The Battered Woman Syndrome

FOURTH EDITION

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THE BATTERED WOMAN SYNDROME
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Preface

This new, fourth edition of *The Battered Woman Syndrome* has been a joy for me to write given the enormous amount of new research and practice that has arisen within the almost 40 years since the first edition was written in the early 1980s. The first edition contained the results of the initial research study that was funded by the U.S. National Institute of Mental Health from 1977 through 1981. It was the first time a psychologist had studied the impact of over 400 women experiencing domestic violence. The amount of data collected was enormous and the first edition contained numerous tables and figures to help explain the findings. Initially, some of the information was used to inform policy makers, especially in helping the criminal justice field become more sensitive to the needs of battered women so they could be better protected. The data were there for the use of new researchers, a process that is used in advancing scientific knowledge.

In the second edition, published in 2000, I integrated the new research that had been published in the almost 20 years since the original data were collected and disseminated. It was exciting to see how the field of study had grown; where it changed and where it stayed pretty much the same. Laws had changed and were enforced. More women were better protected. Political discourse about what to call domestic violence became a challenge, with advocates wanting to use the term “intimate partner abuse/violence” rather than “domestic violence” or even “battered women.” The links and boundaries with child abuse and other family violence were established. The commonalities with other forms of gender violence such as rape, sexual assault, exploitation, and harassment were clarified. Calls for more policy changes, especially to better protect children and mothers going through divorces, were issued. The data were there, but the time was not right to make the necessary changes in family court laws and presumptions to better protect abused women and children, despite the fact that the issues in domestic violence were similar around the world. During this time period, the United Nations and World Health
Organization became involved and collected and disseminated information to encourage all countries to make policy changes.

By 2009, when the third edition of *The Battered Woman Syndrome* was published, I had moved to Nova Southeastern University and began collecting data again. It was exciting to see that the original information that was learned from the first study was still relevant. This made it possible to look in more depth at some of the areas that seemed to be difficult for battered women in their attempts to heal from the abuse. The research team culled through the original Battered Woman Syndrome Questionnaire (BWSQ) assessment instrument and began the task of eliminating questions that did not yield useful information and add others that we hoped would give us the data we needed. As we began to analyze the old and new data, we were able to develop the framework for how to measure the battered woman syndrome. This was important because battered woman advocates and some other researchers did not like the term, for several reasons. First, they believed that labeling a syndrome would continue to victimize women by focusing on their mental health. Second, they believed that there were other explanations for the dynamics of intimate partner abuse that would better explain the situational as well as psychological variables noted. For example, a focus on the violation of the woman’s civil rights was preferred to the focus on health and mental health.

While the members of our research team accepted that their concerns were valid, we still believed that there were significant health and mental health consequences from being abused that could respond to efforts by psychologists to assist in their healing and empowerment. In the third edition, the actual psychological variables were listed that were considered part of the battered woman syndrome.

Our research team continued the data collection and analysis and these new results are integrated here in this fourth edition. In addition, we have included new chapters that highlight some of the other forms of violence against women, to demonstrate the close relationship of all forms of gender violence and its impact. In this edition, the focus is on the psychological and physical damage to children raised in homes where their fathers abuse their mothers. Three chapters dealing with the psychological effects on children living in domestic violence homes have been included, with more details on impact from coercive control, child abuse, and sex trafficking. We emphasize how our data are similar to the large-scale study
conducted by Felitti and his colleagues (1998) on adverse childhood experiences (ACEs). A fourth chapter included in this edition emphasizes the high risk to divorcing moms who lose the ability to properly parent and protect their children when the family courts force shared parenting without understanding the dynamics of coercive control used by the batterer to continue his dominance and abuse. This risk extends to murder and suicide cases studied by the research team, where we found the highest risk when the domestic violence family was separated and involved with the family court. A chapter discussing these findings on murder–suicide has been added to this edition. Information on identifying the lethality potential with some risk assessment instruments was added to the chapter on risk assessment.

Although battered women are better understood in the criminal justice system, we looked at the numbers of women who are serving time in prison because they gave a false confession about their roles in the death of someone. We have been following the work of the Innocence Project that has exonerated over 200 men, many of whom falsely confessed, and are attempting to design methodology for better identifying women, especially battered women, who falsely confess for a variety of reasons described in the new chapter on false confessions. Given our concerns with health and mental health consequences, we added discussions on these issues, as well as reviewed the advances made in trauma-informed psychotherapy. We have analyzed the data from over 500 people who have been involved with our evidence-based STEP program in the jails and have slightly revised the program, developed new materials, and created a manual to assist in its administration. Although we knew the program was not the same as typical group psychotherapy, we now better understand that it is still a form of psychotherapy that includes psychoeducation and skill building along with time to process the new information. This program is ideal for working within the constraints of jails and other confined detention facilities as well as in clinics and independent practitioners’ offices.

We plan to take the research to the next level by validating the BWSQ instrument statistically and attempting to streamline it so that it will be a useful assessment tool for all who are working with battered women or survivors of any form of intimate partner violence. The model we have developed and are beginning to test will involve scaling the data collected into areas of preabuse conditions, adding the frequency and severity
from the abuse itself, and then testing to see if the seven factors we have identified so far as the battered woman syndrome will continue to hold up statistically.

Lenore E. A. Walker, EdD

REFERENCE

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All of the four editions of *The Battered Woman Syndrome*—or “the book” as we like to call it in our research laboratory at Nova Southeastern University College of Psychology—have been a labor of love for all the graduate psychology students who have joined our research team in the past 14 years. As we have had over 30 students per year, there are too many to name individually. However, each of their contributions has been important to gathering and analyzing the data reported in the book. Most learned how to administer the Battered Woman Syndrome Questionnaire (BWSQ) to the hundreds of courageous women who volunteered to participate in our study. Some spent the many hours looking up and reviewing the latest research in our library system, now mostly on the Internet data collections. Others drew the flyers that we passed out in the community to gain as representative a sample as possible. They helped fill out the myriad of forms needed to get institutional review board permissions each year for the studies. They made copies of materials, stapled them together, and then removed all staples from those that were brought into the jails. They sat at the computer and tediously entered the data. They helped analyze the results, but only some were able to present at conferences. We all laughed and cried when we would get together to share the stories told by the courageous women who participated in the study. I sincerely thank each and every one of the research assistants who worked together with us over these years.

There are a few of these researchers and now psychologists whom I want to single out, as they were driving forces behind the rest of us. Dr. Kate Richmond was one of the major sources of energy to help me revise the original research on battered woman syndrome (BWS) when she was a student at Nova Southeastern University College of Psychology. She brought Dr. Rachel Needle into the group as she graduated and Dr. Needle continues to work with us as an adjunct professor, now on the sexuality and body image areas. Dr. Needle and I took a side path together to publish
Acknowledgments

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

After Dr. Richmond graduated, Dr. Rachel Duros took over organizing the data analysis and demonstrated how BWS was empirically a part of posttraumatic stress disorder. Aleah Nathan coordinated data analysis when Dr. Duros graduated. Dr. Heidi Ardern organized the data collection section and when she graduated, Allison Tome continued her work. Gretchen Lamendola and Ron Dahl assisted in developing the reference list. Rebecca Brosch has been our research link with the women in the jail, while Kelley Gill, Crystal Carrio, Gillespie Stedding, and the rest of the women in the forensic practicum have organized the STEP program that has added such richness to our knowledge of the psychological impact of intimate partner violence on women. Cassandra Groth and then Vera Lopez Klinoff took over the management of the BWSQ, and together with the current coordinator, Lauren Schumacher, trained the researchers of the next few years.

