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THE BARRIERS MODEL: AN INTEGRATED STRATEGY FOR INTERVENTION WITH BATTERED WOMEN

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This article examines the barriers facing victims of domestic violence and offers therapists an integrated model of intervention combining both case management and psychotherapy strategies. Visually represented, The Barriers Model places the battered woman in the center of four concentric circles. Each circle represents a layer of barriers in the battered woman's experience that potentially impedes her safety. These layers include: barriers in the environment; barriers due to family, socialization, and role expectations; barriers from the psychological consequences of violence; and finally, barriers from childhood abuse/neglect issues. Therapists are provided with an explanation of each layer of barriers, questions to help identify the extent to which these barriers are preventing the woman from becoming safe, and strategies to address these barriers with the battered woman.

While resources available to battered women have grown in recent years, professionals working with this population have continued to struggle with meeting the needs of these women. Today, many cities across the country have shelters or domestic violence resource centers available. In addition, more and more therapists are citing family violence as an area of clinical expertise. Women experiencing family violence, however, continue to report difficulties in receiving these services. Battered women often report that there are numerous barriers impeding their efforts to free their lives of violence. This article examines the barriers facing victims of domestic violence and offers care providers an integrated model, combining both case management and psychotherapy strategies, for working to meet the needs of this population of women within the context of these barriers. The model was developed as a result of the authors' combined experience of 23 years of work with thousands of battered women in shelter and nonshelter settings.

The Barriers Model was developed in response to the strong codependency movement of the late 1980s that pathologized battered women without recognizing or addressing the external and internal oppression accounting for their behaviors and symptoms. Clearly, battered women and their therapists recognized the behaviors of battered women in the proliferation of self-help books that appeared on the topic of codependency. Hagan (1993) summarized several attributes defined in the literature as codependency, such as external referencing, martyrdom, poor self-esteem, controlling behavior, demoralization, and needing to be needed. Indeed, many battered women do display these qualities. What these books failed to acknowledge is that these symptoms identified as codependency may not have been a disorder resulting in unhealthy patterns of intimacy, but instead, the very behaviors that allowed women to survive relationships with violent partners. As Hagan (1993) explains, the term codependency

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masks the political context of oppression in which women live. The neutrality of the term minimizes the power differential between men and women and pathologizes women who have been socialized into a system of dominance (Hagan, 1993).

The temptation for both therapists and clients to collude with the belief that the oppressed individual is to blame is understandable. Victims are likely to be drawn to the idea that they are at fault for the violence in their lives because it is consistent with their socialization as women (Hagan, 1993). It is conceivable that battered women may prefer to believe that the problems in their relationships are rooted within themselves and thus changeable, rather than acknowledge the lack of social and legal controls placed on their partners and the resultant low probability that they will actually become nonviolent. Therapists may be tempted to collude with victims' investment in the label of codependency because most traditionally trained therapists have been taught to view all clients' struggles from an individualistic, not social, perspective. Asking therapists to recognize the barriers facing these women is asking therapists to recognize a daunting and overwhelming world view. Yet, this is precisely what is required to work effectively with this, and any, oppressed population. To continue to collude with an individual pathology framework is at best, ineffective and, at worst, detrimental to the welfare of clients from oppressed populations.

The Barriers Model is presented to facilitate a paradigm shift for therapists working with marginalized populations. This model is presented with the recognition that the most important client of feminist therapy is the very culture in which the therapy takes place (Brown, 1994). The model provides a theoretical road map for therapists working with clients who are experiencing problems living in a patriarchal society due to externalized and internalized oppression. It presupposes that symptoms displayed by clients are often the result of colliding with socially imposed barriers to well-being rather than deep-seated, individually rooted pathology. By definition, The Barriers Model places the primary

