The Feminist View of Wife Battering and the Use of Feminist Therapy with Battered Women

Mary R. Zapart
Loyola University Chicago

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CHAPTER 1
INTRODUCTION

The problem of domestic violence and battered women has been well documented and established over the last 15-20 years. Domestic violence is prevalent in every social, economic, racial, and religious group and is the leading cause of injury to women. Approximately thirty to forty percent of the women murdered in the United States are killed by their husbands, ex-husbands, boyfriends, or ex-boyfriends (Federal Bureau of Investigation (FBI), 1994; Gelles & Straus, 1988; Lockhart, 1987; Straus and Gelles, 1990). In the mid 1980's, FBI statistics indicated that in the United States, a man beat a woman every 18 seconds. By 1989, that figure was every 15 seconds. In 1992, it was every 12 seconds, and in 1994, it was every 9 seconds (FBI, 1982, 1986, 1994; French, 1992; Jones, 1994).

Domestic violence consists of physical, emotional, or sexual abuse between people who are married, living together, or have an ongoing or prior intimate relationship. Although domestic violence can be directed at either partner, studies have consistently found that 95-97 percent of the victims are female, and 93-97 percent of the abusers are male (Dunford, Huizinga, & Elliot, 1990; Elk & Johnson, 1989; Sherman & Berk, 1985; U.S. Department of Justice, 1991). National Crime Survey data, studying violent offenses against women between 1979-1987, found that women were victims of violent intimates at a rate three times that of men, and that women were six times more
likely than men to be victimized by a spouse, ex-spouse, boyfriend, or ex-boyfriend.

During that nine year period, spouses, ex-spouses, and boyfriends committed 4.2 million violent victimizations against women, an average annual of almost 472,000 (U.S. Department of Justice, 1991).

Groundbreaking books such as Del Martin's *Battered Wives* (1976) and Lenore Walker's *The Battered Woman* (1979) exposed and explored the myths and facts about battered women and domestic violence. Since then, there have been numerous studies examining the reasons, dynamics, and consequences of domestic violence, and theorizing about prevention and treatment strategies (Pagelow, 1992). Domestic violence is of concern to psychologists, sociologists, and feminists who are attempting to help women end the repeated violence they are experiencing at the hands of their loved ones (Yllo & Bograd, 1988).

Over time, the focus has shifted from studying only the pathology of the individuals involved to studying the problem as a social issue. Because the abuse is directed toward women, the issue has also been examined from a feminist perspective. Russell (1988) classifies theories of wife assault into either psychological, including psychoanalytic and family systems theories; or sociological, including feminist theories. The feminist perspective towards domestic violence is the perspective examined in this thesis.

A feminist approach to domestic violence emphasizes the dimensions of gender and power in the abusive relationship and in marriage in general. Feminist theorists call attentions to the biases in using a non-feminist approach to conceptualize and treat.
domestic violence (Yllo & Bograd, 1988). A feminist perspective states that woman abuse continues to occur because of an inequality of power between women and men (Bograd, 1990; Schecter, 1982; Yllo & Bograd, 1988).

Feminist researchers, clinicians, and activists ask the question, “Why do men beat their wives?” rather than “What psychopathology leads to violence?” or “How is violence in the family related to our violent society?”. Instead of examining why this particular man beats this particular wife, feminists seek to understand why men in general use force against their partners (Chapman and Gates, 1978; Dobash and Dobash, 1979; Martin, 1976; Pagelow, 1981; Schecter, 1982; Walker, 1979, 1984; Yllo and Bograd, 1988). Feminist analysts see the institutions of marriage and family as special contexts that may promote, maintain, and even support men’s use of violence against women (Bograd, 1988).

The growth of feminist activism revolving around domestic violence led to the battered women’s movement during the 1970’s and 1980’s. The political activism of the battered women’s movement was instrumental in the development of battered women’s shelters, safehouses, and social service agencies specifically targeted to the needs of battered women attempting to escape their abuse (Carden, 1994; Schecter, 1982).

The women’s movement also provided the impetus for feminist research into the mental health establishment, finding it a particularly misogynist and oppressive subculture that served the interest of the patriarchy and pathologized the traditional sex roles and socially created problems that women face (Burstow, 1992). In an often cited research study of sex role stereotypes (Broverman, Broverman, Clarkson, Rosencrantz,
& Vogel, 1970), both male and female mental health practitioners equated the definition and perception of a "socially competent adult" as synonymous with the definition of a "socially competent man" with sex role traits such as assertiveness and independence. Women were considered "socially competent," when they were more submissive and emotional and less competitive and objective than either a "socially competent man" or a "socially competent adult" of unspecified gender. Similar results were found in a more recent study by Swenson (1984). Studies such as these validate the need for an alternative to the male biased mental health models in existence. Feminist therapy has emerged and grown as a result of this growing research into alternatives to existing male based therapy systems.

Although feminist therapy has no specific founder, certain principles exist as to what constitutes the feminist therapy value system. Feminist therapy emphasizes sexism as a reality in our present system and one of several contributors to women's misery. Feminist values and counseling techniques promote egalitarian rather than hierarchical relationships, respect for the client's inherent expertise about herself, and acceptance of negative feelings as normal, expected responses to oppressive conditions in society (Greenspan, 1995; Rosewater & Walker, 1985; Sturdivant, 1980; Zerbe-Enns, 1993).

Some theorists believe that a feminist therapy approach may be integrated within any psychotherapy model, such as psychoanalytic (Alpert, 1986; Chodorow, 1992; Sullivan, 1989; Young-Eisendrath, 1987), family systems (Bograd, 1984, 1988; Braverman, 1988; Hare-Mustin, 1978; Luepnitz, 1988) and behavioral (Fodor, 1985, 1991). Others (Brown & Brodsky, 1992; Burstow, 1992; Walker & Dutton-Douglas,
1988) see feminist therapy as distinct from traditional therapy theories, even those modified by feminist principles. Some feminist therapists believe the specific therapy techniques used are not as important as the communication of the feminist value system to the client (Walker & Dutton-Douglas, 1988; Zerbe-Enns, 1993).

Three important aspects of feminist therapy are the issues of power, sex roles, and relationships. Feminist therapy works on empowering the client to recognize her strengths and choices. Traditional sex roles are discussed and examined in order to help the client understand how adherence to these roles has influenced the client’s choices in her life. Also, the therapist/client relationship is modeled as an egalitarian relationship, and special care is given to allow the client to establish her own goals and pace and to be an equal partner in the therapy process (Gilbert, 1980; Greenspan, 1983; Rosewater & Walker, 1985; Sturdivant, 1980; Zerbe-Enns, 1993).

It is those three issues, power, sex roles, and relationships, that are especially relevant in using feminist therapy with battered women in light of the feminist analysis of wife battering. A battered woman can learn how to use outside sources and discover her own strengths to gain personal and interpersonal power. She can become aware of societally imposed restrictions on women and explore a range of options and choices in her own best interest. She can learn and practice being in a relationship that allows for her own needs to be identified and met. Although there is a difference between the immediate crisis intervention needs of a battered woman and her longer term therapy issues, a feminist therapy approach appears to be a logical choice in helping battered women at all stages.
A recent development in the treatment of battered women is the use of the diagnosis of post-traumatic stress disorder (PTSD) in order to provide a framework for understanding and treating the trauma of the ongoing battering (Browne, 1993; Dutton, 1992; Walker, 1991, 1994). Walker (1994) and Dutton (1992) have further expanded on feminist therapy principles and developed therapy approaches for battered women which take feminist therapy a step further by also treating the battered woman's psychological trauma.

Purpose of the Study

Over the past 15-20 years, the battered women's movement and the feminist movement have been instrumental in developing a new approach to treating battered women. The purpose of this thesis is to provide a review of the current research on the feminist perspective on domestic violence and on the use of feminist therapy with battered women in light of its apparent theoretical appropriateness.

The fact that this thesis focuses specifically on the battered woman's treatment seems to be a contradiction of the feminist viewpoint of wife abuse. A research focus on the battered women, rather than on the patriarchal structure of society which supports the battering, has been feminists' main criticism of traditional research on woman battering (Bart & Moran, 1993; Dobash & Dobash, 1979, 1992; Schecter, 1982; Stanko, 1985; Stark, Flitcraft, & Frazier, 1979) since it implies that the woman has some personality trait(s) that make her especially vulnerable or partially responsible for the abuse. Feminists believe that researchers and activists must shift from perceiving of male violence against women as a psychological problem to analyzing the structural and
institutional supports for violence against women (Bart & Moran, 1993; Yllo & Bograd, 1988).

As the focus of this study is on the battered woman's issues, I will examine the battered woman's psychological symptoms in their sociological, feminist context in order to discover her immediate and longer term needs, and the potential for meeting some of those needs with feminist activism and feminist therapy. As Walker (1991, p. 22) states:

...politically, it is believed that only changes toward a more egalitarian society, not psychotherapy, will eradicate such violent behavior.

However, it can be acknowledged that appropriate psychotherapy can be beneficial to help the individual woman victim deal with the psychological consequences of domestic violence so that she can become a survivor.

(Douglas, 1987; Rosewater, 1988; Walker, 1984a, b)

This thesis will provide a feminist analysis of research showing the causes and effects of the battering, the psychological issues the battered woman faces, and the process and use of feminist therapy in empowering the battered woman.

Limitations of the Study

The scholarly study of domestic violence has exploded in the past twenty years with research being conducted across many perspectives including the legal, political, medical, psychological, sociological, and religious fields. The unit of study may be the battered woman, the abusive man, the couple, the children, the family, women as a group, men as a group, or society as a whole.
This study focuses specifically on the sociological causes and psychological consequences of battering on the battered woman in a heterosexual relationship and therapy issues for the woman from a feminist viewpoint. Studies used in this thesis are primarily from social work, psychology, interpersonal violence, family violence, and feminist books and journals. This narrow focus may seem to oversimplify the complexity and multi-disciplinary nature of the study of domestic violence. Also, psychological and sociological theories that did not explicitly consider the roles of gender and power dynamics in the battering relationship were not included in this study. By focusing only on the feminist viewpoint, the potential interaction between individual and societal factors is not considered here.

Another limitation of the study is that many research studies focus only on physical violence, as it is the most measurable form of abuse. It is important to note that psychological, sexual, and property violence often occurs along with the physical violence and may be underreported in studies that only measure physical abuse. Also, in studies using clinical samples of battered women found in shelters, caution must be used in generalizing findings to all battered women. Shelter samples represent women who have taken steps to escape the abuse by leaving their homes. This active help-seeking behavior may be reflective of the severity of the violence in the relationship, the woman’s resolve to escape, or the lack of other social supports. Their behaviors, attitudes, etc. may not be the same as battered women who are still living with the batterer. Similarly, caution must be used when studying nonbattered women, since samples of nonbattered women are often taken from the general population. Given the prevalence of violence
against wives, the assumption that these women are not the victims of violence by their male partners may be erroneous.

**Definition of Terms**

**Wife abuse**: Male violence against their intimate female partners regardless of actual marital status. May take the form of (a) physical abuse: violent acts carried out with the intent to control or injure the woman; (b) psychological abuse: using isolation, intimidation, or fear as a means of control; (c) sexual abuse: marital rape or forcing the woman to perform sexual acts against her will; and/or (d) economic abuse: control of household money or property.

**Battered Women or Battered Wives**: Women who have been subjected to physical, psychological, sexual, and/or economic abuse by their male intimate partners.

**Domestic Violence**: Physical violence between married or intimate partners.

**Patriarchy**: A system having two basic components: A structure in which men have more power and privilege than women and an ideology that legitimizes this arrangement.

**Feminist Therapy**: A psychotherapy approach that incorporates the principles of feminism in therapy by recognizing the situational context of women's lives and acknowledging sexism as a major oppressor of women. The major goals of feminist therapy are to empower individual clients and to advocate for equality.
Summary and Organization of Thesis

This chapter presented an introduction to the feminist perspective on wife abuse and the use of feminist therapy to help battered women. The purpose of the thesis, limitations of the study, and definition of terms were presented.

In Chapter 2, I will provide an overview of contemporary feminist theories and research about wife battering with a specific emphasis on feminist views of the battered woman's issues. Historical and institutional factors supporting men's violence toward wives and obstacles faced by battered women will be discussed.

Chapter 3 combines the feminist approaches of studying wife abuse with the applications of feminist therapy in order to examine how feminist therapy is being used with battered women and the effectiveness of this approach. I will also discuss feminist models for treating the effects of PTSD with battered women. Specifically, I will be reviewing the literature in order to answer these questions: How is feminist therapy used to treat battered women? When and where is it used? What are the results of using feminist therapy with battered women?

Chapter 4 offers a summary and discussion about the feminist view of wife battering and the use of feminist therapy with battered women. How effective is feminist theory and therapy in understanding and ending men's violence against women? Limitations and suggestions for further research are also presented.
CHAPTER 2
A FEMINIST CONSTRUCTION OF WIFE ABUSE

The feminist viewpoint validates battered women’s experiences, is angered by victim-blaming models, and locates the abuse of women in an historical political context as part of the subjugation of women (G. Walker, 1990). Three main features distinguish the feminist analysis of wife abuse from other psychological and sociological views. These features are the belief that wife beating is part of male violence against women vs. part of family violence or individual pathology, the use of feminist language to understand and describe wife abuse, and the use of feminist research methods to study wife abuse. A description of each of these features follows.

Components of the Feminist View

Focus on Male Violence Against Women

Kurz (1989) looks at the difference between family violence research and feminist research on wife abuse and states that a family violence focus suggests individual and family pathology is the cause of wife abuse. A feminist perspective suggests that the causes of wife abuse in the family are largely a result of male domination and institutional support of violence (Bart & Moran, 1993; Bograd, 1990; Davis & Hagen, 1992; Jones, 1994; Yllo & Bograd, 1988).
The feminist viewpoint of wife battering contends that it is just one example of male violence against women including rape, sexual harassment, pornography, and obscene phone calls (Bart & Moran, 1993; Stanko, 1985; G. Walker, 1990). According to this viewpoint, all implied or actual violence against women benefits men as a whole by maintaining their control over women and reminding all women of their vulnerability to men’s power. All forms of male violence against women keep women “in their place” and therefore benefit all men. A feminist definition of male violence against women has expanded to include verbal threats and abuse, economic deprivation, sexual coercion or deprivation, and the creation of a general climate of fear that limits the full participation of women in society (G. Walker, 1990).

Use of Feminist Language

Because of the preponderance of findings that the majority of cases of domestic violence involve the male partner abusing the female partner, terms such as domestic violence, conjugal violence, spouse abuse, and family violence mask the reality that nearly all cases involve male to female violence. Instead, feminist researchers use the terms battered woman, battered wife, wife abuse, and wife assault to more accurately describe the reality of the battering relationship (Hoff, 1990; Kurz, 1989; Lamb, 1991).

