

BEST PRACTICES MANUAL

*for*

Stopping the Violence  
Counselling Programs  
in British Columbia

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*For*

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## SECTION ONE

# Setting the Context

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### **1.1 Introduction**

This Manual identifies best practice issues and provides practical guidelines for Stopping The Violence Counselling, for both clinical and administrative practices. It is the hope of the B.C. Association of Specialized Victim Assistance and Counselling Programs (BCASVACP) and the authors that this Manual can support STV counsellors by identifying practices that can be applied consistently province wide, despite the wide variety in programs. The Manual is not comprehensive, nor is it a policies and procedures manual, although policy issues are addressed. Group work is one important part of STV counselling that is not addressed, although a list of group work resources is included in Section 8.1.

The Manual is also not entirely linear; different sections overlap and references are often made to other sections where more information on a topic can be found. The Manual is best thought of as a woven web, an image often used in counselling to describe the work done together by client and counsellor. A web has many interconnecting strands, creating a whole much stronger than each individual thread. Yet there is structure to a web that radiates from a clear centre. Our intention is that the Manual have both a defining structure and strength to support STV counsellors in their challenging work, and yet have the flexibility and fluidity to allow for practice differences. Although there are sections on special issues—for example, mental health and aging women—it has not been possible to address every diverse group equally. The integrated model offered here provides guidelines for supporting women from diverse backgrounds.

Although the STV Counselling Program is mandated to work with women victims of violence, the guidelines and best practices described in this Manual are also applicable to men who have experienced abuses of power and violence, and to victims of trauma generally.

### **1.2 The Program Mandate**

The Stopping The Violence Counselling Program was developed in 1992/1993 with the mandate of providing mid-range counselling to female survivors of childhood abuse, sexual assault and abuse and violence in intimate relationships. Establishing best practices for the STV Counselling Programs presents a number of challenges. First,

the programs are delivered through a broad range of organizational structures that attempt to meet a wide diversity of community needs, challenges and contexts. These factors combine to produce a situation where the mandate of mid-range counselling (which is, in itself, not easy to define) is challenging.

The second issue revolves around the changing conditions in which the programs are being delivered. In the following sections, program variations and the current context in which STV counselling services are provided are identified, followed by a discussion of what best practices can look like within these parameters.

### **1.3 Program Variations**

STV Counselling Programs are delivered in both rural, isolated communities and large urban centres; they are delivered in stand-alone anti-violence agencies or as part of larger, multi-service agencies; they might serve primarily Euro-Canadians, or First Nations, or immigrant and refugee communities. There is a range of staffing levels, from one part-time staff working a few hours a week to programs with multiple full-time staff and administrative support. The STV counselling model of valuing life experience and on-the-job training as well as formal education leads to a broad range of educational backgrounds and experience. Each of these variations has implications for how counsellors implement the STV Counselling Program, and for their specific needs regarding best practices.

Examples of how STV Counselling Programs are delivered include:

- **Duncan/Cowichan Valley:** The population of the Cowichan Valley is about 70,000 people, and is spread out over a large geographic area that includes several small cities, suburban areas, and rural and very isolated communities. Cowichan Women Against Violence is a feminist umbrella agency that has been operating for 25 years and holds contracts for the Transition House, Children Who Witness Abuse Program, Community-based Victim Services, a pre-employment program for women and a community development program that focuses on addressing issues of community safety and violence. The STV counselling contract is for 1.36 full-time equivalents (FTEs), split between two part-time staff.
- **Prince George:** Prince George has a population of approximately 80,000 people. The centre is a non-profit grassroots agency that has been in the community for 23 years. The STV Counselling Program consists of one full-time counsellor and one half-time counsellor.
- **Tumbler Ridge:** Tumbler Ridge is a rapidly expanding northern community. The current population approaches 4,000. The STV counselling contract is

funded for a 0.5 FTE and held by Tumbler Ridge Counselling Services, part of the unionized Northern Health Authority. There is also a Safe Home position within the agency, funded for a 0.5 FTE.

- Vancouver: MOSAIC is a non-profit multicultural community agency with three satellite offices. The STV counselling position is at the central site, which also offers employment programs, family programs, settlement services, interpretation and translation services, volunteer programs and many more contracted services. There is one full-time STV counsellor, one full-time specialized victim assistance program worker and a part-time multicultural outreach services worker. The services are provided to immigrant women victims in various multiple languages. The services are provided in partnership with other family programs staff, settlement counsellors and bilingual counsellors and interpreters.
- Victoria: The population of Greater Victoria is 350,000 people. The STV Counselling Program is embedded in the Victoria Women's Sexual Assault Counselling Centre, which also has a Solicitor General contract for victim services and other fund-raised and grant-sponsored programs. Some of the funds raised go to the STV Counselling Program. There are three full-time STV staff and one part-time supervisor. Victoria also has an STV Counselling Program attached to the Transition House, with another based in Colwood.
- Robson Valley: The Robson Valley has a population of 4,000 people located along 200 kilometres of the Yellowhead Highway. Seven communities are served by the STV Counselling Program: Albreda, Valemout, Tête Jaune Cache, Dunster, McBride, Crescent Spur and Dome Creek. The STV Counselling Program is administered by the Robson Valley Home Support Society, an umbrella social service agency. The half-time STV counsellor works in offices located in McBride and Valemout, travelling about 400 kilometres per week.

#### **1.4 The Current Context for STV Counselling Program Delivery**

The conditions in which the STV Counselling Programs are delivered have changed dramatically since the government initiated social service cutbacks in 2002. There have been cuts to social assistance and legal aid, cuts to sexual assault centres and women's centres, cuts to sexual assault centres and local women's crisis lines, and increased pressures on remaining (and often reduced) services such as mental health and addictions.

Effective responses to victims require a number of essential services. Ontario's Joint Committee on Domestic Violence (1999) describes these essential services as the provision of long-term counselling, sexual assault services and transitional support services, emergency

shelters, hospital-based emergency and other health services, transitional housing and transitional supports, including access to housing, employment assistance and child care. In the absence of adequate community supports, programs and staff are at stressful capacity. In rural areas where these essential services are unavailable or only available considerable distances away, long-term counselling is even more problematic.

The B.C. Ministry of Community Services (formerly the Ministry of Community, Aboriginal and Women's Services, MCAWS), in its own evaluation of STV Counselling Programs that began in 2000, identified service delivery changes in the STV Counselling Programs as a result of the cutbacks (Walker 2004). The BCASVACP teleconference call reports of 2002-2003 (BCASVACP March 2004) and 2003-2004 (BCASVACP February 2005) reported a changing clientele and changing service delivery conditions. These changes, listed below, add stress to the STV Counselling Programs.

- Generally, less time is available for counselling and more time is spent on support and advocacy. In short, services formerly provided by women's centres and other community agencies are now being requested of STV Counselling Programs;
- Wait-lists have increased;
- Referrals from other overtaxed services and agencies, such as mental health, have increased;
- Because of cuts to legal aid, more women are representing themselves in court or choosing to avoid any situation that might require legal intervention. This has required STV counsellors to learn more about the law;
- More poor women are in crisis situations regarding finances, shelter and safety; consequently, much more basic advocacy is needed regarding food, transportation, child care, legal issues, housing and accessing community services. STV counsellors are spending considerable amounts of time assisting with disability and legal forms;
- More women are accessing STV Counselling Programs with serious mental health and addiction problems, including bipolar disorders, dual diagnoses, depression, cocaine and crack use and eating disorders;
- More drop-ins by women who would have previously used women's centres; and
- Fewer supports in the community mean more barriers to women's safety. More women are staying in abusive relationships, and fewer women who do leave are willing to go to court for protection or custody because they must

represent themselves. This has increased the demand for STV counsellors' assistance in managing increased risk.

These changes create specific problems for STV counsellors. Staff lack training to meet these changing needs (for example, in legal advocacy). Fourteen of the twenty-two STV Counselling Programs in the MCAWS evaluation focus group reported providing services beyond contractual agreements (Walker 2004). Paradoxically, staff have less time for counselling, yet women are presenting with very severe emotional disturbances and complex life challenges.

The 2004 MCAWS evaluation of STV Counselling Programs identifies two major areas of service that the programs are dealing with: acute short-term interventions and women in chronic situations with long histories of abuse and violence. It is hoped that increases in funding made in 2005 to STV Counselling and outreach programs will have a positive impact on this situation.

Currently, however, STV counsellors often report they feel overwhelmed, are worried that they are working beyond their competencies and lack options for referral. Although they are willing to help all women who have been victimized, they are concerned about their abilities to manage the more complex referrals. In addition, they are at serious risk for vicarious traumatization.

STV Counselling Programs have attempted to meet these challenges in different ways. In larger urban areas with more resources and referral options, some programs have placed strong limits on the women they accept for STV counselling, screening out women who have substance use issues, are actively suicidal or have severe dissociative presentations. Other communities, often more rural, accept women with these issues precisely because no other referral sources exist.

## **1.5 Developing a Best Practice Model**

The authors struggled with the question of whether to design best practices for the programs as defined in the mandate—the provision of mid-range counselling services—or whether the best practices should reflect the increased advocacy and support role that STV counsellors are filling. At the same time, the MCAWS evaluation recommends increasing the “mid-range counselling” mandate to include clinical counselling to reflect more accurately what many program staff are doing.

Given the program variations and the current context of the STV Counselling Programs described in the previous sections, best practices are best viewed as ethical guidelines rather than rigid requirements. The best practices in this Manual attempt to respond to the varying needs of STV Counselling Programs by:

- Identifying the training, knowledge and experience necessary for the general provision of counselling to women victims of violence;
- Describing best practices from a perspective that integrates both feminist and trauma intervention approaches to this work;
- Naming core ethical best practices and providing ethical decision-making guides;
- Identifying basic issues related to assessment and counselling planning;
- Clarifying the conditions that must exist before counselling can begin;
- Addressing some of the increasingly common and challenging clinical presentations;
- Providing administrative best practices for several administrative issues related to service delivery; and
- Providing several useful resources for more information in each best practice section.

## **1.6 How to Use This Manual**

Counsellors can access any part of the Manual to find information related to a specific topic. Each section might include cross-references to other places in the Manual where more information on a topic can be found. However, for maximum benefit, it is suggested that counsellors familiarize themselves with the entire document, as each section builds on the one before. Specialized issues are best addressed after the sections on general best practices have been reviewed.

The Manual includes resource sections after most topics. These resource sections are not intended to be all-inclusive; rather, they merely suggest several books, articles or Web sites that the authors have found helpful. These resources are also compiled, with additions from the advisory committee, in Section 8.1. References cited within the text are in Section 8.2.

### **A note about language**

We have tried to use language that demystifies and depathologizes the experience of a woman who has suffered violence. Therefore, we speak of post-traumatic responses rather than post-traumatic stress disorder, of survivors rather than victims (although we use “victims” when referring to the moment of violence), of clients rather than patients, and of adaptations or coping skills rather than symptoms.

## **BWSS Program Description**

*“Working with what is in front of us”*

Battered Women’s Support Services has been providing support services to women survivors of violence in the Greater Vancouver and surrounding area since 1979. A feminist organization originally focused on support services for women survivors of relationship abuse, BWSS program mandate has expanded to include all women survivors of violence including childhood sexual abuse, adult sexual assault, historic residential school abuse, dating violence and violence/abuse in intimate relationships.

BWSS STV program is one piece of an integrated service delivery model. BWSS service delivery model is holistic integrated and trauma informed. First contact with BWSS usually involves accessing the crisis and intake line. The intake process is thorough, relational and systemic seeking to gather information to assess women’s need and identify her requests to determine the best internal referral. Through the intake process women are offered a range of support options including crisis support, long term counselling, advocacy, legal advocacy, victim services, accompaniment and a variety of support groups.

BWSS works from a trauma informed, empowerment model with case management and includes service adaptations appropriate and relevant for immigrant women, Aboriginal women, lesbians and bi-sexual women, and women isolated by various disabilities. Support services are designed to assist women in being safer and gaining a sense of empowerment. Women are assisted with safety plans, accessing resources managing the effects of abuse, including coping mechanisms that grow from the effects of trauma including severe and complex post trauma reactions, and substance use/addictions.

Services are provided in person, over the phone and in groups. Groups are central to the BWSS STV program where there are between five to 12 groups running at any given time at the organization.

BWSS is also working from a partnership model, where we seek out and nurture a variety of partnerships with collateral agencies to better meet the needs of women marginalized by poverty, culture, language and race. Through establishing partnerships with collateral agencies BWSS is providing women-centred culturally relevant services to marginalized women.

BWSS service delivery model is punctuated by hiring practices and volunteer recruitment that are designed to ensure that women providing the services are reflective of the community and the women accessing services. Upwards of 8000 service delivery requests are made by women each year at BWSS and our commitment is to work with what is in front of us, from where women are at, not where we think they should be.

*Courtesy: Battered Women’s Support Services*

## SECTION TWO

# Feminist Trauma Intervention Best Practices

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This section provides an overview of feminist and trauma intervention theory and clinical approaches. It is intended to describe the ideas and values that underlie both feminist and trauma approaches to intervention, as well as the relationship between the two. Best practices are always rooted in a clearly articulated theoretical model. This section lays the ground for the whole Manual.

### 2.1 The Feminist Model

#### **STV mission statement**

STV Counselling Programs provide counselling and related support to women who have experienced violence or abuse. Provided from a feminist perspective, and within an accessible, safe and supportive environment, the STV counselling model is based on respectful relationships. Program services are delivered in a manner that respects each woman's individual rights, safety and human dignity, regardless of economic status, gender, age, race, cultural or ethnic origins, physical or mental ability, or sexuality.

#### **STV counselling draft program standards**

STV counselling services are delivered within a feminist framework. The BCASVACP developed a draft document entitled *Program Standards for Stopping The Violence Counselling Programs* in 1998. The standards state that the feminist counsellor:

- Utilizes knowledge of the impact and dynamics of violence and abuse, and of the power imbalances in society that expose women to violence or abuse;
- Places highest priority on the safety of women and children rather than keeping families together, where these two may be in conflict;
- Confirms the abuser's responsibility for the abuse and does not place blame on the woman;
- Validates the woman's experience of abuse, and acknowledges and respects the woman's expertise with respect to her own experience;

- Provides services in a non-judgmental, non-labelling manner;
- Provides services to address the woman’s needs while respecting her right to self-determination; and
- Fosters self-empowerment by supporting the woman toward increased control over her life, maximizing her control over the counselling process itself and reducing the power differential between the counsellor and the woman.

### **Feminist counselling is rooted in an analysis of societal power**

Women’s individual circumstances are viewed within the broad systemic framework that identifies patterns of power within a woman’s life—both gendered and otherwise. “Feminist therapy,” writes Laura Brown (1994), “concerns itself not simply with individual suffering but with the social and political meanings of pain and healing...the first and foremost commitment of feminist therapists is to radical social transformation.”

From the beginning of the women’s movement, women of colour and other marginalized women have engaged in an analysis of oppression that included the intersecting realities of race, ethnicity, class, ability, age, sexuality and other identities on women’s experiences of violence and of society’s response to her victimization. Feminism is a political philosophy, emerging from women’s intersecting experiences of oppression and silence within patriarchal society.

### **Accountability**

Accountability is central to the feminist approach. Feminist family therapist Virginia Goldnor (1998): “Given the moral and psychic complexity of [family violence] issues, work with clients should aim to develop the most comprehensive understanding of abuse and victimization, without compromising a clear moral vision regarding issues of accountability, *that is, without blaming the victim, shaming the victim, or allowing the perpetrator to misuse psychological insight to avoid taking responsibility for his actions*” (italics added).

### **Relationship is central**

Appreciating that relationships have always been central to women’s lives and tasks, feminist counsellors support building relationships in which women are equal partners with equal voice.

Connectivity and mutuality are valued. The Jean Baker Miller Institute (Stone Center) has been instrumental in developing the model now called relational-cultural therapy. This model emphasizes empathy, therapist authenticity, mutual and shared power and growth and differentiation within the relationship. The primary task is to stay present

and engaged and to value the relationship. When the client feels that the relationship is far more important to her than it is to the counsellor, she feels disempowered and at a disadvantage. The counsellor has a responsibility to be present in “ways that minimize the potentially shaming impact of such felt powerlessness” (Walker 2004).

“The feminist ethic is also the ecological ethic of relationship and interrelationship, a philosophy of dialogue with multiple voices...going beyond gender into a politics of inclusion, of empathic connectedness” (Roszak 1995).

### **Feminist therapy moves toward egalitarianism**

An egalitarian relationship is one that is structured to move toward equality (Brown 1994). Feminist counsellors acknowledge the inherent power differential in the two roles and are committed to addressing real power differences wherever they occur: within the counselling office, within families and in the hierarchical systemic structures of society.

Women should take an active part in the counselling process, including being involved in setting goals, giving feedback and evaluating how the process is working for them. The counsellor resists adopting the stance of expert interpreter and advice-giver, and includes the client in the assessment and counselling goal-setting process. Feminist models view women’s knowledge to be as important as the counsellor’s skills, highlighting women as experts on their own lives.

### **Demystification of therapy and symptoms**

The woman has a right to be informed of the process of counselling, what she might expect, what approaches and techniques will be used and how long the process might take. The “rules” are overt and agreed upon.

Feminists commit not to impose diagnostic labels and medications, and to reconceptualize mental illness as non-pathological. Women’s painful symptoms and behaviours are rooted in attempts to manage and master the consequences of personal and social experiences. Feminist counsellors see strengths and stories within symptoms, and focus on enhancing strengths rather than repairing weaknesses.

### **The goal is empowerment**

Women are supported to access and express their authentic and often silenced voices. Women’s experiences and perceptions are honoured. When women find their own voices and new skills for participating in life, they begin to find strength and power within themselves. They have fuller emotional expressions, more sense of choice in their lives and understanding of how choice has been narrowed or taken from them. They identify internalized, judgmental and constricting messages from family and

society, and move toward replacing these with new and positive cognitions. Empowerment within relationships means deeper and more genuine connections with others and behaviours that enhance intimacy and allow autonomy.

### **Challenges within feminist counselling**

The emphasis on egalitarianism provokes tension between client and counsellor in terms of distance and boundaries. Generally, the feminist literature argues for generous self-disclosure, as the self of the counsellor is considered an essential tool in the counselling process. However, excessive self-disclosure can create various responses in clients, including anxiety and an attempt to take care of the counsellor. Similarly, the desire for egalitarianism can lead to unclear boundaries.

A related challenge is role confusion. Although feminist counsellors understand the survivor's need for structure and boundaries, this can sometimes conflict with feminist desires to move too fast toward equality (a problem within early feminist counselling models). Loose boundaries lead to over-involvement, rescuing and an impulse to play parent to the client's wounded child.

Feminist counsellors are often challenged regarding the issue of women's violence. Their training and outlook has primarily focused on women as victims, and they have at times excused women's violent behaviours as the outcome of their own victimization. This has not served women well, as many victims who have also hurt others are tremendously shamed by their offending behaviours. Although feminist counselling now engages more directly with women regarding their violent or abusive behaviours and understands the need for accountability, many counsellors lack the skills and the comfort level necessary for these conversations.

Finally, it is often difficult to translate theory into practice. Many counsellors have a feminist orientation that is more philosophical than clinical. As a result, many feminist counsellors who believe deeply in feminist values are counselling primarily from a humanist perspective. Conversely, a feminist perspective is unskillfully presented to clients: poor timing, rhetorical language or tone of voice and strong opinions can contribute to silencing women.

## **2.2 The Trauma Model**

### **Trauma and its impact**

Trauma has a powerful impact, with many victims developing symptoms and behaviours that seriously affect their capacities to function. Although victims of diverse experiences have unique responses, it is now generally understood that there is a trauma response that crosses these differences. Survivors may develop acute or chronic post-traumatic

stress problems of intrusion, numbing and hyperarousal. Dissociative mechanisms that enabled them to survive trauma make it difficult to see clearly and respond effectively to the challenges of the present. Attempts to resolve and escape the pain can turn into dangerous re-enactments of the event and may lead to addictive and other self-harming activities. Victimization profoundly impacts and changes a woman's perspectives on self, other, world and spirituality.

### **The phase model of trauma intervention**

The three phase model of trauma intervention is also known as the consensus model, because many theorists, researchers and clinicians support this perspective. Bessel van der Kolk et al. (1996), Judith Herman (1992) and Christine Courtois (1999) are amongst leading trauma psychologists who have helped develop this model.

- Stage one: Safety and stabilization. This involves working toward internal and external safety, building a therapeutic alliance, understanding the impact of trauma and violence, self-care, sobriety, and developing resources to increase the ability to tolerate affect (emotion), self-soothe and improve self-esteem. Survivors begin to make connections and learn skills for managing their symptoms.
- Stage two: Once safety and stabilization have been achieved, this is the time to address the deeper impact of trauma by processing and integrating the traumatic experiences. This is a time of grief and mourning (Herman 1992), deconstructing negative beliefs (van der Kolk et al. 1996), developing positive schemas or beliefs (McCann and Pearlman 1990a) and addressing and intervening in post-traumatic symptoms (Briere 2002; Miller 1994).
- Stage three: Perhaps best stated by Judith Herman (1992), this is a time for reconnection with others and with "ordinary" life. In this stage, the counsellor is somewhat of a sounding board as the survivor practises new learnings and behaviours and builds new experiences.

### **The importance of neuroscience**

Traditionally, the brain belonged to science and the mind to psychiatry. The boundaries are blurring as neuroscience research shows that the fragmentation of self that occurs with trauma is reflected in stunted and narrowed firing patterns within the brain. New brain scanning technologies demonstrate that after treatment for trauma or depression, new parts of the brain start firing. Integration is biological as well as psychological.

### **The need for structure/boundaries**

Violence and abuse violate the boundaries of the body and the self, leaving a legacy of rigid boundaries that attempt to keep the survivor safe, or poor boundaries that leave the survivor open to revictimization. Sometimes survivors alternate between these two extremes. The counsellor's job is to set clear and appropriate boundaries that support the survivor in learning a new, more flexible way of being in relationship that allows both intimacy and autonomy.

### **Managing ambiguity**

Ambiguity is a constant companion in trauma counselling. Internally conflicted and fragmented, survivors are often at war with themselves. If the counsellor allies with one aspect of this conflict—perhaps the aspect she is most comfortable with or the aspect that seems to represent the most positive perspective—the survivor no longer feels that all aspects of her are valuable.

Another place where ambiguity emerges is in the domain of memory, particularly in survivors of chronic early abuse. Although a survivor may ask the counsellor to believe her story, this might mask her own inner uncertainty. For example, Dalenberg (2000) describes how the question “Do you believe me?” could have different underlying needs. It could mean “Do you care about me?” or “I’m not sure if I believe this myself” or “Do you really think I’m crazy?”

### **Understanding and managing the counselling relationship**

Survivors of violence carry unmet needs and damaged schemas in the relational areas of safety, trust, intimacy, esteem and control (Pearlman and Saakvitne 1995). They often experience intense attachment conflicts and bring an intense life and death quality to the therapeutic transference (Herman 1992). They often engage in unconscious re-enactments of the trauma, ways of “remembering, knowing, communicating, or integrating through reliving” (Pearlman and Saakvitne 1995, 44). In these re-enactments, counsellor and survivor can rotate through roles of perpetrator, victim, rescuer and bystander.

In addition to complex dynamics of transference and counter-transference, survivors attempt to manage their intrusive symptoms through behaviours often hard for helpers to witness: dissociation, self-injury, suicide attempts or addictions. It is imperative that the counsellor understand the relational dynamics that may emerge in counselling and possess the required skills to respond.

### **Trauma and attachment**

In recent years, trauma clinicians increasingly have appreciated the role of attachment and child development. The interplay between attachment and trauma is critical to

assessing and responding to survivors of childhood abuse, as is understanding attachment patterns and issues for adult victims of violence.

Barach (1991) suggests that the development of dissociative identity disorder is the result of profound attachment problems complicated by acts of abuse. The combination of trauma and disorganized attachment (in which frightened, frightening, disorienting or dissociated parent behaviours lead to chaotic, erratic and conflicted child responses to caregivers) is a “double whammy” (Liotti 1992). Attachment and trauma require equal attention.

### **Traumatic memory**

Understandings of memory have evolved over the past hundred years into a current appreciation for the complexity of how memory functions in both the brain and the psyche. Research validates that trauma can result in memory loss (for example, the longitudinal study of Williams (1995), who sought out adults hospitalized for sexual assault as children). Traumatic amnesia is real, although the mechanisms of how memory retreats and returns remain the subject of much research and debate.

However, there is now general agreement that memory is a “process, not an event, and is imperfect and fallible . . . a corollary principle is that memory is dynamic and fluid rather than static . . . Traumatic memory, like normal memory, is reconstructive, subject to error and influenced by conditions of memory retrieval” (Courtois 1999). This is tricky and complex territory. The counsellor is required to have both knowledge about memory and the ability to manage her own reactions.

### **Challenges in trauma counselling**

“Because the tasks of the first stage of recovery are arduous and demanding, patient and therapist alike frequently try to bypass them. It is often tempting to overlook the requirement of safety and to rush headlong into the later stages of therapeutic work. Though the single most common therapeutic error is avoidance of the traumatic material, probably the second most common error is premature or precipitate engagement in exploratory work, without sufficient attention to the tasks of establishing safety and securing a therapeutic alliance” (Herman 1992). Going too fast puts the therapist in the role of perpetrator, pushing past boundaries. Going too slow puts the therapist in the role of passive bystander who sees, but says nothing.

One of the central challenges is the impact of bearing witness on the self of the counsellor. McCann and Pearlman (1990b) first pioneered the concept of vicarious traumatization. It is now accepted that trauma counsellors can expect intrusive symptoms similar to post-traumatic stress reactions, as well as changes in their world views, spirituality and beliefs about themselves.

## 2.3 Integrating Feminist and Trauma Counselling

The roots of current trauma psychology and feminist interventions with survivors of family violence and abuse are interwoven. The women's movement of the 1960s and 1970s opened society's eyes to women's experiences of violence and violation within the family and on the streets. Rape crisis centres and transition houses began to identify the dynamics and consequences of violence. Hartman and Burgess (1988) described acute and long-term stages of rape trauma syndrome. At the same time, traumatized Vietnam veterans in the United States were beginning to talk to each other and name the post-war traumatic symptoms they experienced. Victims generally began to speak out loud and these different strands, working separately, slowly began to identify similar dynamics. This came together in the 1980 inclusion of PTSD (post-traumatic stress disorder) in the Diagnostic and Statistical Manual-III (DSM-III). This was the first time real events (traumatic experiences) were taken into consideration in a psychiatric diagnosis. Since then, there has been much cross-fertilization of ideas and interventions, although some differences in opinion and practice remain.

### **Feminist and trauma counselling: Areas of similarity**

- The survivors' symptoms, experiences and behaviours are not pathological, but, rather, the outcomes of victimization. These symptoms and behaviours came into existence for the positive purpose of psychic and physical survival.
- Both models support the empowerment of survivors in the following ways.
  - Prioritizing safety (inner and outer);
  - Normalizing symptoms as understandable responses to overwhelming events, and working with survivors to regain control over their lives and symptoms;
  - Appreciating the empowering nature of information and of psychosocial educational interventions;
  - Valuing the role of witness;
  - Stressing the importance of building circles of support and connection, and the healing aspects of joining groups with others who have similar experiences;
  - Finding, valuing and expressing survivor voices that have been silenced; and

- Taking a strong position that the victim did not deserve the violence and that the victim is not responsible for the violence.

### **Feminist and trauma counselling: Points of difference**

- Feminist perspectives are more likely to emphasize the systemic oppression of gender, as well as other variables such as age, class, race, sexuality and poverty. The notion of trauma is expanded beyond the individual victim to view the ongoing suffering and humiliation of oppressed groups as traumatic. Feminists are sensitive to the ways in which the systemic roots of violence are invisible. For example, some feminist writers are alarmed by the gender-neutral terms of “domestic violence” or “family violence” that have replaced “battered women,” and the concurrent disappearance of the analysis of power and gender. Trauma practitioners, although not blind to the wide sweep of violent injustice, tend to respond from a humanitarian desire to help without the insight of a political/systemic analysis of violence.
- Although many feminists were part of the struggle for the successful inclusion of the PTSD diagnosis in the DSM-III in 1980, others felt uneasy by what is still a psychiatric diagnosis. Anti-psychiatry feminist activists and therapists, such as Burstow (2003), view institutional psychiatry as a regime of ruling. “Having invented the concept of ‘mental disorder’ and broken it down into distinct diagnostic categories, psychiatrists impose the categories on vulnerable others, while studying those others and calling the result ‘knowledge.’” Burstow would like to dump language such as “recovery,” “symptoms,” “diagnosis” and “PTSD.” Although many trauma clinicians (including psychologists and psychiatrists) also critique psychiatry for its failure to listen to what victims are trying to say, they are also much more likely to have training in this system.
- As a result, some feminist counsellors employ PTSD and dissociative diagnoses as ways to normalize client symptoms, while others do not. Generally, feminist counsellors are uncomfortable and unfamiliar with diagnostic DSM-IV-TR terminology, often feeling disempowered by the psychiatric system and wanting to avoid it entirely. Building alliances between those working within the medical and social service systems and those working in women’s services is often fraught with suspicion. STV counsellors have tremendous difficulty finding allies within the psychological, medical and psychiatric communities. (It must be said that many trauma model-oriented psychologists and psychiatrists also face peer rejection, and experience frustration about finding supportive teams to provide comprehensive treatment.)

- Similarly, feminist counsellors have varying opinions about the use of psychiatric medications; some are concerned that medication may be used instead of counselling. In addition, many survivors are inappropriately prescribed too many medications and have experienced the psychiatric system as damaging. In the trauma model—especially with the growth of neuroscience—medications may be viewed as helpful and are often utilized as part of the stage one stabilization process. This model says that medications, if used properly, enable survivors to find enough solid ground from which to engage in counselling.
- Current feminist approaches tend to support the trauma approach that survivors need strong and clear structures, boundaries and frameworks. However, this can sometimes appear to be in conflict with the principle of women setting the counselling agenda and maintaining control over their counselling.
- The crisis nature of much STV counselling work, and the practice of a primarily subjective and conversational approach to assessment, can look very different from the trauma model’s emphasis on the need for extensive assessment, particularly before entering the second stage of recovery.
- Questions of responsibility and accountability can differ somewhat. While both feminist and trauma intervention models identify the offender as carrying responsibility for the violence, subtle differences regarding the victim’s responsibility for choices in the past and present may exist. Historically, the women’s movement has sometimes excused women’s use of violence and not acknowledged the degree to which men, too, are wounded by male violence. The trauma model, on the other hand, has often not managed to incorporate ideas of social oppression into understanding offending behaviours and developing appropriate interventions.
- Counsellors working within women’s services such as STV Counselling Programs offer safety and refuge to women and their children. Feminists fought hard to create places of safety and refuge for women fleeing violence. However, the insulation of these services also poses the risk of isolation and resistance to innovative ideas. These much battled-for essential programs can limit exposure to innovative ideas in the trauma field about working with families or couples in a manner that still supports feminist values and ensures safety for women and their children.

Goldnor (1998), for example, argues for innovation and inclusion of multiple approaches and voices to the grave problem of family violence, including joint

counselling for carefully screened couples. Clearly, STV counsellors will not be delivering couples counselling, but there is much to learn from understanding creative approaches that maintain the bottom line of safety, accountability and equity. Non-feminist counsellors often need to improve their “bottom line” and feminist counsellors need to consider a wide range of interventions.

- Although new understandings about the fluidity and construction of memory help counsellors respond to issues of traumatic memory, there is still tension between the feminist “need to believe” and finding an empowering practice around memory, doubt and trauma.
- Some feminist relational theorists emphasize that connectivity between people is the goal, criticizing models that prioritize intra-psychic fragmentation. Addressing internal disconnection is central to the trauma paradigm, yet trauma counsellors also understand the counselling relationship is critically important, as is supporting survivors to build or rebuild supportive relationships in their lives. The tension lies in whether the relationship is the central work or whether building relationship is a precursor to the “real” work of addressing violence and trauma.

## **2.4 Integrated Feminist and Trauma Model Best Practices**

### **Introduction**

The authors believe that none of the tensions between the feminist and trauma models are irreconcilable. Whichever side a particular counsellor leans toward, the space in between is one of important dialogue. Feminist practice reminds the trauma field that services cannot be separate from an exploration of the root causes of violence. Feminist theory and practice can support STV Counselling Programs from becoming overly professionalized and mainstream. At the same time, trauma psychology offers a broad range of understandings and tools that can help build strength and safety and support women to resolve the consequences of violence.

Danger resides in delivering services (both at the individual counsellor and agency levels) to victimized women without understanding the nature of this debate. We hope that STV Counselling Programs can take the best core practices of the trauma model (which the women’s movement has played a significant role in creating) while maintaining and integrating a critical analysis of power relations in society. We hope that, in the midst of the tremendous stresses and difficulties of service delivery, and despite the isolation of so many counsellors, invigorated debate on these issues can thrive and continue.

This section identifies best practices in 10 central areas of an integrated feminist/trauma approach to counselling women survivors of violence. An integrated model links the trauma understanding of the shattered self with the feminist emphasis on finding voice. The feminist approach highlights the systemic nature of oppression that underlies trauma, while the trauma model draws in biological understandings to support healing and recovery. The feminist anti-psychiatry stance mediates the trauma model's location within mainstream psychological and psychiatric institutions.

The best practices begin with those related to the broad context of the work: 1) applying systemic analysis and building community supports, and 2) diversity and oppression. The next sections refer to the initial tasks of counselling: 3) creating a safe relationship within a safe framework, 4) stage one interventions and 5) attachment and relationships. Responding to general trauma reactions is next: 6) post-traumatic stress reactions, 7) dissociation, 8) memory and 9) stage two and three interventions. Finally, a summary of best practices for training is provided (10).

#### **2.4.1 Applying systemic analysis and building community supports**

Feminist perspectives on power and oppression guide your assessments of family and social context, and help you develop a hypothesis for planning and intervention. “Radical trauma practice is necessarily based on an awareness of the centrality of oppression in the traumatizing of human beings, communities and the earth itself. It is also based on compassion and respect for traumatized individuals and communities: their history, their strengths, their naming, their conundrums, their choices” (Burstow 2003).

A systemic analysis leads to a commitment to providing services that bridge difference and challenge oppression. Here are some strategies that can support you to integrate systemic and community issues into your counselling in the best possible way. These best practices begin with what you can do in your individual sessions, and then make recommendations that go beyond the counselling relationship.

We understand that your commitment to individual women makes it difficult to find time to participate in activities for change as well. Our intention is to encourage you to think systemically about your counselling work, and to act in wider circles when possible. STV counsellors are well-situated to participate in building good community supports for women victims of violence. Effective client advocacy, outreach to communities seeking equity and prevention programs all can lead toward building stronger community systems that value safety for all members.

- Begin from a place of challenging your own response to violence and appreciating that anti-violence work means being for human rights and justice for all people.

- Use a wide definition of culture. The American National Association for Social Work's *NASW Standards for Cultural Competence in Social Work Practice* (2001) defines culture as “the integrated pattern of human behaviour that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious or social group. Culture is often referred to as the totality of ways being passed on from generation to generation. The term culture includes ways in which people with disabilities or people from various religious backgrounds or people who are gay, lesbian or transgender experience the world around them.”
- You can bring systemic issues alive with a client by gently exploring her personal trauma, the historical trauma in her family and the trauma in her community. Look for interconnections between these traumatic experiences and engage in a questioning dialogue that can support your client to find her own understanding of these links. Sharing your analysis with the client is the least useful way forward—better that your thoughts guide rather than lead the conversation.
- Stay alert to the entire continuum of trauma experiences, inviting your client to see herself on this continuum rather than on the other side of a great divide that somehow separates the survivor from the rest of us—while still acknowledging the truth that not all traumatizations are equal (Burstow 2003).
- Make sure that your assessments include explorations and tools that help you and your client identify and explore the dynamics and intersections of personal, family and social oppressions.
- You need to balance the work of repairing the victim's shattered inner world with repairing her fragmented interpersonal world. Shifting your focus from the individual self to the client's relationship to the world can be very helpful. Support her involvement in activities such as support groups, community memorials, shared art projects, political action, reconnecting with nature and grief rituals. Work together with your client to ensure that these activities are appropriate to the stage of healing and the focus of counselling.
- Be a good advocate for an individual woman's needs. This grows out of your systemic analysis of how society is structured. Avoid advocacy that rescues, and thereby demeans. “Relationships based on rescuing are power-structured and create inequality and hierarchies between potential equals. These relationships ultimately support oppressive social systems” (Arizona Coalition Against Domestic Violence 2000). The Arizona Coalition's *Best Practices Manual* suggests giving up advocacy that is:

- Aggressive—taking over and doing everything for the woman;
  - “Smile and be nice”—playing up to your agency contacts to get what the woman needs. Both of these are entrapping, especially as workers in other agencies would rather work with advocates than with the women themselves;
  - Passive, surrendering advocacy—this happens when the helper/counsellor is intimidated, lacks confidence and acts in a way that gives up power; and
  - Do-gooder, bleeding heart advocacy—based on a “poor thing” attitude. Smacks of class bias disguised as sympathy.
- Stand in solidarity with victims of violence. Post information on anti-violence events in your counselling space. Demonstrations and actions provide an affirming venue for clients to reconnect to their community and they appreciate knowing their counsellor is involved at that level.
  - Educate for change at a systemic level. Expand the circle of communities to whom services are delivered. Remember that advocacy and activism keep you connected to the big picture. This helps to prevent the burnout that comes when service delivery becomes isolated and disconnected. Find your own voice and a way to articulate what you know without betraying confidentiality.
  - Work with other STV counsellors and programs to develop community connections, outreach and prevention programs, and to identify ways to build alliances with marginalized and/or silenced communities.
  - Continue to deepen your understanding of how violence against women and children is connected to other manifestations of violence in our society, such as war and assaults on the environment.
  - Consider how wraparound approaches can be adapted to family violence situations. Wraparound is an integrated system of care that involves children, families and communities in planning support and treatment that reduce risks to children and families. Wraparound stresses community commitment; a child-centred and family-focused approach; a focus on safety first; individualized and culturally competent plans and interventions; a strength-based approach; a partnership between youth, family and professionals; community collaboration; and social networks.

## Resources

Bloom, S. and M. Reichert. 1998. *Bearing witness: Violence and collective responsibility*. Binghamton, NY: The Haworth Press. This book argues that we live in “trauma-organized systems” in which “trauma and its immediate and long-term effects have become a central organizing principle for our entire social structure.” The book provides multiple examples for prevention at all levels: primary (ending the cycle of violence), secondary (“containing the traumatic infection”) and tertiary (“fixing what is already broken”).

Herman, J. 1992. *Trauma and recovery*. New York: Basic Books. A passionate integration of feminist and political perspectives on trauma with one of the first descriptions of the phase-oriented approach. This book has stood the test of time. Radical feminist theorists such as Bonnie Burstow deeply appreciate Herman’s work while also viewing it as located within a psychiatric framework.

## Selected Web sites

[www.vroonvdb.com](http://www.vroonvdb.com) is a site that provides information about wraparound approaches. Although focused on supporting families with troubled youth, it offers an entry into comprehensive community response. Preliminary research (Peterson et al. 2004) suggests positive gains for children and families.

### 2.4.2 Diversity and oppression

The draft program standards for STV Counselling Programs (BCASVACP 1998a) state that the programs are committed to accessibility, with the intention of ensuring that services “are accessible and welcoming to all women, including those groups who face multiple barriers, such as Aboriginal women, women with disabilities, immigrant women, women of colour, lesbians, sex trade workers, elderly women, poor women and isolated women.” STV Counselling Programs and counsellors are committed to adapting the counselling process to the reality of marginalization so that it may better address an individual woman’s needs.

Gender is one system of oppression, amongst others. The domestic violence literature identifies two perspectives, and Sokoloff (2004) suggests that we need both. The first is the “race/gender/class” perspective that focuses on multiple and interlocking oppressions, and the second is a “structural” perspective that critiques systems of power and privilege. Both “difference,” including culture, and “structural inequality” must be addressed to understand women’s experiences. These interlocking oppressions—or intersectionality—in which no single dimension is privileged—i.e. gender and inequality works as an explanation of violence.

This quote from June Jordan (2004) will guide you well. “To attend to the cultural context of the therapy relationship is to recognize that therapy itself is a political act—one that has the potential either to reproduce the wounding disconnections of a power-over culture or to restore and enhance the capacity of each participant to co-create sustainable connections in the living world.”

- Commit and recommit to developing and deepening an analysis of intersectionality, which acknowledges that people live many layered identities. The stronger your commitment and understanding, the more able you will be to see the multiple dimensions of a woman’s experiences, and how inequities such as class and race form her perspective on the world.

We live in social contexts “created by the intersections of systems of power (e.g., race, class, gender, sexual orientation) and oppression (prejudice, class stratification, gender inequality, and heterosexist bias” (Bogard 1999, 276). Intersectionalities, then, Bogard goes on to say, colour the meaning and experience of violence, including how it is “experienced by self and responded to by others, how personal and social consequences are represented, and how and whether escape and safety can be obtained.”

- Intersectionality means that patriarchy differs across cultures and is viewed differently from different points within that culture. “In today’s world of increasing global migration, a cross-cultural understanding of patriarchy is important” (Ahmad et al. 2004).

Create an environment in which you and your client can participate in cultural conversation about patriarchy. Remember, these explorations are indirect and client-driven. Questions that explore patriarchal beliefs are very helpful. The questions that Ahmad et al. (2004) use in their research to scale patriarchal beliefs are examples of useful questions:

- Is it acceptable for a man to decide whether his wife or partner should work outside the home?
  - Is it acceptable for a man to decide whether his wife or partner should go out in the evening with her friends?
  - Is it acceptable for a man to have sex with his wife or partner even though she may not want to?
  - Is it acceptable for a man to decide how much money a woman can spend on herself?
- Expect that women from marginalized communities will have different attitudes and expectations of the criminal justice and social service systems, coming from their experiences of, for example, poverty, racism and oppression. These varying attitudes and expectations will extend to you and your program. Although it is difficult to be identified as an oppressor, it is essential that you

be willing to engage in conversation on these issues, and that you are alert to the truths in the client's perspective.

- Explore the strengths of the culture(s) a woman belongs to, and how those can be accessed to provide support and protection.
- You might want to learn how to construct “cultural genograms” (Hardy and Lazloffy 1995). A genogram is a graphic intergenerational description of a client's family of origin. A cultural genogram expands the genogram into issues of cultural pride and shame. This activity can create a structured environment for discussion of culture and race. The resources listed at the end of this section contain information on both approaches.
- Appreciate that “working with a client who is substantially different from ourselves inevitably evokes a range of emotional reactions...generated by uncertainty and anxiety about the unknown and about our ability to understand and relate to someone whose world view and life experiences may be at variance with our own” (Tuckwell 2003). You may experience a disconnection between your desire to “do it right” and your commitment to equality, on the one hand, and your conditioned responses to otherness on the other hand.
- Appreciate the common pitfalls of white therapists: patronizing the client who is of a different culture, being insensitive to the client's individuality (prejudging on the basis of stereotypical beliefs about the client's racial or cultural group) and disbelieving the client's stories of oppression (Tuckwell 2003). Tuckwell goes on to suggest that white counsellors need to ask themselves how they might be:
  - Blocked from exploring racial identity issues because of a lack of awareness of white identity;
  - Working from a narrow approach that leaves out racial factors;
  - Avoiding socio-political implications of race by focusing on psychological processes; or
  - Slipping into a socially conditioned posture of white superiority (overtly or covertly).
- Educate yourself about different cultures. Don't assume sameness. For example, a research study showed that four Asian communities (Vietnamese,

Cambodian, Korean and Chinese) each had unique cultures and immigration histories and, consequently, somewhat different attitudes toward family violence (Yoshika et al. 2001).

