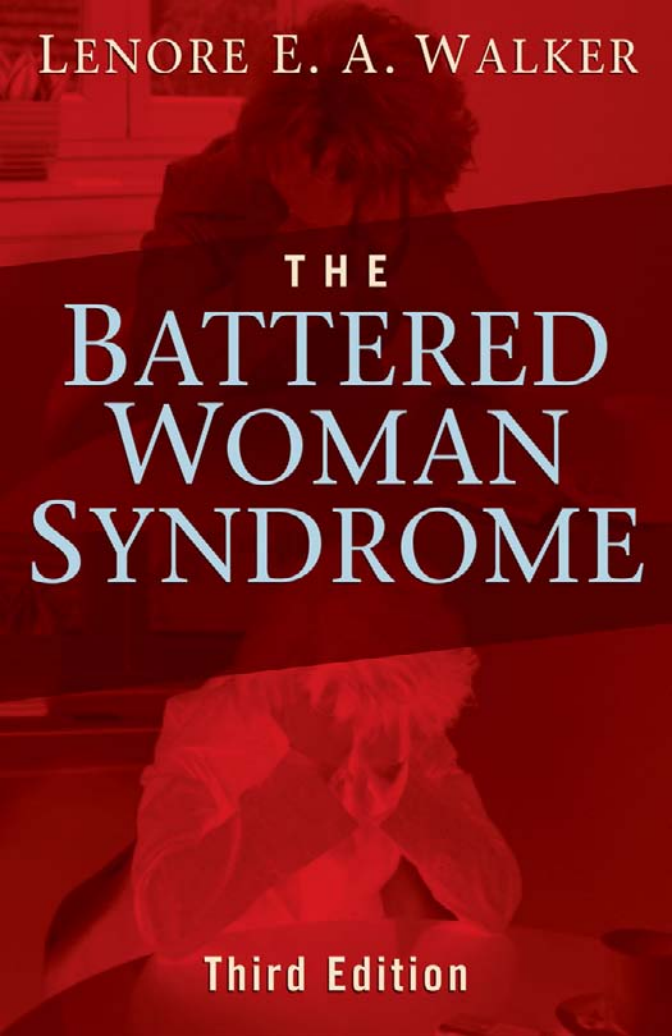
LENORE E. A. WALKER

THE BATTERED WOMAN SYNDROME



Third Edition

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EDITION

The Battered Woman Syndrome

Lenore E. A. Walker, EdD, is a Professor at Nova Southeastern University Center for Psychological Studies and Coordinator of the Clinical Forensic Psychology Concentration. She is also in the Independent Practice of Forensic Psychology. Dr. Walker specialized in work with victims of interpersonal violence particularly battered women and abused children. She earned her undergraduate degree in 1962 from CUNY Hunter College, her Masters of Science in 1967 from CUNY City College, and her EdD in psychology in 1972 from Rutgers, the State University in NJ. In 2004, she received a Post Doctoral Masters Degree in Clinical Psychopharmacology at NSU. She has been elected as a member of APA governance since the mid 1980's having served several terms on the APA Council of Representatives, on the Board of Directors, and President of several divisions including Division 35, the Society for the Psychology of Women; Division 42, Independent Practice; Division 46, Media Psychology, and on Boards and Committees such as the Committee on Legal Issues (COLI) and the Committee on International Relations in Psychology (CIRP).

She has worked on high publicity, and thus, high risk cases such as with battered women who kill their abusive partners in self defense and testifies on behalf of protective mothers who are being challenged for custody by abusive dads. She lectures and does training workshops all over the world about prevention, psychotherapy, legal cases, and public policy initiatives for abused women and children. Dr. Walker has authored numerous professional articles and 15 books including *The Battered Woman* (1979), *The Battered Woman Syndrome* (1984/2000), *Terrifying Love: Why Battered Women Kill & How Society Responds* (1989), *Abused Women & Survivor Therapy* (1994), *Introduction to Forensic Psychology* (2004, coauthored with David Shapiro), *Abortion Counseling: A Clinician's Guide to Psychology, Legislation, Politics, and Competency* (2007, coauthored with Rachel Needle), and *A First Responders Guide to Abnormal Psychology* (2007, with William Dorfman).

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EDITION

The Battered Woman Syndrome

With Research Associates

Lenore E. A. Walker, EdD

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Preface

When I wrote the first edition of *The Battered Woman Syndrome* in the early 1980s there were very few articles and no books that described empirical data about conducting research with battered women. There was a great deal of interest in learning more about domestic violence and although some were interested in the psychological theories, more wanted to hear directly from the women themselves. Our original research team had learned a lot about how to obtain reliable and valid data from the women and I wrote the first edition to share our knowledge. For example, we chose to ask both open-ended as well as forced-choice questions. These women had a lot to say and we wanted to capture it all in this first exploratory study. Over 4000 variables later, we learned an enormous amount of information about what living in a battering relationship was like for the women. We emphasized the areas that the original 400 women had in common and shared the numerous descriptive statistics to demonstrate what they said to compare them with each other. As we understood it would be as difficult for other researchers to obtain a matched sample of non-battered women as a control group, we explained how we solved that problem by using each woman who also had a nonviolent relationship to be her own control and used statistical techniques to manipulate the many variables that would help us develop those important comparisons. This turned out to be over half of the sample. At the time, this was considered innovative research methodology but today, holding variables constant with various statistical techniques is much more commonly used with large samples.

Fifteen years later, I wrote the second edition of the book, after there was much new research that supported our original conclusions. I used the same categories as in the first edition but integrated the newer data into the sections. I also

demonstrated that scientific support continued to exist for the theories I proposed earlier. Learned helplessness, despite its politically incorrect name, was one of the outcomes for women who remained in battering relationships. However, subsequently, even Martin Seligman who named the phenomenon from his earlier experiments in the laboratory, changed its name. First, learned helplessness became reversed or even prevented by learned optimism and then, it became part of the movement towards positive psychology. Despite the empirical data, there were political reasons for battered women advocates to dislike the name, learned helplessness, as it suggested these women who survived such horrendous abuse and violence were helpless, rather than the more accurate picture where these women survived but were unable to escape safely. Paradoxically, the concept of learned helplessness, which demonstrates how someone can lose the ability to perceive that their actions will have a particular outcome or in psychology terms, the loss of the contingent response-outcome paradigm, was one of the most useful concepts to help jurors understand how a battered woman could be driven to use deadly force against her batterer in self-defense. Many battered women who had an expert testify on their behalf and explain learned helplessness were found not guilty of murdering their abusive partners.

Battered woman syndrome also came under fire in the 1990s from feminist advocates who decided that the use of a syndrome to explain the psychological effects from battering was neither empowering nor able to explain all the symptoms that battered women could experience. They preferred to use a model that embedded the clinical symptoms within the environment that produced them calling it an ecological approach. This caused me to become interested in re-examining the construct of battered woman syndrome when I became a professor at Nova Southeastern University in 1998. I enlisted several graduate psychology students to work with me on revising the original Battered Woman Syndrome Questionnaire (BWSQ) and embedded newer standardized tests such as the *Trauma Symptom Inventory* and the *Detailed Assessment of Posttraumatic Stress* that assessed for Post Traumatic Stress Disorder (PTSD). Some of these former students whose work appears in this book are now practicing psychologists themselves are still writing together with me

such as Kate Richmond, Rachel Needle, Heidi Ardern, and Rachel Duros.

The preliminary results showed that the three clinical criteria for PTSD (reexperiencing the trauma, high arousal, and emotional numbing and avoidance) were associated with battered woman syndrome. But, three other criteria were also consistently occurring in our new samples of women: disrupted interpersonal relationships associated with the batterer's power and control and isolation of the woman, distorted body image and physical illnesses, and sexual issues. So, we added and developed scales to measure these areas, also. Once we had developed our improved BWSQ, we began to interview women in our local South Florida area and then, began to translate the BWSQ into different languages and interview women in other countries. We also went into the local jail as so many battered women were incarcerated there.

This third edition has dropped some of the statistical tables that were found in the other two editions and instead, has added statistical results where it helps to understand how battered woman syndrome is manifested in the new group of women interviewed. Each year new graduate psychology students were joining the research team, and analyzing data that were of interest to them. In some cases we were able to compare with the original data. In other cases, the data were based on the new scales and assessment instruments. Some of the categories are the same as the original areas but others are newer areas that emerged over the past thirty years.

The goal of this edition has been to integrate the newer scientific data about the lives of battered women and how it leads to the development of battered woman syndrome together with the literature on domestic violence. We added the emphasis on culture and ethnicity, looking at how country of origin and culture interact with the impact of domestic violence. We looked at the special situation of women in jail, learning that for many of them, being in jail was their first stable environment. And, in direct contrast to many of the advocates' messages, we emphasized the benefits of trauma therapy in helping some battered women heal from the psychological effects of their abuse. In most of the chapters, I acknowledge the contributions of the graduate students who so generously gave of their time and commitment while helping us all learn more about women who live with

intimate partners who use violence. Each of them has begun to use their newly developed knowledge to help victims of domestic violence while they practice psychology whether in an agency, in jails and prisons, in our colleges and universities, in our courts, or in the independent practice of psychology.

We hope that the information we present here is of use to stop the enormous toll that all violence against women takes on people all over the world.

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March 2009

Acknowledgments

The third edition of the *Battered Woman Syndrom*e or "the book" as we like to call it in our research laboratory at Nova Southeastern University Center for Psychological Studies (NSU CPS) has been a labor of love for all the graduate psychology students who have joined our research team in the past five years. As we have had over thirty students per year, there are too many to name individually. However, each of their contributions has been important to gathering and analyzing the data reported in the book. Some spent the many hours looking up and reviewing the latest research in our library system, now mostly on the internet data collections. Others drew the flyers that we passed out in the community to gain as representative a sample as possible. They helped fill out the myriad of forms needed to get Institutional Review Board permissions each year for the studies. They made copies of materials, stapled them together and then, removed all staples for those that were brought into the jails. They sat at the computer and tediously entered the data. They helped analyze the results and only some were able to present at conferences. We all laughed and cried when we would get together to share the stories told by the courageous women who participated in the study. I sincerely thank each and every one of the research assistants who worked together with us over these years.

There are a few of these researchers and now psychologists who I want to single out as they were driving forces behind the rest of us. Dr. Kate Richmond was one of the major sources of energy to help me revise the original research on Battered Woman Syndrome when she was a student at NSU CPS. She brought Dr. Rachel Needle into the group as she graduated and Dr. Needle continues to work with us as an adjunct professor now on the sexuality and body image areas. Dr. Needle and I took a side path together to publish

Abortion Counseling (Springer, 2007) while we were working on this research as we realized that many of the few women who had emotional difficulties after an abortion were abuse victims. This book presents a clear view of the politics and psychological research for mental health professionals.

After Dr. Richmond graduated, Dr. Rachel Duros took over organizing the data analysis and demonstrated how BWS was empirically a part of Post Traumatic Stress Disorder. Aleah Nathan coordinated data analysis when Dr. Duros graduated. Dr. Heidi Ardern organized the data collection section and when she graduated Allison Tome continued her work. Gretchen Lamendola and Ron Dahl assisted in developing the reference list. Rebecca Brosch has been our research link with the women in the jail while Kelley Gill, Crystal Carrio, Gillespie Stedding, and the rest of the women in the forensic practicum have organized the STEP program that has added such richness to our knowledge of the psychological impact of intimate partner violence on women.

The international friends that have been a part of my life remain some of my closest confidantes. Dr. Christina Antonopoulou, a Greek psychologist who I met at a Victimology meeting in Il Ciocco, Italy over twenty years ago remains one of my best friends. She is the Director of the Domestic Violence Institute of Greece and works on collecting data and training new psychologists there. We have traveled the world together. I have been friends with Dr. Patricia Villavicencio, a psychologist in Spain, since we met at a meeting of feminist psychologists in Amsterdam over twenty years ago. Dr. Villavicencio has also contributed to my thinking and some of her work with her colleagues is discussed in this book. Drs. Carmen Delgado and Mark Beymach from the University of Salamanca and the Catholic University in Salamanca where I've been teaching in their gender violence program, Dr. Jesus Melia from the University of Granada, and others in Spain have all contributed to our new understanding of the commonalities found in battered women in other countries. My good friend, the Honorable Saviona Rotlevy, a judge from Israel who we met at a meeting in Rome over fifteen years ago, helped rewrite the laws to reflect children's rights there, has helped keep me informed about the progress that the International Women's Judge's Association has been making in helping develop world-wide initiatives to keep women and children safe. Dr. Josepha Steiner, a social worker and good

friend from Israel has gathered data on battered women in that war-torn country where PTSD abounds. These are just a few of the fabulous people working to make life better for women and children all over the world.

The professional friends that I have met along this fantastic journey have filled my life with riches. I learn so much from the others I meet at each of the many conferences I have attended in the U.S. as well as all over the world. My women's writer group, W2W, a group of seven women who all have been strong leaders in psychology, have helped me to shape my own thinking over the years. Together with Dorothy Cantor, Carol Goodheart, Sandra Haber, Norine Johnson, Alice Rubenstein, and Karen Zager we spend time together percolating ideas for our books on psychology each year in wonderful places. Our first book together, *Finding Your Voice: A Woman's Guide to Using Self-Talk for Fulfilling Relationships, Work and Life* (2004) did not earn us a million dollars in money but working on it together certainly did create a million dollar bond of friendship. We tried our luck at the Kentucky Derby a few years later, but alas, although we had a fabulous time with the Kentucky Colonels we won just a few dollars on the horses. We all love our chosen careers in psychology and the ability to help our clients and other professionals make a better world.

I thank my wonderful friend and editor, Sheri W. Sussman, who has been with me since the first edition of the book was published by Springer. We grew up together over these past thirty years, laughing and crying with friends who are no longer with us, like Lillian Shein who was my first editor at Springer. Sheri has been so patient with my delays and the million excuses I've had that postponed the completion of the book. Through it all her vision has helped shape the manuscript although any errors are wholly my own.

The incredible work of my dear friend, the Honorable Ginger Lerner Wren, the first mental health court judge in the U.S. that opened in Broward County over ten years ago, has taught me so much about the intersection between mental health issues and domestic violence. She has taught us all about keeping the respect and dignity for those who have emotional problems and helping them take responsibility for their recovery. We need not be afraid of stigmatizing battered women by using the language of psychology, especially talking about PTSD and BWS, where it is appropriate. Instead

we must be vigilant against victim-blaming and infantilization of women who can heal from the terrors of domestic violence. The Honorable Richard Price from NYC began the arduous task of training judges to better understand battered women who come before them many years ago and continues this important work today. The Honorable Mark Speiser, who developed the Broward Felony Mental Health Court, has assisted in getting my students access to the court and jail.

And I've saved the best for last in thanking my dear life partner, Dr. David Shapiro, who has helped nurture me while I pulled together all this information and wrote all the chapters. He has been a source of strength and I love him dearly for all that we have built together as a dual career couple. Our children and grandchildren, who keep expanding bringing new partners and babies into our lives, have been a source of joy and inspiration. My brother, Joel Auerbach and his children, David, Jocelyn, and Rebecca add to our joy as does our entire family which is too large to mention all by name here. And finally, the biggest thank you and kiss for my wonderful 92 year young, mother, Pearl Moncher Auerbach, who helped shape my values and tenacity in working in difficult places.

Lenore Elizabeth Auerbach Walker
March 2009

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The Battered Women Syndrome Study Overview

Lenore Walker

Over the years, it has been found that the best way to understand violence in the home comes from listening to the descriptions obtained from those who experience it, whether victims, perpetrators, children or observers. Until the first large-sized empirical study reported in the first edition of this book, in 1984, accurate descriptions of the violence had been difficult to obtain from women as well as men, partly due to the effects of the abuse experience as well as feelings of shame and fear of further harm. This particular study pioneered in using methods that were rarely used by researchers thirty years ago, although these methods are quite common today. I learned these techniques from my earlier exploratory study published in a book for the general public, *The Battered Woman* (Walker, 1979). Women were given the opportunity to fully describe

their experiences in context, using what researchers call an "open-ended" technique combined together with "forced-choice" responses that prompted their memories and went beyond the denial and minimization that were the typical first responses. As a result, with a grant from the U.S. government, the study collected ground-breaking data that had never before been totally heard by anyone, including mental health and health professionals.

After almost 30 years, it seemed like it was time to revisit the information collected in the original study in 1978–1981. In 2002, with a Presidential Scholar Grant from the President of Nova Southeastern University, where I have been a professor, the main assessment instrument, called the Battered Woman Syndrome Questionnaire (BWSQ) that was used in the first study was modified. A team of graduate students worked together with me, discarding some of the questions that yielded less information and strengthening those questions that appeared to assist women in remembering their experiences with an abuser. One of the most important areas in the original study was whether or not there was an identifiable collection of signs and symptoms that constituted the "Battered Woman Syndrome" (BWS). New questions that were specifically designed to assess for BWS were added to the BWSQ as were several standardized instruments measuring trauma that were developed by others during the intervening years. The questions were developed with the understanding of battered women gained from observations and interventions with them over all these years. The attention paid to multicultural and other diversity issues in all aspects of psychology has increased during these years, so the new sample has included women from other countries who either live in their country-of-origin or in the U.S.

The understanding of domestic violence reported here was learned from the perceptions of the courageous battered women who were willing to share intimate details of their lives. The current study suggests that even though trauma and victimization is more widely studied today, it is still difficult for women to talk about their experiences, just as it was during the late 1970s and early 1980s when we first started collecting this information. The data from both the earlier and this recent study indicated that events that occurred in the woman's childhood as well as other factors

in the relationship, interacted with the violence she experienced by the batterer, and together they impacted upon the woman to produce her current mental state. The research demonstrated that psychologists could reliably identify these various events and relationship factors and then measure their impact on the woman's current psychological status. These results could then be utilized to formulate treatment plans or present as testimony in court cases involving criminal, civil, family, juvenile or other matters where the person's state of mind was at issue. Although the data we obtained supported the theories that I proposed at the time, it has become even more relevant today, over 30 years later, to recognize the robust nature of these findings that continue to be reaffirmed in subsequent research.

After analyzing reported details about past and present feelings, thoughts, and actions of the women and the violent and nonviolent men, the data led me to conclude that there are no specific personality traits that would suggest a victim-prone personality for the women (see also Brown, 1992; Root, 1992), although there may be an identifiable violence-prone personality for the abusive men (Dutton, 1995; Holtzworth-Monroe & Stuart, 1994; Jacobson & Gottman, 1998; Kellen, Brooks, & Walker, 2005; Sonkin 1995). From the woman's point of view, the batterer initiated the violence pattern that occurred in the relationship because of his inability to control his behavior when he got angry. There is still an ongoing debate in the field about whether the batterer is really unable to control his anger, as was perceived by the woman, or if he chooses to abuse her and therefore, is very much in control of where and when he uses violence. The women's reports of the man's previous life experiences indicated that engaging in such violent behavior had been learned and rewarded over a long period of time. The women in the first study who reported details contrasting the batterer's behavior with their experience with a nonviolent man further supported this view. Information about the batterer's childhood and his other life experiences follow the psychological principles consistent with him having learned to respond to emotionally distressing cues with anger and violent behavior. The high incidence of other violent behavior correlates, such as child abuse, violence towards others, destruction of property, and a high percentage of arrests and convictions support a learning theory explanation for domestic violence.

These data compelled me to conclude then, as well as now, that from the woman's point of view, the initiation of the violence pattern in the battering relationships studied came from the man's learned violent behavior. The connections between violence against women, violence against children, violence against the elderly, and street/community violence have been demonstrated in subsequent research (APA, 1996a; Walker, 1994; Cling 2004). Patterns of one form of violence in the home create a high risk factor for other abuse. Alcohol and other drugs appear to exacerbate the risk for greater injury or death. Men continue to use physical, sexual, and psychological abuse to obtain and maintain power and control over women and children, because they can. Violence works to get them what they want, quickly and with few if any consequences. Recent analysis of data from batterer treatment programs gives a very dismal picture of efforts to help offenders stop their abusive behavior (Fields, 2008). Thus, we must continue to study the impact of violence on women in the total context of our lives, to better understand its social and interpersonal etiology as an aid to prevent and stop violence. If this mostly male to female violence is learned behavior, and all the psychological research to date supports this view (APA, 1996a; Koss et al., 1994), we must understand how men learn to use violence, what maintains it despite social, financial and legal consequences, and how to help them unlearn the behavior.

New BWS Research

Since the original battered woman syndrome research was competed in 1982, the field has been most often studied by social policy, health and mental health scientists, students and professionals. In 1994, I was asked by the President of the American Psychological Association (APA) to convene a special task force composed of some of the most respected psychology experts in the area of family violence to review the research and clinical programs to determine what psychology has contributed to the understanding of violence and the family, including battered woman. Our goal was to prepare materials for policy-makers to aid them as they created social policy to stop and prevent all forms of interpersonal violence. This anti-violence initiative is still ongoing

in the Public Interest Directorate of the APA, continuing to publish materials (APA, 1995, 1996a, 1997). In fact, the 2008 APA President, Dr. Alan Kazdin, has chosen violence against women and especially domestic violence as one of the topic areas on which to focus in a presidential initiative.

Although we have much more data on the topic today, in fact, the conclusions I reached and stated in the 1984 and 2000 editions of *The Battered Woman Syndrome*, still hold up today, over 30 years after I first proposed them in 1977. Intimate Partner Violence (IPV), as battering of women, wives, or other intimate relationships is sometimes called, is still considered learned behavior that is used mostly by men to obtain and maintain power and control over a woman. Lesbians and gay men also engage in violence against their partners, but, the limited available research suggests that while there may be some differences in same sex violence from male to female heterosexual violence, its use to obtain power and control over one's partner is still primary. In particular, research has found less physical harm in lesbian relationships (Lobel, 1986; Renzetti, 1992) and more physical harm in brief but not long term gay male relationships (Island & Letelier, 1991). Our findings were that although racial and cultural issues might impact on the availability of resources for the victim, they do not determine incidence or prevalence of domestic violence (Browne, 1993; Browne & Williams, 1989; Gelles & Straus, 1988). New research looks more carefully at other cultural groups including African and Caribbean American women (Shakes-Malone & Van Hasselt, 2005) and is reported in a later chapter. Many factors appear to interact that determine the level of violence experienced and the access to resources and other help to end to violence. Although there are some who have designed intervention programs to help save the relationship while still stopping the violence (see below and Chapter 6), it remains a daunting and difficult task with only limited success (Harrell, 1991; Fields, 2008).

Batterer Intervention Programs

One of the most important facts we have learned about domestic violence is that it not only cuts across every demographic group we study, but also that both batterers and battered women are very different when they first come

into the relationship than when they leave. Although there are "risk-markers" for both men and women, increasing the probability of each group becoming involved in a violent relationship, the most common risk-marker is still the same one that the battered woman syndrome research study found; for men it is the exposure to violence in their childhood home (Hotaling & Sugarman, 1986) and for women, it is simply being a woman (APA, 1996a). Other studies have found that poverty, immigration status, and prior abuse, are also risk factors for women to become battered, although they are not predictive (Walker, 1994). We decided to conduct the same research with women who have come to live in the U.S. and were battered in their countries of origin in this latest round of data collection to help determine the relationship between the women's immigrant status in the U.S. and the abuse by her intimate partner.

New research on batterers suggests that there are several types of abusers. Most common is the "power and control" batterer who uses violence against his partner in order to get her to do what he wants without regard for her rights in the situation. Much has been written about this type of batterer as he fits the theoretical descriptions that feminist analysis supports (Lindsey, McBride, & Platt, 1992; Pence & Paymar, 1993). However, most of the data that supports this analysis comes from those who have been court ordered into treatment programs and actually attend them, which is estimated to be only a small percentage of the total number of batterers by others (Dutton, 1995; Hamberger, 1997; Walker, 1999). Recently, the dynamics of how power and control are used to terrorize and control women and children by men have been studied. O'Leary (1993) suggested that psychological control methods are separate but an important part of domestic violence while Stark (2007) has found that the techniques used by abusive men are similar when it comes to psychological coercion whether or not physical and sexual abuse are actually present.

The second most common type is the mentally ill batterer, who may also have distorted power and control needs but his mental illness interacts with his aggressive behavior (Dutton, 1995; Dutton & Sonkin, 2003). Those with an abuse disorder may also have coexisting paranoid and schizophrenic disorders, affective disorders including bipolar types and depression, borderline personality traits, obsessive compulsive disorders. Also, those with substance abuse

disorders may have a coexisting abuse disorder (Sonkin, 1995). Multiple disorders make it necessary to treat each one in order for the violent behavior to stop. As the intervention methods may be different and possibly incompatible, it is an individual decision whether to treat them simultaneously or one at a time. Usually, different types of treatment programs are necessary for maximum benefit whether or not the intervention occurs at the same time.

A third type of batterer is the "antisocial personality disordered" abuser who displays what used to be called psychopathic character flaws that are difficult to change. Many of these men commit other criminal acts including violence against other people making them dangerous to treat unless they are incarcerated. Dutton and Sonkin (2003) suggest that this type of batterer is a variant of men with an attachment disorder that produces borderline personality traits. Jacobson and Gottman (1998) suggest that there are actually two subtypes within this group. They call them "pit bulls" and "cobras." Pit bulls are the more common type who demonstrate the typical signs of rage as they become more angry. Cobras, on the other hand, become more calm, lower their heart rates, and actually appear to be more deliberate in their extremely dangerous actions. Women whose partners exhibit cobra-like behavior are less likely to be taken seriously as their partners do not appear to be as dangerous to others.

Understanding the motivation of the batterer appears to be quite complex, especially when consequences do not appear to stop his abusive behavior. Information gained from new research suggest that there may well be structural changes in the midbrain structures from the biochemicals that the autonomic nervous system secretes when a person is in danger or other high levels of stress. Fascinating studies of "cell memories" (Goleman, 1996; van der Kolk, 1988, 1994), changes in the noradrenalin and adrenalin levels, glucocorticoids, and serotonin levels (Charney, Deutch, Krystal, Southwick, & Davis, 1993; Rossman, 1998) all may mediate emotions and subsequent interpersonal relationships. The precise impact of these biochemicals on the developing brain of the child who is exposed to violence in his or her home has yet to be definitely studied. Obviously, this research is critical to our understanding of the etiology of violence and aggression.

High Risk Factors

Some reported events in the battered women's past occurred with sufficient regularity to warrant further study as they point to a possible susceptibility factor that interferes with their ability to successfully stop the batterers' violence toward them once he initiates it. It was originally postulated that such a susceptibility potential could come from rigid sex role socialization patterns which leave adult women with a sense of "learned helplessness" so that they do not develop appropriate skills to escape from being further battered. This theory does not negate the important coping skills that battered women do develop that protect most of them from being more seriously harmed and killed. However, it does demonstrate the psychological pattern that the impact from experiencing abuse can take and helps understand how some situations do escalate without intervention. While our data supported this hypothesis, it appears to be more complicated than originally viewed. This viewpoint also assumes that there are appropriate skills to be learned that can stop the battering, other than terminating the relationship. In fact, the data from the study did not support the theory that doing anything other than leaving would be effective, and in some cases, the women must leave town and hide from the man in order to be safe. Later, it was found that even leaving did not protect many women from further abuse. Many men used the legal system to continue abusing the woman by forcing her into court and continuing to maintain control over her finances and children.

Learned Helplessness and Positive Psychology

The concept of learned helplessness, one of the cornerstone theories in the original research, has continued to be refined through this and other research, despite its controversial name. As we have learned, and these studies confirm, battered women are not helpless at all. Rather, they are extremely successful in staying alive and minimizing their physical and psychological injuries in a brutal environment. However, in order to maintain their core self, they must give something up. The theory of learned helplessness suggests that they give up the belief that they can escape from the

batterer in order to develop sophisticated coping strategies. Learned helplessness theory explains how they stop believing that their actions will have a predictable outcome. It is not that they can't still use their skills to get away from the batterer, stop the abuse at times, or even defend themselves, but rather, they can't predict that what they do will have the desired outcome. Sometimes they use force that might seem excessive to a non-battered woman in order to protect themselves or their children.

In the intervening years since Seligman (1975) first formulated the theory of learned helplessness, his work has moved towards finding ways to prevent it from developing. He has concentrated his research in the area of positive psychology, teaching children and adults what he has called "learned optimism" (Seligman, 1990). In this era of empirically supported interventions, Seligman and his colleagues have provided new understanding of human resilience and the ability to survive such horrible traumatic experiences as family violence, terrorism and torture, wars, and catastrophic environmental disasters like hurricanes, floods, tsunamis, and earthquakes (Seligman 2002).

Sex Role Socialization

It was expected that battered women who were overly influenced by the sex role demands associated with being a woman would be traditional in their own attitudes toward the roles of women. Instead, the original data surprisingly indicated that the women in our study perceived themselves as more liberal than most in such attitudes. They did perceive their batterers held very traditional attitudes towards women, which probably produced some of the disparity and conflict in the man's or woman's set of expectations for their respective roles in their relationship. The women saw their batterer's and their father's attitudes toward women as similar, their mother's and nonbatterer's attitudes as more liberal than the others but less so than their own. The limitation of an attitude measure is that we still do not know how they actually behaved despite these attitudes. It is probably safe to assume that the batterer's control forced the battered women to behave in a more traditional way than they state they would prefer. From a psychologist's viewpoint, this

removes power and control from the woman and gives it to the man, causing the woman to perceive herself as a victim. It also can create a dependency in both the woman and the man, so that neither of them feel empowered to take care of himself or herself.

One area for further study is the relationship between the political climate in the woman's country where she currently lives and the frequency of, severity and impact from domestic violence. If women continue to hold more liberal attitudes towards women's roles and men become more conservative, it would interesting to know if a conservative political climate would put women at higher risk for being abused. It is known from other studies (Chesler, 2005) that women's behavior is more controlled by men in countries where there is state-sponsored violence or where fundamentalist religious values are the norm. It is difficult to tell if women have bruises under their burkas and veils and long modesty dresses. There are arguments from both sides about whether women in these countries, particularly those that subscribe to the Muslim faith, actually are free to make their own life choices, as they state, or if they comply because they have to obey if they choose to stay within the community.

Physical and Sexual Abuse as Children

Other events reported by the women that put them at high risk included early and repeated sexual molestation and assault, high levels of violence by members in their childhood families, perceptions of critical or uncontrollable events in childhood, and the experience of other conditions which placed them at high risk for depression. These are discussed in greater detail in the following chapters. At the time of the original research, we were surprised at the high percentage of women in the study who reported prior sexual molestation or abuse. Although the impact of having experienced sexual assault and molestation was consistent with reports of other studies, we, like other investigators at the time, tended to view victims by the event that we learned had victimized them, rather than look at the impact of the entire experience of various forms of abuse. Since that time it is clear that there is a common thread among the various forms of violence against women, especially when studying

the commonality of the psychological impact on women (Walker, 1994; Koss et al., 1994; Cling, 2004).

Finkelhor's (1979) and Gold's (2000) caution that seriousness of impact of sexual abuse on the child cannot be determined by only evaluating the actual sex act performed was supported by our data. Trauma symptoms were reportedly caused by many different reported sex acts, attempted or completed, that then negatively influenced the woman's later sexuality, and perhaps influenced her perceptions of her own vulnerability to continued abuse. Incest victims learned how to gain the love and affection they needed through sexual activity (Butler, 1978). Perhaps some of our battered women did, too (Thyfault, 1980a, 1980b). Gold (2000) has found that the impact of the other family patterns have equal if not greater impact on the effects of the sexual abuse on the child. These findings were consistent with reports of battering in dating couples studied on college campuses (Levy, 1991). The critical factor reported for those cases was the level of sexual intimacy that had begun in the dating couples. At the very least, the fear of losing parental affection and disruption of their home-life status quo seen in sexually abused children (MacFarlane, 1978) was similar to the battered women's fears of loss of the batterer's affection and disruption of their relationship's status quo (Janoff-Bulman, 1985).

The impact of physical abuse reported in the women's childhood was not clear from these data. Part of this difficulty was due to definitional problems that remain a barrier to better understanding of violence in the family. The women in this study were required to conform to our definitions of what constituted battering behavior, so we know that their responses about the impact of the violence were based on that definition. But, we do not know the specific details of more than four of the battering incidents they experienced. This makes it difficult to compare our results with other researchers such as Straus, Gelles, & Steinmetz (1980) who used different definitions of conflict behavior without putting events into the context in which they occurred. However, we do have details of over 1600 battering incidents, four for each woman in the first sample and many more in the new samples reported in this book. Our data indicated the women perceived male family members as more likely to engage in battering behavior that is directed against women. They perceived the highest level of whatever behavior they defined

as battering to have occurred in the batterer's home (often their own home, too), and the least amount of abuse to have occurred in the nonbatterer's home, in the first study. Interestingly, if the other man really was nonviolent, then the relationship should have had no abuse reported, not just the comparatively lower amount. This type of confound supports the need to be extremely precise in collecting details of what women consider abusive or battering acts.

The opportunity for modeling effective responses to cope with surviving the violent attacks but not for either terminating or escaping them occurred in those homes where the women described witnessing or experiencing abusive behavior. Certainly, the institutionalized acceptance of violence against women further reinforced this learned response of acceptance of a certain level of battering, provided it was defined as occurring for socially acceptable reasons, like punishment. Even today, those who work with batterers report that the men who do take responsibility for their violent behavior often rationalize their abuse as being done in the name of teaching their women a "lesson" (Dutton, 1995; Dutton & Sonkin, 2003; Ewing, Lindsey, & Pomerantz, 1984; Jacobson & Gottman, 1998; Sonkin et al, 1985; Sonkin & Durphy, 1982). This is dangerously close to the message that parents give children when they physically punish them "for their own good"or to "teach them a lesson." In fact, although the psychological data are clear that spanking children does more harm than good, the fact that it remains a popular method of discipline is one of the more interesting dilemmas (APA, 1995).

Alcohol and Other Drug Abuse

The abuse of alcohol and perhaps some drugs is another area that would predict higher risk for violent behavior. They are similar forms of addiction type behavior, with the resulting family problems that can arise from them. The clue to observe is the increase in alcohol consumption. The more the drinking continues, the more likely it seems violence will escalate. Yet, the pattern is not consistent for most of our sample, with only 20% reportedly abusing alcohol across all four acute battering incidents. It is important to note that the women who reported the heaviest drinking patterns for themselves were in relationships with men who also abused alcohol.

Thus, while there is not a cause and effect between alcohol abuse and violence, this relationship needs more careful study. We have begun looking at these details in the new research program. When looking at alcohol and other drug abusing women, there is a high relationship with a history of abuse. Kilpatrick (1990) suggests that prior abuse is the single most important predictive factor in women who later have substance abuse problems. Our work with women who have been arrested and found to have co-occurring disorders, who attend a mandatory residential facility, indicate that their treatment plan must include intervention for their substance abuse, for whatever mental health issues they may have, and for trauma. Without the trauma component, they will risk relapse. Mothers who abuse substances, especially during pregnancy, are almost all abuse victims (Walker, 1991). They too have not been receiving trauma-specific intervention even when they do attend substance abuse and mental health treatment programs.

Problems with the Learned Helplessness Theory

Learned helplessness theory predicts that the ability to perceive one's effectiveness in being able to control what happens to oneself can be damaged by some aversive experiences that occur with trauma. This then is a high risk for motivation problems. The perception of lack of self-efficacy can be learned during childhood from experiences of uncontrollability or noncontingency between response and outcome. Critical events that were perceived as occurring without their control were reported by the battered women and were found to have had an impact upon the women's currently measured state. Other factors such as a large family size also may be predictive of less perception of control. It seemed reasonable to conclude that the perception of learned helplessness could be reversed and that the greater the strengths the women gained from their childhood experiences, the more resilient they were in reversing the effects from their battering, after termination of the relationship. Those who have developed learned helplessness have a reduced ability to predict that their actions will produce a result that can protect them from adversity. As the learned

helplessness is developing, the person (a woman in the case of battered women) is motivated to choose responses to the perceived danger that are most likely to work to reduce the pain from trauma. Sometimes those responses become stereotyped and repetitive, foregoing the possibility of finding more effective responses. In classical learned helplessness theory, motivation to respond is impacted by the perception of global and specific attitudes that may also guide their behavior. It is important to recognize that their perceptions of danger are accurate; however, the more pessimistic they are, the less likely they will choose an effective response, should such a response be available. One of the criticisms of learned helplessness theory, in addition to the name of the theory that is not very specific to how battered women really behave with coping responses, is that there are very few effective responses available to the woman that will protect her and her children from the batterer's non-negotiable demands.

As was stated earlier, psychologist Martin Seligman, who first studied learned helplessness in the laboratory (1975), has now looked at the resiliency factor of "learned optimism" as a possible prevention for development of depression and other mental disorders (1991, 1994). When I first used the construct of learned helplessness to help explain the psychological state of mind of the battered woman, it was with the understanding that what had been learned could be unlearned. Many advocates who worked with battered women did not like the implications of the term, learned helplessness, because they felt it suggested that battered women were helpless and passive and therefore, invalidated all the many brave and protective actions they do take to cope as best they can with the man's violent behavior (Gondolf, 1999). However, once the concept of learned helplessness is really understood, the battered women themselves and others see the usefulness of it. It makes good sense to train high risk children and adults to become more optimistic as a way to resist the detrimental psychological impact from exposure to trauma. It is also important to recognize that many battered women who become so desperate that they kill their abusers in self-defense have developed learned helplessness, too. They reach for a gun (or, sometimes it is placed in their hands by the batterer) because they cannot be certain that any lesser action will really protect themselves from being killed by the batterer.

Although certain childhood experiences seemed to leave the woman with a potential to be susceptible to experiencing the maximum effects from a violent relationship, this did not necessarily affect areas of the battered women's lives other than her family life. Most of the women interviewed were intelligent, well-educated, competent people who held responsible jobs. Approximately one quarter of them were in professional occupations. In fact, they were quite successful in appearing to be just like other people, when the batterers' possessiveness and need for control was contained. Once we got to know them, we learned how to recognize the signs that this outward appearance was being maintained with great psychological cost. But battered women adopt behaviors in order to cover up the violence in their lives. The women who had terminated the relationship and were not still being harassed by the batterer, spoke of the sense of relief and peacefulness in their lives now that he was gone. The others still faced the high-tension situations on a regular basis. For most it seemed that severing the batterer's influence was one of the most difficult tasks for them to do. Unfortunately, separation and divorce usually did not end the man's attempts at continued power, control, and influence over the woman. In fact, the most dangerous point in the domestic violence relationship is at the point of separation.

Violence Prone Personality of Men Who Batter

Although the patriarchal organization of society facilitates and may even reward wife abuse, some men live up to their violent potential while others do not. Violence does not come from the interaction of the partners in the relationship, nor from provocation caused by possibly irritating personality traits of the battered women; rather, the violence comes from the batterers' learned behavioral responses. We attempted to find perceived characteristics that would make the occurrence of such violence more predictable. While a number of such perceived characteristics were identified, the best prediction of future violence was a history of past violent behavior. This included witnessing, receiving, and committing violent acts in their childhood home; violent acts toward pets, inanimate objects, other people; previous criminal record; longer time

in the military service; and previous expression of aggressive behavior toward women. If these items are added to a history of temper tantrums, insecurity, need to keep the environment stable, easily threatened by minor upsets, jealousy, possessiveness, and the ability to be charming, manipulative, and seductive to get what he wants, and hostile, nasty, and mean when he doesn't succeed, the risk for battering becomes very high. If alcohol abuse problems are included, the pattern becomes classic.

Many of the men were reported to have experienced similar patterns of discipline in their childhood home in the earlier study. The most commonly reported pattern was a strict father and an inconsistent mother. Their mothers were said to have alternated between being lenient—sometimes in a collusive way to avoid upsetting her own potentially violent husband—and strict in applying her own standards of discipline. Although we did not collect such data, it is reasonable to speculate that if we had, it could have revealed a pattern of the batterer's mother's smoothing everything over for the batterer so as to make-up for or protect him from his father's potential brutality. Like the battered woman, the batterer's mother before her may have inadvertently conditioned him to expect someone else to make his life less stressful. Thus, batterers rarely learn how to soothe themselves when emotionally upset. Often they are unable to differentiate between different negative emotions. Feeling bad, sad, upset, hurt, rejected, and so on gets perceived as the same and quickly changes into anger and then, triggers abusive behavior (Ganley, 1981; Sonkin, 1992, 1995). The impact of the strict, punitive, and violent father is better known today—exposure to him creates the greatest risk for a boy to use violence as an adult. Although we called for further study into these areas with the batterers and their fathers themselves over twenty-five years ago, such research is still not available.

Relationship Issues

There seems to be certain combinations of factors that would strongly indicate a high-risk potential for battering to occur in a relationship. One factor that has been mentioned by other researchers (Berk et al., 1983; Straus et al., 1980) is

the difference on sociodemographic variables between the batterers and the battered women. Batterers in some studies are to be less educated than their wives, from a lower socio-economic class, and from a different ethnic, religious, or racial group. In this study, while there was some indication that his earning level wasn't consistent and was below his potential, we felt that the factor was not as important a variable as others in domestic violence relationships. We looked at the different earning abilities between men and women, but since we didn't account for the difference in value of dollar income for different years, these data could not be statistically evaluated. We concluded that it is probable that these issues are other measures reflective of the fundamental sexist biases in these men that indicated their inability to tolerate a disparity in status between themselves and their wives. Perhaps they used violence as a way to lower the perceived status difference.

Marrying a man who is much more traditional than the woman in his attitudes toward women's roles is also a high risk for future abuse in the relationship. Traditional attitudes go along with the patriarchal sex role stereotyped patterns that rigidly assign tasks according to gender. These men seem to evaluate a woman's feelings for them by how well she fulfills these traditional expectations. Thus, if she does not have his dinner on the table when he returns home from work, even if she also has worked outside the home, he believes she does not care for him. Women who perceive themselves as liberal in their attitudes toward women's roles clash with men who cling to the traditional sex-role stereotyped values. They want to be evaluated by various ways that they express their love and affection, not just if they keep the house clean. If the man also has a violence prone personality pattern, the conflict raised by the different sex-role expectations may well be expressed by wife abuse.

Men who are insecure often need a great amount of nurturance and are very possessive of the women's time. These men are at high risk for violence, especially if they report a history of other abusive incidents. Most of the women in this study reported enjoying the extra attention they received initially, only to resent the intrusiveness that it eventually became. Uncontrollable jealousy by the batterer was reported by almost all of the battered women, suggesting this is another critical risk factor. Again, enjoyment of the

extra attention and flattery masked these early warning signs for many women. There is a kind of bonding during the courtship period that was reported which has not yet been quantified. The frequency with which the women, men, and professionals report this bonding phenomenon leads me to speculate that it is a critical factor. Each does have an uncanny ability to know how the other would think or feel about many things. The women need to pay close attention to the batterer's emotional cues to protect themselves against another beating. Batterers benefit from the women's ability to be sensitive to cues in the environment. At the same time they view the battered women as highly suggestible and fear outside influence that may support removal of their own influence and control over the women's lives.

Another factor that has a negative impact on relationships and increases the violence risk is sexual intimacy early in relationships. Batterers are reported to be seductive and charming, when they are not being violent, and the women fall for their short-lived but sincere promises. It seemed unusual to have one third of the sample pregnant at the time of their marriage to the batterer, although we had no comparison data then. We did not control for pre- and post-liberalization of abortion to determine how battered women felt about the alternatives to marriage, including abortion or giving the child up for adoption. Thus, then as now, we were unable to analyze these data further. However, in this new round of data collection, we have added several scales to measure sexual satisfaction, intimacy, and body image. The earlier research has suggested that sexual abuse victims have greater difficulties with their body image after the assault. We are in the process of assessing these factors to see how they relate to psychological impact after domestic violence.

Summary

It is interesting that we reported the findings from this study as "risk factors" long before the recent categorization of family violence in similar terms. Once it was established that family violence and violence against women was at epidemic or even pandemic proportions by U.S. Surgeon General Everette Koop (1986), violence began to be conceptualized as a public health problem that would be best understood

through epidemiological community standards. Planning intervention and prevention programs could use the criteria of "risk" and "resiliency" factors rather than thinking in more pathology terms of "illness" and "cure." One of the most interesting analogies comes from the public health initiative to eradicate malaria.

It was found that people would be less likely to become sick from exposure to malaria if they were given quinine as a preventive measure. So, strengthening the potential victims by prescribing quinine tablets was an important way to keep safe those who could not stay out of the malaria-infested area. Once it was learned that diseased mosquitoes carried the malaria germs, it became possible to kill the mosquito. However, unless the swamps that bred the malaria germs that infected the mosquito were drained and cleaned up, all the work in strengthening the host and killing the germ-carrier, would not have eliminated malaria—it would have returned!

So, too for domestic violence. We can strengthen girls and women so they are more resistant to the effects of the abusive behavior directed towards them and we can change the attitudes of known batterers so they stop beating women. However, unless we also change the social conditions that breed, facilitate, and maintain all forms of violence against women, we will not eradicate domestic and other violence—it will return!

Our data support the demand for a "war against violence inside and outside of the home." The United Nations has placed this goal as one of the highest priorities for its member nations in order to foster the full development of women and children around the world (Walker, 1999). It is a goal worthy of the attention of all who read this book today.

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History

Lenore Walker

With

Kate Richmond, Tanner House, Rachel Needle, and K. Bryant Smalley

Identification of battered women and protection of women and their families from all forms of men's violence had risen to a priority in the new women's movement beginning around the mid 1960s in the United States of America (U.S.) and other Western European countries. In the 1970s, the United Nations (UN) focused on the eradication of violence against women as one of the most important strategies for women to achieve equality with men. Sexual abuse, rape, sexual harassment in the workplace and the academy, sexual exploitation by men in authority and power positions, as well as violence against women and children in their own homes were the major topics discussed. Conferences were held, scientific papers were written, and by the 1995 Fourth UN Conference on Women held in Beijing, all member nations were required to present the results of their studies on the eradication of violence

against women in their nations. Yet, despite the knowledge that all forms of woman abuse create the atmosphere that damages women's self esteem and prevents them from reaching their full potential and equality with men, we still have not been able to stop men from abusing women.

Battered Woman Shelters

In the early 1970s, a British woman, Erin Pizzey (1971) began the first refuge or battered woman's shelter in Chiswick, England. Following the popular psychiatric beliefs of the times, Pizzey theorized that women liked the excitement and chaos that intimate partner violence caused in their lives. Although today's research, presented later in this book, does find that some women have issues with attachment to intimate partners, it is better understood as a result of the abuse they experience rather than a personality trait. An article by Pizzey, published in *Ms. Magazine* in the mid 1970s, describing her book, *Scream Quietly or the Neighbors Will Hear,* caught my attention and many others in the U.S. and around the world who were trying to understand why men battered women and how best to stop it. Battered woman shelters began to spring up all over the world giving the message to men that if they abused their intimate partners, then the community would protect and give them shelter. Although the early shelters, such as Pizzey's refuge, were more of a long term residential therapeutic community model than today's shelters that permit only a short term stay, each country began to develop methods of protecting women that were consistent with their own culture. Almost immediately, advocates were attacked for being against traditional values and for wanting to break up families. There was also backlash from feminists who believed focusing on the woman further victimized and blamed the victim for being battered.

Today, over 30 years later, the battered woman shelter remains the cornerstone of the movement to protect women and children from intimate partner violence. Feminist psychologists and other health professionals began to work together with advocates who were providing services at the shelter. Many mental health professionals helped begin shelters and services in their communities and served on advisory boards. Groups were formed for women who were

not in residence but still needed the assistance of others to normalize their experiences, safely leave the relationship, and remain violence-free. Nurses and doctors developed protocols for identification and protection of battered women who sought medical help whether in hospitals or doctor's offices. Social workers, psychologists, and other mental health professionals began to identify battered women and the explained their behavior through the concept of *masochism*. They implied that women somehow felt they deserved, and therefore, liked being abused. The outdated idea of masochism has now been exchanged for more relevant explanations of why women stayed in abusive relationships.

Although it was learned that men who abuse women do not let them go and are most likely to seriously harm or kill the woman if she tries to leave, the most frequently asked question continues to remain, "Why doesn't she leave?" Interestingly, we now know that leaving the relationship does not stop the abuse, as most batterers will continue to stalk and harass the woman throughout their lives. The family courts around the world encourage and facilitate the continued abuse by insisting that batterers can appropriately share parenting of children despite the data that demonstrates the emotional and sometimes physical and sexual harm to the children. Untrained mental health workers accuse protective mothers of attempting to alienate these fathers from their children without acknowledging the danger to both the children and their mothers. This is discussed further in Chapter 11.

One of the earliest analyses of intimate partner violence was done by Del Martin, a feminist activist who was a strong force in organizing the feminist reforms during the 1970s. Her voice at the Houston National Conference for Women in 1976, where I also attended as a delegate from Colorado, made sure that men's violence against women was a top priority on the women's agenda moving forward. Her book, *Battered Wives* was one of the first to alert the general public to the plight of women trapped in abusive relationships (Martin, 1976). Along with Martin's work, two other feminists's books had major impact on the work that followed. Susan Brownmiller, a social historian, wrote her seminal work *Against Our Will: Men, Women and Rape* in 1975. Historian Ann Jones published her seminal work on abused women, *Women Who Kill* in 1980. Brownmiller (1988) went on

to publish *Waverly Place* which questioned the role of abuse in the famous Hedda Nussbaum-Joel Steinberg relationship that resulted in the death of their not-quite-legally-adopted daughter, Lisa Steinberg, for which Steinberg served time in prison. Jones (1994) went on to publish other books in the field including *Next Time She'll Be Dead: Battering and How to Stop It.*

These important works, which greatly influenced my own thinking about women abuse, were also built on the feminist psychology put forth by Phyllis Chesler, one of the most important and prolific authors in the psychology of women who is still publishing books, articles, and now has a blog (http://pajamasmedia.com/phyllischesler). Chesler's (1972) seminal book, *Women and Madness,* detailed the societal abuse of women, many by their intimate partners and then by their doctors who kept women psychiatrically mummified with psychotropic medications that reduced their need and ability to complain. Chesler's later book, *Mothers on Trial* (1991) was the first major feminist work to question the negative bias against women in the family courts. Broverman, Broverman, Clarkson, Rosencrantz, and Vogel (1970) published research demonstrating how women were placed in a no-win situation by mental health professionals. These mental health professionals believed that the healthy man had the same characteristics as the healthy person, but those same characteristics indicated mental health problems for women.

Interestingly, Chesler's latest work has examined the nature of fundamental religion and its impact on controlling both women and men. In her book, *The New Anti-Semitism: The Current Crisis and What We Must Do About It* (2005), she describes the rise of anti-Semitism among the Muslim population, its demand for being politically correct, and how that contributes to the violence in countries such as Iran, Iraq, and Afghanistan. Chesler had been married to an Afghan man many years ago. She poignantly describes how she was held captive during what she thought was just going to be a visit with her husband's family. Finally she was able to escape with her life. Intermingling her own experiences with her keen observation of world events as they swirl around us daily, Chesler's blog, Chesler Chronicles, is fascinating literature that integrates violence in the home with violence in the world.

Chesler (2002) has also published a new book, *Women's Inhumanity to Women*, detailing the abuse between women, which she claims is at least as dangerous as that which men do to women, although the abuse is more emotional than physical or sexual in nature. Most of us who have worked in the feminist battered women's movement during this time understand that the Achilles heel of this movement is the insistence of a few that everyone subscribe to the exact same views, often dubbed as being "politically correct." When women disagree with some supposed truth or politically correct way of acting, they are personally 'trashed' or told that none of their views are important any more. This nasty behavior often drives women away from the feminist movement, rather than keeping them involved and debating the contradictory issues.

This occurred when I myself worked on the O.J. Simpson case. I became "persona non-grata", speaking contracts were cancelled, and positions on advisory boards of various groups, such as the Domestic Violence Hotline were rescinded. I discuss this phenomenon further later on in this chapter. Considering the fact that we haven't made much progress in stopping men's violence against women and the fact that many women talk about similar experiences when they didn't walk the party line, it seems that it is time to reexamine the so-called "feminist battered women's movement" and begin to determine if there are better ways of dealing with different or opposing opinions.

There were many topics on the feminist agenda almost 40 years ago that have yet to be resolved. These include the rights of women to control their own bodies including if and when they reproduce children, equality of women and men in the workforce with equal pay for equal work, removal of the so-called "glass ceiling" in the corporate world that only permits a few women to rise to the top, and freedom from violence in the community and in their home. Although as I write this book, voters in the primary elections for president of the U.S. have had the choice between a black man and a white woman, something unthinkable in the 1970s, race and gender still dominate the conversation and none of these agenda items have been resolved towards equality between women and men. All of these items have links back to men's violence against women. I recently co-authored the book, *Abortion Counseling: A Clinician's Guide to Psychology,*

Legislation, Politics, and Competency (Needle & Walker, 2007) to challenge the misinformation that is put out to the public by those who are opposed to women controlling their own bodies. While doing the research for the book, not surprisingly, I found that the few women who are at highest risk to have psychological issues post-abortion are those who are trauma victims and particularly, those who have been abused by their intimate partners or in their families-of-origin.

Battered Woman Advocates

In the U.S. 30 years ago, the battered women advocates attempted to take control of what loosely was called, "the battered woman's movement", away from the professionals. The tensions between the two groups, professionals and advocates remain today. Several reasons prompted this move including the proposal of financing the shelters through state and federal block-grant funding rather than mental health funding, which they had learned diverted monies designated for rape crisis counseling to other mental health needs in the community. Rape victims, the supposed recipients of that funding, were not given priority treatment as was the original purpose in the community mental health legislation of the 1970s.

Another reason was the desire by the government, supported by the feminist battered woman's movement at the time, to use the criminal justice system as the gatekeeper for intervention with batterers rather than focus on the woman who was the victim (Schechter, 1982). While this focus was appropriate in getting law enforcement and the criminal justice system involved in protection of women, it prioritized the focus on physical violence against women and minimized the impact from the psychological and sexual violence which continue to remain a major problem for women who are abused by intimate partners. Using the legal system also created the need to overcome many of the sexist barriers still there. Shafran (1990) and others have documented the extent of gender bias throughout the courts that still persists today, although not as visibly. In some countries where the public health system rather than the criminal justice system is the gatekeeper to all services, the psychologically abused woman gets more attention.

The psychological results of domestic violence have been the primary discussion in this book even though the

injuries from physical and sexual abuse of women remain a major detriment to women leading a full and satisfactory life. Interestingly, the Centers for Disease Control's (CDC) (2008) recent survey of the adverse conditions and health risk behaviors associated with intimate partner violence (IVP) or battered women, found that IVP causes 1200 deaths and 2 million injuries among women, and nearly 600,000 injuries among men according to a 2005 Behavioral Risk Factor Surveillance System survey. As a clinical and forensic psychologist, my research, clinical work, and experience in the courts have led me to conclude that exposure to abuse is traumatic for all women and therefore, some women may develop reactions that are consistent with the aftermath of trauma or Post Traumatic Stress Disorder (PTSD). I called these signs and symptoms Battered Woman Syndrome (BSW) over 30 years ago, before PTSD had been clearly defined in the diagnostic manuals. Although feminist politics sometimes have taken issue with BWS, in fact, the research data presented here demonstrates that BWS is measurable and continues to be present in many women who are abused by their intimate partners.

Relationships Between Advocates and Professionals

Unfortunately, battered women advocates and mental health professionals have not had a smooth relationship over the years. Advocates have been suspicious of professionally trained researchers and clinicians, often causing disruption of conferences such as occurred during the 1980s with the advocates displeased with the research presented at the New Hampshire conferences with Straus, Gelles and their colleagues. Advocates quickly label a professional who does not agree with their positions as unfriendly and uninvite them from participating in conferences or even on their publicly-funded advisory boards as was mentioned earlier. Many professionals who have worked in the battered women's movement have described being "trashed" which is a term used in the feminist movement when the person and not their work is targeted.

Professionals have also been guilty of creating suspicion of their motives by destructively challenging long held concepts as if co-existence of different theories cannot occur. In one prestigious publication another psychologist challenged

the concept of BWS in expert testimony without looking at primary sources or empirical data supporting its existence (Follingstad, 2003). A recent example occurred when old data were analyzed in attempt to "tear down the gender paradigm in favour of families", rather than simply stating that this researcher's analysis suggested men and women hit each other at similar rates (Nicholls, 2008). Immediately upon publication, the Internet listservs were ablaze with competing data from other scholars and advocates who moved the discussion away from finding answers to this complex problem and back to fighting with each other.

Another example occured after 1995 when advocates were angry with my participation in the O.J. Simpson trial. I was dismissed from a position on the national crisis helpline advisory board of directors, my theories were openly denigrated without appropriate scientific criticisms, and I was uninvited or not invited to participate in many conferences with funding from the same government sources that previously invited me. Although I tried to explain that forensic psychology called for reporting objectively, which could only help the cause of battered women, the emotional dislike for O.J. Simpson and belief that he had killed Nicole Brown and her friend, Ron Goldman outweighed any rational discussion. I was considered a heretic to the battered woman's movement for being hired to perform a forensic psychological evaluation of him to assist the attorneys and possibly the judge and jury in deciding if he was guilty of their murder. I stood fast on my own principles and eventually worked out a truce with both advocates and professionals.

Trashing

Trashing is a common phenomenon when working in the violence against women arena; the danger from abuse is so pervasive and the resources for protecting women are so limited, that there is no room for debate about what the best courses of action to take are. Unfortunately, this behavior on the part of both advocates and professionals continues to foster suspiciousness and often places those who work in this field into lonely positions. Considering the fact that men's violence against women is so pervasive and has such a long history, I believe we need every voice as an advocate. Dismissing people who could be helpful in one area even though they may not

agree in other areas seems foolish and counter-productive to the main goal, which is to stop men's violence against women. I never testified in the criminal trial and in the civil trial I made it clear that I believed O.J. was a batterer but that didn't automatically mean that he killed Nicole and Ron. Other evidence would be needed to make such a determination.

One result of this strong advocacy to protect battered women and their children has been the development of an opposition movement often contained in the fathers' rights groups who accuse battered women of alienating them from their children. They use non-scientifically validated terms such as Parental Alienation Syndrome and Psychological Munchausen-by-Proxy as part of their quest for attention in the courts. The anger and violence advocated by some of these groups can be seen in their websites on the Internet. Recently they have been filing grievances against mental health professionals who they claim are biased against men and are "breaking up families" with phony allegations of domestic violence and child abuse. As I write in later chapters, these different groups are working against each other rather than trying to find solutions to the big problem, causing major confusion in the human services, social welfare, and legal systems, and keeping violence against women and children from being stopped.

Interestingly, many battered women advocates who work in shelters or on task forces ultimately come to the opinion that they need more training in psychology to really be effective and they become professionals, themselves. Many of them come to those of us who are professors in training institutions and offer important insights from their experience working in shelters and community programs. But, the next group of advocates who take their places, usually young women eager to be helpful, don't trust them anymore than the former advocates trusted the group that came before them and went on to graduate schools, usually in mental health or law. They also drive away young men who must be part of the solution, too. Unfortunately, this schism between advocates and professionals makes it difficult for the professional psychologist to also be an advocate, as if there might not be room for both types of activities in one's professional life. I believe that it is the fertilization between the various viewpoints that helps better address the enormous problem domestic violence causes in people's lives.

US Funded & Congressional Actions

In 1978, Health and Human Services funded a meeting of ten battered women shelters that was held in Denver, Colorado, hosted by the interdisciplinary task force that formed the original National Coalition Against Domestic Violence the following year. The purpose was to identify models of protecting battered women that could be replicated elsewhere. Shelter advocates and government officials came together to plan a national strategy. U.S. Congress called for testimony that year to determine the direction of services to battered women. It was determined that the model for intervention should be primarily grassroots support with local programs encouraged to develop using funds set aside for training and employment opportunities. Advocates, not counselors were encouraged to provide services to battered women. The goal was not to further victimize battered women by pathologizing them. While this was an important policy decision, in fact, those battered women who needed competent mental health services did not always receive them.

The following year, similar funding brought Erin Pizzey to the US, and a large national conference was held in Denver where the National Coalition Against Domestic Violence was formed. This organization continues to provide information and resources about ending domestic violence. Also, in 1979, the US Civil Rights organization held a major conference in Washington, DC and another Congressional Committee took more testimony to assist the new Reagan government that was about to take office in planning its initiative to assist battered women. A Federal Committee that coordinated activities between the various governmental departments was also formed during that year. In the early 1980s there was more Federal activity with Congress encouraging both research and services to battered women. A conference in Belmont, Maryland where leading theorists and researchers into male offenders and violence against women were invited, set the stage for the development of "offender-specific" intervention programs for batterers that were funded through the Department of Justice. Interestingly, treatment for one type of batterer was encouraged as a pre or post adjudication diversion for men who battered women. However, the intervention was conceived as a psychoeducational program to change men's attitudes towards women which was thought to then

result in a change in their abusive behavior. Over the years it has proven to be an effective first step but not enough to get most men to completely stop their abusive behavior towards women. Harrell (1991) found that some men who went through these short, usually 6 to 12 week, programs actually became more effective at using psychological abuse when their physical abuse was stopped. Recent literature that is reported in Chapter 6 suggests that these offender-specific intervention programs are not as helpful as they were originally thought to be.

Later in the 1980s and 1990s, Congressional action encouraged major changes in the legal system to further protect battered women and their children. Laws were changed that facilitated women obtaining temporary and permanent protective orders that restrained their partners from making contact with them (Hart, 1988). Criminal prosecution of batterers was encouraged by providing law enforcement officers with training in the proper response to domestic violence calls. It was also encouraged with the adoption of pro-arrest policies which eliminated the need for the victim to sign an arrest warrant or even testify against the batterer who may have been engaged in loving behavior by the time the case was set for trial. Victim-witness advocates were hired by prosecutors' offices across the country as it was learned that with support, many more victims would testify against their abusers provided they were offered the option of diversion into batterer's treatment programs. Prosecutors' offices were redesigned for "vertical prosecutions" meaning one assistant prosecutor handled the case from start to finish rather than switching from intake to litigation prosecutors.

At the same time, battered women who killed their abusive partners in self-defense were legally able to obtain a fair trial with expert witness testimony to educate lay juries and judges as to the reasonableness of their fear of imminent danger when they defended themselves against the often escalating aggression from the batterer (Browne, 1980; Ewing, 1987; Walker, 1989). State by state, testimony on "Battered Woman Syndrome" was permitted, often after appellate decisions defined BWS to include the psychological effects of abuse, as well as the dynamics of the abusive relationship, which included the cycle theory of violence and the learned helplessness theory in some states. These cases are further discussed in Chapters 6 and 14. Women who did

not get the benefit of this testimony at trial and were serving long sentences, often life without parole in state prisons, were reexamined and clemency petitions filed with the governors and parole committees in many states. The women who have been released have gone on to live productive lives, proving the testimony that they were not murderers but rather, killed to save their own or their children's lives.

Sex Role Sterotypes and Mental Health

At the same time the interest was focused on domestic violence and other types of violence against women, mental health professionals were also examining the biases that sex-role stereotyping introduced into scientific research. As was stated earlier, in the early 1970s, the Broverman et al (1970) research on attitudes towards women demonstrated that professionals placed women in a double bind by finding that the healthy man but not the healthy woman was the same as the healthy person. Chesler's (1972) book, *Women and Madness* documented a different kind of abuse that mostly male mental health professionals engaged in to keep uppity women in their place, often by hospitalizing and over prescribing the then new psychotropic medications. Although less common today, some women continue to abuse these medications in order to bear the abuse in their homes.

The American Psychological Association (APA) and other mental health organizations began to identify the biases that occurred because of sex role socialization patterns during the 1980s and 1990s. The Association for Women in Psychology was founded in the early 1970s leading to the founding of the APA Division 35, Psychology for Women that is now the Society for the Psychology of Women. In 1980, the Feminist Therapy Institute was founded as a place where mental health professionals could obtain advanced training in feminist therapy. Adoption of one of the slogans from the feminist movement, "the personal is political" occurred, which reminded members that if one woman remains abused, all women are abused.

In 1985, when the American Psychiatric Association was about to revise the Third Edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, it became clear that the task force was considering two diagnoses that were filled

with the stereotyped bias, "Masochistic Personality Disorder" and "PreMenstrual Dysphoric Disorder." In neither case were there sufficient scientific data to support these diagnoses. After organized protests, both of these diagnoses were eventually dropped from the *DSM-III-R* and *DSM-IV* books but not without a great deal of controversy. Interestingly, the *DSM-V* is being prepared and rumors fly about the introduction of Parental Alienation Disorder as one of the more controversial new diagnoses being discussed. Meanwhile, the categories of "Post Traumatic Stress Disorder" (PTSD) and later on, "Acute Stress Reaction" (ASR) were added to the *DSM* where it became possible to diagnose women who demonstrated evidence of BWS as having a subcategory of PTSD. This is further discussed in Chapter 15.

Psychotherapy for Battered Women

In the 1980s it was determined that many of the battered women who were identified, especially those who obtained protective orders and those who came to shelters, were able to heal and get on with their lives with the help of a good support system. Often, advocate-facilitated groups run by the task forces and shelters were sufficient to help women normalize their experiences and reconnect with family and friends whose relationships were disrupted by the power and control and sometimes isolation from the batterer. However, some of those women who already have been identified with a mental disorder that is exacerbated by the abuse or those who develop BWS and PTSD from the abuse itself, may need some psychotherapy to help them heal and move on with their lives.

The most popular models of therapy to emerge include those supported by the feminist advocates who are not trained in the human services. These models of therapy include the prevention of intimate partner violence by encouraging the empowerment of women model, advocacy for social equality of women and men, and understanding that the responsibility for use of violence must be placed totally on the man because of his abuse of power and need for control over the woman. Therapy is not considered an important option in this model as this would label the abuse as the woman's issue because of her mental health problems. The non-feminist but human

services model advocates for a social services approach that emphasizes assistance to women and children, without attempting to destroy the family structure. This is most often favored by religious groups who advocate for the violence to stop without breaking up the family. Family systems therapists also support this model. This model places responsibility for the abuse as having a joint contribution and tries to teach the woman to be better at meeting the man's needs in order to lower his need to use violence to control her. Obviously, this model may reduce the violence but increases the man's ability to control the woman by giving him more power over her.

The feminist mental health professionals also support empowerment of women and responsibility placed on the batterer to change his abusive behavior. However, they add a PTSD and BWS treatment focus to help strengthen the woman and heal from the psychological impact from power, control, and dependency that comes from living with domestic violence. Non-feminist mental health professionals may support the feminist models but also focus on various other mental health diagnoses such as depression, borderline personality disorder, bipolar disorders, and engage in some intentional or non-intentional victim-blaming which suggests if the woman only would change, the abuse would stop.

Feminist politics have caused some feminist mental health professionals to abandon the PTSD and BWS models in favor of an ecological model that emphasizes the societal contributions to the intimate partner violence (Dutton, M., 1992). Corsi originally proposed the ecological model from his work in Argentina and the rest of Latin America but he has also kept the BWS and PTSD issues integrated within this model. His work with the batterers has created a curriculum that trains other mental health professionals to work in this field. Villavicencio has worked with her colleagues in Spain using a feminist mental health approach with women who have both BWS and PTSD and other more serious mental health diagnoses such as Bipolar and Major Depression and Borderline Personality Disorders. Her model for treatment of women who are hospitalized is discussed in Chapter 15. I have developed a model called *Survivor Therapy* which is a combination of feminist and trauma therapy and can be used with survivors of different forms of men's violence against women (Walker, 1994). In addition, I have designed the

Survivor Therapy Empowerment Program (STEP) which is a group treatment program for women who have been abused by men. These are also described later in this book in Chapter 15 and the STEP program used with battered women in jails in Chapter 16.

As trauma treatment begins to more clearly define itself (Briere & Scott, 2007) it becomes evident that a combination of feminist and trauma theories are needed to adequately address the psychological problems that battered women may face. Since many battered women have other concurrent problems such as having experienced rape and sexual abuse, substance abuse, organic brain syndromes, poverty and its deprivations, and medical issues, it is important to provide them with the appropriate interventions to help them heal. APA, as well as Newbridge Communications and Brunner/Mazel have each developed a series of videos where feminist therapy techniques can be viewed. Trainings are also offered through Continuing Education venues.

Child Custody and Access to Children

At the same time all these things were happening to try to better protect women from men's abuse, the family law courts at the urging of father's rights groups were lobbying to change the laws to permit them equal access to parenting their children. Unfortunately, many of these father's rights groups were led by men who lost their parental rights because of allegations that they were abusing their intimate partners and/or their children. The research data suggests that between 40% and 60% of men who abuse their intimate partners also physically, sexually, and psychologically abuse their children (Holden, Geffner, & Jouriles, 1998). Many of these men are demanding unsupervised access to their children, often as a way to avoid paying child support if they have equal parenting time with the children's mothers (Bancroft & Silverman, 2002). Unfortunately, this is occurring across the world with little recognition by the legal system that there are serious flaws in protecting "the best interests of the child" as is required by the law.

As was mentioned earlier, perusal of the Internet today will yield many such groups with hostile and angry messages against their children's mothers as well as advocates

for protection of children. In fact, there are groups opposing attempts to protect children from abusive fathers who target mental health professionals and file grievances against them in what is currently called a "mobbing" or "targeting" technique (Shapiro, Walker, Manosevitz, Peterson, & Williams, 2008). That is, they get together, and purposely target an individual to stop them from providing testimony against them. Although this is clearly illegal witness tampering, the legal authorities have yet to identify and stop them. In a recent hearing before the Maryland licensing board, they issued an apology to a psychologist who had six grievances filed against her, some by men whose children she had never even seen. The board proceeded to sanction this psychologist who refused to accept their findings that she did not follow the appropriate guidelines and violated the rules and regulations of the board. Instead, she took the case to trial and proved to the satisfaction of the hearing officer that she had been targeted by these individuals when she tried to protect the children from further sexual abuse. Shapiro, et al (2008) have dealt with helping mental health professionals to protect themselves from this attempt to chase competent professionals away from working with victims of this violence.

The issue of protective mothers has been an important one as mothers are losing custody of their children when judges do not believe that the children are in danger of abusive fathers. The issue seems to be focused on allegations of sexual abuse of children as it is often difficult to gather evidence other than reports from the child. Many of these children are too young to withstand the cross-examination by attorneys and methods of protecting them while preserving their testimony seem to be conflicting with the accused persons' right to confront their accusers. Meanwhile, protective mothers are punished by courts that become angry when they do not obtain sufficient evidence to legally prove their cases. In some cases, protective mothers appear to overstate their case or manipulate the children into making statements that lead courts to mistrust their credibility. While this occasionally may occur, in fact, most of the time these mothers are simply not listened to because most people do not want to believe that a father could do such terrible things to his own child. As a result, these children go unprotected and their attachment and relationships with both parents become damaged by the court.

Mothers are often forced to continue a relationship with the batterer by the family court that does not permit them to relocate with the children so that they are all protected from the father's stalking and use of the children to continue his surveillance and abuse of the mother. Shared parenting plans with children forced to negotiate two totally dissimilar parenting styles do not benefit them. The presumptions of joint custody in the law today keep battered women from being able to move on with their lives (Saccuzzo & Johnson, 2004; Saunders, 2007). The Leadership Council (www.leadershipcouncil.org) along with other organizations maintain information on their websites to educate those who provide assistance to the courts so that professionals can take advantage and become informed.

Teen Violence

Another issue that has been raised over the years without adequate intervention is the role teen violence plays in perpetuating domestic violence into the homes of the next generation. Straus et al., (1981) research data demonstrated how boys who were exposed to domestic violence in their homes were 700 times more likely than those who were not exposed to use violence in their own homes while boys who were also abused themselves raised the risk to 1000 times those who were not (Kalmuss, 1984). Yet, as mentioned above, courts continue to place children with batterers despite the problems with their power and control issues that negatively impact parenting (Saunders, 2007).

It should be no surprise then that "physical dating violence" (PDV) has been found to impact almost 1 in every 11 adolescents according to the 2005 National Youth Risk Behavior Study (Masho & Hamm, 2007). Over 12,000 youth, about evenly divided between males and females, were surveyed with approximately 10% of each group reporting being victims of PDV. This rise in violence used by girls, as well as violence used by boys, in dating relationships is comparable to the rise in violence used by teenage girls who have been arrested and placed in detention centers. As is described later, a study in one detention center found high scores on assessment measures of PTSD and family violence although these girls did not report exposure to violence in

their homes during clinical interviews. In the 2005 National Youth Risk Behavior Study, both boys and girls engaged in current sexual activity, alcohol use, physical fighting, sexual victimization, and suicidal thoughts were at higher risk to be engaged in a PDV relationship, while boys who used illicit drugs and girls who had a poor body image were also at higher risk.

Summary

The history of society's newest interest in the eradication of violence against women and children demonstrates both the intricacies of the problem and the difficulties in dealing with it. Although shelters do provide safety for only a small number of women and children, their presence in a community sends a message about zero tolerance for such abuse. Expensive to run, shelters and advocates must continue to battle for funding from politicians in national and local positions along with other worthy causes. The attempt to professionalize the interventions for battered women have included positive changes in both legal and psychological delivery systems. However, advocates and professionals still do not regularly work well together especially when there are political or personal differences.

The problems yet to be solved include:

- Some battered women are harmed by the abuse and want or need psychotherapy.
- Treatment goals become fuzzy and feminist therapy models are rarely used.
- Forensic testimony is not accepted within the criminal, civil, family, and juvenile courts without a diagnosis and is sometimes rejected or ignored even with a diagnosis.
- Many battered women are losing custody of their children when they attempt to protect them from exposure to an overcontrolling and abusive parent.
- Constant battles occur with other diagnoses without empirical support being offered and accepted by the uninformed courts such as Parental Alienation Syndrome or Psychological Munchausen by Proxy.

- Advocates working in shelters and other programs are entering into graduate schools wanting more information about psychological theories; feminism is not as attractive to them as is the lure of psychodynamic and other theories.
- There is less support in mental health community for the feminist model, perhaps because of the feminist advocate trashing of professionals who teach and supervise students.
- There is growing distance between advocates and professionals rather than a coming together to solve the common problems.

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3

What is the Battered Woman Syndrome?

With

Rachel Duros, Heidi Ardern, Colleen McMillan, and Allison Tome

The term, Battered Woman Syndrome (BWS), was first used in 1977 as the title to my U.S. National Institute of Mental Health (NIMH) funded research grant that collected data on over 400 self referred women who met the definition of a battered woman that formed the basis for this original research. The details of the original study were reported in the previous editions of this book and only a summary will be repeated here (Walker, 1984; Walker, 2000). Although the term BWS appeared prior to the addition of the diagnostic category, Post Traumatic Stress Disorder (PTSD), in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III)(APA, 1980),* the theoretical basis upon which the BWS was developed was similar to what later became known as PTSD. Over the years since then, BWS has been used in the psychological literature as a subcategory of

PTSD, but, until now, it was never empirically demonstrated to have the same or similar criteria. Despite its popularity in clinical and forensic psychology, and its similarity to trauma theory, until now BWS had not been subjected to the scientific analysis provided by this current research. The lack of testable hypotheses permitted a small group of advocates, who feared the stigmatization that may accompany labeling, to raise questions about the existence of BWS as a syndrome or collection of psychological signs and symptoms that often occur from the same cause (APA, 1980; APA, 2000).

BWS, as it was originally conceived, consisted of the pattern of the signs and symptoms that have been found to occur after a woman has been physically, sexually, and/or psychologically abused in an intimate relationship, when the partner (usually, but not always a man) exerted power and control over the woman to coerce her into doing whatever he wanted, without regard for her rights or feelings. As there are significant differences between the theory underlying the construct of BWS, and there are no empirically-supported data yet, it has not yet been applied to battered men. Therefore, the term used is BWS rather than a gender-neutral Battered Person Syndrome (BPS) or even Battered Man Syndrome (BMS). Of course, men are abused by women but the psychological impact on the man does not appear to be consistent with trauma in most cases. This will be further discussed in Chapter 6.

The research has now demonstrated that BWS has six groups of criteria that have been tested scientifically and can be said to identify the syndrome. The first three groups of symptoms are the same as for PTSD while the additional three criteria groups are present in intimate partner victims (IPV). They are:

1. Intrusive recollections of the trauma event(s).
2. Hyperarousal and high levels of anxiety.
3. Avoidance behavior and emotional numbing usually expressed as depression, dissociation, minimization, repression and denial.
4. Disrupted interpersonal relationships from batterer's power and control measures.
5. Body image distortion and/or somatic or physical complaints.
6. Sexual intimacy issues.

These six areas are more fully described later in this chapter.

Post Traumatic Stress Disorder

Although all forms of trauma are identified by the same three groups of signs and symptoms using the *DSM-IV-TR* (APA, 2000) criteria, in fact, there are differences between the different types of trauma that occur. For example, traumatic events that only occur one time, such as environmental catastrophes like the tsunami in the far east, Hurricane Katrina in New Orleans and the gulf coast of the United States, or the major earthquake in Pakistan; or disasters such as the hostile events of September 11, 2001, when airplanes crashed into the World Trade Towers in New York City and a part of the Pentagon in Washington, D.C. causing the buildings to collapse, killing thousands of people, an airplane crash killing hundreds, or a terrorist bomb causing fire in the main train station in Madrid, Spain, all produce similar psychological effects in people who have experienced some part of the event even if they were not at the site when the disaster occurred. The event is usually experienced as unexpected, out of the person's control, and causes disruption to how a person may think, feel, or act. One time traumatic events such as physical or sexual assault by strangers may also produce similar psychological impact. Repeated traumatic events, such as soldiers who are at combat sites in Iraq, children who are physically or sexually abused by people who show them love, and those who are battered by intimate partners, also experience similar psychological impact although those who know who the enemy is, such as soldiers, do not develop the same type of coping strategies as do victims of child and intimate partner abuse where the enemy is also their loving protector at times.

Physical, sexual, and psychological abuse that occur in families or with intimate partners have their own special characteristics that go beyond those seen in the typical PTSD. The fight or flight response to danger can be seen in each of the different types of trauma responses. For example, when the person taking a walk sees a lion, he or she becomes physiologically and psychologically aroused

and wants to protect himself or herself, and if possible, that person runs away from the lion. The autonomic nervous system that controls our emotional responses becomes activated producing sufficient cortisol, adrenalin, and other neurochemicals to help activate the nervous system so it responds to the threat of danger. The response to traumatic events is similar. We call events that can evoke this response in people, "trauma triggers." The trauma triggers will have to be desensitized during trauma-informed treatment because they continue to cause the trauma-response long after they are no longer present as they are reexperienced in the person's mind and produce all the same emotions, as if they were reoccurring. Trauma therapy is further discussed in Chapters 14, 15 and 16.

When domestic violence events occur and reoccur, the woman recognizes the man's escalating anger and she becomes physiologically aroused with fear that activates the autonomic nervous system to release its neurotransmitters and hormones that then produce hyperarousal. Then she assesses the threat, and decides whether to cope with the problem or flee, which in this case means physical or psychological escape. Women who have been abused repeatedly learn to develop good coping strategies that usually occur as a tradeoff to escape skills. Therefore, the typical fear or trauma response of the battered woman triggers her to become hyperaroused and then, to psychologically escape using a variety of methods including minimization or denial of the danger from the particular incident, depression, dissociation, or even repression and forgetting. The psychological escape, then, can include minimization or denial of the danger reducing fear, repression, depression, dissociation, or a combination of these automatic psychological processes that are further described in the later chapters. These are avoidance responses that protect the woman from experiencing the full blown trauma response. The trauma responses are mediated by the autonomic nervous system and not consciously employed, at least initially. In repeated traumas, such as domestic violence or child abuse, where the person does not believe he or she can escape, a pattern is established that permits coping with a minimum of emotional pain. The lack of belief in the ability to escape is part of the "learned helplessness" response that is further discussed in Chapter 4.

DSM IV-TR Criteria for PTSD

There are three sets of psychological signs and symptoms that are required to make the diagnosis of PTSD using the *DSM-IV-TR*. In addition, there are three threshold criteria that must be met in order to consider this diagnosis. The threshold criteria are:

1. The person must experience a traumatic event that includes fear of personal bodily safety or death.
2. The after effects of that experience must last for more than four weeks. If less than four weeks, then it is diagnosed as an Acute Stress Reaction.
3. The after effects must impact on some important part of the person's life such as job performance, school, or social relationships.

As can be seen, most battered women, especially those who believe that the batterer can or will kill them, would meet these three criteria here. Even those women who are not physically harmed often fear that the batterer can and will hurt them worse if they do not do whatever the man demands. In some cases, the women do not feel the full extent of their fear until later, even after the relationship has been terminated. This is similar to the delayed PTSD that may be seen in soldiers who do not develop symptoms until many years later when another incident occurs that triggers the memory of the same fear they may have repressed when the first trauma occurred. This is commonly seen in child sexual abuse victims who knew what was happening to them (such as those abused by clergy) but did not experience the full PTSD symptoms until later in life when they were adults.

The second set of PTSD criteria, paraphrased from the *DSM-IV-TR* (APA, 2000) include three different groups of psychological signs and symptoms:

1. The person must reexperience the traumatic event(s) in a variety of ways that include intrusive memories, nightmares, night terrors, day dreams, flashbacks, and physiological responses with or without exposure to the same stimuli.
2. The person has a hyperarousal response that includes anxiety reactions, crying, sleep or eating problems,

hypervigilance to further harm, exaggerated startle response, and other fearful responses.
3. The person has a numbing of emotions and wherever possible avoids making things worse. These avoidance responses may take the form of depression, dissociation, denial, minimization of fear or harm, decreased activities, isolation from people or other indications that their lives are being controlled by another person.

A series of analyses of the data collected using the Battered Woman Syndrome Questionnaire (BWSQ) is described below.

Empirical Support for BWS

Data Collection

In the original study, there were several different ways used to collect data about the actual abuse experienced by the women. First, a set of criteria needed to be met to establish eligibility to participate in the study. The following were the criteria used in both the original and the current study:

- Excessive possessiveness and/or jealousy
- Extreme verbal harassment and expressing comments of a derogatory nature with negative value judgments ('put-downs')
- Restriction of her activity through physical or psychological means
- Nonverbal and verbal threats of future punishment and/or deprivation
- Sexual assault whether or not married
- Actual physical attack with or without injury

Although in the original study we wanted to interview women who had experienced at least two physical attacks, whether or not they were injured, to assess for the rise in psychological impact and learned helplessness, in the current research we were not as strict about physical abuse. It has been demonstrated that for most women the psychological abuse is the most significant part of the relationship and causes the most unforgettable painful

moments. However, even realizing the devastating power of psychological maltreatment, most women do not consider themselves battered unless they have been physically harmed. This is also true for women who have experienced severe sexual abuse as we discuss in Chapter 8.

Methodology of BWSQ Revisions. The BWSQ #1 that was used to collect the data analyzed in the original study was a 100-page questionnaire with forced-choice and open-ended questions that took over six hours to administer in a face-to-face interview with a trained interviewer and the volunteer subject. Embedded in the BWSQ #1 were questions to collect information about a non-violent relationship that approximately half (200) of the 400 women reported. Also embedded were several well-known research scales. Over 4000 variables were available for analysis but not all could be analyzed due to constraints on time and money. Over 400 self-referred women were evaluated in a six-state region of the U.S. Details of this research and the results have been published in the first two editions of this book (Walker, 1984; Walker, 2000).

In the current research, the BWSQ #2 was developed, after several pilot data collections helped eliminate variables that did not adequately discriminate (Richmond, et al, 2003). Then, scales were developed that measured the constructs that appeared to hang together using simple regression analyses. To measure the validity of the scales (and the theories), standardized tests and other assessment instruments were embedded in the BWSQ #2 and analyses were done comparing the scales with these assessment instruments. Controls were provided by the groups from the standardized tests. The interviewers were trained and a multi-site, multilingual, and multi-country data collection was begun in 2003. Each student interviewer completed a thorough standardized training prior to their acceptance as an interviewer and received a copy of the manual for future reference (Walker, Arden, Tome, Bruno, & Brosch, 2006).

To assist in uniformity of data collected, a written manual for interviewers was prepared and like the BWSQ #2, was translated into the appropriate languages (Walker, Arden, Tome, Bruno, & Brosch, 2006). Translations were done either by professional translators or graduate students in psychology from the country in question and then, translated back

into English from the translated version so as to check on veracity. In some cases, it has been necessary to slightly change the wording of a question in order to tap the actual data in a particular country. For example, in Russia the term *substance abuse* is less frequently used while *drug and alcohol abuse* would be the more accurate translation. In Trinidad we changed *spanked* to *got licks* to make sure interviewees understood the questions about childhood discipline and abuse. There are statistical techniques that have been used in some analyses to account for these slight variations in data groups as described below in the PTSD study (Duros, 2007).

In this chapter, the validation of the theory of PTSD and BWS is discussed and in the subsequent chapters, various analyses of other variables have been described and discussed. Some analyses utilized the subjects from the four initial countries; the U.S., Russia, Greece, and Spain. Other analyses utilize one or more countries as the data has been collected. The research project is still underway with recruitment continuing in the above countries and data also beginning to be collected in various other countries as described in Chapter 12.

Demographic Data. The two study groups were comparable on some demographic items but not on others. A beginning analysis is shown in Table 3.1.

As can be seen in this Table 3.1, the population is somewhat different in demographics. It is possible that some groups of women who had been battered previously now have received protection from the new community measures taken to deal with domestic violence. However, the differences seen could be expected for several reasons. First, the data are still being collected and therefore, those that have been evaluated were from a convenience sample without correctional factors to make sure that the sample is stratified or equal to the percentage of demographic and especially ethnic groups in the community from which they are collected as was done in the original research.

A second reason could be because the sample is cross-national, from several different countries, so that these demographic groups do not make as much sense in some countries as in the U.S. For example, the breakdown of racial and ethnic groups is different in other countries. This is why the "other" column contains 40% of the population studied.