The definition of terms and careful attention to language is an important issue in the feminist viewpoint, since specific terms that accurately reflect reality are viewed as important tools to use in exposing the myths about wife battering (Bograd, 1988; Hoff, 1992; Lamb, 1991). For example, the use of the term “battered women” was the result of
the battered women's movement's efforts to bring the problem of male violence against
women to public attention and to graphically depict the real injury being done to women
by their male partners (Schecter, 1982). Feminists also believe that battered women need
to be able to understand and name the abuse for what it is as a first step toward recovery
(Kelly, 1988; Jones, 1994).

Lamb (1991) did a study of 46 research articles on wife abuse published between
1986 and 1987 in 11 journals representing psychology, social work, family
therapy/development, and sociology. She looked for sentences in which the abuse by
men was obscured by language that involved diffusion of responsibility (such as the
terms "spouse abuse," "family violence," etc.), acts without agents/passive voice (stating
that women "had been beaten" but not by whom), acts without agents/nominalization
(calling men's violence "the violent behavior," "the abuse," etc.), victims without agents
(referring to the woman who the men had injured without reference to the man who
abused her), and gender obfuscation (obscuring the gender of the violent man and the
injured woman by using the words "victim," "mate," "assailant," and "perpetrator").

Lamb noted that she was "surprised at how rarely the language projected an
image of a man harming a woman" (p. 255). She found that at least half of all the
sentences about abuse did not specifically hold the man responsible for his violence
toward his female partner. The most common problem was diffusion of responsibility,
found in 46% of the sentences. She found that articles written by men or by men and
women in partnership were more likely to write problematically (M=56.54) as women
who wrote alone or with other women ($M=38.74$). Lamb notes (p. 255), “Feminist theorists would claim that a style of writing so advantageous to violent men is neither accidental nor the product of editorial demands.” Lamb observes that even the term “battered woman” is problematic since it has lost its graphic connotations and does not hold men specifically accountable for their violent acts.

Fine (1993) describes problems with the term “battered woman” for a different reason. She discusses a study with Schecter and Phillips that interviews women survivors of male violence and finds that the women are distancing themselves from the term “battered woman” because they feel they do not fit the category. They do not see themselves as battered women for various reasons, for example, because they hit back, or they do not feel helpless, or they are ambivalent about the abuser or the relationship. A woman may not describe herself as a battered woman because the term may suggest to her a helpless victim doing nothing to try to survive or someone subjected to constant serious physical assaults (Jones, 1994). Similarly, Kelly (1988) found that while many women in her study did not say they were raped, they described being forced into sexual activities against their wills. The word “rape” to them constituted a violent attack by a stranger in a dark alley, not an act by a husband, relative, or acquaintance.

While it is important that women be able to define and describe the abuse (Kelly, 1988), caution must be used in order to avoid imposing labels on women that they may not be comfortable accepting or may not express that woman’s particular reality. Feminist activists have been instrumental in calling attention to the real issues women
face through the use of strong feminist language and terms such as battered women and marital rape, but individual women may not be ready to see themselves or their situations in those terms (Jones, 1994; Kelly, 1988). Therapists and researchers need to allow women to express themselves in their own terms and must validate their definitions of their experiences.

Use of Feminist Research Methodology

Feminist research is based on the position that although researchers attempt to be "value-free," all research is taking place in a social context that is patriarchal and characterized by the domination of men over women. This leads to biases that are unrecognized and unacknowledged. Feminist researchers openly communicate their values in order to balance the unspoken and inherent values of traditional research and therapy practice (Bograd, 1988; Greenspan, 1995).

Feminist research may be either quantitative or qualitative. The distinguishing features are that the feminist viewpoint is openly expressed and that research questions are asked and results reported in consideration and acknowledgment of the context of women's status in society and in marital relationships (Hoff, 1990; Murphy & O'Leary, 1994; Smith, 1994; Yllo, 1988).

Schechter (1982), in her analysis of violence against women in the family, notes that two questions need to be examined in order to understand wife battering. The first question is "Why do men batter women?" This question must be addressed in order to develop a social theory of why men as a group direct their violence against women in
general and their wives in particular. The second question to be asked, only after answering the first question is “Why do women stay with abusive men and why can men get away with beating women?” (p. 224). Wife abuse researchers are still asking and studying those same questions (Barnett & LaViolette, 1993; Bograd, 1988, 1990; Carden, 1994; Jones, 1994). A feminist analysis of these two questions follows.

Why Do Men Batter Women?

Patriarchy and Wife Beating

Feminist viewpoints consider the family as an institution that embodies the political oppression of women on a personal level (G. Walker, 1990). Traditional marriage is seen as a central element of a patriarchal society and actually maintains the patriarchy (Martin, 1976; Yllo & Straus, 1990).

Martin (1976), Dobash and Dobash (1979), and Schecter (1982), provide powerful historical analyses of male domination over women in general and wives in particular. Early marriage laws recognized the family as the domain of the husband and forced women to conform to the man’s will. The wife was essentially the property of her husband. Slowly, the legal and moral authority that husbands have held over their wives has loosened through the 19th and 20th centuries, but the patriarchal legacy that supports a husband’s rights to control his wife have persisted (Dobash & Dobash, 1979; Schecter, 1982, G. Walker, 1990). Although most of the gross inequities have disappeared in western society, women are still subordinate to men and are frequently the victims of male violence (Smith, 1990). Research studies have provided support for
the feminist theory that there is a relationship between patriarchy and violence against women.

Yllo and Straus (1990) examined the relationship between wife beating and patriarchal social structure and the relationship between wife beating and patriarchal social norms using U.S. state census data and research results obtained from Straus, Gelles, & Steinmetz's (1981) first national family violence survey. They defined patriarchal social structure as the status of women as a group compared with the status of men as a group in key institutions—economic, educational, political, and legal—using a Status of Women Index. They then ranked each state from least to most egalitarian.

To measure the ideological component of patriarchy, or the patriarchal norms, they measured the degree to which state residents believed that husbands should dominate family decision making and have "the final say." Again, the answers were aggregated, and the states were ranked from those having the least to those having the most patriarchal norms.

The results indicated a curvilinear relationship between patriarchal structure and the rate of wife beating. As expected, wife beating was highest in states where structural inequality was greatest. As the status of women improved, the rate of wife beating declined; however, in the top five highest ranking states, wife beating was also very high. Yllo & Straus interpreted these results as the operation of two different dynamics. The low status states may have the most wife beating in order to maintain the low status of women where they have fewer alternatives to violent marriage. The violence in the high
status states may reflect increased marital conflict in which the husbands feel threatened by the rapidly changing sex roles and balance of power between men and women.

Yllo & Straus found a linear relationship between patriarchal norms and wife abuse. The more patriarchal the norms about marital power, the more wife abuse. The rate of wife abuse in states with the most male-dominant norms at 6.2% was double that in states with more egalitarian norms at 3.1%.

Coleman & Straus (1986) analyzed nationwide data examining the attitudes and behaviors of male-dominated couples, female-dominated couples, and egalitarian couples. Egalitarian couples had the highest consensus regarding power distribution and the lowest rates of conflict and violence. Male-dominated couples had the lowest rate of consensus about the legitimacy of power distribution, the highest levels of conflict, and the second highest violence rates. Female-dominated couples had the highest rates of wife abuse. These results coincide with Yllo & Straus’ conclusions that men may beat their wives because they feel threatened by the nontraditional sex roles and power balance.

Men’s Belief in Stereotyped Sex Roles

Some studies have found a relationship between wife beating and men’s belief in traditional sex role expectations. Walker (1984), in interviews with battered women, discovered that battered women perceived their batterers as having more traditional sex role expectations than nonbatterers with whom they had also been intimately involved. Telch & Lindquist (1984) also found that violent husbands were significantly more likely
than nonviolent husbands to have traditional sex role attitudes. Other studies attempting to distinguish violent from nonviolent husbands based solely on their sex role attitudes failed to find a significant relationship between sex role attitudes and wife beating behavior (Dutton, 1988; Neidig, Friedman, and Collins, 1986; Rosenbaum & O'Leary, 1981).

Although research is inconclusive about the relationship between holding rigid sex role attitudes and wife beating, research that includes measures of men’s approval of the use of violence against wives along with their sex role attitudes does indicate a positive relationship between the attitudes and the abusive behavior (Smith, 1990; Stith & Farley, 1993).

Smith (1990) examined whether the individual men who beat their wives adhere to an ideology of familial patriarchy compared to the men who do not beat their wives. Smith’s study examined the ideological component of familial patriarchy, which are the beliefs and attitudes behind the patriarchal structure. Feminists have noted that even as patriarchal social structures are slowly eroding over time, patriarchal ideology remains strong (Ferraro, 1988; Schecter, 1982; G. Walker, 1990). Smith defined familial patriarchal ideology as a set of beliefs that legitimized male power and authority over women in marriage and a set of attitudes or norms that support violence against wives who violate the patriarchal ideals. He focused on the themes of a wife’s obedience, respect, loyalty, dependency, sexual access, and sexual fidelity.
Scores on Smith's Patriarchal Beliefs Index and Approval of Violence Index were positively related to measures of wife beating. The more patriarchal the husband's beliefs and attitudes, the more likely he was to be violent toward his wife. Thus, Smith found support for the feminist theory that men who hold attitudes and beliefs that support familial patriarchy and are more approving of the use of violence against wives are more likely to beat their wives than men who do not hold such beliefs.

**Attitudes Approving of Wife Beating**

The feminist hypothesis that society's attitudes about violence and distribution of power in the family are related to violence against wives has received some research support. Dibble and Straus' (1980) national survey revealed that 24% of males and 22% of females viewed minor violence between spouses as normal. Gentemann (1984) in a survey of women, found that 19% of women accepted that wife assault was sometimes justified. Greenblatt's 1985 study revealed that 25% of college males and 14% of college females agreed with the statement that assaulted wives enjoyed being hit. While these results do not show if the same people holding these attitudes are the same people involved in abusive relationships, these studies do indicate that there is at least a portion of the population that views wife assault as normal and/or acceptable.

Smith (1991) examined the attitudes of male friends of abusive husbands to determine if the friends of wife assaulters were more likely to approve of violence against wives than male friends of nonabusive husbands. He also studied to what extent this male peer approval reflects an ideology of familial patriarchy. His results did provide support
for the hypothesis that husbands who physically abuse their wives get social support for this behavior from male peers and that such support reflects an ideology of familial patriarchy.

**Institutional Support for Male Violence Against Women**

Traditionally, institutions such as religion, criminal justice, health care, and mental health have provided little assistance to women seeking help from battering. Often the response is based on victim-blaming and/or patriarchal values and reflect an ignorance of the woman's reality and the context of her situation (Dobash & Dobash, 1979; Hoff, 1990; Schecter, 1982). Feminist research and activism have been influential in educating and changing procedures in these institutions, but woman-blaming attitudes and myths still prevail. Battered women having the courage to seek help from these institutions not only are often not adequately served, they are often victimized again by those they turn to for assistance. Each of the institutions mentioned above will be discussed.

Religion, patriarchy, and battered women. Many domestic violence experts have contended that traditional theologies have contributed to the victimization of women by using the Bible as evidence that God ordains patriarchy and women's inferior status to men (Dobash & Dobash, 1979; Pagelow, 1981; Stacy & Shupe, 1983; Walker, 1979). A battered woman seeking help from her minister, rabbi, or priest may be told that, in accordance with theological beliefs, a wife is subordinate to the husband, marriage is an unalterable life commitment, or suffering is the lot of the faithful (Clarke, 1986).
Fortune (1993) contends that violence against women is fostered by society's notion of amorality that is often based on religious teachings. She states that religious institutions promote the acceptance of violence against women by their depiction of women as the ultimate source of evil and destruction, implying that women are legitimate targets of violence. Also, society's difficulty in naming violence against women as morally wrong or as sin is said to promote the acceptance of such violence.

Alsdurf (1985) mailed questionnaires to 5700 Protestant ministers in the United States regarding their experiences and views on counseling battered women. His results indicated that 84% of the respondents had counseled battered women, and their views on patriarchy, among other beliefs, affected their responses to the abused women. Twenty-six percent of the surveyed ministers believed that a wife should submit to her husband and trust that God would reward her submission by either stopping the abuse or giving her the strength to endure it. Approximately 50% of the ministers cautioned against overemphasizing the husband's aggression and using it as an excuse for breaking up the marriage. One third of the ministers surveyed felt that only severe abuse justifies a wife leaving her husband, and 21% believed no matter what the amount or severity of the abuse, it is not justification for breaking up a marriage. Only 17% believed that occasional physical violence was reason enough to allow a woman to separate from her husband. Alsdurf's findings support the view that abused women who turn to religious leaders for advice and assistance are likely to encounter patriarchal views that are
accepting of wife beating. Alsdurf believes that the clergy's responses in his study mirror society's acceptance of patriarchal practices.

Criminal justice, patriarchy, and battered women. Ferraro (1993) states that since the criminal justice system is designed to protect the social order by punishing individual deviance, and since a feminist analysis of wife battering blames male violence on class, race, gender, and privilege rooted in the social order, not on individual pathology, then by design, the criminal justice system is working in opposition to a feminist analysis of wife beating. Ferraro further states that violence inflicted by dominant groups, such as white male property owners, against their subordinates, such as slaves, wives, and children, has historically been accepted by the criminal justice system as necessary and just.

Police departments have traditionally viewed family violence as noncriminal acts and have avoided getting involved in what they consider a "family issue" (Waaland & Keeley, 1985). Waaland and Keeley found that one of the reasons police cited for their lack of response to domestic violence calls is the reasoning that if he beats her and she stays, there are no real victims. Police generally view battering in gender-neutral terms as a problem between two equal family members (Ferraro, 1993). Dutton (1988) estimated that the police arrested suspected batterers only 21% of the time, even in the face of direct evidence of assault.

Although laws against domestic violence are now in place in all 50 states (Jones, 1994), police enforcement of the laws is often lacking. Even in states with mandatory
arrest policies, police must evaluate and interpret the events they observe to determine probable cause for arrest and fault. If officers decide both partners are equally to blame, both partners will be arrested (Dobash & Dobash, 1992). In some cases, the same woman who called the police for help was arrested and put in jail (Ferraro, 1989).

Thanks to the activism of the battered women’s movement, considerable progress has been made in the area of law, policy, and police training regarding the protection of battered women (Dobash & Dobash, 1992; Ferraro, 1989). Studies still indicate, however, that women seeking help from the police and criminal courts are often met with unhelpful and even harmful responses (Ferraro, 1993; Jones, 1994).

