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POST-TRAUMATIC STRESS DISORDER IN WOMEN: DIAGNOSIS AND TREATMENT OF BATTERED WOMAN SYNDROME

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Women victims of marital abuse suffer many symptoms of PTSD. This article discusses issues of diagnosis, evaluation, interviewing, treatment, and legal implications of the battered woman syndrome.

The debate around the addition of the newly proposed diagnostic categories to the personality disorder section of the DSM–III–R (APA, 1987) began in 1985 (*cf.* Widiger, 1987) and has continued to date, especially concerning battered women syndrome. The debate itself has focused attention on the inadequacy of the current mental health classification system for women victims of violence even though the situationally based anxiety disorder, Post-Traumatic Stress Disorder (PTSD) (APA, 1987, pp. 247-251) comes closest to describing battered woman syndrome, the group of psychological symptoms often observed after a woman has repeatedly experienced physical, sexual and/or serious psychological abuse. Like in other subclassifications of PTSD that measure dysfunction following repeated *man*-made trauma, such as rape trauma syndrome, battered child syndrome, child sexual abuse accommodation syndrome, and combat war syndrome, there are different symptom patterns observable in addition to the core group of arousal, avoidance, and intrusive cognitive memories present in a PTSD.

The addition in the DSM–III–R Appendix A (APA), 1987, pp. 371-374) of Self Defeating Personality Disorder, which is the new name given to the old concept of masochistic personality disorder, has caused it to become one of the most controversial diagnoses, especially for those working with women victims of non-accidental trauma from interpersonal violence (Rosewater, 1987, Walker, 1987). While it is harmful for all women to learn to behave in ways resembling the specified criteria in order to become more attractive and marketable to men (Caplan, 1985), some of these behaviors are adopted because they are especially important to keep battered women as safe as possible. These behaviors often include putting the man's needs before her own, even at her own psychological expense, remaining in a relationship that is causing her psychological (and perhaps, physical) harm, and behaving in a seemingly passive and dependent manner. Given the fact that battered women develop many coping skills to keep themselves less seriously harmed or killed that could be considered maladaptive in other contexts, psychologists must understand the important role they play in a battered woman's survival. This calls for a thorough situational analysis before using any diagnoses that apply the label of pervasive and enduring personality disorders such as is suggested by Self-Defeating Personality Disorder or others such as Borderline Personality Disorder, Dependent Personality Disorder or even Passive–Aggressive Personality Disorder (*cf.* APA, 1987, pp. 335-359).

There are both political and clinical reasons that support the use of the diagnostic category of PTSD with battered women who meet the criteria even though the generic criteria may not be specifically tailored to measure the entire collection of psychological symptoms that constitutes battered woman syndrome (Walker, 1984, 1989*a*). The feminist perspective states that woman abuse continues to occur in our society because of an inequality of power between women and men (Dobash & Dobash, 1983; Stark & Flitcraft, 1983). Discrimination against women occurs in the work place, in all societal institutions, and in our homes.

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Serious injuries from repeated physical, sexual, and psychological abuse most frequently occur when men beat women or children (Straus, Gelles, & Steinmetz, 1980). The Centers for Disease Control statistics indicate family violence is now the leading cause of death in the United States (Rosenblum, 1989). Some women learn to fight back in self-defense, perpetuating the use of violence (Walker, 1989*b*). Witnessing fathers beat mothers puts a boy at a 700 times greater risk to use violence in his own home (Kalmuss, 1984; Straus et al., 1980). Family violence is clearly a societal problem rather than one of individual pathology. Therefore, politically it is believed that only changes toward a more egalitarian society, not psychotherapy, will eradicate such violent behavior. However, it is acknowledged that appropriate psychotherapy can be beneficial to help the individual woman victim deal with the psychological consequences of domestic violence so that she can become a survivor (Dutton-Douglas, 1987; Rosewater, 1988; Walker, 1984*a,b*).