In addition to the graduate students, there were a number of professors on our faculty who have been of enormous help in conceptualizing and operationalizing the research program. Dr. Vincent Van Hasselt has been a good friend and colleague whose knowledge about violence has been invaluable in understanding both our methodology and data analysis. Dr. Steven Gold, a superb traumatologist who has his own amazing research program, has also been available to share ideas. Dr. Tara Jungersen, who came on the faculty as an assistant professor wanting research experience, has become a strong member of our team, adding the counseling perspective to our work especially in analyzing and revising the STEP program. Her work with the local domestic violence council and Women in Distress battered women shelter has been invaluable in adding another group of volunteer participants to our data. Dr. Ryan Black, an incredible statistician, has provided the exact data analysis conceptual and operational backup to the project after the untimely death of Dr. Al Sellers who had helped us revise the BWSQ initially. Dr. Timothy Ludwig and Dr. Michelle Sanchez, psychologists at the Broward Sheriff’s Organization’s detention centers, were extraordinarily helpful in facilitating our work in the jails. Dean Karen Grosby has been more than
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The international friends who have been a part of my life remain some of my closest confidantes. Dr. Christina Antonopoulou, a Greek psychologist, whom I met at a victimology meeting in Il Ciocco, Italy, over 20 years ago, remains one of my best friends. She is the director of the Domestic Violence Institute of Greece and works on collecting data and training new psychologists there. We have traveled the world together. I have been friends with Dr. Patricia Villavicencio, a psychologist in Spain, since we met at a meeting of feminist psychologists in Amsterdam over 20 years ago. Dr. Villavicencio has also contributed to my thinking, and some of her work with her colleagues is discussed in this book. Drs. Carmen Delgado and Mark Beymach from the University of Salamanca and the Catholic University in Salamanca, where I have been teaching in their gender violence program, Dr. Jesus Melia from the University of Granada, and others in Spain have all contributed to our new understanding of the commonalities found in battered women in other countries. My good friend, the Honorable Saviona Rotlevy, a now-retired judge from Israel whom we met at a meeting in Rome over 15 years ago, helped rewrite the laws to reflect children’s rights there and has helped keep me informed about the progress that the International Association of Women Judges has been making in helping develop worldwide initiatives to keep women and children safe. Dr. Josepha Steiner, a social worker and good friend from Israel, has gathered data on battered women in that war-torn country where PTSD abounds. These are just a few of the fabulous people working to make life better for women and children all over the world.

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

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it all her vision has helped shape the manuscript, although any errors are
wholly my own.

The incredible work of my dear friend, The Honorable Ginger
Lerner-Wren, the first judge appointed to head the first U.S. mental health
court, which opened in Broward County over 15 years ago, has taught me
so much about the intersection between mental health issues and domestic
violence. She has taught us all about keeping the respect and dignity for
those who have emotional problems and helping them take responsibility
for their recovery. We need not be afraid of stigmatizing battered women
by using the language of psychology, especially talking about PTSD
and BWS, where it is appropriate. Instead, we must be vigilant against
victim-blaming and infantilization of women who can heal from the ter-
rors of domestic violence. Many years ago, The Honorable Richard Price
from New York City began the arduous task of training judges to better
understand battered women who come before them, and he continues this
important work today.

And I have saved the best for last in thanking my dear life partner,
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Lenore E. A. Walker
Part One

Myths and Science of Domestic Violence
CHAPTER ONE

THE BATTERED WOMAN SYNDROME STUDY OVERVIEW

WHAT IS THE BATTERED WOMAN SYNDROME?

The research over the past 40 years reported in this book has led to the validation that living in a domestic violence family can produce psychological effects called the battered woman syndrome (BWS). The research team of professors and graduate students that I head at Nova Southeastern University’s College of Psychology has been analyzing the data we have been collecting to determine if there is a group of psychological signs and symptoms called “BWS.” The answer is, “yes.” BWS is identified with seven factors:

1. Reexperiencing the trauma events intrusively
2. High levels of arousal and anxiety
3. High levels of avoidance and numbing of emotions
4. Cognitive difficulties
5. Disruption in interpersonal relationships
6. Physical health and body image problems
7. Sexual and intimacy issues

The first four factors are the clinical categories from the posttraumatic stress disorder (PTSD) diagnostic category. So it is said that BWS is a subcategory of PTSD. The second three factors are specific to what the women in our research told us.

The model we are using to statistically verify BWS from our data includes: childhood and preexisting situational conditions that interact with the severity and frequency of the abuse to create the seven factors of BWS in an individual.

We are entering the next phase of the research by identification of all the variables that will statistically validate the model and then hopefully
will be able to develop an assessment tool to help identify and ameliorate the effects from violence.

In this edition of *The Battered Woman Syndrome*, the data that are being used to build the model are presented. Data from the previous research are included as they are being used in the creation of the model. Hopefully, it will encourage other investigators to look carefully at where these data take us.

**WHAT IS THE SCOPE OF THE PROBLEM?**

On September 16, 2015, all domestic violence programs in the United States were asked by the National Network to End Domestic Violence to report a census of services provided in a 24-hour period. The figures are both alarming and satisfying in the high number of battered women, over 70,000, who needed and received services during that day. At the same time, these agencies (almost 2,000 of them or 93% of known agencies reporting) had to turn down over 12,000 other requests for services, including emergency shelter, housing, transportation, child care, and legal representation because of lack of resources. Agencies reported answering over 25,000 hotline calls, averaging more than 14 hotline calls per minute, that day. The National Domestic Violence Hotline answered an additional 953 calls on the survey day. The services provided included:

- Individual support or advocacy
- Children’s support or advocacy
- Emergency shelter
- Transportation
- Court advocacy/legal accompaniment
- Group support or advocacy

That is the good news. *But*, it was also reported that over 1,200 staff positions were eliminated in the past year and most of them were direct service providers.

This is just in the United States. All the other countries, most of which responded to the United Nations’ calls to document services to all gender violence victims, make it clear that violence against women impacts everyone. Hopefully the research reported in this edition of *The Battered*
Woman Syndrome will make an impact on reducing or eliminating all forms of gender violence, including intimate partner abuse.

**RESEARCH METHODOLOGY**

Over the years, it has been found that the best way to understand violence in the home comes from listening to the descriptions obtained from those who experience it: victims, perpetrators, children, or observers. Until the first large-sized empirical study reported in the first edition of this book, in 1984, accurate descriptions of the violence had been difficult to obtain from women as well as men, partly due to the effects of the abuse experience as well as feelings of shame and fear of further harm. This particular study pioneered in using methods that were rarely used by researchers 30 years ago, although these methods are quite common today. I learned these techniques from my earlier exploratory study published in a book for the general public, *The Battered Woman* (Walker, 1979). Women were given the opportunity to fully describe their experiences in context, using what researchers today call *mixed method* with an “open-ended” technique combined together with “forced-choice” responses that prompted their memories and went beyond the denial and minimization that were the typical first responses. As a result, with a grant from the U.S. government, the study collected groundbreaking data that had never before been totally heard by anyone, including mental health and health professionals.

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

The understanding of domestic violence reported in the third edition was learned from the perceptions of the courageous battered women who were willing to share intimate details of their lives. That study suggests that even though trauma and victimization are more widely studied today, it is still difficult for women to talk about their experiences, just as it was during the late 1970s and early 1980s when we first started collecting this information. The data from all our research indicated that events that occurred in a woman’s childhood as well as other factors in her life interacted with the violence she experienced by the batterer, and together they impacted upon the woman to produce her current mental state, which has been called “BWS.” The research demonstrated that psychologists could reliably identify these various events and relationship factors and then measure their impact on the woman’s current psychological status. These results could then be utilized to formulate treatment plans or present as testimony in court cases involving criminal, civil, family, juvenile, or other matters where the person’s state of mind was at issue. Although the data we obtained supported the theories that I proposed at the time, it has become even more relevant today, almost 40 years later, to recognize the robust nature of these findings that continue to be reaffirmed in subsequent research.

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

These data compelled me to conclude then, as well as now, that from the woman’s point of view, the initiation of the violence pattern in the battering relationships studied came from the man’s learned violent behavior. The connections between violence against women, violence against children, violence against the elderly, and street/community violence have been demonstrated in the subsequent research (American Psychological Association [APA], 1996; Cling, 2004; Walker, 1994, 2015). Patterns of one form of violence in the home create a high-risk factor for other abuse. Alcohol and other drugs appear to exacerbate the risk for greater injury or death. Men continue to use physical, sexual, and psychological abuse to obtain and maintain power and control over women and children, because they can. Violence works to get them what they want, quickly and with few if any consequences. Recent analysis of data from batterer treatment programs gives a very dismal picture of efforts to help offenders stop their abusive behavior (Fields, 2008). Thus, we must continue to study the impact of violence on women in the total context of our lives, to better understand its social and interpersonal etiology as an aid to prevent and stop violence. If this mostly male-to-female violence is learned behavior, and all the psychological research to date supports this view (APA, 1996; Koss et al., 1994), we must understand how men learn to use violence, what maintains it despite social, financial, and legal consequences, and how to help them unlearn the behavior.

NEW BWS RESEARCH

Since the original BWS research was completed in 1982, the field has been most often studied by social policy experts, health and mental health scientists, students, and professionals. In 1994, I was asked by the then-president
of the APA, Dr. Ron Fox, to convene a special task force composed of some of the most respected psychology experts in the area of family violence to review the research and clinical programs to determine what psychology has contributed to the understanding of violence and the family, including battered women. Our goal was to prepare materials for policy makers to aid them as they created social policy to stop and prevent all forms of interpersonal violence. This antiviolence initiative is still ongoing in the Public Interest Directorate of the APA, continuing to publish materials (APA, 1995, 1996, 1997). In fact, the 2008 APA President, Dr. Alan Kazdin, chose violence against women and especially domestic violence as one of the topic areas on which to focus in a presidential initiative. Dr. Bob Geffner has gone on to form other organizations such as the Institute on Violence, Abuse and Trauma (IVAT) for educational purposes and the National Institute to End Intimate Partner Violence (NIEIPV) to support policy development.

