PSYCHOTHERAPEUTIC CHALLENGES IN A DOMESTIC VIOLENCE CONTEXT

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In 2004 a representative study was published for the first time in Germany regarding violence against women and its large extent was demonstrated. Violence mostly takes place in the domestic environment and affected women are challenged with many health consequences. Usually male partners are committing violence and are disclosing structural gender inequalities that continue to exist. In this article the psychological effects of violence in intimate relationships are reviewed from a clinical and critical perspective. Considerations on psychotherapeutic consequences for the treatment of someone who experienced domestic violence are made. The focus is on the understanding of health and illness, related diagnostic challenges and therapeutic techniques.

Keywords*: domestic violence, partnership violence, posttraumatic stress disorder, feminist psychotherapy, Germany*

1. Introduction

Since the 1970s, feminist movements have brought the issue of violence against women increasingly into public light (Herman, 1993). However, it was only in 2004 when the first representative study was made available. It demonstrated the high extent of violence against women (BMFSFJ, 2004). The study interviewed more than 10,000 women about their experiences of violence in different stages of life and the results indicate that at least one in every four women aged 16 to 85 years old living in a partnership have experienced physical assault (23%), and in some cases also sexual assaults (7%) at least one or more times (ibid.). Men are the predominant offenders and women and children the ones affected by violence. The pattern of intimate partnership violence is not random, but the study shows a gender-based social structure for both the committing and the suffering of violence.

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The term ‘partnership violence’ refers to any violation of the physical or mental integrity of a person by someone who is in a structurally stronger or more powerful position. Most often these acts are committed by men against women. Men are also affected, but not to the same extent or in the same way (Senatsverwaltung für Arbeit, Integration und Frauen, n.d.). Available studies suggest that the types of violence women and men commit vary. Additionally, health consequences seem to be gendered as well (Swan, Gambone, & Caldwell, 2008) and although there is evidence to suggest that male victims also suffer psychological harm through partnership violence, studies find more negative mental health effects for women compared to men (Tjaden & Thoennes, 2000; Anderson, 2002; Ehrensaft, Moffitt, & Caspi, 2006). This article is limited to the findings of the needs of adult women. A children`s perspective is beyond the scope of this paper (for further literature see, among others, Kavemann & Kreyssig, 2007; Kindler, 2002; Peled, 1997).

The consequences of partnership violence are complex and can be life-threatening. In Germany, 64% of women affected by violence have reported physical injuries. These range from bruises, hematomas or sprains to muscle tears. At least one third of these women sought medical help as the injuries were serious. Broken bones, brain damage due to blows to the head, damage to internal organs, scarring and disfigurement of the face, missing teeth, curved or missing fingers, decreased visual or hearing capacity are other consequences of domestic violence (BMFSFJ, 2004). The partner is the murderer in 38 % of all reported female homicides. Women affected by violence also have about a 16% higher chance of having a baby with low birth weight and a 1.5-fold increased likelihood of infection with HIV, syphilis, chlamydia or gonorrhea (WHO, 2013).

The diverse body-related injuries are often accompanied by tremendous socioeconomic or psychosocial stress. Structurally embedded discrimination is usually enhanced in times of violence (gender pay gap 22% in Germany in 2014)[1]. In order to leave a high threat situation the socio-economical stress factors in domestic violence contexts can range from precarious living conditions due to abrupt job loss or homelessness, or even the threat of losing a residence permit for those without German citizenship. Social psychiatric research has shown that the poorer one's socioeconomic conditions are the higher one's risk is for mental suffering and psychiatric hospitalization. This was found regardless of economic hardship or type of mental health problem a person is suffering (Hudson, 2005).

