

DOMESTIC VIOLENCE EVIDENCE PROJECT



Counseling Services for Domestic Violence Survivors **A Review of the Empirical Evidence**

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OVERVIEW OF THE DV EVIDENCE PROJECT

Increasingly, domestic violence programs are being asked to learn more about, contribute to, and describe how they are engaging in evidence-based and evidence-informed practices. Funders, policymakers, researchers, and advocates themselves are also more interested today in what evidence exists that a particular intervention or prevention strategy is making a positive difference for survivors, or is meeting the outcomes it was designed to achieve. With this information, domestic violence programs can better secure continued support for proven programs and practices, and can more easily identify, develop, and/or adapt innovative or exemplary approaches from other communities.

To respond to this new emphasis on evidence-based and evidence-informed practice, the National Resource Center on Domestic Violence (NRC DV), with support and direction from the Family Violence Prevention and Services Program at the U.S. Department of Health and Human Services, engaged in a two-pronged approach. First, evidence was collected and synthesized from published, empirical research studies.

Second, in recognition that controlled research studies are not the only form of evidence to consider in determining program effectiveness (Puddy & Wilkins, 2011; Schorr & Farrow, 2011), the project also identified where emerging and promising evidence exists that specific programs and practices are effectively addressing complex social problems in community settings.

This research summary, one of a series developed by the NRC DV's **Domestic Violence Evidence Project**, should be viewed as an important piece of information to consider, but it does not include the broad scope and continuum of services being delivered across the country or globe. Practice-based evidence being generated by the field and captured in the project's Program and Practice Profiles should also be considered.

"In one field after another, we are learning that so much of the most promising work in addressing the most intractable social problems is complex, multifaceted, and evolving."

Schorr & Farrow, 2011; p. 22

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Introduction

Many domestic violence victim service programs offer **counseling** as one of their core services. “Counseling” is a broad term, defined by the American Counseling Association as “a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (ACA Governing Council, 2010). As such, this term includes counseling offered by non-degreed practitioners with crisis intervention and support training (often referred to as peer counselors), as well as degreed practitioners with formal training in using therapeutic techniques to facilitate healing. Regardless of how it is delivered and by whom, counseling offered within domestic violence programs typically involves helping survivors recover their personal sense of power and control. It is also one way through which survivors learn about common emotional and behavioral responses to domestic abuse.

Counseling services offered by domestic violence programs incorporate a variety of therapeutic approaches (e.g., cognitive-behavioral, solution-focused, empowerment-based, art therapy) tailored to the individual needs and desires of survivors. Some programs offer individual counseling, some provide group counseling, and still others offer both (Howard, Riger, Campbell, & Wasco, 2003). The general intent behind counseling interventions is to alleviate the distress that often accompanies victimization (e.g., depression, anxiety, posttraumatic stress symptoms, guilt, shame) and to increase survivors’ sense of self and well-being. The purpose of this review was to systematically locate and review the empirical evidence behind providing counseling services to survivors of intimate partner violence (IPV) within or in collaboration with domestic violence programs.

Method

This systematic evidence review involved three components. First, we searched for potential programs and treatments using national registries of evidence-based practices (Campbell Collaboration, Canadian Best Practices Portal, Blueprints for Violence Prevention, Cochrane Reviews, Community Guide, Evidence for Policy & Practice Information & Coordinating Center, Home Visiting Evidence of Effectiveness, Crime Solutions, Promising Practices Network on Children, Families, and Communities, Coalition for Evidence-Based Policy Social Programs That Work, and the National Registry of Evidence Based Programs and Practices). The keywords abuse, domestic violence, intimate partner violence, interpersonal violence, counseling, effectiveness, evaluation, longitudinal, intervention, randomized, control group and “services or intervention” were used in combination for each registry that had search functions. In those cases where the registry did not have a search function, we browsed the provided categories for programs.