3.1 Socio-Demographic Data for Battered Women

Demographic Variable	Original Sample N	Original Sample %	Current Sample N	Current Sample %
Racial and Ethnic Group:				
White/Caucasian.....	321	80	46	43
Hispanic/Latina.....	3	8	9	9
Black/African.....	25	6	9	9
Native Indian.....	18	4	2	2
Asian/Pacific Islander.....	1	0	1	1
Other……....	4	1	39	37
Marital Status:				
Single…….….....	26	6	29	27
Married/Living together...	103	24	21	20
Separated/Divorced….....	261	65	48	45
Widowed…….……..	11	3	8	8
Education:				
Less than High School.....	66	12	29	27
High School Only……..	99	25	42	40
Some College……...	160	40	17	16
College & Post Grad….....	92	23	10	10
Mean Years of Education:	12.7 Years		12.11 Years	
Mean Age:	32.2 Years (Range: 18–59)		38.07 Years (Range: 17–69)	
Mean Number of Children:	2.02 Children (Range: 0–10)		1.79 Children (Range: 0–8)	

After we looked at these statistics, we changed the ethnic categories to better reflect the international demographics. For example, in Spain most of the "other" category included women who had immigrated to Spain from nearby countries such as Morocco and Algiers. A third reason is also due to the difficulty in comparing different national samples. Although the mean years of education are comparable (12.7 years in the original sample with 12.1 years in the current sample), in fact twice as many women in the new sample completed less than a high school education, with fewer still completing some college or post graduate school. Access to education is different in countries other than the U.S. More women called themselves single rather than separated or divorced in the current sample but it is not known if they really were never married or if there was simply a misunderstanding of how the terms were to be used when translated.

Profile of Battering Incidents. In the original study, we analyzed details about the four specific battering incidents that were not reanalyzed in the current study. These include months when abuse was more likely to have occurred, days of the week, and time of day. We found that abusive incidents were pretty evenly spread out over the twelve months of the year with perhaps a slight rise in incidents in the hotter months. This is consistent with a slight rise in other crime statistics during the summer months. Weekends were the most likely days for abuse to have occurred, perhaps reflecting the amount of time spent at home and away from work. Evenings were the most likely time for a battering incident to have occurred, again perhaps reflecting the time couples spend with each other.

Battering incidents were most likely to start and stop at home, often starting in the living room, kitchen or bedroom and ending in the same room in which they started. Interestingly, if the incident did not start at home, the most likely place was a public setting or someone else's home. This corresponds with some women's descriptions of fights that start because of the man's jealousy of attention she pays to others. It also corresponds with some who describe picking a fight with the batterer in front of other people to minimize the harm from his angry explosion. These women know that the tension is so high that the acute battering incident will occur no matter what they do and they have learned the

best protective behaviors. These responses were intuitive, corroborated by police reports and other research, and so, we felt that it did not need continued investigation in the current study.

Details of Four Battering Incidents. As in the original study, the interviewers collected details about four specific battering incidents that the women could remember. This included the first incident they could remember, the last battering incident before they were interviewed, the worst or one of the worst incidents if the last one was the worst, and a typical battering incident. Data were collected using both open-ended and forced-choice questions. This method was found to yield the most useful information about battering incidents in the original study and continued in the current study to provide the richness of information expected. Ardern (2005) analyzed some of the open-ended responses using qualitative methodology while Duros (2007) analyzed the data gathered from the forced-choice responses together with the PTSD checklist and the Briere (1995) *Trauma Symptom Inventory (TSI)*.

PTSD Analysis

The initial data from the current study, using the BWSQ #2, were subjected to analysis to determine if the women reported signs and symptoms consistent with the diagnosis of PTSD using the criteria from the *DSM-IV-TR*. Duros (2007) compared 68 women's responses on the details of the psychological, sexual, and physical abuse from the four battering incidents reported, their responses on the PTSD checklist and their results on the standardized test, *TSI* (Briere, 1995) that was embedded within the BWSQ #2. In the more recent version, the *Detailed Assessment of Postraumatic Stress (DAPS)*, also developed by Briere (2001) is also included as this test actually gives a PTSD score in addition to measuring the various components of PTSD from specific incidents reported. The TSI measures the clinical scales that make up the PTSD diagnosis in general. For this analysis, Duros utilized the scales that measured anxious arousal, depression, intrusive experiences, defensive avoidance, dissociation, tension reduction behavior, and impaired self reference. As their titles suggest, these scales are consistent with the PTSD criteria used to make the diagnosis.

Using a standardized linear regression analysis between the total number of PTSD symptoms endorsed and the four battering incidents and followed by a logistic regression analysis to assess prediction of endorsement of necessary PTSD criteria based on the psychological, physical and sexual abuse present in the four battering incidents, Duros (2007) found PTSD in the linear and logistic regression results. An interesting statistical technique utilized in the analysis was a *factorial invariance*, which is designed for multi-group comparisons, in order to ensure that a given construct, in this case PTSD, is measured in exactly the same way across different groups. The procedure does this by accounting for and assuming an error, such as translation or adaptation issues in the different versions of the BWSQ. With this procedure, a higher confidence level is established that potential differences between groups, or in the case of the present study, lack thereof, can be interpreted as a truly reflective measure of variability in PTSD.

The results can be seen in Tables 3.2, 3.3, and Figure 3.1.

In general, the criteria that would require a diagnosis of PTSD were found in the samples used. No significant difference in PTSD was found among the sample of battered women from the U.S., Greece, Russia, and Spain. This is consistent with other research including Keane, Marshall, & Taft (2006) who also found equivalent presentation of PTSD symptoms cross-nationally in the general population. Interestingly, Keane et al found that being a woman increased the probability of developing PTSD around the globe. Given the high frequency and prevalence of violence against women around the world, this is not surprising.

These analyses gave some interesting and clarifying information about the development of PTSD, especially since not every woman who is battered will develop it, nor will all battered women, with or without PTSD, develop BWS. However, the use of a trauma model to help explain and perhaps even predict who might develop PTSD symptoms can assist in both prevention and intervention efforts by strengthening those who might be most likely to develop the psychological sequelae. This could include building women's resilience through extra community or familial support or even through administration of certain medications immediately post assault. Duros (2007), in her analysis, found that the amount of physical and sexual violence in the incidents

3.2 Standard Linear Regression Summary (Duros, 2007)

Predictors	R Square	F	p	B	t	p	Size*
First Episode	.223	2.770	.059	--	--	--	M-L
fPsych	--	--	--	.112	.518	.609	S
fPhysic	--	--	--	.250	1.145	.261	S-M
fSexual	--	--	--	.209	1.101	.280	S-M
Most Recent Episode	.413	6.560	.002	--	--	--	L
mrPsych	--	--	--	.056	.251	.804	--
mrPhysic	--	--	--	.269	1.427	.165	S-M
mrSexual	--	--	--	.413	2.025	.053	M-L
Worst Episode	.208	2.366	.093	--	--	--	M-L
wPsych	--	--	--	–.068	–.246	.808	--
wPhysic	--	--	--	.445	1.861	.074	M-L
wSexual	--	--	--	.099	.459	.650	S
Typical Episode	.247	3.724	.020	--	--	--	L
tPsych	--	--	--	–.012	–.045	.964	--
tPhysic	--	--	--	.424	1.824	.077	M-L
tSexual	--	--	--	.137	.678	.502	S

*Descriptor of effect size as per Cohen (1988): RSquare (Small= .01; Medium= .09; Large= .25); B (Small= .10; Medium= .30; Large= .5).

was associated with the severity of reported symptoms, particularly in the most recent incident reported and the most typical incident described.

While it is understandable that the most recent incident would generate a large effect size for PTSD because of temporal proximity to the traumatic event, it was surprising that the typical rather than the worst incident also generated such a large amount of PTSD symptoms endorsed. The *DSM-IV-TR* (APA, 2000) for example, states that the more intense the trauma, the stronger the likelihood of developing PTSD. On the other hand, the typical abuse incident may well be repeated over any number of times, which of course, is what made it typical to the woman, and so, that might be experienced as more

3.3 Logistic Regression Analyses of PTSD as a Function of Battering Incidents (Duros, 2007)

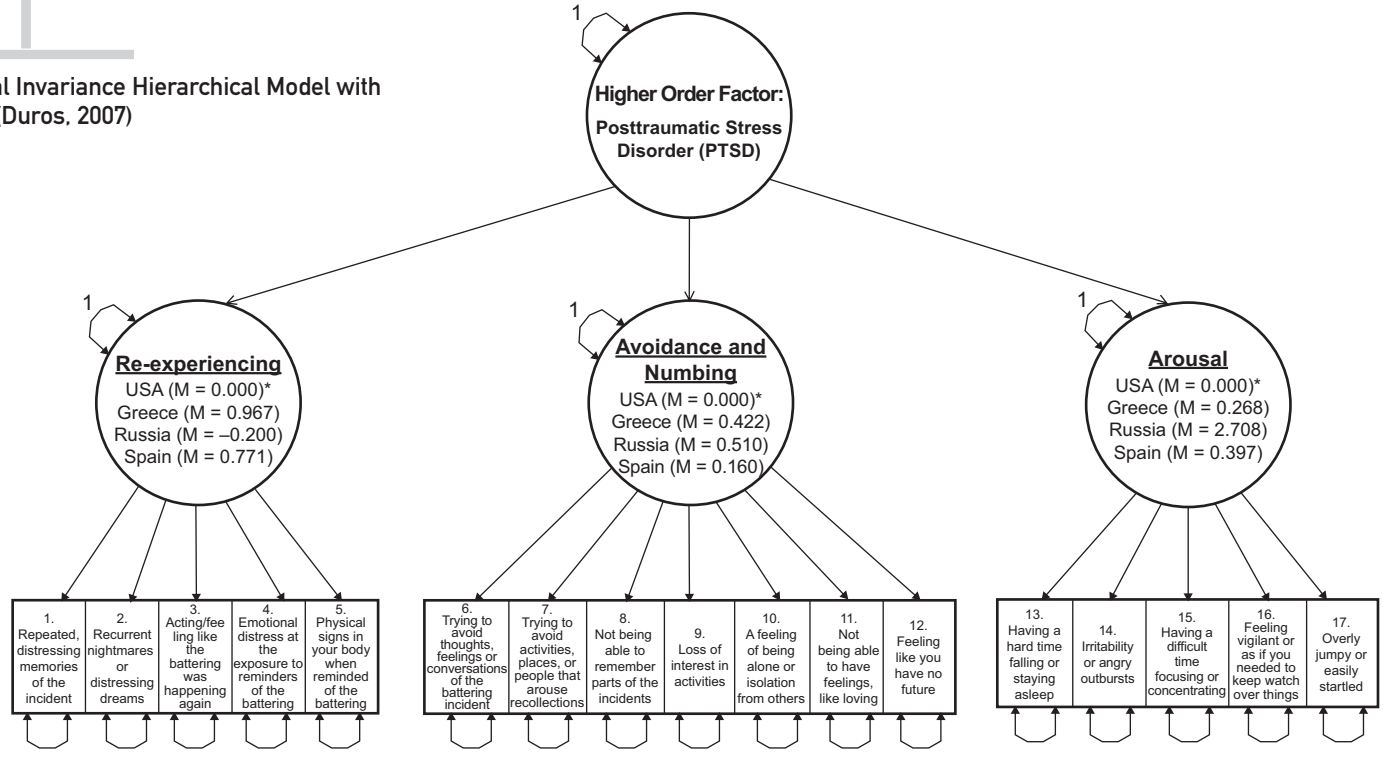
Variable	B	WALD	Odds Ratio	95% Conf. Int. for Odds Ratio
Overall RSquare = .182	.342	.301	1.407	.415 – 4.771
fPsych	.512	.486	1.668	.396 – 7.029
fPhysic	1.050	.832	2.859	.299 – 27.297
fSexual	–.256	.146	.774	
Constant				
Overall RSquare = .492	–4.69	.314	.625	.121 – 3.231
mrPsych	.644	1.133	1.905	.581 – 6.240
mrPhysic	8.316	1.826	4089.33	.024 – 7.1 E+008
mrSexual	–.293	.114	.746	
Constant				
Overall RSquare = .195	–.400	.385	.670	.190 – 2.370
wPsych	1.237	3.059	3.445	.861 – 13.782
wPhysic	.254	.126	1.289	.318 – 5.232
wSexual	–.145	.046	.865	
Constant				
Overall RSquare = .182	–.036	.003	.964	.266 – 3.491
tPsych	.834	1.910	2.302	.706 – 7.508
tPhysic	.190	.112	1.209	.398 – 3.675
tSexual	–.169	.055	.844	
Constant				

intense than one single incident, no matter how awful it is, and that may account for the PTSD symptoms it generated.

Battered women also describe the totality of the abuse in the relationship as most traumatic, so the typical incident may represent the entire battering relationship to these women. In addition, the theory that the psychological effects from battering incidents increase geometrically rather than additively over time would predict that the impact from the most recent event would include the totality of the battering

3.1

Factorial Invariance Hierarchical Model with Means (Duros, 2007)



***U.S. Sample set at M = 0.000 so that it is used as the comparison group**

experience up until that event, rather than simply measuring the impact from one single event. This result lends support to the feminist jurisprudence scholars who have called for domestic violence to be considered as a continuing tort in the law, rather than consider each incident independently.

It was also interesting that the amount of physical abuse that was described during the typical incident was related to the prediction of PTSD symptoms. As Ardern (2005) and others found in their analysis of battered women's descriptions of the battering incidents themselves, it is the psychological abuse that seems to be the most troublesome for the women to deal with. However, results in the present study did not reflect a difference between physical and sexual abuse and psychological abuse alone in producing PTSD symptomology. These data suggest that physical abuse together with the anticipation of further abuse is what the typical incident measured in this study.

Further logistic regressions were performed by Duros (2007) to determine if the categorical PTSD status of the woman would be related to the physical, sexual, and psychological incidents rather than the continuous number of PTSD symptoms endorsed. That is, no matter how many PTSD symptoms endorsed, if the woman had a sufficient number of symptoms to reach the diagnostic threshold, would the type of trauma be predictive of whether or not PTSD would occur? In this analysis, the most recent and the worst incidents were most predictive as the theories would expect. However, when an odds ratio was calculated, it became clear that the presence of sexual abuse played a much stronger role in the development of PTSD than did psychological or physical abuse alone. For example, if the first incident recalled by the woman involved sexual coercion or abuse, the odds ration suggested the woman would be more likely to develop PTSD. So too for sexual abuse or coercion reported in the most recent incident. Physical abuse was implicated in raising the odds of a higher PTSD score if it occurred in the typical and worst incidents.

Does the TSI Assess for PTSD in Battered Women?

An earlier analysis of 56 of the women in the same cross-national sample developed the checklist of PTSD symptoms from the data collected with the various clinical scales on the

TSI (Duros & Walker, 2006). The PTSD checklist is presented in Table 3.4 and accounts for the five criteria under the reexperiencing of the trauma, the seven criteria under the avoidance symptoms, and the five criteria under the anxious arousal section. Table 3.5 indicates the symptoms reported by this sample.

A distribution of the standard scores on the TSI clinical scales was then compared for a smaller number of the sample. These results are in Figure 3.2 which measures the scores on the scale assessing for Anxious Arousal, Figure 3.3 which indicates the scores that measure the scale for Depression, Figure 3.4 which measures the scores on the scale for Intrusive Experiences, Figure 3.5 which measures the scores on the scale for Defensive Avoidance, Figure 3.6 which measures the scores for the scale assessing Dissociation, Figure 3.7 which measures the scores for the scale that assesses for Impaired Self Reference or self-esteem, and Figure 3.8 which measures the scores for the assessment of Tension Reduction Behaviors.

In Figure 3.9 the summary of all the Trauma Scales as Reported on Briere's TSI, all the women were at least one standard deviation above the mean (M = 50, $S.D.$ = 10) and approaching the clinical significance which is set by the test at least one and one half standard deviations beyond the mean or 65 or higher scores. With a larger sample, it is anticipated that these scores will actually reach significance for the group. Obviously, individual women already have reached a sufficient level of significance to be considered being diagnosed with PTSD even though the entire group cannot be said to have done so.

Further analysis of an earlier sample of women from the U.S., Russia, Spain and Greece looked at the three groups of PTSD symptoms from the data collected. These included reexperiencing the trauma, avoidance and numbing, and hyperarousal symptoms. Table 3.6 presents the results from this analysis. It is clear that while the women from each different country had different PTSD scores, all the groups were above the required criteria for diagnosis. The Russian women were more likely to use avoidance behaviors including emotional numbing to deal with trauma, not unlike their political and cultural history, while the Spanish women were more anxious than the other three groups. The Greek women experienced the most PTSD symptoms from their abuse and

3.4 309.81 Post Traumatic Stress Disorder

A. Exposure (experienced, witnessed, or confronted) to a traumatic event(s) that involved actual or threatened death, serious injury, or threat to physical integrity of self or others AND person's response involved intense fear, helplessness or horror.

B. Traumatic event(s) persistently reexperienced in at least one of these ways:
   1. Recurrent and intrusive distressing recollections of event (thoughts, images or perceptions)
   2. Recurrent distressing dreams
   3. Acting or feeling as if trauma is reoccurring (sense of reliving experience, illusions, hallucinations, & dissociative flashback episodes including upon wakening and when intoxicated).
   4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the trauma.
   5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the trauma.

C. Persistent avoidance of stimuli associated with trauma AND numbing of emotional responsiveness as indicated by 3 or more of the following:
   1. efforts to avoid thoughts, feelings or conversations associated with trauma
   2. efforts to avoid activities, places, or people that arouse recollections
   3. inability to recall an important aspect of the trauma
   4. markedly diminished interest or participation in significant activities
   5. feelings of detachment or estrangement from others
   6. restricted range of affect
   7. sense of foreshortened future

D. Persistent symptoms of increased arousal as indicated of 2 or more of the following:
   1. difficulty falling or staying asleep
   2. irritability or outbursts of anger
   3. difficulty concentrating
   4. hypervigilance
   5. exaggerated startle response

E. Duration of symptoms in B, C & D more than one month

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

Acute – Symptoms less than 3 months

Chronic: 3 months or more

Delayed Onset: symptoms 6 months after stressor

3.5 PTSD Symptoms (Duros & Walker, 2006)

	Re-Experiencing (Mean; SD)	Avoidance/ Numbing (Mean; SD)	Hyper-Arousal (Mean; SD)
Overall	3.04; 1.41*	4.21; 2.90*	3.23; 1.32*
US	3.00; 1.48	3.87; 2.08	3.03; 1.52
Colombia	3.00; 1.87	3.00; 2.00	3.20; 1.30
Russia	3.10; 1.25	5.05; 1.19*	3.55; 1.32
Caucasian	2.60; 1.35	3.60; 2.14	2.60; 1.43
Hispanic	2.50; 2.07	2.50; 2.17	2.83; 1.47
African American	4.50; 0.58*	3.75; 0.96	4.25; 0.96*
Asian (n = 1)	4.00; xx	7.00; xx	5.00; xx
Other Ethnicity	3.24; 1.23	5.08; 1.15*	3.23; 1.32
Outpatient (n = 1)	4.00; xx	4.00; xx	3.00; xx
Mental Health	2.22; 1.86	2.33; 2.00	2.33; 1.50
Prison	3.37; 1.30	5.03; 1.43*	3.73; 0.98
Advertisement	2.83; 1.03	3.67; 1.83	2.75; 1.42
Other	2.75; 1.89	4.00; 2.16*	3.00; 1.83

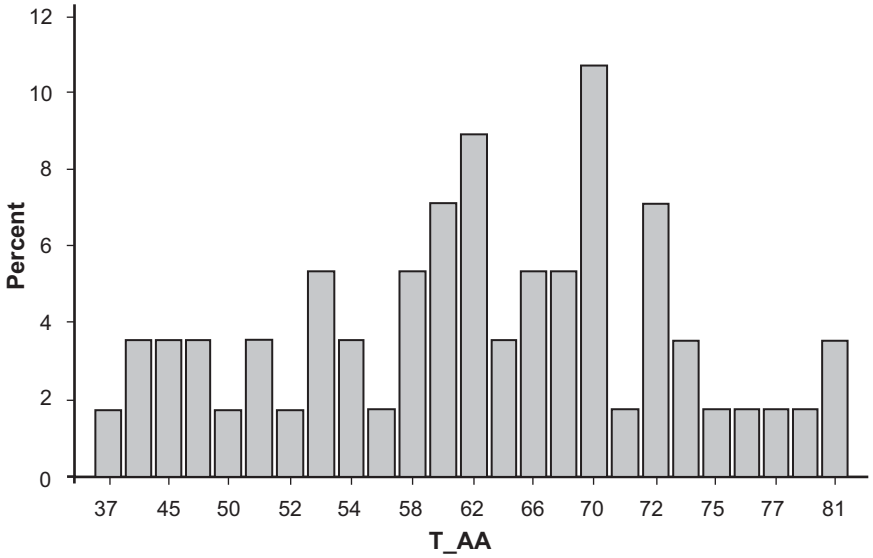
*Observations referenced in chapter discussion.

continue to reexperience the trauma even after they are safe from it actually reoccurring. Interestingly, the Greek women reexperienced more trauma than the Russian women did but were less likely to be hyperaroused by their experiences. Perhaps there was a higher degree of expectancy for the Greek men to act abusively towards them. The women in the U.S. sample were the least likely to develop severe PTSD as compared to the other groups although they also met the criteria for the diagnosis.

These results are the first empirical confirmation of the theory predicting that intimate partner violence is experienced as a trauma and is predictive of the woman developing PTSD following the traumatic events. The likelihood of PTSD being the response continues to occur over the course of the relationship, as is measured by the four battering incidents in

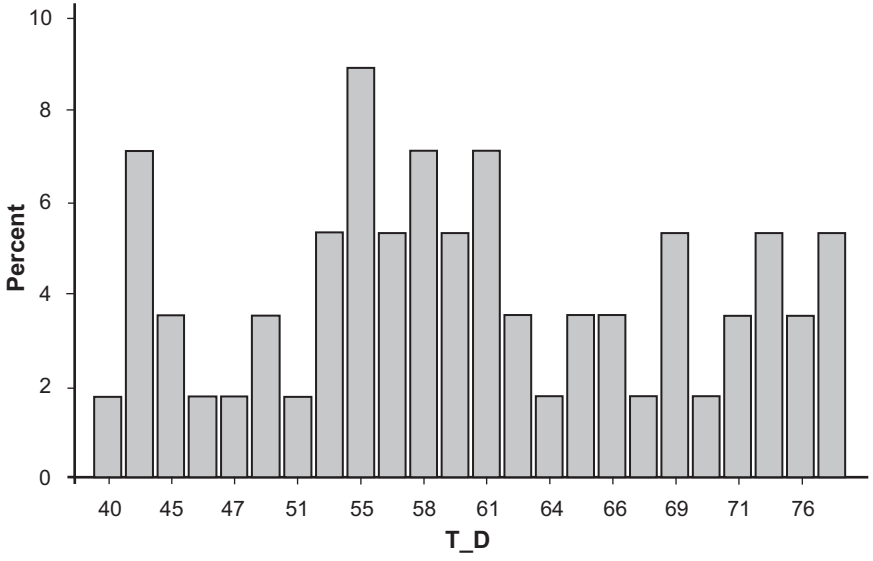
3.2

TSI Anxious Avoidance Distribution of Scores (Duros & Walker, 2006)



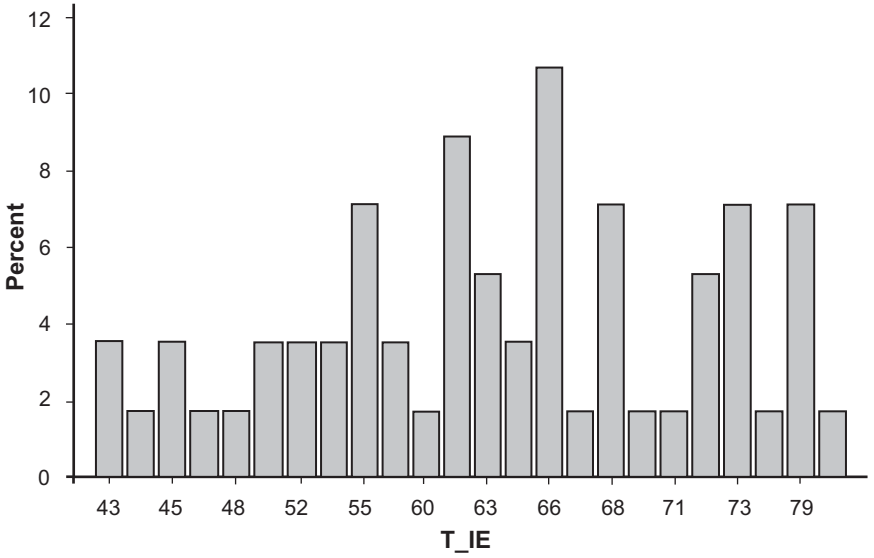
3.3

TSI Depression Distribution of Scores (Duros & Walker, 2006)



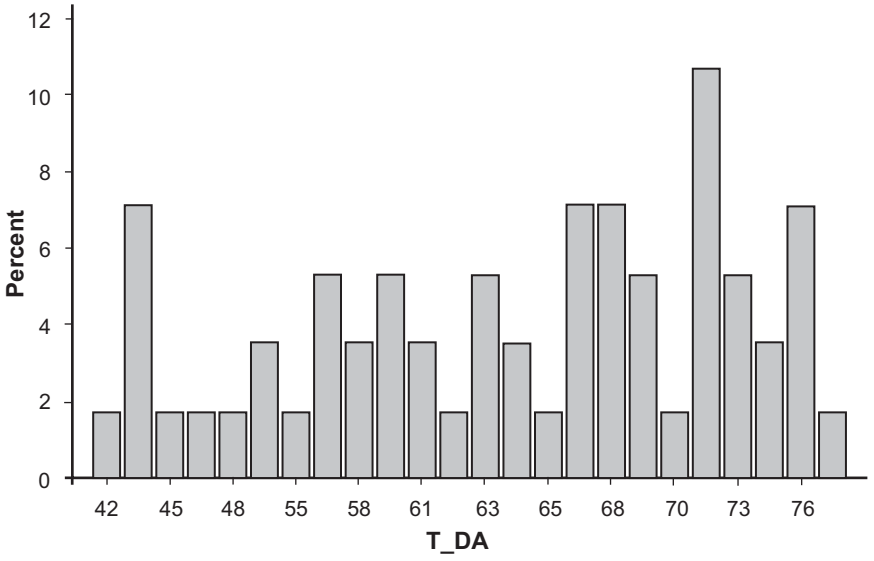
3.4

TSI Intrusive Experiences Distribution of Scores (Duros & Walker, 2006)



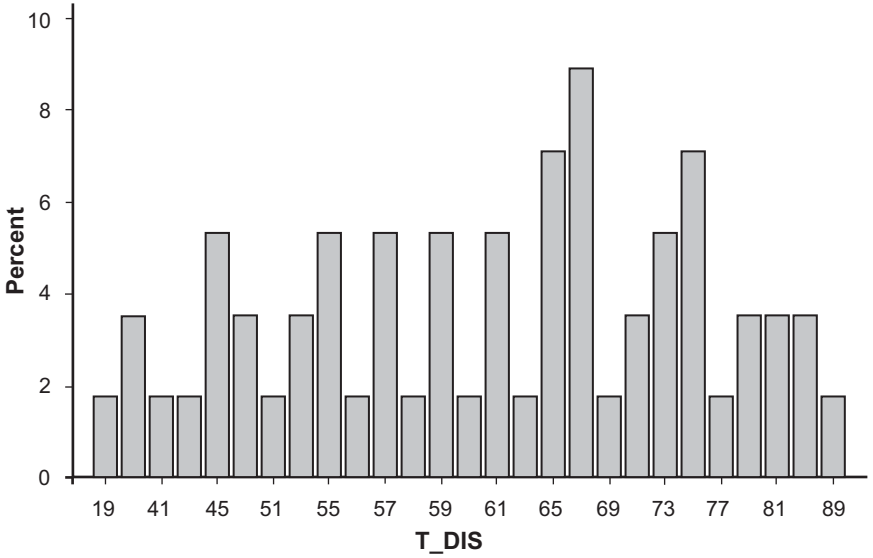
3.5

TSI Defensive Avoidance Distribution of Scores (Duros & Walker, 2006)



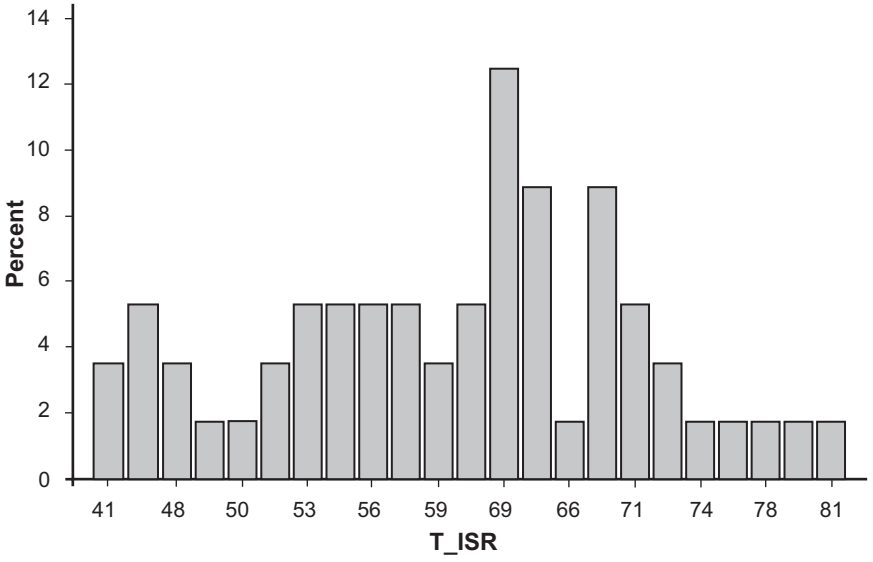
3.6

TSI Dissociation Distribution of Scores (Duros & Walker, 2006)



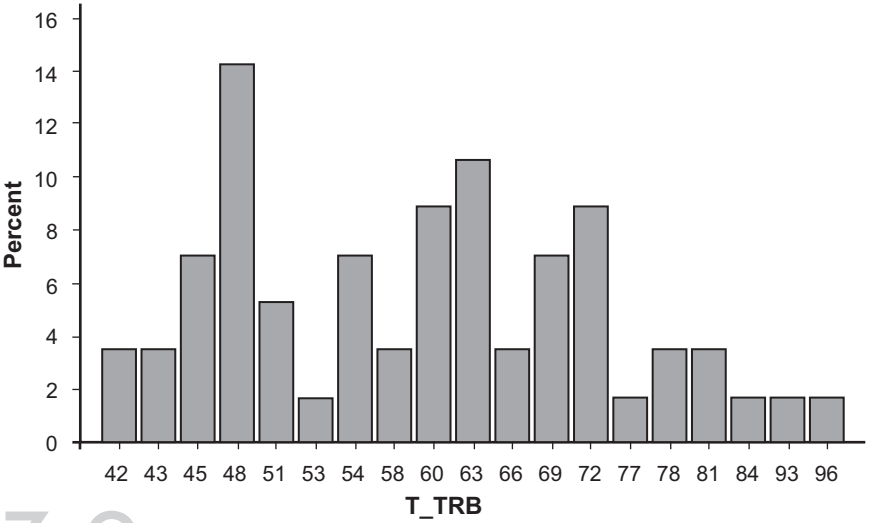
3.7

TSI Impaired Self-Reference Distribution of Scores (Duros & Walker, 2006)



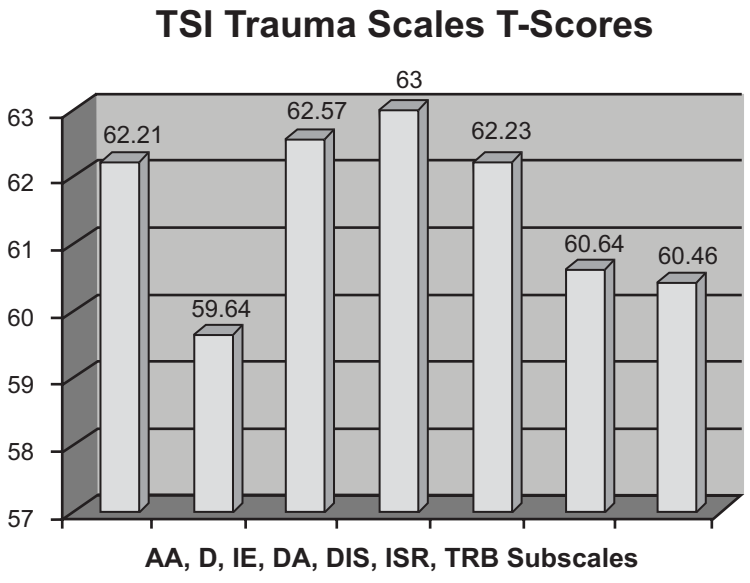
3.8

TSI Tension Reduction Behavior Distribution of Scores (Duros & Walker, 2006)



3.9

TSI Trauma Scales Distribution (Duros & Walker, 2006)



the research. The scale developed from the BWSQ to assess for PTSD symptoms was found to be as good as the *TSI* in assessing whether or not sufficient PTSD symptoms were present to make the diagnosis. Furthermore, the experience of intimate partner violence can cause PTSD for women who live in different countries and cultures in the world, particularly in Spain, Russia, Greece and the U.S.

There are limitations on generalizing these results. Obviously, this was not a random sample but rather a convenience sample so there may be untold numbers of biases that were not controlled. For example, it may be that the women who volunteered to be interviewed for the study were different from other battered women or maybe there were no differences with other women in that particular demographic group. However, these women were similar in demographics from the battered women who volunteered to participate in the original study. Although we do not assess for the veracity of the women's reports of violence, it is assumed that large sample sizes will eliminate the individual variances in self-report data. This analysis is with a small sample and needs replication with larger and stratified samples of women from these countries as well as the additional countries from where the research is being conducted. Nonetheless, it is an important step forward to know that there is some empirical support for the theories that have been around for over 30 years now.

Battered Woman Syndrome Qualitative Results

The above analyses measure the first three criteria that were in the definition of BWS. The three additional criteria include the Disruption in Interpersonal Relationships from the abuse of power and control and isolation of the woman, the Difficulties with Body Image and Somatic Symptoms, and the Sexual Intimacy Issues.

Disruption in Interpersonal Relationships. Ardern (2005) analyzed the power and control theme across all the battering incidents described by the Spanish, Russian, and U.S. women in the new sample. She found similar methods as were seen in the original study. In addition to physical violence and sexual

coercion, batterers use many forms of manipulation including isolation, following his rules, sex, degradation, jealousy, unpredictability, and direct and indirect threats of more violence.

Isolation, which was common across all cultural groups, included being treated as a possession, controlling when and if she saw family and friends, accompanying her to and from her job, restricting her time if she was allowed to go out by herself, frequent telephone contact, and the like. Sonkin has a detailed list of all the different common techniques batterers used to isolate women on his website (www.Daniel-Sonkin.com/ domestic violence assessment software: including risk assessment and violence inventory, last viewed December 18, 2007). One Russian interviewee gave as an example,

> "If I wanted to go somewhere, he would take a knife and threaten to kill my dog or people I cared about."

Women described many different types of *manipulation*. Examples include a man threatening to kill himself if the woman leaves, threatening to break up with her if she doesn't move in with him, telling a pregnant wife that he won't buy food if she doesn't do outside chores, or other ways of "molding me to his way," as one woman put it.

Degrading comments were more commonly reported in the U.S. group, such as:

> "He could do everything and I was made to feel like I could do nothing."
> "He scolds me like a child, inadequate, inferior, stupid."

The Russian women also reported typical degradation, translated from Russian:

> "He almost managed to persuade me that I'm nobody. Not worth a human life."
> "He did everything to make me feel that I needed him and couldn't live without him."

Some of the manipulation included *unpredictable behavior* especially in the U.S. group. For example:

> "I was fast asleep. He came home from the bar and was mad because there was no supper. I woke up to him

> dragging me by my hair down three flights of stairs. I was frightened and confused. I was asleep, what could I possibly have done wrong?"

The Spanish women also described typical incidents:

> "There was no argument. I returned to his house and without a word he hit me. I asked him, 'why do you hit me?' He said, 'because you are a woman.'"

Men used fear and threats in all the groups to force them into compliance. Typical threats included accusations that the woman was crazy, that he would take away their children and they would never find them, and that he would call immigration or other authorities. In some cases, the men actually called the police first, and reported the woman for domestic violence knowing full well that she had only hit him in self-defense during the fight that he started. One Russian woman told of a terrorizing night when, "he took an axe, put it under the pillow, and then told me that I should go to bed." Not surprisingly, she reported a sleepless night.

These types of incidents made it difficult for the woman to continue relationships with her family and friends partly for fear that the batterer will make good his threats to harm them and partly to keep him calm so he hurts her less often.

Difficulties with Body Image and Somatic Symptoms. Most women, whether or not exposed to domestic violence, do not like certain parts of their bodies. Research by others indicates that some women do not like their breasts, others do not like their thighs, and others do not like their stomachs or other body parts. However, battered women often talk about not liking their bodies as an entire entity, perhaps consistent with their low self-esteem and difficulties in protecting themselves after becoming dependent upon the batterer. In Chapter 8 we describe the body image issues that the women in this research study described.

Some psychologists have considered this a change in their normal functioning and label them depressed (Dutton, M., 1992). Others have studied the greater number of physical ailments that these women experience and concluded that trauma must be associated with the lowering of the body's immune system (Koss, 1990). Health problems

including those associated with immunology such as fibromyalgia, asthma, and others are more often reported by battered women. Although the exact relationship is not yet known, the new field of neuropsychoimmunology, which combines neurological and biological bases of behavior together with psychological issues including trauma, and its impact on the immune system may provide the answers from their research.

Sexual Intimacy Issues. A consistent theme in the battering incidents reported by the cross-national samples of women was the amount of jealousy in the relationships. Talking with other men, regardless of the context, or spending time with other people besides the batterer often resulted in an acute battering incident. Even tending to babies or older children's needs could precipitate the batterer's jealousy and a beating followed. One woman said her partner's favorite expression was, "Either you will be mine or you won't be at all."

Sex was used as a way for the batterer to mark the woman as his possession. He controlled whether the couple would have loving sex or abusive sex. Some women reported that the man would insist that she provide sex for his friends or prostitute themselves to earn them money. As long as it was impersonal and rough sex, the man was not jealous. However, if the other men or the woman showed any emotions towards each other, then the woman would get beaten. In a small minority of cases, the batterer would not touch the woman sexually, making her feel as if she was flawed as a woman. These men often displayed cold anger and rarely showed warmth or love in their behavior. Most of the women reported that the man would insist upon having sex right after beating her whether or not she was ready. In fact, few women reported that sex was satisfactory for them.

The inability to be intimate was another theme throughout the descriptions of the relationships. It appeared that once domestic violence began, the ability to attach to others was lost. Dutton and Sonkin (2003) have found that some types of batterers actually have attachment disorders that stem from childhood. It is unknown if they find women who also have problems with attachment or if living with an abusive partner actually creates attachment problems for women. Further analysis of this area can be found in Chapter 9.

Summary

The analysis of the data obtained from the women who participated in this research indicated that BWS existed as a subcategory of PTSD. The data were obtained from both open ended and forced choice questions and compared with results of standardized tests for trauma symptoms embedded in the BWSQ. Although not all women who were battered demonstrated sufficient criteria to be diagnosed with PTSD, many of them did and the others were approaching significance. The results were similar for women in the four countries that have been analyzed to date. As will be reported later, research on the women from Trinidad and Colombia yielded similar results. More research is needed to determine what role early traumatization plays in development of PTSD and BWS after being battered in an intimate partner relationship.

4

Learned Helplessness, Learned Optimism and Battered Women

Lenore Walker

When I first proposed using the theoretical construct of *learned helplessness* to help explain why women found it difficult to escape a battering relationship (Walker, 1978, 1979), I received support from other scientists (e.g. Barnett & LaViolette, 1993) and criticism from the feminist battered women's community (Bowker, 1993; Gondolf & Fisher, 1988). Learned helplessness was confused with being helpless, and not its original intended meaning of *having lost the ability to predict that what you do will make a particular outcome occur* or in scientific terms *loss of contingency between response and outcome*. At first I was puzzled by the harsh criticism, as I saw learned helplessness as a theoretical concept. I saw learned helplessness as accounting for how the aversive stimulation of the battering incidents themselves became paired in an identifiable pattern with reinforcements, such as the positive

parts of the relationship. A learning theory explanation of the effects that are so easily observed in battered women's coping behavior meant that what was learned could be unlearned, an important finding for developing future intervention strategies. The theory provided a coherent and reasonable counter-explanation to the prevailing theory of the times—masochism or more permanent personality traits in battered women that caused them to provoke their abuse, enjoy the chaos and to stay in violent relationships (Shainess, 1979, 1985). Learned helplessness is a research-based theory, it is simple and elegant, and furthermore gives direction for prevention as well as intervention. It is used by psychologists all over the world as a paradigm to explain animal as well as human behavior (Candido, Maldonado, Meigas, & Catena, 1992) including responses to psychopharmacological interventions (Torres, Morales, Megias, Candido & Maldonado, 1994).

The criticism then, was a good lesson in battered women's feminist politics, the subject of which could fill another book. I must say I was disappointed that there could not be a good scientific data-based debate with its critics, primarily because they did not understand the theory. Rather they were reacting to the name that contained the word "helplessness", a concept that advocates were working very hard to deconstruct from the image of a battered woman. Eventually even those colleagues who understood the concept of learned helplessness began to reject it in favor of post traumatic stress theory, which was first introduced in the late 1970s and appeared for the first time in the 1980 version of the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III)*. Interestingly, even the PTSD theory has been rejected by some of its original supporters in favor of an ecological system explanation that was seen as less likely to be misused against individual battered women to pathologize them (e.g. M. Dutton, 1993).

Today, the debate over the misinterpretation of the term, "learned helplessness" is less important, particularly since the originator of the theory, Martin Seligman, has looked at the less controversial flip side, *learned optimism*. Instead of concentrating on the negative, Seligman has used the same concepts and made them more politically correct by renaming them more in a positive direction (Seligman, 1991, 1994). And while Battered Woman Syndrome has been similarly criticized for making it easier to continue to pathologize battered women, it is my opinion that as a subcategory of PTSD,

it is the most useful diagnostic category to use for battered women when it is necessary to use a diagnostic formulation. In any case, the discussion about the theory of learned helplessness and learned optimism are both relevant to finding a theory that many can embrace that helps to explain the complex relationships found in domestic violence.

History of Learned Helplessness Research

The theoretical concept of learned helplessness was adapted in this research to help explain why women who could develop such intricate and life-saving coping strategies, found it so difficult to escape a battering relationship (Walker, 1978, 1979). Seligman and his colleagues discovered that when laboratory animals (usually dogs, in their early experiments) were repeatedly and noncontingently shocked, they became unable to escape from a painful situation, even when escape was quite possible and readily apparent to animals that had not undergone helplessness training. Seligman (1975) likened what he labeled, *learned helplessness*, to a kind of human depression, and showed that it had cognitive, motivational, and behavioral components. The inability to predict the success of one's actions was considered responsible for the resulting perceptual distortions. Although not tested in this study, Seligman's theory was further refined and reformulated, based on later laboratory trials with human subjects (Abramson, Seligman & Teasdale, 1978) to determine how attributional styles and expectancies were connected and how hopelessness related to the original theory of helplessness (Abramson, Metalsky, & Alloy, 1989).

For example, depressed humans were found to have negative, pessimistic beliefs about the efficacy of their actions and the likelihood of obtaining future rewards; helpless animals acted as if they held similar beliefs. Both depressed humans and helpless animals exhibited motivational deficits in the laboratory. Both showed signs of emotional distress with illness, phobias, sleep disturbances, and other such symptoms similar to those described as part of the Battered Woman Syndrome as a subcategory of PTSD. A review of the learned helplessness literature, including the reformulations with the attributional style can be found in Peterson, Maier, and Seligman (1993).

Learned Helplessness Hypothesis Research Study

On the basis of clinical work with battered women, it was hypothesized that the women's experiences of the noncontingent nature of their attempts to control the violence would, over time, produce learned helplessness and depression as the "repeated batterings, like electrical shocks, diminish the woman's motivation to respond" (Walker, 1979). If a woman is to escape such a relationship, she must overcome the tendency to learned helplessness survival techniques—by, for example, becoming angry rather than depressed and self-blaming; active rather than passive; and more realistic about the likelihood of the relationship continuing on its aversive course rather than improving. She must learn to use escape skills compatible to the survival behaviors already adopted.

In order to test the hypothesis that women in a battering relationship would show more signs of learned helplessness than women who had managed to escape such a relationship, each woman in our initial sample was asked a series of questions about her reactions to the four specific battering incidents: the first, second, last, and "one of the worst." With the exception of the "worst" incident, these provided a sketch of the battering relationship as it developed over time. If learned helplessness occurs in battering relationships and must be overcome if a battered woman is to escape, women whose "last" battering incident marked the end of a relationship should have become, over time, more angry, disgusted, and willing to seek intervention; less fearful, anxious, and depressed. Also, these women's reactions to the "last" battering incident should indicate less learned helplessness than the reactions of women who are still in the battering relationship, for whom the "last" incident was the most recent but not necessarily the last in the relationship. Of course, since it took some initiative to come to our interview, the women in our sample who were still in battering relationships may not have been as "helpless" as women who heard about the study but took no action to participate. This factor may decrease the size of the differences between women we are referring to as "in" or "out" of battering relationships. However, the "ins" reached a higher level of unpleasant emotions such as fear, anxiety, and depression across the three

battering incidents than the "outs," especially at the second time point.

The curves for anger, disgust, and hostility increase for both "ins" and "outs," but the level for outs was higher, especially at the "last" time point. For both groups, a measure of "resigned acceptance" was also administered. Both showed a rise at the second time point. Combining these results, it appears that "outs" reached a high point of fear/anxiety/depression and then became less fearful and depressed as they approached a peak of anger/disgust/hostility. At the same time, their resigned acceptance decreased. Perhaps the "ins" had not yet reached the peak of fear and depression, and their level of anger, while rising, hadn't reached the level of the "outs" anger when the "outs" decided to leave the relationship. Coming to our interview might have been a small step toward leaving, since anger was increasing and resigned acceptance was declining.

These results are compatible with learned helplessness theory. However, they do not indicate why some women become disgusted and angry enough to leave a relationship and others do not. Analysis of the cost-benefit ratio, or specifically the relationship between positive and negative reinforcement which is discussed in Chapter 5 on the Walker Cycle Theory of Violence, may prove more illuminating. Also possible is the reaction of their abusive partners to the woman's attempts to leave the relationship. As was later found, many men stalk women and increase the danger when she starts to leave (Sonkin, 1995; Walker & Meloy, 1998), while others are so cunning and controlling that the women are too fearful and paralyzed to even try to leave (Jacobson & Gottman, 1998). No matter how good a woman's coping strategies are, she needs a different set of skills to be able to terminate her relationship with these types of batterers despite what Bowker (1993) and others suggest. Bowker, for example, argues that the extraordinarily capable coping responses of battered women prove that they are capable of escape as well as coping, and they are simply waiting for a less dangerous time to get away from the batterer. Our research argues that the women trade away their escape skills in order to develop the good coping strategies and until they are able to regain the belief that they can safely escape, breaking the learned helplessness, they will not be able to leave the relationship psychologically.

Implications of Sex Role Socialization to Development of Learned Helplessness

It has also been suggested that "being a woman, more specifically a married woman, automatically creates a situation of powerlessness" (Walker, 1979, p. 51), and that women are taught sex role stereotyping which encourages passivity and dependency even as little girls (Radloff & Rae, 1979, 1981; Dweck, Goetz & Strauss, 1980). While most women do not perceive themselves as powerless in all situations, it is more likely that a battered woman who has not gotten community or family support will come to believe that the man holds more power in domestic violence situations even if only by his greater physical strength. Seligman's research indicated that the experience of noncontingency between response and outcome early in an animal's development increased that animal's vulnerability to learned helplessness later in life. He hypothesized that the same principles apply in human child raising practices and his recent research into positive psychology applies his work further to all people (Seligman, 1975, 1997, 2002). To the extent that animal and human helplessness are similar, childhood experiences of noncontingency between response and outcome, including socialization practices that encourage passivity and dependency, should increase a woman's vulnerability to developing learned helplessness in a battering relationship. Palker-Corell and Marcus (2004) examined battered women in shelters and found that their sample did indeed develop the belief that they are powerless against the batterer. Further, this attribution contributed to development of depression and trauma, but not necessarily to the development of more learned helplessness than the average woman might develop.

Original Learned Helplessness Research

In order to further explore the possibility that women who were abused as children will be at higher risk to develop learned helplessness than women who were only abused by adult partners, many questions were asked in our original

interview concerning childhood experiences, parental attitudes, and family dynamics. Answers to these questions were combined into scales (e.g., childhood health, mothers' and fathers' attitudes toward women's roles, sexual abuse during childhood) and the scales were intercorrelated to see whether they could be combined to form a single measure of childhood contributors to learned helplessness. For short, we called the resulting measure Child LH. The following scales were standardized and summed to form the Child LH measure (which has an internal consistency reliability alpha = .57):

1. The number of critical life events which occurred before age 18. "Critical events" included such things as divorce, death of a family member, sexual assault, moving—events that might make life seem relatively uncontrollable.
2. Mother's Attitude Toward Women Score, based on Spence and Helmreich's (1973) short form, as completed by the woman being interviewed when instructed to recall what her mother's attitudes were like "when you were growing up." (Coefficient alpha for this 25-item scale was .91).
3. Father's Attitude Toward Women Score (alpha = .93).
4. Number of battering relationships in the woman's childhood home (e.g., father battering mother, mother or father battering the subject or siblings).
5. Subject's relationship with mother during childhood and adolescence. This measure was based on 17 items concerning discipline, communication, affection shown, and parental expectations and values. Coefficient alpha for this 17-item measure was .83.
6. Subject's relationship with father during childhood and adolescence. Also a 17-item measure, using the same items as above; coefficient alpha = .84.
7. Childhood health scale, based on 11 items covering such things as migraine headaches, eating problems, hospitalization, allergies, and serious injuries. Alpha = .73.
8. A measure of childhood sex acts, based on questions about forced fondling, oral sex, or intercourse. These acts were weighted equally in determining a total score because recent literature suggested that impact is determined less by the act itself than by degree of force, perpetrator, and so on.

Although alpha for the combined Child LH measure is not as high as we would have liked (Alpha = .57), its components are generally reliable, and the SPSS program we used to compute reliabilities indicated that alpha would not have been higher if any component scale had been dropped. Further, it seemed wise to use a broad measure of possible childhood antecedents of learned helplessness in this initial exploration.

A similar procedure was followed to develop a tentative measure of learned helplessness within the battering relationship. Theoretically plausible indicators were intercorrelated and only those with Pearson product moment coefficients significant at the .05 level of significance were retained. Fifteen indices met this criterion. When standardized and summed, they yielded a scale with a reliability coefficient of .67. The components of this scale are as follows:

1. The frequency of battering incidents.
2. The number of abusive acts within a typical battering incident.

3-8. The number of injuries within each of six injury categories, averaged across four batterings described in detail during the interview.

9. The frequency with which the woman was forced by her batterer to have sex.
10. Whether or not the woman thought the batterer might kill her.
11. The extent to which the woman thought she could control the batterer or influence his actions.
12. The extent to which the woman adopted a placating stance toward the batterer in everyday life.
13. The woman's emotional reaction to the typical battering incident, summing across "fear," "depression," and so on. Coefficient alpha = .90.
14. The interviewer's rating of the woman's activity-passivity after each of the four reported incidents, averaged across incidents.

The combination of these variables was called Rel LH, or learned helplessness during the battering relationship. While a better measure of this construct could be designed for future studies, analyses indicated that reliability would not have been increased by dropping any of the components,

and we wished to retain as broad a concept as possible for our initial investigations of learned helplessness.

In addition to measures of Child LH and Rel LH, we wanted to assess each woman's current state on the same indices that might be related to learned helplessness. The following current state measures were considered: depression (Radloff's CES-D scale), attributional style (Levenson's internality, chance, and powerful others scales), anomie (a 4-item version of Srole's [1956] scale), self-esteem (a 20-item scale created for this study), current health (an 11-item scale, parallel to the one designed to measure childhood health), and the subject's current attitudes toward women's roles (Spence and Helmreich's full-length scale, 55 items). Reliabilities for these measures ranged from .49 to .94; only Levenson's internal scale (.49) was below .70. Each correlated with every other beyond the .05 significance level. It seemed reasonable, for preliminary analyses at least, to combine them into a single Current State measure by standardizing and summing the components. Current State yielded an alpha of .76.

In order to see whether Child LH is a determinant of Rel LH, and whether either of these is a determinant of Current State, a series of path analyses was conducted. In the first one, shown in the entire sample was included. Results indicate that both Child LH and Rel LH influence current state, and that the childhood measure is actually a bit more influential than the relationship measure. (For the final multiple regression analysis upon which the path diagram is based, $F(2,400) = 22.56$, p c .001.) Contrary to the hypothesis that childhood experiences cause a woman to be more or less vulnerable to helplessness in a battering relationship, there is essentially no relationship between Child LH and Rel LH. Thus, learned helplessness has equal potential to develop at either time in the battered woman's life.

Because the path diagram might differ for women still in an abusive relationship compared with women who have left such a relationship, we recomputed the path analysis for each of these groups separately. Surprisingly, there was not much difference, despite the fact that the current state of women who are no longer in a battering relationship might be expected to be less influenced by Child LH or, especially, by Rel LH. Even when we looked only at women who have been out of the battering relationship for more than a year,

the path coefficients remain the same. This suggests either that the influence of Child LH and Rel LH persists, almost regardless of later experiences, or that subjects who selected themselves for our interviews at various distances from battering experiences were still troubled by them.

In order to explore this matter further, we performed an analysis of variance on each of the learned helplessness scores (Child LH, Rel LH, and Current State) with the independent variable being whether the woman was, at the time of the interview, (1) still in the battering relationship, (2) out less than one year, or (3) out more than one year. If large differences were discovered, it might mean that these three groups differed in ways that render the path analyses invalid or misleading. In fact, none of the tested differences were significant. The means revealed some interesting trends, however. Women who are still in the relationship report worse (more "helpless") childhoods and fewer current problems with learned helplessness. If this is true, it might help explain why they are still in a battering relationship. Perhaps they did have somewhat more "training" for learned helplessness during childhood than women who have left a battering relationship, and either their battering experiences are not as severe or they do not yet see them as so severe. In the discussion of results related to the cycle theory that follows in Chapter 5, the point is made that women still in a battering relationship did not report as great a level of tension-building before the last reported incident of violence. Since the differences in the last analysis are nonsignificant, we cannot be sure they are meaningful. Nevertheless, the pattern shown would be worth following up in future studies using more refined measures.

Expert Witness Testimony

The concept of learned helplessness has been quite useful in expert witness testimony to help jurors understand how difficult it is for women to leave the relationship and why some women become so desperate that they must arm themselves against the batterer. While it is only one part of the explanation, jurors who have been interviewed following a trial suggest that it was an important factor in voting to acquit the woman on the grounds of self-defense. In addition to

explaining the concept of learned helplessness using animal and student research as an example, I have also presented charts that describe how the woman fits into the learned helplessness factors based on this research. To describe childhood factors leading to Child LH, I use the following:

1. Exposure to Physical Abuse During Childhood
2. Sexual Molestation
3. Critical Periods of Loss of their Power and Control
4. Traditional Sex-Role Socialization Activities
5. Health Problems

To describe relationship factors leading to Rel LH, I use the following:

1. Pattern of Abuse
   a. Cycle of violence
   b. Frequency and severity of violence
2. Sexual Abuse
3. Power and Control Factors
   a. Isolation
   b. Jealousy
   c. Intrusiveness
   d. Over-possessiveness
4. Threats to Kill
   a. Direct threats against the woman
   b. Indirect threats against the woman
   c. Direct or indirect threats against family and friends
5. Psychological Abuse
   a. Amnesty International definition of psychological abuse
6. Violence Correlates
   a. Her knowledge of his violence against other people
   b. Child abuse
   c. Abuse of pets
   d. Destruction of objects
7. Alcohol and other Drug Abuse

The data for all of these factors comes from the BWSQ. However, it can also be obtained in standard clinical interview if the clinician asks the appropriate questions. The questions we used in the BWSQ can be found in Table 4.1.

4.1 Women's Reports on Controls on Behavior in Battering Relationships

Variable	Original Sample N	Original Sample %	Current Sample N	Current Sample %
How often did he know where you were when you were not together?				
Never	3	1	6	6
Occasionally	23	6	11	10
Frequently	376	94	89	84
How often did you know where he was when you were not together?				
Never	44	11	22	21
Occasionally	180	45	42	40
Frequently	179	45	39	38
Were there places you wanted to go, but didn't because of him?				
Never	51	13	15	14
Occasionally	129	32	37	35
Frequently	223	56	50	47
Did you generally do what he asked?				
Never	0	0	1	1
Occasionally	44	11	20	19
Frequently	359	89	87	81
Did you emotionally withdraw to get what you wanted?				
Never	82	21	33	31
Occasionally	233	58	53	50
Frequently	85	21	21	20
Did you restrict his freedom to get what you wanted?				
Never	293	74	82	77
Occasionally	94	24	18	17
Frequently	11	3	6	6

Did you stop having sex to get what you wanted?				
Never	215	54	47	44
Occasionally	142	36	37	35
Frequently	43	11	23	22
Did you threaten to leave to get what you wanted?				
Never	105	26	29	27
Occasionally	211	52	38	36
Frequently	84	21	40	37
Did you use physical force to get what you wanted?				
Never	304	77	79	75
Occasionally	91	23	19	18
Frequently	2	1	7	7
Did you say or do something nice to get what you wanted?				
Never	37	9	12	11
Occasionally	180	45	38	36
Frequently	184	46	57	53
Who wins major disagreements?				
Always him	159	40	40	37
Usually him	130	33	21	20
Equal	37	9	14	13
Usually her	29	7	4	4
Always her	0	0	2	2
Other (e.g., unresolved)	45	11	26	24
How woman shows her anger: (May choose more than one response)				
Curses or shouts	198	52	71	66
Sulks, no speaking	279	73	78	73
Directed at children or pets	63	16	14	13
Directed at objects	132	35	43	41
Physical violence toward him	58	15	26	25

Most interesting is the disparity in knowing where their partners are when they are not together. The women reported that almost all of the men frequently knew where they were when they were not together. Less than half of the women knew where their partner was. Over 80% of the women in both samples said that they frequently did what the batterer wanted them to do and almost half of them said that they did not go places they wanted to go because of the batterer. Other forms of social isolation including access to financial resources is presented in Table 4.2.

4.2 Women's Reports of Social Isolation

Demographic Variable	Original Sample N	Original Sample %	Current Sample N	Current Sample %
Frequency of Women Reporting they did not have access to:				
Checking Account	134	34	34	36
Charge Accounts	204	51	36	39
Cash	108	27	28	30
Automobiles	89	22	36	40
Public transportation	116	30	24	26
Phone	–	–	10	12

If Learned Helplessness Exists in Battered Women, What Can Reverse It?

If battered women do develop learned helplessness from childhood abuse or from the actual battering relationship, what would that mean for psychological prevention and intervention strategies? First, it would suggest that prevention strategies would be possible to protect girls from developing learned helplessness should they be exposed to such abuse. Learning to focus on the positive side of experiences rather than on the negative side is one such strategy to use

when raising a child. Another strategy is to help promote the strengths in each child as he or she grows up in order to develop feelings of self-efficacy and self-confidence. A third strategy would be helping people develop flexibility in solving problems so that when one way doesn't work, the person can turn to other methods. Teaching boys and girls ways to resolve conflicts without using mental coercion and physical force is another strategy. This last one is the most difficult as we live in a world that appears to reward those who fight their way to the top of whatever area they wish to conquer. Psychologist, Albert Bandura (1973) has developed behavioral strategies that can be used in classrooms, other group activities, as well as counseling techniques to model positive behaviors that teach children how to feel competent in their work.

Once the social psychology construct of learned helplessness has begun to develop, it is possible to reverse it by purposely using positive behavioral strategies to feel better about oneself. The goal is to encourage self-efficacy and overcome feelings of paralysis or inability to accomplish what the person sets out to do. For women and children exposed to man's violence, it may require the support of others to help them learn new ways to live violence free. For example, most battered women's shelters have "no-hitting" rules for mothers when disciplining children. The goal is to learn new ways of appropriate and respectful discipline of their children. Using other types of consequences and rewarding positive behavior helps reverse the negative impact from living with unpredictable abuse and physical punishment. We discuss specific intervention programs later in this book. The important point to be made here is that learned helplessness, if it begins to develop, is reversible.

Summary

Although these results support the theory of learned helplessness being one of the factors that keeps battered women in abusive relationships, it has been so controversial amongst those who provide services to battered women that the theory has not been utilized to its fullest psychological potential. Nonetheless, it is a theory that does have some empirical support and can be integrated into other treatment theories and strategies without even using its name. It is not the

construct of helplessness that is the key here, but rather, the understanding that random and negative behavior towards a person can produce the belief that the person's natural way of fighting such abuse will not succeed in stopping it. Thus, the person stops trying to put an end to the abuse and rather, develops coping strategies to live safely with the possibility that he or she will continue to be abused. It is the motivation to keep trying to escape from violence that is lost and must be regained. There is great potential for developing new and positive child raising strategies in order to be a protective factor for children who do become exposed to family violence, even if it is not possible to prevent all forms of domestic violence at this time.

5

Descriptions of Violence and the Cycle of Violence

Lenore Walker

Introduction

One of the most important findings from the original BWS research was the existence of a three-phase cycle of violence that could be described and measured through careful questioning of the battered woman. Most women who experience intimate partner violence have experienced the three phases in the cycle, at least some of the time. Once their own cycle is plotted on a graph, or sometimes just giving her help in identifying the three phases, it is possible for the woman to break the cycle of violence and no longer be under the abuser's control. In this chapter, we describe the cycle, update it by adding information from the courtship period, and divide the third phase into several different sections where appropri-

ate so that there may not be any loving-contrition or even respites from the abuse at times during the relationship.

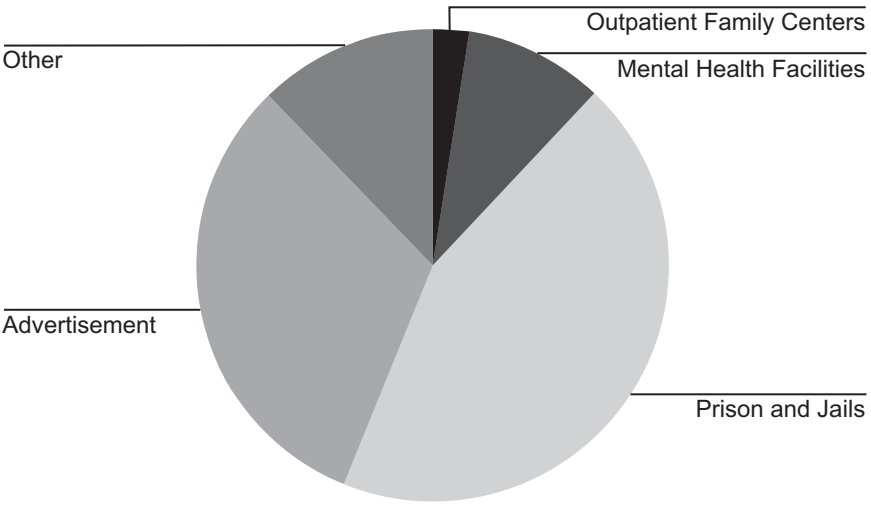
Descriptions of Violence

Sample Demographics in the Current Sample

We interviewed battered women who were recruited from Prison and Jails (44%), Advertisement (32%), Mental Health Facilities (10%) and Outpatient Family Centers (2%). We used other sources to recruit battered women as well (12%). Figure 5.1 depicts the referral location. The sample is approximately equal between women in jail and those who come from the community.

5.1

Referral Location



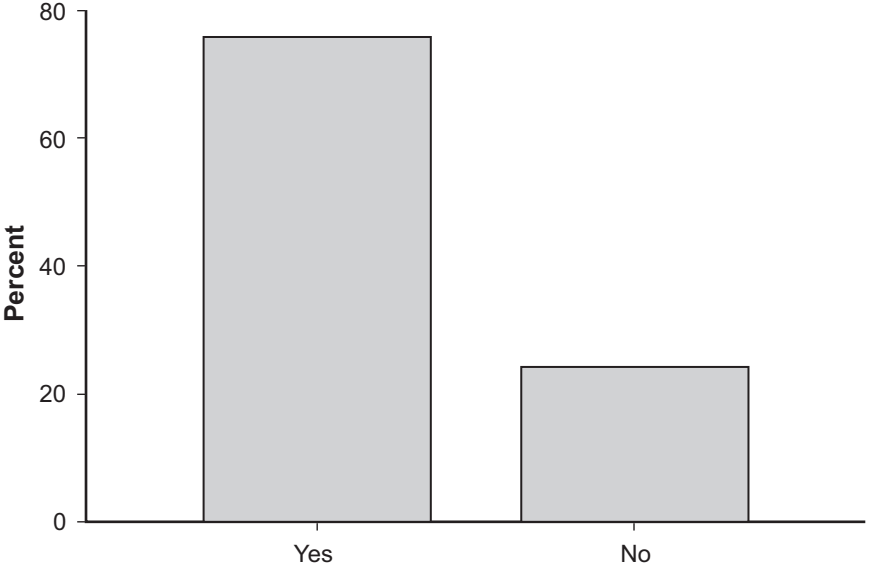
Childhood History of Abuse:

Frequency analysis indicated that 68% of the battered women reported that they were exposed to battering in their childhood home, as compared to 22% who were not so exposed

and 10% who did not report. This is seen in Figure 5.2. Further descriptive statistics revealed that 93% of the sample was spanked before 12 years of age, and 54% reported that they were hit with an object. Regarding sexual abuse, 66% of the sample indicated that they were inappropriately touched, as compared to 34% who reported no inappropriate touching as a child. This is similar to the original research that indicated a large proportion of the women battered in an intimate partner relationship also had been exposed to battering in their childhood homes.

5.2

Exposure to Battering in Childhood Home



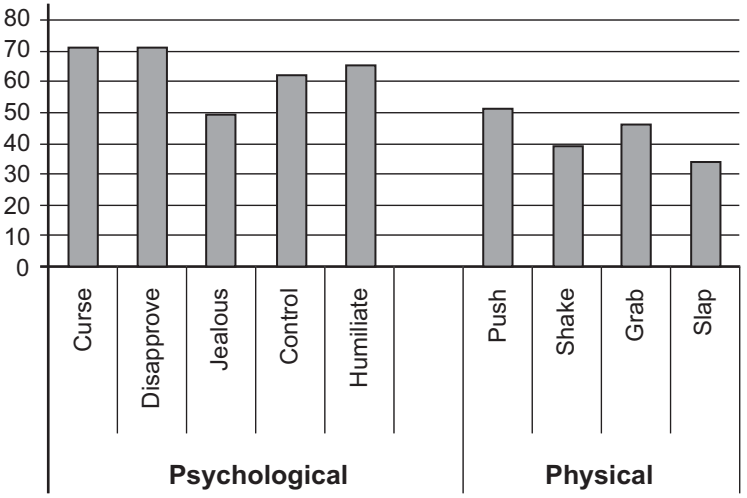
Adult History of Abuse:

Figure 5.3 depicts the significant areas of adult psychological and physical abuse that the women reported in the current research. It is clear that in the psychological domain the significant portion of battered women experienced being cursed at, humiliated and having controlling partners. With respect to physical abuse more battered women reported being

pushed, shaked, grabbed, and slapped. The most common psychological abuse tactics used by the batterer were cursing at the woman, humiliating her, constant disapproval, and trying to control her behavior. It was also reported that his use of jealousy was used frequently, often to justify his further abuse. These psychological tactics are similar to those reported in the first study.

5.3

Relevant Areas of Adult Abuse



The Relationship Between Childhood History of Abuse and Adult Experiences:

A test analysis was conducted to determine if exposure to battering while growing up led to physical abuse in adulthood. Results are shown in Table 5.1 and indicated that there was a significant relationship between battered women who were exposed to battering while growing up and those who were shaken and grabbed later in adulthood by an intimate male partner ($p < 0.05$).

5.1 Independent Samples Test of Women Exposed to Domestic Violence as a Child and Battered by an Intimate Partner as an Adult

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
push	Equal variances assumed	2.781	.108	1.812	24	.083	.3609	.19921	–.05025	.77206
	Equal variances not assumed			1.613	8.870	.142	.3609	.22372	–.14631	.86812
shake	Equal variances assumed	4.328	.048	2.693	24	.013	.5414	.20105	.12641	.95630
	Equal variances not assumed			3.007	13.569	.010	.5414	.18003	.15407	.92864

Continued

5.1 Independent Samples Test of Women Exposed to Domestic Violence as a Child and Battered by an Intimate Partner as an Adult (Cont'd)

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
grab	Equal variances assumed	.047	.831	2.211	24	.037	.4511	.20407	.02994	.87231
	Equal variances not assumed			2.132	10.066	.059	.4511	.21163	–.01999	.92225
slapping with open palm	Equal variances assumed	3.646	.068	1.074	24	.294	.2406	.22410	–.22191	.70312
	Equal variances not assumed			1.100	11.259	.294	.2406	.21878	–.23958	.72078

Cycle Theory of Violence

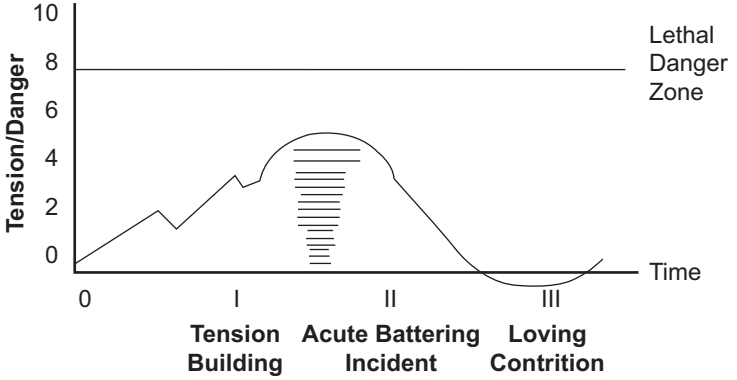
Once the four battering incidents were analyzed for the different types of violence experienced, these data from the second study were subjected to analysis of the second major theory that was tested in the original research project, Walker Cycle Theory of Violence (Walker, 1979). This is a tension-reduction theory that states that there are three distinct phases associated with a recurring battering cycle: (1) tension-building accompanied with rising sense of danger, (2) the acute battering incident, and (3) loving-contrition. The cycle usually begins after a courtship period that is often described as having a lot of interest from the batterer in the woman's life and usually filled with loving behavior. Some women describe this behavior from the batterer turning into stalking and surveillance after a while. But by the time this occurs, the woman has already made a commitment to the man and does not have the energy and often the desire to break off the relationship. Further, many of these women report that they tell themselves that once they are married, the man will feel more secure in their love, and will not have the need to continue his surveillance behavior. Unfortunately, this rarely occurs and instead, the first two phases of the cycle of violence begins with the third phase of loving behavior in the relationship similar to the good parts of the courtship period. Figure 5.4 shows the cycle as it can be used in treatment.

Phase I

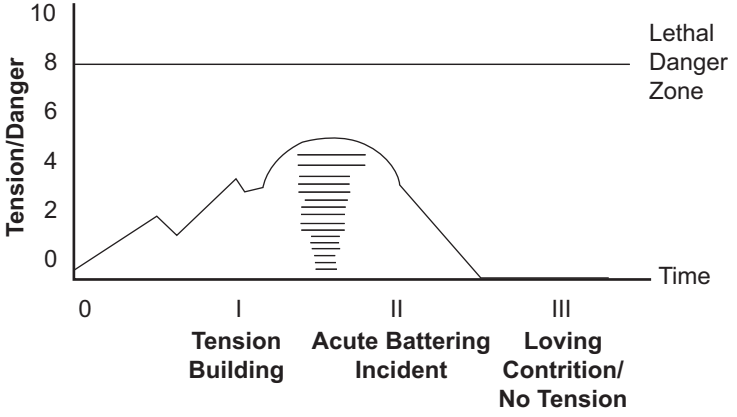
During the first phase, there is a gradual escalation of tension displayed by discrete acts causing increased friction such as name-calling, other mean intentional behaviors, and/or physical abuse. The batterer expresses dissatisfaction and hostility but not in an extreme or maximally explosive form. The woman attempts to placate the batterer, doing what she thinks might please him, calm him down, or at least, what will not further aggravate him. She tries not to respond to his hostile actions and uses general anger reduction techniques. Often she succeeds for a little while which reinforces her unrealistic belief that she can control this man. It also becomes part of the unpredictable noncontingency response/outcome pattern that creates the *learned helplessness*.

5.4

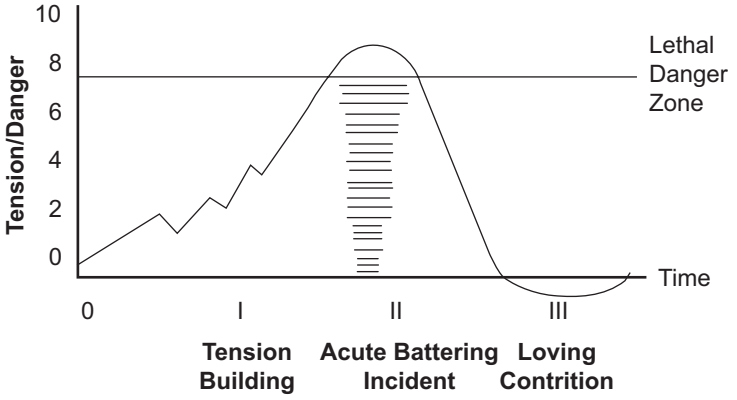
(A) Typical Cycle of Violence



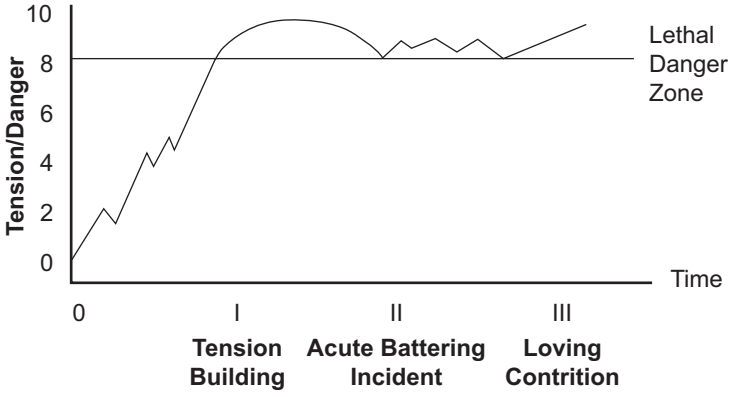
(B) Modified Cycle of Violence



(C) Life-Threatening Cycle



(D) Life-Threatening Cycle in Which the Woman Believes She Could Die at Any Time



Phase II

The tension continues to escalate, the woman becomes more fearful of impending danger, and eventually she is unable to continue controlling his angry response pattern.

"Exhausted from the constant stress, she usually withdraws from the batterer, fearing she will inadvertently set off an explosion. He begins to move more oppressively toward her as he observes her withdrawal…. Tension between the two becomes unbearable" (Walker, 1979, p. 59).

The second phase, the acute battering incident, becomes inevitable without intervention. Sometimes, she precipitates the inevitable explosion so as to control where and when it occurs, allowing her to take better precautions to minimize her injuries and pain. Over time she may learn to predict the point in the cycle where there is a period of inevitability—after that point is reached, there is no escape for the women unless the man permits it.

"Phase two is characterized by the uncontrollable discharge of the tensions that have built up during phase one" (Walker, 1979, p. 59). The batterer typically unleashes a barrage of verbal and physical aggression that can leave the woman severely shaken and injured. The woman does her best to protect herself often covering parts of her face and body to block some of the blows. In fact, when injuries do occur they usually happen during this second phase. It is also the time police become involved, if they are called at all. The acute battering phase is concluded when the batterer stops, usually bringing with its cessation a sharp physiological reduction in tension. This in itself is naturally reinforcing. Violence often succeeds because it works.

Phase III

In phase three that follows, the batterer may apologize profusely, try to assist his victim, show kindness and remorse, and shower her with gifts and/or promises. The batterer himself may believe at this point that he will never allow himself to be violent again. The woman wants to believe the batterer and, early in the relationship at least, may renew her hope in his ability to change. This third phase provides the positive reinforcement for remaining in the relationship, for the woman. Many of the acts that he did when she fell in

love with him during the courtship period occur again here. Our research results demonstrated that phase three could also be characterized by an absence of tension or violence, with no observable loving-contrition behavior, and still be reinforcing for the woman. Sometimes the perception of tension and danger remains very high and does not return to the baseline or loving-contrition level. This is a sign that the risk of a lethal incident is very high.

Assessment of the Cycle of Violence

In our original interviews with battered women, we asked for detailed descriptions of four battering incidents: the first, the second, one of the worst, and the last (or last prior to the interview). The first two and the last incident, taken together, reflect the temporal course of a stream of acute battering incidents. Each of these is an example of "phase two" in the cycle theory.

After the description of each incident, basing her judgment on both the open-ended description and a series of closed-ended questions concerning the batterer's behavior before the event ("Would you call it.... irritable, provocative, aggressive, hostile, threatening"—each on a 1–5 scale) and after the event ("nice, loving, contrite"), the interviewer recorded whether or not there was "evidence of tension building and/or loving contrition." Comparisons between interviewers' responses indicated a high level of agreement.

In 65% of all cases (including three battering incidents for each woman who reported three) there was evidence of a tension-building phase prior to the battering. In 58% of all cases there was evidence of loving contrition afterward. In general, then, there is support for the cycle theory of violence in a majority of the battering incidents described by our sample.

For first incidents, the proportion showing evidence of a tension-building phase is 56%; the proportion showing evidence of loving contrition is 69%. Over time, these proportions changed drastically. By the last incident, tension building preceded 71% of battering incidents, but loving contrition followed only 42%. In other words, over time in a battering relationship, tension building becomes more common (or more evident) and loving contrite behavior declines.

Since our sample included 24% of women who were still in the battering relationship, it is possible that there was a difference in the pattern between those who were in the relationship and those who had left the relationship by the time of the interview. The former group may not yet have experienced the truly final battering incident as they were asked about the last incident prior to their coming to the research study.

When we separate the two groups, both show the same decline of loving contrition, but the patterns of tension building are different. Women still in a battering relationship report less evidence of tension building preceding the last incident before our interview. This may be a valid indication of a difference between battering incidents that cause a woman to leave the relationship and battering incidents other than the final one. Or it may indicate a defensive bias on the part of women who choose to remain in the relationship. Our data do not allow us to distinguish between these two possibilities.

It is clear, however, that our data support the existence of the Walker Cycle of Violence. Furthermore, over the course of a battering relationship, tension building before battering becomes more common (or evident) and loving contrition declines. Thus, results strongly suggest further investigation into the psychological costs and rewards in these relationships.

Theoretical Implications

Most battered women in our original sample perceived three different levels of control over their lives. They scored significantly higher than the norms on the Levenson IPC Locus of Control Subscales of Internal, Powerful Others, and Chance. These findings suggest that the internal-external locus of control dichotomy does not fully explain battered women's attributions. Women still in a violent relationship did not report powerful others as being in any more control of their lives than themselves. Perhaps a battered woman cannot begin to terminate her marriage while there is this lack of realization that her batterer really is in control of her everyday activities and of her life.

Seligman's (1978) reformulation of learned helplessness theory would suggest an attributional style of assigning

causality for successful experiences to external and specific factors and failures to internal and global ones. Thus, someone with an external attribution might think that their success was due to luck and a particular combination of things that day, whereas their getting a beating was because they failed to keep their mouth shut and didn't pay enough attention to him. Our measurement of attributional style was not designed to test this reformulation as our study was designed prior to its publication. Therefore, our sample's perception of both internal and external causation may not be unusual in light of this reformulation of learned helplessness theory.

Self-Esteem. In the original research, the woman's self-esteem was measured by use of a typical Likkert style semantic differential scale. It was predicted that battered women's self-esteem would be quite low and our results, surprisingly, show the opposite. They perceived themselves as stronger, more independent, and more sensitive than other women or men. It is possible that battered women develop a positive sense of self from having survived in a violent relationship, which causes them to believe they are equal to or better than others. However, there is incompatibility between these high self-esteem findings and the reports of depression and other learned helplessness measures. Given these conflicting results, more careful study into the mental health of battered women is recommended.

Depression in the original sample was measured by the CES-D scale (Radloff, 1977). Our subjects scored higher than the high risk for depression cut-off score. Younger women in the sample were more likely to be depressed than older ones, as were those who were unemployed. An interesting but surprising finding was that women out of the relationship were more likely to be more depressed than those still in it. They were also not consistent in demonstrating the negative cognition and moods we would have expected in other indices within the questionnaire.

Depression. Lewinsohn's behavioral reinforcement theory of depression might explain some of our findings on depression (Lewinsohn, 1975; Lewinsohn et al., 1981). It postulates that depression occurs when there is a sharp reduction in the amount of positive reinforcement received by people. A lower rate of rewards would result in a lower response rate

or passivity, which then spirals downward into a depressed state. Cognitive or affective disturbances occur simultaneously to the downward spiral or is a consequence of the lowered reinforcement rate. This is similar to the learned helplessness theory, which postulates the lowered behavioral response rate or passivity as learned response to uncontrollable trauma. It also postulates distorted perceptions in the cognitive and affective domain. While the learned helplessness theory did not specify when these cognitive and affective perceptions occurred, the reformulations suggest an attributional style which serves as a cognitive set for a depressive state to develop.

Learned Helplessness. The finding of a set of factors that could result in childhood learned helplessness, and another, responsible for development of learned helplessness in the relationship, supports the application of this theory to battered women. Unfortunately, actual learned helplessness is usually directly measured in a laboratory setting under experimentally controlled conditions. Our research attempted to identify its presence from variables that cause it to develop as predicted by the literature. Although our results are positive, it is strongly recommended that a controlled laboratory setting be constructed to test if learned helplessness can be easily induced in a sample of battered women comparable to this one. Such direct measurement is necessary to confirm the theoretical application to battered women.

Walker Cycle Theory of Violence from the Research

The Walker Cycle Theory of Violence (Walker, 1979) was also confirmed by our data. Sufficient evidence supports the three phases in battering relationships that occur in a cycle. Over time, the first phase of tension building becomes more common, and loving contrition, or the third phase, declines. Our results also show that phase three could be characterized by an absence of tension or violence and no observable loving-contrition behavior and still be reinforcing for the woman. In those cases, it is the relationship interactions themselves that propel the cycle and not just the three distinct phases with their corresponding behaviors.

Lewis (1981) has tested the cycle theory in the laboratory to match its compatibility with the anxiety arousal model of the delay of punishment paradigm. This paradigm has been found to have three phases of anxiety arousal: increase during the anticipatory period; asymptote at the moment of stimulus delivery; and then, relief with a return to baseline levels. People have been found to prefer the immediate delivery of a negative stimulus in order to avoid a prolonged anticipatory period. Thus, the experimental model parallels the cycle theory derived from battered women's descriptions of the battering incidents. Lewis (1980) attempted to measure the differences between battered and nonbattered women's responses on a classic delay of punishment paradigm and compared these results to the cycle theory. The description of the cycle theory used came from her independent reading of published work (Walker, 1978; 1979) and not through direct contact with this project. Nevertheless, the results are interesting in that they extend the descriptive work to experimental laboratory analogues.

Lewis (1980) hypothesized that battered women have learned the probability of receiving a beating by recognizing specific predictive cues emitted by the batterer in phase one of the cycle. These predictive cues result in a high level of anxiety arousal which the battered women may attempt to reduce through several different means, one of which is to avoid delaying the beating any longer. She hypothesized that battered women would be more likely to avoid delay of punishment in the experimental analogue she constructed. Using the Conflicts Tactics Scale (CTS) developed by Straus et al. (1980), she measured battering behavior and found that it was not useful in identifying an adequate sample of battered women. However, she did generate a sample with a variety of marital conflicts and found that the cycle theory held for couples' less violent disputes, also.

Thus, her results support her hypothesis that women may elect to receive a brief aversive stimulus immediately and yet also prefer to delay a somewhat longer aversive event. This research offers promising insights into why battered women chose various tactics to respond to the batterer's behavior, particularly during phase one of the cycle. For example, a woman may choose a delay tactic, such as withdrawing or doing something to calm the batterer, or she may choose to get the beating over with immediately, depending upon her perception

of the intensity and probability of the predicted battering incident. The commonalties between the anxiety arousal model of marital dispute cycles demonstrated in the laboratory and the cycle theory of violence, which developed from battered women's descriptions, were supported in this analogue study.

Cost-Benefit Models. The analysis of lower reinforcement rates presented with the results of the Walker Cycle Theory of Violence demonstrates that women who left the battering relationship, left after the ratio between the tension-building and loving-contrition phases sharply diverged. Women still in the battering relationship reported more positive reinforcement (loving-contrition) following the last battering incident they discussed. Thus, women who were less depressed while still in the relationship may have still been receiving some rewards from it despite the violence. Once the cost-benefit ratio changes, however, and the rate of reinforcement decreases, then the women may be more inclined to leave the relationship, but subsequently become depressed as a result of the separation. Further investigation into the psychological cost and benefits in these relationships is still necessary.

