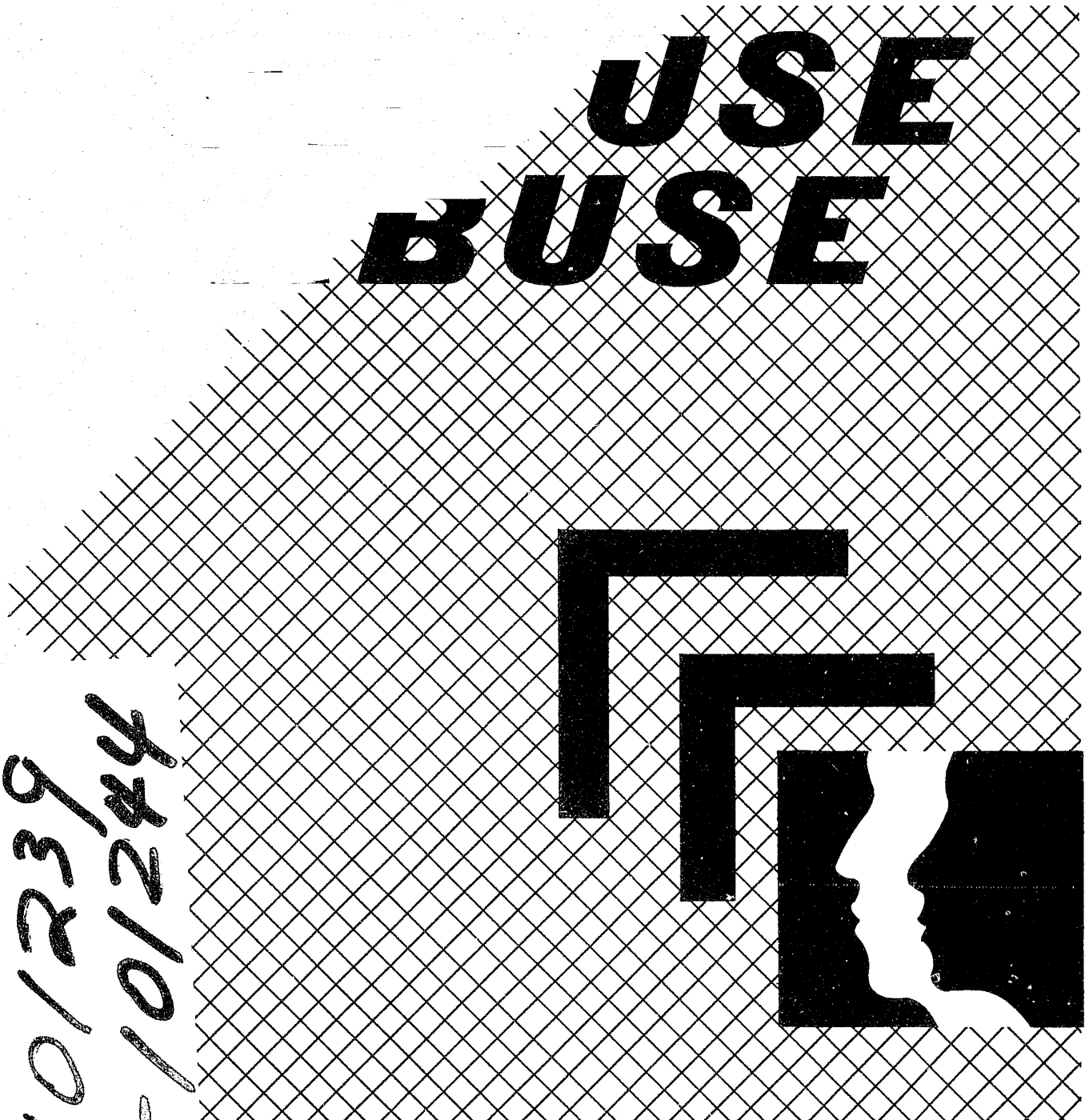
Proceedings

Identification and Treatment of

SUBSTANCE USE DISORDERS



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Long Island Jewish — Hillside Medical Center

IDENTIFICATION AND TREATMENT OF SPOUSE ABUSE
Health and Mental Health Agency Roles

Proceedings of a Conference
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Edited by Abraham Lurie, Ph.D., and Elizabeth B. Quitkin, C.S.W.

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Welcome

Elizabeth B. Quitkin

On behalf of Long Island Jewish-Hillside Medical Center I welcome you to this conference -- "Identification and Treatment of Spouse Abuse, Health and Mental Health Agency Roles."

Long Island Jewish-Hillside Medical Center first became significantly aware of the problem of battered women in 1977, through our social workers in the emergency room. At that time we were unable to find services for many of the battered women and none at all for couples who were interested in working on the problem together subsequent to the emergency room visit. In response, a small, nontraditional program using volunteers supervised by professional staff was developed within the Medical Center and initially funded by the United Hospital Fund. In our own work and in our contact with other agencies over the past 3-1/2 years it has become abundantly clear that no one program relating specifically to spouse abuse comes close to meeting the need. Battered women have many entry points into the system: the emergency room, the psychiatric clinic or hospital, the courts, the welfare system, through their children's problems, and through medical clinics, health maintenance organizations, and private physicians, among others.

It seems clear that the professionals meeting these women in whichever setting need to expand their knowledge of the women's needs and develop techniques for working with this population. The need seems even more urgent now, when we can anticipate very little, if any, Government spending in this area for new programing and most probably cutbacks in already existing programs. To this end we have designed the conference today to offer health and mental health professionals an opportunity to share and examine new perspectives and innovative approaches to the identification and treatment of spouse abuse. Major presentations on traditional and nontraditional viewpoints will highlight this morning's session. The afternoon workshops will be devoted to specific areas of practice. From the enthusiastic registration for this conference it appears that many in the community feel the need for this kind of educational process.

Introductory Remarks
Robert K. Match, M.D.

Dr. Robert K. Match, M.D., is President of Long Island Jewish-Hillside Medical Center. He is a Diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons. He is Professor of Community Medicine, State University of New York at Stony Brook, and consultant in surgery at L.I.J. Dr. Match's commitment to the concepts and principles of community medicine has for more than 10 years put Long Island Jewish-Hillside Medical Center in the forefront of efforts to develop programs meeting the health needs of the community. Dr. Match himself has been consistently supportive of experimentation and new programs, particularly as they relate to the interface of medical and psychosocial practice. - E.Q.

First let me say that I'm astonished by the turnout here, and I know that unfortunately many, many others were turned away. From this I think we can deduce several points: first, the subject is one that's increasingly on the minds of both public and health professionals and almost everyone else in our society; second, in addition to an increased awareness of the problem of spouse abuse, the problem itself is becoming greater, as our society turns more violent. That's unfortunate, but true.

I think most of you know that the seminar is sponsored both by the Departments of Psychiatry and Social Work Services of Long Island Jewish-Hillside Medical Center and the State University of New York at Stony Brook and that it was made possible by a grant from the Department of Health and Human Services, the Office of Domestic Violence, in Washington, D.C. It is significant that, at least up to this point, we are still seeing Federal funding for this type of activity. Let's hope it continues.

Spouse abuse is both a family, social, and public health problem in this country, and it is more and more being confronted directly and recognized by those of us who interface with it, seeing it as a very serious and growing issue. There are often very complex interactive factors that produce the syndrome of spouse abuse, and most frequently it is the emergency room staff that is confronted with these problems. No matter how complex the initiating factors, we have found that often the problems are intensified by a lack of awareness and sensitivity on the part of medical personnel, law enforcement officers, and families -- almost everyone who surrounds these people at the time of the crisis.

The basic thrust of our efforts today, in this conference, and in our emergency room and other programs is to try to increase the awareness and sensitivity of people to this problem, to dispel some of the myths and misinformation surrounding it, and to remove some of the impediments surrounding the issues of spouse abuse to be dealt with. At L.I.J.-H.M.C. we have often initiated programs to deal with very special problems that are being neglected or ignored by those around us, and spouse abuse is another such example. Our emergency room, which is quite active, was

seen as a key point for identification and early intervention in the problem of spouse abuse. With a grant from the United Hospital Fund, we started a small, experimental pilot program to see if we could begin to make some impact and develop a referral network for dealing with people involved in this program. It quickly became clear there was a need for both expanded services of this type and an improved referral network to deal with the many complex issues surrounding spouse abuse. So I'm particularly pleased that so many people are here today. I think we have an outstanding faculty who will provide a very interesting and stimulating day for all of us.

Introductory Remarks
Abraham Lurie, Ph.D.

Dr. Abraham Lurie is Director of the Department of Social Work Services at Long Island Jewish-Hillside Medical Center. Over the years Dr. Lurie has helped the department pioneer many innovative programs and professional services. He was instrumental in helping the Medical Center obtain Funding for the Abused Spouses' Counseling Program and has provided ongoing support and encouragement to those of us involved in this area of practice and programing. Dr. Lurie is Professor of Social Work at the State University of New York at Stony Brook and Clinical Professor of Social Work at Adelphi. -- E.Q.

I wish to bring greetings from Dr. Charles Rabiner, Chairman of the Department of Psychiatry, which is a co-sponsor of this project. Unfortunately, he is not able to be here this morning because of an emergency.

There is no question that spouse abuse is a reflection of societal and family tensions, and that these tensions arise from a variety of sources -- economic problems, prejudices, and psychological forces. Family life today is undergoing a tremendous transition, as evidenced by recent published statistics. In 1979 there were approximately 2,360,000 marriages and 1,120,000 divorces; about 65 to 70 percent of the people who are divorced remarry. We are living in a pluralistic and polygamist society that gives many people several opportunities to become involved in marital relationships. In this process tensions are created, and they may result in problems, as social workers and others in the behavioral field know only too well. While it is true that in spouse abuse the patients who come to our attention are almost all women, occasionally a man who has been battered does appear.

Years ago in a very popular comic strip, "Maggie," the man was depicted as coming home at night drunk and trying to tiptoe into the house. He was always caught by Maggie and invariably hit over the head with a rolling pin. I suppose this does not happen any more, although there are other forms of abuse today that we're not as thoroughly familiar with as perhaps we should be, such as psychological abuse which affects both men and women.

The reasons for family abuse have been debated. In an article in the recent issue of Social Service Review, Dr. R. Peterson has raised several questions concerning the cause of family abuse, based on data after several years of study. He has indicated that we should not ignore the social-class issue related to social structural change. And the second possibility is that violent behavior is learned in the family of origin. Violence has also become a subject of discourse that is throughly familiar and ingrained through the mass media, and the question of its impact might well be raised. One factor that has helped bring this problem out of the closet is the changing role of women. The reverence for family structure does not appear to exist as it once did, and women are able to come forth and indicate more resolutely what their problems are. There are

still significant cultural biases, however, and we still have a sexist society.

We need more research on and evaluation of some of our methods to help people with this problem. And we hope that you who are representatives of those agencies that have had some difficulty in dealing with this problem will gain an awareness on the basis of our conference today and begin to plan steps to deal with it.

We do need an effective network of services that will be able to provide crisis intervention to help the abused spouse with difficult situations. We need protective, appropriate counseling and psychiatric services. We are hopeful that this conference will make a small contribution to understanding the problems of this very often forgotten group, particularly those we would consider a high-risk group, and make available to them appropriate and accessible facilities. We also hope this conference will give impetus to providing a better quality and more humane service for those in need. We hope that as a result of the interaction here the consciousness of all of us will be raised to the point where we will be able to contribute our expertise at a level that can ameliorate this very difficult problem.

PAPERS

Psychiatric Perspectives on the Abuse of Women: A Critical Approach

Evan Stark, Ph.D.

Evan Stark is currently Fulbright lecturer in Sociology at the University of Essex, England. The work described in this paper was done while he was a Research Associate in the Department of Surgery and Center for Health Studies at Yale University and Director of the Family Violence Research Program there. Dr. Stark is a founding member of the New Haven Project for Battered Women. -- E.Q.

Introduction

We will address three questions: What are the major clinical presentations of abuse? What impact do medicine, psychiatry, and social work have on "the battering syndrome"? What lessons can we learn from the impact of therapeutic intervention on the evolution of the syndrome?

In sections I and II we draw on the medical histories of abused and nonabused women to distinguish battering as a socioclinical syndrome in which specific therapeutic approaches develop alongside injury and general medical and mental health problems. First, we describe the strictly clinical signs of battering. Next, we identify typical patterns of medical, psychiatric, and social work intervention. Then, in section III, we argue that the clinical signs of abuse and the typical patterns of intervention are structured into the syndrome through a staging process, during which the victims of abuse are taught to accept responsibility for their battering and often within reconstituted families where further violence is virtually inevitable. Finally, we consider the implications of the prevalent tendency to project therapeutic failure onto a patient population at risk for abuse. We argue for a positive therapeutics based on political support for current changes in normative sexual and family roles.

Last year, approximately 8 million women in the United States were in abusive relationships, and more than 1 million of these women turned to emergency medical services.[1] Since many abused women are beaten on a regular basis and most have long histories of injuries, and since battered women comprise a significant percentage of rape victims, suicide attempts, psychiatric inpatients, mothers of abused children, alcoholics, and women who miscarry and abort, the medical needs and demands of this group are even greater than these numbers imply.[2] Finally, our research shows that battered women make multiple visits to medical and psychiatric services for general health problems, which superficially appear to be unrelated to assault but which are as much a part of the battering syndrome as physical injury. Indeed, on an average, almost one woman in five who uses the emergency trauma service at Yale New Haven Hospital is battered, and almost half of the injuries women present to this service occur in the context of ongoing abuse. When Hilberman asked female patients at a rural psychiatric clinic about abuse, half acknowledged they had been beaten.[3] Pilot research indicates that almost half of the women in a Colorado mental hospital have been beaten.[4]

Despite these facts, physicians, psychiatrists, and social workers rarely identify abuse or select it as a point for intervention. At the hospital where our research is conducted, medical personnel recognize ongoing abuse as the source of a battering injury in fewer than one case in 10 and almost never appreciate its etiological significance. Similarly, in Hilberman's clinic, abuse was virtually never mentioned by persons making the psychiatric referrals.[5] Why is this?

That we are often innocent about social problems goes without saying. Until a decade ago, physicians and psychiatrists confronted with child abuse resorted to extensive workups to discover blood and metabolic disorders that could explain an accumulating history of multiple bruises and fractures.[6] Then too, sexual, racial, and economic bias presentsa purely objective consideration of complaints presented by poor, black, or female patients.[7] At a prestigious emergency service, women who consistently present with vague complaints are termed "TBP's" (short for "total body pain"), a degrading euphemism that masks a frequent sign of abuse. Finally, work pressures limit our capacity to consider situational problems unsupported by immediate breakdown.[8]

These explanations might be adequate were the failure to see abuse not compounded by a failure to see that we do not see. Medicine, psychiatry, and social work fail to identify abuse as a primary etiological factor even though it has received widespread publicity for over a century and even though female patients repeatedly insist on its current importance. In practice, instead of comprehending the significance of assault, the helping services conceal its importance behind alternative perceptions, diagnoses, and interventions -- diverse means of nonrecognition that uniformly aggravate the abused woman's situation. Given the systematic nature of clinical nonrecognition, a purely technical approach to identification is unsatisfactory.

The fact that medicine, psychiatry, and social work often contribute to the battering syndrome raises political and therapeutic issues. Battering is epidemic, a phenomenon of mass, not just individual, psychology, and fully intelligible only in relation to normative behaviors and structures, including the "normal" ideas and habits of family life. Throughout the 19th century, wife beating was fought by elite groups combating material deprivation and demanding legal protection and equal status for women.[9] But formal equality and limited protection have not ended female subordination in domestic life. Recognizing this, many in the Women's Movement stress female independence and self-help; emergency, community-based shelters; and the education of service professionals about female oppression.[10] But is education enough? Or are more basic changes in the social services needed to remove their apparent commitment to traditional female and family roles? Current therapeutic modalities are conservative, converging with broader efforts to sustain male dominance in and outside the home. Since battering is one consequence of this dominance, it is not surprising that the present therapeutic approach often makes abuse inevitable.

I. Battering in a Clinical Context

In this section, we identify the medical and psychiatric presentations of abuse and describe the immediate clinical response.

Identifying Abuse

Since clinicians rarely identify abuse and even less often use "battering" as an explicit diagnosis, estimates of abuse based on official figures will vastly underestimate the extent of the problem. However, a conservative estimate of abuse can be derived by reviewing the full trauma histories of each woman in a given patient population and by classifying each trauma incident, and ultimately the women themselves, into one of the following categories of risk:

positive: at least one injury was recorded as inflicted by a husband, boyfriend, or other male intimate;

probable: at least one injury resulted from a "punch," "hit," "kick," "shot," or similar and deliberate assault by another person, but the relationship of assailant to victim was not recorded nor was the episode an anonymous assault of mugging;

suggestive: at least one injury was inadequately explained by the recorded medical history.

A women is assigned to the reasonable negative category only if each injury in her medical record is adequately explained by the recorded etiology. When we applied these risk criteria to a sample of 3,500 women using the emergency trauma service, we found that 18 percent had a history of abuse, a prevalence estimate that approximates studies using similar identification methods in a Philadelphia hospital and a random Harris poll of Kentucky housewives.[11]

This prevalence estimate reflects the magnitude of abuse confronting a medical system with no adequate means to identify or respond to battering. In such a context, the extent and complexity of abuse can be grasped only when it is viewed historically in relation to the medical and psychosocial problems that accompany physical injury.

In order to determine which characteristics, problems, and types of medical resource utilization distinguish battered from nonbattered women in the clinical population, we randomly selected 690 nonbattered women as controls for our sample of 637 at-risk women. A review of the medical records of these women indicated that the abused women can be distinguished from nonbattered women by the type, anatomic location, and frequency of injury (trauma history), the reproductive history, the pediatric medical history, and psychosocial problems. In addition, we looked at battering risk among a separate sample of women who attempted suicide.

Medical Presentations

Battered women are injured three times as frequently as nonbattered women; they have used the service twice as long; and the location of

injuries that result from abuse is different from those resulting from other causes. Injuries to multiple anatomic sites or to the head, face, neck, throat, chest, and abdomen tend to be battering injuries. In contrast, injuries to the extremities or hip area are not generally associated with domestic assault. The types of injury also differ significantly. Battering injuries are likely to be abrasions or contusions, or pains for which no physiologic cause can be determined. Nonbattering injuries are more likely to be sprains or strains. Fractures, dislocations, and lacerations occur with similar frequency to battered and nonbattered women.

Although battered and nonbattered women had similar numbers of children, battered women had three times the number of abortions and twice the number of miscarriages. Battered women were far more likely to be pregnant when injured, a finding that is widely supported by other studies.[12] The fact that the rate of pregnancy among battered women (live births plus abortions and miscarriages) is far higher than the rate among nonbattered women suggests an important familial pressure that may aggravate as well as derive from ongoing abuse.

The Medical Response

Three nontrauma sites provide the major source of medical care for abused women -- the medical emergency service, the psychiatric emergency service, and the obstetrics and gynecology service. Approximately 3 percent of all women using emergency medical services receive labels such as hysteric, hypochondriac, or women with "vague medical complaints." Although battered women are labeled at this rate prior to their first at-risk incident, after the onset of abuse they are labeled as such four times as frequently. In addition to receiving a disproportionate share of punitive labels, battered women are significantly more likely to receive prescriptions for analgesics and minor tranquilizers, prescriptions that are often contraindicated by complaints of pain. Despite the fact that the injuries battered women presented were no more severe than other reported injuries, battered women got 80 percent of the pain prescriptions and 78 percent of the minor tranquilizers. A small minority of abused women are referred to services for battered women, but battered women are no more likely to be referred to social or psychiatric services at the time of injury than nonbattered women.

Thus, medical personnel ignore battering as a primary problem and treat the complaints associated with abuse symptomatically. Instead of pursuing this present practice, clinicians should immediately suspect abuse when a woman presents with central and/or multiple injuries; when she is injured while pregnant or has a history of multiple or self-induced abortions; when she tells "funny stories"; or when she presents persistent or vague medical complaints. Beyond this, battering should be part of the differential diagnosis of every encounter with an injured woman and taking a trauma history should be routine.

Psychiatric Presentations of Abuse

Although there is no evidence that abused women are frequently mentally ill, 33 percent of the battered women who use the emergency

medical service have also visited the psychiatric service, and battered women use the psychiatric facilities five times as often as nonbattered women. Their most significant presentations are rape, attempted suicide, alcoholism, drug abuse, chronic tranquilizer use, multiple somatic complaints, severe agitation, anxiety with insomnia, and violent nightmares. These problems often result from a combination of inappropriate treatment and ongoing abuse, not from violence alone. Hospitalized women who are battered have typically been diagnosed as suffering "personality disorders" rather than psychoses, and abused women seen on an out-patient basis are frequently reported to be "depressed."[13] We cannot say whether these diagnoses are simply fashionable or reflect distinct symptomatology.

Almost 50 years ago, Karen Horney compared psychiatry's view of women to the little boy's image of the little girl.[14] Her criticism is even more applicable today, when the psychiatric model is applied widely in nonclinical settings and rooted deep in popular consciousness. With few exceptions, the psychiatric literature on battering replicates sexist stereotypes. Women are assessed in relation to their domestic chores and "love." If they refuse these obligations, they are "aggressive," "frigid," or "masochistic." When they adhere to prevailing norms, they are "immature," "passive," or "helpless."[15] In one paper, a woman is "hostile," "domineering," and "masculine" because she fights back and refuses to sleep with her husband when he is drunk.[16] When behaviors are abstracted from the situational contexts that make them intelligible, typical presentations of abuse, such as chronic anxiety, appear to be symptomatic of psychopathology.

Two views in particular deserve critical comment, if only because they enjoy wide currency. According to the first, abused women learn to accept their situation, causing them to react passively even when help is offered. The second view traces battering to parental violence.

Learned Helplessness

Seligman has argued that animals that remained submissive even when previous punishment was removed had "learned helplessness." Walker has extrapolated this theory to explain why abused women often appear indifferent, stay in abusive relationships, fail to report their problems, suffer depression and withdrawal, and resist advice even when real alternatives are presented.[17] Although the theory of learned helplessness parallels the psychoanalytic theory of female masochism in its association of outside punishment with a negative self-image, it suggests that with appropriate support women can unlearn this harmful adaptation. Walker, however, has no evidence to support her theory.[18] To the contrary, all available evidence indicates that, as a group, battered women frequently leave home when hit; fight or fight back; divorce and separate; regularly report their attacks to friends, relatives, police, clergy, physicians, and social workers; and even "invent" symptoms in order to call attention to their plight prior to an anticipated attack.[19] Unfortunately, neither separation nor an appeal to the helping services presently offers much protection. Indeed, the risk of abuse probably increases during separation.[20] In the absence of real alternatives, explanations for battering based on a woman's failure to act decisively shift attention from the

lack of available resources to the victim herself. Even such alleged symptoms of helplessness as attempted suicide and depression are often "pleas for help," or, alternatively, desperate efforts to control a situation. From a therapeutic standpoint, the fact that battered women continually strive to make the best of a bad situation is far more relevant than their supposed resignation.

Child Abuse and Intergenerational Violence

Perhaps no idea about wife abuse is as widespread as its presumed link to child abuse and to violence in the family of origin.[21] There is little evidence to support this theory, however, at least in general terms. Child abuse may reflect family conflict. But the fact that family conflict is so much more common suggests its link to child abuse in particular families results from intervening social factors and pressures. Only 1 percent of the female patients we studied indicated their children were in the battered subgroup. Battering most assuredly affects the young and is commonly associated with a multiplicity of somatic, emotional, behavioral, and sleep problems in children.[22] Still, when a private practitioner identified a group of battered women among his patients, he concluded it was rarely accompanied by child abuse.[23]

The theory of intergenerational transmission of violence, what is sometimes termed "the cycle of deprivation," is equally suspect. We know of no studies that follow abused youngsters into adult life, and retrospective evidence linking male violence with the abuse of these males as children is based either on tiny samples of violent criminals or on interviews in which battered women report the childhood experience of their assailants.[24] The results of this work are contradictory; occasional fights are subsumed under "family violence"; women who currently see violence as a problem are more likely to recognize violence in others; social service personnel are trained to identify a history of pathology with "the problem family"; and studies give a uniform validity to information that differs widely in quality. Since battered women enter shelters because their children are at risk, conclusions about the frequency of child abuse based on the shelter population are deceptive. There is no conclusive evidence linking child abuse by women, battered or not, to the abuse of these women by their parents.[25]

Our research does suggest a significant association between child abuse and eventual victimization as an adult woman. The battered women we identified were far more likely than the nonbattered women to have a pediatric history including severe trauma or abuse, a finding that is consistent with theories linking early dependence on helping institutions to subsequent isolation, "secondary" deviance, and adult victimization.

Despite the lack of support for theories of "learned helplessness" and the "cycle of deprivation," they have an intuitive appeal to persons working in social service settings, including shelters. It is difficult to know what to do when the alternatives we proposed don't work. Often in such situations, the only apparent alternative to blaming ourselves is to fix blame in the patient or, better still, in a historical context that explains both the patient's victimization and her inability to act. Whatever their basis in fact, these theories remain important

as means by which social workers (and social scientists) rationalize their inability to change the political reality that confronts them.

Our own view is that the behaviors and personality traits commonly identified with battering are intelligible only when the history of helping encounters is treated as a key situational determinant. For instance, battered women who are labeled and who must extricate themselves from the presumption of being "sick" commonly transfer their anger from the assailant to their "helpers." This expression of hostility often initiates a process during which the helping professional may actually "understand" how a man might become sufficiently frustrated with this woman to abuse her. The implicit identification with the assailant frequently leads to punitive hospitalizations or superficial evaluations with no followup (see the case of Mrs. Jones below). By contrast, patients who willingly view their crisis through the prism of mental illness often present as excessively passive and withdrawn, apparently lacking appropriate affect, like the victims of "rape trauma syndrome." Like Mrs. Smith below, this woman has "learned" to internalize the image projected by her helper. Subsequent clinic visits typically involve maintenance on a variety of psychoactive medications.

Suicide Attempts

Suicide attempts have increased sharply in the United States since World War II, particularly among women. Female suicide attempts outnumber male attempts by more than three to one.[26] In New Haven, hospital admissions for attempted suicide increased more than 1,000 percent from 1955 to 1970; this is far in excess of predictions based on shifts in demography or health care.[27] The typical suicide is a high-status, isolated, white male. The typical attempt, however, is made by lower-status married women "after work" (when others are present) and often in "residential areas."[28] This suggests that attempted suicide is not simply failed suicide but a distinct epidemiological phenomenon associated with the unique situational problems confronting women in this society.

Battered women frequently attempt suicide. An estimated 77 percent of the battered women identified in a Colorado mental hospital had attempted suicide at least once, and women in shelters report only slighter lower rates.[29] To determine the prevalence of abuse in a psychiatric population of women who attempted suicide, we reviewed the medical records of 176 female patients who had attempted to take their lives.

Battering may be the single most important precipitant of suicide attempts among women in the emergency psychiatric population. We found that 25 percent of the women who had made multiple attempts or gestures were battered, and 50 percent of the black women had a history of abuse. Ongoing abuse was clearly the context for the suicide attempt. Not only had almost all the battered women been previously treated for an abusive injury at the hospital, but in a majority of cases an injury had been treated during the last 6 months. Women who mentioned a marital or lovers' quarrel as a precipitant of the suicide attempt were likely to have trauma histories indicative of battering. This was ironic, since 70 percent of the abused women were single, divorced, or separated.

Finally battered women made almost half of all traumatic attempts, as opposed, for instance, to overdose and poisonings.

Psychiatric Response

The psychiatric response left much to be desired. Not surprisingly, the battered subgroup comprised half of those judged to have "marital maladjustment." But battered women were also overrepresented among those labeled "hysterical" or inadequate or borderline personality. Ironically, not only were battered women referred for voluntary in-patient or out-patient care less frequently than nonbattered women, but they were sent home with no referral or consigned to the State mental hospital more frequently than nonbattered women.

The traditional wisdom is that suicide attempts are failed suicides for which medicine bears little responsibility, that they arise at the juncture of individual psychopathology and exogenous stress, and that disposition should respond to the presenting symptoms and underlying intrapsychic or behavioral problems, with little attention to immediate precipitants or the relevant social situation. It follows from this that the home is the preferred context for treating complaints about family quarrels or marital maladjustment. Clearly, this position requires reexamination. Abuse must be suspected in all cases of female suicide attempts, regardless of marital status and the medical seriousness of the gesture.

Probing should be particularly intense where marital conflict is mentioned, where a history of multiple attempts or gestures is revealed, where a woman is pregnant (or has recently miscarried), or where a review of previous trauma suggests the risk of abuse. At a minimum, the disposition should be based on the full medical and psychosocial history. Beyond this, as Maris and Hilberman suggest, the suicide attempt, like the reactive depression, sexual problems, or alcoholism that often accompanies it, may be read as a primary defense against "more serious" aggressive behavior (e.g., a "homicidal rage"), albeit a defense enacted within the diminishing range of options open to the victims of abuse.[30] By contrast, the present response -- labeling, neglect, misdiagnosis, tranquilizing medication, and inappropriate referrals -- can be an important factor in a battered woman's growing sense of fatalism.

Alcoholism

As a major cause of death among American males, alcoholism is highly correlated with many major social problems. There is no compelling evidence, however, to view it as the major precipitant of abuse in America. Widespread reports by battered women that their assailant's drinking stimulates abuse must be weighed against survey data indicating that drink is involved in relatively few domestic crimes and in just 8 percent of the cases where police are called to mediate domestic disputes.[31]

The disjuncture between the perceived etiological importance of alcoholism and its actual role in stimulating abuse is partially explained by the use of the label in the therapeutic encounter. The diagnosis

"alcoholism" gives an abused woman a potent rationalization for domestic violence and may help her accept the Jekyll and Hyde character of a violent relationship, excuse her desire to "help" her assailant,defend her against victim-blaming explanations, and suggest a course of "treatment" upon which she and her physician can readily agree. Alcoholism provides one answer to the plaguing question: "How can I exlain what is happening to me without thinking I am a fool?"The clinical focus on alcoholism, meanwhile, provides a means of avoiding both the moral and political issues battering raises and its health consequences for the individual woman. The following exchange suggests how patient and physicians may use drinking to conceal a volatile social crisis:

D: Come in, What can I do for you?
P: Well, I have got flu, doctor, I have got all pains in my arms.
D: When did you start to feel not so well?
P: The weekend. It started Saturday afternoon ... shivering with cold ... It came mostly about my head; it is paining me a lot. My husband ... with a shoe, it cut me there. I couldn't comb my hair or touch my hair.
D: Oh, dear, when was this?
P: Saturday night.
D: How come?
P: He came home drunk as usual. He has hit me in the past but not for a long while ... causing trouble people next door banging on the wall ...
D: Does he drink much during the week?
P: ... it is a young couple next door ... disturbing them ... banging on the walls and this is affecting my nerves.
D: Does he drink at all during the week?
P: Well, maybe once or twice.
D: Does he get drunk then?
P: Not bad.[32]

Women are frequently blamed for their husband's alcoholism,and the family is universally recognized as the appropriate context for treatment.

Whatever doubts there may be about the extent to which alcoholism stimulates abuse, it is unquestionably an important consequence and sign of battering among women. Fifteen percent of the at-risk women in our sample had a history of alcoholism. Not only was this eight times the rate among nonbattered women, but this difference emerged upon the abused women only after their first reported incident of battering. Ironically, after a battered woman has become an alcoholic, abuse is frequently seen as one of its consequences, a consequence for which some form of family maintenance therapy is required.

Rape

The sexual nature of domestic violence is suggested by the central location of abusive injuries, the frequency of abuse during pregnancy, and by reports that sexual abuse, including rape, often accompanies physical assault. By contrast, even when "acquaintance rape" is discussed, the prevalent view is that rape is a traumatic sexual assault isolated in time and space from a victim's "normal" physical, emotional,and social life and that, therefore, the reconstitution of this normal

life, particularly insofar as it involves intimate or familiar relationships, provides the best supportive milieu.

The discovery that a significant minority of women seen by the Rape Crisis Team at our hospital had been attacked by family members or male intimates prompted research to apply the criteria for battering risk outlined above to the caseload of rape victims over a peroid of 2-1/2 years. Of 98 adult rape victims (over 16) for whom medical records were available, 39 percent had a trauma history indicating they were in abusive relationships. And the percentage was even higher when rape victims were included for whom we had no trauma history but who had apparently been raped and beaten by a male relative. The rape victims who had been battered were older than the nonbattered women and more likely to be married and have children at home. More than half of the rape victims over 30 years old were battered women.

The battered woman who is raped may reject the psychiatric protocol for rape, resisting attempts to have a male intimate telephoned, for instance, and refusing to talk to police. Her failure to fit the stereotype of the rape victim in other ways as well increases the chance that she will be labeled "uncooperative" and blamed for precipitating the incident. While rape victims under 16 are referred to protective services automatically as abused children, adult rape victims rarely receive social service referrals and almost never for physical abuse.

In sum, although alcoholism, child abuse, attempted suicide, and rape frequently occur in the context of ongoing physical abuse, the therapeutic response considers these events apart from their social context. At the same time, reconstituted families are the most frequently chosen sites for treatment. The victim-blaming cycle is complete when the failure to treat the woman in a reconstituted and still-violent family provides still further evidence that the problem originates in the woman and that a "stable" home is even more desperately needed.

II. The Therapeutic Response

Thus far, we have described the medical and psychiatric presentations of abuse from a clinical standpoint, as so many discrete sequelae isolated in time and space from one another, from the clinical response and from the aggregate history of the cohort of abused women using the medical complex. Let us now consider the impact of the therapeutic response on the abused woman, assessing its meaning and value in relation to her total situation.

The medical approach confronts abuse as an escalating pattern of apparently discrete injuries and complaints with no unifying pathophysiological explanation. Psychiatry focuses on "the individual woman," not, however, as an object of exogenous stress or as a subject capable of explicating her situation or extricating herself from it. Instead, she becomes available for treatment only insofar as her social situation and symptoms are mediated through behavioral and emotional problems that she "owns." Her mental space becomes a terrain onto which psychiatry projects its failings. The social therapeutic approach sees and

simultaneously reifies the family, so historicizing the woman's existential crisis that the specificity of sexual assault dissolves beneath an undifferentiated mass of problems. By overcontextualizing abuse, social work reproduces its context.

Case 1. The Medical Approach

First, consider 6 months from the medical history of a woman we know is battered. Between May 1960 and January 1961, Mrs. Smith makes 14 visits to the hospital. She is seen in the medical clinic, the medical emergency service, and the surgical emergency service, and she complains of tension headaches, flank pain, general pain and dizziness, various abdominal and chest pains, "heart pounding," and "numerous somatic problems."* Her injuries include a rib fracture and a facial laceration. After her fourth visit in December, she is referred to psychiatry. The note reads: "She related in somatic terms but there is no convincing psychiatric pattern ... psychiatry can do nothing for her. She is probably a borderline schizophrenic."

What, you may wonder, would Mrs. Smith have to do to be "convincing"? In June, the record notes that Mrs. Smith "was beat up by boyfriend with iron ashtray striking her on head and arms and kicking her in the chest." Her September headache ensues "after a beating" and her facial laceration was apparently caused when she was "struck by a broom." But these facts, which the patient presents about her social situation, are recorded only because they may have clinical relevance to the strictly medical implications of her presenting symptom (e.g., does the manner of injury suggest a neurological workup?) and are not considered etiologically relevant. Of course, her persistent general complaints are even less susceptible than her injuries and pains to symptomatic response and gradually create what we term "a crisis of the cure." The occasional disjunction between presenting complaints (e.g., abdominal pain and a black eye) and the explanation offered ("I walked into a door," which motivates the physician to ask, "Did he also hit you in the abdomen?") is now displaced by a more general disjunction between the patient's overall physical state (e.g., "vague medical complaints") and medicine's repertoire of categorical explanations. So, she is referred or labeled or both.

Case 2. The Psychiatric Approach

The director of Education and Training at a prestigious psychiatric institute provides interns with this example of the typical "crock."

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*It may be noted parenthetically that "heart pounding" and somatic complaints frequently reveal the buildup of anxiety and stress before the outbreak of domestic violence. Their presentation, properly diagnosed and probed with supportive questioning, permits preventive intervention and suggests that the "cycle of violence" theory proposed by Walker whereby women seek help only after severe beatings is at best a half truth.

> Mrs. Jones came to this country from Eastern Europe in 1914, worked as a domestic in Washington, D.C., until 1928, when she moved to a medium-sized university town in New England to marry. During the next 40 years (from 1928 to 1967) she saw 394 physicians (including 17 psychiatrists) averaging a visit a month or 424 visits overall (340 non-psychiatric, 84 psychiatric). Despite an "unremarkable history," Mrs. Jones repeatedly complained of problems to head, eyes, ears,face,throat (12 times), chest, breathing, vagina, and so forth, in addition to ill-defined "pain all over." She did not receive elaborate workups, however, since her problems were "transparent." As a consequence, she received almost no followup -- most of her visits were unscheduled and no diagnosis was made, therapy suggested, or return visits scheduled. To the contrary, resentment of her "psychosomatic disguise" provoked psychiatrists to use labels for Mrs. Jones such as "crock," "immature personality," "hysterical," "emotional overlay," "conversion reaction," etc., and she was eventually committed to a State mental hospital for "punitive"reasons.[33]

The psychiatrist is unusually candid, because his intent is to teach interns to select medically relevant details from a wealth of biographical information and to organize them diagnostically and in relation to appropriate prognosis and treatments. There is, he tells us, nothing that can be done for Mrs. Jones. But, whereas Mrs. Smith was dismissed only as a "possible borderline schizophrenic," Mrs. Jones can be"managed."Recognizing this saves valuable time and resources and protects the budding psychiatrist from frustrating and repeated failure. Since Mrs. Jones is a common figure in clinical practice, we are assured that "the skills acquired" through her management will "be invaluable in private practice." Mrs.Jones has been"seen through" (the literal meaning of diagnosis); she is "transparent." What becomes clear is that she has so many complaints and problems because she is the **sort** of woman she is. With this, insight probing stops. Or nearly.The management is enforced by an admittedly punitive hospitalization.

Returning to her record, we discover that in 1928, the same year Mrs. Jones begins her transparent career as a "crock," her husband begins to beat her regularly. Her spouse is alternately described as "psychotic" and "aggressive." But no link is made between Mrs. Jones's battering, her multiple physical complaints, and her numerous mental health problems. To the contrary, since the diagnosis "crock" allows for frequent unscheduled visits, it is well suited to a family situation where violence is sporadic.

Mrs. Jones and Mrs. Smith make multiple and desperate efforts to draw attention to their plight. But these pleas for help are diagnostically reorganized until the problems they have appear to reflect the problem they are, for themselves as well as for medicine and psychiatry, and to conceal the social etiology of their "multiple vague complaints." From bad to mad, as Laing would have it.[34] Mrs. Smith's abuse is recognized, but simply as an explanation of her discrete injuries, not as their "cause." Mrs. Jones' problems are linked together but their social connectedness is no more visible as a result. In both instances, diagnosis is the magical act that makes the social situation disappear.

Case 3. The Social Therapeutic Approach

Mrs. Brown presented her first trauma associated with abuse when she was 3 months' pregnant with her fourth child. One month after her baby was born, she returns after her boyfriend beat her with a club, and she is treated for multiple contusions on her legs and arms, a large hematoma on her head, a laceration on her right hand, and a dislocated left thumb. Although family counseling is suggested, she is sent home, only to return a few hours later because "she can't care for her four children [all under 6] with both hands splinted." The social worker notes:

> I saw this patient yesterday in the ER. She presented herself as nervous and I felt she was postpartum depressed. She requested voluntary inpatient psych help as she felt too nervous to go home. She was referred to Family Services ... her last pregnancy was stormy and she wanted to abort the fetus ... Mrs. Brown worried throughout her pregnancy and is still worried that her baby may be abnormal. In addition she did not want this baby. The baby's father and she have had a very problematic relationship ... she was raised in a "cruel" foster home until age 12, at which time she went to live with her natural father for 2 years. Both her foster parents and her natural father beat her [emphasis in record]. She describes herself as having been abused as a child. Her father has a drinking problem ... her current admission might have been avoided if her need for psychiatric hospitalization had been realized when she was initially seen in the ER.

Like those of Mrs. Smith's, Mrs. Brown's subsequent injuries are frequently traced to beating by her boyfriend. She is investigated for possible child abuse, but in each case found to be a "reliable" mother who manages baby and child care well. After a particularly severe fight in which she sustains multiple injuries, she defends herself by "throwing some hot water on her boyfriend." Although Mrs. Brown is refused admission because someone "must care for the children" and there are "no medical complications," the boyfriend is admitted "because there is no one at home to care for him." In another fight, the patient throws a brick at her boyfriend and is arrested. Later, although the patient appears "confused about what happened," the boyfriend is shot four times, and Mrs. Brown is committed to the State mental hospital.

A year later, her newborn child is considered at-risk for neglect or abuse "because of the long history of physical abuse of the mother." Her other children are already in foster homes for the same reason. The women's clinic notes she is "nervous" and social service records she is "passive, withdrawn, with a history of depression and suicidal idealization." She has failed to keep appointments with the Battered Women's Group, a voluntary therapy group organized in the hospital for the dual purpose of research and support.