PTSD stresses the abnormal nature of the stressor which causes the mental health symptoms, not individual pathology. Such a disorder theoretically can happen to anyone who is placed in a similar situation. This takes the onus of blame away from the individual woman, yet still lets psychotherapists work with her in finding her own way to heal and move on with her life. Those battered women who are able to terminate the abuse, usually by terminating the relationship and finding some way to get the man to leave her alone, may experience a Post-Traumatic Stress Reaction (PTSR) that is less enduring than a PTSD. Those with a mild form of PTSD may be able to heal without psychotherapy. Others, particularly those women who have other mental health problems in addition to a PTSD may need long-term psychotherapy. It is the practitioner's role to make a proper assessment and treatment plan to decide what would be the best course of action.

Assessment

Although some battered women come into a therapist's office during a crisis period where they are able to disclose the extent of the abuse, the literature suggests that many more seek help when they are feeling particularly strong. Women in my research study (Walker, 1984) talked about their fears of being labeled "crazy" if they sought mental health treatment. This fear is supported by the batterer's accusations that she is crazy, her own belief that she can't think clearly and still stays with him despite his violence, and his behavior that acts out a crazy-making pattern of love and violence that my research has labeled the cycle of violence (Walker, 1979, 1984). In addition, the battered woman often does not have a sense of competency or self-confidence in her abilities, especially if she has listened to the batterer's litany of deprecating remarks over time.

Ready to accept responsibility for the mess she has made of her life by the time she walks into the psychotherapist's office, the battered woman is vulnerable to suggestions and ultimately, misdiagnosis and poor treatment. It is the therapist's role to refuse to assign blame and responsibility initially, and instead first try to get an unedited and descriptive history rather than an interpretation of events in her life. If she is still in danger and/or in crisis at the time of the first interview, a special crisis intervention plan can also be implemented. In either case, the most important goal for each therapeutic contact is to help the battered woman find her own strength, often called reempowerment.

There are several features of the PTSD diagnosis that are helpful in this process. Conceptualization of the psychological injury from abuse suggests that the emotional impact may be on a continuum anchored on one end by a short crisis period that has no lasting psychological effect once it is resolved and on the other end, serious emotional devastation. The diagnosis of battered woman syndrome as a subcategory of PTSD is probably the most prevalent manifestation of psychological trauma from living with repeated violence. The Severity of Psychosocial Stressors Scale in the DSM–III–R (APA, 1987, p. 11) lists ongoing physical or sexual abuse as an example of an enduring circumstance that is rated at a Level 5 Extreme on a 6-point scale. Those women who are held captive by their abusive husbands would meet the highest or Catastrophic Level 6 criteria. Levels 5 and 6 (physical and/or sexual abuse and psychological torture) meet the trauma threshold for the first criteria in the PTSD diagnosis. This rating would appear on Axis IV using the DSM diagnostic system (APA, 1987, pp. 18-20). Women who are still living in the abusive situation as well as those who are no longer with the batterer may demonstrate clinical symptoms that can be related to a response to prior trauma as well as anticipation of further abuse. Thus, proper assessment is an essential component of any treatment plan.

The symptoms can be grouped into the major categories of the PTSD diagnosis including recurrent thoughts of the abuse incidents, avoidance, numbing, or depression to avoid dealing with the situation which frequently changes interpersonal relationships, feelings, and lifestyle, and increased arousal symptoms such as pervasive anxiety, panic attacks, phobias, and hypervigilance to cues of further harm. In many cases, with or without treatment, a supportive environment causes the symptoms to run their course and the victim gets on with her life. Removal from psychological harassment as well as physical danger is critical to the healing process. However, it is often difficult for a battered woman to avoid contact with her abuser, especially when there are children involved. The realities of her situation must be understood by the clinician or the woman will not be well served. Some battered women also have other diagnosable mental health problems but clarity about these rarely will occur for several months, after the situational factors seem to be under better control. If there are contested legal proceedings pending, the situational factors are usually so salient that most other diagnoses should be deferred.