Second, empirical studies were located using ProQuest (PsycINFO, PsycARTICLES, PILOTS, ProQuest Psychology Journals, and ProQuest Research Library), PubMed, and Web of Science scientific databases, and the same combination of keywords. Results were limited to peer-reviewed, empirical articles published after 1980 and written in English. Third, additional articles were located using a backward search through relevant articles. The

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focus of the review was to identify counseling interventions that: (1) specifically targeted adult survivors of IPV; (2) were provided within or in collaboration with domestic violence programs; and (3) included comparison or control groups to examine treatment impact. The original search yielded 13,945 results, but the vast majority of these were not empirical articles that fit the review criteria. Six articles met the inclusion criteria for this review.

Findings

Three of the six articles included in this review evaluated counseling services that included cognitive behavioral therapy (CBT). CBT is a broad term that encompasses a variety of short-term treatments that include both cognitive techniques (such as learning to think about something differently) and behavioral components (education and skill-building to put new thoughts into practice). It is typically delivered by psychologists, social workers, counselors or nurses who have received training in this particular method, and it can be provided in office settings, domestic violence programs, or other community-based agencies.

The therapy is generally offered once a week for a few weeks to several months, and involves homework to put new concepts and skills into practice. When used with trauma victims, it sometimes includes “prolonged exposure,” or recalling and discussing the traumatic event in order to reduce the emotional response to it (Foa et al., 2005), although this technique is controversial given the concern that such recall may exacerbate, rather than reduce, trauma symptoms (Cloitre, Koenen, Cohen, & Han, 2002).

Johnson and colleagues (2011) created a CBT program specifically for women residing temporarily in domestic violence shelters, which they named *HOPE: Helping to Overcome PTSD through Empowerment*. HOPE involves 9-12, twice-a-week, 60-90 minute individual sessions (over a maximum of eight weeks) that address issues especially salient to abused women. Based heavily on Herman’s (1992) multi-stage model of recovery, it involves three stages: (1) re-establishing safety and a sense of self-care; (2) remembering and mourning; and (3) reconnection. The treatment prioritizes women’s safety needs, does not include exposure therapy, and focuses heavily on women’s empowerment. Specifically, therapists focus on women’s individual needs and choices, and help them develop any skills needed to reach their personal goals. Later sessions focus on building cognitive and behavioral skills to manage posttraumatic stress disorder (PTSD) symptoms and triggers, while optional modules are available that address common co-occurring issues such as substance abuse and managing grief.

Women were eligible for this study if they met subthreshold PTSD criteria, which means they did not meet the full clinical diagnosis for PTSD, but were re-experiencing the traumatic event (e.g., through flashbacks) and were also either avoiding reminders of the abuse or were experiencing hyperarousal (e.g., easily startled). Symptoms had to have persisted for at least 30 days, and causing women significant distress. Additional inclusion criteria included:

This paper was prepared for the *Domestic Violence Evidence Project*, an initiative of the National Resource Center on Domestic Violence. The overall goal of the DV Evidence Project is to combine what we know from research, evaluation, practice and theory to inform critical decision-making related to domestic violence intervention and prevention efforts. We encourage you to visit www.dvevidenceproject.org for additional materials, including research summaries, community practice summaries and evaluation tools.

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(1) no diagnosis of bipolar disorder or psychosis; (2) not concurrently in individual therapy; (3) no changes in psychotropic medications over the prior 30 days; and (4) no significant suicide ideation or risk. The six therapists who provided the treatment had either doctorates or master's degrees in psychology or counseling, and had at least one year's experience conducting HOPE.

