

# Battered women's syndrome essay



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Battered Women's Syndrome: A Survey of Contemporary Theories Domestic Violence In 1991, Governor William Weld modified parole regulations and permitted women to seek commutation if they could present evidence indicating they suffered from battered women's syndrome. A short while later, the Governor, citing spousal abuse as his impetus, released seven women convicted of killing their husbands, and the Great and General Court of Massachusetts enacted Mass. Gen. L. ch. 233, 23E (1993), which permits the introduction of evidence of abuse in criminal trials. These decisive acts brought the issue of domestic abuse to the public's attention and left many Massachusetts residents, lawyers and judges struggling to define battered women's syndrome. In order to help these individuals define battered women's syndrome, the origins and development of the three primary theories of the syndrome and recommended treatments are outlined below.

I. The Classical Theory of Battered Women's Syndrome and its Origins The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), known in the mental health field as the clinician's bible, does not recognize battered women's syndrome as a distinct mental disorder. In fact, Dr. Lenore Walker, the architect of the classical battered women's syndrome theory, notes the syndrome is not an illness, but a theory that draws upon the principles of learned helplessness to explain why some women are unable to leave their abusers. Therefore, the classical battered women's syndrome theory is best regarded as an offshoot of the theory of learned helplessness and not a mental illness that afflicts abused women.

The theory of learned helplessness sought to account for the passive behavior subjects exhibited when placed in an uncontrollable environment.

In the late 60's and early 70's, Martin Seligman, a famous researcher in the field of psychology, conducted a series of experiments in which dogs were placed in one of two types of cages. In the former cage, henceforth referred to as the shock cage, a bell would sound and the experimenters would electrify the entire floor seconds later, shocking the dog regardless of location. The latter cage, however, although similar in every other respect to the shock cage, contained a small area where the experimenters could administer no shock. Seligman observed that while the dogs in the latter cage learned to run to the nonelectrified area after a series of shocks, the dogs in the shock cage gave up trying to escape, even when placed in the latter cage and shown that escape was possible. Seligman theorized that the dogs' initial experience in the uncontrollable shock cage led them to believe that they could not control future events and was responsible for the observed disruptions in behavior and learning. Thus, according to the theory of learned helplessness, a subject placed in an uncontrollable environment will become passive and accept painful stimuli, even though escape is possible and apparent.

In the late 1970's, Dr. Walker drew upon Seligman's research and incorporated it into her own theory, the battered women's syndrome, in an attempt to explain why battered women remain with their abusers.

According to Dr. Walker, battered women's syndrome contains two distinct elements: a cycle of violence and symptoms of learned helplessness. The cycle of violence is composed of three phases: the tension building phase, active battering phase and calm loving respite phase. During the tension building phase, the victim is subjected to verbal abuse and minor battering

incidents, such as slaps, pinches and psychological abuse. In this phase, the woman tries to pacify her batterer by using techniques that have worked previously. Typically, the woman showers her abuser with kindness or attempts to avoid him. However, the victim's attempts to pacify her batterer are often fruitless and only work to delay the inevitable acute battering incident.

The tension building phase ends and the active battering phase begins when the verbal abuse and minor battering evolve into an acute battering incident. A release of the tensions built during phase one characterizes the active battering phase, which usually last for a period of two to twenty-four hours. The violence during this phase is unpredictable and inevitable, and statistics indicate that the risk of the batterer murdering his victim is at its greatest. The batterer places his victim in a constant state of fear, and she is unable to control her batterer's violence by utilizing techniques that worked in the tension building phase. The victim, realizing her lack of control, attempts to mitigate the violence by becoming passive.

After the active battering phase comes to a close, the cycle of violence enters the calm loving respite phase or "honeymoon phase." During this phase, the batterer apologizes for his abusive behavior and promises that it will never happen again. The behavior exhibited by the batterer in the calm loving respite phase closely resembles the behavior he exhibited when the couple first met and fell in love. The calm loving respite phase is the most psychologically victimizing phase because the batterer fools the victim, who is relieved that the abuse has ended, into believing that he has changed.

However, inevitably, the batterer begins to verbally abuse his victim and the cycle of abuse begins anew.

According to Dr. Walker, Seligman's theory of learned helplessness explains why women stay with their abusers and occurs in a victim after the cycle of violence repeats numerous times. As noted earlier, dogs who were placed in an environment where pain was unavoidable responded by becoming passive. Dr. Walker asserts that, in the domestic abuse ambit, sporadic brutality, perceptions of powerlessness, lack of financial resources and the superior strength of the batterer all combine to instill a feeling of helplessness in the victim. In other words, batterers condition women into believing that they are powerless to escape by subjecting them to a continuing pattern of uncontrollable violence and abuse. Dr. Walker, in applying the learned helplessness theory to battered women, changed society's perception of battered women by dispelling the myth that battered women like abuse and offering a logical and rationale explanation for why most stay with their abuser.