Relevant History

Obtaining a diagnostic history is the first step in both data gathering as well as treatment planning. It takes a long time for a repeatedly abused woman to trust anyone, even a competent professional. Sometimes a battered woman becomes so compliant that she loses her ability to be discriminating in who she talks to and what she says due to her extreme need for approval. In my practice, I support the development of a woman's skepticism as it is a coping skill and a strength not to be naively trusting without knowing the person. Thus, I make the assumption that it will take her more time than the usual new client to feel comfortable enough to tell me all the relevant facts, not just what she thinks I want to hear and I leave sufficient time (usually a double session) for an initial intake. Battered women often are sensitive to another person's reactions to them, which is another coping skill, and so, if the psychologist appears impatient, skeptical, horrified by the abuse details, or does not attempt to understand what she is talking about, she will probably give a sanitized version of the story. A slow, step-by-step, non-judgmental, compassionate attitude is the way to demonstrate trustworthiness, and it will encourage the woman to give accurate details. Comments that indicate empathy with her situation are helpful, but care must be taken not to make suggestible or judgmental comments about either her or his behavior as she describes it. A general statement indicating that violence is not justified under any situation except self-defense, no matter what her behavior was, along with acknowledgement of the variety of feelings experienced when living with violence is most helpful. Denigration of the man by the therapist makes it difficult for the client to seek treatment and still try to save the relationship.

I generally suggest what type of information I would like to learn about at the beginning of the first interview and allow the woman her own perference as where to start. This gives her some opportunity initially to control the pace and direction, avoids the need to be manipulative, and therefore, avoids increasing her fears. If she has no preference, then I usually suggest starting by describing the time when she met the abuser and then recount the history chronologically until the present. Then, I go back and gather relevant childhood information and details of her life prior to meeting the batterer. I ask for details of the abuse that occurred during the first time he battered her, a typical incident (or several if it seems that there are different time periods in a long-term relationship), the worst or one of the worst incidents, and the last incident prior to her coming to see me. If the case has been referred for forensic evaluation, the final incident is usually one in which the legal issues arose.

Assessment of PTSD Symptoms

As the woman tells the details of the abuse, I gently ask questions in order to assess for PTSD symptoms. Minimization and denial are typical coping strategies and to be expected. Many victims "forget" incidents that are too emotionally painful to remember. However, with direct questions, the necessary details can often be obtained. It is not unusual for battered women to go into a mild dissociative state as they re-experience the trauma in their mind's eye. Facial expressions, eye movements, changes in grammatic tense and tone of voice, inability to stop a description with minute details, all contribute to the diagnosis. Some women become so fearful that they demonstrate physiological anxiety symptoms or even panic attacks as they describe the abuse scene. Others shut off all emotion and appear to be stoic and unfeeling. Still others go off on an irrelevant tangent, often as a way to reduce anxiety and regain emotional

control. These observations are one type of validity check to the content of the historical information.

Lethality Issues

During this time, it is important to assess for lethality, especially if the woman is still in the situation. Presence of weapons, reports of abuse incidents that lead to choking, throwing the woman into objects, forceful shaking, head-banging, and threats to kill are the most important signs (Browne, 1987). I also ask the woman if there have been times when she believes she would have been killed had something not intervened. Most battered women come to understand that the abuser could kill them under certain circumstances. Some women begin to feel the depth of their anger at the man, particularly if they are out of the immediate situation and they fear they could kill him if he starts to hurt them again. This may be considered an appropriate self-defense stance rather than a threat necessitating a warning unless a woman says she is specifically stalking him or gives other information that indicates a specific plan to kill him. If someone is to die, it is more likely for the man to kill the woman (Browne & Williams, 1989). The most dangerous time for the man to actually kill the woman is at the point of separation or shortly afterward, when he realizes that she really wants to be free to live her own life. In fact, Browne and Williams (1989) found that there is an increase in the number of women being killed by husbands and ex-husbands in 35 states while there has been a decrease in women who kill abusive husbands in states where there are the most extra-legal services for battered women. Batterers interpret the woman's need to be independent as abandonment and often refuse to let the woman go, stalking her with unwanted phone calls, visits, and promises to change; behaviors that are all reminiscent of the third-phase of loving–contrition in the battering relationship (Walker, 1979, 1984, 1989*b*).