Health care, patriarchy, and battered women. Research has found a discrepancy between women who come to health care providers with symptoms related to ongoing abuse and appropriate detection and intervention by medical staff (Hilberman, 1980; McLeer & Anwar, 1989; Stark, Flitcraft, & Frazier, 1979). Studies of emergency room and hospital personnel have found that medical personnel neglected to appropriately document and treat, beyond presenting medical symptoms, obvious victims of battering in a majority of the cases (Kurz & Stark, 1988; Warshaw, 1993).

Kurz and Stark (1988) reviewed two studies of emergency medical response to battered women. In the first study, even though the hospital had adopted a procedure to use with battered women which includes referral to counseling or a shelter, 80% of the women positively identified as assaulted by a male intimate were not referred. While only 4% of nonbattered women received labels in their medical records, 20% of battered
women were given labels such as "neurotic female," "hypochondriac," and "well-known woman with vague complaints." A majority (86%) of all the women who received labels from medical personnel in their records were battered women, implying that the labels serve as a "flag" to justify a punitive response, according to Kurz and Stark.

In their second analysis of the medical response to battered women, Kurz and Stark (1988) studied the interactions between battered women and emergency room staff at four different emergency rooms. Two staff views about battered women emerged: Staff characterized the battered women as "evasive," even though the women provided explicit information about their abuse; and they viewed the women as "repeaters," implying that battered women could readily stop the assaults if they really wanted to. These analyses showed that women with injuries received by their male partners were stigmatized and labeled, and were seen as mentally ill or as "deliberate deviants" for refusing to change their situations to prevent the abuse (Kurz & Stark, 1988).

Warshaw (1993) analyzed emergency room records of encounters between medical staff and 52 battered women with a high probability that they were assaulted by a male intimate partner at a hospital with a formal protocol for identifying and treating battered women. In the majority of the cases, the women gave strong clues about the abuse, and although the clues were recorded, they were directly addressed by medical staff in only one case. In all cases but one, the domestic violence was not mentioned in the discharge diagnosis or disposition of the case despite its continued risk to the patient. Warshaw states, "Physicians in other clinical situations would not discharge a patient
from the emergency room with a potentially life threatening situation” (p. 138). The hospital’s formal protocol recommended a psychiatric consultation and a social work consultation, or at least a referral list of shelters and other resources be provided to a suspected battered woman; however, there was no psychiatry consultation in 96% of the cases, no social work consultation in 92%, and no referral list given in 98% of the cases.

By medicalizing the problem and addressing physical symptoms only, medical staff reinforce the feelings of helplessness, isolation, and futility the woman may already have been feeling and invalidate her experience. Reducing the battered women’s experience to mere medical facts and not acknowledging the battered women’s reality recreates the abusive dynamic and reinforces battered women’s needs to distort and hide her reality in order to avoid the pain of revictimization (Warshaw, 1993). The medical model with its focus on reducing symptoms to categories it can handle and control is harmful to women in the same way the traditional scientific research method with its inherent patriarchal bias is harmful to women (Kurz & Stark, 1988; Warshaw, 1993; Yllo, 1988) because these models do not take into account the context of women’s experiences.

**Mental health, patriarchy, and battered women.** The mental health profession’s use of psychiatric diagnoses, labeling, and the medical model with women has been criticized by many feminists because of their inherent male based assumptions and definitions about “normal” vs. “crazy” behavior. Traditional mental health approaches have been called “misogynist” because of their failure to address women’s oppression
and the context of women’s lives (Burstow, 1992; Kaplan, 1983; Rawlings & Carter, 1977; Rosewater, 1988a, Sturdivant, 1980).

Mental health personnel tend to define the problem of wife battering as one of individual pathology (Bograd, 1990; Davis, 1987; Kurz, 1989). Psychiatry has been notorious for blaming and labeling battered women, considering them to be masochistic (Shainess, 1979), pathologically dependent (Smith, 1984), or partially to blame for the abuse (Dobash & Dobash, 1992; Hilberman, 1980).

Mental health practitioners may fail to distinguish the symptoms of victims of violence from the symptoms of those who may legitimately suffer from mental illness. Rosewater (1988a) found that Minnesota Multiphasic Personality Inventory (MMPI) profiles of battered women could be misinterpreted as schizophrenic or borderline profiles by practitioners not aware of or sensitive to the women’s exposure to repeated violence.

Family therapy has also been particularly harmful to battered women (Bograd, 1984). Seeing a violent husband and battered woman in the context of systems theory implies that the woman is partially responsible for the abuse directed toward her. Also, a battered woman is unlikely to feel free to completely express herself in a therapy session with her abusive partner in the room and the real threat of facing further violence from him after the session (Bograd, 1984).

Feminists conclude that traditional mental health interventions to domestic violence emphasize attempts to keep the family together or reinforce “appropriate” sex
role behavior and actually set the stage for the violence to continue (Schecter, 1982; Stark & Flitcraft, 1983). The current mental health system, which relies heavily on individual diagnosis and treatment, runs the risks inherent in using the medical model (medicalizing women’s reality into symptoms) and labeling (reducing women’s reality into terms based on male norms).

Feminist mental health researchers and practitioners have developed and refined feminist therapy theories and techniques that address the biases of traditional theories and therapies and reflect the reality of women’s lives. Feminist mental health approaches with battered women will be discussed further in Chapter 3.

**Why Do Women Stay with Abusive Men?**

A commonly asked question about women involved in a relationship with an abusive man is “Why don’t they just leave?” Battered women’s advocates note that the question itself denotes blame of the battered women and puts the responsibility for the men’s violence on the victims of that violence. Jones (1994) notes that the question “Why don’t they leave?” which has just been asked of women in the past 20 years, assumes that there are now social and institutional supports in place for the women who leave. The question blames a woman for not leaving based on assumed options for women just as women who do leave are often blamed for destroying the traditional family. While society blames women for not leaving, it does not take the responsibility to keep all women safe from violence (Hoff, 1990; Jones, 1994).
Herman (1992) states that women may have trouble facing the facts of sexist violence directed against them. Most women instead deny the degree of men’s hostility toward them and prefer to see male-female relationships as more benign than they really are. Women like to believe they have more power and freedom than they actually do.

Research has found that battered women commonly do attempt to leave their batterers several times before successfully escaping them (Follingstad, Hause, Rutledge, & Polek, 1992; Gelles & Straus, 1988; Gondolf, 1988; Hoff, 1990; Okun, 1986; Strube & Barbour, 1983; Walker, 1984). Sullivan (1991a) reported that 95% of her sample of shelter residents left the assailant at least once prior to the current separation, and 15% had left more than ten times in the past. The escalation of the violence provides the main impetus for women to leave their abusive husbands (Kalmuss & Straus, 1982; Walker, 1989b, Wilson & Daly, 1993). Women also leave when they see the effect of the violence on the children or when the men start abusing the children (Walker, 1984).

Research with battered women has found several factors that conspire to keep women trapped in abusive relationships. Several of the commonly cited reasons given for remaining with or returning to abusers follows.

Lack of Access to Resources

A critical reason why so many women remain with or return to their abusive husbands is the lack of access to adequate community resources such as housing, legal assistance, employment, education, finances, and childcare that would allow them to live...

Gondolf’s study (1988) of more than 6000 residents of 50 battered women’s shelters examined the battered women’s help-seeking behaviors. He found that although the battered women persistently contacted community sources for help, they rarely received enough assistance to allow them to leave the relationship for good. Also, those who turn to battered women’s shelters are often turned away due to lack of available space (Frisch & MacKenzie, 1991).

Economic Dependence/Inequality

Men’s use of violence for control over their wives is perpetuated not only on norms about a man’s rights in marriage, but also by women’s continued economic dependence on their husbands. This economic dependence makes it difficult for a woman to leave her violent husband, especially with the inadequate resources for child care and job training that many women face (Dobash & Dobash, 1992; Hoff, 1990; Kurz, 1989).

Studies have found that employed women are more likely to leave the relationship than unemployed women (Aguirre, 1985; Hilbert & Hilbert, 1984; Johnson, 1992; Stacy & Shupe, 1983; Strube & Barbour, 1983, 1984). Stacy & Shupe (1983) reported the most frequent response women gave for returning to abusers was economic reasons (30%).

Batterers often use economic abuse such as threats or prevention of economic security to maintain power and control over women. By using violence or threats to keep
women from working outside of the home, the batterer further restricts the woman’s ability to escape the relationship (Pence & Paymar, 1986). Shephard and Pence’s study (1988) found that battering negatively impacted the work records of wives who did work resulting in the women’s absenteeism, lateness or leaving early, batterer harassment at work, and job loss. In addition, 33% of the women in the study reported their batterers prohibited them from working; 59% were discouraged from working; 50% were not allowed to attend school; 24% were discouraged from attending school; and 21% were prevented from finding work due to the abuse.

Kalmuss & Straus (1982) found that wives who were economically dependent on their husbands were more likely to remain in an abusive relationship than wives who were not. Further, many women remained in relationships because of their perceived dependence on their husbands, regardless of the actual economic situation. Frisch & MacKenzie (1991) noted that women who did not escape battering relationships were more likely to report feeling unable to succeed in the workplace than women who did leave the relationship.

Women who do leave their abusive partners without viable economic and social resources may find themselves facing “the feminization of poverty.” Sixty five percent of black children live in a family headed by a single mother, and 45% of all American families headed by a single mother live in poverty (Jones, 1994). Female workers still earn about 60-70% as much as male workers (Gelles & Straus, 1988), and 80% of women who work full time earn less than $20,000 per year (Faludi, 1991). Battering is
also considered a major cause of homelessness for women and children who have no other alternatives to a violent home (Hoff, 1990; Jones, 1994).

**Fear**

Threats and intimidation are common and successful persuasive techniques used by batterers to prevent their wives from leaving them. While in the relationship, batterers often threaten their partners with more severe violence or murder if the women attempt to leave them (Wilson & Daly, 1993). Other threats batterers use are that they would hurt or kill their wives’ children, friends, family members, or coworkers, keep the children away, destroy property, take all the money, or kill themselves (Barnett & LaViolette, 1993). The batterer’s assaults and threats are coercive tactics that serve to terrorize the woman and keep her under his control (Campbell, 1992; Pence & Paymar, 1986; Wilson & Daly, 1992).

A woman who does not leave her batterer or who returns to him after leaving because of fear of increased violence or murder is acting in a manner based in the reality that the woman is indeed at increased risk at the time of separation. Research has shown that the abuse often escalates at the point of separation, and batterers are more likely to kill the woman upon separation than at any other time (Smith, 1990; Sullivan, 1991a; Walker, 1989b; Wilson & Daly, 1993). Batterers who continue to stalk and assault their estranged wives often have the mentality, “If I can’t have you, no one will” (Campbell, 1992; Wilson & Daly, 1993).
Women's Belief in Stereotyped Sex roles

According to Walker (1989b), the socialization process of little girls teaches them to grow into women who accept men's "temper tantrums." Women are trained to believe that men are naturally "imperfect," and women must tolerate every imperfection in the men they love in order to receive love in return. Battered women, like most women in our culture, are trained to make excuses for men's imperfections even at the risk of their own well-being. The battered woman often blames herself for his behavior, for example, believing that if only she had been a better wife, he wouldn't have hit her.

Girls often grow up learning the value of relationships and to keep relationships together at all costs. Gilligan (1982) discovered that boys and girls differ in their moral development and reasoning. While boys tended to value justice, girls tended to value relationships in their decision-making processes. This research has important implications in the dynamics of family relationships as women have been socialized to see themselves in relationship to others, especially in the roles of wife and mother. For a woman to separate from her husband, even if he is abusive, goes against everything she has been socialized to believe about what a woman "should" do. Battered women's repeated forgiveness of their violent husbands reflects their socialization about what they have been consistently taught is their role in relatedness and caring for others (Hoff, 1990).

Cycle of Violence

Walker has proposed (1979) and documented (1984) a "cycle of violence" theory that can serve as a useful model in studying the progression of violence in marriages.
According to Walker, the battering cycle has three distinct phases. The first phase is the tension building phase in which the batterer increasingly uses control tactics such as verbal abuse, threats, and minor physical violence. The abused woman often attempts to please or pacify the abuser during this phase. Interviews with battered women revealed their denial of the impending violence, rationalizations for the abusive behavior, or an unrealistic belief that the women could control the abusers and prevent the abuse. Some women who realized the inevitability of the upcoming battering incident actually provoked the abusive incident to “get it over with” (Walker, 1984).

The second phase is the acute battering incident, in which the batterer unleashes a barrage of psychological and physical violence which had been built up during phase one. It is in this phase that the woman experiences the most severe injuries and may involve outside intervention such as police or medical care. Women often express a futility in trying to escape from the batterer during this phase. The acute battering phase is concluded when the batterer stops, and there is a sharp psychological reduction in tension. The tension reduction in itself is reinforcing, and thus the violence “works” in bringing about the reduction of tension.

The third phase is the honeymoon or loving contrition phase in which the batterer may apologize, show kindness and remorse, and shower the woman with gifts and/or promises. He may believe that he will never be violent again, and the woman, at least early in the relationship, may believe him and feel hope in his ability to change. A honeymoon-like period follows, and this phase provides the positive reinforcement for
the woman to stay in the relationship. During this phase, the battered woman sees the
“real” man she fell in love with and re-experiences her loving, supportive feelings toward
her partner (Barnett & LaViolette, 1993). Phase three could also be characterized as an
absence of tension or violence without any loving contrition behavior and still be
perceived as reinforcing for the woman. The honeymoon phase has also been said to
cause battered women to develop “learned hopefulness” that the batterer will change his
abusive behavior or personality (Barnett & LaViolette, 1993; Frisch & MacKenzie,
1991; PageKow, 1981). Eventually, the couple drifts into a new tension building phase,
and the cycle repeats.

Over time in a battering relationship, tension building becomes more common or
more evident and loving contrition declines and eventually disappears (Carlisle-Frank,
1991; Walker, 1979, 1984). Also, the acute battering incidents tend to increase in
Although the cycle of violence does not occur in all relationships at all times (Hoff,
1990; Schuller & Vidmar, 1992; Walker, 1984), it was reported to occur in over half of
the relationships in Walker’s 1984 study.

The cycle of violence model may help explain why women stay in a battering
relationship. In the initial stages, as the violence follows this three cycle pattern, women
have the reinforcement and hope of the loving contrition phases to keep them in the
relationship. As the violence escalates and the loving contrition fades over time in the
relationship, battered women are more likely to attempt to leave (Walker, 1984; Wilson & Daly, 1993).

