Counseling Services for Battered Women

A Comparison of Outcomes for Physical and Sexual Assault Survivors

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Approximately 15% of married or cohabiting women and as many as 60% of battered women are raped at least once by their partners. This study compared community-based counseling outcomes of battered women with outcomes of women who were both raped and battered by their partners. Over time, both groups improved in well-being and coping. Although those both battered and raped progressed more in counseling, they had lower scores before and after counseling compared to women who were battered only. Implications for research and intervention are discussed.

Keywords: *domestic violence; evaluation; marital rape; counseling*

Research suggests that approximately 25% to 30% of all rapes are committed by husbands or intimate partners[1] (George, Winfield, & Blazer, 1992; Kilpatrick, Best, Saunders, & Veronen, 1988; Randall & Haskings, 1995; Resnick, Kilpatrick, Walsh, & Vernon, 1991). Women raped by their intimate partners are often raped repeatedly, resulting in serious physical and psychological harm (Bergen, 1996; Campbell & Alford, 1989; Finkelhor & Yllö, 1985; Russell, 1990). However, no published studies examine the impact of counseling for women raped by their partners, what types of services and treatment are most beneficial, or whether maritally raped women require different services than women who are battered but not raped. This study ana-

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lyzes counseling outcomes for women who have been raped and battered by their partners compared to women who have been battered but not sexually assaulted.

Estimates indicate that between 10% and 14% of women who marry or cohabit with an intimate partner will be raped at least once over the course of the relationship (Finkelhor & Yllö, 1985; Russell, 1990). The 930 women in Russell's (1990) study reported more than 2,500 incidents of rape and attempted rape. Russell accounted for multiple assaults by the same perpetrator, which is often the case in marital rape, by counting each incident rather than number of perpetrators. With this method, 38% of the rapes and attempted rapes were committed by current or former husbands, whereas 13% were committed by a lover or ex-lover, 9% by acquaintances, 8% by a dating partner, and 6% by a stranger. Each year, it is possible that women are raped more often by husbands than by other types of perpetrators. Several studies have documented the high chronicity of marital rape. Between 15% and 30% of women who are raped by their partners report being raped once, 22% to 37% report 2 to 20 rapes, and between 30% and 55% are raped more than 20 times (Bergen, 1996; Finkelhor & Yllö, 1985; Mahoney, 1999; Russell, 1990).

Intimate partner rape appears to be most common in relationships characterized by other types of violence. Several studies have shown that battered women are at risk for rape, with 32% to 59% of battered women reporting at least one, if not many, incidents of rape by their partners (Bowker, 1983; Campbell, 1989; Campbell & Soeken, 1999; Eby, Campbell, Sullivan, & Davidson, 1995; Frieze, 1983; Mahoney, 1999; Randall & Haskings, 1995; Shields & Hanneke, 1983; Walker, 1984). Although rape and battering exist separately in some relationships (Hanneke, Shields, & McCall, 1986; Russell, 1990), evidence suggests that sexual and physical violence often co-occur, placing battered women at high risk for partner rape and further complicating their attempts to cope with the violence or leave the relationship.

The Impact of Marital Rape

Finkelhor and Yllö (1983) contended that marital rape "touches a women's basic confidence in forming relationships and trusting intimates. It can leave a woman feeling much more powerless and isolated than if she were raped by a stranger" (p. 126). The powerlessness and feelings of isolation are due, in part, to the fact that the woman must live with the rapist, a constant reminder of the humiliation, pain, and continued threat. The impact of sexual assault in intimate relationships may be severe as women deal with conflicting feelings about trusting their partners, issues of power and dominance, and

questions about the meaning of sex in the relationship. They may be reluctant to seek help due to social pressures, isolation from social support, economic dependence on the partner, and the threat of future attacks (Mahoney, 1999).