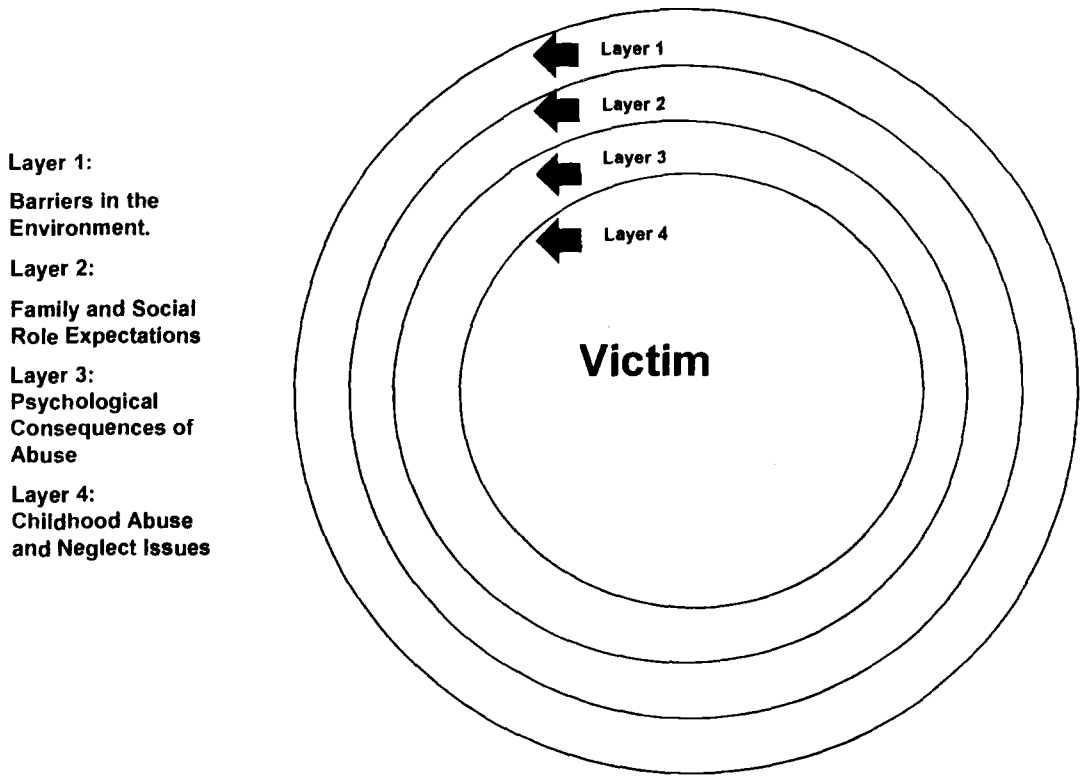

Figure 1. Model of Barriers: Effects of External Environment and Life Experiences on Victims of Domestic Violence

locus of analysis on society and context rather than on the individual.

The Barriers Model

Visually represented, The Barriers Model places the battered woman in the center of four concentric circles (see Figure 1). Each circle represents a cluster of barriers in the battered woman's experience that potentially impedes her safety. These clusters, or layers, are not linear. Victims may experience barriers in all four layers or in some combination of them.

In working with domestic violence victims, one should begin with a focus on the barriers in Layer 1 (Barriers in the Environment). Until these barriers have been addressed, focusing therapy around issues presented in the other three layers will be ineffective and could contribute to the victim's isolation and self-blame, and thus, the danger she is in. Contrary to traditional training and practice, which often focuses exclusively on the innermost layers represented in this model (i.e., purely psychological or childhood issues), care providers are advised to avoid initial focus on the more internal layers for two primary reasons. First, helping the victim access resources and eliminate the barriers in her environment (Layer 1) may save her life. Second, focusing on the more internal barriers before addressing the external ones will reinforce her sense that there is something wrong with her, or that her history caused her to be abused. Each of the layers will now be considered individually.

Layer 1: Barriers in the Environment

Depending on the resources in any given community, these barriers may or may not be influencing a victim's perception and experience of resources needed to escape a violent partner. It is unlikely that all of these barriers would be present in one client's life, but many battered women will be experiencing several of them.

Information/Misinformation

Because of the social isolation battered women experience (NiCarthy, 1986), they often have little access to information about the dynamics of abuse, where they can go to get safe, community resources, and legal options for a more permanent separation from the abusive partner. For many, the batterer is a central source of information about the abuse. The abuser's messages such as "no one will believe you," "no one will help you," "they will remove the children if you go to a shelter" often become her only reference information. Even when victims have contact with outsiders, they are often not given the information they need. One study (Sugg & Inui, 1992) found that more than half of physicians in the United States report being uncomfortable asking patients about the cause of injuries being treated. This silence allows even victims who reach out to remain uninformed about their options and rights.