A study conducted by the World Health Organization (WHO) in 2013 has shown that women experiencing violence in relationships are twice as likely to develop depression and almost twice as likely to abuse alcohol or other drugs. The designation of sufferings like “depression” or “abusive consumption of alcohol or other drugs” is usually linked with referrals to psychiatric and psychological health services. It depends on the perspective, whether the development of mental suffering is seen in the light of missing personal resources and skills, i.e., individual vulnerabilities (e.g.,among others, Steinert, Steib, Uhlmann, & Tschöke, 2014), or in the context of social power relations, i.e., broader financial, legal and social structures (among others, Burgard, 2002). This paper discusses the health consequences of partnership violence both from a pathological (section 2) as well as from a socio-critical perspective (section 3). I argue that the clinical and the critical perspective imply different psychotherapeutic attitudes and interventions. This contribution concludes with challenges for psychotherapy in domestic violence contexts

[1] https://www.destatis.de/DE/ZahlenFakten/Indikatoren/QualitaetArbeit/Dimension1/1_5_GenderPayGap.html (15.04.2016).

arising from a critical approach. As the pathological or clinical perspective still dominates health services in Germany, section 2 elaborates on current practices and introduces possible pitfalls.

2. The Clinical Perspective in the German Mental Health Care System

In the German mental care health system, the concept of illness or mental disorder is paramount. The International Classification of Diseases (ICD-10) of the World Health Organization (WHO) is the mandatory system for the classification of mental disorders. A diagnosis is needed to achieve access to public mental healthcare services. Diagnosis is based on the current symptoms a person is suffering. Therefore, several mental disorders can be present at the same time (comorbidity). According to the European medically oriented, evidence-based (S3) guidelines for posttraumatic stress disorders (PTSD), comorbidity is rather the rule than the exception in the context of traumatic events (Flatten et al., 2011)[2]. Guidelines are strongly linked to existing trends of psychotherapeutic research and built on theoretical models as described below. They are structured around diagnostic entities and suggest evidence-based therapeutic techniques per diagnosis (and not for comorbidities). The usefulness of separate categories to describe a state of suffering of *one* person is questionable. Social contexts, structural inequalities, cultural values and morals are rarely considered. For example, cognitive-behavioral therapeutic approaches recommend confrontational techniques in case of PTSD. However, the therapeutic approach needs to be more flexible and process-oriented, focusing mainly on stabilization as is common practice in cases of comorbidities. Furthermore, in clinical logic the general focus lies on deficit-oriented beliefs of a person. Therapists engage in a disputation with the client's personal fears and support a re-evaluation of the client's emotions. This approach remains rooted in clinical-psychopathology. Section 3.1 shows alternative theoretical models that manage to integrate these contexts.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) (the classification system of mental disorders for the USA) was published by the American Psychological Association in its fifth edition in 2013. Usually the International Classification of Diseases (ICD) (the classification system of mental disorders for Germany) is influenced by the DSM. The release of the 11th edition of the ICD has been announced for the year 2017. The DSM-5 applies a new structure of mental disorders and PTSD is no longer subsumed under the group of anxiety disorders, but a separate chapter called trauma and stressor-related disorders was created (APA, 2013). The positive aspect of this restructuring is that extreme psychological stress due to violence is not only considered, but is defined as an integral part of this disorder group. It is the only disorder group that points to events that are potentially traumatizing experiences and thus to the context. Otherwise, the sole focus of attention lies on the individual with his or her pathology in the prevailing clinical logic otherwise.

Similar to other Western societies, Germany has a history of medicalization and individualization of distress. The use of diagnostic labels places the source of distress firmly within the individual. This psychopathological perspective may foreclose consideration of the

[2] The Federal Joint Committee (G - BA) is the supreme decision-making body of the joint self-government of physicians, dentists, psychotherapists, hospitals and health insurance companies in Germany. The G - BA publishes guidelines that aim at ensuring adequate, functional and economically affordable psychotherapeutic and psychiatric services.

social and political context and interpersonal relations as sources of unhappiness or dysfunction (Hare-Mustin & Marecek, 1997). The greatest problem posed by diagnostic categories is that their role in the training of clinicians and the significance of them in professional literature often lead to their being regarded as identifying and naming objectives feature of reality, when on the contrary, they are largely socially constructed (Pérez-Álvarez & García-Montes, 2007).