Reactions to physical battering include shock, numbing, fear, depression, posttraumatic stress symptoms, and anxiety (e.g., Astin, Lawrence, & Foy, 1993; Kemp, Rawlings, & Green, 1991; Saunders, 1994; Watson, Barnett, Nikunen, & Schultz, 1997). Although few studies have examined the specific impact of partner rape, the evidence available suggests that women who are both battered and raped by their partners, especially those who are raped repeatedly, may also experience pronounced effects that are specific to surviving marital rape. Survivors of partner rape may experience lower self-esteem, altered body image, physical and gynecological complications, and higher levels of psychiatric problems such as depression, anxiety, sexual dysfunction, psychosomatic responses, and phobias than women who are battered only (Campbell, 1989; Campbell & Soeken, 1999; Shields & Hanneke, 1983; Shields, Resick, & Hanneke, 1990). The effects may also include increased distrust of men and others, aversion to intimacy and sex, changes in sexuality, increased anger, desire for vengeance, and withdrawal (Finkelhor & Yllö, 1985; Frieze, 1983; Russell, 1990).

Being raped in addition to being battered may be more stressful and have a more traumatic effect than physical violence alone (Shields & Hanneke, 1983, 1992; Shields et al., 1990). Moreover, each type of violence has a separate impact on the woman. Shields and Hanneke (1983) found that feelings and emotions, in particular self-esteem, were most influenced by the rape; whereas severe physical abuse was more likely to produce an action response such as discussing the physical abuse and seeking help. Compared to battered women, maritally raped women had lower self-esteem and higher fear and depression levels, somatic complaints, and anxiety-related problems (Shields et al., 1990). Studies have shown that experiencing multiple types of interpersonal trauma such as child sexual abuse and adult sexual assault and physical abuse may have a cumulative effect on survivors' well-being (e.g., Follette, Polusny, Bechtle, & Naugle, 1996; Messman-Moore, Long, & Siegfried, 2000). This research suggests that psychological distress, such as anxiety and post-traumatic stress disorder (PTSD)–related symptoms, may increase with the number of different traumas experienced.

Battered women and those who are both raped and battered share similar psychological reactions to the physical abuse. However, the reactions of women who experience both physical and repeated sexual assaults may be compounded by the additional power and control dynamics in the sexual relationship and the additional social stigma associated with the sexual violence. In sexually and physically violent relationships, the partner often controls not

only a woman's access to social supports, where she goes, what she wears, or how she takes care of the children, but also controls her sexually. She may be unable to control when she is touched or engages in sex and what types of sexual behavior she participates in. The rapes may diminish survivors' feelings of power, self-determination, coping skills, and dignity. As the sense of ownership of her body is eroded, her enjoyment and expression of her sexuality may also fade. Complicating those feelings, survivors may also struggle with shame, disgust, and guilt for having participated in degrading sexual acts or for not being able to stop the attacks. Thus, raped and battered women are likely to have more problems with feeling in control of their lives, identifying and using coping skills and social support networks, feelings of self-blame and shame, or talking about the abuse with others, which may influence recovery and counseling outcomes.

Evaluation of Domestic Violence Counseling

Over the past three decades, domestic violence agencies offering a wide range of services for battered women, including counseling, have proliferated. However, there have been very few empirical studies examining the efficacy of counseling for battered women and no studies examining counseling outcomes for women who have been battered and sexually assaulted by their intimate partners. The existing evaluation studies of counseling services for battered women suggest that supportive, psychoeducational, shelter- and community-based individual and group counseling may be an effective model for improving self-esteem, affect (anxiety, depression, and hostility), assertiveness, social support, locus of control, coping abilities, and self-efficacy (Cox & Stoltenberg, 1991; Mancoske, Standifer, & Cauley, 1994; Tutty, 1996; Tutty, Bidgood, & Rothery, 1993). Most of these evaluations focused on group interventions and used small, nonrandomized samples. The only study to use a control group was Cox and Stoltenberg (1991). In addition, the counseling services being evaluated varied widely in framework, theoretical orientation, and technique (e.g., feminist and social services models of care, cognitive restructuring therapy, assertive communication, problem solving, body awareness, vocational counseling, gender socialization, self-esteem building, concrete plan development, and grief resolution–oriented counseling). Yet these studies provide an initial illustration of battered women's responses to primarily group counseling. This study will compare the pre-counseling well-being and coping of raped and battered women to those of women who were battered only. Differences in pre- to postcounseling improvement on measures of well-being and coping between these two groups of women will also be examined.

METHOD

This study analyzed data collected by a project evaluating state-funded, community-based domestic violence and sexual assault programs in Illinois (for details see Riger et al., 2002). Researchers collaborated with 87 programs to develop and implement a year-long evaluation of counseling, shelter, crisis hotline, and advocacy services. The study presented here uses counseling data from domestic violence survivors. Participants in this project received counseling while residing in a domestic violence shelter or through a domestic violence agency's community-based counseling program.

