THE BATTERED WOMEN'S MOVEMENT AND THE ROLE OF CLINICAL SOCIAL WORK

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At a Battered Women's Conference in Nashville, Tennessee, in 1983, one of the workshops was given by a former battered woman from Texas. She told the group, composed of battered women, former battered women, and counselors and advocates from the Movement, her story. In brief, she was battered for years. As her three children grew and left the home one by one, the violence got worse. Finally, when she was living alone with her husband, the beatings reached their most dangerous level. One night, her husband, having stopped at the local tavern, returned incredibly drunk(1), beat her unconscious in the kitchen, then went to the bedroom and passed out. She awoke, the house dark, she bloody and bruised, and her husband snoring loudly. She went to the stove put on the kettle and let it come to a boil. She took the kettle into the bedroom, woke her husband up and said "Listen to me, you son-of-a-bitch. If you ever beat me again I'll wait till you're asleep, put on the kettle, and pour this over you." "What happened next?" asked one participant in the audience. "Well," said the woman, "he stopped beating me, increased his drinking something awful, and one night when he was coming home drunk he got hit by a truck and killed." The audience went wild! They clapped and cheered. The woman smiled broadly; the workshop ended.

Later in the day the speaker was alone in the hall. A participant said, "That was quite a talk." She replied, "Yup, the s.o.b bought it." "But," the participant queried, "What did you do with your feelings for him?" She looked up with astonishment, her mouth agape, then leaned against the wall and wept. "No one," she said through her tears "has ever asked me that before."

To understand how it could have happened that no one had ever asked her that question, and thus to posit the real contribution clinical social work can make to battered women, it is necessary to understand how the battered women's movement started. After a brief history and a description of its activities, the role of professional clinical social in this movement will be discussed.

For a thorough history of the Battered Women's Movement Susan Schechter's fine book, Women and Male Violence, published in 1982 (2) is recommended. For the purposes here it is only necessary to understand that the roots of the Battered Women's Movement are in the Anti-Rape Movement of the late 1960's. That Movement, in turn, was influenced by the Civil Rights Movement, the Anti-War Movement, and the most recent Women's Movement. Those movements, and struggles, set the tone for yet another feminist attempt at equality. In the 1970's, using their feminist theoretical base, women developed their own organizations throughout the United States. One of these organizations was the Rape Crisis Center. The process of its development, and the experience of providing its service, was the Anti-Rape Movement.

Rape Crisis Centers were overwhelmingly "staffed" by volunteers. Some were high school

graduates, some college students or graduates, few were social workers, and all were advocates. The Centers dealt with all forms of rape. In 1979, Burgess and Holmstrom, a nurse and a sociologist from Boston College, identified four forms of rape.(3) Their classification is still useful today. The first type of rape is Stranger Rape in which the victim does not know her attacker. The second is called Confidence Rape. In this form the rapist gains access to the woman by winning her confidence through a ruse. He may pose as the Con Ed man to get in the apartment door, or as a motorist in distress to get her to stop her vehicle to help him. The third form is called Acquaintance Rape, now often referred to as Date Rape(4). An Acquaintance, against the woman's wishes, forces her to have sex, rapes her. The fourth type of rape is Marital Rape, rape occurring within the context of marriage.

The predominant type of rape the Rape Crisis Centers saw in the beginning was Stranger Rape. This is not hard to understand. If you think of the types of rape, and our society's view of women's culpability in rape(5), then those who were victims of Stranger Rape could more easily identify as "worthy" victims. The more a women was removed from the "worthy" status, i.e. she was responsible because she fell for the ruse and let him in the door, or dated him, or married him, the less likely she was to see herself as a victim "worthy" of service, and therefore she generally did not seek it.

Rape Crisis Counselors, by and large, were not social workers, were not trained except by each other, and saw themselves as unabashed advocates for survivors of rape. But, even though they were dealing mostly with Stranger Rape, or more "worthy" victims, they still had to deal with a woman's feelings of guilt expressed as "I should not have been on that block; I should have dressed differently; I should have worn less makeup, etc." This was particularly hard for the counselors to deal with effectively. The problem for them was one of politics vs. clinical intervention. They were from a movement based on feminist philosophy, armed with the accurate information that rape is not an act of sex but an act of violence. They had the evidence that rapists do not discriminate as to who they rape; that any woman young or old, attractive or not, revealingly dressed or dressed like a nun, was a potential victim. It was hard for the original counselors and advocates not to drown out the rape victim's voice with a polemic about how it was not her fault. What they did not understand was that the woman was taking control in assigning herself guilt. The later clinical contribution to the work on rape was the understanding, uncomfortable as it is, that women needed to feel guilt at first so that they could feel control. If they had done something to "cause" the rape, then they could do something else to prevent it in the future. It is only in the process of working through the experience, of learning that one can survive whole, that women can come to grips with the horrifying fact that indeed there is nothing that one does to provoke rape. Ultimately the political lesson - you did not cause the rape, no matter what society says - is learned. But it is learned in a process which entails guilt, then giving up the guilt, and thereby relinquishing the perception of control.

