intake or crisis assessment, unless related directly to the immediate victimization or trauma. The goals of this stage are assessing and identifying critical areas of intervention, while also recognizing the duration and severity of violence and acknowledging what has happened.

Stage 2. Establishing Rapport and Communication: Survivors of acute crisis episodes and trauma may question their own safety and vulnerability, and trust may be difficult for them to establish at this time. Therefore, active listening and empathic communication skills are essential to establishing rapport and engagement of the client. Even though the need for rapid engagement is essential, the crisis worker should try to let the client set the pace of intervention. Many crisis victims feel out of control or powerless and should not be coerced or confronted into action, until they have stabilized and dealt with the initial crisis and trauma reactions (Roberts, 2005).

Stage 3. Identifying the Major Problems: The crisis counselor should focus on helping the battered women to prioritize the most important problems or impacts by identifying these problems in terms of how they affect the survivor’s current status. Encouraging the client to ventilate about the precipitating event can lead to problem identification, and some clients have an overwhelming need to talk about the specifics of the battering situation. This process enables the client to figure out the sequence and context of the event(s), which can facilitate emotional ventilation, while providing information to assess and identify major problems to be worked on.

Stage 4. Dealing With Feelings and Providing Support: It is important for the crisis counselor to demonstrate empathy and an anchored understanding of the victim’s experience, so that her symptoms
and reactions are normalized and can be viewed as functional strategies for survival. Self-blame is a common reaction and many victims blame themselves, so it is important to help the client accept that being a victim is not one’s fault. Validation and reassurance are especially useful in this stage because survivors may be experiencing confusing and conflicting feelings. Catharsis and ventilation are critical to healthy coping, and throughout this process, the crisis worker must recognize and support the client’s courage in facing and dealing with these emotional reactions and issues (Roberts & Roberts, 2005).

Stage 5. Exploring Possible Alternatives: In this stage, effective crisis counselors help the client to recognize and explore a variety of alternatives, such as (1) situational supports, which are people or social work agencies that can be helpful to the client in meeting needs and resolving crisis related problems; (2) coping skills, which are behaviors or strategies that promote adaptive responses and help the client reach a precrisis level of functioning; and (3) positive and rational thinking patterns, which can lessen the client’s levels of anxiety, stress, and crisis.

The crisis counselor can facilitate healthy coping skills by identifying client strengths and resources. Many crisis survivors feel they do not have a lot of choices, and the crisis worker needs to be familiar with both formal and informal community services to provide referrals. For example, working with a battered woman often requires relocation to a safe place for her and the children. The client may not have the personal resources or financial ability to move out of the home, and the crisis worker needs to be informed about the possible alternatives, which could include an emergency shelter program, a host home or safe home, a protective order, traveler’s aid, or other emergency housing services (Roberts, 2005).

Stage 6. Formulating an Action Plan: In this stage, an active role must also be taken by the crisis worker; however, the success of any intervention plan depends on the client’s level of involvement, participation, and commitment. The crisis worker must help the client look at both the short-term and long-range impacts in planning intervention. The main goals are to help the client achieve an appropriate level of functioning and maintain adaptive coping skills and resources. It is useful to have a manageable treatment plan with short attainable goals, so the client can follow
through and be successful. Do not overwhelm the client with too many tasks or strategies, which can set the client up for failure. Clients must also feel a sense of ownership in the action plan, so that they can both increase the level of control and autonomy in their lives and ensure that they do not become dependent on other support persons or resources. Termination begins when the client has achieved the goals of the action plan, or has been referred. It is important to realize that many survivors may need longer term therapeutic help and referrals for individual, family, or group therapy should be considered at this stage (for further discussion of termination, see chapters 2 and 3 in this book).

Stage 7. Follow-Up Measures: The sixth stage should result in significant changes and resolution for the client in regard to his or her post-crisis level of functioning and coping. This last stage should help determine whether these results have been maintained, or if further work remains to be done. Typically, follow-up contacts should be done within 2 to 8 weeks after termination. At this stage, the four tasks of crisis resolution should have been addressed, which are (1) physical safety and survival, (2) ventilation and expression of feelings, (3) cognitive mastery, and (4) interpersonal adjustments and adapting to a new environment.

CONCLUSION

The hospital costs, judicial costs, and law enforcement costs that result from domestic violence cases are enormous. Although the vast majority of cases coming into the criminal justice system from intimate partner violence never go to trial and are partially remedied by family court judges or through plea bargaining, the costs still remain high. The amount of money paid in overtime to law enforcement officers for working extra hours on many cases alone constitutes significant costs. As Roberts and Roberts (2005) suggest, the police and courts can be used effectively to stop battering. The role of the police and the courts is to better protect victims of domestic violence. If state and county criminal justice agencies begin to have the same commitment with general revenue funds as the federal government has had through the federal Violence Against Women Act (VAWA II) and the $3.3 billion allocated for 2000 to 2005 for criminal justice and other domestic violence services, then the future holds much
promise. With the passage of VAWA III on October 30, 2005, the 5-year allocation was increased to $3.9 billion for fiscal years 2005 to 2010. This is very promising in terms of the delivery of much-needed social services and criminal justice services to under-served groups of battered women throughout the nation.

The rapid assessment of the duration, intensity, and lethality of woman battering are among the most critical issues in forensic mental health and social work. This chapter provides a new evidence-based continuum for evaluating battered women and improving risk assessments of dangerousness. It should be used to determine the number and length of treatment sessions by behavioral health clinicians, family counselors, as well as other mental health clinicians. It can also facilitate court decisions on whether battered women are at low, moderate, or high risk of continued battering, life-threatening injuries, and/or homicide (Roberts & Roberts, 2005).

Biopsychosocial and lethality assessments should begin with an evaluation of the psychological harm and physical injury to the victim, duration and chronicity of abusive incidents, and the likelihood of the victim escaping and ending the battering cycle. The continuum presented in this chapter provides a classificatory schema by which forensic specialists and clinicians can make reasonably clear predictions of lethality and the repeat of the violence. It is important for all counseling, social work, public health, and criminal justice practitioners to document the duration and intensity of battering histories among clients in order to provide customized safety planning, risk assessments, crisis intervention, and effective services.

REFERENCES