As the classical theory of battered women's syndrome is based upon the psychological principles of conditioning, experts believe that behavior modification strategies are best suited for treating women suffering from the syndrome. A simple, yet effective, behavioral strategy consists of two stages. In the initial stage, the battered woman removes herself from the uncontrollable or " shock cage" environment and isolates herself from her abuser. Generally, professionals help the victim escape by using assertiveness training, modeling and recommending use of the court system. After the woman terminates the abusive relationship, professionals give the

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victim relapse prevention training to ensure that subsequent exposure to abusive behavior will not cause maladaptive behavior. Although this strategy is effective, the model offered by Dr. Walker suggests that battered women usually do not actively seek out help. Therefore, concerned agencies and individuals must be proactive and extremely sensitive to the needs and fears of victims.

In sum, the classical battered women's syndrome is a theory that has its origins in the research of Martin Seligman. Women in a domestic abuse situation experience a cycle of violence with their abuser. The cycle is composed of three phases: the tension building phase, active battering phase and calm loving respite phase. A gradual increase in verbal abuse marks the tension building phase. When this abuse culminates into an acute battering episode, the relationship enters the active battering phase. Once the acute battering phase ends, usually within two to twenty-four hours, the parties enter the calm loving respite phase, in which the batterer expresses remorse and promises to change. After the cycle has played out several times, the victim begins to manifest symptoms of learned helplessness. Behavioral modification strategies offer an effective treatment for battered women's syndrome. However, Dr. Walker's model indicates that battered women may not seek the help that they need because of feelings of helplessness.

II. An Alternate Battered Women's Syndrome Theory: Battered Women as Survivors.

Over the years, empirical data has emerged that casts doubt on Dr. Walker's explanation of why women stay with their batterers or, in extreme cases, why they kill their abusers. Two researchers, Edward W. Gondolf and Ellen R. Fisher, make reference to voluminous statistics that refute the classical battered women's syndrome theory, and suggest Dr. Walker erroneously attributes a victim's refusal to leave her batterer to learned helplessness. For instance, the two, in discounting Dr. Walker's theory, cite a study conducted by Lee H. Bowker that indicates victims of abuse often contact other family members for help as the violence escalates over time. The two also note that Bowker observed a steady increase in formal help-seeking behavior as the violence increased. In addition to citing empirical data, Gondolf and Fisher point out that using Dr. Walker's theory to explain the battered woman's actions in extreme cases creates the ultimate oxymoron: a woman so helpless she kills her batterer. In an effort to account for the shortcomings of the classical battered women's theory, Gondolf and Fisher offered the markedly different survivor theory of battered women's syndrome, which consists of four important elements.

The first element of the survivor theory surmises that a pattern of abuse prompts battered women to employ innovative coping strategies and to seek help, such as flattering the batterer and turning to their families for assistance. When these sources of help prove ineffective, the battered woman seeks out other sources and employs different strategies to lessen the abuse. For example, the battered women may avoid her abuser all together and seek help from the court system. Thus, according to the survivor theory, battered women actively seek help and employ coping skills

throughout the abusive relationship. In contrast, the classical theory of battered women's syndrome views women as becoming passive and helpless in the face of repeated abuse.

The second element of Gondolf and Fisher's theory posits that a lack of options, know-how and finances, not learned helplessness, instills a feeling of anxiety in the victim that prevents her from escaping the abuser. When a battered woman seeks outside help, she is typically confronted with an ineffective bureaucracy, insufficient help sources and societal indifference. This lack of practical options, combined with the victim's lack of financial resources, make it likely that a battered women will stay and try to change her batterer, rather than leave and face the unknown. The classical battered women's syndrome theory differs in that it focuses on the victim's perception that escape is impossible, not on the obstacles the victim must overcome to escape.

The third element expands on the first and describes how the victim actively seeks help from a variety of formal and informal help sources. For instance, an example of an informal help source would be a close friend and a formal help source would be a shelter. Gondolf and Fisher maintain that the help obtained from these sources is inadequate and piecemeal in nature. Given these inadequacies, the researchers conclude that the leaving a batterer is a difficult path for a victim to embark upon.