Participants

The participants were drawn from a larger sample of approximately 5,200 battered women who sought domestic violence counseling services and completed counseling evaluation measures at any one of 54 domestic violence programs in Illinois from July 1, 1999, to June 30, 2000. Inclusion in the current study was based on (a) having completed both precounseling and postcounseling measures, (b) responding either yes or no to a postcounseling measure question asking about sexual assault by a husband/wife/partner,[2] and (c) being at least 18 years old. Table 1 displays the demographic characteristics of the 500 women who met these inclusion criteria.

The women in the sample were primarily Caucasian, between 18 and 40 years of age, and were still in the abusive relationship or had left within the past year. Difference tests were conducted to assess differences between the two groups of women on demographic and other variables. Overall, the battered group and the raped and battered group were similar in age, ethnicity, time since the abuse last occurred, and types of counseling received (see Table 1). Compared to the battered group, raped and battered women attended significantly more counseling sessions and reported more prior physical and sexual victimization.

Procedure

Counselors at each of the 54 domestic violence agencies incorporated the evaluation into their intake procedures. Counselors described the purpose of the evaluation to new clients older than 18 years of age and recruited their participation. Participants were informed that participation was voluntary, that they could end their participation at any point, that questions could be skipped, and that their choice about participating would not affect the services they received. It was explained that their participation would be anony-

TABLE 1: Demographic Characteristics of Participants (*N* = 500)

	Raped and Battered (n = *143)*		*Battered* (n = *357)*	
Characteristic	n	%	n	%
Age				
18 to 30 years	53	37.1	151	42.3
31 to 40 years	48	33.6	130	36.4
Older than 41 years	42	29.4	76	21.3
Ethnicity[a]				
African American	39	27.3	94	26.3
Caucasian	87	60.8	235	65.8
Other[b]	17	11.9	27	7.6
Time since abuse[a]				
Still occurring	37	25.9	113	31.7
Less than 1 year ago	61	42.7	166	46.5
1 to 5 years ago	33	23.1	47	13.2
6 or more years ago	11	7.7	20	5.6
Type of counseling[a]				
Individual	133	93.0	325	91.0
Group	75	52.4	147	41.2
Other	27	18.9	50	14.0
Number of counseling sessions**[a]				
1 to 5	70	49.0	234	65.6
6 to 10	31	21.7	47	13.2
11 or more	30	21.0	53	14.8
Sexual abuse history[c]				
Childhood incest**	49	34.3	84	23.5
Stranger rape**	26	18.2	21	5.9
Acquaintance rape**	38	26.6	34	9.5
Date rape**	52	36.4	48	13.4
Sexual harassment**	58	40.6	56	15.7
Physical abuse history[c]				
Childhood*	57	39.9	110	30.8
Adult dating partner	69	48.3	161	45.1
Adult ex-dating partner	51	35.7	111	31.1
Adult ex-intimate partner**	81	56.6	104	29.1

NOTE: Differences tested via chi-square.
a. The number of participants may not equal the total *N* due to missing data.
b. Other includes Asian/Pacific Islander, Hispanic/Latina, Native American, and multiracial.
c. Participants could endorse more than one form of sexual or physical abuse.
$^{*}p < .05$. $^{**}p < .01$.

mous and that identifying information such as name, birth date, phone number, address, social security number, or any other type of identifiers would not appear on any of the evaluation forms. Clients who agreed to participate com-

pleted a precounseling measure before counseling started.[3] In most cases, the postcounseling measure was administered at the end of the last counseling session or during the exit interview.[4] Completed surveys were sealed in envelopes and mailed to the research team.