- At the same time, avoid cultural stereotypes. The best cross-cultural understanding comes not so much from knowing the details about a culture, as from a willingness to engage with the woman on these topics.
- Find a balance between sameness and difference. Sameness is about universality and our common need for wholeness and connection. Difference is about our uniqueness, our particular cultures and individual stories. You need to walk carefully between sameness and difference, honouring both.
- Don't let race, ethnicity, ability or any other form of difference between you and the woman in the room become invisible and unspoken. Ask the woman how her experience in these areas has impacted her experience of violence. Be curious and interested, but don't ask her to educate you.
- Work to create culturally competent and community-based alternatives for program delivery. These programs may need to be outside the traditional counselling set-up. When women-only services are not seen as helpful to some family oriented cultures, STV Counselling Programs can play a role in supporting the establishment of family programs that are strongly feminist and safety focused.
- To connect with women from diverse cultural backgrounds, it is important to move outward to where they are (Sharma 2001). Find programs and projects that are already doing this work effectively, and consider what might work in your local community.
- Consider setting up family-based programs, or partnering with reserve communities or multicultural, immigrant or refugee organizations that may already be doing this. One example is the "Cultural Context Model," which provides a wide range of services to the entire family. Full accountability is placed on abusers and, at the same time, both men and women attend "culture circles" in which they can discuss how structural factors may have influenced or shaped their choices in relationship to family violence (Sokoloff 2004).
- When working with immigrant and refugee women, you will need a working knowledge of immigration and refugee law and the resources available to women. Appreciate the powerlessness and isolation that comes with adapting to a new culture and situation. Sharma (2001) summarizes some of the issues facing immigrant and refugee women as:

- Fears about deportation and unfamiliarity with their rights;
  - Worries about child custody if they leave;
  - Loss of established way of life and support systems;
  - Reliance on violence amongst men who have come from countries where regimes have legitimized and used force for social control;
  - Linguistic problems; and
  - Strong values within some cultures regarding family and a commitment to protecting the family unit “contrary to feminist therapeutic interventions that focus exclusively on the battered woman and neglect her larger familial network” (1415).
- Canadian Aboriginal women have specific needs when seeking help with sexual violence. Any discussion of the needs of Aboriginal women must be couched in the context of history where the colonization process (the Indian Act, residential schools, etc.) eroded Aboriginal family, socio-economic, political and cultural structures. The impact of multiple generations of trauma can never be underestimated—it is, in large part, responsible for the high rates of sexual and physical assault within Aboriginal communities.

Although traditional Aboriginal cultures valued equality between men and women, Aboriginal cultures are not monotheist. Some are patriarchal and patrilineal; others matriarchal and matrilineal. Cultural and healing processes varied widely. Violence against women was not introduced by Euro-colonial contact, nor did matrilineal and matriarchal cultures necessarily preclude it (LaRocque 1996).

The Canadian Panel on Violence Against Women’s *Final Report: Aboriginal Women* (1993) tallied the barriers that Aboriginal women face when seeking service. Sadly, too little has changed. Obstacles identified include:

- Difficulty in naming the behaviour as abusive;
- Difficulty assessing oneself as “battered” or “abused” when violence has become normalized in a closed or isolated community;
- Fear of retaliation or being banned from the community;

- Fear of children being taken away (replicating the “Sixties Scoop” when numerous Aboriginal children were removed not only from their homes, but also their communities, and placed in foster or adoptive non-native homes). Although most provincial child welfare legislation urges that native children remain within the extended family and/or community, fear of losing children is very high;
- Fear of racist stereotypes and judgments;
- Family or community pressure to remain in the relationship, especially given the important role of the family and the family unit in the community;
- Loss of self-esteem because of the cumulative impact of colonization and residential schools;
- Geographic isolation, poverty or lack of housing options; and
- Loss of indigenous language while having, at the same time, constricted English vocabulary due to learning under traumatic conditions.

At the same time, however, it is important that STV counsellors not make generalizations about an Aboriginal woman’s needs and wants.

- Since family is the bedrock foundation of Aboriginal communities, some women will want to return to the batterers. If it is the choice of a woman to return to her partner, intervention must deal with the whole family—something that STV Counselling Programs are not set up to do.
- Do not assume that women will want to use cultural healing processes such as sweat lodges or pipe ceremonies. Some may not be attached to their culture. Others may have been abused by spiritual leaders in their communities and feel these processes are no longer safe (McEvoy and Daniluk 1995).
- While much consideration is given to alternative criminal justice programs such as sentencing circles, some women survivors value the symbolic role of punishment and the practical value of incarceration above cultural or neo-traditional approaches to justice (McGillivray and Comaskey 2000).
- Lesbian, bisexual and transgender (LBT) women experiencing violence in relationships have specific needs, and you will need specific understanding and skills to support them effectively. You must be committed to understanding the social context in which violence occurs in LBT women’s lives; appreciate

their fear that, by speaking out, they may betray or lose their LBT communities. Also appreciate the isolation and invisibility of many LBT relationships. You need to be clear about myths and stereotypes about these communities and feel comfortable talking about them and how they might have impacted your client.

Understand specific issues related to safety and disclosure. Ask yourself what an LBT woman risks by coming forward. What fears might she have that you will not understand her situation or make judgments? What safety resources can she access, and what sort of attitudes might she expect? Will the client be seeing her ex-partner in her community, and how will she handle that? What are the issues involving children?

The small and insular nature of LBT communities means that it can be very hard for individuals to avoid abusive ex-partners. This is intensified for LBT women who are of colour, immigrants or Aboriginal, as well as those in rural areas and small cities. It may be much easier for abusive partners to gather information and stalk their partners/ex-partners in small, insular communities. In a heterosexual and homophobic culture, there are a limited number of places that LBT people can go to socialize comfortably and openly. Your job, as always, is to support your client's safety and her right to make decisions that feel best to her.

In many cases, it may seem clear to you that one person is maintaining power and control over another; it may seem clear who is being abusive and who is being abused. However, in other cases, you may be confused. Be willing to grapple with the complexities of same-gender abuse. "Behaviours can be used in a variety of ways. Behaviour alone does not tell you enough about what is going on or what has happened in abusive same-gender relationships. It is important to look at the context. As well, explore the intent, effect and/or patterns in order to understand the behaviour. Some people in abusive same-sex/gender relationships have identified a pattern and/or cycle of abuse while others have described abuse happening less often, in a less predictable way" (Holmes 2005).

Despite complexities in power, it is important not to assume that the abuse is mutual. This can perpetuate a stereotype about same-gender relationship abuse: that because it is two women or two men, it is mutual, and not as dangerous or important.

The following suggestions (Holmes in press), helpful when counselling any survivor of violence, are particularly useful in facilitating a safe environment and mutual understanding with an LBT woman who has experienced relationship violence.

- Use open-ended sentences.
- Explore how the client views the situation.
- Help her to slow down the story, and encourage her to tell her story without leading her in a certain direction.
- Find out the events leading up to an incident: what she was feeling and thinking, who said what and who did what.

## Resources

American National Association for Social Work. 2001. *NASW standards for cultural competence in social work practice*. Washington, DC: NASW Press. Approved by NASW Board of Directors. [www.naswdc.org/practice/standards/NASWCulturalStandards.pdf](http://www.naswdc.org/practice/standards/NASWCulturalStandards.pdf). Standards focusing on values and ethics, self-awareness, cross-cultural knowledge, cross-cultural skills, service delivery, empowerment and advocacy, diverse workforce, professional education, language diversity and cross-cultural leadership.

Green, K. 1996. *Family violence in Aboriginal communities: An Aboriginal perspective*. Ottawa: National Clearinghouse on Family Violence. [www.phad-aspc.gc.ca/ncfv-cnivf/familyviolence/famvio\\_e.html](http://www.phad-aspc.gc.ca/ncfv-cnivf/familyviolence/famvio_e.html).

Hardy, K. and T. Lazloffy. 1995. "The cultural genogram: A key to training culturally competent family therapists." *Journal of marital and family therapy* 21: 227-237.

Holmes, C. 2005. "Assessment handout—Abuse in same-gender relationships." *Safe choices: Support and education program curriculum*. Vancouver: B.C. Association of Specialized Victim Assistance and Counselling Programs (BCASVACP).

Holmes, C. In press. "Appendix B: Safety assessment and planning for women in abusive same-gender relationships." In *Aid to safety assessment and Planning (ASAP)*. S. Agar. Vancouver: B.C. Institute Against Family Violence. This excellent resource explores the impact of homophobic stereotypes and myths about violence in lesbian relationships, explores important factors in assessing abusive lesbian relationship dynamics and provides guidelines for safety assessment and planning.

McEvoy, M. and J. Daniluk. 1995. "Wounds to the soul: The experiences of Aboriginal women survivors of sexual abuse." *Canadian psychology* 36:3. [www.findarticles.com/p/articles/mi\\_qa3711/is\\_199508/ai\\_n8726838](http://www.findarticles.com/p/articles/mi_qa3711/is_199508/ai_n8726838).

McGoldrick, M. and G. Gerson. 1985. *Genograms in family assessment*. New York: W.W. Norton. Everything you need to know about constructing a genogram.

Mirkin, M.P., ed. 1994. *Women in context: Toward a feminist reconstruction of psychotherapy*. New York: The Guilford Press. An edited book that includes articles by many leading feminist theorists and practitioners, all focusing on examining the context of women's lives in relation to class, race/ethnicity, gender, sexual orientation, age, etc.

Pacey, K. 2003. *Assisting immigrant and refugee women abused by their sponsors: A guide for service providers*, 2d ed. Vancouver: B.C. Institute Against Family Violence. A guide for service providers working with immigrant or refugee women; women in Canada under family class sponsorship;

women experiencing abuse by their sponsors; and women who want to separate from their sponsors but are at risk of deportation. For more information, contact [reception@bcifv.org](mailto:reception@bcifv.org).

Symington, A. 2004. "Intersectionality: A tool for gender and economic justice." *Facts & Issues* 9 (August). Toronto: The Association for Women's Rights in Development (AWID). [www.awid.org](http://www.awid.org). "This primer explains what intersectionality is, including its critical role in work for human rights and development, and suggests some different ways in which gender equality advocates can use it."

White, C. and J. Goldberg. In press. "Appendix C: Safety assessment and planning in abusive trans relationships." In *Aid to safety assessment and Planning* (ASAP). S. Agar. Vancouver: B.C. Institute Against Family Violence. Another excellent resource that explores the realities and myths of transgender individuals, how myths and stereotypes impact interventions with trans people, specific tactics of violence and control that may be perpetrated on trans people and guidelines for assessment and intervention.

### **Selected Web sites**

Aboriginal Canada Portal. [www.aboriginalcanada.gc.ca](http://www.aboriginalcanada.gc.ca). A Web portal that provides dozens of links to other Aboriginal organizations and issues.

Abuse Counselling & Treatment Inc. [www.actabuse.com](http://www.actabuse.com). Has specific pages on Asian, First Nations and Latina women's perspectives.

Indian Residential School Survivors Society (formerly the B.C. Residential School Project). [www.turtleisland.org](http://www.turtleisland.org).

National Aboriginal Circle Against Family Violence. [www.nacafv.ca](http://www.nacafv.ca).

Native Women's Association of Canada. [www.nwac-hq.org](http://www.nwac-hq.org). Wealth of information about issues facing indigenous women in Canada.

Ontario Women's Justice Network. [www/owjn.org/resource/margins.htm](http://www/owjn.org/resource/margins.htm). An annotated bibliography of resources for marginalized women. This excellent resource, containing resources for disabled women, Aboriginal women, immigrant and refugee women, women of colour, rural women, LBT women, incarcerated women and young women and girls, is reproduced in full in Section 7.17 of this Manual.

[www.rosenet-ca.org](http://www.rosenet-ca.org) is a Canadian Web site with resources on the law and abused immigrant women.

Turtle Island Native Network. [www.turtleisland.org](http://www.turtleisland.org). Has links to most other First Nations organizations and resources.

### **2.4.3 Creating a safe relationship within a safe framework**

The counselling relationship is key to successful outcomes. You and your client have a lot of work to do. Together, you must negotiate how you will communicate and interact. You must also explain clearly how you structure the counselling (guidelines, boundaries, limits, expectations, what happens and doesn't happen in and out of the counselling, etc.). This is often called the frame, and exactly what it looks like can vary. However, the chaotic and fragmented world of the survivor begins to relax when the frame is made explicit.

- You must have a working theoretical model as well as practical skills in identifying and responding to common dynamics in the counselling relationship. Two useful—and related—models are: 1) transference and counter-transference and 2) mutuality and connectivity. Both promote connection and integration, value the counselling relationship and stress the importance of the self of the counsellor.
- Counter-transference, originally a psychoanalytical concept, has been expanded by trauma intervenors to include all of the counsellor’s responses to the violent act, the survivor and the survivor’s behaviours. Traumatic transference includes the feelings, thoughts, hopes and fears that have grown out of the client’s experiences of violence and abuse, and that the client projects (transfers) to the counsellor. Together, transference and counter-transference provide a map for exploring intense and often overwhelming relationship dynamics, and for understanding how the trauma has affected the client’s way of being in a relationship.
- The relational model of connectivity was developed by the feminist theorists of the Stone Center, who see relationship as both the process and goal of human development. In this model, relationship is not the precursor to “the real work,” but the work itself. This model can push us to deeper places. “As long as the utilitarian value of relationship is emphasized, relationship becomes yet another resource or commodity that must be acquired or mastered if the person is to enjoy optimal health” (Walker 2004, 6). This challenges us to move beyond the need to have a relationship, to presence and being in relationship.
- Use the simple acronym RICH to remember the four most important things you can offer: respect, information, connection and hope (Saakvitne et al. 2000).
- Safety means different things to different people. You will need to discuss with your client what it means to her. Never assume it will match what you think. For example, to you, safety may mean giving up self-injuring behaviour, but to the client, safety may come from cutting because it helps avoid intolerable feelings and terrible memories. It’s important to define safety together. What does safety mean to her? Has she ever felt safe? What helps her feel safe? What would it be like to feel safe while working with you? (Saakvitne et al. 2000).
- Clarify structures, boundaries and limits. See Section 3 for best practices for creating written and verbal contracts with clients. Use this process of clarification to engage the client in open discussion. Be open to modifications.

“Clarifying the terms of the relationship with the client helps protect the client from destructive enactments of power” (Walker 2004).

Clients who expressed satisfaction with their counselling named five things that allowed them to recover from their abusive experiences.

- The therapeutic alliance;
- That their counsellors were aware of the power imbalance and did not abuse it. That the counsellors explained what they were doing, and why, and involved clients in the decision making;
- That watching the counsellors talk about, enforce and sometimes modify boundaries helped the clients learn how to do this in their own lives;
- That counsellors explained how these boundaries enhanced the client’s own well-being; and
- That the counsellors believed in the clients and expressed hope in the recovery journey (Barrett 2004).

Not incidentally, Barrett’s research also revealed that counsellors who developed and maintained secure boundaries also had the lowest levels of compassion fatigue and remained active counsellors for longer periods.

- Include a format for feedback. This could take the form of inviting the client every three or four sessions to let you know what is and is not working, any aspects of your relationship that she is finding uncomfortable or unhelpful, and what her most important goals are for the next sessions. Victims of violence generally do not feel safe to say what they need, and the hierarchical structure of counselling reinforces their silence. Once you have agreed on a feedback format, make sure you stick to it and don’t forget to make time. The client will not forget.
- Maintain the counselling framework once established. Any changes should be carefully scrutinized to see what power dynamics are involved and whose interests they serve. For example, when a boundary is changed (extra sessions, exchange of gifts, etc.), the relational-cultural approach would ask how this change serves connectivity and whether it moves the relationship toward shared power. Evaluating boundary-related practices through questions like the following is important (Walker and Rosen 2004).

- What is the potential impact of the practice on the client, the counsellor and the relationship?
- Will the behaviour move the relationship toward expanded connection, either by increasing the likelihood of empathic joining or by encouraging the client to embrace a challenge?
- How does the practice affect the therapist’s ability to be present to, and responsive in, relationship?
- Relationship best practice requires that you make a commitment to:
  - Provide the best witness possible, strive for genuineness and presence, acknowledge mistakes and self-disclose appropriately;
  - Identify and examine your own responses and reactions, such as rescuing and avoiding, that move the relationship away from connection;
  - View the client’s responses as opportunities to engage more deeply in the relationship; and
  - Separate the symbolic relationship (re-enactments of trauma and abuse) from the real relationship (what is happening in the here and now).
- The depth of your commitment to exploring the impact on yourself of providing witness to survivors also determines best practice. You should be familiar with concepts of vicarious traumatization and compassion fatigue. You engage in personal and professional growth through activities such as meditation, art, journalling, your own individual or group therapy, peer consultation and supervision. You take care of yourself, but never at the expense of the woman. You take care of yourself so that you can bring a full presence to the woman and not retreat behind your own defence structures. In summary, you successfully engage with the strong feelings, thoughts and imagery evoked by your work.

## Resources

- Dalenberg, C. 2000. *Countertransference and the treatment of trauma*. Washington, DC: American Psychological Association. A comprehensive look at counter-transference issues that includes the author’s own research on client perspectives on their therapists. Very readable and practical.
- Pearlman, L. and K. Saakvitne. 1995. *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: W.W. Norton. This classic text is indispensable for working with survivors. It includes, for example, chapters on setting the therapy

framework, dissociation in sessions and how to respond, and the relationship between vicarious trauma and counter-transference.

Saakvitne, K., S. Gamble, L. Pearlman and B.T. Lev. 2000. *Risking connection: A training curriculum for working with survivors of childhood abuse*. Baltimore: Sidran Press. Designed for agencies providing a range of services, it is an accessible and comprehensive curriculum with sections on understanding and responding to survivors, and a strong focus on connection and relationship.

Walker, M. and W. Rosen. 2004. *How connections heal: Stories from relational-cultural therapy*. New York: The Guilford Press. An edited book that summarizes some of the ideas of this approach and applies them to a broad range of situations through detailed case explorations. This is a therapy committed to active exploration of socio-economic variables such as race/ethnicity, sexual orientation, class, etc.

Ziegler, M. and M. McEvoy. 2000. "Hazardous terrain: Countertransference reactions in trauma groups." In *Group psychotherapy for psychological trauma*, 116-137, edited by R. Klein and V. Schermer. New York: The Guilford Press. [www.psybc.com/pdfs/Hazardous.pdf](http://www.psybc.com/pdfs/Hazardous.pdf). A review of the literature and themes related to relationships in trauma groups, combined with journal reflections on the authors' experiences of co-facilitating groups for survivors.

#### **2.4.4 Stage one interventions**

Most STV counselling takes place in stage one. Women with multiple traumas, oppressions and barriers will likely still be working on stage one at the end of a year of counselling. Women with single traumas, strong attachment histories and strong senses of self spend less time in stage one.

- You should be competent in the skills that embody best practices for stage one. All of the following skills are expanded on elsewhere in this section or in the Manual.
  - Establishing goals for counselling;
  - Managing crisis and planning for safety;
  - Assessment;
  - Supporting a client with substance use issues in achieving harm reduction or sobriety;
  - Supporting the client to develop a range of skills for managing violence-related symptoms and behaviours, such as intrusive memory and self-injurious behaviours;
  - Developing self-caring and self-soothing routines;

- Building the ability to tolerate painful feelings (affect tolerance);
  - Containment;
  - Developing a strong and therapeutic alliance, including clarifying the rights and responsibilities of both client and counsellor;
  - Establishing (and maintaining) the frame for counselling;
  - Creating safety in the counselling relationship by committing to move toward equalization of power, honesty and clarity of expectations and counselling boundaries;
  - Psychosocial education about trauma, violence and victimization; and
  - Developing additional life supports.
- Safety comes first. Your safety assessments will be relevant to the situation, as well as to the program and your skills. You need to assess for internal safety, including self-harming and suicidal behaviours. External assessments are also important. This includes identifying and assessing verbal threats, threatening behaviours, stalking and lethality. Safety assessments also focus on social situations such as poverty, housing, etc. See Section 4 for detailed information on assessment best practices, including assessing for suicide and self-injury.
  - When a woman is using substances, recognize this as a method of coping. Stage one self-care skills can support a woman to find alternatives to drugs and alcohol, as well as incorporate a harm reduction approach. It must be understood, however, that counselling related to violence and trauma requires sobriety for the client who has had substance use issues. See Section 5.1 on substance abuse.
  - Phase-oriented approaches are guides to intervention. There will be times when it will be impossible to avoid dealing directly with the traumas, but your job is to return to the principles of stage one as soon as possible. In stage one, a woman's experiences of violence are not solicited in detail. Go into the painful memory or story only to the degree that is necessary to provide safety. This includes safety in the relationship: you must be clear about why you do not want to hear more at this time. Let her know you are willing to hear more as she feels safer in the relationship with you. Exposure too early is retraumatizing.

You must explain “in some detail the rationale for not plunging immediately into the traumatic content; simultaneously [you] must offer reassurance that this does not mean that [you] are unaware of or uncaring about the patient’s suffering. To the contrary. In order to prevent more distress, traumatic material is specifically not re-stimulated until the patient has some skills to be able to slow down and manage the powerful affects that get unleashed” (Courtois 1999).

- When the traumatic material or event must be addressed directly to assess immediate safety needs, or written or told to police or criminal justice representatives, you must be aware of the restimulating nature of this telling and provide adequate containment activities afterward.
- A strong focus on staying in the present is essential and must be encouraged from the beginning. A present orientation must be explained to clients. If a woman cannot speak of the trauma without dissociating or experiencing flashbacks, she does not have the ability to stay in the present. To retell in such a manner is retraumatizing.
- In crisis situations, the focus of the session or the phone call should be on safety and stabilization. Crisis interventions (other than those of immediate danger to the woman) should focus on teaching and supporting self-care skills. Avoid getting caught up in detailed and dramatic accounts of behaviours and events. Avoid giving advice.
- There is no timeline for stage one interventions. The length of stage one is “measured in terms of the mastery of skills and development of ego resources and personal stability, not time” (Courtois 1999).
- It is very helpful if you are able to explain the basics of the impact of trauma on the body and the brain to your clients, as simple explanations of neurobiology can be normative and reassuring. The resources listed at the end of this section can help you understand neurobiology enough to create a handout or explain to a client.
- Plan on a lengthy stage one when any of the following indicators are present (adapted from Leeds 1997).
  - A history of early neglect, abandonment or inadequate attachment to caregiver(s);
  - The client has difficulty in accurately naming and describing feelings;

- The client reports being, or is observed to be, easily flooded with feelings and is not able to identify the trigger(s);
  - At times of emotional distress, the client is unable to speak or articulate her thoughts;
  - Her accounts of stressful events are unclear or vague and self-critical;
  - She appears to have chronic low-grade depression although she doesn't report depression and sees this as a normal state;
  - She reads situations poorly and doesn't trust her own perceptions or feelings;
  - She lacks adult perspectives; or
  - She doesn't have the skills that enable her to have access to social and economic support.
- A woman who has been victimized but who has a strong sense of self can sometimes enter stage two directly, if the counsellor has appropriate training.

## Resources

- Banks, A. 2001. *Post-traumatic stress disorder: Relationships and brain chemistry*. Wellesley, MA: Jean Baker Miller Institute, Victims of Violence Program. A useful educational manual for both clients and counsellors that describes how violence changes brain chemistry and the role of medications.
- Cozolino, L. 2002. *The neuroscience of psychotherapy: Building and rebuilding the human brain*. New York: W.W. Norton. This is a thorough and readable overview of the interconnections between neuroscience and psychotherapy, including chapters on trauma.
- Haskell, L. 2003. *First stage trauma treatment: A guide for mental health professionals working with women*. Toronto: Centre for Addiction and Mental Health. A great resource for stage one work.
- Rosenbloom, D. and M.B. Williams. 1999. *Life after trauma: A workbook for healing*. New York: The Guilford Press. Designed as a self-help book, this is also a resource that clients and counsellors can work through together. It can also help organize the counselling. It is excellent for stage one work, containing chapters on understanding trauma, regaining safety, regaining control, thinking things through and valuing yourself and others.

### 2.4.5 Attachment and relationships

The feminist focus on relationship merges with the attachment literature to highlight the need to understand the significance and power of relationships. Disrupted, erratic and neglectful early childhood relationships can create dissociative patterns and behaviours in children, including significant memory loss.

Not all sexually abused children experience clinical levels of post-traumatic stress, but all experience relational trauma, which could be described as a disruption in a child's sense of trustworthiness, openness and clarity of family relationships, as well as the emotional turmoil, loyalty binds and dilemmas that follow (Sheinberg and Fraenkel 2001). All survivors of violence guard against future harm, typically approaching people with fear, distrust and often anger.

For survivors of early violence and betrayal within the family, there is a double wounding of trauma and attachment. A key to creating an effective counselling plan is an understanding of the childhood attachment experiences of an adult woman who has experienced violence within a relationship or from sexual assault.

You may see women who have been diagnosed as borderline personality disorder. We support the reframing of BPD as serious relational derailment due to early abuses within a dysfunctional family system (Laviola 2001). In this model, a child learns to disconnect. She denies her own psychological reality and sense of self in attempts to gain care-taking. In adulthood, she craves intimacy and expects abandonment, often leading to a suspicious and conflicted relationship with the counsellor.

- All of the best practices outlined in Section 2.4.3 will help you provide safe containment for a woman victim of violence who also has disrupted and damaged attachment experiences.
- Remember to find common goals. “Our goal is to create a collaborative relationship. The survivor’s goal, in contrast, is to protect himself or herself from the harm s/he expects from any relationship. The [common goal] is for the treatment relationship to be helpful and non-traumatizing” (Saakvitne et al. 2000).
- It is very helpful to have a working knowledge of current attachment research and theory, including the types of attachment (secure, avoidant, ambivalent, disorganized) and the implications of each for a client’s hopes and fears regarding the counselling relationship. Siegal (1999) provides a good summary.
- Developing a relationship with a client who has a BPD diagnosis, or who engages with you in a critical manner—pushing you away while demanding closeness—is very challenging. She may respond to you with tremendous need and equally great hostility about how you might have failed her. You must provide a steady consistency. Laviola’s (2001) model of helper as keeper clarifies your role in developing a relationship:
  - You are the keeper of the truth of the past, supporting a validating and

non-pathologizing understanding of the past, while also supporting a new model of relating in the present.

- You are the keeper of the ambivalence. You need to avoid getting knocked over or trapped in the intense feelings of need and fear that fill the room. Your job is to hold all the feelings.
- You are the keeper of safety; support only behaviours that lead to well-being. However, safety will be lost if the client feels shamed by your interventions.
- You are the keeper of the pace of healing. Hold onto your understanding of the phase model and the importance of stage one in the face of sometimes highly intense demands to process trauma.
- You have to help your clients learn the basic skills of negotiating relationships—first with you and then in other aspects of their lives. The ability both to negotiate relationship and regulate one’s internal process is not developed in isolation. Appreciate that attachment difficulties result in an inability to manage relationships successfully, reinforcing abandonment and distrust.
- Familiarity with at least one simple assessment tool, such as the Traumatic Antecedents Questionnaire (TAQ), to identify central attachment and relational themes assists in understanding the relational struggles of clients. See the resources listed below, as well as Section 4.

## Resources

- Laviola, M. 2001. “Challenges in defining the therapy relationship with women who are commonly diagnosed as borderline: A relational reframing.” *Women and therapy* 23(4): 31-41. A compassionate and useful exploration of building a relationship.
- Linehan, M. 1993a. *Cognitive-behavioral treatment of borderline personality disorder*. New York: The Guilford Press. Do not be put off by the BPD label. This manual, and the following, are in-depth and compassionate explorations of working with BPD.
- Linehan, M. 1993b. *Skills training manual for treating borderline personality disorder*. New York: The Guilford Press. Although this manual describes Linehan’s group treatment program to teach interpersonal effectiveness, emotion regulation, distress tolerance and mindfulness, the reader will find much to help negotiate individual work with BPD clients.
- Sheinberg, M. and P. Fraenkel. 2001. *The relational trauma of incest: A family-based approach to treatment*. New York: The Guilford Press. Although this book focuses on children and their families, it is invaluable for combining feminist approaches (power) and systemic approaches (loyalty) within families.

Siegel, D. 1999. *The developing mind: Toward a neurobiology of interpersonal experience*. New York: The Guilford Press. Chapter 3 focuses on attachment, providing a summary of attachment research and current understandings, and relates attachment to new neuroscience learning. It includes Main and Morgan's description of the disorganized and disoriented attachment behaviours seen in children exposed to frightening and/or frightened parents.

Van der Kolk, B. n.d. *The traumatic antecedents questionnaire*. Assessment tool. [www.traumacenter.org/assessment.html](http://www.traumacenter.org/assessment.html). A simple self-administered assessment tool gathering information about lifetime experience. See Section 4 for more information on this tool.

Ziegler, D. 2002. *Traumatic experience and the brain: A handbook for understanding and treating those traumatized as children*. Phoenix, AZ: Acacia Publishing. Ziegler's clinical expertise is working with children who have attachment difficulties.

#### **2.4.6 Post-traumatic stress reactions**

Not all victims become symptomatic. However, some form of post-traumatic adaptations is seen in many survivors of violence, whether one-time or chronic. It is safe to assume that most survivors of childhood abuse and neglect have developed some post-traumatic symptoms as well as dissociative strategies. (See Section 2.4.7 for more information about dissociation).

The post-traumatic stress response is a roller coaster of intrusive flashbacks, denial and numbing. Post-trauma response also includes compulsive re-exposure to trauma with the infliction of harm on self or others.

The post-trauma response lives in the body. "Although people with PTSD tend to deal with the environment through emotional constriction, their bodies continue to react to certain physical and emotional stimuli as if there were a continuing threat of annihilation; they suffer from hyper-vigilance, exaggerated startle response, and restlessness" (van der Kolk and McFarlane 1996, 13).

- It is important not to focus obsessively on this diagnosis. For example, a survivor who has "simple PTSD" as the result of a violent episode such as a sexual assault may be more likely to identify with depression, anxiety or uncontrolled anger (van der Kolk and McFarlane 1996). Four possible responses to trauma—post-traumatic stress disorder, dissociation, somatization and depression—have been described by Matsakis (1998).
- You should also be familiar with the ways in which the PTSD model does not account for the complexity of survivors with chronic histories of abuse, exploitation and attachment injuries. A more appropriate model with the suggested name of "complex post-traumatic stress disorder" has been proposed by Herman (1992). This model identifies the alterations in perceptions of self, perpetrator and others, as well as in systems of meaning and consciousness.

- Using the term “post-traumatic stress” or “post-traumatic stress reactions” provides validation without psychiatric labelling. However, familiarity with post-traumatic stress disorder (PTSD) as described in the DSM-IV-TR—the diagnostic manual of the American Psychiatric Association—is essential. (See Appendix 7.1) Understanding the formal diagnosis helps you advocate for women within the psychiatric system and helps prevent misdiagnosis. For some women, a psychiatric diagnosis grounded in real injury can be positive.
- Take the following steps:
  - Consider that your client might have post-traumatic stress reactions.
  - Do some basic assessment to determine if her symptoms fit into the category. This can be done both subjectively and through the use of objective self-reporting assessments. (See Section 4 for self-reporting assessment tools.)
  - If it appears that your client has post-trauma reactions, provide her with information about post-traumatic stress (through discussion and/or written material); discuss what the assessments suggest, and enter into a conversation about the usefulness of understanding symptoms within this framework. The conversation and the level of connectivity are at least as important as the information.
  - If your client does not appear to suffer in a significant way from this constellation of symptoms, do not ascribe it. If the client believes she has PTSD but you don’t think so, explore further to understand her adaptations and self-perceptions with the goal of coming, over time, to a shared understanding.
  - John Briere’s (2002) approach to working between the two poles of traumatic intrusion and avoidance is very helpful. Staying in the therapeutic window between overwhelming exposure and excessive avoidance is a core best practice. Stage one work widens the window, making stage two processing work more possible.
  - Undershooting the window (going too slow/staying too long in stage one) leads to consistent avoidance of traumatic material. It also results in over-focusing on support and validation with a client who could tolerate greater exposure to the trauma. There is no harm to the client, except a sense of frustration that she isn’t getting to the work she is ready for.
  - When you overshoot the window (go too fast/go too quickly to stage two),

too much focus on the violence/trauma can result in harm to a client. An overwhelmed client doesn't have enough time to integrate. She is unable to mobilize her defences, resulting in flooding, fragmentation, disorganized and incoherent thinking and more extreme dissociative strategies.

## Resources

Briere, J. 2000. *Inventory of altered self-capacities (IASC) and Traumatic stress inventory (TSI)*. Published tests. Odessa, FL: Psychological Assessment Resources, Inc. [www.parinc.com](http://www.parinc.com). See Section 4 for more information on these and other structured assessments to identify self- and relational capacities and traumatic and dissociative symptoms.

Briere, J. 2002. "Treating adult survivors of severe childhood abuse and neglect: Further development of the integrative model." In *The APSAC handbook on child maltreatment*, 2d ed., 1-25, edited by J.E. Myers, L. Berliner, J. Briere, C.T. Hendrix, T. Reid and C. Jenny. Newbury Park, CA: Sage Publications. This article clearly explains John Briere's model of working within the therapeutic window.

Matsakis, A. 1992. *I can't get over it: A handbook for trauma survivors*. Oakland: New Harbinger Publications. A good book for clients and counsellors to explore all aspects of PTSD.

Meichenbaum, D. 1994. *A clinical handbook/practical therapist manual: For assessing and treating adults with post-traumatic stress disorder*. Clearwater, FL: Institute Press. This practical book, working from a narrative approach, provides many questions that are useful in assessment and treatment.

Williams, M.B. and S. Poijula. 2002. *The PTSD workbook: Simple effective techniques for overcoming traumatic stress reactions*. Oakland: New Harbinger Publications. An outstanding client resource that is also helpful for counsellors.

### 2.4.7 Dissociation

Basically, dissociation is a compartmentalization of experience and mental process that results in some information not getting integrated with other information. This leads to a disconnection of one part of memory from other parts. The information has not disappeared or been forgotten; it is just not available.

Dissociation is connected to post-traumatic stress disorder. When victims dissociate or numb at the moment of the trauma, they are more likely to develop PTSD (Courtois 1999). Victims who dissociate when the violence is occurring often say things like "I was outside my body looking down," or "I felt numb—there was no pain at all," or "It was someone else going through that, not me."

Counsellors are immensely challenged by client dissociation. A high level of self-awareness and a deeply connected relationship provide the primary anchors for returning from dissociated states. Survivors learn to dissociate in response to external threats and overwhelming inner states. Within the counselling office, it is often a break in connection between client and counsellor that results in a flight into dissociation.

- An understanding of the continuum of dissociative experiences—from mild

daydreaming or spacing out to dissociative identity disorder, in which aspects of self are deeply hidden from each other—is important.

- Familiarity with the dissociative disorders in the DSM-IV-TR is important. (See Appendix 7.1) An understanding of the categories of dissociative amnesia, dissociative fugue, dissociative identity disorder, depersonalization disorder and dissociative disorder not otherwise specified (DDNOS) will help you support clients through the murky waters of the psychiatric system, and will help them understand more specifically how they cope with violence and abuse.
- Saakvitne et al. (2000) describe forms of dissociation that can appear in counselling settings:
  - Spacing out—with obvious changes in consciousness;
  - Flashbacks—when the survivor appears to be reliving a painful experience as if it was happening in the here and now; and
  - A change in identity, such as appearing very little or talking in a different voice, may signal that the client has dissociative identifiers.
- Saakvitne et al. go on to suggest the basic goals of crisis intervention are essential when clients are dissociating. Your job is to help the client separate the past from the present by constantly orienting her to the here and now, helping her to see her choices in the present moment and where she can regain control, helping her to be connected to safe people. This present orientation is also encouraged when clients can make connections between past experiences and present behaviours. You might say, for example:
  - “You’re here now, remembering what happened. It isn’t happening now. It’s in the past and it’s safe to remember it now.”
  - “Just look around the room and tell me what you see. What do you notice in my face? What do you imagine I’m feeling? What is it like to tell someone in the here and now about what happened to you in the past?”
- Once the client is back in the present, you need to explore together with her what triggers dissociation. Triggers are the sights, smells, sounds, interpersonal interactions and so on that remind the survivor of un-integrated experiences and information. Often survivors say: “I was here and then I was gone.” Encourage them to explore the in-between place: “Can you think back over what happened and tell me what was going on just before you went away?”

- Be positive when the client has difficulty identifying triggers and dissociative behaviours. Present this as a skill to be learned.
- After identifying the triggers, the most important thing to do is to work with your client to help her develop a sense of control. Teaching and practising frequent grounding are essential. You must be familiar and comfortable with a variety of ways of doing this. Examples are breathing, imagery and body awareness. Najavits (2002a) and Haskell (2003) are good resources for learning grounding practices.
- Do not collude with language that supports dissociation or fragmented views of the self. It is okay to acknowledge that people have “parts.” This is true for everyone. But resist language of personalities or language that supports or even encourages fragmentation. You must always support wholeness and an increasing toleration of complexity and ambiguity. Saakvitne et al. (2000, 118) offer the following reframes that support encouraging a less polarized and divided world:
  - “When a client says ‘either x or y’ we can offer ‘both x and y.’”
  - “When a client says ‘but,’ we can suggest ‘and.’”
  - “When a client says ‘always and never,’ we can ask about ‘usually and sometimes.’”
  - “When a client says ‘black or white,’ we can wonder about ‘gray.’”
- Over time, you need to discern the level of dissociation and how it impacts the client’s life. The Dissociative Experiences Scale (DES) assessment tool is a simple self-reporting activity that generates considerable information. A score over a certain threshold indicates dissociation that is significant and important to address in any counselling planning. See Section 4 for more detail.

## Resources

- Carlson, E. and F. Putnam. n.d. *Dissociative experiences scale (DES)*. Published test. The Sidran Institute. [www.sidran.org](http://www.sidran.org). See Section 4 of this Manual for more information.
- Haddock, D. 2001. *The dissociative identity sourcebook*. Chicago: Contemporary Books. Written from a client’s perspective, this book explains the intermingling of dissociative and post-traumatic symptoms. It covers a wide range of topics from the genesis of DID to exploring various treatment approaches.
- Najavits, L. 2002a. *Seeking safety: A treatment manual for PTSD and substance abuse*. New York: The Guilford Press.
- Saakvitne, K., S. Gamble, L. Pearlman and B.T. Lev. 2000. *Risking connection: A training curriculum for*

working with survivors of childhood abuse. Baltimore: Sidran Press. Section 4, “Working with dissociation,” is an excellent introduction.

Steinberg, M. and M. Schnall. 2001. *The stranger in the mirror: Dissociation—the hidden epidemic*. New York: Harper Collins. A comprehensive overview of the varying dissociative presentations. Includes case studies and suggestions for survivors.

The International Society for the Study of Dissociation publishes a quarterly journal, *The journal of trauma and dissociation*. More information can be found at [www.issd.org](http://www.issd.org).

### **2.4.8 Memory**

It is not possible to provide counselling to survivors of violence, particularly of childhood abuse, without an understanding of how memory functions. The feminist commitment to believing what women tell us must be balanced with current understandings that memory can be unreliable and even inaccurate. Trauma continues to be the most common source of post-traumatic and dissociative symptoms; however, it is important to remember that, occasionally, such symptoms can result from other circumstances (Chu and Bowman 2000).

The feminist model supports the necessity of always holding the systemic knowledge that violence and abuse—often unbelievably horrific—is a profound social reality. Refusing to fall into denial, feminist counsellors are advocates for individual survivors and for social change.

Counsellors must understand that memory can be lost and found. It is also true that specific memories can be distorted through developmental capacities at the time of the event, can represent similar events combined together and altered or can involve fantasy elements. Sometimes memories can be unconsciously embellished or created through vulnerability to suggestion. Sometimes personal history can be misrepresented to meet needs (Chu and Bowman 2000). Individuals who suffered severe and chronic trauma in early childhood may never know exactly what happened to them.

- It is essential that you have a basic understanding of memory so that you are able to provide basic education on this topic to your clients. This includes:
  - A basic understanding of the neurology of memory;
  - Understanding of the different types of memory; and
  - Understanding of the variety of memory disruptions across a person’s lifespan (ranging from a repeatedly abused child to a woman with total memory loss for the three days after a severe rape).
- It is useful to document baseline memories at the beginning of the session.

Focus on what women already know, rather than on what they suspect or are uncertain and confused about. See Appendix 7.10 for sample baseline questions about historical sexual abuse.

- At the same time, “one must stay firm in understanding one’s role: not as judge or jury, but as a resource to the client as s/he sorts out his or her beliefs and experiences. You do not need to (nor can you) corroborate the literal truth of a person’s historical experience in order to provide a supportive, empowering, therapeutic relationship. You do need to pay attention to your responses to the client and his or her material to understand what is happening in the treatment relationship” (Saakvitne et al. 2000).
- To maintain your role as a resource to the client, you need to stay technically neutral yet morally cognizant of the prevalence and possibility of abuse (Herman 1992). It is important not to ask leading or suggestive questions (that imply a certain answer). Questions should be open-ended rather than closed or directive. Keep an open mind about all possibilities!
- Often, you will have to accept not knowing what is true and not true. You will need to support clients with emerging images or sensations and, at the same time, become comfortable with not knowing exactly what they may mean. If you are comfortable with ambiguity, you will be able to help your clients to develop this ability.
- Do assessments that are as comprehensive as possible given the situation you are working in. Don’t ask questions only about abuse or violence, but strive for a broad picture of the client’s life. Check Section 4 for tools that can broaden the picture (such as the Traumatic Antecedents Questionnaire (TAQ) and genograms).
- Gently dissuade a client who brings an agenda of memory retrieval to counselling. This is NEVER a goal. Honour the woman’s search for truth, be interested in her story, encourage her to be curious about her own life and allow the possibility that memory might emerge, but don’t go searching.
- Do not assume that blanks in memory are related to repressed childhood abuse. Memory structures are developed in relation to many relational experiences such as neglect, insecure or disrupted attachments, or being raised by dissociated parents.
- Do not encourage women to confront their families or alleged perpetrators following newly found memories. The woman must have time to process and integrate this material, arriving eventually at a narrative that makes sense to her.

- You must resist the temptation to collude with clients either to dismiss or confabulate fragments of sensory or somatic memory.
- If recommending self-help books, articles or groups, make sure that these present a perspective on memory congruent with current best practice.
- Follow best practices in this Manual specifically related to 1) record-taking (see also the BCASVACP *Record Management Guidelines* (Ruebsaat and Porteous in press), 2) consultation and supervision and 3) not using techniques you are not trained for.

## Resources

- Courtois, C. 1999. *Recollections of sexual abuse: Treatment principles and guidelines*. New York: W.W. Norton. This is an essential resource. Courtois describes the evolving understanding of memory, the social context in which this has occurred and guidelines for clinical response. Her work is the basis for much of the above section.
- Dalenberg, C. 2000. *Countertransference and the treatment of trauma*. Washington, DC: American Psychological Association. Chapter 4, “Do you believe me?” deals with counter-transference responses to client doubt and reality-testing.
- The International Society for Traumatic Stress Studies (ISTSS). n.d. *Childhood trauma remembered: A report on the current scientific knowledge base and its application*. Northbrook, IL: ISTSS. Contact [istss@istss.org](mailto:istss@istss.org) for copies of this readable summary of scientific findings and their clinical applications.
- Van der Kolk, B. 1999. “The body keeps the score: Memory and the evolving psychobiology of traumatic stress.” In *Essential papers on PTSD*, edited by M. Horowitz. New York: University Press. [www.trauma-pages.com/vanderk4.htm](http://www.trauma-pages.com/vanderk4.htm).
- Whitfield, C. 1995. *Memory and abuse: Remembering and healing the effects of trauma*. Deerfield Beach, FL: Health Communications.

### 2.4.9 Stage two and stage three counselling interventions

Stage two interventions are about processing the violent experiences and memories in order to integrate them into experience, and to be able to create a coherent narrative of events.

