

The Importance of Cultural Responsiveness When Treating Domestic Violence Survivors

Laurie A. Vargas, M.S.
Shannon A. Dickson, Psy.D.

Laurie Vargas has received her M.S. in Counseling from CSU, Sacramento specializing in Marriage, Family, and Child Counseling and is currently working at a domestic violence and sexual assault agency in Sacramento, CA. Email: l.vargas@earthlink.net

Shannon Dickson has received her Psy.D. from the University of San Francisco and is currently an assistant professor at CSU, Sacramento. In her private practice as well as professorship, Shannon specializes in working with multicultural issues as well as children.

In 1993, the United Nations recognized domestic violence as an international human rights concern and issued a *Declaration of the Elimination of Violence Against Women* (Lemon, 1996). Domestic Violence (DV), also known as, Intimate Partner Violence (IPV) has historically been seen as a family problem and for many years had been a well kept secret. Additionally, DV had been a crime that was relegated to married couples and families of working class and poverty status (Dobash & Dobash, 1992). It oftentimes went unreported and denied by the survivor, abuser and the larger society (Gelles & Loseke, 1993). In recent times, its definition has broadened to include two persons who once were or are currently in an intimate relationship. Unfortunately, much of the research conducted in this area continues to be based on heterosexual relationships.

IPV is a topic that can evoke many emotions such as shame, fear, and guilt. Furthermore, it affects people regardless of their ethnicity, class, gender or sexual orientation, thus, requiring sensitivity on the part of mental health providers. The cultural forces that play a significant role in survivors' lives are not limited to survivors, but also include mental health providers because how providers perceive domestic violence and survivors' situation can potentially determine the positive/negative outcomes related to assessment,

intervention and treatment practices. To provide culturally responsive care to survivors provides must consider the multiple realities in which survivors live (e.g., racial identity, acculturation level, potential language barriers, class, and sexual orientation).

Culturally responsive assessment is an essential component of IPV (The Family Violence Prevention Fund, 2004) and there have been a number of protocols developed to assess DV incidents related to both survivors and perpetrators (The Family Violence Prevention Fund, 2004). However, these protocols have been developed primarily from law enforcement and medical perspectives with the focus being on perpetrators' potential for violence and survivors' physical symptomology (The Family Violence Prevention Fund, 2004).

According to Lenore Walker (1979), there are three phases involved in domestic violence and each phase is different in each relationship. The tension building phase most often includes a feeling of walking on eggshells, or electricity in the air. Anything, everything, or nothing at all can trigger an explosion (the second phase) which includes one or more types of abuse: 1) physical, 2) emotional, 3) sexual, and 4) financial. One or a combination of many repeated flare-ups in a cyclical manner constitutes domestic violence. The honeymoon is considered the third phase. According to Walker (1979), a relationship is not considered to be a DV relationship until the couple has been through the cycle at least three times. Each DV relationship is different in regards to the frequency, duration, and intensity of the explosions. In some relationships, a couple may go through the cycle many times a day, whereas, in other relationships there may be months in between each complete cycle. During the assessment process it will be important to interview survivors to determine the frequency, duration and level of abuse.

Culturally responsive assessment must include both subjective (nonstandardized) and objective (standardized) measures. Nonstandardized measures include clinical interviews and observations, while standardized measures can include personality tests, structured questionnaires and inventories. The research literature on assessment and evaluation has well documented cultural bias' inherent in objective measures, however, these tools provide valuable information about survivors' when integrated with other data (e.g., clinical interviews, medical reports and information received from family members and friends; Suzuki, Meller, & Ponterotto, 2000).

The clinical interview is an essential part of the assessment process and allows for an integration of survivors' own cultural worldview as well as their perceptions and interpretations related to their experiences associated with IPV (The Family Violence Prevention Fund, 2004). When interviewing survivors' it is important to assess any immediate concerns related to IPV using culturally responsive questions and language (e.g., use of survivor's words, use of interpreters) for the purposes of facilitating survivors' comfort in sharing pertinent information. If it is determined that a crisis situation exists, it is essential that a mental status exam (MSE) is conducted to evaluate survivors' suicidality/homicidality, coping skills and whether a safety plan is in place. If survivors' do not have a safety plan, assist them in developing a viable plan for safety. The MSE also allows for direct observation of behavior(s) that require attention such as hypervigilance and mobility problems due to current/past physical injuries.

When the counselor determines that the crisis situation has been resolved, it is important to conduct an expanded clinical interview using a biopsychosocial format. Its purpose is to provide the counselor with an organized way to evaluate a variety of areas and it provides a context of within which survivors' live. The format incorporates the following domains: a) biological, includes information about survivors' current/past medical history; b) psychological, includes information about survivors' acculturation level, sexual orientation, religious beliefs, and c) social, includes information about survivors' social support system and potential barriers (e.g. financial resources). The gathering of information can include direct/indirect unstructured questions that require survivors' verbal responses as well as having survivors' complete a personal history questionnaire and reviewing the written information.