The case is complicated and there are a number of possible areas of entry. Mrs. Brown consistently cares for and is concerned about her children. Why then are they eventually taken away shortly after the boyfriend is shot, which presumably eliminated the one compounding

factor? We might emphasize sexist bias. He is admitted, not her. She is arrested, not him. She is sent home with both hands completely bandaged to care for the children (i.e., do her work); he is hospitalized because there is no one to care for him at home. We might stop here and consider medicine's contribution to any growing resentment Mrs. Brown feels toward her children or to her "passivity." Or, we might contrast Mrs. Brown's sympathetic reception in early years with her stereotypical and impersonal treatment later on. How hard it is for the social worker to see that the unattractive woman who now appears passive and withdrawn is the same "reliable" mother whose struggle for psych hospitalization was so admirable. [We might point out the classic clinical indicators of abuse: injury during pregnancy, multiple unwanted births, building anxiety around medical visits, multiple and centrally located injury, labeling, suicidal idealization, and passivity in the face of medical indifference. Or, finally, we might simply startle at the sheer pain and suffering endured in medicine's presence, the repeated demonstration with virtually no recognition of the physical impact of patriarchal power.]

Our primary concern here, however, is the peculiar means that social services employ to conceal abuse. The early social service note discovers a myriad of problems in the woman's history, including postpartum depression, nervousness, unwanted pregnancies, early and cruel foster care, childhood abuse, and paternal alcoholism. Indeed, the picture that emerges of a multiproblem family is so complex that the main feature of her present social situation, the determining feature, and arguably the only feature about which she can do anything substantial -- her battering -- disappears. Alongside childhood abuse and paternal alcoholism, her "problematic" [sic] relation with the baby's father seems minor, almost natural, at best the inevitable culmination of a tragic life rather than the point where intervention must begin. Psych hospitalization is recommended not to protect her from the problem her family is for her, but to exorcize the family inside her, the lived memory of childhood pain that she presumably reproduces in her "problematic" relations with her boyfriend. Whatever contribution childhood abuse, abandonment, and paternal alcoholism may actually make to subsequent battering are of secondary importance here, because in the social therapeutic approach these explanations are joined in ways that make the immediate predicament opaque. Once labeling, misdiagnosis, callous indifference, and punitive treatment help make Mrs. Brown the "victim of circumstances" she is supposed to have been from the start, the opacity of her social situation is projected onto her. She, not the hospital, is passive and withdrawn. Where once she was sent home almost mummified, now Mrs. Brown is cited for failing to report to the hospital-based support group.

To persons working in community-based programs for abused women, it may seem remarkable that in none of these cases was the police called, lawyers suggested, counselors provided, or shelters offered either for the women or their children. To the contrary, medicine, psychiatry, and social work uniformly neglected the real social crisis, attempted to contain its presentations within traditional therapeutic and conceptual modalities, and, failing this, resorted to punitive measures. We have merely illustrated diverse forms of nonrecognition, i.e., the ways in

which clinicians insure that they will not see what they do not see. We may now argue that these forms of nonrecognition -- the symptomatic, individualistic, and social therapeutic -- appear to contribute to the actual stages of "the battering syndrome."

III. The Battering Syndrome

When we organize the aggregate date on abuse and its sequela historically and put them in relation to medical, psychiatric, and social service interventions, we uncover a "battering syndrome," a distinct clinical entity that includes medical and psychiatric problems as well as physical injury and that calls forth (and is called for by) specific patterns of diagnosis, treatment, and referral. The interaction between the presentations of abuse and therapy can be illustrated by dividing the syndrome into stages. The first stage is characterized by repeated physical injury, relatively minor medical and/or mental health complaints and problems, and by the "medical approach," i.e., purely symptomatic treatment. During stage two,more serious psychosocial problems accompany the proliferation of physical injuries, heightened complaints, and psychiatric referrals. In the final stage, physical injury may be less pronounced than "behavioral" problems,including multiple suicide attempts or severe medical and mental health problems, and medicine and psychiatry may call on the social services. Now the woman's social situation is reconstituted, but less to explain her abuse than to explain it away. Just as the tragedy she has been trying to bring to our attention appears, the woman seems "overwhelmed" by the complexity of it all and unresponsive to our best efforts.

Stage 1. Symptomatic Treatment of Multiple Injuries

At first, the battered woman's discrete individual injury is defined as the only appropriate object for medical care. The fact that the injury was caused by a "punch" is no more significant than that it resulted from a "fall," and if the cause is recorded, there is no comment.

> Mrs. Scott came to the emergency service with multiple complaints of pain. She had a "negative exam." The diagnosis was "beaten up, mild contusions, etc. Plan home. No follow up needed." The woman's history is consulted only if it can help resolve an apparent diagnosit dilemma. Ms. Green was in a car accident resulting in multiple fractures, including a compression fracture of her spine. She came to the emergency service within a month after "falling" on her fractured arm, and within 3 months after falling down the stairs." She was readmitted to the hospital four times in the next year for continued pain. After a year of relatively unsuccessful physical therapy, her therapist noted "Ms. Green is aware of counseling at the center for beaten wives." Her abuse was never mentioned again.

Thus, the official record more nearly reflects the number of pragmatic problems abuse has posed to medicine than the actual incidence of battering in the patient population.

Both the medical model and the limited repertoire of interventions at the physician's disposal circumscribe the perception of what is wrong with the woman. The purely medical definition of the situation displaces any alternative definition a woman may offer. The repeated injuries appear as a series of unfortunate "accidents." No apparent physiological event links one visit or injury to the next. But these "accidents" do not stop. Within 1 year, Ms. Davis reported the following separate injuries: She kicked at something and fell downstairs, was shot in the thigh, and accidentally stuck a toothpick a half inch into her temple, which was still there after 3 weeks. She also came to the medical emergency service complaining of headaches.

Stage 2. From Injury to Self-Abuse

Gradually the accumulation of injuries is supplemented by physician notes about "vague medical complaints." Finally, a complex of problems is recognized, including "trouble with neighbors," alcoholism, drug abuse, attempted suicide, depression, "fear of child abuse," and a variety of alleged mental illnesses. Although these problems appear disproportionately on the medical records of abused women only after the initial assault, in medicine's eyes the sequence of events is reversed.

By recording the woman's secondary problems, medicine joins the woman in acknowledging the ineffectiveness of symptomatic relief. The patient's persistence, reflected on the medical record by the aggregation of incongruous injuries, forces the physician to recognize that this collection of trauma has been borne by a particular woman and suggests a "failure of the cure," posing problems of cooperation and "inappropriate demand." Suddenly the solution to the problems the patient has appears to lie in the problem the patient is. She is referred, typically, to psychiatry or to family and social service. The secondary problems developed in the course of "treatment" provide the helper with a way to "organize" her history of otherwise unrelated "accidents." She is, after all, an alcoholic, or she is suffering from a "female disorder" such as depression, hysteria, or hypochondriasis. This explains why she has had so many injuries and why she occasionally appears to have had "fights." Whereas in the medical setting abuse is noted to describe physical presentations, when the actual source of the patient's repeated injuries becomes unavoidable, it is explained as a consequence of her "more basic" problem, her alcoholism or her "rigid personality," for instance. These diagnoses are "labels" because they persist in the absence of evidence that they are either accurate or therapeutically relevant, and they often have purely punitive consequences.

A patient's "symptoms" may include headaches or other suffering directly attendant upon repeated beatings or the isolation that leads victims of abuse to turn anger inwards. But they may also result from prior medical attempts to control a woman's complaints with classic psychiatric methods. Thus, battered women frequently attempt suicide by taking an overdose of the medication provided to ease their "secondary problems." For the woman, the suicide attempt or alcoholism signals entrapment within a predictable syndrome associated with battering. For the physician, the sociopathic symptoms also suggest a "solution," a

cognitive and therapeutic strategy for comprehending otherwise unintelligible medical events.

Abused women are often labeled at the height of their vulnerability when the signs of their outward collapse suggest to them the problems implied by the label. Because of this, the label can easily be read by the victim as an alternative interpretation of her situation. Both she and her physician may now come to see her life with an abusive male as a symptom of her more general pathology and dependency. She now thinks she is sick, perhaps even requiring her assailant's help.

Stage 3. From Self-Abuse to Battering

Whatever clinicians intend their interventions to accomplish, their consequence is to reduce the victim's capacity to understand, adequately respond to, or resolve her crisis by leaving the violent home or struggling against the malevolent other. If the woman's attempts to "escape" from the most painful aspects of her situation through self-abuse are defined as her primary problem, the "cure" typically involves the reimposition of traditional female role behavior and, often, within the same violent context in which she is being beaten.

> When Mrs. Miles became pregnant at the age of 16, her father literally jumped on her and beat her so that she would lose the baby. After the baby was born, she came to the medical clinic, where she reported that her husband drank and beat her. The diagnosis was reactive depression, and the treatment Seconal. Betty went home and overdosed on the Seconal. This time the diagnosis was postpartum depression and she was sent to the State mental hospital. Within 2 months she went to the Domestic Relations Bureau to see if she could get support. According to the medical record, the bureau was making every effort to "reconcile the couple."

Battered women are typically referred to "de-tox" programs, drug dependence units, mental health clinics or hospitals, and to a variety of counseling programs, most of which are committed to supporting stereotypic female behavior within traditional family contexts. At the State mental hospital, release is often contingent on a willingness to "look pretty" and to perform housework routinely("Won't dearie clean her room today?").

Social work referrals may have less dramatic but equally negative consequences. The psychological orientation can transform an initial complaint of abuse into victim-blaming.

> Mrs. Booth was referred to social service, where it was noted that she had a 17-year history of domestic difficulties characterized by an abusive, often nonworking husband. One month later social service notes that she is a "dull woman who projects all of her difficulties on her husband."

The social worker may also simply accept the do-nothing attitude of authorities.

Before long, the case worker sees what she has been taught in school to expect from the beginning, the "multiproblem family." Not only is the woman beaten because she drinks. More broadly, both alcoholism and violence are expected symptoms of the family constellation peculiar to low-income or black communities. The family is not the battered woman's problem. She is the problem for it.

Now the cycle is complete. Serious injuries lead to the development of secondary problems. Secondary problems are labeled, and these consequences of violence are reinterpreted as its cause. The referral strategy for the secondary problems includes some form of family maintenance. By reinforcing families where there is abuse, repeated injury is virtually guaranteed, as is the permanent dependence of the woman, and her family, on the helping agency. All family members,including the victims of abuse, may even come to define violence as a natural part of their collective identity. Mrs. Frank's suicide note gives insight into the extent to which her husband's violence and institutional neglect form a continuum of entrapment.

> Mrs. Frank did not present primarily to the emergency service with injuries. Rather, she appeared at the medical clinic on various occasions with back pain and complaints of pain when swallowing. These complaints were thought to be psychosomatic and she was discharged without further inquiry into the fundamental cause of these symptoms. She became pregnant frequently because she was afraid of her husband's violence but terminated five of these pregnancies herself with Lysol douches. Through the years, her husband continued to beat her severely. She came to the emergency service with facial fractures, "blacking out" episodes due to repeated head trauma, and obtained treatment for only her presenting complaints. Interspersed with her battering incidents she presents with complaints of depression, addiction to drugs, and multiple suicide attempts. At one point in the record her husband is described as "a gentle, quiet, small sort of man." She is now taking 25 Valiums a day to cope,she states. Her suicide note follows: "I am frightened. No one can help me. My children and I live in danger. My husband beats us.The police say they can't help me. I have been to the doctors many times. I sent my children to relatives because I do not want them hurt.There is no other way to protect them. Please tell them I love them. I don't know any other way."

There is another way. But its development and success depend on a radical restructuring of the present therapeutic approach.

IV. Therapeutic Politics and Therapeutic Technique

At present, medicine, psychiatry, and social work lack the technical means to accurately identify abuse. But the nonrecognition of abuse also reflects a failure of therapeutic nerve that is deeply rooted in personal styles of coping, professional commitments, and the political history of the institutions where we work. Because abuse stems from many of the behavioral norms to which the clinical services are committed, it is unclear that we would move speedily to prevent abuse even if we understood how to do so. To the contrary, since violence against women

is neutralized by a variety of clinical strategies even when it is acknowledged, expanding the treatment role may not be the most effective approach to battering.

Class, race, and sex bias are obvious problems. Our data and the case material show that such bias results in battered women being denied help, in stereotypic labeling, and in punitive referrals and treatment. Even when abuse is not recorded as the source of injuries or complaints, battered women are more likely than others to be given pain medication or tranquilizers, to be sent home without referral or followup, and to be institutionalized. Helping the abused woman anticipate and understand the negative response of our services will allow her to negotiate for the support she needs.

There are less obvious but no less demeaning expressions of bias. The radical social worker intent on advocacy may "blame the system" but forget that the acceptance of individual responsibility is the essence of initiative, not simply of guilt.[35] Or the social worker may so completely "understand" the social basis of abuse that he or she decides to "go slow" and fails to present the immediate options or inform the patient of the health consequence of staying in a violent relationship. The feminist shelter worker may see her client only through the prism of abuse, forgetting that she still has interpersonal needs, and think of her as a helpless victim who must, as one guide to counselors puts it, "accept her nothingness" before she can be helped.[36]

An adequate response begins when we elicit and accept a woman's assessment of her "emergency," even in the absence of supporting "evidence." And it requires keeping anger, moral judgment, and first impressions under control. Too often, the shock at domestic violence reflects our own make-believe picture of the happy family. Shock may tell a woman she is grotesque. Conversely, the rush to judgment is frequently precipitated by an inability to accept fear and ambivalence toward violent impulses in ourselves, toward violent men or aggressive women.[37] Failing to "own" their anger, clinicians may alternately demand that a woman leave her assailant, only to drop the protectionist pose, when the woman hesitates or becomes defensive, for a judgmental, even angry attack on the patient. Assuming responsibility for a case even as we share our ambiguity can help a woman discuss her own ambivalence ("You see, I love as well as hate this man and want to help him") without letting it paralyze her.

Premature closure and a tendency to rationalize fear and ambivalence are also created by the fear of failure. Until we accept that, many, perhaps most, of the solutions we propose frequently won't work; we will project our insufficiency onto our clients, diminishing their capacity for initiative and concealing the most important political fact about abuse -- namely, that battered women often have no choice but to return to violent homes. Indeed, recognizing the objective limits facing a victim of abuse -- the paucity of jobs, the difficulty of living "without a man" in many communities, the absence of day care, unequal law enforcement, and so forth -- can help us accept the limits of therapeutic practice and recognize that the source of both the objective and therapeutic limits is ultimately the same -- namely, the inadequacy of private

or individual solutions to problems whose construction is eminently social. Only by moving from therapeutic practice to the politics of therapy can we escape the dilemma created by a need to blame either the patient or ourselves for the failure of intervention.

Once we step outside this paradigm of blame, we can recognize the battered woman for what she is, a person of enormous courage and initiative whose very presentation at the clinic may be an act of resistance. Individual women are frequently attacked for no apparent reason. But domestic violence generally arises when women refuse the dependency implied by their traditional work and its reward, in power struggles over money, sex, housework, child care, and food.[38] This refusal pits the battered woman against male superiority, and is therefore a "feminist" struggle regardless of whether she is aware of the programmatic demands of the Women's Movement. Even the sense of helplessness resulting in multiple suicide attempts, alcoholism, or depression must be viewed, as Fanon illustrates in his analyses of oppressed people, as the consequence of a woman's putting her selfhood at risk, hurling it in a futile but nonetheless political gesture at the attempt to keep her in a subordinate status in private life.[39] Her helplessness, in other words, is the mark of her struggle against dependency, including institutional dependence, a sign that now that formal equality has been won, submission can only be maintained through such informal means as psychological management and erratic brutality.

Here, preventive psychiatry comes to a crossroad. Helplessness must be overcome. But in what context? At present, battering is "treated" by the attempt to reconstitute dependence. The point is not so much that this effort is morally or politically misguided, but rather that it is a therapeutic disaster, reproducing the context that makes both resistance and further battering inevitable. And this is because, apart from the support the services and economy lend individual males, force is one of the few remaining sources for patriarchal authority in private life. The founders of our respective disciplines often saw the amelioration of individual suffering as the practical extension of fundamental political change. Nevertheless, our professions have survived in a context that takes material deprivation and female subordination for granted. Reducing suffering is no small matter. As Nietzsche reminds us, however, suffering is most disturbing not simply because it exists, but when it is unnecessary. Each subsequent generation of clinicians must discover for itself whether the conditions that appeared to make a particular form of suffering inevitable are still intransigent, whether, that is, individual therapeutics is still to be preferred to social therapeutics. With respect to battering, the question may be put this way. Is domestic violence the pathological expression of an otherwise legitimate system of authority? Or, have we reached a point in the development of our human powers when there no longer exists any material justification whatsoever for continued male domination? Our present therapeutic practice answers for us. But, like our battered patients, we may yet decide that there is nothing inevitable about female subordination or patriarchal violence. Indeed, we could take an important step toward ending violence against women simply by deciding to recognize and respond adequately to it.

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Violence-Prone Marriages

Martin Symonds, M.D.

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I want to share with you the psychodynamic understanding of the personality traits and interpersonal reactions of marital couples that produce violence-prone marriages. My first experience with domestic violence occurred many years ago when I was a police officer. A youngster came over to the radio car and said, "My father is beating up my mother." I ran up the stairs -- my first house call to a battered wife -- and was confronted with a man in his underwear, obviously drunk, and his wife, obviously bruised and cowering in a corner. The man said as he kept poking me in the chest, "Officer, you know what my wife did? She poured my whiskey down the sink." I said, "If you don't stop poking me, I'll pour you down the sink." At that moment his wife came alive and started berating me; she pushed me actually. Since I had harmoniously gotten the two of them united against an insensitive pig, I beat a strategic retreat. Now, while the capacity for violent behavior is present in all of us, the expression or even discussion of violence generally makes people uncomfortable.

Throughout this paper I will be discussing violence,aggression, and hostility, and although those words are commonly used they're poorly defined; they weren't helpful to me until I actually devised my own definitions from a compilation of ideas. As I use it, aggression can be violent or nonviolent. Aggression is the expression of feelings or acts in order to force or control another person's behavior, to make that person either submit or comply with one's needs. First, there is what I call vertical aggression, which is a direct face-to-face confrontation, where the violence or the threat of violence is used to get someone to submit or comply to the aggressor's wishes. Vertical aggression can also be nonviolent. For example, a husband throws his dinner plate on the floor and says to his wife, "You bitch, don't serve me dog food; make me real food, and clean up the mess before I kick your ass." These are actual quotes. At this point he's trying to get her to comply or submit through fear based on his needs. A wife says to her husband, "If you hit me again I'll call the police and have you locked up." These are clear messages -- either the threat of violence or the threat or fear of consequence will cause the other person to obey.

Aggression can also be horizontal. One tries to get the other to comply to one's needs not through fear, as in vertical aggression, but through guilt. For example, a wife says to her husband, "If you go out

tonight I'll go off my diet." Or a husband says. "If you go out tonight I'll start drinking again." A mother says to her son, "If you marry that girl I'll kill myself." The threat of what's going to happen to the other individual is the motivating force to compel compliance. Whenever you use guilt a relationship is implied -- guilt has no leverage with two people who are strangers. In my studies of criminals and criminal behavior I have found that guilt-inducing statements are singularly ineffective with a criminal. For example, a woman is about to be raped and she says to the criminal, "I have a weak heart, I'm an old lady. I have children, I am pregnant." It means zilch to the criminal. If she says, "I have syphilis," it's a different matter -- that may produce fear in him.

Intimately related to horizontal aggression is a concept called hostility. As I use it, hostility is behavior usually expressed by an attitude; it is generally nonverbal. While aggression is an expression of an act, an expression of feelings, hostility is an attitude or stance, intending to inform another -- or sometimes the whole world -- that the person has been injured or pushed around. Hostility produces violent feelings in the recipient. For example, there is something I call the flinching syndrome. I walk past a kid and he ducks. I say, "What the hell are you ducking for?" He says, "I thought you were about to hit me." He implies feelings not felt by me. That's when I get angry and I probably will hit him, or think of hitting him. The hostile attitude is expressed in another way. A person sits on a bus, takes up three seats, smokes, and has his radio on loud. It engenders violent feelings in the recipient, and can lead to a violent confrontation. It's crucial to appreciate the difference between hostility and aggression: aggression is an active act in which the person is trying to get you to do something either through guilt or through fear. The hostile attitude is informative, and impersonal.

If you recognize a stance as hostile you have the power to escalate the situation into violence. In my work with the Board of Education dealing with aggressive, assaultive youngsters, studying the number of confrontations where teachers have been beaten up, we found out that over 95 percent of the incidents were hostile attitudes on the part of the youngster that escalated into a violent confrontation. Here is an example. A teacher walks into the corridor and there's a kid smoking. She violates a number of rules by first going over to him and taking the cigarette out of his mouth. Sometimes there's a violent confrontation leading to injury. I taught her to deal with it as follows: First identify yourself and identify the behavior. "I am Miss So and So. You are smoking in the hall, which is a violation of the rules. May I have your name please." If the kid says, "Fuck you," the teacher says, "Will you please wait here until I call the security guard?" If she does that she won't be beaten up. I know the kid will run away, but he's running away from the law. Most of us have what we call pride reactions, which lead to violence. "How dare he say that to me!" Well, he did say it to you; what about it?

I'm emphasizing the pride reaction because many of the violent situations in marriage result from pride responses. Envisage an outer circle and an inner circle -- what I'll call a diagram of personality.

The outer circle is for most of us what I call the self-preservative core, and the inner circle is our pride system, our pride responses. Whenever we experience danger and we have an outer self-preservative core, we'll experience fright. We'll submit, we'll appease, we'll ingratiate, and so forth, but we ourselves will preserve our pride. Unfortunately, most of the violent people I know have the circles in reverse; the pride is the outer core, self-preservation inside. Whenever you make a contact with them, they experience an injury to pride, and any time that happens the response is anger, getting even. We call these people the macho people. I can tell you that in the police department, when we are examining applicants for the position of police officer, we're particularly looking for evidence of excessive violence proneness to screen those people out. We've found not only the macho male but also the macho female. So there are women just as well as men who have a pride outer core of personality.

Violence is a motor act, the means whereby you express or use assaultive behavior. There is also verbal violence -- abuse -- through which you attack someone through his idealized image. Men generally utilize physical violence. Women generally utilize verbal violence with no expectation that there will be a response; unfortunately, there will be.

There are three closely interrelated issues in marriage that consistently act as trigger points for violent reactions -- power, intimacy, and boundaries. While power struggles are common in any interpersonal relationship, they are particularly present in marriage by the very nature of the mutual dependency intrinsic in the marital relationship. Constructive resolution of marital conflict requires that the individuals be flexible, open to each other, and have a healthy sense of humor; they must be able to negotiate changes and modify their needs without experiencing diminishment of their sense of self. All too often people experience ordinary healthy marital friction as war. If you have warfare, in which you feel one person must win and one person must lose, you will also find that the wars are continually being refought. The art of negotiation is to make sure both people win. If one experiences losing, that war will be refought again and again.

Overt power struggles probably form the basis for violent marriages where violence is brought into the relationship as a solution to conflicts as early as the courtship. In such marriages where violence is brought in very early, it is exclusively the husband who tries to restore his feelings of power through the use of force. His feelings generally are based on a pervasive inner sense of powerlessness. Of all the facts I've learned in terms of violence -- I've studied a number of individuals who've been muggers, rapists, and murderers, and I've been studying violence in various forms -- I think the most conclusive one is that people who feel powerless generally resort to violence. If you feel powerful you generally don't. For example, I was a consultant to a residential home for disturbed youngsters for about 10 years, and these youngsters all had engaged in proven acts of violence. They were also rejects of the school system. I used to ask them the following question (I've probably asked it over a thousand times): "If you had the power to change the world, what would you do with it?" Almost all said -- I

rarely got an answer to the contrary -- "If I had the power to change the world I'd make Russia and America be at peace. I'd make everyone happy. I'd give people money." They look on power as something to be used constructively. So people who feel powerful generally have no need to resort to violence. Remember, I'm talking about feeling powerful, not being powerful. Some people who are powerful don't feel it. It's the feeling of powerlessness that engenders violence. For example, children who feel inferior generally act belligerent. They'd rather be thrown out of school for being a bad kid than a dumb kid. Quite often, then, you find out that if you feel inferior you feel powerless and you try to resort to an expression of power, or confrontation, in order to get your demands. You try to dramatize or exaggerate the "power."

Men who bring violence early into their marriages generally have no quilt about expressing it. For them violence is ego-syntonic. Whatever feelings they have about it -- shame, fright, or even anger -- are directed at their behavior being exposed to the scrutiny of others.Guilt is no force where violence is brought early into the marriage. You can't make them feel guilty. You simply get them angry and violent when you try to make them feel guilty. Such people, and they certainly include the violent criminals, can live with the acts they commit.

A man in this ego-syntonic violence group has very poor control of his aggression. He's impulsive; he's immature; he's relatively inarticulate about his feelings. He's a short-fused individual, using his fists rather than his mouth. He's action-oriented. There's a violence clinic in Baltimore run by Dr. John Lyon, and his consistent findings bear out a picture of such men as being generally violence prone, impulsive, immature, and explosive, and, finally, deficient in imagery. They don't think about what they're going to do; they reflexively act on it. The majority of us have the capacity for violence, but we also have the capacity for violent fantasy. The very fact that we can fantasize the act diminishes it. In encouraging his patients to fantasize, Dr. Lyon has found that the impulse for violence diminishes. The patient says, "I'll kill the son of a bitch." Lyon says, "How would you do it?" "With a knife." Lyon asks, "Where would you get the knife?" "From the drawer." "There are lots of knives in the drawer." "The biggest one." "How big?" Lyon keeps on drawing the fantasy out, eliciting details. People inexperienced with violence say, "My God, you're giving the guy ideas. He's going to do it." We've found quite the contrary. The point is that we're not giving him ideas; we're drawing from him. We're not encouraging the fantasy in the sense of elaborating for him. We are trying to get an inarticulate person, who ordinarily would have done the violence, to <u>think</u> about it. This reflection does diminish the impulse.

Such violence-prone individuals generally have a history of early exposure to family violence, and they might have been abused as children. Emotionally insulated, this kind of man sees his wife and children as merely objects of displacement of his life's frustrations. With many action-oriented individuals, if you're not the object of their violence, they're very pleasant guys. One of the problems of dealing with violent criminals in jail, actually a hazard for social workers, is that the criminal seems to be generally a "nice guy." He's a terrible guy.

Since he isn't neurotic he acts on his impulses, although at this point there's no need to act on his impulses with you; he's friendly and likable. It's like the Godfather. He can talk about pigeons and flowers and do extermination from 9 to 5. He can be a very nice neighbor. But if you're the object of his violence he becomes emotionally insulated from you, unrelated to you, and deadly. This individual for whom violence is ego-syntonic, who brings violence into the marriage early on, is the general picture of all the violent people you'll ever see -- whether criminals, or violent patients, or abusers.

There is another type of poorly controlled aggressive individual, the Dr. Jekyll and Mr. Hyde personality. He differs from the first type in that he appears highly anxious and extremely guilt-ridden when he's confronted with the results of his violent behavior. He's generally a compliant, dependent individual whose aggression is released by alcohol, and when confronted with the results of his violent behavior he will deny it or say he blacked out. He may become very contrite, and like a frightened, helpless child he begs forgiveness and promises and promises never to do it again. He has a "kiss-and-make-up" marriage. He has a self-effacing resentment about being pushed into something and tries to rewrite his imprisonment after some alcohol. He has quite often what I call "sweet hostility." I'll give you an example. Twenty years ago a man took his future wife out to dinner. In recounting this long past incident to me he said. "You know what that bitch did?" I said, "What?" "She ordered steak. I was so furious with her, I said to her, 'How about a nice bottle of wine?' and she said 'great.'" In other words, he tried to needle her. Another man went to a manicurist and she butchered his cuticles, making them bleed. I said, "What did you do?" He said, "I gave her a dollar tip, cause I wanted her to feel guilty about what she did to me." I said, "Well, she'll probably go around butchering everyone now." In other words, he was trying to give people the needle in such an indirect way that no one recognized it, but the anger builds up a head of steam and if he drinks or otherwise lets go, it becomes violence. The majority of wifebeating cases seen in the newspapers, in emergency clinics, in Family Court result from these two kinds of personalities, where violence is brought early into the marriage.

There are a few other types of violent marriage partners; I'll describe one more. This is an overly controlled, compulsively hostile individual, whom Karen Horney has described as having an arrogant-indicative character structure. In marriage vindictiveness is expressed by cruel and sadistic behavior toward the marital partner. Right from the beginning of this man's marriage he's preoccupied with the struggle for power, and through criticism and silence he continually tries to keep his partner off balance. Although violence for him is also syntonic, he uses emotional torture, which I've called "gaslighting," from the movie where Charles Boyer turns the gas lights on and off and denies he's doing it, driving his wife crazy until she gets validation from some outside source that her husband is doing this nonvalidating sadistic behavior. He presents a phenomenon, then rejects the other person's observation by denying its existence. He generally provokes violence in others as well -- in other words, he brings violence into the marriage and many times the wife responds or he may respond in a way I call third-party aggression; he'll get someone else to do his intent. For

example, a woman I knew was hospitalized for an acute depressive reaction with suicidal thoughts. She was recovering and doing well. The husband came to me and wanted to discuss his wife. He said, "I love my wife. How about giving her shock therapy?" I said, "She doesn't need it." He said, "How about 20 shock treatments, doctor?" I said, "No, no." He said, "How about 10?" In other words, under the guise of trying to help his wife he's trying to get someone else to act out his violence.

I'll leave you with one concept that all of you will be caught up in; I call it "third-party aggression." Someone gets you in a froth about what's happening to them and then, when you start fighting the other third party, he or she disappears. For instance, someone says to me, "My boss is making me work 80 hours a week; he's paying me $10 a week; and he's taking out $8 in benefits." I say, "That bastard."He says "Don't say that; he's a nice guy." Or, when I call the boss and say, "What the hell are you doing this for?", the injured party suddenly doesn't validate it: "I didn't say anything, you know." I've seen social workers, pastoral counselors, and many other professionals become the barking dog to a self-effacing individual who continually gives out information that makes one fly off the handle. These people describe incidents that get you worked up; you take action; and suddenly the couple is back together again happily. It is a common problem in this complex world of violent families.

Stopping Wife Abuse: A Feminist Approach

Jennifer Baker-Fleming

Jennifer Baker-Fleming is the founder and director of the Women's Resource Network in Philadelphia, which provides technical assistance, training, and consultation to programs providing services in the area of family violence as well as to criminal justice and mental health personnel. Her book, Stopping Wife Abuse -- A Guide to the Emotional, Psychological, and Legal Implications for the Abused Woman and Those Helping Her, has a wealth of material that is sensitive as well as practical, and it meets the needs of those of us helping battered women; it is also very useful as a training manual. -- E.Q.

Before I begin talking specifically about wife abuse I want to talk about the concept of feminism, and why we even have a talk labeled, "A Feminist Approach to Wife Abuse." I've been involved in the feminist movement for a long time. After 10 years I'm only just beginning to really grasp what the essence of feminism is. The closer I get to that essence the further away I get from polarization and from separation. I think one of the mistakes we tend to make when we talk about feminism is that we equate it with polarization, separateness, or conflict and I think in many ways this is a limited understanding of the term.

For me, feminism has come to mean wholeness. It's come to mean a vehicle for inner growth and development for both men and women that ultimately has nothing to do with sex. It has to do with who we are as people, what a human being is. The reason I use the term wholeness is because sexism, along with many other forces currently at work in the world, has resulted in men and women who have many missing pieces. Our sex role conditioning leaves us all incomplete. As women, some of our missing pieces may be (of course I'm grossly generalizing, but for purposes of discussion) self-confidence, inner strength, physical strength, assertiveness, and/or a certain rational, intellectual approach to understanding the world and ourselves. For men, some of the missing pieces may be tenderness, gentleness, the ability to nurture, or the ability to parent. Feminism is a means for us to begin filling in those missing pieces; it's crucial that we do that, because as long as men and women continue to look to the other sex to fill them in we are all doomed to failure, because each individual must complete himself or herself. There's no way one human being can complete another human being. When women make the mistake of looking to men for the strength and self-confidence they need in order to cope with life, they're doomed to failure. When men look to women for that gentleness and tenderness they have been taught to suppress and deny, they're doomed to failure as well. We have to learn how to complete ourselves, to fill in the missing pieces that are a result of our sex role conditioning.

Understanding feminism and beginning to respond to the demands that a feminist consciousness makes upon one are important processes in terms of how we ultimately define ourselves as human beings. So when I

talk about a feminist approach to wife abuse and when I talk about feminism, what I'm talking about is a whole approach, an approach that does not omit the realities of how men and women are conditioned in our culture. If we leave them out, then no matter how good our intentions and how great our skills, we ultimately end up perpetuating the very problem we are trying to address.

Those of us helping battered women cannot say about a feminist approach: "Well, do I want to adopt a feminist approach? Let me see, what does it mean? It says I have to be a victim advocate and this and that and the other thing. I can either do that or not do that. I can take another approach and maybe that will be just as good." But it's not possible for another approach to work just as well, not because feminism is the only truth, but because feminism is a way of perceiving reality that is based on understanding the current social order in which we exist. And if we approach any problem without taking that current social order into consideration, we don't get very far.

Part of understanding the current social order involves going back a little and taking a look at the history of marriage and the history of women as wives. I don't want to bore you with a long speech on the powerlessness of women, but let me share just a few brief examples, starting with the Code of Hammurabi, the first known legal code. One of its provisions stated that if a woman spoke back to her husband, her name would be carved into a brick which would then be used to bash her teeth out. Now the code was fairly severe in general, but the subordination of women to men within marriage was written into the earliest laws we know of and it has remained written into law until very recently. This has a great deal to do with how we as a society have rationalized and condoned abuse against women within marriage, and abuse against women in general. Let's move on to Roman law, which is the basis for English common law, which is the basis for our legal system. Under Roman law, the word familia, from which we get the word "family," referred to a man's total holdings. It referred to the farm, the cows, the pigs, the horses, the children, and the wife. The husband had absolute power over all those holdings. I'm sure that some of you working on wife abuse have heard of some of the other ancient prescriptions of women's subordination to men -- the old folk sayings such as: "A woman, a spaniel, and a walnut tree; the more they are beaten the better they be." All these quaint colloquialisms, which we tend to chuckle at, played a very serious role in the definition of women's role within marriage.

Our own legal system, until the turn of the century, reflected the same kinds of basic concepts regarding marriage and women's role in it. Property laws for example: Married women were not permitted to own property in their own name until the mid-19th century. Provisions within the marriage laws provided for the man's chastisement of his wife. In fact, men were often encouraged to discipline their wives regularly. Men were legally responsible for their wives, much as we are legally responsible for our children, because women ceased to exist as separate legal identities once they became married. The custom of a woman taking her husband's name upon marriage is an illustration of the fact that legally she did not exist. She was simply an extension of her husband,

so he had the right to discipline or chastise her. And it was considered proper, just as it is considered proper for us to disciplne and chastise our children. If our kid goes out and breaks someone else's window, we're held legally responsible. Therefore it's proper that we have the authority to discipline or chastise the child. The same thing was true with husbands and wives.

Even today, if you look at certain provisions in the marriage laws, you find many that discriminate against women. Until the recent passage of no-fault divorce in Pennsylvania, there were grounds for divorce, and one ground for divorce was desertion. Interestingly enough, however, the definition for desertion was different for a husband than for a wife. If you were a married woman in Pennsylvania and your husband got a job in another State, you were obligated by law to follow him. If you did not follow him you were guilty of desertion. Basically, the desertion ground in Pennsylvania was based on the Biblical injunction that wheresoever a man goeth, the wife shall follow. Another interesting provision that existed in the Pennsylvania law was the right to sue for the loss of what is called "consortium." If a husband and wife were involved in an automobile accident and the wife was disabled as a result, the husband had the right to sue the responsible party for loss of consortium, meaning the wife's ability to provide companionship, labor, and sexual services. The wife, however, did not have the same right to sue.

Evan Stark was saying earlier that the majority of the rapes he studied were part of a long pattern of abuse. Those working with battered women know that rape often accompanies a beating, follows a beating, or precedes a beating. But it is not illegal to rape your wife, except in a few States where provisions have been made for separated women to prosecute their husbands for rape. So there's no such thing as raping your wife because of the nature of the marriage contract.

I'd imagine that almost everyone in this room is either married or has been married at one time or another. It's interesting how many of us make that move without any kind of education, without any awareness of what we're signing up for legally. It's probably the most important decision we ever make in our lives and yet it's the one we're least prepared for. In most States, the modern marriage contract is set up in the following way: husbands have the same responsibilities to their wives that slave owners had to the slaves under the Southern Slave Codes. They had to provide food, clothing, and shelter, and in return they got free labor and sexual services.

These obligations are illustrated by some interesting court decisions. In 1950 a woman in the Midwest took her husband to court. They were still living together. They were living in a house with no running water, no electricity, no heat. She had hardly any clothes to wear. Her husband was making $40,000 to $50,000 a year. The court found in favor of the husband, stating that as long as he was putting food in her mouth, clothing on her body, and a roof over her head, he was meeting the obligations of the marriage contract. Let's take a look at child support. Most women get married under the assumption that if their husband's good will is no longer forthcoming, all they have to do is

trot down to Family Court and file a little complaint and they'll get what they deserve. Those of us who work with battered women know that the Family Court system does not work that way; regardless of what the law says a woman is entitled to, her ability to collect adequate child support is severely limited. Many of us who counsel battered women will tell them to rely on the welfare system rather than the Family Court system, because even with the small amount of money that welfare provides, at least it comes regularly. Trying to live on money that's been ordered through Family Court, without going into all the depressing details, is an exercise in futility and frustration for the majority of women who try to utilize that system.

In some States, there are couples who want to get married but don't want to do it the old way. They want to do it a new way, and are developing marriage contracts where they spell the marriage out as an equal partnership, where they're going to share the housework, share the child care, etc. These contracts have not been recognized by the courts and won't be enforced by the courts (except for financial provisions) because they are contrary to the marriage contract as it is currently defined. For example, in Pennsylvania a woman who works in her husband's business for 10 years cannot sue him to collect the wages that he might have promised her, because under the marriage contract she owes him that labor. These are just a few illustrations of the continued powerlessness of women within marriage. Understanding the history of woman as the property of man is necessary if we are going to understand why wife abuse has not only gone on but also why the legal system and the criminal justice system have been rather slow to respond to the problem.

That's the legal system, and that's just one system. We have other systems too. We have religion, which has played a major role in prescribing the way people live their lives. Someone recently talked about how men were urged from the pulpit to regularly discipline and beat their wives and women were urged to kiss the rod that beat them. Did you ever hear of that expression -- "Kiss the rod that beat them?" And of course we have the legacy of the Catholic Church and the Madonna complex -- women were born to suffer, we were bad because we bit the apple, and we're going to be punished forever. The religious input has not helped the situation in terms of wife abuse.

When religion began to lose its pervasive influence, a new institution arrived, which in many ways has replaced religion -- psychiatry. I want to briefly discuss my favorite shrink of all, Sigmund Freud. Sigmund left us a heritage that is one of the most damaging forces against women in the world today. I don't know what Siggy's problem was re women, but he certainly had one. My favorite quote from Siggy is: "Women are like the masses, in wanting to be conquered and ruled." That doesn't say a great deal for the way he perceived women, or ordinary folks either if you think about it. His perceptions regarding the innate nature of women are based more on who he was as a person and as a man than on reality. He was followed by Helene Deutsch, unfortunately a woman, who said: "Masochism is the most elemental power in female life."

Those of you who are peer counselors and volunteers in shelters have to remember what our poor psychiatrists have been put through

when they've gone through medical school and all of their training. We have to take a very tolerant attitude and proceed to educate those professionals who continue to believe the masochism myth. Let me share with you a quote taken from a study done in 1964 on wife beaters and their wives that was written up in Time magazine: "The periods of violent behavior by the husband serve to release him momentarily from his anxiety about his effectiveness as a man while at the same time giving his wife apparent masochistic gratification and helping probably to deal with the guilt arising from the intensity expressed in her controlling, castrating behavior." That was 1964; and we would hope that by 1970 or 1971 we would be hearing something different. Unfortunately, such is not the case. Dr. Symonds mentioned John Lyons from the University of Maryland. In 1971, Dr. Lyons wrote: "It is my feeling that probably a majority of wife battering cases involve some overt or covert participation of the victim or wife." Another quote from Dr. Lyons: "The wife was seen with the husband, during which time she appeared as a rather hostile and castrating individual." Another quote: "Certain wives may gain psychological satisfaction from beatings and batterings." That's 1971. And then, just a couple of years ago Natalie Shainess in "Psychological Aspects of Wife Beating," which appeared in Maria Roy's book Battered Women, writes: "It may come as a surprise that the wife almost inevitably plays a part in her own assault." Although she says that she does not mean to assess blame, the message is clear.