The fourth element of the survivor theory hypothesizes that the failure of the aforementioned help sources to intervene in a comprehensive and decisive manner permits the cycle of abuse to continue unchecked. Interestingly,



Gondolf and Fisher blame the lack of effective help on a variation of the learned helplessness theory, explaining help organizations are too overwhelmed and limited in their resources to be effective and therefore do not try as hard as they should to help victims. Whatever the case may be, the researchers argue that we can better understand the plight of the battered woman by asking did she seek help and what happened when she did, rather than why didn't she leave.

Because the survivor theory of learned helplessness attributes the battered woman's plight to ineffective help sources and societal indifference, a logical solution would entail increased funding for programs in place and educating the public about the symptoms and consequences of domestic violence.

There are battered women's advocacy programs in place in courts located throughout the country. However, inadequate funding limits their effectiveness. By increasing funding, citizens can assure that all battered women will receive the assistance that will permit them to escape their batterer. Additionally, if we educate citizens about the harmful effects of domestic abuse, the public will no longer treat victims with indifference.

To recap, Edward W. Gondolf and Ellen R. Fisher developed the survivor theory of battered women's syndrome to explain why statistics indicate that battered women increase their help seeking behavior as the violence escalates. The theory is composed of four important elements. The first recognizes that battered women actively seek help throughout their relationship with the abuser. The second element posits that a lack of options, know-how and finances creates anxiety in the victim over leaving her batterer. The third element describes the inadequate and piecemeal help

the victim receives. Finally, the fourth element concludes that the failure of help sources, not learned helplessness, accounts for why many battered women remain with their abusers. Under the survivor theory, the best method for helping battered women is to increase funding for battered women's assistance programs and agencies and educate the public about the harmful effects of domestic abuse.

### III. Battered Women's Syndrome Equals Post Traumatic Stress

Disorder Although the DSM-IV does not recognize battered women's syndrome as a distinct mental illness or disorder, some experts maintain that battered women's syndrome is just another name for post traumatic stress disorder, which the DSM-IV recognizes. The post traumatic stress disorder theory is also applied to individuals who were never exposed to domestic abuse, and, in the domestic abuse ambit, does not exclusively focus on the battered woman's perception of helplessness or ineffective help sources to explain why she stayed with her batterer. Instead, the theory focuses on the psychological disturbance an individual suffers after exposure to a traumatic event.

In 1980, the American Psychiatric Association added the post traumatic stress disorder classification to the Diagnostic and Statistical Manual of Mental Disorders III, a manual used by mental health professionals to diagnose mental illness. Although the diagnosis was controversial at the time, post traumatic stress disorder has gained wide acceptance in the mental health community and revolutionized the way professionals regard human reactions to trauma. Prior to the disorder's inception, experts attributed the cause of emotional trauma to individual weakness. However,

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with the advent of the theory of post traumatic stress disorder, experts now attribute the etiology of emotional trauma to an external stressor, not a weakness in the psyche of the individual.

Since 1980, the American Psychiatric Association has revised the criteria for diagnosing post traumatic stress disorder several times. Currently, the diagnostic criteria for post traumatic stress disorder include a history of exposure to a traumatic event and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms and hyper arousal symptoms. Recent data indicate that many individuals qualify for a post traumatic stress disorder under the current diagnostic criteria, with prevalence rates running between 5 to 10% in our society.

As noted earlier, in order for a diagnosis of post traumatic stress disorder to apply, the individual must have been exposed to a traumatic event involving actual or threatened death or injury, or a threat to the physical integrity of the person or others. The authors of the early theory of post traumatic stress disorder considered a traumatic event to be outside the range of human experience, such events included rape, torture, war, the Holocaust, the atomic bombings of Hiroshima and Nagasaki, earthquakes, hurricanes, volcanos, airplane crashes and automobile accidents, and did not contemplate applying the diagnosis to battered women. The American Psychiatric Association loosened the traumatic event criteria in the DSM-IV, which replaced the DSM-III and DSM-III-R. Presently, the traumatic event need only be markedly distressing to almost anyone. Therefore, battered women have little trouble meeting the DSM-IV traumatic event diagnostic

requirement because most people would find the abuse battered women are subjected to markedly distressing.

In addition to meeting the traumatic event diagnostic criteria, an individual must have symptoms from the intrusive recollection, avoidant/numbing and hyper arousal categories for a post traumatic stress disorder diagnosis to apply. The intrusive recollection category consists of symptoms that are distinct and easily identifiable. In individuals suffering from post traumatic stress disorder, the traumatic event is a dominant psychological experience that evokes panic, terror, dread, grief or despair. Often, these feelings are manifested in daytime fantasies, traumatic nightmares and flashbacks. Additionally, stimuli that the individual associates with the traumatic event can evoke mental images, emotional responses and psychological reactions associated with the trauma. Examples of intrusive recollection symptoms a battered woman may suffer are fantasies of killing her batterer and flashbacks of battering incidents.