Measures

The research team collaborated with domestic violence service providers from across the state to develop the measures (for further details on the measure development see Riger et al., 2002). In surveys and focus groups, service providers were asked to identify impacts that they hoped their counseling services were having on their clients. At the outset, agency representatives provided feedback to the evaluation team that shifted the focus of the counseling evaluation from postviolence psychological responses (e.g., depression, anxiety, posttraumatic stress) to protective factors that influence and facilitate the recovery process. Rather than evaluate therapeutic techniques for reducing psychiatric symptomatology or disorders, agencies preferred to measure whether counseling was helping women make healthy decisions, take action to rebuild and regain control of their lives, and begin to repair the damage caused by the abuse. Based on the outcomes suggested by service providers, the evaluators formulated the following measurable evaluation objectives: (a) clients will experience decreased self-blame; (b) clients will increase their ability to discuss the abuse; (c) clients will experience increased ability to build and access an appropriate social support system; (d) clients will feel an increased sense of control and enhanced problem-solving skills, self-esteem, and self-efficacy; and (e) clients will be able to identify their coping skills and use an increased number of healthy coping mechanisms.

Items from several published measures were proposed as evaluation items (e.g., Heppner & Peterson, 1982; Rogers, Chamberlin, Ellison, & Crean, 1997; Rosenberg, Schooler, & Schoenbach, 1989). An initial set of items was presented to the service providers, who suggested modifications based on their experience with battered women. Several versions of the measures were pilot tested. The final eight-item precounseling and postcounseling measure combined items developed by service providers with those adapted from published measures. These items are scored on a 5-point Likert-type scale ranging from 1 (*never*) to 5 (*always*). The eight items conceptually correspond to three domains: self-blame, self-efficacy and control, and social support (see Table 2). Eight items is generally considered to be too few to conduct a factor analysis (Tabachnick & Fidell, 2001). Therefore, responses to the precounseling and postcounseling well-being and coping items were summed to create precounseling and postcounseling indexes of well-being

TABLE 2: Means and Standard Deviations of Well-Being and Coping Items by Group and Time

	Battered (n = *357)*				*Raped and Battered* (n = *143)*			
	Precounseling		*Postcounseling*		*Precounseling*		*Postcounseling*	
Domain	M	SD	M	SD	M	SD	M	SD
Social support								
I have someone I can turn to for helpful advice about a problem	3.81	1.10	4.10	0.95	3.62	1.19	3.92	1.01
I have someone who would help me in times of trouble	3.92	1.13	4.11	0.97	3.50	1.22	3.78	1.10
Self-efficacy and control								
I trust my ability to solve difficult problems	3.69	0.94	3.79	0.92	3.33	0.88	3.51	0.90
I am confident about the decisions that I make	3.70	0.92	3.74	0.93	3.37	0.92	3.52	0.96
I feel like I am in control of my own life	3.44	1.10	3.72	0.98	3.07	1.03	3.47	1.06
I have ways to help myself when I feel troubled	3.70	1.00	3.95	0.86	3.30	1.02	3.66	0.96
Self-blame								
I know the abuse was not my fault	4.03	1.07	4.20	1.07	3.66	1.28	4.07	1.11
I am able to talk about my thoughts and feelings about the abuse	3.89	1.06	4.13	0.99	3.64	1.11	4.02	1.09

NOTE: Scores ranged from 1 (*never*) to 5 (*always*). Lower scores indicate lower levels of well-being and coping.

and coping. Higher scores on the precounseling and postcounseling indexes represented more positive well-being and coping, and lower scores represented poorer well-being and coping. The postcounseling measure also inquired about counseling process issues, such as identifying and making progress toward goals and safety planning (see Table 3). These items are scored on a 5-point Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The postcounseling measure also asked about demographics, counseling session format, number of counseling sessions attended, amount of time since the last abusive incident, and childhood and adult sexual assault and physical abuse experiences.

Because the battered only and raped and battered groups had significantly different prior victimization experiences, a new variable was created to serve as a covariate by summing the dichotomous (yes or no) responses to the prior sexual and physical abuse items. This index is referred to as prior abuse. Responses to the item inquiring about sexual assault by a husband/wife/partner were excluded from this index because it was used as a grouping variable. Because prior abuse was significantly correlated with precounseling ($r = -.11$, $p = .02$) and postcounseling ($r = -.12$, $p = .01$) well-being and coping indexes, it was used as a control variable in all analyses. Although the two groups differed significantly in number of counseling sessions, this variable was not significantly correlated with scores on the postcounseling well-being and coping index (Spearman's rho = .04, $p = .39$) and was not used as a control variable in the analyses.