It is appropriate for the psychologist to tell the client his or her concerns for her safety if the lethality check proves positive. This helps counter the woman's tendency to want to deny the dangerousness even after it is accurately perceived. Teaching the battered woman to trust her own perceptions helps reverse negative effects of the batterer's verbal abuse. Although it may heighten the woman's use of survival behavior, such validation from the practitioner also calms down the anxiety without forcing her to use avoidance behavior.

Specific techniques such as behavior rehearsal of protecting herself should another battering incident begin are critical to teach a woman who is still in danger. When the psychologist uses the woman's own descriptions, it helps her recognize when an incident is impending and give her permission to leave the situation safely. To be safe means, at a minimum, she must leave prior to the start of the second phase or acute battering incident (Walker, 1984*a*). Some women can put into words the clues they have when such an incident is about to start. Others can describe the details when they go back over another incident and are helped to remember his facial features, gestures, words, and other actions which represent the escalation of the incident.

Designing an Escape Plan

During the first session in which I learn about the violence, I help the woman design an escape plan before she leaves my office, so even if she does not return, she has gained some ability to keep herself safer than before. For example, if an incident starts in the kitchen (or whatever room), I have the woman describe in careful detail how she would get the children, her purse, the car keys, the pets or whatever she needs to be able to leave safely. Does she need to hide additional clothes, money, a precious heirloom? What is the route to the nearest exit? Where would she go as soon as she exits the house? Which way does she turn? Where is the nearest neighbor, telephone, safe-house, police station, etc.? Although it is time consuming, and requires attention to minute details, this exercise gives the woman courage to use such an escape plan should the time arise. It also allows the psychologist to permit the woman to decide what to do about the relationship in her own time frame without making demands that she leave immediately because of the psychologist's own fears for her safety. And, knowing she could escape under certain conditions, gives her more confidence in breaking the learned helplessness, which is simply another way to describe the loss of prediction over whether what she does will have a particular outcome (Seligman, 1975). Learned helplessness does not mean that the woman is helpless, but rather, that she tends to only use behavior that has a high degree of predictability because she has lost the ability to predict the

successful outcome for other low-level probability behaviors (Walker, 1979, 1984, 1989*a*).

Diagnostic Correlates

During the diagnostic interview, it is important to assess for the presence of other diagnosable conditions including any signs of neurological damage. It is common for battered women to demonstrate neuropsychological signs that appear to have been caused by repeated head injuries. This is especially important if there is a history of hitting her head. Assessment for other health problems is also important, especially if there is relevance to her psychological state of mind. Women who abuse alcohol or drugs as a way to avoid the pain of living with abuse may need special treatment for their addiction.

I do not find the popular co-dependency theories helpful for work with battered women (Walker, 1989*a*). It simply reifies their learned helplessness by blaming the victim rather than supporting their strengths. Other diagnoses such as separate affective or anxiety disorders also need to be evaluated but, it is usually necessary to spend additional time with the client to be able to differentiate between longstanding emotional responses and those brought about by the PTSD from living in violence.

Standardized Testing

Symptomatology often appears to be at very high levels in many PTSD clients even though they may try to cover their symptoms, too. If standardized tests are utilized, the women may appear to have a more serious mental disorder than is clinically observed. When using a test such as the MMPI, a pattern that mimics schizophrenic or borderline diagnoses can appear (Rosewater, 1985). The MCMI can not differentiate PTSD from personality disorders and therefore, gives confusing results when used with battered women and rape victims. Scores on the Modified Fear Survey (Douglas, 1987) are often higher than the norms especially when sexual abuse is present, too. Rosewater's (1985) research indicates that battered woman syndrome is identifiable by the high scores on MMPI scales measuring depression, anger, suspiciousness and confusion. Using subscale analysis to determine what pushes the particular scale up so high is helpful in making a differential diagnosis. Low ego strength is also typically found in repeatedly battered women. I have found that women who have a single severe trauma, such as a rape victim, may also have similarly high scores on the MMPI, but in addition, they are high on scales measuring physiological symptoms, anxiety, and rumination. Those scales are less frequently elevated when chronicity has set in, except when there has been marital rape.