Stage three interventions focus on reconnecting and reintegrating the client into everyday life. Having come to terms with the traumas, which are now part of the past and no longer tormenting her in the present, she practises engagement with life from a new and integrated place.

- The goal of stage two is “to gradually face and make sense of the abuse/trauma at a pace that is safe, manageable, and not overwhelming” (Courtois 1999). You don’t want to strive for high intensity remembering, but, rather, to

reintegrate split-off aspects of the self slowly, so that your client can feel more whole and become free of symptoms in a way that allows for meaningful participation in life.

- You need to spend considerable time informing and preparing clients for stage two activities; provide information about the reason for such activities, the particular methods you will be using and what she might expect to experience, as well as your training and experience in these techniques. Informed consent is essential. The client must be encouraged to voice reservations and hold a “stop” veto power.
- Client reservations and reluctance about particular techniques or about trauma processing in general must be respected. No client should ever be pressured to participate in a particular technique. Many individuals feel satisfied through stage one activities and are not yet ready to engage in stage two. This must be respected, leaving the door open for the client to return if their symptoms return or increase, or if they decide that they need to enter this new stage to live more fully.
- The “law of thirds” for working with dissociative clients, suggested by Kluft (1993), will be helpful to you. The first third of the session is for checking in, following up and exploring the direction for this session. The second third is devoted to trauma processing. The final third is for ensuring stabilization and safety. This “law of thirds” is also an excellent practice to follow when structuring groups for survivors.
- Stage two work requires you to be able to hold the intensity of the client’s experiences, memories and emotions while maintaining a genuine and empathic witness. Much healing comes from re-experiencing the events differently: in the present with a trusted guide, no longer suffering alone. This can challenge you, and you need to be committed to working with your own relational understandings and to processing the impact of the sessions on yourself.
- In general, phase two tasks (as described by Harvey 1996) include:
  - Measured recall of the traumatic past (reworking, not reliving);
  - Separation of the past from the present;
  - Clarification of the impact of the past on the present;

- Integration of memory and affect;
  - Grieving;
  - Shifting perception of self from victim to survivor; and
  - Increasing the ability to modulate and tolerate affect.
- You need to make sure your interventions address all aspects of traumatic experiences: thoughts, feelings, sensations and behaviours.
  - Best practices for processing and integrating traumatic material require you to understand how trauma is held in the body and to incorporate at least some somatic and experiential methodology. This can include basic body awareness processes; creative processes such as art, writing or sand play; depth body-oriented psychotherapies for trauma such as bodydynamics or somatic experiencing; or controlled somatic reliving through flooding.

It is important that you understand that traumatic memory is stored in the body as well as in thoughts, memories and feelings. There is a general consensus in the trauma field that talk interventions are not enough to provide the comprehensive resolution that marks a successful stage two. Van der Kolk's (1999) classic article, "The body keeps the score," is a good beginning for understanding psychobiology.

Despite the importance of including a somatic component to counselling, best practice remains to stay within your competency. Better to build a healthy and productive talking relationship than to work beyond your ability and risk destabilizing the client's body functioning.

- Other interventions considered best practices are:
  - Marsha Linehan's (1993a, 1993b) dialectical behavioural therapy, highly effective with traumatized individuals suffering from serious attachment disruption;
  - EMDR (eye movement desensitization and reprocessing), an integrative model of trauma treatment that incorporates a model of bilateral stimulation;
  - Cognitive behavioural therapy (CBT); and

- Somatic experiencing and bodydynamics body therapies.
- The tasks of stage three, described by Harvey (1996) as moving beyond survivorship, include:
  - Moving through grief to making meaning of the past and acknowledging gains;
  - For some, taking action in ways that commemorate personal and collective victimization through memorializing activities, victim advocacy, helping other victims, etc. is essential;
  - Practising new ways of being in relationship, developing and strengthening attachments, holding appropriate boundaries and exploring intimacy;
  - Holding the violence and abuse as a memory, rather than as painful current reality;
  - Using the counselling as a feedback loop to explore and examine new behaviours and relationships; and
  - Evaluating the counselling together with the counsellor and moving toward separation.
- Your role is different in stage three. You are now a coach, supporting the client to try new behaviours, reach toward new goals and dreams and learn about intimacy. You support her as she experiments and then returns for discussion and feedback. You watch her embrace life.

## Resources

- Levine, P. 1997. *Waking the tiger: Healing trauma*. Berkeley, CA: North Atlantic Books.  
[www.traumahealing.com](http://www.traumahealing.com). Levine is the founder of somatic experiencing, an in-depth body psychotherapy.
- Ochberg, F. 1993. *Gift from within*. Counting method video available from the Justice Institute of B.C. Library.
- Rothschild, B. 2000. *The body remembers: The psychophysiology of trauma and trauma treatment*. New York: W.W. Norton.
- Shapiro, F. 2001. *Eye movement desensitization and reprocessing: Basic principles, protocols and procedures*. New York: The Guilford Press. [www.emdr.com](http://www.emdr.com).
- Van der Kolk, B. 1999. "The body keeps the score: Memory and the evolving psychobiology of traumatic stress." In *Essential papers on PTSD*, edited by M. Horowitz. New York: University Press. [www.traumacenter.org](http://www.traumacenter.org).

## Selected Web sites

Bodynamics. [www.bodydynamic.ca](http://www.bodydynamic.ca).

Sensorimotor Psychotherapy Institute. [www.sensorimotorpsychotherapy.org](http://www.sensorimotorpsychotherapy.org).

### **2.4.10 Adequate training, experience and supervision**

Regardless of whether you are providing short-term, mid-range or long-term support or counselling, a certain level of training and information is required. Familiarity with the core theories and practices of the feminist/trauma approach is essential for STV counsellors. The more training and supervised practice, the better equipped you will be to respond to a broad range of violence-related issues. You will also be less vulnerable to vicarious traumatization.

The draft program standards for STV Counselling Programs (BCASVACP 1998a) suggest that training standards include the participation of all agency members in anti-oppression education and workshops, and in educating themselves on the impact of trauma on the lives of women. The standards also stress self-awareness of biases and values, as these internal perspectives impact the counselling process.

Here are some additional best practices, coming out of the preceding sections.

- You need a strong background in the basics of supportive counselling, including core skills such as beginning and ending counselling, empathic listening, setting goals and directions and problem solving. Without solid core skills, it is impossible to provide effective support and counselling to survivors.
- In addition to familiarity with the feminist analysis of violence in the family and society, you need practice in translating this understanding of the dynamics of power into the counselling setting in a way that is not rhetorical or ideological.
- You require a current working knowledge of the dynamics of battering, sexual assault and childhood sexual and physical abuse.
- Memoirs and autobiographies are useful ways for counsellors to educate themselves about post-trauma responses. As each person is unique, one person's story does not illustrate all of the ways that survivors adapt to their trauma experiences. Nevertheless, it is a way into conversation, such as "I once read a memoir about XXX and that person said YYY; has that ever been your experience?" See the list of resources in Section 8.1 for a sampling of autobiographies the authors have found useful.

- A working understanding of the phase-oriented treatment of trauma and considerable experience and practice in stage one interventions are necessary. If you are providing long-term counselling, you must be trained in current effective models of working with all three stages of treatment.
- You need to have a clear understanding of how violence is experienced and the short-term and long-term consequences of violence, including post-traumatic responses and dissociation. You need basic skill training in assessing for the presence and severity of post-trauma symptoms.
- Training in assessment is essential, including safety and lethality assessments, suicide assessment and family history assessment, along with basic tools for identifying the impact and consequences of trauma.
- You need training in understanding how traumatic and non-traumatic memory works, and skill in communicating information about memory to the client.
- Basic training in the DSM-IV-TR and current psychotropic drugs used for trauma enables STV counsellors to be effective advocates for women within the system.
- You need to commit to ongoing work on the “self of the counsellor.” You must be willing to examine deeply your own history, biases, unmet needs, triggering events, etc. This is an essential component of finding your way through the transference/counter-transference maze.
- Ongoing support, consultation and/or supervision is the only route to doing this work successfully. We cannot reiterate enough what you already know: the work is hard and challenging. In its tremendous complexity, even the most skilled counsellor will doubt her direction and ability, and be unable to see clearly the way forward. It is easy to lose a sense of treatment direction or to feel overwhelmed by the desperate life circumstances and horrific abuse.
- Perhaps reading these best practices indicates there is an area that you are not very knowledgeable about; for example, neurobiology. Ask your supervisor to explain the basics and then pursue the topic with readings or workshops.
- A sample contract for supervision is in Appendix 7.19.

## SECTION THREE

# Ethical Best Practices

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Given the preceding discussion about the feminist and trauma models of counselling, certain principles emerge that can guide STV counsellors in the many ethical dilemmas this work entails. The STV counsellor has a number of responsibilities to provide ethical service. Think of these responsibilities as a cluster of interrelated principles, an interwoven web designed to support the counsellor. Ethical principles are not mere abstractions. Instead, they represent the living, dynamic engagement with the complexities of anti-violence work.

STV counsellors frequently encounter many ethical dilemmas. Some are smaller in scope: Should I accept this gift from my client? Some are everyday concerns, such as living in a small community and walking the tightrope of dual relationships. Others are huge: How do I honour my client's right to choose whether to live or die?

This section first identifies some models for ethical decision making. Then, best practices for ethical behaviour are discussed. Some ethical dilemmas are explored through the various lenses of the ethical decision-making models.

### **3.1 Models for Ethical Decision Making**

Given that ethics is a fluid concept, counsellors will repeatedly encounter situations that require ethical thinking. To that end, we offer three models of ethical decision making that support best practices.

#### **3.1.1 Model one: Laura Brown's ethical ladder**

Laura Brown (1994) introduced the concept of the ethical ladder. She invites feminist counsellors to become ethical thinkers rather than blindly applying rigid concepts of right and wrong. The ladder is a way of thinking about ethical decisions: Do they move us up the ladder toward an ethical practice, or do they move us down the ladder to places where we are at risk, perhaps for ethical violations? This notion can free us from internal judgments that we have done something good or bad and allow us to question our interventions. If we think we are sliding down the ladder, what can we do to stop that slide and begin to move upward? This allows for investigation, process and ambiguity.

“The function of ethical standards is not to create new hierarchies of value, new rules of right or wrong, of political correctness or deviance. Ethical standards exist as stimulants to the process of knowing, thinking, intuiting, and struggling towards actions that reflect feminist values of equality, empowerment and radical social change. The burden is on the feminist therapist to be an ethical activist rather than a passive recipient” (Brown 1994, 211).

This way of thinking challenges patriarchal notions of how we should behave. Feminist counsellors, like everyone else, often crave a set of rules that provide concrete direction. But creating new feminist rules simply reproduces sets of behaviours that feminism is committed to changing.

### **Case example: Boundaries**

All counsellors fail to maintain perfect boundaries (were there such a thing!). You can get over-involved and extend session time more than is necessary or helpful. You can be overly available at home, until you start drowning in resentment. You can fail, through words or behaviours, in your task of creating safety within the counselling setting. Often ashamed, you may try to justify your behaviour or even to blame the client. The ethical ladder invites you to ask yourself questions such as:

- What are the power dynamics in this situation?
- How has the power of my role inadvertently contributed to this problem?
- Are my needs being more privileged than the client’s?
- Is my need to “help” stronger than my judgment about what is in her best interests?
- What is my responsibility in re-establishing boundaries that are safe and supportive?
- Is consultation important to help me understand my own behaviour and the situation?
- Do my feelings about having broken boundaries in some ways keep me from seeking consultation?
- Is my reluctance to talk to anybody about this going to slide me down the ladder?

Brown (1994) suggests boundary violations have three characteristics:

- 1) Objectification of the client. “The client is no longer met as a human with unique needs and feelings, but instead becomes, temporarily or over a long time, an object for the satisfaction of the therapist’s needs” (216). Brown gives the example of needing positive feedback from a client.
- 2) Acting out or gratifying the counsellor’s impulses. “When I act impulsively,” Brown says, “I am privileging my own needs, be they to comfort a crying client, decrease my own feelings of ineffectiveness, reduce my frustration over a client’s residence on an emotional plateau, diminish real difference between myself and the person I am working with, or demonstrate my importance in their life” (217).
- 3) Excessively privilege the needs of the therapist. “When feminist therapists do not acknowledge their needs for recognition, power, and emotional and sexual intimacy in their peer relationships, they are at greater risk of making those needs important in the counselling context where they are in the dominant position” (218).

### **3.1.2 Model two: Kitchener’s five moral principles**

Kitchener (1984) wrote the classic on ethical decision making in counselling settings. She described five moral principles that should guide decisions:

- 1) Autonomy—allowing an individual freedom of choice;
- 2) Non-maleficence—do no harm;
- 3) Beneficence—contribute to the client’s welfare;
- 4) Justice—people should be treated equally unless there are compelling reasons; and
- 5) Fidelity—notions of loyalty, faithfulness and honouring commitments.

She then took these principles and created the ABCDE strategy for making decisions:

- **Assessment:** Identify the situation, the client’s status and resources, the counsellor’s values and feelings and the laws;
- **Benefit:** Determine what benefits the client, the counselling relationship and significant others. Different benefits may exist with different solutions;

- Consequences and consultation: Consider ethical, legal, emotional and therapeutic consequences that could occur from possible actions. Consult, consult, consult;
- Duty: Consider to whom duty exists; and
- Education: Review cases to determine what can be learned about appropriate actions and use this information with similar ethical dilemmas.

### **3.1.3 Model three: Hill et al.'s focus on the decision makers**

Some feminist theorists suggest that the problem with mainstream models of ethical decision making is that they diminish the role of the persons making the decision, most notably the counsellor and her clinical consultant (see the model depicted at the end of this section from Hill et al. 1995). They suggest that the counsellor's own personal reactions can provide valuable insight. Further, they acknowledge that the power held by the clinical consultant may subtly influence the counsellor's decision(s).

#### **Case example: A too challenging client**

As is so often the case, it has only recently become apparent that your client is highly dissociative. This is not an area in which you have much training or experience. Using the Hill model, you take your concerns to your supervisor. You explain your sense of unease that, due to your lack of training in this area, you might make a serious mistake. However, there are not many other places to refer this client. In addition, your client is very attached to you and looks forward to sessions with you. You worry that, no matter what decision you make, your client may suffer.

In the Hill model, an important factor is the person with whom you talk this situation over, since this may affect the outcome. Suppose you discuss your concern with your program manager or executive director. Dissociative clients are usually well beyond the STV Counselling Program mandate of mid-range counselling. Dissociative clients certainly require lengthy service of three to five years, minimum. The program manager may consider other—potentially unacknowledged—factors, such as the wait-list, when considering whether to continue providing service to this client. If you take your concerns about this client to an independent clinical consultant, different variables might get weighed.

It is entirely possible that, after much conversation, you, the clinical consultant and the program manager may agree about the best course of action. Hill's point is that the role (and power associated with the role) of the program manager or the clinical consultant is an important element that might influence you as you make your decision.

Table 1. Feminist Ethical Decision-Making Model

Rational–evaluative process	Feeling–intuitive process
<u>Recognizing a problem</u>	
Information from therapist's knowledge; advice from supervisor or colleague	Uncertainty about how to proceed in situation
	Identify what stands in the way of working through the problem: feelings about the nature of the issue, feelings about the consultant or about asking for help
(Decision to consult may occur here)	
<u>Defining the problem</u>	
What is the conflict? Who are the players? What are the relevant standards? (rules, codes, principles)	What else is my discomfort about? What do my feelings tell me about the situation? What am I worried about?
What personal characteristics and cultural values do I bring to this decision? How do these factors influence my definition of the problem?	
How does the client define the problem?	What are the client's feelings about the dilemma?
(Decision to consult may occur here)	
What personal characteristics, values does the consultant bring to this process?	How do the consultant's characteristics affect me?
<u>Developing solutions</u>	
Brainstorm possibilities Cost–benefit analysis Prioritize values	What do my reactions to each choice tell me?
<u>Choosing a solution</u>	
What is the best fit both emotionally and rationally? Does this solution meet everyone's needs, including mine? Can I implement and live with the effects?	
<u>Reviewing process</u>	
Would I want to be treated in this way?	Does the decision feel right?
Is the decision universalizable? Would this decision withstand the scrutiny of others?	Have I given myself time to let reservations emerge?
How are my values, personal characteristics influencing my choice? How am I using my power?	Does the manner in which I carry out this decision fit my style?
Have I taken the client's perspective into account?	
<u>Implementing and evaluating the decision</u>	
Carry out the decision Observe consequences Reassess the decision	Is this solution the best I can do?
	Does the outcome continue to feel right?
How has this decision affected the therapeutic process?	
<u>Continuing reflection</u>	
What did I learn?	Have I changed as a result of this process? How?
What would I do differently?	How might this experience affect me in the future?

Note. From "A Feminist Model for Ethical Decision Making" by M. Hill, K. Glaser, and J. Has (1995). In E. J. Rave and C. C. Larsen (Eds.), *Ethical Decision Making in Therapy: Feminist Perspective*. New York: Guilford Press.

## 3.2 Ethical Best Practices

### 3.2.1 Seek informed consent

Give the woman all the information she might need to make decisions about using your services. (See Section 6 for further discussion of possible policies on some of these bullets.)

- Describe yourself, your counselling training and experience.
- Explain the mandate, services and constraints of the program.
- Explain the hours, expectations, cancellation policies, out-of-session contact guidelines, availability of services during counsellor absences, etc.
- Explain what might happen if a woman misses several sessions.
- Explain limits in terms of time and number of sessions and how termination of counselling occurs.
- Explain the limits of confidentiality, including duty to report if 1) a child is at risk, 2) you believe the client is a risk to herself or to others or 3) the court orders the release of records. See Appendix 7.4 for a generic release of information form that counsellors may adapt to review with clients.
- Provide information about who to contact regarding issues related to the records. The new Personal Information Protection Act (PIPA) (January 2005) requires such a person be identified.
- Describe supervision provisions. If you work in a multidisciplinary agency and you share case consultations, explain how confidentiality is handled within the agency. This is particularly important for women who see multiple service providers within the agency.
- Provide information about who to contact if a client has a complaint. This could be an agency supervisor and/or a professional body of which you might be a registered member. If you belong to a professional body, provide your registration number.
- Generally the STV counselling contract assumes that women will be adults and thus old enough to give consent. However, the contract also allows service to be provided to “young women living an adult lifestyle.” See Section 5.3 for more discussion.

- If you are working with a woman who has been advised to seek counselling by a social worker from the B.C. Ministry of Children and Family Development (MCFD), clearly define your and the client's expectations about the counselling sessions and what, if any, reporting back to MCFD will occur.

All STV counsellors need to be familiar with the best practices manual published by MCFD in May, 2004 ([www.endingviolence.org](http://www.endingviolence.org)). Among other points, it explains how forcing counselling upon a woman is rarely successful. It also addresses the issue of STV counsellors being unable to disclose information about their clients to MCFD. "It should be recognized that they (the service providers) are complying with their confidentiality policies," (18), and then goes on to say that if MCFD workers believe they need the records, they should follow the procedures laid out in section 65 of the Child, Family and Community Service Act to request an order to release information.

- For a woman who is mandated by court order (and administered through probation), it is important to explain what the consequences will be if the woman chooses not to attend counselling sessions. It is rarely useful for you to cover for her. Describe the reporting process. If it is possible for you to involve her in the reporting process (e.g., by discussing a draft of your report), describe how that will unfold.

This is a lot of information for a woman to absorb, particularly if she is already anxious about coming to an STV Counselling Program. Therefore, it might be useful to develop an orientation letter or contract that outlines this information. See Appendix 7.5 for a listing of points that might be covered in such a letter. A document will make it easier for you and your client to review the information together, particularly if you are concerned about literacy issues. After your joint review, both of you can sign it. Give a copy to the woman to review at home. At the next session, ask again if there are any questions or concerns related to the information.

Begin to provide this information in short form during the intake process. Encourage her to ask any questions about these issues. You will provide more detail to her once you begin to provide the requested service.

If the woman arrives in crisis, it may not be possible to give a full orientation to your agency's service. Instead, focus on the minimum basics of limits to confidentiality. Gain the woman's consent. Then, at the next meeting with the woman, explain the entire procedure.

All documents should clearly list the name and address of the agency, the date and your name.

### **3.2.2 Work collaboratively**

This principle perhaps illustrates most the tension between the feminist and trauma models of counselling. The long cherished feminist therapist maxim is that the woman is her own best expert and, therefore, knows what she needs. The trauma model, on the other hand, suggests certain counselling practices proceed in a particular order. For example, feminist counselling best practice would support a woman coming to counselling and telling her trauma story in the way she sees fit. Yet trauma counselling best practice would discourage immediate retelling of the trauma story, instead focusing on safety and containment first. Indeed, aspects of the trauma model can be quite directive. Working within this edgy alliance, the counsellor must ensure she offers the woman information and education, choices and decisions.

Survivors will feel safest when they are actively participating and making decisions in the counselling process. Clients are most empowered when you:

- Assess their symptoms and vulnerabilities, as well as strengths and abilities;
- Set mutual goals;
- Provide information on reactions to trauma and the therapeutic process;
- Guide and help them in establishing the pace of counselling; and
- Invite them to offer feedback on their experience in counselling (Haskell 2003).

### **3.2.3 Be aware of power differentials**

Even in the most egalitarian situations, the counsellor always has more power than the woman seeking service. The power differential becomes more acute when speaking with a person rendered vulnerable by some form of sexual violence. Counselling is inherently dangerous in that we are asking clients to discuss terrifying events. Finally, adding the dynamics of race, class, education, sexual orientation, age and physical health further sharpens the power issues.

“It is vital to attend to these issues in STV counselling work, because the client’s experience of violence involved an abuse of power, often within a trusting relationship . . . The client will be acutely aware of any verbal or non-verbal indications of not being believed, of not being respected, of being blamed, or of being let down. It is possible for counsellors to maintain non-judging, believing, accepting, respectful positions with the women with whom they work, but it is rarely possible to never let down a client. Thus, counsellors must be prepared to listen to and address women’s experiences of being let down in the counselling relationship in an open and genuine manner, without blaming their clients or themselves” (BCASVACP and JIBC 1998).

See also Section 2 for more information on feminist trauma interventions, particularly 2.4.1, 2.4.2 and 2.4.3.

### **3.2.4 Make a public commitment**

Post your agency's "mission statement" or vision in various places around your agency. A posted statement will help educate newcomers to your service and also serve as a reminder to you. Here is an example (taken from the Women's Counselling Service of the Sunshine Coast Community Services Society) of a written commitment to addressing power imbalances and diversity:

"The Program offers services relevant to diversity of persons served, recognizing differences in culture, age, gender, sexual orientation, spiritual beliefs, socioeconomic status and language. The person seeking service is consulted about any special needs or concerns [she] might have. Where possible, efforts will be made to accommodate those needs. For example, if mobility is an issue, home visits or telephone counselling is offered. If language is an issue, efforts are made to find translation. Bus passes are available for those having difficulty with transportation costs. Childcare subsidies are available if women have no access to childcare during appointments. If resources are not available to address those needs within this program, referrals are made to more appropriate services. To ensure respectful and culturally sensitive service, the counsellor will attempt to familiarize herself about cultural differences and preferences when working with women from various cultural backgrounds."

### **3.2.5 Work within your own competencies**

The Feminist Therapy Institute Code of Ethics (1999) states, "A feminist therapist works only with those issues and clients within the realm of her competencies." Given the current pressure to do more with less (see Section 1.4), an STV counsellor faces ethical and moral quagmires when making decisions about providing a service that might be beyond her competencies. Some counsellors reported in past evaluations (Walker 2004; BCASVACP March 2004; BCASVACP February 2005) that they felt pressure to help a woman because no other counsellor/agency was available in the community. It is of little consolation to know that all counselling interventions begin with stage one interventions.

The increased pressure to provide more service combined with women presenting with increasingly complex situations creates a volatile and combustible situation. It is not sustainable. Lacking sufficient training or ongoing clinical supervision to address these complex clinical presentations, STV counsellors are at high risk.

- You must conduct an honest inventory of your knowledge, skills and abilities. If a client is presenting with an issue that is outside the parameters of your expertise, you must explain the situation to her.

- You may consider providing limited supportive counselling only if absolutely necessary. The BCASVACP draft standards (BCASVACP 1998a, 15) suggest that if a woman needs services beyond the skill, training or knowledge of the STV counselling staff, she should be referred, if possible. Draft standard 3.4 states that if this is not possible “or appropriate because of a lack of sensitivity to feminist issues, the STV counsellor, with the woman’s informed consent, may provide limited counselling services intended to avert a crisis or to reduce the possibility of further harm to the woman.”
- Questions about competencies to provide services should always be discussed with a supervisor or peer.

### **3.2.6 Advocate for yourself in the workplace**

Request in-service programs to discuss common ethical dilemmas that you and your colleagues encounter; to discuss the impact of the work (vicarious traumatization); and to seek additional training, such as substance use interventions.

### **3.2.7 Remember the ABCs of sustaining yourself in this work**

Pearlman and Saakvitne (1996) remind us to pay attention to the three realms of our lives (workplace, organizational/agency and personal), and to strive for awareness, balance and connection:

- Awareness
  - Being attuned to one’s needs, limits, emotions and resources;
  - Heeding all levels of awareness and sources of information; and
  - Practising mindfulness and acceptance.
- Balance
  - Maintaining balance among all activities, especially work, play and rest;
  - Balancing workload and variety; and
  - Maintaining inner balance that allows attention to all aspects of oneself.
- Connection
  - Staying connected to oneself, to others and to something larger;

- Breaking the silence of unacknowledged pain; and
- Staying connected to offset isolation and increase validation and hope.

You might wonder why we place self-care as an ethical principle. The Feminist Code of Ethics is the only code that affirms the importance of self-care as an ethical standard. Laura Brown (1994, 223) puts it this way: “Anything that undermines feminist counselors cannot help but undermine and oppress others as well. Conversely, when they practice subversion of patriarchal values in their own lives by caring for themselves, they enhance their ability to facilitate this process in their work.”

### **3.2.8 Be self-aware**

All counsellors need to train themselves to review their interactions with clients.

Given the severe, long-standing and complex issues that women bring to STV counselling, it is completely natural for counsellors to have less-than-perfect interactions with their clients. An STV counsellor needs to be sufficiently self-aware that she recognizes when her defences have been stimulated to such a degree that she is no longer able to be present.

Always pay attention to feelings of uneasiness and uncertainty, feelings of being overwhelmed or desires to avoid your client. The hope is that you and your supervisor can create a safe working relationship that allows you to discuss these concerns. Talk about the impact of this client. Explore your counter-transference in the fullest sense of the word: all of your responses to this client, her story and her behaviour, your conscious and unconscious defences, unfinished family of origin issues and vicarious traumatization (Pearlman and Saakvitne 1996).

### **3.2.9 Seek support and supervision**

STV counsellors need ongoing support to manage the complexities of their work. Such support can be provided through peer support, debriefing, individual and/or group case consultation and clinical supervision. It is preferable to provide several avenues. Telephone supervision is a poor facsimile, acceptable only when no other alternatives exist. “The setting must offer permission to express emotional reactions as well as technical or intellectual concerns related to the treatment of patients with a history of trauma,” (Herman 1992, 151). The STV Counselling Program Contract, Schedule A requires that contractors provide ongoing counsellor support. See Appendix 7.19 for a sample contract for supervision.

Counsellors themselves must be willing to engage in the process of case consultation and supervision. Chu (1998) eloquently explains that counsellors need to practise what

they preach and seek interpersonal support and connection. Anti-violence and trauma work is draining; support is vital.

Inform your client of supervision discussions as appropriate. The major rationale for doing this is that it allows your client to understand what other influences may be present in the counselling room. This requires sensitivity and skill, as well as judicious self-disclosure.

### **3.2.10 Join a professional counselling organization**

Many STV counsellors are also members of organizations such as the Canadian Counselling Association or the B.C. Association of Clinical Counsellors. These organizations offer some form of accreditation. Accreditation helps make counsellors accountable to clients and also gives clients an avenue for complaint in cases of counsellor mistakes. In addition, such organizations provide a source of continuing education. They also provide a window into the broader world of counselling, alleviating the tunnel vision of trauma counselling.

### **3.2.11 Know your code of ethics**

Familiarize yourself with the code of ethics if you are a member of a registered counselling body such as the B.C. Association of Clinical Counsellors or the B.C. Art Therapy Association. These organizations have standards of practice and codes of ethics that may help counsellors who are wrestling with dilemmas. They may also provide person-to-person consultation.

### **3.2.12 Keep current with legislation that affects our field**

For example, in January 2005 the Personal Information Protection Act (PIPA) came into effect. PIPA has numerous provisions regarding the collection and dispersment of private information. Bill C-2 came fully into effect in January 2006. This Bill has a number of provisions, including support for vulnerable witnesses testifying in court and new offences for voyeurism and child pornography. For more information, see the newest edition of the BCASVACP *Record Management Guidelines* (Ruebsaat and Porteous in press).

### **3.2.13 Know the difference between legal and moral imperatives**

Some issues facing STV counsellors are legal; some are ethical/moral and some overlap. It is critical to be able to recognize situations in which legal rules apply. For example, a client may disclose that she sexually abused a child when she was a teenager. She is now 32 and has not inappropriately touched a child since then. Under the federal Criminal Code, you are not obligated to report this incident to the police. Under the B.C. provincial Child, Family and Community Service Act, you are required to consider whether children might be at risk from your client. The ethical dilemma might be

your competency to judge the risk of re-offense. The moral dilemma is one of redress and amends for the victim. These are separate but obviously linked issues. Consultation is helpful in sorting the issues out.

### **3.2.14 Be cautious about dual relationships**

Avoiding dual relationships is not always possible, especially in rural settings. If rural counsellors avoid dual relationships, they may find that the existing social isolation is exacerbated by limiting contacts within the community. This can contribute to seclusion and burnout. In addition, if rural STV counsellors connect only with other community professionals, they may not learn about the unique barriers facing marginalized rural women.

Jeffery Younggren, who served as the APA Ethics Chair for many years, offers these questions to help decide when it is appropriate to enter into a dual relationship. He points out that few of these questions are easy to answer, especially alone, and encourages all counsellors considering whether to enter dual relationships to seek consultation and to document the decision (Younggren 2002).

- Is the dual relationship necessary?
- Is the dual relationship exploitative in any way?
- Who does the dual relationship benefit? For example, suppose your client owns the local car dealership. To avoid a dual relationship, you buy a car from the dealership in the next town. However, in doing so, you might harm the therapeutic alliance by upsetting your client. In addition, you might bring harm to your client because others might wonder why you didn't buy your car from the local dealer.
- Is there a risk the dual relationship could damage the client?
- Is there a risk that the dual relationship could disrupt the therapeutic relationship? This question must be asked before entering the dual relationship, but also during the relationship. An example occurs when a woman whose children attend the same school as your children becomes your client. Given that both your client and you volunteer at the school you are aware of each other as parents and school volunteers. How will observing her in her interactions with her children or her with your children impact the therapeutic relationship? What happens to the therapeutic relationship if each of your children become friends and want to have contact with each other outside of school?

- Am I being objective in my evaluation? This is very hard to ascertain on one's own.
- Have I adequately documented the decision-making process in my clinical notes?
- Did the client give informed consent? This includes giving information about how to handle public meetings.

Brown (1991) suggests that feminist therapists will inevitably find themselves facing dual relationship situations simply because of the way they live their lives. “Because feminist therapists often live and work in the same social and political worlds as their clients, they sometimes occupy the sociological and psychological equivalents of small towns” (Brown 1994, 210). She prefers the term “overlapping relationships” to refer to those aspects of counsellors’ and clients’ lives that will intersect despite all efforts of the counsellor to avoid dual roles. Overlapping relationships are not motivated by the counsellor’s needs, but reflect a common interest or concern in the broader social context.

Brown suggests that the first step to manage these overlapping relationships ethically is to acknowledge their legitimate existence. Next, take deliberate steps to speak with your clients about any situations that can be anticipated. Finally, she suggests that feminist therapists must engage in more complex discussions of ethical behaviours. For example, instead of assuming attendance at a client’s university graduation is not ethically possible, a counsellor should analyze the decision in light of broader factors, such as the cultural context. See Appendix 7.3, Section III of the Feminist Therapy Code of Ethics for more information on this topic.

## Resources

Brown, L. 1991. “Ethical issues in feminist therapy.” *Psychology of women quarterly* 15: 323-336.

Brown, L. 1994. *Subversive dialogues: Theory in feminist therapy*. New York: Basic Books. Chapter 8, “Feminism and Ethics,” is an important contribution to the development of a feminist ethical practice in counselling. It includes general discussion on ethical theory, practice and challenges, as well as some specific topics such as responding to ethically problematic colleagues and self-care as an ethical notion.

Feminist Therapy Institute. 1999. Reprint. *Code of Ethics*. Georgetown, ME: Feminist Therapy Institute. Original edition, Georgetown, ME: Feminist Therapy Institute, 1987. [www.feministtherapyinstitute.org](http://www.feministtherapyinstitute.org). This code lists ethical principles in five key areas: cultural diversities and oppressions, power differentials, overlapping relationships, therapist accountability and social change. See Appendix 7.3 for more information on the Feminist Therapy Institute.

Hill, M., K. Glaser and J. Harden. 1995. “A feminist model for ethical decision making.” In *Ethical decision making in therapy: A feminist perspective*, edited by E.J. Rave and C.C. Larsen. New York: The Guilford Press.

Pearlman, L. and K. Saakvitne. 1996. *Transforming the pain: A workbook on vicarious traumatization*. New York: W.W. Norton. An excellent workbook for counsellors to assess their levels of vicarious traumatization and to develop specific self-care plans.

Younggren, J. 2002. *Comments on dual relationships*. Retrieved November 3, 2005 from [kspope.com/dual/index.php](http://kspope.com/dual/index.php).

### **Codes of ethics**

B.C. Art Therapy Association. [www.arttherapy.bc.ca](http://www.arttherapy.bc.ca).

B.C. Association for Marriage and Family Therapy. [www.bcamft.bc.ca](http://www.bcamft.bc.ca).

B.C. Association of Clinical Counsellors. [www.bc-counsellors.org](http://www.bc-counsellors.org).

B.C. Association of Social Workers. [www/bcasw.org/content/home.asp](http://www/bcasw.org/content/home.asp).

Canadian Counselling Association (formerly the Canadian Guidance and Counselling Association). [www.ccacc.ca/ccca.htm](http://www.ccacc.ca/ccca.htm).

Canadian Psychological Association. [www.cpa.ca](http://www.cpa.ca).

## SECTION FOUR

# Assessment and Counselling Planning

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This section introduces best practices and resources for assessment and planning. Appropriate assessment and planning are critical to the success of counselling interventions. Yet STV counsellors often find themselves responding to crisis situations rather than thinking ahead. It is challenging to find a way to bring a planning focus to crisis situations and chaotic, fragmented individuals, but this is essential to creating the safe and structured environment needed by survivors. Sometimes counsellors create a plan with the client at the outset of counselling, but don't get back to it because something keeps coming up. This leaves the client wondering why the plan has been abandoned.

Best practices with survivors of violence include careful and appropriate assessment and the development of counselling plans. Plans can be altered but must not become invisible. Survivors need counsellors to chart a path with them. Assessment and counselling planning should occur co-operatively and over time.

For the purposes of this Manual, assessment starts when a woman begins to receive the counselling services she requested. The STV Counselling Program draft standards (BCASVACP 1998a) state that agencies need to have written policies and procedures for safety planning and assessment (standard 5.1). These policies should place priority on a woman's physical and emotional safety from an abusive partner, from others or from herself (standard 5.2). Where a threat to safety is identified, the STV counsellor fully explores the immediacy the threat poses for the woman and/or others, and takes appropriate action to promote a woman's safety. To the extent possible, the STV counsellor includes the woman in discussions and decisions regarding the nature of action to be taken (standard 5.3).

This section focuses on a range of assessment approaches, beginning with assessing for safety. Specific issues such as stalking, self-injurious behaviour and suicidal ideation are discussed. Principles of crisis intervention are also addressed, followed by the topic of exploring readiness for counselling and developing a counselling plan.

### **4.1 Principles of Crisis Intervention**

The general principles provided here are followed by detailed discussions of four common crisis presentations: domestic violence, stalking, suicide and self-injurious behaviour. Any recent trauma can unleash the hounds of post-traumatic crisis. For example, a

woman who was abused as a child may be overwhelmed by a car accident, let alone any other form of assault. The recent trauma can overload the survivor's psychic resources and cause flooding to occur, either of childhood events or an intense reliving of the recent trauma. Conversely, a woman who finally escapes to safety may experience a downturn in her ability to cope.

A useful synonym for crisis is turning point. Remember that crisis is not a permanent state.

- Crisis intervention goals are to:
  - Help the client separate the past from the present (grounding);
  - Help the client exercise control and choice;
  - Help the client stay connected or regain connection to others; and
  - Help the client, wherever possible, to recognize the connection between her past experiences and present behaviours and feelings (Saakvitne et al. 2000, 78).
- Crisis does not necessarily mean the violence occurred recently. Should the woman decide to talk about the violence 10 years after it happened, she could still be in a crisis stage. Therefore, counselling interventions must focus on the present symptoms, which can include flashbacks, intrusive memories, panic, fear, insomnia and body memories.
- It is normal for clients in a crisis state to forget appointments, to arrive late, etc. Therefore, it is necessary for you to repeat important information, give handouts or provide clients with appointment cards at every session.
- Normalize your client's responses. Explain about common crisis predictors, such as triggers, markers, timers, developmental milestones, death of an offender, etc. Counsellors may have a guideline of possible impacts, but not everyone will experience those impacts. Clients will cope in different ways; counsellors should work to support survivors to access coping skills that work for them.
- Always remember that every crisis or symptom has meaning. It reflects the woman's attempted solution to a problem.
- Stabilize and help the survivor to ground herself by:

- Really listening without judging or asking questions;
  - Resisting the urge to offer advice or suggestions. If you become too frightened for your client’s safety, you are at greater risk of trying to control the situation or rescue her. Also, if you hold all the fear, she may not have to experience it, allowing her to minimize or deny the gravity of her situation;
  - Helping your client to focus on her current environment; and
  - Helping your client to focus on her body; e.g., breathe deeply, feet on floor, shuffle in seat.
- Within the mandate of your program, support your client’s decisions with respect to reporting her circumstances to the police.
  - Identify current concerns from the crisis; e.g., the need for parenting support.
  - Collaborate in problem solving. Crisis intervention involves breaking down problems into small and manageable pieces.
  - Introduce many stage one activities to build self-soothing skills. Remember that early trauma will often derail a person’s abilities to self-soothe.

## **4.2 Safety Assessment**

### **4.2.1 Domestic violence**

Research (Peterson et al. 2004) into what motivated women to seek assistance about domestic violence revealed three main factors:

- 1) Increased knowledge about their rights and the cycle of abuse;
- 2) Reaching an emotional or physical breaking point; and
- 3) Concern about their children’s safety.

Obstacles to seeking help included a belief that one is not supposed to talk about intimate partner violence; not recognizing the situation as domestic violence or as wrong; self-doubt and low self-esteem; fear of potential losses; fear of the perpetrator and a desire to protect the perpetrator.

- It is important to create a safety plan with a woman who is currently in an

unsafe situation. See Appendix 7.17 for a safety plan from the “Community Coordination for Women’s Safety” project. Other examples of good safety plans can be found in Roberts and Roberts (2005), and from Sheltersnet or the Arizona Coalition Against Domestic Violence (see the list of resources at the end of this section). Use the checklists provided in these resources to help you focus on problem-solving needs.

- Safety planning is an ongoing process and needs frequent reassessment. Look for patterns of escalation. Be aware that while a woman may minimize or deny her risk, she is also in the best position to assess it. The goal of safety planning is to turn this assessment into a conscious, proactive plan (Agar 2003).
- Remember that safety may mean something different to your client than it does to you. Discuss the meaning of safety together. You and your client have had different experiences around safety, and this may impact your interventions. For example, you may be pushing for more safety than the client is willing to entertain due to her denial and/or defences. You are both attempting to install safety, but may completely miss each other in session. The following advice will guide you in discussing safety with your client.
  - Ask her about times she has felt really safe in her life. What was the experience like in her body? Are there times she feels that way in her relationship? How does she experience unsafe? What are the cues—emotional, physical or cognitive—that she is not safe?
  - Use activities such as visualization or art to establish further her connection with safety.
  - If you are working with a dissociative client, remember that her ability to discern safety in the here and now may be determined by her ability to be in the present.
- Remember that many women have and will sacrifice their personal safety to defend themselves from overwhelming feelings of aloneness, nothingness and unworthiness.
- Focus your initial questions on the here and now. Because a controlling partner often lays all the blame on her, a client is likely to hear any questions about her actions, her background or her personal life as accusations. Many women feel particularly blamed when outsiders ask probing questions about their childhoods. When you do explore the woman’s history, do so with care and sensitivity.

- Many controlling behaviours occur before the onset of physical violence. The Shrinking Woman Test (Jones and Schechter 1993) offers a series of questions you can ask your client about how partners can control through criticism, moodiness, anger, overprotection and “caring,” denying a woman’s perceptions, ignoring a woman’s needs and opinions, making all the decisions, denying money, shifting responsibility, limiting contact with other people, physical intimidation, sexual humiliation and, finally, physical and sexual violence.
- Emotional abuse is another common precursor to physical violence. See Appendix 7.7 for questions to assess emotional abuse.

### **Questions for a woman who is currently unsafe**

#### **Part A: Questions to open up a conversation about her experience.**

If she wants to talk but can’t get started, any of the following questions might help. Notice that these questions do NOT imply that you are psychoanalyzing her, looking for explanations of her behaviour, challenging her or passing judgment. Instead, they invite the woman to talk about what the controlling partner does and what she feels about it. Notice also that these questions assume the abuser is male. Lesbian, bisexual and trans women have specific needs in terms of safety assessment and planning. See Holmes (in press) and White and Goldberg (in press).

- What’s it like at home for you?
- What happens when you and your partner disagree or argue?
- How does your partner handle things when he doesn’t get his way? What does he do?
- Are you ever scared of him? Does he threaten you?
- Does he ever prevent you from doing things you want to do?
- Does he ever follow you?
- Do you have to account to him for your time?
- Is he jealous, hard to please, irritable, demanding and critical?
- Does he put you down, call you names, yell at you or punish you in any way?
- Does he ever push you around or hit you?
- Does he ever make you have sex? Does he ever make you do sexual things you don’t like?

#### **Part B: Questions to determine her safety from her abuser(s)**

Again, notice that these are generic questions. You will likely need to ask additional questions that fit the woman’s specific context. For example, if you were speaking with

a rural woman, you would need to ask questions such as: “Has he ever frightened you by the way he operates a vehicle, power tools or machinery?” or “Have you ever experienced fear and intimidation when he demonstrates he is capable of killing when he slaughters livestock?” In addition, a safety assessment for a rural woman needs to include a discussion on the location of her residence, degree of isolation, location of firearms, means of reliable transportation, status of the road in adverse weather conditions, accessibility of neighbours and alternative options for care and feeding of livestock.

- Where is the abuser now? Does he have access to you?
- Does he have weapons?
- Does he know that you are seeking counselling?
- How do you think he might respond if he knew you were here?
- Is it safe for me to contact you at home? Is it safe for me to leave a message?
- What has been the pattern of violence? Has it been escalating in degree of lethality (e.g., it started as restraining, then progressed to pinching, punching and kicking, and now involves objects in the assault). Has it been escalating in the degree of force (even if the form of abuse stays the same, it may be escalating so that now the woman is unconscious after an assault)?
- What is the abuser’s attitude toward the police and the law? Is he afraid of the police or does he disregard them?
- Have the police ever come to your house? How did they respond?
- Has he ever been charged?
- Has he ever violated restraining orders in the past?
- Have you ever gone to court? What was your experience there?
- Does the abuser have a history of violence in other settings and/or relationships?
- Does he misuse alcohol and/or other drugs?
- Has he ever threatened to kill you?
- Has he ever threatened to hurt or kidnap the children?
- Has he ever hurt or kidnapped the children?
- Other?