RESULTS

This study investigated differences between women who were both battered and raped and women who were battered only in regards to (a) precounseling well-being and coping and (b) counseling outcomes (see Table 2). It was predicted that compared to battered women, women who were both battered and raped would have lower precounseling well-being and coping scores and would make less progress from precounseling to postcounseling than battered women. These hypotheses were partially supported.

Precounseling Well-Being and Coping

A one-way ANCOVA was performed on precounseling well-being and coping scores. When controlling for prior abuse, a significant difference was found between the two groups, $F(1, 497) = 18.11$, $p < .001$, $\omega^2 = .04$. Even

TABLE 3: Mann-Whitney Test Results of Counseling Process Items

Item	*Battered*			*Raped and Battered*			*Mann-Whitney Test*	
	n	M	Mdn	n	M	Mdn	z	p
I was an active participant in setting goals with my counselor	346	4.43	5.00	140	4.37	5.00	–0.49	.31
I have made progress toward my goals	348	4.22	4.00	138	4.12	4.00	–0.85	.20
My counselor helped me develop the skills I need to be able to meet my goals	344	4.31	5.00	140	4.13	4.00	–1.40	.08
Counseling has given me new ways of looking at abuse	345	4.37	5.00	141	4.37	5.00	–0.55	.29
I have a better understanding about the effects that abuse has had on my life	349	4.49	5.00	140	4.46	5.00	0.48	.32
I have a better understanding of the choices and resources available to me	348	4.53	5.00	140	4.50	5.00	–0.28	.39
My counselor listened respectfully and took me seriously	351	4.73	5.00	142	4.68	5.00	–0.96	.17
My counselor understood the impact the abuse had on me	347	4.65	5.00	142	4.58	5.00	–0.94	.18
My counselor let me know I am not alone	347	4.71	5.00	141	4.70	5.00	–0.32	.38
My counselor helped me develop a safety plan	342	4.51	5.00	137	4.34	5.00	–1.08	.14
My counselor explained that domestic violence is not only a personal problem but also a social problem	342	4.54	5.00	141	4.49	5.00	–0.37	.36

NOTE: The *p* value is for a one-tailed test. All *z* scores were nonsignificant.

TABLE 4: Precounseling and Postcounseling Mean Scores by Group

	Precounseling		*Postcounseling*	
	M	SD	M	SD
Battered	30.18	6.03	31.73	5.55
Raped and battered	27.49	5.77	29.94	5.92

NOTE: Lower scores represent lower levels of well-being and coping.

after holding the effects of prior physical or sexual abuse constant, women who were raped and battered began counseling with lower levels of well-being and coping ($M = 27.49$, $SD = 5.77$) than the battered only women ($M = 30.18$, $SD = 6.03$). Specifically, raped and battered women felt less in control of their lives and less self-efficacious, had less ability to identify and use social supports, and were less able to recognize that the abuse is not their fault.

Precounseling to Postcounseling Improvement

A Group (battered, both raped and battered) × Time (precounseling, postcounseling) ANCOVA indicated that when controlling for prior abuse, there were main effects for both Group and Time. Over time, all women in this sample made progress in counseling, with higher postcounseling well-being and coping ($M = 30.88$) scores than precounseling scores ($M = 28.87$), $F(1, 497) = 61.79$, $p < .001$, $\omega^2 = .11$. Collapsing across time, the raped and battered group had lower well-being and coping scores than the battered group, $F(1, 497) = 15.07$, $p < .001$, $\omega^2 = .14$. These findings support the first hypothesis.

As predicted, there was an interaction between Group and Time, $F(1, 497) = 4.12$, $p < .043$, $\omega^2 = .01$ (see Table 4). Results of the simple effects analysis did not support the hypothesis that the raped and battered group would make less progress in counseling than the battered group. There was a significant improvement from precounseling to postcounseling for both the battered and raped group, $F(1, 497) = 59.29$, $p < .001$, $\omega^2 = .12$, and the battered group, $F(1, 497) = 23.73$, $p < .001$, $\omega^2 = .05$. But the effect size analysis indicated that the effect for time was stronger for the battered and raped group than for the battered group. It is important to note that they began and ended counseling with lower well-being and coping scores than the battered group. Differences between the two groups should be considered within the context of the small effect size found for the interaction, which accounted for only

1% of the total variance. The effect of time for the raped and battered group explained 12% of the 1% of total variance.