Now, a whole approach, a feminist approach to wife abuse does not necessarily deny that there may be an occasional element of masochism involved in wife abuse, nor does it deny that the interaction that goes on between husband and wife is an important consideration in the counseling process. But it does condemn the process of taking the 1 percent of victims who are hooked on violence and using that to rationalize and justify the overall abuse of women in marriage. We must stop blaming the victim for the abuser's inability to deal with life nonviolently. The abuser's use of violence is his problem. It doesn't matter who the woman is and it doesn't matter what she does. The victim is not responsible for the behavior of the perpetrator. When we blame the victim, we become part of the ideology that creates the problem. That is why we must reject this approach and adopt the whole approach.

What is the whole approach based on? First, it is based on understanding the victim. I was glad to hear Dr. Symonds talk about terror, because very rarely, except for those who work directly with battered women, do we hear people talk about the fear factor and the role that fear plays in the battered women's behavior -- in her powerlessness, her paralysis, her helplessness, and her inability to cope. Lenore Walker describes a series of experiments that were done with rats. A rat was put in a maze. The exit to the maze was wired electrically, so every time the rat would find its way to the exit it would receive a shock. Naturally, the rat stopped trying to exit the maze. The interesting point about the experiment was that even when the researchers took the electricity out of the exit and stuck the rat in the exit, the rat still would not leave, even though it did not receive the shock. Learned helplessness. That can be compared to the battered woman who goes to the minister and the minister tells her that Jesus suffered on the cross and she should go home and be a better wife and mother. She goes to the

psychiatrist, who says, "Well, don't you really like it?" She goes to the cop and the cop says, "We're sorry, but there's nothing we can do." She goes to her mother and her mother says, "You made your bed; you might as well lie in it." What happens? Eventually she stops trying. And when real help finally appears on the scene she doesn't know what to do with it; the battered woman ends up reinforcing the myth of her own masochism because the learned helplessness has become so entrenched that she's unable to move. Those of us who are trying to help conclude that she must like it because she won't leave.

The fact of the matter is that unbecoming a battered woman is a long, intense process directly proportional to how many years she has endured the abuse. The battered woman suffers something I call the victimization process. Before she marries or moves in with her boyfriend violence is usually not present in the relationship. Dr. Symonds talked about Dr. Jekyll and Mr. Hyde. It's a very common phenomenon. The batterer is a charming guy and the courtship is all flowers and candy and romance. When the first beating occurs, the woman is truly shocked. She doesn't believe that her husband or her boyfriend is capable of such behavior, and she doesn't want to believe it because she loves him. This first phase of the victimization process is denial. She denies it; it's not really happening. "He only hit me because he was upset over something that happened at work. He only hit me because his mother keeps harassing him. He only hit me because the baby wouldn't shut up." So she denies what is going on. The batterer helps in the denial process because 9 times out of 10 he is begging for forgiveness. He's never going to do it again. It's back to the flowers and candy.

Lenore Walker also describes this syndrome in the cyclical theory of battering -- the tender loving respite, the part that comes after the beating. It is part of the cycle that locks the woman in over and over again. She's denying what's happening, but the abuse continues. And not only does it continue but it also escalates; that's the nature of wife abuse. It always escalates. The guy who's slapping his wife around a little bit on a Friday night at one point is pushing her down the steps 5 years later, and 5 years after that he's holding a gun to her head.

So the denial phase sets in.

The inability to admit what's happening is then followed by what I call the "we'll get help" phase. That's when she reaches out. Often she wants her husband to reach out too, but he usually refuses. So she's reaching out and she gets pushed back, as I was describing earlier.

At the same time all this is going on the fear factor is building. Some studies were done on the population in Belfast at the height of the terrorism, and the researchers found that much of the population was paranoid. No one knew when the next bomb was going to go off. Everyone felt powerless to stop the attacks and everyone was afraid to leave their homes. Well, that's the battered woman. She feels powerless to stop the attacks because she's learned after years of struggle that nothing she does makes any difference. She never knows when the next beating may occur; it can occur out of the clear blue. Not all beatings

occur during or after a fight. Her husband can come in drunk; she'll be asleep and he'll start beating her up. She's afraid to go out of the house because she has become isolated by hiding what's happening from the outside world and by being cut off from family and friends.

Eventually she gives up. And that's when the alcoholism and the drug abuse and all the rest of it set in permanently. She anesthetizes herself to the pain. There are women who go to shelters with third-degree burns on their bodies, and they don't even know they have them. She anesthetizes herself to the pain and she learns to endure. In some instances the violence escalates to the point where either he kills her or she kills him. Thirteen percent of all homicides occur between spouses, so it's not an occasional event.

I want to speak about racism because for many battered women it isn't just sexism; it's racism as well. The failure of the helping professions is double, triple, quadrupled when you're talking about women of color. A "whole" approach to wife abuse incorporates antiracism. It incorporates funds to deal with the racial conflicts that are arising in shelters around the country, and there are many. There should be special programing to meet the needs of women of color and low-income battered women. Their needs are different, their responses are different in many ways, their resources are not the same. Their situation is much more severe than that of middle-class women who have well-to-do families they can turn to. So the whole approach is not only a feminist approach but an antiracist approach as well.

The primary counseling goal of a whole approach to working with battered women is to develop the emotional independence of the victim. The counseling goal is not to get her to leave or to get her to stay. The counseling goal is to get her to be her, to help her get in touch with her own power. Once she is in touch with her own power she will no longer be a victim, whether that involves leaving or whether it doesn't. The question is not whether she leaves or stays; the question is whether the woman retakes control of her life. In helping her accomplish this, the most important lesson for the counselor is accepting her where she is. That means if she wants to stay and take the abuse and she thinks that she can change her husband, fine. Accept her there and work with her on that basis. She herself will come to see whether or not that is really a possibility. As she develops her assertiveness, as she gets in touch with her own power, as she becomes more self-confident and realizes she's a human being and not a doormat, she will make the right moves. She will retake control of her life.

You cannot help her to this control without victim advocacy. Dr. Symonds made a comment at the end of his talk to the effect that you can become a barking dog for one person or another and the next minute you're the third person out. It's true that this may happen on occasion, but there are reasons for it. There are reasons why a battered woman will call the police and then turn against the police when they get there, which I'll try to talk about in my workshop this afternoon. When it comes to child abuse, no one questions victim advocacy. The first priority is protecting the child; then you deal with the parents. Everyone recognizes that the parents have problems, and everyone recognizes that

you want to keep the family together, but you don't allow the child to be destroyed because you need to keep the unit together or you want to help the parents. You protect the child. The same standards should apply to wife abuse. You protect the victim and then worry about the abuser, the family unit, and all other considerations. It's not a question of taking sides; it's a question of saving lives.

In wife abuse everyone's a victim. Men are victims too, whether they're abusers or whether they're abused. We are beginning to respond to the problem. We have several hundred shelters around the country. We have several hundred hotlines around the country. We did have legislation, but I understand it has been killed. We've made a beginning, but we need to very pragmatically assess where we're going. I support the shelter movement wholeheartedly, but the number of battered women that we can actually house in a shelter and empower within a shelter is minuscule compared to the number of battered women who exist, minuscule compared to the number who will exist, so I have moved from direct service to prevention.

I do not see any way we are going to make a dent until we start talking about creating whole people in our society. If you run a shelter, I recommend that you put some time into the school systems in your area. Talk to the kids in junior high school, even in grade school, and say, "How do you perceive the opposite sex? What do you think marriage is about?" Start teaching our boys and girls to respect one another, start teaching our boys to stop denying and suppressing the female parts of themselves, stop teaching our little girls to deny and suppress the male parts of themselves; tell them that it's good for boys to cry and be gentle and that it's good for girls to be strong and tough. When we start creating whole children, we will have whole adults, and when we have whole adults we won't have any more wife abuse.

Legal Remedies: Part of the Cure for Battered Women

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Background

Legal remedies are an essential component in the treatment of battered wives. Legal relief validates their sense of outrage. It helps battered women overcome their powerlessness by removing the legal and economic ties to their abusive husbands. Courts can provide protection for battered women, as well as restrain husbands who batter their wives. Psychologists, social workers, nurses, and physicians therefore should understand the legal system, its potential contribution to therapy, and its shortcomings. Health professionals then can encourage battered wives to pursue this necessary element of relief without raising unrealistic expectations.

The extent of wife beating is appalling. Brooklyn Legal Services Corporation B, a federally funded free legal service for the poor, has represented over 3,000 battered wives in divorce actions in a period of 9 years. Seventy percent of all the women divorce clients represented by Brooklyn Legal Services have been beaten by their husbands.

The problem is not restricted to the lower class. Middle-and upper-class family violence is simply more difficult to observe, because middle- and upper-class reliance on private physicians and psychiatrists has prevented researchers from studying these battered wives. For example, the Women's Center of Greater Danbury in Fairfield, Conn., provided counseling for 26 battered wives in its first 2 months of operation. All but 2 of the abusive men were professionals, including lawyers and physicians.[1] A survey of over 1,000 adults conducted by the National Commission on the Causes and Prevention of Violence showed that more college-educated men and women "could approve of a wife slapping a husband, or a husband slapping a wife under some circumstances" than those who had a grade school education only.[2]

Wife beating leads to a disturbingly high number of homicides. There were 2,359 spouse murders reported in the 1975 FBI Uniform Crime Reports. This was 11.5 percent of the total number of criminal homicides reported in that year.[3] One study showed that in 90 percent of the domestic murder cases, the homicide had been preceded by one or more "disturbance" complaints to the police in the 2 years before the homicide,

and in 50 percent of these cases by 5 or more calls to the police in the 2 years before the homicide.[4]

Physical abuse of a wife is inevitably accompanied by emotional abuse. Continual threats and degradation are integral parts of the batterer's pattern of control over his wife. Because the battered wife is bound to her abusive husband legally, financially, and emotionally, she feels powerless to change her victimized condition. These feelings of powerlessness are accompanied by continuing stress and low self-esteem. The battered wife often blames herself for having caused the beatings she endures, and in turn finds herself the object of victim blaming by those from whom she seeks help.[5]

One of the reasons wife abuse persists is that, as a class, battered wives are trapped by an unresponsive legal system, which leaves them without effective remedy against the men who seek to dominate them. Studies show that they are discriminated against by the police, prosecutors, and judges.[6] While battered wives are not believed when they report attacks, their husbands' denials and countercharges are given presumptive credibility. Police, prosecutors, and judges often assume that battered wives are the guilty parties who have provoked, deserved, and wanted the beatings. Wives are expected to keep their feelings and opinions to themselves and to accept their husbands' abuse.

A principal failing of the legal system is its historical denial of wife abuse as a crime and a social problem. It has regarded wife abuse as a private matter in which State involvement was not warranted. Society has attributed to the victim partial or full responsibility for the violence she suffers. Legal reforms have been enacted, but hundreds of years of policy and practice change slowly. Prejudices of individual legislators, judges, prosecutors, police officers, and jurors will delay and reduce the legal relief that battered women may obtain.

A wife, unlike the victim of violent crime on the street, resides with her attacker. It is therefore especially important that the police protect her by responding to calls for help and arresting the abusive husband, unless the women requests otherwise. Historically, however, the police have been unresponsive to wife abuse. The police have given these complaints low priority, often failing to respond to calls or leaving the scene quickly, without insuring that the wife is safe. They have refused to arrest violent husbands, and have discouraged wives from prosecuting their husbands on criminal charges.

These police policies have changed in New York City. On June 26, 1978, the New York City Police Department settled a State court declaratory judgment action brought by 12 women who were assaulted by their husbands and were denied police protection.[7] In this settlement, the first of its kind in the United States, the police department agreed to reverse its policy of mediating family violence. The responding officer is now required to arrest when there is probable cause to believe that a felony has been committed, unless the victim requests otherwise. In those cases in which an arrest is not made, the officer must remain on the scene to provide protection for the battered woman so that she may leave. Medical aid must also be obtained.[8]

The new recruit training course at the New York City Police Academy embodies these policy changes. These new course materials articulate the concern for the crime victim's rights and for insuring the safety of family members. A distinction is made between appropriate response to "domestic disputes," the old catchall for police cases involving family members, and appropriate response to "domestic violence," newly regarded as a serious crime problem. When there is violence, police investigative work to gather evidence is stressed.[9] It is encouraging that the New York State Division of Criminal Justice Services has adopted this 14-hour training package to replace its present 2 hours of training on "domestic disputes."

Such reforms in police policy are promising, but it will take time for them to result in consistently improved treatment of battered wives by individual officers. These changes have not been adopted by many of the 650 local police departments in New York State. Years of continued pressure are needed to affect the performance of rank and file officers.

The legal process is slow. The criminal court system is disorganized and understaffed because of the simultaneous increase in the crime rate and the decrease in the allocation of funds for the courts. The accused has the right to counsel and due process. These protections are needed to allow the accused to defend against the prosecution, which theoretically has the unlimited resources of the State at its disposal. The complaining witness has no rights, and minimal protection at the discretion of the prosecutor, who represents the interest of the State only.

Prosecutors have also been reluctant to take wife beating seriously. Without regard to the history of violence in a given case or to the seriousness of the assault, they tended to "adjust" the matter and make inappropriate referrals.[10] Criminal court "diversion" at the prosecutorial level is made by referral to independent, community mediation and arbitration services. While mediation and arbitration are valuable in family situations when each spouse is in an equal power position, this is not the case when wives have been battered persistently. Established patterns of spouse beating, moreover, cannot be altered in single 2-hour mediation or arbitration sessions.

Mediation techniques place part of the blame for family violence on each party. The battered wife's feelings of guilt are therefore exacerbated, and she is denied the vindication of her rage. The abusive husband, on the other hand, has his feelings of justification validated by his wife's acceptance of responsibility for his violence. Thus, mediation fails to correct the abusive spouse's violence and worsens the victim's sense of guilt and powerlessness.[11]

Even when wife-beating cases get to trial, studies indicate that prosecutors are not diligent. In an informal study of six courtrooms in Cook County, Ill., during 1976, the following patterns emerged. Prosecutors stated that husbands' attacks against wives were not as serious as attacks against strangers. Husbands were prosecuted on charges of disorderly conduct without regard to the seriousness of the violence, and prosecutors failed to engage in legal argument when judges

dismissed complaints based solely on the irrelevant basis that divorce actions were pending.[12]

One of the reasons prosecutors have given for reliance on diversion programs to address wife beating is that battered women often refuse to sign complaints, or fail to appear in court to testify. It is generally agreed that more than half the battered-wife complainants either do not cooperate with the prosecution or request that charges be withdrawn.

This "dropout rate" is due partly to the prosecutors' failure to screen cases carefully. Brooklyn Legal Services has found that the longer the marriage, the more frequent and severe the beatings, and the greater the number of previously unsuccessful attempts to get help, the more likely a woman is to follow through with criminal prosecution and divorce. With these elements in mind, a careful screening of battered women could identify those women who will pursue prosecution.

The dropout rate is also raised by intimidation from husbands. Because, in many cases, wives are not protected from their husbands during the prosecution, the opportunity for intimidation exists. Shelter and collateral support services provided directly or through referrals reduce the dropout rate.

One positive trend is the creation of special units for prosecution of family violence cases. These units take wife beating seriously, treat women sympathetically, and pursue convictions with determination. As a result, conviction rates are much higher than average when these units are involved. The Domestic Violence Prosecution Unit of the Westchester District Attorney reports that in the last 2 years they have prosecuted more than 1,500 wife abuse cases. Their complaining witnesses have withdrawn from only 18 percent of these cases.[13] This dropout rate is no greater than the rate experienced in cases involving strangers. Similar special units are functioning in the Bronx, Brooklyn, and Queens District Attorney's offices.

Finally, prosecutors could be encouraged to reevaluate abandoned cases as beneficial. Official threats of prosecution may cause husbands to stop assaults and seek help, or to leave the home. Wives may decide that their best solution is leaving, and they are able to do so because their husbands are under restraint. Thus, the failure of battered wives to follow through with complaints may not waste prosecutorial time from the viewpoint of public policy. The arrests and commencement of prosecution may have ended the violence, without the added expense of trials.

Judges should constructively apply the available legal remedies to protect and assist battered wives, and to restrain abusive husbands. Instead, criminal court judges have historically dismissed many wife-beating cases. They have suggested and accepted the reduction of charges from assault to minor violations, and diverted cases to mediation. Meaningless sentences such as unsupervised probation have been imposed on convicted offenders. The refusal of judges to punish wife abusers is particularly serious because offenders are vindicated and emboldened by what they perceive as judicial condonation of wife abuse. The judicial

attitude of laissez-faire toward offenders also discourages prosecutors and police from protecting battered wives.

New York Family Court judges rarely impose jail sentences for contempt for violating orders of protection*, although the complete case histories are always before the court. The judges choose inaction in spite of the option they have to sentence respondents to serve jail time at night and on weekends so that they can continue working and pay support to their families. Judges avoid making decisions by issuing "mutual orders of protection," which direct each party not to harm the other. This, in effect, makes women equally guilty for beatings they suffer, and relieves wife beaters of responsibility for their violence.

Judges in all courts also refuse to give family violence cases the expedited hearings warranted in these emergency situations. Crowded court calendars therefore make the processes of criminal prosecutions, Family Court actions, or divorce cases work in favor of husbands who usually control the family income and assets. Getting temporary orders of protection, child custody, and child support can take months, sometimes as long as a divorce itself.

Women seeking divorces are in no better financial position now that New York has enacted its marital property law.[14] Litigation to define marital property and to obtain equitable distribution can continue for years after divorce or dissolution. These difficulties in obtaining custody, protection, and financial support force women to remain with their abusive husbands.

The legal system traps women who seek to flee their abusive husbands. Mothers' claims to custody are prejudiced when they leave the marital residence and do not take the children, even if the "abandonment" was to escape beatings. In States like New York where divorce is available for fault only, women may lack grounds for divorce if they leave home before the beatings become frequent or serious. In States retaining fault defenses to alimony and equitable distribution of property, beaten wives may appear to have deserted their husbands by fleeing, thereby increasing their burden of proof to establish their alimony and property rights.

The ultimate legal irony is that even when wives get temporary or permanent awards of alimony and child support, the amounts are usually too low for them to maintain themselves and the children. Frequently the awards are not paid at all. A 10-year study of court-ordered child support in an urban Wisconsin county showed that only 38 percent of

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*Orders of protection granted by a Family Court are civil injunctions directing the physically or verbally abusive spouse to cease his offensive conduct. Jail or a fine for contempt of court are the penalities for violation of Family Court orders of protection. Orders of protection are also available in Supreme Court in connection with divorce cases, and in criminal courts in connection with criminal prosecutions.

husbands fully complied with the child support provisions of divorce judgments less than 1 year old. As the age of the judgment increased to 10 years, the number of fully compliant husbands dwindled to 13 percent.[15]

A recent study of child support compliance in 10 Illinois urban and rural counties reveals that for judgments entered in 1970 there was full compliance in 43 percent of the cases and noncompliance in 33 percent during the first year. In the fifth year, full compliance dropped to 18 percent and noncompliance rose to 65 percent.[16] Because separated or divorced wives cannot expect continued payment of child support, many battered wives stay with their husbands. Professor Richard J. Gelles, a sociologist who has studied battered wives, found that "...the variable which best distinguishes wives who obtain assistance from those who remain with husbands is holding a job.... Thus, the less dependent a wife is on her husband, the more prone she is to call for help in instances of violence."[17]

If one still asks why battered women do not leave and get a job to support themselves and their children, Federal Government statistics on women's wages answer the question. In 1977, the median earnings of year-round, full-time working men exceeded those of year-round, full-time working women by 70 percent. In 1955, however, the median earnings of year-round, full-time working men exceeded those of year-round, full-time working women by only 56 percent. The earnings gap expressed in dollars has widened from $1,533 in 1955 to $6,008 in 1977. Sixty-three percent of working women earned less than $10,000 a year, compared with only 24 percent of working men in 1977.[18]

Without doubt, the most pressing need of battered wives is free or inexpensive refuge for themselves and their children. This need stems from the inadequate legal protection for women and the economic disadvantages they face. Government funding for family shelters, however, has been minimal. Funding is being further reduced or terminated in response to what elected officials perceive as a grassroots espousal of right-wing, antiwomen, and antisocial welfare politics.

Prescription

In spite of the legal system's shortcomings, it is a critical component in the treatment of battered women. Women can obtain protection and independence from abusive husbands, along with a sense of justice and vindication, through use of the legal system. Medical professionals who treat abused wives should encourage them to seek legal redress. Part of the healing professionals' job is to show battered women that they have enormous strength, which must be used for self-preservation instead of self-sacrifice.

Nurses, social workers, psychologists, and physicians can help battered women contend with the legal system by believing the horror stories of their experiences with police, prosecutors, judges, and court clerks. Most of these stories will prove true, although the women may need help in understanding their meaning. Second, encourage clients to continue with legal remedies, but without raising unrealistic expectations of

immediate success. Third, be willing and able witnesses in court when necessary.

You should begin with a network of lawyer and court referrals, as well as a knowledge of the possible legal remedies. Take time to make understandable notes in your records and to save evidence. Thus, you will provide the tools to help battered women succeed in the legal system.

One of the options for battered women is divorce. Divorce usually puts an end to the beatings because it is an unequivocal statement of rejection of the husband and his abuse. In addition to dissolving the marriage, the divorce action may resolve issues of custody, visitation, support, maintenance (which has replaced the term "alimony" in New York), and property ownership and use. Orders of protection may be requested while the divorce is pending and in connection with custody and visitation provisions after the divorce. Obviously, divorce is the most complete legal action, because it concludes all the civil legal problems of battered women.

Contrary to what many abusive husbands tell their wives, women can get divorced without their husbands' consent. Battered women in New York have grounds for divorce if they have been beaten once in the 5 years prior to starting the divorce, or if they have suffered a continuous course of minor physical or mental cruelty.[19] When clients have these problems they can get divorces more easily than they can get other forms of legal relief, such as orders of protection in Family Court or criminal prosecutions.

The battered women's sworn testimony of abuse is sufficient proof to sustain the request for divorce if the divorce is not contested by the husband. If the divorce is contested, other evidence is necessary. Records of medical treatment and statements to treating physicians, photographs of injuries, photographs of destruction of the household, or items of torn or bloody clothing are evidence in these cases. A health professional can gather this evidence and encourage patients to give the evidence to their lawyers or the district attorney.

Divorce actions require attorney representation because the issues are complex and the paper work is difficult. Clients should retain lawyers promptly. Predivorce relief is available in the form of temporary custody, child support, and maintenance. Women need not wait for the divorce to be completed in order to flee their abusive husbands. They may leave the family home without committing the marital wrong of abandonment. Abandonment is desertion without cause or justification. These matters, however, must be discussed with the attorney.

Another option for battered wives is getting a Family Court order of protection. This provides limited relief without affecting the marital status. The respondent is not given a "criminal record." An order of protection is advisable when women do not want divorce, or if they will lose valuable Government or employee-spouse benefits if their marriages are dissolved.

Orders of protection may include custody determinations and establish visitation rights. They may remain in effect for as long as 1 year, and may be renewed after that.[20] To obtain support, separate proceedings must be instituted in Family Court; orders of protection cannot include support provisions. Support orders, however, may include orders of protection.[21] Having a lawyer in Family Court increases the woman's chance of success, but Family Court is organized to assist those without attorneys. (In order of protection cases the accused spouse has the statutory right to court-appointed legal counsel; the victim does not have this right.)[22]

Crowded court calendars and delay tactics by husbands can prevent prompt relief. The judges are in control, and they may deny orders of protection if they believe the husbands. The factual and legal issues are not as clear as in divorce cases. Clients gain control when they take action that shows their husbands the abuse must end. Orders of protection, which are more equivocal than divorce, should be viewed as cease-fire directives, pending which family or marriage counseling is pursued.

Family court orders of protection are difficult for unmarried women to obtain. They may request these orders only in connection with paternity cases against the children's fathers.[23] This course of action has its own pitfalls. Fathers can seek visitation rights or custody of the children in response to the paternity suit. Thus, the best route to safety for unmarried women is to move away from the men who are abusing them and to take no family court action.

A third option available to battered women (whether or not they are married to their abusers) is criminal prosecution in the course of which they may request orders of protection if they are or were married to the defendant.[24] This, however, is a last resort, because it is the most difficult legal process. The district attorney has absolute discretion to decide whether or not to prosecute. Defendants have the constitutional right to lawyers, but victims do not. The complaining witnesses (the battered wives) must have medical or other evidence or witnesses to corroborate their testimony, because they must prove their cases beyond a reasonable doubt. The court proceedings are open to the public and there is likely to be a jury to convince. Finally, as the preceding discussion detailed, judges tend to dismiss family violence cases before they get to the jury trial stage.

Criminal prosecution is advisable only in the most serious cases of physical cruelty or prolonged harassment. Dismissals or acquittals of abusers vindicate them, increasing the danger to the clients. The victims' threats to have their abusers thrown in jail are proven empty, leaving the women defenseless.

Finally, the patient's privilege of confidential communication with health professionals is waived when the patient calls her social worker, psychologist, nurse, or physician to testify on her behalf. The husband's attorney can cross-examine the wife's witnesses, calling into question professional credentials, expert opinions, and authorities cited. Aspects of the client's condition that are unfavorable and could hurt

her case may be brought out in cross-examination. This exposure makes it imperative that there be candid discussion of all aspects of the client's condition and history. The lawyer needs all the facts, good and bad, to make an informed determination of whether or not the medical and psychological testimony will help or hurt the client.

Conclusions

Given the legal remedies that are available, what specifically can a health professional do to assist a battered woman with her legal options? The first job is to uncover and record evidence. The health professional can provide objective corroboration of visible injuries and the client's statement of how they occurred. Notes taken during the interview or immediately upon its completion should describe the injuries observed or complained of and the client's statement of their cause.

Next, make a referral for legal assistance. Encourage the client to pursue her legal remedies, without creating great expectations. Listen to a battered woman's tales of trouble with the legal system with a sympathetic yet educated ear. Many times a woman will have a bad experience with the court, but, for instance, it may be that the judge who seemed hostile was merely granting an adjournment. A knowledgeable health professional can help sort out a client's experiences and indicate what they really mean.

Talk with a client's lawyer. Offer to help the attorney with evidence and emotional support of the client; this will also provide a chance to appraise the quality of the attorney's work for the client. The client may need help understanding what the lawyer is doing or may need a new lawyer.

I am not suggesting that the health professional assume control of the client's case. But if the lawyer does not appear to be doing enough for the client, attempt to get the lawyer's reasoning on the case. One test of a good lawyer is his or her acceptance of the health professional's involvement.

The health professional must be willing to come to court and testify. Notes or affidavits cannot take the place of live testimony. In fact, notes will be admitted in evidence only if the health professional is present in court to identify them. Affidavits are not accepted, since they do not permit the affiant to be cross-examined. Live testimony, on the other hand, provides legal protection to each party and gives the judge an opportunity to evaluate the expert witness. It may be the key to the client's legal victory. Furthermore, witnesses help overcome the disadvantage that women litigants suffer. Women are viewed as untruthful and manipulative. Men have the benefit of presumed truthfulness. Women gain credibility through the testimony of corroborative and expert witnesses; this additional testimony establishes equality and assures a just outcome.

Your cooperation is needed to better help our mutual clients in individual cases and to improve the response of the legal system. When

you suspect failures or abuse by police, lawyers, court clerks, or judges, take notes, write down remarks verbatim, and discuss them with your local legal resources. Let the Governor's Task Force on Domestic Violence know about problems that repeat. [Author's Note: The Task Force can be contacted at the New York State Council on Children and Families: (518) 474-6294, or call Brooklyn Legal Services, Family Law Unit: (212) 855-8029.] We need to identify patterns to correct them. Only with this information can we continue to make reforms that will increase the efficacy of the legal remedies for battered women.

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Sheltering the Battered Woman

Verona Middleton-Jeter, C.S.W.

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I am going to share with you some of our experiences running a shelter for battered women for 3 years. Our shelter consists of 18 apartments in a tenement that's also used as a shelter for homeless welfare families. In the shelter we provide services for battered women who are welfare eligible with children.

During these past 3 years we have been searching for answers to questions that would help us to better understand the needs of battered women and their children, which in turn have helped us run a more effective program.

Some of the questions we struggled with and are still struggling with are:

1. Who are we talking about when we say battered women?

2. Why do women use this shelter?

3. What intervention approach should we use in the shelter?

4. What part does fear play in the lives of these families?

5. Where do battered women go when they leave the shelter?

6. Does the lack of a more varied funding source encourage polarization of intervention methods?

7. What else can the community do?

For our purposes we consider a battered woman to be any woman who has been physically abused or seriously threatened with abuse by a man with whom she is intimate. This definition works for our shelter because we cannot risk making a misjudgment and having the woman killed or seriously injured because she did not convince us that she was in danger. Generally, we have found the term "battered woman" to be too broad, because it encompasses women in different categories. This has implications for program planning and a better understanding of the problem. Steve Leeds, a researcher hired by the Henry Street Settlement to study the problem of battering, made a similar observation. He said:

> The diversity we observed extends beyond the woman's demographic traits to the kinds of abuse they suffer and how they react to it. While we may call all these women "battered" as a convenient term for describing them and while it is clear that a number often have been severely assaulted, others have never been beaten either severely or repeatedly. The nature of her prior abuse is not necessarily an accurate predicator of a woman's present danger nor of just how threatened she feels.[1]

We have found one of Erin Pizzey's theories to be helpful in thinking about the diversity. (Erin Pizzey is the founder of Chiswick Women's Aid, in England, the first shelter established specifically for battered women and their children.)

One of Erin Pizzey's theories that has far-reaching implications for shelters and the services they offer is her differentiation between two types of victims of domestic violence. Pizzey said that the most prevalent is the "battered" woman. Pizzey describes her as "accidentally involved in a violent relationship" and caught in a situation of economic and emotional dependence but possessing the inner resources to escape it. "All she needs of the shelter," says Pizzey, "is a place where she can gather her strengths and go on to renew her life elsewhere with her children."[2]

An example of this kind of woman in our shelter is Ms. N, a mother of three children who was in an abusive relationship for 4 years before coming to the shelter. She got a divorce while staying in the shelter and then transferred to a shelter in Colorado. She remarried, is going to school, and doing very well. According to Pizzey:

> The other type of victim is the "violence prone" woman who tends to seek help in a refuge as a temporary respite in a continuous boxing match, only to return to her violent family life. This woman comes from a violence-prone family that has been repeating the violence cycle for generations. Pizzey sees this woman's family relationship as an "addiction to violence" in much the same way that a drug abuser is addicted to drugs and asserts that it takes years of repeated stays at a refuge to wean her off violence.[3]

Ms. R is an example of this kind of woman, who seems to have been weaned off violence. Her mother was a battered woman. She is a mother of five children abused by her husband for 7 years. He abused one of the children so badly that placement was required. About a year after placement, Ms. R was able to terminate this relationship. She then took up with another batterer, who caused her to come to the shelter. She reconciled her differences with the batterer while living at the shelter and returned home. In less than a year she had to return to the shelter, but this time more determined to win the battle. She enrolled in a training program, terminated her relationship, and started a relationship with another man, Mr. W. There was no physical abuse in this relationship for over a year while she was in a training program, but when she started job hunting Mr. W became abusive. She requested couple counseling and the abuse ceased.

Although the objective in assisting these two categories of women is to help them to have a violence-free relationship, their situations call for different approaches to the problem.

> Pizzey distinguished between a shelter and a refuge, describing the former as a short-term residence serving the battered women. The refuge offers the violent-prone woman an indefinite stay in an environment where she can receive help from specially trained staff.[4]

In New York City we presently have three shelters, with plans for two more. We do not have any refuge. The idea of a refuge is a good one, because the need for this type of service is indicated daily as women go from shelter to shelter. This long-term refuge could also allow a woman to return as many times as she needed. This would decrease the embarrassment and guilt feelings associated with having to return.

Just as it is hard to categorize battered women, because of the diversity in their situations, there are a variety of reasons why women use the shelter. Some of the reasons are:

1. A lack of financial resources;

2. Inaccessible financial resources, in the sense that the bank account is in the batterer's name;

3. Limited financial resources, such as welfare or Supplemental Security Income, with such resources being controlled by the batterer;

4. Having a support system such as a friend and relatives but fearing that the violence will be directed toward them;

5. Exhausted support systems, in the sense of having to use them too often or because the batterer has been violent toward them;

6. The lack of emotional and physical strength to continue to think of ways to prevent the abuse;

7. The need for supportive services while terminating the relationship; and

8. Fear of being killed.

Most of the battered women who used our shelter had one or a combination of reasons for using the shelter. The variation in reasons for using the shelter had far-reaching implications in our planning of programs and our intervention approach.

We adopted (with some modifications) a task-centered, problem-solving model. This approach was chosen because we wanted to be able to address the needs of the families through individual, group, and family counseling.

The task-centered, problem-solving model is an ego-supportive method of intervention with the primary objective of improving and enhancing the clients' general functioning. This model assumes that self-esteem and self-respect are improved and sustained when the person is able to carry out role tasks and cope with interpersonal relationships. We emphasize the importance of the client's right to define the problem and encourage a mutual goal-setting process. Through the use of this approach with the families we have a better understanding of what is happening in their lives, and what their priorities are.

During the shelter stay, women and children are concerned with issues such as ambivalence, poverty, relationships, rehousing, the prevention of battering, employment, health, being found by the batterer, violence in discipline, racism, sexism, education, and a host of their day-to-day problems, with fear described as the most dominant feeling.

Most of the women say that the fear of not being able to find a decent apartment is more prevalent than the fear of being found by the batterer and being physically abused. This fear is related to the discriminating practices of our society.

Women fear being discriminated against because they are black, Puerto Rican, poor, on welfare, single with children, and also battered. These factors dictate that a battered woman and her children will not be able to find a decent apartment and will generally be treated as second-class citizens. Hours upon hours are spent thinking of ways to beat the system so the family can have a decent place to live. This should be a right, rather than a privilege.

The children's fear is related to their loyalties to both parents and whether they are doing the right thing by staying with their mother, not telling Daddy where they are, and by still loving Daddy even though he was abusive. They are afraid to tell their old friends why they had to move. They are afraid to tell their new friends why they are in the shelter, and they are embarrassed to let anyone know that their home is not the sanctuary they'd always heard it should be.

Fear also comes into play with practitioners encountering battered women and their children -- the fear of violence. Social workers have been condemned for being unresponsive to the needs of battered women because of their subscription to certain personality theories or the fact that they see themselves as "preservers" of the family unit. The fear that the violence might be directed toward the helping person may also be a conscious or unconscious factor in our inability to respond to battered women. I've always admitted to being afraid that the violence would be directed toward me and I try to help battered women make plans that would protect us both.

After directing a shelter for about 2 years, feeling pretty confident with my practice, I was called one Saturday morning because a batterer was on the premises. I went to the woman's apartment to let her know that the batterer was around. As I was going through the door to help her get the children, he was coming through the window. All I could say was: "Let's run." We ran to the office and called the police.

This incident pointed out two things as I sat shaking in my office. I realized that fear could have a paralyzing effect on the potential victim, which is what happens to a lot of women. One woman said that fear can make you do a lot of things, and fear can make you do nothing. This was the first time I realized how fearful and helpless I was in confrontation with a violent man. In order to avoid such confrontations, some practitioners use the professional defense of "blaming the victim," asking to meet with her and the batterer, or making many other unconscious or conscious requests that would discourage the battered woman's attempt to get help.

We can be effective in our work with battered women, but we must first take stock of our own feelings about violence. Violence is a life-threatening factor that most of us are unprepared to deal with. After raising your own consciousness about this factor, you should decide if you could still be effective with a battered woman. If you are afraid of violence and the threat of it frightens you, your fear is normal and acceptable. Once you have acknowledged the fear, and if the thought of it does not make you immobile, then you must develop the courage and skills to deal with the fear.

In our shelter our formula is caution: proceed with cautious confidence, respect the individual's right to a point of view, make it very clear that we do not and will not tolerate violence, and use common sense to think of ways to protect yourself and your client. This might be as simple as making sure that the confrontation is public, where help can be summoned. In the shelter we have a list of survival skills that we update on a regular basis. When women leave the shelter they use some of our survival skills and they continue to develop their own.

About 60 percent of the women establish new homes when they leave the shelter; of that 60 percent we know that 20 percent had the batterer join them in their new homes. Five percent of the women move in with friends and relatives; 25 percent return to the batterer; and 10 percent leave without notice. Initially these figures were surprising and had a negative impact on the staff. That was because our expectations were unrealistic; we defined success as terminating the relationship with the batterer.

The feedback we are getting from former clients is that the shelter stay was beneficial for most of the women to a greater or lesser degree. Women report feeling stronger by being able to share the battering experience openly, knowing that others have similar problems, getting support while considering their options, and knowing that there are resources available.

There are a limited number of resources available for battered women and their children, and there is clearly a need for additional programs. These programs must be funded through a variety of sources in order to insure that women of all classes will be able to avail themselves of the same type of services.

The Leeds report stated:

At least in the inner city, shelters draw abused women disproportionately from the lower socioeconomic groups, whereas counseling programs draw more from the middle and upper classes.[5]

There could be several reasons why this is happening, such as a lack of resources, differences in concrete problems, the severity of the abuse, or the funding source. The Human Resources Administration is the only funding source available for shelters in New York City, thus tying shelters into welfare eligibility. This is an acceptable way of funding shelters, but when it is the only way, it helps to polarize intervention efforts, since shelters will be used only by poor women, and this fact could perpetuate the myth that spouse abuse occurs mostly in poor families.

Poor women have been complaining for years of being battered, and nothing was done. Middle-class women began saying that they too are being battered, and efforts were begun to stop it. We need a concerted effort to stop spouse abuse regardless of the socioeconomic level. We cannot allow the apparent conservative mood in this country to fragment our efforts.

Before closing I would like to emphasize that shelters are an integral but small part of the total community response to meet the needs of battered women and their children. Just as we are continuing the fight for varied sources for shelters, we must fight equally as hard for other kinds of supportive community services.

These should include:

1. Advocates and brokers to help battered women and children get to the appropriate services.

2. Supportive services in the community for: (1) battered women leaving the shelter, (2) battered women who could not get into the shelter, (3) battered women who do not want a shelter, (4) unidentified battered women, and (5) potential battered women.

3. Nontraditional, innovative programs for batterers and potential batterers.

The community, including governmental agencies and other systems, must be sensitized to understand the nature of the ambivalence and the dynamics of being a battered woman. They must be made to understand that battered women are desperately crying for help; they want the abuse stopped.

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WORKSHOPS

Working With Couples

Janet Geller, C.S.W.
Louise Garin, C.S.W.

Janet Geller: I have worked in the area of spouse abuse for 4 years and I also do it in my own private practice as well, keeping abreast in consulting. I'd like to talk about the rationale for working with the spouses as a couple.

At the Victim's Information Bureau of Suffolk, we implemented a treatment model I developed, where we worked with a victim in any way in which the victim found helpful. If a woman wanted to separate from or divorce her husband, there would be provisions for that and services for that, as well as services if she wanted to remain in the marriage, but without the abuse. I think we pretty well know that battered women need a variety of services for themselves, depending on what it is they are asking for. I believe you start with "where a client is." You give people what they want; you do not impose your values on them. Let me also say that when I use the word "spouse," I'm referring to a person who is married.

Generally, it is the woman who calls for services. This is true in the field of mental health in general, and certainly in the area of spouse abuse, more women avail themselves of psychological services than men do. It is often the woman who makes the initial contact. When a couple calls, I think it's up to the worker to say, "What is it you want?" Of course, the woman is going to say, "How do I know? I'm being beaten and what I want is for the beating to stop." Some say this is the service we can provide, and this is what you can get, and if you don't want this you can't have anything.

There is a range of options, determined by what the goals of the woman are. Initially, she may not know, but she does have some idea. There are some women who want to separate and divorce; for them, it seems to me appropriate to provide concrete services like helping them obtain a lawyer, letting them know of women support groups, working out what kind of income she can rely on for herself, etc. She should also be offered some sort of transitional counseling, since she will be in need of a support system.

If a woman says, "I'm not going to leave my husband, but I want the abuse to stop," then, as far as I'm concerned, the treatment of choice is to work with the abusing couple as a couple. If she is going to remain in the marriage, the best way to effect change in the battering syndrome is to work with the abuser, and there are programs now that are beginning to emerge. One of them is called EMERGE, which works with the abusing partners.

I feel that working with the couple lends another dimension that I think is viable. I agree that the battering is the sole responsibility of the batterer. No matter what a woman does to involve herself in a

way that leads to the kind of argument that escalates to battering, it is not the woman's fault. There are many women who nag, complain, instigate arguments, etc., and not all of those women are getting hit. If a woman is getting hit, you have to look at the abuser to determine why.

It is not up to me to say whether a woman should leave her abusing husband. I may feel that way, and if I'm in an abusive relationship, I may do that. We all know the reasons now why a woman remains in the marriage; if that is her choice, and we cannot get the husband to come in, then we should help find alternatives for her to deal with the issue, with the least amount of pain and trouble.