A distinction between natural and man-made trauma is still missing in the diagnostic manuals although the probability of related disorders and the complexity extent of symptoms are dependent on the nature and circumstances as well as the frequency of traumatic events (Schellong, 2013). Since the coping resources of children and adolescents are not as mature as those of adults, the psychological consequences of violent experiences become more severe the earlier the experience is made, the closer the relationship to the perpetrator is (as opposed to acts of violence perpetrated by strangers) and the longer the experience of violence persists (Reddeman & Dehner-Rau, 2012). A positive development in the DSM-5 is indeed that sexual violence is explicitly mentioned, however, an extension to experiences of violence in intimate relationships is still lacking (Friedmann, n.d.). With the exclusion of socio-political contexts and living conditions there is an increased risk that institutionalized discrimination against women or children and the resulting violence contexts are individualized as mental disorders (Burgard, 2002). The common treatment of mental disorders in Germany is still strongly influenced by the medical point of view, which primarily suggests psychiatric hospitalization and treatment with psychotropic drugs. The trend to individualize and medicalize is reflected in the common theoretical models of psychotherapeutic training and research.

There are several theories and models on etiology of mental disorders: The vulnerability-stress model (Zubin & Spring, 1977), the bio-psycho-social disease model (Engel, 1980) and more integrative models such as the GxE (gene-environment interaction) model by van Os and Kapur (2006). The GxE model includes genetic predispositions, e.g. for schizophrenia, and psychosocial factors that moderate genetic expression. Vulnerability is understood as a complex interplay between genetic predispositions and other factors such as traumatic childhood experiences or the increasing urbanization and migration in the course of social isolation and discrimination. There is constant interaction between biological and organic medical factors, such as the so-called derailment of various neurotransmitter systems, psychological factors, i.e. individual coping resources or lack thereof, and social factors, such as excessive demands at work. The biological understanding of vulnerability easily suggests the prescription of psychotropic drugs. During psychotherapeutic training, students learn to use this bio-psycho-social picture as an entry to enhance adherence to medication. Space for critical discussion is rare. The German Society for Social Psychiatry[3] emphasizes that patients (and health workers) are not sufficiently informed on the mechanisms of action and adverse effects of drugs. Other serious abuses with regard to pharmacological treatment of mentally burdened people are highlighted for example in unjustifiably high doses, off-label use in children, adolescents and the elderly, lack of monitoring in combination with other medicines, etc. (Aderhold, 2010, gives a critical overview and exemplarily concludes with recommendations for the group of neuroleptics).

The contexts and social formations that produce violence are usually neglected in clinical praxis. This helps reproduce existing power structures by silencing and pathologizing those who are most in need. For example, the book *Komplexe Traumafolgestörung* (*Complex trauma*

[3] http://www.dgsp-ev.de/stellungnahmen/stellungnahme-zur-behandlung-mit-psychopharmaka.html (15.04.2016).

related stress disorders, published by Sack, Sachsse, & Schellong, 2013) considers gender not as a cross-cutting issue, but devotes a separate chapter to gender issues without any socio-critical approach (Gahleitner, 2013). Gender-specific prevalence rates are hardly part of a critical discussion at the faculties of psychology or in psychotherapeutic training institutes in Germany.
In a nutshell, the clinical psychiatric or psychotherapeutic perspective rather distances itself from sociological and political approaches, isolates personal experiences from macro-social contexts and medicalizes personal suffering. In most cases violence in intimate relationships is not a single event. Affected women often experience threats and humiliation, financial and social violence such as isolation and physical and/or sexual violence for years. Partnership violence is often characterized by highly intensive feelings of fear, helplessness and horror. The unpredictable change between brutality and tenderness contributes to developing pathological bonds that outsiders hardly can understand (Teegen & Schiefer, 2002; Herman, 1993). Many affected women downplay or conceal the experience of violence in itself as well as related mental and physical health consequences when talking to doctors and psychotherapists (Roberts, O'Toole, Raphael, Lawrence, & Ashby 1996). This climate of fear and silence is supported by social taboos: "Relationship violence is not perceived by the social environment. It is rarely questioned or trivialized by doctors and therapists, which leads to an underestimation of the debilitating consequences as well as misdiagnosis and improper treatment" (Teegen & Schiefer, 2002, p. 90). All in all, this leads to the fact, that in the reality of psychotherapy, professionals hardly screen for domestic violence contexts although they could produce observable symptoms.