Although we have much more data on the topic today, in fact the conclusions I reached and stated in the 1984, 2000, and 2009 editions of The Battered Woman Syndrome still hold up today, almost 40 years after I first proposed them in 1977. “Intimate partner violence” (IPV), as battering of women, wives, or other intimate relationships is sometimes called, is still considered learned behavior that is used mostly by men to obtain and maintain power and control over women. Those who identify as lesbians, gay men, bisexual, transgender, and others who are nonconforming also engage in violence against their partners, but the limited available research suggests that, while there may be some differences in same-sex violence from male-to-female heterosexual violence, its use to coercively obtain power and control over one’s partner is still primary. In particular, research has found less physical harm in lesbian relationships (Lobel, 1986; Renzetti, 1992) and more physical harm in brief but not long-term gay male relationships (Island & Letelier, 1991). There is no reported research on violence in partners with the other groups. Our findings were that, although racial and cultural issues might impact the availability of resources for the victim, they do not determine incidence or prevalence of domestic violence (Browne, 1993; Browne & Williams, 1989; Gelles & Straus, 1988). New research looks more carefully at other cultural groups including African and Caribbean American women (Shakes-Malone & Van Hasselt, 2005) and is reported in a later chapter. Many factors appear to interact that determine the level of violence experienced and the access to resources and other help to end the violence. Although there are some
who have designed intervention programs to help save the relationship while still stopping the violence, it remains a daunting and difficult task with only limited success (Fields, 2008; Harrell, 1991; Hart & Klein, 2013).

**BATTERER INTERVENTION PROGRAMS**

One of the most important facts we have learned about domestic violence is that it not only cuts across every demographic group we study, but also that both batterers and battered women are very different when they first come into the relationship than when they leave. Although there are “risk markers” for both men and women, increasing the probability of each group becoming involved in a violent relationship, the most common risk marker is still the same one that the BWS research study found: for men it is the exposure to violence in their childhood home (Hotaling & Sugarman, 1986), and for women, it is simply being a woman (APA, 1996). Other studies have found that poverty, immigration status, and prior abuse are also risk factors for women to become battered, although they are not predictive (Walker, 1994). We decided to conduct the same research with women who have come to live in the United States and were battered in their countries of origin in this latest round of data collection to help determine the relationship between the women’s immigrant status in the United States and the abuse by her intimate partner.

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

The second most common type is the mentally ill batterer, who may also have distorted power and control needs but his mental illness interacts with his aggressive behavior (Dutton, 1995; Dutton & Sonkin, 2003). Those with an abuse disorder may also have coexisting paranoid and schizophrenic disorders, affective disorders including bipolar types and depression, borderline personality traits, obsessive-compulsive disorders. Also, those with substance abuse disorders may have a coexisting abuse disorder (Sonkin, 1995). Multiple disorders make it necessary to treat each one in order for the violent behavior to stop. As the intervention methods may be different and possibly incompatible, it is an individual decision whether to treat them simultaneously or one at a time. Usually, different types of treatment programs are necessary for maximum benefit whether or not the intervention occurs at the same time.

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

Understanding the motivation of the batterer appears to be quite complex, especially when consequences do not appear to stop his abusive behavior. Information gained from new research suggests that there may well be structural changes in the midbrain areas from the biochemicals that the autonomic nervous system secretes when a person is in danger or other high levels of stress. Fascinating studies of “cell memories” (Goleman, 1996; van der Kolk, 1988, 1994, 2015), changes in the noradrenalin and adrenalin levels, glucocorticoids, and serotonin levels (Charney, Deutch, Krystal, Southwick, & Davis, 1993; Rossman, 1998) all may mediate emotions and subsequent interpersonal relationships. The precise
impact of these biochemicals on the developing brain of the child who is exposed to violence in his or her home has yet to be definitely studied. Obviously, this research is critical to our understanding of the etiology of violence and aggression.

**HIGH-RISK FACTORS**

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

**LEARNED HELPLESSNESS AND POSITIVE PSYCHOLOGY**

The concept of learned helplessness, one of the cornerstone theories in the original research, has continued to be refined through this and other research, despite its controversial name. As we have learned, and these studies confirm, battered women are not helpless at all. Rather, they are
extremely successful in staying alive and minimizing their physical and psychological injuries in a brutal environment. However, in order to maintain their core self, they must give something up. The theory of learned helplessness suggests that they give up the belief that they can escape from the batterer in order to develop sophisticated coping strategies. Learned helplessness theory explains how they stop believing that their actions will have a predictable outcome. It is not that they cannot still use their skills to get away from the batterer, stop the abuse at times, or even defend themselves, but rather, they cannot predict that what they do will have the desired outcome. Sometimes they use force that might seem excessive to nonbattered women in order to protect themselves or their children.

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

**SEX-ROLE SOCIALIZATION**

It was expected that battered women who were overly influenced by the sex-role demands associated with being a woman would be traditional in their own attitudes toward the roles of women. Instead, the original data surprisingly indicated that the women in our study perceived themselves as more liberal than most in such attitudes. They did perceive their batterers held very traditional attitudes toward women, which probably produced some of the disparity and conflict in the man’s or woman’s set of expectations for their respective roles in their relationship. The women saw their batterer’s and their father’s attitudes toward women as similar, their mother’s and nonbatterer’s attitudes as more liberal than the others but less so than their own. The limitation of an attitude measure is that we still do not know how they actually behaved despite these attitudes. It is probably safe to assume that the batterers’ control forced the battered
women to behave in a more traditional way than they state they would prefer. From a psychologist’s viewpoint, this removes power and control from the woman and gives it to the man, causing the woman to perceive herself as a victim. It also can create a dependency in both the woman and the man, so that neither of them feels empowered to take care of himself or herself.

One area for further study is the relationship between the political climate in the woman’s country where she currently lives and the frequency of severity and impact from domestic violence. If women continue to hold more liberal attitudes toward women’s roles and men become more conservative, it would be interesting to know if a conservative political climate would put women at higher risk for being abused. It is known from other studies (Chesler, 2005) that women’s behavior is more controlled by men in countries where there is state-sponsored violence or where fundamentalist religious values are the norm. It is difficult to tell if women have bruises under their burkas and veils and long modesty dresses.

There are arguments from both sides about whether women in these countries, particularly those that subscribe to the Muslim faith, actually are free to make their own life choices, as they state, or if they comply because they have to obey if they choose to stay within the community. More recent analysis of Muslim terrorist actions indicates that women have been trained to use violence along with men, perhaps because they are less likely to be detected. It is possible that women in these countries have taken a way out of being controlled by men by assuming the terrorist role themselves. Not enough information is known about how much power these women actually do have. However, some analysis of terrorist actions, such as the bombing of a government building in San Bernardino, California, appears to have been led by a radicalized woman terrorist who married an American and radicalized him also. She appeared willing to die for “the cause” despite the fact that she had an infant child, defying many stereotypes about women’s behavior.

**PHYSICAL AND SEXUAL ABUSE AS CHILDREN**

Other events reported by the women that put them at high risk included early and repeated sexual molestation and assault, high levels of violence by members in their childhood families, perceptions of critical or
uncontrollable events in childhood, and the experience of other conditions that placed them at high risk for depression. These are discussed in greater detail in the following chapters. At the time of the original research, we were surprised at the high percentage of women in the study who reported prior sexual molestation or abuse. Although the impact of having experienced sexual assault and molestation was consistent with reports of other studies, we, like other investigators at the time, tended to view victims by the event that we learned had victimized them, rather than look at the impact of the entire experience of various forms of abuse. Since that time it is clear that there is a common thread among the various forms of violence against women, especially when studying the commonality of the psychological impact on women (Cling, 2004; Koss et al., 1994; Walker, 1994).

Finkelhor’s (1979) and Gold’s (2000) caution that seriousness of impact of sexual abuse on the child cannot be determined by only evaluating the actual sex act performed was supported by our data. Trauma symptoms were reportedly caused by many different reported sex acts, attempted or completed, that then negatively influenced the woman’s later sexuality, and perhaps influenced her perceptions of her own vulnerability to continued abuse. Incest victims learned how to gain the love and affection they needed through sexual activity (Butler, 1978). Perhaps some of our battered women did, too (Thyfault, 1980a, 1980b). Gold (2000) has found that the impact of the other family patterns has equal if not greater impact on the effects of the sexual abuse on the child. These findings were consistent with reports of battering in dating couples studied on college campuses (Levy, 1991). The critical factor reported for those cases was the level of sexual intimacy that had begun in the dating couples. At the very least, the fear of losing parental affection and disruption of their home-life status quo seen in sexually abused children (MacFarlane, 1977–1978) was similar to a battered woman’s fears of loss of the batterer’s affection and disruption of their relationship’s status quo (Janoff-Bulman, 1985).