I think women need to learn survival skills. They should learn how to hide money, because if they have to leave immediately, they will need financial resources immediately available to go to a hotel, to take a cab, or whatever is necessary. If she has a car, she should be able to keep the keys to the car pinned to her somehwere -- the inside of her bra, whatever. Those of you who know anything about battering know that the abuser will go to all kinds of lengths to prevent his wife from leaving, and one method is taking the car keys, as well as blocking the doors, pulling out the wires of the car, or whatever. Therefore, the woman needs her own survival plan. She needs her own way of getting out of the house if she has to. If there is a 4-year-old child, then somehow that 4-year-old has to be trained to go get someone before the husband knocks the wife across her head. The woman also needs to learn the kind of clues signaling her that the man is about to hit her. If you're being abused over and over again, you can say "ouch" just so long. If you feel you have no control, at some point you say, "It doesn't hurt anymore," "It doesn't hurt the way it used to," and you lose the sensitivity to realize that tonight, when he walked in, you are going to get it.

These are some of the issues a worker can take up with women who are not about to have their husband come in for treatment and who are also not about to separate and divorce. The statistics of women leaving are very low. There is a very small percentage who leave the relationship, but there certainly is an extremely high percentage of women who want the abuse to stop. I have never received a call from someone who said, "He hit me and I loved it." Clearly, people do not want to be abused, and that is why they are asking for our help.

Very helpful to women who are locked into a pattern of abuse is having their self-image boosted. They need other women whom they can relate to, who can let them know there is nothing wrong with them. We know that one of the things batterers do is blame the victim; furthermore, society blames the victim and the victim blames the victim. She is a product of our society too, and she says, "It must be my fault; I didn't do it right and I'll do it right the next time." What happens to her is that she isolates herself more and more, even though we say to her that she doesn't have to be ashamed of the fact that her husband is beating her. That is something he ought to be ashamed of. We know that women are not going to go around saying, "My husband beat me up." So her world gets much smaller as she continues to be battered. She doesn't go out and show off her bruises. There are just so many times

you can say you walked into a door or fell down the stairs. If she has children, they will certainly respond to the abuse in the home and they will begin to act up. The woman has difficulty managing them, and thus she develops feelings of inadequacy around a task central to her sense of self. It doesn't take long before she too believes that she must be doing something to cause the abuse. A woman who is being beaten continuously and unpredictably does develop a feeling that she's not as good as someone else or that she's not as good as she wants to be. She does develop feelings of inferiority. She does have her self-esteem damaged. To meet with other women who are going through what she is going through is very important for her just in terms of self-image. We all know the effect of peer-group relationships, how they help you identify your problems as related to others. In addition, however, she needs to look at these other women, whom she finds perfectly acceptable, presentable, and nice, and realize that since she finds them nice and it doesn't follow that they are at fault, perhaps it is not her fault either.

The above is a very quick sketch of the kind of alternatives available other than working with the couple. However, as far as I'm concerned, if a woman wishes to remain in her marriage without battering, then the treatment of choice is couple counseling.

I have worked with men alone, and that's very effective also, but what you need to do is work on the relationship factors. If you work with the abuser alone, although that is starting with who has the hitting problem, you leave out what has happened to the woman over the years, the fact that she's been abused. You leave out what has happened to her feelings about him as her husband, what has happened to her self-image, and what psychological damage she's been through. Ultimately, it seems to me that you are going to have to work with the woman anyway. It is more efficient if you work with the couple together, if you look at things in terms of interaction between the couple.

Now, not all men who beat their wives are willing to come in for treatment, and not all men who beat their wives are amenable for treatment. Those who aren't fall into several groups. There are some men who beat their wives because of organic impairment; these men will benefit from appropriate medication. There are also psychotic conditions, and the most effective form of treatment for them is psychiatric intervention. Psychotic abusers are not going to acknowledge that they have a problem or that they are beating their wives, and treatment is very complex, something for highly qualified professionals.

However, there is a large percentage of men amenable to treatment, who are your normal "average, everyday citizens." They are your neighbors, your big brothers, your PTA members, people who hold good jobs, etc. They are not guys who get in barroom brawls and fight with everybody. They may be men whose only form of deviate behavior relates to their interaction with their wives, and that's plenty, that's enough. They are not acting in a generally antisocial manner in society, just in the marital relationship. These men will come in for treatment.

The form of therapy I think is effective begins with pulling no punches: you have to make it very clear that the battering is the abuser's problem, and he has to take responsibility for the battering. However, in addition to that, you must work on the interaction in the relationship, and it's really much more a joint marital therapy model. I've done some work in family therapy. The kind of family therapy that Minuchin, Haley, Satir, and Sager do is the kind of treatment model I've adopted in working with the battered spouse syndrome, and in my experience it does not take very long for the battering to be controlled. There may be regression, but the battering becomes more a symptom of the problem in the marriage, and since there is a way to work on interaction that improves the relationship, battering gets treated as a symptom. If the battering continues, you address the aggression just the way you address anything else. When there's aggression, what gets talked about is that the battering is the abuser's responsibility. Continued battering is not a reason to terminate treatment, or determine that the treatment is a failure. If you treat it as a regression, you respond in the same way one responds to any form of regression in counseling or therapy.

The initial contact is extremely important, and it is there that I think people working in this area get into some difficulty. Women who are beaten have really developed a feeling that they are victims. When they call you, there is a way in which they often appear helpless, unable to do anything, not knowing what they want to do. Symonds talks about the stages of being a victim. One of these is infantilism. Lenore Walker talks about helplessness.

Often a woman will present herself as being in a desperate situation and indicate that you have to do something immediately. I believe strongly that if you don't take the immediate step of getting the husband in, and if you respond to her need for intervention, immediately, you are going to have a lot of trouble seeing the couple as a couple -- because the model I'm talking about is based on a no-blame motto. The husband already knows he has 10 points against him. First of all, he knows that assault and battery is against the law; he's known from childhood that boys don't hit girls. Whatever way you want to view it, he knows he's doing something wrong. He does what we all do when we're acting in a way we feel is out of our control. He denies and he rationalizes; he uses whatever defenses are available to him to avoid thinking he has a problem. In general, it's going to be very hard for him to come in. It will be even harder if he feels he is at fault and that you will tell him he's at fault. The critical factor here is playing neutral, and that has to start at the first moment of contact.

The first contact usually occurs over the telephone. When a woman calls in, I think you have to determine right then, over the phone, what form of treatment you are going to give her -- whether you are going to work with her alone, get her into a shelter, whatever. Let's say the decision is made that she is going to be seen in couple therapy with her husband. If that's the decision, then you can't have her come in for a session alone. What you have to do is get her to persuade her husband to come in. That's very difficult.

In systems theory, there is a statement about "maintaining the status quo" or the "homeostasis" -- in other words, the familiar is much more comfortable than the unknown. Misery is comfortable to us because it's ours. It doesn't mean we don't want to get rid of it; it doesn't mean we do not want to be happy; but there is a way we keep what we are comfortable with. In the case of spouse abuse or any family therapy, what you are talking about is a system that works -- poorly or destructively, but functioning. People get into the system and behave a certain way. There are certain roles played, and it's hard for people to make changes, even though they want to. Generally, there is a small part that wants to change and a larger part that wants to remain the same. A major effort in therapy is to get the person to want to change.

When you are dealing with a battered woman, there are roles already established. She's the victim and he's the bad guy; to get the two of them to move out of those roles takes a long time and it's hard to do, and I say it starts at the initial contact. So, when she calls you and you determine that the treatment of choice is couple therapy and you say to her, "Listen, I want your husband to come in," and you get her to agree that that's a good idea, then your biggest struggle is not to give in to seeing her before her husband comes in.

We all know what is good for us and what isn't, but it doesn't necessarily mean we change the way we are. The reason we don't change is because we're not anxious enough to change. We rationalize and deny. But at some point that anxiety surfaces, producing a shift of thought. We know that battering is a chronic syndrome. We know it goes on for a long time, most often beginning at the inception of the marriage or relationship. When a woman calls for help, in more cases than not, something has happened that is different from what has happened previously -- and that is why she calls. Occasionally it is something that happens all of a sudden. He hit the kid when he never did that before; he struck her in the face when he used to hit her in the chest; he used a weapon when he used to use his fist. Whatever the circumstances are, there is something that makes her more anxious about her situation and prompts that phone call.

That anxiety, the change, is the pivotal point. You have to maintain the woman's motivation to get her husband to come in. If you see her, if you succumb to your desire to help and respond to what you hear as helplessness or need on the part of the battered woman, you are probably going to have a very difficult time getting the abuser in, and you may never get him in at all.

What I feel needs to be done -- and it is indeed the hardest part for the helper -- is to hold to the agreement that the woman has to get her husband to come in if that has been determined as the treatment of choice. You'll hear all kinds of resistance to that. You'll hear, "That is the problem; he never does anything I want. How am I going to get him to do this? He says he'll never come for help. If I ever approach it, he's going to get angry." You'll hear all kinds of reasons why she cannot ask him to come, even though she has said, "Yes, I do want him, and yes, I do want to remain in my marriage. When he is not hitting me, there is love in my marriage, I do want him to come in, but ..." You

always get the "but." You have to push past the "but," and help by saying, "Look, if he doesn't come in, how are we going to work on his battering? It's logical; it makes sense. Listen, you've tried to get him to stop hitting you, haven't you?" Is there any woman who is going to say, "No, I haven't tried." Of course she's tried. You need to say, "If you can't get him to stop hitting you, what makes you think that just by coming to see me I'm going to enable you to stop him from hitting you? The only way he'll stop hitting you is if he comes in too."

It makes sense. There are very few people who will argue with this logic. Furthermore, this argument changes the notion that the abused person is the victim, since victim means you can't do anything and things just happen to you. Even if you lose the case because she doesn't call you back, you've planted the notion that she can do something to change the situation. And she may act, later. I have had that happen. There was a woman who called over and over again. She said, "Yes, I will." It took her 6 months, but then she called me up and made an appointment for herself and her husband. It was a very important step for her to ask him to come. The major part of the work is working with the couple relationship, and if you are going to have only one partner, then the other part of the couple is missing. I think it's crucial to have both.

Another slant on this approach is that you are not acquiescing to her sense of guilt. The man is saying about her, well, it's your fault; your hair is too short, your hair is too long, I wanted dinner on the table at 6:01 and you put it on the table at 6:02, you don't raise the kids well -- you are too lenient, you are not lenient at all. There are any number of excuses, and if the woman believes it's her fault and you see her alone, then on one level you are confirming that she is the problem -- otherwise, why wouldn't you push to get him in? There are arguments to seeing the abuser alone. I think that is a more desirable treatment then seeing the woman but if you are going to try to work on the relationship, I think the most efficient and effective method is seeing the couple together.

If you see the woman at first, the man knows that you are seeing her alone and he will think that you are on her side. Part of the problem for such couples as the ones we deal with is that the two people are in enemy camps. Who is going to beat up his wife? Someone who really sees her as the enemy. Who is going to sit in a situation where she gets abused? Someone who feels she deserves it. Sometimes I feel that we lose some sensitivity in working with domestic violence. These are people who are building a life together, having a family together, and closing their eyes together. These people who are in armed combat are sleeping next to each other.

We are really dealing with people who don't understand what friendship is about, what cooperation is about, who are not in a mature love relationship. Often when you look at these couples you really see a lot of infantile and adolescent behavior. There is a lot of "Whose friend are you going to be, mine or his?" And that's what they do in the family. The kids have to be on someone's side. If you see one partner without the other, and particularly at first, then the other

partner says, "I know she told you things about me that are going to prejudice you about me." I've heard men say that. I tried it many different ways at first, because this was all experimentation. I heard men say, "Once the worker saw my wife alone, I never felt I could relate to that worker." And I heard the reverse. There was a case where the man started first; he brought his wife in later. He said, "I always thought the worker liked me better." That is not a good way to begin.

The best way to begin, if you are saying you are there for the both of them and you're not a judge but someone who works with people in pain, trying to alleviate that pain, is to do something to demonstrate that. You have to resist the pull for sympathy -- "Can I come in for one session and then get my husband to come in?" We all live with our own anxiety. What do you do with a suicide threat? The woman will generally attempt to do anything she can to get you to see her alone, and she has a right; she has a reason; she doesn't believe she can get her husband in. She believes he is going to kill her. If you see her alone, she tells her story and the anxiety gets diminished. You alleviate some of it, and her need to get him in isn't as great. I'm talking about resistance or maintaining a homeostasis. What the worker needs to say is, "You know, I really think we'd be better off beginning as a couple."

Once you get the couple in together, it's very important to let them know verbally that you are not on anyone's side, because the first thing that is going to come out is: "You know what she did to me?" You have to make it clear that you are not the judge or the police and that you are not going to take sides. Anybody who works in family therapy knows the way in which the system attempts to draw you in, and you have to resist that pull.

Secretly, men who beat their wives believe that the situation is hopeless. I've heard men say, "I really think I'm crazy; otherwise why would I do a thing like this?" They are afraid to expose themselves to a helping person because they think you may decide they are crazy or have them locked up. The abuser comes in with tremendous reluctance, suspicion, rationalization, and fear, and you have to see those emotions as part of the process. Not uncommonly at first, he will lay all the blame on the woman, taking none for his behavior. It must be made clear whose responsibility the battering is and that the battering can't go on; you have to convey this without sounding punitive, and that sometimes is not easy to do.

When I first started to work with violent couples, I said, "My God, what kind of man is he if he beats his wife?" I came to understand that one has to see his side of the issue also. I'm in no way saying that the woman is responsible for the battering. No matter what she does, the physical abuse is not something she provokes or is at fault for. He is solely responsible for the battering. However, they both have to do something to modify the problem in their interaction. I'll give you an example.

One of my workers was seeing a couple where the battering continued over a year. In our experience, after working with over 155 couples, in every case the battering stopped quickly. So this was a rare case. The man was saying, "I must be crazy, maybe I ought to get my head examined," and I thought maybe he was right. Why wasn't the abuse stopping?

The couple was put behind the one-way mirror, which I feel is a valuable training technique, and we took a look at what was going on. Several points relating to their interaction became clear. First of all, on some level neither one of them was taking the issue very seriously. They were very unhappy, and she was getting hurt quite a bit. However, there was a way in which they didn't see the situation as one of life and death, and she didn't have enough anxiety to work hard at making sure the battering didn't take place. Second, agreements were being broken. The couple had agreed that he would have a room to himself whenever he felt he was angry enough to hit her. If that kind of argument took place he was to go into the room and wait until he calmed down; then he could come back and continue to fight at that point. We discovered that he went into the room, but she followed him. All she had to do was stay out of the room; that was part of the contract. Sometimes it's that simple. You say, "Stay out of the room," and she says "Okay, I'll stay out of the room."

Often it's more complex than that, because you are dealing with a change in the system and you have to uncover the reason why either one of them is not following whatever treatment plan is being devised to help modify the situation.

There is a further requirement, and I learned it in my work with adolescents -- they're wonderful; they'll tell you whatever they feel. I think it's very valuable to work with adolescents for a year, because it weeds out the good from the bad; adolescents will let you know if you are good or bad. They say, "All you do is talk." They're right; all we do is talk. And that isn't enough; there has to be action. There particularly has to be action when you are dealing with life-threatening situations like battering, because if there isn't action, the woman might be dead before you get to the therapy. You have to develop specific techniques to get the battering under control. You also have to be realistic. So, the next step has to be exploring some other way to modify the abuser's behavior.

Lots of people have lots of theories as to why men beat their wives. I think everyone in this room has feelings of aggression, and when we're angry we think of all kinds of things we could do to the other person, and those often border on murder. I might think about shooting the bus driver, cutting him up in little pieces, slashing his face; I don't do it, however, because I know that's not acceptable. Instead, I fantasize or channel my aggression in a more acceptable way. The problem with abusers is that they don't control the impulse to strike out; they respond to it. Part of what they need to do is learn impulse control. It's not a hard thing to teach. The only problem is that it has to happen at the moment.

One of the best aids for learning impulse control is a hotline, where a person can call up and say, "I'm so angry I'm going to call that M.F.," or whatever. The person on the hotline should be someone the abuser can turn to easily. If you can't develop a hotline, then there are some other ways for you to do it.

One method is helping the person imagine ways of controlling the anger or venting it elsewhere. You have to ask the person what he sees as effective, and get him to agree to do that when he is angry. If he's resistant to such imagining, the approach can be frustrating.

In any event, you have to ask the couple what they feel they can do. You have to elicit the woman's cooperation. She has to agree to the treatment plan, and if the agreement is broken, as with the couple who misused "the other room" technique, it has to be agreed upon again. The contract has to be reestablished. This happened with another couple I treated. Although they'd agreed that he could leave the house when he felt too angry, she would block the door and say, "Where are you going?" Of course, she got hit again.

You have to develop a contract. You have to contract, number one, that this is a good thing to do, that he wants to do it, that he is motivated to do it, and number two, that both people will make sure the contract gets carried out. If the contract doesn't get carried out, that is an issue to take up in a therapy session. You have to find out why they didn't follow the treatment plan they had agreed on. It was their treatment plan, not yours. If it wasn't a good treatment plan, then you have to change it.

Another way to build in the immediate intervention is using members of a group (if the man does attend a group) or friends. These other people will then know the problem and be available for help in terms of intervention. Let's say the man calls up someone but does hit his wife later. At least there has been a delay; he didn't strike out immediately. He did something else instead, thereby taking a step toward channeling the aggression.

Most often, when a couple is willing to contract to this kind of plan, they follow through on it. If they don't, you have to reevaluate it, rediscuss it, and reinstitute it, in another way if necessary. You also have to remember it. That is where the action comes in. When a man has been successful in not hitting the woman, it makes him feel better, less hopeless; it lets him say, "Yeah, this is possible." She feels that too, and it becomes an important piece in terms of modification.

Of course, the couple may decide to separate and divorce in the end. That is okay. Whatever they want is their decision, but at least we can help make it happen in a good way rather than a bad way.

Most of the couples I have worked with have remained in the relationship and the battering has stopped. After the battering gets under control, the focus is on the interaction within the marriage. The problems are the same as in any marriage with problems -- poor communication,

lack of trust, the inability to cooperate, etc. All of those issues get worked on. Often the men are not very verbal, and part of the problem relates to the fact that they stifle their feelings. They need to be helped to express their feelings, as well as to cry, which, believe it or not, men find hard to do. There are some couples who wind up splitting up, but as far as I'm concerned, they split up after they did what they could do to make things better.

Participant: I have a question. In terms of making a diagnosis over the telephone, as far as determining whether couple therapy is the best choice, how do you judge the woman's information? Do women exaggerate often, making it hard to say, "Yes, bring your husband in?"

Janet Geller: I haven't found it to be that difficult. It depends on your criteria. For me, psychosis, a primary problem of alcoholism, and a serious chance of the woman being killed if she tells him are the only criteria for not advocating couple therapy.

I didn't talk about the relationship between alcoholism and wife battering, but one question you have to ask initially is: "Does your husband drink?" "Yes, he drinks." "Does he drink a lot?" You have to really embellish and elaborate on a question like that. "Yes, he drinks a lot." "Would you say that he's an alcoholic?" Now, some women deny that, because alcoholism is a no-no in our society. Then you have to ask what happens to him when he drinks. Then you ask whether the battering takes place when he's drunk. "Yes." "Does the battering take place even if he is not drinking?" If the woman says yes to that question, you know you're not dealing with a primary problem of alcoholism, but a secondary one. If it's primary, then the chances are that the battering will take place only when he's drinking. If it is secondary -- he is beating her whether or not he is drinking -- I would say it is treatable. Once you get him in, you may also want him to enroll in an alcoholism program. However, I wouldn't consider someone hitting his wife whether or not he's drinking to have a primary diagnosis of alcoholism. You can be wrong; you can miss on the few.

As I understand it, the definition Alcoholics Anonymous uses for an alcoholic is someone with impaired functioning. If a man hits his wife when he is drinking, then that is an impairment in functioning. There are some you have to ask more questions about. Has he ever been hospitalized? Has he ever seen a psychiatrist? Has he ever taken any medication, and what kind? Valium is not a psychotic medication, but Thorazine or Stellazine indicates some psychosis. You ask several different questions that relate to the same statement.

In terms of "he'll kill me," you also have to ask a number of questions to develop a diagnosis. And you have to listen to the answers. If you say, "Well, it sounds to me as though a good thing to do is bring your husband in," and she replies, "If I even told him I'd made this call he'd kill me," you believe her. But: "I don't think he'll come." "What if you told him you'd called me and I said you have to bring him in?" "Well, he wouldn't like it." This reply is different from, "If he knew I'd placed this call, he'd hit me."

Sometimes you miss. You can't get it 100 percent, but if you develop the questioning in a very careful way, you can get a lot of it. And if you are wrong, you can always change it at some other point. In my experience, though, you generally get the situation pretty accurately or accurately enough to determine an initial treatment plan. You can always safeguard it by saying, "Well, you're telling me that if your husband even knew you'd called, he'd kill you. So, I guess what you're saying is there's no way you can get him in, right? We can see you in a group, we can see you by yourself, but I want to make it clear to you that unless he comes in there is no way I can get him to stop hitting you." You have to ask those questions and spell out what the implications are if he doesn't come in.

Louise Garin: I'd like to speak briefly about the alcoholism. I've done a lot of work with alcoholism. In my experience, I've found that in treating alcoholics who are abusers one must approach the alcoholism first. If you begin treating the alcoholism and treating the marital problem at the same time, I find you have much less success. Alcoholism is a disease of such magnitude. The less stress put on that individual at the early recovery stage, the more success there will be later on.

Working With the Abuser

Shelley Garnett, C.S.W.
Phyllis Frank, M.A.

Phyllis Frank: I hope the information we have to share with you today about "Working With The Abuser" can be enlightening, and I would like to talk about the programs we have developed in Rockland County for abusers. First, however, Shelley Garnett will speak.

Shelley Garnett: I am Director of Social Services, Abused Women's Aid in Crisis, in New York. Our program for the batterer is a psychiatric therapeutic model for individual males who are either self-referred or have been referred by a correctional facility.

When I speak of self-referred males, I do not mean those who are court-mandated. These are men whose wives either are in treatment at the agency or whose wives may say, "This is the place to go." They may be men who see our public service announcement on television, or who write and call up to come for treatment for themselves, with or without the wife. In most cases, they do not bring the wife; they come for individual services, these professional or working-class men.

They are from all ethnic backgrounds, from the age of 26 to 71. In fact, the median age is 35. They are stockbrokers, correctional officers, police officers, social workers, lawyers, draftsmen, bus drivers, payroll clerks. They are all working, in other words.

Most of the assaults, the crimes they commit upon their spouses, occur about 2 days before they call the hotlines. These are the kind of men who, if they went to a different kind of mental health facility, would walk in and be misdiagnosed, if you didn't ask them about abuse. Facts don't help. Very often, in an initial interview, if we didn't ask questions, they wouldn't tell us about the violence. They would tell us a little bit, maybe. These are the kinds of cases who go to different agencies; most of these men, after a time, defect from these agencies and finally end up with us.

Most of the men we see have a very deep underlying depression, with severely impaired egos. They almost always have a problem with anger control and an inability to resolve conflict. So the man is left with a limited sense of self-esteem, resulting in the release of aggression. Our basic formula therapeutic model is that what we are dealing with are males who have aggressive personality disorders.

These are not substance abusers, because we do not see substance abusers. They are not men with long histories of mental illnesses. But they have very long histories of severe depression, and what underlies our model is that one has to get at the depression in order to stop the aggression.

Here are some clinical details about this model.

The aggression protects the ego. The main task of therapy becomes clear when the batterer begins to feel and cope with the depression that accompanies any experience of frustration. All of our men have histories of fire setting or bed wetting.

These men usually carry a facade of seduction, but underneath they are saying, "Don't come too close." Sex plays a very important role in such a man's life and he is often aggressive; he always lacks an emotional intent in these sexual relationships. The need for sexual relations helps to build the self-esteem of the abuser, as well as to get revenge on the woman.

One of my patients, who is a 44-year-old male, stated that once he got these women, there was no problem in retaining the relationship, because the sex was always very good. The sex, of course, lacked any kind of emotion. There was no touching, caressing, or kissing. It was just pure sex. This was, in actuality, the reason for his great waning sense of sexuality, and also the whole ambivalence he feels in terms of the sexual relationship, since underneath he does know that it is empty, and lacking. And there is depression along with this realization. However, the depression that is maintained there he will not bring out; he will not bring up the depression. The anger is surfaced underneath. This theme, in terms of sex, is the hardest for us to deal with.

I have seen this man in treatment for nearly 4 years. It is a very long, slow process, and a very costly process. This man would also use sex as a means of control. When he finally separated from his wife, there were things in the household he wanted -- dishes, furniture. What he would do is have sex with her, and she would give him whatever he wanted.

As he became more and more connected with his own ineptness and lack of love, he stopped all of his rather promiscuous behavior, and is now struggling to develop a healthier relationship. In fact, he does not go out with women at this point because he is still in a middle stage, knowing that the relationships he has had in the past are not healthy. And he doesn't want to choose a woman like those he has chosen in the past.

Hand in hand with the batterer's limited capacity for delayed gratification is his own frustration in relation to his success in the working world. All of the men we have seen could probably have achieved much more in their work situations than they have. Even though they have the intellectual capability, they cannot compete against other men in the working world, or they are really deathly afraid of succeeding, because if they were to succeed, it would mean that they are really not as bad as they think they are. They know they are bad because of the kind of things they do.

Also, if they were to excel, this in turn would force them to sever the unresolved, almost insatiable childlike need for parental approval, and if they were to succeed, they would cut their tie with the parent.

I am not talking about adolescent men. These are men who are still looking for parental consent in terms of what they are doing. All of our men tend to make a parent of the wife. We see it frequently -- the kind of relationship where you will hear the wife say, "He treats me like his mother," or "He wants me to be his mother; he'd like me to do this." The men's strong need to do this goes to a point where there is no clear boundary or differentiation between the real parent and the projected parent. And all of the anger and rage he was unable to project onto the parent gets vented on the wife. One patient told me, after almost 3 years of treatment, "I wish I could have belted my mother in the mouth, and then maybe I would not hit my wife."

Of course, there is a lot of focus on the mother-male relationship, and not enough work has really been done on the father-male relationship. And that's what we have really been seeing as the crux of the problem. The men I work with are deathly afraid of other men, and relate them to their father. For some reason they were unable to please the father, or the father was just not available to them. This is often one of the reasons they do not excel in the working world. Excelling would mean, for most of these men, doing better than their father did and thus proving the unacknowledged impotency of the father. This complex is part of the problem that we have in getting men into groups. The males we see, I think, are really not ready for groups. That is why we provide a spectrum of services to go into, because the males we see are nowhere ready to go into groups. They know that.

Part of the reason we have been successful -- and I don't know if this is a plus or not -- is that we have a number of female staff, and the males who come into the agency would much rather see a female. They know that they can use their old patterns of relating to a woman, whereas they could not use them with a male. They are really deathly afraid the male might see right through their facade. They don't think women will. Actually, they really don't want male counselors. Very often male counselors will be assigned a male, and during the first two sessions, resistance is tremendous to the male counselor.

Most of the agencies in the cities send referrals to us as soon as they know they have a batterer case; the agencies are afraid to see the men. Actually, these men are not violent when they come to an agency or shelter. All research shows that these men never assault the worker, unless they are provoked or have psychopathic behavior patterns. There is no reason for them to attack a worker.

Additionally, if you remember that these are severely depressed people, then they won't appear as frightening. You are not in a position where you have taken away his life or have disrupted the balance in his household. If you are a worker at a mental health clinic, you are there to help anyone who comes needing help.

Incidentally, more agencies are going to have to start taking these cases if the funding does not come down from the state government. At present, in New York City, the big mental health clinics will not see batterers, or battered women for that matter. The agency is not

ready to see them. And there is a lot to say about the agencies not being ready -- agencies do have to be ready.

I would like to say something about our treatment procedure.

Lenore Walker, in her research, has said that a bond seems to exist between a couple that says, "We may not make it together, but alone we will surely perish." This is the real crux of it. The batterer needs his spouse and, maybe, the battered woman needs him. However, I know for sure that the batterer is in desperate need of his spouse. This knowledge is based on the work we have been doing.

You must start to establish what component functions are necessary if you are going to stop violence.

Furthermore, it is not enough to deal with the pathology; you can't deal with that. You must also look at the act of violence itself. This is very difficult for those of you who use nondirective therapy. We suggest that this work cannot be nondirective. You can't do one without the other. It just doesn't work.

For the batterer, along with the need for a projected parent figure is the need to keep the spouse dependent, lacking in autonomy. While we can treat the woman clearly enough, the male must also be encouraged to function independently. Here the need for the wife becomes clear, in the fear these men have in being alone. All of our patients, upon separation from the spouse, almost immediately got into another relationship.

We tend not to think of men as being unable to live alone or to function self-sufficiently, but these men cannot function alone, and they actually need a woman. They think they need a woman.

What happens is that periodically there is a shift in the relationship, and the male, who is really very shaky underneath and very depressed, has a violent eruption, therefore creating homeostasis, where he can believe he is really in control most of the time. In truth, he isn't. Treatment thus begins with a look at the violence, and reconstructing a healthier sense of self.

We do not try to salvage the relationship. But we do expect the violence to cease. We don't say to the person, "You can't stay in this marriage." Sometimes, actually, we do, but that is not our goal. Our goal isn't to keep the relationship together. We don't really have a goal in terms of that aspect.

Batterers can and do learn to act differently, because, again, it is a learned behavior pattern. Insight-oriented treatment can be a very costly process, as I mentioned before. But it does result in personality changes. We look at the forces behind the behavior, and less time is spent on the spousal relationship than in most programs.

The focus in the first session is developing a contract to work, based on the recognition that the patient has deep-rooted internal

problems, which are vented aggressively. We presently make the patient admit to, own up to, that fact.

The violent behavior is exposed in an attempt to provide the man with an opportunity to begin dropping the facade in a safe environment, where he need not fear the impotency or threat of a relationship.

Most of these men have never had any form of therapeutic relationship or psychotherapy. Nor have they ever spoken to anyone about their feelings. This process, in itself, will create anxiety.

A foundation must be laid so that the men understand that, in time, the underlying depression will surface. This is the most important point I want to make -- that we make it very clear that the depression is there; that it is going to surface. And we say that so they know.

We also appeal to their narcissism: "It's going to be hard work; there are going to be bad times; you know it's going to be scary, but we are going to be here; we are going to work on it."

Working with skilled female therapists helps to create transference with a more adequate female role. And thus it rebuilds that impaired relationship.

Untimely termination always seems to hang in the air, since the process of repairing the ego is obviously a very, very slow process. The therapist might be supportive and firm and available to the man in times of need. Very often, as a depression starts to surface, the patient will have suicidal tendencies, or start to "act out." At that point, you must watch carefully what is going on.

Very often we will suggest that a patient come in at least twice a week, because we are the external control. We don't expect that the male has the internal controls developed.

Should someone require medication, we refer him out. We don't have anyone on staff to do that, so when a case develops to that point, where it requires that, we do have to refer it out.

When the treatment becomes a living situation for the patients, the depression starts to come out. At this point, very often they make a decision to separate and, as I said before, we encourage such a separation. However, the separation will then cause isolation, loneliness, and the impotency they so dread. It forces the depression to surface, as opposed to the aggression they have been letting out all these years. You must make an interpretation of the symptoms so the patient doesn't fear a lack of control, or that his world is changing. In essence, it really is at this stage that treatment is often recommended more than once a week, or we refer the patient out.

This technique is similar to the Ganley and Harris project in Tacoma, Wash., which places abusers in a residential setting. Ours is a modified step with the same principles.

Focusing on the therapeutic relationship and pointing to the changes and the new gratification they bring helps to build the batterer's sense of self. His work performance gets better, and the choice of object relationships is a hundred times improved. Most of these men maintain contact with their families, but they do not go back to them.

That is basically our treatment with the men.

In addition, I want to tell you briefly about a prevention program that we have at Arthur Kill Correctional Facility and Bedford Hills. One is a male staff and one is a female staff. Here, we run groups and do individual counseling. We run large, open forums to disseminate information about domestic violence to get people involved in question-and-answer periods. We break off afterward into small groups to discuss personal problems. We contract for individual treatment when the person would like it and we work with the Pre-Release Center, which is an inmate co-led project, which works with men 90 days before they go to the Parole Board.

Our purpose behind the program is that these men and women are going to get out and go back to their families. While they have been incarcerated, they haven't learned anything new. They haven't learned how to communicate. There are going to be tremendous problems upon reentering jobs and housing. And then there is most probably going to be an outbreak of domestic violence in the family. What we are hoping to do in the project is talk to these men and work with them, so that when they do reenter, we see the family, we see the couple, and we see the male. We hope that with this assessment, and by continuing to see the families at various stages, the violence won't erupt again. That is basically the program. It was funded for this year, and ran for a year before without funding. It has been running for about 4 months and, hopefully, at the end of the year, we will be coming out with material on the modality and how to start a program. We have been seeing some wonderful results from the program, and it is my feeling that no one is hard to reach. You have to be ready and willing to reach out to them.

Participant: Father Vincent Gere. Brooklyn Catholic Charities.

If insight therapy is so costly and long-term, are there other treatment modalities that may be indicated? Particularly, what is the rate of success with group therapy?

Phyllis Frank: I don't think enough programs have been in operation long enough to have an answer to what the rate of success is. I think the programs are first being developed to focus in on men who are violent against women and their families. I think it will take some time before we can figure out what the percentage rate is for people who get better.

Shelley Garnett: No matter what programs males go to, there is a success rate. Everything works. Treatment service is the oldest program; it is 5 years old, and with males. I have been seeing people 3-1/2 years and I think I was one of the first people in New York City to see a male.

Phyllis Frank: The Volunteer Counseling Service of Rockland County has been in operation for 10 years. We serve a population of resistant, hard to reach clients from Family Court and the Probation Department, as well as referrals from other agencies and from individuals. Therefore, for 10 years, we have had experience with people who have been referred because of violence within the family.

During this time we were finding ourselves dealing mostly with women victims. When men would be referred, they might come once or twice, or not at all. But in large part we were not serving males. In serving the women, we began to realize that there was a scarcity of concrete services for domestic violence victims.

Our awareness of domestic violence grew in the early 1970s. By the middle of the 1970's we had developed an effective model for counseling and assisting women victims. In addition, we were working toward establishing a shelter in Rockland County, a must service for the care and safety of the victims of domestic violence, women and children.

In the development of the model, we became cognizant of the fact that we were dealing with women who were 100 percent responsible for their own behavior -- and sometimes that was reprehensible behavior. But we were not seeing the men, who, we believe, were 100 percent responsible for their behavior, which is the violent act. It was obviously important for us to find a way to get to the men if we were going to stop domestic violence. Since they were not volunteering for services of any kind, we needed a way to force them to come in. Luckily, we had a supportive Family Court judge who was willing to mandate men into an educational workshop -- which we would design.

For example, when a woman brought a man into Family Court accusing him of a violent act against her, the judge could order this man to attend a spouse abuse educational workshop, in the same way judges would order someone who was picked up for drunken driving to attend a course on drinking while intoxicated. That was our leverage to get men into the program.

We felt at that time that if a judge ordered a man in for a year, it was so long that we might never see him. We decided on a 6-week design for the course, because it felt long enough to effect something and short enough so that the abuser, though he might be hostile and angry and resistant to attending, would see an end in sight.

At the beginning of the program we confronted participants with the illegalities and damaging consequences of their violent acts. We found out very quickly what minimization and denial meant. If we didn't know before, we found out then. If we were going to build our workshop on the premise that we were going to confront him with his acts, 6 weeks weren't enough to convince him or get him to admit that he had done anything. And in fact, an Order from the Family Court often did not mean it had been proven that he had committed that act, just that he had been accused.

We clearly remembered our title! We were an educational workshop. So, instead of spending our time confronting the man with the illegalities and damaging consequences of his act, we redesigned, and began to confront the illegalities and damaging consequences of violent acts. This clearly became an educational workshop, with two main goals: The first goal was to stop domestic violence. That is why we were doing it in the first place. Our second goal was, within this 6-week period, through our teaching about the illegalities and consequences of violent acts, to encourage this person to entertain the idea that he might need some ongoing assistance in the process of changing his behavior.

We had 6 weeks to motivate him to continue to receive service, and we did this in a number of ways.

The illegalities are spelled out very clearly in the workshop. That means that we have to understand the current legal processes and the legal consequences if someone gets arrested or if the police come, or if someone reports him.

We also clearly delineate the damaging consequences on three different levels.

1. We talk about the damage and consequences to the person getting hit. That's pretty obvious and not very new to anyone in the workshop.

2. Less obvious and new to some of the men who have participated is the fact that violent acts within a family are always damaging to the children. We make it clear that it is damaging to those children, whether or not they are present when the violence takes place; whether they are only within earshot; or whether or not they are home. If a violent relationship exists, children who live within that family are damaged by it. Many of the men who have been through the workshop are very caring, and have concern about their children. When this damage to children has been pointed out, it has sometimes been the hook to getting the man to want to continue receiving some kind of help.

3. Last, and hidden from most of the men, is the fact that violent behavior is damaging to the person who is committing the violent acts.

We have been in operation for a year, and we are about to begin our seventh workshop. We have not been in operation long enough for me to tell you what the batterer looks like. But we are beginning to get a sense, as men come through, that we are dealing with a wide variety of people, representing a cross-section of race, religion, and socioeconomic status. So far, we are dealing mostly with batterers who come through Family Court. That means we are touching only the segment of the population that is using the Family Court for the problem of violence within the family.

We use discussions and a media presentation. We talk to the men in the room and educate them in the areas I have already mentioned.

In addition, we tell participants what is going on in the community in terms of family violence. We let them know that the films we are

showing to them are being shown to clergy, to policemen, and to students. We tell them that attitudes toward family violence are changing.

We acknowledge clearly in the workshop that men work and live in a society of pressures, and that we are all victims of that societal pressure.

We expose sex role stereotyping. We align with the men in the workshop, while never condoning their violent acts. We make a statement about the inappropriateness of violent family acts.

We hope, and we indicate it to the men, that should they be involved in committing acts of violence, that someone -- their wife or mate -- will call the police and they will be confronted by a policeman who no longer has stereotypical attitudes toward batterers, who will not say to the wife, "Be good," and then let the husband off. We will let them know that we are working hard to make sure that those changes take place.

We let the men know that they deserve and need services to help them through difficult times.

Some of the following statements have been made by men who have been forced to attend the workshop: "How come we're here and the women aren't? This is a woman's world; women get away with everything; how come they're not here?" We respond: "There are women's services all over the county. Isn't it about time there is a service for men?" We turn around the negative thinking, and let them know that they deserve service as well. That becomes one of the themes of the group, because by the fourth session in the workshop we are beginning to indicate to them that help is available in the community for men.

We start letting them know where that help is. We spend the last three sessions educating them as to what is outside, and letting them know we will facilitate their getting in touch with an appropriate ongoing program, be it for subsequent abuse, be it for counseling in the same agency or a mental health center.

Incidentally, I think it is very interesting to note that many of the men coming out of early workshops wanted to continue in a group format. Something good was happening for them.

We canvassed our community and found no appropriate community men's groups. The Volunteer Counseling Service response to the needs of these men was the development of a self-help group, MOVE (Men's Ongoing Voluntary Exchange). Male volunteers were recruited and trained to act as group facilitators. This men's supportive discussion group deals with the issues of family dynamics, sexual stereotyping, the difficulties of being male in a changing society, the fear of finding one's own power, discovering better ways to communicate,etc.

Our men's program cannot, I believe, exist in a vacuum, because if we are saying that the world is changing, we have to be doing the work to make sure the world is changing. Therefore, the Domestic Violence Project of the Volunteer Counseling Service has five components: 1.

the men's groups -- the spouse abuse educational workshop and the ongoing voluntary exchange; 2. individual, couple, and family counseling; 3. data gathering and research in the area of domestic violence, and program evaluation (Dr. Beverly Houghton will present some of the evaluations of our first year of operation); 4. presentations on the subject of domestic violence to any high school, junior high school, or community group that will let us speak on the subject of domestic violence; 5. improvement of the domestic violence service network. We will give technical assistance to all mental health facility workers, attorneys, police, nurses, doctors, etc. who give direct service to victims and offenders in family violence cases. I don't think any of these services can exist in a vacuum. I think there is community effort that needs to be made to make it possible for a men's service program to exist, and for men to be referred to it.

Beverly Houghton will speak about some of the evaluations of our operation.

Beverly Houghton: The men in our groups really do fit the overall profile of Rockland County residents in terms of race, background, and so forth. Most of the men are in their 30's.

A frequent question raised about batterers concerns alcohol involvement. We ask questions on our questionnaire about alcohol and we look at the court records that come with the referral forms, which come with the men from the court, to see if there are any men who are involved with alcohol. We discovered that a possible one-third were involved in alcohol, which corroborates evidence heard this morning, which is that not only drunk men beat their wives.

At the end of the fifth workshop, 51 men had been referred to our program from one source or another.

Of these, about three-quarters come from either Family Court or Probation -- that is, they were Family Court-mandated after proceedings, or had been referred by the Probation Department before they came to the proceedings. Four men were referred by the Justice Court. Two came because their wives had to go to a shelter; two came from individual counseling programs; and two came on their own. We did not find a tremendous difference between those mandated to appear and volunteers as to whether they stuck with the program.