It is interesting that other family violence researchers are also examining the costs and benefits of battering relationships. Gelles (1983) presented an exchange/social control theory of intrafamily violence in which he attempted to construct a multidimensional causal model to account for all forms of family abuse, including child abuse, spouse abuse, and sexual abuse. Although Gelles does not use a social learning theory paradigm, he suggests that human behavior follows the pursuit of rewards and avoidance of punishment (Gelles, 1983, p. 11). As a sociologist, it is understandable that he utilized traditional exchange theory (Blau, 1964) rather than the reciprocal contingency contracting models developed by behavioral psychologists (Weiss et al., 1973; Patterson, 1982). If the discipline vocabulary can be set aside, it is apparent that there are similarities between this approach and the one suggested by our data.

Gelles (1983) suggests that a multidimensional causal model needs to be explored—a concept these data certainly support. Inequality between men and women is one area that we both agree must be a part of that model. Our results indicate that sex role stereotyping is a primary cause for men battering women. Gelles also suggests that such unequal

gender socialization patterns are causal in other forms of family violence, specifically sexual assault and child abuse. He states that the privacy of the family reduces accessibility to outside agencies of social control. Our results support this concept, as the social isolation measures were the highest for women living with their batterers.

Once the cost of living in a violent relationship begins to escalate, paralleling the escalation of the seriousness of the abusiveness and injuries, women's help-seeking behavior breaks through the privacy of the home, if they perceive actual help is available. Gelles also included the cost of loss of status because the label "wife" or "child beater" is less a factor in subcultures where aggressive behavior is held in high esteem. Perceived status of the men was not measured in either of our studies. However, our data suggest that this factor is probably significant so long as it does not approach the risk of the man losing his wife and family, which would then result in a loss of status in many subcultures. This analysis is consistent with the behavior seen by the man's mother towards his wife. The mother-in-law is often the most supportive to help the woman heal from an acute battering incident until the time comes when the woman is ready to leave the relationship. Women described being shocked at the immediate change in their mother-in-law's behavior towards them should they decide to leave the family.

While he goes on to describe other factors in his model, Gelles' primary thesis is that men abuse women because they can, and suggests changing the contingencies so that the costs become too high. Gelles does not discuss the key principle of learning theory; that is, people will repeat behavior that is positively rewarded especially if reinforced with social approval. Aversive stimulation or punishment will stop negative behavior initially but it will return at even higher base rates if the external control (in this case, higher costs) is removed. While none of our results would be incompatible with this view, it is seen as not being comprehensive enough. For example, our data suggest behavior patterns in men and women that are associated with violence. We argue that these are temporary-state like characteristics related to the situation of being battered, for the women, and, either temporary-state like learned behaviors or perhaps more stable personality traits seen in the men. Battered women seem more likely to respond to the batterer's behavior than he does to hers.

Although the concept of mutual reciprocity cannot be disproved, the striking differences we found between the woman's perceptions of her behavior with the batterer and a nonbatterer lend strong support to this belief in her reactive behavior. Measurement of the tactics used by couples that do not take such inequality into account, such as the CTS, may well obscure the field rather than add to the knowledge base. It emphasizes the violent nature of all of society, while our results would place the greatest emphasis on the position of women in a society where they are the predominant victims of such violence.

Cycle Theory and Interventions

When I first began collecting data from individuals and using the information to plot their individual cycle graphs, it became clear that once the code for the individual's own personal cycle is broken, it becomes necessary for the woman to begin to protect herself and her children more vigorously. Although battered women are quite sensitive to the rise of tension and perception of danger, they often shut off their intuitive feelings while trying to calm down the batterer. Rarely do they connect the quiet during the aftermath of the violent incident with a constant repetitive cycle. Nor are they consciously aware of how similar the behavior the batterer displays is to the behavior they saw during their courtship period. Rather, they associate the phase three behavior with who they believed their batter really is. They reason that they were able to smooth the world for the batterer and so the *real man* emerged once again. This became a powerful message for the woman, fitting right into the sex role socialization that teaches women to believe that they are responsible for the health, well-being, and psychological stability of their husbands! Thus, it becomes important to teach battered women their cycle of violence so they can choose to stop being held captive by their belief that the person they see during the third phase is the *real man* and somehow, if the behavior he displays during phases one and two disappears, then they will be left with the person they fell in love with. Only when they see the inevitability of the recurring cycle and understand that their partner has both the ability to be both loving and cruel will they be able to better protect themselves and their children.

In battered woman shelters, support groups, and psychotherapy sessions, battered women are being encouraged to graph their own cycle of violence. It is important to gather data on at least four battering cycles. Usually, the woman is encouraged to remember the first time she was hurt by the batterer. Sometimes this includes a physically abusive act during phase one or two, other times it is some act that humiliated the woman and hurt her feelings. Most women remember the incident that made them first realize that this man was able to hurt them in ways they never dreamed of. By asking her to remember and recount the details of what happened before and led up to it, what happened during the acute battering incident part, and what happened afterwards, it is possible to get an idea of how to rate the seriousness of the incident, what level of tension the woman felt, and how much danger she perceived herself to be in at the time.

I suggest using a graph such as is seen in Figure 5.4 rather than the circle that many other battered woman center facilitators suggest because it is possible to demonstrate the escalation and repetitiveness of the cycle easier. I try to get materials to her from the actual project. On the vertical axis of the graph put the measurement of tension and perception of danger. Use the scale from zero to ten with anything over an eight considered life-threatening violence. On the horizontal axis place the three phases of the cycle over time. By drawing the incidents on this graph, it makes a powerful statement that the abuse is escalating and that the woman is becoming more frightened of the dangerousness of her situation.

If I want to measure the rapidity of the escalation of violence in a relationship, I often ask for the details of the next (second) incident she can remember. This helps get data about how frequent and how serious are the acute battering incidents initially as compared later on in the relationship. I then draw that incident as continuous to the first on the graph. The next incident that I ask about is the last one before the woman has come in to see me. Sometimes this is quite recent but in other clients who don't come for treatment until after she has terminated the relationship, it might be quite some time ago. This becomes the anchor on the other side of the graph. Sometimes the loving-contrition in the third phase is still present, more often it has decreased or disappeared entirely. Then, I ask for a third (or fourth by now) incident

that the woman describes as the worst one, unless the last one is the worst and then, it is one of the worst that she picks out to discuss. Although this incident frequently deals with humiliation and not necessarily physical injuries, it is important to diagram it attached to the others. The final incident that I request is a typical battering scene. Often more than one incident gets put together here but again, it is important to see how the woman perceives the abuse in general, on a day-to-day basis rather than just when there are more dramatic incidents occurring. In long-term relationships, there might be more than one typical incident. When there is sexual abuse in the relationship and the woman is willing to talk about it, those incidents are often reported in this section.

It is interesting to see how quickly most battered women catch on to the graphing of these battering incidents. In a film that I made about therapy with abused women, I demonstrate this technique in connection with the development of a safety plan (Walker, 1996). Most battered women cannot leave the house when an acute battering incident is beginning because they wait too long and the batterer is in too much of an angry, controlling state to let her go. However, if women can be taught to recognize the signals that the tension is building and an acute battering incident is approaching threshold before exploding, then it may be possible for her to get out then. During the development of a crisis plan, battered women are often taught when to leave and they can decide if they want to tell the batterer that they intend to leave if they get scared his violence will escalate, but they will come back to discuss it later when he calms down.

Just knowing there is a cycle to the violence and that it is repetitive helps the woman better assess her situation. It also helps the man understand that he no longer will be able to manipulate the woman by his behavior during the third phase. Sometimes what seemed to be so loving in one context actually seemed a continuation of the controlling and over possessive behavior of the batterer. For example, in the film, Sara tells the therapist that after one battering incident her husband filled the dining room with lilac bushes so when she came downstairs that was all she saw. Then they spent the entire day planting those bushes. Sara liked that sequence, especially the attention that Dan, her husband gave her as they planted the bushes that day. However, he gave her no choice but to be with him planting bushes even though she

might have made other plans that didn't include him. Not until the therapist pointed it out did Sara realize that her husband's supposedly nice gesture was an example of the third phase of their cycle that also had secondary benefits for his needs to keep her as close to him as possible.

Summary

This chapter describes the violence that the women in our study reported occurred during the courtship period, the four specific battering incidents they were asked about, and the loving-contrition or absence of violence that they experienced. The cycle of violence that measures the magnitude of the woman's perception of danger and feelings of tension over the time that it took for the four incidents they reported was also described. Teaching the woman how her perception of tension and danger rises to an acute battering incident after which she experiences feelings of relief and then, gets seduced back into the relationship by the batterer's loving behavior, often similar to what they experienced during the courtship period, has been found to be helpful in breaking the cycle of violence that keeps the woman in the relationship.

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6

Risk Assessment and Lethal Potential

Lenore Walker

With

David Shapiro and Kelley Gill

The amount of violent behavior expressed in abusive families is enormous. Those of us in the project over the past 30 years have been continuously surprised by what we have heard and we have never habituated to the high level of brutality. Instead, our amazement and respect keeps growing for the battered woman's strength, which has permitted her to survive such terrifying abuse. Today, the amount of violence in these relationships is less shocking to the general public than 30 years ago, especially since we now know that most of the reported homicide/suicides often occur in domestic violence families. Most of the reported kidnappings of children occur in families where there has been domestic violence; either protective moms escaping from abusive judicial orders to place their children in harm or abusive dads trying to get control of their children without sharing with their former partners. We are

much more aware of the fact that from the point of separation to about two years afterwards is the most dangerous time in a battering relationship. But, despite all we have learned and all the steps we have taken to help society's institutions and agencies be more supportive towards battered women, we still have difficulty in protecting women and their children from men's abuse.

Women's Perceptions of Danger

At the time we collected our original research data, it seemed as if either the man or woman or both of them could have died any number of times, given the lethal level of some of the acts and threats against her. We wondered if the women knew how close to death they actually were. Women were asked directly about their perception of danger with the batterers. Their responses are reported in Table 6.1 (in previous editions Table 16). We have not yet analyzed these responses from the current cross-national samples in the current research program but initial review indicates similar if not actually more fearfulness and violence.

These results indicate the women's perception of the high risk of lethality, or of someone dying in battering relationships. The women believed the batterer could or would kill them in three quarters of those relationships; and in almost half, that they might kill him. Only 11% said they had ever tried to kill the batterer, and 87% believed that they (the women) would be the one to die if someone was killed. Half of the batterers and about one third of the women had threatened to commit suicide. We did not ask if either had made an actual suicide attempt. However, from the literature on suicide, we can assume the likelihood that actual attempts followed at least some of the threats in a number of these high risk relationships. Jens (1980) points out the ease with which batterers move from being suicidal to homicidal in violent relationships, as does Boyd (1978), Ganley (1981), Jacobson & Gottman (1998), Kaslow (1997), Sonkin and Durphy (1982), Walker (1979, 1989a), and others. From this we assume that suicide threats by the batterer should be taken as a warning of homicidal tendencies, also.

A study in Washington state by the Domestic Violence Fatality Review Board examined 113 domestic violence deaths occurring between July 2004 and June 2006 found that

6.1 Women's Perceptions of Danger with the Batterer

Variable	Original Sample N	Original Sample %	Current Sample	Current Sample %
Did you think he ever would or could kill you?				
Never	32	8	12	22
Maybe	22	6	0	0
Yes, accidentally	46	12	7	13
Yes, if mad enough	99	26	14	26
Yes	184	48	21	39
Did you think you ever would or could kill you?				
Never	181	45	32	63
Maybe	37	9	0	0
Yes, accidentally	14	4	2	4
Yes, if mad enough	75	19	4	8
Yes, only in self-defense	--	--	8	16
Yes	92	23	5	10
If someone were to die during a battering, who would it be?				
Neither	14	4	0	0
Him	24	6	2	4
Me	341	87	43	86
Both	10	3	2	4

the man rarely committed suicide alone. Rather, in almost one half of those cases examined, the man shot his current or former partner and then, committed suicide. Another quarter attempted to kill their partners before killing themselves and ten children were also killed. When expanding their research, they found that almost one third of the 320 abusers who committed homicides between January 1997

and June 2006, committed homicide-suicides with an additional 12 abusers killing themselves after attempting to kill their woman partners. In many of the cases examined where the man did not kill or physically harm the partner, he did psychologically manipulate her into believing that it was her fault for not saving him from death (Washington State Coalition Against Domestic Violence, 2006).

Other studies have supported our findings that the woman herself can provide a good assessment of the man's dangerousness. Eisikovitz, Winstok, and Gelles (2002) examined escalation from nonviolence to violence in couples relationships and found that there were at least five junctures that they could identify where the woman perceived that the abuse could have escalated. Interestingly, the batterers perceived their use of aggression as a way to solve a problem with the woman, while the women perceived it as the man intensifying his use of aggression if she did not do what he required. Although Eisikovitz and her colleagues attempted to use these different perceptions as a call for revising the terms *victim* and *aggressor* in favor of understanding the reciprocal process going on, in fact, years of marital therapy using this model only seemed to increase the level of aggression if the woman did not give in to the batterer's demands. This is not new and has proved not helpful in lowering aggression especially where the woman is the victim of physical injury.

O'Leary and his colleagues have also studied the escalation of the man's aggression towards the woman and have found several points where the abuse went from psychological to physical violence and then, lethal violence (Arias & O'Leary, 1988; O'Leary, 1988). Their analysis indicated that there were interventions that psychotherapists could make that would prevent this escalation and may even stop the aggressiveness in the relationship. However, they acknowledged the difficulties of such interventions, preferring to work with couples where the abuse had not escalated into physical abuse. Some have called this period, *domestic discord*, rather than battering or domestic violence. Although Eisikovitz et al., found that their couples could return to a nonviolent level, most other researchers have found that once the violence turns physical, it is extremely difficult if not impossible to return to a violence-free relationship.

Jacobson and Gottman (1998) also studied the violent couple and found that there were at least two types

of batterers whom they termed the *pit bull* and the *cobra*. The pit bull is the type of batterer who won't let go of the woman. His anger escalates and is visible in his physiological signs such as heart pounding, blood rushing to the head, and heavy breathing accompanying his rising aggressiveness. The cobra gets calmer as he gets angrier and appears to be under very tight control, often physiologically shutting down with a slower heart rate and more deliberate actions. These terms have been found to be quite helpful in getting judges to recognize that even when the man is well dressed and well spoken, he can be extremely dangerous. The Jacobson and Gottman researchers found that women in a relationship with the cobra have a much more difficult time leaving the relationship due to fear that he will continue to stalk and harass her, using all kinds of verbal threats and surveillance techniques to keep her under his control. The cobra's aggressiveness is usually well thought through while the pit bull is more impulsive and reactive to what the woman does or does not do. Jacobson and Gottman also have designed several scales to assist in measuring psychological abuse techniques, particularly isolation and denigration and humiliation of the woman.

In the original BWSQ study, 60% of the original sample reported that they never felt that they really had control over the batterer's behavior; over three quarters believed he would continue to be a batterer, and four fifths believed he would batter another woman. What is even more surprising is that despite the women's perception of danger, 17% still believed he would eventually change, and not batter any longer. Perhaps they were in the group who was still living with the batterer at the time of the interview and still in denial about the seriousness of the violence. Power and control issues in the current study were discussed further in Chapter 3 as they contribute to the fourth factor in the BWS criteria.

Batterer's Violence-Prone Personality Patterns

In the original research it became clear that the women's reports of their batterer's personalities suggested they all went to the same *school* to learn the lessons of violent behavior.

The attitudes and behavior patterns in the men reported by the women strongly suggest the men have a violence-prone personality although it is not known if this is learned or genetically determined. While I previously estimated that only about 20% of the population of batterers exhibited other forms of violent behavior (Walker, 1979), the data from the first study caused me to reverse those statistics and estimate that only 20% limit their abusive behavior as just toward their wives. The other 80% may also engage in abusive behavior directed against other targets, such as child and parent abuse, incest, hurting pets and other animals, destroying inanimate objects, and responding abusively to other people. The high number of arrests (71%) and convictions (44%) as compared to 34% arrests and 19% convictions for nonbatterers in the first study also indicated a generalized pattern of violence-prone behaviors.

Abuse in their Childhood Homes

The women reported that many of these men have always lived in an atmosphere of violence in their families. This can be seen in Table 6.2. Spouse or child abuse occurred in 81% of the batterers' childhood homes as compared to 24% of the nonviolent men's homes. In 63% of the men's families, their fathers beat their mothers. This is in contrast to abuse in only 27% of the nonbatterers' homes. In 61% of the men's childhood homes, they told the women that their fathers battered them and in 44%, they told the women that they were battered by their mothers. In some cases, they were battered by both. These data become even more significant when compared to the 23% of nonbatterers beaten by their fathers and 13% beaten by their mothers. And, perpetuating the high level of violence in the family, over one half of the batterers (53%) reportedly battered their children. This is consistent with Hotaling and Sugarman's (1986) study that the highest risk marker to predict if a man will use violence in his relationship is if he was exposed to abuse in his childhood home.

Although the women reported these data about the men in the original sample, other research and clinical reports indicate they are still accurate (see for example, Brewster, 2003 and Mohandie, Meloy, McGowan, & Williams, 2006 on stalking and increased dangerous of batterers). Clinical experience has shown that batterers will volunteer little detailed information about the violent acts that they commit. However, once in effective offender-specific treatment programs, the

6.2 Battering History

Variable	Original Sample N	Original Sample %	Current Sample	Current Sample %
Battering in Childhood Home	267	67	67	66
Battered by Mother	147	41	43	50
Battered by Father	144	44	45	51
Father Battered Mother	156	44	56	62
Mother Battered Father	104	29	21	26
Mother Battered Sister(s)	62	21	22	29
Mother Battered Brother(s)	61	20	19	26
Father Battered Sister(s)	85	29	13	18
Father Battered Brother(s)	97	32	25	23
Spanked as Young Child	353	89	87	82
Spanked as Older Child	332	83	46	44
Hit with an Object	317	78	52	62

men's information corroborates the women's reports of their dangerousness (D. Dutton, 1995; Hamberger, 1997; Jacobson & Gottman, 1998; Lindsay, McBride & Platt,1992; Sonkin & Durphy, 1982). Orders of protection were sought by over one third of the women when living with a batterer as compared to 1% when with a nonbatterer. The issue of the effectiveness

of restraining orders will be discussed later. In any event, battered women feel stronger if they are armed with such an order and the police are more likely to offer protection when it is produced.

These findings are consistent with other research. In one of the few studies at the time of our original research that actually questioned the batterers, Hanneke and Shields (1981) found they exhibited three general patterns of violence. The three groups were: (1) men who were violent against family members only, (2) men who were violent against nonfamily members only, and (3) men who were generally violent against both family and nonfamily members. They found that men in groups 2 and 3 used the most severe forms of violent behavior and showed more similar characteristics than men in group 1 who were only violent with family members. Yet, despite important differences between these three groups, including groups 2 and 3 using violence as a general interpersonal strategy, they found no significant differences between them in use of life-threatening behaviors against the women they battered. This is supported by our data indicating that almost all of our subjects thought the batterer was capable of killing them.

Psychopathology or Learned Behavior?

While others have looked to some form of psychopathology to predispose men to become batterers, most of the literature suggests that they learn to be violent because such coercive behavior works. They usually get what they want with very few negative consequences. Exposure as a child to the use of violence as an interpersonal strategy seems to be a common pattern for batterers as found in our study and by Hanneke and Shields, 1981; Fagan et al., 1983; Hilberman, 1980; Straus et al., 1980; Frieze et. al., 1980; Gelles, 1983; Patterson, 1982; Reid et al., 1981, and others. However, such socialization alone is not enough to create a batterer. Certain environmental situations must also occur and the combination then creates a man who uses coercion (physical, sexual or psychological) as his primary means to obtain his needs.

Hanneke and Shields (1981) suggested that all three of their groups of violent men started out being generally violent as adolescents, perhaps similar to Patterson's (1982) and

Reid's et al., (1981) aggressive children. Their group 1 men, who were only violent in their family, tended to have higher educational levels and careers. They were more law-abiding in general than men in groups 2 and 3. Hanneke and Shields suggest that the more middle-class the man, the more likely his violent behavior will remain in the family only. This serves to keep his violent behavior invisible and doesn't threaten his social status.

But, at the same time, they found that about one half of the group of men were never violent towards family members despite their generally deviant life style. Hanneke and Shields suggest that perhaps there are some factors in those relationships that stopped them. Our data suggests that the men themselves may set such limits, and they can keep them only if they never do express physical violence directly towards their wives.

Reinforcement of violence as a strategy occurs at all levels in our society. It is particularly evident in some of our child-raising practices. When we teach children that it is appropriate to hit them for disciplinary purposes, we also teach them that the people who love them the most have the right to physically hurt them if they do something wrong. It should not be a surprise, then, that the men say they have the right to physically hit the women they love if they do something wrong. The women accept such minor abuse in the name of discipline. However, unlike most cases of child discipline, physically punishing an adult woman rapidly escalates into violent abuse. Considering that there are many more effective methods of disciplining children, such as time-out procedures, I strongly urge adopting no-hitting rules for all members in families.

Men's dominance over women in a patriarchal society is an important factor in spouse abuse, as is discussed in this book. Our data—Straus et al., (1980), Berk et al. (1983), and Fagan et al. (1983)—all demonstrate that in homes where the man is more dominant, the woman is more likely to suffer serious battery. The Berk study found that white men married to Hispanic women tended to be the most brutal in their sample. Martin (1976) has found that Asian women married to American servicemen tend to be brutally beaten. However, our research indicates that in general, race and ethnicity does not determine dangerousness.

Attachment Disorders

Psychologist Daniel Sonkin (www.daniel.sonkin.com) has been treating and studying batterers for the past 30 years. He has found that there are very high insecure attachment rates among both perpetrators and victims of abuse. His work has examined the ability of both the men and women who live in domestic violence relationships to regulate their feelings or their *affect* as feelings are sometimes called in psychology terms. Attachment theory states that all organisms need soothing behaviors from a figure with whom they will attach, especially if they cannot do so themselves. If the attachment figure does not take care of their needs and provide the soothing needed to make them comfortable, then they may get angry. This anger motivates the needy person to try to get those needs met somehow, usually by trying to get the attention of some attachment figure. If they do find some way to feel better, then the neurobiological alarm that went off will shut off. In some people, the anger does not dissipate and instead keeps festering, especially if there are long periods of feeling unsatisfied. Research has suggested that these neural pathways are formed by late adolescence or early adulthood, but if the person is subjected to high levels of certain biochemicals such as cortisol, which is released during fear and other uncontrolled emotions, then the pathways may not form properly. Thus, the capacity for attachment may be altered by both biology and environment, which means attachment disorders may be amenable to psychotherapy and good relationships (Dutton & Sonkin, 2003). The role of attachment issues is further discussed in Chapter 9.

Social Class

It is also interesting that in the many countries where I have traveled, the domestic violence problem is always ascribed to whatever group occupies the lowest status there. For example, in Israel, at first it was those who immigrated from Arab lands, then Ethiopian immigrants, and then the Russian immigrants who supposedly had the most violent relationships; in China, it was those who lived in the rural countryside; in England, it was the Indians and Pakistanis; in Latin America, the poor, unmarried women; in Africa, the tribal cultures; and in the United States, poor people of color. While most of the women who use the battered woman shelters

are indeed economically disadvantaged minority women, often with young children, in my travels, I have met battered women from all social strata. Battering is not a class issue although access to resources and safety may be. But, again like the middle-class men reported by Hanneke and Shields (1981), violence in the family can more easily remain invisible in the dominant class.

This is important information for other researchers to pay attention to. When studying domestic violence, it is of critical importance to the findings, to carefully select from where the population is to be gathered. If the sample to be studied is gathered from the criminal justice population only, it will skew the data towards the overrepresentation of the poor and marginalized classes. If social service or battered woman shelter populations are studied, data will also be skewed, as these groups are overrepresented using these services. On the other hand, in university clinics and counseling centers, mental health centers and private practice populations, more of the so-called advantaged or educated populations will be found. Divorcing populations would probably give a good cross-section from which to sample although many states that do not require a reason for divorce other than "irreconcilable differences" would not provide access to large numbers of those who seek dissolution of their marriages and thus, only those with problems will become known to the court.

Women's Violence Towards Men

Despite the opportunity men have had to report domestic violence by their female intimate partners, the rates of woman to man intimate partner violence has not changed much since statistics were first collected (Walker, 1984/2000). Analyses of Straus, Gelles and Steinmetz's first survey of family violence indicated that women used physical abuse against men (Steinmetz, 1978). However, it was later found that she extrapolated large numbers from the reports of six men in a small part of the study. Nonetheless, the attempt of some researchers and advocates to reanalyze the Straus and Gelles data, both in the first and other surveys has continued to claim that women are as violent towards men as are men to women, but men are too well socialized into not reporting it. Hamel (2005) has made one of the most cogent arguments based on clinical data he has gathered from court-ordered

batterer's intervention groups, but even his work has been critiqued by researchers for many of the same arguments that have surfaced over the past 30 years. For example, social worker, Ila Schonberg (2005) suggested that Hamel's misinterpretation of data, particularly from the Straus and Gelles National Family Violence Surveys of 1976 and 1985 is fueled by a backlash against women's fighting back against being abused. Although, Hamel presents data from his study of several California batterers' treatment programs demonstrating that less than one third of the men court ordered to attend the program claimed to have physically battered their intimate partners, it is unclear whether these men are responding to another definition of battering behavior, which Hamel proposed, or if they were simply in denial of their behavior. Unfortunately, imprecision in the definition of terms used within this field of study has hampered the ability to compare data from one study to another.

An attorney who produces the Domestic Violence and Sexual Assault Report and is well connected within what is loosely called the Battered Women's Movement, Joan Zorza (2005) likens the backlash in family violence to when Galileo risked torture and death when he dared to report the scientific findings from his telescope. The continued reports that women are equally violent as are men makes it even more difficult for agencies, particularly the courts, to believe women's perceptions of danger from further violence and then, leaves women more vulnerable to further abuse. However, the argument raised by Hamel is one that can only be answered by examining both the efficacy of batterer treatment programs, not just in Contra Costa County, California but in general and by reevaluating the way batterers are treated in programs. As Harway (2004) reminded us, not all batterers are alike, and many need different types of treatment programs rather than the one-size-fits-all that currently occurs. Some would be better served in psychiatric hospitals, others while incarcerated, and still others while in drug rehabilitation centers rather than in community-based offender-specific treatment groups.

The question of women's violence against men also has been investigated when women and men are dually arrested for domestic violence. In heterosexual couples it has been found that women are arrested for two types of violence; one type is for self-defense and the other type, is using violence instrumentally, or to get something they want. In one recent

study, these two types of behavior seem to be confused or perhaps, it is not confusion or rather, the police are using dual arrest to thwart the legislative intent of pro-arrest policies when on a domestic violence call. Henning and Feder (2004) found that almost five times as many women were arrested in a dual arrest situation in comparison to their male counterparts. While it is possible that these women were both victims and perpetrators of domestic violence, it is not consistent with the gendered model seen in other research such as the National Crime Victimization Survey (NCVS) where 85% of reported domestic violence victims are women. More recently a new national study was completed that once again found women were much more likely to report being abused by their current or former intimate partners than were men (22% vs. 7%, respectively) (Tjaden & Thoennes, 2000).

Critics of the gendered approach to reports of domestic violence suggested that there may be an offender effect where both male and female offenders underreport their violence relative to reports from their victims (Arias & Beach, 1987). Self-help books such as *Men are From Mars and Women are From Venus* (1992) have popularized the knowledge gained from social psychology research that women more often describe events in context rather than one event at a time. This has been found to be true in domestic violence research also (Walker, 1989b). Currie (1998) found that both men and women underreported men's violence directed towards women but men overreported women's violence towards them. Others have found that women's violence against men was more often used as self-defense (Cascardi & Vivian, 1995; Saunders, 1998; Henning & Feder, 2004). In fact, the only researchers who seem to favor the explanation that women are equally as violent as men, are those who have used the Conflict Tactics Scale to collect their data or have attempted to interpret parts of the Straus and Gelles data.

Nonetheless, there is a dearth of information about women offenders who have been arrested for domestic violence. Much of what is known supports the self-defense argument. However, there are increasing numbers of women who are arrested for other problems but who also have been victims of domestic violence. In Chapter 14 several programs for women in jail including the application of the Survivor Therapy Empowerment Program (STEP) by psychology students in jail is described. Feder and Henning (2005)

studied 317 dually arrested men and women, with 80% African American and 20% Caucasian. Their ages were similar to those in our current study, but 72% of the couples were unmarried and dating partners and almost two thirds of the women had children living in their home at the time of the offense. Their results indicated that obtaining data just from the criminal justice records did not match what the women and men described in the clinical interviews. For example, the criminal justice arrests recorded that women-only were only 5% of all the domestic violence cases while women together with men were dually arrested in one third of the arrests. Slightly more than one third of the arrests involved a weapon and about one fifth of the injuries required medical attention. Alcohol or other drug use was noted in over one third of the arrests.

No significant differences were noted between men and women arrested. However, when men and women were interviewed, there were major differences noted. Women were more likely to use a weapon against their partner, while men were more likely to have abused alcohol or drugs. But, dually arrested men were more likely to have physically assaulted their partners in an escalating pattern of violence causing injuries than did dually arrested women. Even more interesting, almost 80% of the women reported that the batterer had used physical violence on them prior to the incident for which they were being arrested with one half having threatened to kill them. Thus, many of the crimes that women have been arrested for may well be associated in some way with their violent relationship. Two thirds of the women had called the police previously. Obviously these differences between male and female arrestees are significant to the argument that female violence against males is not the same as male violence against women.

Domestic Violence Treatment Programs

When first designed as an alternative to incarceration for batterers who were motivated to change their abusive behavior, domestic violence or offender-specific treatment programs were hailed as an important strategy in stopping violence against women. However, review of 30 years of providing special treatment programs has suggested that it has not

fulfilled its promise. More battered women have cooperated with the criminal justice system when there is a treatment program for their batterers. But, the effects of the program have been limited and account for only a minimal impact on reducing recidivism beyond the actual arrest and overnight incarceration. In trying to understand why these programs have such a minimal effect on getting batterers to change their behavior there are two major reasons. First, these programs are not psychotherapy but rather, psychoeducational in nature, and are too short to be of much value even when therapists are well trained in the area. Second, all batterers do not need the same type of intervention and these types of programs are designed to be manualized; meaning the therapists must follow the same steps for all those who attend the groups. For example, although the literature suggests that psychopaths get worse with psychotherapy and it is believed that at least 20% of batterers who are arrested have psychopathic traits or tendencies, they are grouped together with other types of batterers.

Far too many batterers have other mental health and substance abuse problems in addition to their propensity to use violence when angry. These groups do not deal with either the mental illness or substance abuse problems, leaving these men without adequate treatment to foster and maintain behavior change. Most of the psychoeducational treatment programs that accept court-ordered men do not pretend to do psychotherapy. In fact, one popular model, called the "Duluth" model because it originated in that city, claims to be strictly looking to change attitudes, which will then change behavior. However, it is lacking focus on the most important ingredient in any behavior change program which is the therapeutic relationship to the therapist. In fact, therapists are encouraged to be in contact with both the victims and the court so that the usual confidentiality that accompanies the psychotherapy relationship is not afforded these participants. It is not known if any of these factors actually account for the lack of success or if getting violent men to change their behavior is just too complex and difficult to expect will happen with psychotherapy or psychoeducational groups. Treatment providers are inconsistent in providing an answer to this dilemma while courts continue to depend upon batterers to stop their abusive behavior when they order them into treatment.

Risk Assessment

Although it has great promise to identify those batterers who might be helped by treatment and those who are too dangerous to be near their families, the relatively new forensic psychology field of risk assessment of potential or further violence has not been adequately studied, nor has it utilized the population of those families involved in domestic violence as part of its basis. This is partly due to a debate in the field with some (Hart, 1988) insisting that the woman's predictions of severity is the best risk assessment, others believing that clinicians working with the woman can best predict escalation and severity of changes over time (see Harris, Rice & Quinsey), 1993), and still others favoring a more statistical analysis (Campbell, 1995, Monahan, 1981). Hart's analysis from shelter claimed that the women themselves are the best predictors of risk as they know the batterer best. However, those women who have made accommodations with the abuse, using denial and minimization in order to be able to stay in the relationship, may not recognize or communicate the rising levels of danger even if they perceive it. Some women actually perceive the rising danger but doubt themselves because the batterer has called them *crazy* or has used other words designed to make them more under the batterer's control (Dutton & Dionne, 1991). Monahan and his colleagues working on the 15 year MacArthur Studies have demonstrated that even clinicians have difficulties in recognizing and reporting high risk situations without the assistance of risk assessment materials.

Risk Assessment Studies in Domestic Violence

Much of the previous research on risk assessment has been conducted with mental patients or adjudicated violent criminals, not those committing domestic violence, most of whom do not get arrested or into mental health treatment on their own. This is problematic for many reasons, perhaps the most important is that there is some evidence that batterers who use the most severe physical abuse during the relationship might be different from those who escalate their physical violence during the threat of separation (Holtzworth-Munroe & Stuart, 1994; Jacobson & Gottman, 1998). There have been

several attempts to develop risk assessment instruments for use by clinicians and researchers. The first to be developed for research was the Conflict Tactics Scale (CTS) (Straus, 1979) but its inability to measure abuse within context, emphasis on physical abuse, dependence upon adding numbers of violent behaviors and not using the multiplicative effects of continuous abuse, and frequent misinterpretation of the data does not permit clinicians to have confidence in its ability to predict risk of dangerousness (Walker, 1989b). When discussing additive violent behaviors it is meant to signify research that simply counts how many times the batterer hits, kicks, bites, throws, chokes, and otherwise harms the woman using physical force. However, all slaps, kicks, and other physical acts are not the same. Some are more frightening than others, especially if accompanied with a certain look on the man's face that signals to the woman that he is out of control. Others, are qualitatively different in the type of slap, the length of time the choke hold is held or other differences in an act described by the classification it fit into. The effect on the woman of each type of act will impact on her behavior that may influence the next act inflicted by the man. This could have a multiplicative effect; in other words, the quality of the act will increase its impact beyond the expectation of its frequency.

One of the most damaging results from research using the CTS is the insistence by some analysts that the data from the instrument proves that women use violence as often as do men and sometimes they are even more violent. This misinterpretation most easily occurs when using an instrument that strips the context from the events. For example, one slap by the woman becomes equivalent to one slap by the man, even if it is the first slap she has used while it is the 1000th slap from him to her (Hamel, (2005). Sonkin (www.daniel-sonkin.com) has developed an assessment instrument to be used on the Internet that calculates risk from the number of times various physical, sexual, and psychological events occurred. This measure is dependent upon the woman's or the man's memory of behaviors that occurred and when. Aside from figuring in the extent of the damage from the abuse itself, it is also important to recognize that who might escalate to violence in an argument first is rarely an accurate way to determine who is the primary abuser. While there are relationships where mutual violence does occur, in fact, most of these relationships start out with the man

abusing the woman and eventually the woman escalates it either to try to equalize the violence, a form of psychological protection, or to protect herself from further physical harm. Attempts to confront the myth that women are as violent as men were discussed earlier in this chapter.

The Spousal Assault Risk Assessment checklist (SARA) has some known validity with certain groups but has not been empirically validated for prediction of danger (Kropp, Hart, Webster, & Eaves, 1999). As the SARA is basically a checklist of factors and domains used in the violence risk actuarials that are based on empirical data, it should not be too difficult to empirically validate the SARA, especially since many battered women shelters and programs embed its items into their data collection. Interestingly, in an analysis of the 1985 National Family Violence Survey, Straus (1996) found that three or more assaultive incidents within a year, along with three or more criteria from a list of 18 including police involvement, drug abuse, extreme male dominance, abuse of a child, violence outside of the family, and frequent verbal aggression were also predictive of increasing aggression. Most of these items are surveyed in the SARA.

Campbell (1986; 1995) and colleagues (Campbell, Webster, Koziol-McLain, Block, Campbell, Curry, Gary, Glass, McFarlane, Sachs, Sharps, Ulrich, Witt, Manganello, Xu, Schollenberger, Frye, & Laughton, 2003) have been statistically developing a risk assessment instrument, Danger Assessment Scale (DAS) to measure the danger of homicide. The assessment scale is used by researchers and clinicians working with domestic violence victims and perpetrators. In a recent study, with multiple sites across 11 cities where femicides occurred Campbell compared these women's danger signs using proxies with others in the same city. Not surprisingly, she found that 79% of the femicide victims had been physically abused prior to their death by the same intimate partner who killed them. They found that two risk markers for femicide accompanied the models; the first was the presence of the batterer's children in the victim's home and the second was the attempt at separation of the couple (Campbell et al., 2003).

Their models for their study demonstrated that the other factors also expected to be risk markers held up with availability of guns owned by the abusers and the victims as highly predictive of a fatality. If the woman is about to leave the batterer for another partner, this also increases the danger, even

more than if she leaves for other reasons. In a small percentage, 5% of the women in this study who lived apart from their intimate partner, owned a gun but there was no evidence that the ownership of the gun was a protective factor. However, never having lived with the batterer was a protective factor. Interestingly, previous arrests were also a protective factor against intimate partner femicide in the final models but all of the cities in the study did have coordinated community responses when such arrests were made. Campbell suggested that practitioners should make reports to the police as a protective factor if the women they are treating wish them to do so. Browne and Williams (1989) had found that women who expected the community responses to work and did not, were more vulnerable to being killed. So it is not just prior arrests but also the follow up that accompanies the arrest that protects women from being killed. It is unclear that clinicians working with battered women have sufficient knowledge about community responses to determine whether or not a report is truly a protection for the woman.

Saunders (1995) reviewed many of the risk assessments available prior to the development and refinement of the current assessment of violence used in the general forensic psychology field today. In a more recent study, with other colleagues (Weisz, Tolman, & Saunders, 2000) they attempted to undertake an actuarial investigation of the domains of domestic violence risk markers using the data generated by Harell's (1991) study of treatment outcomes from batterer's offender-specific treatment programs. This permitted comparison of the survivors' general rating of risk markers, a statistical approach similar to Campbell's *Danger Assessment* instrument, and a combination of both approaches. The authors defined severe violence as threats to kill and threats with a knife or gun as they both usually precede or accompany the death of the victim. Using bivariate and multivariate analysis, they found that the risk markers alone were not as strong as predictors of further violence alone but with the addition of the women's predictions of danger of repeated violence, the risk rose to a higher level of dangerousness and lethality. Still, the ability to predict risk of further violence was weak for a four month period.

Other studies have attempted to use longer periods, such as 15 months in the Heckert and Gondolf (2004) study. A history of repeated violence between court dates was perhaps the most significant risk marker in the Weisz et al (2000)

study while the Heckert and Gondolf study found several other risk markers using a different statistical design. Not surprisingly, they found that if the woman felt *uncertain* if the man would repeat the violence, he usually did repeat, but her report of feeling safe was not necessarily accurate. For example, they found that the woman's assessment of feeling *somewhat safe* as compared to *very safe* was the best predictor of repeated violence. There were also limitations to the risk assessment instruments that were used by Hecker and Gondolf including the above discussed Campbell *Danger Assessment Scale* (DAS) and the *SARA*. Interestingly, the predictive value of these risk assessment instruments was enhanced by the addition of the woman's own predictions of danger. Although the limitations in both of these studies may have introduced bias, for example, the woman gave both the self report for the repeated violence as well as the prediction of further violence, albeit at different times, it is still important to emphasize that both predictions are an important part of risk assessment. Unfortunately, as a rule, the courts do not respect women's predictions and in fact, often penalize the woman and accuse her of exacting revenge against the man, or when children are involved and the woman attempts to protect them, label her as causing "parental alienation" or having other mental health diagnoses.

Sonkin and Walker (1995) in our review of the studies of homicides indicated that there were approximately 15 factors that stood out as adding to the high risk:

LETHALITY CHECKLIST

- Frequency of violent incidents escalating
- Frequency of severity of violence escalating
- Man threatens to kill woman or others
- Frequency of alcohol and other drug abuse increasing
- Man threatens to kidnap or harm children
- Man forced or threatened sex acts
- Suicide attempts
- Weapons at home or easily accessible
- Psychiatric impairment of man or woman
- Close to each other at work and at home (stalking and surveillance)
- Man's need for control around children
- Current life stresses

- Man's prior criminal history
- Man's attitude towards violence
- New relationship for man or woman

Forensic Psychology and Risk Assessment

Courts have traditionally asked mental health professionals for predictions of dangerousness. Although battered women advocates and researchers have demonstrated that the woman's perceptions of dangerousness are better than the risk assessment tools alone, and enhances the models of prediction of further danger, they are not being used in the same way as the general violence risk assessment. Recent research from the MacArthur Foundation has challenged the assumption that there is a unitary concept called "dangerousness." Rather, the research suggests that what mental health professionals can do best is to reframe the question of dangerousness into one of risk assessment. Instead of a dichotomous statement (danger, yes or no), the risk assessment research suggests that we can identify relevant risk factors, evaluate a given individual to see on which risk factors there is loading, modify those risk markers in terms of various contextual factors, and then provide a probability estimate of the likelihood of future violent behavior. Even in the larger forensic field, there has been a great deal of controversy regarding what kinds of assessments would be most appropriate, ranging all the way from a purely clinical to a purely actuarial approach. Since in assessing for general dangerousness there is usually not one repeated victim, like in domestic violence, so the victim's predictions of future dangerousness has not been seen as an option to add to the models generated.

The tendency in the field at the present time is to use some kind of structured interview format, in which the areas of inquiry are fixed, based on the extant research in a particular area. This is referred to as a structured clinical approach, and is the basis for instruments such as the Historical, Clinical, Risk Factors (HCR-20), the Sexual Violence Risk (SVR-20), and the Psychopathy Check List, Revised(PCL-R). The BWSQ was developed using these principles. Once there is an estimate of the potential for violence, given a certain context, various intervention strategies can be devised to address the specific risk. For the most part, however, as suggested earlier, most of this major research has not studied,

as a separate entity, domestic violence. Even the risk assessment instruments that show some promise, with similar structured interview formats, (such as the SARA and DAS discussed above), but the research in this area appears to be lagging behind studies of more generalized forms of violence. In doing any kind of risk assessment, the examiner needs to specify what the referral question is. For example, what kind of violence are we trying to assess?, what does the empirical data regarding base rates show for a given population?, are there idiographic factors that make a particular individual more or less like the hypothetical person described by the actuarial data?, what contextual factors further modify this assessment?, how should that information should be communicated?, and what intervention strategies may be effective in lowering the risk of further violence?

Actuarial Approach to Risk. Let us now look at some of the specific assessment instruments used in violence risk assessment to see if there is applicability to the field of domestic violence risk assessment. As noted earlier, at one extreme is the pure actuarial approach, where various static variables, such as age, number of years of education, family structure, number of previous offenses, and substance abuse are plugged into a formula. What emerges is a likelihood of recidivism percentage. Proponents of this approach maintain that since it does not rely at all on clinical judgment, it is *pure* and not influenced by variability among clinicians. Proponents of this approach further maintain that attempting to modify or adjust the actuarial equation with clinical input actually reduces the accuracy of the prediction. Some examples of these instruments are the Violence Risk Appraisal Guide (VRAG), Sexual Offense Risk Assessment Guide (SORAG), the RRASOR (Rapid Risk Assessment of Sexual Offense Recidivism), the STATIC 99, and the Minnesota Sex Offender Screening Tool, Revised (MNSOST-R).

On the opposite extreme are the purely clinical approaches, in which an individual clinician, guided by her or his own theoretical orientation regarding the etiology of violence asks a series of questions that are supposed to elicit answers helpful in determining the potential for recidivism. There are no standardized questions or tests used here, since the interview approach of one clinician may differ from another. The middle ground is occupied by those assessments described as structured clinical approaches. Here, a body of research, such

as the MacArthur Foundation, may be surveyed to determine what are the primary risk factors to be considered in an assessment of violent behavior. These factors are then used to structure the interview; as long as the clinician covers all of the risk factors, how she or he goes about doing the interview is left up to the individual. As noted above, the HCR-20 and the SVR-20 are examples of these assessments.

The MacArthur research has identified approximately 30 "domains" or risk factors that need to go into a comprehensive risk assessment. These are presented in Table 6.3. Some of these are "collapsed" into other factors, as seen in the 20 factors of the HCR-20 presented in Table 6.4. As was mentioned earlier, the HCR-20 is the only risk assessment that uses clinician report as well as static variables in the MacArthur group. While there is some variability, generally the examiner looks for various demographic variables that "anchor" the assessment, and then looks at psychological, sociological, biological, and contextual variables.

6.3 MacArthur Variables

- Demographic Variables
  - Age Range, Sex, SES
- Sociological Variables
  - Peers & Family support violence
  - Economic Instability
  - Familiarity & skill with weapons
  - Size of potential victim pool
    - Particular pattern or random
- Biological Variables
  - History of head injury
  - Soft neurological signs
  - Abnormal neuropsychological findings
- Psychological Variables
  - Mental Disorders
  - Substance Abuse (most powerful predictor)
  - Poor Impulse Control
  - Low Intelligence

6.4 HCR-20 Variables

- Historical Items
  - Age at first battering - younger = higher risk
  - Early maladjustment
  - Other relationships with abuse
  - Employment Problems
  - Substance Abuse Problems
  - Major Mental Illness
  - Personality Disorder
    - Psychopathy
- Clinical Items
  - Lack of insight
  - Negative attitudes
    - violence justification
  - Active symptoms of major mental illness
  - Impulsivity
  - Unresponsive to treatment
- Risk Management Items
  - Plans lack feasibility
  - Exposure to destabilizers
  - Lack of personal support
  - Stress

Of some interest is that a risk factor that weighs heavily in virtually all of the risk assessments noted, both clinical and actuarial, is the dimension of psychopathy. As described by psychologist, Robert Hare (1996), psychopathy is a constellation of affective and behavioral characteristics including not only antisocial behavior, but also impulsivity, irresponsibility, a grandiose sense of self, a callousness in interpersonal relations, a tendency to externalize all responsibility, and pathological lying. Table 6.5 lists some of these variables.

There does appear to be some overlap between the psychopath as described by Hare, and some types of batterers, particularly the cobra, as described by Jacobson and Gottman, but this has not been researched at the present time. Using Straus's (1996) list of risk markers together with Campbell et al., (2003), Saunders (1996), Sonkin (www.daniel.sonkin.com)

6.5 PCL-R Variables

- Glibness/superficial charm
  - Does he have Dr. Jekyll -Mr. Hyde lability?
- Grandiose sense of self worth
  - Narcissism
- Need for stimulation/boredom
  - Fear of being alone
- Pathological lying
- Conning/manipulative
- Lack of remorse or guilt
  - Blames others or is always feeling guilty
- Shallow affect
  - Very affectionate or shallow affect
- Callous/Lack of empathy
  - Over concern or no empathy
- Parasitic Lifestyle
  - Over invested in power job
- Poor Behavior Controls
  - Poor boundaries or over control
- Promiscuous Sexual Behavior
- Early Behavioral Problems
- Lack of Realistic, Long Term Goals
- Impulsivity
- Irresponsibility
- Failure to Accept Responsibility for Actions
  - Blames others or situations
- Many Short term relationships
- Juvenile Delinquency - Adult criminality
- Revocation of Conditional Release

and Weisz et al., (2000), as described above, it is possible to develop a risk assessment instrument that would include all of these variables.

Homicide

Occasionally, the violence between the man and woman escalates out of control and someone dies. Most of the time, it is the woman; her batterer either kills her or she commits suicide as a result of his abusive behavior. Sometimes they both die; he kills her and then himself. And, in a smaller number of cases, the woman strikes back with a deadly blow and kills the batterer. While statistics vary, just reading the newspaper gives a good estimate of the number of such deaths. The 1994 FBI Uniform Crime Report indicated that approximately one quarter of all homicides in the United States occur within the family. Wolfgang (1968), studying homicides in Philadelphia, found that one quarter of those homicides occurred within the family and one half of those were between spouses. Of those, only 11% of the homicides were committed by women.

Campbell (1981), in her study of homicides in Dayton, Ohio, found that 91% of the murderers of women during an 11 year period (1968–1979) were men. She also reports that in 1977, of the 2740 American female homicide victims, 2447 of the perpetrators were men. Of the 8565 male victims, 1780 of the offenders (21%) were women. In her Dayton sample, 19% of the perpetrators who killed men were women. Steadman (1986) notes that the homicide rate in the U.S. occurs at a base rate of 9 in 100,000 and the homicide rate where there is known family violence is 16,000 in 100,000. Another way to look at the risk is in percentages; the Bureau of Justice Statistics (1994b) indicated that 16% of all murder victims whose killers were tried in large urban courts in 1988 were members of the defendant's family. The remainder were killed by friends or acquaintances (64%) or strangers (20%). Among black partners, women were about equally responsible for killing their partners as were men but among white partners, 38% of the victims were men killed by women and 62% of the victims were women, killed by their man. It would be interesting to know how many of those women had told others that they knew their batterer would not seriously harm or kill them. In family murders, 45% of those killed were women but only 18% of those killed were women in non-family murders.

Campbell concluded that the predominance of men killing women results from the misogyny created by our patriarchial society. Certainly, it doesn't appear to be accidental.

Ann Jones (1980) has found that, historically, the rate of women committing homicide against anyone has remained around 15%. However, today we know that it is more likely that the women who kill men are doing so in self-defense after a period of having been the victim of his violence. An Italian psychiatrist, who studied 30 men in prison for killing their wives, found that almost all had been seriously abusing the women prior to their deaths (Neschi, personal communication, 1981). Charles Ewing's (1987) studies have similar findings. However, although 74% of all defendants on trial for murder had a prior criminal record of arrest or conviction for a crime, a substantial percentage of victims (44%) also had a prior criminal record. Only 19% of family murder victims had a prior criminal record as compared to 51% of non-family murder victims and only 56% of family murder defendants as compared to 77% of other murder defendants had a prior criminal record (BJS, 1994b).

Interspousal homicide is rarely unexpected. Battered women in our sample recognized the potential for lethality, even though they often denied it would really happen. Almost all of the women (92%) believed that the batterer could or would kill them and 87% of the women believed if someone would die during a battering incident, it would be them. About one half said they could never kill the batterer, no matter what the circumstances, while the other half said they possibly could kill him. Only 11% said they had tried to kill him and 9 women out of the original sample of 403 actually had been successful. Several men had killed themselves while the woman was involved with our project and others had done so earlier. Relationships that have a high risk for lethality can be recognized, albeit retrospectively, although prediction is still difficult given the large number of high risk battering relationships that do not result in homicide. In fact, the number of women who are killed by men with whom they have been in a violent relationship is about the same as those who do not have any earlier abuse history. The latest NCIS reports indicate that these figures break down into 40% of women who live in suburbia and 60% of those in urban areas who are killed by former or present partners (BJC, 1994a).

Angela Browne (1987) analyzed the data from the original research study for lethality patterns and found that there

were a number of high risk factors to look for when attempting to protect women from being killed. Some characteristics of relationships at high risk for interspousal homicide include an intense level of attachment and involvement between the two parties, a history of physical and psychological battering, and threats of further violence, or even death. Pathological jealousy, sexual assault, violence correlates such as child abuse, injury to pets and animals, threats and actual violence against others, and alcohol and/or drug abuse are also part of the highly lethal relationship.

In Chimbos' (1978) study of Canadian spousal homicides, 70% reported repeated physical abuse and 83% reported a physical fight within four months of the fatal incident. In many of our cases, there is also a longer period of loving-contrition behavior, as described in Chapter 5 as the third phase of the cycle of violence, and then a gradual escalation of the abuse again. In the Chimbos study, over half of the survivors reported threats to kill made either by the offender or victim, prior to the fatal incident. The threat, which had occurred many times before, was taken or given more seriously this last time, and someone died. These data have continued to hold steady in more recent studies as well (APA, 1996a). A Kansas City study found that there had been a domestic disturbance call at least one time prior to the homicide in 85% of the cases, and in 50% the police had been involved at least five times (Gates, 1978). It was not uncommon for the women in our study to report that neither the police, nor others they had told, took the threats of further violence or death seriously. The problem caused by the police officer's inability to understand the high risk of lethality in responding to domestic disturbance calls will be discussed later. However, in the intervening years, there have been significant changes in how police respond to domestic violence calls helping to keep women safe.

Several factors are more common in the life histories of individuals where an abusive relationship ends in the death of one or both partners. Some of these factors, such as a high degree of social isolation, longstanding battering histories, use of coercion as the major form of communication in resolving interpersonal conflicts, and a high degree of withdrawal through the abuse of alcohol and drugs have been confirmed by the major researchers in this field, to date. (Chimbos, 1978; Totman, 1978; Gelles, 1972; Straus et. al., 1980; Jones, 1980; Berk et al., 1983; Fagan et al., 1983).

Women Who Kill in Self-Defense

In our work at Walker and Associates since the original research project, we have had the opportunity to evaluate over 400 battered women, in addition to the original nine, who have struck back in self-defense with deadly force. The data on the first 100 cases were reported in another book, *Terrifying Love: Why Women Kill and How Society Responds* (Walker, 1989a). These interviews, similar to those done with the over 500 women in the research projects, have provided a rare glimpse into the escalation of violent behavior to its ultimate conclusion, death and destruction of human lives. In each case there were numerous points when some intervention might have prevented the tragic outcome. The women felt that no one took them seriously, that they alone had to protect themselves against brutal attacks, and that they knew by observable changes in the man's physical or mental state that this time he really would kill them. Most of the time the women killed the men with a gun; usually one of several that belonged to him. Many of the men actually dared or demanded the woman use the gun on him first, or else he said he'd kill her with it. Others seemed to set up their own death in other ways, similar to the group Wolfgang (1968) studied.

Some women, who had made suicide attempts previously, at the last second before killing themselves this time, turned their rage against their tormentor. Most women who killed their batterers have little memory of any cognitive processes other than an intense focus on their own survival. Although, retrospectively, it can be seen where her defenses against denial of her anger at being an abuse victim are unraveling, the women do not have any conscious awareness of those feelings. Their descriptions of the final incident indicate that they separate those angry feelings by the psychological process of a dissociative state and thus, do not perceive them. This desperate attempt at remaining unaware of their own unacceptable feelings is a measure of just how dangerous they perceive their situation. They fear showing anger will cause their own death, and indeed it could, as batterers cannot tolerate the woman's expression of anger.

In less lethal situations, the battered woman might deal with the high level of appropriate anger at being abused in other ways. Our data showed that going "crazy," becoming physically ill, abusing prescription drugs and alcohol, becoming passive and servile, and expressing anger in safe, public

situations all helped lower the immediate risk of homicide or suicide, but only for a time. The women all told of ways they learned to keep control of their own minds, recognizing that the batterer had the ability to control their bodies. They let the batterers think they were stupid or suggestible and appeared to conform to his wishes. Sometimes, despite these efforts at only making believe, his mind control techniques were successful. For some of the women who kill, however, their violence is a desperate attempt to keep him from gaining total control of their minds, too. For example, several told us of how the men managed to convince doctors to prescribe major psychotropic drugs for the women and began supervising their taking them.

Desperation

Although our data indicate the women kill their abusers for different reasons, they all resorted to using such violence as their last attempt at protecting themselves from further physical and mental harm. These findings are similar to other's who have also concluded that women don't kill unless it is their last resort (Browne, 1987; Ewing, 1987; Jones, 1980; Walker, 1989a). They don't want the batterer to die, but rather, they just want him to stop hurting them. Thus, to predict the risk of lethality, it is important to assess the level of the victim's coping skills. If she is feeling terrified, overwhelmed, angry, or trapped, and perceives a high level of dangerousness in his behavior, then, in certain situations, she could respond in self-defense with deadly force.

Children

Children in the home add to the stress and opportunity for more violent behavior, although their presence is not sufficient to add to the risk factor unless they are involved in the violence. This involvement can include protection of their mother from abuse or the woman's attempt at protection of the children from the father's abuse. Several women shot their husbands rather than let them physically or sexually abuse their children. Others acted with adolescent or adult children for protection with one or the other or both administering the fatal blow to the man who had abused them. In several cases, the presence of adult children in the home

served as a deterrent; once they left, the batterer's violent behavior escalated.

Threat to Kill

Another high risk situation which increases the potential for a lethal incident is the occurrence of threats to kill made by the batterer. In the original research sample, over half of the women (57%) reported that the batterer had threatened to kill someone else beside herself, and half reported that he had threatened to commit suicide. Women who killed in self-defense recognized that something clanged in the final incident and believed that he was going to act out his threat this time. Only 11% of the women studied said they had ever threatened to kill anyone other than themselves. Very few of the women who actually killed the batterer had threatened to do so earlier, although overzealous prosecutors often try to use a general kind of statement, like, "I'm gonna kill him for that," as evidence of premeditation. This is consistent with the Browne (1987), Ewing (1987), Jones (1980), Pleck (1979), and Bende (1980) reports of actual homicides committed by women.

Suicide Ideation and Attempts

Over one third of the women told us about having made suicide attempts while living with a batterer. There is no way to know how many women who successfully commit suicide were driven to it by abusive men. We do know from suicide studies that the threat of death from a terminal illness raises the likelihood that a person will choose to die at his or her own hands. Perhaps, battered women believe that batterers will inevitably kill them and choose to kill themselves instead. Since the original study, clinical reports indicate that many women feel that the only way to take back control over their lives is to choose when to end it, especially if they believe that they have a foreshortened future, as is common in trauma victims.

Presence of Weapons

The presence of weapons in the home also seems to increase the risk for a lethal incident to occur. While about 10% of the

battered women in the research study reported being threatened by a dangerous weapon during an acute battering incident, many more indicated that the presence of guns in their homes constituted a constant threat to their lives. In contrast, in the sample of 50 women who did kill their batterers, almost all of the men reportedly seemed fascinated by weapons and frequently threatened the woman with a weapon during abusive incidents. For that sample, of the 38 women who killed the batterer with a gun, 76% used the same weapon with which he had previously threatened her. Each of them believed he was prepared to make good on his threat to use it against her. In the later samples we found similar proportion of homicides committed with the same gun that the batterer had used to threaten to kill the woman with.

Isolation

Threats of retaliation made by the batterer also raise the risk for lethality. Women commonly reported phrases such as, "If I can't have you, no one will"; "If you leave, I'll find you wherever you go"; "Just do that and you'll see how mean I can really be." Threats of bodily mutilation such as cutting up her face, sewing up her vagina, breaking her kneecaps, and knocking her unconscious also served to terrify women and confirm their fears of receiving lethal blows. They often isolate themselves from family and friends who could help because of the batterer's threats to hurt, mutilate, and/or kill them, too. Many of the women said that they learned not to let him know how much someone meant to them, simply to protect that person from being threatened by the batterer. The more isolation, however, the higher the risk for a lethal incident to occur. In fact, one of the main hints for families and friends of battered women is to keep hanging in with contact as the more the isolation can be broken, the more likely the woman will be rescued from serious or fatal injuries.

Jealousy

The presence of the man's excessive jealously has been described as a major component in battering relationships. Campbell (1981) cites data to support jealousy as the predominant reason given by men who kill their wives or lovers. Hilberman and Munson (1978) found pathological jealousy

to be a cornerstone to homicidal rage in their study of family violence in North Carolina. Based on our data, this jealousy is most often unfounded; the abused women in our research were not that interested in another sexual relationship. However, the batterers' need to control their women leads them to be suspicious and intrusive. Sometimes their very possessiveness drives some women briefly to another man. But, more often, it is the batterers who are involved in other sexual liaisons. Some of the battered women were unable to control their jealous feelings, especially when the men flaunted the other women. A few of the women killed the man when he set up the situation to be "caught." For these women, the defenses to control their anger were no longer adequate, and their rage exploded. The jealousy seems to be used as a catalyst for the women while it provides the entire rationale for the men who kill. Nevertheless, despite the differences in men and women, the presence of excessive jealousy is a high risk factor for prediction of lethality.

Substance Abuse

Alcohol and drug abuse is another high risk factor for potential lethality. While the exact relationship between alcohol intoxication and battering is not clear, excessive drinking is often present in those relationships in which there is a fatality. None of the research, to date, including ours, finds a direct cause and effect relationship between chemical substance abuse and aggressive behavior. Nonetheless, it cannot be ignored that 88% of the men and 48% of the women were frequently intoxicated in the 50 homicide cases, as compared to 67% of the men and 20% of the women in the research study. Although getting high or drunk is not a cause of abusive behavior, it may facilitate it. An offender may become intoxicated to excuse or escalate the violence, or the altered state of consciousness may cause poor judgment in dealing with the aggression. A full discussion on the findings concerning alcohol can be found in a later chapter.

In our study we found that both the frequency and severity of the abuse escalated over time. Two thirds (66%) of the women said that the battering incidents became more frequent, 65% said that the physical abuse worsened, and 73% reported that the psychological abuse became more severe.

Escalation of Abuse

It is often helpful to contrast the violent acts reported in first battering incidents with more recent incidents. Higher lethality risk is predicted when the first incident starts out with life-threatening or severe violent acts or injuries. Sharp escalation rates are also a predictor. In working with battered women, it is useful to graphically demonstrate how the violence is increasing so she can recognize its dangerousness and her need for greater protection.

Although the prosecutors in the O.J. Simpson murder trial claimed that his anger towards Nicole Brown was escalating and therefore this proved that he killed her, in actuality there were no data that supported this allegation. In fact, O.J. had been away playing golf and working on a film for most of the two week period prior to Nicole's death. The weekend before she was killed, he and his then current girlfriend, who had been seen at a charity event, had signed a contract with a designer to redecorate his bedroom to accommodate their different tastes. The day of the murders a videotape taken by another person supported O.J.'s contention that he was in a good mood at a dance recital that they both had attended for their young daughter. Reports from people who sat next to him on the airplane to Chicago that left after the murders had occurred also reported his good mood. Although many of the domestic violence advocates wanted this case to be a poster for danger of homicide in these relationships, in fact, the pattern of their last few months together was not typical of what has been found in the research where other batterers have killed their estranged partners.

Measuring Severity of Violence: The Battering Quotient

Neither the violent acts or the resultant injuries alone cannot measure the severity of the battering relationship. Rather, a combination of both must be used. To predict lethality, two other factors must be included: the frequency with which the beatings occur and the total length of time in the relationship. The latter variables were measured directly in the questionnaire, while the first two variables require interpretation, since perceptions of seriousness or severity were not directly assessed.

One of the goals, following completion of the original research, was to develop a Battering Quotient to assess severity and predict lethality in a battering relationship. This task was begun, with hopes of further funding, by having both battered women and shelter staff rate their perceptions of severity of injuries and violent acts on a 1 to 100 scale. The battered women living in shelters who completed these ratings turned out to be "unreliable" because they tended to give rating scores of 100 to acts or injuries they themselves had experienced, regardless of a more "objective" standard of seriousness or severity. This has become a more important finding today than we initially thought at the time because of the difficulty in identifying those women who are more likely to heal from their experiences and become survivors and those who remain caught up in a victim lifestyle. There appears to be several stages of healing that take place for those who go on to become survivors including an intense self-focus without the ability to discriminate protective actions, which is then supplanted by a more generalized view of violence against women from which there is no effective protection and then, the development of some ability to protect from some violence even if it is not complete protection.

Consequently, in order to proceed with the development of a Battering Quotient, we had the acts and injuries rated by 20 shelter staff and project interviewers. Each act was rated under three headings: threatened but not committed, committed briefly, and committed repeatedly. The higher the score, the more serious or severe the act. The severity of injuries was also given ratings from 1 to 100; the higher the score, the more severe the injuries were thought to be, in general.

These ratings have a lower variability than would have been expected given their range of "objective" seriousness. Our raters were not able to use the bottom third of the scale for acts threatened or bottom half of the scale for rating injuries. Most of the severity ratings for the acts and injuries specified clustered in the top third of the scales. And, when the battered women rated their seriousness, almost all clustered in the top 10% of the scale. It is possible that once people are involved in understanding the extent of violence that occurs in battering relationships, there is little tolerance for any kind of abusive behavior. For example, in my work as a forensic psychologist, I am often questioned by prosecutors who trivialize slaps, punches, and bruises that

do not necessitate emergency medical care. Many of those same state attorneys have great difficulty prosecuting cases unless they have broken bones or injuries requiring stitches to repair them.

This attitude can be understood by looking at the addictions field where former victims also provide many of the services to those current victims who are trying to become survivors. Recovered alcoholics in the AA program would rate one drink with a higher seriousness than would those who have not been involved in alcohol abuse. Probably, so would alcohol counselors who have seen first hand its destructive impact on people. Thus, a standard of battering severity or seriousness must take into account that high upper range, too. In finalizing the ranked orders of acts and injuries, it would be useful to add the opinions of those not directly involved with the syndrome. We have not done so at this time but report our work-to-date as encouragement for those who are interested in finding new directions for their own studies.

The categories of acts and injuries that we used in this preliminary exercise were take from the acts and injuries most frequently reported and therefore measured in the interview. We planned the analysis from the data already collected in this research study. Given what we have learned from our results, I would change some of the categories if new data were being gathered. Delineating areas of the body struck and psychological acts and injuries more carefully seems to be a necessary addition if this scale is to be more useful. I would also add a measure of the Patterson (1982) and Reid et al. (1981) component of "fogging" or "chaining" of acts which our headings of "briefly" and "repeatedly" committed tried to tap. Sonkin (1998) has attempted to be more specific in his rating scale that is used by many domestic violence workers. In addition, I would add some categories that we did not measure in the research but now find important in looking at potential long-term neurological injuries that occur from head-banging, head and shoulder-shaking, and hair pulling, all of which are more frequently associated with closed-head injuries and neurological demyelinization disorders.

Had funds continued to be made available, we would have attempted to develop the Battering Quotient (BQ) using two different methods of computation. The first method is based on standard scale construction techniques. The four

variables are inter-correlated, and the BQ is computed using either an equally-weighted or factor-weighted sum, depending upon the correlations obtained. The second method is one that relies more on stronger assumptions. Logically, overall battering severity would seem to be a multiplicative (rather than additive) function of duration frequency, and average severity of acts and injuries. If a woman is battered once a week for two years, for example, the number of incidents would be 104 (52 × 2); each incident (or the typical incident) can be weighted by the average severity of acts and injuries, determined as described above. Therefore, the two severity variables are combined (again, in a way based on their inter-correlation) and multiplied some form of these times duration and frequency. The relative power of these two battered women variables will determine which computation method is more accurate and useful.

The usefulness of the BQ is obvious in predicting lethality. Violent couples could learn their BQ scores, much like learning other medical high risk factor scores, such as their blood pressure which indicates the life-threatening nature of hypertension. Perhaps translating the lethality potential of domestic violence to a numerical value might help people take it more seriously. Spouse abuse is a life-threatening disorder that is "catching." It can be prevented, by changing individual life style behaviors and, thus, societal norms. But it is causing an enormous loss of life, now. Our data indicate it can be stopped.

Summary

Assessment of the risk of future violence in domestic violence relationships has been one of the most difficult areas to obtain real data. Assessment instruments that merely count physical acts or take the violence out of the context of the entire relationship give misleading pictures of what really goes on in domestic violence relationships. Newer methods of risk assessment for dangerousness have not yet been able to account for violence in the home even though these instruments are beginning to assess for general violence in the criminal justice population and in the community. Important studies such as the MacArthur Foundation that studied violent behavior over 15 years did not assess for violence

within the home. Several domestic violence researchers have begun to develop instruments that may be useful in assessing for risk of dangerousness. However, at this time, it is clear that whether objective measures such as actuarials or clinical assessment are used, the accuracy rate of risk of future violence is enhanced when the battered woman's own perceptions are taken into account.

7

Body Image and Health Concerns

Lenore Walker

With

Rachel Duros, Aleah Nathan, Kelley Gill and Rachel Needle

In the original study of battered women, one of the surprises we found was how important the issue of health concerns were to the risk of development of learned helplessness. The impact of somatic symptoms on the development of learned helplessness was true for illnesses in childhood as well as adulthood in that sample. As we tried to understand our data, it made good intuitive sense as there is a lack of predictable control over the child's or woman's environment usually associated with chronic illnesses. Learned helplessness, as we described it in Chapter 4, is about the loss of the ability to predict between something that happens and its outcome, so the perception of unpredictability would be consistent. In the current study, we attempted to expand our focus beyond illnesses to broader health and body concerns. The concern for prevention of diseases either caused by or exacerbated

by lifestyle has become much more focused on what we eat, where we live, and how much exercise we get.

Thirty years after the original study, we know much more about how our bodies work, including issues about stress and how it impacts nutrition, sleep, exercise and lifestyle choices. Also, we now understand the association between stressors and the exacerbation or the reduction of some illnesses depending upon the amount of stress to which the person is exposed. So, it makes intuitive sense that the more health concerns a battered woman has experienced as a child or as an adult will contribute to the psychological impact from the domestic violence.

Health Concerns

Original Research

We explored the women's health and other potential stress factors while growing up. Almost 90% of the women stated that their physical health was average or above during childhood, although about one quarter reported problems with eating, menstruation, sleep, and weight, and two thirds reported suffering from depression. This inconsistency in reporting the presence of symptoms indicative of less than adequate health, yet labeling their childhood health as average or better, was a constant problem in interpreting our results. This is a case where the population needed to be asked more structured questions, with specific response choices, rather than to assume that they responded consistently to a general definition. Obviously, this is a problem with qualitative data collected in a context-specific method. While we anticipated definitional problems in many areas, we did not hypothesize the importance of prior health issues emerging as a factor in determining the impact of abuse or occurrence of battered woman syndrome.

We also looked at the frequency of critical periods in the women's childhood as a factor to produce learned helplessness. The critical periods were self-defined and included events perceived as uncontrollable like moving a lot, early parent loss from death or divorce, school failure, shame or humiliation because of poverty or other reasons, one or both parents as substance abusers, sexual assault, family

disruptions, and so on. Over 91% of the women in our sample reported experiencing such critical periods, with the mean number of critical periods experienced being 2.1. This is further discussed in the learned helplessness theory section. We concluded that it was the impact of the uncontrollability and unpredictability of response-outcome at an early age that we measured, rather than simply the outcome from the individual events themselves, that formed the factor we measured.

It was predicted that battered women and batterers came from homes where traditional attitudes toward sex roles were held, and that they would also hold such traditional attitudes. Using the AWS (Attitudes Toward Women Scale) as a measure, we found that the women reported that the batterers and their fathers held very traditional values. Their own attitudes toward women's sex roles were self-reported as more liberal than 81% of the normative population, while the scores of their mothers and the nonbatterers were reported at about the average level. The implications of these results are discussed later in this chapter as we explore the impact on the woman's body image. It is evident that the women perceived their family members as less liberal in their attitudes toward women's roles than themselves.

Medical Attention

In our sample, the need for medical attention increased from about one fifth of the women after the first incident to almost half after one of the worst incidents. Despite that need, only about two thirds of the women who needed it, actually went for medical treatment. This was consistent with other reports at the time of the original study that battered women were less likely to seek the medical treatment they required (Stark, Flitcraft & Fraiser, 1979; Walker, 1979). Others had found that even when medical treatment was sought, doctors were less likely than nurses to ask patients about the origin of their injuries. This made it even more likely that if they did seek treatment, they didn't tell the doctor about the abuse. During the 1990s, the American Medical Association and other doctors and nurses groups began an education campaign for their members, teaching them how to ask women who appeared to be battered the appropriate questions. The most recent data suggests that battered women are more likely to talk to their doctors about the abuse they experience if

they seek out treatment, although it is still unclear about how many battered women never go for medical treatment.

Doctors describe those women who do seek treatment as having a greater tolerance for the pain usually associated with their injuries. Two things appear to account for this observation. First, it is quite probable that, like our interviewers, they are observing the woman in a process of dissociation, whereby the battered woman perceives her mental state separate from her physical body. Descriptions and observations of the battered woman's disassociation suggest it is similar to a form of self-hypnosis with intense focus on surviving the physical and emotional trauma. The second explanation is in the more recent studies of biochemical changes in the autonomic nervous system that lower the pain threshhold during the experience of trauma (Cotton, 1990; Goleman, 1995). Changes in the glucocorticoids that are secreted in the midbrain structures lower the perception of pain at the time of the trauma. This is obviously an adaptive response helpful to the organism for survival in crisis situations.

PTSD and Brain Chemistry

The new research mentioned above has linked PTSD together with a breakdown in the body's capacity to fight illness and disease (Crofford, 2007). This field of study is called psychoneuroimmunology or PNI. The immunological system is located in the midbrain area along with the brain structures that produce and secrete the biochemicals that regulate our emotions. Many of the symptoms that make up the diagnosis of PTSD are actually produced by the autonomic nervous system that is part of our life force involuntary responses to protect us from death or serious injuries. It is the perception of danger that is key, here. So, it is not surprising that human service workers who spend long hours listening to the experiences of trauma survivors would also develop secondary PTSD or what is also called "compassion fatigue" (e.g. Adams, Figley & Boscarino, 2008; Figley, 2002; Pearlman & Skaativine, 1995).

The brain perceives a stressor and it sends the message to the autonomic nervous system which then releases the appropriate neurotransmitters into the blood stream. As our nervous system needs both electrical impulses and chemicals to work properly, these neurotransmitters facilitate the conduction of the electrical impulses throughout the body.

When the danger has passed, the autonomic nervous system shuts off their production and clears the chemicals from the synapse, which is the gap between neurons that the electrical impulse must jump through in order for the message to be continuous. This is like a kitchen faucet; under stress the hormones and biochemicals that make up the neurotransmitters flood the system and when the stress is over, they recede. When battered women say they are "feeling nervous" it is usually because they are feeling the effects of so much nervous activity. The human stress response does have numerous checks and balances that are built in to make sure that it does not become overactive. However, these normal checks and balances often fail in the case of severe or chronic stress and then, the person becomes vulnerable to disease. According to McEwen (2003) physiological mediators of the stress response are catecholamines, glucocorticoids, and cytokines. These chemicals also have an important role in maintaining the body through these types of changes, called allostatis.

Obviously, this has wear and tear on both the structural parts that produce and utilize these neurotransmitters as well as the body itself. This affects the immunological system that needs to respond to fighting intrusions to the integrity of the body. Newer research suggests that traumatic events produce inflammatory responses in the body that mediate the response between traumatic stressors and health problems (Kendall-Tackett, 2008). For children who are exposed to such stressors, the latest research suggests damage to the brain structures as well as the rest of the neurological system and the body including cardiovascular disease (Steinbaum, Chemtob, Boscarino, & Laraque, 2008; Danese, Pariante, Caspi, Taylor, & Poulton, 2007; Batten, Aslan, Maciejewski, & Mazure, 2004). For adults, there are a whole host of health problems that can be associated with PTSD depending on how long and how serious the traumatic response is (Sareen, Cox, Stein, Afifi, Fleet, & Asmundson, 2007; von Kamel, Hepp, Buddenberg, Keel, mica, Aschbacher, et al (2006); Woods, Page, O'Campo, Pugh, Ford, & Campbell, 2005; Sutherland, Bybee, & Sullivan, 2002). Chronic illnesses such as cardiovascular disease, asthma, diabetes, and gastrointestinal disorders have long been associated with high levels of stress (Black & Garbutt, 2002; Speilberger, 1991). Other somatic disorders such as fibromyalgia, chronic fatigue syndrome, temporomandibular disorder (TMJ), and irritable bowel syndrome (IBS) have also

been associated with high stress. One of the factors is the constant reexperiencing in the person's mind of the trauma as if it were reoccurring, causing the autonomic nervous system to secrete its neurotransmitters to deal with the extra stressors. This then causes a number of responses including systemic inflammation which then alters the immune system. Blood pressure rises, the person's focus narrows to deal with the perceived threat, and the rest of the body systems, such as the digestive system, take second stage to dealing with the trauma.

Although the above description is a simplification of the complex reactions that PNI measures, at this time, the presence of the systemic impact of PTSD is only assessed through psychological tests and not biomedical tests such as blood tests. Even more alarming, without precise assessment of the impact from the inflammation that alters the immune system when PTSD is present, it is difficult if not impossible to assess what body systems are being impacted. Thus, body reactions associated with PTSD and BWS are often misdiagnosed or ignored until it is too late to prevent chronic disease. In some cases, it is possible to measure the amount of cortisol releasing factor (CRF) in the blood which is one of the major body signals to start the autonomic nervous system response to stress and danger. After exposure to a traumatic event, cortisol appears to shoot up to unusually high levels when another stressor is perceived. Some researchers have found that starting someone exposed to a traumatic event on medication that will quickly calm down the autonomic nervous system's stress response can prevent long term PTSD (Pico-Alfonso, Garcia-Linares, Celda-Navarro, Herbert, & Martinez, 2004). Drugs such as alpha-2 agonists, the antidepressants, or even the atypical antipsychotic medications may help although the most efficient would be a medication that could directly control the amount of cortisol released when faced with a stressor. We discuss the issue of psychotropic medication later in Chapter 15 when discussing intervention and treatment.

Researchers have found that PTSD is just as good an indicator of a person's long-term health status as having an elevated white blood cell count. An elevated white blood cell count can indicate a major infection or a serious blood disorder such as leukemia. The study also found a high erythrocyte sedimentation rate (ESR) which indicates inflammation. There was a similar finding for a possible indicator of serious

neuroendocrine problems (Boscarino, 2008). There have been similar findings of the damage to other organs such as the heart in those with chronic long-term PTSD (Black & Garbutt, 2002) and the gastrointestinal system and its disorders (Leserman & Drossman, 2007). Kendall-Tackett (2008) suggests that the flight or fight response to trauma by the sympathetic nervous system, a response that releases catecholamines such as norepinephrine, epinephrine, and dopamine, signals the hypothalamic-pituitary-adrenal (HPA) axis that then releases chemicals such as the corticotrophin releasing hormone (CRH). This causes the pituitary to release adrenocorticotropin hormone (ACTH), which causes the adrenal cortex to release cortisol, a glucocorticoid. The immune system then responds to the threat from the traumatic stressor by increasing inflammation by releasing proinflammatory cytokines which help the body fight infection and heal wounds. Researchers in PNI have been able to measure PTSD responses triggered in this way with three plasma markers; proinflammatory cytokines, C-reactive protein, and fibrinogen. So, both psychological and physiological markers can signal how the body and mind responds to both one time and repeated traumatic events.

The U.S. Centers for Disease Control (CDC) has conducted studies about adverse health conditions and health risk behaviors in those who have experienced Intimate Partner Violence (IPV). Using the 2005 Behavioral Risk Factor Surveillance System (BRFSS) telephone survey, data were collected from over 70,000 U.S. homes with approximately 40,000 women and 30,000 men completing the optional IPV module. Questions on adverse health conditions included current use of disability equipment such as a cane, wheelchair or special bed, and whether they were ever told they had high blood cholesterol, non-gestational high blood pressure, non-gestational diabetes, cardiovascular disease (heart attack, angina, coronary heart disease or stroke), joint disease (arthritis, rheumatoid arthritis, gout, lupus, and fibromyalgia), or current asthma. In addition, the survey inquired about some high risk health behaviors such as risk factors for human immunodeficiency virus (HIV) infection or sexually transmitted diseases (STDs). This included whether or not during the preceding year the responder had used intravenous drugs, had been treated for an STD, had given or received money for sex, or had participated in anal sex without a condom. Other health risk behaviors assessed

were if the person currently smoked and how much alcohol the person drank. For alcohol, the person was assumed to be a heavy or binge drinker if for a man he drank more than two drinks per day on average or if for a woman she drank one drink per day on average. Further, an alcohol binge was defined as five or more drinks on one occasion during the preceding 30 days for both men and women. The final health risk was a body mass index (BMI) over 25 which is calculated by weight in kilograms over height.

Lifetime IPV prevalence estimates were calculated using age, sex, race/ethnicity, annual household income, and educational level. Lifetime prevalence rates were higher among multiracial, non-Hispanic, and American Indian/Alaskan Native women and higher among lower-income respondents who often have poor access to good health care. Lifetime prevalence rates for IPV women were calculated separately and again, with the exception of diabetes, high blood pressure, and BMI over 25, battered women reported significantly higher numbers of health risk factors and risk behaviors than those who had never experienced abuse. Interestingly, those men who reported being victims of IPV also had higher health risk factors and risk behaviors than those who did not experience abuse. The men particularly had increased use of disability equipment, arthritis, asthma, activity limitations, stroke, risk factors for HIV infection or STDs, smoking, and heavy or binge drinking (CDC, 2006).

The high numbers of women (and men) who report childhood abuse and IPV and receive no assistance in healing from the psychological effects obviously will be seen in medical clinics, often too late to stop a disease process that might have been prevented had their PTSD responses been dealt with earlier. As the above CDC study shows, high risk behavioral activities co-exist with those who have PTSD. Dutton, Kaltman, Goodman, Weinfurt, and Vankos (2005) describe different patterns of IPV and their correlates and outcomes. Coker, Davis, Arias, Desai, Sanderson, Brandt et al., (2002) also detail the physical and mental health impact for both male and female IPV victims. Eventually, it may be possible to predict what types of impact will produce certain PTSD responses in people with certain types of psychological and neurological histories. In our work, we have seen the impact of PTSD from multiple lifestyle stressors on women who have been arrested for various crimes, often substance abuse that is usually associated with

their partners. We describe some programs in the jail for battered women willing to work on reducing the impact of domestic violence. However, when PTSD co-occurs with substance abuse and other health concerns, the psychological issues are both more difficult to treat and less likely to get attention from caregivers. This suggests the need for programs to reduce the trauma responses to be more widely integrated in medical and psychological services especially for battered women.

When Health Care is Available

Even when health care is available, it is difficult for some battered women to utilize it on a consistent basis. However, battered women do use emergency rooms and urgent care centers for acute medical care even if they are unable to follow up with nonacute or even preventive medical care (Flitcraft, 1977; Stark, Flitcraft, & Frazier, 1979; McLeer & Anwar, 1989; Ulrich, Cain, Sugg, Rivara, Rubanowice, & Thompson, 2003). Kelley Gill (2008) attempted to compare battered women from six shelters in Connecticut with a similar sample of moms from a day care center. She found that like the earlier studies, battered women were less likely to employ the services of a primary care doctor or clinic than non-battered women. This did not appear to be due to barriers in access to treatment but rather barriers from their life situation in utilizing treatment consistently. Although they did utilize emergency rooms more often than non-battered women for crisis intervention and they reported significantly more traumatic life events in the recent past and overall, they did not utilize the preventive health information disseminated there. Interestingly, battered women did report visiting the dentist and gynecologist as often as non-battered women. Gill suggested that these two health care settings may be the most efficient places to distribute preventive health care information that they could not utilize from the emergency room when they are in crisis.

Although health care is often available for battered women, there are still many barriers for them to access the care. Ambuel and Hamberger (2008) have been attempting to train health care professionals to reach out and improve their own health care response skills when a battered woman does come in for treatment. In their model, developed at the Medical College of Wisconsin, they encourage health care clinics to partner with individuals who have expertise in IPV

prevention and women's advocacy organizations to better deliver services. One of the most important changes in the organizational culture of the modern health care clinic is the need to provide adequate time for the woman to relax sufficiently to be able to confide in the doctor. Unfortunately, health care clinics today are organized to move people in and out of service in the fastest and most efficient manner possible. Yet, even with posters and brochures portraying healthy relationships decorating the office and asking appropriate screening questions, Ambuel and Hamberger found that without making the time to talk with the patient, it would be difficult for the battered woman to reveal her situation.

Body Image

The above discussion indicates that all three types of domestic violence, physical, sexual, and psychological abuse, all have an impact on both psychological and physical health of the victims. One of the most negative and lasting effects of IPV on women appears to be the impact on the woman's body image which is related to their self-esteem. In the earlier work, we focused on assessment of self-esteem in battered women we studied. Although we mention body image we did not understand the extent to which body image is affected by both physical and psychological abuse tactics used by the abusers. However, the literature on development of both body image and self-identity tie the two together (Cash and Prunzinsky, 1990). They define body image as a person's attitudinal dispositions toward the physical self and suggest that positive body image development is crucial to healthy self-esteem. There is also evidence that negative body image is associated with negative self-confidence (Cullari, Rohrer, & Bahm, 1998), social interactions (Cash & Fleming, 2002), and physical intimacy within romantic relationships (Wiederman, 2000). In addition, body dissatisfaction has been linked to eating disorders such as anorexia and bulimia nervosa (Stice & Shaw, 2002). Sexually assaulted women have been found to develop negative body image as one result of their victimization (Widman, Lustyk, & Paschane, 2005) but until recently, there has been only limited research with battered women who have reported forced sex with their partners (Campbell & Soeken, 1999).

Self-Esteem

In the first two editions of this book, I discuss the difficulty in measuring self-esteem with battered women. It is clear that self-esteem is not a unitary concept. People who have good self-esteem often express self-confidence and feel that they can accomplish the things they wish to do (self-efficacy). Most of us like some things about ourselves and do not like other things. If we have participated in psychotherapy, we often spend many hours trying to learn about ourselves and learn to give up or simply accept those things we do not like. Most of the time we are successful, at least with the most noxious things that go into making up our self-esteem that can be changed. This was true for the battered women in the original study. Interestingly, they liked themselves better than they liked other women but felt that they were not as strong in doing many things as were men.

Although low self-esteem has been associated with powerlessness (Aguilar & Nightingale, 1994) and depression (Cascardi & O'Leary, 1992) more recently, it has also been found to be a component of body image. Whether physically or emotionally abused, the more severe the abuse, the more often the battered women report symptoms associated with low self esteem (Follingstad, Brennan, Hause, Polk & Rutledge, 1991; Pagelow, 1984). In fact, Follinstad et al., found that different types of emotional abuse had a different impact on women with humiliation, name-calling, and verbal harassment being the worst. However, emotional abuse that was considered isolating, restricting, and controlling also had a negative impact on battered women (Aguilar & Nightingale, 1994). Stark (2007) has developed a detailed analysis of various forms of emotional and psychological abuse including the controlling behaviors that are so common that many dismiss their potential damage on the recipients.