- Become familiar with lethality assessments and consider completing one with your client to assess the most appropriate intervention or service. This can also help a battered woman see the subtle or hidden abuse within her relationship.

A lethality assessment is also a teaching tool that provides information and skills to help the client protect herself in the future.

- STV counsellors will soon have access to the *Aid to Safety and Assessment Planning (ASAP)* for women who experience violence in their relationships (Agar in press). This document provides a very thorough assessment process. It provides a worksheet that either a counsellor or a justice system worker can complete with the woman. The worksheet asks a series of questions to examine factors related to the abuser and factors that may influence safety.

– Factors related to the abuser include:

- Abuser's violence;
- Violent threats, ideation and intent;
- Escalation of physical/sexual violence or threats;
- Violations of civil and criminal court orders;
- Negative attitudes;
- Other criminality;
- Response to shifts in power or control;
- Employment or financial problems;
- Substance use;
- Mental health problems; and
- Other considerations.

– Factors related to safety and support, both positive and negative, include:

- Level of personal support;
- Living situation;
- Level of fear;
- Barriers created by attitudes and beliefs;
- Health impacts of the abuse;
- Employment or financial problems;
- Child-related concerns;
- Substance use;
- Access to services;
- Responsiveness to services;
- Provision of information; and
- Coordination of services.

When these characteristics appear in a group, there is reason to believe that there is an increased risk to the woman. It is not predictive, but it will give you a baseline measure from which to determine a safety plan with a battered woman.

No magic number of “yes” answers creates a highly lethal situation for a battered woman. In some cases, it takes all characteristics to create a high-risk situation. In other cases, one or two factors are sufficient to indicate risk. Together, you and your client can decide when there is reason to believe that she is in danger and needs to look for shelter, call the police or take other corrective action to ensure her safety.

Lethality assessment is an ongoing process throughout your interventions with your client. Assessments occur at first contact, while she is deciding to leave the relationship, while she is in shelter or with family or friends and when she has established an independent household. (For many abused women, the most dangerous period is in the 18 months after leaving the relationship.)

### Resources

Agar, S. 2003. *Safety planning with abused partners: A review and annotated bibliography*. Vancouver: B.C. Institute Against Family Violence.

Agar, S. In press. *Aid to safety assessment and planning (ASAP)*. Vancouver: B.C. Institute Against Family Violence. A comprehensive document. Includes two excellent appendices: “Appendix B: Safety assessment and planning for women in abusive same-gender relationships” and “Appendix C: Safety assessment and planning in abusive trans relationships.”

Arizona Coalition Against Domestic Violence. 2000. *Best practices manual for domestic violence programs*. Phoenix: Arizona Coalition Against Domestic Violence. [www.azcadv.org](http://www.azcadv.org). Includes an overview of potential policies and procedures that can be followed when providing victims with support and assistance. The topics covered in the manual include: crisis intervention, advocacy, hotlines, safe homes, shelters (from initial contact and intake to physical infrastructure and follow-up), transitional housing, case management, counselling, support groups, children’s programs, legal advocacy, community education and administration. Also includes a lethality assessment.

Chesley, L., D. MacAulay and J. Ristock. 1998. *Abuse in lesbian relationships: Information and resources*. Ottawa: Health Canada. [www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/index.html](http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/index.html).

### Selected Web sites

Duluth Minnesota Domestic Abuse Intervention Project. [www.duluth-model.org](http://www.duluth-model.org). Includes links to a risk assessment tool for victim safety and public policy.

#### 4.2.2 Stalking

Stalking is a form of violence that frequently happens to women. In Canada, it also became a crime when criminal harassment legislation was introduced in 1993. Approximately 80 percent of the 4,450 stalking victims in Canada in 1996 were women. The number of reported stalking victims had increased by 32 percent in 1999. Eighty-eight percent of the accused were male (METRAC 1998). In a national study of U.S. college women, 13 percent of respondents said they had been stalked; the average stalking incident lasted 60 days (Fisher et al. 1999).

Stalkers seem to fall into three broad categories: ex-partners, casual acquaintances and people suffering from obsessive thoughts, including erotic fantasies about celebrities. Stalking behaviours include: repeated phone calls or faxes; unwanted gifts; following/watching; vandalizing property; posting a photo and personal information on the Internet; threatening harm to your client, her loved one or her pet; assault (sexual and/or physical) and kidnapping.

Stalking that occurs within the context of domestic violence is more complicated than stalking by a stranger because of the multiple strands that form an intimate relationship. A Toronto study found that 57 percent of stalkers were partners or ex-partners of the women (METRAC 1998).

A U.S. study (Melton 2004) indicated that, in many instances, the abuser may no longer physically hurt a woman after some police or court action, but may either initiate or continue with stalking behaviours. In addition, some of the violent perpetrators continued to make harassing phone calls while incarcerated. Moreover, the women in Melton's study indicated that while police responded to the physical assault aspects of women's complaints, they tended to ignore the stalking aspects.

Rates of stalking are highest for young women, which is consistent with patterns of other kinds of violence against women. Fifty-eight percent of stalking survivors are under 34 years old (Statistics Canada 2004).

On-line stalking is known as cyber-stalking, and can occur through chat rooms, message boards and e-mail. Although there is little research on the topic, preliminary evidence suggests that women are the primary targets of cyber-stalking, just as they are most vulnerable to other kinds of stalking.

- Educate your client about stalking. Ignoring the stalker seldom works. However, victims of stalking should not approach the stalker themselves. Many stalkers are deliberate in their behaviours and any contact with the women they are stalking only serves to increase their sense of power and control.
- Documenting all behaviours of the stalker can be beneficial. It can help your client to identify the stalker's patterns and will assist the police in their investigations. If the stalker is charged with criminal harassment, this information will be used as evidence against him. Encourage your client to record the following information.
  - The name of the stalker (if known);
  - The physical description of the stalker;

- Incidents of contact by the stalker (phone calls, faxes, letters, visits, e-mails, text messages or messages through other people);
- Incidents of harassment or threats to family, friends or pets;
- The date and time of all incidents;
- A description of what the stalker was wearing, if known;
- Physical evidence and any witnesses; and
- Measures she has taken to protect herself.

Your client should not record her personal feelings or reactions in this document. If she wishes, she could keep a separate journal/diary.

- Some stalkers may stop their behaviour following a warning from police that their behaviour is inappropriate and, in fact, criminal. However, marginalized women may feel uncomfortable approaching and dealing with the police for many reasons.
  - Discuss with your client the implications of reporting to the police. Your client can ask the police to complete a risk assessment that will evaluate the level of threat. Your client's reception by the police may vary according to attitudes and beliefs of individual police officers.
  - Many women are afraid to approach the police for fear this will put them at greater risk of further stalking. One study of women's experiences with stalking found that after criminal justice intervention, stalking behaviours decreased considerably (Melton 2004). Melton suggests that if more women use the court systems it would "lead to greater conviction rates and could improve justice personnel's view of victims in general" (55).
- Walk a fine line between planning for safety and colluding with your client in denial or minimization of the extent of the threat. Stalking is considered a "building block crime" because it often starts with small incidents that get bigger, more frequent and more threatening. In the worst case scenario, there were nine stalking-related murders in Canada between 1997 and 1999; in each case, the woman was killed by a recently separated partner (Hackett 2002). Without unduly scaring your client, you must encourage her to take this problem seriously.

- Build safety plans with your client. Encourage your client to consider things like:
  - Changing her routine and her routes;
  - Carrying a cell phone;
  - Changing or adding locks or installing out-of-reach motion detectors;
  - Installing a security system;
  - Being alert while in her car or using other forms of transportation;
  - Having someone else collect or open her mail;
  - Obtaining a private postal box;
  - Removing her name from reverse directories;
  - Getting call display on her telephone;
  - Reporting threatening calls to the telephone company;
  - Learning how to prevent display of her phone number;
  - Arranging a place to stay;
  - Having a friend or relative go places with her;
  - Keeping people informed of where she is;
  - Deciding in advance what to do if the stalker shows up at her home, at her work, at her school or in public;
  - Keeping a list of readily available contact people and their phone numbers;
  - Taking a self-defence class such as WEN-DO;
  - Telling her family, friends and co-workers, and involving security staff at her job or school;
  - Distributing a photograph of the stalker to her family, friends and co-workers; and

- Packing an emergency bag with clothing, money, important phone numbers and documents in case she needs to get away quickly.
- Stay current with recommendations. For example, traditional advice has been to get a new telephone number. The most recent research suggests that when women discard their old numbers, virtually 100 percent of their stalkers escalated to in-person stalking. Thus, the current advice is for women (who have the financial resources) to keep their old numbers connected to answering machines and get new numbers at the same time.

### Resources

- Boon, J. and L. Sheridan, eds. 2002. *Stalking and psychosexual obsession: Psychological perspectives for prevention, policing and treatment*. West Sussex: John Wiley and Sons.
- Davis, J. 2001. *Stalking victims and victim protection: Prevention, intervention, threat assessment and case management*. Boca Raton, FL: CRC Press.
- Gross, L. 2000. *Surviving a stalker: Everything you need to know to keep yourself safe*. New York: Marlowe & Co.
- Mullen, P., M. Pathe and R. Purcell. 2000. *Stalkers and their victims*. New York: Cambridge University Press.

### Selected Web sites

- End Stalking in America. [www.esia.net/safety\\_tips.htm](http://www.esia.net/safety_tips.htm). Provides a comprehensive list of safety tips for women being stalked.
- Stalking Resource Center, through the (U.S.) National Center for Victims of Crime. [www.ncvc.org/src](http://www.ncvc.org/src). Most stalking sites have links to this site.
- Stalking Victims (SVS). [www.stalkingvictims.com](http://www.stalkingvictims.com).
- The Metropolitan (Toronto) Action Committee on Violence Against Women and Children (METRAC). [www.metrac.org](http://www.metrac.org).

### 4.2.3 Suicide

Thinking about killing oneself is an extreme solution to intolerable psychic pain and/or an intolerable situation. Trauma survivors frequently think about suicide. Survivors of childhood trauma, in particular, experience high suicidal ideation, though not the highest completion rate. Thus, STV counsellors can expect to work with a number of suicidal clients and will need to conduct assessments. All highly suicidal clients need to be brought to the attention of your manager/supervisor.

In general, more women than men attempt suicide, but more men complete the act. The majority of completed suicides experienced concurrent issues of depression, bipolar conditions or substance use. In B.C., the most frequent method of suicide overall is

hanging (28 percent) followed by gunshot (23 percent) (UBC Suicide Prevention and Information Centre 1997).

- It is essential for your program to have a policy for responding to suicidal thoughts and behaviours. STV draft program standard 5.5 states: “In situations where a woman expresses thoughts, desires or intentions to commit suicide or homicide, the STV counsellor fully explores the nature of those impulses and the immediacy of the threat posed for the woman and/or others, and follows appropriate agency policies concerning the situation” (BCASVACP 1998a).
- Recognize warning signs. Not all individuals who attempt suicide are depressed; however, depression is a significant risk factor. Ask your client questions about:
  - Disrupted sleep patterns;
  - Lack of interest in usual activities;
  - Feelings of guilt, particularly survivor guilt;
  - Decreased energy, feeling like she is moving through molasses;
  - Inability to concentrate;
  - Disrupted eating patterns, more or less; and
  - Suicidal thinking.

Other warning signs your client may exhibit or tell you about include:

- Hopelessness, helplessness, despair and loneliness;
- Talking or writing about death, dying or suicide;
- Rage, uncontrolled anger or thoughts of revenge;
- Reckless or risky behaviour;
- Feeling trapped, like there is no way out;
- Increased substance use;

- Telling you that she has obtained the means to hurt herself (e.g., has an extra refill of medication, has a knife);
  - Withdrawal from friends, family and community;
  - Anxiety, agitation or panic;
  - Physical illness, chronic pain/disability or terminal illness;
  - Dramatic mood changes;
  - Writing a suicide note or completing a will;
  - Giving away prized possessions;
  - Feeling that she has no reason for living, no purpose in life;
  - No future orientation other than a preoccupation with death;
  - Comments such as: “Sometimes I wonder if it’s worth going on” or “All this won’t matter soon anyway” or “I’ve made such a mess of things—my (partner/family/children) would be better off without me”; and
  - Sudden increase in energy and lifting of depression with no corresponding change in life circumstances. Your client could be relieved about having decided to kill herself. It may sound strange, but a person with depression may be most likely to attempt suicide just when he or she seems to have passed an episode’s low point and be on the way to recovery. Experts believe there is an association between early recovery and increased likelihood of suicide. As depression begins to lift, a person’s energy and planning capabilities may return before the suicidal thoughts disappear, enhancing the chances of an attempt. Studies show that the period six to twelve months after hospitalization is when patients are most likely to consider or reconsider suicide (Depression and Bipolar Support Alliance 2005).
- You must directly ask your client specific questions, such as:
    - Are you telling me that you are considering suicide?
    - If yes, what method do you intend to use?
    - Do you have access to the means? (E.g., stockpiling medications.)

- How lethal is this method? (E.g., pills vs. a gun; means other than ingestion usually mean a higher level of lethality.)
- Do you have a date, time and place in mind for your plan? (E.g., soonest vs. sometime; using the garage or jumping off the balcony.)
- If you believe your client is contemplating suicide, consider using a suicidal assessment form (see the example of a Critical Incident Suicide form on page 92). This chart will help you determine what level of care is needed. Even a client with low risk requires some intervention. To fill out this chart, you will have to ask your client more questions, such as:
  - Have you attempted suicide before (a high risk factor)?
  - Has anyone in your family/friendship circle completed suicide?
  - Have you recently experienced other losses? Is it an anniversary of a major loss?
  - Has there been some other kind of precipitating crisis?
  - Do you have a history of mental illness?
- Identify internal and external supports. Often called “resiliency factors” in the suicide literature, these include:

<p><b>Individual</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Resiliency</li> <li><input type="checkbox"/> Personal autonomy</li> <li><input type="checkbox"/> Capacity to tolerate frustration</li> <li><input type="checkbox"/> Prior experience with self-mastery</li> <li><input type="checkbox"/> Adaptive coping skills</li> <li><input type="checkbox"/> Can identify a range of feelings and situations; i.e., sees choices</li> <li><input type="checkbox"/> Self-understanding</li> <li><input type="checkbox"/> Optimistic outlook</li> <li><input type="checkbox"/> Sense of humour</li> <li><input type="checkbox"/> Religious affiliation</li> <li><input type="checkbox"/> Can make concrete plans regarding alternate actions in crisis situations</li> </ul>	<p><b>Family</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Relationships characterized by warmth and belonging</li> <li><input type="checkbox"/> At least one family member available to meet basic needs</li> <li><input type="checkbox"/> Adults modelling healthy adjustments</li> <li><input type="checkbox"/> High and realistic expectations</li> </ul>
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<p><b>Relationships</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Social competence</li> <li><input type="checkbox"/> At least one affirming, mutual relationship</li> <li><input type="checkbox"/> Positive peer modelling</li> <li><input type="checkbox"/> Acceptance and support</li> </ul>	<p><b>Community</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Opportunities to participate</li> <li><input type="checkbox"/> Affordable, accessible resources</li> <li><input type="checkbox"/> Sense of belonging</li> <li><input type="checkbox"/> Community self-determination and solidarity</li> </ul>
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- Attempt to assess your client’s thought processes. How clear is her intent to die? Most people who attempt suicide experience deep ambivalence about dying and need help to explore reasons for living. Nevertheless, resist the temptation to argue in favour of living; this allows your client to hold all the arguments for dying. Instead, both you and she must hold the ambivalence. Some part of her wants to die, yet some part of her wants to live (that is why she is talking about it with you). Ask her what she would miss if she completed her suicide plan. The following considerations may also help you in your assessment.

- How impulsive is your client? Impulsivity is compounded by substance use, when inhibitions are decreased.
- How rigid is her thinking? Rigid or black-and-white coping styles may make it difficult for your client to entertain other options for dealing with her pain.
- Discover what underlies her suicidal statements. Ask your client what wish is reflected in her suicidal thinking (Saakvitne et al. 2000). Is it to be at peace and to stop hurting? To have control when other aspects of her life feel out of control? To harm herself? (See Section 4.2.4.) To communicate pain and distress? To evoke or deserve care-taking or protection from another person? To hurt, punish or reproach others? To facilitate a reunion with a dead loved one? To avoid negative feelings (anticipating the breakup of a relationship)? To stop causing pain to others (if yes, who)? This last question may elicit concerns that:

She perceives herself to be her family’s problem, and that they are better off without her;

She is responding to a parental wish to be rid of her; or

She is attempting to distract the family from other problems.

## Critical Incident Report—Suicidal Intention

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Counsellor Name: \_\_\_\_\_

Client Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Situation: \_\_\_\_\_  
\_\_\_\_\_

Level of Risk Designated: \_\_\_\_\_

### Risk Levels

#### Low

- Suicidal ideation
- No clear plan
- No established means of attempting suicide
- Support available
- Sense of hopelessness, but strong future orientation

#### Moderate

- Suicidal intent
- May have plan, but vague
- May have means to carry out suicide
- Possible supports available
- Hopeless, but has some future orientation

#### High (Imminent)

- Determined suicide intent
- Plan includes how, when and where
- Means of intent has high degree of lethality
- No perceived supports
- No future orientation

Other Indicators of Risk (e.g., previous attempts, suicides or attempts by family or close friends, important anniversary dates, a number of personal losses):

\_\_\_\_\_

Contra-indicators of Risk (strengths and resiliencies):

\_\_\_\_\_

Action Taken: \_\_\_\_\_  
\_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

*Courtesy: South Fraser Women's Services Society*

Interventions with highly suicidal clients are as follows:

- Your goal is to create other options and open up your client's tunnel vision. Discuss with your client what support is needed and how this support can be accessed.
- Follow your agency's policy and/or your community suicide protocol on limits to confidentiality when a client is a high risk for suicide. Inform your client of the requirement that you disclose her level of risk to another person. Discuss with her how this disclosure may best support her and involve her in the disclosure.
- Be cautious in accepting a promise from your client not to complete suicide until you have completed an adequate assessment that confirms she has sufficient self-control. Some questions in this regard might be:
  - On a scale of 1-10 (1 being low and 10 being high), how much do you feel in control right now? (Listen to see if the client feels in control precisely because her intent to die is so high.)
  - Have you had times when you felt out of control?
  - What were you doing? (Listen for substance use.)
  - Is that similar in any way to how you feel today?
- Reports vary about the effectiveness of contracts with suicidal clients. One of the inherent difficulties is that a contract assumes your client has a measure of control and is able to withstand the overwhelming impulse to stop the pain. However, a contract can give you an indication of how safe your client is feeling. If, for example, she does not think she can keep herself safe for the next 24 hours, you need to take action.

As always, contracts cannot be issued in an authoritarian manner. See if you can reframe a contract into a commitment to self; e.g., "I will not harm myself, either accidentally or on purpose or in my imagination. I will keep myself alive and well." Some counsellors use a "Plan for Life." See Appendix 7.16 for an example.

Be very cautious when setting a contract with a highly dissociative client. The discussion may not be heard or held by all aspects of your client. Avoid setting up a contract in such a way that a client may feel shame for not keeping it—perhaps even so ashamed that she will not return to counselling.

- Make sure your client is in a safe, secure environment if you need to make urgent arrangements to refer her to a psychiatrist, mental health team or a general practitioner. If your client suddenly leaves your office, you must consider notifying her family and/or calling the police.
- Stay with your client until someone arrives to take her to the doctor/hospital, or accompany her there yourself.
- Also see Section 4.1 for more information about principles of crisis intervention. And don't forget that suicidal clients require regular and ongoing supervision!

Interventions with clients who have recently attempted suicide include the following:

- Remember that, for someone who has recently attempted suicide, there is a short window for you to intervene, since another, possibly more serious attempt may follow. Ask your client to tell you, in her own words, what recently happened. The goal is to re-instill a sense of mastery for her. The other purpose of this frank talk is to address the issues of trust, shame and blame that both you and your client may be experiencing (Ramsay and Newman, 2005).
- A client attempting suicide is a critical incident in a counsellor's life, often engendering ambivalent feelings. You may need to debrief and discuss some of your feelings with a supervisor or peer. You may, for example, wish to keep working with your client because you want to make it all turn out better or because you are afraid you will look incompetent. Or, you may be feeling frightened and unsure of whether you can continue with this client. You may be wondering if you should visit your client in the hospital. Clinical discussions might include examining whether the suicide attempt revealed factors that need consideration in the counselling. Perhaps a more specific referral is needed.
- Consider whether you need to revise the counselling ground rules. For example, how you will handle cancellations, missed appointments or unreturned phone calls.
- Make definite plans for help, for additional referrals as necessary and for a future appointment.

#### **Selected Web sites**

Alberta Alcohol and Drug Abuse Commission. [www.gov.ab.ca/aadac/index.html](http://www.gov.ab.ca/aadac/index.html).

Canadian Association for Suicide Prevention. [www.suicideprevention.ca](http://www.suicideprevention.ca).

Centre for Suicide Prevention. [www.suicideinfo.ca](http://www.suicideinfo.ca).

Children, Youth and Families Education and Research Network. [www.cyfernet.org](http://www.cyfernet.org).

Project Resilience. [www.projectresilience.com](http://www.projectresilience.com).

Resiliency In Action. [www.resiliency.com](http://www.resiliency.com).

Suicide Prevention and Information Centre, UBC Mental Health Evaluation and Community Consultation Unit. [www.mheccu.ubc.ca](http://www.mheccu.ubc.ca).

#### 4.2.4 Self-injurious behaviour

Self-injurious behaviour (SIB)—also known as self-harm or self-inflicted violence—consists of self-inflicted injuries such as cutting, burning, head banging, bleaching, sniffing gas, cheek biting, hair pulling, picking at skin, genital mutilation, failure to seek medical care and hitting oneself, walls or other hard objects.

Eating disorders are sometimes included in the definition as well. Another category of SIB is overdosing on drugs; e.g., deliberately ingesting a handful of pills. The intent is not suicidal but is often misconstrued as a suicidal act. Clearly, however, the risk of death is high.

Turp (2003) invites us to consider the following continuum as a means of understanding that SIBs are simply one end of a continuum that we all live on.

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Good enough Self-care	Moderate Self-care	Compromised Self-care	Mild Self-harm	Moderate Self-harm	Severe Self-harm
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Approximately one percent of people—mostly women—perform acts of self-harm, according to the American Self-Harm Information Clearinghouse (retrieved December 2005). The vast majority of those women are survivors of traumas who have learned to use SIBs as means of coping with overwhelming feelings and responses associated with their traumas. STV counsellors can expect that a portion of their clients practise self-harm, although it is rarely the presenting problem, as most self-injurers tend to hide their problems.

- It is useful to matter-of-factly and directly ask about SIBs. Say that it is a common coping mechanism among survivors and ask her if that has ever been her experience. In doing so, you are setting the frame for further disclosure. It communicates your familiarity with the problem and your willingness to have an open discussion when she is ready.
- Recognize that SIB will likely cause great anxiety in you. It is tough to sit with a client who recounts stories of cutting, burning or slashing themselves. We

can experience feelings of repulsion, ineffectiveness, fear and helplessness. Working with SIB clients requires us to monitor our counter-transference feelings constantly without moving to rescue the client (and perhaps idealizing them) or to persecute (perhaps by using an authoritarian tone of voice when discussing SIB or by avoiding discussion).

Be compassionate yet dispassionate. You cannot take responsibility for your client's injuring. A stance of empathic confrontation is useful. For example: "I understand that you are in a lot of pain and the self-harming is how you cope. That makes sense to me. I'm wondering if you would be interested in exploring other ways of helping you manage, ways that didn't leave you feeling ashamed. Or having to deal with other people's reactions. Does that sound like something worth discussing?" Courtois (1999) states that counsellors must respond to the disclosure of SIB. To ignore it is to replicate the stance of the non-offending parent or witnessing bystander who does not act. However, do not set immediate cessation of SIB as a goal.

- Be careful with contracts. You need to ask yourself whose benefit a contract serves. For many counsellors, contracts may help contain their anxiety. For the client, however, the danger is that if she does self-harm, she is likely to feel rejected, possibly even reabused. Forbidding SIB behaviour may merely drive it underground (Waites 1993). In addition, it may snare you in a power struggle in which you insist that the behaviour stop, and your client becomes reticent and distrustful, thus reducing the chance that a useful therapeutic alliance will be formed.
- Establishing good boundaries within the therapeutic relationship is of utmost importance. You will need to set boundaries that keep you safe, while at the same time allow your client freedom to wrestle with her SIB. A counselling setting must be a safe haven. It is important that no SIB take place in the counselling premises (office, bathroom, etc.), and that the consequence for breaking this safety agreement may be to renegotiate counselling goals. You also need to explain that if SIBs escalate during counselling, the focus on trauma may not be appropriate (Miller 1994; Rivera 1996). Be cautious in setting boundaries that you may find hard to keep; e.g. "Call me whenever you need to." Connors (2000) offers an extensive discussion about establishing a therapeutic alliance with a self-injurious client.
- It is important to listen to your client explain why she self-harms, in what Burstow (1992) calls co-exploration. Rarely is SIB about suicidal gestures or manipulating for attention; believing these myths tends to lead to unhelpful attitudes and interventions.

- Self-harm is a way of preventing suicide, not a failed attempt at suicide. Most self-harmers clearly distinguish between cutting as a coping mechanism and attempted suicide, the latter of which is often done through other means.
- Clients who self-harm are not manipulating for attention in the usual pejorative description. In most cases, self-harm is not done for the response it evokes in others. It may be a traumatic re-enactment in the sense of a traumatized child who is crying out in the hopes that someone will see the pain she is in (Miller 1994). If this is the case with your client, it is important for you to discern the message behind the SIB. Encourage your client to put words to the behaviour; e.g., “If your cutting could talk, what would it say . . .?”
  - Self-harm does have aspects of learned behaviour. Witness the imitation of in-hospital patients or group home roommates who quickly teach each other the basics of cutting or other SIBs. If secondary gain is a question, it is important to intervene on an individual level, not in a group setting.
  - It is not true that only people with borderline personality disorder (BPD) self-harm. It is true that SIB is one criterion for the BPD diagnosis but there are eight other, equally important criteria. Not everyone with BPD self-harms, and not all people who self-harm have BPD, regardless of practitioners who automatically diagnose anyone who self-injures with BPD. If we must use a label, complex PTSD is likely to be a more accurate description.
- SIBs are “tension reduction behaviours” (Briere 1996), attempts by the survivor to manage overwhelming states on one of three points on the PTSD axis:
  - Flooding (too many flashbacks);
  - Arousal (too much anxiety or anger); or
  - Dissociation (too much numbness).

SIBs are harsh but effective means of restoring some form of balance. “Survivors who self-mutilate consistently describe a profound dissociative state preceding the act. Depersonalization, derealization and anesthesia are accompanied by a feeling of unbearable agitation and a compulsion to attack the body. The initial injuries often produce no pain at all” (Herman 1992, 109). Depersonalization is the sense of not being real and derealization is experiencing the environment as two-dimensional, strange or unreal; therefore, to cut is to know you are alive—you exist in the real world. Thus, SIBs seem to be employed when the survivor needs to manage dissociation—to facilitate it when emotions are too over-

whelming, and to diminish it when she feels too disconnected from herself and the world (Mazelis 1998).

In addition, survivors report using SIBs as means of self-punishment because they believe they deserve punishment or because they hope self-punishment will avert worse punishment from an outside source. SIBs are also a powerful method of expressing feelings that have no label; alexithymia (literally no words for feelings) is quite common in people who self-harm. Therefore, a very important principle of working with a self-harming client is never to assume the role it plays, but instead inquire how it is a helpful coping tool for her. A simple assessment of the role SIBs play for your client follows:

### **A simple assessment for SIBs**

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. The behaviour(s)
2. How does this behaviour help the client? What problem/s does it solve?

Ask the client for specific examples. Some clients may use one behaviour for one purpose and another behaviour for another purpose.

- Expresses strong feelings; e.g., anger
- Punishes self (especially before someone else can)
- Blocks strong feelings (serves as a distraction, uses physical pain to block emotions, thoughts, memories)
- Manages behaviour (stops one from doing something else; e.g., suicide)
- Creates or strengthens dissociation
- Helps client to stop dissociating, to feel more real
- Helps client to re-enact the trauma without consciously remembering it
- Strengthens the client's feelings of self-control over her body
- Helps reinforce internal rules; e.g., I don't need anyone, I have no desires
- Gives expression to a state that seems to have no feelings
- Other

3. What is the client's cycle of SIBs, and what is the window of intervention?

*Adapted from Saakvitne et al. (2000).*

- Avoid inadvertently encouraging SIBs. It is important to maintain a present focus, even if your client discloses a history of child abuse and neglect. Exploring trauma memories can precipitously trigger more episodes of self-injury. Apply the same principles when intervening in substance use. Do not focus on details and fantasies associated with SIBs. Discuss the cycle of SIBs with your client. Identify triggers and danger points. Once the cycle has been mapped out, identify points where she can delay or interrupt the SIBs. Consider at what stage of change your client may be in and match your interventions accordingly (see Appendix 7.14 for more information on the stages of change model).
- Successful intervention with SIBs depends heavily on teaching your client new ways of coping with stressors. Simply understanding the connection of SIBs to a trauma history is not enough. Patterns of SIB that are not immediately dangerous are best handled by exploring their origins and meanings. Validate the needs that SIBs serve. Clearly acknowledge their value as coping mechanisms. Respectfully name your client's feelings. At the same time, assist your client in developing alternative means of coping with the feelings and urges associated with the SIB cycle.
- Negotiate for periods of delay (at least 15 minutes) before self-injury. Offer your client alternative solutions and behaviours to use during that 15 minutes, such as breathing exercises, meditation, self-hypnosis, listening to a tape that you create, substituting short-term painful experiences (such as plunging her hand into a bucket of ice or snapping a rubber band) and drawing and writing (on the body as well as on paper). (See Appendix 7.15 for more alternatives to SIBs.) This is when having a safety plan is useful, since clients often have difficulty remembering the strategies discussed in the comfort of your office when faced with the overwhelming need to use sideways coping mechanisms (whether SIBs, substance use or other adaptations). Some clients will repeat the 15 minutes again and again.
- Consider using expressive therapies to express the SIB urges, assuming you have the training and your client is relatively stable (i.e., is oriented to the present or can discriminate between safe and dangerous play). Waites (1993) writes that when a client mentions an impulse to cut, she encourages her to "do it on the paper!" (201)
- At first, most clients will delay as long as they can, but ultimately will see no other option but to self-harm. If this is the case with your client, urge her to set definite limits on her SIB. Ask her to decide beforehand exactly what she will allow herself to do and how much is enough. The goal is to stick to those

limits and begin to exercise some control over a behaviour that seems completely out of control.

Encourage your client to keep herself as safe as possible while injuring herself (e.g., by not sharing cutting implements or keeping cuts shallow). Ask her to keep first aid supplies on hand. Encourage her to take responsibility for the injury and to bandage herself or, if necessary, to go to the hospital. Busy emergency room staff are often perplexed by deliberate self-injury and may believe some of the myths listed above. Your client should be prepared for a cool and perhaps confrontational response.

- Hospitalization is a treatment of last resort and should be time-limited and voluntary. In terms of medication, research indicates that the best pharmacological treatments to date are high doses of SSRIs (the new generation of anti-depressants) or atypical neuroleptics such as Clozapine or Risperidone.

## Resources

- Alderman, T. 1997. *The scarred soul: Understanding and ending self-inflicted violence*. Oakland: New Harbinger Publications. This self-help book for self-harmers explores the cycle of SIBs from various perspectives, including addiction and operant conditioning. Lots of exercises as well as discussions about alternatives to self-injury.
- Burstow, B. 1992. *Radical feminist therapy: Working in the context of violence*. Toronto: Sage Books.
- Connors, R. 1996. "Self-injury in trauma survivors: Functions and meanings." *American journal of orthopsychiatry* 66(2): 197-216.
- Connors, R. 2000. *Self-injury: Psychotherapy with people who engage in self-inflicted violence*. Northvale, NJ: Jason Aronson Inc. A very readable, comprehensive book that examines many facets of self-injurious behaviour. Also has a chapter on the counsellor's reactions.
- Courtois, C. 1999. *Recollections of sexual abuse: Treatment principles and guidelines*. New York: W.W. Norton.
- Favazza, A. 1996. *Bodies under siege: Self-mutilation and body modification in culture and psychiatry*, 2d ed. Baltimore: Johns Hopkins University Press.
- Herman, J. 1992. *Trauma and recovery*. New York: Basic Books.
- Mazelis, R., ed. *The cutting edge: A newsletter for women living with self-inflicted violence*. The Sidran Institute. [www.cuttingedge@sidran.org](http://www.cuttingedge@sidran.org).
- Miller, D. 1994. *Women who hurt themselves: A book of hope and understanding*. New York: Basic Books. An important book that examines how self-injurious behaviour is a form of traumatic re-enactment.
- Saakvitne, K., S. Gamble, L. Pearlman and B.T. Lev. 2000. *Risking connection: A training curriculum for working with survivors of childhood abuse*. Baltimore: Sidran Press.

- Strong, M. 1998. *A bright red scream: Self-mutilation and the language of pain*. London: Penguin Books.
- Trautmann, K. and R. Connors. 1994. *Understanding self-injury: A workbook for adults*. Pittsburgh: Pittsburgh Action Against Rape.
- Turp, M. 2003. *Hidden self-harm: Narratives from psychotherapy*. London: Jessica Kingsley Publishers. Introduces the continuum of self-care to self-harm and discusses Turp's work with five self-injuring clients.

### **Selected Web sites**

[www.nch.org/self-harm](http://www.nch.org/self-harm) is a U.K. site that posts a guide to understanding and responding to self-injury called Look beyond the scars.

[www.palace.net/llama/psych/injury.html](http://www.palace.net/llama/psych/injury.html) is a site that provides lots of information about self-harm. The site also hosts the "bodies under siege" e-mail support list.

## **4.3 Assessing Readiness for Post-crisis Counselling**

After the immediate crisis has passed, some clients may wish to enter stage one of trauma counselling. Other clients will arrive ready to enter stage one. In either case, it is important to do a round of assessment to broaden the picture.

Assessment is a continuous process; it is not complete after filling out a form. Although many agencies require counsellors to complete an assessment form within the first few appointments or first few weeks of counselling, you will continue to assess throughout the entire counselling experience. Some conditions, such as the extent of dissociation, do not become apparent until the counselling is well underway. It takes time to know the "truth." Clients disclose over time.

- Ask your client about common coping skills that have shame attached to them, such as alcohol, drug use and/or self-injurious behaviour. You can approach this by commenting that these issues are quite common for survivors, and that you are wondering if she has any experience with them. You may not receive full disclosure, but you are providing education and validation. In effect, you are planting a seed that, with the growth of a therapeutic alliance, may germinate into disclosure.
- In later counselling sessions, ask about the purpose, meaning and usefulness of "dysfunctional" coping skills. Such coping skills represent an effort to manage overwhelming experiences. Remember that trauma derails normal childhood development, specifically capacities to take care of oneself in healthy ways.
- Strive for a broad picture of the client. Try to get a sense of her overall life, her sense of herself as someone other than a survivor. Assess for strengths and resources as well as trauma reactions.

- Be wary of overwhelming your client. Completing genograms and/or life histories can be extremely stimulating. If your client has a background of multi-generational traumas of abuse, violence and alcohol, capturing all of those dynamics on one piece of paper may simply crush your client’s capacity to stay present or to self-soothe.
- Consider genogram alternatives such as pictures or models of animals that can illustrate various family members and their positions within the family constellation. Such alternatives have the advantage of being non-verbal and concrete, two modalities that often assist survivors.
- Create a cultural genogram by expanding the genogram to include personal events that reflect cultural pride and shame.
- Consider asking your client to complete an eco-map, a rendering of significant relationships in her present life and the degree of intimacy or conflict she experiences within those relationships. See Appendix 7.8 for a sample eco-map of a client’s support system.
- Gather histories in a contained manner. See Appendix 7.9 for ideas.
- Ask about life events other than violence. When reviewing your client’s history—either through conversation, genograms or life histories—look for other traumatic events such as deaths or accidents. Also note disconnections and attachment injuries. Similarly, note persons who provided resources to your client, or experiences that your client can draw on for support.
- Remember that medical events and illness can cause trauma responses. For example, a client who was hospitalized at an early age may suffer from post-trauma responses, or a client who had asthma in childhood may wonder if her memories about being out of breath are related to sexual abuse.
- Don’t forget the physical side of assessment. Ask your clients to have their symptoms checked medically. Klonoff and Landrine (1997) have written about physical illness that may also mimic psychological symptoms.
- Check to see if your client has the essential elements for survival. Some women are missing some of the basics, such as safety, shelter, financial resources or food. In addition, she may be facing legal issues. These basics will need attention before trauma work can begin.

- Ask your client what has helped her to manage overwhelmed states in the past. Build on whatever past successes she has experienced.
- Ask your client if she has ever gone to counselling before. If yes, what was her experience like? What was most helpful for her? What was least helpful? If she replies that she has seen five counsellors who were all wrong for her, you need to understand what the problems were. Set your boundaries tight. It is always easier to loosen them than to try to tighten them later.
- Subjective assessment (general questions and conversations) can be enhanced by simple assessment tools that involve your client. Structured assessments are best used in medium- to long-range counselling settings. Short-term, crisis-focused interventions often have time for only basic safety assessments. Structured assessments help identify trauma- or violence-related symptoms, thus helping to normalize reactions. They can also assess the client’s self-capacities to tolerate painful feelings or soothe herself, helping both the woman and the counsellor identify the client’s ability to move beyond stage one. Additional considerations when using assessment tools are as follows:
  - Consider your purpose in using assessment tools. Some clients find them very validating as “proof” that they have legitimate issues; others find the diagnostic language intrusive. You can introduce these tools by saying they often provide further understanding of clients’ unique situations, specifically identifying issues or topics you haven’t thought to ask them about.
  - Familiarize yourself with the instruments. Certainly try them on yourself or your colleagues before using them with clients. Know the time involved and leave time for grounding. Most instruments are stimulating.
  - Assessment instruments such as Briere’s Inventory of Altered Self-Capacity (IASC) and the Traumatic Stress Inventory (TSI) are appropriate for clinical counsellors who have an understanding of test scoring and interpretations. For assessments of complex post-traumatic stress, consider using the Structured Interview of Disorders of Extreme Stress (SIDES) (Pelcovitz et al. 1997) and the Self Report Inventory for Disorders of Extreme Stress (SIDES-SR) (Spinazzola et al. 2001). See the list of resources at the end of this section.
  - If you think your client may be overwhelmed by the stimulating nature of most assessment measures, complete the assessment with your client in the office. Another advantage of completing the assessment together is that you often learn about your client’s sidebar experiences (events that are not directly related to the assessment questions but still important for you to hear about).

**POSTTRAUMATIC STRESS ASSESSMENT**

Date \_\_\_\_\_

Client Name \_\_\_\_\_ Trauma \_\_\_\_\_

Since the trauma which of the following is being experienced and how frequently:

SYMPTOM	Frequent 3-5x/wk	Occasional 1-2x/wk	Seldom 1x/wk	Never 0
<b>INTRUSION</b>				
*Intrusive thoughts and images				
*Recurring dreams-nightmares				
*Flashbacks				
Anxiety attacks				
Crying spells and tearfulness				
Feeling of shame, embarrassment				
Guilt feelings (* If only... *)				
<b>WITHDRAWAL</b>				
*Withdrawal				
*Depression-diminished interest				
*Feeling of detachment or estrangement				
*Inability to recall specific events of trauma				
*Disorientation, confusion				
*Restricted affect				
*Avoidance of thoughts of trauma				
Fear				
Job difficulties				
Sexual dysfunction				
Numbness-emotional/physical				
Helplessness, loss of control				
<b>AROUSAL</b>				
*Sleep disturbances				
*Anger/Rage				
*Difficulty in concentrating				
*Hypervigilance				
*High startle response				
Headaches				
Muscle tension				
Nausea				
Eating disturbances				
Difficulty in breathing				
Cold sweat				
Increased alcohol usage				
Increased drug usage				

Presently taking medication? Yes \_\_\_ No \_\_\_ Describe \_\_\_\_\_

Specific health problems \_\_\_\_\_

Doctor \_\_\_\_\_

*Courtesy: Maggie Ziegler*

- Even if you do not tend to use assessment instruments, it is useful to note some of the questions and slip them in as part of your overall assessment. For example, the Traumatic Antecedents Questionnaire (TAQ) asks simple questions—such as, “Was anyone available to make you breakfast in the morning?”—that help to assess for childhood neglect.
- The preceding page is a simple chart that assesses for the DSM-IV-TR symptoms of post-trauma, as well as other common presentations.

## Resources

- Harvey, M. 1996. “An ecological view of psychological trauma and trauma recovery.” *Journal of traumatic stress* 9(1): 3-23. Explains the eight domains that are indicators of recovery from trauma.
- Haskell, L. 2003. *First stage trauma treatment: A guide for mental health professionals working with women*. Toronto: Centre for Addiction and Mental Health. A comprehensive guide to stage one interventions with trauma survivors.
- Klonoff, E.A. and H. Landrine. 1997. *Preventing misdiagnosis of women: A guide to physical disorders that have psychiatric symptoms*. Thousand Oaks, CA: Sage Publications. Explains some illnesses that are physically based but can be misdiagnosed as psychiatric conditions.
- Pelcovitz, D., B. van der Kolk and S. Roth, F. Mandel, S. Kaplan and P. Resick. 1997. “Development of a criteria set and structured interview for disorders of extreme stress (SIDES).” *Journal of traumatic stress* 10: 3-16.
- Saakvitne, K., S. Gamble, L. Pearlman and B.T. Lev. 2000. *Risking connection: A training curriculum for working with survivors of childhood abuse*. Baltimore: Sidran Press. A magnificent resource.
- Spinazzola, J., M. Blaustein, C. Kisiel and B. van der Kolk. 2001. “Beyond PTSD: Further evidence for a complex adaptational response to traumatic life events.” Paper presented at the American Psychiatric Association Annual Meeting, New Orleans.

## Selected Web sites

- Psychological Assessment Resources. [www.parinc.com](http://www.parinc.com). Includes J. Briere’s Inventory of Altered Self-Capacities (IASC) and the Traumatic Stress Inventory (TSI). The IASC provides scales for clinical counsellors who have had some training in test scoring and interpretation. The TSI is a 100-item self-scoring test of post-traumatic stress and other psychological consequences of trauma, including rape, spouse abuse, physical assault and childhood abuse. All questions begin with: “In the last six months, how often have you experienced . . .?” The TSI also includes a manual for scoring and interpreting results.
- The Sidran Institute. [www.sidran.org](http://www.sidran.org). Includes E. Carlson and F. Putnam’s Dissociative Experiences Scale (DES), a 28-item self-reporting instrument that can be completed in 10 minutes and scored in less than 5 minutes to assess dissociative behaviours in simple to understand language.
- The Trauma Centre. [www.traumacenter.org/assessment.html](http://www.traumacenter.org/assessment.html). Includes B. van der Kolk’s Traumatic Antecedents Questionnaire (TAQ), a simple self-administered assessment tool to gather information about lifetime experience in 10 domains: competence, safety, neglect, separation, family secrets, conflict resolution, physical trauma, sexual trauma, witnessing trauma and exposure to drugs and alcohol. The information is gathered for four different age groups, giving a

comprehensive look at developmental issues. This questionnaire generates good discussion, helps set treatment direction and brings to light historical information that might not otherwise become visible.

## **4.4. Developing Counselling Goals and Counselling Planning**

### **4.4.1 Developing a counselling plan**

STV counsellors provide a continuum of service possibilities. On one end of the continuum of counselling possibilities is a woman who just wants validation that she should get out of an abusive relationship. She seeks some tips on how to do that and successfully moves on with her life. On the other end is a client who has long involvement with the mental health system and who seeks ongoing support, counselling and advocacy.