The avoidant/numbing cluster consists of the emotional strategies individuals with post traumatic stress disorder use to reduce the likelihood that they will either expose themselves to traumatic stimuli, or if exposed, will minimize their psychological response. The DSM-IV divides the strategies into three categories: behavioral, cognitive and emotional. Behavioral strategies include avoiding situations where the stimuli are likely to be encountered. Dissociation and psychogenic amnesia are cognitive strategies by which individuals with post traumatic stress disorder cut off the conscious experience of trauma-based memories and feelings. Lastly, the individual may separate the cognitive aspects from the emotional aspects of

psychological experience and perceive only the former. This type of psychic numbing serves as an emotional anesthesia that makes it extremely difficult for people with post traumatic stress disorder to participate in meaningful interpersonal relationships. Thus, a battered woman suffering from post traumatic stress disorder may avoid her batterer and repress trauma-based feelings and emotions.

The hyper arousal category symptoms closely resemble those seen in panic and generalized anxiety disorders. Although symptoms such as insomnia and irritability are generic anxiety symptoms, hyper vigilance and startle are unique to post traumatic stress disorder. The hyper vigilance symptom may become so intense in individuals suffering from post traumatic stress disorder that it appears as if they are paranoid.

A careful reading of post traumatic stress disorder symptoms and diagnostic criteria indicates that Dr. Walker's classical theory of battered women's syndrome is contained within. For instance, both theories require that the victim be exposed to a traumatic event. In Dr. Walker's theory, she describes the traumatic event as a cycle of violence. The post traumatic stress disorder theory, on the other hand, only requires that the event be markedly distressing to almost everyone. Thus, the cycle of violence described by Dr. Walker is considered a traumatic stressor for the purposes of diagnosing post traumatic stress disorder. Additionally, like the classical theory of battered women's syndrome, the theory of post traumatic stress disorder recognizes that an individual may become helpless after exposure to a traumatic event. Although the post traumatic stress disorder theory seems to incorporate Dr. Walker's theory, it is more inclusive in that it recognizes that different

individuals may have different reactions to traumatic events and does not rely heavily on the theory of learned helplessness to explain why battered women stay with their abusers.

There are several methods a professional can utilize to treat individuals suffering from post traumatic stress disorder. The most successful treatments are those that they administer immediately after the traumatic event. Experts commonly call this type of treatment critical incident stress debriefing. Although this type of treatment is effective in halting the development of post traumatic stress disorder, the cyclical nature and gradual escalation of violence in domestic abuse situations make critical incident stress debriefing an unlikely therapy for battered women.

The second type of treatment is administered after post traumatic stress disorder has developed and is less effective than critical incident stress debriefing. This type of treatment may consist of psychodynamic psychotherapy, behavioral therapy, pharmacotherapy and group therapy. The most effective post-manifestation treatment for battered women is group therapy. In a group therapy session, battered women can discuss traumatic memories, post traumatic stress disorder symptoms and functional deficits with others who have had similar experiences. By discussing their experiences and symptoms, the women form a common bond and release repressed memories, feelings and emotions.

To summarize, many experts regard battered women's syndrome as a subcategory of post traumatic stress disorder. The diagnostic criteria for post traumatic stress disorder include a history of exposure to a traumatic event

and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms and hyper arousal symptoms. After exposure to a traumatic event, defined by the DSM-IV as one that is markedly distressing to almost everyone, an individual suffering from post traumatic stress disorder may suffer intrusive recollections, which consist of daytime fantasies, traumatic nightmares and flashbacks. The individual may also try to avoid stimuli that remind him/her of the traumatic event and/or develop symptoms associated with generic anxiety disorders. Critical incident stress debriefing, psychodynamic psychotherapy, behavioral therapy, pharmacotherapy and group therapy are all recognized as effective treatments for post traumatic stress disorder.

IV. Conclusion Although there are many different theories of battered women's syndrome, most are all variations or hybrids of the three main theories outlined above. A sound understanding of Dr. Walker's classical battered women's syndrome theory, Gondolf and Fisher's survivor theory of battered women's syndrome and the post traumatic stress disorder theory, will permit the reader to identify the origins and essential elements of these various hybrids and provide them with a better understanding of the plight of the battered woman. Given the prevalence of domestic abuse in our society, it is important to realize that the battered woman does not like abuse or is responsible for her victimization. The three theories discussed above all offer rationale explanations for why a battered women often stays with her abuser and explore the psychological harm caused by abuse while discounting the popular perception that battered women must enjoy the abuse.

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