More recent studies have found that the opposite is also true: that is, the more the woman is satisfied with her body, the more likely she is to have higher self-esteem. For example, Gillen, Lefkowitz, and Shearer (2008), in their cross-national study of over 400 college students, found that sexually active women who were satisfied with their body image were less likely to engage in unprotected sex and other risky behaviors. The authors noted that a positive view of their body provided

an extra dose of confidence in the women they sampled. Further, they suggest that programs that focus on improving young women's attitudes towards their bodies could help promote healthy relationships for women. Interestingly, this was not true for the men they interviewed as those with a more positive body image and were happy with how they looked, were more likely to engage in sex with multiple partners without using a condom. The authors then suggest that programs be separated by gender with men learning more about respect for themselves and women so they are less likely to engage in risky behaviors.

Body Image in Current Study

In light of the new research connecting body image, self-esteem, and other psychological symptoms from both physical and emotional abuse in intimate relationships as well as from sexual abuse, we decided to try to measure women's satisfaction with their physical bodies in the current study. We added a number of questions in the BWSQ that were specific to body image. These can be found in Table 7.1 and the analysis of their significance in Table 7.2.

Further, our findings indicated that:

- More women reported being never/rarely satisfied with their unclothed physical appearance (61.3%) as opposed to often/always being satisfied (19.4%).
- More women reported never/rarely having knowledge that their weight is appropriate (63.3%) as opposed to often/always knowing that it is appropriate(20%).
- More women reported often/always thinking their stomach is too big (67.8%) as opposed to never/rarely thinking it is too big (25.8%).
- Alarmingly, 43% of the women reported occasionally, often, or always restricting food intake.

Consistent with our hypothesis, independent sample t-test results reveal that there is no significant difference between sexually abused and non-sexually abused battered women on body image (t=.686; p=.498). Therefore, our study suggests that physical, sexual, and emotional abuse all can produce distortions in body image.

7.1 Responses on the Objectified Body Conciousness Scale

Objectified Body Consciousness Questions	SD/D %	Slightly Disagree %	N %	Slightly Agree %	SA/A %	N/A %
I rarely think about how I look……	75		12.5		12.5	
When I can't control my weight, I feel like something must be wrong with me……	62.5				25	12.5
I think it is more important that my clothes are comfortable than whether they look good on me……..	37.5		37.5	12.5		12.5
I think a person is pretty much stuck with the looks they are born with……..	25	50	12.5	12.5		
I feel ashamed of myself when I haven't made the effort to look my best……..	25	25	25	12.5	12.5	
A large part of being in shape is having that kind of body in the first place…….	12.5	37.5	37.5		12.5	
I think more about how my body feels than how my body looks…….	37.5	12.5	25	12.5	12.5	
I feel like I must be a bad person when I don't look as good as I could……..	50	25	12.5	12.5		
I rarely compare how I look with how other people look……	50	12.5	37.5			

Continued

7.1 Responses on the Objectified Body Conciousness Scale (Cont'd)

Objectified Body Consciousness Questions	SD/D %	Slightly Disagree %	N %	Slightly Agree %	SA/A %	N/A %
I think a person can look pretty much how they want if they are willing to work at it…..		37.5	12.5	25	25	
I would be ashamed for people to know what I really weigh……..	50		12.5	25		12.5
I really don't think I have much control over how my body looks……	50	37.5		12.5		
Even when I can't control my weight I think I'm an okay person…….	12.5		25	12.5	25	25
During the day, I think about how I look many times……..		25	25		50	
I never worry that something is wrong with me when I'm not exercising as much as I should……..	25		12.5	25	25	
I often worry about whether the clothes I am wearing make me look good……...	12.5	12.5	12.5	37.5	25	
When I'm not exercising enough, I question whether I am a good enough person……...	62.5		12.5	12.5		12.5

I rarely worry about how I look to other people……..	37.5		25		37.5	
I think a person's weight is mostly determined by the genes they are born with…	50	12.5	25	12.5		
I am more concerned what my body can do than how it looks……	25		37.5	12.5	25	
It doesn't matter how hard I try to change my weight, it's probably always going to be about the same…….	37.5			12.5	12.5	37.5
When I'm not the size I think I should be, I feel ashamed……	25		37.5			12.5
I can weigh what I'm supposed to when I try hard enough……	12.5		37.5		37.5	12.5
The shape you are in depends mostly on your genes……	25	12.5	25	12.5	25	

N = 8 Participants from English Sample

SD/D = Strongly Disagree/ Disagree

N = Neutral

SA/A = Strongly Agree/ Agree

7.2 Body Image Questions

Question Asked	Never/ Rarely	Occasionally	Often/ Always
I am happy with the way that I look.	29%	32.3%	38.7%
I am aware of changes in my weight.	3.2%	12.9%	83.8%
I am happy with the way that I look with no clothes.	61.3%	19.4%	19.4%
My body is unattractive.	35.5%	29%	35.6%
I know that my weight is normal for my age and height.	63.3%	16.7%	20%
If I gain a pound, I worry that I will keep gaining.	45.1%	19.4%	35.5%
I am preoccupied with the desire to be thinner.	29.1%	38.7%	33.3%
I think that my stomach is too big.	25.8%	6.5%	67.8%
I exaggerate or magnify the importance of weight.	32.3%	32.3%	35.5%
I sometimes restrict food intake as a way to lose weight.	58.1%	9.7%	33.3%

7.3 Body Image Results

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means				
							95% confidence Interval of the Difference	
		F	Sig.	t.	df	Sig. (2-tailed)	Lower	Upper
BODTOTAL	Equal variances assumed	.495	.487	.686	29	.498	–4.54004	9.1234
	Equal variances not assumed			.689	28.808	.496	–4.50840	9.0917

We were pleased that we were able to create the *Objectified Body Consciousness Scale* using the questions that are seen in Table 7.1. When put together the results can assist those working with battered women in understanding what areas of body image need to be resolved for the womens' self esteem to raise to a higher level. This is an important tool as many of the women who are in the STEP groups, described later in Chapter 16, ask for ways to improve their self esteem. The concept of self esteem is difficult to assess and purposefully change, so attempting to assist the women in better understanding their own body image issues along with sexuality issues as is further discussed next in Chapter 8 will provide some ways to help them heal.

Given the large numbers of battered women who have difficulties with their body image we included these variables in the analysis of what factors are found in Battered Woman Syndrome. As has been stated in earlier chapters, body image distortion and somatic concerns have been found to be one of the six factors that constitute BWS. We further discuss these issues in Chapter 8 when describing the sexual intimacy responses that battered women described in our studies.

Medical Issues in the Current Study

We measured common physical ailments in both the original and current study to attempt to determine if there were common somatic complaints for the women. These results can be found in Table 7.4.

Interestingly, the most frequent somatic complaints that women reported were depression (50%), sleep problems (46%), headaches (40%) and weight problems (32%). We further analyzed them and the results can be found in Table 7.5.

When asked about these responses, most women included the feelings of sadness and unhappiness when asked about what made them feel depressed. It is possible that the feelings of depression were consistent with PTSD rather than a true clinical depression but they were not asked for that clarification and we did not attempt to compare their responses on the TSI with this scale. The sleep problems were most often mentioned because of the partners' waking them or not letting them sleep. They reported the partners' demands that they stay up with them while being harangued

7.4 Somatic Complaints Questions

How often do you experience the following?	Never	Rarely/ Sometimes	Often/ Most Times
Headaches	14%	47%	40%
Hospitalizations	57%	33%	9%
Eating Problems	39%	39%	22%
Depression	10%	41%	50%
Serious Injury	75%	22%	4%
Menstrual Problems	57%	24%	18%
Serious Disease	80%	11%	10%
Weight Problems	40%	28%	32%
High Blood Pressure	64%	16%	19%
Sleep	28%	26%	46%
Allergies	63%	21%	17%
Asthma	71%	15%	15%
Gastrointestinal Problems	67%	17%	16%
Other	66%	13%	22%

with the partners' negative ranting and raving, usually about whatever he thought they had done wrong.

Summary

Our findings that body image distortions and somatic concerns are part of BWS placed an emphasis on these areas both to better understand how to help already abused women to heal, and as a way to develop protective factors towards healthy relationships. The research into PTSD and PNI provide an explanation to understand how the immune system is more likely to be damaged by trauma, especially chronic abuse experienced by battered women. Studies that indicate how the actual parts of the autonomic nervous system work

7.5 Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means				
							95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Lower	Upper
Headaches	Equal variances assumed	1.457	.230	–3.029	103	.003	–1.41088	–.29432
	Equal variances not assumed			–2.779	31.668	.009	–1.47786	–.22734
Depression	Equal variances assumed	.000	.993	–2.925	103	.004	–1.36755	–.26235
	Equal variances not assumed			–2.820	33.626	.008	–1.40258	–.22732
Weight problems	Equal variances assumed	3.314	.072	–2.587	102	.011	–1.59323	–.21031
	Equal variances not assumed			–2.858	41.599	.007	–1.53866	–.26488
Sleep	Equal variances assumed	1.368	.245	–3.233	102	.002	–1.81095	–.43382
	Equal variances not assumed			–3.454	39.259	.001	–1.77951	–.46525

both to protect the body against trauma and what happens to them when such resiliency is lost are important to help the women better understand why they have so many physical as well as emotional ailments. Although the health care system has attempted to deal with battered women, in fact both the structure and function is not set up to be helpful, especially when chronic illnesses are exacerbated by environmental stressors such as living with domestic violence. Not surprisingly, all these issues create a climate where the battered woman's self esteem and her body image become lower than before, which provides a cyclical pattern—low self esteem, distorted body image, psychological depression and anxiety, PTSD, physical damage to the nervous system, low self-esteem, and so on. It is difficult to rebuild self-esteem as it is made up of so many components. However, newer research demonstrates the ability of raising women's self-esteem by increasing satisfaction with their bodies. Obviously, there are many points at which intervention can be successful in helping battered women recover from IPV. Assisting in raising body image may actually help in preventing more serious damage to body organs as well as raising self-esteem and increasing psychological functioning.

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8

Sexuality Issues

Lenore Walker

With

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The definition of a battering relationship has always included sexual abuse as part of intimate partner violence. However, until the data from this research were collected, it was not known precisely how the sexual abuse in the battering relationship differed from other forms of sexual abuse. Perhaps the most significant fact was the realization that sexual abuse in intimate relationships is more like incest than stranger rape, which has more physical violence. The women in this research reported that it was not unusual for batterers to use sexual coercion to shame and humiliate the women, making it easier for them to gain their desired psychological control. Battered women often use sex to barter for their safety—they think that if they give in to sex, even when they do not desire it, then perhaps they will not be as badly physically or psychologically harmed. Therefore, one of the interesting areas

that we studied in the original research was the impact of repeated sexual coercion and assault by someone who is capable of tender lovemaking at other times (Finkelhor & Yillo, 1983, Walker, 1979, 1994).

In the new research we expanded our studies into the impact of abuse on the woman's sexual satisfaction in general (Needle, et al., 2007; Duros, et al., 2006). In addition, our researchers, like others (Russo & Denious, 2001) found that many of the women who develop mental health issues after an abortion have previously experienced abuse in their lives (Needle & Walker, 2007). This is an important finding as those few women who do have negative reactions to an abortion could be counseled about abuse and trauma rather than just mental health issues alone, so as to prevent these problems from exacerbating.

Marital Rape

Rape within marriage or marriage-like relationships has been found to occur far more frequently than previously estimated (Laura X, 1998; Martin, 1982; Russell, 1975, 1982). Part of the difficulty in measuring incidence and prevalence rates is that of confusing definitions. Since marital partners are presumed to engage in sexual relations, and such consent is given automatically along with the marriage vows, it is difficult for many to conceive of either partner having the right to say, "no." Sexual assault statutes used to exclude marital rape but due mostly to the untiring work of Laura X, at the National Clearinghouse for the Study of Marital Rape, all states in the United States now permit some form of criminal prosecution (Laura X, 1998). However, as long as the couple is living together, unless the forced sex includes physical assault that can be prosecuted under the regular assault or domestic violence laws, it may not be considered criminal behavior and its effects are usually discounted. Even when they are no longer living together, it is difficult to persuade prosecutors to take on these cases.

Occasionally a civil tort action may be filed for damages from sexual abuse within the intimate relationship but unless the damage is obvious and severe, such as transmitting a sexual disease or preventing the ability to bear a child,

it is difficult to persuade others of the damage. Some cases have been successful, however, such as *Curtis v. Curtis*, a 1988 Idaho case. In this case, Sandra Curtis claimed that her common law husband, Carl Curtis had sexually abused her during the 10 years they lived together by using cocaine and coercing her into all-night sex that included pornography. Mr. Curtis attempted to show videotapes that he took during sex to prove that Ms. Curtis was enjoying herself. Ms. Curtis countered by stating she perceived more danger if she didn't give in to his demands. The jury agreed and she won 1.2 million dollars in actual and punitive damages. Mr. Curtis appealed both the decision and the amount of the award but the Idaho Supreme Court affirmed both. In a Colorado case, the amount won by another woman was considerably less, but the precedent was set. The facts in the Colorado case have been used for a mock trial conducted by University of Colorado law school professors teaching future lawyers the important issues of both personal injury torts and battered woman syndrome.

Given the difficulties in reaching a common definition of marital rape, our first research project decided to measure the woman's perception of their entire sexual relationship with the abusive partner. Questions about sexual abuse were embedded in the section that asked other questions about sex. We decided to use a broad definition of sexual abuse that included any kind of forced oral, anal or vaginal penetration. Washburne and Frieze (1980) found that women were more likely to discuss sexual abuse in their relationships if they were asked in a more indirect way. They found that they gained more reliable and valid information by asking questions like, "Is sex with your batterer ever unpleasant for you?" and then giving her several answers from which to choose, such as, "Yes, because he forces me to have sex when I don't want to." A more direct question, and perhaps more threatening one for the women, would be, "Did he ever force you to have sex?" We included some questions worded the same way as Frieze and her colleagues did as well as some that asked for the information in a more direct way. This also helped us better understand the contradictions often seen when battered women answer questions differently from one interviewer to another.

Sexual Issues and Domestic Violence Research

Original Study

We did not use the term "rape" in the questions we asked as other researchers had reported that it is such an emotionally loaded term that women will be less likely to use it to describe what their husbands do to them (Russell, 1982; Doron, 1980). This is interesting as more recently there have been articles appearing in the news that judges in rape cases are prohibiting victims from using the term, "rape" to describe what happened to them, finding it is so pejorative that the term itself would likely prejudice the defendant from getting a fair trial. That was not why we did not use the term "rape,". Rather, we were concerned that women would not connect the term with sex with their husbands even if it was not consensual.

In the original research, the questions regarding sexual abuse were placed at different parts of the interview rather than in just one section to both reduce the stress around these emotionally charged questions and provide a reliability check. While many of our questions required a forced-choice response, some allowed the woman to respond with open-ended answers. An entire set of questions were asked about the woman's relationship with both the batterer and the nonbatterer in the 200 cases where such data were collected. The specific incidents described supported the contention that sex can and is used to as a way to dominate, control, and hurt them even if there is no physical abuse. Table 8.1 presents the results from both the original sample and the current one. Thirty years later, with a totally different sample of women, their responses were pretty similar.

Of our sample, 59% said that they were forced to have sex with the batterer as compared to 7% with the nonbatterer. Of course, the men who were described by those 7% were not actually nonbatterers by definition of the behavior described here, but the women perceived them as such obviously not defining forced sex as battering behavior by itself. With the batterer, 41% were asked to perform what they described as unusual sex acts, as compared to 5% of the nonbatterer. Women reported being forced to insert objects in their vaginas, engage in group sex, have sex with animals,

8.1 Women's Report on Sexual Relationship with Batterers

Variable	Original Sample N	Original Sample %	Current-Sample N	Current-Sample %
Who initiates sex?				
Neither.....	1	0	0	0
Man…….....	257	64	67	63
Both….....	115	29	30	28
Woman……	29	7	9	9
Sex unpleasant for the woman?				
Never…….....	59	15	24	23
Occasionally…	186	46	43	41
Frequently…...	155	38	39	37
Sex unpleasant for the man?				
Never…….....	200	53	73	72
Occasionally…	122	32	21	21
Frequently…...	50	13	7	8
How often are you jealous of his affairs?				
Never…….....	128	32	36	34
Occasionally…	163	40	47	44
Frequently…...	112	27	23	22
How often is he jealous of you having affairs with other men?				
Never…….....	26	6	11	10
Occasionally…	101	25	21	20
Frequently…...	275	68	74	70

and partake in bondage and various other sadomasochistic activities. A large variety of uncommon sexual practices were reported similar to that which were told to me during my previous research (Walker, 1979).

When asked if sex was unpleasant, 85% said "yes" with the batterers and 29% with the nonbatterers. Of these, 43% of them said that the sex was unpleasant because he forced her when she didn't want it. Interestingly, about one half thought that sex with her was unpleasant for the batterer but only 12% thought it was unpleasant for the nonbatterer. As we shall see later, a large number of battered women were also incest survivors for whom any sex may have been seen as traumatic. This may also explain those who reported sex with nonbatterers as unpleasant.

Almost two thirds of the women reported that batterers almost always initiated their sex, while both initiated sex with one half of the nonbatterers. This is an important finding to refute the often-held notion that battered women are frigid and cause their marriages to fail (Snell et al., 1964). Two times as many women felt guilt and shame about the sex that they had with the batterer. No specific questions were asked to determine how many women perceived nonviolent sex as rape although they were clear that they did not want it at the time. The open-ended responses to the question of why sex was unpleasant, for those 85% who said it was, indicated that they gave in to his coercive demands so that it would calm down the batterer. These women believed the men were in total control of their sexual interactions. Some of the reasons given were as follows: initiating sex to avoid a beating, having sex after a beating to calm him down, having sex after he beat the baby for fear he would do it again. For some women, refusing sex meant they didn't get money for groceries or other essentials for their survival.

Couples in an abusive relationship often withheld sex from one another as a means of getting what they wanted. Forty-six percent (46%) of the women said they had stopped having sex with the batterer to get what they wanted from him. Forty-five percent (45%) of them said the men stopped having sex with them. In contrast, 16% of the women said they stopped having sex with the nonbatterer and 11% of the nonbatterers did the same. Although these percentages are similar to those who said that sex with the batterer was unpleasant for them, our analysis did not permit us to see if they were the same responders. A small number of women said that the batterer refused to have sex with them, especially as the violence escalated. These women were

psychologically devastated by this rejection and felt that the pain experienced from the psychological humiliation and cold anger demonstrated by these men was as cruel and abusive as were the other psychological and physical abuse they experienced. Jacobson and Gottman (1998) in their study found this behavior was consistent with the type of batterer they called a "cobra." They found this type of batterer used a lack of sexual passion and withholding of sex as a deliberate control technique.

New Study Results

From the earlier data we created a scale to assess for satisfaction with sexuality for the 2005 BWSQ. At present we are attempting to refine the scale using the preliminary cross-cultural data. The initial scale using these questions can be found in Table 8.2.

Pearson two-tailed correlations were done between the BWSQ and the TSI's *Sexual Concerns* (SC) and *Dysfunctional Sexual Behavior* (DSB) scales. The results indicated no significant relationship (r= .299, p= .103 for SC; r= .055, p= .770 for DSB), based on results from the 31 women participants.

Furthermore, Pearson two-tailed correlation were computed between the BWSQ and each scale of the DISF-SR. The results revealed no significant relationship, and there does not appear to be a relationship between the TSI sexuality scales and the scales of the DISF-SR either, based on the 15 participants who completed all three measures (See Table 8.3).

Results generated from the TSI's *Sexual Concerns* (SC) and *Dysfunctional Sexual Behavior* (DSB) scales revealed respective means of 57.06 (SD= 14.713) and M= 56.97 (SD= 15.398). Although these means fall short of the cutoff score for clinical significance (i.e., minimum t-score of 65), they are somewhat elevated.

A total score on the DISF-SR that is below a standardized score of 40 is considered clinically significant. The mean total scores generated from our sample fell well beyond clinical significance on all of the DISF-SR scales (Sexual Cognition/Fantasy M= 15.80, SD= 9.63; Sexual Arousal M= 8.50, SD= 7.50; Sexual Behavior/Experience M= 10.13, SD= 9.83; Orgasm Score M= 8.87, SD= 7.86; Sexual Drive/Relationship Score M= 10.50, SD= 5.389).

8.2 Frequency results from the BWSQ's Sexuality section

Question Asked	Never/ Rarely	Occasionally	Often/ Always
How often do you find yourself interested in sexual activity?	32.2%	38.7%	29%
How often do you find yourself satisfied with your arousal during sexual activity?	33.4%	30%	36.7%
How often do you find yourself satisfied with your arousal during sexual activity?	46.7%	23.3%	30%
How often do you achieve orgasm?	45.2%	19.4%	35.5%
In general, how satisfied are you with your sex life?	43.3%	30%	26.6%
How often do you experience pain during sexual activity?	65.5%	31%	3.4%
How often do you have sexual thoughts or fantasies?	50%	26.7%	23.3%
In general, how often are sexual activities enjoyable for you?	40%	23.3%	36.7%
How often do you find yourself sexually excited?	53.4%	30%	16.7%
How often do you experience pleasure during sexual activity?	30%	27.6%	41.4%

8.3 Two-Tailed Pearson Correlation for the BWSQ's Sexuality Section, the TSI's SC and DSB Scales, and the DISF-SR Scales

Correlations

		TSI_SC	TSI_DSB	Sexual Cognition/ Fantasy Score	Sexual Arousal Score	Sexual Behavior/ Experience	Orgasm Score	Sexual Drive/ Relationship Score
TSI_SC	Pearson Correlation	1	.783**	−.030	−.066	.382	−.037	−.079
	Sig. (2-tailed)	.	.001	.916	.823	.160	.897	.788
	N	15	15	15	14	15	15	14
TSL_DSB	Pearson Correlation	.783**	1	.046	−.005	.327	−.261	−.400
	Sig. (2-tailed)	.001	.	.871	.988	.234	.348	.157
	N	15	15	15	14	15	15	14
Sexual Cognition/Fantasy Score	Pearson Correlation	−.030	.046	1	.575*	.432	.307	.320
	Sig. (2-tailed)	.916	.871	.	.032	.108	.266	.264
	N	15	15	15	14	15	15	14

Continued

8.3 Two-Tailed Pearson Correlation for the BWSQ's Sexuality Section, the TSI's SC and DSB Scales, and the DISF-SR Scales (Cont'd)

Correlations

		TSI_SC	TSI_DSB	Sexual Cognition/ Fantasy Score	Sexual Arousal Score	Sexual Behavior/ Experience	Orgasm Score	Sexual Drive/ Relationship Score
Sexual Arousal Score	Pearson Correlation	–.066	–.005	.575*	1	.739**	.772**	.595*
	Sig. (2-tailed)	.823	.988	.032	.	.003	.001	.032
	N	14	14	14	14	14	14	13
Sexual Behavior/Experience	Pearson Correlation	.382	.327	.432	.739**	1	.713**	.454
	Sig. (2-tailed)	.160	.234	.108	.003	.	.003	.103
	N	15	15	15	14	15	15	14
Orgasm Score	Pearson Correlation	–.037	–.261	.307	.772**	.713**	1	.717*
	Sig. (2-tailed)	.897	.348	.266	.001	.003	.	.004
	N	15	15	15	14	15	15	14

Sexual Drive/Relationship Score	Pearson Correlation	−.079	−.400	.320	.595*	.454	.717**	1
	Sig. (2-tailed)	.788	.157	.264	.032	.103	.004	.
	N	14	14	14	13	14	14	14
SEXTOTAL	Pearson Correlation	.	.	−.360	−.433	−.285	−.381	−.118
	Sig. (2-tailed)	.	.	.188	.122	.303	.161	.688
	N	.	.	15	14	15	15	14

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

These questions were utilized in the first analysis of the factors contributing to PTSD and BWS and they found that sexual issues were a separate factor that made up BWS as was described earlier in Chapter 3. In the Duros analysis of PTSD, she found that the most recent battering incidents that reported sexual abuse produced the most severe PTSD symptoms in the women who made these reports. This is understandable and consistent with the literature on temporal proximity as a significant factor in the development of PTSD symptomatology. In addition, she found that sexual abuse in the first battering incident increased the woman's likelihood of developing PTSD nearly three times.

As we learned more about the negative impact of sexual abuse in battering relationships, we also decided to use the Derogatis (1978) *Sexual Satisfaction Inventory*, an already developed questionnaire about sex in intimate partner relationships that is now included in the new BWSQ. These results will be analyzed and published separately. It is interesting that in our Greek sample we have a group of Albanian women who were kidnapped and kept in sex slavery by international groups. They had been set free and placed in a shelter for battered women to help them heal from their ordeal (Antonopoulou, 2005). We are analyzing their data separately to see what common factors there might be between them and other women held hostage by their intimate partners.

Discussion of Our Research with Other Researchers

Much research has been devoted to exploring the consequences of sexual victimization, in addition to the association with emotional problems such as depression, anxiety (Bartoi, Kinder, & Tomianovic, 2000), and Post Traumatic Stress Disorder (Janoff-Bulman, 1985, Walker, 1994). The impact of such trauma can be found to change attitudes and cognitions related to sexuality (Finkelhor, et al., 1988; Dutton, Brughardt, Perrin, Chrestman, & Halle, 1994), and sexual functioning and relationships (Finkelhor, et al., 1988; Sarwer & Durlack, 1996; Merrill, Guimond, Thomsen & Milner, 2003). Additionally, victims of childhood sexual abuse (CSA) have been found to be less satisfied in their sexual relationships, more likely to experience marital disruption (Finkelhor, et al.,1988), are

more dissatisfied with their relationships, and experience more interpersonal problems (Greenwald, Leitenberg, Cado, & Tarran, 1990; Bartoi & Kinder, 1998) than nonvictims.

Victims of rape, domestic violence, and battery are at risk of developing Post Traumatic Stress Disorder (PTSD) (APA, 2000) and other symptoms related to it such as depression (Dutton, et al., 1994; van Berio & Ensink, 2000; d'Ardenne, et al., 2001, Walker, 1994, 2007). Similar to victims of CSA, adult sexual victimization has been found to be associated with sexual desire disorders, vaginismus, anorgasma, polarized sexual activity frequency, and other sexual difficulties (d'Ardenne, et al., 2001.; van Berlo, & Ensink, 2000; Bartoi & Kinder, 1998). In a recent preliminary study Needle et al., (in press) looked at the relationship between battered women and sexual abuse victims and hypothesized that there would be an overlap of both within the same woman. Preliminary findings supported the hypothesis that regardless of sexual abuse history, similar to those with histories of sexual abuse, battered women had poor body image, decreased sexual satisfaction, and increased sexual dysfunction. These results are more fully discussed in the previous Chapter 7.

Our finding that over half of the battered women in the earlier research study reported forced sex is consistent with that of other researchers on violence against women. Frieze, et al., (1980) found that 34% of the battered women in her sample were victims of at least one incident of marital rape with 11% stating it occurred several times or often. Finkelhor and Yllo (1985) report that Spektor's study of 10 Minneapolis battered women shelters found that 36% and Pagelow's (1982) study found 37% said their husbands or cohabiting partner raped them. This compares to 59% in our sample, a figure that is almost twice as high as the others. None of these studies used a random sampling technique due to the difficulties in obtaining a sufficiently large population of women who had only experienced partner abuse. One explanation for our larger number is that our questions were more carefully worded due to the experience of underreporting that the other researchers had previously reported.

Diana Russell (1982) surveyed a large-sized (930) random sample of women in the San Francisco area to learn more about their experiences with various forms of sexual assault. Of the approximately two thirds who were married, 12% said that they had been sexually assaulted by their

husbands at least one time. She found that sexual assaults by marital partners were twice as common as sexual assaults by strangers. Interestingly, she used a conservative definition of marital rape that had to include forced intercourse with penetration. If these data can be generalized to the population at large, then battered women have three to five times the risk of being sexually assaulted by their partners than do nonbattered women.

Yllo (1981) discusses two types of marital rape in addition to the violent type that she found in her research. They were, (1) those that occur in what she defines as relationships with little or no physical abuse, and (2) those that occur in relationships where the man is apparently obsessed with sex. Our data didn't support such distinct categories although my clinical evaluations of battered women who are involved in litigation do. It is interesting to speculate on whether marital rape and acquaintance rape produce the same or different psychological impact given the literature that suggests that the person's expectations and attributions about what constitutes a rape will modulate the influence of situational factors (Frese, Moya, & Megias, 2004).

In fact, it is not unusual for men obsessed with sex, demanding vaginal intercourse, oral and anal sex several times daily, to also physically and psychologically abuse their partners. A subsection of these men also have a history of abusing other women and children. These men often demand shared parental custody of their children and when their partners attempt to protect the children from their seductive and grooming behavior, these men make allegations of parental alienation and other spurious charges against the women. They rarely understand the impact of their inappropriate or even abusive behavior on the child. Whether this is a subtype of batterer or a combination of a batterer and a sex-offender is not clear at this time.

Our findings are consistent with Yllo's conclusions that forced sex occurs more frequently as a form of violent power and control rather than the more common stereotype of the sexually deprived husband who must use force to get his sexual needs met. Her women report, as do ours, that they would be delighted to engage in warm, tender, love-making with their partners who are more frequently hostile than lustful, interested in their own pleasure!

Sexual Jealousy

Sexual jealousy is one of the most frequently reported features of violent relationships (Browne, 1993; Frieze, 1980; Koss et al., 1994; Dutton & Goodman, 1994; Hilberman & Munson, 1978; Martin, 1976; Pagelow, 1982; Roy, 1978; Straus et al., 1980; Walker, 1979). This earlier finding was confirmed by our data and continues to be found in later research. When asked if the batterer was ever jealous of her having an affair with another man, almost every woman said "yes" with over half saying such jealousy "always" occurred. Of those women reporting on a nonviolent relationship, about one quarter said the batterer was sometimes jealous, and only 6% said it "always" occurred. Almost one quarter of the sample said the batterer was also jealous of her having an affair with another woman as compared to 3% of the nonbatterers. As we did not inquire if the woman was actually having an affair, these findings cannot be analyzed for accuracy of his jealous perceptions. In most cases, the women described battering incidents that were triggered by unfounded jealous accusations. Women said they'd learned to walk with their eyes downcast, to not speak to others in public, to not smile too much or dance too long with others at a party. Sometimes jealousy was responsible for them being kept as prisoners in their own homes, resulting in further social isolation.

The women reported on their own feelings of jealousy with batterers and nonbatterers. In 67% of the cases, the women were jealous of the man having an affair with another woman and in 12%, with another man. This contrasts with one half of them being jealous of the nonbatterers having an affair with another woman and 1% with another man. About one half of the women said the men actually had an affair at least once to their knowledge and another 14% suspected it but weren't sure. These data support our conclusions that sexual jealousy is often part of the battering relationship and like sexual assault is part of the battered woman syndrome. In essence, what we have observed is a breach in the kind of trust and the boundaries expected in an intimate relationship. Insecurity about the relationship was apparent no matter how the woman tried to reassure the batterer.

Abuse During Pregnancy

A large number of women stated they became romantically involved with the batterer rather quickly. This involvement usually involved sexual intimacy and over one third of the women were not married when they first became pregnant. Our subjects had an average of two pregnancies and 1.53 children while in the battering relationship. Battering took place in each of the three trimesters. It is probably accurate to assume that many of those pregnancies that ended in a miscarriage, were terminated by the batterers' violent acts.

Our sample, like Gelles' (1975) reported that a high degree of battering occurred during each pregnancy with 59% reporting battering occurred during the first pregnancy, 63% during the second, and 55% during the third pregnancy. These data were further analyzed to see if there was a difference in which time period during the pregnancy the woman was battered, and the results indicated that if it occurred, it was likely to happen across all three trimesters. Over 50% of the batterers reportedly were happy about the pregnancy, at least initially, even though she was later battered, so the women did not perceive the men's unhappiness about the pregnancy as the violence trigger.

We looked for differences in birth control methods in battering and nonbattering relationships, but no major differences were seen. In about two thirds of the cases, the women assumed responsibility for the use of birth control, with the most popular methods being the pill and the IUD. Surprisingly, about one fifth of the women used no birth control at all. Most of the women did not report religious reasons, but rather, because the batterer would not permit her to use any birth control. Although we didn't inquire in this study, because it was too early to be aware of the dangers, it has later been shown that batterers also do not permit women to protect themselves from the possibility of HIV transmission by making them use condoms so that they are at high risk for the transmission of the virus that causes AIDS (Seligson & Bernas, 1997).

In many cases, the batterer kept detailed records of the woman's menstrual cycle and may have known more about her body than she did. The women did not regularly report abortion as a birth control option. However, it must

be remembered that this study was conducted a few years after *Roe v Wade* became the law, in 1972, and women first became able to obtain safe and financially possible abortions. One quarter of the women interviewed had no pregnancies, and there was a relatively small number of pregnancies and live births for the rest. Again, this may be explained by the battering relationships, as many women said they did not want to bring a child into a domestic violence family, but it wouldn't explain the nonbatterers' relationships. However, some women may have been beyond the childbearing years and others may not have been in a relationship with a nonbatterer long enough to have a child with him.

Issues Around Abortion

One area of psychology that is extremely controversial is that of whether or not having an abortion should be considered a trauma which causes long-lasting emotional consequences. The term post-abortion syndrome (PAS) has been used by anti-choice activists, despite a lack of scientific data to support it (Needle & Walker, 2007). Charles Everett Koop, who served as the Surgeon General of the United States from 1982 to 1989 under Ronald Reagan's presidency, issued a report confirming that abortions alone do not cause physical or emotional harm. He did this despite his personal opposition to abortion. According to more recent studies, women who have emotional problems following an abortion are likely to have had them prior to the abortion. There remains no scientific validity supporting PAS. Unfortunately, those few women who do experience some psychological problems after having an abortion tend to misattribute these problems to the abortion rather than to other factors such as life experiences, biochemical changes during pregnancy, and expectations set up by misinformation and scare tactics used by abortion protestors (Needle & Walker, 2007). The most common factors found to impact emotional adjustment after terminating a pregnancy are preexisting psychiatric conditions and a history of physical and sexual abuse.

It is important to control certain factors when doing research on the psychological sequelae to abortion. In order to gain an accurate understanding of what may cause

undesirable effects after a woman has had an abortion, trauma variables have played an important part. For example, Russo and Denious (2001) at first found greater depressive symptoms, diminished life satisfaction, and a greater likelihood of experiencing rape, child physical or sexual abuse, and partner violence when they compared a sample of women who had experienced abortion (n _ 324) with a sample of women who had not (n _ 2201). But after controlling for all aspects of the women's violence histories, they found that the abortion itself had no effect on the women's mental health variables.

Other researchers also found that a history of violence may be related to post-abortion, distress-related moderating factors such as social support and unstable relationships (Colemanet al., 2005). However, their analysis has been criticized as methodologically flawed because they did not control for variables lost by excluding certain groups of subjects from the study initially. Additionally, interpersonal pressure, which could be another way to label controlling behavior, from a male partner has been found to significantly predict continuous post-abortion distress at both six months and two years after an abortion (Broen, Torbjorn, Bodtker, & Ekeberg, 2005). Although it seems obvious when studying the literature on domestic violence and controlling partners that they would be more likely to cause the woman's emotional distress rather than the misattribution to the abortion, this is rarely stated due to abortion politics where anti-abortion supporters wish to emphasize the possible negative effects of the abortion itself. Most importantly, there are trauma-specific techniques that mental health professionals can use to work with those few women who do have emotional distress from abuse issues that rise to the surface after an abortion. Needle and Walker (2007) present them in their recent book on the topic.

Sexual Abuse of Children

The two areas of sexual abuse of children that were studied here included the sexual abuse of the children living in the home with the batterer and the prior sexual abuse of the battered women interviewed when they were children. Although we had to compromise the data we collected on sexual abuse of children living in the home because of the

conflict with the mandatory child abuse report laws in Colorado at the time of the original study, we were able to get information that supported the findings of other researchers who were specifically studying child sexual abuse and report these results in Chapter 11, which discusses the negative effects on children. Moreover the frequency with which incest occurred in homes where other forms of family violence existed was much higher than expected. We report the frequencies of various child sexual abuse acts in Table 8.4 and the racial and ethnic composition of those who engaged in child molestion in Table 8.5. As is evident from these data, like other forms of family violence, child sexual abuse within homes where mothers are battered by fathers cuts across all demographic lines.

Reports on child sexual assault by victims of battering in their adult homes is quite different from the typical rape victim report because of the complicated nature of the relationship between the father and child. Most of the sexual assaults were incest committed by fathers against daughters although some were brothers, uncles, and other family members. Incest is more similar to marital rape and sexual coercion not only because of the complicated relationship with the perpetrator but also because the goal is to gain affection from the child even using coercion and force. It is dissimilar to physical child abuse in that it includes some kind of genital behavior and its primary goal is usually not to inflict pain on the victim. Rather, most incest perpetrators begin with what is called "grooming" behavior, where the father slowly engages the child and prepares her for further sexual behavior by giving her rewards of affection and sometimes special privileges to comply with his demands. It is dissimilar to other forms of coerced genital behavior as the young victim often perceives the perpetrator as needing love and affection from her as she does from him. Obviously, incest—whether or not overt violence is involved—has serious psychological ramifications for the victim. Although we suggested that our results be interpreted cautiously at the time they were first collected 30 years ago, we realize today that we only touched the tip of the iceberg. It is clear that incest occurs far more often than previously thought in battering homes especially, and the impact is more far-reaching than we suspected (Herman, 1992; Goodman et al., 1993; Koss et al., 1994; Walker, 1994).

8.4 Frequency of Childhood Sexual Assault Acts

Sexual Assault Acts:	Original % Attempted	Current % Attempted	Original % Single Incident	Current % Single Incident	Original % Several Time	Current % Several Time
Child Fondled:						
By father.....	.5	0	3	4	12	9
By Sibling.....	4	5	7	0	12	2
By Relative.....	7	2	11	3	27	15
By other.....	5	4	19	13	23	24
Child Fondles:						
By father.....	.5	0	1	0	2	5
By Sibling.....	2	2	.5	0	5	0
By Relative.....	0	2	2.5	0	10	8
By other.....	3	2	2	6	5	9
Oral Sex:						
By father.....	1	2	0	0	.5	0
By Sibling.....	1	0	0	0	2	0
By Relative.....	2	0	1	2	5	5
By other.....	3	0	3	3	3	5

Sexual Intercourse:						
By father.....	2	2	1	0	0	0
By Sibling…..….....	4	0	2	0	2	0
By Relative….....	3	0	3	0	5	5
By other…….....	6	1	11	9	6	13
Watch Sex Acts:						
By father.....	0	0	.5	3	1	7
By Sibling…..….....	1	0	1	2	.5	2
By Relative….....	.5	0	2	2	3.5	11
By other…….....	1	0	3	13	2	16
Other Abuse:						
By father.....	–	0	–	0	–	2
By Sibling…..….....	–	0	–	2	–	2
By Relative….....	–	0	–	0	–	8
By other…….....	2	0	6	2	4	2

8.5 Racial and Ethnic Background of Women Reporting Childhood Sexual Assault

	Original Sample N	Original Sample %	Current Sample N	Current Sample %
TOTAL Sample				
White/ Caucasian	321	80	46	43
Hispanic/ Latina	3	8	9	9
Black/ African	25	6	9	9
Native Indian	18	4	2	2
Asian/ Pacific Islander	1	0	1	1
Other	4	1	39	37
Women Reporting Childhood Sexual Assault				
White/ Caucasian	144	45	10	42
Hispanic/ Latina	23	68	2	8
Black/ African	14	56	3	12
Native Indian	8	44	0	–
Asian/ Pacific Islander	1	100	0	–
Other	2	50	9	37

It is interesting to speculate on the relationship between being molested as a child and subsequent physical and sexual abuse later in life as an adult. As previously described, almost one half of these battered women reported they had been repeatedly sexually victimized as children. This is two and one-half times the number expected from other survey data available at the time of our study (Finkelhor, 1979). In his study of 795 college students, Finkelhor found that 19% of college women reported such early sexual victimization. He was also surprised to find that 9% of the college men reported childhood sexual experiences. In almost all cases, the aggressor was an adult male in the family—similar to our data. Finkelhor concluded from his data that the vulnerability for such sexual experiences could be created in the family, particularly where there are unhappy marriages. Our data suggests that the risk for sexual victimization of children increases if there is also violence in these families with poor boundaries between its members.

The knowledge of the impact on the child of early sexual molestation, with or without physical violence as part of the coercion, has expanded over the last 15 years. Most believe that such behavior is always coercive because of the adult's greater size, strength, and position of power over the child. However, there have always been some who question the actual harm to a child, especially if there is no physical violence or if there is fondling and no genital penetration. It is true that definitions keep changing even since our research. We were less conservative than Diana Russell who used the classic definition of rape that only includes penile-vaginal penetration with our definition of a broader array of sexual behaviors as described above. In fact, no reports of child sexual abuse are totally free from the emotions of the reporter. It is abhorrent to think of an adult having sex with a child for most people, even its defenders. That may be why today, it is more common for the general public to not want to believe that child sexual abuse, and particularly incest, really happens. There is a whole entire industry that has sprung up to deny its existence by claiming that there is an epidemic of mental health professionals whose business depends on the epidemic of child sexual abuse reports (Loftus, 1993) or the mother is using false reports to alienate the child from the father (Gardner, 1987; 1992). Pope (1996, 1997) has demonstrated that using little relevant empirical data advocates

for a false memory syndrome and obscures the clinical field so that children who may report truthfully are disbelieved. Unfortunately, this group of alarmists include many of the former defenders of child sexual abuse who used to claim that it wasn't harmful to the child if it was done with loving intentions on the part of the perpetrator. Information countering their information can be found on the website of The Leadership Council, an interdisciplinary group whose purpose is to make accurate and scientific information on child abuse available (www.theleadershipcouncil.org).

Courtois (1999) among others have demonstrated that the memory of adults who experienced sexual abuse as children is far more stable than otherwise believed although from time to time, certain facts are remembered and forgotten. Freyd (1994,1996) suggests that the betrayal of the parent is a significant cognitive trauma that also must be assessed along with the actual physical, sexual, and other psychological behavior. Obviously, this debate makes the understanding of child sexual abuse even more complex than it already has been. See Chapter 11 for a further discussion on this topic.

Children who experience early sexual molestation have been found to develop certain personality characteristics that assist their adaptation to an uncontrollable and frightening situation (Brown, 1992; Butler, 1978; Courtois, 1998; Finkelhor, 1979; Herman, 1992; Leidig, 1981; MacFarlane, 1978; Walker, 1994). Little girls learn they can control their mothers and fathers by being seductive and cute especially since this behavior is reinforced and rewarded. They also learn how important it is for them to keep this behavior a secret (Walker, 1988). Most incest survivors learn to equate sexuality with intimacy as they never fully experience the developmental stages of adolescence that encourage the growth of psychological intimacy. Their need for secrecy gets in the way of developing close friendships with girls in early adolescence. They also perceive, perhaps accurately, that other girls may not understand their feelings about boys and sex. Some report that they view non-sexually experienced girls as more naïve and less mature than themselves. These feelings are similar to our sample of battered women, at least as measured by their responses on the self-esteem scales. In essence, they report they missed out on teenage companionship and fun, but they also report they feel more experienced in other areas of their life, particularly in sexual matters. Monica Lewinsky,

the woman who had a sexual affair with President Clinton that almost brought down the Clinton White House, is a good example of such a person. Some incest victims report that they develop a sexual relationship with a boy closer to their own age, often as a way of terminating the sexual molestation. They rarely report platonic friendships with adolescent boys either. This may promote different social skills that can leave the woman more isolated than if she had been able to develop more variety in her friendships during adolescence.

Terminating incest is usually accomplished by the victim, often during middle adolescence by using a variety of methods (Finkelhor, 1979). Usually they seek assistance from a supportive peer or adult indirectly; that is they don't ask directly for help but they do give enough hints or actually talk about the sexual molestation so that help is received. Sometimes they threaten the offender that they will disclose if it doesn't stop immediately. Depending on the offender, this may be sufficient to stop it, which helps reempower the girl. Victims hint that they might have dropped hints to their mothers but rarely do they tell her openly, perhaps recognizing the mother's own vulnerability to the batterer's abuse. The whole issue of complicity in mothers in permitting incest to continue has been one that has been given much attention in feminist analysis (Cammaert, 1988; Yllo, 1993). Given women's lack of power in some marital relationships, they may not have the ability to protect their daughters. In incest families where there is also spouse abuse, the girls perceive their mothers' inability to deal with the violence against themselves, too. While some girls harbor deep resentment against their mothers, usually for not being strong enough, they also report that they protected them from the knowledge and they believed that giving in to their father's demands protected their mothers and the rest of the family from his violent behavior. This is an interesting perception as it includes some sense of power and purpose for these young women that may provide them with some resilience to a more severe impact from the abuse.

Some specialists in incest and child abuse have blamed the mother for encouraging the father's incestuous behavior as a way to escape from what they named as the mother's own obligations and "wifely duties" (Helfer & Kempe, 1974). Using this analysis, however, does not permit the man's sexual misconduct to be accurately understood. The data indicates that he

is more likely to be attracted to the daughter precisely because she is a young girl who can be more easily coerced. Abel et al., (1981) have found that despite reports to the contrary, the incest fathers they evaluated demonstrated physiological arousal patterns in the laboratory similar to other child molesters. This occurred when they viewed slides of young girls and adult women in erotic poses. A penile-tumescence-measuring device recorded their responses sexual arousal to the pictures of young girls. Thus, it appears that many family members who molest young children are more sexually aroused by children than by adult women. This empirical evidence certainly supports the victims' and their mothers' retrospective incest accounts. It has serious implications for reevaluating family treatment modalities and creating new treatment programs for offenders that follows the protocols that have been developed for other pedophiles (Becker, 1990).

The impact of child sexual abuse including incest, like battering and other interpersonal trauma, seems to be based on a multidimensional model that includes intervening contextual or mediating variables together with the acts that occurred, who did them, and over what time span. Finkelhor (1979) for example, found that some reported long-term and repeated occurrences had the same psychological impact as did some short-term behavior. Some reported encounters that involved exhibitionism and/or fondling as equally as traumatic as some where intercourse was completed. These findings have been responsible for the broadening of the definition of child sexual abuse so that it is understood that the impact must be studied from the child's perspective and not just the arbitrary assignment of severity to acts committed by the perpetrator. Father-daughter incest was reported as the most devastating for the child, perhaps because it robs the child of her right to have a father and a mother in her life. Sex with other family members was seen as devastating as sex with a stranger in our population. Finkelhor's study, like ours, found that sexual abuse accompanied with violent force reportedly produced the most serious psychological trauma. Some of these children run away from home at an early age and become caught up in a life of drugs, sex, and violence (James, 1978). In our sample, over half left home before the age of 17. Obviously, it is critical to try to prevent the toll that this kind of violence takes on the family and especially the future lives of these girls.

Battered Women, Sex, and Intimacy

Many of the behaviors described by our battered women were similarly described by those who work with sexually molested children. They include "manipulativeness" that is important to help "keep the peace," the unrealistic sense of power achieved through the use of seduction, the intense concentration on self-survival, the willingness to become dependent upon a man who can be both loving and violent at times, the fear of attempting survival alone, the knowledge of how to decrease a man's violence by demonstrating love to him, and the joy from experiencing intense intimacy. It is quite possible that early exposure to sexual abuse, with or without accompanying violence, creates a dependency upon the positive aspects of the intense intimacy experienced prior to the beginning of the battering behavior and maintained throughout the third phase of loving-contrition.

This raises some questions about these battered women's ability to make distinctions between sexual and emotional intimacy. It seems as if both the violent man and the battered woman confuse their need for emotional intimacy with sex, thinking they have met both needs through their intensely sexual relationships. However, the men cannot sustain such intimacy without becoming intensely frightened of their growing dependency on the women, the women become frightened by their dependency on the men as well as their own, and both begin to pull away from each other. Then, needing the intimacy to lessen the violence, both come back together again. Although the women do not need or like the violence that is part of this cycle, they often accept it as part of what they have to put up with in order get all the other benefits of this relationship. Only when the costs of the relationship outweigh the benefits will a battered woman take steps to terminate it. If the man permits her to leave, then it is over like so many other relationships. But if his dependency needs, possessiveness, and vindictiveness get in the way, he will not let her go even after the ties may be legally severed.

Stalking and continued harassment of battered women by their current and former abusive partners is better understood now than it was 15 years ago (Burgess et al., 1997; Walker & Meloy, 1998). Some of the reports we had during the research are similar to the attachment theories

proposed by Meloy (1998) and for those where there is also sexual abuse, Meloy's construct of *erotomania* may also apply. Erotomania, considered part of a psychotic delusional disorder, occurs when a person falls in love with someone without any evidence that the other person has any feelings of affection or love towards them. Some people diagnosed with erotomania have never even met the object of their intense love, such as movie or television stars. They may follow their love object around, stalk them, sneak into their homes, write them love notes, and find other ways of attempting to make a reciprocal relationship. Of course, the issue of stalking in domestic relationships is broader as is described in Chapter 6, but in relationships where sexual abuse is a featured component, it is important to assess for these issues, too.

Battered Women and Sexually Transmitted Diseases

HIV and AIDS

Although this research asked many different questions about sexuality, we did not inquire into the issue of sexually transmitted diseases, especially HIV and AIDS. However, new data since our study inform that there is a higher risk for battered women to be unprotected during sexual intercourse with an abusive partner (APA, 1996a; Koss et al., 1994; Koss & Haslet, 1992; Seligson & Bernas, 1997). Both the coercive nature of the sexual relationship together with the need for the batterer to have control over the woman makes it difficult if not impossible for her to demand that her partner use condoms and other protection during sex. Women who have been sexually abused previously are also known to be more likely to have unprotected sex (APA, 1996a) although it is not known if it is a lack of assertiveness especially around sexual matters or a naïve belief that their partner is not sexual with anyone else unless he tells them so. It is interesting that battered women shelters do not ask for this information while women live in shelter, perhaps because they would not know what to do with the women should they turn out to be HIV positive. Therefore, they are exposing the other women and children to high risk when taking simple precautions would permit an HIV positive woman to live in the communal home.

Those who have become prostitutes also have a much higher risk of contracting a sexually transmitted disease including HIV and AIDS. Although many young women who have escaped from abusive homes do go into prostitution, often to support drug habits they have developed, for a short period of time, if they do not use protection during sexual contact, they may not be able to get out of that life as they often plan to do. In any case, the need for good education and training for professionals as well as battered women in this area is critical (Dalla, Xia, & Kennedy, 2003).

Pornography

The issue of pornography and sexual abuse is one that has divided feminists for many years; not in their collective understanding that there is a relationship with those who frequently use pornography, particularly to stimulate themselves to orgasms, but rather, in what to do about it (Mackinnon, 1990). Many feminists, particularly those who have contributed to the scholarship in feminist psychology (Brown, 1994; Farley, 2004) and feminist jurisprudence (MacKinnon, 1983) debate the civil rights issue of freedom of speech and other First Amendment arguments while acknowledging the inherent dangers of access to the brutal violent images of defiled women often seen in popular pornography. Men interested in changing gender role stereotypes believe that pornography contributes to the "macho-man" image (Brooks, 1996; Levant, 1997; Levant & Pollack, 1993).

Lederer (1980), Rave (1985) and others have written about how pornography is a negative leveler by men against women, permitting them to see women as sex objects. Brooks (1996; 1998) supports this feminist position and details how men permit themselves to shut off their real feelings and violate women by numbing themselves to the full range of sexual expression while focusing on pornographic and centerfold images. These men are much less likely to feel empathy, sympathy or support for women who then can more easily become their victims. Many of these men engage in frequent masturbation, sometimes as much as hourly during each day. Obviously, these men have learned to self-soothe their anxiety and other unpleasant emotions using sexual stimulation and relief. We still don't know if there is a direct behavioral connection between frequent masturbation, frequent viewing of pornography, and violence, although the studies

point to trends in that direction. However, recent studies have demonstrated that men who use pornography are significantly more likely to sexually abuse as well as physically abuse their intimate partners and those who also use alcohol with the pornography increase the odds of a battered woman being sexually abused (Shope, 2004).

An interesting phenomenon that ties use of pornography on the Internet together with the sexual abuse of women and children has been found in the legal community. This is especially common in treatment centers for pedophiles. These men will molest anywhere around several hundred victims, most of whom are too frightened into not making disclosures. Some of the most difficult child custody cases involve men who molest children copying the images they have downloaded on their computers or rented from adult video stores. In fact, it is common for divorce attorneys to subpoena the family computers and learn what websites have been entered to view or even interact with pornography and chat rooms.

Dating Violence

Young women have been found to be at risk for abuse in their dating relationships especially if they become sexually active when young teens (Levy, 1991). Studies have shown that maybe as many as 25% of teens are abused by their boyfriends on a regular basis (Makepeace, 1981). Often these girls come from homes where they have witnessed abuse of their mothers by their fathers. It is not unusual for the abuse to begin after sexual intimacy occurs in a battering relationship, often starting with jealousy, possessiveness, and attempts to isolate the woman. Many teenage girls who want the security of a boyfriend are uncomfortable with the abusers' attempt to isolate her from high school activities and other friends. Monopolizing her perceptions before she has a chance to learn how to think for herself is a typical way dating violence starts. In a number of cases, the women reported that the first sexual encounter was really a battering incident and a rape where the men refused to stop sex when she asked him too. The women stated that they thought they were just kissing and fooling around with no intentions of having sexual intercourse when all of the sudden, they realized the men

were gratifying themselves without communicating with or showing concern for the women.

Sometimes the young women went on to marry the men hoping that this would prove to them that they really loved them and wanted the relationship to work out. Some of the women described themselves as very religious or from other cultures where their virginity was essential to getting a good husband to marry. These women felt that they had no choice but to marry these men, speaking as though there was now no going back!

Table 8.2 (formerly Table 24) indicates the different types of intimate relationships that these women described in the interviews. On average they had 2.1 intimate relationships with one half married to the man and one half in significant relationships with other living arrangements. Interestingly, they had been dating less than six months when they moved in or married. The average age of the women in our sample when the relationship became intimate was 22 years old for battering and 24 years old for non-battering relationships. Our data suggest that sexual intimacy may occur sooner in the dating period of battering than nonbattering relationships. No apparent differences were found in where in the life relationship history sequence was the battering relationship. It could have been the first, second, or in another sequence.

Sex and Aggression

Researchers have postulated a connection between sex and aggression in some individuals, usually men, that appears to have been conditioned in an earlier stage of development (Abel, Becker & Skinner, 1980; Donnerstein, 1982; Feshback & Malamuth, 1978; & Malamuth & Check, 1982). In several studies, average male college students were exposed to movies that depicted sexual aggression and then given a situation to discuss concerning their potential to take sexual advantage of a young woman. Interestingly, the more aggression associated with the sex in the movie, the greater the "rape proclivity" found in their responses. Although the researchers did not collect data on the exposure of the males to violence in their childhood home or their current sexual behavior if they were dating, our results would predict that

these attitudes would result in more use of violence in their homes. However, Donnerstein (1982) and Malamuth and Check (1982) found that debriefing the subjects carefully in a discussion group that talked about the feelings that were aroused right after the movies lowered the "rape proclivity" to even lower levels than the baseline levels collected prior to exposure to the sex and aggression movies. This is important information for prevention programs for those children who are at high risk for developing such attitudes and behavior pairing sex and aggression when they become adolescents. Talking about their feelings or psychotherapy may well be an important prevention tool.

Summary

The research project that we conducted found support for other research that links sexual abuse to other forms of violence in the relationship. Several points stand out and need further clarification. What role does early sexualization of a relationship play in later sexual violence that occurs? Obviously to answer this question, we would have to follow women over a long period of time to see what happens in their lives and once we appear as permanent or even semi-permanent parts of their lives, we will change the outcome. After all, we have learned that the less isolation and more supportive presence of others in the woman's life, the greater the chances of stopping the abuse or at least mitigating against serious effects! We also need more information about the interrelationship between child sexual abuse, specifically incest, and later sexual abuse in the relationship, and then, sexual abuse of the woman's children by the adult abuser. To collect the data in this area is more difficult given the interrelatedness of several legal systems (family, criminal, and juvenile) and the involvement of child protective services. However, it is not impossible to do so as is discussed in the next chapter on children. Finally, it would be interesting to know more about the battered woman's perceptions of emotional and sexual intimacy and how that impacts on her during the time she is in the relationship. Comparing these data to women who are sexually abused as children but not as adults will help us gain more knowledge in this area.

9

Battered Women's Attachment Style and Interpersonal Functioning

Lenore Walker

With

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Attachment Theory provides a rich conceptual framework for understanding issues that arise in intimate partner violence that have not been well studied previously. It has been politically sensitive within the battered women's community to discuss possible problems that battered women may have within the relationship for fear of victim-blaming. Nonetheless, intimacy issues have been an important theme when analyzing the data from this project and it seemed important to try to better understand it from a feminist perspective. For example, women who have recently left their abusers often exhibit a pattern closely associated with an anxious or ambivalent attachment style. While both styles tend to characterize women who are no longer in an abusive relationship, their effect upon future relationships may be tremendous. This may be one reason why so many of the

women in our study do not go into another relationship with a man. A woman characterized by a fearful style has a conscious need for social contact but is held back in doing so, as she fears the consequences of establishing and maintaining social interaction. As a result, she feels as though she does not deserve the love and support that distinguishes positive intimate relationships.

On the other hand, a dismissing approach lends the woman to become defensive in denying the need for social contact. These women then have a tendency to minimize their personal distress and need for relationships as they hold on to a positive model of the self, which only serves to continue their cycle of rejecting future relationships. Bartholomew (1990) and his colleagues have found that overall, fearful and dismissing attachment styles are both forms of avoidance. However, each style differs in approaching intimacy—fearful women have a strong dependency on others to maintain positive self-regard, whereas dismissing women rely heavily on themselves, opposing others' acceptance, in order to maintain a positive self-image (Bartholomew & Horowitz, 1991).

Bowlby's Attachment Theory

Bowlby (1973) originally proposed the Attachment Theory on the premise that a child's early relationship with his or her primary caregiver serves as a template for future relationships (Karen, 1994; Klein, 1975). Attachment was initially conceived as a neurobiological based need for the purpose of safety and survival. The theory stated that all humans are innately driven to seek attachments or close enduring emotional bonds with others in a relationship. Moreover, through the attachment process individuals develop an internalized set of beliefs about the self and others, otherwise known as "internal working models" (Bowlby, 1973 & 1988). The internal working model of self influences one's perceptions about his or her self-worth, competence, and lovability, whereas the working model of others is responsible for expectations about the availability and trustworthiness of others. This begins in infancy and continues through childhood as the neural pathways are forming. However, today we believe that the development of healthy attachment continues throughout the lifespan.

Subsequently, an individual's relationship formation is influenced by his or her internal representation of attachment. These structures of the self and others are unique; as they are both distinct and interrelated and they become implicit action strategies when an individual feels threatened or violated (Lopez & Brennan, 2000). Additionally, Bowlby (1973) proposed that an individual's representation of attachment, and in turn the internal working model, is activated in stressful, unpredictable, and unstable situations. Thus, attachment to others will assist in learning about regulation of emotion or affect as it is sometimes called.

Levels of Functioning

With regards to attachment styles, there are three levels of functioning: the first level, attachment security, is described as the healthy orientation found in most people. In the second level, attachment functions are organized, but considered flawed, as they are considered insecure. Insecure attachment forms two models that are able to predict individual differences in behavior—attachment anxiety and attachment avoidance. Consequently, research supports the conceptualization of secondary attachment operating as two dimensions, or functions (Lopez & Brennan, 2000; Brennan, Clark, & Shaver, 1998).

The first dimension, attachment avoidance, is characterized by a pervasive discomfort with intimate closeness and a strong orientation toward self-reliant and counter-dependent relationship behavior. The second dimension, attachment anxiety, is represented by low self-esteem and dependent relationship behavior. Whereas the avoidant dimension is closely related with a negative model of the self, the second style is associated with anxious attachment. The third level, disorganization, is rare and is suggestive of extreme interpersonal problems. Interestingly, Dutton and Sonkin (2003) suggest that some batterers demonstrate disorganized attachment patterns.

In adult relationships, attachment processes are activated by way of a cognitive-affective-behavioral triad. An individual is first cognitively aware of a perceived threat or danger which then leads to the activation of their attachment system. In turn, anxiety is felt in response to the perceived threat leading to behavioral avoidance. Since this cognitive triad is

part of cognitive-behavioral theory, treatment for attachment disorders may need to cross both relationship and cognitive therapy, stressing the newer affect regulation techniques.

Sonkin (www.daniel.sonkin.com) suggests that attachment in batterers is governed by three important principles first postulated by Bowlby as an inate attachment behavioral system.

First, a stressor activates an alarm to the individual that he or she is in need of emotional soothing. This releases biochemicals that alert the emotional system (remember the autonomic nervous system described earlier in Chapters 3 and 6) and help support the cognitive awareness of a perceived problem or threat. Emotional soothing can come from a variety of sources but most commonly, it is the soothing behavior of the attachment figure. In infants, only physical contact with the attachment figure will provide the soothing needed to turn off the alarm. Therefore, the child engages in behaviors designed to get the attention of the attachment figure: visually checking for her or him, signaling in some way to try to reestablish contact, calling, pleading, and moving towards the person. In children raised in homes where parents or caretakers are inconsistent, they may become confused and become unable to establish a useful routine to soothe their anxiety. In adults, there are a variety of ways to reduce the tension produced, some more self-destructive than others. Alcohol and other drug use, cutting behavior, and hostile abusiveness are several negative features. Relaxation, meditation, reading a good book, playing computer games, and engaging in other pleasurable activities may be more positive ways of calming down.

Second, when the system has been activated for a long time without soothing and shutting down the alarms, the person becomes angry. Here the infant screams and cries, sometimes without the ability to shut off the alarm easily even if physical contact does arrive. Sonkin suggests that anger is an attempt to recapture the person who can soothe the child's tension and distress before the child can do so alone. It also tells the attachment figure that he or she is wanted or needed. But, anger can become dysfunctional and actually distance the person who could have provided soothing behavior from the person needing it instead of bringing them closer. This is what often occurs in the early and middle stages of dependency relationships such as domestic violence.

Third, if soothing and protection is consistently not found, the child's attachment capabilities become suppressed or disorganized. These children tend to be disinterested in whether or not the caretaker is present or absent. However, some studies suggest that they really purposely engage in avoidant behavior to reduce their anxiety. They are called *anxious-avoidant*.

If the attachment behavioral system is inconsistently modulated, then the signaling behaviors become stronger and the child becomes preoccupied with the attachment figures availability. This is seen in hypervigilance and anxious behavior, perhaps even phobic responses or panic attacks. They are called *anxious-ambivalent* because they become very distressed when the parent leaves the room and even if the attachment figure does return, this will not soothe these infants or children. There is a third group that originally was not understood by Bowlby and his colleagues but later other researchers such as Main and Solomon found a common denominator and called it *disorganized attachment*. These children would approach the attachment figure when it reappeared but then, stop and turn away. This approach and avoidant behavior seemed to demonstrate what researchers called a collapse of the strategies in managing distress. There is no organized strategy for obtaining their attachment needs.

The continuum of attachment goes from *secure* when the person's anxieties and emotions can be regulated and *insecure* when they are not. The insecure may be resistant and ambivalent, avoidant and dismissing, or disorganized and unresolved. The secure may signal and get their needs met, the resistant may cling but still not be soothed, and the avoidant may ignore the attachment figure and not be soothed. Interestingly, Main and Hesse found that the disorganized children were more often being abused by their caretakers and suggested that they were experiencing fear without solution. Other caretakers themselves had been abused and the effects had not been resolved for them, preventing them from being able to attach to their children. These parents became frightened when their children needed protection or soothing and thus, were unable to provide it.

These same factors have been found to develop in the women and men involved in domestic violence relationships. This is consistent with other research indicating that attachment is closely related to an adult's ability to regulate their

emotions, creating unusual dependency in relations. Feminists suggest that women are more in need of attachment with others than are men. For example, studies published by researchers at the Stone Center at Wellesley University have indicated these gender differences. How gender, biology, and environment interact together is now being studied by psychologists. However, there are some areas that are well understood.

Interpersonal Functioning

Given the development of attachment, it is not surprising that other researchers have found that battered women are likely to demonstrate increased dependency on others and less able to function independently (Henderson, Bartholomew, & Dutton, 1997). Studies also indicate that battered women with low self-esteem and dysphoria have an inclination to employ high perceived control over their current abuser and greater use of substances, behavioral disengagement, denial, and self-blame as coping mechanisms. Similar to the fearful and dismissing styles, these women carry their coping mechanisms to future relationships. On the other hand, Clements, Sabourin, and Spiby (2004) found that women who believed they could control their futures in abusive relationships, primarily exhibited lower dysphoria and hopelessness, in addition to increased self-esteem. While not totally validated by the investigators, attachment style seems to play a monumental role in all coping mechanisms discussed. In addition, there's evidence to suggest that battered women's depressive symptoms increased while reported self-esteem decreased as a result of the number, type, severity, incremental quality, and consequence of intimate partner abuse (Cascardi & O'Leary, 1992).

Current Study of Battered Women's Attachment Style

The data gathered in BWSQ #2 began an investigation of battered women attachment styles along the dimension of secure, avoidant, and anxious-ambivalent. Based on Attachment Theory, (1) we expected battered women to be at an elevated risk for avoidant and/or anxious-ambivalent attachment styles, and

less likely to exhibit secure attachment styles, (2) we expected battered women to exhibit high levels of interpersonal functioning difficulties, and (3) we expected that attachment style would be implicated in interpersonal functioning difficulties. Unfortunately, our data could not permit determining when attachment difficulties might have begun; either before, during, or after the battering relationship (Darby/Nathan, Duros, Tome & Walker, 2007).

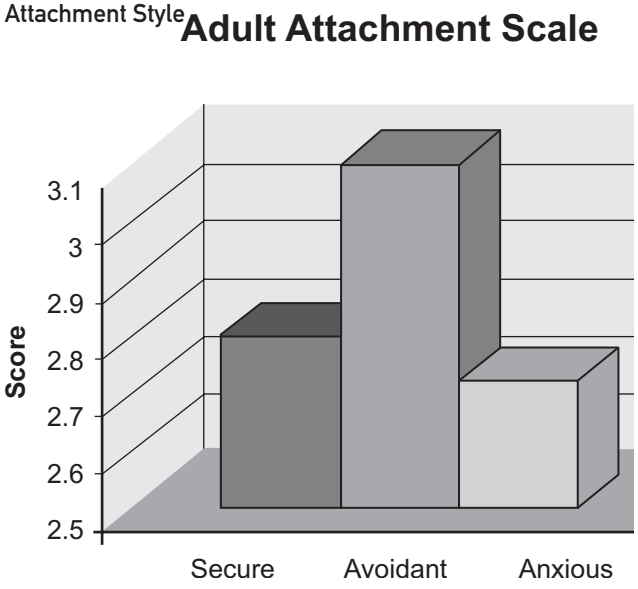
Methodology

Participants. The sample consisted of 32 women who reported a history of domestic violence. Their ethnic composition was as follows: 64.5% Caucasian, 12.9% African American, 6.5% Hispanic, 3.2% Asian American, and 12.9% of "other" minorities. Participants age ranged from 18 to 69 years of age, with a mean age of 42.56 years (SD = 13.10). Their level of education ranged from 6 to 16 years, with a mean of 13.38 years (SD = 2.55). The majority of the participants were recruited from advertisements in the community or from forensic settings.

Measures. In addition to selected questions from the BWSQ #2, *The Revised Adult Attachment Scale* (RAAS) was used to assess for attachment style in adults. The RAAS (Collins, 1996) is a self report questionnaire that assesses adult attachment style in adult relationships. The 18 item scale was first proposed by Hazan and Shaver (1987) who categorized three dimensions of attachment styles from the questionnaire: the capacity to be close (close), the capacity to depend on others (depend); and the anxiety over relationships (anxiety). Collins (1996) later undertook an extensive statistical analysis of these categories and found that there were merits to identifying the categories as nominal variables, namely secure, avoidant, and anxious/ambivalent. Participants score each of the 18 items using a five point Likert scale ranging from "not at all characteristic of me" to "very characteristic of me." In this study, the RAAS has valuable psychometric properties yielding a Cronbach's alpha of .629.

Results. Results confirm the hypothesis that battered women are at an elevated risk for avoidant and/or anxious/ambivalent attachment styles, and less likely to exhibit secure attachment

9.1



styles. Indeed, results indicate that the participants predominantly exhibited an avoidant attachment style. However, fewer exhibited an anxious attachment style, even when compared to secure attachment. See Figure 9.1.

Frequency results confirm the hypothesis that battered women experienced interpersonal functioning difficulties. Some of the more striking interpersonal issues can be seen in Table 9.1. By collapsing the rarely/occasionally and often/always categories, approximately half or more of the women in the study include feeling dependent on others (47%), feeling trapped in a relationship (60%), having no real friends (47%), feeling lonely (65%), feeling afraid to form close relationships (69%), and being treated like a thing (53%). Also noteworthy is the women's report that they become good friends quickly (88%). It would be interesting to compare their responses to those women who claim never to have been battered. Perhaps as we collect more data, we will be able to break down these data into cross-national and cross-cultural groups for comparisons.

9.1 Frequencies

How often do you feel…	Never	Rarely/ Occasionally	Often/ Always
…dependent on others	38%	41%	6%
…you have difficulty making friends	25%	22%	13%
…trapped in a relationship	22%	44%	16%
…you have no real friends	25%	34%	13%
…you need to control your relationships	22%	41%	9%
…lonely	25%	56%	9%
…people love you	–	38%	44%
…you become good friends with someone quickly	6%	60%	28%
…afraid to form close relationships	25%	56%	13%
…people treat you like a thing	25%	50%	3%

Further Statistical Analysis. A standard multiple regression analysis was performed between reported interpersonal difficulties as the dependent variable (as measured by the BWSQ), and the three attachment styles, including secure, avoidant, and anxious as independent variables (as measured by the RAAS), using SPSS. Overall, results supported the hypothesis that a significant relationship would be observed between interpersonal difficulties and attachment style. More specifically, results suggest that approximately 42% of the variance in interpersonal functioning difficulties can be accounted for by attachment style (*RSquare* = .415), with statistically significant ANOVA results (F = 6.623; p = .002). According to Cohen's (1988) *RSquare* effect size classification, large effect size was evidenced for the overall regression. As for the individual components of the regression equation, results yielded small to medium effect size for secure (B = -.276), avoidant (B = .210), and anxious/ambivalent (B = .363). See Table 9.2.

9.2 Linear Regression Summary

Predictors	R Square	F	p	B	t	p	Size*
Attachment Style	.415	6.623	.002	–	–	–	L
Secure	–	–	–	–.276	–1.746	.092	M
Avoidant	–	–	–	.210	1.183	.247	S-M
Anxious	–	–	–	.363	2.197	.036	M

* Descriptor of effect size as per Cohen (1988): RSquare (Small= .01; Medium= .09; Large= .25); B (Small= .10; Medium= .30; Large= .5).

The Relationship between Battered Women and Attachment Style

Overall our results confirmed the hypothesis that battered women are at an elevated risk for avoidant and/or anxious/ambivalent attachment styles, and are less likely to exhibit secure attachment styles. More specifically, results generated from our frequency analysis indicated that battered women are more likely to have an avoidant attachment style when compared to anxious and secure attachment styles. This finding is consistent with the literature which states that battered women have an increased tendency to be less secure in their intimate relationships. There are several possible explanations.

The first, which is consistent with the literature on the effects of the inconsistent attachment in an adult relationship would be expected to result in either anxious-avoidant or anxious-ambivalent attachment styles as described above. From the literature we extrapolated that battered women report histories that include risk factors for poor attachment, such as exposure to trauma from residing in domestically violent households and experiencing the personal trauma of being abused in their intimate relationships. Therefore, the women's life experiences alone

may have exposed them to insecure forms of attachment. Indeed, it is probable that relational trauma is a precursor for their avoidant attachment style.

On the other hand, the attachment literature is also replete with data that these attachment styles come from insecurities developed during childhood. Examination of the women's childhood experiences does not suggest that this group had reported being exposed to more risk factors than others according to the National Violence Survey (Straus & Gelles, 1990). Hotaling and Sugarman (1986) found that there were no risk markers in the epidemiological survey except for being a woman.

Furthermore, in light of Bowlby's (1973) Attachment Theory it appears battered women developed an internal working model that is associated with them having an overly pessimistic self-representation pertaining to their self-worth, competence, and lovability. This can also largely account for battered women not being secure in their intimate relationships or once that relationship is terminated, avoiding other intimate relationships. Additionally, our view of battered women's avoidance is consistent with Lopez and Brennan (2000) who proposed that when placed in a threatening situation, one's attachment response is activated and that the person will progressively develop a behavioral avoidance pattern to minimize fear.

The Relationship between Battered Women and Interpersonal Functioning

Results generated from the frequency analysis revealed that the battered women in our sample continued to experience interpersonal functioning difficulties at the time of their participation in the study. This finding is consistent with our hypothesis that batterers train battered women into dependency relationships. The statement "becoming close friends with others too easily" received the highest endorsement (88%). It may be an indication of the battered women's neediness and hasty decision-making as well as their potentially indiscriminant behavior when selecting interpersonal relationships. It is possible that battered women possess a higher level of dependence on individuals they come in contact with,

while failing to weigh their needs and wants with what the person is actually able and/or willing to provide. A part of their internal working model may include feeling that whatever their partner does, even if it includes violent behavior against them, is justifiable and interpreted by the women as something they deserve. There is a possibility that battered women have low self-esteem and may devalue themselves as well as think of themselves as undeserving of someone who will respect and love them without being violent. On the other hand, it could also be a result of the enforced isolation imposed on the women by the batterer so that once out of the relationship, they are eager to make new friends. Or, it could be a combination of both of those reasons.

Interestingly, fear of forming close relationships was the second highest frequency statistic. While this could be contradictory to the first statement, with most of the women saying they make friends easily, this finding appears most closely related to the predominance of avoidant attachment style endorsed by battered women in this sample. Based on Attachment Theory, the avoidant individual desires an intimate relationship but is fearful of forming an attachment of that nature. Such fear may stem from past and/or current relationships where they have either witnessed or experienced domestic violence. Furthermore, their social milieu likely taught them that the world is unsafe, thereby leading the women to prematurely withdraw from relationships and/or maintain more superficial and therefore less dependable interpersonal relations. In summary, the conditioned perception of an environment that is untrustworthy and devoid of stable and nurturing qualities may very well lead to inconsistent and avoidant behavior toward that environment.

All remaining interpersonal functioning statements confirm that battered women experienced interpersonal functioning difficulties. For example, they reported feeling trapped and dependent on others signaling that the women may lack autonomy and/or self-reliance. Consequently, when involved in abusive intimate relationships they feel as though they lack the skills and resources to leave their male partner. This finding is consistent with the existing literature on battered women's increased sense of dependency (Henderson, Bartholomew, & Dutton, 1997). However, these results should not be interpreted as an indication that a battered woman is innately more dependant than the average woman. Indeed, the present study did not have the capacity

to establish the women's disposition prior to their first abusive episode/relationship. On the other hand, there is more established evidence that the women's power and control limitations during their involvement in abusive relationships foster more dependence.

The Relationship Between Attachment Styles and Interpersonal Difficulties in Battered Women

In an effort to determine the implication of attachment style on interpersonal functioning, we performed the multiple regression analysis between interpersonal functioning as the dependent variable and attachment styles as the predictor, as seen in Table 9.2 above. It should be noted that although avoidant attachment was the predominant style reported by the women in our sample, we were surprised that more participants endorsed items depicting secure attachment style when compared to anxious attachment style. On the other hand, secure attachment was negatively correlated with interpersonal difficulties, indicating that the more secure the women, the less interpersonal difficulties they experienced and vice-versa.

As expected, our results indicated that interpersonal functioning difficulties are significantly implicated in attachment styles. More specifically, results suggest that approximately 42% of the variance in interpersonal functioning difficulties can be accounted for by attachment style. Whether the women's insecure attachment style was formed in childhood and/or formed or exacerbated by abusive intimate relationships in adulthood, it is reasonable to conclude that, consistent with the literature (Karen,1994; Klein,1975), the attachment style formed in past experiences may have set the template for future behavior and consequent interpersonal difficulties.

Attachment Behavior and Perpetrators

Psychologist Donald Dutton (1995) has put forward a classification system suggesting that there are three types of batterers, each of whom developed a different attachment style.

His research on batterers who were court ordered or voluntarily sought psychotherapy to stop their domestic violence divided them into those who were the *Psychopathic Batterer* who committed antisocial behavior and violence both inside and outside of the home, *Borderline Batterers* who demonstrated the cyclical pattern of abuse with high levels of jealousy, and *Overcontrolled or Preoccupied Batterers* who appear jovial and avoid conflict but mask high levels of hostility. When Dutton applied Attachment Theory to these three groups, he found that the Psychopathic Batterer had a *dismissing* attachment style, the Borderline Batterer had a *Fearful and Disorganized* attachment style, and the Overcontrolled Batterer had a *Preoccupied* or *Avoidant* attachment style.

Further analysis demonstrated that those with a dismissing attachment style were more cold and distant and managed their vulnerabilities by devaluing their partners. They sound similar to Jacobson and Gottman's (1998) *Cobras* who used carefully controlled and deliberate attacks against their partners. Those batterers with a preoccupied or avoidant attachment style learned to manage their emotional vulnerabilities by keeping their distance. Some even learned to soothe themselves to the exclusion of any dependence upon a relationship. Not surprising the group who demonstrated a disorganized attachment style was more confused and depressed without a consistent strategy to regulate their emotional distress. Most of them also had histories of unresolved trauma as children and learned to use an approach and avoidance style when they felt emotionally vulnerable.

When understanding the batterers' behavior through the attachment behavior analysis, it becomes clear that one type of batterers' treatment program will not be adequate to meet the needs of these men. At a minimum they will need treatment plans that address their attachment issues. But, even then, they will need more specific and individualized treatment as within each group there are factors that interact such as substance abuse and other mental health diagnoses. The interaction of insecure men with insecure women appears to be a high risk for an abusive relationship to develop between them and there are negative implications for any children they may attempt to parent together.

10

Substance Abuse and Domestic Violence

Lenore Walker

With

Josephine Tang and Aleah Nathan

The association of alcohol and other drugs with domestic violence is well known by those who work with victims and perpetrators. It is commonly thought that alcohol and abuse of some other drugs, particularly the amphetamines and cocaine derivatives are directly associated with violent behavior even though there is no clear cause and effect relationship nor is the strength of the relationship known. (Coleman & Straus, 1983; Maiden, 1997; Van Hasselt, Morrison, & Bellak, 1985). More recent investigators have begun to look at the additional risk substance abuse has on acute battering incidents (Lipsky, Caetano, Field, & Larkin, 2004), finding that men's alcohol use especially is associated with greater risk of injuries needing hospital emergency room attention, while no similar relationship is seen when women abuse substances. However, a recent CDC study, more fully

described in Chapter 7, found that women who drink one drink per day on average or binge drink, often have IPV in their history. In our earlier research we found that women were less likely to be able to leave a domestic violence relationship if they had substance abuse problems. Given this high association, there has been a great deal of research on the nature of the relationship over the past 30 years since we originally asked women about their partner's and their own use of these substances. Even so, it still remains that there are few programs that combine treatment for both domestic violence and substance abuse problems.

Deferral Into Therapeutic Courts

Most of the research over the past 30 years has demonstrated that different treatment methods are necessary to change both behaviors (APA, 1996; Maiden, 1997) although there is still controversy whether to treat simultaneously or eliminate one behavior before the other. Complicating the issue is the co-occurrence of substance abuse and mental illness together with violent behavior, necessitating different treatment methods for all three behavioral areas (see www.gainscenter.samsha.gov for program information). Many domestic violence courts, such as the Miami/Dade County Domestic Violence Court, order all three types of interventions for those who are willing to go for treatment as a condition of deferral or probation. However, the new mental health courts and drug courts that defer defendants into community or residential treatment programs often do not screen for prior domestic violence perpetrators (if the current arrest is for domestic violence the defendants usually get deferred into domestic violence court) and these defendants rarely get all three types of treatment at the facility to which they are sent.

Voluntary and Involuntary Intoxication

In most countries debate still occurs concerning the role of alcoholism and other drugs in a variety of criminal offenses. In the U.S., where domestic violence is considered a separate crime, some states differentiate between voluntary and involuntary substance abuse. Thus, if it can be proven that the individual's reactions under the influence of alcohol and other drugs are not under his or her control, it could be

considered an involuntary drug reaction that has less responsibility under the law than if the drug response was controllable. This often creates a legal argument about whether or not the use of substances is under the person's control if an addiction is present (Collins & Messerschmidt, 1993). While it is generally known that alcohol abuse can increase physically violent behavior in the laboratory settings (Taylor & Gammon, 1975; Zeichner & Pihl, 1979), and lower inhibition to commit other types of criminal behavior (Powers & Kutash, 1978), some of these effects can be due to expectation of other nonphysiological effects (Coldstein, 1975; Lang, Goeckner, Adesso, and Marlatt, 1975). Gondolf and Fisher (1988) and Jacobson and Gottman (1998) suggest that the high rate of alcoholism in the population of known batterers may play a role in their high arrest rate, also. We review some of the more recent studies below as the association remains complex and still not fully understood although we do have a better idea of base rates particularly with alcohol abuse.

Intimate Partner Violence and Alcohol Abuse

Linking alcohol abuse with batterers and battered women, then, is a natural association (Bard & Zucker, 1974; Frieze & Knoble, 1980a; Gelles, 1972; Richardson & Campbell, 1980; Van Hasselt, Morrison & Bellak, 1985). Some have found its abuse to be a risk marker for more dangerous injuries and death (Browne, 1987; Hotaling & Sugarman, 1986). The association of violent behavior with drug abuse is less well-documented although it has been appearing in recent reports of PTSD seen in war veterans (Roberts et al., 1982). Given the high expectation of a relationship between alcohol, drug abuse, and violence, we carefully measured its reported use in our research.

As was mentioned earlier, research exploring the link between substance abuse and violence against women dates back over 30 years with the more rigorous studies looking at reports of substance abuse by men in batterer treatment programs finding that more than 50% of the participants are also diagnosed as substance abusers (Gondolf, 1999, Tolman & Bennett, 1990). Studies of men in domestic violence

treatment programs have reported that from 50% to over 60% of their sample participants were alcohol and/or drug abusers (White, Ackerman, & Caraveo, 2001; White et al., 2002). Researchers acknowledge that identifying whether these men were primarily substance abusers using violence or domestic violence offenders using substance was difficult. Studies of batterers (Stith, Crossman, & Bischof, 1991) and substance abusers (Brown, Caplan, Werk, & Seraganian, 1999) each found that there were no significant differences in their childhood histories, substance abuse and frequency, and severity of domestic violence initiated by men.

At first glance, domestic violence is closely related to substance abuse and vice versa. According to a meta-analysis of 22 studies examining the treatment efficacy of programs for male batterers (Babcock, Green, & Robie, 2004), most interventions only generated a minimal effect on the recidivism measure. Simultaneously, no significant differences were found when comparing the effectiveness amongst these treatment models. Evidence showed that alcoholic men who successfully quit drinking reported levels of partner abuse comparable to demographically similar nonalcoholic men (O'Farrell, Van Hutton, & Murphy, 1999).

When reviewing this literature, the question amongst our researchers that arose is, "should practitioners focus on the addictive behavior of the batterers prior to treating their aggressive behavior toward their partners?" This is an important question and has not been answered, partly because the practitioners in the domestic violence and in the substance abuse fields generally do not communicate with each other. In many states, practitioners in each area require different certifications to work with court ordered clients. This results in each group staking out their own domains without integrating their work together and keeping the relationships among mental illness, battering, and substance abuse unclear. Although they appear to be correlated (meaning there is some association among them), the Kantor & Straus (1987) study found that 60% to 75% of batterers they surveyed said they were not drinking during their battering incidents. This is similar to the findings in our original study as reported below. These findings are not as contradictory as it seems on first glance, as a batterer who is a substance abuser may well be engaged in abusive behavior while sober as well as when he is high or drunk. The assumptions are many, either they

may be in their early phase of abstinence or they may not be able to obtain their substance of choice. In any case, the term *dry drunk* is often used to explain such behavior in substance abuse treatment programs.

Alcohol and Violence

An early prevalence study (Kantor & Strauss,1987) estimated that physical partner assaults in a U.S. population survey was observed to be approximately three times higher for men who frequently engaged in binge drinking compared with alcohol-abstaining men. Based on the research that male partners were reported to frequently have been drinking prior to their assaults (Walker 1979, 1984), in our original study (BWSQ 1), we interviewed 400 self-identified battered women on the drinking habits of their male partners, both batterers and non-batterers, and found that 67% of male batterers reportedly frequently consuming alcohol (as compared to never drinking or occasionally drinking) versus 43% of non-batterers. In one of our early analysis of the first 77 participants in this current study (BWSQ 2), we found that only 53% of the batterers were said to be frequently consuming alcohol. Whether this is really a drop in the rate of alcoholism in general or just for this small sample, is not known. Frequencies comparing responses of the participants in both studies can be found in Table 10.1.

Over the years, numerous studies have found greater alcohol abuse and problem drinking patterns among batterers when compared to other groups of men, as well as higher alcohol consumption as a risk factor for partner violence amongst alcoholic men (Fals-Stewart, 2003; Leonard & Quigley, 1999; Murphy, Winters, O'Farrell, Fals-Stewart & Murphy, 2005). Moreover, studies (Brookoff, O'Brien, Cook, Thompson, & Williams, 1997) have also found that heavy drinking can result in more serious injury to the victim than if the perpetrator was sober (Brecklin, 2002).