Suzuki et al (2000) discussed the importance of cultural sensitivity in the use of standardized assessment protocols. The researchers have illustrated that caution in the use and interpretation of objective measures is warranted because these measures have continued to support the social, economic, and political barriers of the culturally and linguistically different. Counselors' awareness and knowledge of the inherent bias in standardized protocols are essential in their selection and use. There are a number of inventories that are used in assessing a variety of areas associated with DV risk factors such as child abuse and substance abuse. Examples of inventories are: 1) The Kempe Family Stress Inventory (KFSI) assesses risk factors associated with child abuse, 2) the Substance Abuse Subtle Screening Inventories-3 (SASSI-3; The SASSI Institute, 2000) assesses for substance use, 3) The Trauma Symptom Inventory (TSI; Breire ,1995), assesses stress related to life events, 4) Screening Questions for Domestic Abuse Assessment

(Brookoff, O'Brien, Cook, Thompson, & Williams, 1997), and 5) the Personality Assessment Inventory (Morey, 1991) assesses individual personality characteristics. It is important to note that some of the assessment protocols mentioned have recommended professional qualifications for their clinical use, clinicians are advised to refer to the specific protocol to ascertain qualifications for use.

A complete assessment guides the treatment modality as well as intervention and prevention strategies. An essential component of the treatment process is to assist clients transform their view of themselves as victims to that of survivors, thus allowing them to see the empowerment in their own healing process. Effective modalities can include group, individual, and family counseling. Psycho-educational groups are effective because survivors can learn about the dynamics of DV as well as share their experiences with other survivors. Within the psycho-educational groups, some valuable topics include sessions on the types of abuse, emotions, and the effects of DV on children.

Individual counseling has the added benefit of working directly with the survivor's situation. The foundation of individual counseling is based on psycho-education as well as assisting the survivor in processing her/his emotions. Additionally, the counselor can help the client recognize the dynamics of IPV as it pertains to him/her. Initially the focus of counseling is to validate the client's feelings, perceptions, and cultural worldview. Three important messages to be given to the client are that s/he is not crazy, the domestic violence was not his/her fault, and s/he is not alone. These messages are essential to the counseling process because the survivor of the relationship believes that the violence was her/his fault, the abuser often refers to the survivor as crazy and minimizes the violence. Oftentimes, clients may believe that the counselor does not understand their experience because the stories may seem unbelievable. Given this perception, it is important that counselors demonstrate their own understanding of how IPV affects each relationship differently. This can be done by reviewing the cycle of violence with clients and allowing clients to share their experiences.

As counseling progresses, the client can begin to learn about safety planning techniques that can be helpful, especially if the survivor remains in the relationship. For example, a survivor can become aware of potentially dangerous situations through recognition of how her/his own behavior can potentially affect a domestic violence episode. In this case, it is especially important for counselors to be cognizant of the blame and guilt a survivor might perceive when discussing her/his behavior in the relationship. The final stages of counseling should assist clients in supporting their grief process (e.g. perceived loss of the

relationship they once knew) as well as intervention/prevention strategies. Allowing clients to devise their own safety plans as it pertains to themselves and family is part of the empowerment process.

Family counseling can also serve as crisis intervention or prevention particularly when children are involved because it is important for them to know that the domestic violence is their fault. Furthermore, family counseling allows the survivor of the relationship and the children to work together and identify the needs of the family. Similarly elements that are focused on during group and individual counseling can also be of benefit in family counseling. Validating the needs and feelings of each person in the family is important as children might have their own feelings of guilt and shame for loving the abuser (usually a parent or step-parent) as well as feelings about the abuser for treating the survivor as s/he did, or towards the survivor for remaining in the relationship. Family counseling is usually most beneficial once the survivor has been able to begin their healing process because s/he has a basic understanding of how the domestic violence affected the relationship.

Oftentimes, DV counseling is seen as crisis intervention, thus additional services may be required such as in-depth counseling, substance abuse treatment, law/advocacy programs and batterer's treatment programs. If clients are not already aware of the local domestic violence agency in their area, it will be important to assist clients become familiar with the services offered. As a prevention strategy, it is important to assist clients recognize the warning signs associated with abusive behaviors that might appear in a relationship (e.g., controlling behavior, isolation, a history of past DV in their partners' relationships).

Whether group, individual, or family counseling, counselors must be aware of how clients' attitude, values and belief system can potentially impact assessment, treatment, and intervention/prevention. It is also vital that counselors have an awareness and understanding of their own cultural worldview and its impact on the assessment and treatment process.

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