The centrality of information as a powerful tool for escape from abuse is best demonstrated by the frequency and intensity of the abuser's attempts to keep the victim uninformed, isolated, and confused. Many battered women report some attempt at isolation by abusive partners, ranging from manipulative attempts to keep the victim out of touch with family and friends, to extreme measures such as removing the phone or wires from the car. If information were not such a powerful tool for escape, abusers would not try to maintain such control over it. Rather than assume the client's level of insight, therapists need to explore what the client knows about abuse dynamics, what help is available, and be willing to link the client to needed resources.

Batterer

Trained therapists often become so focused on what is going on in the victim's psyche that they often forget tangible, even physical barriers to her leaving. In severe and advanced battering situations, the abuser physically prevents the victim from leaving. This includes locking her in the house or out of the house away from medication, the children, money, and other resources. Victims living with extreme domestic violence are locked in rooms and accompanied in public by the batterer at all times. Some report being kept in the house by their abuser's relatives or friends when he needs to leave the house; in extreme cases older children are inducted into this role. An Ohio judge shared a classic lesson learned about how real a barrier the abuser can be. Frustrated by the number of domestic violence complaintants not appearing for the arraignment of the defendant, other local judges had issued bench warrants so that they could arrest the victim to get her to come to court. This judge, not wanting to take such punitive measures, sent a deputy to the home of one such battered woman who had failed to appear at court. The deputy peered through the win-

dows prior to seeking entrance only to find the defendant literally sitting on top of the victim on the living room floor, preventing her from appearing at court, in hopes the charges would be dropped. Therapists need to explore what tactics the abusive partner has employed to keep the victim from leaving.

Money

The better-compensated caregivers are, the more difficult it may be to remember or imagine life without enough money to get by. Leaving an abusive partner is an expensive venture in and of itself, irrespective of the general means on which one has to live. Consider fees for attorneys, housing and utility deposits, transportation, and child care. Starting a home from scratch means replacing basic items such as sheets, towels, and household supplies. Some victims have additional medical bills from injuries or stress-related illnesses for themselves and their children. While the victim may have been living a middle-class existence or higher, leaving the abuser often means leaving everything behind. Often when a victim flees the home after an assault and attempts to remove funds from a bank account to live on, she finds her partner has anticipated her next move and closed the account. Still many other battered women, whose partners control information in the relationship, do not know how much money is in bank accounts or where they are.

Once the victim with children has committed to terminating the relationship, more serious costs may arise. If the abuser is the legal or biological parent of the children, seeking custody of the children is a frequently used strategy to get her to come back. Some battered women, not able to afford psychological evaluations or sustained court battles, reconcile when it appears they may lose permanent custody of their children. Therapists need to understand the financial means their clients have, to actually make a transition to independence from the abuser, and be familiar with community resources to which they can link clients for financial assistance.

Transportation

Many victims, particularly those in rural communities, lack transportation to get to safe shelter, and subsequently to appointments for themselves and their children (e.g., medical, legal, looking for housing, welfare). Those working with victims who are physically isolated will need to creatively address their needs to move around the community as they implement plans for safety or separation. This includes a plan for how the victim will get to a shelter if necessary.

Police Assistance

The police can provide key tools to escape or put up serious barriers to safety. Many in the psychological field assume that consistent police response occurs, and are sometimes surprised to hear stories to the contrary from clients. First, not every state in the United States has a mandatory or preferred arrest statute. This means that for many battered women, a call to the police may still be answered by officers practicing antiquated strategies such as mediation, walking the abuser around the block, advising the victim to buy a gun because "there is nothing we can do," and threatening to place both parties in jail if they are called back. Before a therapist focuses on clinical resistance as an explanation for a client's reticence to call the police, more information about local police practice is needed by the therapist. Care providers are encouraged to explore answers to the following questions: What policies do the police have in your community regarding arrest? Will the victim be required to cooperate with criminal prosecution to get the abuser arrested? Will anyone be there to explain what that means to the victim and assist her through the difficult prosecution process? Do police enforce violation of protection orders with arrest? For any battered woman, involving outsiders, especially powerful entities like the police, is a risky venture. If the police do not respond firmly with the offender, both the victim and the abuser learn a powerful lesson: that no one will stop the violence and hold the abuser accountable. The abuser's message that "no one will help you if you try to leave" is validated.