The prevalence of alcohol consumption is related to its legitimacy, accessibility, and its "cost effective" outcome. Studies have found high rates of domestic violence among men and women in substance abuse treatment programs. Schumacher, Fals-Stewart, and Leonard (2003) found that 44% of men perpetrated one or more acts of physical violence in the year preceding treatment. Chermack and Blow (2002) found

10.1 Report of Batterer's Substance Abuse During Relationships in BWSQ 1 & BWSQ 2

Drug:	Original N	Original %	Current N	Current %
Alcohol:				
Never	40	10	22	29
Occasionally	92	23	14	18
Frequently	269	67	41	53
Prescription: Drugs:				
Never	188	8	62	83
Occasionally	125	32	7	9
Frequently	81	20	6	8
Marijuana:				
Never	154	40	36	51
Occasionally	143	37	4	6
Frequently	91	23	31	44
Street Drugs:				
Never	249	65	59	85
Occasionally	75	20	3	5
Frequently	57	15	8	10

that more than 67% of men reported perpetrating moderate or severe violence in the 12 months prior to their entering a treatment program. Brown, Werk, Caplan, Shields, and Seraganian (1998) reported almost 58% of men in alcohol or drug treatment had perpetrated physical violence or abuse toward a partner or child, and, with the inclusion of verbal threats, this figure rose to 100%.

Comparing two samples, men entering a domestic violence treatment program and domestically violent men entering an alcohol treatment program, Fals-Stewart (2003) found the odds of male-to-female physical aggression to be 8 and 11 times higher, respectively, on days when men drank than on days involving no alcohol consumption. A study (Pan, Neidig, & O'Leary, 1994) employing a sample of nearly 12,000 white male military participants, found that the odds that

men with alcohol problems would use physical aggression against partners was 1.28 times higher than those for men without alcohol problems.

Problem-Solving Coping Style. The above studies have concurred that alcohol appears to be the highly correlated risk factor of physical aggression of male batterers, although other plausible factors cannot be ignored. Parallel to the trend of conceptualizing aggression between intimate partners as a multifaceted phenomenon, it is crucial to examine the relative importance of and causal directions amongst other risk factors.

The previously mentioned study (Pan et al., 1994) indicated that having an alcohol and/or drug problem uniquely increased the risk of severe physical aggression. Marital discord and depressive symptomatology further increased the odds of physical aggression. Those who were severely physically aggressive, usually earning covarying with lower incomes, were more likely to report an alcohol and/or a drug problem, and had more marital discord and depressive symptomatology. Snow and Sullivan (2006) found that men who employed inappropriate problem-solving coping styles to deal with relationship problems were characterized by abusive behavior through problem drinking. For instance, greater use of avoidance coping strategies was more likely among problem drinkers. By contrast, men who used higher levels of problem-solving coping skills were less likely to be problem drinkers.

Alcohol Effect on Cognitive Functioning. Until recently, the impact of alcohol on various aspects of cognitive functioning was not widely investigated. The majority of studies on this relationship have only been carried out over the last 15 years. Studies suggested that acute alcohol intoxication impairs cognition, including episodic memory (Tiplady et al., 1999), verbal and spatial learning (Mungas, Ehlers, & Wall, 1994), and visuospatial attention (Post, Lott, Maddock, & Beede, 1996). The literature on substance abuse and neurology also suggested that alcohol's most pronounced effects are on the cognitive abilities associated with the pre-frontal cortex (Peterson, Rothfleisch, Zelazo, & Phil, 1990). All of these studies are in agreement with neuroimaging studies that show acute intoxication reduces glucose metabolism in the prefrontal cortex (de Wit, Metz, Wagner, & Cooper, 1990; Volkow et al., 1990;

Volkow, Wang & Doria, 1995) which decreases the ability of the brain to function upon commands. These studies have shown a direct causal relationship between alcohol and an increased likelihood of interpersonal aggression. Despite the neurological data suggesting otherwise, Arbuckle and colleagues (1996) stated that homicides caused by domestic violence were less likely to involve alcohol and drugs than homicides resulting from other causes. However, domestic violence homicides involving substance abuse was still high at 54%. In an analysis of the first 100 cases where battered women killed their abusers, I found a high rate of alcohol use (Walker, 1989) as did Browne (1987).

Perception of the Batterers When Using Alcohol by the Battered Women. A qualitative study (Galvani, 2006) reiterated that the majority of women felt that alcohol alone was not enough to explain their partner's violent and abusive behavior. Instead, these women held the men responsible for their inappropriate actions. The majority of the women in this study perceived alcohol as having an impact on aggression but felt it "depended" to a greater or lesser degree on the presence of other variables. The impact of their partners' emotions prior to drinking was crucial to their post-alcohol behavior. As a result, women often become hyper-vigilant about their partner's emotional state together with their alcohol intake, in determining a strategy for avoiding possible violence or abuse. In addition, women evidently attempted to minimize the potential violence and abuse that might occur by mitigating their partner's "bad mood" through their own behavior. However, the resulting abuse or violence was no different than if they had made no attempt to pacify their partners. Nevertheless, some women in abusive relationships often blame themselves for "provoking" their abusers, especially when they were drunk.

Legal and Illicit Drugs

The relationship between substance abuse (alcohol and drugs) and aggression and/or interpersonal violence is more complex because of the pharmacological and physiological interaction of the different substances. A recent study indicated that

cocaine use was significantly associated with being sexually active and used in exchange for sex (Raj et al., 2007). Among the psychoactive substances examined, the use of alcohol and cocaine were associated with significant increases in the daily likelihood of male-to-female physical aggression (Denison, Paredes, & Booth, 1997; Fals-Stewart, Golden, & Schumacher, 2003). One study indicated that cannabis and opiates were not significantly associated with an increased likelihood of male partner violence (Fals-Stewart, Golden, & Schumacher, 2003). It is, therefore, necessary to examine the effects of the various types of illicit drugs and their unique withdrawal symptoms in relation to aggression and domestic violence.

Sedatives-Hyptnotics-Anxiolytics (Benzodiazepines)

The American Psychiatric Association in a task force report (1990) recommended that benzodiazepines (well known anti-anxiety medication like Valium, Xanax or others) be prescribed for short-term treatment only in the lowest dosage possible and for the shortest period of time. Benzodiazepines may have a heightening effect on aggression by interfering with the anxiety/threat detection system. This effect has been repeatedly demonstrated in numerous studies (Cherek, Spiga, Roache, & Cowan, 1991; Weisman, Berman, & Taylor, 1998). While this effect has been shown to be statistically significant, specific individual differences in the majority of users have been shown to be clinically insignificant. However, it has been demonstrated that men given a control dose of benzodiazepines have a more aggressive response than those taking a placebo. A moderating factor may be identified, such as a pre-existing level of hostility or an expectation of increased aggression to explain the increase in aggressive responses. Other factors including pre-existing brain damage and alcohol consumption in association with benzodiazepines have also revealed greater aggression than would normally be expected. An important variable determined by the studies is the dosage. Controlled experiments which did not show benzodiazepines related increases in aggression involved relatively low dosages (Cherek et al., 1991).

It is important to better understand the effect of benzodiazepines on people's behavior because they are widely

prescribed medications and easily available on the street market. They are also very effective in reducing anxiety responses that occur in PTSD and especially in stopping panic attacks. They also help with insomnia. However, they are dangerous when used inappropriately and are physiologically addictive which means the dose must be increased when the person habituates to the initial dose. Even more dangerous, they can be fatal if too many pills are taken or if they are taken together with alcohol. While psychiatrists are hesitant to prescribe them for these reasons, many family doctors will and since they do not need to build up to a steady state as do antidepressants such as the SSRIs, people often share them with friends and family members, without realizing how dangerous they can be.

Opiates (Morphine, Heroin, and Codeine)

Similar to benzodiazepines, there is considerable confusion regarding the extent that opiates are linked to interpersonal aggression. There appears to be a complex interaction of interpersonal and pharmacological factors including withdrawal factors as the cause of violence initiated by opiate abusers. Studies have shown that the level of aggression by opiate users seems to be more related to individual personality traits than to the effects of the drug. There are, however, some anomalies and inconsistencies in published literature. In a study of 533 opiate addicts (Rounsaville, Weissman, Kleber, & Wilber, 1982), the co-morbidity of this sample was as follows: depression (53.9%), alcoholism (34.5%), and antisocial behavior (26.5%). The National Drug Control Strategy (1997) stated that the drug itself may not cause the aggressive behavior; however, the aggression may be caused by the need minus the availability of the drug. The report highlighted that opiates have the capacity to absorb all of an individual's attention, resources, and energy, which become devoted exclusively to obtaining the next dose at any cost.

Cannabis (Marijuana)

Although cannabis has been widely labeled a social menace, most recent research has found that cannabis users are less likely to act aggressively. However, cannabis intoxication can cause increased anxiety, paranoia, and even panic, particularly

in inexperienced users (Thomas, 1993). There are no documented fatalities from cannabis overdoses (Hall et al., 1994). Alcohol is the drug most commonly use in conjunction with cannabis and augments the level of intoxication and impairment in an additive way (Chait & Perry, 1994; Hall et al., 1994). The relationship between cannabis use and aggression is still controversial although some studies seem to support the linkage in cannabis withdrawal syndrome (Kouri & Pope, 2000). The Diagnostic and Statistical of Mental Disorders-Fourth Edition, Text Revision (DSM-IV-TR; APA, 2000) did not include cannabis withdrawal as a diagnostic category.

Cocaine and Amphetamines

Both of these drugs and their derivatives are psychostimulants, and are usually obtained illegally. Cocaine is more expensive than its derivative crack, and therefore, it is not surprising that more wealthy abusers use powder cocaine while crack cocaine is more likely to be found in poorer communities. Methamphetamine pills can be made in the laboratory and are easily available on the street but their strength is not easily calibrated. Extensive literature concludes that both types of stimulants may generate aggression (Taylor & Hulsizer, 1998). In Warner's 1993 study, violent behavior was found to be the leading cause of death amongst stimulant users, with the most common forms of death being accident, suicide, and homicide. In fact, cocaine has been associated with more deaths than any other drug (National Institute on Drug Abuse, 1990). The stimulants cause acute dopaminergic stimulation of the brain's endogenous pleasure center. Users experience euphoria, heightened energy and libido, decreased appetite, hyper-alertness, and bordering on over confidence. High doses cause intensification of euphoria, accompanied by heightened alertness, volubility, repetitive behavior, and increased sexual behavior. Aggression, under these circumstances, may be due to interpersonal factors that existed prior to the psychostimulant use or aggression displayed in an effort to obtain these drugs. Behavioral changes are also part of the criteria for stimulant intoxication; these include fighting, grandiosity, hyper-vigilance, psychomotor agitation, impaired judgment, and impaired social functioning (Fischman & Schuster, 1982).

Several studies have associated cocaine, crack, amphetamine, and methamphetamine use with increased violence

(Brody, 1990; Wright & Klee, 2001). The reasons are likely to be varied and multifaceted. First, individuals who abuse psychostimulants may be inherently aggressive, antisocial, or psychopathic sensation seekers. It has been suggested that only individuals with pre-existing impulse control problems may act aggressively when under the influence of psychostimulants (Powers & Kutash, 1978). Second, an intense dependency on these drugs may make users in even mild withdrawal more aggressive. A recent study indicated that cocaine dependent individuals were significantly more aggressive than a non-dependent control group (Moeller, Steinberg, Petty, & Fulton, 1994). Third, aggression may result from a physical need to obtain the drug due to the expense and the difficulty of procurement.

Interestingly, the battered women in both the original study and the recent one contribute greater levels of violence, particularly sexual abuse, to cocaine use by the batterer. Batterers are able to stay up for days at a time when using cocaine. Although they are able to maintain an erection, unlike alcohol abusers who rarely can obtain or maintain one, they have more difficulty in ejaculating, so they blame the woman and keep trying through both sexual intercourse and oral sex. It is common to find forced anal sex during cocaine use, also. Many of the women in the jail sample also described their addiction to drugs as contributing to their vulnerability to being coerced into committing crimes so they could get money to buy these drugs.

Phencyclidine (PCP)

As with psychostimulants, the linkage of PCP abuse and violence is not supported by empirical evidence. Violent behavior by PCP abusers may be explained by factors other than pharmacology. The literature on PCP-producing violence is at best inconsistent. Careful examination suggested that PCP does not directly induce violence in individuals who are otherwise not prone to violence (Brecher et al., 1988). Rather, it appeared that the injuries occur in the context of trying to subdue an agitated or irrational user who, by virtue of being relatively anesthetized, will not respond to typical methods of restraint and may seem to have "superhuman strength." However, McCardle and Fishbein (1989) found that personality characteristics and usage history were more accurate

predictors of aggression and hostility. Very few of the women in our study discussed PCP as a drug commonly used by themselves or their batterers.

3, 4-Methylenedioxymethamphetamine (MDMA; "Ecstasy")

MDMA users usually experience a dreamy state sometimes accompanied by hallucinations and delusions, along with an increase in motor activation, stimulation, and general arousal. The duration is relatively short (Watson, Ferguson, Hinds, Skinner, & Coakley, 1993) which is why it is often used at late night clubs where it is easily obtainable.

In a recent study (Gerra et al., 2001), individuals with a history of MDMA use and a control group of non-users were tested on a measure of aggression. The user group was found to be more aggressive than non-users. It also found that the user group's aggressiveness was associated more with MDMA's pharmacological effects than with their personality traits which may be due to the possible neurotoxic effect of the substance. However, more research is needed.

Common Themes of all Substance Studies

The common theme of the above-mentioned substance studies is that each of the drugs including alcohol, the drugs themselves do not cause violence; rather, they may trigger a reaction in the individual who is predisposed to aggressive and violent behavior. Some studies have shown that alcohol or drugs disinhibit our human tendency toward aggression. For example, Pernanen (1991) found that the classical disinhibition is a psycho-physiological perspective in which psychoactive substances disengage lower brain functions (i.e. sex, aggression) from higher brain control. It is commonly assumed that drugs and alcohol have a direct chemical effect on the brain, disinhibiting violence; this, however, is a myth as no violence-inhibiting center exists in the brain. Lang, Goeckner, Adesso, and Marlatt (1975) challenged the theory of disinhibition through experimentation. They suggested that the expectation of an alcohol-aggression effect may better predict aggressive behavior than alcohol itself. In another experiment, Cheong, Patock-Peckham, and Nagoshi (2001) demonstrated a more complicated pattern between

expectancy and alcohol-related aggression. This study showed that the direct influence of the substance on domestic violence, independent of a person's cognitive processes, beliefs, and social contexts, is minimal.

Original BWSQ 1 Study of Alcohol and Other Drugs

In the original study we looked at the woman's report of the batterers use of alcohol and other drugs in general as well as her report of both her and her partners' use during each of the four battering incidents (the first, the most recent, the worst, and the typical incident). We also compared the batterers use of substances with the non-batterers use in those who gave details about a battering and non-battering relationship. The frequencies for BWSQ 1 as compared to BWSQ 2 for the first incident and worst incident can be found in Table 10.2.

Interestingly, the women's alcohol use appears to be a little higher than the national level for alcoholics as found by Callahan (1970). There was a slight rise from 16% in the original group to 25% in the current group in use of alcohol during the worst incident. Other drug use also showed a rise with 7% in the original study to 22% admitting using other drugs during the current first incident and 8% during the original study to 14% in the current study. The drop in drug use from the first incident to those battering incidents later on is similar in both groups, supporting our original results that battered women use fewer drugs to cope with the increasing domestic violence from their partners.

The women's reports of the batterer's overall drinking pattern, and her reports of his alcohol use during these incidents in the original study were correlated at .77. The mean differences between the two groups on the variables measured demonstrated that distinctions could be made using the variables themselves. The discriminant function coefficients show that two variables make statistically significant contributions to differences between no alcohol and excessive alcohol users.

The question of the relationship between alcohol use and the degree, severity, and number of battering incidents was explored in an analysis of the data done to meet part of

10.2 Women's Report of Alcohol and Drug Use During First and Worst Battering Incidents in BWSQ 1 and BWSQ 2.

Original Data	Original First Incident		Current First Incident		Original Worst Incident		Current Worst Incident	
	BBW% %	BBP% %	BBW% %	BBP% %	BBW% %	BBP% %	BBW% %	BBP% %
Alcohol:								
Yes	2	0	0	1	6	6	5	1
No	8	6	2	0	3	2	6	4
Not Sure	0	4	8	9	1	2	9	6
Drug Use:								
Yes	7	5	2	8	8	7	4	1
No	2	1	7	7	2	8	5	4
Not Sure	0	4	1	6	0	5	1	5

BW= Battered Woman
BP= Battering Partner

the doctoral program requirements for one of the data analysts (Eberle, 1982). The discriminant results of the analysis she used are reported here. (Some of the numbers may be different from our other analysis, as these data were run using a smaller sample, N = 390.) A multivariate approach was used to discriminate differences between those batterers reported to abuse alcohol and those who did not use any alcohol at all. Our data permitted comparisons of multiple measures of violence, some of which were used to create composite measures.

This resulted in the creation of the following seven variables, which were used in the discriminant analysis: (1) The total number of battering incidents reported; (2) severity of injuries inflicted on the battered woman; (3) perceptions or actual violence toward the children in the family; (4) the batterer's criminal background; (5) the victim's use of alcohol; (6) the average age of the batterer for the four battering incidents reported; and (7) the batterer's socioeconomic status. The dependent variable used was a dummy variable created by computing the batterer's alcohol use-rate over the four battering incidents. Only those who either did not use alcohol at all or used it excessively through all four battering incidents were selected, decreasing the N to 131. There were 73 subjects whose batterers reportedly did not use any alcohol and 58 who used it excessively.

This procedure produced an interesting finding: The frequency distributions depict a bimodal distribution, with each battering incident having about 50% of the subjects using excessive alcohol, and the other half being sober. However, when looking at batterers' drinking patterns individually, they were not consistent in its use across the four battering incidents. For example, it was reported that the batterer could use "a lot" of alcohol during one incident, "some" during another incident, and "none" during the third. This inconsistent pattern of alcohol abuse across all the battering incidents had not been reported before, perhaps because multiple measures had not been available.

Battered women in the first study who used alcohol were more likely to be older than those who did not (.46). Three of the four violence measures that were calculated at the time contributed less significantly to the discriminant function, and the fourth, criminal behavior, was dropped from the analysis during the stepwise selection procedure. Adding other

violence correlates to that variable might have given it more power. The variable which represented the degree and severity of the woman's injuries was approaching significance (.26), lending some empirical support to the clinical observation that batterers who abuse alcohol inflict more serious injuries on the women. More research is still suggested in this area.

This analysis shows some support for the discriminant function of the other variables used, as they are in the predicted direction, but they still do not make a major contribution. The .25 coefficient for the variable measuring social status indicates that violent men from a low socioeconomic status may be more likely to be alcohol abusers. This finding was supported by the literature which indicated that, in general, there are more drinking problems in the lower socioeconomic class (Calahan, 1970). Thus, batterers may not be that different from the rest of the population when it comes to drinking problems. This is an important finding to consider, as Calahan's (1970) data indicated a 15% alcohol abuse rate for men and a 7% to 14% alcohol abuse rate for women. Our sample of batterers and battered women also falls into that range, when the consistent pattern over more than one battering incident is used as the measure.

Current BWSQ 2 Study of Alcohol and Other Drugs

In this study we analyzed what 98 of the battered women from five countries (U.S., Russia, Spain, Greece, and Colombia) in our study described about their male partner's substance abuse and the subsequent battering incidents. This sample is different from the U.S. only sample we analyzed in the original study. Again, we wanted to assess the types and frequencies of substance abuse and whether batterers who engaged in acute battering incidents would be more likely to be under the influence of alcohol and other drugs across all four incidents.

Questions relating to substance use in the BWSQ 2 were more carefully designed to capture the accuracy of the alcohol consumption and drug use as well as the severity of the battering incidents than in the BWSQ 1. Simultaneously, the BWSQ 2 also consists of a comprehensive Substance Use Inventory, which is a 20-item self-report measure that is

designed to assess the type of substance and its frequency of use for the batterer and the battered woman. The types of substance on the questionnaire included prescription drugs, sedatives-hyptnotics-anxiolytics, opiods, stimulants, GHB, cannabis, alcohol, hallucinogens/phencyclidine, and others as described above. All items are on a frequency scale that coded by 1 = "never", 2 = "daily", 3 = "weekly", 4 = "monthly", and 5 = "yearly."

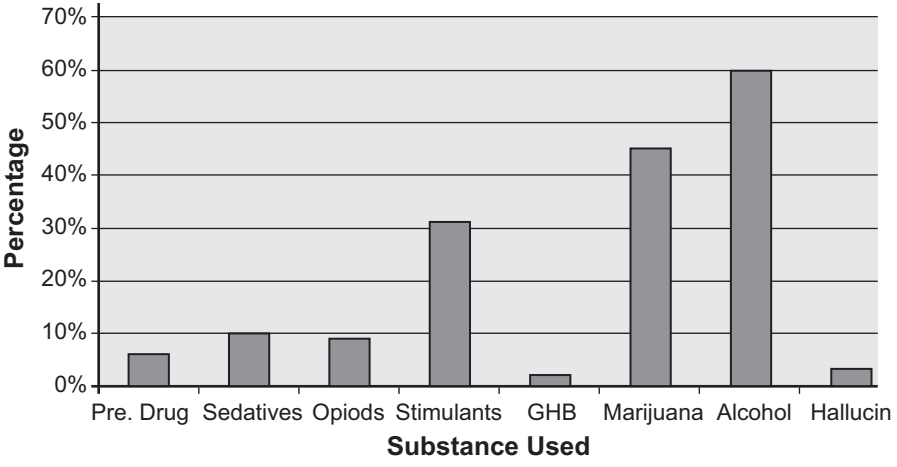
Results

Our frequency analysis indicated that the women described three leading substances that batterers consume: Alcohol (60%), Marijuana (45%) and Stimulants (31%). Other substances used by the batterers included prescription drugs, sedatives, opiods, GHB, and hallucinogens. Figure 10.1 reveals the substance use frequencies of batterers as reported by the battered women.

As was consistent with the results of BWSQ 1, the women in this study also stated that alcohol was the most common drug used by the batterers. Therefore, we conducted further analysis to investigate the batterer's alcohol consumption during the battering episodes as reported by the battered

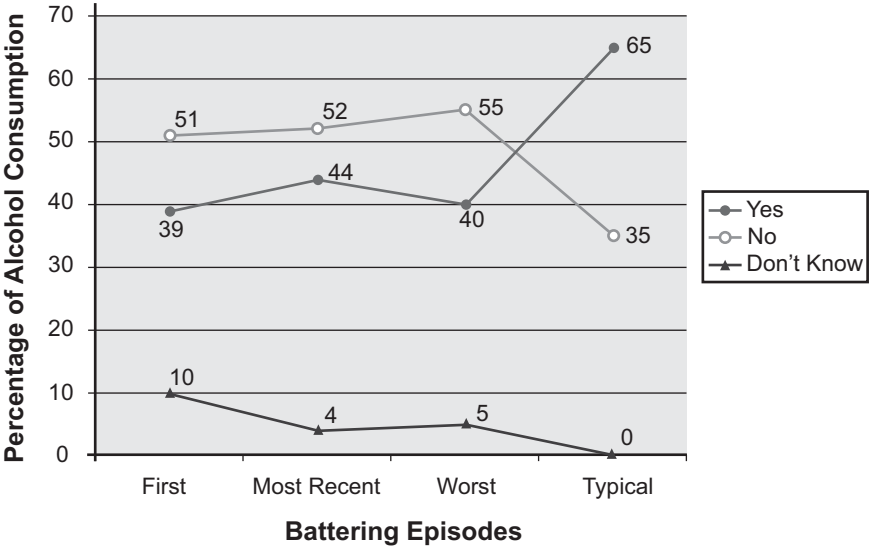
10.1

Batterers Substance Use



10.2

Batterer's Alcohol Consumption across Battering Episodes



women in this sample. We found that alcohol was consumed in 38% of the first battering incident reported, in 44% of the time during the most recent battering incident reported, in 40% during the worst, and in 65% during the typical battering incident reported. See Figure 10.2 for these results.

A standard multiple regression was performed between substance use and battering incidents. When all the substances were looked at collectively, results revealed that substance use accounted for approximately 29% of the variance in battering incidents that can be accounted for substance use (*R Square* = .287). This was significant at the .05 level.

Further analysis was conducted to determine for each substance use how badly the woman was injured by the male batterer. Overall, results indicated that of all the substance used, alcohol was the only significant predictor in how badly battered women were injured during the battering incidents (p = .020). See Table 10.4.

10.3 ANOVA Summary

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.535[a]	.287	.095	.736

a. Predictors: (Constant), Hallucinogens, Opidos, Stimulants, Alchohol, Sedatives/Hyptnotics, Prescription, Drugs, Marijuana

Pearson Correlation was performed to examine the relationship between substance use and severity of injury during the battering incident. We did analysis across all battering incidents: general, typical, most recent, first, and worst incident. Our results indicated that for the most recent episode there was a significant relationship between alcohol consumption and degree of injury during the most recent episode. No significant relationship was found for other episodes. See Table 10.5.

Discussion

Overall, the results of our study confirmed the hypothesis that batterer's engage in substance use during battering incidents. Based on the frequency analysis, it is evident that batterers used a range of substances including but not limited to alcohol, marijuana, stimulants, prescription drugs, hallucinogens, and opiates. This finding is similar to that of previous research reflecting that approximately 50% of batterers used substances (Gondolf, 1999, Tolman & Bennett, 1990). When taking an even closer look at the substances used, we saw that alcohol consumption was the leading drug category indicating that this may be the drug of choice among batterers. This finding provided further confirmation that alcohol was the most used drug by batterers and is consistent with the literature as well. More specifically, 60% of batterers reported engaging in alcohol consumption.

10.4 Substance Use and Injury During the Battering Episodes

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1.868	.252		7.420	.000
	Prescription Drugs	–.105	.385	–.052	–.273	.787
	Sedatives/Hyptnotics	.043	.496	.016	.086	.932
	Opiods	–.608	.819	–.135	–.743	.464
	Stimulants	.638	.500	.355	1.275	.214
	Marijuana	–.659	.560	–.394	–1.176	.250
	Alchohol	.845	.339	.505	2.490	.020
	Hallucinogens	–.402	.716	–.150	–.562	.579

a. Dependent Variable: How badly were you injured by what he did to you?

10.5 Pearson's Correlation

		Were you injured during the most recent episode?	Was he using alcohol during most recent incident?
Were you injured during the most recent episode?	Pearson Correlation	1	–.330(*)
	Sig. (2-tailed)		.013
	N	62	56
Was he using alcohol during most recent incident?	Pearson Correlation	–.330(*)	1
	Sig. (2-tailed)	.013	
	N	56	66

* Correlation is significant at the 0.05 level (2-tailed).

When looking at alcohol consumption across episodes, it was apparent that during the first, most recent, and worst episodes batterers were less likely to have reported drinking alcohol. This was rather surprising as we expected that batterer's alcohol consumption would have been the same or greater over time, especially since it was reported that during the typical episode, batterers reportedly drank approximately 60% of the times. One explanation is that the women are less likely to remember the use of alcohol specifically during some individual battering incidents, but can remember that the men typically drank over time. Others have also found that batterers do not consistently abuse alcohol in each battering incident, even though over time they do (Kantor & Straus, 1987). This finding has major implications for treatment as it suggests that substance abuse intervention without offender-specific treatment will not be enough to help men stop their abusive behavior.

Consistent with the literature reviewed above, our study found that alcohol abuse is a risk factor for intimate partner violence, especially amongst alcoholic men. From the regression analyses conducted it was evident that of all the substances used, alcohol was the only significant predictor in how badly the woman was battered. As we know, alcohol intoxication impairs cognition and the possibility exists that while under the influence of alcohol, the batterers may demonstrate less judgment when "beating" their female counterpart, which may lead to a more severe degree of injury. Other studies have also corroborated that abusing alcohol increases the risk of severe physical aggression (Pan et al., 1994). Collectively, drugs are perceived to be used as a form of self-medication. It is not known if batterers' poor problem solving skills lead them to resort to drug use to avoid dealing with their problems or if it is simply an escape. In any case, our data demonstrates how substance use is definitely associated with domestic violence.

Although alcohol was the most significant predictor in physical aggression, we expected that there would have been more statistical significance across all the episodes. One limitation of this study is that the batterer's substance use is reported by the battered women, therefore the possibility exists that the figures could be over or under reported. Additionally, as postulated by Galvani (2006) women who have

been battered often feel that alcohol alone is not enough to explain their partner's violent and abusive behavior.

With regards to further research, attempts should be made to interview the batterers so that we can attain a more accurate picture of batterers substance use. Having batterers complete the section on substance use is crucial for substance use issues. Additionally, when questioning women and men about substance use issues, a more detailed and comprehensive substance use inventory should be utilized in order to determine a wider perspective of their use of substances. In this study, the questionnaire used included only closed-ended questions and Likert scale items which restricted the interviewees' responses. This issue is particularly relevant when considering the impact of substance use on the Battered Woman Syndrome.

Role of Alcohol and Other Drug Abuse in Battered Women

Alcohol and drug abuse has been found to be used as a form of self-medication to block the intense emotions that are often experienced by abuse victims, particularly physical and sexual assault victims. Kilpatrick and Resick (1993) found that the highest risk factor for alcoholism in women after a sexual assault was exposure to prior abuse. Goldberg (1995) reviewed the literature on substance abusing women and found that although they were a diverse group, the major risk factors were not poverty or exposure to substance abusing parents, as was common for substance abusing men, but rather childhood physical or sexual abuse, adult victimization by domestic violence, and a partner who abuses substances. It is interesting that in the original study, too, many of the women who reported to being alcohol-dependent were also living with alcohol-dependent partners. Some of those women said that they avoided further abuse by going out and drinking with their partner. It is not uncommon for women to become addicted to drugs that are supplied by their batterer who then has greater power and control over the woman as he dispenses their drugs based on how she behaves. We have not yet completed the analysis of battered women who were also substance abusers in the new study. However, we have some observations from the Women in the STEP progam in jail detailed later in Chapter 16.

Women's Substance Abuse and Public Policy

In the 1980s the government began to arrest and prosecute pregnant women who potentially were harming their children through the ingestion of alcohol and other drugs. However, when a closer look was taken at these women, it became clear that over 90% of them were battered women (Walker, 1991). Research by others found that there were no treatment programs for substance abusing, pregnant, battered women. Battered women shelters would not take them nor would drug treatment centers. Putting them in jail was not a solution, especially since detoxification needed special techniques to protect both the mother and the fetus. Removing the baby from the mother at birth exacerbated the child's potential developmental problems, which appeared to have a direct relationship with the degree of bonding that could occur between the mother and the child. The best solution, of course, was to provide assistance to the woman to stop her substance use, for the womant to get out of the violent relationship, and to bond with her baby. Given the fact that many battered women temporarily get more depressed when they leave an abusive relationship and are in greater danger especially if the batterer stalks and finds her, this is a problem without satisfactory resolution much of the time.

Substance abuse treatment programs for women need to have trauma therapy in addition to other types of intervention. In 2000 to 2002, we provided a day treatment center program for 70 women with serious mental illness who had some kind of criminal justice involvement. Most of these women also had substance abuse problems and over 85% of them were also battered in their homes and on the street. We found that without trauma-focused intervention, these women could not stop their substance abuse, even with appropriate medication management. Most important was helping these women begin to rebuild interpersonal relationships, in some cases with families of origin who had given up on their ever being sober, and in other cases with families of choice, where women worked on developing close friendships that served as family. We have found that very few programs for women who have the co-occurring disorders of severe mental illness and substance abuse include the trauma component. While this book focuses

on battered women, in fact, many of those women experiencing domestic violence also have experienced child physical and sexual abuse, sexual assaults, rape and harassment, head injuries causing neurological problems, prostitution, addictions to substances, poverty, racism, and other forms of discrimination. These multiple problems can leave the woman emotionally exhausted in trying to cope with all of them.

Intervention

Although our data show that batterers are reported to drink and use drugs more frequently than the battered woman, further study of these variables in abusive relationships is needed to provide more specific information. For example, in a review of over 400 homicide and attempted homicide cases in which the abused victim becomes aggressive towards the abuser, there are frequent reports of alcohol and other drug abuse in one or both parties. The level of severity of injuries from the assaultive combat while intoxicated appears to be more serious in many of those cases. We first found this association during an analysis of first 100 homicide cases (Walker, 1989) and over the years it appears to be fairly consistent.

The use of alcohol may start out to calm one's nerves or be a pleasant relaxant, but it quickly takes on menacing properties. So too for other drug use which also reportedly starts out as a pleasant way to overcome tensions and anxieties, but soon takes over as a way of life. In some of our cases, the women described how their entire days were spent trying to find ways to obtain sufficient prescription drugs to keep themselves and their batterers calm so they'd be less likely to beat them up. These women report quickly becoming addicted. In one case, the woman told of how she allowed herself to be caught by the police for passing forged prescriptions, perhaps as a way of finding safety in jail. In other cases that escalate to homicidal or suicidal levels, it has been found that cocaine and its derivatives, particularly crack, crank, amphetamines, and meth-amphetamines are the drugs most likely to be used in addition to alcohol (Walker, 1989, 1994).

It is important for drug and alcohol treatment programs to recognize that violent behavior cannot be stopped through alcohol and other drug counseling. Neither will a substance-abusing battered woman gain the assistance she

needs to become independent and remain violence-free. Programs which appropriately deal separately with the violence and the substance abuse are crucial. Communities that have special domestic violence courts often have a drug court that is associated with it. Thus, even if an alcoholic batterer becomes sober, he will not become a non-batterer until he goes through a process designed to teach or help batterers become nonviolent. And women who abuse substances to self-medicate from the symptoms of PTSD and BWS need specialized treatment for the abuse they have experienced in addition to treatment for alcohol and other drugs. We discuss treatment programs in more detail in Chapters 14, 15 and 16.

It is important to recognize that alcohol and other substances used on a regular basis over a long period of time can lead to serious cognitive deficits. In those who have had a chronic substance abuse problem, it is often necessary to participate in a cognitive rehabilitation program similar to those used with stroke victims. This type of treatment will help retrain the brain so that the effects of chronic substance abuse will be moderated. Without such treatment it is less likely that they will be able to make use of traditional verbal psychotherapy.

Summary

The relationship between substance abuse and domestic violence is clearly demonstrated in numerous studies over the past 30 years. However, the new problem-solving courts have added mental illness as a third factor that must also be investigated. Alcohol is frequently the drug of choice that is associated with intimate partner violence although cocaine and methamphetamines are also frequently reported. Battered women are likely to use substances to self-medicate from the psychological effects of abuse. Women who have been arrested for drug offenses often have been abused by intimate partners. Cognitive rehabilitation as well as trauma treatment and drug treatment are all needed, especially for those who have been abusing substances over a long period of time.

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11

Impact of Violence in the Home on Children

Lenore Walker

Introduction

The impact of exposure to violence in the home on children has been found to have a most detrimental effect on them, even more significant than being raised in a single parent home. It would be a rare person who would argue that children would not be better off raised in a home with two loving and nonviolent parents. However, the data are clear; children who are exposed to violence have a significant risk for using violence themselves, becoming delinquent, demonstrating school and behavior problems, and having serious and lifelong mental health problems including depression, anxiety, and PTSD symptomology. In fact, some have suggested that an exposure to both domestic violence and violence in their

community may be the most toxic combination for negative outcomes for both children and their parents (Jaffe, Wolfe & Wilson, 1990, Prothrow-Stith & Spivak, 2005).

Wolak and Finkelhor (1998) reviewed four large scale surveys and estimated that approximately 11% to 20% of children lived with parents where domestic violence had occurred during a one year period. Childhood prevalence rates were higher, close to one third of all children have been exposed to fathers battering their mothers. Using a population of school children, Singer, Anglin, Song, and Lunghofer (1995) found that between one quarter to one half of them reported seeing a family member slapped, hit, or punched during the past year and one third reported witnessing someone being beaten up in their home. In some of these cases, it was siblings who were physically harmed in the home. There are also other ways besides directly observing domestic violence that children can be exposed. These include overhearing verbal conflicts, becoming a target of the violence or attempting to intervene in it, and observing the aftermath while not the actual conflict itself (Edleson, 1999). Studies have reported major discrepancies between what parents think and what children state they are exposed to when there is violent conflict in their homes (O'Brien, John, Margolin, & Erel, 1994). Based on these estimates, however, most would agree that somewhere between 10 to 17 million children who live in the U.S. are exposed to intimate partner violence each year.

In the 30 years since the original BWS research, there has been a plethora of data collected about children who have been exposed to domestic violence, particularly by their fathers or father-like substitutes abusing their mothers. Along with the physical and psychological damage done to these children, even if they are never physically abused themselves, it is clear that they are in danger of being killed along with their mothers by their unstable fathers who are unable to tolerate separation from their families. The attitude, "If I can't have you, no one will" is still widely quoted by the women we have studied. Typical are the news reports of homicide of all family members and then suicide by the father. This problem has not been seriously addressed by communities or the courts who still insist that shared parental custody is healthy for children, even if the father is a batterer. Those of us who work with battered women and support their protection of their children believe that these

senseless deaths can be prevented. We can also prevent living with this fear if mothers are permitted to protect their children from angry and often mentally unstable batterers. However, the courts around the world will have to change their attitude and use their powers to empower mothers to make decisions about the best interests of their children themselves instead of forcing shared parental responsibility (Walker, 1999). Abusers must prove to the courts that they can stop their controlling behavior before they regain their parental responsibilities.

In this chapter, we will address some of the negative effects on children when exposed to violence against their mothers by batterers. We have added a section on teenagers as more data have become available about teens, delinquency, and violence in their homes. We have also added a section on child custody issues as this appears to be one of the most significant areas of controversy amongst mental health professionals, many of whom do not pay sufficient attention to the dangers of not protecting children from the rampant power and control issues that batterers subject them to, especially when using them as pawns against their mothers for control or revenge.

Modeling Aggressive Behavior

The probability that spouse abuse has a profound influence on children who are exposed to it during their early years was found to be consistent with most psychological theories popular at the time of our original research. Social learning theory would predict its significance for future violence as typified by Bandura's (1973) and Berkowitz's (1962) writings on the learned aspects of aggressive behavior. Eron and colleagues have detailed the role of parenting in the learning of aggression (Eron, Huesman, & Zilli, 1991). Gelles and Straus (1988) have theorized about the connection between wife abuse and child abuse using data from the Family Violence Research Center at the University of New Hampshire.

More recently, Cummings (1998) reviewed the data on conceptual and theoretical directions and discussed the interaction factors that occur from the different ways conflict and violence are expressed together with constructive parenting behaviors in a particular family. He found that children respond emotionally to adults' disputes by a variety of behaviors and those

responses may be aggravated by some factors such as comorbidity of alcoholism in one or more parents, parental depression, and the meaning given to marital conflict by the children. On the other hand, Cummings also found that constructive conflict resolution may mediate the effects of children's exposure to destructive conflict and prepare them to develop better coping strategies for future exposure. Graham-Bermann (1998) found that although only 13% of the children from families where there was domestic violence that she studied met all the criteria for a PTSD diagnosis, more than half of the children were reexperiencing the battering incidents that they had been exposed to, 42% experienced arousal symptoms, and fewer children experienced avoidance symptoms that are part of the criteria for the PTSD diagnosis. Others have also found PTSD in children who have been exposed to domestic violence in their homes (Goodwin, 1988; Hughes, 1997; Pynoos, 1994; Rossman & Rosenberg, 1998; Terr, 1990).

Rosenberg and Rossman (1990) suggest the impact of exposure to domestic violence on children has ranged from minimal to placing severe limitations on personality development and cognition. Further, most child abuse experts agree that the next generation of abusers will come from those who have been abused themselves (Garbarino et al., 1986 & 1991; Geffner et al., 1997; Gil, 1970; Helfer & Kempe, 1974; Holden et al., 1998; Peled, Jaffe, & Edleson, 1995; Jaffe, Wolfe, & Wilson, 1990; Rossman & Rosenberg, 1998). Carlson (2000) reviewed the research on children exposed to violence by intimate partners in their homes and found that there were factors that moderated the distress experienced by the children. These moderators included the nature of the violence, the child's age, gender, exposure to other forms of maltreatment, and social supports that protected the child or served as a "buffer" (Carlson, p. 321).

Patterson's (1982) studies of aggressive boys, based on learning theory, assume that all social interactions are learned from that which is directly or indirectly modeled by other persons. Given the high rate of aggressive behaviors to which all children are exposed, and therefore learn, the question becomes why some perform aggressive acts at higher rates and in different patterns than others. The Coercion Theory developed to answer this question came from methodical observations of the interaction of behaviors emitted by family members studied in a variety of environmental conditions. The implication of Coercion Theory is that if modeling takes

place in interactive, conditioning relationships, then children raised in violent homes are at high risk to develop those same violent patterns whether or not they are themselves deliberately abused. Interestingly, Patterson's research on Coercion Theory in families with an aggressive boy has found the same cross-gender abusive behaviors among the family members that our study has found associated with domestic violence (Patterson, 1982).

Other theories such as stress and coping perspective by Lazarus and Folkman (1984) and the trauma perspective given the PTSD responses prevalent in the children (Silvern & Kaersvang, 1989; Briere & Scott, 2007), have also been used to explain how children respond to the violence as a stressor. There is new research that documents how earlier exposure to violence as a child creates brain dysfunction and diseases (Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008) in adults. We discuss some of these diseases in Chapter 7 on body image and health concerns. Carrion (2007), working at the Stanford University School of Medicine's Packard Children's Hospital, looked at the brain function of severely traumatized children with functional magnetic resonance imaging (*f*MRI) and found that these children were more impulsive, agitated, hyperactive, and engaged in avoidance behaviors. Many children with PTSD from exposure to violence in their homes and on the streets are misdiagnosed with Attention Deficit Hyperactive Disorder or other learning problems and placed on medication that is inappropriate for their problems. In many cases that we evaluate through our forensic clinic, we found children diagnosed with a variety of different disorders who have PTSD after being removed from an extremely abusive family home and placed in one or more foster homes. These children are very aggressive or very avoidant, have attachment problems, and do not function well in a learning environment or with other children.

Interestingly, boys are not alone in the escalation of violence. From 1999 to 2004, we studied teenage girls who were arrested, charged with delinquency, and held in the detention center. Although more than half of them denied exposure to abuse in their families when asked directly, over 85% of them scored in the PTSD range on standardized tests that measure the impact of abuse on children's psychological functioning. Reports from other psychologists who work with the juvenile justice population also report an increase in girls' violent behavior. Although the movies and other media that

portray this violence (Walker et al., in press; Wedding, Boyd, & Niemiec, 2005) suggest that it may be due to changes in women's social roles, in fact, it appears that these girls are acting out the impact from the abuse they have received themselves. This is further described below.

Empirical Evidence

Empirical evidence about the exact nature of the impact of witnessing or experiencing family violence on children has grown during the past 30 years. Our data has added a little more to the still small knowledge base. While we asked some direct questions concerning child development, most of our data is inferred from open-ended responses and thus, must be cautiously interpreted. However, it is important to add these data to the knowledge base as they are from a more heterogeneous sample, while most of the other studies come from homogeneous samples of children who are in shelters or under state care and have been exposed to the most serious forms of abuse. In the original study, we dealt with ethical and legal issues that forced us to deliberately sacrifice the ability to question our subjects directly about present or potential child abuse because of the difficulty posed by Colorado's mandatory child abuse reporting law. If you remember, this study was predominantly conducted in Denver. However, we are aware that most studies on child abuse indicate that in more than half of them, abuse of their mothers has also occurred, usually by the same perpetrator (APA, 1996a).

As a licensed psychologist and principal investigator of the original research grant, too, I was in the category of professionals who must report any *suspicion* of harm to a child. In some states the law requires some actual *knowledge* or *belief* of harm, a different standard. *Willful nonreport* of suspected abuse would have been grounds for removal of my license to practice psychology and criminal prosecution. As the principal investigator, all project staff were under my supervision, which also made me liable for reporting any evidence they *suspected* or *uncovered* during the interviews. The widespread community publicity announcing our original project caused several Colorado juvenile court judges at that time to assure us that we were going to be held responsible to report any disclosures relevant to *potential*, *suspected*, or *current* child abuse. Failure to report, we were told, would result in immediate prosecution despite our protests that

accuracy of our data could be compromised if we were forced to report past or suspicions of child abuse. Nor would the Department of Justice's Certificate of Confidentiality, which was intended to protect our data from being subpoenaed in a court action, suffice to protect the project. Today, these issues have been taken care of in research projects looking directly at child abuse, but back in the late 1970s this was the first project to directly assess for the impact of domestic violence on the family.

This unexpected difficulty caused us to revise our original intent to collect data on perceived child abuse in homes where women were being battered. Instead, we compromised by asking about past child abuse and discipline procedures. We also agreed we would make a formal report if we inadvertently uncovered any current instances of child abuse. Since our research was designed to measure women's perceptions of events, there was no way to verify the accuracy of their self-reported data. Therefore, unlike in clinical interviews, potential risk for child abuse could not be directly ascertained from the questions we asked, and thus, could not be considered "willful nonreport" as the statute demanded. The resolution satisfied the Colorado legal community, the National Institute of Mental Health (NIMH) funders, and did not compromise the project goals.

As a result of our dilemma, NIMH and the Department of Justice have negotiated a new agreement that extends the Certificate of Confidentiality to protect research projects needing to collect such sensitive child abuse data without being subject to the numerous states' mandatory report laws. There are also newer statistical techniques that allow for systematic sampling that can overcome this problem. We found that establishing personal contact with understanding child protective services caseworkers, guarded against possible punitive responses toward those few women for whom we did file a report, with their knowledge and cooperation.

Child Abuse Correlates in the Original Research

Despite these difficulties and subsequent compromises, our results are consistent with other researchers in this area. It is interesting to note that 87% of the women reported that the children were aware of the violence in their homes. Most

field workers now believe that closer to 100% of children who live in domestic violence homes are aware of their father's abuse against their mother, even if they do not discuss their perceptions with their mothers. The APA Task Force on Violence and the Family (1996a) considered exposing children to domestic violence as a form of nonphysical child abuse because of the similarity of the psychological effects that also occur with other forms of child abuse.

These results also point to the inadequacy of understanding this form of child abuse and neglect in previous, more medically-oriented child abuse literature such as is represented by Helfer & Kempe (1974) that stress can physically injure children. Often, their condemnation of the mother for not protecting her child overlooked the possibility that she might have been without the ability to control the man's violent behavior against herself or her children. Perhaps the most visible case where this was graphically seen was with Hedda Nussbaum who could not protect her daughter, Lisa Steinberg. Hedda Nussbaum was an author and editor for a major New York publishing firm while her common-law husband, Joel Steinberg was a successful lawyer. However, he battered her and the children, sometimes while under the influence of cocaine, and eventually killed six-year old Lisa. Steinberg was found guilty of manslaughter and sentenced to prison. Hedda Nussbaum was not arrested but was condemned by the public for failure to protect Lisa and the younger boy (Brownmiller, 1988). I suggest that perhaps any other intervention she might have done could have made things worse, perhaps even getting them all killed (Walker, 1989a). She has spent many years recovering from her own mental health and substance abuse issues and today speaks against domestic violence around the world.

Our original research found a high overlap between partner and child abuse. While living together in a battering relationship, over one half (53%) of the men who abused their partners reportedly also abused their children. This result compares favorably with other research that suggests as high as a 60% overlap between child and woman abuse. Further, one third of the batterers also threatened to physically harm the children whether they did it or not. This compares with about a quarter of the women (28%) who said they abused their children when living in a violent home, and 6% who threatened to abuse the children. Clearly, in our sample, children were at greater risk of being hurt by the batterers

although not out of harm with a quarter of their mothers who were being abused themselves.

One of the more popular myths about child abuse and family violence is that the man beats the woman, the woman beats the child, and the child beats the dog. It is so common that even nursery rhymes tell of such a hierarchy. Given its popularity, we tried to measure whether or not the woman abused her children when angry with the batterer. We found that 5% of the women said they did use physical violence against the children when angry with the batterer. But, only 0.6% of the women said they did so when living in a nonviolent relationship. This supports the notion that anger begets more anger. Violence begets more violence. Some newer research is suggesting that it is not just abuse that creates the psychological harm to children but also the environment within which abuse takes place. For example, Gold (1997) has found that the impact from child sexual abuse can be moderated or buffered by some positive social supports in the family environment. However, his research also found that most homes where incest has occurred had a very dysfunctional environment in addition to the sexually inappropriate behavior that occurred.

Our mothers said they were eight times more likely to hurt their children while they were being battered than when they felt safe from violence. Only 0.6% said they occasionally used physical force against the children to get something from the batterer. Thus, from our data, it can be concluded that the level of reported child abuse by the women was low enough to disprove the pecking order myth. The alternate possibility that men who beat their wives also beat their children has much more support from these data. However, although many of these mothers were unable to totally protect their children from the batterer's psychological power and control abuses, they were better able to protect them when living with the batterer than when they tried to terminate the relationship.

Protection of Children

In analyzing why mothers seem to get so much of child protective services caseworkers' and child abuse experts' wrath, the most plausible explanation seems to be the prevailing view that women are expected to take care of their children

and prevent them from harm no matter what the cost to themselves. In high risk incest families, the presence of a strong mother reportedly does prevent serious child abuse (APA, 1996a). Positive parenting by mothers can moderate against damages from exposure to abuse. Thus, the focus of some child abuse treatment programs has been to help women become better wives and mothers, often without realization that these women were also victims of terrible intimate partner abuse. Others, such as children's programs in battered women shelters focus on cognitively restructuring the family to define it as a mother-child bond without the inclusion of the father. Unfortunately, the divorce courts do not accept this model and often perpetuate the abusive environment by failing to protect either the mother or the child from the abuser. Forensic mental health experts who specialize in child custody evaluations come more from the perspective of child protection and rarely understand how to support and reempower the mother who has been abused. Rather, they often mistake the mother's behavior as causing alienation and estrangement of the child towards the father, instead of accepting that children exposed to parental domestic violence may be frightened of the father because of his controlling and often psychologically abusive behavior rarely seen by the evaluation instruments used by these forensic evaluators. The controversy about parental alienation syndrome and other similar so-called mental illnesses perpetuates further abuse of children.

Although the long term consequences of redefining the family unit on the child's mental health have not yet been established, the critics have attacked this model as being evidence of women's vindictiveness and labeled it as "*parental alienation syndrome*" using old models of the two-parent home as needing to be extended to the child's equal contact with two parents. Gardner (1987, 1992) who was one of the loudest critics, stated that he exempted domestic violence cases from his model, but then he redefined domestic violence in his own way often excluding cases that had police evidence of physical abuse if they did not meet his idiosyncratic criteria. These issues are further discussed below.

Washburne (1983) examined how such child welfare programs reinforce traditional female role patterns rather than help women develop skills to strengthen their ability to be independent and strong. She cites examples of how cleaning up her home and improving her appearance are often required of a woman who wants her children returned

from foster care placement. One of our subjects was in serious jeopardy of losing her children in a custody fight because when the assigned caseworker made an unannounced home visit she was feeding the children dinner from MacDonald's restaurants! It would be more beneficial to parents and children to teach them non-sexist parenting skills in treatment programs than perpetuating stereotyped roles that are no longer valid in our lives.

Interestingly, many abusive men are now using the child welfare system to retaliate against women who accuse them of being batterers. Forced to co-parent children, they call the child abuse hotline if they see a bruise on the child, refusing to accept the mother's explanation of how it occurred. Public Advocate, Betsy Gotbaum, was so concerned about the increase in these false calls that she prepared a report for her supervisors in New York City (Gotbaum, 2008). Given the concern about the use of the city's child abuse reporting laws maliciously, they established a program to monitor these calls and develop ways to prosecute offenders. In Fort Lauderdale, Florida, the Broward Sheriff Organization has developed guidelines to assess for harassment using cell phone text messages from the batterer against the woman. Telephone and text messages as frequent as 50 or more per day have been seen especially when the woman has parenting time with a child. Continued use of the telephone, emails, or text messaging from and to cell phones is a newer form of harassment and a way to continue power and control over the woman by the man using the child to get to her.

Modeling Non-Violent Behavior

Modeling learned behavior of parents is probably the most powerful way that violence as a strategy gets passed down to the next generation. In a 25-year longitudinal study, Miller and Challas (1981) found that men who were abused as children were almost two times more likely to become abusive parents than were women. While they do not look at the natural reinforcement of male aggression in a sexist society, their conclusions certainly support such a concept. In the original research, we attempted to measure the differences between men and women on their attitudes towards the role of women. Our results indicated that there were widespread differences, consistent with sex role conditioning. Given the consistency of most of the literature on the gender issues in

violent relationships, we did not continue to measure it in the new research.

Reports from battered women shelters support the learning theory of aggression. Male and female children, some as young as two years old, model "daddy hitting mommy" to get what they want from her (Hughes & Marshall, 1995). Shelters, in order to give mothers and children an opportunity to learn new ways of communicating with each other, have almost universally adopted "no-hitting rules." Washburne (1983) found that mothers are more likely to abuse their children when they are the major caretaker. This is consistent with our finding that mothers are more likely to abuse children when they are living in a violent situation. Some women report using more controlling parenting techniques out of fear that the batterer will use even more harsh discipline should the child continue to misbehave. Despite some of the difficulties in shelter living, including crowded conditions, even abusive mothers are able to learn and use new nonabusive, nonphysical discipline techniques (Hughes & Marshall, 1995).

For the families surveyed in the Straus, Gelles, and Steinmetz (1980) study, the rate of marital violence increased in direct proportion to the amount of physical punishment experienced as children. Thus, the frequency and type of physical punishment of children need to be carefully evaluated. Early learning history of whether frustration and other negative emotions are linked with aggression can be of importance. Social factors can mediate the learned responses, both inhibiting and facilitating the display of aggressive behavior when experiencing frustration or other such emotions.

The battered women in our original study reported that two thirds of batterer's fathers battered their mothers while almost one half of their fathers and one quarter of the nonbatterer's fathers battered their mothers. Three times as many fathers of batterers than nonbatterers battered sisters and brothers when they were growing up. A smaller number of mothers of batterer's were reported to batter their children but, again, it was more than the mothers of battered women or nonviolent men.

Discipline, Punishment, and Positive Comments

In addition to inquiring about the perception of being battered as a child, we also directly asked about discipline

methods used by their parents in the original study. We found that almost all of our subjects (89%) had been spanked as a young child age six or younger, while 83% had continued to be spanked when older. Even more surprising was the report that over three quarters of the women (78%) had been hit by an object. About half of the batterers were reported to have received "strict" discipline while the other half received "lenient" discipline from their mothers. "Lenient" and "strict" were subjectively rated by the responders. But, nonviolent men were reportedly divided into approximately thirds: one third experiencing "strict" discipline, one third "lenient," and the remainder "fair" discipline from their mothers.

While more fathers were rated as administering "strict" discipline than mothers (for batterers), one and one half times as many more nonbatterers fathers were perceived as "strict." Four times as many nonbatterers were reported to have received fair discipline from fathers. Approximately one quarter of batterer's and nonbatterer's fathers reportedly were "lenient" which could also have been the catch-all category for noninvolvement in their children's upbringing.

Personality Development

Another measure of childraising patterns, albeit indirect, is the perception of whether or not separation and individuation from parents has been completed. The observation of the extreme dependency abused children have on their mothers and fathers to the point of protecting them by refusal to cooperate with social service investigations has been well-documented (Helfer & Kempe, 1974; Lystadt, 1975). Such dependency is also seen in battering relationships (Dutton, 1980, 1995; Giles-Sims, 1983). Giles-Sims discusses the bonds that a closed system such as an abusive family can foster. Often, this pattern of intimacy gets carried over into children's own marriages and families. In our questionnaire, we asked about dependency upon mothers and fathers and found that twice as many batterers as nonbatterers were said to still be dependent upon their mothers and fathers as adults. Over half of the violent men reportedly had unresolved dependency issues, which were seen as being perpetuated in their dependency upon their wives and children too. Direct measures of dependency in their children would be warranted.

Another way of looking at dependency relationships is analyzing their attachment issues in relationships with people. In Chapter 9 we describe attachment issues we found in the current research. Children exposed to intimate partner violence have not been studied as a group to determine if their attachment issues come from before or after exposure to the abuse. We do have one study in progress by Aleah Nathan who is attempting to compare attachment styles between battered women who also were abused during childhood and those whose only abuse was in the adult intimate relationship.

Hughes attempted to measure the psychological functioning of children who came to an Arkansas battered woman's shelter using several standardized anxiety and self-esteem measures. She found the children displayed the characteristics of jumpiness, nervousness, withdrawal, fright, and impaired academic performance (Hughes & Marshall, 1995). Pizzey (1974) found fear, poor academic performance, confusion, reticence in discussing violence, and fantasizing about a different home life in the children seen at Chiswick Women's Aid refuge in London. Only one fifth of Labell's (1979) sample of 521 battered women with 682 children reported emotional, behavioral, or physical problems. This is a much lower figure than would have been expected from a mental health professional's observations. Perhaps the abused women who were interviewed while in crisis and at a shelter couldn't identify their children's problems until they themselves were out of crisis. Rarely do studies look at long term impact on the child's personality from exposure to intimate partner violence. In Carlson's review (2000) she found that most studies used problem checklists such as the Child Behavior Check List (CBCL) (Achenbach & Edlebrok, 1983) and although they have found that most children score in the clinically significant range, it is not known if this has a permanent impact on their personalities.

The Hughes study actually measured the children's personality development. They found that preschool children were the most disrupted by violence in their homes and often showed signs of obvious developmental delay. Boys' self-concept tended to be more negative than girls', who had more anxiety, worry, and oversensitivity. As would be expected from all other reports, boys demonstrated more aggressive behavior than girls at every age. And, not surprisingly, mothers rated boys more negatively on conduct and personality

problems than girls. Yet, all the children viewed physical punishment as the primary mode of parental discipline. Interestingly, a bimodal split occurred in mothers' discipline preferences. After a short stay in the shelter, one-half of the mothers reported preferring non-physical discipline while the other group continued to use physical punishment. Giles-Sims (1983) also found a drop in the number of previously violent families continuing to use physical punishment after a shelter experience. Considering the Straus et al., (1980) survey findings of widespread acceptance of physical punishment as a discipline technique, it is heartening that so many shelter mothers are adopting the no-hitting rule for their families.

Garbarino, Gutterman, and Seeley (1986) have measured the impact of psychological abuse on children who are maltreated and found that in many cases it has a more detrimental effect over a longer period of time. Children are able to communicate in their own way when they are distressed by the danger to which they are exposed (Garbarino, Kostelny, & Dubrow, 1991). Cummings suggests that if parents resolve the conflict so that the child is aware of the peaceful resolution, it might mitigate some of the psychological impact (Cummings & Davies, 1994). Others have suggested intervention programs that remediate the damage (Peled, Jaffe & Edleson, 1995). However, it is important to note that the newer studies that suggest that the very structure of the brain is altered by the biochemical changes from chronic post-traumatic stress reactions and the studies of attachment styles described earlier in this book strongly suggest that there is a more lasting impact on these children's personalities.

Cummings (1998) has observed children's emotional responses to simulated conflict situations and found a great deal of distress including discomfort, anxiety, concern, anger, fear, sadness, guilt, shame, and worry when exposed to audiotaped conflict situations with actors posing as parents fighting. Laumakis, Margolin, and John (1998) also used similar vignettes to assess children's emotional responses to conflict. They found more negative responses to the scenarios with threats to leave as well as physical aggression compared to benign scenarios, especially with boys who had been exposed to similar situations in their own homes. These analogue studies are the closest measures to what really happens to children as they are being exposed to parental anger and violence. It is the aftermath that is more often studied.

The most troublesome behaviors reported in children exposed to domestic violence are those that can be seen by others—or externalizing behaviors. These include aggression, disobedience, noncompliance, hostility, and oppositional behavior. However, it is difficult to separate the impact from the domestic violence in the home and the aftermath from being forced to live in two different homes with two different sets of rules and expectations after parents separate and divorce. Unfortunately, courts have been counseled by well-meaning professionals who do not understand these effects of exposure to domestic violence, to keep the children in constant contact with both parents so the children are constantly in the middle of the power struggles and attempts to protect them. In one family that we've been working closely with, we found that in the two year period since the parents divorced, the now six year old child has gone from a happy, easy to care for child to a defiant, aggressive, and hostile child who has become seriously overweight so he cannot engage in athletics with other boys his own age. He has been expelled from school for aggression against other children. The court has ordered that the father be permitted to telephone this child and speak for 30 minutes every evening before he goes to bed so that the mother never has the opportunity to develop her own bedtime routines uninterrupted from the father. This child was not exposed to physical abuse although he hears horrible screaming and yelling as his father tries to control his mother even after they have been divorced and the father has remarried. However, the consequences for him are no different than we see in another case, a four year old boy who also has been expelled from school because he stuck a pencil in another child's eye. This child witnessed his father kill his mother after being exposed to domestic violence for over one year.

Physiological Changes from PTSD

Charney et al., (1993) have found changes in the levels of some neurotransmitters associated with PTSD. This includes elevations in adrenalin and noradrenalin that raise the heart rate and blood flow and prepare the body and muscles for quick action in the "fight or flight" reaction to danger that occurs in such traumatic situations. Focus is narrowed and

agitation increased which probably is associated with the difficulties in concentration and attention reported by victims. Greater levels of glucocorticoids help the body to deal with injury by reducing inflammation but also impact the memory functions of the hippocampus. Memory may also be interfered with by the high levels of endogeneous opiates that also reduce the perception of pain. High levels of dopamine in the frontal cortex stimulates thought processes but may also facilitate the intrusive memories and reexperiencing of the trauma. Serotonin levels have also been found to be lowered, which may interfere with regulating emotional arousal that is also associated with PTSD. Rossman (1998) describes these physiological changes and suggests that the prolonged threat to survival may leave the individual in a dysregulated state where perception, cognition, and emotional systems are attempting to compensate for the changes being experienced. Children who experience prolonged traumatic stress may well experience permanent and irreversible physiological responses. Goleman (1996) suggests that the new field of psychoneuroimmunology (PNI) can help account for some of the cognitive, emotional, and behavioral changes seen in children exposed to abuse in their homes. One of the most critical areas of emotion controlled by this mid-brain system is the social interaction between the child and peers including the lack of development of ability to experience empathy for others. We further describe these issues in Chapter 7 and in Chapter 15 where medication issues are discussed.

Issues Commonly Found in Children Exposed to Abuse

Children tend to model and identify with powerful adults so that they, too, can feel safe and powerful. While children are young, many batterers are reported to be very nurturing fathers. They care for their sons and daughters and, when not angry, show genuine concern over their upbringing. Many battering incidents reportedly occurred over fights about who had a better method of taking care of the child. Yet, as children grow older and become more independent, these men are less able to tolerate the separation and individuation necessary for the child's healthy development. They often become as possessive and intrusive into their child's

life as into their wife's. lf they take too much control over the child's life, then self-esteem and feelings of self-worth are less likely to develop, and can result in learned helplessness when the child doesn't perceive personal power.

Children who grow up in violent homes show its effects in their overall socialization process as well as in mental health symptoms. The areas most likely to be affected are affectional relationships, anger, sexuality, stress coping techniques, and communication problems. They often develop with certain skill deficits including an inability to deal effectively with confrontation and aggression and have greater confusion about interpersonal relationships. Some children are developmentally delayed while others develop so rapidly they miss major parts of their childhood.

Learning to cope with angry confrontations and aggressive behavior is one of the critical areas for these children as reported in my clinical practice. Some adapt to the seemingly limitless anger expressed in their homes by withdrawing, both emotionally and physically. Unresponsiveness and failure to thrive is noted in some during infancy. Many learn to use television or the stereo as a way to shut out the loud yelling. This is one of the more popular tactics still visible when I visit battered women's shelters. As these children grow older, they are more likely to leave the house when the fights begin. Many continue this withdrawal pattern through the use of drugs and alcohol. Others react to anger in more aggressive ways themselves. Two- and three-year-old boys and girls have been forced to join their fathers in actually beating their mothers. When their daddy is not present they become his surrogate and help keep their battered mommy in line. No doubt many of these children do commit parent abuse and granny-bashing as they become older. They also become aggressive with each other and perhaps repeat their violent behavior in their own adult homes. This finding gave way to the APA Task Force on Violence and the Family's admonition to always look for other forms of interpersonal violence when one form of violence is found in a family (APA, 1996a).

Anger

Children who live in violence are exposed to more uncontrolled angry feelings than most. At the worst times, such anger can be displaced onto the children by parents who

are too preoccupied with their own survival to adequately parent them. Other times, the parenting they receive is quite appropriate. Most of them learn how to control their parent's anger through manipulative tactics. They learn to expect unpredictable criticism, abuse, and neglect and cope as best they can, terrified of being abandoned. When they are young, they become confused that they are the cause of their parents' anger, and believe that if they behave better then the violence will cease. Thus, they become like other victims, accepting the responsibility for causing their own predicament, but feeling frustrated, depressed, angry, and so on when they cannot stop the aggression. When they are successful in getting the violence to stop, they develop feelings of omnipotence, which only encourage them to try harder for harmony at home. The association with unlimited violence causes them to fear anyone's expression of anger. As they grow older, they are more likely to give in on little things than take a chance of unleashing such rage. Yet, should the rage be unleashed, some become the aggressor in order to handle it by covering up their fear.

Over-Parentified Children

Many of the children reportedly become so extra-sensitive to cues in their environment that they cease behaving like a child and become *over-parentified*, or begin to take care of their parents, so they can reduce the tension. They may try to stop the violence but they fear making a mistake as their errors are measured in pain. These children are similar to those who take care of alcoholic parents and there has been literature describing them as "children of alcoholic parents." In many ways the experiences of both these children are similar. They never know if they are waking up or coming home to a calm or chaotic situation. The over-parentified child is always anxious and tries hard to keep things calm and stable as best they can. They are the ones who clean up the mess after an acute battering incident. If they are the oldest child with siblings, they help raise the younger ones, making sure they are fed and safe. Some of these children choose not to marry and raise their own families, stating that they have already raised one family and cannot do it again. Some end up as battered women in their own homes, caring for dependent men who cannot take care of themselves.

Alienated Child Syndrome

As children exposed to domestic violence grow older, many stop trying to please and drop out of productive society. Some of them begin using alcohol and other drugs early, often while in middle or high school. I have labeled these children with "alienated child syndrome" and we sometimes see them in the juvenile detention centers. They are not leaders and rarely plan antisocial events but rather, go along with others in a loose social group, and may get in trouble.

These youth can be easily persuaded to accompany others on a variety of missions ranging from a benign searching for companionship for an evening to "wilding" or going out and killing another person. These teens appear to have lost the capacity for empathy for another person and rather, appear to have no visible emotions or connections to societal norms. They are different from teens who join gangs and adopt the gang-norms rather than those of their culture. They seem to be alienated in a manner similar to those described in a popular book, *The Lord of the Flies* (Golding, 1959). I have worked with some of these teens after they are arrested for participating with others in heinous crimes, some of which appear to be senseless. Traumatized while very young, these teens do not subscribe to any cultural norms. Nor do they have any connections with other people or groups to help give them guidance. Rather, they agree to go out with a spontaneously put together group of others, most of whom they do not know beyond acquaintanceship. Some of them might be homeless and drifting from one city to another, while others might be from local homes, appearing seemingly normal from the outside, like Eric Harris and Dylan Klebold, who gunned down and killed 13 others and themselves during the 1999 Columbine High School massacre in Colorado. There is usually one charismatic leader and one or more "enforcers," who are chosen by the leader to carry out the job of keeping control over the others. In the 1999 Columbine High School case, it appears that Eric Harris was the leader and managed to get help from several others besides Klebold despite his "weird" and "scary" fringe-type behavior.

For example, there were several boys and girls who participated in the killing of Bobby Kent in a deserted sand pit near Fort Lauderdale, Florida some years ago. One girl in

particular, was present at the several meetings where killing this high school student was discussed as well as at the scene of the homicide. She had also been present at the previous attempt on his life about a week prior to the actual homicide. During the initial evaluation, this teen described events in an almost emotionless manner. She was totally disconnected from her feelings as she talked about her entire life that was filled with different forms of trauma including exposure to domestic violence. When asked why she went along with the other kids, if she thought they might kill someone, she shrugged her shoulders and said that she didn't have anything else to do when they invited her to come along. It sounded like she put the invitation in the same category as I might if asked to go to the movies with a friend.

Some of these youth have left abusive homes and live with other teenagers wandering around the world in unstable groups. Once they drop into this culture, they learn where the safe places are and travel there with very little in material things. For example, there has been a group of them who live under a bridge in downtown Portland, Oregon and steal money and food to survive. In Fort Lauderdale, Florida, a group of four boys roamed the deserted streets in the middle of the night, and beat up and killed several homeless men who were sleeping on the streets. When asked why they did it, one of the followers repeated his father's stereotyped bigotry. Further evaluation revealed his mother was suffering from PTSD and BWS, unable to supervise her teenaged son and his father who was hostile and derogatory towards women. Her husband was quick to criticize any behavior that did not conform to his own rules and used violence in the family to maintain his power and control.

While exposure to intimate partner violence in their homes is not the only behavior that results in producing an alienated child, there is a pattern that I have noted in these forensic cases. Occasionally, a very charismatic and charming older man, usually in his twenties, comes along and energizes some of them into a loosely formed group and persuades them to engage in antisocial and violent activities. This charismatic leader usually picks on another teenager or someone in his twenties, who is very angry and willing to use violence to win the leader's attention. Both often come from homes where they were exposed to severe parental conflict. The teen then becomes the leader's enforcer, making sure

the others in the group go along with what is being planned. The kids drift in and out of these groups, with some going on to becoming part of the invisible homeless population in the U.S., others spending a long time in detention centers or prison for their antisocial actions, and others cleaning up and dropping back into society. As might be expected, they often need psychotherapy to help them learn to feel and express emotions and make important connections with interpersonal relationships.

Gangs and Cults

Some children exposed to violence in their homes continue to look toward peers for comfort and support, albeit with gangs and cults, or through sexual exploitation and other antisocial group norms. Unlike the alienated youth, these children actually believe in the norms of the gang or the cult and do have good interpersonal relationships, albeit with a group that often espouses antisocial ideas and engages in similar behaviors. Interestingly, the gang kids are the easiest to help back into society once they become motivated to do so as they often have good interpersonal skills and can express a range of emotions despite their antisocial behavior. It is the motivation that is the problem as they fear being killed or seriously harmed if they go against the gang norms and betray the other members. Many of the youth who belong to gangs become intricately involved in the culture and engage in selling and distributing of drugs and other antisocial activities to maintain the gang. This is a major problem in some of the large cities in the U.S. The gang membership extends to the jails and prisons when they are arrested, with other members welcoming them into their new housing and rules of life there. Like on the outside, power and control is maintained by the dominant members using violence and threats to establish fear-based control.

Premature Sexualization

Another area reportedly affected by the home environment is learning to use sexuality as a means of winning approval. Little toddlers can learn to smile cutely, and tell mommy or daddy, "I love you," as seductively as their parental models, to reduce tension and avert an acute battering incident.

Sexual expressions can then be substituted for intimate love. The men take advantage of less powerful children by reinforcing and encouraging such behavior. This is called "grooming" behavior. The rate of incest between batterers and their children is much higher than ever suspected. These children, normally girls though in some cases, boys, too, have learned how to manipulate other men using their sexuality. For those who become prostitutes, the lifestyle can be more of a comfortable and familiar choice rather than a reflection of the rebellion professionals often assume it is. The demand for child sex partners continues around the world with exposes of illegal child trafficking frequently publicized. Attempts to put them out of business frequently fail especially with the use of the Internet to procure these children's services. Many of these children earn more money and live better than they did in their family homes. In other countries, parents may actually sell their young children to pimps who manage brothels where providing child sex partners may be legal or simply ignored. The amount of money and the corruption it brings are extreme and lead to such abuses. Unfortunately, many of these children are exploited and abused in this life style.

Substance Abuse and Domestic Violence Issues

There are several studies of the family backgrounds of teenagers who show up at drug treatment centers and drop-in centers around the country. Most report a history of abusive family behavior (Freudenberger, 1979). In an interesting study, King and Straus (1981) evaluate the retraining procedures in nonviolence for residents of Odyssey House, a New Hampshire residential drug treatment center. They found that the structured encounter groups along with a strictly enforced prohibition against violent behavior was quite successful in helping individuals use nonviolent and noncoercive problem-solving techniques. The typical home pattern reported for teenage girls who enter into the prostitution and pornography industry is one filled with physical, psychological, and sexual violence according to James' (1978), Farley and Barkan's, (1998), and Farley's (2004) research. Barry (1979) describes the abuse that many of the prostitutes have experienced throughout their lives. All in all, adolescence is

the time when children (and parents) need the most strength to cope with pressures. Those who have lived with violence at home seem to be more vulnerable to succumbing to those negative pressures. Yet, not all do. Examination of the mediating factors which can protect these vulnerable children is an important next step in research.

Children Exposed to Other Traumatic Experiences

Much has been learned about how children are impacted by trauma given some of the large scale traumatic events that have occurred around the world from rescue workers in countries where earthquakes, tsunamis, and hurricanes have devastated the populations. Psychologist Annette LaGreca and her colleagues have studied children's reactions to these disasters (LaGreca, Sevin, & Sevin, 2005). One of the most important lessons for first responders to learn was the total disorganizing features of these traumas especially on children who already have been exposed to domestic violence and other traumatic experiences. Depending upon the age of the child, they have been found to lose all ability to communicate with the world or to even becoming part of a gang that steals from others in forced confinement because homes have been damaged. Training in domestic violence and other trauma is important for all rescue workers (Dorfman & Walker, 2007).

Adolescent Developmental Issues

Teen-aged children exposed to domestic violence are reported by others to become withdrawn and passive like their mother, or else, violent like their father. It often depends on who has the money and power. It is commonplace to see teenagers in the family choose one or the other parent to identify with rather than the norm of identification with both parents. Davidson (1979) cites the tendency of teenage girls to identify with their fathers and like him, also abuse their mothers at least verbally. Of course, teenagers are often verbally abusive to anyone who tries to control them or deny them the privileges they demand. Pizzey (1974) describes her British teenagers in sex stereotyped terms; girls are seen as passive, clinging, anxious, with many psychosomatic complaints, while boys were seen as disruptive and aggressive. In many of those families, the girls, especially

if they were older, had to do more than the usual child care functions. Hilberman and Munson (1978) report similar findings in their rural Appalachian sample. There is more likelihood of fathers abusing teen-aged children than of mothers committing such abuse (Martin, 1982) and some researchers have suggested that abuse during adolescence is a high risk factor for later emotional and behavioral disturbance.

Adolescents and the Juvenile Criminal Justice System

Another way to look at the impact of a violent home life on children is to assess the childhood homes of those adolescents who have gotten into some kind of serious difficulty. I have been involved in evaluating several teenagers who have killed their parents. In each case, there was previous identifiable violence in the family. In two cases, incest was also suspected. In another instance, a father shot and killed his teenaged son after the boy previously had broken the father's arm. Upon closer examination, the obvious parent abuse was only the latest form of violent behavior that had occurred in this family (Walker, 1989b). Steinmetz's (1978) analysis of parent abuse and Patterson's (1982) study of coercive family processes support the interrelatedness of these kinds of family violence. Interestingly, Kozu (1999) describes the Japanese family where the first type of abuse that brought public attention was filial abuse where children used violence towards their parents.

The U.S. Department of Justice Office on Juvenile Justice and Delinquency Programs (JJB, 1998) estimated that 2.8 million arrests of persons under the age of 18 were made in 1997 in the United States. This is an increase of 49% over the 1988 level of arrests of juveniles with a violent crime arrest rate of 19% greater than ten years earlier. Juveniles accounted for one out of five (19%) of all arrests, one out of six (17%) of all violent crimes arrests, and one out of three (35%) of all property crimes arrests in 1997. They were involved in 14% of all murder and aggravated assault arrests, 37% of burglary arrests, 30% of robbery arrests, and 24% of weapons arrests in 1997. Juvenile murder arrests peaked in 1993 with 3800 youth arrested. In 1997 the number decreased by 39% with 2500 arrested for murder, which

is 11% over the 1988 level. Interestingly, only 6% of those arrested for murder in 1997 were girls. Approximately 26% of the 2.8 million juveniles arrested for all crimes were girls with 16% violent crimes in 1997.

Girls are still more likely to be arrested for status crimes than other crimes in 1997. A status crime is one in which the person's age is a major factor in making the behavior illegal. Those data include 56% of the 1400 arrested for prostitution, 58% of the 196,100 runaways and 31% of the curfew and loitering arrests. Only 9% of the 52,200 arrested for weapons violations were girls and they were only 9% of the 18,500 arrested for sex offenses other than prostitution. Girls made up approximately 15% of the arrests for various crimes involving alcohol and other drugs except for liquor law violations where they made up 30% of those arrested. For most girls, this is the most serious crime that they were arrested for. Like adult women, girls are still being arrested for property crimes with 28% of the 700,000 arrests, forgery and counterfeiting with 39% of the 8500 arrests, and embezzlement with 45% of the 1400 arrests made in 1997.

When the statistics are broken down into age groups, it is clear that the younger juveniles, under the age of 15, were most likely to be arrested for arson (67%), sex offenses (51%), vandalism (45%), larceny-theft (42%), other simple assaults (41%), and runaways (41%). Interestingly, 45% of the vandalism arrests were 14 years old or younger. Juveniles under the age of 15 made up 32% of the total number of juvenile arrests in 1997. These data come from the Uniform Crime Reporting program of the F.B.I. who obtain the data from local law enforcement agencies. The major increases that are reported are reflective of greater numbers of juveniles committing crimes and are not due to a greater population increase in the number of juveniles. These arrest rates are not equivalent to number of persons arrested because the same person may be arrested for more than one crime during the year. However they do give us some idea of the contact juveniles are having with the juvenile justice system and for what types of crimes they are arrested for. While fewer juveniles have been arrested for major crimes in the last few years, the numbers are still extremely high. In fact, the number of these youth being sent to adult criminal court rather than being handled in juvenile court is increasing, reflecting a punishment rather than a rehabilitative

atmosphere in the community. Unfortunately, there is no information to determine the relationship between exposure to family violence and subsequent arrest in these statistics, although other studies of the juvenile system indicate a very high relationship as was discussed earlier. Certainly a prevention and rehabilitation rather than punishment model might be more useful in preventing future violence and crime with these youth. The sex and violence scandals that are consistently being reported in various state juvenile detention and other facilities indicates that many of these youth simply go from one violent placement to another.

Current Research with Juvenile Girls

Given the growing numbers of girls who are in juvenile detention centers around the world who also have been exposed to abuse in their families, we decided to better understand the impact of their home life on their current behavior. We performed two different research studies that help us understand what motivated these girls' behaviors.

The data described earlier that were collected over a five year period from a juvenile detention center in South Florida were analyzed to determine what if any impact the exposure to abuse in their family homes might have had on the girls there (Anzelone, More, Rigsbee, Schlesinger & Walker, 2003). As we were part of the team of attorneys who represented these juveniles at arrest, all girls who were arrested and brought to the detention center were screened by being administered a life history questionnaire (LHQ), the Traumatic Symptom Inventory (TSI) (Briere, 1995) and the State Trait Anger Inventory (STAXI-2) (Spielberger, 1991). The TSI was used rather than the TSCC because the norms on both do not cover the 16 to 18 year olds and we chose the older version which would give us the ability to compare the same girl as she got older if she was rearrested. The STAXI-2 is a brief four-point Likert scale where juveniles rate themselves on how frequently and how severe they experience and act out angry feelings. The STAXI-2 has been translated into many different languages and has been used in numerous large scale research programs.

Analysis found that approximately one third (29%) of the girls reported experiencing physical abuse and one quarter (24%) reported being a victim of sexual abuse. Of those who

reported sexual abuse, almost three quarters (71%) of them also said they were physically abused and almost half (41%) of them described symptoms consistent with PTSD. The most prevalent risk factor reported by these girls indicated somatic complaints by two thirds (66%) of the entire sample. Substance abuse was admitted to in almost half (47%) of the girls as were Conduct Disorder or Oppositional Defiant Disorder symptoms (46%) and depressive symptoms (44%). One quarter (27%) stated present or previous suicidal intent and homicidal (24%) intent. Most interesting was the 13% of the girls who indicated they experienced psychotic symptoms but did not receive any treatment. Although suicidal ideation and gestures are an important issue in juvenile detention centers, even when attention is given to it, it is rare to find connections to prior abuse in the lives of the juveniles (Hayes, 2000).

When analyzing these data further, we found that girls who reported abuse on the LHQ and completed the TSI showed significantly higher scores on the scales measuring Anxious Arousal, Intrusive Experiences, Defensive Avoidance, Dissociation, Trauma, and Dysphoria than juveniles who did not report abuse. The results of the STAXI-2 showed that abused girls suffered from higher levels of trait anger and have higher levels of acting out behaviors with stronger anger reactions than those who did not admit to having been abused.

Research into Portrayal of Girls in Movies. A group of doctoral students decided to investigate the data behind the portrayal of girls in movies as "mean" and "bad" rather than "angry" and "traumatized" from exposure to abuse in their homes. These psychologists presented an analysis of over ten movies that portrayed teenage girls as nasty, mean, and without empathy and showed how the abuse they experienced was ignored in the scripts. Their data were presented in a symposium at the American Psychological Association convention to a large and interested audience of other psychologists together with the above cited research results on the impact of exposure to trauma for these girls in the juvenile detention facility (Coker, Baca, Baute, Dorsainville, Ipke, Robinson, & Walker, 2005).

Team Child. Perhaps one of the most beneficial programs to assist these youth who have been arrested as delinquents is one that is funded and run by the Legal Aid Foundation. The two programs that I have been aware of are in Seattle,

Washington and Broward County, Florida. Part of the screening for the Broward County Public Defenders office attorneys representing juveniles upon arrest was to identify teens who might benefit from the advice of a civil attorney. This program permits those teens who request such legal assistance to be represented by a legal aid attorney who can assist in a variety of legal issues from getting the child into the proper school program, making arrangements for a residential school with mental health services, obtaining an appropriate psychological evaluation for a special needs child, applying for a Medicaid card so the teen can receive medical services, and applying for emancipation if it is what the child desires. This program empowers these teens by teaching them how to make the system work for them. The Broward Legal Aid program, headed by attorney Walter Honaman, has helped reverse the impact of helplessness for hundreds of children since its inception.

Dating Violence

Violence between teens and college-age students who are dating has been studied more than dating violence among an older population. Almost all of the research has been of heterosexual couples yet it is known that violence in the gay, lesbian, bisexual, and transgender (GLBT) occurs at a similar prevalence rate. It is also known that dating violence among teenaged girls has less sexual abuse than among heterosexual couples, similar to abuse in the lesbian community but different from the more violent gay male community. However, little is known about abuse in the teenaged gay male community. Lundberg-Love and Marmion (2006) have provided a review of relationship violence integrating some of the original and newer findings and applying it to dating violence among intimate partners. They identify issues of class, race, and culture and attempt to tie together the unfortunate history of under education and high rates of unemployment in violent urban communities where women of color often live without access to many resources. Dating violence is related to gender inequality which contributes to multiple forms of violence against and devaluation of girls and women. Also included in this discussion of global violence against women is female infanticide, female genital mutilation, honor killings, and trafficking of women and children.

Child Custody, Visitation and Removal Issues

I hesitated to add a section on child custody, visitation and removal issues for fear of being unable to do it justice given the enormity of the topic. If there is any area that impacts women and children the most, it is the inability of the family court to take seriously their fears of further abuse and need for protection. Rather than focus on the danger to children and women, the courts and legislators, with the approval of many mental health professionals who do not understand the issues of domestic violence, focus on the right of equal parental access to children. In order to justify this misguided focus, they make claims that it is in *the best interests of the child* (the standard that must be met when a child custody decision is made) to have a relationship with both parents. However, this is a belief that is based on theory, religion, and custom and is not supported by the literature.

Prior to the adoption of the best interests test, legislators had issued laws, rules, regulations, and guidelines to the courts to follow what was then called the *Tender Years Doctrine,* which permitted children to live with mothers as long as necessary. Although fathers were granted visitation rights, they often abdicated their parental responsibilities including not paying to support their children. In the early 1970s, along with the feminist movement in the U.S. to expand women's right to enter the workplace and enjoy careers besides motherhood, legislators were persuaded to pass laws that would hold fathers more accountable to their children. This led to the *Best Interests Doctrine*. As child support payments were based on the amount of time mothers or fathers spent with the child, it became popular for fathers to demand equal time so they could limit the amount of money they had to give their children's mothers. But, it is not always in the best interests of children exposed to domestic violence to be equally shared by their fathers. In fact, most batterers continue to abuse their power and control against the children and their mothers when such custody arrangements are ordered by the court (Bancroft & Silverman, 2002; Holden, Geffner, & Jouriles, 1998).

This is a highly controversial area with very heated emotions from fathers' rights groups on the Internet soliciting

others to harm the careers of psychologists and lawyers they do not like (Shapiro, Walker, Manosevitz, Peterson, & Williams, 2008), to heated emotions from domestic violence and child abuse advocates who demand that mental health professionals get out of the child custody evaluation business. Numerous websites, listservs, and blogs exist, each with a different idea about how to handle this difficult problem. Mothers who run away with their children, fearing that disappearing is the only way to protect them from an abusive father, are frequently caught and brought back to the U.S. They are prosecuted to the fullest extent of the law despite their pleas that this is their first offense and they only did it to protect their children. Even more frightening, the courts are so angry with these women, that they punish them by giving sole custody to the abuser.