The impact of physical abuse reported in the women’s childhoods was not clear from these data. Part of this difficulty was due to definitional problems that remain a barrier to better understanding of violence in the family. The women in this study were required to conform to our definitions of what constituted battering behavior, so we know that their responses about the impact of the violence were based on that definition. But, we do not know the specific details of more than four of the battering incidents they experienced. This makes it difficult to compare our results with other researchers such as Straus, Gelles, and Steinmetz (1980) who
used different definitions of conflict behavior without putting events into the context in which they occurred. However, we do have details of over 1,600 battering incidents, four for each woman in the first sample and many more in the new samples reported in this book. Our data indicated the women perceived male family members as more likely to engage in battering behavior that is directed against women. They perceived the highest level of whatever behavior they defined as battering to have occurred in the batterer’s home (often their own home, too), and the least amount of abuse to have occurred in the nonbatterer’s home, in the first study. Interestingly, if the other man really was nonviolent, then the relationship should have had no abuse reported, not just the comparatively lower amount. This type of confound supports the need to be extremely precise in collecting details of what women consider abusive or battering acts.

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

**ALCOHOL AND OTHER DRUG ABUSE**

The abuse of alcohol and perhaps some drugs is another area that would predict higher risk for violent behavior. They are similar forms of addiction-type behavior, with the resulting family problems that can
arise from them. The clue to observe is the increase in alcohol consumption. The more the drinking continues, the more likely it seems violence will escalate. Yet, the pattern is not consistent for most of our sample, with only 20% reportedly abusing alcohol across all four acute battering incidents. It is important to note that the women who reported the heaviest drinking patterns for themselves were in relationships with men who also abused alcohol. Thus, while there is not a cause and effect between alcohol abuse and violence, this relationship needs more careful study. We have begun looking at these details in the new research program. When looking at alcohol and other drug-abusing women, there is a high relationship with a history of abuse. Kilpatrick (1990) suggests that prior abuse is the single most important predictive factor in women who later have substance abuse problems. Our work with women who have been arrested and found to have co-occurring disorders, who attend a mandatory residential facility, indicate that their treatment plan must include intervention for their substance abuse, for whatever mental health issues they may have, and for trauma. Without the trauma component, they will risk relapse. Mothers who abuse substances, especially during pregnancy, are almost all abuse victims (Walker, 1991). They too have not been receiving trauma-specific intervention even when they do attend substance abuse and mental health treatment programs.

PROBLEMS WITH THE LEARNED HELPLESSNESS THEORY

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

Those who have developed learned helplessness have a reduced ability to predict that their actions will produce a result that can protect them from adversity. As the learned helplessness is developing, the person (a woman in the case of battered women) is motivated to choose responses to the perceived danger that are most likely to work to reduce the pain from trauma. Sometimes those responses become stereotyped and repetitive, foregoing the possibility of finding more effective responses. In classical learned helplessness theory, motivation to respond is impacted by the perception of global and specific attitudes that may also guide their behavior. It is important to recognize that their perceptions of danger are accurate; however, the more pessimistic they are, the less likely they will choose an effective response, should such a response be available. One of the criticisms of learned helplessness theory, in addition to the name of the theory that is not very specific to how battered women really behave with coping responses, is that there are very few effective responses available to the woman that will protect her and her children from the batterer’s nonnegotiable demands. As it is detailed in the chapter on family courts, women are often better able to protect their children from their fathers’ abusive behavior by staying in the marriage rather than looking to family court for protection.

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

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

The sense of danger from the batterer seems to have a long life even after separation. In some cases the women are so terrified that they take the blame for criminal behavior of the batterer, often willing to get themselves in trouble with the law, rather than face the batterer’s wrath. I detail the cases of women who falsely confess to killing someone out of that fear. In one case, a woman whose infant son was killed by her abusive husband did not admit to the domestic violence in their relationship until after she was convicted of the homicide. Only when she was safely in a jail cell, away from him, was she able to tell the truth of what happened in their relationship. Some women give up relationships with their children, their valued property, and sometimes all they have lived and worked for in friendships and family, to escape from the batterer, breaking the learned helplessness bonds, if they ever had been trapped by them.
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VIOLENCE-PRONE PERSONALITY OF MEN WHO BATTER

Although the patriarchal organization of society facilitates and may even reward wife abuse, some men live up to their violent potential while others do not. Violence does not come from the interaction of the partners in the relationship, nor from provocation caused by possibly irritating personality traits of the battered women; rather, the violence comes from the batterers’ learned behavioral responses. We attempted to find perceived characteristics that would make the occurrence of such violence more predictable. While a number of such perceived characteristics were identified, the best prediction of future violence was a history of past violent behavior. This included witnessing, receiving, and committing violent acts in their childhood home; violent acts toward pets, inanimate objects, other people; previous criminal record; longer time in the military service; and previous expression of aggressive behavior toward women. If these items are added to a man’s history of temper tantrums, insecurity, need to keep the environment stable, easily threatened by minor upsets, jealousy, possessiveness, and the ability to be charming, manipulative, and seductive to get what he wants, and hostile, nasty, and mean when he does not succeed, the risk for battering becomes very high. If alcohol abuse problems are included, the pattern becomes classic.

Many of the men were reported to have experienced similar patterns of discipline in their childhood home in the earlier study. The most commonly reported pattern was a strict father and an inconsistent mother. The mother was said to have alternated between being lenient—sometimes in a collusive way to avoid upsetting her own potentially violent husband—and strict in applying her own standards of discipline. Although we did not collect such data, it is reasonable to speculate that if we had, it could have revealed a pattern of the batterer’s mother’s smoothing everything over for the batterer so as to make up for or protect him from his father’s potential brutality. Like the battered woman, the batterer’s mother before her may have inadvertently conditioned him to expect someone else to make his life less stressful. Thus, batterers rarely learn how to soothe themselves when emotionally upset. Often they are unable to differentiate between different negative emotions. Feeling bad, sad, upset, hurt, rejected, and so on gets perceived as the same and quickly changes into anger and then triggers abusive behavior (Ganley, 1981; Sonkin, 1992, 1995). The impact of the strict, punitive, and violent father is better known.
today—exposure to him creates the greatest risk for a boy to use violence as an adult. Although we called for further study into these areas with the batterers and their fathers themselves over 25 years ago, such research is still not available.

RELATIONSHIP ISSUES

There seem to be certain combinations of factors that would strongly indicate a high-risk potential for battering to occur in a relationship. One factor that has been mentioned by other researchers (Berk, Berk, Loeske, & Rauma, 1983; Straus et al., 1980) is the difference on sociodemographic variables between the batterers and the battered women. Batterers in some studies are less educated than their wives, from a lower socioeconomic class, and from a different ethnic, religious, or racial group. In this study, while there was some indication that the batterer’s earning level was not consistent and was below his potential, we felt that factor was not as important a variable as others in domestic violence relationships. We looked at the different earning abilities between men and women, but since we did not account for the difference in value of dollar income for different years, these data could not be statistically evaluated. We concluded that it is probable that these issues are other measures reflective of the fundamental sexist biases in these men that indicated their inability to tolerate a disparity in status between themselves and their wives. Perhaps they used violence as a way to lower the perceived status difference.

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

Men who are insecure often need a great amount of nurturance and
are very possessive of the women’s time. These men are at high risk for
violence, especially if they report a history of other abusive incidents.
Most of the women in this study reported enjoying the extra attention
they received initially, only to resent the intrusiveness that it eventually
became. Uncontrollable jealousy by the batterer was reported by almost
all of the battered women, suggesting this is another critical risk factor.
Again, enjoyment of the extra attention and flattery masked these early
warning signs for many women. There is a kind of bonding during the
courtship period that was reported, which has not yet been quantified.
The frequency with which the women, men, and professionals report this
bonding phenomenon leads me to speculate that it is a critical factor. Each
does have an uncanny ability to know how the other would think or feel
about many things. The women need to pay close attention to the batterer’s
emotional cues to protect themselves against another beating. Batterers
benefit from the women’s ability to be sensitive to cues in the environment.
At the same time they view the battered women as highly suggestible and
fear outside influence that may support removal of their own influence
and control over the women’s lives.