**Learned Helplessness**

Walker (1979) was one of the first researchers to apply the concept of learned helplessness to the study of why women find it difficult to escape an abusive relationship. The concept of learned helplessness is based on Seligman and Maier’s (1967) research showing that animals subjected to repeated noncontingent, inescapable shock responded with passivity, submission, and compliance. Eventually, the animals in their study were unable to escape from the painful situation, even when escape became possible and was apparent to animals who had not undergone helplessness training. Walker (1979, 1984) hypothesized that the same phenomenon of learned helplessness would be found among severely abused women whose perceived lack of control over the abuse would diminish their motivation or ability to respond effectively. The three components of learned helplessness are motivational impairment (passivity), intellectual impairment (poor problem-solving ability), and emotional trauma (feelings of helplessness, incompetence, frustration, and depression) (Seligman, 1975).

Some research has supported the learned helplessness theory in battered women (Carlisle-Frank, 1991; Hofeller, 1982; Kuhl, 1985; Walker, 1984; Wilson, Vercella, Brems, Benning, & Renfro, 1992). Other researchers have documented only some components of learned helplessness among battered women (Finn, 1985; Lanius & Lindquist, 1988).
According to Walker (1989b), as part of the learned helplessness phenomenon, battered women learn to adapt to the aversive situation through the use of cognitive distortions such as minimization, denial, and disassociation or splitting of the mind from the body during the abusive incidents. These actions help them cope by minimizing the pain and enhancing their chances of survival. These highly developed coping and survival skills may be misinterpreted as passivity. When the battered woman perceives that these coping skills will no longer protect her or her children, she usually attempts to escape.

Research on the help-seeking behaviors of battered women seem to contradict the learned helplessness theory. The concept of learned helplessness has become controversial in the battered women's literature because it denotes battered women as being helpless victims, when in fact many women do manage to leave abusive situations. Research has demonstrated that battered women tend to increase their help-seeking behaviors as the severity of abuse increases (Gelles & Harrop, 1989; Gondolf, 1988; Hoff, 1990; Sullivan, 1991a; Walker, 1984; Wilson et al., 1992). Walker (1984) notes that learned helplessness theory does not explain “why some women actually become disgusted and angry enough to leave a relationship and others do not.” (p. 89)

On the basis of research portraying women as active help-seekers rather than passive victims, Gondolf (1988) and Hoff (1990) refer to battered women as “survivors”. Both researchers found that battered women's repeated help-seeking behaviors were often met with unhelpful or incomplete responses by the sources they turned to for help, and that often resulted in their returning to the abusive situation. Gondolf (1988) and
Hoff (1990) contend that battered women should not be labeled “helpless” when it is really the inadequacy of the sources they turn to for help and the lack of resources to support their departure that are really to blame for their apparent helplessness.

Wilson et al. (1992) recommend that learned helplessness and active help-seeking should not be viewed as incompatible or mutually exclusive. In their study, even though the women in the shelter group and the support group measured high levels of learned helplessness, they exhibited help-seeking behaviors by virtue of the fact that they were in a shelter or support group. They believe the high measures of learned helplessness may refer to the women’s feelings of helplessness if left to their own resources. Wilson et al. (1992) further suggest that perhaps the abused women who did not seek help may not actually feel helpless, but may believe they can rely on themselves to alter the situation.

Learned helplessness may be viewed as one component of battered woman syndrome which in turn is considered to be a subcategory of PTSD (Douglas, 1987; Walker, 1991). These concepts are part of the psychological effects of battering and will be examined in the next section.

**Psychological Effects of Battering on Battered Women**

In studies of psychological symptomology of battered women, identified characteristics appeared to be an outcome, not a cause of the assaults (Hotaling & Sugarman, 1986, 1990; Romero, 1985). Feminist psychologists such as Browne (1987, 1993), Koss (1990), Rosewater (1988a), and Walker (1979, 1984, 1989a, 1994) reframe behaviors, emotions, and cognitions found to be typical of battered women as
consequences and coping strategies resulting from the repeated brutalization and terror rather than as pre-existing contributing factors of the abuse. This distinction is important in order to avoid further pathologizing or victim-blaming.


Research studying self-esteem has been inconclusive. Some studies show lower self-esteem in battered women than nonbattered women (Cascardi & O'Leary, 1992; Dutton & Painter, 1993; Frisch & MacKenzie, 1991; Mills, 1985; Telch & Lindquist, 1984), while others found no significant difference in self-esteem between battered women and nonbattered women (Hotaling & Sugarman, 1990; Russell et al., 1989; Walker, 1984).

Battered Woman Syndrome

Walker (1984) found a syndrome of similar psychological disturbances among the battered women in her study that she termed “battered woman syndrome.” The symptoms included anxiety, depression, cognitive distortions, the reexperiencing of traumatic events, and the disruption of interpersonal relationships. Douglas (1987) described battered woman syndrome as the traumatic effects of victimization by violence,
learned helplessness, and self-destructive coping responses. Other effects include psychic numbing, generalized hyperarousal, idealization of the abuse, denial of danger, and suppression of anger (Douglas, 1987). A battered woman syndrome pattern on the MMPI has been found (Douglas, 1987; Rosewater, 1988a). Dutton and Painter (1993) also found levels of the battered woman syndrome in their study of battered women.

The term “battered woman syndrome” is used both to describe the patterns of violence typically experienced by battered women and the psychological impact this violence has on the women (Barnett & LaViolette, 1993; Browne, 1987). Battered woman syndrome is frequently used as a basis for self-defense in legal cases where battered women have killed their abusers to attest to the woman’s state of mind and feelings of hopelessness (Douglas, 1987; Schuller & Vidmar, 1992; Thyfault, Browne, & Walker, 1987). Battered woman syndrome is now considered a subcategory of PTSD similar to rape trauma syndrome and battered child syndrome (Walker, 1991, 1994).

Post-Traumatic Stress Disorder (PTSD)

Similarities among abuse victims and comparisons with other victims of extreme psychological trauma such as Viet Nam war veterans (Figley, 1985, 1986; Ochberg, 1988; Van der Kolk, 1987) led to the development of post-traumatic stress disorder (PTSD) as a specific diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (DSM III) (American Psychological Association, 1980). The definition has been further refined and expanded in the DSM III-R (American
The diagnostic criteria for PTSD from DSM IV includes the following:

1. Exposure to a traumatic event that involves actual or threatened death or serious injury or a threat to one’s physical integrity, and a response of intense fear, helplessness, and horror.

2. The traumatic event is persistently reexperienced by recurrent distressing recollections of the event, including thoughts, perceptions, images, or dreams of the event; acting or feeling as if the event were recurring (such as hallucinations and flashbacks); intense psychological distress or physiologic reactivity at exposure to cues that resemble or symbolize an aspect of the event.

3. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness as indicated by efforts to avoid thoughts, feelings, conversations, activities, places, or people that arouse recollections of the trauma; inability to recall an important aspect of the trauma; diminished interest in significant activities; feeling of detachment or estrangement from others; restricted range of affect, or sense of foreshortened future.

4. Persistent symptoms of increased arousal including difficulty falling or staying asleep, irritability, outbursts of anger, difficulty concentrating, hypervigilance, or exaggerated startle response (American Psychological Association, 1994).
The use of the PTSD diagnosis with battered women provides a useful model and systematic criteria for diagnosing the effects of the trauma resulting from the ongoing abuse (Browne, 1993; Dutton, 1992; Herman, 1992; Walker, 1994). Goodman, Koss, Fitzgerald, Russo, & Keita (1993) note four advantages to using the PTSD diagnosis with victims of interpersonal violence. First, it depathologizes the victim’s responses by portraying the psychological symptoms as normal reactions to traumatizing events. Second, it enables researchers and practitioners to learn from the vast psychological trauma literature available. Third, it integrates many disparate symptoms while differentiating them from other disorders making it the most parsimonious diagnosis. Finally, the PTSD diagnosis encourages the development of broad, comprehensive theoretical models for understanding women’s reactions to violence as it finds relationships among seemingly unrelated symptoms.

Several studies have found diagnosable levels of PTSD among battered women (Astin, Lawrence, & Foy, 1993; Dutton & Painter, 1993; Gleason, 1993; Herman, 1992; Houskamp & Foy, 1991; Kemp, Green, Hovanitz, & Rawlings, 1995; Kemp, Rawlings & Green, 1991; Saunders, 1994). One study found that 63% of a sample of nonbattered but verbally abused women met the PTSD criteria (Kemp, et al., 1995).

In general, the more severe and more frequent the abuse, the more extreme the PTSD symptoms (Astin et al., 1993; Houskamp & Foy, 1991; Kemp et al., 1995; Kemp et al., 1991). For example, Kemp et al. (1995) found that battered women with PTSD experienced more physical abuse, more verbal abuse, more injuries, a greater sense of
threat, and more forced sex than battered women without PTSD. Abuse recency also is related to the severity of PTSD symptomology (Astin et al., 1993), but the symptoms of PTSD often continue long after the battering relationship has ended (Gleason, 1993; Kemp et al., 1995; Walker, 1984, 1994). Other variables found to be positively related to PTSD symptom severity in battered women are past trauma or abuse, childhood family stressors (such as an alcoholic parent, poverty, parental divorce, mother or siblings abused, etc.), concurrent negative life events as additional stressors, lack of actual or perceived social support, and the use of disengagement coping strategies (wishful thinking, social withdrawal, problem avoidance, self-criticism) to handle the abuse (Astin et al., 1993; Dutton, 1992; Finn, 1985; Foy, 1992; Kemp et al., 1995).

PTSD in battered women may be more complex than PTSD in other trauma survivors of discrete, time-limited events such as rape and combat because the battered woman is often repeatedly traumatized over a long period of time. Also, even after the couple separates, the woman often must be continuously exposed to the abuser due to child custody or legal proceedings (Astin et al., 1993; Browne, 1993; Herman, 1992). Some research has indicated that human-made violence seems more likely to lead to more extreme PTSD symptoms than natural phenomenon (Davidson & Baum, 1990), and PTSD is more likely to develop when traumatic events occur in a place previously deemed safe (Foa, Steketee, & Rothbaum, 1989). Because of this combination of additional risk factors for battered women, Herman (1992) proposes a category of
Complex PTSD be used to account for the magnitude of the circumstances faced by battered women due to their prolonged and repeated exposure to the trauma.

Other diagnostic correlates that may be found in battered women as a result of battering include alcohol or substance abuse, anxiety disorders (including obsessive-compulsive disorders, panic attacks, and phobias), depression and affective disorders, eating disorders, suicide or homicide risk, psychosexual dysfunction, neuropsychological damage from injuries inflicted by the abuser, and physical health problems (Dutton, 1992; Gleason, 1993; Walker, 1994).

This chapter presented a review of research findings supporting the feminist view of wife battering, specifically analyzing why men beat their wives and why women stay with abusive men. In the next chapter, feminist therapy is described as a means to help battered women escape from the violence. Feminist therapy philosophies and techniques as they are used to help battered women are described, and a review of research on the effectiveness of feminist therapy with battered women is presented.
CHAPTER 3

FEMINIST THERAPY WITH BATTERED WOMEN

Feminist therapy began in the 1970’s operating mainly in reaction to traditional misogynist approaches to mental health (Rawlings & Carter, 1977; Sturdivant, 1980). Early feminist therapy defined itself based on its differences from traditional therapy rather than on a specific approach or theory of its own (Walker, 1994; Zerbe-Enns, 1993).

Initially, feminist therapists borrowed techniques and theories from existing therapies and modified them to be consistent with feminist philosophy and values (Walker, 1994; Zerbe-Enns, 1993). Through the 1980’s and 1990’s, feminist theorists and therapists have made efforts to further define feminist therapy as an entity in its own right, examining stages of feminist therapy and outlining a specific theory of feminist therapy (Brown & Ballou, 1992; Dutton-Douglas & Walker, 1988; Rosewater & Walker, 1985). Other developments in feminist therapy include the examination of diversity and multicultural differences within feminist therapy (Brown & Root, 1990; Burstow, 1992), the creation of feminist development models for girls and women (Conarton & Silverman, 1988; Gilligan, 1982; Jordan, Kaplan, Miller, Striver, & Surrey, 1991; Kaschak, 1992), the examination of feminist ethics in psychotherapy (Lerman & Porter, 1990), and the application of feminist therapy with different populations such as
women, men, lesbians and gay men, and the elderly (Dutton-Douglas & Walker, 1988) and with various issues such as the effects of battering, rape, incest, and divorce (Burstow, 1992; Dutton-Douglas & Walker, 1988; Walker, 1985; Yllo & Bograd, 1988).

Feminist therapy is less interested in helping the client conform and adjust to the mainstream and more interested in helping the client identify and overcome the oppressive social pressures that exist for women and men. The ultimate goal of feminist therapy is the elimination of the patriarchal power structure in society. On an individual basis, this goal translates to helping the client overcome the effects of oppression in her life while recognizing the external factors that make this goal difficult (Dutton-Douglas & Walker, 1988).

Although there are varieties and divergences in feminist therapy (Zerbe-Enns, 1993), several distinguishing features are common to the practice of feminist therapy. Some of these characteristics and beliefs are empowerment of the client, rejection of traditional sex role stereotypes, recognition of the effects of sexism as a reality in women's lives, open expression of the feminist value system, demystification of the role of the therapist and the process of therapy, rejection of the medical model and labels, focus on the client's expertise rather than the therapist's, shared power in the therapy relationship, focus on client strengths vs. deficits, educational, non-pathological model, and feminist advocacy. Common techniques often used in feminist therapy include mutual goal-setting, nurturing and validating, reframing, role modeling, self-disclosure,
bibliotherapy, information giving, assertiveness training, role playing, guided imagery, relaxation techniques, and consciousness raising (Burstow, 1992; Butler, 1985; Cammaert & Larsen, 1988; Dutton-Douglas & Walker, 1988; Gilbert, 1980; Rawlings & Carter, 1977; Sturdivant, 1980). These principles and techniques will be discussed as they are used in feminist therapy with battered women.