Seventy IPV survivors were randomized to either receive HOPE or to continue receiving standard shelter services. Shelter services included case management and support groups but no therapy or counseling services. All women were then re-interviewed 1 week, 3 months and 6 months after they left shelter. A number of positive findings were reported from this study. Compared to women in the control condition, those in the HOPE condition were less likely to experience abuse six months after leaving shelter. Further, women receiving services as usual were 12 times more likely to experience reabuse than were women who received at least 5 sessions of HOPE. With regard to PTSD symptoms, there were no significant condition differences over time except for emotional numbing (in the desired direction). Those randomized to receive HOPE also showed significant improvement over time on depression severity, empowerment, and social support compared to women in the "services as usual" group.¹

It is also noteworthy that women's satisfaction with and engagement in treatment was high, with only two women dropping out. Thirty-four of the 35 women assigned to receive HOPE participated in at least one session, and 63% attended at least five sessions (26% attended all 12). Sixty-nine percent of the women did not complete all 12 sessions because they left shelter prior to completing HOPE.

Based on these study findings, the authors concluded that, while receipt of HOPE appeared superior to receiving only "services as usual" in a shelter context, a number of modifications may be in order for the future. For example, they recommend that this treatment be available after women leave shelter, given that 63% of the women exited shelter before completing HOPE, and 33% exited before having the opportunity to receive at least five sessions. A larger sample in a future study might increase power enough to detect PTSD differences that approached but did not reach statistical significance in this study as well.

Crespo and Arinero (2010) tested a CBT treatment for IPV survivors in Spain that included many of the same components found in Johnson and colleagues' intervention. They too consulted with IPV experts to design a treatment that would be most beneficial for IPV survivors. Similar to HOPE, this intervention focused on: (1) psycho-education about IPV and its impact on survivors; (2) raising self-esteem and mood; and (3) problem solving skills for independent living. They also added diaphragmatic breathing to their treatment, as a means of reducing hyper-alertness.

To be sensitive to the fact that many abused women have other pressing issues to attend to, and have to "get on with their lives," the treatment was designed to be delivered through eight 90-minute sessions. The group format was intentionally used in order to reduce the isolation many abused women feel. This trial specifically excluded

¹ However, it should be noted that "services as usual" did not include any form of counseling, which is often offered within the shelter context.

women with full clinical diagnoses of PTSD because this study was to see if treatment worked with women who had subthreshold symptoms of PTSD, as this may capture a larger percentage of women who are still in need of therapeutic help.

Crespo and Arinero were also interested in empirically testing the concern that exposure therapy may not be effective for women currently experiencing domestic violence. They therefore compared two treatment groups that were identical except that only one included exposure treatment. The other included communication skills in order to equalize the amount of therapeutic contact received. Fifty-three women were recruited from a variety of domestic violence agencies in Spain and randomized into one of the two treatments. Interviews were conducted pre, post, and at 1-, 3-, 6- and 12-month follow-up. Women's mean age was 41. Just over half (51%) were separated from, and more than a third still lived with, the abusers. Before beginning treatment, even though none met the diagnostic criteria for PTSD, 42% of the women met criteria for re-experiencing, 51% for hyper-alertness, and 21% for avoidance. Mean anxiety was moderate-severe, with 39% reporting suicidal ideation. Over half (53%) were below the cutoff on self-esteem, and mean depression scores were in the severe range.

Results of this study were promising for both treatments. Post-traumatic stress symptoms virtually disappeared within the first month after each treatment and this was maintained across the year. Depression and anxiety significantly decreased within the first month post-treatment as well, with more pronounced changes in the Exposure group, initially. However, women in the Exposure condition had higher educational levels and more prior experience with therapy, which may have confounded the findings. Nonetheless, both treatments appear to be effective, and for women who are not comfortable with exposure therapy, the communications skills modality offers a useful alternative.

Treatment adherence was fairly typical for this study. Twenty-six percent of participants dropped out of treatment before completion. Eighty percent attended all sessions of the Exposure condition, while 63% attended all sessions of the Communication Skills condition, but this difference was not significant. The most notable limitation of this study was its lack of a "services as usual" condition against which to compare the two treatments. However, this small clinical trial was promising, corroborating some of the main findings from Johnson and colleagues (2011).