In the following section I will argue that in order to illustrate structural inequalities it is paramount to study both individual experience *and* the macro-social matrix in which experiences are configured.

3. The Critical Perspective: Rethinking Psychotherapy in Domestic Violence Contexts

The critical perspective takes the social context and unequal power relations as the starting point for a partisan cooperation with affected women. This has implications for the understandings of disease and health, as well as on the therapeutic relationship and applicable psychotherapeutic techniques.

Mental disorders can be understood as problem-solving strategies and coping patterns of those who had to find a way of dealing with mostly long-lasting violent excesses of all kinds. A socio-critical attitude, as is the case of feminist movements, reflects the unequal access to and control over financial, political and symbolic resources. Burgard (2002) deconstructs the theoretical basis of the clinical mainstream, which focuses primarily on the pathology of individuals. In praxis this can promote behaviors that are culturally adapted through therapy and the prescription of psychotropic drugs. Unequal power relations remain unchallenged in this clinical practice. The feminist psychologist Burgard shows how the bearing of and suffering from domestic violence reflects structural inequalities between men and women. The individual experience is classified in social structures and their related options of influence and control.

For a critical perspective on mental "disorders", the terms mental "burdens" or "suffering" are used in this article. They emphasize that certain behaviors are not genuinely "disturbed" or "ill", but that cultural norms play a part in the definition of what is considered a disorder and what is

not. The concept stresses that the definition of what is perceived as a disorder is always based on the deviance from a norm and not exclusively on the deviance from a person's wellbeing - as implicated by the clinical concept of a disorder. Due to the tendency of psychopathology to focus on the isolation of individuals from societal contexts the hidden normativity, power relations, and inequalities on mental health become further blurred. A critical approach requires a change in terms of our understanding of health and disease: "An understanding of illness and health specific to women requires analyzing and criticizing traditional medical and psychological disease models and their concept of health. Health is not only the fulfillment of societal notions of normality but the ability to self-determined labor, profit-sharing, and capacity for love, among other things" (AKF, n.d.).

Theoretical and practical implications deriving from a critical stance are detailed hereinafter. Instead of individualizing diagnostic categories I argue for a broader psychosocial model that includes financial, legal and social contexts as well as one that defines domestic violence contexts as the paramount starting point.

3.1 Emphasizing Contexts in Psychotherapy

Not all women affected by domestic violence need psychological or psychotherapeutic support in order to process their suffering. The coping resources are crucial for the process of healing and determine whether a person can find a successful mental integration of the extreme experience. These resources can be defined primarily on an individual basis, as is the case in clinical-psychopathological perspectives, or can be understood contextually, as is the case in critical perspectives.

The S3 guidelines refer to a continuum between salutogenesis and pathogenesis (Flatten et al., 2011). In a clinical perspective, a traumatic experience that exceeds individual-based coping mechanisms leads to an acute stress reaction, an adjustment disorder, PTSD as well as to fears, depression, somatization addiction and dissociation. In case of missing options for integration or compensation due to inadequate healing-promoting factors a complex PTSD or personality disorder may develop. Reddemann and Dehner-Rau (2012) emphasize that psychosocial processing of the experience of violence requires time. Stress symptoms such as sweating, panic and insomnia are considered to be normal in the immediate aftermath of traumatic life events. Processing these events may take from a few weeks to several years and takes place by alternating back and forth of intrusions (remembering the experience of violence, which can be triggered by internal or external stimuli) to constriction (the avoidance of such triggers). Several factors are important for successful integration, for example the awareness about the fact that one is currently safe. This can be supported by staying in a women's shelter with an anonymous address. A socially supportive environment, physical recovery (the balance between physical activity and rest, sufficient sleep, healthy diet) and emotional stability (awareness of emotions, present orientation) are also crucial for processing traumatic events.