To explore possible explanations for group differences found between precounseling and postcounseling, responses to the counseling process items were analyzed. The Mann-Whitney test results displayed in Table 3 indicate that the two groups of women did not significantly differ in their responses to the process items that assessed identification and progress toward goals, increased knowledge about the abuse, understanding about the effects of abuse, feeling believed and not judged by counselors, and safety planning.

DISCUSSION

This participatory evaluation study is the first statewide evaluation of community-based counseling services for battered women. It is also the first to demonstrate how intimate partner rape survivors respond to services offered by these organizations. The results support previous evaluation findings (Cox & Stoltenberg, 1991; Mancoske et al., 1994; Tutty, 1996; Tutty et al., 1993) that battered women's well-being and coping improve with psychoeducational and supportive counseling services offered by domestic violence agencies (as evidenced by the significant main effect of time). Previous evaluation research has focused primarily on group counseling with small sample sizes. This study used a large sample size, of which 90% attended individual counseling, 40% received both individual and group counseling, and 4% received group counseling only. Despite the limitations of this study (e.g., no control group or differentiation between group and individual counseling outcomes), the findings provide further evidence that community-based domestic violence counseling services benefit battered women.

The findings suggest that women who have been raped and battered by their partners begin and respond to counseling differently than battered women who were not raped. Maritally raped women entered counseling with lower well-being and coping skills than battered women (as evidenced by an approximately 3-point mean difference on the precounseling outcome index score) (see Table 4). For example, compared to battered women, the raped and battered women scored lower on items that measured feelings of blame for the abuse, ability to talk about the abuse, and feeling in control in their lives. This confirms the expectation that although raped and battered women have similar reactions to physical violence, the negative impact on their well-being and ability to cope may be compounded by the aftermath of the sexual assault. Results from precounseling analyses suggest that rape by an intimate

partner may have additional negative effects on women's self-esteem, coping skills, attribution of blame, and feelings of shame. This is consistent with previous research on marital rape survivors as well as those who survive multiple traumatic experiences (e.g., Finkelhor & Yllö, 1985; Messman-Moore et al., 2000; Russell, 1990; Shields & Hanneke, 1983).

Both groups of women demonstrated improved well-being and coping from precounseling to postcounseling. Although contrary to expectations, raped and battered women's outcome scores improved more than battered women, suggesting that the counseling may have had more of an impact on these women. There are several possible reasons for this finding. Because the battered women began counseling with higher well-being and coping scores than the raped and battered women, one might argue that the battered women had less room for improvement. Counseling may have provided the raped and battered women with a safe, supportive environment in which to talk about the abuse, both physical and sexual. However, analysis of the counseling process items indicated that the raped and battered women did not differ from the battered women on indicators of the client-counselor relationship such as feeling believed and not judged by their counselor. It is also possible that their improvement had little to do with discussing the sexual violence, if it was even addressed at all. Because battered and raped women have more difficulty labeling and talking about rape than other types of abuse (e.g., Allison & Wrightsman, 1993; Frazier & Seales, 1997; Mahoney, 1999; Russell, 1990), counseling sessions may have focused more on the physical violence, which may have been a less intimidating topic than the rapes for both the counselor and client. Because this evaluation did not collect information about the specific issues addressed in counseling or inquire about the techniques or theoretical perspectives of the counselors, these are speculations that require further longitudinal research.

Although the raped and battered women progressed more in counseling, it is important to note that their precounseling and postcounseling well-being and coping scores were lower than the scores for the battered only women (see Table 4). This suggests that when counseling ended, the raped and battered women were still having more problems than the battered women with issues such as understanding that the abuse was not their fault, identifying and using supportive resources, trusting their ability to solve problems, and feeling more in control of their lives. These findings demonstrate that although many of the issues related to being a battered woman are similar between the two groups of women, the raped women contend with additional physical, emotional, and psychological implications of being raped by their partners (e.g., Campbell & Alford, 1989; Shields & Hanneke, 1983; Shields et al., 1990). For many survivors, this includes more difficulty trusting them-

selves and others, more difficulty talking about the rape versus just the battering, and having been stripped of feelings of efficacy, self-esteem, self-worth, and control over their lives and bodies (Campbell, 1989; Finkelhor & Yllö, 1985; Frieze, 1983; Russell, 1990). Although this study did not examine psychiatric symptoms, it is also possible that the raped and battered women may have progressed less in counseling due to the combined impact of multiple traumas and psychological distress in the form of anxiety, depression, or PTSD.