Treatment

Treatment for battered women with PTSD has several important features which makes it different from treatment for other problems. First, it needs to be continuously clear to the woman that she is being helped to heal from an abusive experience and is not being treated for a mental illness. This will lower her fears of being labeled "crazy" and reduce resistance. It also begins to re-establish her faith in herself. The primary goal of treatment is the woman's *re-empowerment*. The woman must be helped to take back control of her life including her time spent in therapy. Psychotherapy theories that place the therapist in an authoritarian position are not beneficial for working with battered women who experience PTSD. Like others in crisis, many battered women use this time to re-examine the direction of their lives. Some merely want to get on with things but feel overwhelmed by the task. In either case, they will heal faster if they know that the course of treatment is not always a smooth one and that there may be times when they feel worse rather than better. This is especially true as the therapist tries to help desensitize them to the pain of re-experiencing the trauma. I use repetition and guided imaging techniques to get through some of the most painful battering incidents. The woman sets the pace of how fast she can move through it.

There are five major areas that have been negatively impacted by the battered woman's coping skills and thus, must be dealt with in therapy. They are manipulation, dissociation, anger, intimacy, and compliance. A discussion of therapy techniques to deal with each area could form the basis of another paper. I will touch briefly on some of the typical issues and practical ways I have found to handle them.

Manipulation and Control Issues

Manipulation of the environment as well as people is one way to keep things calm and under control so as to avoid more serious beatings. Battered women learn that they are safer when they

control things and so develop such good manipulation skills that they often forget to stop making sure everything is going the way they need it to happen. Since this technique is particularly effective during the first cycle of violence phase of tension-building, it also serves as a useful technique to reduce anxiety. For many battered women it is such routine behavior that they do not even notice when they are being manipulative. Since the purpose is control, the most useful and parsimonious way to deal with manipulation in therapy is to give the client as much control as is possible. Most therapists are trained to always keep control of a session themselves. However, for effective therapy with a battered woman, she needs to perceive her own control, moving from indirect to direct methods. One particularly effective way to help her perceive control is for the therapist to explain why certain things are done or why certain questions are asked. This demystifies the treatment process and is a useful feminist therapy technique, too. The therapist must be careful not to give away so much control that limits aren't properly set. Obviously, a proper balance is needed.

Dissociation

Most battered women learn a mild form of self-hypnosis or dissociation to keep from experiencing the intensity of pain during the physically abusive incidents. Women who were also abused as a child tend to go into body/mind splitting more easily. Work with children who are learning to make their minds go somewhere else when they are hurt gives some interesting insights into the development of this natural form of a pain-killer. However, it can cause memory loss and frequent splitting between good and bad or other polar extremes even during non-threatening situations if it continues without the woman learning how to monitor herself. Physical exercise or other ways to get back in touch with ownership of her body is another important way to help the battered woman restore body integrity. Sometimes actual training in self-hypnosis or relaxation training activities helps her regain better control over the dissociative states.

Anger

Most battered women accumulate a great deal of anger and even rage over the entire period of abuse. Many of them come to fear the unleashing of this stored up anger and are still keeping it bottled up when they enter therapy while others are having trouble containing their angry feelings. While they are living in a battering relationship, fearful of setting off an acute battering incident, these women learn to hold in their anger or else express it toward the abuser in safe but indirect ways. Sarcasm, passive–aggression, passivity, and sugary sweetness are some of those ways. Learning to feel one's anger and then express it in non-destructive ways is an important therapeutic activity. Most battered women store up their angry feelings and avoid confrontation until they are so angry they cannot manage it. Some are so scared that they will not let themselves even feel angry.

Validation of anger and help with its appropriate expression in small doses can occur in therapy. As the woman becomes more comfortable with her anger, she will begin to tap into the stored-up rage. When this occurs, she needs lots of reassurances that she can put limits on how she expresses these feelings and if she cannot control it, then the therapist will help her by providing assistance. This stage of treatment is crucial to get beyond if therapy is to be successful. All too often the woman's rage frightens the therapist, too, and it is cut off before it is fully under control. Women therapists, especially those with feminist therapy training who have learned to deal with their own anger, are the most likely to be able to tolerate the woman's anger long enough to get her through to the other side of it. Unfortunately, many battered women are going through this stage just at the time they are going through custody evaluations and mental health professionals misinterpret it as her permanent state of mind placing her in danger of losing her children if this should happen.