According to clinical logic, pathology develops when the individual-based coping mechanisms do not meet the situational demands. However, if coping strategies are defined in its historical and social dimension, it is clear that access to and control over certain resources are not equally distributed, which in turn can have significant impact on the concrete coping strategies available to a person at a specific time. If a battered woman has sufficient social and financial resources, she will rather decide to seek safety at the place of a friend or at a hotel than living in

a women's shelter where unacquainted people have to live together in a confined space with little retreat options. A woman with German citizenship and with knowledge about her legal rights may cope differently compared to an asylum seeker with little knowledge about the German law system. To illustrate the inequality of coping resources I will showcase an example from the psychological counseling activities in a women's shelter.

Devi, a 30-year-old woman, descends from a respectable family in India that belongs to a higher caste. She came to Germany with her Indian husband who was working as a businessman in Germany before their marriage. Devi had a strong bond with her father, who offered guidance and advice in their relationship problems that have been piling up since her marriage. Extramarital affairs of the husband lead Devi into increasingly deep despair. She contracted several sexually transmitted diseases and failed to get pregnant. Her husband and his family started blaming her for the childlessness of the young family and for her physical vulnerability. The implementation of safer sex practices seemed impossible as the affairs of her husband were officially denied even though he began to invite his affairs into their home. Devi suffered increasingly due to this confrontation, however, she saw no possibility to influence the behavior of her husband, nor did she have any alternative accommodations in order to avoid conflict. Since marriage she has been financially dependent on her husband, has not established a social network in Germany nor does she have any options for employment. She experienced herself and her ability to act as very dependent on her husband. Due to Devi's close contact with her family back in India, she learned that the neighborhood had started gossiping about her, about her childlessness and that the family honor had been "stained". Then her father died suddenly in the course of an accident. Doubts about God, the feeling of injustice of life and anger against her husband increasingly developed. Due to the social stigma and the family's financial burden since the loss of her father there was no option to return to India for Devi. The uncertainty of her residency status and social isolation in Germany, the continued wait for the German authorities to decide whether she can stay in Germany to receive access to integration and language courses have led to a downward spiral and a loss of resources for her. Familiar strategies of self-calming like meditation have stopped working for Devi who started doubting herself and the meaning of life. When I got to know Devi, she was in a suicidal crisis.

The *Conservation of Resources Theory* (COR) of Hobfoll (2011) helps to understand individuals and their coping strategies in the context of social background and cultural differences of power and resources contrary to the well known approach to stress of Lazarus that emphasizes individual dimension (Zaumseil & Schwarz, 2014). According to Lazarus and Folkman (1984), in primary or demand appraisals, a person evaluates whether or not there is any challenge, threat, harm or loss with respect to commitments, values, or goals in his or her interaction with the environment. In secondary or resource appraisals, a person evaluates what can be done to overcome or prevent harm or to improve his or her prospects for a beneficial outcome. This theory strongly emphasizes the cognitive assessment processes that a single person would do on their own. Other clinical psychological theories rather point to processes of finding meaning (among others, Park, 2010) or to religious-spiritual processes (among others, Pargament, 2011). The main and most common element in these theories is the focus on an individual level (and neglect of contexts). Hobfoll and Buchenwald (2004) note that in the assessment-based theories of stress individualistic and cognitive aspects dominate and they criticize the dichotomous division into problem-focused coping versus emotion-focused coping by Lazarus and Folkman (1984).

Hatch and Dohrenwend (2007) examine the distribution of stressful and traumatic events as dependents of demographic variables such as ethnicity, socioeconomic status, gender and age in a review of literature from 1967 to 2005. The study does not exclusively focus on the relationship between psychological and physical disorders and symptoms of traumatic and stressful events. The authors illustrate how a context-oriented understanding of coping resources can be implemented in research. They close their review with the following conclusion: Groups with a low socio-economic background, ethnic minorities and young people are increasingly exposed to traumatic and stressful events with corresponding trajectories.