Despite greater progress made by the end of counseling, the women who were raped and battered had not attained the level of well-being that the battered women began counseling with, suggesting that intimate partner rape survivors may have different or additional needs than battered women. For example, raped and battered women may need more counseling sessions, or they may need different types of counseling formats or techniques. As others have posited, raped and battered women may benefit from group counseling with other survivors of intimate partner rape that focuses on both the sexual and physical violence as well as the intersection of the two (Bergen, 1996; Thompson-Haas, 1987, as cited in Russell, 1990).

As this is the first study to evaluate outcomes for maritally raped women, the results should be considered preliminary, and conclusions drawn from these data are primarily speculative in nature. This evaluation of counseling services did not use random assignment or a control group and relied on self-report descriptions of well-being and coping. Hence, improvement cannot be unequivocally ascribed to the counseling. The findings could be confounded by participant satisfaction with services or a tendency to respond positively to help the organization. Moreover, in the absence of a control group, we cannot rule out the possibility that improvement may be due to other factors, such as the passage of time. Differences between battered and raped women and battered women could have been attributed to numerous other factors that were not assessed or controlled in the evaluation, such as circumstances in the women's lives or other services received from the agency. For example, advocacy services that helped participants obtain a restraining order, find housing or a job, file for divorce, or send the batterer to jail could have helped the women feel safer, stronger, and more in control of their lives, which may have had more of an effect than the counseling.

Future Directions

Studies in the future on this topic should consider several issues. Assessing counseling efficacy in the context of other services, such as advocacy and living in a shelter, or other life situations, such as living in the com-

munity with or without the batterer, is a task for future research. An important area for examination is the impact of the counseling environment, counselor characteristics, and client-counselor relationship quality on progress in counseling for women who are both battered and raped by their partners. Longitudinal designs with control groups that evaluate well-defined programs/interventions may be useful in understanding the effect of counseling for different groups of battered women. Finally, it may also be beneficial to understand the cumulative effect of exposure to multiple forms of violence by measuring both psychiatric symptoms and variables such as those included in this study. Such a study may also provide valuable treatment information about the effect of psychological distress, such as PTSD or depression, on how battered women reduce self-blame, use social supports, regain a sense of control, trust their decisions, talk about their abusive experiences, and rebuild their lives.

Conclusion

This study contributes empirical evidence of the positive effects of community-based domestic violence counseling services for battered women and women who have been raped and battered by their partners. These findings suggest that women who are raped and battered may not achieve similar levels of well-being and coping as a result of counseling as women who are battered but not raped. With few studies examining the intersection of battering and rape in intimate relationships, the current study a step toward documenting the distinctiveness of this population.

NOTES

1. The terms *marital rape*, *wife rape*, and *partner rape* contain embedded assumptions about the gender of those involved and exclude women in same-sex relationships. Therefore, when appropriate, this article will use the terms *rape* or *sexual assault* to refer to women raped by their intimate partners in committed, cohabiting relationships and use gender-neutral terms in reference to perpetrators.

2. Koss (1993) suggested that rape incidence will be underdetected if survivors must conceptualize and label their experiences as rape during screening. Koss advocated for behavioral questions assessing specific acts, which may be more effective than questions that require survivors to identify or label themselves as a *rape survivor*. However, in this study, we were limited by service providers in the number and types of questions.

3. Service providers indicated that building trust and rapport with domestic violence survivors takes time. Therefore, counselors were given the option to administer the precounseling measure after the first counseling session if it was not appropriate to administer it as part of the intake procedure, given the client’s emotional state.

4. A data collection approach was developed to address agency concerns that domestic violence survivors may not have been able to complete a standardized counseling treatment (i.e., clients may terminate services suddenly or stop attending counseling after a few sessions for reasons such as safety or mobility issues). Service providers determined the average number of counseling sessions that their clients attended and administered the postcounseling measure after the client completed the average number of sessions. In some cases, women completed the postcounseling measure twice: once at the average number of sessions and once at the end of counseling. When more than one postcounseling measure was collected, only the last was analyzed.

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