Of the 51 men who were referred, 34 have participated in at least one workshop session.

Since the end of the workshop, we have maintained contact with 25 of those men. The 9 we have lost moved away, joined the Army, cut off their phones, or otherwise disappeared.

Of the 25 we have maintained contact with, we can tell you a little about what happened. We have two criteria of success at the workshop. One, did the violence stop? The second is, have we got them referred to further service? We know we are not going to make a total impact in 6 weeks, and we want them in something else as followup.

In terms of violence, of the men with whom we have maintained contact, 20 men, or 80 percent, have remained violence-free during the period of followup, which is calling every 6 weeks and talking to them about how things are going. The followup I'm referring to here is from July to November.

Of the men we have followed up, 17, or 60 percent, are in some kind of therapy.

What we are also finding is that some of the men -- those we thought we had lost contact with or those still in contact but not in continuing therapy -- are coming back to us. They thought everything was okay. They started trying to go it on their own, but when it came to a crisis, they came back. I think three to four have come back at a later time, after going to the workshop.

We asked a question at the beginning of the workshop about whether the men wanted to be there, whether they wanted to change their patterns of dealing with their wives, and whether they were angry at being put in the workshop. We take that as an index of motivation. We find that that index of motivation does not make a difference in whether the men stick and it does not make a difference in the success rate. In fact, something like 80 percent of the men who initially came in saying they didn't want to make a change were indeed changed, and remained violent-free in the follow-up period. The workshop does appear to be a major force in changing the behavior of men who originally saw no need to change.

Phyllis Frank: I would like to add that as a result of this program, Governor Carey signed into law legislation that clearly empowers Family Court judges in the State of New York to mandate educational workshops for men who are accused of violent family acts. Therefore, if any of you are from New York State, and if you have the ability to start up this kind of program, and have a connection with a men's group, a counseling service, or a church, and you let your Family Court judges know that you are aware of their ability to mandate men into the program, you might begin to be able to have this kind of project in your own area.

Participant: Did you get any sense of the relationships breaking up or staying together?

Beverly Houghton: I don't have specific numbers on it.

Phyllis Frank: Looking at the overall picture of Rockland County, I think that a greater number of couples are choosing to remain together than we would have liked to think about at the beginning. People are staying together more often than we originally expected to find -- certainly from our shelter.

When we are dealing in a workshop with men who are separated, they may call and say, "But I have left my wife; we are not living together any more and I don't have to come." We will respond with, "All the more reason to come." Anyone who is going through a separation or

divorce, even afterward, is going through a tough time and this workshop can be very supportive and helpful -- it is for the person, not the relationship.

Beverly Houghton: Let me corroborate something. Jennifer Baker-Fleming stated that "violence does not stop with separation," and according to police records in Rockland County, 40 to 60 percent of the domestic violence calls are from nonmarried couples. Something like 18 percent are from divorced or separated couples. We have cases on record in some of the police departments of women whose ex-husbands have violently harassed them for 5 or 6 years -- sometimes making as many as 30 to 40 calls in a year or virtually weekly. Separation is no reason for men not to go into a program.

Participant: Chuck Hoffman, Bronx Adult Supervision, New York City Department of Probation. I co-led a group of battering men in Queens Family Court for a number of months. A real difficulty in any court-mandated program is a matter of enforcement and engagement, because you are dealing with a very resistant client population. The kind of client population you have been talking about sounded unbelievable to me, since, in my experience and from what I have read about other people with client experience, sustaining these men in ongoing programs has been an overwhelming slow experience. If courts mandate that people have to be involved in therapy, or some form of treatment/educational workshops, how do you enforce that if they don't come?

Phyllis Frank: The Probation Department is an arm of Family Court. We go in knowing that all Probation Departments are overworked, understaffed, underpaid, and so on. When we get a referral we will begin by immediately writing a letter to the man, letting him know that he has been referred and that he will hear from us as to the startup date. If more than 2 weeks go by, we will write a second letter reminding him that we know he is still out there. We encourage interim attendance in The MOVE group. Still, again, we will write him a third letter and we will call him to let him know that we are there to answer any questions he might have.

If we are going to wait for these men to come, we are not going to get them.

If the man referred still does not come in, we will follow up after two sessions, and after three sessions we will pretty much admit we didn't get him. At that point we will send a report back to the referring source, indicating that we didn't get him. What is happening today is that the Family Court will sometimes strongly urge him to come, and sometimes they might give him a call and say, "You better get over there or we will take this into court." Sometimes that is enough to get him to come in. Of course, if the wife no longer complains about additional violent acts, he may fall through the crack. What we are in the process of doing now is finding the appropriate cases to put a violation on, and the end result of that violation can be incarceration.

The fact that referrals do come through the Family Court has made it possible for men to participate in the program. I wish we could

help every single person, but I am going to emphasize that we are reaching some of the court-mandated referrals.

I encourage these programs to start up, with less worry about the ones who get through the crack, since we are doing a job on the ones who don't.

Contempt for the court has existed, and that is clear. People treat the court contemptuously when nothing happens, and that is an ongoing problem we are attempting to resolve. But it is not a problem that is serious enough to say, "Scrap the program." That is a problem to be worked out while the programs are being developed.

Shelley Garnett: We don't write letters to people and we don't encourage them to come in, but we have hundreds of men coming in -- doctors, attorneys, teachers, and social workers. They don't want to go to clinics, but they are coming to these agencies because they batter. The men's groups in New York City are just starting a Batterers Anonymous. We did one newspaper article and we got calls flooding the hotlines. So, again, I always ask what the agency's outreach is. Is the agency ready for the program it is attempting to start?

I think that we have an agency that is responsive, and a staff that is responsive. Programs don't close up for lack of clients; they close up because they don't get funded.

Phyllis Frank: There are hundreds of people who wanted to come who aren't ready, in addition to the people who are.

The more exposure this problem gets, the more voluntary participants will come forward. The response to this problem is lending credibility to battering as a problem that needs addressing. We have found men calling our programs, saying, "I have heard of you and though I am seeing a psychiatrist or a therapist, I don't know if my problem is being addressed, and I hear you do good work with batterers."

Participant: Sydney Schweid, Long Island Jewish-Hillside Medical Center.

I wonder whether or not something like family counseling is a way to help these types of families.

Shelley Garnett: Eugene Flynn is a family therapist, and he is working in our present program, which is aimed at getting the families together. We haven't done it a long time.

Participant: From what I am finding, there isn't much work using family therapy as a modality to deal with this particular problem.

Shelley Garnett: When we started, everything was, "Get the woman into a shelter." Nowadays, there is a duality situation; sometimes it is the shelter and sometimes the counseling.

Originally, I worked on the intake for the women going to the Henry Street Shelter, and most of the women I saw really wanted to have some kind of communication with their spouse. They wanted the shelter but they wanted some kind of communication too. They didn't want to leave their homes. At that time, there were no mediating centers. No one looked at the family; no one cared about the male; no one said anything about helping the male. Forget it. It was just unheard of to do that.

So, that is when we looked at the problem. We said, "There is a battered woman, and there is a battered man." I think you are going to see more and more family work being done and more and more couple counseling being done, where, in the beginning, there wasn't anything.

There has been so much care given to not calling back the victim, blaming the victim, or suggesting couple counseling and therapy. I think that the early movers of the domestic violence movement wanted to get away from that, as a way of protecting the victims. However, I think that the professionals are now becoming conscious that any method of therapy or counseling can be used appropriately by someone who knows how to use it.

Participant: In White Plains there are two family institutes. Can you work out something with them, where they really work with the batterers very differently in terms of assistance, with whatever kind of problem? Can you start up this type of program?

Participant: We are trying to.

Shelley Garnett: We have been around to see how the movement progressed, and I don't want to be demeaning about this, but the people who started were not professional people. There were people who took a stand, and it diluted their purpose to worry about the male, because they wanted changes in the society. They had to look at what was going to work, and women were, are getting killed.

Sometimes, in my agency, we forget about what we are doing because we see nice cases. We see people like those here in the audience; every once in a while we have a bad case guy. So, yes, we forget.

When I started talking about treatment for the men, somebody would always say, "Why are you doing that? Why are you talking about that?" No one was giving money.

Someone will say, "What about the battered man?" We see battered men. We don't turn them away. They have the same symptoms as the women. This whole area of concern is a growth process, and more professional people are getting involved. I think the early people were really committed -- not that we aren't, because we are -- but they looked at one perspective, and it was moving.

Participant: Jack Cole, Battered Persons Resource Center, New Jersey. Another good reason for involving the men, and the reason I swung around to working with them, is that, in my experience, we'd get one woman away from a man, and 6 months later get another woman away

from him, and 8 months later get still another. We have some men who hae gone through a half dozen women, and we have got to stop this.

Shelley Garnett: All my patients had three or four, and they will continue if they don't get some kind of service. That is why when I was given one case, I was so pleased that he had not made a choice, because at least he was looking for the right choice.

Phyllis Frank: Should a man go through the workshop, and should he and his wife want couple counseling, we make that available in the agency.

However, we do make a statement that we will not treat couples in couple counseling if there is ongoing violence within that relationship, which means if there is a violence interaction during the course of couple counseling, we will break up that couple counseling and see the two people individually until such time as we renegotiate and see that the violence will end. We are saying that a relationship cannot be worked on while there is violence ongoing; that his problem of hitting must be addressed immediately and that we will teach methods of stopping it right now. Then we will work toward getting a couple together again, if that is what each spouse wants.

I would also like to mention that all of the couple counseling done at the Volunteer Counseling Service is done by well-trained and supervised volunteers from the community. All of the workshops are run by trained and supervised volunteers from the community. So, when we talk about funding these programs, in our present political and economic state one might want to think about the possibility of having these well-trained and well-supervised volunteers, who do, in my estimation certainly, a professional level of work.

Participant: It sounds as though the kind of client you work with is particularly one who would fit into the common drum of the average young, attractive, verbal, intelligent society case. How do you work with the majority of clients going through the agency (AWAIC) who are young, black or Hispanic, and not particularly verbal?

Shelley Garnett: They don't come to us. There are blacks and Hispanics referred, but they don't contract with us. They take one look at the agency, go through the initial interview, and don't come back. That's okay. I have a small staff. I turn away more than a few people, so it is fine with me. I can only service what I can service.

The truth is, we don't get blacks and Hispanics. That has to do with the location of the agency and the image we have, the kind of radio or television coverage given.

We charge a fee on a sliding scale and we don't get immediate reimbursement. We do see persons who are unable to pay or who are on public assistance, and we don't charge a fee. But we have a definite population. I always stress that. Not because we don't want to see blacks and Hispanics, but because we are not seeing everyone. We see whom we see. We have self-referred and very motivated people.

Participant: What kind of representation would be from people who are predominantly black or Hispanic, or who might have nonverbal tendencies to act out angry or passive behavior? How many go through the program in Rockland County?

Phyllis Frank: We have a percentage of people who would fall into that category. The biggest problem we have with non-English-speaking people and illiterates is the questionnaire, and we are working hard now to get volunteers who are specially trained in this area. We will work with anyone we can, to get them into our program.

It is my belief that there will be some way to communicate with any client who is referred in, and we are willing to bend our way of working with them. We are here to service the community. We are not here to pick those who fit into what we would like to work with.

Beverly Houghton: I might just add, looking at the statistics, that a person who is more likely to stick with the program and participate in a large number of sessions would obviously be middle-class, educated, and employed.

On the other hand, of these 25 out of the 34 whom we have been able to follow up, one of our biggest successes in terms of sticking with the therapy after the program was over was a Hispanic fellow who couldn't answer the questionnaire at the beginning. We have had similar successes with a number of other semi-illiterates. The people who could barely spell their own names, the people who had resisted initially, are for the most part the people who made it through.

Shelley Garnett: Our particular model (AWAIC) is geared toward people who are motivated for therapy. It is very important to them, as I said before.

I did a workshop 2 weeks ago at Columbia, and one of the participants said, "It is all fine with me, but you try and get my agency to see violence-prone individuals." Where there are agencies like that, you have to almost teach the agency to be receptive. It annoys me that there are still agencies wanting to refer their clients out, saying, "We don't know what to do with them." There is no reason for that person to be referred out, especially if there has developed a prior relationship with an agency worker.

Participant: Our agency has five mental health centers throughout Brooklyn and Queens, and in one of them I am treating a fellow who is a spouse abuser.

What source of funding does the Rockland agency have? Is it county, State, or Federal?

Phyllis Frank: The Domestic Violence Project of the Volunteer Counseling Service of Rockland is currently funded by ACTION. We have been getting some funds from organizations and donations but, certainly, after this year of operation, we will have to find alternative sources of funding, and that is going to be extremely difficult.

What we have to do is get this program integrated into the community so we can look for local and State funds. It is a program that can exist as a model, so that projects like this can be created where there is a desire. We have already gone to the State legislature, since the Family Courts ultimately are empowered to refer the men out to community agencies.

We have got to start programs, and at the same time we are continuing our educational workshops. We have got to help raise the level of consciousness of the mental health workers in the community regarding domestic violence so there will be additional places for the men to be treated. This is why we try to keep up the dialogue.

We have been fortunate to have all the workshops led by male/female co-leaders. In some cases, we have a husband and wife team as co-leaders.

Linda Lyon Bern co-led two of these workshops with her husband, Elliot, modeling a healthy marital relationship.

Shelley Garnett: My agency is a private nonprofit organization. We rely on volunteers.

I supervised six M.S.W. students, who make up the core of our center, and all the people on staff are volunteers. We have two funded projects. One is State-funded, which we received for the Batterers' Rehabilitation project we got this year, and one grant was for a training project.

Funding is not easy to get for these programs. Everyone is out for the funding. And looking for funding is exactly what it says -- looking for funding. I know the population in general is not shelling out dollars for battered women. We are going to start showing children with dramatic looks on their faces so that people will give money. The money situation has been horrendous in terms of State funding, and we don't believe it is getting any better.

Phyllis Frank: Starting men's groups is tough. You have to find men to run them, who are willing to commit their time and energy. Let it be known in the community that you are doing this work. I encourage you to start somewhere, anywhere, and make it public that this issue is being addressed.

The Impact of Abuse on the Family

Kathryn Conroy, C.S.W.
Barbara Gordon, M.D.

Kathryn Conroy: I am currently the Director of Preventive Services for the Sisters of the Good Shepherd Residences, Inc. I am an adjunct lecturer at Hunter College. I was one of the founding members of the Board of Directors of Women's Survival Space -- the Center for the Elimination of Violence in the Family. And I was cofounder of the Safe Homes Project.

The interest I have in battered women emerged from my experience as a child care worker for numbers of youngsters who were sent away for acting out in their attempts to get out of dysfunctional family units. In social work school I did a lot of organizing, and in organizing I developed a program that answered a need. This program has become the Park Slope Safe Homes Project. It is the only community-based program in New York State that offers counseling, advocacy, hotlines, and safe houses in a particular neighborhood.

I have five points or concepts that I am literally going to march through in presenting what I feel is crucial information for understanding the effects of wife abuse on families and the kind of fallout that the other people in the family go through. I am also interested in the repercussions that arise from issues concerning the place of women in society, women in the family.

Concept 1. One of the critical issues is isolation, and it is an issue around which we have formulated all kinds of catchwords like systems, networks, supports, resources. We still, within these catchwords, do not identify the psychological, emotional, and sociological problems involved in wife abuse. A major premise for me in working with battered women is that if we don't deal with the isolation, we don't deal with the problem.

There is an obvious cyclical process between abuse and isolation that must be dealt with. As the woman is abused more and more, her lack of self-esteem is aggravated, her sense of dignity is diminished. The bizarre situation she finds herself in enhances her feeling of being alone in her problems, that there is no one who cares, that she is the only woman faced with such a horrifying situation. Not only is she afraid; she is embarrassed as well. How can she share her secret with anyone else -- would anyone even be able to understand? This enhanced sense of isolation leads to greater frustration, which, in turn, will most likely tend to aggravate the abusive situation.

No matter how much counseling you do, if you don't hook up a woman with someone she can call, either in an emergency situation or for referral for treatment or help in any other way, or if she leaves you

with no more of an insight into her situation or an understanding that she is not alone, that there are other battered women around, then her sense of isolation will not be alleviated in any way and your interaction with her has not been successful; most likely it has exacerbated both the problem itself and the isolation. If we don't have a feeling for this cyclical nature of abuse and isolation, then we don't have a feeling for the bizarre situation the woman experiences.

We carry within ourselves a myth of the family, which is day by day enforced externally. This myth is a picture painted for us as children, internalized by us through many years of exposure to it, and ultimately strived for by us as a goal that must be reached. The picture painted is that of perfection -- being the perfect family, and attempting to achieve it. This involves adherence to the various roles taught to us through our childhood. As mothers, we are supposed to do this, as children we are supposed to do this, as fathers we are supposed to do this. It is the rule of the "should" and it is impossible to adhere to. We believe that if we could only do this the right way, the way we "should" do it, our family would be just like the Brady Bunch; we must be doing it wrong if we are a family that is arguing, fighting, drinking, abusing.

The problem with this belief is that it is a myth, and the more we strive to create that myth by adhering to the shoulds, the more problems we have; the more problems that come up, the harder we try; and the more we try, the more difficult it becomes to replicate the perfect family, finally resulting in great turmoil and often violence. I suggest the thesis that violent families are trying the hardest to adhere to this perception of the traditional roles.

Within the family, there are basically three roles: the mother, the father, and the kids. Very simply, the role of the mother is to nurture: to love, comfort, feed. That is basically her role -- emotional nurturing, and implicit in the role of nurturing is holding the family together. The role of the father is to provide for and to protect. And the role of children is basically to be dependent.

Now, these are the roles, and as roles they have certain rights. The mother has the right to expect that her husband will provide and protect her and her family. The father has the right to be nurtured; the kids, besides having some responsibility, have the right to expect to be dependent, and they can use their dependency to be nurtured.

How many of you know proud parents of fully obedient children? Can you imagine what kind of turmoil that family will go through when those children go through adolescence? The effective parent learns that you don't start out any negotiations with your children at the point where you hope you will end up. I live with a 13-year-old. I will tell her that I want her to be in at 7 o'clock, hoping actually that I will get her in at 9; this is because we compromise. This takes a certain amount of skill. It also takes a certain amount of my giving up my role of nurturing and this child giving up her role of being

dependent. It is a constant process, through which she develops her individuality and starts to individuate, to separate. And I find myself doing the same thing. We are both letting go of our traditional roles.

In the normal, average, muddling-through family, there are certain internal stresses for which there are no roadmaps and no training. The learning is done on a daily basis -- compromising, bending, trying to find the best way. But there are also the external stresses imposed on us by social tradition, which cause us great conflict. After struggling and muddling through on an internal level, we often find ourselves trying each time we fall down to go after the most traditional way we know, because that, in the end, will make it perfect, and that is really the only thing that truly works. The myth again.

When I was a kid, my mother was a screamer, and boy, could she scream. I was the oldest, and the only girl. When it got to be too much, she would scream her brains out for about 3 minutes and then stop; she would feel a lot better. I could always tell when she was about to scream because she would run around the house and close all the windows so the neighbors wouldn't hear her. Years later and a lot of training later, I went home and said to my mother, "You know, you were closing the windows and so was everyone else." Everyone was hiding the fact that they were screaming and yelling too.

We must deal with this problem of isolation. No one seems to realize that family secrets are, in actuality, shared by most others. The dysfunctional families are those most ruled by the shoulds, and these shoulds become the basis for most neurosis.

Concept 2. The second concept is the relationship between violence and caring. Murray Strauss has done a great deal of work on violence as learned in the home. Some of the statistics and initial research about battered women that came out about 4 years ago were saying that there is a one-to-one correlation between the subject being abused and the subject's past family life, that either she or her husband came from a family where the father was a batterer. Strauss found that these correlations are, in fact, high, though not on a one-to-one basis as had been described by others.

Regardless of the figures, violence -- defined as an act perpetrated by one person against another, causing pain -- is learned in the home. I would suggest that 95 percent of you in this room would say that the first person to hit you was either a parent or sibling; that for most of us, in terms of childrearing, the unwritten rule is that when all else fails, those who care for you have a right to hit you.

I always get asked if I have an answer to this problem. And the fact is, I don't know what to do about it. The child reaches for the pot of boiling water. You pull the child's hand away and you're going to hit the child's hand and teach him that life-sustaining lesson. Most parents, in the final analysis, teach the life-sustaining lessons through violence, using the definition I gave.

What happens, then, is that we have a very early link between violence and caring, because these first acts of violence come from those who care; and the issues around violence are very slow in leaving us. When I was 18 years old, I got my driver's license. I was coming down the block about 30 miles an hour, did a two-wheelie into the driveway, where a younger brother jumped out from behind a tree into the side of the car, and then fell down onto the grass as if I had smashed into him. I jumped out of the car -- I was hysterical -- crying and screaming, "I can't believe I've done this to you! My God! Are you alive? What have I done?" Then he laughed, and I proceeded to beat the living daylights out of him.

We mix the issues of violence and caring very dramatically, and these lessons die very hard. We must try to resolve them in some way. We run a teen/parent project in Brooklyn, and I am absolutely aghast at the number of adolescent girls who say they know their boyfriends love them because they hit them. I think we must look at some of the material we have here today in order to understand this complex construct.

In New York State, a study was done in the 1970's whereby the researchers got from the computer the names of all the kids in the 1960's who had been adjudicated in the Family Court to see who had been abused and to see how many of these youngsters later came up somewhere in the criminal justice system (involvement with the criminal justice system was used as a point of reference for dysfunction). The researchers discovered that far more neglected youngsters than abused youngsters came up in the criminal justice system, but within the smaller category of violent crimes, more youngsters who had been abused rather than neglected came up. You could almost extrapolate that any attention is better than no attention at all, and that negative attention is better than neglect -- that is, of course, if you are using the criminal justice system as a way of looking at who is dysfunctional and who is not.

If this early link between violence and caring is not resolved at some point it is carried throughout our lives and found existing in all our relationships. We know that we seek in mates, or spouses, a fulfillment of what we did not get from our parents. If left unresolved, those needs carry us back into virtually the same family situation we were so eager to leave as children.

Concept 3. The third concept I would like to cover is justice. In terms of justice, one looks at the children. Children see the world as a just place and early on have the conception that those who are good get rewarded and those who are bad get punished; at about the age of 6, the kid becomes cynical and realizes that those who are good at least get left alone.

The problem with the concept of justice is that we all know it's not true, and yet we operate as if it were. The concept of justice is the basis of everything in life we do, as well as the foundation for most of our laws. Why? Because if we didn't have this concept, what would we have for dealing with the reality of the world? One would have no concept of cause and effect. The problem with the issue of

justice is that the more sophisticated we are, the more schizophrenic we become.

In a family in which there is violence and adherence to traditional values to replicate the perfect family, you can find an even greater adherence to the concept of justice. What I would suggest is this: If a woman is battered, she is going to make up a reason for why she is battered. If she does not do this, then the world makes no sense whatsoever, and she will be thrown into a therapeutic mess. She will then have to deal with why she married her husband. In the first place, her mother didn't like him; second, she knew he drank; and on and on. Rather than dealing with the hard and painful reality of her situation, she finds it much simpler to revert to the concept of justice -- the good get rewarded and the bad get punished -- and, therefore, to blame herself. You often find the woman feeling that she must deserve what she is getting. If only she could do this and that better, then she wouldn't be battered. She grasps this idea of getting what she deserves, and will fabricate specific reasons in an attempt to justify the crazy situation she's in.

Concept 4. The fourth concept I'd like to deal with is the family system's dysfunction. I'd like to address myself to three issues that I think get tremendously exacerbated in the family -- triads, secrets, and blame. These concepts are present in any family, but they become dramatic and traumatic in a family in which there is violence. By way of explanation I'd like to share a story related to me by a very close friend concerning her family. And, by the way, until we look at the universality of these issues, at their existence in all of our family lives, we will always have a "we and they" kind of attitude. It is very important to remember that we are all only a little bit away from this violent end of the continuum.

Jean, my friend, started studying family systems and got very excited about the idea of dyads. A dyad is that dynamic interaction between two people, confronting and dealing on a one-to-one basis with each other, as opposed to triads, which involve a third person. A triad consists of two people who spend the majority of their time talking about a third party, thus avoiding confrontation and dealing with each other effectively. Jean decided one day to call her mother, and in the course of the conversation told her that no longer were they going to engage in triads; she wanted to talk to her mother about just the two of them. They found themselves with almost nothing to say for about 6 months. Then she decided to try to share information with her mother in the most nonthreatening way possible; she got her mother to bring out all the old family pictures and they began to put together an album, starting with the maternal grandmother, going on to her mother, and to herself. Her mother would tell her about the pictures and the stories about the people in those photos. They began by talking about the mother's relatives whom Jean had never known by name, and from there they got into a very strong dyadic dialog, where they learned a great deal about each other. This went on for a number of months and was fairly successful until her mother called her at work one day. The minute Jean got on the telephone she heard a tirade about how her brother had just been arrested for drunken driving. Immediately everything

they had learned was gone. The relationship immediately reverted to a triad. The mother also said, "You're the only one I can tell. There's no one else I can turn to. Don't tell anyone you know, even your brother." So the secrecy element was introduced.

The whole family could now blame the son and brother for why the family had never worked from the beginning. Mind you, my friend had been on the outs with her family for 2 years. There seems to be always someone on the outs; that way, no one has to deal with why the family doesn't work perfectly. At that point, she was so grateful to be in with her family that she couldn't care less that her brother was on the outs.

This took place right before Thanksgiving. It was her mother's habit -- and we can probably all relate to this -- to call up all the kids beforehand and tell them what relatives were going to be at Thanksgiving dinner, and what they were allowed to talk about at the dinner table and what not to mention. Naturally, making any mention of the drunken driving was out of the question. Thanksgiving dinner rolled around, and everything was going smoothly and peacefully until about halfway through dinner an aunt turned to her brother and said, "So, whatever happened with that drunken driving charge?" Well! All hell broke loose. Within seconds, the whole dinner had been destroyed. And, sure enough, everyone had known about it. Not only did everyone know about it, but each believed himself or herself to be the only one who had been confided in, so they had all tried to keep the secret. Most of them knew even before Jean herself was told.

What the incident taught her is that the process happens in any family where there are problems. What happens even worse in a family where there's abuse is this: You develop a secret around the person and you cut that person off from any service or intervention. Because Jean had concurred with her mother in a secret, she could not call up her brother and say, "Don't you want to talk?" Her other brother couldn't call him up and ask, "Do you want to stay at my house for a while?" No one was able to reach out to him and express concern because they were all involved in the secret about what he had done. Furthermore, he carried the blame then for the holiday being a disaster.

By using triads, secrets, and blame, we allow ourselves easy answers for the reasons our family doesn't work rather than simply acknowledging that there is no perfect family and then spending our time finding a better way to survive, to stay connected. The tasks of family life are all at opposite ends of the scale. The dependent, the independent. The tasks are opposite tasks, and rather than deal with the ambiguity and the differences we believe that somewhere in the middle lies perfection. We must come to grips with the fact that we are not in the middle, nor can the middle be found.

What we do instead, usually, is use secrets and blame to isolate different family members. In violent families, the violence becomes the secret. We feel that we must, at all costs, keep the secret. This becomes incredibly hard on children from violent families who are told to maintain the secret or Daddy will be taken away. Can you imagine the

stress and internal conflict of these children who so desperately need to be reached and helped but who can't open up and talk about it because if they tell, "something horrible will happen?"

Concept 5. The last point I wanted to make is very basic and very simple. I think we have to look at work with battered women as political work, because if you're working with battered women you're working with family structure; if you're working with family structure you're working around issues of male dominance. If you're working on that you're challenging the economic system, and we should look at that in terms of emotional backlash. There will be, at certain points, a backlash in dealing with women's issues, because these kinds of issues go to the very root of society as we know it; this is true whether you are the caseworker or the person out there on the line. It is political.

Barbara Gordon: I was the Assistant Director of the Child Mental Hygiene Clinic at Bellevue Hospital for the Pediatric Project. I am an Instructor of Clinical Psychiatry at New York University Medical Center. I am now at Long Island Jewish Hospital as the Coordinator of the Pediatric Liaison Program at L.I.J. and I work both in the in-patient and out-patient departments.

The first issue I would like to discuss is this: If you have seen one battered child, you don't stop to reflect on whether or not this is a result of a family striving for normality and perfection; your initial reaction -- and justifiably so -- is one of shock. Somebody is sick; something is dreadfully wrong in that family. You need to see just one abused child. For example, you need to see the two little boys I interviewed in the pediatrics ward at L.I.J. They were 11 and 12 years old. Both of them came in with welts all across their backs. They had both been punched mercilessly; they had black eyes, cuts all over their faces, and lacerations on their scalps.

In abused families, I would say that if the wife is being abused, then it is almost certain that someone is abusing the children. Whether it be the husband doing the beating or even the wife -- at times both -- I would say this: You must investigate the situation and find out if the children are being abused. Most often, there has to be a way for the woman to retaliate. After being abused by the husband, she may, in turn, abuse her children. This is part of the isolation. In her total frustration and because she accepts being beaten -- not that she likes it, but it may have been normal for her throughout her life -- she finds no other suitable outlet for her intense frustration, and vents her anger on her children. Furthermore, in the few families where this does not occur, where the children are relatively free from the physical violence, they are still suffering just as deeply.

We must try to end this isolation; we must reassure the woman and try to help her in acknowledging the situation and the impact it makes on the child. We must intervene somewhere along the line and help the woman gain awareness of exactly what is going on.

Opening and releasing the secrets of the family eases tremendously that sense of isolation; it's an important step. We must impress on the

abused woman the fact that her children have witnessed violence, that the children are going to be suffering internal violence akin to internal bleeding through their exposure to the situation. They must be reached and they must be helped.

You must understand the type of family we are dealing with here. We are not talking about the father who comes home from his job as professor at Columbia University and says to his adoring wife, who happens to be president of some large corporation, "Good evening, my dear, and how are our delightful children today?" We're dealing with the man who comes home and says, "Goddamn broad, would you get some food on the table?" This is one level; and if it's not said in such a manner, it is implied. For example, in our building there is a couple whose daughter used to come to our apartment to play with my daughter. One day my daughter came crying to me and asked if she had to keep playing with this little girl, that this girl hit her all the time and she didn't want to play with her any more. I told her that of course she didn't have to play with her any more. However, the incident made me wonder. One day soon after that, we went over to their apartment for something or other and stayed there a few minutes. The husband came in and started berating his wife about all the things she hadn't done that day. The wife then turned to the child and said that the reason she hadn't gotten anything done that day was because of the daughter, and, with that, gave her a slap across the face.

The cycle keeps on going. You must not be misled. It happens often, anywhere and everywhere, regardless of social level. The isolation comes from the woman feeling that she, in some way, deserves this abuse, that she must be doing something to deserve it. You must do some kind of intervention.

One of the little boys I was talking about before -- the 12-year-old, the most outgoing of the two and the brightest -- told me that he was trying to protect his younger brother, that many times he was beaten because he was trying to protect the other sibling. What did the mother do? She stood silently, watching, obviously just thanking God that she wasn't getting it herself. In her childhood her father had beaten her nightly. She had grown up with an intense feeling of isolation -- the sense that even if she had reached out, there would be no one around to give a damn. As a child, of course, you can't possibly believe that there might be something psychologically wrong with the parent who abuses you. In a child's mind, parents are never questionable; they are always the picture of perfection. So the child begins to feel it's her fault; there must be something wrong with her in order for her to be beaten. So she grows up actually believing that she must be deserving of the abuse.

When you work with these families on a psychiatric level, you have to know about the sexual issues involved, and as Kathryn Conroy was saying, you must begin explaining all these factors to the family.

First, you have to explain to the woman that wife abuse or being a battered woman comes about because in some way or at some time in her life she was either a party to it herself or experienced it, or watched

it happening to other siblings; in a way, she's reacting in a manner that she's been trained to react in. You must immediately tell her that she's been not only taught but also trained to accept it as natural in her life.

You must stress the importance of the children and the necessity to have them come in to see you, so you can assess and evaluate the damage that has been done. No matter what, you must do this, and quickly; you should very quickly move in and help to uncover and expose this family secret. You must find out if the child is functioning or nonfunctioning. The child is the most important issue. If the child is still functioning in school in terms of behavior, you have a child who is not too badly off. If his school behavior is abnormal or below average, you must refer the child for some kind of treatment. And you must always impress on the mother that the battering -- whether physical or emotional -- is causing delays in the emotional development of the child and will result in severe identification and psychological problems. You must find the proper place to refer the child.

Here is another example of the perpetuation of domestic violence. A woman as a child had been severely beaten by the aunt -- who was her substitute mother -- while the father watched. To get out of the home, she married a junkie. The episodes of violence were legion -- once she was stabbed by her husband -- and all were witnessed by the child, who was 4 when we saw her. The mother didn't move out of the house. Where was she going to go, back with her father? Considering what the father and the aunt had done to her, she had married a man who simply fit into and followed the pattern.

When we evaluated the child, she was ricocheting around the room; we couldn't peel that kid off the wall. The psychologist said that she couldn't test the child, and I agreed. The mother finally came to me and said that she was afraid of killing the child. I recommended the child to a residential treatment center. The father came in and told me that if I took their child away he would kill me. I was amazed at the time that I didn't faint. We kept the child at St. Barnabas. The nurses said the child stayed up all night; she wouldn't sleep until the morning came. Evidently, she was accustomed to being awakened throughout the night since the father would come home at night to beat the mother up. We finally got the child on a normal schedule, sleeping at night and being awake during the day. I can't tell you the number of times when the mother would come in and just go crazy. She needed the child at home. She was terribly frightened and needed the child.

We kept her at the hospital, however. Six months later we tested her; her mental development was above average -- she was extremely bright, calm, and coordinated -- after only 6 months of residential care.

You have got to arrest the family situation. I know that with our limited services this is extremely difficult, but you must realize that the abuse extends way beyond the wife. In terms of developmental interference, abuse of any member of the family interferes with a child's sexual identity and interferes with a child's internal developmental progress. I do not care whether it's immediately obvious or not; it can

be deeply hidden in childhood, but this interference in development is bound to have an effect at some point in the child's life.

In our society, there is a high incidence of disciplining by a crack or a hit. This may not progress to actual child abuse, but those people who discipline their children in this fashion have very poor impulse control. Kathryn Conroy was saying that the neglected child is most often the juvenile delinquent. Abuse takes its toll in many other ways. Do not forget the learning-disabled child who may also have difficulty controlling impulses. There exists a whole continuum we haven't gone into as to who is really the abused child, but you must at least look at the children. We know that the wife is of tremendous importance, but it is the children who are going to perpetuate abuse in our society.

Participant: The focus of the presentation has basically been just the abused female, and I feel we ought to consider the other parties. What about the person who's doing the battering? It's not just the wife you have to worry about; it's the total system that has to be looked at. It seems to me that this is a severe failure in our social service system, that we focus all our attention and energy on the wife. There must be ways of engaging all the members of a family in therapeutic systems and approaching the problem in a more effective manner.

Kathryn Conroy: I talked about isolation before, and keeping the violence a secret. There are also families that we have all called "multiproblem" families, those who just don't care; it's all up front. What we do as a society is isolate them. I'm in the supermarket and I see someone swatting her children; I quickly walk down another aisle. I choose not to get involved in any way. You find someone who's battered and you work with her in trying to help her make connections with her neighbors and not keep it a secret. Yet we are all guilty in some way of perpetuating that very secret.

Barbara Gordon: I do think that now and then we ignore the violence -- basically because we are afraid. When we witness a violent incident, we get some idea of how frightening this raw, primitive violence is, and that may be why we don't work with the batterer, because we may be afraid. I was deathly afraid that the husband I spoke of before was going to wait for me on some dark night and stab me.

As for abusers, it is difficult to research the time needed for the violence to stop. In California, they found out that it's been almost impossible to research the long-term effect of working with the batterers. You can't really expect to call up after 6 months and ask a man if he's still beating his wife.

The use of too much psychological terminology and going backward and forward with the intergenerational issue keep us also from seeing the problem for what it is. Look for child abuse in situations where the women have been battered. We have just recently come to the point in the examination of wife abuse where we are learning how to recognize and effectively deal with these battered children.

As a matter of fact, we are really just getting to the point of recognizing wife abuse. We have to look at the total family,the husband and children as well as the wife. And what can we possibly offer the woman? How we can support her, who can provide for her to help her achieve financial and emotional independence?

Participant: I would like to know if the incidence of incest is higher in violent families than nonviolent ones. Also, since I work with families of handicapped children, I am curious to know whether the stress of a handicapped child will be more likely to produce isolation in domestic violent situations?

Kathryn Conroy: There has been, as far as I know, no study done on the correlation between incest and wife abuse, or involving incest and prostitution. But this is certainly one area that should be looked at. The issue of the handicapped is coming up as people are looking at the elderly. Now is the time to do the research.

Participant: I think there has been a study on incest and wife abuse that will appear in the next issue of Social Casework. One of the women I work with has done a study in Iowa, and she found a very high correlation between incest and wife abuse.

I also want to mention a great concern of mine. I do training with child-protective workers within the context of domestic violence and wife abuse; and I have to agree with Dr. Gordon that it is important to think about the children as well; I want to protect the child. I find that women isolate these children so much; they don't realize that if the children remain in the home they are eventually going to end up being abused, whether directly or indirectly.

Barbara Gordon: Of course -- these children will eventually be abused. I think that there exists a very strong correlation between a child protecting the mother, or another sibling, and actual child abuse itself. It's difficult to find out whether the child was actually a target of the abuse or whether he simply got in the way of a situation.

Of course, the complexity of the system we are trying to work with is enormous. Two issues not addressed much today reveal this complexity. First, women who are beaten usually are not able to just pick up their children and move out. Somebody once told me that it seemed as if her mother had worried more about finding an apartment than she did about being beaten. This leads to the second issue: Why does it occur? There are many reasons, but one of the most important results from the idea of staying home. Staying home and being a housewife, being taken care of, is a very seductive idea. However, the nonworking mother is totally dependent financially on the husband. The battered wife's self-esteem decreases and she becomes unable to move away -- not only unable to break the emotional ties, but also terrified of the financial future as well and her potential to deal with it on her own.

Participant: Then why do they come to you?

Barbara Gordon: Usually they have been beaten so badly, or their children have been beaten so badly, that they finally come to me. But what is most unfortunate -- and so terribly sad -- is that most often these women don't come to me. There are millions of women out there, suffering in these terrible situations, and afraid to come out.

Kathryn Conroy: And this is another failure of the network we are working with; it's absurd. In the State of New York, if a women admits to being abused -- and has children -- she can be charged with negligence for having her kids in a situation where she's being battered. In many situations where women revealed the facts, their husbands were charged with wife abuse; then, since he'd admitted that he was battering his wife, the court took her kids away. You would not be in a good situation if you were a battered woman and you needed help. Until you give these women immunity, or some sense of security that their kids won't be taken away but that they too will have some kind of protection, you can't ask women to tell you that they have been battered. You continue the secret.

Barbara Gordon: There is also the fear factor. Women are afraid to move out, and rightly so -- who's going to hire them? How can a woman move out into a good job when she hasn't had the training, and she can't afford to hire someone to take care of the children? We have good reason for some women to stay home and be battered. They are going to be battered either in the home or in society; so why not stay home and be battered there?

With wife abuse, what we're really looking at, I think, is a way of keeping women deprived of dignity and of social and economic means of support. Unfortunately, the professions women tend to come of age in -- like teaching, and oddly enough, pediatrics, where you're dealing with children -- are denigrated; you're looked down upon when you're working with women or children; you're not part of a macho society. One can look at wife abuse as the men really saying, We still dominate, and I think that in this manner it becomes very hard for us to protect women and children because they are the people, really, in this society who have been the least protected.

Kathryn Conroy: That brings up a critical issue I forgot to mention earlier. I think it is very important to ask the woman who comes for help why she thinks she's being battered and also why she stays in the situation. You know, social workers don't ask that. We don't ask her why she thinks she's abused, or why she stays, because we immediately assume that she should be out. If we would just ask her these two questions, we'd have a decent assessment of the family and the woman as well. But we don't. A person comes into the office and says she has family problems. Immediately something comes to mind about how to work with a problem family. When I suggested to my workers that part of their intake questions should be concerned with abuse, a large majority of them were against such questioning. But I think we should ask these questions; they're essential for proper assessment. Of course, there is a fairly good reason for not wanting to do the assessment. When we do the assessment we get the problem, and we don't know what to do with

it. So, in a way, we then give the client the message: "Please don't tell me, because if you tell me I really won't know what to do for you, and, don't tell me because you're not worth it anyway." So, in this sense, we really haven't asked the proper questions.

Participant: I hear you social workers admitting to a lot of things that we find wrong when we refer women to you. There are a lot of mistakes being made. I have been a battered woman. As a matter of fact, several of my colleagues have been battered. So, we are quite familiar with what can happen in these situations. When we get someone, we send them to County Mental Health; it's only a matter of time before these women come back to us, since they're not getting what they need. The primary thing we try to do when we get these women is try and set them on their feet; teach them that they are worth something. Then we do our referrals out -- take care of housing and so forth. Independent counseling we don't do; we just try to get them on their feet. Then, when they go back to County Mental Health, they return still saying that nothing is being done for them. I can finally see what some of your problems are. You're saying that there are many things you really don't know.