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

Although the earlier research seemed to point to different typologies in the types of the men who used violence against women, as mentioned earlier in this chapter, more recently there have been proponents putting forth the perspective that there are different typologies of domestic violence with some being less dangerous than others. Dr. Dan O’Leary (1988) first proposed the notion that some domestic violence relationships that have only psychological coercion and maltreatment will not naturally escalate to physical abuse without something pushing them over that point. In fact, when interviewing battered women with our methodology, we found that in many of those relationships that originally were classified as psychological abuse only, there were incidents of physical or sexual abuse, but because there were no serious injuries, the relationships were not reported as physically abusive. In other cases, what appeared to be low-level abuse quickly escalated to physical abuse without any warning. And, in some cases where there had been physical abuse, there was the ability to stay with coercive control in frightening acute battering incidents without escalation to physical abuse. A good example of this is from the highly publicized trial of O. J. Simpson, the famous football player accused of killing his wife, Nicole, and her friend Ron Goldman in 1995. In one incident when O. J. was angry with Nicole, it was reported that he ran into the house, yelling and smashing objects. She ran upstairs and hid in a bedroom behind a locked door. He pounded on the door and continued yelling while she was calling the police, but did not smash down the door or physically abuse her. He then left the house.

I cite this case and refer to others where it is simply impossible to predict where it will go next. The prudent action to take is always whatever will afford the best protection so further harm does not occur. Yet, there are those who do not study the large numbers of domestic violence cases, are willing to take the risk, and place children in harm’s way. The damage done to children’s self esteem and confidence, their learning ability, and their ability to reach their fullest potential in the name of protecting the father–child relationship, is probably the biggest mistake in this country’s policy. It leads to the continuance of domestic violence and other forms of violence from generation to generation. Children need to
be protected from the coercive control methods used by abusive men and the defensive strategies sometimes used by their mothers trying to protect themselves and their families. I begin and end the edition of this book by calling for family court reform that affords children and mothers protection from abusive fathers.

DOES PSYCHOTHERAPY HELP?

As a psychologist, I often wonder how people can reject psychotherapy as a tool to assist in healing from wounds of many kinds. I understand the fears and shame of being labeled as mentally ill and the misery and mistreatment that this labeling has caused so many people. Yet, as a psychotherapist who has helped people heal using trauma methods that are much more developed today, I find it sad that so many people continue to suffer from the effects of abuse. Most of these people were abused through no fault of their own; rather, they have the misfortune to be born or entered into an abusive family. They often suffered in silence, knowing that to speak out might cause them further pain. Some made bad decisions that affected their lives or others’ lives. Some sit in jails and prisons today having committed acts that were a product of their difficult lives. Some have created their own prisons in their minds or homes. All could be helped in some way, today. New medication, new trauma-focused and specific therapies could make a difference. I write about both preventive mental health to stop the downward spiral and psychotherapy techniques like the Survivor Therapy Empowerment Program (STEP) that will make a difference in the lives of women, children, and men who have lived with domestic violence.

SUMMARY

The book begins with a description of what the research here calls the “BWS.” Although there are those who would prefer not to use a term that denotes psychological consequences from living with domestic violence, in fact, abuse negatively affects all those in the family. The impact is not only in the emotions of those affected but also in how they live.
their lives. It affects everyone in their family, in their community, and in
some cases, spills over to indirectly affect innocent people they do not
know. We can and must stop the epidemic destroying people and fami-
lies. Hopefully using this research can help move policy makers to make
a difference.

It is interesting that we reported the findings from this study as “risk
factors” long before the recent categorization of family violence in similar
terms. Once it was established that family violence and violence against
women were at epidemic or even pandemic proportions by U.S. Surgeon
General C. Everett Koop (1986), violence began to be conceptualized as a
public health problem that would be best understood through epidemi-
ological community standards. Planning intervention and prevention pro-
grams could use the criteria of “risk” and “resiliency” factors rather than
thinking in more pathological terms of “illness” and “cure.” One of the
most interesting analogies comes from the public health initiative to erad-
icate malaria.

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

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

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


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CHAPTER THREE

WHAT IS THE BATTERED WOMAN SYNDROME?¹

The term “battered woman syndrome” (BWS) was first used in 1977 as the title to the U.S. National Institute of Mental Health (NIMH)–funded research grant that collected data on over 400 self-referred women who met the definition of a battered woman, which formed the basis for this original research. The details of the original study were reported in the previous editions of this book and only a summary is repeated here (Walker, 1984, 2000, 2009). Although the term BWS appeared prior to the addition of the diagnostic category “posttraumatic stress disorder” (PTSD) in the Diagnostic and Statistical Manual of Mental Disorders (3rd ed.; DSM-III; American Psychiatric Association [APA], 1980), the theoretical basis upon which the BWS was developed was similar to what later became known as PTSD. Over the years since then, BWS has been used in the psychological literature as a subcategory of PTSD, but, until the BWS research study, it was never empirically demonstrated to have the same or similar criteria. Despite its popularity in clinical and forensic psychology, and its similarity to trauma theory, until now BWS had not been subjected to the scientific analysis provided by this research. The lack of testable hypotheses permitted a small group of advocates, who feared the stigmatization that may accompany labeling, to raise questions about the existence of BWS as a syndrome or collection of psychological signs and symptoms that often occur from the same cause (APA, 1980, 2000).

BWS, as it was originally conceived, consisted of the pattern of the signs and symptoms that have been found to occur after a woman has been

¹This chapter includes data that were collected by faculty and students at Nova Southeastern University’s College of Psychology, including Rachel Duros, Heidi Ardern, Rachel Needle, Kate Richmond, Lauren Schumacher, Vera Lopez, Dr. Tara Jungersen, and Cassie Groth. Dr. Ryan Black worked with us on validating the BWSQ assessment instrument on which the data were collected.
physically, sexually, and/or psychologically abused in an intimate relationship, when the partner (usually, but not always, a man) exerted power and control over the woman to coerce her into doing whatever he wanted, without regard for her rights or feelings. As there are significant differences between the theory underlying the construct of BWS, and to date there are no empirically supported data, it has not yet been applied to battered men. Therefore, the term used is BWS rather than a gender-neutral battered person syndrome (BPS) or even battered man syndrome (BMS). Of course, men are abused by women, but the psychological impact on the man does not appear to be consistent with trauma in most cases. This is further discussed in Chapter 12.

The research has now demonstrated that BWS has seven groups of criteria that have been tested scientifically and can be said to identify the syndrome. The first four groups of symptoms are the same as for the DSM-5 (APA, 2013) criteria for PTSD, while the additional three criteria groups are present in victims of intimate partner violence (IPV). They are:

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

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

POSTTRAUMATIC STRESS DISORDER

Although all forms of trauma are identified by the same four groups of signs and symptoms using the DSM-5 (APA, 2013) or ICD-10 (World Health Organization, 1992) criteria, in fact, there are differences between

\[2\text{Although this criterion is a new group of symptoms clustered together, the actual symptoms previously were found under the other three criteria in earlier versions of the DSM.}\]
the different types of trauma that occur. For example, traumatic events that only occur one time, such as environmental catastrophes like the tsunami in the Far East, Hurricane Katrina in New Orleans and the Gulf Coast of the United States, or the major earthquake in Pakistan, or disasters such as the terrorist attacks of 9/11 when airplanes crashed into the towers of the World Trade Center in New York City and a part of the Pentagon in Washington, DC (causing the buildings to collapse and killing thousands of people and injuring thousands more), an airplane crash killing hundreds, or the terrorist attacks in a Paris concert hall, stadium, and restaurant, all produce similar psychological effects in people who have experienced some part of the event even if they were not at the site when the disaster occurred. The event is usually experienced as unexpected, out of the person’s control, and causes disruption to how a person may think, feel, or act. One-time traumatic events such as physical or sexual assault by strangers may also produce similar psychological impact. Repeated traumatic events, such as soldiers who are at combat sites in Iraq, children who are physically or sexually abused by people who love them, and those who are battered by intimate partners, also experience similar psychological impact, although those who know who the enemy is, such as soldiers, do not develop the same type of coping strategies as do victims of child and intimate partner abuse.

Physical, sexual, and psychological abuse that occur in families or with intimate partners have their own special characteristics that go beyond those seen in the typical PTSD. The “fight or flight” response to danger can be seen in each of the different types of trauma responses. For example, the person taking a walk sees a lion, becomes physiologically aroused and wants to protect himself or herself, and if possible, runs away. The autonomic nervous system that controls our emotional responses becomes activated, producing sufficient cortisol, adrenalin, and other neurochemicals to help activate the nervous system so it responds to the threat of danger. The response to traumatic events is similar. We call events that can evoke this response in people “trauma triggers.” The trauma triggers will have to be desensitized during trauma-informed treatment because they continue to cause the trauma response long after they were present; they are reexperienced in the person’s mind with all the same emotions, as if they were reoccurring. Various forms of trauma therapy are further discussed in Chapters 14 to 16.