The Appropriateness of Using Feminist Therapy with Battered Women

Feminist advocates for battered women note that battered women do not need “treatment,” they need services specifically designed to help them choose whether or not to stay in their relationships (Davis & Hagen, 1992) and more fundamentally, they need to live in a nonsexist society that does not tolerate wife abuse (Dobash & Dobash, 1992; Yllo & Bograd, 1988). There is some concern among feminist activists that promoting therapy of any kind with battered women enforces the belief that the woman is to blame or that wife battering is an individual issue rather than a social problem (Caplan, 1992; Dobash & Dobash, 1992; Kurz, 1989). Caplan (1992) notes that feminist therapists need to wonder if by doing psychotherapy, they are unwittingly reinforcing the idea that women’s unhappiness comes from within rather than from society’s promotion and acceptance of the oppression and objectification of women. Caplan questions the use of therapy as an opiate for women, when feminist therapists and clients should be focusing more energy on stopping men’s violence towards women and society’s acceptance of that violence.
Dobash and Dobash (1992) state that the battered women's movement was successful in transforming the view of wife beating from personal pathology to the larger social problem of male domination and inequality. However, in the United States, the focus has again shifted to the individual therapeutic approach instead of the larger social concept (Davis, 1987; Dobash & Dobash, 1992). Dobash and Dobash state that the United States' emphasis on individualism and the strength of the mental health movement helped transform the complex social, political issue of wife abuse into one of psychological problems and individual deficiencies. They attribute this to the ideal of independence and individualism rooted in American history. Dobash and Dobash promote political activism and advocacy for battered women as the main activity for those interested in helping battered women.

Dobash and Dobash (1992) do, however, recognize feminist therapy as an exception to traditional therapeutic approaches with battering. While traditional therapy is the antithesis of the battered women's movement, feminist therapy attempts to work with individuals within the wider socio-economic context and supports the goals and visions of the battered women's movement. The emphasis is on encouraging the women's strengths and capabilities while acknowledging the problems they must confront.

Most feminist therapists working with battered women have objected to seeing couples together in traditional couples therapy or family therapy (Bograd, 1984, 1992; Walker, 1984, 1989). This objection is related to the criticism of interpreting and
examining wife battering from a family violence perspective rather than from a violence against women perspective (Kurz, 1989; Yllo & Bograd, 1988).

Some family therapists have integrated feminist concepts and power and gender analyses into their practice of family systems therapy (Bograd, 1984, 1992; Goldnor, Penn, Sheinberg, & Walker, 1990), but most feminist therapists recommend against conjoint therapy with battered women and their abusive partners at least until the violence has come to a complete end. The most recommended psychotherapy approach from a feminist perspective is a feminist group or individual counseling with battered women and a separate feminist men’s group for the violent men (Adams, 1988; Bograd, 1984, 1992; Kaufman, 1992; Ptacek, 1988; Walker, 1989a).

Therapists’ Issues with Battered Women

The feminist therapist working with battered women needs to have an understanding of the dynamics of the battering relationship, the cycle of violence, and the social context in which battering is allowed to occur. The therapist needs to appreciate battered women’s internal and external obstacles to leaving and not push her to leave before she is ready. The therapist needs to be able to listen nonjudgmentally to stories of horror and brutalization (Walker, 1994). Specific issues which the therapist working with battered women must face are described in the next sections.

Rescuing

The temptation to rescue the client is a common problem for therapists working with battered women (Burstow, 1992; Walker, 1990). This desire to rescue comes from
caring and from the difficulty involved in waiting for a battered woman to go through the process of leaving and returning to the battering relationship several times (Burstow, 1992; Walker, 1985). Rescuing is disempowering for the client, who must go through the process at her own pace and learn to trust her own instincts and decision-making ability.

After being under a batterer's control, a battered woman has had her physical and psychological integrity taken from her. Her feelings of vulnerability may make her feel dependent on the therapist. A battered woman seeking therapy may not feel capable of being treated in an egalitarian manner, but the feminist therapist must be careful not to take over the therapy process (Walker, 1990). The feminist therapist and client together should negotiate limits that are good for both therapist and client. For example, the therapist and client may agree that the client will make a daily or weekly phone call to the therapist at a specific time, gradually decreasing the frequency of the phone calls through renegotiating several times (Walker, 1990).

Vulnerability/Fear

Feminist therapists need to deal with their own issues of vulnerability to personal violence (Walker, 1990). Schecter (1982) believes formerly battered women can become good counselors with battered women, but only if they have worked through their own painful experiences. Formerly battered women therapists may become role models of survival, but they need to use extra caution that their self-disclosure is appropriate and timed to their clients' needs, not their own (Schecter, 1982; Walker, 1984).
Anger

Feminist therapists working with battered women are likely to feel angry about abuse against women. Walker (1990) cautions that the feminist therapist needs to give the client time and space to sort out her own feelings at a pace that may be slower than the therapist’s. For example, a feminist therapist may express sorrow or sadness about the client’s painful experiences, but the therapist should not express anger at the client’s batterer. The appropriate approach is to reflect the client’s directly or indirectly expressed angry feelings. Also, the therapist may ask the client how she is feeling or tell her that other women in her situation might feel anger, but the therapist must be careful not to tell the battered woman how she should feel (Walker, 1990).

Victim-Blaming Attitudes Toward Battered Women

Feminist therapists working with battered women need to come to terms with their own attitudes about domestic violence and battered women. Although the title “feminist therapist” indicates that the therapist has an understanding of women’s oppression and its affect on women’s behavior, therapists working with battered women also need to have an understanding of the obstacles battered women face. If the feminist therapist has difficulty understanding why a battered woman doesn’t just leave or why she keeps returning to live with the batterer, the therapist may consciously or unconsciously convey a judgmental attitude toward the battered woman (Gerard, 1991). For example, the question, “What were you fighting about?” implies that there could be a justifiable reason for the violence.
The Process of Feminist Therapy with Battered Women

Feminist therapy treatment is based on the client's need, request, and decision for treatment. Walker (1985, 1990) cautions that although feminist therapy is the treatment of choice when therapy is indicated, some violence victims may heal without therapy. A battered woman seeking help should not automatically receive a recommendation for psychotherapy. Crisis intervention and support groups are sufficient for many women (Walker, 1994).

Although some patterns and similarities do emerge, all battered women and all battering relationships are not alike, and the treatment for a battered woman must focus on her particular issues and needs (Follingstad et al., 1991; Snyder & Fruchtman, 1981; Walker, 1984). Some variables that have been found to affect a battered woman's service needs include race, the woman's abuse history as a child, the nature of the marital abuse (emotional, physical, and/or sexual), and the severity and frequency of the abuse (Follingstad et al., 1991). Recognizing variability and diversity among battered women, while simultaneously trying to find common treatment approaches is a step toward reducing stereotypes about battered women (Follingstad et al., 1991). Specific feminist therapy principles and techniques as applied to therapy with battered women will be discussed in the next sections.

Empowerment

Empowerment includes helping women be aware of and value the power that they already have. “Feminine” power is as valued as “masculine” power (Smith & Siegel,
1985). McWhirter (1991) lists six factors which facilitate client empowerment in the counseling process. Although McWhirter does not define the process as feminist, all of the factors listed are components of feminist therapy. They are: (a) the therapist expresses a belief in the client’s abilities to make constructive changes in her life; (b) the therapist recognizes the political, social, and economic context as the source of the problem while helping the client develop alternatives to cope with this external reality; (c) the therapist demystifies the therapy process while helping the client understand that counseling is not magic, and that the client, not the therapist, has the power to change the client’s situation; (d) both therapist and client contribute to problem definition and the establishment of goals in a collaborative process; (e) the therapist supplements the client’s awareness of social inequities with information about efforts to change the system through grassroots effort and advocacy; and (f) the therapist helps the client with skills development through interventions such as assertiveness, decision-making, and social skills training exercises and helps the client develop skills in networking, self-analysis, brainstorming, and reframing as a means of empowerment (McWhirter, 1991).

The therapist needs to help the client determine what decisions need to be made immediately and what decisions can wait until the immediate crisis is over and the client feels more in control (Walker, 1990). The therapist should work with the client to identify the client’s prior strengths and help her use them in making the essential immediate decisions. By being a calm listener, the therapist teaches a client in crisis to
take time to plan out her life and communicates a message that the therapist believes that
the client's life will get better (Walker, 1990).

An important approach for a feminist therapist attempting to empower or
reempower the battered woman is to focus on her strengths and reframe her behaviors in
the context of her situation (Burstow, 1992; Walker, 1994). By reframing her behaviors
as survival techniques, the therapist can help a battered woman see that she is not
“crazy” as her batterer and others may have led her to believe, but doing the best she
could to protect herself and her children from further harm. Her manipulative behavior
and hypervigilance may also be reframed as survival mechanisms in her attempts to
control her environment while living under the constant threat of violence and abuse
(Walker, 1994).

For some time after seeking help, most women continue to try to improve the
situation and make the relationship work (Barnett & LaViolette, 1993; Burstow, 1992).
The feminist therapist’s job in these cases is to provide emotional support and honest
feedback to the woman while continuing to nurture, consciousness-raise, and address
safety issues (Burstow, 1992).

Some feminist therapists suggest their clients write two lists, one with her
partner’s behaviors that she likes and one listing her partner’s behaviors that she dislikes.
The therapist asks the client to focus on each item in both lists and examine what benefits
and harms result from each item. This process allows the woman to gain a clearer
understanding of the cost/benefit ratio of the relationship (Burstow, 1992; Walker,
1994). Later, if the woman does decide to leave the relationship and is tempted to return due to loneliness, the feminist therapist may suggest for her to reread her list of her partner’s behaviors that she dislikes to remind her of why she left (Burstow, 1992).

The therapist can further empower the client by helping her to begin imagining a life without her partner. This prospect may be very frightening for the woman, and the therapist needs to respect the client’s timeframe for imagining or discussing these options. The feminist therapist recognizes that the more the client imagines and plans for the possibility of leaving the relationship, the less frightened and more self-confident the client becomes about her ability to make it on her own (Burstow, 1992). The feminist therapist should encourage the woman to consider such decisions as where she would live, what friends or relatives might be helpful, what resources does she need, what kind of job or training could she get, etc. (Burstow, 1992). The feminist therapist may also empower the battered woman by encouraging her to talk to other women currently involved in or successfully out of similar situations, and to read relevant literature such as survivor success stories and feminist writings, to explore the commonality of the dynamics of wife battering (Burstow, 1992).

Communication of the Feminist Value System

Feminist theorists and therapists have pointed out the male-centered biases in traditional therapies that claim to be neutral or value-free. Feminist therapists, therefore, openly acknowledge and express to their clients the feminist value system upon which the therapy is based (Greenspan, 1995).
When working with battered women, this means the feminist therapist openly states the feminist viewpoint regarding the allocation of responsibility for the battering through such statements as "No woman deserves to be beaten," and "Men are solely responsible for their actions." The feminist therapist also needs to express to the client the belief that men and women can control their behavior, the right of all people to physical safety, and the ways in which victim-blaming shifts attention away from the patriarchal context of battering (Bograd, 1984).

**Rejection of Traditional Sex Role Stereotypes**

The feminist therapist rejects traditional sex role stereotypes and recognizes the restrictions and oppression that result from believing in and adhering to rigid sex role stereotypes. By conveying these beliefs to the battered woman client, the feminist therapist helps the client sort out the common gender aspects of oppression that help perpetuate men's violence against women, especially towards their wives or partners. The feminist therapist should convey that no one has a right to harm a woman even if it has been done for centuries and even if society seems to condone such violence (Walker, 1990).

Rejecting traditional sex role stereotypes may mean helping the woman understand that she is not a failure as a human being or as a woman if she leaves her abusive partner, even though society's and her own internalized socialization may tell her otherwise. Other internalized stereotypes like "a woman can't live without a man", "a man needs a woman to take care of him", and "women are the 'weaker sex'" should be
explored and discussed in therapy as part of the dynamics of oppression and violence against women (Burstow, 1992; Walker, 1990). Burstow (1992) also recommends problematizing the notions of romantic love, jealous rage, and wifely obedience and duty.

**Educational/Non-Pathological Model**

Feminist therapy is an educational rather than a medical model, focusing on the client's positive aspects rather than negative or "pathological" thoughts, feelings, and behaviors. Using this nonthreatening approach, a battered woman client may feel less frightened that her defenses will be stripped away and less resistant to the feminist therapy relationship (Walker, 1990). Sharing information is also part of the educational model of feminist therapy.

Sharing information about community resources that are available to the client, such as a battered women's shelter or group, empowers the woman to make decisions about her options. As appropriate, the therapist can help her gather and evaluate additional information about these and other sources of help. As the client begins to take the initiative to make the contacts she needs to take care of herself, she learns to become an active agent in her recovery. This mastery may help reverse some of her feelings of learned helplessness and increase her feelings of self-confidence, self-efficacy, and self-esteem (Walker, 1994). Educating the client about the three stage cycle of violence and discussing if and how it has occurred in the client's relationship with the batterer is helpful in teaching the battered woman to understand how the dynamics of the cycle keep her hooked into the relationship (Walker, 1994).
The "chart of coercion" published by Amnesty International (1973) documents ways that political prisoners, hostages, and concentration camp survivors have been tortured and brainwashed. Some of the control tactics include isolation, threats, occasional indulgences, demonstrating omnipotence, degradation, and enforcing trivial demands. The chart does not mention any physical violence. Feminist therapists often use this chart as a tool to help battered women identify and describe some of the ways the batterer has controlled them with the same coercion techniques (Jones, 1994; Nicarthy, Merriam, & Coffman, 1988). For example, the "honeymoon stage" of the battering cycle may be understood as part of the batterer's coercion process in providing occasional indulgences (Jones, 1994).

**Shared Power/Egalitarian Relationships**

Feminist therapy relationships do not follow the hierarchical structure of traditional therapy relationships. The client is seen as more of the expert of her own life, and power is shared between client and therapist.

Battered women, especially, can benefit from the egalitarian philosophy of feminist therapy as they are dealing with an abusive relationship which is far from an equal partnership. Feminist therapists encourage their clients to take control of their therapy as a beginning step to taking control of their lives (Walker, 1989a).

According to Greenspan (1986), self-disclosure is discouraged in traditional male-oriented models of therapy, such as psychoanalysis, which instead encourages the culturally male traits of the detached, disciplined, unemotional therapist/expert.
Traditional psychoanalysis believes that the therapist who self-discloses interferes with the transference process and loses the professional boundaries between the therapist/expert and the client/patient. Feminist therapy disputes this line of reasoning, seeing this type of traditional therapy as a masculine model in which the therapist is another patriarchal expert who cures the passive, powerless patient. Instead, the collaborative nature of feminist therapy is facilitated by appropriate therapist self-disclosure. Self-disclosure is seen as crucial to the success of feminist therapy, especially in building a strong therapeutic alliance. Further, feminist therapy recognizes that therapists reveal themselves to clients all the time, deliberately or not, and the perfectly neutral, value-free therapist is a myth (Greenspan, 1986).

Although feminist therapy attempts to share power in the therapy relationship, the feminist therapist must recognize that there is an inherent expertness and power in the role of therapist. Egalitarian relationships, therefore, are an ideal to strive for, with the awareness that whatever the therapist does and says is viewed by the client with a certain amount of vulnerability. Because of this dynamic, therapist suggestions carry different meanings to a client than they would to a friend, no matter how much the feminist therapist attempts to make the relationship egalitarian (Greenspan, 1986).