The essence of counselling planning is the ability to define the client's needs and desires, and to set goals together based on your understanding of what is possible. Negotiate as necessary to create realistic expectations about outcomes, particularly if time constraints are involved.

Just as assessment is an ongoing process, so too is counselling planning. The STV counsellor is always considering the client's specific issues, needs and resources within the backdrop of the three-stage trauma model. Discuss your considerations with your client. Discuss the stages and the specific implications for your work together. One of the authors of this Manual uses a handout to review the overall process of trauma recovery with clients (see Appendix 7.12).

The benefits of a counselling plan are twofold: 1) it provides a road map for your client, who may be entering uncharted territory, and 2) it gives you permission to rein in wayward sessions by referring back to the counselling plan.

- Explain the differences between support, counselling and advocacy. Your client may not be clear about the services you can offer.
- Give your client some ideas about what to expect. Explain that you place such strong emphasis on safety and containment at the beginning of the counselling because exploring abuse experiences is difficult.
- Be clear that discussing your relationship is part of the road map. The amount of discussion required will likely depend on the intensity of the services you are providing. For example, in a counselling relationship, the client can expect to experience feelings of anger and dependency toward you, the counsellor. Explain that this is normal and can be resolved. One study of 132 survivors in therapy found that the therapeutic alliance was strengthened when the

counsellors took steps to explore angry outbursts and their own roles in them (Dalenberg 2004).

- Based on your assessment, you will have identified gaps in your client's resources. Begin to formulate a plan about how to aid the development of those resources, approximately how much time you will need and other options that may also be utilized. For example, you may realize that your client does not have an internal schema of safety, so you decide to help her create a safe place and a container to store painful memories. You know that if you dedicate two or three sessions to this piece of the work, it could be completed and you will be able to use these tools to ground your client throughout your sessions. However, you may encounter obstacles: crises that erupt, the client's discomfort with guided imagery or not having ever experienced a safe place, etc. Therefore, you will need to alter your counselling plans and substitute other approaches.
- Set achievable goals that are specific, measurable and appropriate to your client's stability and the stage of counselling; e.g., "Here's what we can focus on." Seek clarification when a client says she wants to "work on my issues." A client may wish to seek validation, request a witness, grieve, reintegrate memories, process frozen feelings, rediscover a capacity for joy, etc. Which is it?
- As your skills and experience build, it is useful to state confidently what you and the client should be able to accomplish in the next six months. For example, "We can create three new strategies to help you deal with your flashbacks." Or, "After two months of mobilizing resources with EMDR, you will feel much better." This is not about bragging but about rallying hope in a realistic manner.
- Be prepared to alter your plans; they are guidelines, not rules.
  - Develop a feedback loop to check in regularly with the client to determine if the counselling is on track and is meeting her needs. A simple method is to ask the client at the end of each session what was useful for her. Another approach is to ask the client every three to four sessions if she feels the counselling is meeting her needs. A more formal approach is to ask the client to complete a written questionnaire. See Appendix 7.13 for an example.
  - Respect the rhythm of the client. Understand that telling her story takes time. Your client is in control of the amount of information she wishes to disclose and when she chooses to do so, if at all. A client's apparent

resistance is really fear. This is normal, and it does not mean she is uncooperative. At times, clients may need to take a break. This is also normal, considering the great effort it takes to confront sexual assault and/or partner abuse and the associated trauma responses. As with any relationship, there are ebbs and flows. There will be periods when your client will reach a plateau and other periods when important work and movement can occur. Periods of consolidation are also important. Sometimes the most important task is to forgo counselling and go out into the world to live.

#### **4.4.2 Planning for the end of counselling**

Much of the literature about planning for counselling to end is directed at private practitioners whose financial gain may compromise timely endings with clients. The opposite problem is often true with STV programs that have a time-limited mandate of either a number of sessions or a period of months in which counselling is available.

The most optimal scenario for ending counselling is when the client initiates the idea of ending and the counsellor agrees that the timing is appropriate. The criteria for optimal endings include the client's sense that she is functioning better and experiencing relief, and the counsellor's intuition that the timing for ending is right. This section addresses some of the less-than-optimal endings that you might encounter.

Just like all the other stages of counselling, the end phase has its particular traps and obstacles. "Endings are so inextricably tied to the basic human connection that fears of abandonment and rejection can be stirred up in both client and counsellor" (Kramer 1990, 2).

- Think about termination from the beginning. Preparation for the conclusion of counselling starts at intake and is ongoing throughout the counselling process. Accept the limitations of the time mandate. STV Counselling draft program standard 7.2 states: "The STV counsellor and the woman jointly establish an initial plan for the conclusion of counselling, and collaborate on subsequent decisions regarding the specific point at which counselling will end" (BCASVACP 1998a). This means you need to explain that each client has unique needs, and counselling begins and ends at different points.
- The meaning of endings is unique to each client. It is important to remember that many clients have experienced abrupt terminations of important attachments in their lives. Explore and discuss this with your client, setting a goal of having the ending be more positive than her prior experiences.
- It is necessary to refer a client if it becomes clear (usually within two to twelve sessions) that you cannot provide the requested service or that her needs would

be better met through another resource. Frankly discuss this issue with your client. Explain that this does not mean she is at fault, but, rather, you have some difficulty in addressing the issues.

- Be wary of precipitous endings that are based on your reactions to your client. Kramer (1990) suggests that many counsellor-initiated endings are driven by the counsellor's counter-transference. "Clients have the right to act out all of their psychological issues on the therapeutic stage, even and especially when they are being boring, being stuck, being overly dependent and all their variants" (31).
- When ending with a fragile client, be clear that you are up for numerous discussions. Offer her a menu of possible reactions that she might be having. Adopt a warm, empathic stance; avoid being neutral.
- If your program has a time-limited or session-limited policy, a useful procedure might be that counsellors bring the case to supervision before they extend either the time or the number of sessions. Generally speaking, the guidelines for extension are that the client is in crisis or another block of time will assist in completing a chunk of work she is currently processing.
- As the counselling sessions progress, offer an occasional reminder about the projected end date.
- Many counsellors do a "slow wean" with their clients where they move from weekly to biweekly and then monthly sessions. Some counsellors offer an automatic follow-up session in a month. Other programs offer a certain number of phone calls. The goal is for a check-in report by your client and not the introduction of new material.
- Discuss with your client if and how she may access counselling services in the future if needed. For example, what should she do if she experiences new memories?
- Some programs ask clients to return for a final session if they have decided to leave counselling. This is an attempt to avoid clients prematurely fleeing; however, it is difficult to enforce. Kramer (1990) suggests discussing a client's pattern of prematurely ending relationships of all types and how that might be an indicator of how the client will leave counselling.
- When clients disappear, it is often difficult to know what action to take and how to maintain a perspective that balances the client's autonomy and yet seeks a positive outcome. A useful guideline might be to make a follow-up phone call. If

you do not receive any answer, send a brief note that acknowledges that you respect her decision to end counselling and that she can contact you or your agency in the future. State at least one positive thing about working with her.

- Clients may have various ways of saying goodbye: some will disappear early or not show up for the last session; others will show their distress by ramping up the crises; others may be silent or laugh a lot. Some will want to cut off all contact and others will pray for follow-up sessions. This is particularly true in groups—some members will not show up while others will be planning the reunion session. Do not rely solely on verbal means. Offer your client options, such as writing you an occasional note or leaving you a message.
- Counsellors often focus on the unfinished business; however a client mostly needs to hear about her positive growth and changes she has made, and how those changes will help her in the future. In addition, you should recognize and affirm any changes that may have occurred in the counselling relationship between the two of you.
- In terms of records management there are several issues to consider at termination.
  - If you have conducted art therapy with your client and have been holding drawings, remember to return them to her. Those materials belong to her. This also applies to your client’s writings and journals.
  - Set a policy that states how much time elapses before you close a file.
  - Set a policy on if/when you will shred session-by-session notes. Most professional organizations, including the BCASVACP in the forthcoming updated *Record Management Guidelines* (Ruebsaat and Porteous in press), suggest that counsellors retain records for seven years. In the case of child clients, this would be seven years from the age of majority. In B.C., the age of majority is 19 years, so you would have to keep session files until the client turns 26 years old.
  - Consider creating a summary sheet that captures the basic information about the counselling process and keeping that information indefinitely.
  - Discuss with your client whether she wants you to inform her about other services that may be helpful to her (e.g., future groups). Under the new Personal Information Protection Act, you need to gain her written permission if you plan to contact her for any reason.

- Ending counselling does not mean that your client will never have problems again, but it will be apparent that the assault/abuse no longer controls her. Adams and Fay, in *Free of the Shadows* (1987, 91-92), include a list of the gains achieved by a client prior to leaving counselling. Below is an adaptation of this list.
- A strong sense that she is not alone;
- An understanding of the phenomenon of sexual and intimate partner violence in our culture and the impact it has had on her life;
- A sense of control over her life and further development of coping skills;
- A sense of physical well-being and knowledge that she can take care of herself and her body;
- Being at peace with her decision to report the assault/abuse to the police and take legal action;
- Being able to express her sexuality in a positive way, and not burying or expressing it indiscriminately or in a self-destructive way;
- Freedom from alcohol or drug dependence;
- Increased self-esteem by having been heard and seen as a person with skills and resiliency;
- Freedom from the desire to get revenge on the offender;
- The ability to choose to talk or not to talk about the assault;
- An ability to trust when she chooses to trust;
- Freedom from guilt or self-blame;
- Memories of the assault/abuse that no longer threaten to overwhelm her;
- Progress from victim to survivor and maybe to warrior; and
- A new picture of the world and her place in it.

## Special Issues—Clinical

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### 5.1 Substance Use

#### 5.1.1 Screening for substance use

In this Manual, substance use is defined as ingesting alcohol or drugs, prescription or illicit. Substance use is very common among trauma survivors. Alcohol, in particular, is a form of self-medication that is readily available. Substances are often used to manage the physical pain from assaults and/or the emotional pain experienced with intrusive memories or images. Women with childhood histories of sexual assault are significantly more likely than other women to report substance use. Since it is so common, it is important that STV counsellors have some understanding of substance use issues.

An old feminist adage is to “meet the woman where she is at.” This is also one of the principles of harm reduction. However, when substances are used as a way of coping with the trauma, abstinence is required for stage two trauma processing. Therefore, the authors have strived for a blended model that reflects the various realities of STV clients.

Following a model of harm reduction means looking for opportunities to provide information on how to use drugs more safely and to offer the substance user information and perspectives that might lead to future change. It does not mean standing by while your client engages in risky behaviour that puts others at risk; that is called enabling. If children are involved and you consider them to be in need of protection, MCFD may have to be notified.

- It is important to ask your client directly about substance use. Framing substance use as a common means of coping—albeit one with negative consequences—may serve to lessen the stigma and shame of disclosing substance use.
- You need to assess your comfort level in exploring issues of substance use. Discomfort may arise because of inadequate training and subsequent feelings of incompetence, or because of personal experiences and beliefs. These feelings or a possible need for further training need to be addressed for you to support women with substance use issues.

- The exact nature of the relationship between a woman's experience of assault and her use of substances is usually complex and unique. Avoid making assumptions. Ask her to describe how she understands the connection between her experiences of violence and her substance use. Najavits (2002a) suggests that substance use can have various meanings for women with post-trauma reactions:
  - To access feelings;
  - To shut off feelings;
  - As revenge against the abuser;
  - As re-abuse of herself;
  - As slow suicide; and
  - As learned behaviour.
  
- All STV counsellors need to know the basics of screening for alcohol and drug use. (See Appendix 7.14 for more information.) One simple screening tool is The CAGE Screening Instrument. This is a four-question test that can identify alcohol problems over a client's lifetime. Two positive responses are considered worthy of further assessment. Although it was first developed to screen dependent drinkers, it has been used successfully with other substances, including nicotine. The four questions are:
  - C** Have you ever felt you should **cut down** on your drinking/drug of choice?
  - A** Have people **annoyed** you by criticizing your drinking/drug of choice?
  - G** Have you ever felt bad or **guilty** about your drinking/drug of choice?
  - E** **Eye opener:** Have you ever had a drink/drug of choice first thing in the morning to steady your nerves or to get rid of a hangover?
  
- You can also use a harm reduction approach to keep your client as safe as possible while she is using substances. You must be clear that, although you acknowledge the trauma in her life, you will not be working to resolve the trauma at this time. Focus on encouraging her to understand the possible links between the trauma and substance use, and on increasing her desire to think about alternatives.

- Weigh the extent of the substance use against the woman’s ability to make use of counselling. For some women, STV counselling may not be appropriate. Specific alcohol or drug treatment may be required. In a situation where a woman cannot effectively use counselling because of her substance use, it is important to discuss alternatives with her. Do not assume she is ready to make changes. If the woman is not yet at a stage to consider modifying her behaviour, you can only offer feedback on what you have observed. Consider your feedback as a seed that might germinate change in the future. If she is at a stage where she is willing to consider making changes, discuss a referral to detox or a day or residential treatment program. Also discuss support programs such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA).
- Provide alternative 12-step models. Some women find the traditional 12-step model disempowering. Consider introducing your client to a feminist version of the 12-step model (e.g., BCASVACP, Handout 3, STV Counselling Program Core Training). Another alternative is the 16-step model, which brings a flexible, socially conscious approach to recovery and seeks to build self-esteem and empower people to find their own voices. The 16-step model is especially useful for women and other marginalized people (Kasl 1992).
- You might also consider offering a group for women who are trauma survivors and substance users, following the “Seeking Safety” model as described in Najavits (2002a). See Gose (2004) for a report of a successful pilot project.
- Know where the woman is at within a stages of change model. Developing a change model is one of the most useful tools for counsellors working with substance users (Prochaska and DiClemente 1994). Substance users, they suggest, have different support needs at different stages of their using/recovery processes. If you are able to identify which stage a substance-using client is at, you can then offer more tailored interventions. If a client is not interested in changing her use, then harm reduction interventions are most appropriate. However, if your client is ready to change, your interventions have more specific intentions. A summary of the chart is below. See Appendix 7.14 for more information.

## Prochaska and DiClemente's Model of Change

Stage	Client stage	Helper's role
<p><b>Pre-contemplation</b> <i>(Actively using)</i></p>	<p>This is a happy user who enjoys drinking. Positives outweigh any costs.</p>	<p>Ask what she wants from you now. Sow seeds for change. Keep the relationship open and supportive. Get to know her and her goals. Give her harm reduction information. Acknowledge her choice not to change. Create/seize opportunities to explore use.</p>
<p><b>Contemplation</b> <i>(Still using but considering change at times)</i></p>	<p>This individual feels that drinking is enjoyable and exciting, but that the costs are starting to mount up. She is now feeling ambivalent about her behaviour. Personal, medical, psychological and family problems may be associated. She is not considering change within the next month.</p>	<p>Go slowly. Elicit reasons to keep using and reasons to change. Explore risks of not changing. Ask what differences she will notice if she changes: in her health, with significant others, at work. Strengthen her self-efficacy to choose to change. Offer choices.</p>
<p><b>Preparation</b> <i>(getting ready to change)</i></p>	<p>This individual has made the decision that her use of alcohol or risk-taking needs to change. She really wants to reduce or stop her substance consumption. She is planning to act within one month.</p>	<p>Work alongside your client to build motivation for change, to develop a menu of options and to assist in determining the best course of action to make change. Prepare your client for what change will be like. Set realistic goals. Contract for brief or small changes while planning for bigger ones. Complete a thorough assessment if not already done. Begin to develop alternative coping skills. Help client identify social support.</p>

<b>Stage</b>	<b>Client stage</b>	<b>Helper's role</b>
<b>Action</b> <i>(changing)</i>	This individual actively commits to a specific behaviour change, such as cutting down or stopping drinking and practising new behaviours during a three- to six-month period.	Help the client take steps toward change. Ask what small adjustments the client could achieve that would demonstrate positive change. Provide support, practical information and techniques to help her through the changes. Focus on restructuring cues and social support. Plan for slips and feelings of discouragement. Congratulate her on positive changes. Continue to develop alternative coping skills. Combat feelings of loss. Bolster self-efficacy for dealing with obstacles.
<b>Maintenance</b> <i>(keeping up the change)</i>	This individual no longer engages in drinking behaviour that is inappropriate or dangerous to her health. She has a continued commitment to sustaining new behaviours for six months to five years.	Assist the client to maintain her change in behaviour. Celebrate. Use strategies to prevent relapse. Identify any remaining issues to address and develop a strategy for them. Plan for follow-up support. Reinforce internal rewards.
<b>Relapse</b> <i>(Oops! Let's regroup)</i>	This individual has resumed risky drinking behaviour. Having relapsed, she reverts to an earlier stage.	Evaluate triggers for relapse. Reassess motivation and barriers. Plan stronger coping strategies. Assist the client to renew the process of preparation and action without becoming stuck or demoralized.

*Adapted by Maureen McEvoy*

- Negotiate as necessary for windows of abstinence. For example, you might ask your client not to come to session if she is high. Then, you might ask her to be clean and sober for 24 hours prior to the appointment. Then, to be clean and sober for 24 hours after the appointment. And so on.

- Negotiate periods of delay. For example, ask her to wait for a period of minutes or hours before she swallows the pills, or to listen to her relaxation tape first and then drink if necessary, or to call her sponsor. This is when having already prepared a safety plan is useful; clients often have difficulty remembering the strategies discussed in the comfort of your office when faced with the overwhelming need to use coping mechanisms such as substance use, self-injury or other adaptations.
- Support harm reduction by encouraging other healthy behaviours such as eating and sleeping well.
- Ask how the substance helps her. The type of drug she is using may offer a clue. If she is using stimulants (uppers such as caffeine, nicotine, cocaine, speed and methamphetamine (crystal meth)), how are they useful? What about downers (opiates such as morphine, codeine, heroin and percodan, or depressives such as alcohol, barbiturates and benzodiazepines)? What about hallucinogens (marijuana, mushrooms, LSD, Ecstasy (MMDA) and angel dust)?
- Acknowledge the client's need for self-soothing, which the substance might be meeting. Discuss alternative means of self-soothing and tolerating painful memories and encourage her to practise these methods. Ask her to describe situations in which she has been able to use alternative methods. Honour all attempts to "do it differently."
- Ask if/how the substance use re-enacts the trauma. Trauma re-enactment is described as an effort to regain one's balance following trauma and abuse (Miller 1994, Miller and Guidry, 2001). A survivor may actually recreate her experience in both literal and symbolic ways. For some substance users, the cycle of use might recreate the process of victimization, represent a search for protection or even represent the destruction of the abuser (Miller 2001, 16).
- Sobriety is necessary for trauma work. Sobriety may not be possible when you first meet with a client, but it is necessary to process trauma memories. It is not useful to insist on abstinence before establishing counselling. Lack of abstinence will, however, limit your interventions to stage one interventions such as safety and self-care. See Najavits (2002a) for stage one strategies.
- Ask what happens after the session. If she reports that she needed to use immediately after session, she was probably over-stimulated. In Briere's terms, you may have overshot the therapeutic window (see Section 2.4.6 for more

information). If necessary, back up. Go slowly. A woman is ready to process trauma memories when she:

- Can stay clean and sober for some length of time;
  - Has the ability to control her self-injurious behaviour;
  - Recognizes and decreases self-sabotaging behaviours;
  - Has the ability to use coping skills;
  - Is in an ongoing system of care;
  - Is willing to do the work; and
  - Is not experiencing any major crises or instability currently.
- Back away from trauma work if your client worsens. A relapse is an obvious sign. However, there are more subtle indicators that your client may be overwhelmed and unable to cope. Ask about intrusive images, body sensations or powerful feelings. A strong urge to use again or signs of dissociation (see Appendix 7.11) are other indications that your client is unable to continue with trauma work at this time. Refocus on building self-capacities.

### **5.1.2 First interventions with substance use**

Resistance to interventions can take the form of:

- Interrupting—cutting off or talking over the helper;
- Arguing—challenging the helper, discounting the helper’s views, disagreement, open hostility;
- Sidetracking—changing the subject, not responding, not paying attention; and
- Defending—minimizing or denying the problem, excusing one’s own behaviour, blaming others, rejecting the helper’s opinions, showing unwillingness, pessimism.

In sum, people with addiction issues do not generally walk through our doors already possessing high levels of denial and resistance. These important coping mechanisms are more functions of the interpersonal interactions that occur during support work.

An important goal in our work is to avoid evoking a woman's resistance (anti-motivational statements). More bluntly put: a woman's resistance is a helper's problem. Counsellors need to pay attention to how we respond to resistant behaviours.

- Never meet resistance head-on. Certain kinds of counsellor reactions are likely to exacerbate resistance, back the woman further into a corner and elicit anti-motivational statements from her. Unhelpful counsellor responses include:
  - Arguing, disagreeing, challenging;
  - Judging, criticizing, blaming;
  - Warning of negative consequences;
  - Seeking to persuade with logic or evidence;
  - Interpreting or analyzing the reasons for resistance;
  - Confronting with authority; and
  - Using sarcasm.
- Try making some of the following motivational statements to your client.
  - I assume from what you've talked about that you have some concerns or difficulties related to your substance use. Tell me about those . . .
  - Tell me a little about your substance use. What do you like using? What's positive about using for you? What are the downsides of using?
  - Tell me what you've noticed about your using. How has it changed over time? What things have you noticed that concern you or that you think might become problems?
  - What have other people told you about your using? What are other people worked up about?
  - What makes you think you might need to make a change in your use?
  - You don't think that \_\_\_\_\_ is harming you seriously now, and at the same time you are concerned that it might get out of hand for you later.

- You really enjoy\_\_\_\_\_ and would hate to give it up, and you can also see that it is causing problems for you, your family, etc.
- Maybe you’ll decide that it’s worth it to keep on using the way you have been, even though it’s costing you.
- I wonder if it is really possible for you to keep using and still have your family too.
- I appreciate you are hanging in there through this discussion, which must be hard to do.
- I think it’s great that you’re willing to recognize the risk here and that you want to do something before it gets more serious.
- You really have some good ideas for how you might change.
- Thanks for listening so carefully today.
- You’ve taken a giant step today, and I really respect you for it.
- Encourage your client to try some of the following strategies to cut down her substance use:
  - Plan the substance use;
  - Set limits on the day and time of use (e.g., only after 8:00 p.m., only on weekends, etc.) and the amount used;
  - Try to have at least two substance-free days per week;
  - Delay the first use and each use after that;
  - Find something else to do as a distraction from wanting to use more;
  - Arrive at the dealer later than usual;
  - Leave the dealer earlier than usual;
  - Spend time with someone who will support your efforts to cut down;
  - Avoid situations where you are likely to use or where you use a lot;

- Plan what days will be normal use and what days will be heavier use;
- Prepare only a little of the substance at a time, even if you intend to use more;
- Place the substance in a place that is hard to get to, or give it to someone who is supportive of your efforts to cut down;
- Reduce your tolerance so you need less;
- Keep a record of how much you are using and check whether you are meeting your goals;
- Do not try to keep up to other people; go at your own pace;
- Take only as much cash as you need when you go out, ensuring you have enough to get home;
- Ask a support person to accompany you when you cash your social assistance cheques;
- Leave your ATM card at home; and
- Consider what else you could try.
- Suggest the following strategies for dealing with her cravings:
  - Identify when the craving starts; knowing what is going on is the first step in doing something about it;
  - Remind yourself that cravings are a normal part of cutting down and that they will pass with time; the more you give into cravings, the stronger they become;
  - Remember that cravings are like a hungry cat: the more you feed it the more it comes back. If you don't feed it, the cat eventually stops coming back;
  - Try to find something to distract you, even if this only delays you from using the substance;
  - Try to learn when you are most likely to crave the substance—for example, in certain situations, with particular people, when you feel a certain way—and plan how you will deal with each situation when it comes up;

- Delay using for an hour or even five minutes. When the time is up, delay for another hour, then another hour and so on. It is easier to resist cravings for a manageable period of time than to try to stop forever;
- Talk to someone supportive when you start to get cravings;
- Do something relaxing and enjoyable instead, like having a bath or a shower, having a massage or using aromatherapy products to induce relaxation;
- If able, go for a walk or a run or do some other physical exercise;
- Visit friends who don't use the substance or won't while you are there;
- Watch a video or go to a movie;
- Listen to relaxation tapes;
- Reward your efforts to cut down, even if you ended up using more than you meant to. It takes time to make a change and being hard on yourself will make it more difficult to change your habits;
- Talk to friends who have been able to cut down their use and find out what worked for them;
- Talk to friends about how they enjoy themselves or relax without drugs to get some ideas that might work for you; and
- Consider what else helps you deal with cravings.

*Written by Angela MacDougall*

### **Resources**

Dayton, T. 2000. *Trauma and addictions: Ending the cycle of pain through emotional literacy*. Deerfield Beach, FL: Health Communications, Inc.

Gose, S. 2004. "Post-traumatic stress and substance use." *Visions journal* 2(4): 23-24. Describes a successful pilot group for women survivors who also use substances, using the Najavits Seeking Safety model.

Kasl, C.D. 1989. *Women, sex and addiction: A search for love and power*. New York: Ticknor and Fields. Discusses how women can learn to experience their own sexuality as a source of love and positive power. Sex can be an expression that honours the soul as well as the body.

Kasl, C.D. 1992. *Many roads, one journey: Moving beyond the 12 steps*. New York: Harper Perennial.

Introduces the 16-step alternative to the traditional 12-step Alcoholics Anonymous model of addiction recovery. Encourages individuals to find their own voices and their own sources of strength and spirituality to guide their healing.

Katherine, A. 2004. *When misery is company: End self-sabotage and become content*. Minnesota: Hazeldon Information. This book complements the 12-step program and also discusses the role of implicit memory.

Kirkpatrick, Jean. 1978. *Turnabout: New help for the woman alcoholic*. Garden City, NY: Doubleday. Written by the founder of Women for Sobriety. Describes the author's own experiences with alcohol and the need for programs that are specifically geared toward women. See also [www.womenforsobriety.org](http://www.womenforsobriety.org).

Miller, D. 1994. *Women who hurt themselves: A book of hope and understanding*. New York: Basic Books. Explains how self-destructive behaviour of all kinds represents a re-enactment of the trauma. Once retelling is recognized, it is easier to interrupt the cycle.

Miller, D. and L. Guidry. 2001. *Addictions and trauma recovery: Healing the mind, body and spirit*. New York: W.W. Norton. Provides a 12-session group model for working with survivors of trauma and addiction.

Najavits, L.M. 2002a. *Seeking safety: A treatment manual for PTSD and substance abuse*. New York: The Guilford Press. An excellent approach to stage one work with people who have both PTSD and substance use issues. Offers a compendium of grounding exercises and themes for group sessions.

Prochaska, J. and C. DiClemente. 1984. *The trans-theoretical approach: Crossing the traditional boundaries of therapy*. Melbourne, FL: Krieger Publishing Company. Explains that users have different needs from helpers at different stages of their using/recovery journeys. By identifying the stage, the counsellor is better able to tailor interventions.

### **Selected Web sites**

Centre for Addiction and Mental Health. [www.camh.net](http://www.camh.net).

Centre for Addictions Research of B.C [www.carbc.uvic.ca](http://www.carbc.uvic.ca).

Psychological Trauma and Substance Abuse in Women. [www.earthlink.net/~bhilliard](http://www.earthlink.net/~bhilliard).

Women's Addiction Foundation. [www.womenfdn.org](http://www.womenfdn.org).

## **5.2 Mental Health Issues**

In recent years, STV counsellors have received increasing referrals of clients with mental health issues (see Section 1.4). STV counsellors often have minimal or no training in this area. In addition, community supports and resources are scarce, especially those with knowledge about the relationship between women's experiences of trauma and the impact on mental health.

There is an inextricable link between mental health issues and experiences of violence and trauma. Although not all persons with mental health issues (particularly major mental health illnesses such as schizophrenia) have trauma histories, researchers with a

trauma focus have shown that many adults with specific mental health problems have experienced trauma, abuse or neglect (Herman 1992). For example, Herman refers to research linking borderline personality disorders with traumatic histories. Haskell (2003) discusses the number of women who have complex PTSD and are often misdiagnosed.

Some mental health issues are more amenable to supportive, mid-range counselling (and clinical treatment in general). For example, if your client has a trauma history and has been diagnosed with PTSD, acute stress disorder, generalized anxiety disorder, dissociative disorders and/or major depression, STV counselling interventions may be helpful. With some other major mental illnesses, it is more difficult to find a useful way to intervene. Trauma survivors with schizophrenia, for example, show little improvement in their levels of functioning, but may benefit from increased self-esteem, better abilities to relate to others and better abilities to self-soothe (Harris 1997).

Dual or co-occurring diagnosis clients are complicated. Dual diagnosis means the woman with a history of trauma also struggles with some type of mental illness (such as schizophrenia) and substance use. Many dual diagnosis clients are not appropriate for STV stage two trauma counselling interventions, but can sometimes benefit from stage one interventions such as self-care, self-regulation, establishing boundaries and developing communication skills. Your role will be mostly limited to education, advocacy and support, as these women are often at higher risk for further abuse and violence. Safety planning is essential (see Section 4.2 on safety assessments; also see Section 5.1 for more information on substance use).

- It is important that you not re-enact the profound silencing so many clients with mental illness have experienced. Explore with your client her current situation and her history. Your client may find this exploration empowering. Assess her level of functioning, her ability to be present and her current medication regime. Ask about her experience within the psychiatric system. Ask about her experience taking medications and her opinion on their effectiveness.
- Many women who have been in the psychiatric system need help with basic life skills such as parenting, communication and connecting to the community. If you have the appropriate training, you can assist your client in the development of these skills; otherwise your role is to help her access community resources.
- Do not inadvertently traumatize a client with severe mental illness and trauma histories; with this type of client, you must pay even more attention than usual to physical, psychological and interpersonal boundaries (Fisher and Choquette 1999).

- Wherever possible, work with your client as part of a team. Ask for permission to consult with her family doctor, psychiatrist or mental health counsellor regarding diagnosis and medications. Ask your client for guidelines about what is permissible for you to discuss. Your goal is to assist in the coordination of treatment planning and delivery.
- You will likely need to educate your community resources about your agency's mandate. In particular, you should explain that a trauma history doesn't mean a woman has the stability or cognitive functioning (that is, the ability to stay present and to follow the conversation) necessary to work through her violent experiences. If your program focuses on counselling as opposed to support, make this distinction clear.
- When working with a woman who has mental health issues, it is important to realize that, for safety reasons, she may have decided a long time ago to hide from herself or others what was going on in her life. This can lead to a general fusion/confusion between the literal and the figurative. Consequently, you may have to reach for the coded meanings in your client's words and actions, instead of focusing on her literal words and actions. Strive to appreciate the problem-solving attempts locked and hidden within certain of her repetitive behaviours and thoughts.
- A client may have retreated far into an inner world that may not be accessible to you. It may be difficult to have a mutual conversation and/or an exploration about her issues. Such a client, for example, may not be able or willing to learn skills; she may require a long time to identify her feelings, despite your best efforts. You will need to lower your expectations and increase your time mandate. Provide lots of encouragement and support.
- If you are working with an STV client who has a mental illness, your role is limited to support, advocacy, safety and stabilization, unless you have training, experience and ongoing supervision from a qualified person. Maintain focus on the here and now.
- Research suggests that the most completed suicides are by people who have been diagnosed with major depression, bipolar conditions and/or substance use. This means you must proceed cautiously with clients who present with suicidal ideation (refer to Section 4.2.3 for more information on suicide).
- To go beyond stage one (stabilization) counsellors need:
  - Basic familiarity with DSM-IV-TR;

- Basic training in responding to mental health presentations;
  - Familiarity with research linking violence/trauma and DSM-IV-TR diagnoses. For example, some clients who have been labelled psychotic may actually be reassociating fragments of traumatic history. In addition, many trauma survivors who hear voices in their heads may be highly dissociative rather than psychotic; and
  - Training and experience in approaches to trauma treatment (such as EMDR) and how they can be applied with women with mental health issues.
- Sometimes an STV counsellor may need to seek consultation to discuss the most ethical choice between providing limited support to a woman or declining to provide service. (See Section 3.1 for more information on ethical decision making.)
  - One method of educating yourself about mental illness is to read memoirs/biographies (see Section 8.1).
  - Once again, it is important to address your own fears and areas of discomfort with, for example, behaviours that may be outside the norm, appearances that may be caused by anti-psychotic drugs, etc.

## Resources

Centre for Addiction and Mental Health. 2002. *Best practices: Concurrent mental health and substance use disorders*. Ottawa: Health Canada.

[www.hc-sc.gc.ca/ahec-asc/alt\\_formats/hecs-secs/pdf/pubs/drugs-drogues/bp\\_disorder-mp\\_concomitants/bp\\_concurrent\\_mental\\_health\\_e.pdf](http://www.hc-sc.gc.ca/ahec-asc/alt_formats/hecs-secs/pdf/pubs/drugs-drogues/bp_disorder-mp_concomitants/bp_concurrent_mental_health_e.pdf).

Fisher, P. and E. Choquette. 1999. *Women, trauma and serious mental illness: Intake, assessment, treatment planning and referral*. Vancouver: Spectrum Press.

Harris, M. 1997. *Sexual abuse in the lives of women diagnosed with serious mental illness*. Amsterdam: Harwood Academic Publishers.

Hilliard, E. 1999. *Manic-depressive illness: An information booklet for parents, their families and friends*, 3d ed. New Westminster, BC: Royal Columbian Hospital.

Mowbray, C. and D. Oyserman. 1995. "Women with severe mental illness: The ignored majority." *Community support network news* 10(3). Boston: Center for Psychiatric Rehabilitation.

Schizophrenia Society of Canada. 1991. *Ray of hope: A handbook for families*, 3d ed. Ottawa: Health and Welfare Canada.

*Visions Journal* is a quarterly journal published by B.C. Partners for Mental Health and Addictions Information. Partners of this network include the Anxiety Disorders Association of B.C.; Awareness and Networking around Disordered Eating; B.C. Schizophrenia Society; Canadian

Mental Health Association, B.C. Division; Centre for Addictions Research of B.C. and the Mood Disorders Association of B.C.

### **Selected Web sites**

Anxiety Disorders Association of B.C. [www.anxietybc.com](http://www.anxietybc.com).

Canadian Mental Health Association, B.C. Division. [www.cmha-bc.org](http://www.cmha-bc.org).

Depression and Bipolar Support Alliance. [www.dbsalliance.org](http://www.dbsalliance.org).

Mood Disorders Association of B.C. [www.mdabc.ca](http://www.mdabc.ca)

Schizophrenia Society of Canada. [www.schizophrenia.ca](http://www.schizophrenia.ca).

## **5.3 Young Women Living Adult Lifestyles**

STV draft standard 3.1 says, “with respect to eligibility, it should be noted that STV counselling is intended for women who are 19 years of age or older. However, STV Counselling Programs may also serve women under 19 years of age if they are leading an adult lifestyle, and if no other resources are available” (BCASVACP 1998a). This issue is exacerbated by a serious shortage of counselling programs for young people, specifically programs with a feminist anti-violence perspective. Your program might consider educating community resources that you are able to provide this service as necessary. This section examines best practices for addressing some of the issues facing STV counsellors in this area.

- Your program needs to define what “living an adult lifestyle” means. In the situation of a “young woman living an adult lifestyle,” the young woman will generally be between the ages of 14 and 19 and either living on her own or with a partner. Likely, she is seeking your services because she is in a relationship in which she is unsafe, or she has experienced recent sexual abuse or childhood abuse.

If she is living with her parent(s), other relatives or foster parents, she is classified as NOT living as an adult. MCFD will likely need to be contacted if there are issues about safety and violence.

Some programs use the criterion that the young woman can receive services if she is a mother.

- If she is in a relationship, you should ascertain that exploitation is not the issue. The Criminal Code of Canada forbids a person in a position of power and/or authority to use his/her position as a means of exploiting young people.

- Similarly, you should ensure that she has truly consented to sexual activity. In Canada, the legal age for sexual consent is 14.
- Your program needs to determine the age at which a young person can consent to receive counselling. Some agencies set 12 as the age at which a minor can seek counselling without the permission of a parent(s). This is consistent with the Infants Act of B.C. Other agencies use 14 as the age of consent (this mirrors the legal age to give sexual consent). Still others set the age of consent at 16.

It is particularly important that STV Counselling Programs embedded within larger community agencies have agency-wide discussions. The goal is to have a consistent age of consent policy throughout all of the agency's programs. Stand-alone STV Counselling Programs can develop their own standards. In both instances, if there is a board of directors, policy should be forwarded to them for approval.

- You must be clear about your duty to report to MCFD. It is useful to develop a relationship with the intake staff at your local MCFD office. You can then advise MCFD of situations that involve minors needing protection, and of your assessment of their needs. Together, you can develop a coordinated approach.

Should the need to report arise, seek the active cooperation of the young woman wherever possible. Even if the woman does not cooperate, and even if she disagrees with your decision to report, in most circumstances it is best practice to tell her that you will be contacting MCFD.

Always a complicated area, reporting to MCFD was further complicated a few years ago when the Ministry tightened the duty to report to include children who had ever been abused along with those who may be abused. Recently, the Ministry reverted back to earlier, long-standing language that a counsellor has a duty to report if she assesses that a child is in need of protection (see section 13 of the CFCS Act). See Appendix 7.18.

- In addition to the emotions commonly experienced by a young victim of sexual assault, being reported to a child protection worker frequently increases her emotional turmoil. Child protection may represent an imposing authority that can exacerbate feelings of loss of control that already exist for her. As a result, when necessary, child protection intervention should be guided by an understanding of the dynamics of sexual assault, and carried out in a non-judgmental manner. Ongoing communication and consultation between

STV counsellors, sexual assault support workers and, where indicated, multicultural and Aboriginal support workers are also necessary.

The goal of child protection intervention in situations pertaining to sexual assaults of adolescents is to ensure appropriate services are offered to them that, depending on the circumstances, may include protective services. The guidelines outline two sets of suggested reporting procedures: one to follow when an adolescent is in need of protection and the other to follow when an adolescent is not in need of protection.

- A situation of a young woman who has been physically or sexually assaulted by a person other than her parent or caretaker, and where she has adequate support, does not need to be reported to MCFD unless section 13 of the CFCS Act, which outlines circumstances when a child needs protection, applies. For section 13(1)(c) to apply, the reporter should have reason to believe that the adolescent's parent(s) is/are unwilling or unable to protect the adolescent. This includes situations where an adolescent has been assaulted by a non-caregiver, and the adolescent does not want to tell her parent(s).
- A situation of a young woman who has been physically or sexually abused by a parent or caretaker, or a situation that fulfills the child in need of protection clauses outlined in section 13 of the CFCS Act, must be reported to a child protection worker.
- In a case where you or a child protection worker are considering contacting the young woman's parent(s), the following are important to consider:
  - Contacting the adolescent's parent(s) without consent can have significant impact on the adolescent's willingness to become involved with a helping agency and to disclose relevant information about her situation. Contacting her parent(s) may also result in severe consequences for the adolescent. A decision to contact her parent(s) should be made in the best interests of the young woman and after careful consideration of several factors that include:

The views of the young woman;

The age of the young woman;

The developmental capability of the young woman;

The young woman's attachment to/involvement with her parent(s);

The current status of the young woman; i.e., independent living, youth agreement, income assistance;

The young woman's previous contacts with the Ministry; and

Factors set out in part 5, sections 76 and 79 of the CFCS Act. (See Appendix 7.18)

- When a young woman does not want her parent(s) contacted, this does not necessarily mean there are problems in their relationship or that the parent(s) is/are unwilling to support her. If a decision is made to contact her parent(s), try to schedule a meeting with the young woman and any support persons designated by the young woman to:
  - Advise them of the decision and reasons for it; and
  - Discuss how and when the contact will be made.

### Resources

B.C. Ministry of Children and Family Development (MCFD). 2004. *Best practice approaches: Child protection and violence against women*. Victoria: MCFD. [www.endingviolence.org](http://www.endingviolence.org).

Central Okanagan Emergency Shelter Society. 2001. *Inside/out: A journey of self-discovery, facilitator's manual*. Kelowna, BC: Central Okanagan Emergency Shelter Society. Available at Box 1575, Station A, Kelowna, BC V1Y 7V8. *Inside/Out* is a flexible plan for ten weeks of one-hour group sessions designed to build self- and social-awareness in adolescent girls.

Dellasega, C. 2001. *Surviving Ophelia: Mothers share their wisdom in navigating the tumultuous teenage years*. Toronto: Random House.

Pipher, M. 1994. *Reviving Ophelia*. Toronto: Random House.

Simmons, R. 2002. *Odd girl out: The hidden culture of aggression in girls*. Orlando, FL: Harcourt Books.

Wold, L. 1997. *Daughters of the moon, sisters of the sun: Young women and mentors on the transition to womanhood*. Gabriola Island, BC: New Society Publishers.

## 5.4 Aging Women

There are specific challenges in counselling aging women who have experienced, or are experiencing, violence or abuse. General fears of aging and the developmental tasks of the last decades of life are complicated and compromised when an elderly woman is the victim of battering or sexual assault, or when an elderly woman has an unresolved history of violent trauma that occurred during her childhood or early adult years.

Both client and counsellor may be afraid to discuss the client's fears of aging and death. They may wish to talk about historical violence but avoid difficult current circumstances. When the violence is current, there are increased barriers to leave or transform a relationship.

- First, assess how many older women are accessing your services. Research suggests that older women do not seek services, especially from domestic abuse programs (Brandl and Cook-Daniels 2002). You need to go where older women are and develop creative outreach programs and services.
- When an older woman does access your services as a victim of family violence, you need to assess whether this is spousal abuse over time, or late onset violence associated with age-related stresses such as retirement, dependency, changing patterns in relationships or sexual dysfunction. You also need to assess whether an older woman being battered by an adult child was a prior victim of spousal assault. Your interventions will depend on this information.
- It is important for you to be familiar with some of the general issues facing aging women: fear of loneliness, dementia, loss of physical abilities, loss of partners, institutionalization and death. You also need to be aware of myths and realities of aging and resources in your community for older women.
- Most of all, you need to be comfortable with issues of aging and dying. Talking about abuse may be easier for you than talking about old age and death—after all, you likely have more training in the former area! Be honest about your own levels of knowledge and comfort, and take steps to increase both. It can be easy for shared fears of death, or shared discomfort with raising these issues, to become ghosts in the room that are never mentioned.
- Exploring the broad context of an aging woman’s life—her health, financial circumstances, support system, sexual intimacy, beliefs about aging and death, strengths and resources—will enable you to support her in making the best choices possible related to her history or current experience of abuse.
- You will have to walk “a fine line between respecting the tradition and history of the older woman and continuing to affirm her capacity for change and adaptation” (Greenberg and Motenko 1994). A careful exploration of her life history (including, but wider than, the violence) supports a successful walking of this line.

There is also a cultural component to walking this fine line; you must be sensitive to specific issues facing particular groups of aging abused women and knowledgeable about how aging women are perceived in their cultures. You may need to explore, for example, how an older Aboriginal woman perceives herself and is perceived within her culture, how speaking out about violence or leaving an abusive relationship would be perceived, and the strength of her personal and community resources for change. Consider the ways in which she views her

experience as similar or different to younger women in her community. Specifically, you might explore:

- What are her beliefs and relationships to community healing processes? Help her understand that, even in community processes, the violence has to stop first (Apo-Way-A-In Mississauga Women’s Shelter n.d.).
- What are her relationships with other Elders? What advice and support is she receiving from them?
- What is her involvement or interest in traditional healing activities such as sweat lodges?

Remember that you (if you are a non-native counsellor) must not get caught up in your own beliefs about her culture or attractions to it. The intent of the above explorations is to open dialogue, create a safe space where she can be all of who she is and make sure that your interventions are not in opposition to her values.