Putting higher emphasis on contexts, this has several implications for psychotherapy. If broader psychosocial models and theories were to be integrated into psychotherapeutic research and practical guidelines, the interaction between professional and client may change and cooperation links between professionals may alter. With regard to the clients, professionals should be aware of unequally distributed societal power relations and their impact on coping options. This could help avoid pathologizing social inequalities and highlights the need of parallel political and social work measures rather than mere therapeutic interventions (for example, by providing information on how to access a language course). Once mental burden has developed in a therapeutic setting, professionals can offer interpretation patterns that take the social dimension into account rather than merely individualizing and medicalizing the client. In stabilization phases of therapy, social work activities or a close cooperation of professionals of this group can be helpful as well as the promotion of a collective narrative. Context orientation may also include political engagement of psychotherapists, for example to improve the legal situation of asylum seekers in general.

3.2 Considering Gender-Specific Violence in Psychotherapy

Apart from the above described emphasis on contexts, an increased awareness of gender-specific violence can help improve the quality of counseling and therapy. Many battered women who are in an acute crisis situation revert to prevailing norms and symbols in order to regain stability and orientation. According to Gahleitner (2013) this means that male victims of violence rather cope instrumentally and with aggression towards others due to gender socialization, whereas battered women tend to cope emotional-expressive, self-destructive and in their social network. These gender-specific patterns of coping are associated with the high probability for battered women to experience a re-victimization (Russel, 1986), and for men to develop perpetrator-oriented representations and practices (Rossilhol, 2002). Healing processes are better supported by coping options that are androgynous rather than exclusively gender typical (Gahleitner, 2013). The therapeutic task then lies in strengthening flexibility in applied coping strategies. Of course, "deconstruction" and "emancipation" cannot be promoted limitlessly in therapeutic contexts, but always need to be adapted to the needs of the clients. According to Gahleitner (2013) it is "about the realistic assessment of options for agency and change, about acknowledging the detention of individuals in historically, socially and psychologically grown situations and about developing interventions that are based on these individual assessments of the situation" (ibid., p. 404).

Strengthening flexibility in applied coping strategies implies the availability of knowledge and sensitivity to dynamics and effects of domestic violence. The NGO S.I.G.N.A.L. provides trainings for doctors in primary health care settings in Berlin. This increases sensitivity and

awareness for signs of domestic violence in the diagnostic phase. Similar training modules could be integrated into clinical psychology during the study phase at German faculties of psychology and into psychotherapeutic training. If symptoms of depression, anxiety, PTSD, cognitive and sleep problems are reported and if suicidal or self-harming behavior is obvious, if the use of alcohol and other intoxicants is striking and if chronic gastrointestinal symptoms are described, past and current living conditions and relationships should be considered diagnostically. If a person is repeatedly consulting healthcare services without a clear diagnosis, and if the person is accompanied by intrusive partners or husbands, professionals should take notice (WHO, 2014; Black, 2011). Only by the emphasis of contexts and by applying a socially critical attitude, a de-individualization of diagnoses can be achieved. Although the S3 guidelines recommend to consider traumatic triggers for reported symptoms (Flatten et al., 2011), the experience of S.I.G.N.A.L. shows, however, that this is still insufficiently implemented in the German health care system.

Once the circumstances of violence are made known, it is necessary to clarify whether the violence has stopped already or is still ongoing. The following example illustrates the neglect and its consequences.

A patient of a psychiatric clinic was obviously distraught before and after the visits of her partner, she looked very confused and troubled. Stabilization methods that were successfully applied in previous sessions were no longer effective. After several weeks, the patient was able to articulate that she wishes no further visits by her partner. She asked the ward staff to support her request. The nurses who had had domestic violence experiences of their own in particular were able to make the rest of the personnel understand and pushed to take the patient's request seriously instead of dismissing it as paranoia. Doctors were little motivated to assist the patient with her request as she had had previous inpatient stays and had had several failed attempts to separate from her partner. It took an additional three months until she left the relationship and we were able to find an apartment for her.