Social Action/Advocacy

Early feminist therapists considered social action and advocacy an essential responsibility of feminist therapists (Greenspan, 1983; Rawlings & Carter, 1977), but more recent feminist therapy writings from the field of psychology have shown less
enthusiasm for social action. Zerbe-Enns (1993) notes several reasons for the increased focus on self-development and decreased focus on social change in the more recent feminist therapy literature. Some of the reasons she notes are that feminist therapists who did not experience the women's movement of the 1970's may view activism as unnecessary or irrelevant (Greenspan, 1985), feminist therapists are questioning whether women are better off now than in prefeminist eras (Meara & Harmon, 1989), the resurgence of general societal trends towards conservatism and individualism (Kahn & Yoder, 1989), and a sense of complacency among professionals now that the most obvious forms of sexism have been eliminated (Zerbe-Enns, 1993).

Feminist therapists working with battered women, however, have generally retained their focus on activism and advocacy as an important component of therapy and an ethical responsibility when working with battered women (Rosewater, 1990; Schecter, 1988; Walker, 1985, 1990). Rosewater (1990) defines advocacy as the process of working for the empowerment of individual clients and women as a group. This entails empowering clients to create constructive changes in their lives while also working for legislative and legal changes that promote social, political, and economic equality. Advocacy provides the way to publicly acknowledge and fight the societal inequities causing the client's distress through such means as working for pay equity, stronger child support enforcement laws, and affordable day care (Rosewater, 1990). Advocacy could include activism related to strengthening domestic violence laws and their enforcement, and delivering educational programs directed to police, clergy, and
health care providers about the myths and realities of battered women’s issues and choices.

Feminist therapists have acted as advocates for battered women in their roles as expert witnesses in custody battles and legal proceedings (Walker, 1985). For example, in a case where a battered woman has killed her abusive partner, the feminist therapist could document the existence of Battered Woman Syndrome or PTSD, explain why the woman remained with her abusive partner, and establish the basis for the battered woman’s perception of imminent bodily harm (Douglas, 1987; Rosewater, 1990; Thyfault, Browne, & Walker, 1987; Walker, 1989b).

Walker (1990) notes that although generally advocacy is usually tricky in therapy relationships because of issues of overlapping roles that may border on dual relationships, she believes that advocacy for a battered woman client actually strengthens the therapy relationship. She states that battered women have learned not to trust anyone and do not understand neutrality, and tend to believe that someone is either for them or against them. By actively advocating for the battered woman, the therapist demonstrates that the therapist is on the client’s side and is willing to take actions on her behalf (Walker, 1990).

**Common Therapy Issues with Battered Women**

**Safety**

The safety of the client is the first and foremost issue for the therapist to address. The therapist has a responsibility to express perceptions and concerns of the danger that
the battered woman may be in, whether she stays or attempts to leave the violent relationship (Walker, 1994). The counselor needs to validate the woman’s fears and to help her devise ways to feel in control of her life (Gerard, 1991). Feminist therapists working with battered women stress the importance of helping the women develop and rehearse a safety plan.

The safety plan should address how the woman will recognize the cues prior to the next battering incident, how she will escape, where she will go, who she will contact, and what she will take with her (Gerard, 1991; Walker, 1994). Some of the components of the safety plan may include hiding a bag with money, keys, personal necessities, important documents and phone numbers, working out a signal with a neighbor or friend to call the police, planning an escape route out of the house, and discussing and rehearsing this plan with the children (Walker, 1994). By having this safety plan in place and rehearsing it in the safety and calm of the therapist’s office, the woman has a better chance of being prepared should she need to leave the home quickly. The safety plan also can help the woman to become more realistic about the potential for future violence and help her face any denial she may be having about the extent of the violence in her life (Gerard, 1991). The therapist has a responsibility to help the client work on this safety plan in the initial visit or the first stages of therapy (Hart, 1988; Walker, 1990).

Concrete Services

Feminist therapists working with battered women should have knowledge of referral sources for the concrete services that the battered woman may need. Depending
on her situation these services may include medical treatment; emergency, transitional, or permanent housing; transportation; monetary assistance; child protection services; job training; employment opportunities; and affordable child care (Gerard, 1991; Sullivan, 1991b; Walker, 1990). Many of these services may be available through a local battered women's shelter. Gondolf (1988) found that the best predictor of whether a woman would remain with or away from her abusive partner related to her having access to the concrete services that would enable her to live independently.

Legal Issues

The therapist should also have an understanding of legal options for the battered women or be able to provide a referral to a legal advocate who is knowledgeable about police responses, criminal and civic orders of protection, and court proceedings that may be relevant to her situation. According to Burstow (1992), a discussion of the legal options available to battered women should include a frank discussion of the reality that the legal system is essentially patriarchal despite its advances in working with battered women. The battered woman needs to be aware of her rights, legal processes, and official procedures and to have this information in writing to consult as needed. She also needs to be aware of the shortcomings of the legal system and the risks and dilemmas in pursuing a legal route (Burstow, 1992; Gerard, 1991). For example, a jail sentence for an abuser may make him angrier and more abusive, but nonarrest sends a message that his violent behavior is acceptable.
A feminist therapist can help a battered woman to understand her legal options and provide support for whatever decision she makes. Role plays involving standing up for legal rights and rehearsals of potential police or courtroom incidents may also prove helpful to prepare the battered woman and to help her recognize her strengths. A feminist therapist should be able to provide a list of feminist lawyers who are sensitive to battered women's issues and who also accept legal aid (Burstow, 1992).

**Ambivalent Feelings Toward the Batterer**

While therapists and helpers may see the situation as a decision to leave or stay, most battered women want the therapist to help stop the abuse, but not the relationship (Barnett & LaViolette, 1993). The therapist should focus on ending the abuse as the therapy goal, whether or not that means ending the relationship (Walker, 1994). The therapist should help the woman understand her ambivalent feelings toward the abuser, recognizing both the good and bad aspects of the relationship. The client may need help in integrating her partner's alternating loving and abusive behaviors towards her. The therapist needs to emphasize that the goal of therapy is to help the client regain her emotional strength so that she can make her own decisions about whether or not to terminate the marital relationship (Walker, 1984).

**Denial/Minimization**

Battered women often deny or minimize the abuse when describing it to a therapist (Burstow, 1992; Walker, 1985, 1994). Some of the reasons for denying or minimizing the abuse are fear of retribution from the batterer, loyalty to the batterer, not
being ready to acknowledge the full extent of the situation, and concern that the therapist will push her to leave (Burstow, 1992; Walker, 1985). Therapists can counter this denial and minimization by encouraging the woman to openly discuss the abuse, nonjudgmentally validating her feelings, and reassuring her that the therapist will not force her into action she is not ready to take (Burstow, 1992).

Trivialization

If battered women do not deny or minimize the extent of the abuse, they often trivialize its importance (Walker, 1985; Burstow, 1992). Some of the reasons for trivializing are the same as those for denying or minimizing, but battered women may also trivialize because of their socialization as women. Women have been socialized to believe that men are more important than women, that what happens to women is not all that significant. The partner's psychological and physical abuse towards her has repeatedly reaffirmed this feeling of insignificance and nothingness (Burstow, 1992).

Therapists should address this trivialization by taking the abuse seriously and affirming the client's importance to the therapist. The message to repeatedly give is that the abuse is not trivial, and that the client and what happens to her matter a great deal. The therapist needs to validate the enormous impact of all forms of abuse, especially the psychological abuse, which is easier for the client to dismiss in importance (Burstow, 1992).
Self-blame

The abuser's and society's messages that a battered woman is to blame for the abuse directed against her are often internalized by the battered woman. She may also blame herself for failing to act or for failing to keep herself safe (Walker, 1985; Burstow, 1992). She may feel guilty for wasting the therapist's time and for repeatedly returning to the abuser even though she has received help (Burstow, 1992).

The therapist should counter the woman's feelings of blame and inadequacy and reassure her that she is doing the best she can in a very difficult situation. She may need to hear this message repeatedly. Educating her about the feminist view towards battering is also helpful as it will help her to understand that her feelings and actions are largely due to female socialization and society's role in allowing wife abuse to continue.

The client may also absolve the abuser of responsibility because of his situation, for example, if he was an abused child or from a disadvantaged group. Her compassion, political awareness, and willingness to accept responsibility are again a result of women's socialization, but they work against her in this situation as she excuses her partner for the injustices done to him and sees it as her responsibility to understand and help him (Burstow, 1992). The feminist therapist's role is to not minimize the injury or oppression her partner experienced and society's role in that injustice, and to express appreciation and understanding for what he has gone through. At the same time, the therapist must clearly express that his injury does not cause him to abuse her or justify the abuse, that his injury is not her responsibility, that her sacrifice of herself does not help him, that her
awareness and sensitivity do not mean she needs to endure abuse, and that being understanding about abuse by male partners is part of the oppression of women (Burstow, 1992).

**Anger**

According to Walker (1989b), anger is an emotion felt sooner or later by nearly all victims of abuse or violence. When a battered woman recognizes her own anger, she also begins to recognize all of the grave injustices she suffered at the hands of the abuser. The battered woman is able to feel the true depth of her anger and work through its resolution only after she is free from her overwhelming feelings of fear and terror (Walker, 1989b).

Walker (1989b) sees anger as an important component leading to client empowerment. Walker notes that the feeling of anger is in direct opposition to the feeling of powerlessness, and as women in therapy get in touch with their anger, they often experience an increase in self-esteem and in clarity of purpose. This empowering anger is an individual version of the collective anger used by oppressed groups to energize their struggles to fight against unfairness and injustice. The feminist therapist can help uncover and explore the battered woman’s anger with the goal being that the woman can use this anger in a positive way to help facilitate the end of her suffering (Walker, 1989b).
Post-Traumatic Stress Disorder (PTSD)

Walker (1994) integrated the treatment approaches of feminist therapy theory and trauma theory and developed a new therapy approach for women victims of male violence that she terms “survivor therapy”. Survivor therapy takes feminist therapy a step further by specifically examining the PTSD literature on battered women in conjunction with a feminist viewpoint of gender, power, and control issues. Like feminist therapy, survivor therapy focuses on the battered woman’s strengths and explores the battered women’s coping strategies in order to help her become a survivor. The woman’s sociopolitical, cultural, and situational context is integrated with her trauma responses, and the focus becomes helping her to feel reempowered to take control of her life.

The goals and principles of survivor therapy are the same as those of feminist therapy with the addition of addressing any PTSD symptoms experienced by the battered woman (Walker, 1994). Restoring cognitive clarity and judgment and healing trauma effects are two of the additional goals of survivor therapy that specifically address PTSD in battered women. Walker (1994) lists eight areas of psychological damage that may need to be addressed in therapy with battered women who develop PTSD symptoms. They are (a) recurrent trauma memories, (b) need for control (manipulative behaviors), (c) anger and rage, (d) dissociation, (e) sexuality and body image, (f) trust and betrayal, (g) emotional intimacy, and (h) compliance and confrontation. Some techniques recommended by Walker (1994) include reframing and cognitive restructuring, assertiveness training, relaxation training, guided imagery, and Gestalt techniques.
Dutton (1992) and Browne (1993) also recommend assessing and treating battered women’s PTSD symptoms with principles, goals and techniques that are consistent with a feminist perspective of wife abuse. Dutton (1992) discusses treatment focused on the battered woman’s post-traumatic effects of abuse as one of three components in a three stage intervention with battered women. The other two issues for the battered woman to address are safety and decision-making.

Dutton’s (1992) model for PTSD treatment with battered women includes four therapeutic tasks that she views as critical elements to promote trauma processing, especially focusing on the cognitive and emotional effects of trauma victimization. Dutton’s recommended approach to these four tasks are outlined here.

Re-experiencing the trauma. Dutton (1992) does not recommend systematic desensitization and flooding procedures with battered women because of concerns with retraumatization. For the battered woman, the therapeutic re-exposure usually occurs when the woman recounts her traumatic experiences to the therapist. The battered woman will self-regulate the re-experiencing process by her willingness to respond to the therapist’s cues for pacing the emotional experience.

The therapist’s role is to facilitate a shift in the battered woman’s cognitive fear structures related to the traumatic experience. The intensity of the fear response is expected to diminish by helping the battered woman integrate information about the probability of current harm from the conditioned stimuli. The battered woman forms new affective and cognitive memories when her past memories and images associated with
the abuse are accompanied by an awareness of her current physical, emotional, and cognitive experience of safety. For this intervention to be effective, the therapist needs to help the woman create an environment in which the woman experiences physical and emotional safety, both within and outside of the therapy session.

**Managing stress.** The therapist may need to help the client manage stress during the course of treatment when the intensity of re-experiencing the trauma is too high. Some of the strategies Dutton recommends to manage stress are refocusing attention to the external reality instead of the internal emotions, teaching relaxation techniques, providing support, and helping the woman develop social support outside of the therapy relationship.

**Facilitating expression of emotions.** The therapist needs to create an emotionally safe environment to facilitate the re-experiencing of the trauma and the expression of emotions associated with it. Facilitating the expression of emotions may be accomplished by encouraging the battered woman to communicate in spoken words, as in the therapy session or support groups; in written words, as in a journal; through the use of sounds, such as crying, screaming, or moaning; and through the use of art or movement, as in art therapy or dance therapy.

**Finding meaning from victimization.** The final task in Dutton’s post-traumatic therapy model is helping the battered woman find meaning from the traumatic events. The process for the woman to find meaning includes establishing a purpose for the abuse (without self-blame), re-establishing a sense of control and predictability over her life,
and rebuilding assumptions and cognitive schemas about herself, the world, and others. Dutton recommends using cognitive therapies to help modify the battered woman’s beliefs, attributions, and appraisals. Dutton also believes that finding meaning and modifying belief systems often occurs effectively during the earlier tasks of re-experiencing the trauma and expressing feelings.

**Applications of Feminist Therapy with Battered Women**

The next sections discuss two specific applications of feminist therapy with battered women. Battered women’s shelters and feminist support groups provide settings widely recommended and especially conducive to the practice of feminist therapy with battered women.

**Battered Women’s Shelters**

Battered women’s shelters developed from the grassroots battered women's movement to provide safe places where battered women could go to evaluate their options and receive services to help them end the violence in their lives (Schecter, 1982). Although shelter services vary, the main functions they provide are crisis intervention services and safety provisions for battered women and their children. Most shelters provide a 24 hour hotline and may offer services such as legal, medical, and economic advocacy, transportation, support and counseling groups for women and children, employment and job training assistance, and child care. Some also offer programs for abusive men. If the shelters do not provide these services, they usually can provide referrals to appropriate resources in the community (Dobash & Dobash, 1992).
Dobash & Dobash (1992) consider battered women’s shelters to be at the heart of the battered women's movement. Besides providing an escape from violence and isolation for individual women, the shelter is the fundamental means for developing and sustaining feminist politics in the battered women's movement. Feminist battered women’s shelters benefit all women, even those who do not ever reside in the shelter, because of the social and institutional changes that result from the shelter’s existence and grassroots activism (Dobash & Dobash, 1992).