Emotional and Sexual Intimacy

Many battered women confuse emotional and sexual intimacy. This is especialy true if the woman was also sexually abused as a child. Here the child learns that love can be obtained through acquiescent sexual behavior. Batterers often demand frequent sex with the woman as a way of proving dominance and love. In my research sample, physical abuse rarely began until sexual intimacy took place (Walker, 1984). One of the most frequent signs of abuse is the persistent and usually unfounded jealousy of the batterer who accuses the woman of having sexual liaisons with anyone with whom she comes into contact. The batterer's obsession with sex confuses emotional with sexual intimacy. Encouragement of same and opposite gender

friendships and enhancement of social skills are two therapy techniques which help to expand intimate relationships. Of course, the process of therapy helps the client learn to define another kind of intimacy, too. Courtois and Sprei (1988) describe other techniques for working with retrospective incest victims that are useful for battered women.

Compliance and Resentment

Compliance with requests helps to assure a battered woman that at least some of the time she is able to keep the batterer calm and avoid confrontation which could lead to more abuse. She learns to please the man so as to minimize the frequency and severity of abuse. This need to please in a relationship often gets repeated in a therapy relationship making battered women great clients, at times. However, their focus on compliance and pleasing behaviors does not last and then resentment sets in. One way it is expressed is in their demanding behavior. At these times they are not such great clients. There is a need to protect the therapist as well as a constant testing of whether the therapist really does care about her. Male therapists may get confused by this behavior, especially when the woman has learned to behave seductively to calm down a man's anger and make him like her.

Some therapists become so confused by this process that they relabel it as borderline behavior because of the intensity of the client's angry or smothering demands. Herman's (1989) recent research demonstrates that the only difference between her sample of women clients who were labeled borderline or those acknowledged to have PTSD was in the direct knowledge of a sexual abuse experience. It is my clinical experience that battered women feel so unlovable that they need to be sure that their therapist likes/loves them, and like adolescents they are constantly testing it. Keeping to firm limits and calm but minimal responses are the most helpful behavior the therapist can engage in. This gives the message that you like her, are willing to stay with her in treatment without being abusive, and understand that she is scared. However, some of the limit setting and distancing techniques recommended for use with borderline clients would be counterproductive for use with a battered woman as they would set up power and control issues and not provide the warmth and understanding needed to regain feelings of safety.

Collaboration with Colleagues

It is not unusual for a battered woman to be involved with other mental health professionals or battered woman shelter staff at the same time as she comes for psychotherapy for herself. Sometimes it is the contact with these other professionals that gives her the strength and permission to do something about herself. Many battered women shelters run outpatient groups for non-residents. This is often a useful adjunct to individual psychotherapy as the woman can learn from others' experiences as well as her own. Participation in the group also helps rebuild the woman's trust in other women and makes it easier to re-establish friendships. If the client is attending such a group simultaneously, it is usually desirable for the psychologist and battered woman shelter counselor to communicate so that the goals for each are compatible.

In my practice I receive referrals and consultation requests from other psychologists who have been treating a client and then uncover physical or sexual abuse issues beyond their training and competence. Sometimes it is appropriate for the client to see both me and the long-term therapist simultaneously, provided there is open communication between the therapists. Other times, the client comes to work on the psychological issues around the abuse and then, returns to the original referring psychotherapist to complete therapy. Again, communication between the therapists is necessary. Other times the client prefers to remain with the current therapist and consultation becomes the most appropriate alternative. And, in some cases the client transfers to my practice. All of these options are possible when there is open communication between the client and the two therapists.

Other occasions for collaboration arise when the client's husband or children are in therapy with other therapists. Here caution must be used not to violate confidentiality nor place any party at greater risk for further abuse. However, it is important to share information about the escalation of violence with other therapists who may not receive the same information from their clients. Many batterers and sometimes battered women prefer couples' therapy to individual or groups specific to abuse issues. However, such treatment does not promote the woman's growth and empowerment nor permit her to make her own decisions about the relationship free from coercion

from the batterer. If violent couples are seen in therapy together, it should only occur after the man has been in special batterer's treatment program to stop the violence and then with two therapists using a specific treatment model is advisable (Harris, 1986).