Kim and Kim (2001) designed a trauma-focused counseling intervention for abused Korean women residing in shelters that was not explicitly described as cognitive-behavioral therapy but that included similar foci. They based their intervention on a feminist analysis of IPV, focusing on empowerment-based education and skill-building rather than on "psychological healing." Model components followed Robert's Seven-Stage Crisis Intervention model, which involve: (1) assessing the situation – including safety concerns; (2) establishing rapport; (3) examining the dimensions of the problem; (4) exploring feelings; (5) assessing past coping responses; (6) implementing a plan to restore cognitive functioning; and (7) providing the option of a follow up or "booster" session three and/or six months later (Roberts & Burman, 1998). Groups lasted 90 minutes and were offered once a week over eight weeks; desired outcomes were changes in depression, anxiety and self-esteem. Counseling was provided by highly trained nurses.

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Sixty women were recruited from two shelters in Korea, with 30 from one shelter assigned to the intervention and 30 from the other shelter serving as a comparison group. No woman declined to participate, but 45% dropped out before the post survey could be administered. The primary reason for dropout was that women exited the shelter. Of the original 30 women assigned to receive the treatment, the 16 who remained in the study (53%) completed all 8 sessions. The only difference found between the groups post-intervention was that those who received treatment scored lower on trait anxiety (an overall pattern of anxiety proneness) than did the comparison group. However, due to the small sample size, significant attrition rate, and missing information about rates of depression, anxiety, and self-esteem at Time 1, results from this study should be viewed with extreme caution. As the authors themselves noted, a more rigorous test would include a larger number of women, a longitudinal design, and measures that have been validated for Korean women.

Comparing Different Counseling Interventions. Two of the articles reviewed herein examined whether one type of counseling was superior than another for IPV survivors. Mancoske and colleagues (1994) compared 10 women who received “grief resolution” counseling to 10 women who received “feminist-oriented” counseling. Women were randomly assigned to condition, and all had first received crisis counseling. Both interventions occurred at a domestic violence program, and it was not reported what other services the women were receiving. Both approaches were offered individually by second-year MSW students, included problem solving and psycho-education, and were 8 sessions in length. The feminist-oriented counseling focused on empowerment, encouraging women to define problems and solutions, instilling hope, and teaching interpersonal skills. Grief counseling focused more on mourning the loss of the relationship and going through Kubler-Ross’s 6 stages of grief: denial, anger, isolation, bargaining, depression, and acceptance. Over half of the women (65%) were white, 25% were black, one was Native American, one was Asian, and one was Hispanic. Women in both types of counseling improved on self-esteem and self-efficacy measures over the course of treatment. Unfortunately, the investigators did not report whether any women dropped out of counseling or failed to attend all eight sessions. Between these methodological limitations and the small N, findings from this study are not generalizable.

McWhirter (2011) compared emotion-focused therapy with goal-oriented therapy for IPV survivors. She collaborated with homeless shelter service providers and residents themselves who had experienced IPV and who were mothers in designing the study. Inclusion criteria were that the women were residing in a homeless shelter, had experienced IPV within the prior year, and reported at least one child present during at least one of the assaults. Fifty women were recruited and randomized into one of the two group therapy conditions. Just under half (47%) were White, 20% were Latina, 16% were African American, 11% Native American, and 2% were Asian American. Ages ranged from 18-47, with the mean at 30-years old. Four women did not receive the intervention due to relocating; none were lost to follow up. Analyses were conducted on 46 women and their 48 children aged 6-12.

Two of the four female therapists providing this intervention were masters-level licensed counselors, and two were masters-level students. Both interventions involved five weekly sessions, each lasting two hours. The first hour was women only (45 min group for children separately), and the second hour was children and women together. Each group had 4-5 women participating. The goal-orientated treatment used motivational

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interviewing and CBT principles to enhance women's and children's understanding of their goals and how to attain them. The emotion focused group focused heavily on understanding and expressing feelings, and exploring personal belief systems. Women and children were interviewed one week prior to the treatment, and at the end of the 5-week intervention.