We are doing a training session very shortly with the Mental Health Department, because they want to find out just how to recognize some points. For example, how do we find out or how do we get these women to admit that they are being abused?

Our basic problem is dealing with the women who keep going back to their situations. We are working on organizing a batterers' group rather than pursuing the individual concept. We are trying to work in groups, so that each person can see that there are other people like them. We're trying to teach them at the same time that they don't have to simply endure; they can change. And now we're trying to bring the children into it, because I sit up there in the center of the room at the desk and I can see the children sitting there, looking quite lost, and no one is doing anything for them.

Barbara Gordon: That's so very true. To follow up on what Kathryn Conroy said, about seeing a child being hit in the aisle and then leaving, this is a feeling most of us have, because what can we do? The denial feeds into that sense of hopelessness and being overwhelmed by it all. This is why it is so inspiring to hear of programs like the one just mentioned, where the entire family unit is being taken care of in some manner.

Participant: There's something here I don't understand. Getting back to the woman who comes to us: She's feeling the shame; she's feeling that it's all her fault. How can we help her, then, and not add to these feelings of guilt, when we ask her to bring the children in? It seems as though it would just be giving her more to be guilty about, more to be blamed for. I mean, here she is, saying, "I've not only caused my husband to do this, but what have I done to my children? I'm pulling them into this whole thing with me. I'm allowing them to be witness to all this madness." How can we help them straighten these feelings out, and not take more upon themselves?

Kathryn Conroy: I think it all depends on the framework of the agency you are dealing with. In my agency, we work with the kids, we work with the women, we work with the husbands. We feel that the children have been affected in many ways. To pretend they haven't would be a terrible mistake. It's better to blow out the secret and give the children some care than to allow the secret to go on for the sake of the woman involved. Whether or not the child is actually being physically abused is irrelevant. Every kid in every family knows everything there is to know after they reach the age of two. So, they are still being affected in some ways. The children must, therefore, be brought in.

Barbara Gordon: You're also just perpetuating the myth if you continue to let the children take it all in, and you're perpetuating the myth if you say that the children are not being affected by the abuse.

Participant: It's great for both the children and the husband to be among other people with the same problem. It's an amazing sight to see, and there are groups that can work wonders. It doesn't isolate them in any way; it makes them see that they're part of a broader problem, that they're not the only case.

Participant: Many battered women you will see are not situationally depressed or clinically depressed. Many do not have complex social problems, other than the fact that they are being battered. It's important that we don't lose sight of this. It's not always so complex an issue that we really can't just ask a woman directly, right out, "How can we help you get what you need?" I would say that two out of three women we see can be dealt with in this way. They need practical help. For example, how can they get out of the house without their husbands following them? Where can they go? Sometimes it's no more than these very basic, primitive issues that need taking care of.

Participant: I agree. That's why we use the idea of showing them their options. Some of them can take off by themselves and help themselves right away.

Barbara Gordon: I admire you for admitting that you were battered. Once women say that this has happened to them, once people can recognize and verbalize their problems, they're on the road to changing their lives.

Finally, I'd like to say that we can only go along with this in stages. Progress takes time. Don't be distressed if things don't work out immediately. It might help if you ask yourself these questions: What would you do if your husband beat you? Would you go back for more? Would you leave? Where would you go for shelter, money, emotional support? Thinking about this may give you some indication of what these women fear they will lose by leaving their husbands.

Being battered is like being raped; you don't want to remember it. It is a shameful, demeaning, degrading, and horrible invasion of your physical privacy, and it leaves many scars. You must remember this: These women may have physical scars, but they have psychological scars

as well. These women need you more than they need anyone else in the world.

Crisis Intervention in the Emergency Room

Kathleen Handal, M.D.
Toni Ruffolo, C.S.W.

Kathleen Handal: I am the Emergency Medicine Director at Long Island Jewish-Hillside Medical Center. I am an M.D. I have also done a specialty of 3 years' training in emergency medicine. As such, I am somewhat different from the traditional emergency physician. In the past, emergency rooms were run by moonlighting residents, retired or retiring physicians, foreign-speaking graduates, or foreign-born graduates -- all of whom wished to make a little extra money. So, I may be a little different and innovative in my approach as an emergency physician.

There are three axioms to being a good emergency physician.

1. The emergency is in the eye of the patient. It is not in Harrison's Textbook of Medicine. It is not in Christopher's Book of Surgery or Nelson's Pediatrics.

2. "Treat the patient and not just the disease." This is very important in emergency medicine, since patients are not myocardial infarctions or broken legs; they are people with those problems.

3. If you care, you can't help but be a good physician; you'll ask, you'll listen, you'll know your limitations.

With those three axioms as a basis, I will show how an emergency physician works, particularly with regard to battered women. He or she is really the captain of the team -- which includes the receptionist, the triage nurse, the social service worker, and the physician.

The procedure starts by identifying a syndrome. You are not aware of the patient's pathology unless you have read it or you have heard of it. In medicine we are taught not always to think of horses when we hear hoofbeats, but to consider zebras also. When a patient comes in with chest pains it is not always a myocardial infarction; it could be an aneurysm. If the patient is young, he could have a Marfan's Syndrome, a hereditary anomaly, etc. This attempt to identify a syndrome is very appropriate to handling the one of abuse.

Anywhere from a third to half of the marriages in the United States have an element of battery in them. A February 1980 article, "The Battered Woman," in The Annals of Emergency Medicine, quoted the statistic of 35 percent. This study was in a 10-week period in Washington State. The author, Warren Appelton, showed that the battered woman syndrome was seen more frequently than appendicitis, corneal abrasions, or rape in that emergency room studied during that time.

The presentation may at first be on another level. Patients who suffer battered syndromes have a high incidence of attempted suicides --

a quarter of them try. So a patient may present as a suicide or an overdose gesture. One in ten has a drug abuse problem. Often we identify these as the problem -- "There is an O.D. in the E.R.," or "There is someone who tried to kill herself." One in seven has an alcohol problem, although, as discussed this morning, this is considered a complication of the syndrome, not the etiology for the syndrome.

The awareness, the suspicion, has to come not only from the physician, but also from the staff -- the clerical staff, social workers, nurses, house staff -- which usually rotates in the emergency room every month. The social workers and the nurses in the E.R. are usually the most educated on the issue of abuse. The attending house staff and the clerical people rank lower in awareness.

In our institution we actually have training sessions in which the social workers and I instruct the house staff, the nurses, the clerks, and the security officers about the treatment of patients and particularly about picking up abuse cases. Emergency medicine must be a team effort.

The nurse, more than anyone else, spends the most time with the patients. The physician does not. The more time you spend with someone the more you speak with them and the more history you can get. Patients will usually tell you what the problem is if you listen and are sensitive to what they are saying and not saying.

A rather gross generalization of the battering syndrome would be: the patient is approximately 31 years old; she is lower, middle, or upper class (needless to say, the upper social stratum isn't without its pressures); she may be divorced; she has experienced on the average 11.2 attacks. One in four has had no prior experience of battering. Three percent do come with partners. However, this does not necessarily mean that battering can be ruled out as a possible etiology to their complaint or trauma. Not all the women are unemployed. A large percentage, perhaps as high as one in three, are pregnant.

The battered patients usually present to the E.R. within two time periods, 10 pm to 2 am or 9 am to noon.

Ten at night to 2 in the morning indicates trauma that couldn't wait for some reason. There was an acute crisis, an acute experience, and the woman needed to get out. Perhaps the attack felt more life threatening to her, and she was so scared she ran to the only place known to be open 24 hours a day for help. The emergency room has evolved as an arena that is always available, that knows what to do. The battered woman's general isolation and the lack of family practitioners also contribute to the E.R.'s reputation as a haven.

Patients commonly present between 9 and 12 in the morning. They are afraid to make a scene, so they wait for their children to go to school or their husband to go to work, or they use the excuse that they are going shopping or out to see a friend, etc.

As mentioned earlier, a large percentage of the battered women are pregnant. A mother (of an abused child) or a pregnant woman is more

concerned about her child than herself; she will repress her guilt about herself, the feeling that she deserved beating, or whatever, and seek help because of the child she's bearing or the child at home.

When the male partner is with the patient, your suspicions should lead to some questions. What are his habits, his job? How does he feel about the woman? Have they been in arguments? Try to see whether there is a short fuse, etc. These male partners, as you know, usually have had a high incidence of arrest, and not for minor things like parking violations. When you see a male patient with an alcohol problem you must also be on the alert for spouse abuse. Needless to say, many abusers do have an alcohol problem.

Usually the patient walks into the emergency room; she isn't rushed there by an ambulance. Since the injury isn't usually major, the woman may sit awhile.

Participant: I work with battered women. It has been my experience that their threshold of pain is very high, so that what would cause you and me to go screaming, they treat as minor. One woman's wrist was broken twice -- once as it was healing -- and she waited till morning to come in.

Kathleen Handal: As you say, the woman usually does mask the pain, and she comes in calmly. She is seen usually by the nurse. The nurse may, on eyeballing her and seeing that she isn't critical, direct her to the receptionist or the clerk who is going to take the initial data: name, address, marriage status, religion, insurance data. If the nurse or clerk notices, for instance, that the patient is a little quiet or inhibited even with a grossly deformed extremity, or is inappropriately dressed, shoeless or with a coat over a nightgown, etc., these are clues enough for suspicion.

People have begun to appreciate inappropriate behavior. Needless to say, we judge by our own reference points. We think it is a little inappropriate to be out at 3 in the morning shoeless, with a horrendous bruise, and sitting alone quietly. Any inappropriate behavior, however, is still usually interpreted as having a psychiatric etiology; the patient is considered to be crazy, as opposed to suffering.

In New York City, social service personnel are required by Emergency Medical Service to be in the E.R. or available on call 24 hours a day. It is during the period of waiting for treatment that the patient should be approached -- either by a social worker, a nurse, or whomever. In our emergency room, the social worker is asked to get involved, as a nonthreatening person by virtue of not wearing a white coat and by virtue of usually having a much more patient approach -- and by patient I mean not rushing, not having to be called in and out of rooms, which goes for the medical personnel. If a nurse happens to see the patient first, and has suspicions, she will most commonly bring the chart and the patient back to a room, giving the patient some degree of comfort.

You have to appreciate the fact that the patient is in fear or under an increasing amount of stress in the strange environment. The

staff can be sensitive to this stress only by being trained to be aware that it is a strange environment. For us, the place is home.

Whoever speaks to the patient should try to get as much information as possible, although often the patient doesn't want to volunteer anything. Furthermore, the social worker, nurse, or clerk can spare that patient a lot if whatever has been learned is communicated to the physician instead of making the patient go through it again. If the patient has volunteered nothing, the interview has to start with, "What is the problem?" or "Can I help you?" If the physician has gained information, he doesn't go over the sensitive points.

The physician begins then to be a little more objective and, appreciating the person's delicate state, introduces himself, as he should, and exhibits a manner that is quiet and confidence-inspiring. Eye-to-eye contact is very important with any patient, and more so with a victim of this syndrome. The physician should also explain to the patient that he's going to do some manipulations and some palpations of her and of the site. He should warn of any pain, "If I hurt you in the examination you tell me and I will stop. I want to know what views of the X-ray I want to order." Really talking to the patient before you go at her is crucial, certainly preferable to a brief introduction as you start mashing or moving her ankle or touching her eye or head. This is commonly the kind of patient who will pull away.

Most physicians are males, so there is going to be some role playing there and some increased anxiety just because of it. You are going to have to win the patient over, just as you have to do in any brief encounter.

Because of this briefness, and because you're a total stranger to the patient, not someone she knows and trusts, you are at a disadvantage any way it's looked at. With a patient who is very much more sensitive and partially involved and perhaps fearing for her life, you have to be extra delicate.

If the nurse or the social worker has not as yet understood that this is a suspect battered woman, then it is up to the physician, because by making or suspecting the diagnosis, he can then involve the social service, and proper referral. Hopefully, the physician is sensitive and professional. In medical school there is scant, if any, training on how to treat a patient humanly, how to interview a patient. The patient's self-image is usually ignored -- the fact that the physician is violating someone's body when drawing blood for a routine test, etc.

At any rate, it can happen that it is up to the physician to notice the syndrome, by recognizing inappropriate histories, going with the body picture.

You should walk in, sit down, and make eye-to-eye contact. Introduce yourself and become very patient, since the woman isn't always going to volunteer immediately what is troubling her. When the patient says, "I fell," you ask, "You fell? Where did you hurt yourself? Did you hurt anything else? Do you fall often? Do you get headaches? Do you get

dizzy? Do you trip? Were you running away? Getting really excited?" etc.

You proceed from a truly medical point of view from dizziness, headaches, palpatations, etc. to the more likely reason for the fall if you suspect this woman has been abused. And then, if the truth comes out, you don't appear to think it is horrendous to be in arguments, to have an altercation or an argument with a person you live with.

"Do you fall a lot? Do you live alone? Could you have fallen and no one realized it?"

"No, I live with somebody."

There can be a patient who doesn't say she fell but says, "I have a pain here and it goes over here and I have it every 3 months and it keeps coming back." You can say, "Does anyone else in your house have that problem? Do you live with anyone?"

You should find out the information by circumvention if necessary. You should get the patient to realize that you care about her and that you are not just looking at her foot or her twisted arm or whatever. That rapport can only be gotten by eye-to-eye communication.And certainly, if other staff members suspect abuse it is their responsibility to warn the physician that the patient is going to take some time to bring out.

We go ahead and examine the patient with her vague complaints and her story that sounds pretty good because she probably made it up awhile ago or she knew someone who used it. Then we tell the patient the truth. We do not give her some medication and say, "You're better." The lead-in is gentle. You say, "I found X, Y, and Z," or, if you found nothing, you admit to having found nothing: "Your lungs sound good, your heart sounds good. I really don't find anything at this time. Have you been stressing yourself a lot?" Usually that is the most benign way to start, since everyone's life is full of stress.

"Have you been stressing yourself long hours? Do you smoke? Do you drink? How are things at home? How many kids do you have? Does your husband work? Have you been eating regularly?" Show concern for the patient every once in a while so as to slowly get a better picture of what things are like at home or how the patient perceives things are at home.

You have to deal with the patient's reality. Do not make judgments. Her reality is that things are great or that things are horrendous at home and that is the reality you deal with. You look at it very objectively. Patients of the upper middle class are a little more difficult to talk with. Ms. Ruffolo will go into the reasons why they come and how they interact in the emergency room.

We have waited through long silences sometimes with our patients. It takes time for them to gain confidence in you. You have to be willing to take that time. The worst thing is to be getting along, coming along, with the patient and be interrupted.

In any of the interviewing, done by physician, nurse or social worker, the tone and questions have to come from common sense and caring about a person. As I said, physicians spend the least time with the patient. Women physicians are usually a little more sensitive than men physicians, and I don't think it is because we identify with the woman being beaten. All of us, male or female, should be professional. We should explain the treatment. "A nurse is going to come in and draw your blood." Or, "A technician is going to come and take an X-ray. Then I'm going to have a look at it and I'll come back and talk with you." That is professionalism, the art of medicine. The abused woman is going to need a little more tender loving care. The lumps and bumps are easy to take care of, and very commonly the lumps and bumps, as was alluded to this morning, are around the face, the head, the chest and the breast, and they are usually minor contusions and ecchymoses. At times, there are broken extremities, usually the arms. Rarely, there are ruptured spleens. The spleen is the easiest organ to fracture. Second to the spleen are the kidneys and the liver.

With pregnant women, it is very important to do an examination. If you suspect abuse and the woman is not volunteering, you might go the route of mentioning that there is a child who could potentially suffer trauma later, etc. Start out by saying, "Husbands don't always realize how delicate pregnancies are. They see you look strong and you are working around the house. Does your husband appreciate the fact that he should have a different way of handling you and that he can't lean on you a lot and he can't be as rough and as tough as he usually is?"Try to draw out information through a benign, natural "line," if you will, or interrogation or dialog with the patient.

After the examination and after the tests have been ordered, we come back to the patient and talk to her. With a stubborn patient,who won't admit abuse, this is, in a sense, the last try. If you can't get her to volunteer and make the statement, voice your suspicion: "Gee, you know, I'm really worried about you: I'm just concerned about how this happened and whether it will happen again." You do not make a comment like, "Boy, next time you can get killed," since if a patient comes from a family where her father beat her mother or threatened, as, "I'll kill your mother if she ever does that," etc., there is a potential fear in her mind that those four letters could become a reality for her.

You have just come out with your suspicion, and it is out; it has been said. It is usually a little easier for the patient to hear it then -- after you have spent the time, gained her confidence, and she's reassured that her body doesn't need to be operated on and that she's going to recover from these injuries. And 90 percent of the time the patients are going to recover; they won't need to go to the operating room. Using eye-to-eye contact -- which our society is down on but is very important -- you must voice the suspicion. She is at a very sensitive time; she might be depressed and she might identify with you and tell you just what happened. If you have a real tough cookie, and she says, "No, no," you should say, "I'd like you to talk to so and so, our social worker, about it" or "Here's a pamphlet that we give out." We have a pamphlet at the hospital, and it is excellent. It is done at an educational level and gives the person the reality of what she actually can do and what to expect. It literally discusses how many lines they

have to wait in at the center, and what the next step at Family Court is, and what the police can and can't do, and how to get around in the system.

Some patients are ready, and they want to talk to someone. If they have never met the social worker in the E.R., you introduce the social worker. Don't just say, "I'll send her in." You get her and you introduce her. It is creating a continuum, the same team. This idea, of course, is not just for the battered women. It is there every time you ask another physician or another consultant to see your patient.

Now I'd like to talk about drugs for multiple contusions, ecchymosis, and muscular, skeletal pain.

Pain killers, like codeine and Demerol, should very rarely be given for multiple aches and pains across the body, because they dull the pain of moving the injured wrist, or whatever, and the patient, not noticing the pain, will continue to move the injured part. It hurts for a reason. Your body talks to you. You've got a sprained ligament or you've got some bleeding into the joints. Walking on an injury with a pain killer is the worst medical therapy. The only time a pain killer is recommended is for chest wall contusions -- bruised or broken ribs, for instance. You have to breathe, and you can't put your ribs at rest. If you don't take good, deep breaths you will get pneumonia.

As for tranquilizers, I've never seen them specified in the literature on battered women. Often the traumatized, battered woman is suffering from aches -- muscular, skeletal aches. She got banged -- nothing really broken -- but the muscles are sore and there is bleeding into the muscle, which hurts every time she moves; it can also go into spasms. Muscular, skeletal relaxers are indicated -- something that stops the spasm. Valium, which originally was designed as a muscular, skeletal relaxer, is the strongest. As a matter of fact, when you dislocate your shoulder, the drug of choice for putting it back is I.V. Valium. It relaxes all the muscles around the deltoid, and then you just pop the shoulder back into place. It is common and conceivable that a battered woman will leave the emergency room on Valium. I use muscular, skeletal relaxers only for back injuries. Muscular skeletal relaxers are not going to kill pain, but they will stop the spasms. They also help with chest injuries, whether the ribs are fractured or not.

Now that the patient has been introduced to the social worker--the physician having either made the diagnosis or perfected the diagnosis--the physician bows out. Take care of my patient, please.

Toni Ruffolo: The social worker in the emergency room usually offers support, advocacy, and counseling. I will talk about that in detail later, but I would like to give a brief outline first as to the program's beginnings and the population we see.

The program evolved when we became aware in the emergency room that many of the principles used in identifying and responding to child abuse were applicable to the identification and response to domestic

relations and abused women. We received a grant from the United Hospital Fund in 1977, and we began our pilot spouse abuse program.

Our hospital serves a very diverse socioeconomic, ethnic, and age population. All of these are represented by the women we see in the E.R. Abused women come to the emergency room for many reasons. The presenting problem is usually medical, but they also see the hospital as a haven. While they are there, they feel protected, safe.

As I said, there are many types we see. In order to give you a picture, I am going to present three types. The first two are certainly not the majority.

The first is usually somewhere between 30 to 45 years old, and she has been in a relationship for relatively long time, anywhere from 8 to 15 years, with one man. She is known not only in our emergency room but also, as we discover, in other hospital emergency rooms in the area. She is by far the most difficult patient to deal with in terms of social work.

She exhibits all the evidence of the past abuse: her fingers are deformed; her nose has usually been broken; she has scars on her body; she is missing teeth; often her hair is rather sparse; and she is generally a mess. She's disheveled. She is responsive and receptive only to the medical treatment. While she is not impolite to the social worker, she is very reticent to discuss any details of how she came to be in the emergency room at that time, not to mention previous times. If you stay with her long enough and you can talk with her, she will give you information but she's guarded; she's terribly frightened, because she really doesn't want to hear anything about her alternatives or choices. She's ashamed to some degree and she doesn't want to change anything.

Recently I saw a woman who, though 34, looked 60. She came in with all of the characteristic signs I have mentioned. In between examinations, while she was waiting, I stayed with her and we talked. She had been married to her husband about 12 years. He worked for the Transit Authority. She had three children who had been in Foster Care for 4 years; she felt that this man had a tremendous number of problems and a very bad temper, but he supported her; he provided her with -- forgive the expression -- food and shelter. She felt there was a tradeoff.

She had absolutely no hesitation about going back home and she could make her own way; she usually had just enough money to get her home. She was not afraid to go home; she knew the pattern of the abuse and knew she was going to be safe for a while. She left.

During the time you are with her you begin by being appalled. Then you become full of pity -- the savior syndrome -- and you want to save this woman from her terrible situation. Then you begin to get angry; you want to say to her, "Hey lady, come on." Nothing happens, and in the end she leaves and you are frustrated. This is a very difficult type, because everything is so up front and she has no affect; there is absolutely none. You see her sitting there pathetic and yet very determined to do her own thing and you are not going to touch her.

The second type, also in the minority, is a woman of about the same age. She, however, knows pretty much what she wants. She's had a violent marriage too, but the beatings are much less traumatic -- pushing, slapping, threats of violence -- and she's got it together. She comes to the emergency room, usually for X-rays, and the one thing she wants is documentation, because she's going to see a lawyer. Someone has told her that documentation of the abuse is good to have -- and it is true. She wants to be sure that she has copies of all of the records, not only detailing the treatment but also stating the circumstances that precipitated the visit.

The third type, and by far the most common, is a woman from age 18 to 68 who comes in not knowing what she wants; she isn't aware of what she is entitled to or what her rights are. She is usually ashamed, embarrassed, frightened, bewildered -- completely traumatized.

Just lately we have been seeing a lot of women who are between 58 and 68 years old, whose husbands are retired. They had traditional marriages, where the husband went out and earned money, came home and was not terribly involved in the family. The roles were very clearly defined. Suddenly this man finds himself with no place to go. He's lost his role, so the couple are at home together for the first time probably in 35 or 40 years. They are together all day. Most often there isn't enough money for any kind of external entertainment or stimulation and probably even if there was they wouldn't take advantage of the situation, since they don't have a sharing kind of relationship. The constant togetherness and his frustration often results in him abusing her. She also is not abused to the extent that she requires hospitalization. It is usually a slap or a shove, but for a woman at this stage, she's very helpless. She's ashamed to go to her children; she's filled with shame.

I will explain later the dynamics of our treatment, but first I'd like to talk about a case I saw last year in August that I feel points out some of the failures in the system, some of the resources available, and, finally, prejudice against women.

A Peruvian woman came in last August with her little boy, who was 13 or 14 months old. She came in with her clothes -- she had just left home and wanted a shelter. She had X-rays taken of her bruised ribs. She had been married for 9 years to her husband and had experienced various assaults. She finally had just packed up and left, and she wanted a shelter. We couldn't find her a shelter, per se, but we were able to put her in a program in Suffolk County for the evening. She returned the next morning. The shelters had no room -- there is usually a waiting list of about 3 weeks -- and she said she had nowhere to go. After talking with her, we were able to find that there was someone she could stay with for a while without going home.

As a matter of fact, this confusion is common. A woman comes in and initially she says, "I can't possibly. There is no place to go." She is terribly upset and usually not thinking clearly, but if you see her several hours later or over a period of time when she is less emo-

tional, you will in most cases find that there is just one person she can go to for a brief period of time.

With Norma, we were able to find someone she could stay with and she did. We were afraid for her to go to Family Court alone because she spoke with a very heavy accent and she was very, very shy; very, very submissive; she was typical of a woman coming out of a Spanish culture, where women are traditionally seen as subservient.

We arranged for someone to go to Family Court with her and walk her through and get an order of protection. The order had to be served on her husband, and he subsequently found out where she was.

To make a long story short, he wanted her to come back. She refused to go back. We tried to get her into a shelter, because she was staying in a home that was already overcrowded. After she had been there for several weeks, she and her husband went to court and she was awarded custody of her son. We found out that Norma was not a citizen, even though she had been here for 10 years; because of that, there was nothing available for her in the way of a shelter or any kind of public assistance.

She said that if the husband could change she would go back home, since the situation she was in was getting bad. The husband came for counseling, and I saw him, and the two of them, for a couple of months. All he wanted was for her to relinquish custody.

He was an extremely violent man. I would go so far as to say a psychopath. He kept guns in his house; his behavior was inappropriate; he was a loner -- no contact with his family; he had been on his own for 25 years. The best time of his life was when he was in Vietnam. He wanted to be a State trooper, that kind of thing. The violence was always there; you could sense it.

Norma went back with him but only to live in the house. They did nothing but live together and barely spoke. The idea was for Norma to save some money, get a job, and get out. She couldn't get a job and she didn't have any money. Instead, she became increasingly nervous and upset.

I saw her from time to time, not on a regular basis, and spoke to her at least every week. In April he took the kid out for a ride, supposedly, but he never came back. He kidnapped the kid; took out the kid's clothes, took out his own clothes, quit his job. He had prepared for the kidnapping.

Norma called me. I told her to wait. She waited. He didn't come back, so I went to Family Court with her and got a warrant for him. We spent the whole day in Family Court and then raced over to the local police station. The police laughed. They said, "Oh, that has absolutely no validity. It has no muscle. It is a Family Court warrant, which means that if she finds her husband and she is in the metropolitan area, she can call a policeman and he will arrest him."

That was that. We spent months trying to track the man down. In fact, I'm seriously considering becoming a private detective. We were able to get hold of people at the airport; we just did everything. A million false leads, a million lies, a million discussions on the phone in order to get information. We found out just last month where he is, by tracking down Visa bills that came to the house. He had covered his tracks so well.

Right now he is in Orlando, Fla. He has an unlisted telephone number, and I have contacted the equivalent of our Bureau of Child Welfare down there. I had her warrant and her custody papers certified and recertified and sent them down. The people at the bureau told me that they can get a subpoena from the State District Attorney's office so the telephone company will have to reveal his whereabouts. They can make arrangements in terms of a pickup order.

In the meantime, it has been several weeks and I haven't heard from them. This is just one of the dead end streets we have come up against. In the meantime, Norma is being seen at Hillside, Eastern Queens. She has lost a tremendous amount of weight and she is very depressed. The landlord discovering that her husband is gone, is trying to make a deal with her, so that if she is nice to him she can pay less rent. She went to one of her husband's friends and wanted to know if he knew anything; he too propositioned her.

It has been horrendous. I don't know what is going to happen, but it certainly is an example of a case that has fallen through the cracks of the system.

Toni Ruffolo: As a social worker in the emergency room I first introduce myself to the woman and then try to make her as comfortable as possible. We like to be able to put the woman into a private room instead of having her wait in the regular waiting room, and we accompany her through just about all the phases of treatment, and that can take hours in the emergency room.

If she doesn't want to talk we don't question her. We talk about just about everything. If she does want to talk, we listen. We tell her what is available to her, we ask her whether or not she has notified the police, and if we can help do that. "What about an order of protection?" We start off that way. We encourage her to give us some feedback as to how she feels about the situation. She usually does not know anything of her rights, so we begin by telling her all the things she is entitled to. Sometimes she hears you; sometimes she doesn't.

We are very interested in finding out where she is going to go when she leaves the emergency room. If she has not asked for shelter we are interested in that, in terms of safety. If she wants followup service we explain our programs. We tell her about the advocacy part -- going to welfare, going to Family Court. For the most part she isn't in any condition to do those things on her own. We tell her that we provide the services, that someone will be with her, and that we will help in whatever arrangements she wants to make. If we really feel that she doesn't want any followup services at that time, we give her a telephone

number. We have a regular brochure, but if she feels as though it might be detected and cause her further abuse, we will just give her a phone number, which she can hide in some obscure spot. If she is not interested in anything, we ask her to write down her name and phone number for us, and we usually follow up with a call to find out how she is doing.

Lots of times she doesn't want to talk to us; lots of times she is embarrassed and doesn't want to discuss it. Other times she is a bit more responsive. That doesn't mean she is going to come in for counseling, but we receive many kinds of responses to our followup telephone calls.

Participant: If they are resistant and fearful are they still able to give out their phone numbers to you?

Toni Ruffolo: We do not just spend a half hour with the woman; we usually spend several hours with her.

Kathleen Handal: Sometimes you make patients wait around just to see that they relax more.

Participant: Very often the abuser will accompany the woman to the emergency room and refuse to leave. In other words, she can't even be examined unless he is there, so she never has a chance, at any point, to tell anyone what has happened to her. What can we do about that?

Toni Ruffolo: I think you should engage him. Instead of taking her away from him, take him away from her. Try to disarm him verbally. You could say something like, "Gosh, you must be awfully worried about her. I think she's going to be all right." That will immediately disarm him. Or, "Would you like a cup of coffee?" That is so disarming. If we suspect that he did it, we simply allude to the fact that he must be terribly concerned about her. We start out with that. We pretend as though some guy on a plane to California did it.

Depending on the time of day, you can say, "You must be tired." In other words, he suddenly becomes the patient, since she is already being taken care of. He's the one you really want to get, so what you do is say, "Can I get you a cup of coffee? Why don't we get out of here? It's so noisy." You would be surprised to see that the majority of abusers are subdued in the hospital -- they are on strange turf.

Kathleen Handal: You can also involve the physician as the last word on the privacy of the patient. The nurse or social worker can say, "It's hospital policy," or the physician can say, "You will excuse me while I examine your wife. I will be out and talk to you; I'll talk to both of you," and you show him to the door. I have -- knock on wood -- never been challenged on my authority to examine the patient. As a matter of fact, it is the physicians's prerogative to examine the patient or not. In the emergency room we see all the patients -- it is State law -- but how and in what manner we examine the patient is our prerogative.

Toni Ruffolo: I'd like to discuss reticence a bit more. Much of the reticence from an abused woman comes from the fact that she knows an outsider might have a tendency to say, "What's a nice girl like you doing in a place like this?" They've been through it. There are women who, for whatever reason, have accepted a certain kind of life pattern. The woman I discussed first gave up her children. They didn't really seem to be the biggest issue in her life. The biggest issue in her life was to go back to her husband and to stay where she was. She didn't want anything else. She was not able, at that particular point, to say, "I've had enough of this; I'm getting out" or to say, "Well, I don't know, maybe I should come in for counseling."

I made an appointment for this woman in our medical clinic, to be seen on a followup basis. She didn't keep it, and she didn't have a telephone.

Participant: You feel she had a choice and this was the choice she made? Isn't it possible that all sense of choice had been beaten out of her?

Kathleen Handal: I think it is probably the responsibility of the social worker and the physician to let her know that she does have a choice.

Toni Ruffolo: There are limitations to the program and external limitations in terms of money, the availability of shelters, etc. However, the woman herself is the one who is going to determine what you are going to be able to do for her, what she will let you do. So many of these women sit and listen and agree, and then they'll say, "Well, I'm going to think about it."

Kathleen Handal: It is not within our jurisdiction to make a woman change her life, leave, whatever. You can educate people, you can try and bring them to some level of authority in seeing things a little more objectively, but you can't be that person. It is for them; it is their decision. The worst thing is to get frustrated and angry at them, because then you will lose them totally. You have to let them know you are still there and you will care. Do not judge them.

Toni Ruffolo: Even though there is a helplessness about the woman, you must realize that, beneath it, she has the strength, etc., but it takes a long time to bring it up. One of the ways to get very quick results if the woman is receptive at all, and this also takes the focus off her, is to say to her, "You know, you've got an 8-year-old daughter who sees all of this. How do you think she feels about all this?" You can pursue that line even if it's a son. If her children are witnessing the abuse, she is probably very concerned. And by focusing on that, you take the focus off her; you apply it to something she can really relate to comfortably, the welfare of her children. That is probably more effective than trying to make her consider coming in for counseling for herself. Then she thinks of her kids as opposed to the long-term digging out of strengths.

Participant: I am Karen Andrews, a victim advocate employed by the Bronx District Attorney's office. I often get referrals from social workers who have made the woman aware for the first time that Criminal Court is now an option. We are very lucky in the Bronx in that the D.A.'s office will monitor the police response; while prosecution is not an effective answer to a battering, having the police aware and available has brought a lot of the women into our system.

Acting as victim advocates, we talk to the woman about the court system, both Family Court and Criminal Court, before she has committed herself to arrest or even a temporary Order of Protection. She can make her decision much more appropriately -- whether Family Court, Criminal Court, or no court at all -- if she feels there is someone in the justice system, as there is someone in the hospital, who is a friend.

When there's a family assault and a weapon is involved, the woman does not even necessarily have to appear as a complainant, because that is a mandated arrest now. I think most women's experience with the court system has been Family Court. We've heard all day that Family Court is totally ineffective, and while Criminal Court is not much better, if you see someone in what you think is a very dangerous situation, they are good people to call. Almost all the courts around New York City provide at least some information.

Kathleen Handal: If we think the situation is very dangerous, we do what we do in child abuse -- we automatically admit the patient. We say, "It looks good now, but I'm concerned about internal bleeding"; this is the most common "line" we use. Or, "We'd like to watch you in the hospital just in case something goes wrong. We'll help you get someone for your children," etc. We do this if we really think the situation is life threatening.

Participant: My name is Julie Morris and I'm a social worker at the Norwalk Hospital. I'm doing some inservice training in emergency room nursing. The hospital personnel say they have many suspicious cases. But they really are not sure what questions to ask, and I wish you could be fairly specific on that. Then they say, "Should I confront her? Isn't that a violation? After all, the woman came in saying she'd had an accident. What right do I have, in a sense, to say, 'You are a battered woman.'" I wish you could be more specific on that.

Kathleen Handal: As I've said, the nurse is generally the first person to be suspicious. She should alert the physician and the social worker.

Participant: How does the nurse say to this patient, "Do you want to see a social worker?"

Toni Ruffolo: She doesn't ask her, ever. The nurse who does the triage usually gets some kind of a line on what's going on. She suspects it, and so she automatically calls the social worker. You just walk in, kind of casually, and introduce yourself.

Participant: That is such a big issue in our emergency room. A patient can't see a social worker unless she or he asks for one or unless the nurse asks, "Would you like to see a social worker?" That's a real issue and I suspect not just in my hospital. Furthermore, in my hospital there are no social workers right in the E.R. We are on call.

Kathleen Handal: The social worker at L.I.J.'s E.R. is Mary Mincy, and that is her domain. She has her own room that is for her use, or any other social worker, 24 hours a day. She is really an advocate and part of the team.

Participant: I think that is great and I wish we had a system like that, but what I am saying is we don't.

Toni Ruffolo: In answer to your question about what a nurse can ask in the brief time available, I don't think there are any specifics. This goes for the social worker too. You really cannot come out and say to her, "You look like somebody beat the hell out of you." There really isn't anything. If the nurse had time, she could say to her, "Gee, who is taking care of your kids?" Or try to reconstruct the events leading to the E.R. in a very benign way. If she has the time -- if she isn't rushed, time being a luxury a social worker has that the medical staff doesn't -- she could say while taking down the history, "Gee, who is at home taking care of the kids? Is your husband at home?" Or ask funny little questions, simple, unthreatening questions about how the injury happened, while she's doing something else. That can be very disarming, and there is a good chance that the woman might come out and say something, especially if the nurse begins by asking about the kids.

Participant: Another question you can ask is: "Were you worrying about something when this happened?" That might give you an idea what was on her mind before she fell. It is very hard for some abused women to give an answer right away, to separate out immediately, but you often get clues to what really happened.

Kathleen Handal: They might slip and tell the truth.

Working With the Individual
Bernice Johnson, C.S.W.
Jennifer Baker-Fleming

Bernice Johnson: I am an Administrative Social Work Supervisor at Long Island Jewish-Hillside Medical Center, Queens Hospital Affiliation.

I am responsible for supervising social workers in the emergency room and in the ambulatory care services. I am also associated with the Psychiatric Day Hospital and inpatient services in the home care division of the general hospital. Therefore, I supervise workers who are very much involved in seeing battered women, although I do not directly work with the individuals myself.

In this workshop, I hope we all participate and share our feelings about the discussion, since I think it's very important as professionals working with battered women, who are victims of a severe crime, that we understand ourselves as well as the person we are working with. Furthermore, I think it is important for us to consider broadening our advocacy of the victim. There is need for more work in the legal system to help battered women.

Jennifer Baker-Fleming: I'd like to present a story I heard at a workshop in a Philadelphia hospital, using it as a start for discussion. I want this to be a skill-sharing session, in terms of the battered women we are working with now, the problems we are running into helping them, and the skills we've developed in providing services.

Mrs. Ann, 26 years old, was admitted for treatment of her right eye, which was injured when hit by a bottle. Written on her chart was "hit by flying bottle." When she came in again and reported that her husband had kicked her in the stomach, someone in the workshop said, "Did they write on her chart, hit by flying foot?" Mrs. Ann was referred to the social worker, who went down to see her. The social worker explained that she was confused about the information she had received on the injury. She asked the client if her husband had thrown the bottle and Mrs. Ann replied quickly, "No, the bottle was thrown by a stranger on the street." When asked if her spouse ever physically abused her, she said, "No, but I have a friend who gets hit all the time."

From that point on, the social worker universalized intervening. She explained that often a man may be gentle, kind, and loving and he would strike at a woman for no apparent reason. She explained that this would also cause normal feelings of shock and embarrassment. She concluded with a statement that "Men who abuse women are not all bad and could benefit by talking it out with trained counselors." Then she gave Mrs. Ann an information sheet, "Resources for Abused Women."

During the interview, Mrs. Ann frequently interrupted the social worker to agree or give recent examples of the abuse her friend had experienced with her husband. She thought the abuse information would

be of help to her friend, and perhaps her friend would be able to talk to her spouse. The interview was concluded and the client was discharged.

Here is a situation where the worker had one shot to try to provide something real for this woman. I'd like to share reactions to the way the social worker did this. Could she have done anything different? Should she have tried to find a way to interview more thoroughly? Should she have broken through the "friend" story?

Participant: I am a social worker at the District Council 37 Legal Services, an interdisciplinary group where social workers collaborate on case situations with attorneys.

Speaking of the vignette, I am not sure exactly what happened when that woman first sat down with the social worker. It seems to me that a person who has been battered needs to have an opportunity to engage with someone. I think to jump right into, "Who hit you with this bottle?" does not really enable the woman to feel safe, to feel that she can share information, to feel that she can even talk about the situation. When I am talking with a woman who has been abused, there is always evident a tremendous amount of shame. First off, there needs to be some kind of atmosphere set so that the person can be able to feel they can share. I don't know, from your vignette, whether this occurred.

Participant: I cover the pediatric emergency room in Downtown Brooklyn Hospital. I am not provided with a physical facility while talking to a patient. There are gunshot wounds being brought in; there are cardiac arrests being brought in.

I would like to agree with you. However, the physical reality of the kindliness and the fact that the social worker let the client be where she was at impressed me; I believe strongly that we should begin where people are at. On the other hand, I also feel that as a worker I have a right to let people know where I'm at. So, if I have suspicions, I might go along and join you, but you might know my suspicions.

Bernice Johnson: We have to be extremely sensitive to the individual who is walking in and seeking help. If we are unable to provide that and a sense of security, even in 5 minutes, we aren't doing it right.

Also, I think one of the important issues for someone who comes in as a battered person is that we can offer something to her; sometimes this is what's very hard, since we operate under such constraint. There isn't much we can offer. As individuals, we can offer ourselves. But what they also need sometimes are concrete services, something to provide them with hope.

Participant: I just wanted to make a comment. The term "social worker" is in itself degrading. When I was in the hospital a woman came to me and said she was a social worker. I could not believe that here I was, respectable me, with my own social worker. It was so degrading. The woman eventually, after a few minutes, turned out to be the

warmest and most loving individual I could have ever met. But because her first sentence was, "I'm a social worker," I cringed even more than I was cringing before. There's a song in West Side Story that says, "I have a social disease," and that's how I viewed someone saying, "I'm a social worker." I just wondered if social workers realize this.

Jennifer Baker-Fleming: To help us, how would you have liked to have been approached in terms of this person identifying herself?

Participant: I think in terms of being honest, you've got to say who you are. I would feel tricked or whatever if it was said at the end. I don't know.

Bernice Johnson: I think I understand what you're saying. So often we go in saying, "I'm a social worker." Some people don't even know what that means. We really need to go in with a different approach, and identify ourselves. "I am Miss Johnson, there are certain things I can do that would be of help to you." Then say, "I am a social worker." At least the client knows what this woman or man is going to be able to provide, and that she or he happens to be a social worker.