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

**DSM-5 CRITERIA FOR PTSD**

There are four sets of psychological signs and symptoms that are required to make the diagnosis of PTSD using the *DSM-5* (APA, 2013). In addition, there are three threshold criteria that must be met in order to consider this diagnosis. The threshold criteria are:

1. The person must experience a traumatic event that includes fear of personal bodily safety or death (but no longer needs to have subjective fear).
2. The aftereffects of that experience must last for more than 4 weeks. If less than 4 weeks, then it is diagnosed as an “acute stress reaction.”
3. The aftereffects must impact some important part of the person’s life such as job performance, school, or social relationships.
As can be seen, most battered women, especially those who believe that the batterer can or will kill them, would meet the first set of criteria here. Even those women who are not physically harmed often fear that the batterer can and will hurt them worse if they do not do whatever the man demands. In some cases, the women do not feel the full extent of their fear until later, even after the relationship has been terminated. This is similar to the delayed PTSD that may be seen in soldiers who do not develop symptoms until another incident occurs that triggers the memory of the same fear they may have repressed when the first trauma occurred. This is commonly seen in child sexual abuse victims who knew what was happening to them (such as those abused by clergy) but did not experience the full PTSD symptoms until later in life when they were adults.

The second set of PTSD criteria includes four different groups of psychological signs and symptoms:

1. The person must reexperience the traumatic event(s) in a variety of ways that include intrusive memories, nightmares, night terrors, day dreams, flashbacks, and physiological responses with or without exposure to the same stimuli.
2. The person has a hyperarousal response that includes anxiety reactions, crying, sleep or eating problems, hypervigilance to further harm, exaggerated startle response, and other fearful responses.
3. The person has a numbing of emotions and wherever possible avoids making things worse. These avoidance responses may take the form of depression, dissociation, denial, minimization of fear or harm, decreased activities, isolation from people, or other indications that their lives are being controlled by another person.
4. The person has negative alterations in mood and cognitions, including an inability to remember some aspects of the trauma event(s), negative self-esteem and expectations from others and the world, often in a pervasive negative state of mind with difficulties in experiencing positive emotions, distorts self-blame, is not as interested in activities as before, and has feelings of detachment from others (DSM-5, APA, 2013).

A series of analyses of the data collected using the Battered Woman Syndrome Questionnaire (BWSQ) is described in the following sections.
Data Collection

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

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

Although in the original study we wanted women who had at least two physical attacks, whether or not they were injured, to assess for the rise in psychological impact and learned helplessness, in the current research we were not as strict about physical abuse. It has been demonstrated that for most women the psychological abuse is the most significant part of the relationship and causes the most unforgettable painful moments. However, even realizing the devastating power of psychological maltreatment, most women do not consider themselves battered unless they have been physically harmed. This is also true for women who have experienced severe sexual abuse as we discuss in Chapters 6 to 8.

BWSQ Revisions

The BWSQ #1 that was used to collect the data analyzed in the original study was a 100-page questionnaire with forced-choice and open-ended questions that took over 6 hours to administer in a face-to-face interview with a trained interviewer and the volunteer subject. Embedded in the BWSQ #1 were questions to collect information about a nonviolent relationship that approximately half of the women reported on. Also embedded were several well-known research scales. Over 4,000 variables were available for analysis but not all could be analyzed due to restraints on time and money. Over 400 self-referred women were evaluated in a six-state region of the
United States. Details of this research and the results have been published in the first three editions of this book (Walker, 1984, 2000, 2009).

In the current research, the BWSQ #2 was developed, after several pilot data collections helped eliminate variables that did not adequately discriminate (Walker, 2009). Then, scales were developed that measured the constructs that appeared to hang together using simple regression analyses. To measure the validity of the scales (and the theories), standardized tests and other assessment instruments were embedded in the BWSQ #2 and analyses were done comparing the scales with these assessment instruments. Controls were provided by the standardized tests. The interviewers were trained and a multisite, multilingual, and multicountry data collection was begun in 2002. Each student interviewer completed a thorough standardized training prior to his or her acceptance as an interviewer and received a copy of the manual for future reference (Walker, Ardern, Tome, Bruno, & Brosch, 2006).

To assist in uniformity of data collected, a written manual for interviewers was prepared and, like the BWSQ #2, was translated into the appropriate languages. Translations were done by either professional translators or graduate students in psychology from the country in question and then they were translated back into English from the translated version so as to check on veracity. In some cases, it has been necessary to slightly change the wording of a question in order to tap the actual data in a particular country. For example, in Russia the term substance abuse is less frequently used, while drug and alcohol abuse would be the more accurate translation. In Trinidad, we changed “spanked” to “got licks” to make sure interviewees understood the questions about childhood discipline and abuse. This year we added data collected in Colombia by Dr. Eduin Caceres and his students. There are statistical techniques that have been used in some analyses to account for these slight variations in data groups as seen in the PTSD study by Duros (2007), who used a factorial invariance, and the results can be seen in Figure 3.1.

In this chapter, the validation of the theory of PTSD and BWS is discussed, and in the subsequent chapters, various analyses of other variables are described and discussed. Some analyses utilized the subjects from the four initial countries: the United States, Russia, Greece, and Spain. Other analyses utilized data that were collected from each country separately or in different comparisons. The research project is still under way with recruitment continuing and data also beginning to be collected in various other countries, as described in Chapter 12.
Figure 3.1 *Factorial invariance hierarchical model with means.*

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

Reprinted with permission from Duros (2007).
**Demographic Data**

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

This is to be expected for several reasons. First, the data are still being collected and therefore, those that have been evaluated were from a convenience sample without correctional factors to make sure that the sample was stratified or equal to the percentage of demographic and especially ethnic groups in the community from which they were collected, as was done in the original research. A second reason could be because the

<table>
<thead>
<tr>
<th>Demographic Variable</th>
<th>Original Sample</th>
<th>Original Sample</th>
<th>Current Sample</th>
<th>Current Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Racial and ethnic group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>321</td>
<td>80</td>
<td>46</td>
<td>43</td>
</tr>
<tr>
<td>Hispanic/Latina</td>
<td>3</td>
<td>8</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Black/African</td>
<td>25</td>
<td>6</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Native Indian</td>
<td>18</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>1</td>
<td>39</td>
<td>37</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>26</td>
<td>6</td>
<td>29</td>
<td>27</td>
</tr>
<tr>
<td>Married/living together</td>
<td>103</td>
<td>24</td>
<td>21</td>
<td>20</td>
</tr>
<tr>
<td>Separated/divorced</td>
<td>261</td>
<td>65</td>
<td>48</td>
<td>45</td>
</tr>
<tr>
<td>Widowed</td>
<td>11</td>
<td>3</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>66</td>
<td>12</td>
<td>29</td>
<td>27</td>
</tr>
<tr>
<td>High school only</td>
<td>99</td>
<td>25</td>
<td>42</td>
<td>40</td>
</tr>
<tr>
<td>Some college</td>
<td>160</td>
<td>40</td>
<td>17</td>
<td>16</td>
</tr>
<tr>
<td>College and postgrad</td>
<td>92</td>
<td>23</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Mean years of education</td>
<td>12.7</td>
<td></td>
<td>12.11</td>
<td></td>
</tr>
<tr>
<td>Mean age (years)</td>
<td>32.2 (Range: 18–59)</td>
<td>38.07 (Range: 17–69)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean number of children</td>
<td>2.02 (Range: 0–10)</td>
<td>1.79 (Range: 0–8)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
sample is cross-national, from several different countries, so that these demographic groups do not make as much sense in some countries as in the United States. For example, the breakdown of racial and ethnic groups is different in other countries. This is why the “other” column contains 40% of the population studied. After we looked at these statistics, we changed the ethnic categories to better reflect the international demographics. For example, in Spain most of the “other” category included women who had immigrated to Spain from nearby countries such as Morocco and Algiers. In Greece, there was a group that had immigrated from Albania. A third reason is also due to the difficulty in comparing different national samples. Although the mean years of education are comparable (12.7 years in the original sample with 12.1 years in the current sample), in fact twice as many women in the new sample had a less than high school education, with fewer women in the international sample having at least some or completing college or postgraduate school. Access to education is different in countries other than the United States. More women called themselves “single” rather than “separated” or “divorced” in the current sample, but it is not known if they really were never married or if there was simply a misunderstanding of how the terms were to be used when translated.