- When an older woman presents with historical abuse and violence, you need to assess the degree to which she has the internal and external resources to address historical violence. Sometimes aging or illness will create an urgency to resolve the past, yet there may be neither time nor internal resources to do this. What energies a woman has may need to go toward her current situation. For an aging and/or very ill woman, resolution sometimes means acknowledging what happened, how it has affected her life, grieving missed opportunities for healing and supporting her to address the developmental challenges of her current life in a present and positive way.
- Be genuine. Mutuality and the creative use of your role are important. More self-disclosure than usual may be appropriate, creating conversations that bridge “the generation gap between an older client and a younger practitioner, affirming the commonalities between the generations; it helps the older person to feel more connected . . . in a familiar and egalitarian manner; and it provides the older client with an opportunity to share some of her wisdom while telling her story” (Greenberg and Motenko 1994).
- For STV counsellors working in rural environments, you may meet older women who have lived rural lifestyles and/or operated farming enterprises who face additional barriers and high levels of social and geographic isolation. The client may be faced with leaving land, livestock and buildings that she has developed and cared for. Conversations about her connection to the farm and her rural lifestyle

need to be part of both assessment and treatment. She might need to talk about her desires and fears related to rural living and farming on her own.

- A review of the literature on the topic of older women and abuse (Brandl and Cook-Daniels 2002) adds the following best practices:
  - Services must be culturally competent.
  - Service providers from a variety of disciplines (such as domestic violence, sexual assault, aging, adult protection, health, faith-based, substance abuse, mental health, etc.) must work together to create a deeper and shared understanding of abuse and older women, and to create a collaborative response to violence.

## Resources

Hightower, H., J. Hightower and M. Smith, eds. 2005. "Building bridges for the prevention of older women abuse: A forum for dialogue." Conference proceedings, February 17–18, 2005, B.C./Yukon Society of Transition Houses (BCYSTH). [www.bcysth.ca](http://www.bcysth.ca).

Hightower, J., M. Smith and H. Hightower. 2001. *Silent and invisible: A report on abuse and violence in the lives of older women in British Columbia and Yukon*. Vancouver: B.C./Yukon Society of Transition Houses (BCYSTH). Research on violence and B.C. women over 50 that identifies the multiple problems/barriers facing aging women.

Older Women's Long-term Survival Society of Calgary (OWLS). 2000. *Out from abuse: Older women survivors*, National Film Board of Canada.

## Selected Web sites

B.C. Coalition to Eliminate Abuse of Seniors (B.C. CEAS). [www.bcceas.ca](http://www.bcceas.ca). Provides on-line resources, including fact sheets and resources such as *Legal issues for seniors: A training manual and Seniors and the criminal justice system: Educational materials*.

B.C. Institute Against Family Violence. [www.bcifv.org](http://www.bcifv.org). Their library contains numerous publications on the topic of elder abuse, many of them related to family violence.

Education Wife Assault. [www.womanabuseprevention.com/html/elder\\_abuse/bibliographies.htm](http://www.womanabuseprevention.com/html/elder_abuse/bibliographies.htm). Web site has an annotated bibliography.

National Center on Elder Abuse. [www.elderabusecenter.org](http://www.elderabusecenter.org). The Web site of this U.S. organization has a wealth of information, including an annotated bibliography on elder abuse compiled by the Clearinghouse on Abuse and Neglect of the Elderly. There is also a best practices section that provides information on organizations throughout the U.S. that provide services to victims.

## 5.5 Custody and Access Issues

STV counsellors are not lawyers, paralegals, mediators, judges or jurors. Yet STV counsellors often find themselves supporting women who are deeply embroiled in custody

battles. In the absence of sufficient legal aid, STV counsellors find themselves in support roles to women who are facing custody battles with former partners. Unfortunately, this already adversarial process is often complicated by abusive ex-partners who attempt to use the legal process to harass and victimize further both women and children.

- Remember, stay in a support and advocacy role without going beyond your expertise. Do your best to find community resources that can assist your client. Don't promise something that you can't deliver, either within the counselling relationship or systemically.
- Encourage your client not to minimize the violence or abuse in her life, especially if she faces custody issues and is engaged with the system. At the same time, encourage her to keep her accounts factual, including the impact on her children. Encourage her not to dwell on "bad-mouthing" ex-partners, as this could be interpreted as selfish or vengeful (O'Reilly 2001).
- Educate yourself and provide informational material for your clients on legal issues surrounding custody and child protection and on myths and realities of custody and access. The Web sites listed at the end of this section can be helpful places to start.
- Consider developing a handout for clients on custody and access issues. The Education Wife Assault Web site provides a sample that could be adapted to B.C. circumstances. See [www.womanabuseprevention.com/html/surviving\\_the\\_system.html](http://www.womanabuseprevention.com/html/surviving_the_system.html).

## Resources

- B.C. Association of Specialized Victim Assistance and Counselling Programs (BCASVACP) and B.C./Yukon Society of Transition Houses (BCYSTH). 2004. *Family law resource manual for community based advocates assisting women dealing with violence issues*. Vancouver: BCASVACP and BCYSTH. [www.endingviolence.org](http://www.endingviolence.org). Can also be ordered through BCASVACP.
- Braun, J. 2001. *Child custody and access in the context of family violence: A review of the literature and annotated bibliography*. Vancouver: B.C. Institute Against Family Violence. [www.bcifv.org](http://www.bcifv.org).
- Denike, M., A. Huang and P. Kachuk. 1998. *Myths and realities of custody and divorce*. Vancouver: The Freda Centre for Research on Violence Against Women and Children. [www.harbour.sfu.ca/freda/reports/myths.htm](http://www.harbour.sfu.ca/freda/reports/myths.htm).
- O'Reilly, G. 2001. *Surviving the system: Custody and access struggles*. Toronto: Education Wife Assault. [www.womanabuseprevention.com/html/surviving\\_the\\_system.html](http://www.womanabuseprevention.com/html/surviving_the_system.html).
- YWCA Munroe House and Battered Women's Support Services (BWSS). 2000. "Custody, kids and court." Pamphlet. [www.ywcavan.org/index.cfm?Group\\_ID=3152#Custody%20and%20Access](http://www.ywcavan.org/index.cfm?Group_ID=3152#Custody%20and%20Access). This is a great pamphlet for women going through the custody/access process, and is also useful for counsellors.

## Selected Web sites

Ontario Women's Justice Network. [www.owjn.org](http://www.owjn.org). An excellent Web site with resources, legal information, and custody information, including "Common custody and access issues," which can be accessed directly at [www.owjn.org/issues/custody/qa2.htm](http://www.owjn.org/issues/custody/qa2.htm).

## 5.6 Child Protection and Violence against Women

- Familiarize yourself with *Best Practice Approaches for Child Protection and Violence against Women*, developed by the B.C. Ministry of Children and Family Development (2004) in consultation with BCASVACP and other provincial anti-violence organizations (available on BCASVACP website [www.endingviolence.org](http://www.endingviolence.org)). These practices—developed to address the concerns of both child protection social workers and those providing services to women and children in violent relationships—are designed to provide the maximum protection for mothers and their children. The focus of this document is “that the safety and well-being of children are often dependent on the safety and well-being of the non-abusing mother and that, wherever possible, supportive services should be offered to the mother in order to enhance her ability to continue to care safely for her child(ren)” (3).

STV counsellors should have a copy of this document for reference and to support social workers and child protection workers to respond appropriately. You should also consider whether these protocols are being followed in your region. If not, perhaps you and/or your agency could advocate for joint meetings and training on using these protocols. If the protocols are being used, how is the process working and how can you advocate for improvement?

These best practice approaches can assist you in helping both women and their children, and give you a way to talk with women about their concerns for their children.

The protocols also suggest that child protection be guided by an understanding of the dynamics of abuse and in collaboration with women's victim services, including the STV Counselling Program. The protocols suggest coordinating and collaborating with women's victim services in all of the following ways:

- Defining when and how child protection concerns related to violence against women should be reported;
- Determining appropriate responses and when to contact police when children are living in the home where the woman is being abused;

- Planning and conducting an investigation;
  - Determining the child(ren)’s need for protection;
  - Finding effective ways to protect children;
  - Preparing for MCFD family court; and
  - Providing ongoing protective family services.
- Advocate for new and innovative approaches to the issues of woman abuse and child welfare. Familiarize yourself with existing examples, such as the domestic violence “specialist” program within the Massachusetts Department of Social Service, pilot programs in Oregon that place women’s advocates into child welfare agencies and the proposal of the Ontario Association of Interval and Transition Houses. All of these examples are described in *In the Best Interests of Children and Mothers*, listed in the following resource section.

## Resources

B.C. Ministry of Children and Family Development (MCFD). 2004. *Best practice approaches: Child protection and violence against women*. Victoria: MCFD. [www.endingviolence.org](http://www.endingviolence.org).

Ontario Association of Interval and Transition Houses (OAITH). 2003. *In the best interests of children and mothers: A proposed child welfare response to violence against women*. Toronto: OAITH. A good overview of the history and issues related to protecting children in both the violence against women sector and the child welfare sector, and a proposal for an integrated approach.

## 5.7 Women’s Violence

The issue of women’s violence can enter STV Counselling Programs in numerous ways. For example: a client might have been violent to her male partner or her children; she might have been violent to a lesbian partner; she might disclose to you current or historical violent activity that she has never told anyone else; she might have offended a smaller child when a teenager; she might have a daughter involved in teen violence as perpetrator or victim.

You may also meet women who have been charged with violence toward their male partners, or are seen as participants in mutual violence by other service agencies in the community. The women in some of these situations may not have used violence at all. However, if your client has been charged with violence, there likely is evidence that she used violence, although she is likely not the primary aggressor. Research reviewed by Bogard (1999) suggests that men are more likely to use severe violence, less likely to be injured and less likely to be intimidated by partner violence. While both genders use

violence to release and express anger, men in heterosexual relationships are more likely to use violence for dominance, coercion, control, self-enhancement and punishment, while women in heterosexual relationships are violent for self-defence, escape and retaliation. Female perpetrators are more likely to be depressed.

Assessing women's use of violence in lesbian relationships can be challenging, as assumptions based on gender, size or other factors cannot be used to determine power and control dynamics. Behaviours alone do not determine which partner is abusive in a lesbian relationship. When assessing dynamics of abuse in lesbian or transgender relationships, refer to the assessment resources listed at the end of this section.

Generally, feminist counsellors feel ill-equipped to respond to women's violence. They often do not know how to respond in an effective manner to women who use violence, and usually have received no training in this area. Additionally, they struggle to integrate women's violence into their gendered analysis of women as victims of violence. Consequently, best practices entail engagement with the social and political issues related to women's use of force to provide a framework for counselling interventions.

We must take female violence very seriously and hold female perpetrators accountable. However, whether violence is by men or women, against men or women, it takes place "within a social, historical and economic context in which men and women, in general, still play different roles, have different opportunities and have different social power" (Worcester 2002).

- In B.C., the RCMP is required to conduct a primary aggressor assessment as dictated by the Violence in Relationship – Violence Against Women in Relationships Policy. It is important to be familiar with this requirement and to know what is included in the assessment. (available at [www.endingviolence.org/publications.org](http://www.endingviolence.org/publications.org) entitled RCMP VIR-VAWIR Policy (March 2005))
- Contribute to creating an open climate about the reality of women's violence in your agency. Discuss and debate the issue, and move toward developing a social analysis about women's violence.
- Assess and identify situations where your client is accused of violence and was not the primary aggressor (reported as the most frequent motivation for a woman's use of violence), or was violent in self-defence or to decrease her chances of victimization. Explore with your client her own perceptions of the events. Even if she was violent in response to another person's violence or as self-defence, do not minimize either the difficult situation she was in or the strong feelings she may have about her behaviour.

- Familiarize yourself with resources and information on mutual battering. Appreciate that many studies reporting equal percentages of male and female violence in heterosexual relationships use the “conflict tactics” scale, which does not identify primary aggression or emotional violence (Dasgupta 2001). Set up a protocol for advocating and supporting women arrested for domestic violence. The Women’s Justice Center in California provides an excellent example that could easily be adapted to B.C. legislation (see the resources listed at the end of this section).
- Having screened for situations in which women are unfairly accused of violence, accept that women are capable of violent behaviours and that they need to be accountable. Similar to approaches to violent men, your job is to help the woman make a distinction between unacceptable behaviour and her basic core worthiness.
- Change comes from a combination of accountability and insight. Don’t focus on one at the expense of the other, but weave a web between them.
- Consider that, unlike many men, women often deal with their shame by wanting to address their violence. Often a woman feels relief when her violence is addressed in counselling, and, in fact, feels terrible if it is not. She may think she has to split off the “bad” parts of herself to merit your attention. If a woman thinks you are interested only in her victimization and not in her aggression, she will hide this part of herself. She might hide that she has hit her children, that as a child she was mean and cruel or that she is terrified of her own rage.
- Learn from lesbian battering experts who have engaged with the complexities of identifying who are the perpetrators and who have been violent in self-defence (Worcester 2002). As anti-violence programs attempt to develop more effective assessment tools, you should support dialogue between those who have worked on lesbian and heterosexual battering assessments.
- Acknowledge that men get hurt by violence. This acknowledgment is essential to support a gendered discussion about violence in a social context where a gendered analysis of violence is disappearing. Acknowledge that men can be hurt by violence perpetrated by women, while appreciating that the vast majority of both female and male victims are assaulted by other men. Be open and knowledgeable about male victimization. Do this without losing an analysis of how quality of life is impacted by gender and other inequalities (Worcester 2002).

- Women abuse their children for many reasons, often as a consequence of ongoing experiences of powerlessness, helplessness and fear in their lives. Working toward effective inter-agency protocols that support both women and children is essential to avoid triangulation. It does not help to support women “against” child protection intervenors if, indeed, the child is at risk with the mother and has been harmed through abuse or neglect. See Section 5.6 for more information on child protection and violence against women.

## Resources

Holmes, C. In press. “Appendix B: Safety assessment and planning for women in abusive same-gender relationships.” In *Aid to safety assessment and planning (ASAP)*. S. Agar. Vancouver: B.C. Institute Against Family Violence.

White, C. and J. Goldberg. In press. “Appendix C: Safety assessment and planning in abusive trans relationships.” In *Aid to safety assessment and planning (ASAP)*. S. Agar. Vancouver: B.C. Institute Against Family Violence.

Ristock, J. 2002. *No more secrets: Violence in lesbian relationships*. New York: Routledge.

Ristock, J. 2004. “Why do lesbians batter: An interview with Janice Ristock.” By H. Fallding, *aware* 11(2): 13. Reprint from *Herizons*, Spring 2003 issue.  
[www.bcifv.org/resources/newsletter/2004/summer/ristock.shtml](http://www.bcifv.org/resources/newsletter/2004/summer/ristock.shtml).

Women’s Justice Center. n.d. *Advocating for domestic violence victims who have been arrested for domestic violence*. Santa Rosa, CA: Women’s Justice Center. [www.justicewomen.com/handbook](http://www.justicewomen.com/handbook).

Worcester, N. 2002. “Women’s use of force: Complexities and challenges of taking the issue seriously.” *Violence against women* 8(11): 1390-1415. This thoughtful article is based on the author’s involvement with a coalition against domestic violence in Wisconsin that has tackled this issue through conferences and discussions.

## Selected Web sites

B.C. Association of Specialized Victim Assistance and Counselling Programs (BCASVACP). [www.endingviolence.org](http://www.endingviolence.org). The “Community Coordination for Women’s Safety” project has a bibliography of resources related to mutual battering and women’s use of force in both heterosexual and same-sex relationships.

## SECTION SIX

# Special Issues—Administrative

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### 6.1 Wait-list Management

Due to the diversity of offerings within STV Counselling Programs, it is impossible to develop a one-size-fits-all policy. Nevertheless, we can determine some of the elements of a good wait-list policy.

- First, have a policy!
- Your intake procedures must include wait-list policies and procedures, and these should be delivered in a clear and consistent manner.
- Generally, most programs have adopted a first-come, first-served policy, with some adaptations for clients who are at high risk or in crisis. Examples of high risk and crisis include: highly suicidal clients, clients who have recently experienced sexual assault or clients who have recently recovered memory of childhood trauma. You need to be clear on your policy for identifying high-priority clients and moving them to the top of the wait-list. Some STV Counselling Programs, for example, have arrangements with other agencies—such as community-based or police-based victim assistance programs—to accept high-priority clients.
- Be clear that your fiduciary responsibility/duty to a client begins as soon as she engages with your program. For example, if a woman at high risk fills in an intake form that is not followed up in a timely manner or is placed on the wait-list, your program can incur liability.
- Work collaboratively with other programs and agencies to ensure that all high-priority clients receive timely service.
- When explaining the wait-list situation to your client, offer to make other appropriate referrals (e.g., to a mental health service for a highly suicidal client). Encourage the woman to call back if she becomes in need of more immediate help. Some programs also operate a crisis line that can offer support to a waiting woman.

- Assuming sufficient resources within your program, provide some form of contact/service to women on the wait-list.
  - Examples within the STV Counselling Programs include a policy of monthly telephone contact and/or drop-in groups to offer education and assistance while women are on the wait-list.
  - Some programs offer two to ten crisis sessions before a woman goes on the wait-list for longer-term counselling. The purpose of these sessions is to teach containment strategies and offer support and information about other community resources.
- You must also develop a policy regarding returning clients. When counselling ends, clients should understand the guidelines for resuming counselling. Some programs give priority to clients who have previously received services; however, many programs require such clients to return to the wait-list. Some programs also require a certain period to elapse before the woman can put herself on the wait-list again.

## 6.2 Caseload Size

Issues regarding caseload often illustrate the conflicting interests between providing client care, ensuring a counsellor's self-care and meeting the needs of funders. STV counselling work is unique from mainstream counselling work in several ways:

- STV counsellors hear steady streams of repetitive stories of violence, abuse and mistrust. These stories have a cumulative impact on the way an STV counsellor thinks about herself, others and the world. Mainstream counsellors hear a variety of stories and, thus, are protected from the constant assault on their internal belief systems and emotions.
- STV counsellors experience pressure from having wait-lists, knowing there are more women in need of services than can possibly be seen. Given that we are engaged emotionally in our work, this adds another level of stress.
- STV Counselling Programs have more clients who experience various and multiple barriers to services and have a higher rate of no-shows than private practices or mainstream agencies. Given the precariousness of some of our clients' lives, STV counsellors may experience additional worry. In addition, more follow-up (e.g., phone calls to clients) is required.
- In rural communities, STV counsellors will hear through the grapevine about

women who have been battered or sexually assaulted. However, these women may not feel safe in accessing counselling services because of the lack of anonymity and limits to confidentiality. This can result in a high degree of frustration and worry for STV counsellors.

The above factors can cause STV counsellors to quit due to feelings of exhaustion, hopelessness and other forms of vicarious traumatization. The issue of caseload standards needs to be examined within this backdrop. Baldly stated, pressing counsellors to provide a high number of counselling sessions per week can lead to a higher rate of employee turnover.

- Common practice within the counselling field is a 60/40 ratio of direct service to non-direct but related work. For example, if you are employed full time (35 hours per week), you are expected to provide an average of 20 hours of direct service per week. The chart below outlines work that falls into the direct service area.

<b>Direct service</b>	<b>Non-direct but related service</b>
<ul style="list-style-type: none"> <li>• Individual sessions with clients</li> <li>• Intake interviews with clients</li> <li>• Planning group sessions</li> <li>• Group sessions with clients</li> <li>• Screening interviews with prospective group members</li> <li>• Telephone conversations between group meetings</li> <li>• Debriefing between co-facilitators (a half hour per two-hour group session)</li> <li>• Writing case notes</li> <li>• Telephone calls with clients</li> <li>• E-mail dialogue with clients</li> <li>• Advocacy telephone calls on behalf of clients</li> <li>• Travel to see clients</li> </ul>	<ul style="list-style-type: none"> <li>• Agency planning meetings</li> <li>• Staff meetings</li> <li>• Public speaking/education</li> <li>• Community liaison</li> <li>• Individual supervision</li> <li>• Group/peer supervision</li> <li>• Training</li> <li>• Professional development activities (reading, workshops, conferences)</li> <li>• Self-care activities</li> </ul>

- The literature suggests that variation in one’s workload is most helpful in mitigating vicarious traumatization (Pearlman and Saakvitne 1996). Due to the STV Counselling Program mandate, however, variety is limited. Nevertheless, whenever possible, staff should be given opportunities to provide individual sessions with clients, lead time-limited groups and conduct public education

talks. A counsellor's existing caseload should be considered when assigning the counsellor a new client from the wait-list to achieve as much variety as possible. Staff should also be encouraged to use (and supported to access training in) a variety of modalities such as art therapy, EMDR or body movement. Some training programs, such as EMDR, require participants to have master's degrees.

- Some STV counsellors try to manage their caseloads through spacing of client's appointments. Best practice is to develop an appointment schedule that is based on your client's needs, not as a means of seeing more clients within your work week. Some clients, for example, need to see you every week or as often as you are in their communities. Other clients might find weekly appointments too stimulating.

### **6.3 Attendance Policy**

Client attendance can be a challenge for STV counsellors working with women who have multiple barriers to attendance. These barriers can be external, such as a lack of transportation, childcare problems, poverty-related impediments, safety constraints or relationship constraints. Barriers can also be internal, particularly for women who have experienced multiple and/or chronic abuse. These women can be deeply conflicted about the process of counselling—sometimes hopeful, sometimes terrified, sometimes highly anxious about the counselling relationship—or can be living in constant states of crisis or re-enactment that pulls them elsewhere. They can feel hopeless and disbelieve that the barriers can be addressed.

- In the first or second session, begin by identifying any external barriers to your client's attendance and addressing these as best as possible. If the external barriers are large, don't set the client up for something that will fail.
- The overarching best practice for attendance is consistency. Whatever your attendance policy is, it must be consistently adhered to. Without this, the frame of counselling can become chaotic and erratic, creating an unsafe environment where your client doesn't really know what the expectations are. This reproduces the uncertainty experienced by many victims. Section 2.4.3 says much more about the importance of the counselling frame.
- Structure and consistency are not the same as rigidity. Sometimes boundary crossings (as opposed to boundary violations) are acceptable. A boundary crossing is a relaxation of a counselling boundary for therapeutic reasons and with a benign effect (Dalenberg 2000). However, flexibility and accommodation must be approached with the question: What is in the client's

best interest? Phoning a client to remind her of the time of her session might be seen as intrusive and overinvolved, but perhaps a contract that this particular client will be reminded once will help her value herself enough to show up.

- It is okay for you to ask if there are any internal or emotional reasons why she might have difficulty showing up for sessions or showing up on time. She knows a lot about this; although she may not tell you everything in the beginning, this question indicates this is an important topic for conversation.
- Having stated above that flexibility is sometimes necessary, flexibility is only possible within shared and clear understandings about attendance expectations. Your client needs to know what's going to happen if she misses one or more sessions. She needs to know what is negotiable in your contract with her and what is not. You might consider some of the following ideas:
  - Set up short-term attendance agreements. For example, ask her to commit to three or four sessions so you can get to know each other and explore what the counselling might look like. After this time, you can mutually evaluate. Mutual agreement to discontinue counselling or mutual recognition that the client's goals have already been met moves you both toward a win-win structure in which the client doesn't feel like a failure if she decides to stop coming.
  - Ask for a reasonable amount of notice for session cancellation. Twenty-four hours is reasonable.
  - Think about how you will respond to same-day cancellations or no-show sessions. You will need to address these with your client immediately, and reset the frame for cancellation. Often, there are valid reasons why she did not show up or contact you in advance, but it is still important to be clear about your expectations.
  - Let her know why you need this advance notice. For example, you could talk about how it honours her commitment to her goals, or your shared time and relationship. You could also talk about how you need to be able to rebook the session with other women who need service.
- Upfront clarity will solve many attendance problems. Clear and agreed-upon expectations give you a structure to return to. However, with some clients, no-shows and same-day cancellations can become chronic. Here are some “do nots” for this situation:

- Do not hold a same-time-each-week slot for a woman who chronically misses sessions;
  - Do not do anything that enables or encourages the chaotic pattern of her life;
  - Do not give in to the impulse to accommodate beyond what is reasonable;
  - Do not rescue by providing a one-hour crisis session over your lunch hour with a woman who did not show up the day before. Notice if this becomes a pattern. Remember, though, that responding to a genuine crisis is not rescuing;
  - Do not provide telephone counselling services to a woman who chronically misses sessions, unless there are clear barriers to attending that you have discussed together; and
  - Do not add another counselling hour to your schedule the following day because you know she needs to see you.
- Best practices for dealing with a woman who has chronic attendance issues include:
    - Clarifying the degree to which you have contact with the woman after a no-show. Generally, this should be limited to rescheduling. If the woman appears to be in crisis, you should still keep the call short; encourage grounding and say that you will talk when she comes in;
    - Discuss your perceptions of her attendance patterns when she comes in; and
    - Ask what is keeping her from attending. Maybe your approach just isn't working, or you are not providing what she really needs or she has angry or conflicted feelings toward you. Maybe there is a reason for her feelings. Maybe the sessions are more frequent than she can tolerate or too stimulating. Maybe she is using substances or hanging out with a boyfriend you thought she had left, and she is ashamed to tell you. Explore all of this, but don't be overly accommodating or overly punitive. Be empathetic and firm about structure. Work with her to figure out what will help her keep her appointments. Adapt your contract to what is reasonable.
  - When none of the above works to resolve a client's attendance issues, you will need to address whether counselling is a viable option for her at this time.

- Sometimes, STV counsellors find themselves providing ongoing telephone counselling, perhaps because a woman lives in a rural remote area, or she has other barriers to leaving her home, such as ability, safety, pressures from extended family or agoraphobia. You should do everything possible to facilitate face-to-face counselling. If it is necessary to provide ongoing telephone counselling—as opposed to crisis support and intervention—you still need to create structure, boundaries and a framework for attendance. All of the above principles still apply. Consistency may be harder to attain, but is just as essential.

### **Resources**

All the resources listed in 2.4.3, “Creating a safe relationship within a safe framework,” 2.4.5, “Attachment and relationships” and 3.2, “Ethical best practices” can guide you through this often challenging issue.

## **6.4 Intake Procedures**

Intake procedures depend on the structure and location of the specific STV Counselling Program. STV counsellors describe the intake procedures of their programs in very different ways:

- One intake/crisis line coordinator does all the intakes;
- The same person who does the counselling does the intakes;
- Both staff and volunteers do intakes;
- Detailed intake assessments are done before women are put on the wait-list;
- The first contact with the woman is very brief; a formal intake/assessment is not done until the first session;
- Intakes are done on an ongoing basis;
- Special intake days are designated as the only days on which new clients are interviewed; and
- Intakes are done immediately or with time deferrals.

It is challenging to identify intake best practices in the tremendously diverse contexts of the STV Counselling Programs. It is even challenging to define what intake is! Our best practices begin with some guiding principles and then move into practicalities.

- Distinguish between intake and assessment. These are two different processes. As described in Section 4, intake for the purposes of this Manual is defined as the initial contact between a woman seeking service and the agency, while assessment begins once the woman begins to receive the service she has requested. Although intake is technically a form of assessment, it is useful to separate these processes, since this makes it clearer what information you need to gather.
- If, during intake, you determine that the woman is unsafe in the moment, you must follow your crisis intervention protocols.
- Have an intake policy! The STV draft standards (BCASVACP 1998a) state that each program should have:
  - A clearly written policy that outlines eligibility criteria for program services and describes procedures for prioritizing intakes; and
  - A structured intake process that assesses the woman’s immediate safety and obtains information to determine her priority for service, eligibility for counselling and services to be provided or to which she could be referred.
- The draft standards also provide a best practice for responding to situations where referral is not possible: “If it is determined that the woman needs counselling or other services which are beyond the current skills, training and knowledge of STV counselling staff, or outside the program mandate, the woman is referred to other resources where the appropriate resources exist. If appropriate resources are not available within the community, or are not appropriate for the woman because of a lack of sensitivity to feminist issues, the STV counsellor will, with the woman’s informed consent, provide limited counselling services intended to avert a crisis or to reduce the possibility of further harm to the woman.”
- Intake should be as regular and ongoing as possible, preferably the same hours every week.
- Your goal at intake is to do an initial assessment to determine the woman’s immediate situation and expectations, and how best to meet her urgent safety needs. You will need to determine the match between what she is seeking and what your program offers.

Don’t seek more information than is necessary for this purpose. Stay connected to the goal of assessing her immediate needs and expectations. Complete the initial

connection with the woman in a timely manner, while still carefully assessing her needs. In ideal circumstances, a woman who contacts your agency and leaves a message should be called back within 48 hours. An intake interview should be conducted shortly afterward. This interview can be in person or over the telephone.

- Be clear about who is doing the intake and be consistent. Intake can be done by a designated intake worker in larger agencies or an STV counsellor.
- Make the intake exploration as mutual as possible. This is an important moment for relationship development between the client and both you and the agency. You will help her feel comfortable if you encourage her to ask questions about your program's policies regarding confidentiality, time mandates, etc. You must, of course, gain her consent before gathering any information and before using or releasing it in any way.

Keep in mind that these early contacts may become the only point of intervention if the woman does not continue with you. Therefore, each contact should provide support, validation and education. Provide resources within the community, in books and on-line. Give options for referral.

- Have a sheet handy to remind you of information that YOU want to give during the intake. Having this written down helps you remember everything, which is sometimes difficult, especially if a woman is very upset. Receiving all relevant points gives the client the opportunity to make a fully informed decision about getting involved with your program. At the same time, don't give her more information than she can handle.
  - Include information on confidentiality and limits to confidentiality. During intake, this information would include actions you would take if you assess that anyone is in danger or a child is in need of protection. Appendix 7.4 is a sample release of information agreement.
  - Identify what you want the woman to know about your organization and its services, about yourself, about the counsellor (who may or may not be the intake person) and about the counselling process.
  - Provide wait-list information and an explanation of your agency's wait-list policy (see Section 6.1).
  - Include referral information, if appropriate.

- Collect only the information you need for this stage. Usually, this will include:
  - Contact information, including her address;
  - Any safety concerns she may have;
  - Her goals for contacting you; and
  - Information that is relevant to her goals.

See the wait-list intake form at the end of this section for sample questions about core information.

It is useful to know how the woman found out about your services—was she referred by another service provider or was she self-referred? Note the contact information of the referral source, if applicable.

Do not collect other information—social, psychological, medical, trauma or other details of her personal history—at this time. This information is more properly collected during assessment. Even then, be cautious.

Be careful when exploring or recording a woman's experience with the mental health system. Ask yourself why you need to ask these questions and document DSM diagnoses. If it seems necessary, be clear about who made what diagnosis and under what circumstances.

- Assess the woman's needs for services. She may be looking for information or a referral, she may be seeking ongoing counselling or she may have immediate safety needs. If safety issues or immediate crisis becomes apparent during your conversation, that must become the focus even if the woman says she's calling for another reason.

Consider whether there is a match between the woman's needs and wishes and your agency's abilities to provide the required service. She may, for example, be seeking help with substance abuse, but your agency may have no qualified staff to provide this type of counselling.

Also consider whether there is a match between the woman's needs and your agency's mandate. Although a woman may have experienced violence, her current needs may focus more on problems that are unrelated or only peripherally related. It does not serve a woman well to narrow everything she is dealing with to trauma in order to justify service.

- Consider developing a two-part form. Part one would collect basic information required to determine the appropriate service and to deliver the specific service requested. Part one would be used to place the woman on the agency's wait-list.

Part two would more accurately be called an assessment form, and would be used when service is about to begin. Part two could collect information about the woman's personal history once the woman has begun counselling. Again the initial focus is on collecting only the information needed to deliver the required service effectively. Your standardized intake form should be applicable to everyone.

The example that follows is from Cowichan Women Against Violence, who achieve a nice separation between wait-list intake and program intake. More detailed history and assessment would follow a program intake like the example shown. However, as the STV Counselling Programs vary so significantly, each program will likely have unique forms.

**COWICHAN WOMEN AGAINST VIOLENCE**

**Stopping The Violence Counselling Program**

**WAIT-LIST INTAKE**

CLIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

MESSAGE OKAY? \_\_\_\_\_

What prompted you to contact us? What is going on right now?

Are you in any kind of emergency or danger? Please describe the situation.

How safe do you feel? Physically? Emotionally? From others? From yourself?

Please describe the situation.

What might you do to get safe? What have you done previously?

What else is important for us to know at this stage of entering counselling? Please do not tell us anything that is too uncomfortable to you.

In what ways do you think counselling might help?

How did you find out about WAV? (Referral source)

Are you interested in individual counselling, a support group, or both?

PLACED ON CLIENT LIST: \_\_\_\_\_

FORM COMPLETED BY/DATE: \_\_\_\_\_

CONTACTS ATTEMPTED: \_\_\_\_\_

INITIAL APPOINTMENT: \_\_\_\_\_

## **COWICHAN WOMEN AGAINST VIOLENCE**

### **Stopping The Violence Counselling Program PROGRAM INTAKE**

What's happening at this time in regard to your original concern?

Have any new concerns arisen since initially contacting WAV?

In what way(s) have you been affected by the abuse you have experienced?

What do you do, or have you done, to cope with those effects?

What other issues impact on your life?

What is your current relationship like with the person(s) who hurt you?

What relationships with partners impact on your life at this time? How do they affect you? Please describe the relationship(s).

What's your current living situation like? Is it adequate? Who lives with you? Ages of children? Isolated location? Etc.

Do you have children who live elsewhere? What's your relationship like? If they are underage, with whom do they live?

Who are the important people in your life?

What activities, groups, hobbies, etc. do you engage in?

DATE FORM COMPLETED: \_\_\_\_\_

## SECTION SEVEN

# Appendices

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This section contains the following appendices:

- 7.1 DSM-IV & DSM-IV-TR: Posttraumatic Stress Disorder (PTSD)
- 7.2 DSM-IV Dissociative Disorders
- 7.3 Feminist therapy code of ethics
- 7.4 Release of information agreement
- 7.5 Elements of a client orientation letter
- 7.6 Essential attributes of culturally skilled counsellors
- 7.7 Emotional abuse assessment guide
- 7.8 Eco-maps
- 7.9 Variations of the life history
- 7.10 Questions about childhood trauma
- 7.11 Dissociative presentations in session
- 7.12 Handout for discussing counselling stages with clients
- 7.13 Client assessment of counselling sessions
- 7.14 Primer on substance use
- 7.15 Alternatives to self-injurious behaviours
- 7.16 A sample plan for life
- 7.17 Safety planning for women with abusive partners or ex-partners
- 7.18 Sections 13, 76 & 79 of Child, Family & Community Service Act
- 7.19 Sample contract for supervision
- 7.20 Ontario Women's Justice Network annotated bibliography of resources for marginalized women

## Appendix 7.1

### DSM-IV & DSM-IV-TR: Posttraumatic Stress Disorder (PTSD)

When an individual who has been exposed to a traumatic event develops *anxiety* symptoms, reexperiencing of the event, and avoidance of stimuli related to the event lasting more than four weeks, they may be suffering from this *Anxiety Disorder*.

#### Diagnostic criteria for 309.81 Posttraumatic Stress Disorder (*cautionary statement*)

A. The person has been exposed to a traumatic event in which both of the following were present:

- 1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
- 2) the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

- 1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
- 2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
- 3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, *illusions*, *hallucinations*, and dissociative *flashback* episodes, including those that occur on awakening or when *intoxicated*). **Note:** In young children, trauma-specific reenactment may occur.
- 4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- 5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and *numbing* of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- 1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
- 2) efforts to avoid activities, places, or people that arouse recollections of the trauma
- 3) inability to recall an important aspect of the trauma
- 4) markedly diminished interest or participation in significant activities
- 5) feeling of detachment or estrangement from others
- 6) restricted range of affect (e.g., unable to have loving feelings)
- 7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent *symptoms* of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- 1) difficulty falling or staying asleep
- 2) *irritability* or outbursts of anger
- 3) difficulty concentrating
- 4) hypervigilance
- 5) exaggerated *startle response*

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

*Specify if:*

**Acute:** if duration of symptoms is less than 3 months **Chronic:** if duration of symptoms is 3 months or more

*Specify if:*

**With Delayed Onset:** if onset of symptoms is at least 6 months after the stressor

## Appendix 7.2: DSM-IV Dissociative Disorders

### DSM-IV: Dissociative Amnesia

Patients with this *Dissociative Disorder* experience marked but reversible impairment of recall of important personal information or experience, usually involving emotional trauma.

#### Diagnostic criteria for 300.12 Dissociative Amnesia (*cautionary statement*)

- A. The predominant disturbance is one or more episodes of inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness.
- B. The disturbance does not occur exclusively during the course of *Dissociative Identity Disorder*, *Dissociative Fugue*, *Posttraumatic Stress Disorder*, *Acute Stress Disorder*, or *Somatization Disorder* and is not due to the direct physiological effects of a *substance* (e.g., a drug of abuse, a medication) or a neurological or other general medical condition (e.g., *Amnesic Disorder Due to Head Trauma*).
- C. The *symptoms* cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

### DSM-IV: Depersonalization Disorder

Patients with this *Dissociative Disorder* experience episodes during which they feel detached from themselves. They may experience themselves or their surroundings as unreal. They may feel outside or lacking control of themselves. They retain awareness that this is only a feeling.

#### Diagnostic criteria for 300.6 Depersonalization Disorder (*cautionary statement*)

- A. Persistent or recurrent experiences of feeling detached from, and as if one is an outside observer of, one's mental processes or body (e.g., feeling like one is in a dream).
- B. During the *depersonalization* experience, *reality testing* remains intact.
- C. The depersonalization causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The depersonalization experience does not occur exclusively during the course of another *mental disorder*, such as *Schizophrenia*, *Panic Disorder*, *Acute Stress Disorder*, or another *Dissociative Disorder*, and is not due to the direct physiological effects of a *substance* (e.g., a drug of abuse, a medication) or a general medical condition (e.g., temporal lobe epilepsy).

### **DSM-IV & DSM-IV-TR: Dissociative Fugue**

Patients with this *Dissociative Disorder* suddenly and unexpectedly travel away from their home geographic location, experience impaired recall of their past. They may be confused about their former entity and may assume a new identity.

#### **Diagnostic criteria for 300.13 Dissociative Fugue (cautionary statement)**

A. The predominant disturbance is sudden, unexpected travel away from home or one's customary place of work, with inability to recall one's past.

B. Confusion about personal identity or assumption of a new identity (partial or complete).

C. The disturbance does not occur exclusively during the course of *Dissociative Identity Disorder* and is not due to the direct physiological effects of a *substance* (e.g., a drug of abuse, a medication) or a general medical condition (e.g., temporal lobe epilepsy).

D. The *symptoms* cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

### **DSM-IV & DSM-IV-TR: Dissociative Identity Disorder (DID)**

Patients with this *Dissociative Disorder* suffer from alternation of two or more distinct personality states with impaired recall among personality states of important information.

#### **Diagnostic criteria for 300.14 Dissociative Identity Disorder (cautionary statement)**

A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).

B. At least two of these identities or personality states recurrently take control of the person's behavior.

C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

D. The disturbance is not due to the direct physiological effects of a *substance* (e.g., black-outs or chaotic behavior during *Alcohol Intoxication*) or a general medical condition (e.g., complex partial seizures). **Note:** In children, the *symptoms* are not attributable to imaginary playmates or other fantasy play.

### **DSM-IV: Not Otherwise Specified (NOS)**

This designation abbreviated NOS can be used when the *mental disorder* appears to fall within the larger category but does not meet the criteria of any specific disorder within that category.

### **7.3 Feminist Therapy Code of Ethics (Revised, 1999)**

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#### **Preamble**

Feminist therapy evolved from feminist philosophy, psychological theory and practice, and political theory. In particular feminists recognize the impact of society in creating and maintaining the problems and issues brought into therapy.

Briefly, feminists believe the personal is political. Basic tenets of feminism include a belief in the equal worth of all human beings, a recognition that each individual's personal experiences and situations are reflective of and an influence on society's institutionalized attitudes and values, and a commitment to political and social change that equalizes power among people. Feminists are committed to recognizing and reducing the pervasive influences and insidious effects of oppressive societal attitudes and society.

Thus, a feminist analysis addresses the understanding of power and its interconnections among gender, race, culture, class, physical ability, sexual orientation, age, and anti-Semitism as well as all forms of oppression based on religion, ethnicity, and heritage. Feminist therapists also live in and are subject to those same influences and effects and consistently monitor their beliefs and behaviors as a result of those influences.

Feminist therapists adhere to and integrate feminist analyses in all spheres of their work as therapists, educators, consultants, administrators, writers, editors, and/or researchers. Feminist therapists are accountable for the management of the power differential within these roles and accept responsibility for that power. Because of the limitations of a purely intra-psychic model of human functioning, feminist therapists facilitate the understanding of the interactive effects of the client's internal and external worlds. Feminist therapists possess knowledge about the psychology of women and girls and utilize feminist scholarship to revise theories and practices, incorporating new knowledge as it is generated.

Feminist therapists are trained in a variety of disciplines, theoretical orientations, and degrees of structure. They come from different cultural, economic, ethnic, and racial backgrounds. They work in many types of settings with a diversity of clients and practice different modalities of therapy, training, and research. Feminist therapy theory integrates feminist principles into other theories of human development and change.

The ethical guidelines that follow are additive to, rather than a replacement for, the ethical principles of the profession in which a feminist therapist practices. Amid this

diversity, feminist therapists are joined together by their feminist analyses and perspectives. Additionally, they work toward incorporating feminist principles into existing professional standards when appropriate.

Feminist therapists live with and practice in competing forces and complex controlling interests. When mental health care involves third-party payers, it is feminist therapists' responsibility to advocate for the best possible therapeutic process for the client, including short or long term therapy. Care and compassion for clients include protection of confidentiality and awareness of the impacts of economic and political considerations, including the increasing disparity between the quality of therapeutic care available for those with or without third-party payers.

Feminist therapists assume a proactive stance toward the eradication of oppression in their lives and work toward empowering women and girls. They are respectful of individual differences, examining oppressive aspects of both their own and clients' value systems. Feminist therapists engage in social change activities, broadly defined, outside of and apart from their work in their professions. Such activities may vary in scope and content but are an essential aspect of a feminist perspective.

This code is a series of positive statements that provide guidelines for feminist therapy practice, training, and research. Feminist therapists who are members of other professional organizations adhere to the ethical codes of those organizations. Feminist therapists who are not members of such organizations are guided by the ethical standards of the organization closest to their mode of practice.

These statements provide more specific guidelines within the context of and as an extension of most ethical codes. When ethical guidelines are in conflict, the feminist therapist is accountable for how she prioritizes her choices.

These ethical guidelines, then, are focused on the issues feminist therapists, educators, and researchers have found especially important in their professional settings. As with any code of therapy ethics, the well-being of clients is the guiding principle underlying this code. The feminist therapy issues that relate directly to the client's well-being include cultural diversities and oppressions, power differentials, overlapping relationships, therapist accountability, and social change. Even though the principles are stated separately, each interfaces with the others to form an interdependent whole. In addition, the code is a living document and, thus, is continually in the process of change.

The Feminist Therapy Institute's Code of Ethics is shaped by economic and cultural forces in North America and by the experiences of its members. Members encourage an ongoing international dialogue about feminist and ethical issues. It recognizes that ethical codes are aspirational and ethical behaviors are on a continuum rather than

reflecting dichotomies. Additionally, ethical guidelines and legal requirements may differ. The Feminist Therapy Institute provides educational interventions for its members rather than disciplinary activity.

## **Ethical Guidelines for Feminist Therapists**

### **I. Cultural Diversities and Oppressions**

- A. A feminist therapist increases her accessibility to and for a wide range of clients from her own and other identified groups through flexible delivery of services. When appropriate, the feminist therapist assists clients in accessing other services and intervenes when a client's rights are violated.
- B. A feminist therapist is aware of the meaning and impact of her own ethnic and cultural background, gender, class, age, and sexual orientation, and actively attempts to become knowledgeable about alternatives from sources other than her clients. She is actively engaged in broadening her knowledge of ethnic and cultural experiences, non-dominant and dominant.
- C. Recognizing that the dominant culture determines the norm, the therapist's goal is to uncover and respect cultural and experiential differences, including those based on long term or recent immigration and/or refugee status.
- D. A feminist therapist evaluates her ongoing interactions with her clientele for any evidence of her biases or discriminatory attitudes and practices. She also monitors her other interactions, including service delivery, teaching, writing, and all professional activities. The feminist therapist accepts responsibility for taking action to confront and change any interfering, oppressing, or devaluing biases she has.