Jennifer Baker-Fleming: The key for me a lot of times is sharing with someone, as opposed to establishing myself primarily as the helper.

You should identify with the person in some way in terms of who you are as a person; explain to her that all women have, at some point or another, felt threatened just by virtue of being a woman, and perhaps share something of who you are and what your experiences have been. I think that's one way of establishing that sensitivity and breaking through some of the barriers.

Participant: I don't know much about what goes on in a hospital emergency room, but I think social workers who work in the interdisciplinary settings have a responsibility to train people -- the other professionals in that setting -- about what they are to do. Then a physician wouldn't say to a patient, "Go speak to Miss Jones, the social worker," but, perhaps, "Well, I have some concerns about your bruises and we have social workers on staff here who may be able to help you." The patient should be given some indication of what to expect as a result of going to talk with that social worker, so that she doesn't come in all blank and confused about why she's seeing someone. That's our responsibility, to let other professionals know how to make that referral work better.

Participant: It's a good point. The physicians themselves have so many feelings about the woman they are treating that we end up becoming their social worker. They are so overwhelmed that they say, "Go to the social worker," and then they feel relieved. You have to calm him or her down and work with the woman. We try very, very hard.

Participant: Apropos identifying with the woman as another woman, I'd like to know how a male social worker breaks through the reticence of the client as well as the sex barrier.

Participant: I work in a mental health center in Rochester, N.Y. In some of the cases I have run into, being the social worker is not the barrier -- being a man is. This is particularly true if the woman has been abused for a long period of time, or was abused as a child by her brother or a father. Then you are the immediate focus; you are the aggressor. This is something that has to be worked through first. And it has to be done quickly. I try to take a very low-keyed approach that is as nonthreatening and understanding as possible. Some of what I do is just educational talk, depending on how they came to the agency -- this is who we are, this is what we do, this is who I am, this is what I can do, and this is how I can help you, work with you. I engage on that level first. Then I take my clues and signals from her and go from there.

Typically, what you wind up with is a very instantaneous, necessary kind of transference. There has to be a hell of a lot that takes place first before the woman is going to share any of that. So, you are really talking about several meetings down the road. The trick, or problem, facing the situation is being the man in that first few minutes -- maybe the first hour. You have to separate yourself out from all the other men and all the other experiences that she had with men.

Participant: I think that's also true for any individual from one group who's working with any individual from another group. It would apply if you were a white therapist with a black patient or vice versa; the immediate feeling is that only a black therapist can understand a black patient. One way to break through that is to tell the patient you have not had the same cultural experiences -- granted -- but then no one has really experienced what a particular individual has experienced. If we project our openness to learning about that experience, so we can help them, there is no reason to pretend that we can in any large way identify with that person except through empathy. I think one's willingness to be open and honest and to learn from the person is an important way to approach it.

Participant: It sounds great, but it doesn't always feel good. That's my only comment.

Participant: It's very difficult, but it's certainly good.

Participant: As a male therapist, what I usually do is try to talk about the sex differences right up front. I'm a man and she's a woman. I try to bring it right out and lay the cards on the table; if it's too much of a barrier, then I make a referral to a woman therapist working specifically with battered women.

Participant: I also used to be a co-therapist. One of our expectations with male therapists was that we were introducing women to nonthreatening males. I do feel, however, that the women should also go to women's support groups.

Participant: I think any one-to-one therapy can be augmented by the woman experiencing this support group, primarily because it reduces her feelings of isolation. She can connect with other women who may

have been worse off than she is but who have extricated themselves from the situation, who have become self-actualized people. The sense of sharing and the bonding that happen in a battered women's support group can be extremely important.

One group I know of became a support system. When one woman decided to leave her husband, the whole group participated. They got a truck and helped the woman move out. It was a group effort, D-Day, emancipation time. It was an extremely supportive action in helping that woman retake control. Six months later, after the group had stopped meeting formally, the women were still in contact with one another.

Bernice Johnson: I work in a hospital where our intervention is really crisis intervention; unless the patient is hospitalized, we have just a one-shot experience with that patient. I would be interested in hearing from other hospital workers how they go about trying to be of some help. There isn't really time to build up a trusting relationship. You have to try to establish it as quickly as possible.

Sometimes all I can do is tell a woman who has acknowledged abuse where she can go for help. The support groups do not want a referral from the social worker; they want the woman herself to contact them. I try to call the patient when she's gone home or I write, but I haven't any authority to go further than that.

Jennifer Baker-Fleming: I have people coming back a year later with my name and number on a tattered piece of paper. I had a kid picked up at Port Authority with his mother. I didn't even remember the kid when he called me on the telephone. So, the way I feel with my own frustrations about this walk-in, walk-out kind of feeling is that I gave them what I could. It doesn't mean it's over. If they don't get the services from me that day, they'll get them some place else. Education began in that moment, and that's all that matters.

Bernice Johnson: Just informing someone that there are resources available is beneficial. Some people don't even realize that there are people to help. We ourselves must be aware of what the resources are. When we do see someone in a crisis situation, usually she tells us -- that's the cry for help. She doesn't necessarily mean to do something right away, but at least she wants to know that there is some hope out there.

Participant: Aside from the education, the contact itself may be crucial. You can sit by her and whether you just hold her hand or make sure she got the medical treatment, because of that she may make some positive association with a helping person. The next time she gets abused, she may say, "Oh, my God, I remember when I spoke to the social worker. Maybe I'll try it again."

Participant: It's interesting how universal the sense of this seed planting is; everyone who works with battered women experiences this -- that sooner or later they come back. Many are embarrassed that they wait so long, but they'll still come back.

Participant: I'm an Assistant D.A. in the Bronx and I am curious what role my office as the prosecutor's office can play in working with battered women from your perspectives. Also, do the hospital social workers ever advise the woman to take out a complaint with the local precinct and advise them that prosecution is an alternative?

Participant: They're out the next morning and go home. And when you are working with very poor people from another culture, it is very hard; they are very frightened.

Jennifer Baker-Fleming: Legislation is going to change. Right now, it's not that the criminal justice system is unresponsive; it's that there are so many restraints. Even those in the system who are most sympathetic have their hands tied a lot because of legislative restraints or what have you.

Let me tell you what's happening in Philadelphia. The shelter has a clinic that operates out of the D.A.'s office. So, when a woman gets sent to the D.A.'s office, instead of encountering some guy who asks, "When did he hit you?" and then says, "He hit you 2 days ago; that's 2 days ago too late, go home" -- which is what used to happen -- the woman gets automatically referred to the clinic. The counselors there screen her first, to find out what her options are. Then the counselors and lawyers make a recommendation to the D.A. in terms of what might be the best tack for this particular client. It may be to file a simple petition; it may be to go to the Criminal Court; it may be both.

What is happening is that the client is getting a sympathetic response from the system and the advocates are collaborating with the counselors and the client. If there is a criminal complaint filed, for instance, the clinic is there to help see the woman through the whole process -- so she is not isolated, left prosecuting her husband by herself. The clinic also provides assistance to the D.A. in terms of the case.

Participant: I've dealt with the Bronx D.A.'s office. I've tried to draw up charges and follow up, but I get very frustrated with the whole situation. I definitely have found myself being an advocate, but I wonder what else I should be doing. There was a woman who was smashed in the face with a bat; her whole jaw was fractured. I was ready to have the guy indicted. He had left the home for a while but was terrorizing the wife's kids so much in the interim that she took him back because there was going to be less violence that way. She informed me that for the time being she preferred to drop the charges. I tried to talk her into keeping them open.

Participant: The situation is frustrating, because it's hard for people to change. I just remind myself of that. But, with contact, the women may begin to make decisions, and that's the way they need to grow. It's not over.

Participant: I work in Westchester County in an abused spouse assistance program. I answer a hotline, and many times my goal is to try to get someone protection, through the Criminal Court. I find that

if you are married, you can get an Order of Protection. It seems to be very effective in some cases. What the D.A.'s office in Westchester also has is a special unit that makes contact with the abuser, if the spouse doesn't prosecute. We write a letter to the abuser, call him into the office and talk to him, let him know we're aware of the situation.

Participant: Yes, but has that proved a deterrent?

Participant: Very much so, to my knowledge, because it scares the abuser and it lets the woman off because she doesn't have to prosecute. A lot of women I work with are afraid of prosecuting or don't want the man punished for one reason or another.

An unmarried woman doesn't have the option of going to Family Court, so the Criminal Court, in terms of the judicial system, is all an unmarried woman has. I find that calling through letters and calling the abuser in is really helpful. I don't know if the D.A.'s office can do it.

Participant: That would be having contact with the potential defendant and I would see that as a conflict of interest. I am not sure that is quite kosher. But I have also had the experience of arguing for a violation as opposed to actually adjourning the case in contemplation of dismissal, because there's a little more weight to that. You get a permanent Order of Protection issued for the woman and a week later the guy has threatened to kill her again.

So, here you've got the Criminal Court sanction against him; the judge has yelled at him; and he is back on the street. Where do you go from there?

If it's a misdemeanor complaint, which would mean harassment, simple assault, or assault in the third degree, which is bruising and shoving, the maximum time an abuser can get for that in jail is only a year. He's not going to get a year.

Participant: I see the double bind of a woman, when she's in a position to prosecute her husband and to have him arrested. She suffers guilt feelings and she's under a terrible fear anyway. I don't even think prosecution is the answer. Let's say the guy does go to jail -- well, he's is going to get out sometime and she'll have to live with that fear. Perhaps a program like that used with drunk drivers could be initiated. Take away the abuser's driver's license and make him attend a program -- he can't get the license back unless he joins the program. This sounds very coercive, but such a mandatory program might work.

Participant: Judges can do that now. They can mandate programs.

Participant: We are working toward a program of that nature. I work with a crisis unit; I'm a registered nurse. The crisis unit is strictly a psychiatrically oriented place. The battered women we see are very ambivalent about the issue of prosecution. We started a program whereby the batterees and the batterers come in together, if they so

desire, and then we talk this over with them. We sign them to a contract whereby they come in two or three times a week, instead of having the wife stay in a shelter. If they agree to the contract, we try to work out something with them instead of having the court or the police involved. It's working out fairly well with us.

Participant: As an Assistant D.A., I do want to say that, from my experience in the criminal justice system, I don't think it is the one providing the answers. It's possible that with a great deal of hard work and with some legislative changes, the criminal justice system will provide advocates and some battered women with some tools. However, the answers obviously do not lie in the criminal justice system alone. In conjunction with enforced social services programs or whatever method will work, the system can apply the clamp and force. But the women will not really get relief from the criminal justice system alone, which is what they sometimes believe.

There's another issue that needs to be remembered -- racism. A lot of advocates for women are making "lock them up" laws concerning abusers. Well, who's going to get locked up? Let's be realistic. What white middle-class professional man in the suburbs who is beating his wife is going to go to jail? Whenever we want legislative changes or increased power of police, we should bear the racism in mind.

Participant: What legal protection is there for the unmarried? One of my difficulties is that the majority of battered women I see are in common-law relationships with their boyfriend or the father of their children.

Participant: If you are not married, you are not entitled to an Order of Protection. If you are married and divorced, under the criminal law now, you are entitled to an Order of Protection; all that is is a piece of paper that sets down certain conditions. If the batterer violates those conditions, he must be arrested for violating the Order of Protection. That's all it does.

If the two parties have a child together in the household and remain in the same household together, the child is entitled to an Order of Protection against the parents; again, conditions can be set. For the unmarried, here's some advice. Say the victim has an action in the Criminal Court for harassment or assault or anything that is a crime. She can prosecute the man concerning those crimes, but I would photocopy the complaint and/or give her a docket number and say to her, "You can tell the police precinct that you've got an active Criminal Court case." If the defendant bothers the woman while the case is open, he can be arrested for tampering with the witness.

If an unmarried woman wants to take action, she has to go to her local precinct. The problem is: if the offense is a violation, the precinct will not make an arrest, since the violation did not occur in their presence. For instance, if the guy yells at her or threatens her over the phone, that's aggravated harassment. Unless that aggravated harassment is done in the presence of the police officer, he cannot

make an arrest. He will refer the woman to 346 Broadway in New York, to take out a summons, and that's a very frustrating procedure.

If there's been assault, a misdemeanor crime, the police can make an arrest at that point. However, that's far down on their priority list unless the injuries are very severe. You don't have an assault unless there's serious physical injury. A broken nose may not even be considered serious physical injury under the law.

Participant: I think it's important to see the potential of the judicial system in effecting change, and helping. For instance, a couple of days ago a Family Court judge ordered a man to go to a therapist three times a week and he mandated that the report be sent back to him. If the man missed any of those sessions, it would be a violation of the order and he would be arrested and put into jail. This is obviously a judge who felt very strongly. The new law that makes it possible to mandate conditions is very helpful, and I think it should be used.

Participant: I think something has to be done so that it will be made easier for these women to get what they need from the legal and other systems. At this moment in New York City, you have to be welfare eligible in order to go to a shelter. I think that's a little idiotic.

Participant: There's a new Public Assistance provision, I believe, that a woman who has been battered can now qualify for emergency assistance.

Bernice Johnson: We have to remember the ambivalence, which is a very important dynamic. I am not saying that going to Family or Criminal Court shouldn't be done or that we shouldn't attempt to move in that direction for whatever kind of relief is necessary, but often we go ahead and get a temporary order of protection, temporary child support, and a week later we get a call that the woman is back with her husband.

I'm not saying that we should not have those supports available. But I think the primary concern at first is whether the woman has somewhere to go where she feels safe. We ought to start with that first rather than, "Do you want to take your husband to court ?" It's a very frightening situation. The woman really doesn't know what she wants to do at that point. I think your agencies might prepare a packet of information that would include the legal remedies available as well as places for counseling or advice, and the names of shelters.

Participant: I work with municipal employees and there are no shelters for them; they can't go and get emergency assistance for battered women because they're workers. They cannot go to the Human Resources Administration. There's nothing out there for them,but I think that the first step, really, is to establish a safe place.

Participant: What I finally came up with, after going back and forth between resource development and emotional support, is that we can have all the resources in the world but if the woman isn't emotionally ready to avail herself of them, they are useless. On the other hand,

if she is ready and we don't have the resources, that's useless also. We need to put equal energy in both spheres.

Participant: There is another reason for resistance to seeing the legal system as a place that's supportive, and I think we haven't addressed it.

I work with a predominantly black population who are suspicious of the court system. It doesn't talk a language that they understand. They feel that when they do go, it doesn't meet their needs and there's a real hostility to using it.

I've been seeing a woman for 4 years weekly, which is very unusual in a poor area. She came to me last Friday. She's pregnant from a man she's put out of the house. He pulled a shotgun on her and she threw a bottle through the window; he broke the door down the next day while the detectives were in the house. She's 6 months' pregnant. I thought she'd have that in her favor when she went before the judge. This man has a history of stabbing his wife, three children, and another woman. He'd been convicted for those attacks.

The woman was told to be ready for court the next Friday; the detectives said they'd pick her up and take her home and indicated that the man would be put away for a long time. He was out before the night was through. She received in the mail a piece of paper that said if the man comes within two blocks of her she should call the police and he will be picked up and arrested. She told me it was a piece of shit and I agreed with her.

The resistance isn't due to fear; it's due to the fact that the system just doesn't work. It's not a reality measure. He pulled a shotgun on her in a Brooklyn street.

Bernice Johnson: Part of the problem is that there are so many wife beaters throughout the criminal justice system itself. Not just police--we know they are notorious. The other day a probation officer who was overseeing the probation of a police officer was arrested for beating his wife. Who knows how many judges are doing it?

So, as I've said, at best all the criminal justice system can do for us is perhaps provide us with a tool that may be used in some cases. That's all we're ever going to get out of it.

Participant: Yet there are a tremendous number of women going to the police precincts demanding that someone be arrested. They turn there first because that's where they hope to get some kind of help; what needs to be established are more working relationships between the criminal justice system and those that provide social services. The women file a complaint because they want the abuse to stop. They don't necessarily want to put their husbands in jail. They don't know where else to go. But, ultimately, the social services, not the courts, enable a woman to get herself out of the situation.

Jennifer Baker-Fleming: Furthermore, ultimately the woman herself is the determinant. She is the determinant as to whether or not she is a victim, except in those cases of total complete crazies -- guys who follow you to the end of the earth. In any other situation, however, the woman is going to be the one to determine; she may use the criminal justice system and she may use social services; she may use her family. Whatever she uses, our job is to get her to start moving in a positive direction. We may use the criminal justice system and we may not. The most important part is getting her to the point where she stops seeing herself as a victim, and when she stops seeing herself as a victim, she will stop being a victim, usually.

Participant: I'd like to comment on the real emotional difficulties of trying to make that process happen.

I work in a mental health clinic in Queens. It is private, nonprofit, which means we exist on medicaid and private fees. The orientation of the clinic is specifically toward psychiatric problems. I see, in my dealings with my clients, the problem of the battered woman. I have found no support within the clinic to recognize that as a problem and I find myself completely lost in many areas. One, I am frightened by my clients' terror, so I am immobilized in terms of guiding them. I don't know the parameters of guiding them. I have been making waves about this at the clinic, but they sit on me pretty much.

Bernice Johnson: That is a problem with many clinics that are analytically oriented. When our clients would like some long-term work, we often have no place to send them. Many places don't want to see it and they say it quite clearly: "We don't take people like that."

Participant: For the last 2 years, my organization has been operating under a Law Enforcement Assistance Administration grant training mental health professionals in traditional agencies, mental health agencies that are nonprofit, city agencies, and centers. We have been able to make real inroads in terms of providing workers at traditional agencies with a more accurate analysis of wife abuse and a more accurate understanding of the victim and the skills to counsel the victim.

We identify individuals within these agencies who want us to come in and train the workers, and what they do is advocate within their agency to bring us to train. I think that this is going to be more useful now that Reagan is in and the funding is going to stop. The advocates aren't going to be around that much longer, and the battered women will have to go to these agencies. It may be a good idea to start really pressuring them to have these training workshops.

Participant: As I said, my clinic doesn't recognize the problem. It doesn't exist. We don't have it -- we have masochists, depressives, whatever you like. We don't have battered women, period.

Participant: I am the administrator of the kind of agency you're talking about, on a smaller scale. Denial of the issue isn't our problem. Our problem is that we are getting referrals faster than we can deal with them, and there really isn't anyone on staff who has the particular

kind of knowledge and expertise to work with this kind of situation. The problem is: where will these training counselors come from?

Participant: There's a technical assistance center here, in New York City. They will, I'm sure, facilitate this kind of training if you get in touch with them. If they can't do something, they'll find a way to do something.

Participant: Even before that, a person has to make an individual choice as a therapist. I work in a mental health center. To want, or not, to work with a particular population is an issue. Battered women are a different population. I can't work with children with leukemia, for instance; it's that kind of thing.

Participant: That sounds like something I've heard before from other mental health professionals. What you are talking about is agency resistance.

Participant: I just want to say one thing about mental health clinics. They go where the money is, and as long as the battered women are not on their American Psychiatric Association lists of disorders, they are not going to look at it. This has a lot to do with what issues are being funded and where they get their medicaid moneys for them.

Bernice Johnson: I would like to sum up what I feel has happened here.

I think it's clear that we must be aware of the need for work with the battered woman.

There is an educational process that we all must involve ourselves in at our individual agencies.

We have to look at ourselves, our own attitudes, and develop a sensitivity to the needs of these particular people. We are constrained by various things -- funds, agency policy, what have you. But we ourselves are committed enough. We have to find our own individual ways of getting the needed programs into our agencies, so that services are provided for these people.

A foremost issue, which is associated with the others, is that we must be advocates. We cannot just sit back and do individual direct services. We must be advocates concerning all the needs. We know that housing is needed. We know that legislation needs to be changed. We know that part of the court system is not as helpful as it could be for this particular problem. We need to be advocates on all levels.

Women's Support Groups

Rosemary Allwood, C.S.W.
Melanie Brown, C.S.W.

Rosemary Allwood: I am Project Director at the Family Abuse Center, Nassau County. Melanie Brown works in a settlement house, where women can go and live. Our support groups in Nassau are run for women who are not in a shelter.

I believe that before we can even consider setting up a support group, we have to examine our own theoretical framework. Most of us, if we've been social workers, gotten a degree in psychology, or worked in a mental health setting or hospital, have a medical-psychoanalytic perspective. If this is your perspective, you will have to reexamine it before setting up a group. When I started in this work, only a year ago, I went into it from a traditional private practice, and I had to reexamine my own theoretical framework, since the psychoanalytic approach did not work. You too will have to continually examine who you are, what your own attitudes are, and how those attitudes affect your work with abused women, because, believe me, they will have an effect.

Let us look at the two models -- the psychoanalytic model and the support group model, as we like to call it. Psychoanalytic groups deal with the unconscious, the exploration of personal relationships and how one's own personality dynamics affect one's behavior. Now, when a woman is in a crisis and she is battered, there is no time for that exploration. Even if deepseated problems should happen to be evident, this is not the time to examine causative factors. She is being beaten. She needs a place to go; she needs money; she needs concrete things, means of action; she may have kids and need to get them out of the situation too -- all of which do not involve personality dynamics.

In a support group, the group process involves a dual focus. First, the group becomes informational, instructional. Second, it becomes an ego-building, self-actualization process, where she is enabled to develop her own decisionmaking process. With both focuses acting, we hope that the woman will begin to see herself as being powerful rather than powerless.

How do you go about setting up such a group? The first process is the selection of a group facilitator. The approach that we found best was selecting two, not one, for very practical reasons. First of all, if that one group facilitator was sick and couldn't be there, the group couldn't meet. Second, should a woman in the group need a service right then, that day, there would be someone available to go through that process with her or teach her how to go through that process.

Who should the group facilitators be? We feel they should be women. Why should there be women in support groups particularly? Would anyone like to speak to that?

Participant: Just a personal feeling about that -- if these women have been instructed and directed and informed by men all their lives, it is about time they started realizing what power women have among themselves as a group, sharing among themselves, giving support to one another.

Rosemary Allwood: Yes, that is one of the major reasons. Another is that when women first come into the group, there is usually fear and ambivalence; we try to lessen the fear, at least by having them see a woman facilitator, not a man.

There are many other reasons, of course, that the group facilitators should be women. And they should have certain personal qualities and qualifications. They should be women who are flexible, who have a sense of their own individual identities, and are aware of what their own attitudes are. They should have a knowledge of not only group skills but also the resources women need in that situation. This does not necessarily mean that the group facilitator knows exactly what every resource is, but she should know how to go about getting them. She should be knowledgeable about very concrete issues -- legal rights, the Department of Social Services system, and what victims of domestic violence are entitled to. She should be knowledgeable about how to assess a woman's safe home possibility -- whether it be a friend, relative, or whatever. She should be knowledgeable about all those things. And, again, she should be really flexible. You cannot walk into a group with a planned format, saying, "Today we are going to do assertiveness training, rights, and roles." You have to first find out what the women's attitudes are and what they want to deal with. Also it is important to assess whether or not a group member is in imminent danger. And you cannot just walk in simply because you have been trained to run a group. We have seen that happen, and it does not work. You have to be willing to arm yourself with resources, information, and educational tools.

Who is going to be in this group? Should the women just walk in or should they be screened first? We believe that screening, as a second process, has to take place. The initial screening is really done by the group facilitators.

The group facilitator should be available to have, at least, a 10-minute talk with the woman to introduce themselves, to get a feel for each other, to make an assessment as to whether or not this victim could benefit from a group. The prospective group member should be an active participant in this assessment decision process.

What do you rule out? We rule out only three things -- psychosis, drugs, or alcohol addiction. That is all we rule out. As a matter of fact, we firmly believe that being in a support group is probably one of the best avenues for a woman who is very depressed, who really is pretty dysfunctional, who really cannot give her name so she uses an assumed name or no name in the beginning. That is okay.

The screening then is to rule out three problem areas that cannot be dealt with in that group. It is to introduce the new group member

and the group facilitator. If that member cannot be hooked into the group immediately, then that facilitator should have ongoing contact with her until she can come into a group. This is important, since this is the first time these women have reached out for help. They are saying, "I don't want this any more; something has got to stop. I want this battering stopped." We recently had a woman in the agency who is 79 years old. She has been battered for 54 years. She came to our agency with the police bringing her, thank goodness, in a wheelchair. That was her first time to reach out for help. So, meet her. If she cannot go into a group, at least she knows that you are there and it is not a one-shot deal with a revolving door.

The third area to consider is the time factor for the length of the group. Our agency is mandated as a crisis center. As a crisis center we must be available for calls 24 hours a day, 7 days a week. A woman must be able to walk in from anywhere and say, "I need to see someone." Our mandate as a crisis center states that we offer direct services, but we can see the person only up to 10 to 12 weeks, whether in individual counseling or a group, for delivery of concrete services. Then we must refer her to a mental health agency if long-term treatment is indicated. That is the mandate; many agencies have such policies. That is one of the ways agencies get set up, but what we have found is it just does not always work. A woman has been in a battering situation for 10, 12, 15 years. In 10 to 12 weeks she really has not had enough of an opportunity to solve a lot on her own, to decide which direction she is going to go in, or even to learn the system out there. So, we have found we need to be flexible and, when indicated, group participation can continue for more than 12 weeks.

We have a heterogeneous mixture in our groups. We have women in the same group who are separated, who are divorced, who are currently living with the abuser, who are in safe homes.

In the screening process it is very important that your positive attitude come through and that you be flexible in your approach. There are a lot of battered women who go back and forth. They try out the group counseling process to see how they feel about it. They need to know that it is okay if they go back to their abuser mates. They need to know that you are not going to throw them out of the group, you are not going to think less of them, you are not going to think they are stupid, you are not going to think all those things they already feel.

Major concerns can be incorporated easily into a flexible theoretical framework. For instance, a woman who has to confront Family Court or Criminal Court needs to know what that process is going to be like. You might have an exercise with her, through role playing with the group observing, that would teach her what it means to go to Family Court, what she can expect, what different judges might be like, what the intake process is like. You can go through the entire process with her and teach her what her rights and options are, what she can expect from the police or not expect from the police, etc. Sometimes you can teach her what the Public Assistance process looks and feels like, and we do that -- we have applications, and we sit down and do that interview, go over all the necessary documents.

At the same time you are doing that very concrete experience with her, which becomes a learning experience for the entire group,you also begin to build her ego strengths. Do not forget these women have survived the situation from which they have come. They are strong. We often hear people say they are powerless and helpless. They do feel helpless, they do feel powerless, they do feel guilty, but do not forget that they have a great deal of strength or they wouldn't have survived; they would never come to us, or to any of you.

Through these methods you can educate the woman as well as build her ego strength so that she begins to feel she can master that system out there and become independent, in control of her own life. It is exciting to see people in the group comparing those experiences of Family Court, D.S.S., and her own growth process. They are comparing and acknowledging their own mastery, they own feelings. They are saying to a newcomer, "I have been through it," which allows that person to see that the action is not so frightening. There is support.

The group members happen to be the strongest support for one another. We begin to help them, but they begin to see the isolation they have lived through,and the group brings them out of that,gives support.

We have a woman in one of our groups who has been separated. She is in the process of divorce. She has been separated for about a year and she is still going through the court process, but she has been through, "What am I going to do? How am I going to reorganize? How am I going to pay the bills?" She has been through that,and the women in the group learn that extra experience.

Participant: A woman says, "Sure I was scared stiff and I'm still scared, but I'm going to do it anyway." That is what is really important -- to share that with the other women.

Rosemary Allwood: I think it is very important that we, as workers, be able to share something with the group members. We have been through some of our own life experiences. The group needs to know who we are, as part of the therapeutic process, not just that we work at the Family Abuse Center. If that is something you are not comfortable doing, then maybe you ought to think about it and try to work it out so that you are comfortable doing that. You get a lot of mileage. A lot of comfort develops within that group when the group facilitator becomes a real person and not an ambiguous figure. You have to be a very active facilitator. You cannot be nondirect.

Participant: That is why the traditional mode will not work, since the group needs to feel support and they need to feel you are a person, not just someone sitting there smacking her head.

Rosemary Allwood: Or dealing with the unconscious. Going back to why the psychoanalytical approach does not work -- within that psychoanalytical group there are no resources brought into the group; there are no immediate actions taken during that time or right after the group; some other agency does that, some other person.

We do, however, have individual therapy. As a matter of fact, there are many women who need something very special, one to one, who ask for that. We try to have the woman who is interested in individual counseling see one of the co-facilitators of her group for individual counseling, so that, again, there is a connection.

Participant: I come from psychoanalytical training. I have worked with support groups, not necessarily only psychoanalytical groups, but I find some difficulty in my role as a group leader or participant. Do you become a participant when you start sharing your own experience? Where is the balance?

Rosemary Allwood: Let me answer with an example. One of the subjects that always comes up in every group is parenting -- parenting skills and the frustrations of being a parent, particularly in a relationship where there is battering.

A woman is talking with you about how she cannot manage the children. It really helps a lot when you can say to that woman, as I do with mothers I see in my private practice, "I have been through that too." I am now trying to undo my own tendency to be overnurturing. When the women hear that you too make mistakes and have to reexamine what you have done, they do not feel so terrible, because you are trained. You are supposed to have all the answers if you are trained; you do not make mistakes if you are trained. You are perfect -- and we are not perfect. They need to hear you sharing yourself.

What happens is that you are using yourself to become the role model, because you have shared a process of having to work something out. Your facilitator role remains intact, because you are educating them through helping them examine this process and you are also helping them to develop and obtain the goals they have stated, even in regard to parenting skills.

Always remember that the goals must be stated by the group, not by us as leaders. They can decide where they want to go. We may have input, of course, because we know the legal rights and resource options, but they have their own ideas. Through this selected sharing process, they relax a little bit and do not feel so negligent, because they were often told that they were negligent as wives, mothers, lovers. Someone tells them they are negligent and they begin to believe it.

Obviously, the group is not a place for you to come and dump. There are also limits as to how much you share, because you are not there to take up the whole meeting time, nor to indiscriminately share. You are there to use your own experiences to help them see that all women have gone through similar experiences.

Participant: What you say about flexibility is very, very important. I work in a crisis center that has a shelter over it, so we have an opportunity to combine our shelter residents with what we call out-of-house residents.

We have several ongoing groups, and I have experimented with a lot of approaches. The combination of the shelter women and those already out in the world provides the shelter women with a support. They tend to then stay connected with the agency and stay in the group.

When the group develops a certain core, with cohesive members, which might be six or seven people, we then close the group and that becomes an ongoing group. I have one that is 2 years old. They deal with issues that come up, and they still relate them to the battering.

Rosemary Allwood: We are just opening up our shelter in December and we want to do the same thing, have women who have been living in the shelter in the group with women who are not in the shelter.

In terms of our agency, we do not close the group for some very practical reasons. We do not have enough staff to start new groups and women cannot wait around while you find the money to hire and train new facilitators. So, we have to keep those groups open. We have tried to close groups, and it did not work. We had too many women on the waiting list.

Participant: I felt it was an advantage to have the group ongoing, and composed of "in-house" people and people from the outside. One of the advantages is that it reveals the "process." One woman turns to the other and says, "It's okay, honey, I was there 5 years ago." I like the open-ended cohesiveness.

Rosemary Allwood: Before any new member goes into one of our groups, the group members have to say okay. Before I walk in to observe, they have to say okay. We find that group members really welcome new members into the group; they immediately take them under their wings.

Let me briefly go over the issues of working with groups. And I cannot emphasize enough that you must acquaint yourself with the whole networking system out there in the community.

You must acquaint yourself with, if you do not know them already, the legal rights of women, because it is not that some of the laws aren't there; they are not being practiced or the women do not know about them. It is your responsibility to take yourself through that legal process, see what it looks like at court. It is your responsibility to know what the Domestic Violence Emergency Act is all about and who is eligible for it.

It is your responsibility as a group facilitator to have some idea about a safe home networking system, which is what we have and are expanding on, because a shelter will not hold that many women. We have to have that as an alternative. Of course, not all women want to go into a shelter, nor should they, but they need a temporary residence to gather themselves together and make some decisions. So, you really need to have some notion of your resources.

Look at all the various needs women do have -- parenting skills, assertiveness training, and concrete resources. Equip yourself with

different models of treatment. I am using the word treatment in a very generalized sense. It's one thing to be a psychoanalytical group therapist and quite another thing to know about values, clarification skills, assertiveness, training skills, personal rights, and role skills. You need to be familiar with these issues because you are also going to be a teacher in that group.

Melanie Brown: I am the Project Coordinator at the Henry Street Shelter for Battered Women.

I would like to take this opportunity to share with you a very specific model of social group work intervention with battered women -- the problem-solving, task-centered approach. In some respects, I'll have to agree with the earlier comments that the psychoanalytical approach to treatment is not an effective approach to treatment with battered women.

What I hope to provide you with in the paper I'm about to read are some concrete examples and suggestions as to what you can try to incorporate in your practice so that you will be able to run a more effective group with battered women. I am not saying that the approach I am suggesting is going to be the answer to battering -- I think it would be foolish to say that -- but I am very pleased to share some of the successes that occurred in my groups.

While various methods of intervention have been employed in addressing the needs of abused women, a rather new phenomenon has been the development of a temporary housing shelter.

Shelters and safe homes are places where women and their children seek refuge from a batterer and/or life-threatening situation. A woman's safety is our primary concern. Consequently, the family's whereabouts are kept confidential. The length of stay can last anywhere from approximately 3 days to 7 months, sometimes longer.

Battered women arrive at the shelter in a state of crisis. Usually a woman's decision to leave is precipitated by a serious assault of life-threatening dimensions. At the moment she decided to leave the house, she did not really want to leave for good; the fear of making it on her own is huge. Her primary concern is for quick and immediate safety and relief from the battering.

Generally, there is a high degree of anxiety or depression and shock. Many women are afraid and feel helpless, and yet in a short period of time, maybe a week or a month, the woman is expected to mobilize herself enough to make a decision whether to return to the batterer or start a new life without him.

This crisis period can be a difficult one for the women and their children. It can also be an opportunity for growth in a supportive environment. Corrective problem solving can take place while the woman is also being offered a chance to explore options and make choices about her immediate future.

The short-term task group is an effective method of intervention in the shelter setting, although I'd like to add that it can also be a highly effective method in working with support groups, not necessarily developed in a shelter.

I am going to illustrate how this approach was developed with battered women at the Henry Street Shelter. I have been a resident social worker at the shelter for the last 5 years. I have an apartment there, and I live with the battered women and other homeless welfare families. The work I'm describing came from my experience in working with and leading groups there over the last 3 years.

The rationale behind the task-centered approach is that decision making is a major dilemma facing battered women. In a temporary housing shelter they must make the ultimate decision, as I mentioned before, of whether to establish a life without the batterer or to return to him. The process of decision making is further complicated by the brief length of the stay and the wide range of conflicting feelings women experience in adjusting to shelter life. Some of these feelings may include ambivalence, loss, fear, anger, guilt, and relief.

You must provide a viable means to facilitate the decision-making process, and here is where that task-centered approach, done through intervention with short-term groups, becomes effective. This approach affords women the opportunity to develop skills for survival and instills in them the feeling of having more control over their lives. Once the woman has been engaged in this process, it will help her begin to make constructive decisions and move out of the limbo state. The shelter time is in a real sense "limbo": the woman there must go somewhere else, either back to the batterer or away, to live on her own. So, we have to look at her in that respect, let her make the choice in a designated time span.

Within this limbo state of the shelter exists also the broader continuum of the woman's life, where she feels closer or farther away from the batterer. Those who are emotionally closer to the man often fluctuate in their choices about their immediate future. They spend time in the shelter thinking. At any rate, the limbo and continuum exist together, and they must be recognized.

I would also like to say that we, as practitioners, have a lot of myths about battered women that we really need to examine. I personally feel from my own experience and my own values that the battered women would feel more comfortable with a female practitioner, but I also have to say that a lot of women would prefer to have a male counselor.

We did have a male social worker student who ran a clinic. We have had battered women who have engaged in short-term counseling with the female social worker at our shelter and who later sought therapy at the Community Mental Health Center, specifically requesting a male counselor. In some of these cases there has been growth, and an important part of that is the fact that the woman had a chance to relate to a man in a positive fashion.

The task-centered approach, designed by Rita Epstein, is applicable in an individual or group context. It has several distinguishing characteristics. One, it is brief, time-limited. Two, its intervention is concentrated on alleviating specific problems, which clients and facilitators contract to work on. Three, work on the client's problems is organized around tasks or problem-solving actions the client gets to carry out.

I'd like to describe the application of the task-centered approach to a group. The five basic steps taken are as follows: (1) the preliminary interview; (2) group composition; (3) group formation; (4) group processes for task accomplishment; and (5) termination. Some of these steps were utilized straight from the case work model, and others were modified in the attempt to achieve the group purpose.

A short-term group was offered to battered women at Henry Street who resided in our shelter for not more than 6 weeks. The purpose of the group was twofold: (1) to provide a situation where women could begin to identify and solve some of their immediate problems and (2) through the process of mutual aid to have an opportunity to explore alternatives to violence, by making decisions about their immediate futures.

Membership in a group was voluntary. A group was formed of up to eight members and then closed to new members after the third meeting, unless the group decided otherwise. Closing the group was done to promote cohesion among members and reduce attrition.

The group met for 8 weeks, for a total of eight 1 1/2 hour sessions. There was an assessment of the experience at the end of 8 weeks. Members then had the option of terminating the group or continuing it for a predetermined number of sessions.

Prior to a group meeting, the members are interviewed individually, and responses that indicate severe anxiety or any other adverse reaction are discussed and dealt with. This is a must. Also prior to the group sessions is orientation concerning the problems of task formulation in the group. These groups are problem oriented, and that aspect must be made clear.

Drawing primarily on my experience living with battered women and secondly as a practitioner, I have found it important to be sensitive to the potential candidates' concern about some of the following issues, some of which have really surprised me.

First, there is often anxiety about belonging to a group with the resident worker. The clients know themselves. Imagine how scary it might be knowing your social worker lives next door to you and you decide to go out and get drunk one night. No one else in the group knows you are an alcoholic. Can you go to that group meeting? It is also possible that fear of the batterer may prevent the woman from attending the group. I think it's important for clients to discuss their feelings about entering a group situation.

I'd like to share some misconceptions and myths that have developed around battered women. First, a lot of us think there is a stigma to being identified as a battered woman. There is a misconception that treatment will press the women into divorcing their husbands or severing all ties with their mates. There is a misconception that going back to the batterer is failure, even a violation of agency policy.

It is important to see how the battered woman views herself. There are some women, for instance, who came to the shelter but did not feel they were battered enough to belong to a group. We tend to feel that because a woman is in the shelter she has accepted her status. That is not necessarily true for her.

In my experience in the shelter I have also found that some women were husband batterers; what happened eventually is that the husbands started beating them back and really crucified them. They were ashamed to get help, because they did not want us to penalize them; they felt we'd say, "You are the kind of battered woman that has made it difficult for other battered woman to get help, so we can't help you." I still think they need to be helped, but I am saying that we have to be very careful not to get caught in developing our own myths and stigmatizing the battered woman.

We also have to realize that many women view joining a group as traumatic. That anxiety must be alleviated, and the members allowed to explore problems. We emphasize the fact that a group should be seen as an opportunity for members to talk about similar and different difficulties they might be experiencing in adjusting to the shelter. In the group the women can share ideas, figure out ways to help one another, and resolve some of their difficulties while making choices about their future. This is basically what I try to convey about a group when I am trying to recruit women for one.

I have also indicated that a group needn't be all seriousness; the members can have fun and plan activities they want. A lot of times we forget play; the battered woman also wants to have fun and good times, and I think that because we are concerned with helping we get caught up in a rescue syndrome. This intensifies the anxiety of the battered women, I think.

The following are examples of efforts to engage members during the preliminary interviews. The first involves a 24-year-old woman with three children. She was extremely ambivalent about living in the shelter, and it worried her that she had not told her children the reason she had left their father. I asked her how she felt about discussing her problems in the group. She responded that she was shy and wanted to know if she had to talk in the group right away. I assured her that no one was forced to talk, that she could speak when she felt comfortable.

On the night of the first group meeting I noticed her lingering outside the meeting room looking quite tense. I told her the meeting would begin in a few moments and asked her how was she feeling about beginning. She responded, "Nervous," and further explained her feelings. She was standing outside to see who went into the meeting, because she

was afraid she'd see a lot of women with black eyes and big, swollen heads. She asked me if everyone was scarred. I told her that no one with visible bruises usually wanted to attend. She appeared to relax somewhat and began laughing as we walked into the meeting room together. She later shared this fear with the other members, who, in turn, discussed similar and different fears they each had about one another.

This story brings out another myth practitioners have -- that battered women find comfort in being with one another, because it cuts through the isolation. Most battered women do find comfort in numbers, but I think what we have to do is be sensitive and tune in to the scary feelings we might label resistance. We have to see how these feelings might interfere with involvement in the group.

It was evident that this woman's fears would have served as an obstacle to her attending had they not been dealt with prior to her first group attendance. It is important to know that at the first meeting she was able to discuss her problem about telling her children that they were on a "vacation" from the father. The group members were sensitive and supportive in helping her explore ways of being honest with her children.