Social work entered the Anti-Rape Movement through the back door. As the counselors at the Rape Crisis Centers successfully advocated and lobbied for services, government at all levels began to supply money. As money became available, hospitals and social service agencies began to apply for funds, rape crisis services moved into Emergency Rooms, the service was bureaucratized, and social workers were hired.

At the same time, some of the original rape crisis counselors and advocates had begun to look at

more issues of violence against women. As the types of rape seen at the clinics expanded from Stranger to Acquaintance and Marital rape, the counselor/advocates began to question the social construct that allowed for violence against women, and to realize the need for services for women trapped in violent relationships. The progression to a Battered Women's Movement was a logical one.

The Battered Women's Movement took physical form, not in centers, but in shelters. This is an exceedingly important distinction. In the early 1970's if a woman left a violent relationship she was denied welfare because she was still legally married. If she went to a public shelter she was placed with fire victims, alcoholics and sometimes the mentally ill. The development of shelters specifically for battered women was a definite advancement. Many of the early shelter founders and staff, coming from the Anti-Rape Movement, saw the shelters as "sanctuary", as a way to "save" battered women. In this context, however, the shelters ran up against two enormous problems: children and ambivalence.

The counselors and advocates at the Rape Crisis Centers had not provided service to children. Perhaps here and there a woman went to a Center with her child because she could not find child care, or did not want to be separated from her child, particularly after experiencing personal violence. But the child was not a focus of any of the work done in the Center. The child was more an appendage. Workers sought other workers to entertain the child while they worked with mom, or hoped the child would be quiet, if young enough to stay with the mother, and not understand what was being said. There was no programming for children in the Rape Crisis Centers.

When the shelters opened, no matter what their size, instantly, two-thirds of the residents were children. In retrospect the reasons seem obvious. A battered woman without children could possibly be more mobile, might have friends able to take in a single person. Women with children would probably be less mobile and their friends, assuming there were some, were less able to house three or four additional people. The shelters, without programs for children, or provision for their care so that mother could navigate the courts, find new housing, look for employment or apply for welfare, suddenly found themselves teeming with children. Programs for children, play rooms, activities, day care, shared child care, were all added after the fact. It is important to understand that the counselors and advocates who began in the Battered Women's Movement came to work with women, not with children.

The second, and perhaps greater problem in the transition from working with rape victims and survivors to working with battered women, was the issue of ambivalence. While the rape counselors had had to confront, though not always effectively, the issue of guilt, they had not had to confront the issue of ambivalence.

The founders of the Battered Women's Movement, of the first shelters, were providing "sanctuary" for women fleeing violent relationships. They were completely unprepared for a woman coming in the middle of the night to safety, bruised and bloody, yet three days later wanting to return to the batterer. The counselors were appalled that women could "love" someone from whom the Movement was trying to save them.

The issue of ambivalence, particularly in the face of violence, is a profound and troubling one. The early workers in the Movement, because they were there to "save" to "rescue," had little

tolerance for allowing a woman to tell her story as it was, and not how they wanted it to have been. They struggled mightily with themselves, as they knew the basis of feminist interaction is to listen and to hear women who have often been silenced or unheard in the past. Bardwick and Douvan, in their wonderful chapter entitled "Ambivalence: The Socialization of Women"(6), articulate some of the causes of women's root ambivalence, but only the most relevant are suggested here.(7)

Women in this society are socialized to be care-givers, nurturers, forgiving. This socialization, appropriate and successful in some situations, is a major obstacle in the face of domestic violence. Consider: many people on learning about a woman being battered ask the question, "How can she stay?" Instead, the question should be framed, "How can she leave?" Leaving a battering relationship flies in the face of all a woman's training, all her socialization.

To complicate matters further, no battering man is purely, always, only violent. There can be tender moments, if only precious few. There can be caring, if only financial. There can be comfort, if only of the familiar.

Therefore, to leave a battering relationship a women must not only fly in the face of all her socialization, and recognize that she will experience economic hardship. She must also leave the sanctioned, the familiar, and suffer the loss of hope. She must come to grips with the fact that he will not seek help, and that therefore things will not get better. This realization requires a mourning process (9) on her part. She needs to mourn the loss of the familiar, the good parts with the bad, to grieve over the loss of her the dream, no matter how meager, that brought her into the relationship in the first place.