If the mother attempts to overcome the presumption of shared parental responsibility it is an uphill battle even when the child provides direct evidence that physical or sexual abuse has occurred. Vulnerable, special needs children are forced into shared custody when they desperately need one safe home with no conflict to grow and thrive. Court appointed psychologists use psychological tests that are not meant to determine custody and do not address the legal issues (Otto, Edens, & Barcus). Guardians-Ad-Litem (GAL) either like or do not like the mothers and base their recommendations on their own preconceived biases rather than a realistic appraisal of the situation and how to best meet the children's needs.

The truth is that battered women lose the ability to properly raise their children when they file for divorce. They will be forced into shared parental custody as that is the presumption in almost every state. This means they cannot choose the school their child will attend, what medical doctor they will see when ill, what religious service to take them to if it is their turn to have them when services are held, or even where to live without permission of the man who has physically, sexually and/or psychologically abused and controlled them. Even if they wish to remarry and move, the batterer can withhold permission. The courts give the man even more control over the woman and the children than he had before the separation. In most homes where domestic violence has occurred, the batterer accepts the socialized norms and gives the woman a lot of freedom in making the decisions on how to raise the children, especially when they are well-behaved

and conform to his rules. He may spend very little time with the children alone, most of the time spent is with other family members present. That all changes the minute a separation occurs and the batterer is thrust into taking care of these children on his own, especially if he does not have a mother around to help him out.

If the battered woman does not terminate the relationship with the batterer, social services may step in and remove the children from her custody, especially if they are found to be harmed by the abuse in the home. If she gets them back and leaves him, she then will be controlled by the state child abuse authorities as well as the batterer. There is no question that the data demonstrate the harm to children exposed to domestic violence with both parents in the home but the continued harm to them when they must negotiate between two homes where high conflict continues because the batterer's power and control needs have not been addressed has not been studied.

This is a no win situation for the battered woman. Together with the batterer she has a better ability to raise the children who are harmed by being in the middle of the abusive atmosphere. But, separated they all have a greater chance of being harmed worse and even killed. And if they survive the separation, the woman will lose the ability to protect the children from an abusive father.

What, if anything can be done to protect the woman and the children from this fate? In other countries, such as Israel and Australia, the laws impacting children have been reformed to give children their own right to legal standing in the court. This means that children themselves can be heard, either by themselves if old enough or by an attorney. Voicing their opinions is empowering and hopefully will impact many judges when they hear repeatedly what horrible situations they have been forcing children into with shared parental responsibility orders. Children can be represented legally by real attorneys who must take their wishes into consideration and not GALs who supposedly act in the best interests of the child but rarely have studied child development, do not know what children need at different ages, and may not have even spent more time with the children they represent than they spend with their parents. Although there is a small movement towards children's rights in the U.S., it is dwarfed by those who fear giving children some power will somehow take away their own power and legal rights. In fact, the U.S.

government has not signed the United Nations Declaration of the Rights of Children despite the fact that many other countries have ratified the document.

I have recommended that children harmed by exposure to a batterer have a time-out from contact with their father. Usually this lasts for one year, giving the child time to develop normally, be available for learning in school once freed up from worry and fear, and live a simple and more normal life. I suggest to the court that the batterer should prove his adequacy as a father by attending offender-specific treatment and the child should be permitted to attend trauma specific therapy where trauma triggers are addressed. The battered woman should choose a child therapist that she can work with effectively to assist the child to heal. However, there are times when children need to stop therapy, especially if they have been attending sessions without much benefit. This should be determined by the mother and the child, taking into account such factors as the age of the child, his or her developmental needs, school performance, behavior of the child, and the ability of the mother and child to further develop their own relationship. Fathers should be required to contribute to the therapy financially as well as continue their support of the child.

Summary and Implications for Parents in Raising Children

Perhaps, a most important first step is to reexamine our child raising practices, especially discipline methods. Straus et al., (1980) says the marriage license is a hitting license. We must also recognize that when we hit a child to teach that child a lesson, we also send the message that the person(s) who loves you the most has the right to physically hurt you in the name of discipline. When we teach children rigid sex role stereotypes delineating how women and men must perform in society, we also teach them to be insecure if their expectations are not met by the other person. Such sexism combined with violence training surely creates the atmosphere necessary to raise a batterer and a battered woman. To eradicate domestic violence and violence in the community, we must stop modeling both sexist and violent behavior. And, we must change the divorce laws to empower children and abused women so they are no longer victimized by the abusers.

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Cross-Cultural and Cross-National Issues in Domestic Violence

12

Lenore Walker

With

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Understanding different cultures has become one of the most important variables to analyze when studying issues such as intimate partner violence that are found in all societies. Recent national surveys on domestic violence estimated that 1.5 million women each year experience physical or sexual violence from a current or former intimate partner in the U.S. (Tjaden & Thoennes, 2000). Most agree this is an underestimate of the problem especially since definitions of what is considered intimate partner violence (IPV) or domestic violence differ. Battered women come from all demographic groups. As I have suggested throughout this book, domestic violence is an enormous social problem in the U.S. as well as in other countries around the world. The United Nations Beijing Conference on Women held in China in 2000 required all member nations to bring statistics on

all forms of violence against women in their countries which demonstrated the perniciousness of the problem. These data support the need to better understand how domestic violence impacts across cultures within the U.S. and internationally.

The attention from the UN stimulated new research that is being collected in many countries around the world and therefore, more information is accessible, especially to English-speaking and reading scholars. Malley-Morrison's (2004) authors sampled countries in various parts of the world such as Western, Central, and Southern Europe, the Middle East, Africa, Asia and the Pacific, and North and South America. Like our project, they found similar issues being raised everywhere, although each country and culture has its own specific problems. Erez and Laster (2000) put together an anthology of global responses to domestic violence in various countries from a feminist perspective and also found similar issues to those raised in our study. In B.J. Cling's (2004) collection of articles on sexual violence against women and children, she found common psychological and legal perspectives with overlapping issues raised by intimate partner violence. I recently attended a large conference on domestic violence in Buenos Aires, Argentina (November 1, 2007) where over 1500 attendees came from most countries in Central and South America (some from Spain and Portugal, also) and brought literature published in Spanish, Portuguese, Catalan, and indigenous languages citing studies done in their own countries and cultures. Despite all the attention and focus on domestic violence, the pervasiveness of men's violence against women is still glaring.

Definitions of what constitutes IPV differ from country to country and cross-culturally, on individual and institutional levels, but it is clear that the experience of women who are abused is similar. From the feminist perspective, "male violence against women is used to maintain women's disadvantaged social and political status" where ever we find it (Russo, Koss, & Goodman, 1995).

Culture is not a cause of domestic violence, but it can have an impact on the level of tolerance of the violence and how the violence is expressed.

What are the commonalities found when we look at intimate partner violence across cultures and nations? Most important for this chapter is the commonality between domestic violence and other forms of violence against women. Sexual assault, rape,

harassment, and exploitation by those in positions of power all have similarities in their impact on women. The link is the use of power by men to force women into submission to their will and desires. Brownmiller (1975) called rapists the "shock troops" who coerced women into monogamous relationships through shame and violence. Jones (1980) added that batterers were the "home guard" who kept women in their place at home. Many cultures are based upon subjugation of women by men, interweaving religion or other forms of authoritarianism into their social mores. If so, then the goal of equality between women and men is a definite threat to the maintenance of that culture. This simple fact may well be a major reason why it has been so difficult to achieve both equality and eliminate violence against women these past 30 years.

Understanding these issues, our researchers decided to look at cultural issues both in the U.S. sample and in data from women in several countries. Psychologist La Toya Shakes Malone analyzed some of our data and together with data from psychologist Vincent Van Hasselt's sample of American women who sought services in the family violence clinic at our university when she worked with us during her postdoctoral year in residence. I present her findings in the study below as it demonstrates that the types, frequencies, and severity of the violence experienced by African and Caribbean American women was not different from other racial and cultural groups even though the ability to seek assistance was limited.

The original researchers on this second research program, that is myself, Kate Richmond, Kristin David, Julie Johnson and Amber Lyda initially chose three countries to study as they provided a convenience sample: Greece as Greek psychologist Christina Antonopoulou from the University of Athens worked with us on the project; Spain because psychologist Patricia Villavicencio from the Complutense University in Madrid worked with us and Kate Richmond went to Spain to collect the data with her from battered women in Villavicencio's hospital treatment group; and Russia because psychologist Amber Lyda spent several weeks in Russia including a visit to a maximum security prison to collect the data. Later, we added Columbia because then doctoral student in psychology, Sandra Jimenez was from that country. Graduate students in psychology are still collecting data that have not yet been analyzed from Indian women because Tarmeen Sahni was Indian-American, Trinidad because Brenda Jeffers gathered

data for her master's thesis there, and Haitian women because Beverly Jean-Jacques is from that country. Shatha Atiya analyzed PTSD in Iraqi Americans at the start of the Gulf War and continues gathering data from this population and Rachel Duros analyzed PTSD across the original four groups as was reported in Chapter 3. The BWSQ is currently being translated to Portugese, Rumanian and Hebrew so we can begin data collection in countries where these languages are spoken. We have trained interviewers who work in a battered women's shelter in Florence, Italy but we are still awaiting their data. We remain open to data collection in other countries.

Cultural Issues in the US

There are at least two major types of cultural issues that need to be understood in the U.S. by researchers and service providers: first, the cultural issues of those with less access to resources and the dominant culture privileges and second, the cultural issues of those who have emigrated to the U.S. from other countries, whether legally or illegally. Obviously, illegal immigrants try to remain more invisible because of the danger of being sent back to their original countries. Unfortunately, the current U.S. policies make it more advantageous for others who object to immigrants who violate immigration policies to identify these people so they can be returned to their native countries regardless of whether they face more beatings and other punishment. Fortunately, the U.S. Violence Against Women Act (VAWA) protects women who are in danger of further abuse and upon legal proof, permits them residency in the U.S. Others have found that women who emigrate to a new country or even other moves resulting in isolation from family and friends are at higher risk to be abused by a partner.

African Americans

The unfortunate legacy of slavery and other horrible and demeaning conditions for African Americans in the U.S. remains a strong force in all of our society today, especially in the U.S. family. African American families are known to be matriarchal-focused with strong women heading up households that are often absent of men, sometimes because they are in prison or sometimes for many other reasons.

When abusive men are part of these families, the women find it difficult to call the police and use the criminal justice system for protection because they believe that the African American man will not be treated fairly by the system (Hampton, 1987). The disproportionate numbers of poor men of African and Caribbean descent in prison today suggests they are not wrong. This is also true for Black women who attempted or actually killed their abusive husbands.

I analyzed 100 cases of women who had killed their abusive partners in what they claimed was self-defense and found that African American women were two times more likely to be convicted on higher charges than were Caucasian or Latina women, many because they were reluctant to damage the reputations of the African American men any further (Walker, 1989). The prosecutors in the O.J. Simpson murder trial learned from the African American women on that jury that they were more reluctant to identify with being a woman instead of their race and culture when they insisted that the domestic violence was not relevant and acquitted him of murder. Some analysts suggest that the use of BWS is somehow to blame for the unfortunate lack of justice for Black women (Allard, 2005) partly because many African and Caribbean American women do not fit the stereotype of the passive, weak, fearful, helpless battered woman suggested by others who were not familiar with our data. However, even if that is true, it is the socialization into these stereotypes and not BWS per se that is responsible for the lack of justice.

Despite the increase in research concerning domestic violence, there are still few empirical studies reported on African or Caribbean American men. In fact, rarely are these two groups separated even though there are both racial and cultural differences between the two groups (Anyalon & Young, 2005; Coley & Beckett, 1988; Walker, 1999). Given the attention to cultural diversity issues in providing clinical services, there is a body of literature that deals with how these services, particularly medical and psychological treatment, must accommodate to cultural differences. Some suggest that the racial differences in help-seeking behavior may be due to different beliefs in internal control and attribution of psychological symptoms (Ayanlon & Young, 2005). Other researchers (Coley & Beckett, 1988) suggest that women of color in domestic violence relationships are less likely to seek help from mental health professionals because they

perceive the helpers as insensitive to the racial and cultural context of their lives.

Shakes-Malone and Van Hasselt (2005) compared the help-seeking behavior of 547 battered women who sought services at the family violence clinic at the mental health center at our university. Only 10% (55) of these women were designated as black with 13% (73) Hispanic, and 60% (379) as White. See Table 12.1 below for more information about demographic data for the participants. As this clinic adopted culturally sensitive treatment methods recommended by the literature, an analysis of their data may help us better understand if we are meeting their needs.

Study of Racial Disparities of Help Seeking Behavior

As was mentioned above, Shakes-Malone and Van Hasselt (2005) studied 547 U.S. women who sought services in a special treatment clinic for those who experienced family violence for a ten-year period of 1994 through 2005. As the clinic is associated with a university, research data were collected from participants. Table 12.1 lists the demographic data for these women demonstrating that black women (including African American and Caribbean American women) were 10% of the participants.

They were about equally divided between those who were never married, still married, separated, and divorced. Approximately two thirds of them were high school graduates or had some college but two thirds of them (66%) stated their own income was less than $10,000 per year. However, one quarter of them stated that their entire family income was also below $10,000 per year while another quarter of the women disclosed their family income was over $40,000.

When comparing racial disparities in help-seeking behavior, it was found that the main sample was most likely to seek help because of psychological distress, while the sample of black women was most likely to seek help because they were court-ordered, either by a child protection agency or while on probation for some unknown criminal acts. Table 12.2 shows the statistical analysis for these findings.

The women were asked about physical and psychological abuse during intake prior to receiving services. Table 12.3 demonstrates the analysis between the groups. It was found

12.1 Socio-demographic Data for Study Participants

Demographic Variable	Current Sample N	Current Sample %
Racial and Ethnic Group:		
White/ Caucasian	379	69
Hispanic/ Latina	73	13
Black/ African	55	10
Other	39	7
TOTAL SAMPLE	547	–
Marital Status:		
Single	156	29
Married/ Living together	137	25
Separated/ Divorce Pending	116	21
Divorced	126	23
Widowed	11	2
Education:		
Below 7th Grade	8	1
Junior High School	35	6
Partial High School	72	13
High School Graduate	178	33
Partial College	181	34
College Graduate or/and Graduate School	70	13
Participant Income:		
Less than 10K	347	66
11K-20K	105	20
21K-35K	60	11
36K-40K	7	1
More than 40K	7	1
Family Income:		
Less than 10K	119	26
11K-20K	91	19
21K-35K	114	24
36K-40K	38	8
More than 40K	104	22

12.2 Racial Disparities in Seeking Help from Mental Health Professions

	SS	MS	F(3, 530)
Abuse From Partner Increasing			
Between Groups	.44	.15	.67
Within Groups	115.80	.22	
Abuse Toward Partner Increasing			
Between Groups	.45	.15	1.92
Within Groups	41.59	.08	
Psychological Distress			
Between Groups	4.82	1.61	7.82**
Within Groups	108.82	.21	
Children at risk from partner			
Between Groups	.39	.13	1.54
Within Groups	44.93	.09	
Children at risk from self			.42
Between Groups	.04	.01	
Within Groups	18.28	.03	
Required by Human Service Agency	1.08	.36	4.22*
Between Groups	45.05	.08	
Within Groups			
Required by Court upon probation	.79	.26	4.14*
Between Groups	33.64	.06	
Within Groups			
Required by Court upon parole	.00	.00	.15
Between Groups	.99	.00	
Within Groups			
Partner Requested/Demanded	.11	.04	1.21
Between Groups	13.35	.03	
Within Groups			

*p <.01 and ** p<.001

12.3 Racial Difference in Physical and Psychological Abuse at Intake

	SS	MS	F(3, 457)
Physical Abuse Index	13.79	4.60	.07
Between Groups	30828.39	70.22	
Within Groups			
Psychological Abuse Index	358.93	114.64	.73
Between Groups	74442.07	162.89	
Within Groups			

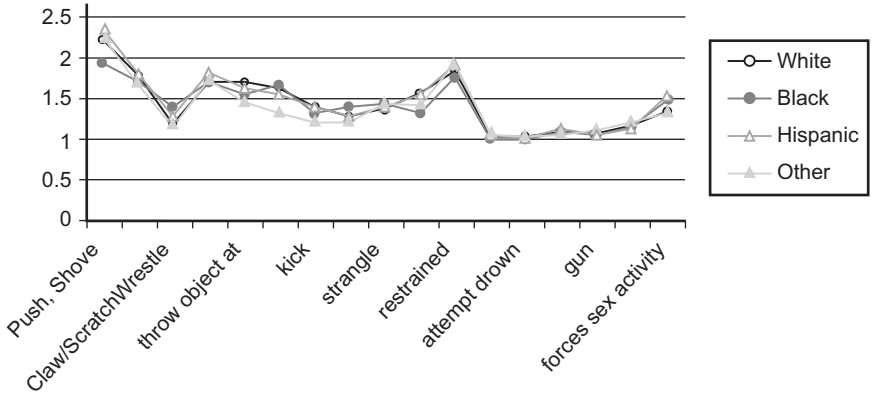
that there was no significant difference between them even though they sought help for different reasons.

This study found that black women who experienced the same type of intimate partner violence did not voluntarily seek mental health services as did Caucasian women, further supporting the literature that suggests African American women view services as more beneficial to others than to themselves. However, once they are in treatment, it appears that they utilized the services and they were appropriate to their needs. The study further suggests the need for more detailed studies of how to motivate women to seek services without waiting for the courts to mandate they do so, especially since culturally sensitive mental health treatment appears to be beneficial.

Some studies have found possible differences in severity of violence across different racial groups (Dutton, Kaltman, Goodman, Weinfurt, & Vankos, 2005). In their study they found that the greater the severity of the violence, the greater the impact on mental health including PTSD and depressive symptomology. This was especially true for women who also experienced sexual violence and for those who had continued contact with the batterer, especially those who were forced to do so because of access to children. In the Shakes-Malone and Van Hasselt study, they found that there was no difference in severity of violence across the different racial and cultural groups studied. Figure 12.1 demonstrates the frequency and severity of the different types of abuse surveyed.

12.1

Incidence of Physical Abuse Experienced in the Past 12 Months



These data are more consistent with studies that compared to African American and Caucasians finding no major difference in the nature and extent of domestic violence (Joseph, 1997). The categories we used were similar to those analyzed by others and included pushing and shoving, restraining the woman (both of which were the highest categories in our sample but not by very much), clawing/scratching/wrestling, throwing an object at the woman, kicking, strangling or choking, attempting to drown, using of a gun, knife or other weapon, and forcing sexual activity. However, further analysis suggests that African and Caribbean American women in particular fight back more often, which may partially explain why more of them are arrested and serve time in jail.

International Perspectives

It has also been suggested that culture makes a difference in how long abuse may be tolerated. For those reasons, we decided to explore the same questions with women who were still living in their countries of origin. Comparisons of cross-national research have been difficult because of the different

social constructions of domestic violence in the U.S. and other countries, particularly in Europe where research has been taking place. In most countries, there are myths that dominate and shape the development of services mostly designed to rescue and save these women from their horrible fates (Davies, Lyon, & Monti-Catania, 1998). These myths include the belief that battered women are pure victims, often without any of their own resources, that they are totally dependent upon their abusive husbands or are housewives with numerous children whom they must care for, that they are women with little or no education or career opportunities, and that they are unable to do anything about their unfortunate situations.

The *Beijing Platform for Action* (United Nations, 1995) and the subsequent *Report by the CEDAW Committee* (United Nations, 2004) following the Beijing Conference where all member nations were required to bring reports of what was being done to improve women's lives in their countries, defined IPV as a part of gender violence rather than a part of family violence, making the social connections between being a woman and being subjected to many different forms of violence by men the focus. Nonetheless, the ability to change social institutions particularly in countries where the family is regarded as sacrosanct because of sociopolitical mores and religious values has been extremely difficult, although changing the ability to receive treatment for victims and sometimes perpetrators has been easier. Given my personal focus on removing the barriers to adequate psychological and legal treatment for battered women, these are the areas that I have concentrated on while acknowledging the difficult and often unrewarding work of others in different parts of this all encompassing problem.

Therefore, we began to look at European countries where IPV was seen as part of gender violence against women rather than family violence as is more common in the U.S. to see if there were differences in the psychological impact on women victims. Spain, Greece, and Russia were our first cross-national studies as the political and social systems were so very different and we had contacts with researchers who were in these three countries.

Spain

Given the high numbers of Hispanic women in the U.S., we decided to accept the opportunity we were offered to go to

Spain and collect data from Hispanic women living there. Psychologist Patricia Villavicencio, part of a group of clinical psychologists and researchers in Madrid, worked with our researchers and especially psychologist Kate Richmond, for three summers (2002–2005) while studying the research and interventions for battered women here in the U.S. Villavicencio was one of several therapists who conducted individual and group therapy for women who were seriously mentally ill and hospitalized in one of the hospitals associated with the Complutense University in Madrid (Valiente & Villavicencio, 2002). As this was a different population from those women we were evaluating in the U.S., it seemed like a golden opportunity to learn what, if any, impact serious mental illness made when coupled with domestic violence. As might be expected many of their women also had childhood sexual abuse histories, so the picture was complex.

In 2004, after the election of a socialist political party, new laws protecting women from gender violence were instituted in Spain, changing a history of oppression against women both from the Franco dictatorship years (1939–1975) when married women were not allowed to open a bank account, receive a salary, or sign a contract on their own. During the first 13 years post-Franco, the new government tried to pass laws for women to gain equality but the conservative Catholic Church and the long tradition of *machismo* were blamed for making the road to equality extremely difficult (Sciolino, 2004). When the socialist party was elected in 2004, they made a commitment to a liberal campaign to change the divorce laws and to enact other laws designed to protect battered women and sexual assault victims. A vigorous education campaign was instituted to help change attitudes and behaviors of health practitioners, those in social service agencies, and legal staff (Pires & Lasheras, 2004). Battered women shelters and outpatient services for victims of intimate partner abuse can now be found throughout the country with local authorities and state-run ministries supporting the development of services with money and social awareness publicity. However, like in the U.S. and other countries, the new laws are difficult to enforce and the family courts have made it more difficult by insisting on shared parental custody of children when parents divorce, even when domestic violence is present. Since 2004, I have been teaching in various universities and programs in Spain permitting the training of service providers to assess

and treat victims of domestic and other forms of gender violence. Therefore, our sample has women from the areas surrounding Granada, Madrid, Salamanca, and Barcelona at this time, although not all participants' responses have been analyzed yet.

Interestingly, intimate partner violence has been considered part of the campaign to end all forms of gender violence against women. It is clearly stated in the *Spanish Organic Act 1/2004 of 28 December* (Integrated Protection Measures Against Gender Violence) that "It is violence against women for the mere fact of being women; considered by their aggressors, as lacking the most basic rights of freedom, respect and power of decision." Using a very public incident where a battered woman, Ana Orantes, was murdered by her ex-husband after she had publicly accused him of domestic violence on a regional television show, the media began an accompanying campaign to educate and change attitudes so that intimate partner violence would no longer remain invisible. Had the risk factors been analyzed, Orantes' death, like so many other battered women's deaths would have been predictable (Campbell, Webster, Koziol-McLain, Block, et al., 2003). The Spanish section of Amnesty International (2003) also described women's fears of public disclosure, but despite the knowledge amongst women leaders, it took a very violent and predictable death to motivate reform in the Spanish institutions, especially in health care.

Several national surveys on intimate partner violence in Spain have been published in Spanish publications (Pires & Lasheras, 2004; Villavicencio, Bustelo, & Valiente, 2007) with a recent summary in English (Medina-Ariza & Barberet, 2003). Using the *Conflict Tactics Scale 2* (CTS2) (Straus, Hamby, Boney-McCoy, & Sugarman, 1996) along with several other measures, women were contacted and a final sample of 90 women was interviewed across Spain about experiences with IPV. The authors discuss the limitations of using the CTS2 including the inability of this instrument to assess for low levels of psychological abuse and controlling behavior. Because abusive acts are taken out of context, data collected from men and women using the CTS2 creates the misimpression that male violence against women is the same as female violence against men, which other studies have found not to be true (Dobash, Dobash, Wilson, & Daly, 1992).

Interesting, the Medina-Ariza and Barberet (2003) Spanish sample had a high prevalence of severe sexual abuse that was almost as high as serious physical abuse. As we discussed in Chapter 3, our findings indicated that the women in our sample did not want to discuss sexual abuse as compared to the U.S., Greek, and Russian women. Their data supports our suggestion that perhaps the Spanish women are less able to discuss sexual abuse within their intimate relationships, but nonetheless, it is occurring with frequencies similar to other groups. Their traditional Catholic culture may well block their ability to even conceptualize forced or coerced sex within a marriage as abuse. These findings would also be consistent with those found by Villavicencio and her colleagues in a more recent study. Another interesting finding from other studies in Spain has been the difference in defining who are the marginalized women in society. In the U.S., it is often seen that women of color are more marginalized than others, while in Spain it is the immigrants from North Africa. However, our BWSQ research did not pick up this group as we were not sufficiently aware of their prominence in the interventions for domestic violence groups.

Bosch Fiol and Ferrer Perez (2004) suggest that although it is estimated that 12% of women in Spain are battered by male partners, less than 4% will report it due to cultural imperatives not to speak about it. Even so, our study, the Villavicencio et al., study, and the Medina-Ariza and Barberet study all found that IPV was as prevalent and serious in Spain as it was in other countries despite the methodological and cultural differences. Further, it was also found in the research into the psychological impact from IPV that BWS and PTSD are present as were more serious psychological disorders including depression and even Complex PTSD as is discussed in Chapter 14. Unfortunately, the Spanish Psychological Association has recently approved the use of Parental Alienation Syndrome in child custody cases, forcing children to continue contact with abusive fathers and sometimes placing them in grave danger.

Russia

In September 2006, I was unexpectedly invited to be part of a group from the Institute for Russian American Behavioral Studies traveling to St. Petersburg, Russia on a faculty

exchange program for a one week meeting with scholars and professionals in law and psychology associated with the University of St. Petersburg and St. Petersburg State University. Russia was beginning to study domestic violence and had already formed several task forces to serve women although they were all part of other women's services and not specific to abused women. Our researcher, psychologist Amber Lyda went into a woman's prison and collected data with the BWSQ (translated into Russian) from women there. According to Amnesty International (2004) violence against women has been treated more as an internal, domestic, or social problem in Russia, often associated with the high alcoholism rate, and not as a gendered human rights violation as in other parts of Europe. Nonetheless, it is estimated that at least 36,000 Russian women are beaten daily, with one woman dying every 40 minutes from a domestic violence incident. The Russian Government's report to the UN Committee on the Elimination of Discrimination Against Women (CEDAW, 1999) stated,

> "Sociological studies show that 30 percent of married women are regularly subjected to physical violence. The situation is exacerbated by the lack of statistics and indeed by the attitude of the agencies of law and order to this problem, for they view such violence not as a crime but as 'a private matter between the spouses' (as quoted in Amnesty International, 2004)."

Horne (1999) describes that throughout Russian history women were considered sinful and needed the dominance and discipline of men. She describes common customs such as the passing of a whip from a bride's father to her new husband during a wedding ceremony taking place until the late 19th century. Other customs have remained unchanged and old proverbs remain in use such as, "if he beats you, it means he loves you" (Horne, 1999, p. 58).

Others have concluded that women's rights have been on a roller coaster in Russia with a declaration of equality that followed the 1917 revolution and attempted to include all women in the Russian workforce. However, women were also expected to fulfill their expected gender socialized roles such as caring for the children, cooking, and other household chores in difficult circumstances, especially since scarce housing

often forced two or more families to share a small apartment. Even so, men were still given preferential treatment in jobs so that women ended up with the low paying and often unfulfilling ones (Horne, 1999; Levant, Cuthbert, Richmond, Sellers, Matveev, Mitina, Sokolovsky, & Heesacker, 2003). A return to traditional women's roles began in the 1970s and by the time of Peristroika in 1991, with the collapse of the Soviet state, the gender-role socialization patterns which underlied power imbalances between men and women were again part of the oppression and coercion of women in Russia. A non-governmental organization, *Stop Violence*, recently attempted to form crisis shelters throughout Russia, but as we learned in our visit, most of these crisis centers were underfunded and overwhelmed with the large numbers of social problems that women presented, despite the Russian cultural value of keeping family matters private. In 2001, according to Amnesty International, over 65,000 women came to crisis shelters for help. These crisis shelters, however, did not deal directly with issues from living with domestic violence given the large number of other social problems needing attention.

In addition to the collapse of the Soviet government in 1991, Russia became more democratic with less dependence upon the society to provide economically. This has caused a shift in the culture as people must depend upon themselves partly and also still partly on the government to provide jobs, housing, and other necessities of life. With the fall of communism, the country became more open to interactions with the Western world, bringing with it a demand for more goods and services. The Russian women's movement began to catch up to others around the world and more has become known about the violence that women have experienced both within their homes and in Russian society in general. As Hemment (2004) suggests, this cultural paradigm shift is still occurring and the fact that violence against women is now being discussed is an indication that its once invisibility is changing. Our research indicates that Russian women are talking about gender violence. Their years of being economically self-sufficient have also helped them believe that they have more power and control in their relationships. These results differ from the responses of women from the U.S., Spanish, and Greek samples as can be seen in Chapter 3.

Greece

In 1975, the new Greek Constitution declared that, "Greek men and women have equal rights and equal obligations" (Greek Helsinki Monitor & World Organization Against Torture, 2002, p. 11). However, Greek society mores still subscribe to traditional socialization with Greek women in the child-raising and homemaker roles and men as the financial providers. Marriage is still vital to Greek society and is the only way for women to get social approval and respect (Chatzifotiou & Dobash, 2001). This means getting a divorce, even if a woman is beaten by her husband, is not accepted. Perhaps even more important, children must have both parents listed on the birth certificate in order to enjoy full privileges in Greek society (Antonopoulou, 1999). An old proverb still thriving in Greece, "it's better to have my eye taken away, than to take away my good name" indicates the woman's plight in Greece even today (Chatzifotiou & Dobash, 2001).

An analysis of the status of women in the Greek work force has found that there is still flagrant discrimination against women with a disparity in wages as well as access to higher level jobs. In 2002, a study conducted by the Greek National Center for Social Research revealed that 88 percent of Greek men are employed compared to only 45 percent of Greek women. Similarly, the Minister for Labor and Social Security stated that female unemployment at 12.9% was almost three times that of males at 4.7% (as cited in Greek Helsinki Monitor & World Organization Against Torture, 2002). In fact, their report indicates that as high as 83% of Greek women have experienced one or more forms of victimization in their homes with 16% having experienced physical, sexual, and psychological abuse collectively. However, most Greek women do not press charges even if they do report the domestic violence, keeping their experiences private for fear of being blamed for their victimization. Although there are battered women shelters in Athens and several other cities in Greece, most battered women do not use them. Interviews with those who have sought services indicate that they didn't seek help until they were exhausted, lost hope of preserving their marriage, and they could not tolerate any more abuse. In some cases, they overcame their fear because

of concern for the safety of their children (Chatzifotiou & Dobash, 2002).

In her 1999 study, psychologist Christina Antonopoulou found that over one third of the almost 700 people she surveyed admitted a history of domestic violence in their childhood homes. Even more astounding, a majority of men believed that gender equality had been achieved in Greece and that women were to blame for domestic violence because of their demands for equality. One third of the men also demanded obedience from their wives while 90% of the women surveyed believed that this clause in the Greek marriage contract no longer mattered. She concluded that without a change in the Greek social attitudes, neither equality for women with men or ending violence against women would be possible (Antonopoulou, 1999). During this research, Antonopoulou administered the BWSQ with a group of Greek battered women in a battered woman's shelter outside of Athens. As was shown earlier, the Greek women's results were similar to those of women from Spain, Russia, and the U.S.

Additional Countries

Our research began to look at battered women who had immigrated to the U.S. both because the literature was suggesting these women were the most vulnerable and also because of our experiences in Spain and Greece with immigrant women (Rogler, 1994). South Florida was an ideal place to find women who fit this description as there were numerous legal and illegal immigrants within different cultures and different immigration policies. The two largest groups were those who emigrated from Cuba and those who came from Haiti. The major influx of Cubans occurred many years earlier and today, the U.S. has a policy that permits people from Cuba to seek legal status if they arrive safely on our soil, even if they arrive without documentation. This is in direct contrast to those who arrive illegally on boats from Haiti, who are sent back if caught. Many others who emigrate from Central and South American countries without documentation may pay large sums of money to gangs that smuggle them into the U.S. Desperate to escape with just their lives that are often in danger in their countries

of origin, many of the women and children cling to hope that life will be better for them in the U.S. Sometimes life for them is better in the U.S., but other times some of these women meet up with abusive men who continue the cycle of abuse, creating multiple stressors that contribute to their BWS and PTSD (Levinson, 1989).

Haiti

The tiny island of Haiti has one of the lowest economic and social conditions in Central America and in the world. Over 60% of the population lives in poverty without any access to services (UN Development Program, 1999). Unemployment is around 70% and half of the population cannot read or write in any language. Many Haitians escape to the U.S. both legally and illegally, often leaving families behind while they come to earn sufficient money to send back to those at home. Thus, the migration back and forth to Haiti is constant, keeping people rooted in the Haitian culture whether they live in the U.S. or in Haiti. Most young people who emigrate to the U.S. learn to speak and write the Haitian language, which is a combination of French and Creole dialects as well as English once they arrive in the U.S. Older Haitians read and write French but also speak Creole. The Haitians' ability in English directly determines their success in finding and keeping jobs and therefore, many of them are unskilled workers, often hired as caretakers of the infirm and elderly or are hired as manual day laborers.

Haiti has a long history of the use of violence in its society. Sexual violence was used during the Duvalier political regimes as recently as the early 1990s as an instrument of political repression (Fuller, 1999). There has been little information on the prevalence of domestic violence in Haiti, although in 1996 one investigation revealed that seven out of ten women revealed experiencing abuse, mostly sexual with over half from their husbands (CHREPROF, 1996). The study also found that 80% of the men interviewed believed that their violence towards the women was justified, usually because the women were behaving badly (rowdy, extravagant) or non-obedient. It is not known if their attitudes towards using violence to control women will change if they emigrate to the U.S.

Although Haiti has been a party to the CEDAW since 1981, it has not lived up to its commitment to make reports

as of 2000. The UN found that there are no laws to protect women from domestic violence in Haiti. All forms of violence against women fall under assault and battery laws, which depend upon the degree of injury and circumstances of the attack (Fuller, 1999). A qualified police force is not in place and therefore, it is not surprising that incidents of domestic violence are rarely reported to the police. Haitians pursue their migration to the U.S. to escape the climates of terror and upheaval generated by the economic and political crisis in Haiti. However, when they arrive in the U.S. they must undergo a transition period of acculturation, which impacts their ability to follow the rules and mores of a different society. Further, many more women migrate than do men, often taking jobs in the U.S. and sending money back home to support their families. It is common for a married woman to leave her husband and children in Haiti with her family although given the increasingly dire situation in Haiti, more families are also migrating together.

Most immigrants will undergo the acculturation process which includes changing behaviors and attitudes. This occurs at different rates for individual family members. Language, socio-economic status, level of education, immigration status, and number of family members in the new country all figure into assessing the level of acculturation of any group. If the immigrants have many ties with their original country and can go back and forth freely, acculturation to the new country takes more time, if at all. This is also true if the immigrants live in a sheltered area and relate mostly to others from their country. For the Haitian immigrant, acculturation will mean giving up ways of violence that were acceptable in his or her own country. This includes intimate partner violence. There are some data to suggest that low acculturated groups are less prone to seek health services (Gil, Vega, & Dimas, 1994) as well as less able to benefit from educational, social, and economic opportunities (Miranda, Frevert, & Kern, 1998). Perhaps it is not surprising that highly acculturated women are younger and better educated than their less acculturated counterparts (Kranau, Greene, & Valencia-Weber, 1982). But little is known about their attitudes towards IPV or if their way of family life changes when they come to the U.S.

Our researcher, psychologist Beverly Jean-Jacques (2007) has studied the acculturation patterns of Haitian-Americans in Miami as she herself comes from a Haitian family. She

has begun an investigation of attitudes towards aggression, attitudes towards domestic violence and relationship to acculturation levels, and is attempting to find if there is a relationship with incidence, prevalence, and tolerance of domestic violence amongst Haitian immigrants. Key variables used include level of education, length of time in the U.S., level of acculturation as measured by the Short Acculturation Scale (Marin, Otero-Sabogal, & Perez-Stable, 1987) and the Attitudes Towards Aggression Scale (Herzberger & Rucckert, 1997). The measure of acculturation that was originally designed for Hispanics will be adjusted to fit the Haitian experience. The *Attitudes Towards Aggression Scale* (ATA) is a modified version of the inventory of beliefs about wife beating that originated from psychologist Dan Saunders work when he was a researcher at the New Hampshire domestic violence laboratories (Saunders, Lynch, Grayson, & Linz, 1987). These data are in the process of being collected and analysis is not yet completed.

One of the most interesting issues that has been raised by the Haitian women who are here in the U.S. is the degree of both poverty and violence they have experienced while living in Haiti. Many of them who lived in poor, rural areas in Haiti were illiterate when they came to the U.S. as children and were not usually sent to school. Some did not even know how old they were much less how to read or write anything but their name. However, they were good business women, often learning how to go to one market to purchase some supplies needed in their towns and then selling them out of their homes to local people. Homes are often open with cooking for meals as a communal activity outside of the house. The police are ineffective in stopping violence by gangs of men who retaliate against families of those who support the people rather than the government. Women are raped and beaten as a lesson to their husbands or fathers to stop their political activity. Religion sustains many of these women and they take their prayers to God seriously. It is a colorful and emotional relationship with God, one with lots of shouting, singing, praying out loud, and touching each other as they move to their own inner thoughts. Some have also been influenced by Voodoo and may appear to be mentally ill to those who are unaware of this part of the Haitian culture. These cultural issues must be understood when analyzing the data obtained about domestic violence.

India

Acculturation patterns of Indian Americans who have emigrated from India to the U.S. are another interesting group that our research group decided to study as one of our graduate students, Tarmeen Sahni comes from such a family. When most Indian families emigrate, they often come together or shortly after arrival focus on bringing other family members left behind to the U.S. It is a long and expensive trip back and forth from India to the U.S. so unlike some Haitians who are able to go back and forth once or twice a year, it takes many years for the Indian American to make such a trip. However, when the Indian family arrives in the U.S., they try to find housing and jobs in communities where there are other Indian families, so their level of acculturation is slower than if they were totally assimilated into American society.

The Indian culture continues to hold patriarchal values that shamelessly believe in the inferiority of women. This is not inconsistent with the strong caste system that also remains in Indian culture where different levels of social class bring with it privileges or penalties. Specifically, in India, sexism is present within different social classes, religions, cultures, and regions. Nonetheless, there have been tremendous changes in women's ability to obtain freedoms that were not previously part of the laws so that women now have the right to vote, own land in their own name, not be considered a man's property, and to be protected by the law against intimate partner and family violence. However, the laws are not always followed nor are there always consequences to the violations. Men and women are still being raised with different ideas of what their value is in the world and societal expectations are primarily based on gender (Niaz, 2003). Males are raised to become the primary providers for the family and their birth is celebrated by the family. Females are considered to fulfill the role of a wife and seen as a burden to the family. Women must be taught to obey and provide for men. Even midwives receive a lower fee if they bring a girl into the world (Moore, 1998).

When girls become women and are married, they are required to go to live in their husband's family home. Traditionally, their families choose their husbands, and the choice is often regulated by the bride price they are able

to afford. Some second generation Indian-Americans are permitted to choose a suitable husband themselves, but he must be approved by their parents based on various factors including caste, status, religion, and family (Bhattacharya, 2004). Women are trained as children to obey their parents' wishes and they continue to be controlled by their parents, their husband, and/or his parents. For some, refusal to obey can bring with it death, as the family cannot tolerate the shame that disobedience from a woman brings. A survey conducted by Bhattacharya (2004) in the major Indian cities of Delhi, Chennai, Bhopal, Lucknow, and Tiruvananthapuram showed that in urban regions physical violence was reported in at least one quarter (26%) of the homes surveyed, with psychological abuse reported in almost one half (45%) of the Indian homes. In rural regions, there was a little less physical abuse reported (20%) while psychological abuse was a little above one half (51%) of the time.

Similar rates were reported in Uttar Pradesh (Koenig, Stephenson, Ahmed, Jejeebhoy, & Campbell, 2006) with 30% also reporting sexual abuse within their homes in the last year. Like in other countries and the U.S., this study found that there was a lower rate of physical violence reported if husbands and wives were educated over seven years in school as well as those who reported higher socioeconomic status. Conversely, when examining individual variables, longer length of marriage, a lack of children, extramarital affairs, and the husband's previous exposure to violence in his family were associated with higher levels of physical violence. Certain contextual variables such as high murder rates of women in a town and community attitude towards domestic violence were predictive of significantly higher rates of physical violence within the year but not associated with the rates of sexual violence in the home.

The Indian government has passed laws forbidding the practice of *sati,* which was the requirement of women to throw themselves on their husband's funeral pyre so they died with him, *dowry deaths*, which was when the husband's family caused the woman to die if her dowry was not paid or was insufficient, and custodial rapes in an attempt to better protect women but unfortunately, most claim it is not sufficient, flawed (Adaval, 2006; Bhattacharya, 2004), and is usually ignored. Before the Protection of Women from Domestic Violence Act in 2005, there was a dearth of laws

which protected women against domestic violence. After much discourse among the government and activists groups in regards to the proposed domestic violence laws in India, the law that finally passed continues to be debated due to its overall elusiveness, unclear use of terminology, and difficulty in implementation. Although the above mentioned law was put into effect in September of 2005, for years women and activist groups had been pushing for the Bill to pass, but problems in regards to the ambiguity in defining domestic violence, only prosecuting a "habitual assaulter," and the right to use violence against women under the excuse of self-defense were seen to thwart the success of the proposed Bill (Bhattacharya, 2004; De Sarkar, 2005; "Protection of women," 2005).

Like in many other countries, there was an emphasis on the importance of family preservation instead of woman's safety. In May of 2004, a new government led by the Congress party, adopted new regulations to increase the reverence of human rights in India (World Report 2005, 2005). The law not only protects against wife abuse, but also expands to include other females in the house including sisters, mothers, and other women living with the abuser ("Protection of Women," 2005). Since this law was passed recently it is hard to predict how well the Indian judicial system and law enforcement will be in executing it. However, the new law alone cannot help fight the battle against domestic violence. Rather change needs to take place within Indian society and their existing mores. According to Pandey (2005), a survey by the International Institute for Population Studies reported that 56% of women in India stated that wife beating was acceptable in some situations. Furthermore, cases that are reported to the police seem to rarely make it to court as a result of bribes the police are willing to accept or the lack of importance law enforcement places on the subject of abuse against women (Narasimhan, 2000). Thus, the negative attitudes towards women continue to exist. These negative attitudes may also be present among Indian immigrants who continue to believe that abuse is tolerable due to the unfair treatment they have observed or experienced as well as sexist traditions such as arranged marriage and dowry, which are still very much a part of Indian society.

Domestic violence in India is usually perpetrated on newly wed women. Unlike the cycle of violence portrayed

in the United States (i.e., Walker, 1989), Indian women often experience the abuse at the beginning of a relationship. Through arranged marriage, women leave their families and are brought to live in unfamiliar environments, a stranger's home to take on the role of a wife. The Indian culture has been one in which arranged marriages are a normal way of life. The parents choose their son or daughter's life partner as they see fit, and the burden of a daughter is considered to be transferred from the parents' household to the husband and his family. To some extent, there is a spill over of arranged marriages seen in second generation Indian-American families who have brought their traditions over from India. Usually both families take an active role in deciding on whether the marriage would be a suitable one. There is a "viewing" of the bride-to-be, and the male is asked whether or not he finds the woman to his liking. The woman has little or no say in regards to her future, and if she voices her opinion against it she is discouraged to do so.

While handing over the burden of the daughter, the parents also practice in a ritual of gifting giving, the dowry system. According to Natarajan (1995), "the amount of the dowry is determined by the groom's family status, level of education, and occupation or income." The marriage "Kanyada," which literally means the act of donating a virgin to the groom (Natarajan) is required to be accompanied with gifts to compensate the husband's family for the responsibility of the daughter. Dowry usually includes materialistic gifts such as gold, jewelry, and any retail gifts that may be purchased. The dowry is also considered to be the daughter's share in the family's property (Fernandez, 1997). It is considered to increase the daughter's self worth when compared to the husband. According to Teays, since the daughter is "viewed as an economic liability, the dowry system acts to balance the added burden" along with "forming part of the wife's conjugal estate.

When the promised gifts are not paid fully, either due to the inability of the parents' financial state or the lack of resources available after the wedding, the bridegroom and his parents according to Natarajan (1995), "may humiliate, harass, and physically abuse the bride." The threat of violence along with actual physical abuse may also be used to obtain more money from the family. Thus, violence becomes a "bargaining tool" for the husband and his family, and more violence may

be exhibited in women who come from affluent families in order to gain more riches (Bloch & Rao, 2002). Many dowry disputes have been speculated to end with the bride's death or with her suicide (Prasad & Vijayalakshmi, 1988).

According to a study by Fernandez (1997), family members contribute to the violence displayed by husbands against their new wives. Although husbands may use violence to discipline and punish their wives, there is a difference in the course domestic violence takes within Indian society when compared to typical domestic violence in the United States. It is used by the husband and his family as a way to castigate the wife for any "inappropriate behaviors." The abuse can start as soon as the wedding day and the trigger factors can vary from jealousy to wanting more dowry, to accusations of not performing wifely duties well (Fernandez). The family members can indirectly or directly contribute to the abuse. They may either encourage the husband to commit violent acts against the bride by fabricating stories (i.e., accusing the bride of inappropriate looks or advances toward other men) or they may partake directly in physically beating them. According to Fernandez, "husbands were considered the primary oppressors, but there was a significant participation of violence from the husband's family members, in particular the mother-in-law and in some cases the sister-in-law." If the extended family includes an increased number of the husband's siblings, the probability of conflict may increase (Natarajan, 1995).

Research has shown that Asian Indian immigrants tend to adapt to their new environment, but hold on to the gender roles they acquired in their home country in order to preserve their ethnic identity (Agarwal, 1991). This may lead to traditional Indian practices in the United States and explain why there may be more acceptance of domestic violence within the Indian community in America as well as the hesitancy in reporting abuse. Also, previous research shows that Asian-Indian immigrant parents and children hold similar attitudes towards women's societal roles, but U.S. born Indian children are more liberal in their view of women's roles than children born in India (Dasgupta, 1998). Furthermore, marginalized and separated acculturated Indians immigrant parents were said to have a positive association with family conflict in relation to American-born Indian adolescents (Farver, Narang, & Bhadha, 2002). In order to assess whether Indian

traditions and values influence domestic violence, it is important to examine if acculturation of Indian immigrants has an affect on the rates of reported domestic violence among Indians in the United States. Moreover, it is important to examine how or whether tradition and customs will interplay with acculturation.

Our researcher, psychologist Tarmeen Sahni (2008) has looked at the problem of domestic violence against Indian women living in the U.S. as they have shown increased rates in reporting domestic violence. Organizations such as "All India Democratic Women's Association" intervenes on an average 50,000 cases of women in distress through its justice centers in different States (The Times of India as cited in Bhattacharya, 2004). Furthermore, many organizations have been specifically established in the United States to provide services for Indian women who are suffering from domestic violence (e.g., SAKHI in New York, Apna Ghar in Chicago), answering 581 calls in 2004 (SAKHI, n.d.) and serving over 5400 domestic violence victims since January 1990 (Apna Ghar, n.d.). Many of these newly married women have been brought over from India by the husband's parents so he can marry a traditional Indian bride. Within a short time, these women report being subjugated into a kind of slavery and without any help from family who do not live within the U.S., she ends up beaten and depressed.

Sahni proposed that the rate of acculturation in an Indian family will have a relationship to those women who will be beaten by their husbands. Sahni suggests that the more traditional the family, the more traditional the marriage, then the more likely the woman will be subjected to intimate partner violence. Although she is still collecting data for her research at this time, it is expected that the Indian American associations will assist her in gathering a sufficient sample so as to answer some of these questions, and in particular, how strong is culture in keeping the negative as well as positive aspects that contribute to wife-beating.

Colombia

The influx of families from various Latin American and South American countries is a major contribution to the culture in South Florida as well as the rest of the U.S. Although they all speak Spanish or Portuguese, the many dialogues

that are spoken provide a glimpse into the richness of the cultural potpourri. When our researcher, psychologist Sandra Jimenez was a graduate student, she translated the BWSQ and went to visit her family in Bogota, the capital of Colombia. In addition to her father's work as a businessman with numerous factories there, he also supports several centers that provide social services to the people of the community. Many of the women who utilize the services are battered by their partners and provided a rich sample of life in this South American city.

The culture of Colombia is different from other South American countries due to the political structure of the government and its close relationship with the U.S. Once ruled by drug lords, especially in the mountain regions, Bogota is now a major city with commerce and trade all over the world. However, like most South American countries, there is only a very small middle class population, with the majority of the people being very poor and a small minority being very rich. The experiences of both the poor and the rich are so different, it is as if they live in two different worlds—which they do. Those who are considered rich by Colombian standards are educated, have jobs, often have maids to assist women with the care of their homes, and live in comfortable homes. However, most of these people would be considered middle-class if they were living in a country such as the U.S. As might be expected, people in each of the two major socio-economic classes in Colombia have different values that impact upon their responses to the BWSQ, so it is important to know what culture the women come from in the sample. Street violence is more common in the lower socio-economic classes while political violence is more common in the cities. Nonetheless, domestic violence occurs in each class.

Culturally, the justification for violence evolves from gender norms. That is, social norms about men and women's roles and responsibilities. Typically, men are given control as long as they financially provide for the family. At the same time, women are expected to take care of house chores, raise their children, and show submission and respect to their husbands. Many cultures hold that men have the right to control and punish their wives, and women who do not behave as expected or those who challenge men's rights over them, could be battered. Consequently, a man might react violently if he perceives that his wife has somehow failed in

her role, stepped beyond her boundaries, or challenged his rights (Heise, Ellsberg, & Gottemoeller, 1999).

As well as in several countries around the world, domestic violence constitutes one of the social problems of greatest incidence in Colombian families. According to the Colombian Service of Communication, domestic violence and its effects are the primary causes of death in women from 15 to 44 years old. While Colombia's Constitution (Article 42) declares domestic violence destructive and orders its penalization, Law 294 of 1996 requests authorities to assist the victims in order to prevent further abuse. However, these laws seem to fall short of fulfilling the system's commitment to eradicate domestic violence because of the unavailability of shelters for battered women and the lack of governmental legal aide services.

A study conducted (Profamilia, 2000) with 7602 Colombian women indicated that 66% were objects of psychological abuse and 41 % were victims of physical aggressions from whom 54% had physical injuries and 15% suffered severe wounds. The results revealed that 37% of women were prevented from having contact with their family and friends, and 11% were sexually abused by their partners. The study also indicates that although 91.2 % of the female population is victimized by some type of abuse, only 5% of women reported the incidents to official entities. However, the significant increase in cases filed during the past years has alarmed both governmental and social entities.

The most common form of domestic violence in Colombia is conjugal abuse as it happens in 62% of all cases of domestic violence; furthermore, women are the victims of this type of violence in 91% of the cases. According to the National Institute of Legal Medicine and Forensic Science, in 2002, domestic violence, was the reason for 64,979 reports of personal injuries. Nevertheless, 62% of battered women did nothing to seek out help. The Colombian Institute of Family Welfare (ICBF) estimates that 95% of all abuse cases are not reported. National and international organizations draw attention to the problem of domestic violence in Colombia. The Human Rights' report for 1999–2000 described domestic violence in Colombia as an "increasing problem."

A survey conducted in 2005 by the ICBF and Profamilia reported that 39% of women across the country were abused by their partners while the percentage in the capital city

(Bogotá) rose to 47%. Physical violence included pushing (40%), beating with hands (35%), hitting with objects (11%), threatening with firearms (8 %), and attempting strangulation or burns (5%). This study also revealed that when faced with attacks, Colombian women responded with aggression as well (64 %).

In 2005, Profamila conducted a national demographic and health survey that included 37,211 families, 38,143 women from 15 to 49 years old, and 9756 women from 50 to 69 years old. The results of the study indicated that 66% of the participants felt controlled by their partners, while 37% were victims of other forms of psychological abuse. 39% were victims of physical abuse, from which 85% presented physical injuries. The study also revealed that 13% of women were raped by their partner or ex-partner.

During 1994, the Institute of Legal Medicine reported an average of 93 cases of domestic violence per day. The same institution indicated that the number of cases increased by 40 percent in1997. The Colombian Institute for Legal Medicine and Forensic Science reported approximately 33,000 cases of domestic violence against women during 2006. However, it pointed out that only a small percentage of cases were reported to the institution. Even though there is legislation that criminalizes violence within the family, domestic violence is generally perceived and managed as a "private" issue. Consequently, many women do not report abuse and those who do report it might not press legal charges (Reports on Human Rights Practices, 2006). According to the Colombian Institute of Forensic Medicine, every six days a woman dies as a consequence of her partner's abuse.

According to the World Organization Against Torture (OMCT), the report "Violence against Women in Colombia" was submitted to the Committee Against Torture, as result of the concern at reports of violence against Colombian women at the hands of both private individuals and state officials. The report states,

> "Discrimination against women in Colombia persists and this discrimination often manifests itself as gender-based violence. Women's main role is that of mother and caretaker, and they are often viewed as sex objects, taught to be submissive from a very early age. In Colombia, women especially experience gender based violence in

their families. With respect to domestic violence as many as 41% of women are victims of violence at the hands of their husbands or partners (The World Organization Against Torture)."

The government of Colombia has taken different actions to condemn violence against women. Currently, family laws in Colombia require that the government provides victims of domestic violence access to shelters and immediate protection from physical or psychological abuse. Therefore, official entities, in some instances, are required to remove the abuser from the household and request him to attend therapy or re-education. The law also includes sentences such as prison time if the abuser causes severe harm to his victim or in cases of recurrent abuse. On the other hand, the Colombian Institute for Family Welfare (ICBF) is intended to provide safe houses and counseling for victims. Nevertheless, its services are insufficient for the magnitude of this problem. The lack of resources and the government's deficient commitment to enforcing the family violence laws leave the victims vulnerable to re-victimization.

With reference to sexual offenses, in 2000, 11% of women reported having been sexually abused by their partner or ex-partner, while the number increased to 13% in 2005 (Profamila, 2000; 2005). Only since 1996, Colombian law on family violence criminalized spousal rape and provided legal recourse for victims of domestic violence. Although the laws related to the prevention and protection of rape and sexual violence has improved, their enforcement remains inadequate. The penalization of sexual violence against women depends on the judge's subjective judgments about the "reputation" of the victim who is frequently considered a "non-credible witness." Consequently, the injustice against women still is pervasive while the perpetrators enjoy a culture of impunity.

Among the effects of domestic violence, previous studies conducted by Profamila (2000, 2005) revealed severe traumatic injuries, sexually transmitted diseases, burns, high risk pregnancies, abortions, and ultimately death. The results also showed significant psychological effects such as anxiety, depression, PTSD, substance abuse, suicide attempts, somatoform disorders, and sexual dysfunction. Furthermore, the effects of domestic violence not only affected the abused

women but also their children. Women who were victims of domestic violence reported displacement of violence toward their children.

Although the number of Colombian women who reported physical and psychological abuse is considerable, the number of women who take measures to prevent further abuse is extremely low. Battered women in Colombia not only rarely report the abusive incidents but also normally maintain the relationship with the abuser. Previous studies conducted in Colombia revealed significant rates of domestic violence. The present study seeks to explore the relation between domestic violence and posttraumatic stress disorder (PTSD) in Colombian women using The Battered Woman Syndrome Questionnaire (BWSQ; Walker, 1978), and the Trauma Symptom Inventory (TSI; Briere, 1991). Participants will eventually include 40 volunteer women who will be required to meet the same inclusive criteria; volunteers are accepted if they are adults and have experienced at least two physical, sexual, and psychological battering incidents. The interviews will be conducted in Spanish using the Spanish version of the BWSQ and the TSI (Jimenez, 2008).

Jimenez analyzed data for the first eight women who have been interviewed to see if they were similar to those of the other countries studied using the BWSQ. Although the sample was not large enough to reliably perform the same statistical analyses, we found that the Colombian women had elevations on the scales that measured PTSD and factors that measured BWS. The results also indicated an elevated endorsement on questions related with the experience of psychological, physical, and sexual abuse occurring during a general battering incident. The women in this sample endorsed several items related to their exposure to psychological abuse; however, the more predominant among all were being cursed at or called names, publicly humiliated, and controlled by their partners. Regarding physical abuse, the participants reported they were frequently hit with objects, slapped or hit with an open palm, and threatened with a weapon. The women in this sample also endorsed items regarding sexual abuse, such as being victims of unwanted sexual advances, unwanted or rough touching of genitals, and forced or coerced sex among many others. As more Colombian women are added to the sample, we anticipate that the results will continue to follow these trends.

Trinidad

One of the most recent samples that we have collected is from Trinidad, a tiny island culture in the Caribbean where the official language is English. Like many of the Caribbean countries, the people Trinidad are mostly poor although there is a growing middle class similar to Colombia and other South American countries. These data are being analyzed and will be ready for the next edition of this book.

Arab American Women

Our researcher, psychologist Shatha Atiya studied the impact of the current American war against Iraq on Arab Americans who lived in the U.S. Although she originally attempted to gather a population of Arab American women who experienced domestic violence, like some of the others, she found it difficult to get people to participate in the BWSQ study even though they were willing to speak about their reactions to the war. As she was a graduate student at the time, Atiya decided to collect the data using the TSI and some questions she had generated for her study (Atiya, 2008). Interestingly, she found that these participants did experience PTSD vicariously, by watching television accounts of the war or speaking directly with family members who still lived in Iraq or other countries in the Middle East. However, the type of PTSD experienced included more physical symptoms rather than the psychological ones more often associated with PTSD.

They reported lack of concentration and difficulty conducting daily routines; sleep problems, fatigue, disinterest in engaging in fun or entertaining activities, and a sense of helplessness. In addition to worrying about their loved ones in their homeland, Americans of Iraqi heritage and Arab Americans watched in terror, anger, and much frustration the robbing, "raping," and destruction of their museums and old libraries that housed thousands of years old treasures, artifacts, and irreplaceable books. They reported a sense of loss of the history and heritage that Arab-Americans are so proud of.

Throughout this ordeal, the Arab-Americans had to deal with additional extraordinary burdens. Most Americans of Iraqi heritage in addition to many of Arabic heritage were contacted and visited by the FBI more than once. They reported

feeling that the freedom every American is entitled to enjoying, the very reason they migrated to this country, was violated. Arab Americans reported their phones being tapped and their conversations being listened to. However, they could not voice their opinions freely. Unfortunately, the Arab Americans are stereotyped and discriminated upon just because of their racial background and looks. Several of them reported harassment at their workplaces, loss of jobs, and their children being discriminated upon in their schools or in their application to schools or jobs. They have to somehow deal with the stigma of Arab terrorists, the media portrayed so intelligently. The two words have somehow become synonymous.

Since September 11th the Americans of Arab heritage not only had to worry, like everyone else, about their safety and children's well being, they had the extra burden and tension of dealing with the stigma and the stereotypes associated with being of an Arabic heritage, or having a Middle Eastern name or look. Many lost their jobs, were harassed, visited by the FBI, and even jailed till proven innocent. These circumstances changed many Arab Americans' outlooks on their rights as American citizens, their safety, their children's future and limitations in the United States. The war in Iraq has revived several of these concerns and more. Americans of Arab descent reported worrying about their stability in the U.S., confiscation of their assets, increased discrimination, and being deported. Many reported avoiding gatherings or places of worship in fear of ignorant retaliation. Therefore, the threat is real, existing, and a precursor to several post-traumatic stress disorder symptomology.

Given this background information about the Arab American population, it was interesting to evaluate those who had been interviewed. Rather than the typical PTSD symptom pattern, they demonstrated a pattern identified by Briere (1998) who noted the similarity to PTSD of several culture-bound syndromes that involve dissociation, somatization, and anxiety related stress responses and are listed in the Appendix I of DSM-IV. Each of these is found among Hispanic, Asian, Western Pacific, Inuit, and Native American societies. They all appear to have significant dissociative features. These syndromes are *Attaques de Nervios*, *Nervios*, *and Susto*.

Attaques de Nervios seems to be triggered by stress such as accidents, funerals, natural disasters, or hearing of or observing the death of a family member. Typical symptoms

of this disorder are crying, trembling, heart palpitations, intense heat rising from the chest to the head, followed by, in some cases, shouting or physical aggression, convulsions, and loss of consciousness. Amnesia for the attaques is typically reported (Briere, 1998).

Nervios typically include a much wider, but potentially less extreme group of symptoms. It used to refer to an individual's general tendency to respond to stressors with anxiety and somatization. The stressors are thought to produce less acute reaction than with attaques and manifest themselves in chronic family dysfunction. Some etiologies of this response may not be related to stressful events. In other cases, nervios appears to reflect chronic anxiety, dissociation, and somatization that arise from an acute stressor. Wider range symptoms of emotional distress may include somatic disturbances and inability to function. Common symptoms include sleep difficulties, nervousness, easy tearfulness, inability to concentrate, trembling, tingling sensations, headaches, irritability, stomach disturbances, and mareos (dizziness with occasional vertigo-like exacerbations) (APA, 1994, Briere, 1998).

Susto, most typically found in Mexico, Central America, and South America, (translated as soul loss) is often precipitated by a frightening or life-threatening event thought to cause the soul to leave the body. Typical symptoms are anxiety, hyper-arousal, appetite loss, sleep disturbance, frequent startle responses, and constant worrying. Depressive symptoms include chronic sadness, decreased motivation, and decreased self-worth. Somatic complaints which include headaches, muscles aches, stomachaches, and diarrhea may be present too (APA, 1994 Briere, 1998).

Atiya is in the process of collecting BWSQ data from Arab American battered women that will be analyzed and compared with the samples from other countries and cultures. These data will also help identify whether or not the attaques de nervosa are consistent with BWS or if it is a different form of psychological or physical disorder that impacts on their health and lives.

Summary

The attempt to understand the psychological impact of domestic violence using a culturally competent approach has brought new richness to our knowledge. Yet, despite the

many differences between people from different countries, the experience of domestic violence appears similar. As long as patriarchal values prevail and sex roles are assigned by the culture, women are treated as less important than men. In some countries, like India, the discrimination starts with paying midwives less who deliver female babies while others are more sophisticated but still discriminate against women. As the world organizations have declared, women must be treated as equals with men before violence against them by men will stop. An important question raised by these different studies is whether it is possible to keep a culture and stop the abuse against women especially when IVP is so ingrained within the other cultural values. There is a feminist phrase that sums it up; the personal is political. If one woman remains battered, all women are in danger of being abused. Cultures within the U.S. as well as cultures within each of the countries we have studied suggest that our differences as well as our similarities must be celebrated, while at the same time stopping the parts of the culture that support violence against women.

13

Domestic Violence Courts and Batterer's Treatment Programs

With

Jeannie Brooks, Kelley Gill, and Michael Kellen

The need for *therapeutic justice* began to receive support within the criminal justice system as those with drug problems began to flood the system during the 1970s. Acknowledging the failure of drug program in the jails and prisons to help inmates "just say no" as was the policy of the U.S. under President Ronald Reagan, residential therapeutic communities and other treatment programs began to develop across the country and in the jails and prisons. Special drug courts were designed to help identify those offenders who could benefit from them as opposed to those offenders who were also selling large quantities of drugs with or without using themselves. So, when the criminal justice system began to deal with large numbers of domestic violence perpetrators in the 1980s, there was already a precedent for a special problem-solving court where arrestees could be referred.

In most large jurisdictions, the chief judges were able to set up such special criminal courts to hear and adjudicate these cases in a domestic violence court.

The policy that developed after research demonstrated its effectiveness was to remove the barriers for law enforcement to make an arrest upon the officer's determination of probable cause for domestic violence having been committed, which eliminated the need for the victim to have to sign the arrest complaint. Domestic violence was then taken off the bonding schedule so that those arrested had to spend time in jail until the next regularly scheduled court appearance. Usually this meant 24 to 48 hours although it could be longer if the person was unable to make bond. Although controversial at first, with the American Civil Liberties Union (ACLU) calling it "preventive detention," in fact, this pro-arrest procedure became the standard protocol when a domestic violence call could result in an arrest after research determined it was successful in preventing further violence in at least some cases (Sherman & Berk, 1984).

Prosecutors identified the issue of bail as a problem for women who were arrested for committing domestic violence against their partners, as men were more likely to make bail whereas the women were typically held, especially if they were both arrested at the same time. They also found that women were intimidated by the justice system and stigmatized by the consequences, which often include having their children removed by child protective services, a record, public housing denials, loss of welfare benefits, immigration issues, and custody hearings. These issues were more salient for women as they are often the primary caretakers. Women were often coerced into treatment even if their abuse was in self-defense and confused by the system in that they did not understand the full implications of a guilty plea.

Not all courts were able to handle these cases, so the special domestic violence court was a natural outgrowth as police began to make arrests and bring defendants into the courtrooms. Vertical prosecutions were recommended so that the more dangerous abusers could be further detained and prosecuted by state attorneys trained in their identification and judges were trained to understand the dynamics and impact on victims. Victim-witness specialists were hired by many prosecutors' offices so that they could assist the victims through the difficulties of the criminal justice system. The victim-witness program actually proved to be one of the

most successful in helping state attorneys win prosecutions as they could spend the time with the victims that was often difficult for the attorneys, get them used to the procedures of that particular criminal justice system, and in some cases, actually assist them in finding doctors and therapists for themselves and their children.

At the same time, agencies in the community providing services to battered women also began a court intervention program working with state attorneys and judges. For example, in Denver, Colorado, they provided assistance to the domestic violence court judges by helping the victims fill out the forms properly, assisting them in learning about their rights, educating them about the court-ordered treatment programs that their batterer might be eligible for, and explaining about restraining orders. Although there has been controversy about whether a restraining order will really protect women from violent abusers, Meloy and his colleagues support the earlier studies that demonstrate obtaining a restraining order wins both the respect of the police and therefore, better protection for women who obtain them, and the deterrence for some types of batterers (Meloy, Cowett, Parker, Hofland, & Friedland, 1997). In many cases, having a judge determine the facts proving domestic violence and issuing a restraining order, may later assist the party in family court when protection of children during custody and visitation are at issue. All agree, however, that a restraining order itself will not stop a batterer who stalks the woman or who is obsessed with harming her. Interestingly, in communities that instituted such programs, the number of arrests have doubled, tripled and in some even quadrupled since the inception of these policies. However, the actual number of cases where this alone deterred further violence remains small, leading most scholars to accept that it is a community-wide integrated approach that is critical and ought to include court follow-up with batterers who do not stop their abuse. More about dangerousness and risk assessments was described in Chapter 6.

Domestic Violence and Problem Solving Courts

The philosophy around domestic violence has undoubtedly evolved in the past several years. Most people are in agreement that violence in the home is no longer a private matter,

but a serious crime plaguing our society. This change in thinking has had implications for many disciplines including, but not limited to, the police and the legal system. Many states have recognized that the domestic crimes need to be handled differently than non-domestic crimes in the court system. One important reason is that, unlike non-domestic crimes, these crimes are emotionally charged and involve people who have relationships, which will not necessarily end with the adjudication of the case. Thus, part of the domestic court role is to be thoughtful about and monitor the continuing relationship between the parties. Family court should adopt this role, as well, but as described in Chapter 11, this rarely happens in that venue. Instead, family court judges seem to prefer becoming mediators in dispensing equity without paying attention to the danger that comes with domestic violence.

According to U.S. Department of Justice (2005), about 22% of murders in the year 2002 were perpetrated by family members, with nearly 9% murders of a spouse, 6% murders of sons or daughters by a parent, and 7% murders by other family members. Although these statistics reflect only fatalities, family violence crimes recorded by the police in the District of Columbia and eighteen states comprised 33% of all violent crimes with more than half of them between partners (U.S. Department of Justice, 2005). In addition, police receive a high percentage of repeat calls for service involving the same offenders and victims. Similarly, in New Haven, Connecticut, domestic violence accounts for approximately 30% of police calls for service and of these, 29% require repeat police calls over time, and are most dangerous for officers, victims, and children (Shaffer & Gill, 2003).

Police calls for service of domestic issues comprise a large percentage of police activity, and the police are trained to treat them as one of the most dangerous types of call to which police officers respond. They are also often reported by police to be the most frustrating and time consuming. These elements may impede the attention to detail and delivery of services by police to the victims that need the services the most: battered women and children (Casey et al., 2007).

In the year 2000, roughly 49% of family violence crimes resulted in arrests. Most offenders (77%) were male, and nearly half of the felony assault defendants were released pending disposition of their cases. However, the conviction rate in family violence cases was found to be 71% as

compared to 61% in non-domestic cases (Bureau of Justice Statistics, 2005). Eighty-three percent of persons convicted of both family and non-family assaults were sentenced to prison or jail. Among family violence felony assaults prosecuted by the state, 68% were sentenced to jail, compared to 62% of non-family violence assaults. As for prison time, the U.S. Department of Justice (2005) reports that 45% of the prisoners incarcerated for family violence received sentences of more than two years. Furthermore, 88% of the jailed inmates convicted of family violence did not use a weapon in the assault, but 55% caused injury to their victim. In addition, 45% of these inmates had a restraining order against them at some point, and 18% had an active restraining order against them at the time of incarceration (U.S. Department of Justice 2005).

The literature is abundant in noting the negative effects on children of exposure to violence in the home as discussed in Chapter 11. For example, Marans (1998), noted that children who were chronically exposed to violence developed symptomatology that impaired their emotional, psychological, educational, and cognitive development. Also noteworthy is that in poor, urban areas where the prevalence of all types of violence is high, "there may be a natural progression from witnessing (violence) to being the victim of (violence) and then to engaging in violence" (Marans, 1996). While most scholars studying the epidemiology of domestic violence agree that it occurs in homes across all demographic groups, more people who are poor appear in domestic violence courts than those who have money.

One of the reasons that domestic violence was removed from the bonding schedule was to equalize the differences between rich and poor, influential and average citizens. In some courts, such as Denver, Colorado and Quincy, Massachusetts this has occurred as no one, not even a Denver Bronco player, is permitted to be released before seeing a judge. In other communities, however, poor men sit in jail for weeks while those who can pay the bond set by the court, are free to go about their business and in some cases, continue their abusive behavior, until their case is scheduled. Often this may be weeks or months after the incident for which they were arrested and witnesses are no longer available or at least their memories are not as sharp as if the case were prosecuted immediately. Psychologists know that learning

theory tells us that the consequences must immediately follow the act or the intended punishment will not be successful in stopping the offending behavior. Yet, we persist in devising policies that work in theory but in a crowded court system are doomed to failure. Nonetheless, with all its flaws, these specialty courts appear to have a modest degree of success if only to support the victim and give her courage to better protect herself and her children.

Models of Domestic Violence Courts

Individual states have developed court models that begin with the same premise: domestic cases need to be handled by a court dedicated to these complex issues. However, each state implements court protocols differently according to resources and philosophy. In addition, states vary in their definitions of what falls under the umbrella of a domestic violence offense. For example, in Connecticut, a special docket has been created with the sole purpose of hearing, monitoring, and adjudicating cases that fall under this umbrella. One judge is assigned to the docket so that the same judge sees perpetrators who later violate the Court's orders. This concept is one of a vertical prosecution in the hope that having to be in front of the same judge will become a deterrent to reoffend. In addition, this court works closely with the agency that provides social services to the victims of domestic violence. So closely, in fact, that victim advocates are housed in the courthouse to allow for immediate intervention and referrals at the time of arraignment (Gill, 2006).

In another attempt to combine all cases involving one family, the courts in Hawaii tried to put both criminal and civil cases together in a unified family court. The civil cases included petitions for divorce, custody and child access disputes, and juvenile court hearings for children in these families. While the original philosophy was a good one, in practice the criminal case requirements including the defendant's constitutional right to a speedy trial, usually within three months, caused the civil cases to back up and the courts became so inundated with the criminal matters that they had to divide the divisions again (personal communication in 1990s, Honorable Frances Wong, Chief Judge at the time).

One program analysis researched by Gondolph (1999) hypothesized that the rearrest rate would decrease when offenders completed a comprehensive program with extra services available to them. Four groups were analyzed: a pretrial group for a three month duration with additional service referrals; a three month post-conviction group including referrals and assessments as well as a women's and a children's group; a six month post-conviction group with referrals and assessments with women's groups; and a nine month post-conviction group that included evaluation and in-house treatment for substance abuse issues, mental health, and women's casework.

Results found differences in reassault rates only in the nine month duration group. A significant difference was noted in severe and repeated assaults between the two three month programs and the nine month program. As hypothesized, women with partners in the nine month program reported feeling that they would not be hit again, but there were no differences between the groups in terms of feeling safer. In opposition to the hypothesis, women in the shorter duration programs reported feeling better off than those in the longer program. This makes sense, as the reassault rates for the men who attended three months of sessions were significantly lower than the nine month group men. This difference could be attributed to the fact that the court reviewed the case at three months thus serving as a deterrent to re-offend. It may be that close court monitoring and accountability can serve to decrease future violence.

Another hypothesis regarding re-offense has to do with the motivation of the individual. Dalton (2001) employed a longitudinal study design to examine whether or not men who perceived more external pressure would be more likely to complete a batterer treatment program. This hypothesis stems from the suggestion in the literature that batterers are not intrinsically motivated to change their violent behavior, but will do so when external pressures are in place. Interviews were conducted upon entrance to one of two programs, followed by chart reviews to discern treatment progress five months after the interview.

The hypothesis in this study was not supported, as the level of perceived external pressure did not predict program completion. This study has a possible confound in that the

men who participated were the men who actually came to treatment, not the ones that were referred but did not comply. Another possible confound is in the program rule that nonpayment of treatment resulted in dismissal from the program. Also, it is important to note that neither program addressed other issues such as substance abuse and unemployment, which could also affect program attendance.

A study conducted by Feder and Dugan (2004) examined whether or not lower rates of violence would be found when men convicted of misdemeanor domestic violence offenses were mandated by a judge to attend either an experimental group or a control group. The experimental group consisted of one year probation and attendance to one of five local Spouse Abuse Abatement Programs (SAAP), all based on the Duluth model of intervention. The control group consisted of men who only received one year probation. The hypothesis was that these men with a high stake in conformity, operationally defined as employment, marital status, age, and residential stability, would exhibit lower rates of repeat violence. All men were interviewed at adjudication and six months later; victims were interviewed at adjudication as well as six and 12 months later. The groups were found to be similar in demographics, stake in conformity, and criminal record but the control group had a mean age two years younger than the experimental group. Also similar were the men's beliefs in responsibility for wife beating and attitudes regarding women's roles.

At the six month mark, no differences were found between both groups for use of violence: 30% self-reported using minor violence, and 8% admitted to using severe violence. Interestingly, younger men without stable residence were significantly more likely to report violent incidents. Again, with respect to stake in conformity, age and employment were significantly related to rearrest while marital status and residential stability were not. The number of months employed was significantly and inversely related to the likihood of rearrest.

Almost one quarter (24%) of men in both conditions were rearrested within the year, but the men who attended all classes were significantly less likely to be rearrested, while men who attended fewer classes were 2.5 times more likely than the control group to be arrested. This study

concluded that the men who do not seem to be deterred from missing their court-mandated treatment, are also not deterred from the consequences of rearrest (Feder & Dugan, 2004).

Similarly, Dobash and Dobash (2000) compared two court-mandated programs for men guilty and on probation for domestic violence with a group of similar men receiving traditional treatment such as fines, probation, and prison time. However, this study also gathered information from the female victims. The participants had similar criminal histories but the men in the program group were more likely to be employed. Evaluations were completed at three intervals: intervention time, 3 months, and again at 12 months (Time 1, 2 and 3, respectively). The program group included participation in group work with a psychoeducational approach, in that the men were provided with education about violence as a learned behavior and the need to take responsibility for their use of violence.

The group portion of the intervention was intensive in that eight stages of a "transformative process" were covered. They are as follows: recognition that change is possible, gaining motivation to change, consideration of costs and benefits of change, viewing the self as a subject and not an object, shifting change internally as opposed to external constraints, using words and ideas that reflect nonviolence, adopting new ways of thinking that require talking and listening to others, and learning new ways and skills for conflict resolution. This comprehensive intervention enabled men to take responsibility for their use of violence and to appreciate the fact that they made a choice to use violence.

The programs seemed to reduce men's use of violence as well as eliminate violence after several months to a year. The men were also less likely to use intimidating and controlling behaviors. Women with partners in the program groups reported a significantly better quality of life than the women with partners in the comparison group as measured by them feeling safer, a better sense of well-being, and positive improvements in their relationships. Quality of life changes for both men and women were more likely to be seen in men who completed the program.

Seven percent of the men in the program were rearrested at follow-up as compared to 10% of men receiving traditional

sanctions. By women's report, the men in the program group used violence significantly less in the two time periods (30% and 33%) as compared to the criminal justice group (61% and 69%). Given this difference, it was also noted that the 25% of the comparison group did remain violence free. Also noteworthy was that at Time 1, there were slight differences between the groups and violence usage compared to Times 2 and 3 where it was significant (Dobash & Dobash, 2000).

Although these studies demonstrate some efficacy for batterer treatment programs, it is difficult to compare them because of the extreme variability from program to program. However, the results are similar to batterer intervention programs that have been studied over the past 25 years that they have been available (Holtzworth-Monroe & Stuart, 1994).

Models of Domestic Violence Treatment Programs

Given the fact that the most common referral by domestic violence courts is to court-ordered treatment, the rationale behind these programs needs to be considered.

Philosophy

Early in the development of batterer intervention programs, both a feminist and cognitive-behavioral model was developed to integrate sociocultural political and individual factors. The sociocultural political model was predominantly a feminist one drawn from the victim's perspective. Historical studies showed that men were the primary users of violence against women, and that patriarchal structures in the community either perpetrated or facilitated violence against women. Institutions within the community rarely intervened to stop men from harming women. This could be due to the inequities in power and resources between men and women at the time. While on a macro-level, men and women agreed with this analysis, as evidenced by the United Nations findings on violence against women throughout the world, while on the micro-level, most men disagreed that such power differentials existed in their own homes.

At first men were eager to place the blame on the few violent men they knew, but when the numbers arrested became staggering, men (and some women) soon became apologists for themselves and then for their brothers, friends, and even acquaintances. Some refused to believe battered women's horrorific accounts of the violence they experienced, particularly if they were in the same social class. Politicians who beat their wives were reelected even when court testimony was exposed. Filling the jails with men who beat their women left no room for the "real" criminals was the cry soon to be heard. The original zero tolerance for any types of domestic violence was soon replaced with cries demanding specifics of "how much violence was really used" or "well, he only hit her one time" and domestic violence became divided into lesser amounts that were called "domestic discord" so that consequences that disrupted the social fabric didn't need to be applied. Today, fewer men who are court ordered into treatment programs actually attend them and programs that do not account for sociocultural, political, and individual uses of violence have appeared. Most egregious has been the family court where children are allowed to be with dads who continue to execute their power and control over their children and wives without any consequences (Fields, 2008).

Models

There are three major models of treatment programs that are usually court ordered around the country. The first is the *Duluth Model* originated in Duluth, Minnesota and is such a well-respected model that parts of it are incorporated in most treatment programs around the world. The second model is the combination of treatment for domestic violence and mental health problems that is represented by *AMEND* from Denver and *EMERGE* from Boston. These two programs have been in existence since the 1970s and are less popular because they require greater resources such as trained therapists to conduct them. The third model is comprised of mental health treatment programs that are not integrated with a sociocultural feminist perspective. Although Don Dutton's treatment programs are sometimes considered part of the second model, he spends more time in individualized approaches to understand how the men's childhood relates

to current violent behavior than an integrated approach and would be considered partly in the third model. This was further described in Chapter 8 on attachment issues with intimate partners.

Does the Duluth Model Work?

The *Duluth Model* is a psychoeducational intervention program that is based on feminist and cognitive-behavioral principles. Although it is the most popular program adopted by most states and even countries around the world, it is not practiced the same from jurisdiction to jurisdiction. As has been said, more recently it has been criticized as insufficient to stop violence because it does not deal with men's individual psychological problems and rather concentrates on sociocultural underpinnings of men's attitudes towards women. Although the actual Duluth program calls for 26 weeks of intervention (Edelson, 1999), in most jurisdictions there are often 12 or fewer weeks of intervention available. Thus, assessment of efficacy is hampered by the various ways the program is implemented even though it is manualized. Even so, there is no change in either arrest rates or batterers' attitudes and behaviors in most of the studies reported based on the amount of time spent in treatment.

The *AMEND* program is also manualized, with 36 to 52 intervention sessions required. Judges are permitted to sentence offenders to two years (104) interventions as well. The leaders of the program train the already licensed volunteer therapists who are then screened and trained to conduct the intervention sessions so there is uniformity in application across the state. As was stated earlier, the AMEND program attempts to deal with the issues raised in the Duluth model as well as mental health issues observed or diagnosed in the batterers, all in a group format. It has a reported success rate higher than that of the Duluth programs alone.

Research Study on Efficacy of Duluth Model. The State of Florida mandates that domestic violence courts use the Duluth model. Several investigators on our project decided to try to assess its success by comparing those men who were court-ordered into the program with those who were there voluntarily (Brooks, Kellen, & Walker, 2005). The records of 100 men who were in a Duluth Model program

during 2002 and 2003 were studied. The men were equally divided into these two groups, court-ordered and volunteers for the study although they attended the program together. Five criteria were used to assess the success of participants: (1) completion of the 26-week program; (2) re-arrest records; (3) post tests upon completion of the program assessing knowledge of what domestic violence is; (4) victim follow-ups; and (5) self-reports. The program was deemed to have been effective if all of the following five criteria were achieved: (1) an individual completed the 26-week program; (2) the participant was not arrested for domestic violence within six months following completion of the program; (3) the participant achieved a score of at least 80% on the post-test; (4) the victim reported no use of verbal, physical or emotional violence upon completion of the program; and (5) the participant reported no use of violence at the end of the program.

Of the court mandated individuals who enrolled in the program, 78% completed the required 26 weeks. This compares to 32% of those who enrolled voluntarily as is discussed below. The remaining participants had been terminated by the facilitator for failing to comply with the rules of the program. For the second criteria, 12% of those who completed the program were rearrested for domestic violence either during the program or within six months of their completion. Third, those individuals who completed the program, 72% achieved a post-test score of at least 80%. The fourth criteria found that 65% of victims, with whom contact was made following their partner's completion from the program, reported that their partner was still engaging in abusive behaviors. Of these, only 10% reported physical violence and 50% of the victims reported that there had been no change in the verbal or emotional abuse experienced prior to intervention, or stated that such abuse had worsened. Upon completion of the program, 100% of the batterers denied any continued use of physical abuse, 12% admitted to verbal abuse, but stated that this was at a lesser level than that which it had been prior to beginning the program.

Of those individuals who enrolled voluntarily in the program, only 32% completed the required 26 weeks, while the remaining participants dropped out of treatment prematurely. None were arrested for domestic violence either during the program or within six months of their completion. Of those

individuals who completed the program, 84% achieved a post-test score of at least 80%. More than half (55%) of victims, with whom contact was made following their partner's completion of the program, reported that their partner was still engaging in abusive behaviors. Of these, none reported physical violence, 20% of the victims reported that there had been no change in the verbal or emotional abuse, or stated that such abuse had worsened. Upon completion of the program, 100% of the batterers denied any continued use of physical abuse, while 40% admitted to verbal abuse, but stated that this was at a lesser level than that which it had been prior to beginning the program. Table 13.1 compares these two groups.

The results of the study suggested that a difference exists in efficacy of the Duluth Model between those individuals who are court mandated to attend services and those who attend voluntarily. Individuals who attended services voluntarily were less likely to complete the program which supports the research suggesting that the confrontational approach of this model is not supportive of men voluntarily motivated to change their behavior. Nonetheless, those that completed the program were less likely to be arrested for domestic violence. These individuals also scored higher on post-tests assessing

13.1 Comparison of Court Ordered and Volunteers in a Domestic Violence Treatment Program

	Court Ordered	Volunteer
Completers	78%	32%
Rearrest	12%	0%
Score 80%+ on test	72%	84%
Victim Report No Abuse	65%	55%
Physical Violence	10%	0%
No Change or Worse	50%	20%
Batterer Report No Abuse	100%	100%
Lower Verbal Abuse	12%	40%

their knowledge of what domestic violence is and, according to their partners, were engaging less in abusive behaviors for which they could be rearrested although power and control issues were still reported. Interestingly however, while fewer of their partners reported the use of abuse, these participants were more likely themselves to admit to the continued use of abuse towards their partners. Considering the high rate of denial reported in this population, this may be an important step in learning self-control of their behavior.

Efficacy of an intervention program to stop men's violence against women can be viewed both as an absolute concept, and relative to an individual's previous behavior. While the Duluth Model appears to have some benefits in reducing abusive behaviors, at least half of those who completed the program continued to exercise abuse. While batterers were less likely to engage in physical abuse, the use of verbal and emotional abuse continued or worsened. As in most studies of batterer intervention programs, the use of sexual abuse and coercion was not dealt with nor measured. Less than 10% of all those enrolled met all five criteria the study assessed.