Children in both groups reported decreased family and peer conflict, and increased emotional well-being and self-esteem. Women reported decreased depression, and increased family bonding and self-efficacy across both conditions. Those in the goal-oriented group reported greater decreases in family conflict, while women in the emotion-focused counseling noted greater increases in social support. However, there was no "no treatment" control condition, so it is unclear how much of these changes were due to the passage of time or other services being received by the families. Given this limitation, it is premature to draw conclusions about the efficacy of these interventions.

Counseling Interventions for Specific Groups of IPV Survivors. Howard and colleagues (2003) compared counseling outcomes for abused women by whether they had been sexually assaulted by their assailants as well. This study compared 357 battered women with 143 battered and raped women who participated in counseling at one of 54 domestic violence programs in Illinois. Women completed self-administered measures pre and post counseling. The brief, 8-item surveys measured self-identified change in self-blame, self-efficacy and control, and social support. Almost two thirds of the sample was non-Hispanic White (64%); 27% were Black, and the other 9% were Latina, Asian American or Native American. The vast majority of the women had participated in individual counseling (92%), 4% received group counseling, and 40% had been members of both individual and group counseling.

After controlling for prior abuse (which was higher for women who had been raped), both groups improved in well-being and coping after counseling. However, women who had been both physically and sexually assaulted had lower scores than the other women both before and after counseling. The investigators concluded that women who are sexually as well as physically abused in their relationships may enter therapy in more distress and experience more self-blame, and may therefore need either more counseling sessions or a different type of counseling that attends to sexual assault victimization.

This study may be especially relevant to counselors working within domestic violence programs, as it included data from 54 domestic violence programs across one state. It is informative that this multi-agency evaluation found that the counseling provided within domestic violence programs is helpful to survivors' well-being. However, it did not include information about differences in technique, therapeutic orientation, topics discussed in counseling, or therapist training across the programs.

Conclusions

The results of this review indicate that counseling treatments designed for IPV survivors hold promise for reducing depression and anxiety, and enhancing well-being. However, the six interventions differed from each other in a myriad of ways (e.g., whether they were offered in group settings or individually, number of sessions offered, counselor education and training, curriculum content), making it premature to determine if there are specific components that might be essential for all survivors, beneficial to some survivors, or even irrelevant to treatment success.

A number of study limitations must be considered when interpreting and utilizing the research findings. An important caution is that the body of evidence under consideration is extremely small. Only six studies met the criteria for this review, and a number of these had serious methodological limitations. Most of the studies also examined treatments that differed in significant ways from others under investigation, so it remains premature to recommend one type of treatment over another.

It is also important to bear in mind that there are a wide range of culturally-specific approaches to recovery and healing that are based on the values and healing traditions of particular communities not addressed by existing evidence-based practices. There are also numerous feminist-oriented and peer counseling approaches being implemented that have not yet been rigorously evaluated. More research on such interventions is sorely needed.²

In conclusion, counseling services hold promise in helping IPV survivors recover from abuse and successfully move on with their lives. While it is too early to know definitively which treatments work best for which survivors, evidence suggests that helpful components may include: (1) psycho-education about the causes and consequences of IPV; (2) attention to ongoing safety concerns; and (3) a focus on women's strengths as well as cultural strengths on which they can draw.

NOTE: *The reader may also be interested in reading a review of trauma-treatments for IPV survivors:*

Warshaw, C., Sullivan, C.M., & Rivera, E. (2012). A systematic review of trauma-focused interventions for domestic violence survivors. Available at: <http://www.nationalcenterdvtraumamh.org/>

² Examples of community practices with emerging evidence for their effectiveness can be found at www.dvevidenceproject.org

Six Studies Included in Review

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Additional References

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