What to do, however, when the contact with the offender persists? As is often emphasized in literature, no trauma-focused therapy should be started while the client has continued contact to the perpetrator (Fliß, 2013). The trauma-focused therapeutic target, namely the perception or belief that the violence is over, is not possible to achieve because the experience of violence continues before and after the therapy session. This requirement excludes many battered women and often leaves them alone in an unbearable and highly harmful situation. Therefore, removing perpetuating factors may very well be a sub-target of psychotherapy. This in turn means that psychotherapists need to adapt and probably need to cooperate more closely with other institutions. In case of ongoing contact with the perpetrator, the primary therapeutic work focuses on mental representations that are loyal to the perpetrator and on related ambivalences. Many battered women feel guilty and responsible for the violence they have endured. This is a kind of protective mechanism from the enormous powerlessness and helplessness they experienced. The patient described above engaged in lengthy explanations for "deserving" aggressive outbursts of her partner as she did not do the housework "right", as she was too slow in general or as she was the "sick" one in the partnership. It is a time-consuming task to develop a sound relationship that eventually allows increased questioning of these self-representations, especially when working with complex traumatized women living in vulnerable conditions. Besides an emotional dependency, many battered women are also economically dependent on their partners, in particular those women whose residence status is reliant on the cohabitation with the perpetrator of violence. It is evident that sole psychotherapeutic interventions are not

sufficient but that cooperation with other services is a matter of priority. This is consistent with the S3 guidelines which recommend organizing a psychosocial helper system (Flatten et al., 2011). Unfortunately this is not encouraged by current financial reward systems and thus continues to be a matter of personal commitment on part of the psychotherapist.

In Schwarz, Tyas, and Prawitasari-Hadiyono (2014), we describe the pitfalls of mere quantitative approaches when working from socio-critical and culturally sensitive points of view. Integrative and narratively oriented therapy techniques could include the social dimension more easily. They promote constructing a coherent narrative and the endowment of meaning. Instead of over-emphasizing western notions of self-efficacy and personal control, narrative methods could also help to be more culturally sensitive and promote work with people from different cultural backgrounds (Abdallah-Steinkopff, 2013). Narrative approaches could also allow for intersectional perspectives, which means that not all women experiencing violence experience suffering equally and that not all affected women experiencing suffering, should be treated equally (Matima, n.d.).

4. Concluding Remarks

When framing women's experiences of partnership violence, the clinical perspective is supported by diagnostic labels. As a consequence, connections between the actions of the abuser and the resulting distress experienced by the affected woman are neglected. The diagnostic label implies that the victim has some pre-existing vulnerability, which in turn detracts from acknowledging the traumatic impact of violence and abuse. Therefore I argue for a more critical perspective in psychotherapy in the context of domestic violence. This includes the integration of evidence-based knowledge regarding domestic violence and its effects on mental health in faculties of psychology and during psychotherapeutic training. A context-emphasizing, socio-critical approach encourages work with a client's biography, cultural values and moral codes. It takes the social context and unequal power relations as the starting point for a partisan cooperation with the affected women, which has implications for the understandings of disease and health, as well the therapeutic relationship and the applicable psychotherapeutic techniques. Mental burdens are understood as problem-solving strategies and coping patterns of those who had to find a way of dealing with mostly long-enduring violent excesses of all kinds. The therapeutic task lies in strengthening flexibility in applied coping strategies in order to avoid repetition of gender stereotypes.

Context orientation may also include political engagement of psychotherapists to help improve the legal situation of certain groups, such as those of refugees. Furthermore, context orientation calls for drawing on theoretical models such as those of Hobfoll to illustrate that access to and control over certain resources are not equally distributed, which in turn can have significant impact on the specific coping strategies that are available to a person.

Not all women affected by domestic violence need psychological or psychotherapeutic support in the processing of experienced suffering. Sometimes informal support systems are sufficient; sometimes the support of other professional groups is more paramount. Overall, the eradication of domestic violence requires a cooperation of different professional groups, whereas psychotherapeutic work can only be viewed as one piece of the puzzle. As the director of FRA, Morten Kjaerum sums it up in a nutshell: "Politicians and policy makers, stakeholders of civil

society as well as employees of the help system must therefore jointly and critically review their recent actions in order to tackle the problem of violence against women in every sector of society. The time has come to come up with a broad strategy to effectively combat violence against women" (FRA, 2014).

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