Although the results of this study appear to highlight the deficiency of the Duluth Model in addressing violence in domestic relationships, there are some positive outcomes and there are recommendations for future researchers to more adequately assess the efficacy of the Duluth Model and for intervening with battering individuals. For instance, instead of grouping all batterers together without accounting for individual differences, it would appear beneficial according to previous research to adequately screen batterers and to classify them into their respective subgroups prior to assigning them to one treatment program, such as the Duluth Model, given the assumption that different categories of batterers would benefit from various forms of intervention. For instance, battering individuals with social skills deficits may have difficulty attending to and benefiting from the group process, which constitutes the Duluth Model. If such individuals are properly screened prior to treatment, time and money may be saved from assigning such individuals to a treatment program they would unlikely benefit from.

Research Study into Typology of Batterers. As has been written elsewhere, there are studies that suggest different types of batterers but each type appears to have its own classification

system. Since the State of Florida mandates use of a uniform form upon which to collect data for just one type of batterer, it was decided to analyze the data on this form from a convenience sample of 700 domestic violence offenders (89% males and 11% females) who were court-ordered into treatment programs during 2004 (Brooks, Kellen, & Walker, 2005). We looked at whether or not these offenders who go before the domestic violence courts had completed the Duluth Model programs that they were court ordered into across the state in this study.

Demographically, 52% of the males in the current sample actually completed the program and 49% of female participants completed the program in its entirety. This completion rate was noted to be lower than that of the previous year (57%). Of those who did not complete the program, 48% were male and 51% were female. Collectively, those participants who did not complete the program, were noted to have either violated their probation, were transferred to another program, or were discharged for disruptive behavior. In terms of participant ethnicity, Caucasians and Hispanics were more likely than African-Americans to complete the program. Thus, ethnic diversity variables are also important to consider when planning an intervention program with those who batter.

At the time of the current analysis, 52 participants were concurrently enrolled in substance abuse treatment, and of these 50% did not complete the batterer intervention program. This suggests that comorbid substance abuse is another important variable to consider when intervening with this population. Research suggests that most individuals who batter have substance abuse problems, although few actually receive concurrent treatment to address these difficulties. But even as these data suggest, when they do receive concurrent substance abuse treatment, early termination rates tend to be higher among batterers with comorbid substance abuse problems.

Higher program completion rates were positively correlated with higher levels of academic achievement, full-time employment, formal legal relationships to the victim (i.e., married, separated, or divorced), and having children. Studies have found that of these variables, employment status is the most consistently related factor to dropping out of treatment. Batterers who maintained legal (married, separated, or

divorced) relationships to their victims were also more likely to complete the program than those who weren't. These findings are similar to those of Berk (1993), Sherman (1992), Sherman and Berk (1984), and more recently, Meloy et al., (1997) as reported above.

The Duluth Model appears to assume that group therapy is the best treatment modality given its current structure. However, it must be emphasized that within this model, there is a lack of focus on individual differences, psychopathology, and anger-management issues. When considering the individual characteristics of those people sent to receive batterer intervention services, individual therapy may prove to be more beneficial for some batterers; for example, those who have themselves experienced abuse, especially childhood sexual abuse. These individuals may not feel comfortable addressing such issues in a group treatment setting, and even if they were, the Duluth Treatment model does not advocate such expression of individual difficulties despite their prominence and likely contribution to battering behavior.

It must also be stressed that for some batterers, incarceration may be the only option, as no psychological intervention would work. This would likely apply to individuals who meet criteria for Antisocial Personality Disorder, based on our clinical experience. Others who fit in this category are those who have arrest records for other crimes of violence and those who have not benefited from prior deferral into offender specific treatment programs.

These two studies from our own research program strongly suggest that a more thorough and comprehensive screening of individuals who batter is necessary to ensure that proper interventions are used that would effectively reduce recidivism and address the individual treatment needs of the batterer. Such screening and assessment could be effectively completed via the use of certain psychological tests, or items from instruments that are able to identify individuals who would be unlikely to benefit from participation in the Duluth Model. For example, items from the Hare PCL-R, the Spousal Risk Assessment Guide (SARA), and the MacArthur Variables obtained from the Assessment Scale for Potential Violence (ASP-V) that assess individual psychosocial history, in addition to the presence of abuse, substance-abuse, and psychopathology could prove to be

quite useful for this purpose. This type of risk assessment was further described in Chapter 6.

Modality. Early in the development of offender-specific treatment it was determined that group intervention was better than individual or family treatment. Far too many batterers were slick talkers and had been in individual therapy and fooled the therapists into believing they had stopped their violent behavior when in fact, they ended up rearrested and proved they had lied in sessions. Other group members were far better in identifying and confronting those who lied, either consciously or unconsciously. Group treatment was more economical for the courts and could be more easily monitored by the courts. It was easier to include didactic or lecture material for psychoeducational approaches in the attempt to change attitudes as well as behavior in a group than in individual therapy. Skill training was possible to accomplish in a group, also.

Intuitively, family therapy seemed like it would be a good modality, especially for those couples who wished to remain together after the violence stopped. However, most family system theories call for shared responsibility of behavior in the family unit and the predominant thinking at that time as well as today, is that the use of violent behavior is the total responsibility of the person who uses it and that no provocation can cause someone to use violence in the home. This message tends to get lost when exploring family dynamics in couples or family treatment. Further, most women victims lose the sense of neutrality when they have been abused. They are hypervigilant to further cues of harm and either the therapist totally supports the women or the therapist is viewed as someone who is dangerous and may either directly or inadvertently cause her to be harmed. A family therapist must support both parties in the session causing the woman to lose confidence in the therapist and therefore unable to benefit from treatment.

Another reason for not doing family therapy is the inability to meet everyone's different needs, especially after a battering incident that results in an arrest and court-ordered therapy. The victim should not be court-ordered into therapy as she did nothing criminal. By including her in the court order, the judge gives the batterer the message that

the abuse is a shared responsibility. She needs time to cool off and to explore her options of staying in the relationship. The batterer also needs time to cool off and think about his behavior. He knows that he has gone too far and becomes scared that the woman will terminate the relationship so he needs to find ways to persuade her to stay. Most batterers will try sweet-talking first, but if his ability to charm and seduce her doesn't work, then he may escalate to threats and other reminders of his power and control over her. No matter how competent a family therapist is, the dynamics of this combination are simply too difficult to manage. Family therapy is predicated on the theory that change in one part of the system will change the family dynamics. This is true, but change could be either for better or worse. Given the intense focus of the batterer and his need to maintain control, it can be expected to change quickly for the worse. In fact, for treatment of couples with reports of domestic violence, the outcome is usually worse for one party or the other, and that party is usually the woman.

Family therapy is dangerous and can risk homicides and suicides. This is also why mediation is not a good option in trying to settle domestic violence disputes. The power imbalance between the man and woman is too pronounced to allow for a fair negotiation. Even in those couples where there is mutual violence and the power seems to be equal, it is only equal in the ability to set each other off negatively. There have been some reports of family therapy occurring after the man has been in offender-specific treatment and the woman has made the decision to stay in the relationship (Holden, Gefner & Jouriles, 1998). In these cases, two or more therapists have been employed so that each can be a support person for their client and watch for escalations of attempts to control the other party. In Milan, Italy, the Italian school of family therapy has reported conducting treatment with families where there is reported child abuse in this manner, with each child and each parent having his or her own therapist in the therapy room with them. Obviously, training and extraordinary skills as a therapist are necessary to participate in this model.

To date, no empirical studies have been found indicating that family therapy is more effective than standard group or even individual treatment. As of 1996, the US Department

of Justice found that 20 states had language in their statutes actually prohibiting the use of family therapy as a treatment modality (Healy, Smith & O'Sullivan, 1998). In some states, such as New Jersey, when a domestic violence restraining order has been issued, it is also not appropriate for forensic evaluators to see the parties together even during a child custody evaluation. In other states, mediation is routinely ordered when petitions for dissolution of marriage are filed and a type of *shuttle mediation* is recommended where the parties are in separate rooms and the mediator shuttles between the rooms bringing recommendations based on what each party desires.

Domestic Violence Program Standards

The Department of Justice undertook a survey of the types of programs available for domestic violence offenders throughout the U.S. In their recent publication, they found:

> Obtaining current and accurate information on batterer interventions is challenging for criminal justice practitioners because programs are extremely diverse in approach and reflect a broad-and often contradictory-range of beliefs about explanations for battering as well as appropriate modes of intervention. In addition, the field is growing and diversifying in terms of the number of programs being offered, staff qualifications, and techniques used.
>
> To assist courts and probation officers in selecting suitable batterer interventions-that is-programs that emphasize victim safety and have goals consistent with those of the criminal justice system-27 states and the District of Columbia had mandated or supported the development of state-level standards or guidelines for batterer programs, and another 13 states were in the process of developing standards by 1997. However, even in states where guidelines or standards are in place, community domestic violence coalitions, the judiciary, probation officers, and other criminal justice professionals often retain considerable discretion over program accreditation and referral. Because of the complexity of the field-and the seriousness of the ongoing

> threat posed to battered women when offenders are mishandled-criminal justice professionals who handle domestic violence cases have increased responsibility to be knowledgeable about the content and structure of batterer programs in their jurisdictions in order to make informed choices among the interventions being offered (Healy, Smith, & Sullivan, 1998, p. 4, emphasis deleted).

The Department of Justice suggested that all domestic violence treatment programs address the most common types of abusive behavior used by batterers (Healy, Smith & Sullivan, 1998, p.5). These are similar to those addressed in the BWSQ research studies and include:

- Physical violence: women are in the most severe danger of physical violence when they try to leave an abusive relationship: 75% of emergency room visits and calls to the police by battered women occur after separation (Stark, E. and Flitcraft, A.). Half the homicides resulting from domestic violence occur after separation (Langhan and Innes).
- Intimidation: including looks, gestures, and actions that remind the victim of the abuser's potential for physical violence. It may also include abandoning the partner in a dangerous place.
- Threats: to hurt the children, her family, or her pets. They also may threaten to commit suicide or to cause trouble for the victim with government authorities, employers, family, or friends. Whether credible or not, threats can be as effective as taking action in deterring the victim from seeking help.
- Isolation: includes controlling what the victim does or whom she sees or contacts. Isolating the victim destroys the support networks a victim usually needs to end an abusive relationship and makes her more vulnerable to the batterer's coercion.
- Emotional abuse: verbal insults serve to undermine the victim's confidence, thereby discouraging her from ending the relationship.
- Sexual abuse: Between 33 and 46% of battered women are subjected to sexual abuse (Frieze, I.H. and Browne, A.), such as rape, unwanted sexual practices, sexual mutilation, or forced or coerced prostitution.

- Using the children: A recent study of batterers in Dade County found that between 30 and 50% of the batterers and victims shared children (Goldkamp, J.S.). By providing for ongoing contact, joint custody enables the batterer to continue to intimidate or attack the victim, the children, or both. Some state statutes now prohibit joint custody in the event of domestic violence convictions, and recent research suggests that witnessing domestic violence has a serious long-term psychological impact on children, including increasing the child's own propensity for violence and delinquency (numerous sources).
- Using economic control: keeping control over all of the family's resources, including the victim's own income if she works, giving her an allowance, or forcing her to ask for money for basic necessities.
- Using male privilege: acting like the "master of the castle," making all-important family decisions, expecting the woman to perform all the household duties and to wait on him.

Special Programs for Women Arrested for Domestic Violence

As has been described, the majority of arrested batterers have been heterosexual men. Straus and Gelles found that men were arrested in 80% of misdemeanor cases, 85% of felony cases, and respondents in 75% of the civil actions. Even so, that leaves 20% of the misdemeanor cases, 15% of the felony cases, and 25% of the civil actions with women defendants.

Among the 5% of female batterers referred to treatment programs, four distinct types of offenders have been identified by program directors, probation officers, and victim advocates according to the Department of Justice Report (Healy, Smith & Sullivan, 1998 p. 6). They are:

1. lesbian batterers;
2. so-called "female defendants" (battered women arrested for violent acts of self-defense);
3. angry victims who have resorted to violence to preempt further abuse; and

4. a small proportion of women batterers who have been the primary aggressors in an abusive relationship.

There are no standards for treatment programs for women arrested for domestic violence. In most cases, interventions in mixed gender groups or even in mixed groups with different types of offenders are not appropriate and may account in part for the high drop out rate for both volunteers and court ordered women as reported in our studies above. Also noted was that women seem to use violence differently than men in that they are usually acting in self-defense or are reacting to abuse in the relationship. Law enforcement and court action would better serve women who are arrested if they understood their violence in a contextual way and not as an isolated incident (Miller, 2001).

Reports indicate that the genuinely violent woman is usually a former victim of some type of violence-child abuse, domestic violence, or sexual crimes and often engages in violent behavior in order to deter future victimization.

Special Programs for Gay Men

Although there are no reliable estimates of prevalence, it is known that gay men also batter their intimate partners and are arrested (Island & Letellier, 1991). They are usually ordered into treatment programs with other heterosexual males as it is rare for there to be groups for gay male batterers. For some men, being forced to reveal their homosexuality in a group could jeopardize their jobs or security, especially in rural areas or other countries where gays do not have any civil rights. This problem has not been sufficiently addressed by the criminal justice system.

Other Community Services

Although the primary referral for domestic violence offenders who choose to accept probation or withheld adjudication is to send them into offender-specific treatment programs, there have been studies to determine other community services that might also be helpful in stopping their violent behavior. The three major areas that impact the offender's use of violence

include child abuse, mental illness, and substance abuse. However, it is rare that communities offer programs specializing in trauma, mental illness, and substance abuse together with domestic violence perpetrator groups. Substance abuse issues have been further discussed in Chapter 10 and mental illness with batterers has been described above. While issues with children have been summarized in Chapter 12, it is important to emphasize the high overlap between battering a woman and abusing a child in these homes.

Physical Abuse as a Child. Although controversial, it is a well known belief in the social science literature that abuse gets handed down from generation to generation. Abuse begets more abuse was the theme of Straus, Gelles, and Steinmetz's (1980) seminal work in this area. More precise studies demonstrate that the generational passing down of this learned behavior is not quite as simple. Nonetheless, there is little argument that boys who are exposed to their fathers abusing their mothers are at higher risk to use violence in their own lives and if they too are abused by their fathers, that raises the risk even higher. There is also a high rate of child abuse reported by prisoners convicted of violent crimes. In fact, based on the forensic psychological evaluations of men who commit the most heinous crimes against women, it appears they have experienced some of the most violent abuse themselves.

Precisely why some men who were abused as boys go on to use violence inside and outside their homes while others do not is not really well understood. Newer trauma treatment methods, such as teaching victims to identify what may trigger their trauma reactions and cause them to reexperience the trauma as if the abuse were reoccurring when they are really not in danger, should be a critical part of any domestic violence treatment program especially if the perpetrator was also an abuse victim.

This is also an area that must be studied so that protective factors can be addressed. There are a few protective factors that are known at this time. Perhaps most important is that boys who go on to lead productive lives have good social skills and relate well to peers as well as adults. This is important as was demonstrated in Chapter 12, children who are exposed to abuse in their homes, often do not make friends easily and may be teased and bullied by other children. A second protective factor is the presence of a supportive adult

in a child's life. Most often mentioned were grandmothers and teachers. Occasionally mentioned were coaches. Boys lucky enough to have Big Brother type of individualized attention were also more likely to overcome their abusive backgrounds. Not mentioned were supportive girlfriends or wives, which is very interesting as most women involved with batterers think that their loving behavior will cure them of their violent tendencies.

There exists a current debate regarding women's use of violence and how it may differ from male violence. In addition, mandatory arrest policies have resulted in the arrests of many women and there is little research on how these arrests are currently handled and should be handled by the criminal justice system. In an effort to examine the differences between male and female aggression, Henning and Holdford (2003) conducted an exploratory analysis on both men and women who were arrested, convicted, or are currently on probation for assaulting a partner. The method included a counselor briefly meeting with the offender, a group administration of paper and pencil tests, a clinical interview, and a written evaluation for the court on information gathered. Results found that most offenders (84.2%) were African American, dating their victims and had a mean age of 32.5, with a range from 18 to 69. Similar numbers were reported for both men and women offenders as to current living arrangements and having children in common. Women were more likely to have some college but were less likely to be working outside of the home.

Similar reports of childhood physical abuse and exposure to minor parental conflict were noted, but men were more likely to report corporal punishment by caregivers than women. Both men and women reported similar results on witnessing parental violence (25%), physical abuse (33%), high rates of parental separation, and substance abuse.

Men reported having more conduct problems as children under the age of 16. They also reported significantly more treatment for substance abuse than women. Women were three times more likely to have attempted suicide and were also twice as likely to have been treated with psychotropic medications. Women were also more likely to endorse symptoms of compulsive personality, histrionic, and borderline personality disorders (95% of the women had elevated scores on one or more of the personality subscales compared to only 69.8% for men).

Women participants were twice as likely to be uncertain about continuing their relationship (29.5% to 14.4%), with 39.4% planning to leave their partners. Assuming their partners are also violent, without effective information dissemination and support, these women could be at higher risk for more severe abuse. For both men and women in this study, the high rates of witnessing and experiencing abuse as children are very noteworthy and can possibly fuel further research and intervention (Henning and Holdford, 2003).

Batterers who Abuse Their Own Children

A study by Shepard and Rashchick (1999), found by interviewing child welfare workers, that although over one third of the cases referred to this child protection agency had known domestic violence issues, no formal or systematic protocol was in place. Furthermore, domestic violence was rarely mentioned in court proceedings even though 14 out of 19 cases were identified as being at significant risk. The other five cases were only mentioned as relevant to protective order hearings.

Workers did directly assess domestic violence in 45% of the referred cases but this was by asking at least one of three assessment questions. In 35% of the cases, the worker asked all three questions. Although most workers did ask about domestic violence, the focus was only on the victim's immediate safety needs without further probing or even providing them with additional support and information. Workers often (92%) utilized at least one domestic violence intervention. However, this only included safety issues, information on crime and calling police, and the dynamics of domestic violence. Specialized referrals, such as, shelters, women's groups, written material, restraining and protective orders, services for children, and an active involvement such as arranging to check-in by phone with the client were very rarely employed.

Given the overlap of partner abuse and child abuse, child protection agencies need to have a more collaborative relationship with the other disciplines involved in domestic violence.

In a study by Miller (2001), information-gathering interviews were conducted with members of several disciplines including: criminal justice professionals, social service providers, directors and case workers of battered women's

shelters, victim service workers affiliated with the police department, probation officers, prosecutors, social workers, providers of arrested women's groups, and family court advocates. These interviews were designed to provide insight on the issues that arise from arrests for domestic violence.

Results found that not one participant believed that women were becoming more violent. They all agreed that the increase in the number of women being arrested was due to changes in police training and protocol such as mandatory arrest. A noted observation by many, either observed or heard from women, was that men manipulated and had become savvy to the criminal justice system in ways to further harm their victim. They would use this knowledge to control women particularly around issues with the children. For example, men would not accept a plea so that, at trial, the women could potentially lose her children or even ended up incarcerated themselves. More examples include: men inflicting wounds on themselves to have her arrested, men calling 911 before she could, and also, the men purposely remaining very calm when the officers arrived. The respondents also agreed that it seemed the police granted more weight to the person who called 911. There is overwhelming agreement that the police are not spending enough time to fully investigate and understand the situation they are called into. Conversely, the police fear liability if they use their judgment.

Summary

Domestic violence courts are part of the new problem solving courts in the criminal justice system, attempting to provide referral to therapeutic services for those arrested for intimate partner violence rather than extended jail time. In some jurisdictions, batterers are only eligible for deferral into domestic violence court if they have committed a misdemeanor while in other places there are also felony domestic violence courts. While deferral into these specialty courts is not voluntary, the defendant may able to decide whether to go into a special offender-specific treatment program or to go forward with a trial and possible jail sentence if found guilty. New data suggest that these treatment programs are not as effective at stopping further intimate partner violence as was originally expected. This is partly due to the fact that

many men who are court ordered into them do not complete the program. Nonetheless, battered women are more likely to cooperate with prosecution if they believe their partner will be able to get treatment. Police are the first responders in most of these emergency calls and although better trained to understand and intervene in domestic violence cases, it is still difficult to stop the violence.

14

Battered Women in Jail and Prison

Lenore Walker

With

Heidi Ardern, Rebecca Brosch, Colleen McMillan, and Allison Tome

Introduction

My first experience in jail occurred when I was asked to evaluate a woman who had killed her husband and claimed that she did so in self-defense. I still remember the haunting sounds of the clanging of the doors that opened to let me in once my credentials were examined. The first door opened into the *sally port*, a tiny vestibule, perhaps 6 feet by 6 feet, and it shut firmly behind me before the second door opened permitting entry into the long hallway that led to the contact rooms. My client was waiting for me by the time I got there. I must have looked as bewildered as I felt, realizing that I had no idea how to get out of there. She tried to calm me down by telling me that it was not so bad, in fact, for her it was better than life with her abusive husband. That comparison

has stayed with me all these years. The loss of her freedom in jail was better than the captivity she had lived with when married to her husband.

The societal institution responsible for maintaining social order that exists in almost every country is the legal system. In the United States, advocates who began working with battered women in the 1980s believed that the most important step to end threats of violence was to punish the batterer and hold him accountable for his misconduct. To do this the legal system had to be encouraged to take action whenever domestic violence was raised. In 1983, following in the successful experience of the President Reagan's Task Force on Violence and Crime, the Attorney General initiated another task force on Violence in the Family. Lois Herrington, the Assistant Attorney General in charge of victim rights was appointed the head of this investigative body and they reviewed research, other documents and witness testimony from all over the United States concerning the problem of violence in the family. In their report they state their conclusions; the legal system and in particular, the criminal justice part of the legal system should deal forcefully with stopping family violence.

This signaled a major change in the attitude of the country and resulted in the criminalization of what had previously been considered private matters. Someone committing any form of violence in the family, not just where the damage was so egregious that notice and intervention could not be avoided, would be subjected to arrest and prosecution to the fullest extent of the law! Of course, the new laws were written gender neutral and so, if the police came to the home and found that the woman was assaultive, she too was arrested. These new domestic violence laws became the gateway for abuse in the home to be more clearly understood as it opened the doors that previously blocked others from knowing what was going on inside. But, it also signaled societal acceptance of imprisoning more women than ever before, even when it meant that their children would end up in state custody.

Many women report pleading guilty to domestic violence and accepting probation and a sentence to an offender-specific treatment program just so they can be released and sent home to care for their children. If they did not do so, there is danger that the children would be sent into the state child protection system. In some highly contested divorce cases, batterers have also been reporting child abuse

charges against their partners (Gotbaum, 2008). It is unclear how much of this inappropriate use of the domestic violence court is due to an attempt for judges to be gender neutral or if there really is an increase in women's violence against men. These arguments have been presented in Chapter 6. However, this practice together with the arrest and prosecution of women for criminal acts, often committed under duress from an abusive partner, has given us the opportunity to study women who are in jails and prisons.

Jails are the detention centers that people are held in until their crimes are adjudicated. Prisons are where people serve their sentences after they are adjudicated, either pleading guilty or being found guilty by a jury or judge. When people are arrested, they are usually able to pay a bond and be released until their case is called before a judge, but those who cannot afford to make bond or do not have anyone who is willing to put up their property as a bond in their behalf, end up staying in jail after being arrested for many different types of crimes. This means that a disproportionate number of poor people remain in jail. In many places, domestic violence arrests have been taken off the bonding schedule, which means those who are arrested and charged with domestic violence must stay in jail until they go before a judge. Both women and men who are charged with domestic violence may stay in jails for long periods of time, especially in states where they may not formally charge someone with a crime for several weeks.

Women and Crime

There has been a growing awareness that many women currently incarcerated in jails and prisons across the country for a variety of offenses have been battered. According to the Report of the American Psychological Association Presidential Task Force on Violence and the Family (American Psychological Association, 1996a, p. 10), four million American women experience a serious assault by an intimate partner during an average 12-month period. The prevalence is even higher for women who are incarcerated in jails and prisons, regardless of the type of crime committed. A special concern for women in jails and prisons is their increased likelihood to have a trauma history.

As a result of women being the fastest growing segment of the prison population this issue deserves attention. The last decade has seen a surge in both the number and proportion of incarcerated women in the United States (Morash, Bynum & Koons, 1998). According to a 1991 United States Bureau of Justice Statistics survey of state prison inmates (Morash et al., 1998), more than 43% of women inmates reported they had been physically or sexually abused prior to their prison admission. Incarcerated women report high rates of victimization, and the violence in these women's lives is often tied to the reasons they entered the criminal justice system as offenders (Browne, Miller & Maguin, 1999). Furthermore, research shows that like the Colorado women first interviewed, many of these female prisoners were convicted and incarcerated as a result of being coerced into criminal activities by batterers.

Unfortunately, the prison system often contributes to the revictimization of women by perpetuating feelings of powerlessness and vulnerability (Bill, 1998). Many prison operations include procedures that may cause vulnerable women to relive their abusive experiences, such as being routinely subject to body searches by male officers, strip searches, intrusive exploration of body parts, and examination of body cavities (Heney & Kristiansen, 1997). This is especially true for women who have been sexually assaulted or even those coerced into sexual activities against their wishes. These and other procedures contribute to the development and maintenance of Post Traumatic Stress Disorder (PTSD) for many incarcerated women as a result of their abuse histories. Furthermore, many female inmates experience a reduced sense of self-worth, shame, and begin to think of themselves as "the kind of person" who deserves only the degradation to which they have been subjected while incarcerated. Still, others may encounter a loss of self-initiative and independence, difficulty using their own judgment, and loss of self-efficacy (Haney, 2001).

Clearly, then, the unique experiences of these women warrant special investigation, and likely require special intervention to assist them in coping with past abuse and preventing a return to abusive relationships. Few studies have attempted to explore the domestic violence histories of incarcerated women, however, and even fewer have utilized an open-ended inquiry in order to personalize these experiences.

Colorado Study

A study of the needs for victims of intimate partner violence commissioned for the Colorado legislature in the early 1990s found that over two thirds of the women in prison stated that they had been abuse victims. Estimates of up to one half of them committed the crime for which they were being punished to avoid further beatings. Forging checks to pay his bills, stealing food or other items that he denied the children, selling drugs to keep his supply filled, and hurting someone else so he didn't hurt her were all acts committed under control of the batterer's threat of, or actual, violence. Some women struck back, most often with great force and usually in self-defense. Few of these women received an appropriate defense for their acts. Most listened to their attorneys' suggestions to avoid trial and plead guilty, often to a lesser negotiated plea rather than pursue a duress or diminished-capacity defense. Today psychologists who testify to the psychological impact of abuse on their mental health functioning and current state of mind at the time of the incident allow more women to present expert witness testimony at their trials. This testimony is discussed later in this chapter.

Several other women's prisons began to organize women's self-help groups often spurred on by consultation from local battered women's task forces. Women in the Wyoming Women's prison in Evanston and Missouri's Women's Prison in Rentz sponsored conferences in the 1990s to educate themselves so as to avoid becoming victims of violence upon their release. In the Women's Correctional Institution in California, the women formed self-help groups concentrating on living more violence-free lives. Women incarcerated in the Colorado prison system begged for interventions, but the legislature was slow to appropriate the funding. Once the new prison was built, closer to Denver where psychologists could more easily volunteer their time, more programs were instituted. Women wardens who understand the special needs of their prisoners have begun to design programs which provide new opportunities in job training, education, and counseling (Schwartz, 2000). It is important for authorities to recognize that most women offenders are victims also.

In jails, where women are usually detained prior to their cases being resolved, special domestic violence units have

been organized and women can volunteer to go into them rather than general population. In some places where problem solving courts are attempting to get mentally ill and substance abusing women back into the community for treatment, women are able to get treatment for the impact from the trauma of having been domestic violence victims. Below is a study of the women volunteers being held in a Florida jail before the crimes they were accused of committing were adjudicated. Initially, these groups were set up for women who completed the BWSQ, but later on, all women in the special domestic violence units in the jail were eligible to attend the Survivor Therapy Empowerment Program (STEP) groups introduced into the Broward County Detention Center in Southeast Florida and further discussed in Chapter 16. As women in jail are moving in and out as their cases are being adjudicated by the courts, this program had to be adapted to jail conditions. Some of the women attending some of the group sessions did not complete the BWSQ or the group treatment even though they were also eligible to attend an out-patient group at the nearby community psychological services center.

Florida Study

The initial analysis of the BWSQ completed by 11 of the women in jail was done using qualitative rather than quantitative analysis (Tome & McMillan, 2006). Although other women began the BWSQ, it was not completed due to legal restraints mentioned above. However, these results were consistent with others reported and give some direction to those interested in designing programs for these women.

A qualitative analysis of the female inmates' narrative accounts of battering incidents revealed three main themes consistent with the other research on Battered Woman Syndrome: power and control, cycle of violence, and learned helplessness. These themes were prevalent in descriptions of battering in general, as well as descriptions of specific battering incidents. The analysis revealed that the inmates' partners used a variety of methods of power and control (including isolation, manipulation, degradation, and fear), and that such techniques typically increased in intensity and escalated in frequency as the relationship progressed. Similarly, the participants' experiences of learned helplessness intensified over time.

The following quotes are consistent with the themes of power and control, cycle of violence, and learned helplessness found in Battered Woman Syndrome:

Power and Control. Of the 11 women interviewed, nine indicated that themes of power and control were common within their battering relationship. A few examples are as follows:

> "I had no freedom, no money, occasionally he let me out to go to the grocery store down the road but if I didn't return on time, he hit me badly."
>
> "At the beginning they're all nice [when dating], but controlling. 'Where are you, who did you go out with.' And then after I moved in they told me, 'You can't see your family, can't do this, can't do that because you're with me.' Then verbally abusive, name-calling, 'you are no good.'"
>
> "I had to sit beside the phone all day to answer his calls. He checked in on me all the time. I wasn't allowed to work or go anywhere without him."

Cycle of Violence. The theme of cycle of violence was found in six of the 11 interviews. These women reported the following examples in their battering relationships:

> "He hit me with an open hand a few times, and put his hands around my neck … he said he didn't mean it, and said he would never do it again … that things would change."
>
> "He hit me, smashed my face on the wall several times, then he apologized, bought me jewelry and swore not to do it again, but he did it over and over."
>
> "After he stopped, he drove to a gas station to get gas. He came out of the gas station with a rose and my favorite drink. He started apologizing as usual. He always did."

Learned Helplessness. The theme of learned helplessness was found among six of the 11 women's descriptions of their battering relationships. A few examples of these descriptions are as follows:

"I felt dominated. Doomed to live life not wanting to live."

"I cannot have a good life without him, nobody would love me, or care about me, or want me, but him. I am worth nothing."

"With time I just got accustomed to the abuse."

The themes of power and control, cycle of violence, and learned helplessness were found through each victim's account of previous abuse. Findings were consistent with previous studies on Battered Woman Syndrome. The small sample size utilized for the study limited the generalization of the results but identifies trends that can help in designing interventions to assist women in jails and prisons to heal from the trauma. Therefore, this research, which explores the dynamics of abusive relationships and female prisoners' responses to the abuse, could lead to the development of specialized treatment programs in jails and prisons, as well as community-based programs for women on probation or parole. These results may also assist women who are involved in the criminal justice system due to crimes committed upon their abusers.

BWS Evidence in the Courtroom

Expert witness testimony on BWS has been permitted in the courts in the U.S. and many other countries for over 30 years now, although the history of its introduction demonstrated the slow legal process that occurred with case by case acceptance (Walker, 1989a & b). I first introduced testimony in a Montana case of Miriam Grieg who shot and killed her abusive husband in the middle of an acute battering incident. After shooting the six hollow point bullets into her husband's body, Miriam ran out of their apartment, and told police to be very careful when they entered, as she was sure her husband was still alive and angry enough to shoot them. This belief in the omnipotence and invincibility of the batterer that battered women display is commonly seen in the women we've interviewed. However, these women have been unable to get the message about their desperation and belief that they will be killed by the batterer to the jurors and courts by themselves.

They need the assistance of an expert witness for several reasons. First, these women were never allowed to talk about what was happening behind their closed doors, so they were terrified to say very much even in their own defense. Second, most of the women believed that they would not be charged with murder once the police understood the danger they had faced. Third, the law only allows a lay witness to testify about facts, not opinions. However, an expert witness can talk about the woman's fears and her psychological state of mind at the time she kills the man, so that the triers-of-face can make a better judgment about the level of responsibility for the woman in these cases.

Research has demonstrated that the use of BWS in court cases helps jurors to make a better decision. Canadian psychologist, Regina Schuller and her colleagues have been investigating both the impact of gender and the use of expert testimony in cases where battered women kill their abusive partners (Schuller, 1992; Schuller & Vidmar, 1992; Schuller & Hastings, 1996; Schuller & Cripps. 1998). Examining different variables including the timing of when in the trial BWS testimony would be introduced, Schuller and her colleagues found that mock jurors were more likely to find mitigating circumstances when such testimony was introduced. Attorneys who have utilized expert testimony in defense cases have written articles published in law journals detailing how they got good results.

Women's Self-Defense Cases

Occasionally (between 10% and 15% of all homicides in the U.S.) a woman will kill her abuser while trying to defend herself or her children. Sometimes, she strikes back during a calm period, knowing that the tension is building towards another acute battering incident, where this time she may die. When examining the statistics, we find that more women than men are charged with first- or second-degree murder. There seems to be a sexist bias operating in which the courts find it more difficult to see justifiable or mitigating circumstances for women who kill (See Walker, 1989a for a more complete discussion of these cases). The now classic Broverman et al., (1970) studies demonstrated that the kinds of behaviors and emotions expressed when committing an aggressive act will be viewed as normal for

men but not for women. On the other hand, women's violence is more likely to be found excusable, if her insanity under the law can be demonstrated. Any changes in the insanity laws will probably have the greatest impact on women and other assault victims who reach a breaking point and no longer know the difference between right and wrong and/or can no longer refrain from an irresistible impulse to survive.

In most states' criminal codes, the use of self-defense is permissible if the woman can demonstrate that she had a *reasonable perception* of *imminent danger*. The definition of what a *reasonable perception* is has been the subject of debate amongst legal scholars—is it what a *reasonable person* or a *reasonable woman* or a *reasonable battered woman* perceives that counts? Is the *perception* an *objective* one that anyone might be expected to conclude or is it a more *subjective perception* that is based on everything the battered woman knows and has experienced? In most states, this argument has been resolved in favor of a compromise—using both objective and subjective perceptions.

Another major area that has had to be defined is what does *imminent* mean? In some interpretations, imminent is seen as immediate. But in most jurisdictions, imminent is believed to mean *about to happen* as if on the edge of a cliff and you are about to fall off. Obviously, this is important because many battered women kill in self-defense by using what otherwise might be viewed as a preemptory strike—like getting a gun and shooting him while he is coming towards her with outstretched arms and a look in his eyes that reminds her of the last brutal beating. It would be a reasonable perception for that woman to believe that serious bodily harm or death is imminent primarily because she has been threatened with death and previously suffered serious bodily harm when he acted in the same way.

In some jurisdictions, self-defense is defined as the justifiable commission of a criminal act by using the least amount of force necessary to prevent imminent bodily harm which needs only to be reasonably perceived as about to happen. The perception of how much force is necessary, then, must also be reasonable. Such a definition works against women because they are not socialized to use physical force, are rarely equal to a man in size, strength, or physical training, and may have learned to expect more injury with inadequate

attempts to repel a man's attack. Thus, some courts, such as Washington State in 1985 in the *Kelley* case, have ruled it would be reasonable for a woman to defend herself with a deadly weapon against a man armed only with the parts of his body he learned to use as a deadly weapon. Courts also have been allowing evidence to account for the cumulative effects of repeated violence in self-defense and diminished-capacity assertions. Expert witness testimony has been admitted in many states to help explain the reasonableness of such perceptions.

One of the major changes in the criminal law is to allow battered women to present evidence of the cumulative effects of abuse in courts through the testimony of a psychologist using what the court's refer to as *battered woman syndrome*. Here, the legal system uses the term battered woman syndrome different from psychologists. Although some advocates do not like the title for political reasons—fearing that labeling the symptoms as a syndrome will infantilize and pathologize battered women, in fact, the legal system has thoroughly embraced the concept and uses it mostly to assist battered women in criminal and civil cases. The courts combine the entire research project together under that title so that the cycle theory and learned helplessness are combined under the dynamics of battering relationships along with the psychological symptoms that are often seen as a result of the abuse.

Expert Testimony

Criminal Cases. As discussed above, presenting evidence of BWS by experts in criminal cases has been successful both in getting psychological testimony admitted in criminal and civil cases and in assisting the triers of fact as was demonstrated by Schuller and her colleagues research (Schuller, 1992). I have now testified in over 400 cases of battered women who killed their abusers in what they claimed was self-defense using the theories of BWS, learned helplessness, and the cycle of violence. In most cases the testimony was successful in either reducing the responsibility from murder to a lesser level such as manslaughter or even not guilty because of self-defense.

Typically, a forensic psychological evaluation of the woman is performed using the BWSQ or a similar clinical

interview and data from standardized tests measuring cognitive abilities and the impact from emotions on those skills. The emphasis on cognition is important since the criminal laws and levels of responsibility are based on what is in the actor's mind and how reasonable perceptions are impacted by emotions. In order to get this testimony admitted into most courts, it may be necessary to also give a clinical diagnosis. In those cases, PTSD or even Major Depressive or Bipolar Disorder may be used, not as an insanity defense, but rather, simply to show how these emotional disorders can impact on the woman's state of mind and her reasonable perception of imminent danger to meet the self-defense statutes. In some states, the legislature has determined that women who assert a self-defense defense based on BWS, must undergo a psychological evaluation by the state's doctor, similar to those who assert an insanity defense. This is unfortunate, as it mischaracterizes BWS by many uninformed mental health professionals as a mental disorder akin to an insanity excuse rather than applying it to justify why she acted as she did.

Then why use BWS at all if it may be misused by those who do not understand the dynamics of domestic violence? This question is answered because of the need to explain the often counter-intuitive behavior of battered women to lay people. Although it is clear that most battered women are actually safer while living together with the batterer, given the high rates of deadly violence used by the batterer when he perceives the relationship ending, the question that continues to be asked is why the woman didn't leave. An explanation of the cycle of violence with its rewards coming during the third phase of the cycle, helps lay people understand that the abuse is not constant and why there is a strong bond of love between the couple that is formed when things are going well. Understanding learned helplessness and its resulting belief that escape is impossible while developing more coping responses including purchasing and using firearms for protection, is another important explanation to put before jurors.

Perhaps most important is the ability of PTSD and BWS to help the trier of fact understand that even when the actual violence is not present, the anticipation of further abuse occurs in the battered woman's mind when the batterer begins his pattern of escalating violent behavior. His behavior becomes a trigger for the traumatized woman who then

reexperiences the past violence as if it was reoccurring at that moment. This is similar to what is reported by war veterans whose memories of combat are triggered by similar sounds such as a helicopter hovering above a grassy area. It is important to remember that it is the reasonable perception of imminent danger, which doesn't have to be accurate, but simply reasonable for the average battered woman that jurors must assess in a justification defense.

Testimony about learned helplessness can be offered by demonstrating that the seven factors that were found in the original research, associated with those who demonstrated learned helplessness from the original Seligman studies, were also present for this woman. As was described in Chapter 4, those factors include:

1. Abuse in the relationship occurred in a particular pattern, usually but not necessarily an identifiable cycle of violence with an escalation of the abuse.
2. Sexual abuse or coercion within the relationship.
3. Isolation, overpossessiveness, intrusiveness and extreme jealousy by the man towards the woman.
4. Threats to kill the woman or other loved ones by the man. These threats can be direct or indirect such as bragging about how he killed other people or forcing the woman (and sometimes the children) to watch as he shoots and kills family pets.
5. Psychological abuse as assessed by the Amnesty International Definition of Torture.
6. Violence correlates including abuse towards children, pets, other people, or destruction of objects.
7. Alcohol or other drug abuse.

Testimony about learned helplessness from childhood factors included:

1. Child experienced molestation or sexual abuse as a child.
2. Child was exposed to domestic violence in childhood home.
3. Loss of power and control experiences such as abuse, frequent moves, poverty and shame, etc.
4. Rigid sex role socialization including orthodox religions.
5. Frequent or chronic childhood illnesses.

Testimony about BWS and PTSD uses the actual criteria from the DSM-IV-TR for PTSD and the three additional criteria for BWS. This included:

1. Reexperiencing of trauma event (s)
2. High levels of avoidance behavior and emotional numbing.
3. High levels of anxiety and hyperarousal.
4. Disruption of interpersonal relationships from loss of power and control and isolation.
5. Distorted body image and somatic complaints.
6. Sexual issues.

Presentation of the factors to the jury may utilize demonstrative aids to assist them in remembering all them. Using charts with the factors first and then adding the specifics found in the evaluation of the particular woman on trial afterwards is a good way to organize testimony so that the jurors and judge can follow how the diagnosis was made and conclusions were reached. This helps separate psychological testimony from the myths that it is not scientific and relies only on the examiners' opinion that is allegedly biased by the fees charged. All professionals involved with legal proceedings charge a fee, whether it is in the salaries of those paid by the state to serve as lawyers, jurors, and expert witnesses, all of whom get paid for their time not their opinions. Forensic psychologists are trained to base their opinions on the data and use it to educate judges and jurors who are the triers of fact. Obviously, even the best professional who is untrained in domestic violence can overlook or misunderstand important data and therefore, base his or her opinion on inadequate data.

Custody Cases

While the use of battered woman syndrome has been very useful in criminal and civil tort cases, it has not been useful in custody actions. Unfortunately, women are still losing custody and access to their children in family courts around the world, and the tendency has been to blame the term, BWS, rather than the lack of understanding and sometimes, gender-bias and outright ignorance of judges who refuse to educate themselves as to the true needs of these children exposed to

domestic violence. Instead, they continue to blame women for complaining about the abuse they or their children receive. However, discarding the term instead of using educational methods will not better serve the purpose as was described in Chapter 11. In many cases, women are erroneously seen as trying to alienate children from their fathers in courtrooms where judges take a dislike to the woman or do not want to hear or understand the evidence that the child presented. Unfortunately, these judges punish the mother by sending the children back into the abusive father's home, often without any protection at all. Many battered women go back to live with the batterer in order to protect their children.

Recent exposes of the mislabeling of women even by powerful psychiatrists indicate that the fears of *woman-bashing* in the family courts are not unfounded (Caplan, 1995; Kutchins & Kirk, 1997; Lerman, 1996; Walker, 1993a). Expectations of motherhood and its supposedly selfless behaviors have been part of sex role socialization for eons. It has created a catch-22 for the woman. Good mothers wouldn't expose their children to domestic violence nor would they take their children's fathers away from them. The woman is expected to stop the man's violent behavior by doing whatever he wants, in order to protect her children. Yet, research tells us that children exposed to a father who batters their mother will have a greater likelihood of growing up and using violence in their own lives. Which is worse? No contact with an allegedly abusive father or exposure to a father's abuse of the mother? Battered women advocates choose protection of the child. Judges still try to be equitable and fair to the father. The result is another generation of batterers and battered women.

Clemency Cases

Once it became possible for battered women who killed their abusers to introduce BWS testimony by expert witnesses, it became clear that there were many women in prisons serving long sentences, even life without parole and death sentences in the US, who never got a fair trial. In many cases they already had lost their appeals or had pled guilty at the behest of their attorneys who didn't know about or wish to utilize a justification defense and therefore were not eligible to appeal their sentences. The only step left for these women

was to petition the governors of their states for clemency and ask to be released earlier than their sentences required. Each state used a different standard for clemency, some utilizing strict parole boards, with others like Florida using the governor's elected cabinet officers. Ohio and Maryland both only needed the governor to make a clemency decision and in the early 1990s, the governors of those two states, courageously granted clemency and released battered women who had killed their abusers in self-defense. Governor William Donald Schaefer of Maryland actually released 13 women after reviewing their histories and visiting with them in prison. Other governors soon followed suit and it is unknown exactly how many women have been released from prison. None have been known to have killed another intimate partner.

Civil Law Personal Injury Cases

A number of the women interviewed told of filing civil lawsuits against their former husbands asking to be compensated for their physical and psychological injuries. Until fairly recently, state laws did not permit women to sue their husbands, but removal of *the interspousal tort immunity* has opened the way for filing of such legal claims. This legal remedy has potential to raise the actual dollar cost of violence so high that men will carefully consider the consequences prior to committing an assault. It also has benefits for individual women that go beyond their recovering the actual dollars expended to heal from their attack.

Being a plaintiff in a civil suit implies an offensive approach. Using such assertive and even aggressive behavior helps women express their anger at having been victimized in a socially acceptable manner. For many of our women, winning money was less important than the whole process of feeling as though the balance of power had changed and knowing they could control their tormentor. The civil law is a long and tedious process, and may be difficult in exposing the woman's entire life including embarrassing things, too, but many of the women stated they enjoyed learning the legal rules and watching the batterer have to conform to them. It wasn't seen as revenge but rather retribution for all that the men had put them through. Winning on ideological points was sometimes as therapeutic as having their financial claims prevail.

Psychologists are now giving battered woman syndrome testimony in these civil courts to prove the psychological damages suffered by battered women. In New Jersey, for example, the *Giovine* and subsequent cases have ruled that domestic violence is a *continuing tort* and therefore, removed the time limit that bars some older incidents from being presented in a case. In many states, women are expected to file within one to two years of an assault. Thus, extending or removing the time limit is important because for many battered women it isn't until they are out of the relationship and beginning to heal that they can start to deal with the long-term effects of abuse and put them in perspective. In New Jersey, however, the claim for damages must be filed in the same court that hears divorce actions although it is now possible to request a jury trial that previously had been barred. The new 1994 Violence Against Women civil rights act also removes the need for a time limit so that women who are barred from taking civil actions in state court may choose to use the federal laws for justice.

Civil Rights Law – Violence Against Women Act of 1994

Despite the advances made in criminal and civil areas of the law, those who wanted to stop the abuse of male violence against women advocated for a federal statute that would declare violence against women to be a civil rights violation—in other words, a violation of every woman's right to be protected under the United States constitution. After several years of political lobbying efforts, the Congress passed and President Clinton signed into law the Violence Against Women Act of 1994. This law did several things. By making male violence against women a civil rights complaint, it made it possible for women to file for compensatory and punitive damages against one or more abusers in federal court without having to prove the nexus between domestic violence and their personal damage from the abuse. Physical and sexual assault of a woman was declared to pose such potential harm for the woman, that it could be deemed a violation of her civil rights if it the assault could be proven to have occurred. It also recognized the difficulty abuse victims have in disclosing their victimization and therefore did not place any time

restrictions on when the abuse had to be reported. This is important because most state civil tort laws do have a one to two year statute of limitation that is difficult though not impossible to overcome. The statute can be tolled (stopped) if it can be proved that the woman did not have the ability to know or report what she knew. The time clock starts running again at the point she is deemed able to know what happened. Interestingly, the standard that she must prove is that the man intended to commit whatever action he took; not that he intended to harm her, which is much more difficult to prove when there is also a love bond in the relationship. Recent case decisions suggest that this law will continue to be challenged in the next few years.

There were several other areas that this law covered in addition to the civil rights portion. One major area was in giving police departments more training and equipment so that they could better protect abused women. At the same time, police departments were instructed to make sure that they did not permit any officer who had been convicted of abuse to carry a gun or other weapon. Obviously, in the United States, it is almost impossible to remain a police officer and not carry a weapon. While this was designed to get better law enforcement protection for battered and sexually abused women, in fact, it caused major difficulties for law enforcement agencies who had many officers in their departments with convictions on their records from many years earlier. Eventually, it will be easier to enforce this section of the law, as law enforcement departments learn to better screen their potential employees.

Other areas of the civil rights laws have also been used to better protect battered women. The most notable case was that of Tracey Thurman, a severely physically abused battered woman who sued the Torrington, Connecticut police department under the 1963 Civil Rights Act for failure to protect her constitutional rights to be free from violence and her safety protected by them. *Thurman v. Torrington* was filed after the police failed to protect her from a brutal beating from her abusive husband. She won over two million dollars in damages in a judgment that also required the police department to change its policies and procedures to better protect all battered women. The award was significant enough to get the attention of police departments across the country and thus, ended up protecting many more battered women.

STEP Groups in the Jail or Prison

Conducting group therapy for battered women in jails is a difficult process that begins with trying to get permission from the command to go into the jail and present the program after it has been designed. Recently, my psychology interns and I presented the 12-week STEP groups in the Broward County Jail to volunteers. This is a 12 unit treatment program based on feminist and trauma therapy theories. Each unit is divided into an educational goal, therapy process time, and a skill to be taught to the women. Weekly exercises are given to the women who want to review what they have learned in the session. All the materials must be approved first by the jail or prison administration. Although, each unit can be done in one or more sessions, in the jails and prisons, weekly sessions are the norm so the entire program can be completed in 12 weeks.

Initially, we offered the program to those who had volunteered to be part of the BWSQ research program. Most of them were on a special unit that was created for women who had been abused and wanted to work on their issues while incarcerated. At least two psychology interns co-led the groups. We conceived of having two groups of the program running simultaneously, on different days. However, in the first group of 12 sessions, the women were so interested in the information being provided that they came both days when they could. Some women began the program, then were transferred to another jail or were in court hearings and couldn't attend for several weeks, and then may have come back again later on. In the second round of 12 sessions, we ran two groups but in two different units of the jail. It became clear that closed groups were not possible in the jail due to the scheduling difficulties of the women so although more difficult to manage, we learned that each unit stands on its own and women can go in and out without difficulty.

One of the most important facts learned was the need to make sure the women do not leave the group so emotionally upset that it disrupts the rest of their routine in the jail. They were not always able to do something to distract themselves or use other defense mechanisms that they had learned to use prior to reopening the painful feelings. These women had to go back to their housing, often with other inmates who were in the group, and despite the cautions

about confidentiality and the rule that whatever happens in the group, stays in the group, some women used the sensitive information to taunt and tease other women. Although we didn't permit those women to return to group if we learned of their behavior, in fact, most of the participants did not disclose this information to the therapists until after the groups were over.

Many of the women we worked with also had co-occurring substance abuse disorders and had learned to numb their feelings with alcohol and other drugs. This is rarely possible in jails so it is important to teach relaxation therapy skills or meditation so they have alternative ways of handling strong emotions. We also found that some of the women did not admit to any PTSD or BWS symptoms on the testing but still came to the groups. It is not known if the women simply like coming as a distraction to an otherwise boring day, if they were really battered women but not able to disclose or feel any of the emotional impact given their situation, or if they were getting something out of the groups despite not being victims of abuse. We have completed the second round of 12 weeks and plan to start another three months of groups shortly, both inside of the jail and in our psychology services center's Family Violence Program. We are also hoping to form STEP groups at a drug treatment center where women are sometimes sent from the jail to complete a program towards sobriety. These STEP groups are further described in Chapter 16.

15

Mental Health Needs of Battered Women

Lenore Walker

To state that women who live with domestic violence have special mental health needs as a group is a controversial statement within the battered women's community. Over the past 30 years there has been much work done to demonstrate that all battered women are not mentally ill. Post modern feminism posits the argument that all women should be treated with equality and respect and when certain classes of women are segregated for special treatment, it weakens the movement towards equality between women and men. While most feminists would agree with the goal of equal opportunity for all, it is abundantly clear that we have not yet achieved it and that some classes of women are more vulnerable than others. Feminists believe that the personal is political; if one woman is being battered, then all of us are in danger of being battered. In order to strengthen the vulnerable women so that they too

have the opportunity to be all that they can be, we must look towards building the resiliency of all women. Psychology can assist in finding ways to accomplish this process.

The research presented in this book demonstrates that there are various psychological issues that get raised for many women who live with domestic violence and if so, then they we believe that they deserve the best care that the mental health community can provide for them, understanding that their mental health needs will vary from person to person. Battered women themselves are terrified about being labeled with a mental illness especially since so many are threatened into silence by their batterers who tell them that everyone will think they are "crazy." While health service providers are now better trained in identification of both health and mental health needs of battered women and their children, there is still little understanding of what to do after identification. Women's continued invalidation in the courts, especially the family courts where batterers succeed in keeping control over the women through the children and through access to money, also makes discussing mental health issues frightening, as they could be used against the woman to persuade the judge to take away custody of her children. In Chapter 11, I described some examples of how accurate this perception may be especially when children are in the home and exposed to domestic violence.

The international community through the United Nations (UN) and the World Health Organization (WHO) has declared that domestic violence is a violation of the person's human rights. This is an important declaration as it supports those commentators who believe that without women being treated as full equals to men, there can be no stopping violence against women. Sociologist, Evan Stark (2007) has suggested that in most abusive relationships, men use a largely unidentified form of subjugation that more closely resembles kidnapping or indentured servitude than physical assault. He calls this pattern *coercive control*. He uses his knowledge gained from working in the domestic violence field to demonstrate how men can use coercive control to extend their dominance in ways that subvert women's autonomy, isolate them, and infiltrate what he describes as the most intimate corners of their lives. Stark has suggested that we must elevate the use of coercive control from a second-class misdemeanor in the criminal justice

system (where most criminal prosecutions of domestic violence cases end up) to a human rights violation so it ceases to permit men to continue to jeopardize women's freedom in everyday life. Psychologist Gerald Patterson (1982) demonstrated how coercive control is modeled by children who learn to use aggression against their mothers by exposure to their father's behavior.

Other sociologists have tied the political structure of a country together with the lack of human rights for women (Dobash & Dobash, 1981). The U.S. Violence Against Women Act (VAWA) that has once again been renewed by the U.S. Congress (2005) clearly declares that domestic violence like rape and other forms of discrimination is against women's civil rights. This Federal Act funds many different programs for battered women including both criminal and civil penalties for those who violate it. It permits immigrant women whose legal status in the U.S. is regulated by an abusive husband to apply for citizenship in their own right and it commands police officers who commit domestic violence to forgo the use of their weapons, which virtually makes it impossible for them to continue in law enforcement. Stopping all forms of violence against women is an important issue around the world, yet despite the promise to pass new laws or enforce those already legislated, the violence against women continues. Women who have experienced male violence must have access to treatment if they have issues resulting from that abuse at the same time that we continue finding ways to both prevent violence and lessen its impact on those who have experienced it.

Public Health Model

The Public Health Model for community distribution of health and mental health services may be a way to conceptualize all of the health services that battered women need to have in place for both prevention and intervention. Many countries outside of the U.S. have strong public health services where victims of intimate partner abuse can seek both health and mental health care without being labeled as having a disease. The public health system in the U.S. attempts to deal with epidemiological problems and while violence against women is considered such a problem, it is the research arm

at the Centers for Disease Control and Prevention (CDC) that appears to drive the services available in public health. Most of these services are in primary prevention through educational programs such as encouraging people to use seat belts for car safety or campaigns to recognize when a woman has been battered and should seek help. Even so, the public health model has a more community-based focus than the traditional medical model, so that people have a way to reduce risk and build resilience to keep their health strong through prevention as well as intervention.

The model attempts to look at prevention and intervention with a tripartite division in services usually referred to as Primary, Secondary, and Tertiary levels. Primary prevention used methods of reaching large numbers of the general population to prevent a disease from occurring in the first place. For domestic violence, it means building resilience in women and lessening the motivation or ability of men to commit violence. Secondary prevention uses early case findings to lessen the impact of the disease on those who demonstrate beginning or mild symptoms, usually in some form of treatment. This would be the outpatient psychotherapy programs for women and men. Tertiary level prevention takes the person already demonstrating more severe symptoms out of the community and helps them heal in a protected environment, usually a hospital but in the case of domestic violence, we can use battered women shelters or jails, also.

Primary Prevention Programs

Primary prevention programs are those that prevent disease from occurring by removing the elements that allows the disorder occur. Sometimes, like in malaria, it means that in addition to strengthening the host and spraying to kill the mosquito, we must also drain the swamps where the infected mosquitos live. The analogy in domestic violence is that in addition to treatment programs to stop men's violence and strengthen women's resilience, we must also eliminate the sexism, racism, and classism that permits violence against women to thrive. In many primary prevention programs the individual is never even seen alone by a health or mental health professional, but rather, the group that the person belongs to is exposed to some educational programs to build resilience and lower risk. Sometimes it is general education

for everyone, like television public service announcements or news stories, and other times it is information aimed at a particular group that is known to have high risk for something.

For example, in the case of domestic violence, pregnant mothers have been considered a high risk group, and therefore, pamphlets offering information and services for victims of intimate partner abuse might be distributed at clinics providing obstetrical services. Targeted programs have been developed for teenage girls who are at a higher risk for abusive relationships than at other ages or even for welfare mothers who are forced into the new TANF (Temporary Assistance to Needy Families) as they are required to get into the workplace within a short period (usually five years) whether or not the batterer approves (Saunders, Holter, Pal, Tolman & Kenna, 2005). Women who have physical and mental disabilities are another high risk group and there are resources for many of them through state and local government services under the Federal Americans with Disabilities Act (ADA).

Some interesting programs have been developed for community workers who often serve as confidantes for women, particularly hairdressers who work in beauty salons where mostly women are served. In some communities where pubs are a gathering place, bartenders have also been trained to provide accurate information about domestic violence to their customers, noting the link between violence and too much alcohol. Religious leaders, particularly in the African American community where there is a strong spiritual connection, have also been trained to provide accurate information about domestic violence. Sermons that decry domestic violence, including men's demanding too much power and control over women, can build resilience in both women and men so that abuse may be prevented from the beginning. The goal of these programs is to build resilience in the women should they become exposed to male violence and to assist men in understanding that violence is wrong and a crime that has serious consequences, including the loss of his family.

Fatalities in the workplace have been found to have a strong link with domestic violence so companies have been providing information to all workers on how to protect women should a batterer enter the premises without permission. Some studies funded by the CDC have found that over one fifth of all full time workers have been or currently are being abused by their intimate partners and lose nearly eight million days

of work annually because they have been threatened, stalked, or assaulted by them. Major companies have begun to address the problem by offering the workers transfers to offices at other sites in an attempt to prevent the abuser from easy access to his victim. Other companies may fire the abusive employee but this may cause certain workers to become so destabilized and enraged that they displace their rage onto the supervisors and commit workplace violence.

Like other psychologists, we have provided risk assessments for corporations who want to know if taking such protective behavior is necessary and wise. For example, in one large corporation with offices in many different locations, we were asked to consult on a case where the woman didn't want to move but the company wanted to keep her working for them and believed that transferring her, at least for a short period of time, would permit the batterer to cool down and get on with his life. He also worked for the company and was told that he had to stop his stalking behavior, go into offender-specific treatment, and follow the court mandates, including observing the restraining order if he wanted to keep his job. As both of these employees' skills were valuable to the company, it was large enough and the supervisors were willing enough to take the risk of keeping them both as employees. In this case, it proved to be a good decision for the company, the family, and the community. In other cases, other recommendations have been made, such as hospitalization if necessary, considering the level of risk of escalating the violence in each case.

Primary Intervention Programs

In primary intervention programs, the goal is early identification of women who are either at high risk for or are already being abused but not showing any symptoms yet. Hospitals, health centers, and private doctor's offices are an important place to encourage early identification and referrals to intervention programs. Literature can be left out for women to take away and read at their leisure or doctors and nurses can talk directly with women who appear to be at risk. For example, a woman whose husband must be in the examining room with her all the time, who answers all the doctor's or nurses' questions for her, or who she seems afraid of would be in that targeted high risk group even though there might

not be any other direct signs of abuse. It may be easier to identify the high risk woman whose husband is argumentative with everyone, speaks rudely to her, and refuses to follow the rules but even so, many health service providers without training in recognizing such behavior as domestic violence, might not recognize it's the significance. Women also have been socialized to protect their man, so even when confrontation takes place, they are hesitant to admit their vulnerability. However, just like the police have been trained to give these women cards with the phone numbers of resources to use when they are ready, so can health service providers do the same along with a brief talk naming the abuse and describing its potential for further violence. The women in our research project talked about visiting doctors for other problems and taking serious what they were told even if they didn't acknowledge it at the time.

The legal system also contributes to the primary prevention and intervention with women who are victims of intimate partner violence. Police have been trained to respond to domestic violence calls quickly and if there is probable cause to make an arrest, then their protocol permits them to do so. This is a major change from when law enforcement expected the victim to sign the complaint before an arrest was made. Women can obtain restraining orders more easily without having to make a decision about their relationships until they get past the crisis. Batterers are taken into custody and many jurisdictions follow the recommended protocol with taking domestic violence off the bonding schedule and detaining the alleged abuser until the next regularly scheduled court hearing. Many communities have victim witness programs where the intimate partner violence victim is seen by an advocate who can direct her to various appropriate resources. Family law attorneys and criminal defense attorneys can also help identify a woman who is battered and needs services.

U.S. Senator Joe Biden has introduced new legislation to support a plan to train 100,000 lawyers specializing in domestic violence and set up a national domestic violence attorney referral project to be managed by the American Bar Association. His legislation would coordinate with the VAWA so that the national hotline supported by VAWA would serve as a referral network. Biden's press announcement (October 18, 2007), issued while he was campaigning as candidate for

President of the U.S., cited statistics of women who could not afford to obtain a lawyer for civil remedies including family law disputes. It might be remembered that Biden was the author of the original VAWA that was passed by Congress in the 1990s. If this new bill passes, it calls for an initial pilot program in five states before going national. How this Federal legislation would coordinate with the myriad of different laws in the 50 states has not yet been determined. However, now that Biden has been elected Vice President of the U.S., he will have access to both Congress and the Executive branch of government to help his efforts to eradicate domestic violence.

In the U.S., the legal system is the gateway to services for battered women, while it is the public health system in other countries such as in Latin America. One major difference is that the public health system sees the problem from the victim's perspective and the legal system, especially the criminal justice system, must protect the alleged perpetrator to make sure he or she is treated fairly and according to the law. One of the major losses for the victim is the lack of attention paid to psychological abuse in the criminal justice system which is much more focused on severe physical violence. Although stalking behavior can be charged criminally, it rarely happens until it leads to attempted murder and other highly dangerous behaviors. In the public health system, psychological abuse is given more attention because it is known that it may be impossible to separate the harm from physical, sexual, and psychological abuse even though the methods are different. Since prevention of harm is the mandate for public health systems, it is unnecessary to make the distinctions that are called for in the criminal justice system. Nonetheless, the criminal justice system has its benefits, particularly in mobilizing law enforcement and the courts to use consequences to stop the batterer from committing abuse in the first place. Unfortunately, the consequences are not applied consistently or fairly across all people resulting in the underserved minorities in society, those with the weakest ties to the values of the society as a whole, who are most likely to get punished by this system. For punishment to work as a deterrent, people must have a stake in the system. Studies of jails and prisons all over the world provide examples of how those incarcerated rarely share the same values as those who have power and control within their society.

Secondary Prevention and Intervention

Secondary prevention programs attempt to use the early identification of domestic violence victims as a way to prevent the development of further psychological and physical injuries. Recent research demonstrated that adults with early symptoms of PTSD who were treated within four weeks of the traumatic event can prevent the development of chronic PTSD (Shalev, 2007). Interestingly, the use of cognitive therapy that helped people change their harmful or unproductive thoughts and desensitization to the traumatic memories was the most effective after three months. Medications that control the cortisol levels in the brain during the few weeks or months after a traumatic event also have promise in preventing more severe forms of PTSD from developing as is further described below.

Another promising program that prevents the development of more serious problems after exposure to disasters in first responders such as police, firefighters, and crisis medical workers is the Crisis Incident Stress Management (CISM) model. These volunteers and workers are encouraged to discuss the horrible events that they witnessed with each other and facilitators provide correct factual information to help them develop a positive outlook that their distress will lessen over time. Although results of empirical studies have not found positive results from this model, individuals who have gone through the debriefing procedures report that it is beneficial in reducing the normal symptoms expected after experiencing trauma. It is important to remember that acute stress reactions are normal after a traumatic incident. PTSD is not diagnosed until the symptoms last for over four weeks. However, the newer research is demonstrating that it is too late to wait four weeks before instituting some interventions to prevent further symptom development.

Studies of people who have been exposed to trauma such as Prisoners of War and women who have experienced physical and sexual abuse and came through these traumas without the usual severe psychic toll from major stressors, demonstrated factors that contributed to their resilience (Charney & Southwick, in press). Having an optimistic outlook on life appears to be the number one factor towards building such resilience. Seligman (1997), the psychologist who first identified learned helplessness in the laboratory discussed in Chapter 4, has also demonstrated the usefulness of optimism

in preventing depression from developing even in those who have familial or genetic propensities towards depression. While Seligman suggested encouraging children to develop optimism as a primary prevention strategy, Charney's work demonstrated that it was possible to develop optimism and the other nine characteristics that were identified in these survivors at any point including during psychotherapy following the traumatic exposure. The ten characteristics are

1. optimism,
2. cognitive flexibility,
3. a personal moral compass or shatterproof set of beliefs,
4. altruism and willingness to help others,
5. a resilient role model or mentor,
6. ability to face one's fears,
7. positive coping skills,
8. ability to establish and nurture a supportive social network,
9. physical well-being,
10. a good sense of humor with the ability to laugh frequently.

Secondary level intervention strategies are the programs that attempt to fix the problems at the earliest levels possible. These may be programs in clinics and private offices of doctors or even in agencies such as battered women shelters and community task forces that conduct outpatient groups for victims of intimate partner abuse. These programs provide remediation and rehabilitation for those who have been harmed by the domestic violence. They are usually designed with the typical victim's needs in mind and some actually follow a general manual of directions while others base treatment on an individual woman's needs. The benefit of a manualized treatment program is that facilitators who are not that well trained in psychotherapy skills can assist women in healing by covering the basic areas that are known to have an impact on those who experience domestic violence. An example was provided in Chapter 14 with discussion of the Survivor Therapy Empowerment Program (STEP) and in Chapter 16 with further details of how trauma therapy is integrated with a feminist therapy empowerment model. Individualized intervention programs are usually given by trained psychotherapists who understand how to treat a

broader range of mental health problems in addition to those specifically caused by domestic violence. These issues can also be inserted within regular psychotherapy although most therapists are not trained to do so.

Information about current intervention programs can be obtained from a local battered women's shelter or the *National Domestic Violence Hotline* at 800-799-SAFE (7233) or 800-787-3224 TYY (for the deaf and hard of hearing), or online at www.ndvh.org. Programs for intimate partner violence prevention can be found in a number of websites including the Centers for Disease Control and Prevention, the National Center for Injury Prevention and Control (NCIPC) at www.cdc.gov, the Gains Center which provides resources for women with substance abuse and domestic violence issues and those who need diversion programs from jail at www.gainscenter.samhsa.gov, the National District Attorneys Association at www.ndaa.org, and grassroots organizing for battered women at www.stopfamilyviolence.org. Perhaps one of the most comprehensive websites is the Community Against Violence network where resources for all forms of violence against women including those with disabilities can be found at www.cavnet2.org. Other websites are listed in the reference section but as websites and domains must be renewed each year, these sites may only be good through the publication date of this book.

Tertiary Prevention and Intervention

Programs at the tertiary level are for those who have such serious problems that they must be out of the community in a protected environment for intervention. Prevention programs at this level do prevent the problems from worsening even preventing death. Intervention programs aim to slow the progress of the damage rather than try for a complete cure and return the person to the community as soon as possible for continued treatment conducted at the community level. The U.S. hospital system is based on the premise that people should be stabilized and then returned to the community for the rest of treatment, when necessary. In Spain, the hospital system keeps people in inpatient treatment for longer periods of time before sending them into outpatient treatment for continuation. Psychologists Carmen Valiente, Patricia Villavicencio, and Delores Cantero (in press) work

at the university-sponsored hospital in Madrid where we conducted some of our research from Spain. Women with more serious diagnoses such as bipolar disorder and borderline personality disorder, who also had developed PTSD from domestic violence were treated there. They found that those with a more complex form of PTSD, first identified by psychiatrist Judith Herman (1992) also had dissociative symptoms and these women needed a more protected environment to begin the healing process such as what could be provided by a longer psychiatric hospitalization than merely a few weeks for stabilization.

For other domestic violence victims, the equivalent of hospitalization is the battered woman shelter where women can remain with their children until they are able to make decisions about where they want to live. Again, in the U.S., stays in the shelter are relatively short as compared to other countries, especially where obtaining adequate housing is an issue. While many do go back into homes with their batterers, they report feeling stronger, understanding the resources available to them, and able to prepare themselves to make better lifestyle decisions. For some, especially those whose batterers also undergo offender specific counseling and legal consequences including jail time, the physical abuse stops, at least for awhile. For others the abuse continues to escalate and they finally do terminate the relationship sometimes after several more attempts to leave.

Battered women shelters are particularly helpful for poor women or those who have been so isolated that they do not have knowledge of or access to services for themselves and their children. In the U.S., these women are assisted with applying for government financial assistance, housing, medical care for themselves and their children, food stamps, and other benefits until they can begin to support themselves. While batterers are required to financially support themselves and their families, many of these men are so destabilized by their mental health conditions and/or substance abuse that they cannot be counted on to provide adequate money. Others choose to join militant father's rights groups, often joining with other men who are angry that their intimate partners have left them, and spend their time obsessing over ways to get even with their partners and the system rather than focusing on rebuilding their lives in a more productive way. Their websites on the Internet are filled with their anger

which sometimes is taken out on lawyers, psychologists, and other professionals who help their partners. It is unfortunate that legitimate fathers' rights concerns have been taken over by these men who teach others how to file spurious legal complaints and demands, tying up the legal system.

Some batterers also need tertiary level care, usually in jails or prisons. In some places, there are programs for men who batter their partners or children conducted in the jails and prisons but like services for battered women, these groups are just beginning. Rather, anger management groups or substance abuse programs have incorporated some information about domestic violence for those arrested and so charged but it is surely not sufficient especially for those batterers who also have mental health problems. In Israel, psychologist Hannah Rosenberg, under the auspices of the organization WIZO has designed a shelter for male batterers. She provides round-the-clock interventions to help men learn alternative ways of getting their needs met instead of using violence against their partners. Interesting, although there was some opposition to spending the limited resources on the men rather than the women victims, in fact, the program has been very successful. In Israel, like many other countries where housing is a problem, most of these men would have had to go back to live with their parents. Since many of those homes still have the same problems as the men were exposed to as children, this was not helpful to stop their violent behavior. By placing them in a residential living arrangement with other batterers, it reduces the shame, keeps the men from contacting the victims inappropriately, and helps them discover new ways of living without violence.

Battered Woman's Shelters

One of the most successful means of providing relief for battered women and their children has been the shelter or safe home concept. It began in England when Erin Pizzey opened the first refuge in 1972 (Pizzey, 1974) and rapidly spread to the U.S. and many other European countries (Martin, 1976; Roy, 1978; Davidson, 1979; Schechter, 1982; Walker, 1979; Dobash and Dobash, 1981). Today, we find battered woman shelters in most countries. The presence of even just one battered

woman shelter, though inadequate to meet everyone's needs, is critical to give the message to the entire community that abuse against women will be not be tolerated. This is particularly important when cultural and religious messages conflict, sometimes even facilitating further abuse by sending the woman right back into the violent home when she seeks help. Of course, there are limitations to the services that battered woman shelters can provide. Although there are few policies regulating who can use the shelter, the programs are usually designed to address women who are battered by male partners and not female partners. Male children over the age of 13 or 14 are rarely accepted into shelter, partly because many have already identified with their father's violent behavior and partly because it is a woman-oriented experience. Rarely can pets be accommodated necessitating making other arrangements in the middle of the crisis that usually brings the woman to shelter. However, veterinarians in many communities have volunteered boarding these animals for the short time that women are in shelter.

While there have been a variety of shelter models provided, all of them meet the primary purpose of protecting women and children from a violent man's immediate abuse. Most shelters are located in their own home-like building whose address is not widely known within the community, but neither is it completely hidden so as not to encourage "hide and seek" type of game-playing for batterers. Usually 20 women and children can be accommodated at any time. During peak periods, overcrowding does occur. A typical shelter costs approximately U.S. $350,000 per year to operate. Some small communities cannot financially support a separate home and, instead, use a system of trained volunteers to provide safety in their own homes. Many places have both systems in operation. Rural areas train people to drive a battered woman to safety and, in some places, a relay system of drivers can get a woman to another state within a short time. An "underground railroad" exists which can move women and children throughout the world, whenever it becomes necessary. The presence in a community, then, makes a clear statement that spouse abuse won't be tolerated, and if it occurs, the community will provide a separate home for the victim.

While there has been lots of debate concerning the correct philosophy of a battered woman's shelter, few dispute

its effectiveness in a crisis. 30 years ago, most shelters in North America were developed using a feminist model. Today, most shelters have evolved into a social service model, perhaps in order to obtain government financing to survive. Loeske and Berk (1981) evaluated what battered women in the Santa Barbara shelter deemed as helpful as an attempt to resolve the service provider/feminist organization issue. They found that stressing the immediate incident that brought about the woman's call to the crisis line was the usual entry into the shelter system itself. Almost one half called for help within one day of an acute battering incident. However, over 20% of their callers reported that the most recent incident had occurred a week or more prior to seeking help, indicating that fear of the future might be more of the woman's concern which finally brought her into the shelter. The diversity that was found in what battered women said they need and expect from a shelter indicates that no one philosophy could meet these needs. Loeske and Berk suggest that it might be helpful if the shelter worker and client both define their goals and the nature of available help within each situation.

Some shelter models suggested that staff roles be limited to woman advocacy and not provide direct services. In West Germany, for example, Hagemann-White (1981) described the conflict surrounding professional training and pay for full-time work in the Berlin shelter and the other 85 shelters in the Federal Republic of Germany. She made a compelling argument for promoting a microcosm of a woman-identified feminist society in the shelter to avoid being merely a band-aid and thus, encouraging women to return to abusive homes. Shelters are seen, then, as more than a crisis haven, but also a place to try out new social orders. In the past 20 years, battered women shelters have created a model of mothers and children developing a new family unit, free from violence. In most shelters, there are no-hitting rules forcing some mothers to learn new forms of discipline, particularly positive reinforcement strategies. This is an important way to reverse the effects of being exposed to violence in childhood and for children to be exposed to many positive experiences. The typical visitation problems that occur when both parents are forced to share parental responsibilities in homes where there has been domestic violence often perpetuate the abuse and prevent children and their mothers from healing from

the trauma. At least when in shelter, women have some time and psychological space to begin to think about their goals for the rest of their lives. Being together with other battered women often helps women to stop blaming themselves and emphasize their own strengths.

Rebecca and Russell Dobash (1981), American sociologists living in Scotland, argued that shelters must provide an alternative to the patriarchal structure fostered in a capitalistic society. Stark (2007; Stark & Flitcraft 1983) still agrees with the need for such a political as well as social analysis. But, while their political analysis correctly predicts class oppression, there is no direct evidence that it makes a substantial difference in the rate of spouse abuse, which is found to occur across all social classes and in all political systems. Rather, it is the way in which women and men are socialized to relate to each other which seems to be most critical. Looking at women in Nicaragua has provided a good example of a country torn apart with political civil war that has been able to provide some services to women while rebuilding the political and economic infrastructure of the country. Not surprisingly, women who were never-married during this period were found to be less depressed and suffer less from the trauma than those who also faced abuse within their marital homes (Ellsberg, et al., 1999). The current status of women in Russia where a socialistic order under communism was expected to provide the opportunity for more equality for women didn't turn out that way (Horne, 1999). Economic rather than political organization may well be a more important variable to women's safety. We discussed these cultural issues earlier in Chapter 12.

Shelters organized around an alternative collective approach seem to have more difficulty staying funded than those more compatible with the social service philosophy within their own countries. In the U.S. there has been much concern that fear of losing funds would be used as a way to scapegoat those feminist and lesbian women who work in shelters where the community political climate became more conservative. This has happened. The original feminist philosophy that prevailed in battered women shelters throughout the United States and Canada has been replaced in many communities by a more social services model. However, the politics of the battered woman movement has remained feminist, often causing conflicts that may impact on

the quality of services delivered in some places. Since there are few training resources for shelter workers outside of the university or national organizations, these tensions remain a part of providing shelter. Further, the tensions between advocates and professionally trained service workers have not been resolved, again placing battered women and their children in the middle—facing hostile husbands on one side and hostile advocates on the other. When this type of situation occurs, no one gets her needs met. However, the political climate amongst lawmakers and policy makers continues to be supportive of finding better ways to provide safety for battered women and their children, which does give strength to the important work of the advocates.

In Finland, Peltoniemi (1982) and Peltoniemi and Aromaa (1982) describe four battered women shelters funded by the government for a three-year pilot period. Over 500 women and an equal number of children used these shelters during the first year. Peltoniemi tells of the deliberate decision to choose a family-dynamic model instead of an alternative feminist ideology despite the Finnish socialist political system. The same occurred when Israel set up fifteen centers for domestic violence around the country where social services, not shelter were offered. Even the funding source came from two different centers in the government—the women's programs and the family programs (Steiner, 1999). The arbitrary dichotomy of family versus feminist orientation is one that is unnecessary although understandable given the fear that women's demands for equality have engendered. Most shelters need to provide family support services and can still do this within a feminist ideology. The goal is to keep the women and children violence-free. If to do so can only occur if there is a separation between husband and wife, then it may be necessary to isolate the violent man to protect the family. This is a stand that the family courts are unwilling to accept, often responding to vocal fathers' rights groups and placing women and children in danger of continued violence.

The decision of whether or not shelters should provide offender-specific treatment for the batterer has been more controversial in the shelter movement. Myers (1982) describes a program for working with the abusers run by the Houston battered woman's center because the women there have requested such a service be provided. Many battered

women feel that they must get help for the men to try to get them to change their behavior before they are willing to give up the dream of making this relationship work. This is particularly true when using the criminal justice system, as was described in Chapter 6 on risk assessment and Chapter 13 on domestic violence courts. Battered women are more likely to testify against the batterer if they believe he will get help to stop his violent behavior, whether or not they want to keep the relationship. The better psychoeducational programs are often supervised by or run by the battered woman groups in a community, as they are careful to include changing men's socialized attitudes towards women within their treatment programs.

On the other hand, many shelters believe that any public or private funding received must go directly into programs for women and children victims. Obviously, in a system with finite resources, decisions must be made to prioritize services. Some shelters would disagree with the Houston approach, insisting as does Hagemann-White, that women must cease taking responsibility for the men's mental health. The need to make these kinds of political decisions has caused tensions that more often divide rather than unite those with different philosophies.

The feminist philosophy supports the power of each woman to make her own decisions. It suggests allowing a battered woman to have the option of trying everything she needs to do before giving up a relationship that has provided her with both pleasure and pain. Yet, there is also a responsibility to demonstrate viable alternatives to the current socialized concept of intimate relationships. The dignity and courage these women demonstrate, even at their greatest point of frustration, can be appreciated when they finally choose to be safe and free from violence. Shelters, whatever their philosophy, do manage to give them that choice. Most women in shelters need some support to move forward with their lives, whether they stay out of the relationship or try to fix it so that they and their children live violence-free. For some women, psychotherapy that empowers and validates them, can be a means to help carry it out. Thus, I have spent the past 15 years training psychotherapists and advocates in new ways to deliver psychotherapy services that empower women to help them go from being victims to survivors.

Crisis Intervention and Safety Plans

Understanding the ability of a domestic violence situation to quickly escalate into a lethal incident, most health and mental health workers understand the need for crisis intervention and safety plans to be implemented. It is important to begin any crisis intervention or safety plans with a good evaluation of the woman to determine if she has developed BWS or any other type of health or mental health injuries from the domestic violence. A standard clinical evaluation encompasses a mental status examination and information about the woman's history is first important to gather relevant information in order to individualize the safety plans if there is time. Otherwise, crisis intervention techniques designed to stabilize the woman must be implemented immediately.

Evaluation for Battered Woman Syndrome

Battered women seek psychological services for a variety of reasons—usually to provide some assistance in coping with a particularly difficult life situation. Sometimes a woman will seek out services because of the violence itself, while other times another reason gets her there. Problems with the courts, substance addiction, psycho-physiological pain complaints and health issues, and school problems of children are frequent indirect reasons for seeking out someone, usually a therapist, with whom to speak. Pleading by family, friends, lawyers, shelter staff, and her own determination to stop the abuse are the usual direct reasons. Whatever brings her to a therapist's office, it is predictable that her basic lack of trust will pull her out if certain measures aren't taken to convince her that the therapist will be helpful (Moore & Pepitone-Rockwell, 1979; Walker, 1994). Several assumptions work well to establish rapport and create the atmosphere she needs to be able to confide her story.

The first one is to believe a woman when she claims to be battered. It is rare that a woman would make up such ghastly stories, and if it should happen, inconsistencies during the interview will alert the clinician's suspicions. Many of the new strategies for detecting malingering and deception have not been normed on a population of battered women, who may have self-interest in claiming to be battered when they are not, but also may be telling as much of the truth as they can,

given their long history of lying and manipulating to cover up for the abuser when they believed they could be hurt more if they exposed him and didn't follow his orders. In performing an evaluation, it is always necessary to remember that what appears to be pathology in a non-abused woman, may well be a coping or survival strategy for a battered woman. Whether or not she can drop that behavior when it is no longer necessary for her safety is the best test of how embedded it is in her personality structure. Obviously, this will necessitate a period of time, usually six months to one year, of her being free from violence and abuse.

History Gathering

It is suggested that at least two hours be allowed for the initial interview with a potential client. A longer time may be necessary if the woman appears to be in crisis. The first hour is usually spent taking a brief history and building trust. If successful, then the battered woman will begin to detail the abuse in the second hour. When I do an evaluation with someone who has not yet taken any steps to terminate the relationship, she and I explore how she might do so safely, examining the trouble spots carefully. I offer to develop a safety plan with her and listen for information in her recitation that will be helpful to do so. Active listening without giving interpretations of behavior can help validate the woman's experiences and reassure that you will not label her "crazy" as both she and her partner have feared. I also label her as a battered woman at some point in the interview so that she has a name for the symptoms she is experiencing. In addition, I give her information about BWS and PTSD, helping her to understand that a normal person may be expected to respond with the PTSD and BWS symptoms in order to cope with the stressful situation. While it may initially frighten some women to be labeled as battered, it also gives them a justification and explanation for the changes they know they have experienced in cognition, emotions, and behavior. It also gives them hope that they can be helped to feel like themselves again.

Risk Assessment in Crisis Situations

In evaluating the risk of further danger, it is most important to learn the frequency and severity of the violence both at

present and in the past. There are various checklists that can be of assistance in gathering the information in a systematic way discussed in earlier chapters (Walker, 1994; Walker & Meloy, 1998). Estimating the rapidity of the violence escalation can be done by using data gathered about the first acute battering incident, a typical one, one of the worst, and the final incident, similar to what we did in this research study. This four-incident method was developed during the research project and has stood the test of time. Since many women minimize violent acts and injuries, it is important to ask specific questions about them. Inquiries are made into threats to kill, available weapons, choking and other life-threatening acts, violence potential towards others, and specific examples of psychological abuse.

While physical abuse is easy to recognize, it is often difficult for therapists to ask for specific details. Figley (1995) and Perlman and Saakvitne (1995) describe the potential effects of trauma on those who provide assistance to trauma victims where it is not unusual to develop secondary post-traumatic stress symptoms themselves. The APA (1996a) Presidential Task Force on Violence and the Family suggested that it is common for professionals who hear repeated stories of the violence to skip the details either because they felt that recounting them would be too difficult emotionally for the victim or they were unable to hear it again. Becoming too compassionate or too emotionally distant from the victim will impede the ability to be genuine and authentic in therapy and may suggest the need for a referral or consultation before proceeding. Stark's redefinition of the batterers power and control needs to coercive control behaviors may make it easier to gather information about psychological abuse that women are subjected to. It is necessary to clarify what is culturally relevant to women in a partnered relationship and what is considered coercive controlling behaviors.

Trauma theory makes it clear that it is important for victims to repeatedly talk about their experiences so that they can gain mastery over the emotions raised and learn new cognitive schemas that give the trauma different meaning (Foa, et al., 1991; Kolodny, 1998) than the initial distortions that sometimes come from retrospective guilt and memory errors. Some interventions, such as EMDR (Shapiro & Forrest, 1997), are more oriented around preverbal memories and therefore, emotional responses are dealt with differently. Some of these

issues are further discussed below. If the woman currently is separated from her partner, it is important to learn how frequent their contact is and what kinds of conflicts occur when they do have contact. Escalation around access to the children is an important sign of increasing danger to both the women and the children (Sonkin, 1995; Walker & Meloy, 1998). The woman's perception of the level of the man's anger at any particular time is also important as she usually is the best judge (Walker, 1994).

Preparation for Psychotherapy

It is crucial for the woman to understand that the purpose of therapy, should she decide to pursue it after the evaluation is completed, is to help her grow and regain her emotional strength and sense-of-self in a violence-free environment, not to terminate the relationship. At some point, she may decide that the only way for her to continue to grow is to leave the battering relationship. This is important because many batterers attempt to intrude on the therapy to make sure the treatment will not be antithetical to his interests in keeping the relationship the same. When he questions the woman, which most report that the man inevitably does if he knows she is in treatment, then she can honestly report that *"my therapist is not interested in whether or not we stay together, just in my staying violence-free and safe."* This also minimizes any power struggles that may result from the initial phase of therapy and permits the woman to begin to develop trust in the therapeutic relationship. This may change once the woman starts to feel stronger and more assertive in the relationship and the woman must be prepared for the possibility that the batterer will react negatively to her growing strength. It is difficult for most batterers to accept any independent actions from the woman, particularly if he is dependent upon her and feels anxious that she will not be there for him. Such reactions often result in a greater amount of power and control through coercion and psychological means first, and then physical abuse should he perceive that he is losing control over her.