**Profile of Battering Incidents**

In the original study, we analyzed details about the four specific battering incidents that were not reanalyzed in the current study. These include months when abuse was more likely to have occurred, days of the week, and time of day. We found that abusive incidents were pretty evenly spread out over the 12 months of the year with perhaps a slight rise in incidents in the hotter months. This is consistent with a slight rise in other crime statistics during the summer months. Weekends were the most likely days for abuse to have occurred, perhaps reflecting the amount of time spent at home and away from work. Evenings were the most likely time for a battering incident to have occurred, again perhaps reflecting the time couples spend with each other.

Battering incidents were most likely to start and stop at home, often starting in the living room, kitchen, or bedroom and ending in the same room in which they started. Interestingly, if the incident did not start at home, the most likely place was a public setting or someone else’s home. This corresponds both with some women’s descriptions of fights that start
because of the men’s jealousy of attention the women paid to others or some who describe picking a fight with the batterer in front of other people to minimize the harm from his angry explosion because others are around. These women know that the tension is so high that the acute battering incident will occur no matter what they do and they have learned the best protective behaviors. These responses were intuitive, corroborated by police reports and other research, and so, we felt that they did not need continued investigation in the current study.

Details of Four Battering Incidents

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

PTSD ANALYSIS

The initial data from the current study, using the BWSQ #2, were subjected to analysis to determine if the women reported signs and symptoms consistent with the diagnosis of PTSD using the criteria from the DSM-IV-TR (APA, 2000), which was in effect at the time. Duros (2007) compared 68 women’s responses on the details of the psychological, sexual, and physical abuse from the four battering incidents reported, their responses on the PTSD checklist, and their results on the standardized test, TSI (Briere, 1995) that was embedded within the BWSQ #2. In the more recent version, the Detailed Assessment of Posttraumatic Stress (DAPS), also developed by Briere (2009), is also included as this test actually gives a PTSD score in addition to measuring the various components of PTSD from specific incidents reported. The TSI measures the clinical scales that make up the
PTSD diagnosis in general. For this analysis, Duros (2007) utilized the scales that measured anxious arousal, depression, intrusive experiences, defensive avoidance, dissociation, tension reduction behavior, and impaired self-reference. As their titles suggest, these scales are consistent with the PTSD criteria used to make the diagnosis.

Using a standardized linear regression analysis between the total number of PTSD symptoms endorsed and the four battering incidents and followed by a logistic regression analysis to assess prediction of endorsement of necessary PTSD criteria based on the psychological, physical, and sexual abuse present in the four battering incidents, Duros (2007) found PTSD in the linear and logistic regression results. An interesting statistical technique utilized in the analysis was a factorial invariance, which is designed for multigroup comparisons, in order to ensure that a given construct, in this case PTSD, is measured in exactly the same way across different groups. Figure 3.1 provides a pictorial view of the procedure.

The procedure does this by accounting for and assuming an error, such as translation or adaptation issues in the different versions of the BWSQ. With this procedure, a higher confidence level is established that potential differences between groups (or in the case of the present study, lack thereof) can be interpreted as a truly reflective measure of variability in PTSD. The results can be seen in Tables 3.2 and 3.3.

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

These analyses gave some interesting and clarifying information about the development of PTSD, especially since not every woman who is battered will develop it, nor will all battered women, with or without PTSD, develop BWS. However, the use of a trauma model to help explain and perhaps even predict who might develop PTSD symptoms can assist in both prevention and intervention efforts by strengthening those who might be most likely to develop the psychological sequelae. This could include building women’s resilience through extra community or familial support or even through administration of certain medications immediately
Table 3.2  Standard Linear Regression Summary

<table>
<thead>
<tr>
<th>Predictors</th>
<th>R²</th>
<th>F</th>
<th>p</th>
<th>B</th>
<th>t</th>
<th>p</th>
<th>Sizea</th>
</tr>
</thead>
<tbody>
<tr>
<td>First episode</td>
<td>.223</td>
<td>2.770</td>
<td>.059</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>M–L</td>
</tr>
<tr>
<td>fPsych</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>.112</td>
<td>.518</td>
<td>.609</td>
<td>S</td>
</tr>
<tr>
<td>fPhysic</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>.250</td>
<td>1.145</td>
<td>.261</td>
<td>S–M</td>
</tr>
<tr>
<td>fSexual</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>.209</td>
<td>1.101</td>
<td>.280</td>
<td>S–M</td>
</tr>
<tr>
<td>Most recent episode</td>
<td>.413</td>
<td>6.560</td>
<td>.002</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>L</td>
</tr>
<tr>
<td>mrPsych</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>.056</td>
<td>.251</td>
<td>.804</td>
<td>—</td>
</tr>
<tr>
<td>mrPhysic</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>.269</td>
<td>1.427</td>
<td>.165</td>
<td>S–M</td>
</tr>
<tr>
<td>mrSexual</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>.413</td>
<td>2.025</td>
<td>.053</td>
<td>M–L</td>
</tr>
<tr>
<td>Worst episode</td>
<td>.208</td>
<td>2.366</td>
<td>.093</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>M–L</td>
</tr>
<tr>
<td>wPsych</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>wPhysic</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>.445</td>
<td>1.861</td>
<td>.074</td>
<td>M–L</td>
</tr>
<tr>
<td>wSexual</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>.099</td>
<td>.459</td>
<td>.650</td>
<td>S</td>
</tr>
<tr>
<td>Typical episode</td>
<td>.247</td>
<td>3.724</td>
<td>.020</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>L</td>
</tr>
<tr>
<td>tPsych</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
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<tr>
<td>tPhysic</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>.424</td>
<td>1.824</td>
<td>.077</td>
<td>M–L</td>
</tr>
<tr>
<td>tSexual</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>.137</td>
<td>.678</td>
<td>.502</td>
<td>S</td>
</tr>
</tbody>
</table>

Descriptor of effect size per Cohen (1988): R² (small = .01; medium = .09; large = .25); B (small = .10; medium = .30; large = .5).

L, large; M, medium; S, small.

Reprinted with permission from Duros (2007).

postassault. For example, there have been some reports that administration of drugs such as selective serotonin reuptake inhibitors at the time of the trauma may prevent or reduce the fear response from developing trauma triggers that maintain the trauma response even after the person is safe. Unfortunately, it is unusual for a battered woman to report the first battering incident that occurs. Rather, it is not until there have been at least two to four battering incidents before she tells anyone. Duros (2007), in her analysis, found that the amount of physical and sexual violence in the incidents was associated with the severity of reported symptoms, particularly in the most recent incident reported and the most typical incident described.

While it is understandable that the most recent incident would generate a large effect size for PTSD because of temporal proximity to the traumatic event, it was surprising that the typical rather than the worst incident also generated such a large amount of PTSD symptoms endorsed.
The *DSM-IV-TR* (APA, 2000), for example, states that the more intense the trauma, the stronger the likelihood of developing PTSD. On the other hand, the typical abuse incident may well be repeated any number of times, which of course, is what made it typical to the woman, and so, that might be experienced as more intense than one single incident, no matter how awful it is, and that may account for the PTSD symptoms it generated. Battered women also describe the totality of the abuse in the relationship as most traumatic, so the typical incident may represent the entire battering relationship to these women. In addition, the theory that the psychological effects from battering incidents increase geometrically rather than
additively over time would predict that the impact from the most recent event would include the totality of the battering experience up until that event, rather than simply measuring the impact from one single event. This result lends support to the feminist jurisprudence scholars who have called for domestic violence to be considered as a continuing tort in the law, rather than considering each incident independently.

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

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

**DOES THE TSI ASSESS FOR PTSD IN BATTERED WOMEN?**

An earlier analysis of 56 of the women in the same cross-national sample developed the checklist of PTSD symptoms from the data collected with the various clinical scales on the TSI (Duros & Walker, 2006). Table 3.4
indicates the specific PTSD symptoms reported by this sample to better illustrate how the aggregate group accounts for the required number of symptoms.

A distribution of the standard scores on the TSI clinical scales was then compared for a smaller number of the sample. These results are shown in Figures 3.2 to 3.9. As can be seen in each of these figures, the average scores for each of the scales on the TSI were either just below or at the 65 level above which would signify clinical significance.

In Figure 3.9, trauma scales as reported on Briere’s TSI, all the women were at least one standard deviation above the mean (\(M = 50, SD = 10\)) and approaching the clinical significance of 65 or higher scores. With a larger sample, it is anticipated that these scores will reach significance for the group. Obviously, individual women already have reached a sufficient level of significance to be considered being diagnosed with PTSD.

Further analysis of an earlier sample of women from the United States, Russia, Spain, and Greece looked at the three groups of PTSD symptoms from the data collected. These included reexperiencing the

![Figure 3.2 TSI anxious arousal distribution of scores.](image)

**Figure 3.2 TSI anxious arousal distribution of scores.**

TSI, Trauma Symptom Inventory.