Forensic Implications

Most battered women will have some contact with the legal system whether it is in the domestic court for a divorce, the juvenile court on behalf of a child, the civil court to assert claims of personal injury, or criminal court as a witness or a defendant in an act that was committed under duress from the batterer or in self-defense. It is important for psychologists to know the process expected during the various types of legal actions in order to assist the client in getting through the difficult periods with some knowledge. For example, depositions in civil cases are usually opportunities for opposing attorneys to try to find the weak spots in your client's case and therefore, can be expected to be an extremely psychologically stressful experience. Often a client begins to doubt that the lawyer really has his or her best interests in mind and the psychotherapist who knows something about the expected legal process can better assist the client in sorting out the legal from emotional issues.

Psychologists need to protect client's records when such court actions arise. In fact, it is a good idea to assume that any records kept may end up in court although everything possible should be done to avoid turning over raw test data and process notes. Although the minimum notes required include dates and times or sessions, type of service performed and fees charged, brief documentation of the assessment process, data, and results, diagnosis, and treatment plan with mutually negotiated goals is often most helpful to have in the records. Then, brief notation about progress toward meeting the goals or changes made in the treatment plan should be added to the record at appropriate intervals.

If the record is subpoenaed, the subpoena must be answered but the records should not be turned over without a court hearing, even if the client signed a waiver of confidentiality. Usually, the client's attorney can handle the legal steps to "quash" the subpoena, or, if that fails, to hold a hearing before the judge to demonstrate the harm to the client's present and future therapy should confidential information be disclosed. In some states the trial court judge will review the therapy notes and make a decision balancing the opposing side's right to know and the client's right to confidential treatment. Although under civil or criminal rules of evidence a client is usually required to sign a waiver of confidentiality when putting her mental health at issue in a civil or criminal matter, the psychologist is required to follow the administrative code under which his or her license to practice psychology is granted and in most states the APA Code of Ethics and the Guidelines for Providers of Psychological Services and Guidelines for the Use of Psychological Tests or a similar code must be adhered to or delicensure is a possible consequence. When two bodies of law are in conflict, such as the case with administrative law that says the psychologist can only turn raw data over to someone who knows how to interpret it (often limiting it to another competent, properly trained psychologist) and the civil or criminal codes that say you must turn over any material on which was formed your opinion, the final decision rests with the court. Psychologists must be prepared to hire their own attorneys should the need to protect their license and proper psychological procedure become necessary.

Conclusion

In conclusion, the diagnosis of battered woman syndrome, the collection of symptoms which is a subcategory of PTSD, can be made using specialized interview techniques. It is important to remember that not all battered women develop PTSD and even when they do, they may not need more than a support group with others in similar situations. Many women continue to be battered even after they separate from and divorce the abusive man. This is particularly frequent with women who are forced into involuntary joint-custody arrangements where they must stay in the same neighborhood and have constant contact with the abuser. PTSD symptoms will not be reduced if there is still danger of being harmed no matter how much therapy the woman receives. However, good feminist-oriented therapy can help the woman who is out of the situation begin to heal from the PTSD symptoms. It is my impression, however, that there is almost always some permanent damage from living with domestic violence over time. I have labeled this damage as a loss of resiliency to stress. Assessment of this loss can be made during the course of treatment.

The toll that physical, sexual, and psychological violence takes on the lives of women is simply

horrendous. Going through the healing process with these women can be both exciting and exhausting for a therapist. Many formerly battered women contribute to society in so very many ways. Some of them have been able to save their children from living their lives with violence. Others were too late to help them. Most of their batterers are still beating up other women and children. More often than not, the men continue to harass the women in subtle and large ways. Too often, no one wants to believe the woman that the abuse is continuing without any encouragement from her. Individual and group therapy can help make a difference for individual women. However, unless we change the power relationships between men and women, some men will always batter women, perpetuating the cycle of violence in the next generation.

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