Dobash & Dobash (1992) discuss four types of battered women’s shelters. The philanthropic approach emphasizes a benevolent reformer helping a needy recipient. The therapeutic shelter corresponds to the mental health movement with trained professionals having hierarchical relationships and authority over their clients in a nonfeminist fashion. The professional bureaucratic shelter is run like a government agency staffed by professionals along bureaucratic lines with a goal of coordinating and delivering services in an efficient manner. The activist orientation is the feminist shelter that is characterized by grassroots action, involvement of abused women, and egalitarian relationships with a focus on the larger political issues of patriarchy and men’s violence against women. The activist shelter represents the feminist approach towards domestic violence espoused here.

Dobash & Dobash (1992) report that although activist shelters are the most prevalent type of shelter in the United States, the other types, particularly the therapeutic, still exist. Rodriguez (1988) maintains that social agency type programs that
individualize, medicalize, and depoliticize the battered women’s problems are the most dominant type of shelter in existence. The main criticism of the nonfeminist approach is that the battered woman is seen as an object or a passive recipient of help, whereas in the feminist approach, the woman is treated as an independent person acting on her own behalf, involved in decision-making, and empowered to create her own life through the process of assisted self-help.

Rodriguez (1988) describes the Family Crisis Shelter (FCS) in Hawaii as an example of a successful feminist shelter that has survived and maintained its feminist agenda despite pressures toward co-optation by conventional social service agencies, lack of funding, and an anti-feminist backlash from the press and the community. The shelter attempts to provide women the social and emotional skills to overcome their depression, dependency, and lack of self-confidence and make them strong and capable of choosing to live independent of abusive men. The characteristics Rodriguez considers to be critical to its success include its grassroots staff of former residents, its open door policy with minimal screening and length of stay restrictions, and its empowerment strategy. The empowerment strategy includes providing the women with an egalitarian organization, the freedom to make their own choices, role modeling, nonjudgmental support, and feminist activism. Residents attend three group sessions each week with a focus on consciousness-raising and politicizing the women’s individual experiences. These sessions help the woman understand that she is not alone, and that men’s violence against women is a problem of our society, not just of her life. Women in activist
shelters reported the main benefits of shelter residence was safety, an end to isolation, companionship, solidarity, independence, and mutual assistance (Dobash & Dobash, 1992; Rodriguez, 1988).

**Feminist Groups**

Feminist all-women support groups are often recommended by feminist therapists since the group format is particularly valuable for the practice of feminist therapy’s major principles (Brody, 1987; Butler, 1985; Butler & Wintram, 1991). In feminist groups, the power of the therapist is diluted so that there is a more egalitarian structure than in individual therapy (Rosewater, 1988b; Zerbe-Enns, 1993). The group setting promotes a democratic structure where all members of the group share power, resources and responsibility (Brody, 1987; Zerbe-Enns, 1993). Other advantages to the feminist group format are that it enables women to validate each other’s strengths, develop mutual support systems, expose themselves to role models of women who have successfully overcome problems, help each other discover and explore areas of growth, and practice new interpersonal skills, such as assertiveness and confrontation (Brody, 1987; Butler, 1985). Group work is also often more cost-effective for women than individual therapy (Butler, 1985).

Consciousness-raising is an important component of feminist groups. Feminist groups encourage the discussion of the effects of social conditions such as sex role stereotyping, sex discrimination, oppression, and victimization in women’s lives (Brody, 1987; Butler & Wintram, 1991; Zerbe-Enns, 1993). The effects of female socialization is
one of the issues that can be freely explored among the women group members. This may include discussing attitudes and behaviors of trying to please others, especially men, having difficulty identifying one’s own needs, playing the caregiver, needing other’s approval and validation, and devaluing other women (Brody, 1987). The group provides a way to explore changes that can be made at a personal level and those that could contribute to social change (Brody, 1987; Butler & Wintram, 1991; Zerbe-Enns, 1993).

Feminist support groups are a popular approach in working with battered women and are a component of most battered women’s shelters and programs (Gerard, 1991; NiCarthy, Merriam, & Coffman, 1984; Tutty, Bidgood, & Rothery, 1993). Education and discussion about the dynamics of the cycle of violence, learned helplessness, and social institutions that perpetuate violence against women are important components in support groups for battered women.

Although the battered woman may be afraid to talk about the abuse because of the batterer’s threats, the woman’s greatest chances for safety lie in her breaking her silence and joining with others for options and support (Burstow, 1992). The group provides an opportunity for the woman to practice telling others what has happened, responding to their reactions, and asking for what she needs. The practice in sharing her story with supportive others proves helpful to the woman in working with victim-blaming social and legal agencies which require public disclosure of her private life (Dobash & Dobash, 1992). A feminist group leader can help encourage each woman to
talk about the abuse, while taking seriously her fears and helping her assess the risks involved in telling about the abuse (Burstow, 1992).

Guidelines and goals often mentioned in feminist groups with battered women include addressing the current and future safety of the women; helping women recognize the realities of the violence without denial, minimization, or trivialization; helping women reduce any self-blame, learned helplessness, or low self-esteem; providing an understanding of why battering occurs in the socio-political context of sexism and oppression; giving women the opportunity to express feelings such as anger or grief; exposing women to role models of other women who are trying to end the violence in their lives; enhancing women's group facilitation skills; and providing an opportunity for women to develop a support network (Bowker & Maurer, 1986; Brody, 1987; Gottleib, Burden, McCormick & NiCarthy, 1983; NiCarthy, Merriam, & Coffman, 1988; Tutty, Bidgood, & Rothery, 1993; Zerbe-Enns, 1993).

Brody (1987) believes a professional therapist can offer expertise and help facilitate change while also maintaining the nonhierarchical structure of self-help groups and the principles of feminist therapy. NiCarthy, Merriam, & Coffman (1988) believe the ideal is a "mutual-help" group with two co-leaders that are as diverse in age, race, outlook, etc., as possible. The leaders may be professionals, paraprofessionals, or volunteer workers as long as they have an understanding of the feminist issues and politics of battering. They recommend a two hour, all woman, drop-in group containing a formal beginning (introduction of members and group focus), brags (each woman,
including the leaders, stating something positive that she has done for herself in the past week), an activity (specific topic or exercise), a short break, another activity, and a formal ending (exchange of members’ phone numbers and safety check of each member). Some of the topics recommended are the progression of violence, alcoholism and drug abuse, holidays and anniversaries, the effects of abuse on the children, and the effectiveness of batterer counseling. Some of the exercises recommended include creating a pamphlet for abused women, visualization of staying and leaving the relationship, examining the brainwashing techniques developed by Amnesty International (1973) and listing ways that the batterers have used those techniques to control them, and listing behaviors that have occurred in each stage of the cycle of violence (NiCarthy, Merriam, & Coffman, 1988).

Feminist therapists have recommended second phase groups for women who have been away from the abuser for six weeks or longer and want to commit to a regular weekly group. This group would focus on longer term issues related to replacing survival behaviors with more useful behaviors once they are violence-free. Topics for discussion may include fear, anger, depression, loneliness, developing friendships with women and men, dating, sexuality, assertiveness, and finding employment (NiCarthy, Merriam, & Coffman, 1988; Walker, 1984, 1985).

Effectiveness of Feminist Therapy with Battered Women

Researchers have commented on the dearth of empirical evidence on the outcome of feminist therapy (Zerbe-Enns, 1993), battered women’s services such as individual
counseling, group counseling, and peer support sessions (Koss, 1990; Mancoske, Standifer, & Cauley, 1994; Rubin, 1991), and empowerment-focused counseling (McWhirter, 1991). Zerbe-Enns notes that outcome research comparing the effectiveness of diverse types of therapy have revealed little or no differences between types of therapy (Stiles, Shapiro, & Elliot, 1986), and since feminist therapists integrate a diverse range of therapies and techniques in their definition of feminist therapy, it is difficult to compare and contrast feminist therapy with other types of therapy.

There have been some studies on the effectiveness of various counseling interventions with battered women. Shelter intervention was found to be most successful, as defined by a decrease in subsequent abuse, when accompanied by other assistance or interventions such as obtaining a restraining order, filing for divorce, and obtaining concrete services in the battered woman's attempt to gain control of her life (Aguirre, 1985; Berk, Newton, & Berk, 1986; Bowker & Maurer, 1986; Russell, 1988). For battered women who use shelters, each additional effort to obtain help reduces the number of subsequent violent episodes (Berk, Newton, & Berk, 1986). Frisch & MacKenzie (1991) found that abused women in a shelter who had counseling were significantly more likely to leave the relationship than women who did not.

Based on earlier research indicating that battered women often need concrete services and material resources in order to leave their abusive partners (Gondolf, 1988; Okun, 1986; Strube & Barbour, 1983), Sullivan (1991b) studied the effect of providing advocacy services to battered women in a shelter who had decided to leave their
assailants. An experimental group of 25 women received assistance from a paraprofessional specifically trained in helping the women obtain community resources such as housing, employment, material goods and services, childcare, and transportation. A control group of 16 women did not receive the assistance of a trained advocate. Of the women who received the advocacy services, 80% reported being very satisfied with both the program and the advocate, and 77% reported that the program had been somewhat or very helpful in helping them remain free of abuse. The women who had worked with advocates reported being more successful in reaching their goals than the women in the control group.

There was no significant difference, however, between the groups on the dimension of independence from their assailants. Follow-up measures conducted five months after the women left the shelter found 83% of the experimental group and 81% of the control group still separated from the men who had battered them. Sullivan concludes that while providing short-term advocacy services is both viable and effective in helping battered women obtain material resources, the role of these advocacy services in helping battered women remain free of their abuser is unclear. Sullivan suggests further research allowing for longer term follow-up data to clarify these findings.

Horton & Johnson (1993) studied 185 women who successfully ended their abusive relationships to determine what they perceived as most helpful. The women in the study rated friends, professional counselors, and shelters as the most effective resources for ending the abuse. The counselors perceived as helpful were those that
exhibited an understanding of the women's plight and the complexity of her situation, while the women criticized counselors who appeared uninformed about abuse issues. Horton & Johnson conclude that clinicians’ advocacy and educational roles are important in stopping the violence, and that counselors need to be sensitive to the complexity of battered women’s issues in order to be perceived as effective helpers. Although they did not specifically label the interventions as feminist, the success factors listed are key principles of the feminist approach to working with battered women.

Bowker & Maurer (1986) provide strong support for feminist groups for battered women. Using questionnaires, interviews, and the written comments of 1000 battered women, the effectiveness of women’s groups, social service/counseling agencies, and the clergy were evaluated for their effectiveness in ending the violence. The battered women rated women’s groups higher than social service or counseling agencies, with the clergy least likely to be perceived as effective. Written comments about women’s groups were overwhelmingly positive; comments about social service and counseling agencies tended to be positive; and comments about the clergy tended to be negative. Statements relating to increased personal power were strongest in the comments about women's groups.

In an earlier study of interventions with battered women, Bowker (1983) found that social service/counseling agencies mainly provide the services of focused talking (32% of all helping behaviors provided) and commanding or directing the client about problem solving (31% of helping behaviors provided). The clergy use about 52% of
helping behaviors on focused talking and commanding and directing. Women's groups, however, use focused talking and commanding and directing as only 10% of their helping behaviors. Women's group's services are mainly modeling (60%) and promoting material aid and direct services (20%). Bowker & Maurer extrapolated this data to their 1986 study results to conclude that battered women consider the feminist interventions emphasizing modeling and providing direct services as more effective forms of help than the social service agency and clergy interventions emphasizing focused talking, commanding, and directing. The other success factor Bowker & Maurer note is that women's groups tend to be staffed by formerly battered women or paraprofessionals specifically trained in battered women's issues so that the leaders, as well as other group members, serve as models for successfully ending violence. Bowker & Maurer recommend a shifting of resources from traditional agencies to women's groups and an increased emphasis on modeling, providing material assistance, and the use of trained paraprofessionals to provide more efficient and cost-effective options for women.

Two studies of battered women's support groups not specifically identified as feminist groups but containing the elements of the feminist model found improved measures in certain issues. Holiman & Schilit (1991) found that role-playing, expressing feelings, and problem solving in the group setting decreased the participants’ feelings of powerlessness. Tutty, Bidgood, & Rothery (1993) evaluated 12 support groups for battered women. The women in the study showed significantly improved measures in the areas of self-esteem, belonging support, locus of control, less traditional attitudes toward
marriage and the family, perceived stress, and marital functioning as a result of participating in the groups. These improvements were maintained and in some cases continued to improve at six month follow-up measures. A majority of the women (87%) reported that the support group program met all or most of their needs and that they would recommend the program to a friend.

An exploratory study by Mancoske, Standifer, and Cauley (1994) studied 20 women who received eight weekly sessions of crisis intervention services and then were randomly assigned to individual counseling with either a feminist counseling focus or a grief resolution focus. Ten women participated in the feminist counseling approach which focused on encouraging the women to define the problem, teaching new interpersonal skills, instilling hope, and building on existing strengths. The content areas emphasized powerlessness, learned helplessness, hostile social conditions, coping mechanisms, values clarification, and self-enhancing cognitive change techniques. The goals of the feminist program were improved self-esteem, confidence, assertiveness, and an understanding of the conditions leading to abuses of power in relationships.

Ten women participated in the grief resolution oriented approach based on Turner & Shapiro’s (1986) model of using grief counseling with battered women to help them mourn the loss of the relationship. The techniques included an exploration of Kubler-Ross’ (1969) six stages of mourning as applied to ending relationships. Handouts were given, and counseling was focused on each of the six stages of denial, anger, isolation, bargaining, depression, and acceptance.
In combined measures of both groups, the women who received the counseling following the crisis intervention had improved measures in self-esteem and self-efficacy, and more positive attitudes toward feminism. Studied separately, the women in the grief resolution counseling group had statistically significant improved gains in self-esteem and self-efficacy, but not in attitudes toward feminism. The women in the feminist group did not show statistically significant improvement in any outcome measure, although all scores did improve.