### **II. Power Differentials**

- A. A feminist therapist acknowledges the inherent power differentials between client and therapist and models effective use of personal, structural, or institutional power. In using the power differential to the benefit of the client, she does not take control or power which rightfully belongs to her client.
- B. A feminist therapist discloses information to the client which facilitates the therapeutic process, including information communicated to others. The therapist is responsible for using self-disclosure only with purpose and discretion and in the interest of the client.
- C. A feminist therapist negotiates and renegotiates formal and/or informal contacts with clients in an ongoing mutual process. As part of the decision-making process, she makes explicit the therapeutic issues involved.
- D. A feminist therapist educates her clients regarding power relationships. She informs clients of their rights as consumers of therapy, including procedures for

resolving differences and filing grievances. She clarifies power in its various forms as it exists within other areas of her life, including professional roles, social/governmental structures, and interpersonal relationships. She assists her clients in finding ways to protect themselves and, if requested, to seek redress.

### **III. Overlapping Relationships**

- A. A feminist therapist recognizes the complexity and conflicting priorities inherent in multiple or overlapping relationships. The therapist accepts responsibility for monitoring such relationships to prevent potential abuse of or harm to the client.
- B. A feminist therapist is actively involved in her community. As a result, she is aware of the need for confidentiality in all settings. Recognizing that her client's concerns and general well-being are primary, she self-monitors both public and private statements and comments. Situations may develop through community involvement where power dynamics shift, including a client having equal or more authority than the therapist. In all such situations a feminist therapist maintains accountability.
- C. When accepting third party payments, a feminist therapist is especially cognizant of and clearly communicates to her client the multiple obligations, roles, and responsibilities of the therapist. When working in institutional settings, she clarifies to all involved parties where her allegiances lie. She also monitors multiple and conflicting expectations between clients and caregivers, especially when working with children and elders.
- D. A feminist therapist does not engage in sexual intimacies nor any overtly or covertly sexualized behaviors with a client or former client.

### **IV. Therapist Accountability**

- A. A feminist therapist is accountable to herself, to colleagues, and especially to her clients.
- B. A feminist therapist will contract to work with clients and issues within the realm of her competencies. If problems beyond her competencies surface, the feminist therapist utilizes consultation and available resources. She respects the integrity of the relationship by stating the limits of her training and providing the client with the possibilities of continuing with her or changing therapists.
- C. A feminist therapist recognizes her personal and professional needs and utilizes ongoing self-evaluation, peer support, consultation, supervision, continuing education, and/or personal therapy. She evaluates, maintains, and seeks to improve her competencies, as well as her emotional, physical, mental, and spiritual well-being. When the feminist therapist has experienced a similar stressful or damaging event as her client, she seeks consultation.

- D. A feminist therapist continually re-evaluates her training, theoretical background, and research to include developments in feminist knowledge. She integrates feminism into psychological theory, receives ongoing therapy training, and acknowledges the limits of her competencies.
- E. A feminist therapist engages in self-care activities in an ongoing manner outside the work setting. She recognizes her own needs and vulnerabilities as well as the unique stresses inherent in this work. She demonstrates an ability to establish boundaries with the client that are healthy for both of them. She also is willing to self-nurture in appropriate and self-empowering ways.

## **V. Social Change**

- A. A feminist therapist seeks multiple avenues for impacting change, including public education and advocacy within professional organizations, lobbying for legislative actions, and other appropriate activities.
- B. A feminist therapist actively questions practices in her community that appear harmful to clients or therapists. She assists clients in intervening on their own behalf. As appropriate, the feminist therapist herself intervenes, especially when other practitioners appear to be engaging in harmful, unethical, or illegal behaviors.
- C. When appropriate, a feminist therapist encourages a client's recognition of criminal behaviors and also facilitates the client's navigation of the criminal justice system.
- D. A feminist therapist, teacher, or researcher is alert to the control of information dissemination and questions pressures to conform to and use dominant mainstream standards. As technological methods of communication change and increase, the feminist therapist recognizes the socioeconomic aspects of these developments and communicates according to clients' access to technology.
- E. A feminist therapist, teacher, or researcher recognizes the political is personal in a world where social change is a constant.

## 7.4 Release of Information Agreement

*Note: This is a generic release of information form. Please modify to meet your program.*

Date: \_\_\_\_\_

I, \_\_\_\_\_, understand that the counselling relationship is confidential within the limits of the (changing) law. I understand these exceptions:

1. If my counsellor, \_\_\_\_\_, has reason to believe that a child is at risk for abuse and/or neglect (physical, sexual, emotional, verbal), s/he has a legal and ethical mandate to report this concern to the B.C. Ministry for Child and Family Development.
2. If my counsellor has reason to believe that I might injure myself or someone else, or that other persons are at risk for the same reason, s/he has a legal and ethical right to intervene, even if this means breaking confidentiality.
3. It may be helpful or necessary for my counsellor to speak to other professionals who may be involved in aspects of my physical and emotional health. Wherever possible, this will be done with my understanding of the intent of such contact. I have the right to know what transpired in any conversations between my counsellor and other professionals.
4. My counsellor has the right and obligation to seek consultation and supervision in order to adequately perform her/his job. S/he agrees to change identifying characteristics. *(Give details of how this happens. Explain if your agency shares files or does case consultations.)*
5. My counsellor has explained to me that, as my counselling is partly funded by government/insurance agencies, s/he will be required to provide progress reports. *(Give details, especially if you are involved in case management meetings.)*
6. Other professionals involved in my health are:

Name	Phone #
e.g., Dr. Smith	604-123-4567

Please list any limitation to the release of information (e.g., “not to be given to ex-spouse”):

7. I understand that if I want to access my records I should contact \_\_\_\_\_ at the \_\_\_\_\_ *(name of agency)*.

8. My counsellor has explained to me that counselling records will be retained by \_\_\_\_\_ (*list agency or name of private practitioner*)  
for \_\_\_\_\_ (*explain your policy*).

Client's signature \_\_\_\_\_ Counsellor's signature \_\_\_\_\_

This consent is valid until I leave counselling or from two years from this date.

## 7.5 Elements of a Client Orientation Letter

The purpose of such a letter (or brochure) is to give your new client all the information she needs about you, your counselling approaches and your office policies. A client is understandably nervous on her first visit and she may not be able to attend fully to your opening statements.

Giving a letter to your client allows her to read it at home and then discuss it with you. It is important that you follow up at the next session and ask if she has any questions.

The letter should be written in simple, direct language. The letter might address the following:

- Limitations of confidentiality, including mandatory reporting, supervisory requirements and reports to funding bodies (e.g., Crime Victim Assistance Program);
- Confidentiality with child clients;
- Confidentiality between marital and/or family clients;
- Access to records, including court-ordered access;
- Who your client should contact if she wants access to the records (PIPA requirement);
- How the wait-list works;
- Access to you after hours, use of telephone, etc. Give the crisis line number;
- Policy about missed or cancelled-with-short-notice appointments;
- Any additional costs such as tests, workbooks, etc.;
- Treatment approaches used and brief explanation of such;
- Any specific program rules; e.g., must be sober for 24 hours before appointment;
- How referrals for adjunct therapies such as body work, groups, etc. are handled;

- Reasonable expectations and potential negative outcomes of treatment (it is important to alert a client that she will probably feel worse before she feels better);
- Any time limits on counselling;
- How termination is handled and whether the client can come back at a later date;
- Avenues for making complaints;
- Information about how the collected personal information will be used and that it will not be released to a third party without the client's consent; and
- Retention policy for records.

## **7.6 Essential Attributes of Culturally Skilled Counsellors**

Corey et al. (1993) identified the following essential attributes of culturally skilled counsellors.

### **1. Beliefs and attitudes of culturally skilled counsellors**

- They are aware of their own values, beliefs, attitudes, feelings and biases, and of how they are likely to affect minority clients. They monitor their functioning through consultation, supervision and continuing education.
- They can appreciate diverse cultures, and they feel comfortable with differences between themselves and their clients in terms of ethnicity and beliefs. Rather than being ethnocentric and maintaining that their cultural heritage is superior, they are able to value and accept cultural differences.
- They believe that there can be a unique integration of different value systems that can contribute to both therapist and client growth.
- They are aware of their limitations and are not threatened by the prospect of referring a minority client to a member of his or her own ethnicity or culture, when necessary.

### **2. Knowledge of culturally skilled counsellors**

- They understand the sociopolitical system's operation in [Canada] with respect to its treatment of minorities.
- They are aware of institutional barriers that prevent minorities from making full use of psychological services in the community.
- They understand how the value assumptions of the major theories of counselling may interact with the values of different cultural groups.
- They are aware of culture-specific (or indigenous) methods of helping.
- They possess specific knowledge about the particular group they are working with.

### **3. Skills of culturally skilled counsellors**

- They are able to use counselling methods and goals that are consistent with the life experiences and cultural value systems of different minority groups.
- They are able to modify and adapt conventional approaches to counselling and psychotherapy in order to accommodate cultural differences.
- They are able to send and receive both verbal and nonverbal messages accurately and appropriately.
- They are able to employ institutional intervention skills on behalf of their clients when necessary or appropriate.
- They are able to make out-of-office interventions when necessary by assuming the role of consultant and agent for change.
- They recognize their limitations and are able to anticipate their impact on the culturally different client.

## 7.7 Emotional Abuse Assessment Guide

*Courtesy of: Education Wife Assault. A copy of this guide is available at [www.womanabuseprevention/html/elder\\_abuse/bibliographies.htm](http://www.womanabuseprevention/html/elder_abuse/bibliographies.htm).*

This guide is intended to assist community professionals or resource people coming into contact with women who are emotionally abused, by providing tools for assessing emotional abuse, and ways to respond.

Emotional abuse is the repeated use of controlling and harmful behaviours by a partner to control a woman. As a result of emotional abuse, a woman lives her life in fear and repeatedly alters her thoughts, feelings, and behaviours, and denies her needs, to avoid further abuse.

### Important Factors to Consider:

- Abuse can happen to any woman regardless of her age, culture, ability, or socio-economic background.
- If a woman has been physically assaulted, she has most likely been emotionally abused as well, although the reverse is not necessarily true.
- Emotional abuse is the greatest predictor of physical violence. Therefore, any woman who has been emotionally abused is also at risk of murder or suicide.
- A woman may seek help indirectly and hope the professional will identify the abuse.
- Abused women have identified that the long-term effects of emotional abuse are greater than any other form of abuse, including physical violence.

### Tactics of Emotional Abuse

It is impossible to create a complete list of the tactics that are used by abusive men to control their female partners. The following list represents the most reported forms of abuse by women who are or have been in an emotionally abusive relationship. When speaking with a woman, it is also helpful to determine whether the acts are of a repeated and ongoing nature, or isolated incidents.

Does the woman report that her partner has:

**Verbal Abuse:**

- Criticized her, told her she is stupid, fat or ugly or called her names;
- Told her that no one else would want her or that she could not make it on her own;
- Made racist comments about her cultural background;
- Criticized her spiritual beliefs;
- Played mind games with her; lied to her or recreated events;
- Refused to talk to her for long periods of time - silent treatment;
- Shamed or humiliated her if she needs him to take care of physical needs related to a disability;
- Denied his actions or minimized them;
- Told the woman that all the problems in the relationship are her fault;

**Isolation:**

- Interfered with her relationships with family, friends or co-workers;
- Made accusations of infidelity if she spoke to another man, or accused her of being a lesbian if she has female friends;
- Interrogated her about her whereabouts and the people she talked to;
- Prevented her from attending her faith community;
- Refused to allow a woman to go to work school or other independent activities;
- Did not allow her to take English classes;
- Refused to provide ASL interpretation where needed for a deaf woman;

**Threats:**

- Threatened to deport her if she does not stay in the relationship;

- Threatened to kill himself; said that he can't make it without her;
- Threatened to take the children from her or ensure she never sees them again;
- Threatened to harm or kill her, her children, family, friends, farm animals or pets;

**Intimidation:**

- Destroyed or thrown out things that were important to her;
- Slammed doors; punched holes in walls; pulled phone out of the wall;
- Yelled at her; would not allow her to speak;
- Held a deaf woman's hands so she could not sign; refuse to use a Blissymbolics board or other communication devices;
- Took her wheel-chair out of reach or damage her scooter;

**Sexual Abuse:**

- Insisted that she have sex with him in whatever manner he wanted and whenever he wanted;
- Threatened to have affairs, or accuse her of having affairs if she did not have sex with him;
- Withheld sex in a malicious way, to punish her or make her feel bad about herself;

**Financial Abuse:**

- Did not allow her any access to financial resources;
- Made her account for every penny she spends;
- Denied her the opportunity to work outside of the home;

**Neglect:**

- Refused to assist a woman with a disability to the toilet, left her in bed or neglected her for long periods of time;

- Denied her basic needs such as food or hygiene;
- Refused to allow additional help in the home to take care of her needs.

### **Impact of the Emotional Abuse**

You may also be able to identify cues to a woman being emotionally abused, by her behaviours and the ways she has been impacted by the abuse. One constant for women who are abused is fear. In addition to the indicators listed below, there are two key questions used to assess if a woman is being emotionally abused:

- Does the woman indicate that she is fearful of negative reprisals from her partner if she does not do what he wants?
- Does the woman alter her behaviour, preferences or choices as a result of this fear?

### **How does she present her partner or the relationship?**

- Does the woman seem to be unable to make a decision independent of her husband/partner?
- Is the woman quick to defend her partner from any criticism or make excuses for her partner's behaviour? Does she minimize his behaviour or the impact on her?
- Does she take responsibility for making things better in the relationship?
- Does she seem fearful of doing anything that might make her partner upset?

### **How does she present herself?**

- Have you noticed that she is becoming less confident and able to speak for herself?
- Is she quick to put herself down or discount positive feedback?
- Does she always take the blame for things, especially anything to do with her relationship?

### **What is her overall well being?**

- Is she having difficulty sleeping and feel repeatedly tired?
- Does she report feeling anxious all of the time? Does she appear jumpy?
- Is she depressed or suicidal?
- If a woman has a chronic illness or disability, does it seem to be getting worse?
- Is she developing health problems that are related to stress?
- Is she using drugs or alcohol to cope?
- Does she say that sometimes she feels like she is going crazy?

### **Level of Isolation/Independence**

- Does the woman have any sources of support outside of the relationship?
- Has she quit or pulled out of work, school or other social activities?
- Does her partner always accompany her to appointments?
- Has her partner relocated the woman away from family, friends or job?
- Does she have access to money?
- Is the woman prevented from learning English?
- If the woman has a disability, does her partner insist that she needs no one but him to help her?

### **Responding To Emotionally Abused Women**

Women consistently report that the biggest problem they have with getting help is that no one takes emotional abuse seriously. Improving your own response to women who have been emotionally abused can truly make a difference.

#### **Unhelpful Responses:**

- Blaming the woman for the abuse or suggesting that if she just tried harder, or was more supportive to her husband the abuse would end;

- Making excuses for her abusive partner, such as he is under stress, or it is due to his alcohol or drug use;
- Suggesting that what they need is couples counselling; implying either directly or indirectly that she is equally responsible for the emotional abuse that she is experiencing;
- Trying to take control of the situation and telling her what she must do;
- Minimizing the abuse, and telling her to be grateful that he is not hitting her;
- Blaming the abuse on the woman's disability;
- Focusing on the treatment of her depression or anxiety - including the use of prescription drugs, and labeling her mentally ill instead of looking at the abuse that has caused it;
- Discounting the abuse as part of her culture.

### **Helpful Responses to Emotional Abuse:**

- Listen respectfully and take an abused woman seriously; ask her what she needs;
- Reassure her you will keep her confidence and clearly explain confidentiality;
- Ask open ended questions about abuse, and include examples of emotional abuse;
- Believe an abused woman's story;
- Let the woman identify what is having the greatest impact on her;
- Help an abused woman see her strengths and survival skills;
- Help an abused woman see how she had been losing self-confidence;
- Assist an abused woman to plan for change;
- Help an abused woman understand the impact on the children;
- Direct the woman to someone who can help her;

- Have brochures available in different languages;
- Ensure that a woman with a disability is asked what she needs to come to the office, such as a Braille map or someone to meet her;
- Utilize trained Cultural or American Sign Language Interpreters;
- Suggest that she get legal advice so she knows her rights and;
- Respect a woman's choices.

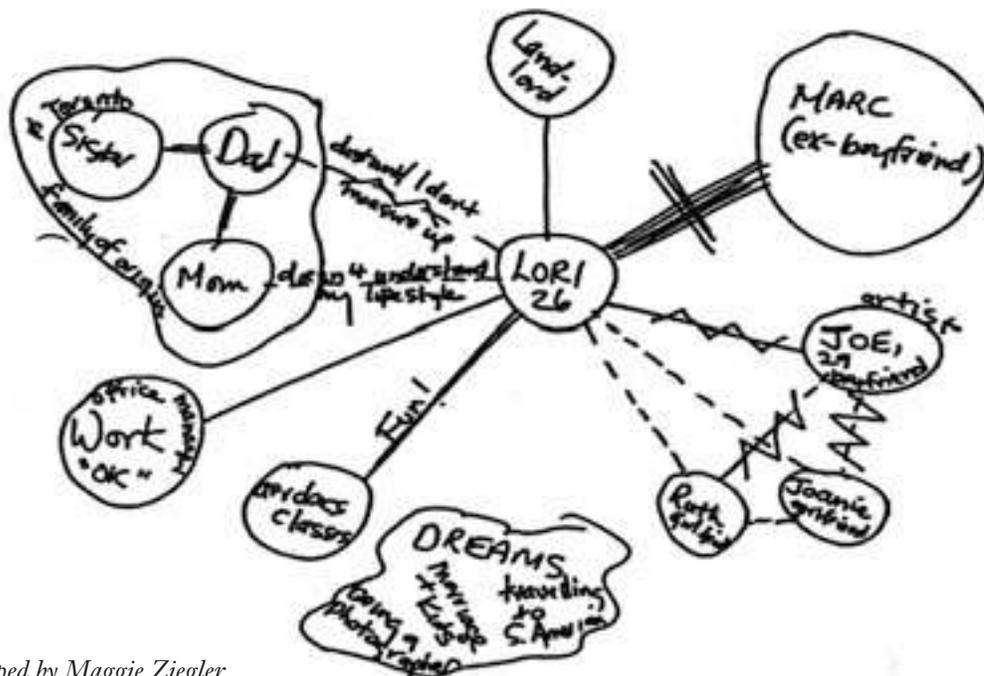
## 7.8 Eco-Maps

An eco-map is another means of assessing relationships in your client's life. In the example that follows, Lori has been in a relationship with Joe for two years. In a situation of escalating violence, Joe's verbal abuse of Lori is being replaced by shoving and slapping. Most recently, Joe pushed Lori hard, and Lori fell down a small flight of stairs. Lori alternates between acknowledging her fear and minimizing the violent incidents. Her self-esteem is practically non-existent. She sees herself as worthless and stupid, and feels lucky to be in a relationship with someone as talented as Joe.

Lori draws this eco-map during a counselling session about three months after initially seeking counselling. Although a strong therapeutic bond is developing between Lori and her counsellor, Lori continues to feel stuck. The counsellor is beginning to feel that way too.

When introducing the eco-map, the counsellor asks Lori to place herself in the middle of the picture and then indicate significant relationships. She can place people closer or farther from her depending on her degree of intimacy with them. By using different types of lines between herself and them, she can indicate the nature of the connection; e.g., cut-off relationships, conflicted interactions, weak connections, intense connections, etc.

The counsellor then asks Lori what it was like to do the exercise, what she notices in her body when she looks at the eco-map, etc. The eco-map becomes a shared assessment tool, leading to short-term goals that might address issues such as boundaries.



*Developed by Maggie Ziegler*

## 7.9 Variations of the Life History

Gathering a life history is an important task in the stage one counselling process.

The main method of collecting a life history is to ask your client to note the important events in her life from birth to the present. Some clients will do this in a chronological form (e.g., create a chart for each year); others will use a narrative stream-of-consciousness writing approach.

However, broad, open-ended life histories may be too stimulating for some clients. Here are some variations of the life history that might be helpful.

- 1) Twelve stepping stones: Take a piece of paper. Draw 12 oval circles on it, starting at one end and meandering around the paper until you reach the 12th stone, which is the present. Ask your client to fill in the other 11 stones to represent significant events that brought her to the present.
- 2) Take a piece of paper and divide it in half. On one side, ask your client to write down her 10 best memories and, on the other side, her 10 worst memories.
- 3) Divide your client's life into chunks—e.g., preschool, school years, teen years, young adulthood, etc.—and note two to four events in each category that are significant. Another variation is to ask her to tell you or to write/draw about the overarching themes of those years. For example, a client may say that her childhood was okay until her preteen years, when her mother started drinking heavily.

## 7.10 Questions About Childhood Trauma

**Note:** Research clearly indicates that recent traumatic events (e.g., being a victim of crime through robbery, drunk driving, assault, etc.) may trigger a release of childhood traumatic memory. Depending on the circumstances, it may or may not be appropriate for STV counsellors to ask these kinds of questions. If the client is experiencing flashbacks and/or describing childhood events, you will need to address these concerns.

If you ask these questions, it is important to document the answers. This forms a baseline of your client's experience when she first entered counselling with you.

- Have you always known about these memories?
- If yes, have you ever had periods when you forget about these memories?
- What can you tell me about these periods of forgetfulness?
- If no, how did you come to recover them?
- What was going on in your life at that time?
- Any traumatic events?
- Were you in therapy?
- What approach did your previous therapist take regarding memories?
- Are you satisfied about that?
- What specific techniques did your previous therapist use?
- What was your experience of recovering the memories?
- Have you ever had a flashback? If yes, can you describe one for me?
- Are there aspects of your memories that puzzle you? If yes, tell me about this.
- (To the client who has no memories but thinks s/he may have been sexually abused) Tell me why you think you may have been abused? What are the bits and pieces (memory, experience, reading, discussions, etc.) that lead you to believe this?

- Ask if she can think of explanations other than sexual abuse.
- Ask about medical history, family crisis/traumas and other known events that may have a bearing.

“ . . . Memories are records of how we experienced events,  
not replicas of the events themselves . . . ”

—Daniel Schacter

## 7.11 Dissociative Presentations in Session

Notice the timing, frequency and intensity of the following types of behaviours by your client. Notice clusters and patterns. Pay attention to your own energy. A client's dissociative behaviours may include:

- Frequently losing thought/changing subject in mid-sentence;
- Marked changes in conversational style, cadence, language, mannerisms, voice;
- Shifts in body energy, posture, language;
- Twisting hair, hand wringing, picking imaginary lint;
- Non-stop disconnected or rapid talking;
- Unrelated/circular responses;
- Word slips; e.g., "I was my father's wife;"
- Eyes glazing, a blank look, jaw slackening, staring into space;
- Eyes rolling, pupil size changing, blinking;
- Staring out the window;
- Leaving the room;
- Smiling or laughing, particularly when inappropriate;
- Shallow breathing;
- Counting, rocking, autistic/robotic presentation;
- Yawning or sleeping;
- Forgetting, asking you to repeat;
- Division between cognition and affect, numbing out;
- Time warps, losses of memory;

- Fogginess, confusion;
- Changes in perception;
- Feeling as if she is no longer in her body, like she is floating;
- Feeling in two places at once;
- Talking “as if;”
- Focuses on therapist, changes in response to therapist;
- Changes in clothes, shoes, make-up, accessories; and
- Partner says “she’s so moody” or “I never know who I’m coming home to.”

Suggested in-session interventions for dissociative presentations include:

- Grounding activities;
- Recognizing courage, normalizing, honouring;
- Educating about dissociation;
- Self-care exercises;
- Asking what has worked before;
- Tracking behaviours in session, noticing them, asking questions about her experience;
- Asking her to be aware of her body and what she notices;
- Breathing exercises;
- Using transitional objects;
- Orienting her to the present time; and
- Orienting her to you and to the office.

## 7.12 Handout for Discussing Counselling Stages With Clients

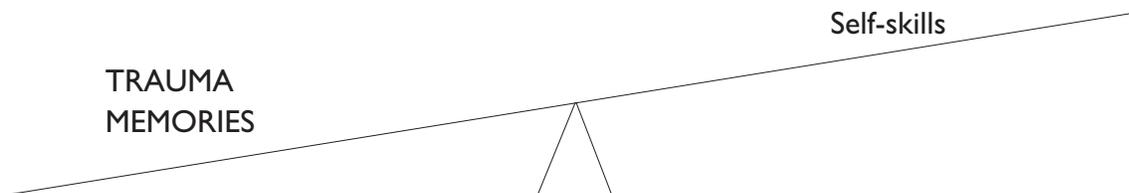
The following is a handout that one of the authors uses with clients to discuss the stages of trauma counselling and to develop concrete goals. Feel free to adapt or modify as needed.

### Stages of trauma counselling and developing goals

*a.k.a. Maureen's shopping list*

#### Key points for clients to understand about trauma therapy

- Slow and steady is the best way to heal from childhood traumas. We will get to the finish line faster if we build a good foundation first.
- People do not come into counselling with a balance of self-skills and trauma memories. Generally, people are overloaded with trauma memories and underdeveloped in their skills for self-soothing, etc.



The temptation for both clients and counsellors is first to lighten the overload of memories and have you, the client, tell stories of what happened to you. However, we've found this usually is not helpful precisely because you do not have many skills to soothe the strong feelings and reactions that emerge when telling memories.

So, we need to start at the other end of the spectrum and focus on building skills to contain, manage and tolerate strong feelings.

- In this kind of counselling work, clients usually feel a lot worse before they start to feel better. That is why I place such strong emphasis on safety and containment skills.
- It is generally accepted that trauma therapy has three phases:
  1. Establishing safety in the client's life and with the counsellor;
  2. Working with the trauma memories and mourning the losses; and
  3. Reconnecting with ordinary life.

## **General assessment activities we will do together**

- Create a family picture (genogram);
- Prepare a life history of major events;
- Develop a “map” of your support system;
- Determine your level of dissociation, through questions and, in some cases, with specific questionnaires. This is an ongoing process;
- Determine your level of compulsive behaviours such as alcohol or drug use, eating, etc. One needs to be alcohol- and drug-free (certain prescriptions excluded) to do this work;
- Explore the frequency of any self-harming behaviours, such as cutting; and
- Assess your need for medication.

## **Safety and containment skills**

The following skills will help clients weather the strong emotions of healing. Like any skill, these skills need to be practised.

- Able to imagine a safe place(s);
- Able to dialogue with “inner child” (imagery, writing, gestalt);
- Have created a container(s) to store memories;
- Understand the process of dissociation (e.g., the BASK model (Behavior, Affect, Sensation and Knowledge));
- Have explored using metaphors such as video projections;
- Have created a safe working conference room (this applies particularly for people with high levels of dissociation);
- Have developed some strategies to close down strong feelings (e.g., 5-4-3-2-1, IV Bottles);

- Have some ability to self-soothe via self-hypnosis, yoga, meditation, painting, writing, etc.;
- Have developed some healing/grieving rituals;
- Able to play relaxation tapes;
- Have some skills in stress management; and
- Have explored the use of EMDR.

### **Signs of readiness to enter stage two**

- More ease in self-care strategies, actually using them;
- Fewer current crises;
- Fewer self-harming behaviours;
- Fewer compulsive behaviours;
- Stronger sense of self, being adult; and
- Stronger sense of safety with me vs. trying to please/resist me.

*Developed by Maureen McEvoy, M.A., 1996.  
Thanks to John Briere for the concept of the teeter-totter.*

### 7.13 Client Assessment of Counselling Sessions

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

SESSIONS REVIEWED: \_\_\_\_\_

**Summary of sessions** (topics covered, homework assignments, etc.):

**Evaluation of sessions** (insights, what was most helpful, what was least helpful, what changes have you noticed as a result of the sessions):

**Future directions** (what is currently most troubling in your life, what would be a goal for the next four sessions):

Name of counselling program and address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Developed by Maggie Ziegler*

## 7.14 Primer on Substance Use

This primer is designed to give counsellors an overview of screening and assessment for substance use. The primer includes:

- Strategies for screening and assessing for alcohol and other substance use
- Simple screening instruments in common use
  - CAGE
  - T-ACE
  - AUDIT
  - MAST
- The stages of change model
- A story about change

### Strategies for screening and assessing for alcohol and other substance use

This section provides an overview of the essential points relevant to screening and assessing for alcohol use. It can also be adapted to screen and assess for other drugs (prescription or illicit).

The goal of screening is to detect a possible alcohol/drug problem, or identify whether the client is at risk of developing such a problem. A diagnostic assessment, on the other hand, is used to establish a diagnosis and to develop a specific treatment plan. Such an assessment is generally conducted over several visits by a counsellor with specific expertise in this area. An assessment may also be requested by police or a judge as part of a criminal investigation.

Here are some best practice strategies for screening and assessing for substance use.

- Routinely ask. If you are working with a trauma survivor (or a first responder), remember that many people use substances as a means of managing their trauma responses or overwhelming feelings. Therefore, it is useful to ask routinely if she uses alcohol or drugs. Your approach should be sincere, respectful, non-judgmental and confidential.

- Get specifics. If she says yes when you ask whether she is using, then ask for specific information. Questions might include:
  - How much and how often do you drink?
  - How many times a week do you have a drink?
  - How much do you drink on each of these occasions?
  - How often do you drink more heavily than this?
- Ask about drinking occasions:
  - What types of drinks (usual and occasional);
  - Strength of the alcohol (if known);
  - Specific occasions of heavy drinking (weeknights/weekends); and
  - Variations from the usual drinking pattern.
- Calculate the client's intake into the number of standard drinks per week. A standard drink in North America contains 14 grams of alcohol and is equivalent to a 12-ounce can or bottle of beer, a 5-ounce glass of wine, or 1½ ounces of hard liquor. Recommended safe guidelines are:
  - For adult women of any age, or adult men under 65 years of age: No more than 4 standard drinks per drinking occasion and no more than 14 standard drinks in any single week.
  - For adult men under 65 years of age: No more than 6 standard drinks per drinking occasion and no more than 21 standard drinks in any single week.
- Consider using a screening instrument. There are literally dozens of screening tools and instruments. The instruments described in the next section are the most frequently used and have good reliability and validity. These instruments can help counsellors identify the need to ask more specific questions.

### **Simple screening instruments in common use**

- The CAGE screening instrument is a very short test that can identify alcohol

problems over the client's lifetime. Two positive responses to the following questions are considered worthy of further assessment.

- C** Have you ever felt you should **cut down** on your drinking?
- A** Have people **annoyed** you by criticizing your drinking?
- G** Have you ever felt bad or **guilty** about your drinking?
- E Eye opener:** Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

- The T-ACE screening instrument, which is based on the CAGE, is valuable for identifying a range of use, including lifetime use and prenatal use, based on the DSM criteria. A score of two or more is considered positive. Affirmative answers to questions A, C or E = one point. Reporting tolerance to more than two drinks (the T question) = two points.

- T Tolerance:** How many drinks does it take to make you feel high?
- A** Have people **annoyed** you by critiquing your drinking?
- C** Have you ever felt you ought to **cut down** your drinking?
- E Eye opener:** Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

- AUDIT (The Alcohol Use Disorders Identification Test). This screening tool was developed by the World Health Organization (WHO) for use in a range of settings and with a wide variety of populations. WHO particularly wanted to be able to have a multicultural screening tool that would assist in the early identification of problem drinkers (as opposed to those already dependent on alcohol). The AUDIT questionnaire is shown on the next page.

- MAST (Michigan Alcohol Screening Test) is a simple, self-scoring test that allows a person to do a self-assessment. A revised MAST follows.

1. Do you feel you are a normal drinker? (Normal = drink as much or less than most other people.) Yes No
2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening? Yes No
3. Does any near relative or close friend ever worry or complain about your drinking? Yes No
4. Can you stop drinking without difficulty after one or two drinks? Yes No

## The Alcohol Use Disorders Identification Test: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

<p>1. How often do you have a drink containing alcohol?</p> <p>(0) Never [Skip to Qs 9-10]            (1) Monthly or less            (2) 2 to 4 times a month            (3) 2 to 3 times a week            (4) 4 or more times a week</p> <p style="text-align: right;"><input type="text"/></p>	<p>6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?</p> <p>(0) Never            (1) Less than monthly            (2) Monthly            (3) Weekly            (4) Daily or almost daily</p> <p style="text-align: right;"><input type="text"/></p>
<p>2. How many drinks containing alcohol do you have on a typical day when you are drinking?</p> <p>(0) 1 or 2            (1) 3 or 4            (2) 5 or 6            (3) 7, 8, or 9            (4) 10 or more</p> <p style="text-align: right;"><input type="text"/></p>	<p>7. How often during the last year have you had a feeling of guilt or remorse after drinking?</p> <p>(0) Never            (1) Less than monthly            (2) Monthly            (3) Weekly            (4) Daily or almost daily</p> <p style="text-align: right;"><input type="text"/></p>
<p>3. How often do you have six or more drinks on one occasion?</p> <p>(0) Never            (1) Less than monthly            (2) Monthly            (3) Weekly            (4) Daily or almost daily</p> <p><i>Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0.</i></p> <p style="text-align: right;"><input type="text"/></p>	<p>8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?</p> <p>(0) Never            (1) Less than monthly            (2) Monthly            (3) Weekly            (4) Daily or almost daily</p> <p style="text-align: right;"><input type="text"/></p>
<p>4. How often during the last year have you found that you were not able to stop drinking once you had started?</p> <p>(0) Never            (1) Less than monthly            (2) Monthly            (3) Weekly            (4) Daily or almost daily</p> <p style="text-align: right;"><input type="text"/></p>	<p>9. Have you or someone else been injured as a result of your drinking?</p> <p>(0) No            (2) Yes, but not in the last year            (4) Yes, during the last year</p> <p style="text-align: right;"><input type="text"/></p>
<p>5. How often during the last year have you failed to do what was normally expected from you because of drinking?</p> <p>(0) Never            (1) Less than monthly            (2) Monthly            (3) Weekly            (4) Daily or almost daily</p> <p style="text-align: right;"><input type="text"/></p>	<p>10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?</p> <p>(0) No            (2) Yes, but not in the last year            (4) Yes, during the last year</p> <p style="text-align: right;"><input type="text"/></p>
<p style="text-align: right;">Record total of specific items here <input type="text"/></p> <p><i>If total is greater than recommended cut-off, consult User's Manual.</i></p>	

5. Do you ever feel guilty about your drinking? Yes No
6. Have you ever attended a meeting of Alcoholics Anonymous (AA)? Yes No
7. Have you ever gotten into physical fights when drinking? Yes No
8. Has drinking ever created problems between you and a near relative or close friend? Yes No
9. Has any family member or close friend gone to anyone for help about your drinking? Yes No
10. Have you ever lost friends because of your drinking? Yes No
11. Have you ever gotten into trouble at work because of drinking? Yes No
12. Have you ever lost a job because of drinking? Yes No
13. Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking? Yes No
14. Do you drink before noon fairly often? Yes No
15. Have you ever been told you have liver trouble, such as cirrhosis? Yes No
16. After heavy drinking, have you ever had delirium tremens (DTs), severe shaking or visual or auditory (hearing) hallucinations? Yes No
17. Have you ever gone to anyone for help about your drinking? Yes No
18. Have you ever been hospitalized because of drinking? Yes No
19. Has your drinking ever resulted in your being hospitalized in a psychiatric ward? Yes No
20. Have you ever gone to any doctor, social worker, clergy person or mental health clinic for help with any emotional problem in which drinking was part of the problem? Yes No
21. Have you been arrested more than once for driving under the influence of alcohol? Yes No

22. Have you ever been arrested, even for a few hours, because of other behaviour while drinking? Yes No (If yes, how many times? \_\_\_\_\_)

### Scoring for the MAST

Please score one point if you answered the following:

- 1: No
- 2: Yes
- 3: Yes
- 4: No
- 5: Yes
- 6: Yes
- 7 through 22: Yes

Add up the scores and compare to the following chart:

- 0-2 points No apparent problem
- 3-5 Early or middle problem drinker
- 6 or more Problem drinker

- Consider further assessment if any of the screening instruments are positive. This depends on what setting you are working in and your level of training or experience you or others in your agency have in alcohol and drug use. A brief assessment covers the following areas:
  - Demographics—age, sexual identity and orientation, ethnicity;
  - Current quantity/frequency of use in the past six months;
  - Age of first use, first intoxications, first regular use and first alcohol-related problem;
  - Overview of pattern of use, problems experienced overall, heaviest six month period and the timing and use in that period, and abstinent periods;
  - DSM-IV-TR dependence criteria met at heaviest period of use;
  - Brief history of other drug use;
  - Brief history of alcohol and drug treatment;

- Other psychiatric history;
- Family history of alcohol and drug use and psychiatric problems; and
- Miscellaneous; i.e., “Is there anything else you would like to tell me, related or not related to your drinking?”

## Model of change

The purpose in asking all of the above questions is to ascertain where your client may be in terms of changing her behaviour. Prochaska and DiClemente (1994) developed a model of change that outlines five stages in the recovery journey. Although it was first developed for use with dependent drinkers, it has also been used successfully with other substance users. Although this model is presented in a linear format, change often does not happen in such a manner.

### Prochaska and DiClemente’s Model of Change

Stage	Client stage	Helper’s role
<b>Pre-contemplation</b> <i>(Actively using)</i>	This is a happy user who enjoys drinking. Positives outweigh any costs.	Ask what she wants from you now. Sow seeds for change. Keep the relationship open and supportive. Get to know her and her goals. Give her harm reduction information. Acknowledge her choice not to change. Create/seize opportunities to explore use.
<b>Contemplation</b> <i>(Still using but considering change at times)</i>	This individual feels that drinking is enjoyable and exciting, but that the costs are starting to mount up. She is now feeling ambivalent about her behaviour. Personal, medical, psychological and family problems may be associated. She is not considering change within the next month.	Go slowly. Elicit reasons to keep using and reasons to change. Explore risks of not changing. Ask what differences she will notice if she changes: in her health, with significant others, at work. Strengthen her self-efficacy to choose to change. Offer choices.

<b>Stage</b>	<b>Client stage</b>	<b>Helper's role</b>
<p><b>Preparation</b> <i>(getting ready to change)</i></p>	<p>This individual has made the decision that her use of alcohol or risk-taking needs to change. She really wants to reduce or stop her substance consumption. She is planning to act within one month.</p>	<p>Work alongside your client to build motivation for change, to develop a menu of options and to assist in determining the best course of action to make change. Prepare your client for what change will be like. Set realistic goals. Contract for brief or small changes while planning for bigger ones. Complete a thorough assessment if not already done. Begin to develop alternative coping skills. Help client identify social support.</p>
<p><b>Action</b> <i>(changing)</i></p>	<p>This individual actively commits to a specific behaviour change, such as cutting down or stopping drinking and practising new behaviours during a three- to six-month period.</p>	<p>Help the client take steps toward change. Ask what small adjustments the client could achieve that would demonstrate positive change. Provide support, practical information and techniques to help her through the changes. Focus on restructuring cues and social support. Plan for slips and feelings of discouragement. Congratulate her on positive changes. Continue to develop alternative coping skills. Combat feelings of loss. Bolster self-efficacy for dealing with obstacles.</p>

<b>Stage</b>	<b>Client stage</b>	<b>Helper's role</b>
<b>Maintenance</b> <i>(keeping up the change)</i>	This individual no longer engages in drinking behaviour that is inappropriate or dangerous to her health. She has a continued commitment to sustaining new behaviours for six months to five years.	Assist the client to maintain her change in behaviour. Celebrate. Use strategies to prevent relapse. Identify any remaining issues to address and develop a strategy for them. Plan for follow-up support. Reinforce internal rewards.
<b>Relapse</b> <i>(Oops! Let's regroup)</i>	This individual has resumed risky drinking behaviour. Having relapsed, she reverts to an earlier stage.	Evaluate triggers for relapse. Reassess motivation and barriers. Plan stronger coping strategies. Assist the client to renew the process of preparation and action without becoming stuck or demoralized.

*Adapted by Maureen McEvoy.*

Prochaska and DiClemente believe that any counsellor or clinician, regardless of approach, can offer better-targeted and more effective therapy by observing the following principles:

- Don't assume that all clients are at the action stage—or want to be. Therapists often design excellent action-oriented treatments, only to discover that the client is not yet ready to embrace change. As a result, clinicians may label the client “resistant” and become quickly frustrated with the case. Remember, only 10 to 15 percent of people are in the action stage.
- Assess the client's stage of change. This need not be complicated. You might simply ask: “Do you think that any particular behaviour is a problem for you now?” Once the client has identified a behaviour, follow up with: “When do you intend to change that?”
- Go slowly. Rather than rushing straight toward action, help your client to move only one stage further along the continuum—for example, from pre-contemplation to contemplation, from feeling it's someone else's problem to thinking about trying to do something about it herself in the next few months. The researchers found that when people progressed from one stage to

the next during the first month of treatment, they doubled their chances of taking action within the next six months.

- Anticipate backsliding. While the term “stages of change” suggests that change marches forward in a step-by-step, linear fashion, it actually occurs in a spiral pattern, which encompasses both forward and backward movement. Some people successfully move into action only to relapse and slide all the way back to the pre-contemplation stage. Therapists should educate clients about the spiralling nature of change to help counteract shame and discouragement about regressing to earlier stages. To minimize backsliding, relapse prevention should be a key part of any treatment plan.
- Do the right thing at the right time. An intervention that is effective at one stage might not work at another. For example, pre-contemplators typically aren’t prepared to take in a lot of information and are best helped by observations and interpretations that gently raise their awareness of their difficulties. By contrast, those in the action stage respond best to specific, behaviour-change interventions coupled with steadfast support from the therapist.
- Avoid inappropriate interventions. One of the most frequent mistakes therapists make is to deliver insight to an individual who is in the action stage—for example, devoting sessions to the impact of a client’s family-of-origin on his marriage at a time when he is actually ready to change his spousal relationship. The likely result: a bored, frustrated client. Another common mismatch arises when clinicians offer action interventions to pre-contemplators or contemplators, which can leave them feeling inadequate and even hopeless. In both cases, clients are likely to feel deeply misunderstood—and misunderstood clients are more apt to drop out of therapy.
- Honour every stage of change. Because the changes that clients make during the action stage tend to be the most visible and dramatic, clinicians often equate change with action. But Prochaska and DiClemente’s research illuminates the fact that each stage is a critical element of the change process, and that negotiating each one requires substantial effort and courage on the part of clients. To help people make enduring change, we must be willing to invest considerable energy and patience in each stage—and to validate our clients as they take each small, significant step toward their goals.

## Resources

Prochaska, J., C. DiClemente and J. Norcross. 1998. "Stages of change: Prescriptive guidelines for behavioral medicine and psychotherapy." In *Psychologist's desk reference*, 230-235. New York: Oxford University Press.

## A story

*By Maureen McEvoy*

This story is about change. It takes place in any town, on a street with many shops. One shop in particular has a beautiful outfit in the window. It is the kind of outfit that anyone would feel fabulous wearing.

One day a woman walks down this street. She is happy with the way she is living her life and she doesn't even see the shop, or the fabulous outfit.

On another day, the woman walks down the street. She has had a few moments of feeling rough lately and her eye catches the window. She stops outside the window and gazes at the outfit and all that it promises. Abruptly, she walks away and continues living her life in the same way.

Another day, she returns to the store. The outfit still beckons. This time, she enters the store and tries it on. For a moment, she is energized with possibilities and a new vista opens for her. Yet she is not quite ready to embrace the outfit. She returns it to the rack and exits the store.