Figure 3.3 TSI depression distribution of scores.
TSI, Trauma Symptom Inventory.

Figure 3.4 TSI intrusive experiences distribution of scores.
TSI, Trauma Symptom Inventory.
Part I  Myths and Science of Domestic Violence

Figure 3.5  TSI defensive avoidance distribution of scores.
TSI, Trauma Symptom Inventory.

Figure 3.6  TSI dissociation distribution of scores.
TSI, Trauma Symptom Inventory.
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Figure 3.7  TSI impaired self-reference distribution of scores.
TSI, Trauma Symptom Inventory.

Figure 3.8  TSI tension reduction behavior distribution of scores.
TSI, Trauma Symptom Inventory.
trauma, avoidance and numbing, and hyperarousal symptoms. Table 3.4 shows that while the women from different countries had different PTSD scores, all the groups were above the required criteria for diagnosis. The Russian women were more likely to use avoidance behaviors, including emotional numbing, to deal with trauma, not unlike their political and cultural history, while the Spanish women were more anxious than the other three groups. The Greek women experienced the most PTSD symptoms from their abuse and continue to reexperience the trauma even after they are safe from it actually reoccurring. Interestingly, the Greek women reexperienced more trauma than did the Russian women but were less likely to be hyperaroused by their experiences. Perhaps there was a higher degree of expectancy for the Greek men to act abusively toward them. The women in the U.S. sample were the least likely to develop severe PTSD as compared to the other groups, although they also met the criteria for the diagnosis.

These results are the first empirical confirmation of the theory predicting that IPV is experienced as a trauma and is predictive of the woman developing PTSD following the traumatic events. The likelihood
The experience of IPV can cause PTSD for women who live in different countries and cultures in the world, particularly in Spain, Russia, Greece, and the United States.

There are limitations to the generalizability of these results. Obviously, this was not a random sample but rather a convenience sample so there may be untold numbers of biases that were not controlled. For example, it may be that the women who volunteered to be interviewed for the study were different from other battered women or maybe there were no differences with other women in that particular demographic group. However, these women were similar in demographics from the battered women who volunteered to participate in the original study. Although

<table>
<thead>
<tr>
<th>Table 3.4 PTSD Symptoms</th>
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</thead>
<tbody>
<tr>
<td><strong>Reexperiencing</strong></td>
</tr>
<tr>
<td>(Mean; SD)</td>
</tr>
<tr>
<td><strong>Avoidance/Numbing</strong></td>
</tr>
<tr>
<td>(Mean; SD)</td>
</tr>
<tr>
<td><strong>Hyperarousal</strong></td>
</tr>
<tr>
<td>(Mean; SD)</td>
</tr>
<tr>
<td>Overall</td>
</tr>
<tr>
<td>3.04; 1.41&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>4.21; 2.90&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>3.23; 1.32&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>United States</td>
</tr>
<tr>
<td>3.00; 1.48</td>
</tr>
<tr>
<td>3.87; 2.08</td>
</tr>
<tr>
<td>3.03; 1.52</td>
</tr>
<tr>
<td>Colombia</td>
</tr>
<tr>
<td>3.00; 1.87</td>
</tr>
<tr>
<td>3.00; 2.00</td>
</tr>
<tr>
<td>3.20; 1.30</td>
</tr>
<tr>
<td>Russia</td>
</tr>
<tr>
<td>3.10; 1.25</td>
</tr>
<tr>
<td>5.05; 1.19&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>3.55; 1.32</td>
</tr>
<tr>
<td>Caucasian</td>
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<tr>
<td>2.60; 1.35</td>
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<td>3.60; 2.14</td>
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<tr>
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<tr>
<td>2.83; 1.47</td>
</tr>
<tr>
<td>African American</td>
</tr>
<tr>
<td>4.50; 0.58&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>3.75; 0.96</td>
</tr>
<tr>
<td>4.25; 0.96&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Asian (n = 1)</td>
</tr>
<tr>
<td>4.00; –</td>
</tr>
<tr>
<td>7.00; –</td>
</tr>
<tr>
<td>5.00; –</td>
</tr>
<tr>
<td>Other ethnicity</td>
</tr>
<tr>
<td>3.24; 1.23</td>
</tr>
<tr>
<td>5.08; 1.15&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>3.23; 1.32</td>
</tr>
<tr>
<td>Outpatient (n = 1)</td>
</tr>
<tr>
<td>4.00; –</td>
</tr>
<tr>
<td>4.00; –</td>
</tr>
<tr>
<td>3.00; –</td>
</tr>
<tr>
<td>Mental health</td>
</tr>
<tr>
<td>2.22; 1.86</td>
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<td>3.73; 0.98</td>
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<td>Advertisement</td>
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<td>2.83; 1.03</td>
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<tr>
<td>3.67; 1.83</td>
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<tr>
<td>2.75; 1.42</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>2.75; 1.89</td>
</tr>
<tr>
<td>4.00; 2.16&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>3.00; 1.83</td>
</tr>
</tbody>
</table>

<sup>a</sup>Observations referenced in chapter discussion.

SD, standard deviation.

we do not assess for the veracity of the women’s reports of violence, it is assumed that large sample sizes will eliminate the individual variances in self-report data. This analysis is with a small sample and needs replication with larger and stratified samples of women from these countries as well as the additional countries from where the research is being conducted. Nonetheless, it is an important step forward to know that there is some empirical support for the theories that have been around for over 30 years now.

**BWS RESULTS**

The analyses in the PTSD Analysis section measure the first three criteria that were in the definition of BWS. The three additional criteria include the disruption in interpersonal relationships from the abuse of power and control and isolation of the woman, the difficulties with body image and somatic symptoms, and the sexual intimacy issues.

**Disruption in Interpersonal Relationships**

Ardern (2005) analyzed the power and control theme across all the battering incidents described by the Spanish, Russian, and U.S. women in the new sample. She found similar methods as were seen in the original study. In addition to physical violence and sexual coercion, a batterer uses many forms of manipulation, including isolation, following his rules, sex, degradation, jealousy, unpredictability, and direct and indirect threats of more violence.

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

“If I wanted to go somewhere, he would take a knife and threaten to kill my dog or people I cared about.”
Women described many different types of manipulation such as threatening to kill himself if she leaves, threatening to break up with her if she does not move in with him, telling a pregnant wife that he will not buy food if she does not do outside chores, or other ways of “molding me to his way” as one woman put it. Degrading comments were more commonly reported in the U.S. group such as:

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

But the Russian women also reported typical degradation:

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

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

“I was fast asleep. He came home from the bar and was mad because there was no supper. I woke up to him dragging me by my hair down three flights of stairs. I was frightened and confused. I was asleep, what could I possibly have done wrong?”

But the Spanish women also described typical incidents:

“There was no argument. I returned to his house and without a word he hit me. I asked him, ‘Why do you hit me?’ He said, ‘Because you are a woman.’”

Men used fear and threats in all the groups to force them into compliance. Typical threats included accusations that the woman was crazy, that he would take away their children and she would never find them, and that he would call the immigration or other authorities. In some cases, the man actually called the police first, and reported the woman for domestic violence knowing full well that she had hit him only in self-defense during the fight that he started. One Russian woman told of a terrorizing night
when “he took an axe, put it under the pillow, and then told me that I should go to bed.” She reported a sleepless night.

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

**Sexual Intimacy Issues**

A consistent theme in the battering incidents reported by the cross-national samples of women was the amount of jealousy in the relationships. Talking with other men, regardless of the context, or spending time with other people besides the batterer, resulted in an acute battering incident. Even tending to babies or older children’s needs could precipitate the batterer’s jealousy and a beating would follow. One woman said her partner’s favorite expression was:

“Either you will be mine or you won’t be at all.”

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

The inability to be intimate was another theme throughout the descriptions of the relationships. It appeared that once domestic violence began, the ability to attach to others was lost. Dutton and Sonkin (2003) have found that some types of batterers actually have attachment disorders that stem from childhood. It is unknown if they find women who also have problems with attachment or if living with an abusive partner actually creates attachment problems for women. Further analysis of this area can be found in Chapter 12.
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SUMMARY

In this chapter, we have discussed the analysis of how the construct of BWS was validated from the various analyses of data collected over the past 40 years. Our team is in the process of validating the BWSQ to be sure that it empirically measures the BWS. Again, the seven criteria for BWS are:

1. Reexperiencing the trauma
2. Hyperarousal of physical and mental symptoms
3. Avoidance symptoms such as depression, denial, dissociation
4. Cognitive disturbance and attention problems
5. Disruption in interpersonal relationships
6. Physical health and somatic symptoms
7. Sexual dysfunction

REFERENCES