The first one or two meetings of a group often involve preaffiliation, a stage characterized by the individual's desire to become involved in and make use of the group and yet avoid and maintain distance. When you find battered women staying away, it looks like resistance. That is a normal part of the process, so expect it and don't feel as though you've failed before you start. The third session usually goes into issues of stigma, trust, confidentiality, and commitment. Once the members began to discuss some of these issues, they were able to begin sharing some of their problems with one another. I make it clear early that I will not share the personal problems of group members I see for individual counseling in the group itself. I tell them that it is up to them to share their concerns with others. Sometimes members need help in telling their problems. In these situations other members encourage and assist them.

Concerning the priorities of the meetings, it is important, as Rosemary Allwood said, to keep that issue flexible, so you aren't saying, "Today we are going to talk about assertiveness training; tomorrow you are going to talk about your feelings," etc. I ask members to help one another check the target problems they want to work on. Housing, of course, is a commonly shared concern.

How do members tell one another about their problems, and what does the helping process look like? How do you know when you are working, how do you know when you are using the problem-solving approach? What does it look like?

By the fourth group session, member meetings were no longer held in the shelter office, but in the apartment of each member on a rotating basis. The informal, cozy atmosphere of the apartments instilled a stronger sense of comfort and privacy. It also instilled independent feelings of control. It was therapeutic for members who were never

allowed to act as hostesses or entertain company at home when they were with their husbands. The members got confidence from one another and from the leader -- and the interaction in the shelter itself after the meetings is indicative of this improvement. Important problems were identified early. The shelter setting also helped the group members have the opportunity to lend support to others and to help them achieve tasks between meetings.

During this stage of the meetings, each member identified and explored her own problems and was helped to define them. Targets were identified and worked on according to the goals of most of the group. Where similarities and problems occurred, I pointed them out -- one way of putting some order to problem resolution. The group was able to negotiate purposes for a few meetings, although flexibility was always permitted, allowing discussion to respond to the spontaneous needs of the group.

I would like to end by describing how the problem-solving process takes place. There are various problems most of these women face: interpersonal conflict; intersocial relations; problems with formal organizations; difficulty in role performance; problems of social transition and reactive emotional distress; and, last, inadequate resources. Once the problems were specified, the leader engaged the members in helping one another to set goals and to accomplish tasks within an agreed upon time. This step is group process for task accomplishment. The applicability of this process is demonstrated in the examples I will give about the problem of inadequate resources.

Money management was a problem for all group members. For those who had been involved in household management before entering the shelter, it was less difficult than for those who had not. Some women in the group expressed feelings of not wanting to return to the batterer but felt they could not explore the problem. Narrowing the focus resulted in members particularizing the problem of setting goals and tasks to alleviate financial strain and improve money management.

Members discovered that much of their money was being spent to replace clothing that was left in the home when they fled. Several women wanted to reclaim valuable clothing and toys that remained with the batterer. One woman, who had difficulty in asserting herself, had given up reclaiming boxes of clothing left at a former shelter -- a worker there had broken promises to send them to her. With the encouragement from the group she decided to make a serious effort to get them back.

The process of setting specific tasks, accomplishing objectives to achieve an end, was made. Tasks and goals were changed if necessary. Other members who had been successful in reclaiming their clothes were helpful. The member who had claimed she had no problems accepted advice from other members about retrieving her belongings. Some of the tasks set for women to reclaim their belongings involved the following: calling someone trusted to find out if the husband still occupied the apartment; if possible, finding out about the condition of their belongings, because some men destroyed them; if fearful for personal safety, calling

a friend or the local precinct police and also making child care arrangements.

Summarizing the outcome of these tasks: S.C. and D. learned that their husbands had destroyed their belongings. A new set of tasks was set that would enable them to reach a new goal, that being to acquire a clothing grant from the Welfare Department. I.M. and I.V. went together to the former's apartment, with the police, to reclaim the belongings. A.A., who had been communicating with her husband all along, admitted that during the early years of the marriage she had been the batterer, that she used to hit her husband; she claimed he had a bad temper and a tongue like a lash. During a role-playing situation, A.A. acted very much like the victim in the manner in which she demanded her clothing back from her husband. Group members helped her to be assertive, less threatened in her approach. This was done, of course, after they helped her ventilate her feelings of rage toward herself. M.P., who was waiting to receive her box of clothes from the shelter, was coached on how to assert herself in a more effective manner. Finally she gathered the courage to call the worker's supervisor. All of M.P.'s clothes were sent to her soon after this call was made.

From these examples, it seems clear that role playing and behavioral theories were instrumental processes for testing out tasks in a safe and supportive environment.

Much praise was given by the leader upon successful completion of tasks. Struggles were encountered along the way, and the members were always responsive in helping one another resolve them.

I would like to close now, giving some conclusions and recommendations, based on the task-centered approach to treatment we use at the Henry Street Shelter.

Battered women in the shelter are responsive to the therapeutic process when interventions are supported and goals and tasks seem obtainable. The self-esteem of abused women will be enhanced through successful accomplishments of tasks. There will be an increased feeling of independence and greater control over their own actions and lives.

Women who have developed destructive coping patterns with violence will gain insight into some of the sources of those patterns and the detrimental consequences. Groups can be used as substitute dependencies if the environment is responsive, accepting, and cohesive.

The task-centered approach is an effective method to use in dealing with battered women, but practitioners must be careful not to be judgmental and deny women the option they have chosen even if it means returning to the batterer.

Alcoholism and Spouse Abuse

Phillip E. Jacobs, C.S.W., Ph.D.
Pearl Levine, C.S.W.

Philip Jacobs: I am Dr. Jacobs, responsible for the Substance Abuse Treatment Branch at the Long Island Jewish-Hillside Medical Center.

The paper I am going to read is entitled: "Alcoholism and Spouse Abuse: The Need for a Coordinated Approach." Until recently, wife beating and child beating were not considered as social problems but, rather, were seen as the prerogative of the male head of the household. The term "rule of thumb" is derived from a common law ruling that a man could beat his wife with a stick as long as the stick was no greater in diameter than his thumb. In medieval times children were regularly beaten, starved, drowned, and physically assaulted in other ways for minor infractions. Society sanctioned corporal punishment as a right, and indeed a responsibility, of parents.

The Civil Rights movement, the women's movement, and the general trend toward the safeguarding of civil liberties have contributed to a redefinition of the use of violence in family settings.

During the 1960's Dr. Henry Kempe coined the term "battered child" to refer to children who were physically abused by their parents to the point of requiring medical intervention. Federal and State offices of Protective Service were reorganized to provide persons with complaints of child abuse with quick and easy access to an official representative. Legislation was passed that protected persons reporting instances of child abuse and/or neglect from criminal prosecution in the event that these charges proved to be groundless.

The decade of the 1970's witnessed a similar evolving process with regard to wife beating and spouse abuse. Increasingly frequent reports of serious physical mistreatment of spouses have led professionals in the field to confront the inescapable conclusion that spouse abuse, similar to child abuse, represents a serious health and safety problem and needs to be addressed professionally within a treatment context. In increasing numbers, professionals are criticizing the current criminal justice system, which frequently treats wife beating as a "family matter" and is reluctant to prosecute criminally any instances of wife beating unless there is imminent peril to life.

Although many Americans would probably have difficulty with recent legislation passed in Sweden that outlaws spanking and all other forms of corporal punishment between parents and children, surely there has been a sea of change in American attitudes concerning the use of violence toward children and spouses. Since the postwar years, there has been a shift of attitude in this whole area, from one where it was considered to be a private family concern to one where the physical abuse of children and/or spouses is perceived as a sign of serious emotional distress

requiring criminal justice attention and/or psychological-psychosocial assistance.

In the field of alcoholism and treatment, one observes a similar development. As recently as a hundred years ago, alcoholism was seen as a moral vice resulting from spiritual weakness rather than as a specific disease entity. Jellinek revolutionized the concept of alcoholism by presenting alcoholism as a disease with definable and predictable stages, which leave its victims incapacitated. The disease model of alcoholism separates the issue of blame and treatment so that the person suffering from alcoholism is seen as someone suffering from a chronic disease, such as diabetes, and is held no more accountable for his aberrant reaction to alcohol than a diabetic is held accountable for his aberrant reaction to sugar. The alcoholic, of course, continues to be held responsible for the behavior leading to the ingestion of alcohol, but this is no different in many ways from holding persons responsible for the deliberate or negligent exposure to other types of disease-causing situations, such as a diabetic consuming high-sugar food, an obese person eating highly fattening foods, and so forth.

Many stereotypes, though distorted and inaccurate in many regards, possess a kernel of truth. The popular notion of the alcoholic person beating his or her spouse and children in a drunken rage, a person beset by financial difficulties with a chaotic family organization and shallow and superficial emotional life is, in fact, seen by many of us working in the alcoholism treatment field. Therefore, it is desirable, as society redefines spouse abuse and alcoholism as medical problems, that we treat these problems as part of an intertwined constellation frequently presented by the same personal family. Unfortunately, there has been, and continues to be, as G. Spieker has noted, an inappropriate split of professional approaches to spouse abuse, child abuse, and alcoholism treatment. Now that our consciousness has been raised to see spouse abuse and child abuse as serious and social problems, we need to integrate and coordinate treatment of alcoholic families so that these extremely important aspects of dysfunctioning are addressed in a planned, effective way together with alcoholism.

In terms of the scope of the problem, the amount of spouse abuse and family violence is staggering. There are probably 1.7 million spouse assaults occurring in the United States per year. The U.S. Department of Justice estimated that 25 percent of all homicides are intrafamilial and that half of these homicides involve the killing of a spouse. The image of street crime homicide is more amenable to scapegoating and righteous indignation, but it is very clear that many persons who are murdered are murdered by their spouse or someone in their family constellation.

It has been estimated that there are more than 6 million incidents of severe physical abuse occurring in families each year, with husbands almost as frequently the victim of physical abuse as wives or children.

I want to speak to the issue of interplay between alcohol abuse and family violence. Dr. Henry Kempe suggests that alcoholism is involved in one-third of all child abuse cases. The American Humane Association

has indicated that alcohol dependency is involved in 17 percent of families with child abuse. Unfortunately, the fields of family violence and alcoholism lack sufficient data to draw clear, strong conclusions concerning alcohol's effect on violence. At this time, contradictory evidence abounds, and studies vary widely as to the types of controls used, the quality of research methodology employed, and the type of violence studied. The conclusions, naturally, also vary.

Steele and Pollack, in 1968, conducted a psychiatric study of parents who abuse infants and small children and concluded that alcoholism was not involved in the child abuse they saw. Scott, in a 1974 report on battered wives, presented the concept of a "battering family," and he noted that wife beaters are also frequently battering fathers. Furthermore, these men are frequently beaten by their own children and sometimes by their wives. Since 25 percent of all homicides are intrafamilial and half of these killings are spouse killings, the study of homicide and alcohol use is of direct relevance to persons interested in studying the interaction of alcoholism and spouse abuse. Herganic and Meyer studied 214 homicides in St. Louis and reported that in 40 percent of the cases, the victims of homicide had 0.1 milligram or more of alcohol in their blood at the time of death. Those who murdered were observed to have alcohol in their bloodstream at the time of the crime in 50 percent of the cases. While research into the relationship between homicide and alcohol ingestion has frequently focused on persons killing others under the influence of alcohol, I find it interesting and unusual to note that this St. Louis study and others have shown a high percent of alcohol present in the bodies of the victims as well as the persons who committed the crimes. The authors hypothesize that many victim-precipitated homicides would have been prevented if the victims had not been drinking at the time of murder. The authors also discovered that in more than two-thirds of what they classified as victim-precipitated homicides, the victims were drinking at the time of death. For example: A homicide victim may become intoxicated in a tavern and enter into a brawl or dispute with a person he or she would avoid if sober. Intoxicated spouses may persist in harassing and haranguing their partners beyond the person's breaking point. Gelles studied homicide in western Scotland and found that 42 percent of the victims of male murders and 30 percent of the victims of female murders were drinking at the time of death. In an old study in Philadelphia, Marvin Wolfgang found that 53 percent of the victims were drinking prior to their death.

Because of the existence of the "battering family," and because many child abusers were abused as children themselves, and frequently physically abused as a spouse, research conducted by Mayer and Black into the link between alcoholism and child abuse is of interest to us as we consider spouse abuse and alcoholism. They found that the emotional climate in many families in which a parent is an alcoholic or has an alcohol problem is one of personal conflict and situational crisis. They concluded that parenting behavior is frequently disrupted by the alcoholic parent's violent verbal and physical abuse of a child or the other parent, by incest due to lessened inhibition caused by drinking, and by inconsistencies such as promises that are forgotten or the ignoring of children during drinking spells. Mayer and Black indicated that a wide spectrum of physical, psychological, social, and economic stress

in alcoholic families is associated with child abuse and, by inference, spouse abuse. They reported that the situational factors associated with child abuse and neglect -- such as a parental history of abuse and neglect, stressful life circumstances, including poverty, chronic physical illness, unemployment and social isolation -- are also situational factors present as a result of alcoholism. Young, in his work on child abuse and neglect, in which he studied 300 families, found that drinking was a primary problem in 62 percent of the families, and heavy drinking was present, but not the primary problem, in additional families.

However, support for the conclusion that alcoholism does not necessarily cause spouse abuse is provided in a Richard Gelles study of physical aggression between husbands and wives. He concluded that alcohol abuse is a "disavowal technique" used by abusive husbands. By that, he means these husbands know they will be held less accountable for their violent acts if they are committed under the influence of alcohol, so they are more likely to beat their wives when they are drunk than when they are not drunk. I want to allude to three recent public examples of the disavowal technique that we have seen at the clinic and in the press. One is Billy Carter, who disavowed some of his antics by saying he was an alcoholic; another is Representative John Jenrette in the ABSCAM case, who claimed he took the money because he was too drunk to know better -- a disavowal; a third is Representative Jon Baumann from Maryland, one of the staunchest conservative right-wing family supporters, who allegedly sodomized an adolescent boy and claimed he did this because of an alcohol problem.

Dr. Ruth Sanchez-Dirks, who was the special assistant to the director of the National Institute on Alcohol Abuse and Alcoholism, recently reviewed the existing literature on alcoholism and domestic violence. This was done in a 1979 issue of Alcohol, Health and Research World, a special issue on family violence and alcoholism. She made three points in this publication concerning these two areas. First, there is a repetitive cycle of both alcoholism and violence from generation to generation. Second, spouses and children are equally likely to be victims of family violence. Third, there are similar personality characteristics in attackers, alcohol abusers, and the children of alcoholics.

This third point is echoed in a study by Spinetta and Rigler. They also found similar psychological characteristics in people who commit family violence, in alcoholics, and in children of alcoholics. They noted the following characteristics of the different groups: They saw child abusers as having low frustration tolerance, low self-esteem, impulsivity, dependency, immaturity, severe depression, problems with role reversals, difficulty in experiencing pleasure, and a lack of understanding of the needs and abilities of infants and children. Children of alcoholics were noted in this study as having poor self-concept, being easily frustrated, having a poor school performance, and being more likely to suffer from adjustment problems and to have problems with role reversals. Alcoholics they found as having a poor self-image, being dependent, depressed, angry, impulsive, frustrated, and immature.

Looking at the similarity of these personal attributes in conjunction with Mayer and Black's similarity of situational stresses, it becomes

clear that we are dealing with the same constellation of problems produced by the same people in different ways when we deal with child abuse, spouse abuse, and alcoholism.

As for treatment, I think the most important issue when considering alcoholism and spouse abuse is the need to bring together the many disparate elements of our treatment system so we can develop a clear, coherent, coordinated approach to these two problem areas,which I believe to be different aspects of the same constellation. Just as a discussion continues in the area of alcoholism and spouse abuse as to which is cause and which is effect, different models of alcoholism are presented with different implications for the understanding of alcoholism and spouse abuse.

The disease model, which was originally developed by Jellinek and is strongly supported by the National Council on Alcoholics and Alcoholics Anonymous, presents alcoholism as a chronic, progressive disease. According to this view, alcoholics are persons who are "allergic to alcohol" and who will inevitably proceed from their first drink to a life of drunken perfidy and debauchery including, but not limited to, unemployment, emotional instability, divorce, violence, and various other forms of self-abasement. Persons adhering to this view see alcohol as the root of all evil and contend that alcohol programs should be primarily interested in helping the alcoholic to achieve sobriety. This disease model, I believe, says that alcoholism is a cause rather than an effect, and once a person attains sobriety many problems thought to be psychiatric in nature will be seen as mere symptoms of alcoholism instead.

Another way of looking at alcoholism is to see it within a family dynamic approach, as defined by Kaufmann and Kaufmann in their recently published book, Family Therapy of Drug and Alcohol Abuse, which drew heavily on family therapy theorists such as Minuchin, Papp, and others to support the idea of alcoholism as a response to a complex set of family interaction variables. According to this perspective, family members, including spouses and children, frequently have a strong investment in keeping the alcoholic disabled and intoxicated; alcoholism is focused on as a coping mechanism, a symptom rather than a cause of dyfunctional family relationships.

A third perspective, related but somewhat different, can be formulated on the relationship between alcoholism and spouse abuse. This model represents spouse abuse and alcoholism as opposite sides of the same coin. Stong evidence exists, even at this preliminary stage of research on the issue, that those persons presenting for alcoholism at alcoholism treatment centers are far more likely than others to suffer from spouse abuse and child abuse, and that those persons presenting to women's shelters and child protective agencies are far more likely than the average person to suffer from the problems of family alcoholism.

What appears to be needed, regardless of the conceptual model utilized, is a concerted effort to treat alcoholism and family violence within the context of overwhelmed family systems, which are unable to cope with the various pressures put on them. Our clinical observation has been that the lines between spouse abuse, child abuse, and alcoholism

are often blurred. What emerges for us as clinicians is not so much a clear case of alcoholism or family violence, but rather a pattern of overwhelming inability to cope, social isolation, and overall borderline functioning. In our practice we see alcoholism and family violence as resulting from the family structure under assault. Persons we see in treatment typically have suffered severe emotional and sometimes physical deprivation as infants and children; they have extreme difficulty in forming object relationships, frequently suffer severe thought disorders, and overall tend to function in a borderline fashion. At the Family Consultation Center we have set the goal of helping these people to cope in a more appropriate, satisfactory way so that abatement of family violence and alcoholism and improvement of overall functioning will be experienced.

I want to conclude by citing some guidelines for future action, which appeared in the article I mentioned earlier, called "Reflections on Family Violence"; it was published in the fall of 1979 in Alcohol, Health and Research World and is available from the National Institute on Alcohol Abuse and Alcoholism. The recommendations were as follows:

1. At present, alcoholism workers generally lack the training to identify and deal with family violence within families they are counseling. Additional training needs to be undertaken to develop this capacity among alcohol workers.

2. Health professionals, protective service agencies, and criminal justice personnel generally do not possess the skills necessary to identify, treat on an interim basis, and refer persons with alcohol problems. Training programs should be developed to train these personnel in the treatment of alcoholism.

3. Additional research should be done to augment the scant data on the relationship between alcoholism and family violence.

4. Since children with alcoholic parents and children with parents who are child abusers have a greater potential for becoming alcoholics, child abusers, or spouse abusers themselves, treatment and prevention programs that specifically try to break this vicious cycle need to be implemented.

5. Since alcoholic attackers are just as likely to attack children as spouses, treatment and protective personnel need to consider families in which only one person has been threatened or attacked as a family in which any member is highly vulnerable to physical attack.

6. Finally, because it is difficult for one agency alone to provide all the programs needed for persons with alcohol problems and families with significant violence problems, formal and informal cooperative agreements between programs need to be developed and put into practical effect, so the treatment will be done in a coordinated, coherent fashion.

Pearl Levine: I am going to present a case from our agency that I feel is typical of the interrelationship between alcoholism and violence. This is a summary of the treatment of a family of five which has been in our agency on and off since May of 1979. When we do an intake at our agency we use an S.C.L. 90 Questionnaire, which provides us with a psychological profile. Families whose lives are filled with alcoholism and violence present a very chaotic lifestyle. Their treatment pattern also reveals the same chaotic trends. Because of this, there is a tremendous need for flexibility on the part of the therapist, and it is essential that the therapist be aware that traditional forms of treatment are not effective.

As I present this case as it developed at our agency I'll share with you the many complexities and frustrations of working with such a family. Ellen Gross is the primary therapist in this case. Judith Leff also worked on the case with one of the adolescent daughters.

I am going to list some issues I feel are of critical importance in dealing with these families.

1. There is the need for the therapist to have flexibility and a noncritical approach.

2. It is vitally important to have a team approach, to use psychiatric components, to have staff members working together and sharing.

3. There is a need for sensitivity, for awareness of countertransferential issues. In addition, it is very important for the worker to be able to talk to someone else about the feelings that have come up when working with such a family, because there is a need to separate what feelings are your own and what feelings a patient is evoking in you that would be evoked in anyone he or she would deal with; it is a relief to be able to speak to someone else who is understanding of these feelings that come up.

4. Through our experience we found the telephone is very important -- so that the patient knows you can be reached, and that he or she can be reached. We use a lot of telephone contact.

5. There is a need for realization by the therapist that there is going to be frequent regression, that a lot of things are going to happen which you will not know about until much later on. Since there is a great deal of hiding and concealing, again, the noncritical approach is crucial -- the patient needs to be able to bring the issues in and not be criticized.

6. There is a need for concern, and also noninvolvement when that is relevant.

7. All of our cases have alcohol-related problems. We have an a nine-part alcohol education series at our agency, in which we discuss alcoholism from a variety of perspectives, including

the medical and the psychological aspects, and we have Alanon and Alcoholics Anonymous speakers. We have found that the series provides a great way of breaking through the denial of alcoholism.

8. There is also a need to reach out to all family members. You start with one person, be available, and try and get anyone else in who's willing to come in. Two major clinical issues are the strong ambivalence regarding treatment and the inability to resolve conflicts. These issues will come up again and again and again. Patience is the motto -- be there for your clients.

Apropos the family in question, treatment began on May 28, 1979. The intake started with the father. He is a 39-year-old white divorced male, who, on intake, stated he had been residing with his mother for the last 6 months. He had asked his mother and aunt for help, and his aunt had contacted Long Island Jewish. He was then referred to our agency.

He is above average height, extremely well built, and somewhat overweight; he gave the appearance of a very, very powerful man.

He was rather anxious during the initial interview. He stated that he began drinking alcohol when he was 19 years old. His drinking increased rapidly, and by the time he was 21 he had been arrested for robbery while intoxicated; he claimed he used a toy gun in the robbery and that he was in a blackout at the time. He was sent to Sing Sing Prison for 3 1/2 years. He has continued to drink excessively and has been having blackouts since he first began drinking at the age of 19.

He stated that he first sought help for his drinking problem 2 1/2 years prior to the intake. He said he was unable to maintain any sobriety after discharge from a detoxification unit. He again was hospitalized for detoxification a year prior to the intake and claimed that he stayed sober for 6 weeks after that.

On intake he had been sober for 4 days; he said he had been drinking excessively 20 of the prior 30 days. He drank beer and hard liquor.

He admitted to many blackouts, difficulty in sleeping, drinking in the morning, missing meals, frequent fighting and quarreling, feeling sick, and often losing control of his drinking. He admitted being fearful of continued drinking. He shared concern about his violent, abusive behavior while in a blackout. He stated that he had been living with a woman and her three children for the past 10 years and although they were not at that time living together, they continued to have a relationship.

On intake he stated that he was terrified of his continued abuse toward her. He had been unable to maintain employment in construction and his unemployment benefits had just stopped. His mother was supporting him.

He is the older of two children, having a brother 3 years younger. His parents were divorced when he was 4 years old and since that time he had no contact with his father. He claimed he knew nothing about his father.

His mother worked to support the family, and his maternal grandparents raised him in the South Bronx. He described the neighborhood as being "bad" and his mother as a "fantastic person."

He stated also that he had dropped out of school in the ninth grade. He married at the age of 19, in 1961, while in a blackout. Two years after marrying he was incarcerated at Sing Sing for 3 1/2 years. He is the father of three children from that marriage, ages 16, 10, and 8.

He was divorced after 10 years of marriage and claimed to have had no contact with that family for the past 5 years. He had been ordered to support his children through the courts and stated that he did not know the whereabouts of his family.

He admitted that he was violent during his first marriage and that his wife had to obtain an order of protection because of his behavior while drinking. He admitted to being in jail for 30 days because of violating that order.

He stated that prior to his divorce he started dating a woman who was separated from her husband. After his divorce in 1971, he moved into her apartment with her three children and remained in a common-law relationship with her until 6 months ago, when he left due to his violence toward her. He claims that he loves her and wants to marry her.

The second time he was seen at the agency, we had him attend the education series. He started coming to individual sessions, maintaining sobriety, and we did a lot of didactic things -- education, pushing A.A., etc. We had him seen psychiatrically. We got more information about him at this time, and there is conflicting information throughout the entire case regarding dates, the history of alcoholism, etc., much of the discrepancy coming from the facts given to the psychiatrist and those previously given during intake.

To the psychiatrist he said he had been drinking heavily only for the past 7 years. He claimed he had been having blackouts only for the past 5, while earlier he had admitted having blackouts since the age of 19. He denied any involvement with drug abuse.

As for additional information, his mother had never remarried nor had any ongoing relationship with a man since her divorce. His mother is 55 years old, in good health, and she continues to work.

He denied any alcoholism in his family. He stated that he works in construction, but has also held other jobs. His brother lives in Florida and is a sergeant in the police force. He stated that his relationship with his brother was very satisfactory.

At this time he gave additional information about his incarcerations. When he was released from Sing Sing and on parole, he got another assault charge, which led to another jail term for 6 months. He claimed that his relationship with his wife had been very poor then, but that he had remained living with her because of the parole.

He talked about his relationship with his common-law wife, saying that he thought the relationship was satisfactory to him. He admitted becoming violent when drinking at home but that he tended to be more destructive to objects than to persons.

The client, a big man, is quiet spoken and somewhat depressed in mood. He is not suicidal at this time, although approximately 1 month ago he did make a suicidal gesture by cutting his wrists with a knife at a time when he was drinking. This incident appeared to stem from depression. After his common-law wife left him, he continued to become bored, perhaps depressed when he was not working, and this appears to have been a contributing factor to his drinking.

The affect of this man is in general subdued and constricted. No thinking disorder is present; he is correctly oriented in all spheres; he shows no memory impairment. The diagnosis was severe alcoholic addiction.

He continued to come to individual sessions and the education series. We encouraged him to bring his common-law wife into the education series as a way of getting her into treatment. About a month later she did come to the education series, bruised. The person doing the education series reached out to her and she was encouraged to come in for treatment.

There were cancellations; he was seen in a group with other alcoholics and also in individual treatment at the same time. He went to a couple of A.A. meetings. There was a lot of denial. He started drinking again, claiming he could control his drinking.

On August 14, the common-law wife came in for an intake. She is a tall, attractive platinum blonde Italian woman, age 36, the mother of three children, 12 to 15. She appeared depressed and was tearful, especially regarding her father's death.

She stated that since the time her common-law husband first came to our agency 3 months ago, he'd returned. She exhibited some difficulty in putting incidents in sequence. She denied drug use and stated she was a social drinker. She complained of being anxious and depressed. She was asking for help in dealing with the effects of her husband (she called him her husband) when he was drinking on herself and her children. She also complained of tension headaches. She stated she had suffered from tension headaches since she was age 15. She presently is experiencing the headaches every other day. She indicated anxiety and depression when she found she was unable to cope with her husband's drinking. She was fearful of physical and verbal abuse, but indicated she would not consider obtaining an Order of Protection, since if her common-law husband was sent to jail she could not bear to be the cause of his returning there. She stated she was concerned about the effect

of alcoholism and anxiety on the children, and she indicated that she found herself screaming at them -- something she claims she does not do at the present time.

She also indicated great disappointment about her husband's inability to maintain sobriety. She had been in treatment a couple of times in the past, once because of her husband's drinking. She went for a few weeks and left treatment because she felt no one could help her.

In 1973, she went to an Alanon meeting and he stopped drinking for a week. She thought everything was okay. She stopped going to Alanon meetings and he started drinking again. She attempted suicide at that time, taking a bottle of Fiorinal, and was taken to Jacobi Hospital, where she stayed for 1 day. She saw a psychiatrist for 3 or 4 weeks following the suicide attempt.

As for her background, she was born and raised in the Bronx, the youngest child, having one brother and two sisters. She said she had a good relationship with her brother until she was 10, when "he started to boss me around." She had not spoken to her brother in about 18 years.

She stated that she had a good relationship with her mother and talked to her when she needed her. She claimed that her father was an old-fashioned Italian who was strict, and she could never relate to him. He died at the age of 74 of a heart attack following a prostate operation. She stated that she was in shock following his death and still has not gotten over it; she does not remember the funeral except that it was very cold out. She said that if he had not died life would not have changed for her. Her mother resides with a brother in Maryland. She stated that she had never been crazy about school and that she left one credit short of getting her diploma. She started to work after high school as a secretary-receptionist, and was married at the age of 19.

Her first husband was a chronic alcoholic; she claimed he had no sense of responsibility and she had to work. On intake she had been separated from her husband for 10 years and was waiting for the divorce to be finalized. Her first husband is the father of the three children.

On August 17, we got the three children in, and Ellen Gross saw them in family treatment. Prior to that, the mother had appeared again with a bruised face. The session with the children revolved around rage at their mother, at her passive attitude toward allowing physical and verbal abuse to continue.

Alanon and Alateen were encouraged, as was ongoing therapy. Meanwhile, the father was not coming in for treatment. The family came in for several sessions, and then the children dropped out of treatment. The mother stayed in treatment sporadically, attending a women's group and being seen individually on an as-needed basis by the group leader.

In March 1980, at a group session, the mother indicated that her daughter and common-law husband had left on Saturday night and had not returned for 2 days; she talked about getting an Order of Protection. It was explored with her in the group and in an individual session after

the group in terms of exactly what had gone on. The mother had not asked any questions. She did not know where the two had gone or what had occurred. She was terrified of finding answers that were unacceptable to her.

At the next group session the group members confronted her, and with Ellen's support they encouraged her to question what had happened. She was frightened and expressed a lot of fear of her husband's violence; there was some discussion about Protective Services being involved at that point, if anything inappropriate was going on. At that point, she mentioned that her husband had, when he was intoxicated, said something about having had intercourse. He denied it later on when he was sober. In a session with Ellen Gross the woman was encouraged to question the daughter about the incident, which she did. She reported that the daughter admitted that intercourse had occurred. She came back for a session and was told that the Protective Services would have to get involved. The group supported her, and members offered to go with her to Family Court. We told her that at that point either she had to report the incident herself or we would do it. We encouraged her to do it herself, to report in Family Court, which she did on the following Monday, and Protective Services became involved.

Phillip Jacobs: So he had beaten the mother, possibly had intercourse with the daughter, and then you worked with her to keep him out of the house?

Pearl Levine: To go for an Order of Protection, to keep him out of the house. Protective Services immediately got involved. The judge spoke to the mother and the daughter. The daughter on the first court appearance could not respond and only cried. She is 15 years old.

In the interim the couple married. That is a very important point. In December they married with the fantasy that if she married him she would cure him. As for the status of the family in treatment, the mother is continuing to be treated. Judy Leff saw the daughter, who denied having intercourse with the father, admitting only that there was some caressing. There was a second incident where he took the daughter to a motel for 2 days, and what really happened we don't know.

As a point of technicality, Family Court cannot get involved unless there is a legal family relationship. An Order of Protection can only be given if in fact the couple is legally married. And this couple was at that point. If the couple isn't married, you have to go to Summons Court or Criminal Court to get an Order of Protection.

The husband was ordered out of the house by the judge. At that time the wife signed a release so that we could communicate with Protective Services. She subsequently retracted those releases and we have not been able to communicate with Protective Services. At this point there is a Protective Services investigation and at the last hearing in court the Probation Department was also ordered to do an investigation. This is in Nassau County. There have been many, many postponements for a variety of reasons: The attorney was ill; once the father made a suicide attempt and was hospitalized at Long Island Jewish-Hillside

Medical Center in a psychiatric unit. For a period of time he was at a detoxifcation unit. The most recent postponement occurred because the wife got a new job and could not take off from work. The next court appearance is scheduled for January.

Phillip Jacobs: What is striking to me about this case is that, as I tried to indicate in the paper, it is a concentration of problems that seem to interact on many different levels -- the beating of the wife, the sexual abuse of the children, the alcoholism of the husband -- and what it seems we are really dealing with are extremely fragile people who have very tenuous family relationships. We are unable to get from the family what their basic emotional needs are.

Pearl Levine: As you can see, treatment has proceeded slowly from May 1979 until the present time. This family has broken 12 appointments and canceled 17. We have provided 8 family, 34 group, 14 individual, and 14 psychiatric sessions. The mother is the only member being seen at present.

When the case is heard in court it can be anticipated that Protective Services will request that the entire family be mandated into treatment.

By the way, we have established lines of communication with the unit that is involved -- the Protective Services Unit -- so we know how they are working and when there are signed releases, we conference the case as frequently as necessary.

Participant: I don't understand why there were so many therapists with such a chaotic family, which already has so many problems in their relationships.

Phillip Jacobs: There was one therapist, Ellen Gross. There is a psychiatrist and someone else for the daughter, since we felt it important that the mother and the daughter both have someone they can trust. The daughter was saying one thing and the mother was saying another. The mother was covering up for the father, who was beating her. There was so much fragmentation already, because this was such a chaotic family situation.

Pearl Levine: One of the things you need to understand is what it would be like for an adolescent to talk in front of her sister and brother, who did not know what had occurred.

Participant: Then can one therapist ever be used as a bridge in this kind of a situation if the kids trust that one therapist?

Phillip Jacobs: Not the same person who is seeing the mother, because I think there would always be concern on the mother and daughter's part that what they told the therapist could get back to the other person.

Pearl Levine: There are different approaches and we made a decision.

Participant: It seems that the thrust of this case is alcoholism, and I am curious about what happened to the abusiveness that was occurring, excluding the sexual abuse. If one believes that alcoholism may be a symptom of a pathological interaction, does one treat the symptom, alcoholism, or does one treat the underlying dynamics--that is, the violence?

Pearl Levine: The mother was the person who had suffered from the violence. The history we got was of extreme violence prior to her entry into treatment. There were two more incidents after she started in treatment. In our experience, we have seen with families in which there is alcoholism that once the person who has been abused is in treatment there seems to be a tremendous reduction in the amount of violence. Whether that is because she/he is using the therapist's ego or because there is a sense of an authority figure involved who will intervene in some way is not clear, but we see a shift, a change in frequency and intensity of the abuse.

Phillip Jacobs: I would like to comment on the sexual abuse of the child. As far as I'm concerned, the sexual abuse is part of the violence to the wife. I see it as the same; I don't see any distinction. I see it as part of the way this man copes with the stress he feels and the problems he has relating to his family and as part of prior psychological and emotional problems that he brings to the situation.

This is a good case example because it is very frustrating and it is not completely tied up successfully with a bow at the end of it. However, it is a process, and I think you have heard enough about alcoholism treatment and spouse abuse treatment to know there is not always a happy ending. Frequently, the people involved remain in the process. This guy would not come into treatment. Maybe the way you should deal with it is to help the person achieve sobriety and then try to approach some of the underlying dynamics of the violence. But he refused to come for treatment. He continued to drink and beat his wife. Then you try to get the wife in for treatment, get her to stand up and follow through on the Order of Protection, move out or separate from the guy. But she remains there in a kind of sado-masochistic relationship with this guy and does not have the strength to remove herself from it or kick him out. That is where I see the effects of alcoholism and both person's problems with the violence.

Pearl Levine: She is still coming to the group and individual treatment, and even though she has not been able to leave, she still wants something.

Participant: How is she better off now than before if the father, the husband, decided not to continue his own treatment?

Phillip Jacobs: I don't know. And he may have stopped coming because his wife was.

Pearl Levine: The intake on the wife was on August 14. Earlier, he broke two appointments and on July 26 he denied his alcoholism. He was drinking.

Participant: Why was she coming for treatment?

Ellen Gross: To help her deal more effectively with what is happening with her children, to be able to cope with her husband's drinking, to find inner strength, to decrease the anxiety and the depression, and to generally help her function at a higher level. She is aware she cannot do that without help.

Phillip Jacobs: She is miserable. This guy is beating her up. He's having intercourse with the daughter; he's running around on her with other women. She has an imminent problem to cope with.

Participant: Is there ever any possibility in that kind of situation to pick one particular focus, so that maybe some minor success could be achieved, some small goal to help the family get organized or set some kind of boundaries? I was thinking about a chaotic family I work with. I cannot say there was any success other than that after 6 months I finally achieved the goal of having the two teenaged children put in separate bedrooms when there had been an extra bedroom all along.

Ellen Gross: There were goals achieved within the treatment goals as stated. For instance, we encouraged the woman to call Protective Services so she could obtain a sense of being able to protect her own children. That she was able to do and she followed through. She was able to go to court and file an Order of Protection to get him out of the house and also to protect her children. It was through the children that I worked because she was not able to see herself as important enough for protection. The children she could see as significant within her role as mother. The very act of working this through helped her increase her feelings of self-worth.

Participant: So you had some success with her?

Ellen Gross: She had a lot of success; she reported that she was better off than when she first came for treatment.

Phillip Jacobs: One of the problems is emotional, in that she has not been able to free herself in the sense of forming a new relationship with someone else. She is tied down to this guy. She doesn't kick him out when he comes around. She lets him in the house. We feel he's going to be abusive again and we are fearful for the children; yet she doesn't have the strength to assert herself and to disengage from this guy.

Participant: I would not recommend, with her history, looking for another relationship, if that is the goal anyone has.

Pearl Levine: We are not recommending anything.

Phillip Jacobs: One of the problems is social isolation. She is totally isolated; she doesn't belong to any church, she doesn't belong to any group where she lives. She doesn't know anyone where she lives. All she knows is to go to work and try to deal with her kids. There is

no involvement with human beings in a positive way other than what she has with this guy.

Participant: In terms of the Order of Protection, can it be stipulated that the man must not only leave the house but also enter into an alcohol program?

Participant: Anything can be stipulated. In reality, the paper is as good as the person who has it. There is no sanction if he does not go into an alcoholic program, because there is no one to check to see whether or not he's in that program. The Family Court Order of Protection is for 30 days. It is not valid if he goes back into the home and the woman permits it even with the Order of Protection. It is her option. She can bury that Order of Protection. So that piece of paper is as valid as the person who holds it.

Pearl Levine: The goal of Protective Services and Probation in Nassau County is to get this entire family mandated into treatment.

Phillip Jacobs: He cannot be prosecuted in Criminal Court.

Participant: He can be prosecuted for harassment.

Phillip Jacobs: She will not go through with that.

Participant: Harassment, trespassing -- he's not supposed to be in that home.

Pearl Levine: In relation to the husband, unless he admits he has a problem, there is nothing you can do. You cannot make him go to an in-patient program or lock him up if he does not see he has a problem. Up to this point, he has been hospitalized three times. During one hospitalization he called our agency and made an appointment to come in for treatment; then he didn't show. I am hopeful that this will come to pass at some time in the future. The fact that he did call means that something went on that was significant, so you have to be patient. This is a typical case, and if you are expecting the situation to change rapidly you are going to be in for a tremendous disappointment.

Participant: After he came in, he stopped coming in part when the agency, with some good thought behind it, invited and tried to get the woman to come in as well. I think that is dynamic.

Pearl Levine: I think the significant point here is that this is the third attempt at treatment within 3 years and that the situation is really the same. One of the factors you have to value or give weight to is: What are the chances of this guy staying in treatment, and do you reach out and work with anybody who is willing to come in? It was our decision to work with anyone.

Participant: As an in-patient worker, I have picked up a lot of cases like this, and I am really impressed with the way you stuck with this because I would be giving up.

Ellen Gross: One of the important points that should be mentioned is that you have to be very aware of your own reaction to dealing with such families. There is a great need for consistency within the treatment.

Participant: I think having maybe two therapists involved in a family matter is something that would help in some ways.

Ellen Gross: I think it would be too overwhelming for one therapist to deal with the mother and daughter and possibly the father at the same time. I wouldn't want to do that. Also, for someone like this, if she'd gone to a shelter for abused women, it would have been a fantastic way of proceeding, possibly successful. But when you talk about prosecuting people for spouse abuse and people who go to shelters, you are talking about a level of personal integration and awareness that many people lack.

Participant: People who go to court are also at a different level from those who maintain their life situation -- battering, or those who go to shelters, those who go to emergency rooms.

Participant: In terms of the group the woman attends -- is alcoholism the only purpose of the group?

Ellen Gross: The women's group, which originally was both alcoholic women in early sobriety and women who are spouses of alcoholics, is a mutual support system.

Participant: How many of them are being physically abused?

Ellen Gross: Physically abused, about half; verbally abused, all of them in varying degrees. The woman in question has a support system from the women's group, and she was able to go to Alanon; thus, she is being involved in yet another support system. Prior to our involvement she had been in this relationship and had little separation. She is now maintaining her own household with her children -- and has been for the past 6 months -- so she still, to some extent, maintains some autonomy from her husband. However, she allows him to come in once in a while.

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