In highly lethal situations, the clinician has a responsibility to share perceptions of danger with the woman and others, where appropriate. It is important to be honest that good therapy will help her be safer, but not always out of the way of the batterer's harm. If the batterer is in treatment and

the woman is willing to give permission, it may be helpful to have some communication with his treating therapist. However, this must be done carefully so that it does not interfere with her trust of the therapist's total allegiance to her. Battered women, like other trauma victims, do not have the ability to perceive neutrality or even objectivity. Either someone is totally on her side, or that person is perceived as being against her. Yet, at the same time, therapists cannot condemn the batterer himself or it may be seen as another power struggle for the woman. Rather, it is important to inform the woman that the battering behavior is unacceptable without passing judgment on the man himself. Examples of how to do this can be seen in training video demonstrations (Walker, 1994; 1998).

Safety Plans

During this first interview, I encourage a woman still living in the relationship to devise an escape plan for when the violence escalates. First, she identifies the cues she perceives as a signal for an impending battering incident. Most battered women can do this even though initially they may have difficulty verbalizing such cues. Sometimes the first cue is their own physiologically perceived anxiety—other times, it is a change in the man's facial expressions, particularly his eyes that are described as "getting darker," "no eye-contact." "looking like nobody is home," and other recognizable patterns being repeated.

Then, we discuss a plan of escape including specifying strategies that must be pre-planned to execute it. For example, one strategy is to locate the nearest telephone, either a cell phone or an independent telephone that he cannot listen in on such as in a nearby store or in a neighbor's home. Other strategies are to make an extra key to the car and house and hide them, leave a change of clothes for themselves and their children with a neighbor, create a personal bank account or make arrangements for other access to cash, alert children to a danger signal so they know what to do if they get scared, and so on. Finally, we rehearse the plan of escape, step by step, both orally and in writing, sometimes drawing a map, in order to estimate how much time it will take for various activities such as dressing the baby in the wintertime. We encourage women to take their children with them if they leave as the

courts will not look kindly on them for leaving them with a violent dad even if they think the dad will not harm them. As we discussed in Chapter 11, the family court system does not look kindly on women, especially battered women who lose control of their children when dad's fight for custody.

The goal is to make it an automatic and familiar response in crisis, in much the way of routine fire drills when you went to school. It makes the therapist less anxious and frightened for the client's safety and gives the woman some hope of really being able to escape. It is important to remember that most women who have developed learned helplessness as described in Chapter 4, have traded coping strategies for escape strategies and are unable to think that escape is even possible during a crisis. Even if this woman does not return after the crisis passes, she has learned an important escape plan that may save her life.

Health Concerns

As was stated above, the separation of health needs from mental health needs is an artificial division that is not useful when providing treatment, especially in domestic violence cases. Continued stressors take a toll on the body as well as the mind. Therefore, it is not surprising that so many women who have been victims of men's violence develop physical illnesses including chronic pain. Studies of those women who seek out services in pain clinics indicate large percentages of them have experienced physical or sexual abuse as children or adults. Back pain, migraine headaches, gastrointestinal, and gynecological problems are common in women having experienced intimate partner violence. Interestingly, in some cultures, PTSD symptoms are largely experienced as physical symptoms such as in the Arab American community where both women and men displayed such symptoms while obsessively watching the U.S. war against Iraq on television. Studies of Cambodian women who moved to the U.S. after the war indicated a large number of cases of idiopathic blindness, as if their psyche was telling them that they had seen enough destruction. Other studies of torture victims, who also have experienced intimate partner and child abuse, have similar physiological and psychological findings associated with PTSD. Therefore, health and mental health

professionals must encourage patients to seek out other services and permit all health service providers to communicate with each other.

PTSD and Biochemical Changes

It is not surprising that those who develop PTSD have measurable changes in the secretion of biochemicals, especially those that facilitate the nervous system. The new PNI research is discussed in Chapter 7. Research by Boston psychiatrist Bessel van der Kolk (1994) first demonstrated that physical injuries were remembered by the cells at the site as well as by the brain. His findings supported the memories that some women had of being abused even before they had the words to describe it. For some women, they may not demonstrate any PTSD symptoms from domestic violence for many years until they experience another trauma when all the symptoms appear. This sometimes happens when battered women are in car accidents and cannot heal from seemingly minor injuries. Or, in some cases, the years of being shaken vigorously by the shoulders, hair-pulling, choking, and head-banging finally produce debilitating neurological damage that appears to be far more widespread than would have been expected from a minor injury which may have triggered the full response.

Studies by Israeli psychiatrist, Arieh Shalev (2002) were some of the first to identify the variable course of PTSD together with the brain chemistry. The major changes occur along the hypothalamic-pituitary-adrenal axis in the subcortical areas of the brain that regulate our emotions. They cause the neurotransmitters and receptors that regulate the nerve impulses to change how they function in order to adapt to the high stress situation caused by trauma. This extremely complex system is just now beginning to be understood as we are better able to measure the minute amounts of biochemicals and hormones released at different stages. The major changes in the autonomic nervous system involve elevations in adrenalin and noradrenalin that regulate our major life functions such as heart rate, blood pressure, breathing, increased glucocorticoids that are regulated by amounts of cortisol signaled by the cortisol releasing factor (CRF), and increased amounts of endorphins which counteract physical pain from injuries. In addition, the major neurotransmitters that regulate our

emotions are also impacted with dopamine being increased and serotonin being lowered. Together, these changes keep us hyperalert and focused on the crisis precipitated by the trauma while being able to ignore other parts of our lives that we normally pay attention to.

Research shows that reexperiencing the trauma memories after the incident may be the single most detrimental factor in producing severe PTSD responses. If intervention takes place within four to twelve weeks, it is possible to lessen the effects. Since the first four weeks after a trauma normal acute stress reactions are expected, it is difficult to know who might be at high risk for more severe PTSD symptoms. Genetics, other mental health conditions, and the environment all can play a role in the severity of the PTSD response in addition to the characteristics of the trauma itself. The more destabilizing the response to the acute trauma including agitation and nervous behavior, high levels of anxiety, sleep disturbances, aggression, and confused thinking all heighten the severity. Charney and Southwick's (in press) studies are most interesting as they used women victims of sexual and physical assault in their studies at Mt. Sinai Hospital in New York City and Yale University in Connecticut and then compare them with others who had experienced torture and imprisonment during war. Not surprisingly, they mostly fared the same.

Medication for PTSD

Both medication and psychotherapy are useful in lessening or even eliminating the PTSD responses after trauma. The medication of choice would be *antiandrenergic agents* such as Propranolol, Guanfacine, and Clonidine or *benzodiazapines* such as Xanex, Valium or Ativan. For severe reactions it is possible to use antipsychotic medications such as Thorazine or injectable Haldol or some atypical agents that have fewer side effects such as Risperdal for impulsive aggression. For insomnia it is possible to use tricyclics such as low doses of Trazadone or Nefazadone and for panic attacks low doses of Amitriptyline. Interestingly, although Selective Serotonin Reuptake Inhibitors (SSRIs) such as Prozac, Zoloft, and Lexapro are often prescribed as first line psychotropic medications for depression, studies show that during the first four to twelve weeks they have little or no effect on PTSD symptoms. This is not surprising

since it often takes four to six weeks for them to start working, which is too late for treating early stage PTSD. However they do show promising results later on in treatment of some PTSD symptoms.

Benzodiazapines are often used first as they are fast acting to calm down the arousal system, help with insomnia, and have few side effects. However, the major problem is that they are dangerous especially when taken together with alcohol and they are addictive, meaning that the more you use them, the more you will have to take to achieve the same effect. Most health professionals prescribe them in low doses and only give a few pills at a time, especially if someone is impulsive or suicidal.

Antiandrenergic agents modulate both physical and cognitive symptoms of PTSD, control hyperarousal and intrusive memories, lower blood pressure, and reduce irritability and aggressive responses. There are some data suggesting their use with alcohol and other drug users but there is little research for their use with PTSD in general. They are counter-indicated for those with diabetes, high blood pressure and heart problems and may lower blood pressure too much with inconsistent dosing. It is important to be careful of other medication combinations when these agents are prescribed and its discontinuance must be carefully moderated. Nonetheless, there is research to suggest that they may modulate cortisol releasing factor (CRF) which controls the levels of cortisol, implicated in chronic PTSD responses. In one study, researchers found that repeat trauma victims have lower resting cortisol levels but when stimulated by another stressor, the cortisol level rises way higher than normal. This study demonstrates the complexity of just one biochemical reaction to chronic stress, so imagine the complexity when several different neurotransmitters, hormones, and catalysts are involved in the response to repeated cycles of domestic violence.

Anticonvulsant agents are often used for seizure control and more recently for mood control in bipolar disorders. They have also been used as an additive for refractory PTSD. In addition to being a mood stabilizer, they often modulate the glutamatergic transmission in the hippocampus and other regions in the midbrain structures controlling emotions. Memory for emotional events gets stored in the hippocampus and only when processed verbally does it move into the cognitive memory regions in the cortex of the

brain. This is what makes verbal trauma therapy so helpful in separating emotions from the events and restoring the less emotional memories in the cognitive memory center. These medications can take several days to weeks to take effect and they also have side effects that include possible liver toxicity as they are metabolized there, so blood serum levels must be checked at three to four month intervals. However, they have been found effective in those with PTSD from car accidents, child abuse, and combat veterans.

Twelve sessions of cognitive psychotherapy that helped people change unproductive thought patterns including stopping their ruminating about the trauma, were most helpful within four weeks after the traumatic incident in the Shalev studies (2002). Cognitive behavior therapy which helped desensitize women's reactions to traumatic memories also worked well in relieving major PTSD symptoms. Although antidepressants did not work as well as psychotherapy during this initial phase of treatment, they may be more useful with modulating PTSD symptoms later on in combination of other medications and psychotherapy.

Mental Health Needs

Psychotherapy

As can be seen from the above discussion about the biological effects of trauma and PTSD responses, trauma therapy can be very helpful for victims of intimate partner violence who develop BWS. In earlier editions of this book, I describe the types of therapy and modalities that are appropriate for intervention with battered women. The admonitions against use of family or couples therapy remain as a counter-indication for the women. Here I will concentrate on the types of intervention that have been found useful for the symptoms associated with BWS and PTSD.

Feminist Therapy. The application of feminist therapy for those who have experienced men's violence has been one of the most successful forms of treatment in helping women heal from abuse. The goal of feminist therapy is to empower or re-empower women to take back control of their lives. An essential feature is the egalitarian relationship between therapist and client. Each brings certain skills that are respected

to the relationship and the power between the two parties is carefully monitored by both but especially the therapist to make sure the woman is no longer coerced into doing things in her life. This requires what is termed "cognitive clarity" or the ability to think clearly and make appropriate decisions based on information available. Learning how to lower anxiety levels when they get high will reduce some of the paralysis that battered women often describe as a residual from BWS. At each step along the way, the woman and the therapist decide together what is needed next. Most important is helping the woman learn to break the psychological hold the batterer has had on her, overcoming her dependency upon him to make decisions for her, and moving on with her life. This will require overcoming any isolation that has occurred during the relationship and for some women, dealing with an associated depression.

Although it is possible to enter into this type of therapy while still living together with the batterer, unless he has stopped his physical abuse and no longer needs to use his power and control over her, feminist therapy could cause further battering incidents as the woman gets stronger. Video reenactments of feminist therapy are available from various publishers to assist in learning the treatment approach.

Trauma Therapy. As more people with PTSD have required psychotherapy to move beyond its effects, new treatment modalities have been developed to deal specifically with the effects of trauma. Often used in conjunction with medication to reduce some of the PTSD symptoms, trauma therapy focuses on reducing the reexperiencing of prior traumatic events, reducing anxiety and learning to control emotional arousal, and moving beyond depression. Like in feminist therapy, the last two groups of symptoms may be treated using medication and other methods of relaxation and overcoming isolation by rebuilding interpersonal relationships. However, unique to trauma therapy is the need to remove the emotional impact of trauma triggers that cause the woman to believe and act as if the abuse was about to reoccur even if she is no longer in danger.

Briere and Scott (2007) have developed a program that assists the therapist in helping the client recognize what her *trauma triggers* are and then reducing their emotional impact using cognitive behavioral techniques such as desensitization by building approximate hierarchies until the trigger effect is extinguished. It is important to make sure that the woman is

not in a fragile emotional state when doing this work so some of this therapy is a slow reempowerment of her emotional strength and stability although it is not so described.

Special Issues. Some issues are so frequently present in battered women with BWS that it is important to address them using whatever techniques seem appropriate to both the therapist and the woman. Some women deal with the trauma by blocking it out and dissociating their minds from their bodies. In these cases, some of the techniques from Linehan's *Dialectical Behavior Therapy (DBT)* such as teaching *mindfulness* or the ability to stay on task may be quite useful.

Trauma memories that are so frightening to the woman may be dealt with using *EMDR (Eye Movement Desensitization Reprocessing)* that may erase the emotional connection to the memories using bright lights or other techniques used to reprocess the brain discovered by Francine Shapiro.

Summary

Although not all battered women need psychotherapy or medication to heal from the abuse they experienced, those who do should be able to obtain appropriate and effective treatment. At present, the two therapy systems that have been found to be effective are feminist therapy and trauma therapy. These interventions can be applied in individual or group settings with or without medication or other adjunctive treatment such as EMDR. The STEP program discussed elsewhere in this book is based on a combination of feminist and trauma treatment theory. Many of the mental health needs of battered women have been met by using a public health model that has primary, secondary, and tertiary level prevention of any impact or at least stopping development of further symptoms and intervention to ameliorate any symptoms at the earliest point possible. Mental health treatment can take place in a variety of settings including battered women shelters, community mental health centers or clinics, hospitals or jails and prisons. Most important is the ability to strengthen the abused woman so she can get on with her life.

16

Survivor Therapy Empowerment Program (STEP)

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With

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Introduction

The Survivor Therapy Empowerment Program (STEP) is a carefully designed, evidence-based psychotherapeutic program that can be used to work with groups of abused women who have experienced intimate partner abuse or other forms of physical, sexual, and psychological abuse. STEP helps women to better understand how the violence they have experienced has impacted their lives and what they can do about it. As it has a psychotherapeutic focus, the program deals with how people think about what has occurred and how it affects their feelings and their behavior. Although STEP has therapeutic benefits by reducing the mental confusion and teaching tools to re-regulate emotions, all of which will change behavior, in fact, it is not psychotherapy: it is psychoeducation. This makes it possible to

use the program in settings where confidentiality is not easily obtained, such as in jails and prisons and for non-mental health care providers to be trained to facilitate the program.

STEP is made up of 12 units with detailed materials for each unit. Some women and places that offer the STEP groups will go through them one week at a time while others will spend a longer time on one or more of the units. Others, in settings where there is less control about how often someone attends the group, will complete only some of the units and not in the usual order as presented in the program manual. Each of the STEPs are theoretically based on current feminist and trauma theory. The feminist component emphasizes the negative effect that discrimination and oppression has on a woman's life and the need to find and take back one's power to overcome these effects. The trauma component incorporates the lessons learned from the research presented in this book so that the psychological impact can be overcome, also.

Each session or STEP has three components: an educational section that provides information about some aspect of domestic violence and its impact on people; a discussion section where participants talk about and process what happened to them; and a skill building section where the leader teaches the women a particular skill that may protect them and help them heal. Exercises, most of which reinforce a behavioral skill that has been taught in that session, are given out to practice the skill until the next session. Some time is spent checking in with everyone when the group begins and some time is spent in closing the group that leaves about 20 minutes for each of the three major sections in a two hour group session.

Why is it "Evidence-Based"?

In the health care world today, there is a movement to try to evaluate treatment effects to see if the treatment really works as it is thought it will. Most of the time we use our clients' reports of feeling better to know that what we have done has been helpful. However, there are also ways to measure efficacy using certain assessment tools. Our research team that began the STEP groups in the jails, described in Chapter 14, attempted to use some of these measurements to determine how helpful the STEP groups were for the women who participated. Although the program was geared

towards women who had experienced domestic violence, some of the women who self-selected to attend had been abused by family members or others. Nonetheless, they reported benefiting from the group and their assessment results confirmed their self-reports. We report some results later in this chapter.

What are the STEPs?

Each of what we call STEPs are the units that can be covered in one or more sessions.

STEP 1 Definitions of Domestic Violence
STEP 2 Overcoming Dysfunctional Thinking and Designing a Safety Plan
STEP 3 Thinking, Feeling, and Acting
STEP 4 Changing to Positive Thinking and Managing Anger
STEP 5 Stress Management and Relaxation Training
STEP 6 Cycle of Violence and the Psychological Effects of Violence
STEP 7 Post Traumatic Stress Disorder and Battered Woman Syndrome
STEP 8 Grieving the End of a Relationship
STEP 9 Effects of Domestic Violence on Children
STEP10 Learning to Ask for What You Want
STEP11 Building Healthy Relationships
STEP12 Terminating Relationships

STEP 1 Definitions of Domestic Violence

Goals:

1. To begin to learn about each other and the rules of the group meetings.
2. To learn the different terms used when we talk about domestic violence.
3. To learn to define what types of domestic violence the woman experienced.

Terms Defined in Educational Component

There are four types of domestic violence or intimate partner violence:

Physical Abuse. Physical violence is any form of touch that is used to control or otherwise intimidate. This includes hitting, slapping, grabbing, pushing, scratching, hair pulling, head shaking and banging, throwing, kicking, choking, hitting with weapons and objects. Even pushing and grabbing is domestic violence.

All types of physical violence are against the law, unless they are used in legal self-defense.

Sexual Abuse. If a partner forces or coerces a woman to have sexual intercourse against her will, even if they are married, it is part of domestic violence. In most states it is usually against the law. In addition to forced sexual intercourse, sexual violence includes forced oral sex, forced sodomy or anal intercourse, sex with animals, forced sex with another person, and forced use of objects in sexual activity. Of course, any kind of sexual mutilation including cutting or bruising a woman's breasts or genitals is sexual violence. The force used does not always have to be physical. Many men use the threat of further violence or other forms of bullying and intimidation such as temper tantrums and angry explosions, yelling and/or degrading demands, and waiting until the woman is asleep to get the sex they demand from their partners.

Psychological Abuse. There are two different ways to define psychological violence; what is legally against the law and what really happens in a domestic violence relationship. 1) In legal situations, psychological violence includes all threats of violence including threats to hit, sexually assault, and threats to kill. Terrorizing by stalking, harassing, bullying and intimidating behavior may also be against the law, especially if the woman has received a restraining order to keep him away. 2) Non-criminal acts but still having a psychological effect in domestic violence relationships, are those that commonly occur to increase the intimidation and fear that the woman has of the man. For example, bullying behavior by those who may also physically abuse the woman just to hurt her, using

intimidation and abuse increases the negative emotional effects of psychological abuse on a battered woman. Psychologically abusive behaviors include name-calling, limiting the woman's freedom through control of finances and cars, isolation from family and friends, humiliation, degradation, and other forms of harassment.

Stalking and harassment behaviors are special types of domestic violence now considered criminal behavior in almost every state in this country. Batterers who stalk and harass women want to intimidate, bully, and coerce victims into compliance with their demands. Most offenders who stalk and harass victims are obsessed by getting their own needs met and will not or cannot stop the obsessive thinking that may result in the compulsive behavior. Those who stalk are a special type of batterer. They may be more dangerous than other batterers, and need more specific treatment to stop this behavior. Sometimes they also demonstrate other forms of mental illness. Usually men who stalk women need several years of treatment before they are able to stop their psychologically abusive behavior.

We use a definition of psychological torture that was constructed by Amnesty International, the international human rights watch group. This differentiates the kind of psychological pain inflicted in dysfunctional relationships from psychological torture that is found in battering relationships. There are different categories of psychological torture in this definition including physical abuse in a particular pattern such as escalation or the cycle of violence, sexual abuse or exploitation, power and control of the woman, isolation, over-possessiveness, intrusiveness, mind control including use of hypnotic-type of repeated questioning, ranting and raving, debilitating tactics such as malnourishment and sleep deprivation, degradation including name calling, harassment and put-downs, threats to kill, and use of alcohol or other drugs. Most battered women experience most or all of them. Women are asked to check the lists on the handouts and see if they apply to each of them individually.

Violence Towards other People. Woman who know that the man has been violent towards other people are even more frightened that he can commit more harm against them if they do not obey him. Often women must protect their children from the man's violent anger. This may result in her getting

hurt instead of a child or another person. If the woman sees the man becoming violent against another person, especially if it is in a jealous rage, she may even join in with the batterer to protect herself from the man's wrath when he is finished with the other person and turns towards her. If the woman learns about his violence towards a former wife or girlfriend, the two women may at first be enemies but eventually have the power to gang up on the man and help law enforcement take care of him.

Violence Against Pets and Property. Many battered women report that they get more frightened of their partner when he harms the pets he may also love and when he breaks things around the house either in a temper tantrum or as a way to demonstrate his cruelty. The batterer may hurt the family dog or cat, or he may even have shot and killed a family pet. Whatever his reason, it is scary to think that he is cold-hearted enough to harm or kill an animal he may love, even if he is upset about it afterwards. Everyone knows that he is capable of harming or even killing the woman and the children. The batterer may also try to control by demanding something with a threat to destroy something he knows the woman loves, like a quilt given to by her grandmother, the furniture she worked hard to save up for, or a piece of china given to her by a favorite great-aunt. He knows these are irreplaceable things, which makes his threats even more sinister. Breaking furniture, banging holes in the wall, smashing whatever is handy are all ways to intimidate and bully her into doing what he wants her to do. This type of property violence is common and helps the batterer establish his dominance.

Injuries from Domestic Violence

Although fewer than 50 percent of battered women ever report their injuries, they still make up the largest number of women treated for injuries in hospital emergency rooms. Women who have been abused visit their personal physician two-and-a-half times more frequently than those who are not battered. The impact on a woman's general health from abuse is serious enough for the U.S. Surgeon General to declare domestic violence a public health issue. More women ages 25 to 35 die from domestic violence than from any other

cause. Women who are abused are more likely to lose time from work because of injuries from the abuse. Many women stay at home and wait for bruises to heal rather than exposing themselves to co-workers. We discuss the most common injuries by asking the women what were some of those they experienced, also.

Discussion Component

Leaders go around the room and ask women to talk about their own experiences. Depending upon how many women are present, several will have a chance to describe their own situations briefly. Others will be able to answer questions or raise their hands to answer some questions that include making them feel part of the group. The goal here is to involve all the women and challenge them to think about the kinds of abuse they have gone through and what psychological or other injuries they have experienced.

Skill Building

The skill focused on here is the ability of the woman to break through some denial and minimization and identify the types of abuse she has experienced and figure out what kinds of consequences it has had for her.

Exercises

Hand-outs listing many different types of battering incidents and possible injuries are distributed so that each person will have the opportunity to go over her own list.

STEP 2 Overcoming Dysfunctional Thinking and Designing a Safety Plan

Goals:

1. Continue feeling comfortable with the group routine.
2. Review your identification of different types of dangerous behavior in your own relationship.
3. Learn about underlying causes of stalking and harassment.
4. Develop a safety plan.

Educational Component of Step 2

Stalking Behaviors and Dysfunctional Thought Patterns. It is common for a batterer's behavior to be controlled more by what he is thinking than by what he is feeling. A woman, on the other hand, is usually socialized to be controlled more by how she feels than by what she thinks. Therefore, this empowerment program will help women learn how to take more safety steps by learning to identify what feelings get in the way of positive action thinking patterns.

Experience has shown that many men who batter are often extremely emotionally dependent upon their partner. The love and acceptance of his partner somehow makes the man feel better about himself, and he may not know how to get this feeling of well-being without her. The majority of male batterers grew up in homes where there were serious problems, such as alcoholism or violence, and therefore have problems with their own self-esteem and worthiness. This may be part of the love women feel for him hoping that their love can make up for what he didn't get as a child. Men who batter their partners also try to justify their behavior by blaming everyone else for what happens to them. He may attribute bad things that happen to what the woman did or didn't do for him. If the dinner doesn't taste right, it is the woman's fault for not cooking it correctly. If the children get sick, it is her fault for not taking better care of them. If the car breaks down, it is her fault because she wanted to buy that model car. Even if he gets into trouble at work, somehow he will find a way to make his partner responsible.

Not accepting responsibility for his own behavior is part of faulty thinking, and we will discuss how to change these attributions later. The woman, too, must learn not to accept the blame that he tries to give to her. Women can learn how to accept responsibility for what is their fault and stop believing everything he attributes to her.

When a man's partner leaves, especially when the man has been using her to make him feel better about himself, he experiences this loss in a profound way. His impulse is to get her back, straighten everything out, and make it better with her. Most women want this to happen, too, as they also have become emotionally dependent on their partner to help them feel better about themselves. This is particularly evident if her partner has isolated her from other family and friends.

Men often think, "if she only understood how much I loved her, needed her, then, I could convince her to return." That is a part of his faulty thinking. But, sometimes it is part of the woman's faulty thinking, too.

Many women attribute their self-esteem to being able to be a good wife and mother. Most girls are socialized to take care of their families. This is not a bad value except when women are unable to also protect and take care of themselves. Perhaps, you were raised to believe that it is important to make your man happy and to keep your relationship together, no matter what you have to do. Girls are taught to give in more often than boys. They are more interested in making connections with other people, to make others feel good. The chances are that you were socialized in the same way and feel bad about yourself if you are not able to keep everyone happy. It is easy to take care of other people's emotions when you have been socialized in female sex-roles, especially when your partner expects it of you.

Many men actually fall apart emotionally when the woman leaves. They can't eat, sleep, or in some cases, work. This falling apart is not about *love*. Nor can it be fixed by *love*. This behavior is about dependence—not much different from any drug addict who is experiencing withdrawal symptoms. To break this dependence, both of the man and the woman must learn how to take responsibility for their own behavior. He must learn to stop thinking he is entitled to the woman's services to take care of all his needs. If he tries to persuade her that this time he has really changed, she must be very cautious that it is only another way of trying to convince her to return. He must first learn how to take care of himself, accept responsibility, and make himself feel better before he will be able to be an equal partner in a relationship. So must she.

Discussion and Processing Component

Here is where the women get to talk about their own dysfunctional thinking about their responsibilities in a relationship. It is important to help the women briefly discuss some of the common "shoulds" that they have been socialized to believe. Some of the women will have been exposed to feminist thinking while others may believe in very traditional relationships. The facilitators will need to help women accept all different beliefs while focusing on

independence and interdependence in relationships, rather than dependence on each other so that neither believes he or she can survive without the partner no matter how badly she is treated.

Skill Building Component of STEP 2

Designing a Safety Plan.

1. How does the woman know it is time to leave and seek safety?
   Women are asked to remember the fear that accompanied the last battering incident and then think backwards to as close a point where there was no or little fear. That is the point that the woman must learn to leave. Women must also take all young children with her when she leaves or she will be at a disadvantage if she ends up filing for a divorce and wants sole custody of the children to protect them. Therefore, if the children are at home, she must devise a signal for them to go with her or leave when they hear it and a meeting place depending upon their ages.
2. How can she leave without making him angrier or violent?
   Many women tell the batterer that she intends to leave when she gets scared that he will hurt her but she will return when she feels it is safe again. This helps the man feel that the relationship isn't totally over and he is more inclined to try to charm and seduce her back.
3. What must she do to prepare to leave in advance?
   Put together a backpack or gym bag filled with money, clothing, keys, documents, important telephone numbers, prescriptions for medicines, and school related items for children in advance. Pack up heirlooms that would be emotionally upsetting if destroyed. Make arrangements with a veterinarian to care for any animals as shelters may not accept them. Decide in advance where she might go, such as a friend's home, a family member's home, or other safe place. Purchase airplane or bus tickets, or get maps if she plans car travel. It is important to think all this through before leaving as after the escape, most women are mentally exhausted and need to move on automatic pilot without having to think and make decisions at that time.

4. Designing the actual safety plan
   Since most battering incidents start at home, it is a good idea to design an escape plan by drawing a plan or map of the house and tracing steps to leave. This includes gathering up children and the bag that has been previously packed unless it is safe somewhere else.
5. Rehearsing the escape
   It is important to rehearse the escape plan, first in the woman's mind, then drawing a map on paper, and finally, walking the possible escape routes. Again, it is better to have thought through obstacles in advance as thinking competently when so frightened is much more difficult.
6. Contact with the batterer
   When and how to make contact with the batterer after escaping, should be reviewed by the woman. She needs to think through how she will know he has calmed down. How much time does she need to decide if she wants to go back or stay away? If she wants to be in hiding, she must not contact anyone he might also contact as someone will most likely give away her location. It is difficult for women not to make contact as they want to know if he is coming after them and how angry he is so they can feel they will be better able to protect themselves. For total safety, they should not use credit cards he has access to and pay for what they need by cash or their own personal credit cards. In any case, any planned meetings should be in a safe place with others around to protect her should the batterer be ready to start another incident.
7. Legal Issues
   It is surprising how many women do not know their legal rights and therefore, are vulnerable to believing anything the batterer tells them about taking their children away, taking all their money, leaving them with no property and so on. Making an appointment with a good family lawyer will arm the woman with the information she needs to know to help her make a decision whether to stay in the marriage or leave. It is also good for the woman to bring copies of documents of property and employment records to the consultation.

Exercise

Women will be encouraged to write their own escape plan.

STEP 3 Thinking, Feeling, and Doing

Goals

1. Learning how to distinguish thoughts from feelings
2. Learning how thoughts and feelings impact on behavior
3. Learning how to keep a thought journal

Educational Component in STEP 3

Three Types of Dysfunctional Thought Patterns
There are three types of dysfunctional thought patterns:

1. negative thought patterns about self or others
   These and similar statements speak to the core of our expectations of ourselves and others in the world. These statements are likely to become self-fulfilled prophesies in that if we look for reasons to distrust we will find them, and if we want to believe we are worthless, we will find evidence of our lack of worth.
2. escalating or exacerbating thought patterns
   These types of thought patterns, unlike the previous one may on the surface appear rational, logical, and realistic, but upon closer examination one discovers that they are negative in that they only serve to escalate negative emotions and support negative beliefs about yourself and others. In their extreme form they can be obsessive thought patterns that are very difficult to stop. Sometimes this kind of obsessive catastrophizing actually prevents feeling the high levels of anxiety present in abusive relationships.
3. irrational thought patterns
   These thoughts reflect an unrealistic appraisal of oneself or others because the woman's feelings define her reality. This includes blowing things out of proportion, being in denial and/or minimizing his problems, over-emphasizing the negative, labeling herself or others, making "should" statements, and engaging in mind-reading. Assumptions, mind-reading, and making "should" statements can indicate irrational thinking. Sometimes irrational beliefs can be identified by their all-or-nothing quality signified by using words such as *always, never, forever, nothing,* or *everything*. Many people who get depressed get stuck thinking these kinds of irrational beliefs.

These three types of thought patterns are not uniquely separate and therefore there is some overlap.

Breaking Dysfunctional Thought Patterns

If you observe the following list of rules, you will be able to challenge your negative thought patterns and turn them into more positive and hopeful ones. When you challenge your dysfunctional beliefs:

1. Be specific.
2. Take a look at the evidence.
3. Question your beliefs.
4. Get input from others.
5. Learn to laugh at yourself.
6. Learn the origin of your patterns.

Let's look at each of these rules in greater detail. Although these examples apply to men who stalk/batter, try to change the language and see if they can apply to you, too, especially when you catastrophize.

Discussion and Process in STEP 3

The discussion should focus on the three types of dysfunctional thinking that the women in the group recognize that they make. It is helpful to look at when they use words such as always, never, forever, nothing, or everything and how that impacts on their levels of pessimism or optimism. Many people catastrophize without even realizing they are developing irrational beliefs and then treating them as if they were true. The goal of separating thoughts from feelings should help guide the process.

Skill Building Component in STEP 3

Thought Journal. It is important to take the new information you have learned in this session and apply it to your life right now. Every day you have many thoughts that give rise to feelings and actions that you probably do not pay attention to. In order to get an idea of what your thinking pattern is and how it affects your feelings and behavior, you may begin to keep a "Thought Journal." This is a powerful tool to help you become more aware. Every day, at least once

per day, write down at least one thought you experience about yourself or the situation with your partner. Chances are you will experience these thoughts when you purposely think about your partner, family, or situation. Sometimes these thoughts may just pop into your head spontaneously. After you write down the thought (or thoughts), try to see if it fits into any of the three categories described in this session: That is,

1. Is it a thought that is negative about yourself or others?
2. Is it a thought that leads to more escalated thinking or catastrophizing?
3. Is it an irrational thought?

Now, try to notice how you feel when you pay attention to each thought you have written down. Did it increase your anxiety, depression, or anger? Did it make you feel more overwhelmed or fearful? Did you take some kind of action based in part or because of this thought? Don't try to change whatever thought or feeling patterns you are experiencing now. Just try to be more aware of what thoughts pass through your mind.

Try the reverse, too. If you find yourself feeling scared, fearful, anxious, depressed, or angry, try to pay attention to what thoughts are going through your mind while you are experiencing these intense feelings and write them down, too. This exercise may be quite difficult initially because most of us are not used to paying attention to what we are thinking, but practice will make perfect (an irrational thought)!!! Really, practice will improve your skills! You may want to use the forms provided for you to begin your Thought Journal.

STEP 4 Changing to Positive Thinking and Managing Anger

Goals:

1. To learn how to move from victim to survivor
2. To learn how to turn negative into positive thoughts
3. To learn "thought stopping" techniques

Educational Component for STEP 4

Understanding Anger. Anger is a feeling that is often based on irrational or rational but negative thinking patterns. In earlier STEPs, these negative thinking patterns have been explored. Sometimes it is helpful to try to understand where the feeling of anger comes from. Usually when it feels as if anger is out-of-control, it is because small angry episodes are not dealt with immediately and instead, the angry feelings and resentment build up and boil over. Living with abuse, people learn that they cannot express their feelings of anger at certain times, or they will face the possible explosion with harm from the abuser. Children who grow up in abusive homes learn when and where it is safe to express their angry feelings. But that doesn't mean these feelings go away; rather, they may build up and explode intermittently. Controlling these feelings with substituting negative thoughts for positive thoughts is an important step in getting rid of the anger. Some women may not even recognize that they harbor angry feelings as they have learned not to permit themselves to feel it. But, they do feel the discomfort and need to own and then discharge it. One of the future STEPs will deal with assertiveness; that is asking for what a person wants but accepting that it might not happen. This is an important substitute for not asking for anything but resenting that what you wanted didn't happen. Most importantly, to move from being a victim to being a survivor it is necessary to give up the anger at the injustices experienced as a victim.

Moving from Victim to Survivor

Many battered women get stuck being a victim. They keep thinking obsessively about what happened to them, how unfair it all seemed, and how to get justice from their abuser. Some women want to make their partners understand … understand what it was like for them to be abused, understand how they really feel and understand that they were right and their partners wrong. Some women cannot seem to get over the negative thoughts around having been betrayed and rejected. Thinking and feeling this way, will stop a woman from getting on with her life. While all of this may make a person feel better immediately, a better strategy is to concentrate on turning the negative into a positive and getting on with life.

Positive Thoughts Bring out the Best in You Rather than the Worst.

Take any of the categories described in STEP 3 and turn them into positive thought patterns. In doing so, it will be possible to begin to understand how positive thought patterns can have the reverse effect on you.

It is possible to…

Take negative thought patterns and replace them with positive thought patterns.

Take escalating or exacerbating thought patterns, and replace them with positive thought patterns that calm and reassure.

Take irrational thought patterns, and replace them with thought patterns that are realistic, balanced, have perspective, and are fair assessments of the situation.

Remember, the best revenge is to live well!

STEP 4 Discussion and Process. What positive thought patterns can the women identify about their current situation? Try to help them be as honest as possible when completing this exercise and because many people have the tendency to be superficial.

If someone can't think of specific positive thoughts right now, transform two of the negative thoughts from their Thought Journal into positive thoughts.

Skill Building Component for STEP 4

Thought Stopping. Sometimes, it seems as if everything you do still does not stop a thought from continuing to repeat itself over and over in your mind. Even if you distract yourself for a short time, the thought comes back again and again. It may even come back when you are sleeping in the form of a dream. It is possible to use a technique called thought stopping to help you stop thinking a particular thought by chasing it out of your mind and replacing it with another thought.

Let's try it.

Think of an unpleasant thought that you just can't get out of your mind. Perhaps it has something to do with an intrusive memory, like when your partner scared you badly,

and you keep thinking the same thing is going to happen again. Perhaps this repetitive thought keeps you from doing some things that you always used to like to do. Try to hold the negative thought in your head for a few minutes so the details are really clear.

Okay, now either clap your hands or stomp your feet. Try to do it so hard that you make a loud noise. There! When you heard the loud noise, were you still thinking the unpleasant thought? Probably not, because at the moment of the loud noise, or soon after, the thought was driven out of your mind and replaced by the totality of the experience of the clapping and stomping and the loud noise it made. You have just experienced one way to drive a negative thought out of your mind and replace it with another, more pleasurable, thought.

Let's try it again.

Suppose you are obsessing over the party you went to, yesterday. You keep thinking about the interesting man with whom you were exchanging very quick peeks. You are now wishing you had the courage to go up to him and introduce yourself, saying something very brilliant and witty. But, if you try to switch your concentration to being pleased that you actually went to the party and mingled with other guests for awhile, you will be substituting the positive thought, "I really went alone to a party" for the negative one, "I didn't have the courage to speak to a man I wanted to meet."

It is better to substitute negative thoughts with positive ones, rather than have to clap or stomp your feet all the time. This exercise hopefully demonstrates to you that it is possible to stop obsessing and change your distorted thinking.

Exercise for STEP 4. Continue working in the Thought Journal this following week. Once a day, write down at least one negative thought that you experienced about yourself or the separation with your partner. Challenge each of these thoughts using the rules described in this chapter. Try to restate the thought into a positive statement and then note how you emotionally felt before and after this process. Did completing the exercise decrease your anger, anxiety, or depression? Don't forget, when you find yourself feeling anxious, depressed, fearful, or angry, pay attention to the thoughts going through your head and write them down. This is probably when you are thinking the most negative thoughts.

STEP 5 Stress Management and Relaxation Training

Goals:

1. To identify feelings of anxiety and relaxation.
2. To learn ways of reducing stress, including Jacobson's Deep Muscle Relaxation Training.
3. To begin using relaxation exercise daily.

Educational Component of STEP 5

Stress: What Is It? We are, among other things, physical beings. And as so, we experience times of activity and times of rest—the most obvious being our waking and sleeping hours. At certain points we also experience certain activities that demand more energy than other activities, such as running five miles versus watching television. At times of high activity, our bodies may experience what is known as stress. Stress is the physiological, emotional, and cognitive changes in our body that demand extra energy in order for us to sustain the activity or stressful situation. Common forms of stress include exercise, meeting a deadline at work, or driving in rush-hour traffic. Less common forms of stress include natural disasters, becoming a crime victim, getting into a car accident, and experiencing a fire at home or work. After experiencing a stressful event or period in our lives, it is important to relax so that the body can replenish its energy stores and return to its baseline level of activity. This is why getting a full night's rest is necessary to function adequately the following day. If this rest period doesn't occur, and the stress continues, the system can begin to show symptoms of deterioration in the form of less efficient functioning, physical symptoms, disease or even death.

Difficult times, as well as tragedy are bound to touch your life at one point or another. Therefore you have minimal power over many of the stresses you experience. However, we do have the power to make the experience less or more stressful than it needs to be. Getting a shot in the arm hurts most people. But if we tense our arm just before we get stuck with the needle, the shot is going to hurt more than if we learn to relax those muscles.

Ways to Reduce Stress. Stress can be a significant factor in the psychological impact of a battering relationship. We call the disorder that may result a Post Traumatic Stress Disorder because of the harm caused by too much stress. Stress can cause accidents, create chaos, and in general, negatively impact your mental and physical health. Research has shown links between stress and the breakdown of the immunological system, which keeps you healthy. It is important to try to reduce some of your stress.

The first and most immediate way to reduce the effects of stress on our minds and bodies is through relaxation. Many recent studies demonstrate the beneficial effects of various forms of meditation and biofeedback exercises. These techniques help us relax both mentally and physically, therefore reducing the negative effect that stress has on our systems. There are quite a variety of meditation techniques that will work. In STEP 5, you will use three techniques to relax: visual imagery, breathing exercises, and deep-muscle relaxation.

Discussion and Process for STEP 5

The discussion for STEP 5 focuses the women in the group to think and talk about stressors in their lives. Most of the women will talk about stress and how it impacts on them.

Skill Building Component for STEP 5

This is the STEP that most of the women like the best as they learn how to relax and escape from their problems even if for only a short while. Although it is possible to use any of the three relaxation techniques, it is the Deep Muscle Relaxation technique that remains with the women for the longest time.

Visualization Exercise. Lie down or sit comfortably and pay attention to your breathing from deep within your abdomen. (See the next exercise for tips on breathing more effectively.) After a few minutes, imagine yourself in a place where you would feel very comfortable—at the beach or out in the woods, under a waterfall or in a special room, for example. In your imagination, use all your senses to experience this comfortable place. If you were at the beach you might see the line of the water with the waves breaking,

hear the sound of the waves and nearby birds, feel the warm sun and the sand beneath your body. You may smell the salt in the ocean while lying in the soft sand. In your mind's eye you may wish to explore the scene around you, or you may just want to stay there and relax comfortably in one place. Take as much time as you wish with this exercise—there is no hurry. When you are ready, slowly return to your present surroundings, and again observe your breathing for a few moments.

Breathing Exercises. Another popular method to help you relax is to concentrate on your internal body functions, starting with your breathing so that the regularity of the autonomic nervous system takes over. Using this method, you concentrate on taking a deep breath, from as deep down in your abdomen as you can, perhaps with your tongue placed on the roof of your mouth. Then slowly exhale, letting your tongue fall to the bottom of your mouth as you get rid of all the air you took in. Repeat this breathing in a steady rhythm, concentrating on how your body feels. Go through all your body systems that often tense up, while staying focused on your breathing, too. (See the relaxation exercise below for suggestions on using the muscle systems to do this).

If you have had a baby using the prepared childbirth classes, you may have already learned different breathing techniques that can be helpful when you are feeling tense. Some of the breathing exercises can even prevent tension from building. And, sometimes, using breathing exercises can improve concentration and attention.

Deep Muscle Relaxation. A third popular method for relaxation training is by focusing on the tightness and relaxed state of your body muscles. This is called Jacobson Deep Muscle Relaxation because it was first proposed as a stress-reduction technique by Jacobson in 1938. We will use this method to practice in the session because it can help you pay better attention to the effect of stress and abuse on your body. Most battered women learn how to "not feel" parts of their body when they get scared or anxious. The pain, of course, comes back later on when you are out of danger. Use any of the tapes of Deep Muscle Relaxation here or the facilitator can make his or her own tape for use in the session and to give to the women to practice their exercise at home.

STEP 6 Cycle of Violence and the Psychological Effects of Violence

Goals:

1. Learn about the cycle theory of violence.
2. Identify the woman's own cycle of violence.
3. To learn the time-out technique.

Educational Component of STEP 6

The research has found that there is a three-phase cycle of violence that may be identified in many battered women's experiences of abuse. The first phase is called the tension-building period where things keep escalating despite the attempt to calm down the batterer and stop the abuse from getting worse. Phase two or the Acute Battering Incident occurs when the tension and perception of danger build up so high that it finally explodes. This is the shortest period of the cycle but the most physical and sexual abuse usually occurs here. This is then followed by a period of calm and maybe even loving and apologetic behavior which is the third phase of the cycle, called Loving Contrition. There are different patterns that occur here and they can be placed on a graph to depict them.

Cycle of Violence Exercise

Without intervention and treatment, most batterers will repeat the cycle of violence and, as the cycles repeat, they will generally become more frequent and more severe. Sometimes the remorse and loving-contrition stages will disappear entirely as the severity and frequency of the violence increases. This phenomenon is called the cycle of severity, and is briefly mentioned on the cycle of violence worksheet. This exercise can teach the cycle of violence, point out the similarities in your behavior, and help you identify where you are in the cycle of violence at any given time. You can practice by using the worksheet to check yourself several times a day. The goal is to help you recognize when your partner is building toward an explosion, teach you to better protect yourself, and help you predict if your partner is going to stop and devise a plan to defuse the tension. If tension builds very

rapidly to dangerous levels, you can learn to recognize the early warning signs and leave safely. Obviously while you are separated from your partner, you will be unable to test out any of these new skills. However, it may help to practice thinking about what you might do differently, by reviewing the three different battering incidents suggested.

Identify Your Cycle of Violence. To do this exercise, you will need to remember three specific battering incidents: the first one you can remember, a typical battering incident, and the worst or one of the worst ones. Describe in detail, to yourself or to the group, the first battering incident you can remember. What led up to it? Did you notice any tension before it occurred? What was the worst part of the incident? What happened afterwards? Did he say he was sorry, in some way, even if not in words? What did he do? What did you do? About how long did it take for this incident to occur? What was the longest part? What was the shortest part? Go back to the abuse history checklist that we worked on in Session I and check off each act that happened during this first incident. Now, try to draw the incident with the first part representing the tension rising, the second part representing how bad the abuse felt at the time, and the third part being how good the loving-contrition stage felt at the time. The scale we are using starts with zero tension and rises to level ten, the most serious violence that can result in your possible death. Remember, the tension will probably be lower during this first incident than later on.

First Incident Remembered:

Now, let's go to a typical battering incident. In most relationships there are fights that happen again and again over the same things. Can you think of what a typical fight might be like? Think of a time that one of those fights occurred. Now, while thinking about that battering incident, answer the same questions. Was there any warning, any sign of tension that was building? What happened? Use the abuse history checklist and check off each act that occurred. Did he try to say he was sorry by words or by doing something nice? Describe what happened. Think about how scared you usually are when he does this to you most of the time. Draw the graph paying attention to the tension and danger level.

Typical Battering Incident:

Do the same for one more battering incident, the worst one or one of the worst that happened. Remember to rate the level of tension and danger so you know how high up to draw the graph.

Worst Incident:

Once you have completed this part of the exercise, share what you have written with another group member or a friend who knows what has happened to you, and see if the other person would rate the amount of tension and danger at the same point you do. Remember to use a scale from zero to ten with ten being the worst, the most likely cause someone's death. Turn back now to the earlier pages where you will find diagrams of different patterns of violence cycles. Where does your pattern fit? Did the abuse start off slowly, with verbal abuse escalating to pushing, shoving, hitting, and then get more serious? Did it take a long time till it got more serious? Or, did it start off with choking and threats with weapons and violence that caused other injuries, too? Was there a pattern of loving-contrition that changed to no tension for awhile, or are you always afraid and tense about the possibility that he could kill you at any time? Once you begin to pay attention to your own cycle of violence, it will be difficult for his loving behavior and apologies to have the same control over you. Can you interrupt the cycle and prevent the tension from escalating so it does not reach the second phase? If both you and your partner cooperate, then the cycle can be interrupted. The best way to do this is to recognize the minor incidents that occur in the beginning of Phase I and stop them right then.

Discussion and Process

The women in the group can describe their own cycle of violence and are encouraged to draw the graph that depicts it.

Skill Building Component for STEP 6

Time-Out. This is the activity that most women are terrified to use and yet, it is most helpful in avoiding another battering incident.

Whenever you feel your anger rising, or your body getting tense like it is going to explode, or you begin to feel frustrated or out of control, say out loud to yourself and your partner, "I'm beginning to feel angry, and I need to take a Time-Out."

Leave your home for one hour (no longer and no shorter), during which time you cannot drink, and you should not drive (unless it is absolutely necessary). It is most preferable for you to do something physical like go for a walk or run. If you begin to think about the situation that made you angry, just say to yourself, "I'm beginning to feel angry, and I need to take a Time-Out." In this way you will be taking a mental Time-Out as well as a physical Time-Out. When you return in one hour, tell your partner that you have come back from your Time-Out, and ask if he/she would like to talk with you.

If you both want to discuss the situation, tell them what it was that made you feel angry. You may also want to talk about what it was like for you to take a Time-Out. If one of you doesn't want to talk about the situation, respect that person's need to not discuss it. In either case, if you find yourself feeling angry again, take another Time-Out.

Some topics of conversation may be too charged to talk about. If this is true in your situation, put that issue on the shelf for a while, acknowledging that it is too difficult for the two of you to discuss alone.

Take these issues and others to a counselor to get some help working them out. Even if it's an important issue that is making you angry, think of your priorities. Nothing can be more important than stopping the violence!

Therefore, we encourage you to practice the Time-Out as much as possible so that you will be more likely to use the technique when you need to walk away rather than fight.

STEP 7 PTSD and Battered Woman Syndrome

Goals:

1. To learn how alcohol and drugs contribute to emotional distress.
2. To learn about PTSD
3. To learn about Battered Woman Syndrome.

Educational Component to STEP 7

The Psychological Effects of Violence on Women. We have been focusing on cognitions and behavior up until now. This session will look at how women deal with feelings. When feelings get too intense, it is not uncommon to shut down and stop experiencing them. Battered women use certain coping strategies such as minimization, denial, repression, depression, and dissociation to shut off negative feelings. Sometimes alcohol and other drugs are also used to block feeling the pain.

Violence is trauma. Research has shown that trauma victims have similar reactions no matter whether the trauma is a natural disaster, such as a flood or an earthquake, or a man-made trauma, such as a car crash, sexual assault, or capture as a prisoner of war. In general, trauma victims frequently re-experience the trauma in their minds, causing great anxiety. Over time abused women, like other trauma victims, may become withdrawn or numb to their feelings, and may develop problems with eating, sleeping and a general nervousness that interferes with daily functioning. In addition to these symptoms, victims of man-made trauma, like battering and sexual assault, often have even more serious reactions because of the feelings of betrayal and knowledge that the violence was purposely committed against them.

The typical psychological response to trauma is a **fight or flight** response. When the mind and body prepare to deal with danger, people usually become physiologically and psychologically aroused. This state of anticipation is the **fight** reaction and feels like most other kinds of anxiety. In repeated trauma situations, like those battered women and children face, there are identifiable anxiety symptoms, such as **difficulty in concentration, jumpiness and being easily startled,** more frequent crying or irritability, disruption in sleep patterns, general nervousness, and hypervigilance to other situations that may cause you harm. The autonomic nervous system becomes aroused and remains on alert until it calms down and the biochemical neurotransmitters go back to normal resting state.

Sometimes women who have been physically and sexually abused also develop phobias, or fear of different things, as well as develop eating disorders, and other nervous habits. If a person cannot actually flee from the situation physically, there are ways to mentally get away, which is the **flight** response. These symptoms include the minimization,

denial, repression, and dissociation that we have talked about in earlier sessions as well as depression and avoidance of situations that may remind you of how bad it feels. Repeated abuse also changes the way you feel about people; your feelings become numb so you won't be so badly hurt by what your partner says or does.

Sometimes when women who were abused feel numb, they may purposely expose themselves to something that is dangerous, just to see if there is a reaction. The more different from others that women feel, the more isolated they become. Sometimes, battered women use alcohol or drugs to help them numb their feelings. While these fight and flight symptoms are developing, most battered women also begin to have trouble with their memory. Some things are remembered clearly—even at times when you do not want to remember them, they pop into your mind—while other things are forgotten one minute and remembered the next. Often, only parts of what happened earlier during another battering incident are remembered, sometimes in bad dreams.

These symptoms are called **Post Traumatic Stress Disorder (PTSD)** and are part of the **Battered Woman Syndrome (BWS).** Women who have also been sexually assaulted will probably have some problems with their body image and sexuality. It is common for sexual assault victims not to enjoy sex for awhile, especially if you begin to deal with past traumas of sexual abuse that happened as a young child. Battered women and others who are exposed to family violence are different from victims of other kinds of trauma. Most other victims experience just one traumatic event and then experience a long recovery period where they are able to understand and get over the feelings. Even if a battered woman experiences the same kind of trauma, before a battered woman can recover from the last episode of violence, another battering incident occurs that causes psychological wounds on top of existing wounds.

Discussion and Process

Encourage women to talk about the symptoms that they have that might be part of PTSD and BWS. Women who have become addicted to substances may be willing to talk about how their drinking or use of drugs helps calm down anxiety and stop the intrusive memories of the abuse.

Skill Building for STEP 7

Participants are encouraged to utilize the following stages of chemical addiction to assess their own substance use and that of their partners and other family members.

The Stages of Chemical Use

In order to better determine if alcohol or drugs are a problem in your *life,* it is important to first understand the stages of chemical use. Like domestic violence, alcoholism and drug addiction are progressive problems that have particular characteristics that develop over time. The following model can be used to describe the progression of chemical use:

Experimentation > Moderate Use > Abuse > Dependency > Death

Experimentation. When a person first tries alcohol or another drug it is called experimental use. This type of use may happen once or twice and last for only a very short period of time. After such use, the person decides either that they like it and want to continue, or that they don't want to use the drug again. This experimentation may occur out of curiosity or peer pressure, but in either case the person decides whether or not he/she liked the experience. If they didn't like the effects, they will no longer use that substance.

Moderate Use. If he/she does decide to use again, he/she quickly moves into the second stage of the process, moderate use. During the second stage of this process, moderate use, a person's use patterns are fairly predictable. They may drink on weekends, in social settings or with dinner. The amount of alcohol or drugs used will vary from person to person.

Abuse. When a person crosses over the line from moderate use to abuse, they are beginning to depend on the substance for its physiological and psychological effects. A person's body undergoes changes that make them less sensitive to the effects of the substance. In other words, he/she has to use more to get the same effect.

Dependency. As a person continues to use, he or she will develop physiological and psychological dependency. The person will be compulsive about using. When he or she does use, the person will not be able to control consumption. The person won't be able to have just one drink, one joint or one line of cocaine. He or she may need to use every day in order to avoid severe withdrawal symptoms, or he or she may have a pattern of periodic binging separated by a few days, weeks or months of no or low use. This person may appear to have it together, but people they are close to both at home and work will become increasingly aware of how alcohol or drugs are affecting the person's life.

By this time in the process, the chemically dependent person's life is becoming unmanageable. He or she may be continually involved with the law, having frequent interpersonal problems such as violence and troubles on the job. Problems are beginning to materialize in all areas of life. Most importantly, the chemically dependent person is in such denial that he or she refuses to see the relationship between the use and the person's problems. He or she blames others or relies on excuses as a way of avoiding responsibility for all problems.

Exercise

Continue assessment of family members in their substance use and its consequences.

STEP 8 Grieving the End of a Relationship

Goals:

1. Learn how to deal with when a relationship ends.
2. Learn how to process issues around relationship decisions.
3. Learn how to decide when to begin a new relationship especially around sexual issues.

Educational Component for STEP 8

Steps to Rebuilding Your New Life. Whether or not you decide to stay in this relationship with your partner or terminate the relationship and begin a new lifestyle, it is important to

make a commitment to change and to rebuild your life so it is violence-free with you in charge. There are 15 steps to get to this new feeling of empowerment according to specialists in helping people get through the often painful divorce process. At the bottom of this pyramid, the first emotions to emerge, are the most difficult and by mastering them, you can build the foundation upon which the new, more exciting and positive emotions emerge and rest.

Fisher's Description of the Pyramid of Emotions:

Self-Acceptance of Divorce. This is the center block upon which the others rest. Although divorce is common in our culture, no one wants to find him or herself in that situation. Most women, especially, put all their energy into making the relationship work. To declare that a marriage has ended is a difficult and traumatic step. When a violent relationship ends, so do the hopes and dreams that the man will once again become the kind-loving-delightful partner remembered from the courtship period, before the violence began, and reinforced by his Phase III, "I'm sorry, please forgive me" type of behavior. This intermittent reinforcement makes it more difficult to separate from a battering relationship. However, once you begin to think that living without him is possible, new feelings can begin to be explored.

The following are the next steps in the grieving of a relationship and rebuilding new relationships:

Loneliness, Rejection, Guilt, Self-Concept, Rebuilding Friendships, Love, Disentanglement, Anger, Sex, Trust, Left-Overs, Aliveness, Singleness, Freedom

The goal of empowerment is to be able to say, "Anyone who would spoil a relationship by using violence must have a serious problem because I am such a neat person that I can't imagine why anyone would not want to have an equally sharing, loving relationship with me.

Discussion and Process

Encourage women in the group to discuss what it might feel like to let go of their relationship. What would feel good? What would feel bad? What is their greatest fear?

Skill Building Component for STEP 8

Begin to fantasize the perfect relationship. What would the person look like? What are the most important qualities to you? What qualities are important but not essential? What qualities are not important. Describe how you would want to spend an evening with your perfect partner. What would you do? Where would you go? What would you talk about? Would you want the partner to become romantic? How should he behave? How forward should he be about sex? What signs would you look for about his need for control over you?

Exercise

Observe the behavior of couples. What do you like? What is a turn-off? How do certain behaviors fit with your ideal relationship.

STEP 9 Effects of Violence on Children

Goals:

1. Understand the impact of exposure to family violence on children.
2. Learn more about male and female stereotyped behaviors.
3. Process issues around growing up female.
4. Learn how to change negative to positive behaviors when parenting children.

Educational Component for STEP 9

The Effects of Violence on Children. Children become involved in spousal abuse in a number of ways. Studies indicate that approximately 68% of children living in violent families actually observe acts of violence perpetrated by the adults in the home. Most children have told us that even if they never saw the violence, they knew it was occurring. Some children try to intervene in violent episodes and as a result, may be injured themselves when the abusing father turns his violent actions towards the child. Children may become unintentional victims of violence. For example,

the father throws a plate across the room and unintentionally hits his child. A battered woman may grab her infant to stop her partner from being violent. A child may grab his father's arm and accidentally get hit in the eye with the father's elbow. A man may batter his partner while she is pregnant which puts the unborn child at risk. Some parents also take out their anger with each other by intentionally victimizing their child. The man will batter the woman, who in turn, will be more easily frustrated by the child and may use force to vent her feelings. Many fathers also physically abuse both their wives and children. Whether the child is directly victimized, witnesses the violence or only hears it from another room, the experience is terrifying, confusing, and potentially damaging to his or her healthy psychological and intellectual development.

Research on the effects of witnessing marital violence on children has revealed significant results, helping us understand the generational cycle of violence. The studies looked at how child witnesses manifest their problems at various ages. Preschoolers and elementary school children show greater psychosomatic complaints, such as stomachaches, headaches, and imagined illnesses; school phobias, bed-wetting, and difficulty sleeping. Older children show more sex-specific behaviors. Boys tend to be more aggressive and disruptive in school and other social settings, whereas girls have more difficulty concentrating on school work. The greatest differences are apparent during adolescence. Boys tend to use force to solve interpersonal conflict, and are vulnerable to acting violent with girlfriends and mothers. Girls have feelings of worthlessness and depression, negative attitudes towards marriage, and distrust of intimate relationships. In general, children who have been exposed to high levels of violence in their families tend to find conflict emotionally threatening, which causes a great deal of anxiety in social problem solving situations. This anxiety may actually interfere with their ability to step back and rationally decide the best way to approach the problem.

Other studies have compared children who witnessed violence with children who have been physically or sexually abused and have found that even though the psychologically abused children (child witnesses) are not being physically or sexually traumatized, they are being psychologically traumatized just the same, and the effects are as devastating for the child witnesses as the other types of abuse victims. Children

who grow up in violent families need to talk about the abuse, their feelings and thoughts. Your children may at some point need to tell you how the violence has affected them. We are not recommending that you initiate this conversation right now. First your children need to speak with professionals trained in this area, and only when they are ready should you approach this issue with them.

Discussion and Process. This topic usually brings lots of discussion from the women in the group about their fears for their own children. They talk about the exposure to violence and their concern that the children are not being well protected especially as they are in jail. Guide a discussion about the women's own childhood and the kinds of abuse they may have witnessed or experienced as a child. What kind of effects do they think it had on them? Have these effects impacted on their relationships, on their ability to parent their own children, or in other areas of their lives?

Skill Building for STEP 9

Helping Children Heal from Exposure to Domestic Violence. If your children were exposed to or experienced violence, there are several things you may be able to do to help them. First, remember that dysfunctional families will impact each child in a family in a different way, depending on their biological constitution, emotional make-up, intellectual development, and social and cultural influences. Sometimes, family violence polarizes the family with some children taking the mother's side and some children taking the father's side. If a separation or divorce occurs when children are in their adolescent years, it is not uncommon for some of the children to choose loyalties by how much money and/or freedom they can get. It is important to keep contact open with your child, even if he or she chooses not to see you for some time. Often men who batter women force the children to make these difficult choices between themselves or you. Most children want to continue their relationship with both parents should there be a divorce. So, it is in the best interests of a positive long-term relationship with your children for you not to regulate the time they spend with their father unless you have reason to

suspect abuse. Be clear that you will always be their mother and leave all lines of communication open.

The more power you give your children to determine how much time they spend with their father, the better their adjustment. You may not have any choice if the court specifies visitation or custody. But, if you do, try to make visitations fun and returning home even more fun.

Although learning how to negotiate a custody battle is beyond the scope of the empowerment program, it is important for you to know that many battered women worry about protecting their children without any assistance from the court. Should a custody battle become inevitable, the best gift you can give yourself and your children is to hire the best lawyer you can afford. Find out what lawyers have been successful with other battered women since this is a special area of the law. Interview a few lawyers before you make a decision, and select the one who seems to have the best legal skills and treats you with respect. Make sure the judge also respects your lawyer; many women have lost custody when their lawyers offend the judge. Remember, you can always find a counselor or advocate to help you deal with your emotions; you need a good lawyer to deal with the complex legal issues.

Changing Negative to Positive Behaviors with Children. Studies of children who grow up to use aggression and of those who do not give us some important clues as to how to change the risk factors if your children were exposed to violence in the family. Of course, if they are also exposed to violence in their neighborhood, as many children today are, then it is even more important to keep the home as violence-free as possible so they can learn better ways to resolve conflict. This means not using physical punishment but rather discipline through discussion and "time-out" behavior as we learned in the earlier session.

Studies of psychologists Gerald Patterson, John Reid, and their colleagues at the Social Learning Research Institute in Eugene, Oregon give us some of the best prevention ideas. They went into the homes of aggressive boys and found that there were more negative interactions between the children and the parents than in homes where boys did not use aggression. There, the parents interacted with more positive statements and behaviors. Interestingly, in homes where there was abuse as well as negative verbal encounters, the

interactions usually were from more powerful males to the less powerful females. These interactions came in bunches, with a lot of negativity and abuse, then a lot of positive interactions, perhaps like Phase III loving-contrition.

So, the best way to help your child grow up without being aggressive is to interact in a positive way. This means compliment them and say positive things to them at least several times a day. Remember, children want to please and they will repeat behavior that they get rewards for doing. The strongest reward is social or parental approval. Surely, this should be easy for you now, especially since you have learned to change negative thinking into positive thoughts! Find nice things to say and do. Remember to hug your children, even if they are grown, and tell them you love them every day!

STEP 10 Learning to Ask for What You Want

Goals:

1. Learn about Assertiveness Training.
2. Process issues around feelings about making choices and expressing them.
3. Learn positive and negative outcomes of being assertive.
4. Learn to identify cognitive distortions that prevent assertive behavior.

Educational Component to STEP 10

Assertiveness Training. Assertiveness training is the name given to the process of learning how to clarify what it is that you want, how to effectively attempt to get it, and how to accept your inability to get what you ask for when you have tried everything to get it. In the 1960s every women's group was learning how to be assertive: how to ask for what you want, directly and without any apologies. Assertive people use "I" statements rather than statements that blame the other party. Although you may not always get what you want when you ask for it, the very process of asking, helps raise your self- esteem. How assertive do you think you are? You will have an assertiveness inventory to complete for homework this week. But, turn to it now, in

your handout and look at some of the areas in which assertiveness is measured.

Can you tell someone else that he or she is behaving in an unfair way? Can you directly ask for what you want in different situations, like asking your boss for a raise, or, asking a salesperson to replace a defective pair of shoes, or, asking for help to find a missing item in the supermarket? These situations all have different emotional components that may interfere with assertive behavior. There are a number of good assertiveness training books that you can read to help you become more assertive. Most of the information takes you step-by-step through making the decision about what is important to be assertive about, then how to differentiate assertiveness from aggressiveness. Let's look at some ways to move from being angry and aggressive to being assertive. Look at the following exercise in your handout that describes angry behavior and see if you can change the statements into more positive, assertive ones.

Discussion and Process. It is common to confuse angry and controlling behavior with assertiveness especially for women who have lived with controlling and abusive behavior. Discussion around the differences between these kinds of behavior and assertiveness is important to facilitate. Examples that illustrate the difference may be helpful. Have women who have used assertive behavior describe their experiences.

Skill Building Component for STEP 10

Moving from Acting Out Angry Feelings to Being Assertive. If you are angry, you would:

SAY hurtful things, call others names, make fun of them, exaggerate their faults, and accuse them of having motives about what they do that cannot be proven.

If you are assertive, you would:

SAY why you feel angry by confronting them using "I" statements and honestly explaining how you were affected by their behavior. An "I" statement would go like this:

"I feel very angry and hurt when you take my favorite shirt and wear it without asking my permission. I would appreciate it if you would ask me next time before you borrow it."

If you are angry, you would:

BLAME others for what has happened whether or not it is reasonable that they caused the problem or whether you had something to do with the problem, too.

If you are assertive, you would

TAKE RESPONSIBILITY for what part you play in the problem but also confront the others who may have contributed to it, too.

If you are angry, you would:

ACT extra nice and try to please because you are afraid that if you show how angry you are feeling, you will get hurt.

If you are assertive, you would:

CONFRONT the reason you are angry and try to get the issue resolved in a non-violent way.

If you are angry, you would:

LAUGH or become funny or even rude as a way of covering up your unacceptable angry feelings.

If you are assertive, you would:

BE HONEST about being upset and angry about something specific, but not attack anyone with your angry feelings.

You probably will not follow through on your promises if you made them when you were angry. Although a little anger may actually help motivate someone to do something, anger is such an intense emotion that it takes up all the energy, and too much can prevent anything else from getting done.

Eating or sleeping patterns are often disrupted when someone is feeling intense anger.

Withdrawal is another response to angry feelings. Sometimes someone who is angry **does nothing** or sulks and pouts.

Destroying property, such as slamming doors and breaking things, is another way some people act out angry feelings.

Playing music real loud is another way to express angry feelings. It can be done because it focuses the angry person's mind on something else that might soothe the anger, or it may be a demonstration of disrespect for other people's feelings when someone is angry.

Exercise

Complete the following Assertiveness Inventory this week. Think about what situations are easy for you to behave in an assertive way and what situations are so filled with emotion

that it makes it difficult. For example, many women find it easy to learn how to tell someone that they should not cut into line in a public place like the supermarket or bus stop. But, some people find that too threatening since it is public, and would rather confront a friend, privately, who asks you to do something you consider unethical. Our culture and history helps to explain why one type of behavior might be easier than another to practice. Also, complete your Thought Journal for this week.

STEP 11 Building Healthy Relationships with Good Boundaries

Goals:

1. Learn how to set limits and boundaries in relationships with women, men, family, friends, and children.
2. Describe positive and negative experiences with boundary setting.
3. Learn how to positively confront others.

Educational Component for STEP 11

Setting Boundaries. Setting boundaries of how far someone can expect another person to help and how much can be obtained from another person is a part of empowerment. It is important to still be helpful to others while also setting limits that prevent being taken advantage of or taking advantage of others. Learning to set appropriate boundaries will assist in building healthy relationships with romantic partners as well as family and friends.

Abused women have learned that many men try to take advantage of women. These men expect to be dominant and have the power and control in their families because of sex-role socialization in their culture. Sometimes they use verses from the Bible to support their demands that a woman be subservient to a man. Religious leaders tell us that the Bible does not justify beating a woman, and in fact, there are many verses to support equal treatment between men and women. Has your partner misused religious and cultural information like this, too? This behavior does not bode well for an egalitarian relationship. Egalitarian does not mean equal but rather each party brings something special to the

relationship and must be respected for his or her contribution. In egalitarian relationships, each person is able to participate in negotiating the roles and tasks he or she wishes to do in the relationship. Since some jobs must be done by one or the other, negotiation will assist in making those choices rather than by gender.

Most people need a certain amount of "space" in which to be free to think about and do what feels right for them. If you are like others, this space separates you from anyone else. Those who grow up in a close and healthy family where everyone shares everything that the family has can still develop a certain core sense of self that separates you from others. But, in unhealthy, dysfunctional and often, abusive homes, those boundaries between yourself and another person become blurred.

Self-protection in abusive homes includes developing sensitivity to always know what other powerful figures are thinking and feeling. If there is any hint of trouble, the victim learns to rush in and do something to keep the situation as calm as possible. The need to repeatedly be sensing the moods of others leaves a child, especially, vulnerable to not developing that sense where she or he begins and the other person leaves off. When adults overpower a weaker person with their demands, they also are violating that person's boundaries. So, if you weren't able to develop clear boundaries when you were developmentally supposed to do so, it becomes more difficult to do so later on.

Why do we all need boundaries?

Suppose you are a child and are visited at night by your father, who doesn't ask permission but simply takes his sexual gratification with you. In doing so, we say that he has violated your boundaries. He has used you for his own purposes without regard for your rights. Then, you grow up and marry a man who also does not respect your setting your own limits about how you want to be treated. He believes that he is entitled, to tell you what to do. He takes control of your life. Again, you do not have the chance to create your own boundaries because he sets the limits to what you do. Then, later on you are asked by your boss to help out. There are many problems and lots of help is needed to meet a deadline. You agree to work 12 hours a day to help get the job done without thinking about your need for recreation, sleep, or any other scheduled activities. Again, having no sense of

your own boundaries, you would be prone to being taken advantage of. This can create an unhappy situation for you and perhaps, for the organization.

In another example, it is your turn to try to find a store that sells a certain kind of medicine for your child who is ill. You are told by your local pharmacy that the medicine is not available. You ask the pharmacist to go to a branch store and get the drugs for you. You feel that this person "owes" this to you because you have always shopped in this store and have exchanged pleasantries with the pharmacist before. However, the pharmacist says that he cannot leave his store to go to pick up the medication. You become very angry, probably more angry than the situation calls for, but recognize that other factors have caused anger to build up. When you calm down, you realize that your expectations that the pharmacist leave the store to get something for you was unreasonable. The extreme nature of your anger in relation to the disappointment is a clue that it is mixed up with other feelings of being taken advantage of in situations. Sometimes your anger goes away almost as quickly as it arose. But that kind of anger does interfere with all kinds of relationships.

Discussion and Process. Encourage discussion about setting boundaries and how to avoid being controlled by relationships. Women in the group will think about their relationships with friends, family, children and significant others. Do they give away all their power? Do they nurture everyone but themselves?

Skill Building for STEP 11

Confrontation. Think back to a time when you were able to confront your mother or father and tell them you didn't like something they were doing and wanted them to stop. What happened? Were your feelings respected? Did your parents react in a way that frightened you as a child? Did you get what you needed, or were your boundaries violated? It is common for those who were exposed to abuse in the family to want to please the other family members. Battered women are pleasers most of the time. They feel safer when they have done something nice for someone else as that person will like them and hopefully, be less inclined to get upset and harm them.

Now, think back to a time within the last few weeks where you confronted someone and told them what you didn't like and what changes you wanted. How did you feel about having the confrontation? Is it easier if you are the one who does the confronting or if someone else confronts you? Was there anything you could do to make you feel better about it? Better preparation? Do you feel better about yourself when you recognize that you have limits, boundaries that cannot be violated? Which boundaries do you still need to work on? Do you have a plan?

Exercise

This week write an essay on what it means for you to be a woman. How did you learn the female role? What do you like about the role, and what do you want to change about your female role? Is the role of being a woman compatible with being a strong business person? How do you want a man to treat you? What aspects of your socialization would you want to change? What aspects do you wish would recur?

Continue working in your Thought Journal everyday this week. You should continue to note the types of dysfunctional thought patterns, and challenge them using the rules described earlier in the group. Also pay attention to how you feel before and after challenging your dysfunctional thought patterns. Don't forget to note any positive thoughts about yourself and your situation.

STEP 12 Terminating Relationships

Goals:

1. Coping with loss and ending positive relationships.
2. Learning to terminate group.
3. Making future plans.

Educational Component for STEP 12

Termination of the Group. This session will be mostly a process session to end the group. Process, if you haven't figured out already, is a term used by counselors and therapists meaning that you are working through some feelings. The feelings

we will deal with today include sadness at facing the end of this program, although there may be some ambivalence, too. For example, it may be nice to have some extra time where you don't have to rush to make it to a meeting, even though it is usually difficult to give up the relationships made with the other group members. But, if you have stayed with it until now, you probably feel a lot wiser but less intelligent than when you started. Wiser, because you learned a lot. Less intelligent, because you are probably wondering how come you didn't know all this, anyway, and wondering how you are going to continue without your counselors for guidance. If you have uncovered some buried memories or just some uncomfortable information about yourself, you may want to go into individual therapy. Find a therapist who is well-trained in abuse issues and is licensed to practice, and continue working on becoming a survivor. If you have made it through the program, then you are ready to go forward.

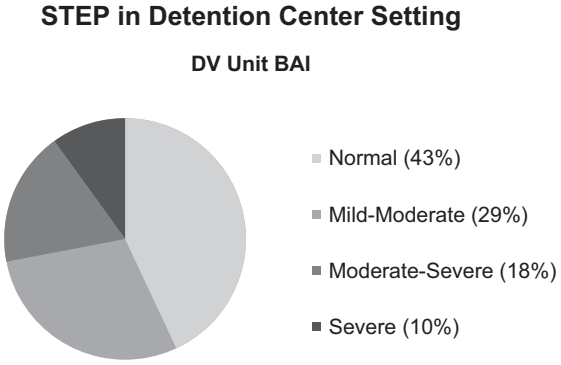
Empirical Findings

As was mentioned earlier, we used this group format with two groups in the jails. One group had volunteered for the domestic violence program which called for 30 to 60 days in that unit and the other group was for those who were identified as having a problem with substance abuse and also called for a 60 day stay in that unit. In the substance abuse unit, the program was called "life-skills" and was often court-ordered. The program consisted of several different "skills" training and our STEP program was considered part of it, so the women were more likely to attend the group to get credit towards completion of their court-ordered program. Even so, the attendance was uneven and in neither group were there women who completed all the STEPs. This was usually due to the interference with court hearings, other programs, or early discharge back to the community or to prison.

We attempted to use a variety of psychological assessment instruments before the groups began and after they were over. However, we only obtained pre-test scores for a small number of women who actually completed different STEPs. Since many of the initial participants did not remain until the end of the program, we abandoned the post-tests and instead administered the Beck Anxiety Inventory (BAI)

16.1

Beck Anxiety Scores for Domestic Violence Group Pre-STEP Program



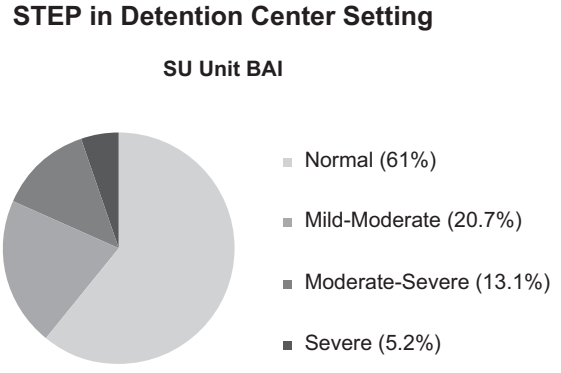
after each session. The initial BAI scores for the domestic violence group as shown in Figure 16.1 showed that almost half (43%) of the women initially did not have a significant amount of anxiety when the group began although almost a third (29%) of the women did have mild to moderate anxiety and another quarter of the women had moderate to severe (18%) or severe (10%) anxiety.

In the substance abuse group, even fewer had severe (5.2%) to moderate-severe (13.1%) anxiety with another fifth (20.7%) with mild to moderate anxiety and 61% reporting normal levels of anxiety on the BAI as shown in Figure 16.2.

When combining all the scores for both groups, Figure 16.3 shows the larger number of normal BAI results with a smaller number of mild to moderate, moderate to severe, and severe scores.

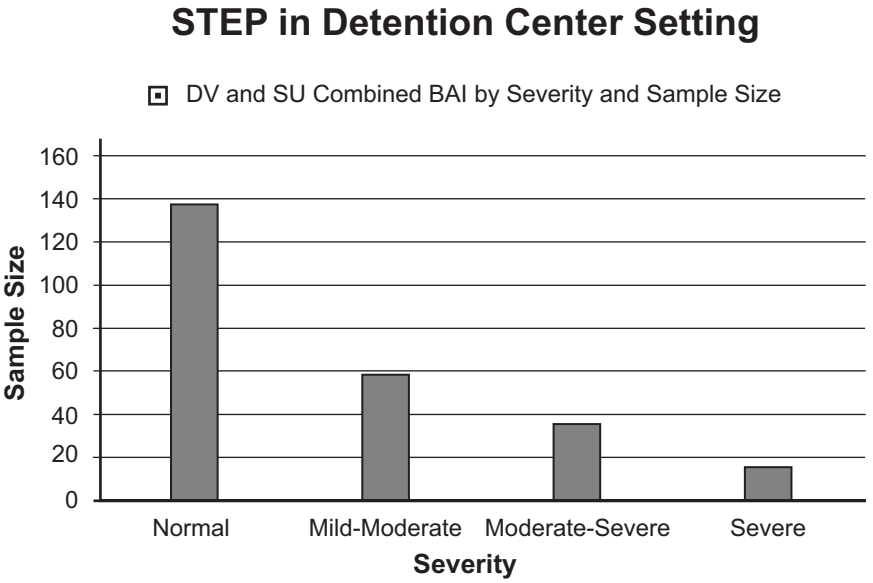
16.2

Beck Anxiety Scores for Substance Abuse Group Pre-STEP Program



16.3

Beck Anxiety Scores for both Domestic Violence and Substance Abuse Groups Combined.

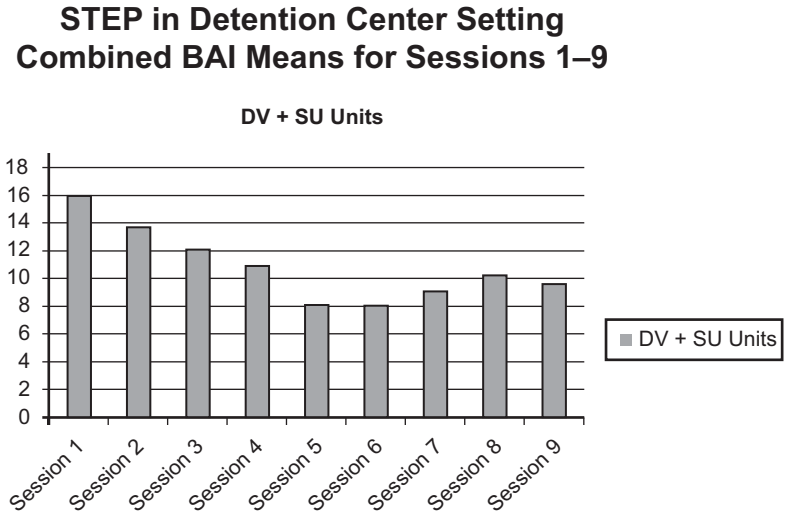


Using the combined groups over the first nine sessions, Figure 16.4 demonstrates the reduction in anxiety scores over time. Interestingly, STEP 5 and STEP 6 show the greatest reduction, perhaps because relaxation training is taught in STEP 5 and anger management is taught in STEP 6. While is might have been expected that anxiety levels would go up in STEP 6 because the women are taught the three-phase cycle of violence that will remind them of their own abuse, the reduction in anxiety remained. The rise in anxiety for session eight may reflect the topic of substance abuse that is discussed there and grieving and children were the topics for STEPs eight and nine respectively.

The Detailed Assessment of Posttraumatic Stress (DAPS), a standardized measure of impact from one particular stressor for both domestic violence and substance abuse unit participants is show in Figure 16.5. Here it can be seen

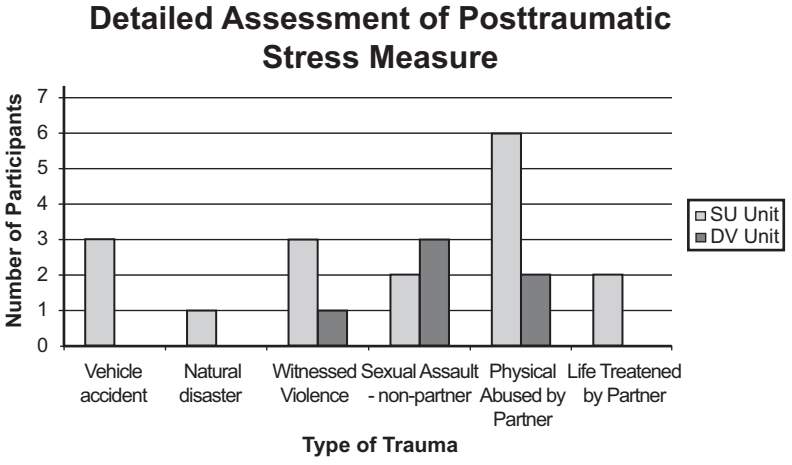
16.4

Beck Anxiety Scores for both Domestic Violence and Substance Abuse Groups Combined after STEPs 1 through 9.



16.5

Detailed Assessment of Posttraumatic Stress Test (DAPS) Scores for Both Substance Abuse and Domestic Violence Groups in STEP



that more women in both units experienced domestic violence and sexual abuse than other forms of trauma, although most were experienced.

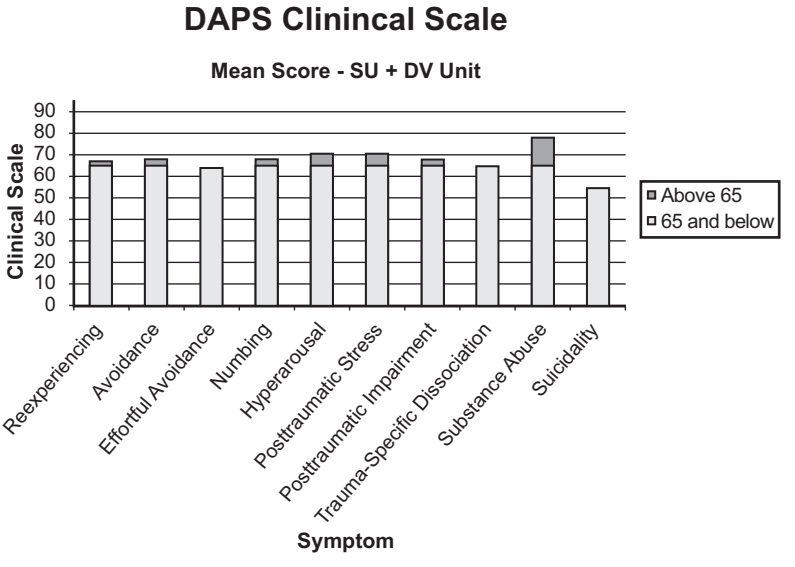
Figure 16.6 indicates the specific clinical scales for both groups on the DAPS showing the small number of women who actually demonstrated statistically significant scores. As might be expected, the highest scale was substance abuse but other scales were also elevated.

The clinical consequences from interpersonal trauma in both units were also measured using the Trauma Symptom Inventory (TSI). This test assesses symptoms that are mentioned. Interestingly, the group results did not show significance (above 65) in any of the scales although several were approaching significance as is seen in Figure 16.7.

Assessment of alcohol and drug abuse for women in both groups was also done before the STEP program began. Figure 16.8 shows those scales comparing both groups. As

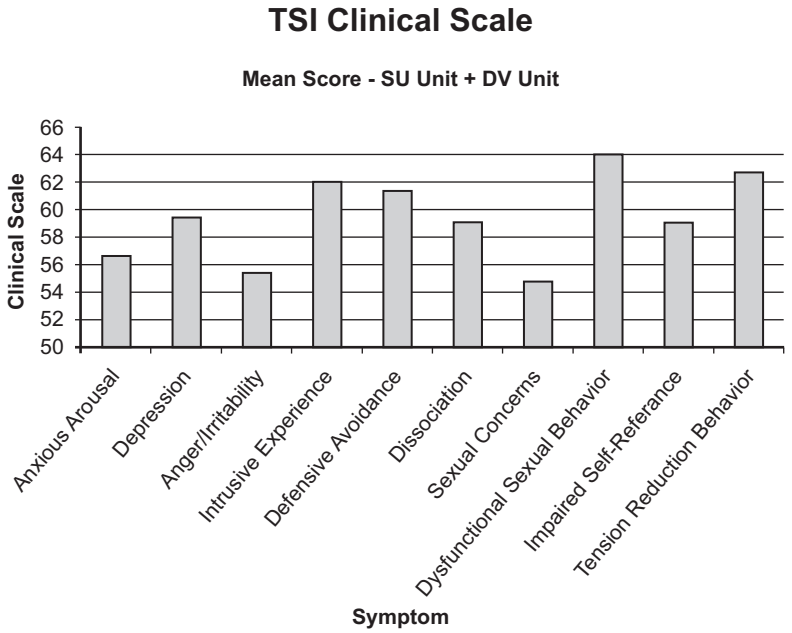
16.6

Significant DAPS Clinical Scores for Domestic Violence and Substance Abuse Groups



16.7

Trauma Symptom Inventory Clinical Scales for Domestic Violence and Substance Abuse Groups



can be seen, the substance abuse group indicated more problems with abuse of substances than did the domestic violence group.

While these assessment instruments could not be used to demonstrate post-test efficacy, except for the BAI scores that were repeated at the end of each session, they do demonstrate the ability to measure the effectiveness of the treatment program. The next STEP program will use the tests at the end of each session to determine if the effectiveness occurs again. Since some of the women will transfer from the jail groups to STEP groups in the community, we will be better able to follow up over a period of time, also.

Summary

The STEP program was conducted in the jail for a second round of 12 sessions with a better ability to obtain some data indicating the effectiveness of these groups despite difficulties in their administration in the jail. The outline of what is done in each of the STEPs was presented in this chapter. A more complete version of the program including a manual is in preparation.

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