On yet another day, she returns again. This time she buys the outfit.

Now I don't know if this woman is one of those women who will put it on immediately or if she will take it home and have it hang in her closet for awhile first. I don't know exactly when she will start to wear this outfit. I do know that, having purchased it, she can keep it.

There may be days when she doesn't feel like wearing this outfit, but I hope her memories of days when she does wear it and feels fabulous will sustain her through times of discouragement.

I hope she goes on to buy several fabulous outfits!

## **7.15 Alternatives to Self-injurious Behaviours**

These suggested alternatives to self-harming behaviours (SIBs) are drawn from survivors recovering from SIBs. Feel free to tailor the list to suit the needs of your client.

### **Need to re-enact**

- Draw on self or photo of self with red marker.
- Draw feelings or actions on paper.
- Use modelling clay to create and recreate images.
- Flatten aluminum cans.
- Rub lotion on parts of your body you want to hurt.
- Apply a fake tattoo.
- Use a henna kit.
- Injure a toy or stuffed animal.
- Warm a small bottle of red food colouring. Press its tip against the place you want to cut.
- Paint yourself using tempera paint.

### **Strategies to feel physical sensation**

- Eat something sour.
- Snap a rubber band against your wrist.
- Put your hand in cold water.
- Squeeze ice or put ice on the spot you want to burn.
- Take a cold shower.
- Drink hot water.

- Give yourself or get a massage.
- Rub liniment under your nose.
- Stomp your feet.
- Bite into a hot pepper or chew a piece of ginger root.
- Rub your body with a soft brush or loofah.
- Exercise; e.g., take a brisk walk or run, crank up the music and dance.
- Do a body scan.

### **Need to express rage**

- Punch a pillow or use a soft bat.
- Yell in the shower.
- Throw ice, pine cones, eggs, rocks or cotton balls at a wall, in the woods or into water.
- Break old crockery or glass in safe ways.
- Rip pages out of a phone book.
- Rip up paper.
- Push against a wall.
- Knead playdough or clay.
- Draw a picture and rip it up.
- Scribble into your journal.
- Play tennis or squash.
- Make a cloth doll to represent things you are angry at. Cut and tear it instead.

### **Need to feel grounded or in control**

- Breathe deeply.
- Meditate.
- Talk to someone supportive.
- Listen to music.
- Play relaxation tapes or a tape your counsellor made for you.
- Do something nice for yourself (e.g., take a bath with candles, read a good book).
- Do something nice for someone else.
- Touch and use objects that are soothing to one or more senses.
- Walk outdoors to explore and observe what's there.
- Scan the environment and describe what you see, hear and sense.
- Hold transitional objects that link you to people and events in the present.

### **Need to gain focus**

- Do a task, computer game or puzzle that requires concentration.
- Eat a raisin mindfully.
- Choose an object in the room and examine it carefully. Write as detailed a description of it as you can.
- Choose a random object (e.g., a paper clip) and list 30 different uses for it.
- Pick a subject and research it on the Web.
- Write a list (e.g., 20 things that give you pleasure).
- Go see a movie.
- Read a book.

### **Need to communicate**

- Write a letter (to yourself, to your SIB, to your abuser, to your parent(s)).
- Make a protest sign.
- Paint a picture.
- Whisper into a pillow.
- Shout in your car.
- Leave a message with a friend or your counsellor.
- Write or draw in your journal.
- Talk into a tape recorder.
- Go on-line to a self-harm support group; e.g., Bodies Under Siege.

### **Need to self-soothe**

- Take a warm bath with candles and music.
- Rock yourself.
- Wrap yourself up in a blanket.
- Make a cup of tea or cocoa.
- Eat a favourite food.
- Play comforting music.
- Play with a pet.

### **Need to feel punished**

- Take a time out in a safe place.
- Delay taking any action.

- Write down the reasons for this need and discuss them with someone trusted.
- Note that your feelings feel punishing right now.

### **Before cutting**

*Directions: Answer these questions in a journal before self harming.*

1. Why do I feel I need to hurt myself? What has brought me to this point?
2. Have I been here before? What did I do to deal with it? How did I feel then?
3. What have I done to ease this discomfort thus far? What else can I do that won't hurt me?
4. How do I feel right now?
5. How will I feel when I am hurting myself?
6. How will I feel after hurting myself? How will I feel tomorrow morning?
7. Can I avoid this stressor, or deal with it better in the future?
8. Do I need to hurt myself?

## 7.16 A Sample Plan for Life

### My Contact Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Cell/Other Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

### My Doctor's Contact Information

Doctor's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Pager/Other Phone: \_\_\_\_\_

### If my doctor is not available, contact these medical professionals

\_\_\_\_\_

\_\_\_\_\_

### My Health Care Information

Preferred Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

2nd Choice Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**My Health Insurance Information (attach photocopy of insurance card)**

Insurance Company/  
HMO: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Policy Number: \_\_\_\_\_

**My Mental Health Provider**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Additional Information**

Allergies/Medical Conditions: \_\_\_\_\_

\_\_\_\_\_

Prescribed and over-the-counter medications I'm currently taking (if any):

\_\_\_\_\_

\_\_\_\_\_

If I start to think about suicide, I will contact these trusted family members or friends  
(in order of priority)

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

## **7.17 Safety Planning for Women with Abusive Partners or Ex-partners**

*Courtesy of: BCASVACP Community Coordination for Women's Safety*

A safety plan is important because it is easier to plan ahead than to plan while dealing with a crisis. The suggestions in this document represent some safety tips that have been learned from women dealing with abusive current and former partners. The suggestions should only become part of your safety plan if they fit with your knowledge of your own unique situation. You likely also have things you are doing to keep yourself/your children safe that are not included in this list.

- Trust your intuition and instincts; do not doubt yourself if you feel unsafe.
- Practice how to get out of your home safely. What doors, window, elevators, stairwells or fire escapes could you use? If appropriate, practice it with your children.
- Alert your neighbours to call the police if they hear a fight.
- Choose a code word to use with children, friends and/or family so they can call for help.
- If an assault seems possible, try to move to a space that is lowest risk (try to avoid bathrooms, garages, kitchens, rooms near weapons and rooms without access to an outside door).
- Plan ahead for where to go in an emergency (explore possibilities including family, friends and local transition houses/safe homes).
- Find someone who will support and listen to you without making judgments.
- Keep extra car keys, money and clothes in a hidden place or at a friend's.
- Seek medical attention for all injuries. Be aware that you may have suffered physical damage you are not aware of, such as internal bleeding or concussions.
- Ensure that colour photographs are taken of all injuries. It is important to take pictures as injuries change in appearance, such as bruising that appears some time after an assault.
- Save torn or bloody clothing.

- Report assaults to the police (be aware that the police must proceed with recommending charges if there is evidence to do so, regardless of your wishes).
- Preserve evidence such as written notes of apology, bank statements, and other documents.
- Record abusive incidents in a journal; keep the journal in a secret spot. Do not give your journal to anyone unless subpoenaed to do so. If you give your journal to Crown counsel, they are required to turn it over to defense and you may be cross-examined on it.
- Keep a list of names and numbers of all people who have witnessed any abuse or threats (their evidence may be useful later).
- Familiarize yourself with family finances.
- If necessary, find out if you would qualify for social assistance and how much money you would have to live on.
- If necessary, take courses or re-enter the work force. If that is necessary but not possible in your situation, familiarize yourself with courses and job training that would be available if your situation changes.

**If separating:**

- It may not be safe to tell your partner you are leaving. Some possibilities for leaving include when your partner is in the shower, asleep, at work, or out of town, or when you are picking up children from school, going to medical appointments, or going to work.
- If you have children, take them with you when you leave. Take copies of children's medical papers, birth certificates and other important documents.
- Take copies of important documents/items with you when you leave. If you are planning to leave put these items in one place if possible. Some important documents/items include:
  - Personal identification
  - Children's birth certificates
  - Your birth certificate

- Social Insurance Cards
- School and Vaccination Records
- Checkbook
- ATM card
- Credit cards
- Keys—house/car/office
- Driver’s license and registration
- Medications
- Social Assistance Identification
- Work permits
- Landed immigrant papers
- Citizenship papers
- Passports
- Divorce papers
- Medical records
- Lease/rental agreement, house deed, mortgage papers
- Bank Books
- Previous tax returns
- Insurance papers
- Small saleable objects
- List of important phone numbers

- Address book
- Pictures
- Jewelry
- Children’s favourite toys and/or blankets
- Items of special sentimental value
- Keep change or a pre-paid phone card available for telephone calls (if you use telephone credit cards, the following month the bill will tell your partner/ex-partner which you called).

**If separated:**

- Change the locks on doors and windows.
- Replace wooden doors with steel/metal doors.
- Install security measures such as additional locks, window bars, poles to wedge against doors, an electronic system, etc.
- Purchase rope ladders for escape from second floor windows.
- Install smoke detectors and purchase fire extinguishers for each floor in your home.
- Install an outside lighting system that lights up when a person is coming close to your home.
- Inform your employer of your situation.
- Change your route to work.
- Change your start and end time at work.
- Walk with someone to your car.
- If your partner follows you, drive to a place where there are people.

- Use different grocery stores, shopping malls and banks than those you used when residing with your partner.
- Change the hours you conduct your shopping/banking.
- Teach your children how to make a collect call to you and to a trusted family member or friend, in the event that your ex-partner takes the children.
- Tell people who take care of your children which people have permission to pick up the children, and that your ex-partner is not permitted to.
- Inform your neighbours that your ex-partner no longer lives with you and to call the police if he is seen near your residence.
- Keep a copy of any protection orders with you at all times.
- Inform necessary people that you have a protection order (employer, children's schools, child care).

### **Resources**

Hart, Barbara and Jane Stuehling. 1992. *Personalized safety plan*. Reading, PA: Pennsylvania Coalition Against Domestic Abuse. [www.mincava.umn.edu/hart/persona.htm](http://www.mincava.umn.edu/hart/persona.htm).

London Abused Women's Centre. 1996. *Safety resource kit for abused women*. London, ON: London Abused Women's Centre (formerly London Battered Women's Advocacy Centre).

Prince George and District Elizabeth Fry Society. 1995. *Abusive relationships: Planning for your safety*. Prince George, BC: Prince George and District Elizabeth Fry Society.

## **7.18 Sections 13, 76 & 79 of Child, Family & Community Service Act**

**13** (1) A child needs protection in the following circumstances:

- (a) if the child has been, or is likely to be, physically harmed by the child's parent;
- (b) if the child has been, or is likely to be, sexually abused or exploited by the child's parent;
- (c) if the child has been, or is likely to be, physically harmed, sexually abused or sexually exploited by another person and if the child's parent is unwilling or unable to protect the child;
- (d) if the child has been, or is likely to be, physically harmed because of neglect by the child's parent;
- (e) if the child is emotionally harmed by the parent's conduct;
- (f) if the child is deprived of necessary health care;
- (g) if the child's development is likely to be seriously impaired by a treatable condition and the child's parent refuses to provide or consent to treatment;
- (h) if the child's parent is unable or unwilling to care for the child and has not made adequate provision for the child's care;
- (i) if the child is or has been absent from home in circumstances that endanger the child's safety or well-being;
- (j) if the child's parent is dead and adequate provision has not been made for the child's care;
- (k) if the child has been abandoned and adequate provision has not been made for the child's care;
- (l) if the child is in the care of a director or another person by agreement and the child's parent is unwilling or unable to resume care when the agreement is no longer in force.

(1.1) For the purpose of subsection (1) (b) and (c) and section 14 (1) (a) but without limiting the meaning of "sexually abused" or "sexually exploited", a child has been or is likely to be sexually abused or sexually exploited if the child has been, or is likely to be,

(a) encouraged or helped to engage in prostitution, or

(b) coerced or inveigled into engaging in prostitution.

(2) For the purpose of subsection (1) (e), a child is emotionally harmed if the child demonstrates severe

(a) anxiety,

(b) depression,

(c) withdrawal, or

(d) self-destructive or aggressive behaviour.

### **Who can act for a child**

**76** (1) A person, other than a director, who has legal care of a child under 12 years of age may, on behalf of the child, exercise the child's rights under the *Freedom of Information and Protection of Privacy Act*

(a) to be given access to information about the child in a record,

(b) to consent to the disclosure of that information, and

(c) to request the correction of that information.

(2) A person, other than a director, who has legal care of a child 12 years of age or older may, on behalf of the child, exercise the child's rights under the *Freedom of Information and Protection of Privacy Act*

(a) to be given access to information about the child in a record,

(b) to consent to the disclosure of that information, and

(c) to request correction of that information if the child is incapable of exercising those rights.

### **Disclosure without consent**

**79** A director may, without the consent of any person, disclose information obtained under this Act if the disclosure is

- (a) necessary to ensure the safety or well-being of a child,
  - (a.1) necessary to ensure the safety of a person, other than a child,
- (b) required by section 64 or by order of a court in Canada to be made to a party to a proceeding,
- (c) authorized by the Youth Criminal Justice Act (Canada),
- (d) required by an enactment,
- (e) necessary for a family conference, mediation under section 22 or other alternative dispute resolution mechanism,
- (f) made when giving or when validly compelled to give evidence in a proceeding,
- (g) [Repealed 1997-11-32.]
- (h) necessary to enable the Public Guardian and Trustee to perform duties and exercise powers as guardian of a child's estate under this Act,
  - (h.1) made to another director,
- (i) made to a director's legal counsel,
- (j) made in Canada to caregivers and the information relates to children in their care, or
- (k) made in Canada and necessary for the administration of this Act.

## 7.19 Sample Contract For Supervision

### **SAMPLE CONTRACTOR AGREEMENT COUNSELLING SUPERVISION**

Made this \_\_\_\_\_ day of \_\_\_\_\_, Year between *The No Name Community Services Centre, 1234 Central Avenue, Anywhere, BC V2A 4C3* (“the Agency”), and *Jane Doe, 123 Main Street, Anywhere, BC, V1A 2B3* (“the Contractor”) for the period covering \_\_\_\_\_ to \_\_\_\_\_.

This contract verifies that the Contractor will provide counselling supervision services to the Stopping The Violence (STV) Counselling Program counsellor(s) of the Agency. This work will take place either at the Agency. This work will take place either at the Agency, the Contractor’s office or over the telephone, whichever is most convenient for all concerned parties, with the exception of the first initial supervision session, which shall be in person.

The Contractor shall perform all services in a professional manner and in accordance with the requests made by the Agency. It is anticipated that counselling supervision services shall occur within a supportive and respectful context for STV counsellors. Further, it is anticipated that counselling supervision occurs within the context of a feminist and trauma-related approach. The Contractor will treat all information gained as a result of this contract as confidential with the following exceptions:

1. If the Contractor has reason to believe that a child is in need of protection.
2. If an STV counsellor indicates that the counsellor is a danger to herself or others.
3. When compelled by a court order.

Should the Contractor encounter any of the above named exceptions, she will report the information to the executive director of the Agency within 24 hours of disclosure.

Effective counselling supervision involves an open exploration of the approaches and skills used by the counsellor, and an examination of transference and counter-transference issues and personal responses as they arise. Should the Contractor encounter any situation whereby she is concerned about the counsellor’s capacity to provide counselling services effectively, the Contractor will provide this feedback to the counsellor so that the concerns can be addressed directly. The Contractor will also report this to the executive director as soon as possible. In addition, the Agency has a right to be appropriately apprised of the general content and progress of counselling supervision; therefore, the Contractor must maintain regular communication with the Agency through review/consultation meetings with the executive director.

Supervisor time will be scheduled in conjunction with the STV counsellor(s) and their schedules. Cancellation of the Contractor's supervision session may be made by either the Contractor or the counsellor in question subject to 48 hours notice of cancellation.

The Contractor shall be reimbursed for her services at the rate of \$80 (eighty dollars) per hour. The Contractor shall be reimbursed for reasonable and appropriate travel costs upon submission of an expense claim to a maximum of \$\_\_\_\_\_. The Contractor shall submit invoices for her services every 30 days and invoices will be paid within 30 days after receipt.

The executive director shall monitor on an ongoing basis the hours of service being performed by the Contractor, and will have the discretion to set a maximum number of hours of service to be provided by the Contractor over subsequent 30 day periods. In any event, the total amount of annual reimbursement shall not exceed the total annual allowable counsellor support funding from the Ministry of Community Services.

The Contractor shall be an independent contractor and not an employee of the Agency, and the Contractor shall be responsible for the payment of all taxes and other deductions on payments received under this contract. The Contractor shall perform all services under the Contract personally, and shall not subcontract any of her services.

It is agreed that the terms and progress of this contract will be reviewed on a quarterly basis.

The Contractor is responsible for providing her own professional liability insurance in an amount and form satisfactory to the Agency.

This contract shall commence \_\_\_\_\_. This contract may be terminated by either party at any time without notice or compensation in lieu of notice.

\_\_\_\_\_  
Acceptance for the Agency

*Jane Smith, RCC*

\_\_\_\_\_  
Name

Executive Director, NNCSS

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Contractor's Signature

*Jane Doe, MA*

\_\_\_\_\_  
Name

Contractor

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

## **SAMPLE CONTRACTOR AGREEMENT CASE CONSULTATION**

Made this \_\_\_\_\_ day of \_\_\_\_\_, Year between *The No Name Community Services Centre, 1234 Central Avenue, Anywhere, BC V2A 4C3* (“the Agency”), and *Jane Doe, 123 Main Street, Anywhere, BC, V1A 2B3* (“the Contractor”) for the period covering \_\_\_\_\_ to \_\_\_\_\_.

This agreement verifies that the Contractor will provide case consultation services to the Stopping The Violence (STV) Counselling Program and STV counsellor(s) of the Agency. This work will take place either at the Agency, or over the telephone, whichever is most convenient for all concerned parties, with the exception of the first initial consultation session, which shall be in person.

The Contractor shall perform all services in a professional manner and in accordance with the request made by the Agency. It is anticipated that consultation services shall occur within a supportive, respectful context for STV counsellors. Further, it is anticipated that case consultation services utilize a feminist and trauma-based approach. The Contractor will treat all information gained as a result of this contract as confidential with the following exceptions:

1. If the Contractor has reason to believe that a child is in need of protection.
2. If an STV counsellor indicates that the counsellor is a danger to herself or others.
3. When compelled by a court order.

Should the Contractor encounter any of the above named exceptions, she will report the information in the form of a memorandum to the executive director of the Agency within 24 hours of disclosure.

It is understood that case consultation services do not constitute supervision but, rather, provide opportunities for counsellors to seek additional input and expertise with respect to approaches to dealing with specific cases or types of issues. The wide range of issues, situations, circumstances and levels of risk characterizing women who seek STV counselling, means that STV counsellors may be requested to provide assistance on issues with which they have limited counselling experience. It is agreed that, should the case consultant encounter any clinical concerns regarding the STV counsellor(s), she will inform the executive director after discussing her concerns directly with the STV counsellor(s).

The Contractor shall be reimbursed for her services at the rate of \$80 (eighty dollars) per hour, to be scheduled in conjunction with the STV counsellor(s), with the total hours of service not to exceed the annual allowable counsellor support funding. The Contractor shall be reimbursed for reasonable and appropriate travel costs upon submission of an expense claim to a maximum of \$\_\_\_\_\_. Payment shall commence and shall be paid upon receipt of a monthly invoice.

Cancellation of the Contractor's session may be made by either party subject to 48 hours notice of cancellation.

It is agreed that the terms and progress of this contract will be reviewed on a quarterly basis.

The Contractor will be responsible for providing her own professional liability insurance.

This contract may be terminated by either party at any time.

\_\_\_\_\_  
Acceptance for the Agency

*Jane Smith, RCC*

\_\_\_\_\_  
Name

Executive Director, NNCSS

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Contractor's Signature

*Jane Doe, MA*

\_\_\_\_\_  
Name

Contractor

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

## 7.20 Ontario Women's Justice Network Annotated Bibliography of Resources For Marginalized Women

Courtesy of: Ontario Women's Justice Network, [www.owjn.org/resource/margins.htm](http://www.owjn.org/resource/margins.htm).

### DISABLED WOMEN

#### The DisAbled Women's Network Ontario (DAWN), Publications

<http://dawn.thot.net>. DAWN is THE source for information regarding women with disAbilities and violence or other forms of abuse. See especially their Guide to Services for Assaulted Women: What Can Women with disAbilities Do to Be Safe and list of Justice Issues and Resources.

#### Education Wife Assault

<http://www.womanabuseprevention.com/>

See their sections entitled "Deaf and Disability" and "Disability Directory". The Directory allows you search the province for accessible services.

#### Fact Sheets on Abuse and Persons with Disabilities

[http://www.archlegalclinic.ca/publications/crime/A73\\_2005\\_003240/index.asp](http://www.archlegalclinic.ca/publications/crime/A73_2005_003240/index.asp)

From ARCH, the Legal Centre for Persons with Disabilities. Five fact sheets, available as webpages and as PDFs, on what you can do if you are being abused, your legal options, what happens when you report to the police, what happens to cases that go to criminal court, and punishments after a criminal trial.

#### Women with Disabilities Violence Prevention Resource Guide

<http://www.enablelink.org/women/WOMEN.html>

Besides its lengthy list of province-wide accessible services, this guide includes three on-line articles and an annotated bibliography.

### FIRST NATIONS WOMEN

#### Za-geh-do-win Information Clearinghouse

<http://www.za-geh-do-win.com>

Information about health, family violence and healing for Aboriginal Communities in Ontario. On the pull down menus, select "Spousal Abuse", "Sexual Assault" and "Family Healing" for publications and videos related to violence against women.

#### Hot Peach Pages

<http://www.hotpeachpages.net>

Abuse info available in Cree, Dene, Inuinnaqtun, Inuktitut and Labradorimiut.

#### Anishnaabe-Kwewag Gamig, Roseneath

<http://www.eagle.ca/~akg/>

Crisis shelter for Aboriginal and non-Aboriginal women and their children. Located in a First Nation near Rice Lake.

#### Native Law Centre

<http://www.usask.ca/nativelaw/>

Located at the University of Saskatchewan, the Native Law Centre is concerned with scholarly research of Aboriginal legal issues. The site lists the library holdings, annotates its publications and provides a bibliography of sentencing (or peacemaking) circle references.

### **The Aboriginal Justice Implementation Commission**

<http://www.ajic.mb.ca/volumel/chapter13.html>

This government organization is a response to an inquiry and its recommendations regarding the state of Aboriginal life in Manitoba. Chapter 13, vol. 1, of the report focuses on justice for Aboriginal women regarding domestic abuse, sentencing and incarceration.

### **FREDA Centre for Research on Violence against Women and Children, Publications**

<http://www.harbour.sfu.ca/freda/pubs/publist.htm>

Related publications are:

Frank, Sharlene. (1996) A Needs Assessment for an Aboriginal Women's Transition House.

Hare, Jan. (1997) Building Healthy Communities: An Aboriginal Family Violence Resource Guide.

## **IMMIGRANT AND REFUGEE WOMEN**

### **For Immigrant and Refugee Women: Questions and Answers**

<http://www.owjn.org/info.htm#imm>. What are your rights as a woman, what is woman abuse, issues related to deportation and child custody, as well as a glossary of terms

### **Multilingual Flyers**

<http://www.owjn.org/info/multilingual.htm>

From OWJN, many topics relevant to women who have experienced abuse in seven different languages; free and may be photocopied for distribution to clients

### **Hot Peach Pages: World Wide Listing of Agencies against Domestic Violence**

<http://www.hotpeachpages.net>. Wife assault and dating violence information posted online in over 70 languages.

### **RoseNet**

<http://www.rosenet-ca.org/>

Legal information for immigrant women who are being abused by their partners or spouses. Lots of information and an online discussion forum.

### **Abuse is Wrong in any Language**

<http://canada.justice.gc.ca/en/dept/pub/awal/abusxdoj.html>

A publication produced by Health Canada with information on what abuse is, where to get help, custody of children, deportation issues and more.

### **Settlement.org**

<http://www.gov.ns.ca/coms/files/facts11.asp>

See Legal Services to learn about such things as legal aid, community legal clinics and human rights. The section called Services for Specific Groups>Women has information specifically for immigrant and refugee women on domestic abuse, including legal definitions and community services.

### **Fact Sheet on Abuse in Ethno-cultural and New Canadian Communities**

<http://www.gov.ns.ca/coms/files/facts11.asp>

From the Government of Nova Scotia.

### **The Double Life Dilemma: Young South Asian Women in Violent Relationships**

<http://www.metrac.org/programs/safe/asian.htm> A flyer from METRAC discussing the fears and challenges young South Asian women face when confront violent relationships. Includes a list of services available in the Toronto area.

### **Immigrant Women and Domestic Violence Fact Sheet**

<http://www.cleo.on.ca/english/pub/onpub/PDF/apr04/immwomdv.pdf>

Community Legal Education Ontario (CLEO) has a number of documents available online or that can be ordered in paper format. This fact sheet looks at sponsorship breakdown in abusive relationships and provides information on related immigration status issues. NOTE: When a federal Bill replacing the Immigration Act takes effect, it will make the information on this fact sheet invalid.

### **Project Blue Sky**

<http://www.projectbluesky.ca/english/index.html>. Serving Asian women in Ontario, this site provide information, support and links to resources on domestic violence. Content is available in English, Japanese, Chinese and Korean. English articles on cultural implications are helpful for both women experiencing violence as well as their advocates.

### **Career Planning for Assaulted Women (CPAW), Community MicroSkills Development Centre, Etobicoke**

[http://www.microskills.ca/support\\_services.html](http://www.microskills.ca/support_services.html)

Microskills is an employment and settlement centre with a priority to serve immigrant, visible minority and low-income women. This special program is specifically designed for women who have experienced violence, especially partner abuse.

### **“Assisting Immigrant and Refugee Women Abused by Their Sponsors”**

[http://www.bcifv.org/pubs/Assisting\\_Immigrant\\_Women.pdf](http://www.bcifv.org/pubs/Assisting_Immigrant_Women.pdf)

A guide for service providers available online from the BC Institute Against Family Violence (2001).

### **“A Complex Web: Access to Justice for Abused Immigrant Women in New Brunswick”**

Dr. Baukje Miedema and Dr. Sandra Wachholz. [http://www.swc-cfc.gc.ca/pubs/complexweb/index\\_e.html](http://www.swc-cfc.gc.ca/pubs/complexweb/index_e.html). Status of Women Canada

### **“Intersecting Inequalities:Immigrant Women of Colour, Violence & Health Care”**

Yasim Jiwani, 2001. <http://www.harbour.sfu.ca/freda/articles/hlth.htm> FREDA Centre for Research on Violence against Women and Children

## **WOMEN OF COLOUR**

### **Project Blue Sky**

<http://www.projectbluesky.ca/english/index.html>. Serving Asian women in Ontario, this site provide information, support and links to resources on domestic violence. Content is available in English, Japanese, Chinese and Korean. English articles on cultural implications are helpful for both women experiencing violence as well as their non-Asian advocates.

### **Black Women’s Health**

[http://www.blackwomenshealth.com/domestic\\_violence.htm](http://www.blackwomenshealth.com/domestic_violence.htm). This American site considers domestic violence “one of the most important public health problems in our country”. It briefly but concisely examines the particular dilemmas Black women face within abusive relationships. Relevant information on Post Traumatic Stress Disorder is also available.

### **Black Women’s Website Against Racism Sexual Violence**

<http://www.bwrap.dircon.co.uk/> A British site for Black, ethnic minority, immigrant, migrant and refugee women who have suffered all forms of assault, sexual violence and harassment, including rape in their country of origin.

### **“Intersecting Inequalities: Immigrant Women of Colour, Violence & Health Care”**

Yasim Jiwani, 2001. <http://www.harbour.sfu.ca/freda/articles/hlth.htm> FREDA Centre for Research on Violence against Women and Children

## **RURAL WOMEN**

### **The Rural Womyn Zone, Violence Against Rural Women**

<http://www.ruralwomyn.net/domvio.html>. Although this is an American site, it offers a useful and extensive analysis of the unique problems of rural women who experience abuse. Spanish resources.

### **“Responding to Wife Abuse in Farm and Rural Communities”**

Jennie Hornosty and Deborah Doherty,

2001 [http://www.uregina.ca/sipp/publications/publicpolicypapers/Regina% 20revised%202002.pdf](http://www.uregina.ca/sipp/publications/publicpolicypapers/Regina%20revised%202002.pdf).  
Saskatchewan Institute for Public Policy

## **LESBIAN, BI, QUEER AND TRANSGENDERED WOMEN**

### **Abuse in Lesbian Relationships: Information and Resources**

[http://www.hc-sc.gc.ca/hppb/familyviolence/html/femlesbi\\_e.html](http://www.hc-sc.gc.ca/hppb/familyviolence/html/femlesbi_e.html). Available both on the web and as a PDF, this guidebook contains Canadian resources and detailed suggestions for coping. From Health Canada.

### **Same Sex Abuse – Education Wife Assault**

[http://www.womanabuseprevention.com/html/same-sex\\_partner\\_abuse.html](http://www.womanabuseprevention.com/html/same-sex_partner_abuse.html). Content includes personal stories and reflections, tips for service providers, facts and myths.

### **Gay and Lesbian Domestic Violence Bibliography - Community United Against Violence**

<http://www.xq.com/cuav/dvbibl.htm>. Bibliography of material on same sex abuse, including male abuse.

### **“Lesbian, Gay, Bisexual and Transgendered Domestic Violence in 2000”**

Ken Moore and Rachael Baum. <http://www.avp.org/publications/reports/2000ncavpdvrpt.pdf>

National Coalition of Anti-Violence Programs & New York Gay and Lesbian Anti-Violence Project, American

## **INCARCERATED WOMEN AND WOMEN IN CONFLICT WITH THE LAW**

### **Canadian Association of Elizabeth Fry Societies / l’Association Canadienne des Sociétés**

Elizabeth Fry

<http://www.elizabethfry.ca/>

While Elizabeth Fry Societies offer various legal supports to women, their key focus is women in conflict with the law.

## **YOUNG WOMEN AND GIRLS**

### **Court Prep <http://www.courtprep.ca>**

An animated web site for youth who are going to court. Includes witness tips, justice procedures and an interactive courtroom. Developed by the Scarborough Hospital Sexual Assault Support Centre and Toronto Child Abuse.

### **Sexual Assault is a Crime**

<http://www.sacc.to/sya/crime/crime.htm>. Legal information from the Scarborough Hospital Sexual Assault Support Centre designed especially for young women.

**Youth Justice Services in Ontario** <http://www.211ontario.ca/yjs/index.htm>. Government and some community resources for youth who are involved with the justice system, especially those in conflict with the law.

**Centre for Children and Families in the Justice System of the London Family Court Clinic** <http://www.lfcc.on.ca/>. Information on the services provided by the London Family Court Clinic as well as resources pertaining to family violence.

**Online Discussion Group for Young Women** [www.nywc.org](http://www.nywc.org)

For young women from immigrant and refugee families. Presented by the North York Women's Centre, although you don't have to live in North York to participate. Follow the "Culture Talk" link. Read about the group then register by **phone**.

**Justice for Children and Youth** <http://www.jfcy.org/>

Legal information for young people on topics such as the Young Offenders Act, school truancy, custody and access, police, and court procedures and legal definitions. You can fill out a questionnaire in order to ask a lawyer a question online. Links to services in Toronto.

**Kids Helpline** <http://kidshelp.sympatico.ca/en/>

Ask questions of counsellors without having to give them your name. Follow the "Tools for Life" link to learn about violence and abuse, bullying, dating and other topics.

## SECTION EIGHT

# Resources and References

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### 8.1 Resources

This resource list was compiled by the authors and members of the advisory committee. It is not intended to be exhaustive or complete. Annotated comments about many of the resources also appear in relevant sections of the Manual.

The resources that follow are organized under the following categories:

- Abuse of older women
- Assessment
- Child protection and violence against women
- Counselling planning: Stage one—Safety and containment
- Counselling planning: Stage two—Working with memories
- Counsellor’s self-care
- Custody
- Dissociation
- Domestic violence
- Ethics
- Group facilitation
- Marginalized communities
- Memoirs, autobiographies and anthologies of writings
- Mental health issues
- Mental health issues for significant others
- Ritual abuse
- Self-injurious behaviour
- Sexual assault
- Stalking
- Substance use
- Suicide
- Trauma
- Women’s use of violence
- Young women

### *Abuse of older women*

- Brandl, B. and L. Cook-Daniels. 2002. "Domestic abuse in later life." VAWnet Applied Research Forum. Harrisburg, PA: Pennsylvania Coalition Against Domestic Violence and National Resource Center on Domestic Violence.  
[www.vawnet.org/DomesticViolence/Research/VAWnetDocs?AR\\_later-life.php](http://www.vawnet.org/DomesticViolence/Research/VAWnetDocs?AR_later-life.php).
- Hightower, H., J. Hightower and M. Smith, eds. 2005. "Building bridges for the prevention of older women abuse: A forum for dialogue." Conference proceedings, February 17–18, 2005, B.C./Yukon Society of Transition Houses (BCYSTH). [www.bcysth.ca](http://www.bcysth.ca).
- Hightower, J., M. Smith and H. Hightower. 2001. *Silent and invisible: A report on abuse and violence in the lives of older women in British Columbia and Yukon*. Vancouver: B.C./Yukon Society of Transition Houses (BCYSTH).
- Older Women's Long-term Survival Society of Calgary (OWLS). 2000. *Out from abuse: Older women survivors*, National Film Board of Canada.

### **Selected Web sites**

- B.C. Coalition to Eliminate Abuse of Seniors (B.C. CEAS). [www.bceas.ca](http://www.bceas.ca).
- B.C. Institute Against Family Violence. [www.bcifv.org](http://www.bcifv.org).
- Education Wife Assault. [www.womanabuseprevention.com/html/elder\\_abuse/bibliographies.htm](http://www.womanabuseprevention.com/html/elder_abuse/bibliographies.htm).
- National Center on Elder Abuse. [www.elderabusecenter.org](http://www.elderabusecenter.org).

### *Assessment*

- Agar, S. 2003. *Safety planning with abused partners: A review and annotated bibliography*. Vancouver: B.C. Institute Against Family Violence.
- Banks, A. 2001. *Post-traumatic stress disorder: Relationships and brain chemistry*. Wellesley, MA: Jean Baker Miller Institute, Victims of Violence Program.
- Briere, J. 2000. *Inventory of altered self-capacities (IASC) and Traumatic stress inventory (TSI)*. Published tests. Odessa, FL: Psychological Assessment Resources, Inc. [www.parinc.com](http://www.parinc.com).
- Carlson, E. and F. Putnam. n.d. *Dissociative experiences scale (DES)*. Published test. The Sidran Institute. [www.sidran.org](http://www.sidran.org).
- Hardy, K. and T. Lazloffy. 1995. "The cultural genogram: A key to training culturally competent family therapists." *Journal of marital and family therapy* 21: 227-237.
- Hart, Barbara and Jane Stuehling. 1992. *Personalized safety plan*. Reading, PA: Pennsylvania Coalition Against Domestic Abuse. [www.mincava.umn.edu/hart/persona.htm](http://www.mincava.umn.edu/hart/persona.htm).
- Harvey, M. 1996. "An ecological view of psychological trauma and trauma recovery." *Journal of traumatic stress* 9(1): 3-23.
- Holmes, C. 2005. "Assessment handout—Abuse in same-gender relationships." *Safe choices: Support and education program curriculum*. Vancouver: B.C. Association of Specialized Victim Assistance and Counselling Programs.

- Klonoff, E.A. and H. Landrine. 1997. *Preventing misdiagnosis of women: A guide to physical disorders that have psychiatric symptoms*. Thousand Oaks, CA: Sage Publications.
- McGoldrick, M. and G. Gerson. 1985. *Genograms in family assessment*. New York: W.W. Norton.
- Meichenbaum, D. 1994. *A clinical handbook/practical therapist manual: For assessing and treating adults with post-traumatic stress disorder*. Clearwater, FL: Institute Press.
- Van der Kolk, B. n.d. *The traumatic antecedents questionnaire*. Assessment tool.  
[www.traumacenter.org/assessment.html](http://www.traumacenter.org/assessment.html).

### **Selected Web sites**

- Arizona Coalition Against Domestic Violence. [www.azcadv.org](http://www.azcadv.org).
- The Trauma Center. [www.traumacenter.org/assessment.html](http://www.traumacenter.org/assessment.html).

### ***Child protection and violence against women***

- B.C. Ministry of Children and Family Development (MCFD). 2004. *Best practice approaches: Child protection and violence against women*. Victoria: MCFD. [www.endingviolence.org](http://www.endingviolence.org).
- Sheinberg, M. and P. Fraenkel. 2001. *The relational trauma of incest: A family-based approach to treatment*. New York: The Guilford Press.

### ***Counselling planning: Stage one—Safety and containment***

- B.C. Association of Specialized Victim Assistance and Counselling Programs (BCASVACP) and Justice Institute of B.C. (JIBC). 1999. "Survivors of violence and the healing process." Part 1 of 2. In *Stopping the violence feminist counselling core training*. Vancouver: BCASVACP.
- Briere, J. 2002. "Treating adult survivors of severe childhood abuse and neglect: Further development of the integrative model." In *The APSAC handbook on child maltreatment*, 2d ed., 1-25, edited by J.E. Myers, L. Berliner, J. Briere, C.T. Hendrix, T. Reid and C. Jenny. Newbury Park, CA: Sage Publications.
- Cohen, B., M. Barnes and A. Rankin. 1995. *Managing traumatic stress through art*. Baltimore: Sidran Press.
- Courtois, C. 1999. *Recollections of sexual abuse: Treatment principles and guidelines*. New York: W.W. Norton.
- Cozolino, L. 2002. *The neuroscience of psychotherapy: Building and rebuilding the human brain*. New York: W.W. Norton.
- Dalenberg, C. 2000. *Countertransference and the treatment of trauma*. Washington, DC: American Psychological Association.
- Haskell, L. 2003. *First stage trauma treatment: A guide for mental health professionals working with women*. Toronto: Centre for Addiction and Mental Health.
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- Williams, M.B. and S. Poijula. 2002. *The PTSD workbook: Simple effective techniques for overcoming traumatic stress reactions*. Oakland: New Harbinger Publications.

***Counselling planning: Stage two—Working with memories***

- Adams, C. and J. Fay. 1987. *Free of the shadows*. Oakland: New Harbinger Publications.
- Dolan, Y.M. 2000. *One small step: Moving beyond trauma and therapy to a life of joy*. New York: Authors Choice Press.
- Levine, P. 1997. *Waking the tiger: Healing trauma*. Berkeley, CA: North Atlantic Books. [www.traumahealing.com](http://www.traumahealing.com).
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- Schmidt, S.J. 2005. *The developmental needs meeting strategy: An ego state therapy for healing childhood wounds*, 2d ed. San Antonio: The DNMS Institute LLP. [www.dnmsinstitute.com](http://www.dnmsinstitute.com).
- Shapiro, F. 2001. *Eye movement desensitization and reprocessing: Basic principles, protocols and procedures*. New York: The Guilford Press. [www.emdr.com](http://www.emdr.com).
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- Bodynamics. [www.bodynamic.ca](http://www.bodynamic.ca).
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***Counsellor's self-care***

- Nelson, T.S. 1996. "Vicarious trauma: Bearing witness to another's trauma." Conference proceedings, April 12-14, 1996, 20th Annual Convening of Crisis Intervention. [www.uic.edu/orgs/convening/vicariou.htm](http://www.uic.edu/orgs/convening/vicariou.htm).
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Stamm, B.H. and C. Figley. 2005. Compassion fatigue and satisfaction scale. Published test. B.H. Stamm, TSRG. For a self-scoring on-line version, see [www.isu.edu/~bhstamm/tests/satfat.htm](http://www.isu.edu/~bhstamm/tests/satfat.htm).

### **Selected Web sites**

Arizona Coalition Against Domestic Violence. [www.azcadv.org](http://www.azcadv.org).

Synchrony: A Place of Connection for Survivor Therapists. [au.geocities.com/synchrony2001](http://au.geocities.com/synchrony2001).

Traumatic Stress and Secondary Traumatic Stress. [www.isu.edu/~bhstamm/TS.htm](http://www.isu.edu/~bhstamm/TS.htm).

### ***Custody***

Braun, J. 2001. *Child custody and access in the context of family violence: A review of the literature and annotated bibliography*. Vancouver: B.C. Institute Against Family Violence. [www.bcifv.org](http://www.bcifv.org).

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### ***Dissociation***

Alderman, T. and K. Marshall. 1998. *Amongst ourselves: A self-help guide to living with dissociative identity disorder*. Oakland: New Harbinger Publications.

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Steinberg, M. and M. Schnall. 2001. *The stranger in the mirror: Dissociation—the hidden epidemic*. New York: Harper Collins.

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First person plural Web ring. [www.stardrift.net](http://www.stardrift.net). Discussion board for dissociative people.

The International Society for the Study of Dissociation publishes a quarterly journal, *The Journal of Trauma and Dissociation*. More information can be found at [www.issd.org](http://www.issd.org).

The Sidran Institute. [www.sidran.org](http://www.sidran.org).

### ***Domestic violence***

Agar, S. In press. *Aid to safety assessment and planning (ASAP): For women who experience violence in their relationships*. Vancouver: B.C. Institute Against Family Violence.

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- The Metropolitan (Toronto) Action Committee on Violence Against Women and Children (METRAC). [www.metrac.org/new/faq-sta.htm](http://www.metrac.org/new/faq-sta.htm).
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### **Selected Web sites on same gender relationship abuse and trans issues**

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- Abuse Counselling & Treatment Inc. [www.actabuse.com](http://www.actabuse.com). Has specific pages on Asian, First Nations and Latina women's perspectives.
- B.C. Association of Specialized Victim Assistance and Counselling Programs (BCASVACP). [www.endingviolence.org](http://www.endingviolence.org). Pamphlets to download from the "Provincial LGBT Anti-Violence Project: Creating Strong and Safe Queer Communities," on the following topics: Abuse in Same-Sex Relationships, Transgender People and Relationship Abuse, Healthy Relationships for Lesbians, Healthy Relationships for Gay Men, Hate Crimes.
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- NW Network of Bi, Lesbian & Gay Survivors of Abuse. [www.nwnetwork.org](http://www.nwnetwork.org).
- Ontario Women's Justice Network. [www.owjn.org/resource/margins.htm](http://www.owjn.org/resource/margins.htm).
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- Depression and Bipolar Support Alliance. [www.dbsalliance.org](http://www.dbsalliance.org).
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American Self Harm Information Clearinghouse. [www.selfinjury.org](http://www.selfinjury.org).

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Metropolitan (Toronto) Action Committee on Violence Against Women and Children (METRAC). [www.metrac.org/new/faq\\_sta.htm](http://www.metrac.org/new/faq_sta.htm).

Stalking Resource Center, through the (U.S.) National Center for Victims of Crime. [www.ncvc.org/src](http://www.ncvc.org/src).

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- Centre for Addiction and Mental Health. [www.camh.net](http://www.camh.net).
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- Psychological Trauma and Substance Abuse in Women. [home.earthlink.net/~bhilliard](http://home.earthlink.net/~bhilliard).
- Women's Addiction Foundation. [www.womenfdn.org](http://www.womenfdn.org).

### ***Suicide***

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- Centre for Suicide Prevention. [www.suicideinfo.ca](http://www.suicideinfo.ca).
- Project Resilience. [www.projectresilience.com](http://www.projectresilience.com).
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Suicide Prevention and Information Centre, UBC Mental Health Evaluation and Community Consultation Unit. [www.mheccu.ubs.ca/SP/publications](http://www.mheccu.ubs.ca/SP/publications).

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The Pilots Database—Bibliography Covering Published International Literature on Traumatic Stress. [www.ncptsd.org/publications/pilots/index.html](http://www.ncptsd.org/publications/pilots/index.html).

The Sidran Institute. [www.sidran.org](http://www.sidran.org).

The Trauma Center. [www.traumacenter.org](http://www.traumacenter.org).

### ***Women's use of violence***

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