Most of the original counselors and advocates for battered women were unprepared for this work. Many of the women who came to the shelters used coping responses that made their leaving astonishing, and their staying away from the violent relationship nearly impossible. Pfouts in her 1978 article "Violent Families: Coping Responses of Abused Wives"(8), described two of these responses as "Self-Punishing" and "Reluctantly Disengaging." In the first instance, the self-punishing woman blames herself for the battering. "If only I were a better wife, a better mother, more attractive, more accomplished, and on, and on, then he wouldn't hit me." In the second, the Reluctantly Disengaged woman leaves the batterer and goes to the shelter, not out of any feminist political position that no woman deserves to be hit, but because of the fear that the battering is beginning to affect the children, or because the most recent beating was so severe she is afraid of being maimed or killed. In both cases, with distance from the last beating, the woman falls back on coping skills that would be helpful in another situation but which here lead her only to return to the batterer. In the first instance, the self-punisher begins to think that she can get a handle on "making things better." She will cook better, discipline the children more effectively, lose weight and wear make-up. Then he will not "have" to hit her. In this case, problem solving skills, and the optimism that things can be fixed, which would stand her in good stead in another situation, conspire against her. In the second case, as the days go by for the reluctantly disengaged woman, the children complain about being in the shelter, missing their friends, missing their father. She has second thoughts. Or, over weeks, the bruises heal, the stitches come out, and her original, accurate assessment of the danger she was in during the last beating is mitigated. In both cases, she returns to the batterer.

The first women to use the battered women's shelters very often returned to their battering mates

because of their socialization and the use of coping skills described above. The original counselors and advocates watched in dismay as a woman entered the shelter, engaged in counseling and group, and then went back to the batterer. They began to notice another phenomena: the woman re-entered the shelter again at a later date. She re-engaged in counseling and group, time went by, she returned to the batterer yet again. And so on, and on.

Those counselors and advocates did not understand: that battered women need to mourn the loss of even an abusive relationship; that mourning takes time; that one way ambivalence is resolved is by practicing new, self-reinforcing behaviors over and over; that few women would leave once and be done; and that repeatedly coming to the shelter, even though they returned to him, could be healthy in the long run - as the practiced behavior of leaving became the practical behavior: left. Because this was not understood, one of two things happened at the original shelters: there was absolutely horrific staff turnover as counselors and advocates burned out, or they began subtly to blame the women. They manifested this by having more and more rules governing the women's behavior in the shelters: particularly having limits on how many times, and in what period of time, a woman could use the shelter.

It is in this context that clinical social work has its greatest role and most profound responsibility.(10) Clinical social work's place is not in the forefront of advocacy, although we should be advocates; it is not in leading program development, although we should develop programs. Clinical social work's most valued contribution should be in the area of clinical intervention itself.

Clinical social workers need to inform themselves about the specific issues of working with battered women and, if need be, amend their practice accordingly. Taking jobs in shelters, providing clinical supervision to battered women's workers and doing training would be invaluable. For example, current training for most counselors in the shelters and elsewhere in the Battered Women's Movement is heavy on the political agenda, light on the clinical. But one does not have to negate the other. This is an important lesson. Politics does not have to be in opposition to clinical intervention. In fact, it is the weaving together of advocacy and clinical acumen that is a cornerstone of social work practice. Consider this: when the original counselors started, they denied that any woman who was battered might also be mentally ill. They took into the shelters women they could not help, or women who should not have been there as they were a risk to themselves or others. To teach that the lives of battered women exist on the same continuum as those of other women, other people, a continuum from mentally healthy to mentally ill, does not eradicate the political message that no woman deserves to be hit. Nor does it say that all battered women are mentally ill (Masochistic or Self-defeating Personality Disorder). It merely says that battered women present the normal range of mental health and should be assessed and served appropriately. Social workers knowledge of mental health, coupled with an understanding of ambivalence, would be a great clinical contribution.

Second, social workers should address the children. Social workers can and must make the children a focus of programming and clinical intervention as much as their mothers. This can be done by training the shelter counselors in working with them. When they feel competent, they will more willingly work with children. Many of the current shelter counselors are young - they need information on normal child development, as well as on assessing the amount of abuse the children have sustained physically, emotionally and psychologically.

With regard to the staff itself, it is not uncommon for shelter staff members to begin to feel that they themselves have become "battered women." They begin to feel hopeless, helpless, and victimized in their work because they are underfunded, overworked, and negligibly supported. Information and competence help one to overcome these perceptions. Staff training on clinical issues, as well as on organization-capacity-building would be more than helpful. A family systems perspective to show how they as an organizational "family" have become dysfunctional is one way to identify for them what has happened to them as an organization and give them intervention skills at the same time..

Social workers must remember that, as a profession, as a group, we were not well represented at the beginning of this Movement and we are not currently well represented on the staffs of shelters. If social workers are to take positions in shelters, volunteer, consult and train in the legitimate areas of clinical social work expertize, it needs to be done with this understanding. Clinical social workers need to learn what shelter staff have learned over time, and need to frame clinical expertize in a political context.

If clinical social workers could join in the work of the Battered Women's Movement on this level there might not be another woman out there who left a battering relationship, however it was possible, and was sheltered and encouraged and praised, but was never asked about her pain.

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NOTES

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