Based on the women's increased measures in self-esteem, self-efficacy, and attitudes toward feminism, the authors conclude that individual counseling that provides basic crisis intervention, followed by short term counseling, improves battered women's self-esteem, self-efficacy, and attitudes toward feminism. Since the results indicated that the battered women seemed to be especially concerned with loss, they suggest that grieving the loss of the relationship be the initial focus of counseling, moving on to feminist issues as the counseling progresses when the women are ready to move beyond the grieving issues. In a related finding, Varvaro (1991) also found that assessing battered women's losses and dealing with them in a support group enabled women to develop self-determination and an ability to overcome the immobilizing effects of grief.

This chapter discussed how feminist therapy is used to help empower battered women to create changes in their lives. The specific application of feminist therapy with battered women in shelters and groups were examined. Research on the effectiveness of
the use of various counseling approaches, including feminist therapy, with battered women was reviewed.

The final chapter provides a summary of the feminist analyses of wife battering, the consequences of battering on the battered women, and the use of feminist therapy with battered women. Limitations of the study and suggestions for future research are presented.
CHAPTER 4

SUMMARY AND DISCUSSION

This thesis examined the feminist approach to studying wife battering and the use of feminist therapy as a way of helping individual women escape from violent relationships. The feminist perspective on wife abuse was examined in Chapter 2. Three features distinguish the feminist analysis of wife abuse from other perspectives. These features are the focus on male violence over women rather than the study of individual pathology or family violence, the use of feminist language, and the use of feminist research methods.

The feminist viewpoint of wife battering states that men’s violence against their wives is one component of men’s dominance over women and societal constructs that accept and condone such violence. Feminists believe that using feminist language that does not mask or neutralize wife abuse and using feminist research methods that openly address the patriarchal bias of “objective” methodology are important first steps in understanding the dynamics of wife abuse. The main questions to be asked are “Why do men batter their wives?” and “Why do women stay with abusive men?”

In the feminist argument, the main reasons given for why men batter women are the dominant patriarchal social structure and patriarchal norms that are rooted in history and still in existence today (Coleman & Straus, 1986; G. Walker, 1990; Yllo & Straus,
1990). Another reason given for men's violence against their wives is men's belief in stereotyped sex roles for men and women, and attitudes approving of wife beating. Men with more traditional views of men's and women's roles and more approving attitudes of men's use of violence against wives have been found to be more likely to be physically abusive to their wives (Smith, 1990; Stith & Farley, 1993). Societal attitudes approving of wife beating and of the legitimacy of male dominance over women also provide some social acceptance for wife beating (Dibble & Straus, 1980; Gentemann, 1984; Greenblatt, 1985; Smith, 1991).

Institutional support for male violence against women has been documented in the institutions of religion (Alsdurf, 1985; Fortune, 1993), criminal justice (Ferraro, 1993; Waaland & Keeley, 1985), health care (Kurz & Stark, 1988; Warshaw, 1993), and mental health (Bograd, 1984; Rosewater, 1988a). If not overtly approving of wife beating, these institutions often offer victim-blaming responses when “helping” battered women. Battered women are often revictimized by the very institutions that they turn to for help.

A feminist analysis of the reasons why women stay in relationships with abusive men was also discussed. Battered women actually do attempt to leave the relationship several times, but return for various reasons before being able to leave permanently (Follingstad et al., 1992; Gelles & Straus, 1988; Hoff, 1990; Sullivan, 1991a). Some of the reasons include the lack of concrete resources such as housing, employment, transportation, and child care, and economic dependence on their partners.
Women who have the skills and means to live independently are more likely to leave the battering relationship than those who do not (Gondolf, 1988; Hoff, 1990). Studies have also found that women’s realistic fear of the batterer keeps the women from leaving. A batterer’s violence toward his wife often escalates at the time she makes a move to separate or to assert her independence, as he attempts to re-establish his control and dominance over her (Smith, 1990; Sullivan, 1991a; Wilson & Daly, 1993).

Women’s socialization to accept men’s “imperfections” and the emphasis on women’s roles of wife and mother also may contribute to battered women’s willingness to remain in the relationship (Burstow, 1992; Hoff, 1992; Walker, 1989b). Women have been socialized to keep relationships together, to keep their husbands happy, and to be dutiful wives. If these sex roles are strongly tied into a women’s identity, she may feel like a failure as a woman if the marital relationship ends.

Another reason discussed for why women have difficulty leaving a violent relationship is the dynamics of the cycle of violence that often occurs in battering relationships (Carlisle-Frank, 1991; Walker, 1979, 1984). The batterer is not constantly abusive, but rather rotates between tension-building, acute battering incidents, and loving honeymoon-like behavior. The occasional loving behavior or even just the absence of violence provides intermittent reinforcement for the battered woman. As the acute battering incidents increase and the honeymoon phases diminish or disappear, the battered woman is more likely to leave the relationship (Carlisle-Frank, 1991; Walker, 1984).
Learned helplessness is a controversial explanation for battered women's seeming submission to the violence. Some researchers have documented the existence of learned helplessness in battered women as evidenced by their depression, feelings of helplessness, passivity, and poor problem-solving skills (Carlisle-Frank, 1991; Lanius & Lindquist, 1988; Walker, 1984; Wilson et al., 1992). Other researchers have pointed to battered women's help-seeking perseverance as contraindications of learned helplessness, and instead, blame the inadequacy of the resources available to battered women when they do seek help as reasons why the women are forced to return or stay (Gondolf, 1988; Hoff, 1990).

Battered women have suffered psychological symptoms as a result of the abuse, including anger, fear, depression, and anxiety (Dutton & Painter, 1993; Gleason, 1993; Okun, 1986; Rosewater, 1988a; Russell et al., 1989; Walker, 1984). These psychological symptoms may be viewed as a whole forming a pattern of battered woman syndrome which is considered a subcategory of PTSD (Douglas, 1987; Walker, 1984, 1991, 1994).

Several recent studies have documented the existence of PTSD in battered women (Astin, Lawrence, & Foy, 1993; Dutton & Painter, 1993; Gleason, 1993; Kemp et al., 1991; Kemp et al., 1995; Saunders, 1994). Some of the symptoms include hyperarousal, psychic numbing, re-experiencing of the traumatic events, and feelings of detachment. Although feminists have generally disapproved of the use of psychiatric labels with battered women, the diagnosis of PTSD has been accepted because it focuses only on the effects of the ongoing traumatic experience without blaming the woman.
Feminist recommendations for ending wife battering are mainly aimed at ending the larger societal context that supports male violence against women. Activism on behalf of battered women, including lobbying for stronger laws and better enforcement of existing laws against domestic violence, providing training for police and other battered women’s service providers, and educating the public about the feminist dynamics of wife abuse are some of the recommended approaches to attacking the problem. These grassroots efforts remain at the center of the feminist approach to ending wife battering.

One approach to helping individual women, however, is feminist therapy. Feminist therapy with battered women addresses the political dynamics of battering while working to empower the individual woman to end the violence in her life. The specific principles and techniques of feminist therapy with battered women were discussed in Chapter 3.

Specific issues the feminist therapist must honestly address before and during therapy with battered women include the therapist’s potential temptation to rescue the client, the therapist’s own vulnerability to men’s violence, the therapist’s feelings of anger at the batterer, and any conscious or unconscious victim-blaming attitudes toward battered women.

The process of feminist therapy with battered women mainly focuses on the goal of empowering the woman so that she may have the resources and feel confident enough in her decision-making abilities to make whatever changes in her life she wishes. The
therapist's role is to help the woman identify and build on her strengths, her power, and her skills in order to reclaim her life. The therapist facilitates this empowerment by demystifying the process of therapy, providing an egalitarian therapy relationship, engaging in mutual goal-setting with the client, respecting the client's pace and expertise about herself, and continually focusing on the client's strengths rather than her deficits. The feminist therapist engages in education and consciousness-raising with the battered woman, exploring the issues of men's oppression over women, sex role stereotyping, patriarchal institutions, and the feminist analysis of wife abuse. The feminist therapist also advocates for the client outside of the therapy session.

Some of the potential issues to be addressed in feminist therapy with battered women include developing a safety plan, providing referrals for concrete services, and understanding legal options. The feminist therapist may also help the battered woman address such issues as the woman's ambivalent feelings toward the batterer; denial, minimization, and trivialization of the abuse; self-blame; guilt; and anger. The feminist therapist focuses on helping the battered woman recognize and accept these (and other) feelings as normal responses to the battering experience and helps her build on these feelings with a positive, forward-moving focus.

Feminist approaches to treating battered women's PTSD symptoms have developed in recent years. Walker (1994) and Dutton (1992) have developed treatment models that address battered women's PTSD symptoms in conjunction with the feminist construction of wife battering. Their approaches represent positive advances in treating
the effects of the trauma of the battering, while still paying attention to the context of the battered woman’s situation, and addressing such issues as safety, obtaining concrete services, and empowerment.

Battered women’s shelters and battered women’s groups are two of the most popular feminist approaches for helping to empower battered women. Both shelters and groups are considered to be essential components of feminist therapy with battered women as they provide the ideal settings for such feminist therapy constructs as shared power, decision-making, role-modeling, safety, social support, acceptance, consciousness-raising, feminist activism, and providing alternatives to violence.

Research studies examining the effectiveness of feminist therapy with battered women has been limited. Most studies have focused on battered women’s use of shelters and support or therapy groups. Some studies have found battered women’s use of shelters has helped them decrease or end the violence, especially when utilized in conjunction with other interventions such as legal aid or obtaining concrete resources (Aguirre, 1985; Berk, Newton, & Berk, 1986; Bowker & Maurer, 1986; Frisch & MacKenzie, 1991; Sullivan, 1991b). Studies examining battered women’s perceptions of the helpfulness and effectiveness of feminist therapy have found that battered women tend to evaluate interventions with feminist components and philosophies as effective in helping them break free from the abuse (Bowker, 1983; Bowker & Maurer, 1986; Horton & Johnson, 1993). Studies examining the effectiveness of battered women’s groups found improved measures in such areas as problem-solving, self-esteem, locus of
control, and perceived stress (Holiman & Schilit, 1991; Tutty, Bidgood, & Rothery, 1993). Other studies found positive results with battered women’s therapy groups that addressed grief-resolution and issues of loss and mourning as additional components of the therapy (Mancoske, Standifer, & Cauley, 1994; Varvaro, 1991).

Limitations of the Study

This study provided a literature review of the research conducted in the past 15-20 years on the feminist analysis of wife abuse and the use of feminist therapy with battered women. As such, it did not present new empirical evidence on the accuracy of the feminist viewpoint or the effectiveness of the feminist therapy methodology with battered women. Research chosen to review was taken mainly from social work, psychology, and counseling journals and books that specifically addressed the feminist view and feminist therapy. Including research from a wider variety of fields would have more accurately addressed the multi-faceted dynamics of the wife abuse issue, but was beyond the scope of this thesis. Also, within the study of feminist therapy and domestic violence, there are discussions and disagreements among feminist therapists on the best way to practice feminist therapy and the best way to address battered women’s issues. The views presented in this thesis provided a summary of the most popular views (as found in mostly mainstream journals) and may represent an oversimplification of feminist therapy theory.

In examining only the feminist viewpoint on wife abuse, focusing only on the societal influences allowing wife battering to occur, the interactive effects which could
help explain why some men are and some are not abusive to their wives was not examined. Issues related to the children caught in the middle of abusive relationships were not addressed in this study as much of the feminist literature does not discuss the effect of the children's issues and the children's potential sense of loss on their mothers' decision-making process. The effects of cultural and racial differences in experiences of wife battering and the issue of battering in same-sex intimate relationships also were not addressed in this study.

**Suggestions for Future Research**

While feminist therapy has received some research support indicating it is an appropriate choice for helping battered women, further research needs to be done on the role feminist therapy plays in freeing women from abuse in order to answer the question, "Is feminist therapy effective in helping battered women?" Following the feminist analysis of wife abuse, this research should be conducted using feminist research methods that address the male-centered context in which wife beating occurs. In-depth interviews and surveys with battered women, such as those conducted by Walker (1984), Hoff (1990), Bowker and Maurer (1986), Horton and Johnson (1993), and Sullivan (1991b), investigating what strategies and services battered women perceive as most helpful in ending abuse and follow-up studies examining if an elimination, not just a reduction, of violence occurs and is maintained as a result of these measures are recommended.
Additional studies examining the effects of feminist therapy in conjunction with other interventions, such as grief counseling and legal interventions, also need to be conducted, building on the research that has established that the battered woman’s use of several help-seeking options, rather than just one, is more likely to result in success. Interviews with therapists and service providers, and surveys of battered women’s shelters and programs investigating the approaches they have used and found to be most successful in helping battered women end the violence would be helpful in discovering the effects of multiple services for battered women. Finally, more research is needed on the combination of feminist therapy and survivor therapy, addressing battered women’s PTSD issues in a feminist context, as this appears to be a promising area for helping battered women obtain safety and freedom from violence, while addressing the traumatic results of the battering.

Psychology and social work researchers will need to exert persistent feminist activism and pressure in order to convince funding sources to direct future resources toward the continued study of feminist theory and feminist therapy for battered women. Concerned professionals, paraprofessionals, and activists across the fields of psychology, social work, criminal justice, health care, and religion need to continue to advocate and work towards an integrated, multi-systems approach for ending men’s violence against women.
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The author, Mary R. Zapart, was born on April 30, 1962 in Chicago, Illinois. She attended grammar school, high school, and college in the Chicago area.

Ms. Zapart graduated with honors from Northern Illinois University in 1985. She received a Bachelor of Science degree in Personnel and Industrial Relations Management and a Bachelor of Arts degree in Psychology. Her professional experience has been mainly in the Human Resources field, specializing in the areas of staffing and placement, employee development, resource management, and employee benefits.

Ms. Zapart is a candidate for January 1997 graduation from Loyola University Chicago with a Master of Arts degree in Counseling Psychology. While in the Master’s program, she completed a nine month practicum at Family Counseling Services in Aurora, Illinois where she counseled children, adolescents, and adults, and co-facilitated a group for adult children of dysfunctional families. Ms. Zapart also was actively involved as a volunteer for three years at Sarah’s Inn, a comprehensive domestic violence social service agency in Oak Park, Illinois. Her involvement included providing crisis counseling on their 24 hour hotline, co-facilitating the women’s support group, and giving presentations in the community about domestic violence and Sarah’s Inn services.
THESIS APPROVAL SHEET

The thesis submitted by Mary R. Zapart has been read and approved by the following committee:

Marilyn Susman, Ph.D., Director
Associate Professor, Counseling Psychology
Loyola University Chicago

Carol Gibb Harding, Ph.D.
Professor, Counseling Psychology
Loyola University Chicago

The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the committee with reference to content and form.

The thesis is, therefore, accepted in partial fulfillment of the requirements for the degree of Master of Arts.

11-19-96
Date

[Signature]
Director's Signature