Criminal Justice System

Similar concerns arise as victims attempt to use the criminal justice system. An analogy about medical care best illustrates the dilemma many victims experience. Suppose someone were suffering from medical symptoms that made them concerned for their life. Suppose they saw a doctor who told them he or she would perform a procedure, but could not explain exactly how it would be done. Imagine that this physician also advises this person that it is impossible to predict whether the procedure will make their health con-

cern any better. Would anyone accept medical care on these terms? Yet this is precisely the premise upon which we ask domestic violence victims to enter the criminal justice system. While some courts permit victims to have advocates with them, even these workers cannot with certainty predict the outcome of the prosecution process. Everyday in many communities, victims cooperate with prosecution of their abusers only to discover pretrial service workers who recommend noncash bonds in the most dangerous of cases. They find prosecutors with mind-boggling dockets who plead their cases down in the hallway without any consultation with them. Some battered women are asked to help enforce house arrest as a condition of bond in cities where jail overcrowding is an issue. Others find that their abuser is released directly from jail, usually without notice to them. They often find judges who still issue the typical sentence of a suspended fine, a suspended sentence, and unsupervised probation. As in the case of the police, abusers and victims can learn powerful messages from the inaction of courts. Offenders can learn that the system is a joke, and that it is unprepared to hold them accountable. Victims often learn there is no help for them here, and may turn to other strategies such as buying weapons.

While best practice in this area has been defined, most cities in the United States lag far behind. Quincy, Massachusetts, has eliminated domestic violence homicide for over nine years; San Diego, California, has reduced their domestic violence homicide by 60% in two years. These cities recognize the risk the victim incurs when she cooperates with prosecution, and they prosecute based on evidence, often without her testimony. Bonds are set high, weapons are removed from abusers, outstanding warrants are checked, lethality assessments are done, and sentencing imposes real limits and a strong message to abusers. Therapists need to explore what the likely response is from prosecutors, pretrial evaluators, judges, and probation officers in their own cities.

Attorneys

Inaccessibility of legal counsel is a major barrier for many domestic violence victims. This is ironic, since the most powerful relief in many states, such as long-term protection orders, child custody and child support, is available under civil codes best accessed through legal counsel. While some states allow *pro sae* filings, it is not advisable for any domestic violence victim, particularly those with children, to enter into a legal process with their abuser without an attorney. With some members of congress attempting to downsize or eliminate the Legal Services Corporation which funds many Legal Aid offices across this country, many victims simply cannot get an attorney to file for emergency protection orders, child custody, and alimony. Many must rely on abusive families of origin to get the money for an attorney. When victims secure pro bono attorneys, they sometimes find they are represented by corporate attorneys with no domestic relations experience, or individuals who do not deliver the same caliber of legal services they provide paying clients. Many victims receive legal advice that prioritizes their property interests over their safety and that of their children. Therapists need to know how clients can retain affordable legal counsel in their community and help clients access these services.

Religious Counseling/Guidance

Many victims seek the help of a priest, rabbi, pastor, or other faith leader first. Depending on the religious values about the family, many victims hear that the abuse is their fault, God's will, and within their control if they are only more obedient partners. Rarely do battered women report that it was the advice of a religious figure that convinced them their safety was the most important issue. Therapists working with battered women who require a spiritual component to their process are encouraged to locate religious guidance that will prioritize safety first.

Mental Health System

Many battered women need therapy to heal from the complex effects of trauma. In the age of managed care, they often discover brief treatment modalities as their only option. For this population, the inaccessibility of longer-term therapy is a barrier to both safety and recovery. Brief modalities exclude the trauma victim's specific needs for time to build trust, time to take the risk of disclosing often humiliating abuse, time to explore options, time to begin implementing a plan of action to escape abuse, and time to begin and complete the exhaustive healing process.

Some battered women end up in the mental health system, after presenting in the hospital emergency room (Stark & Flitcraft, 1982). What many of these women find is a system so focused in a disease/pathology model, that mental health

becomes paramount over survival and safety. Many battered women develop anxiety and depression, as well as chemical-abuse problems in response to ongoing trauma. Some develop posttraumatic stress reactions. These are real symptoms that need attention, but within the context of trauma. A common mistake is to move toward medication immediately, in the name of stabilization. What care providers may forget is that domestic violence victims need all their faculties, and that certain drugs may impair their ability to perceive imminent danger and react to it. Further, many are unaware of the correlation of domestic violence with suicide. One study found that one out of four female suicide attempts was preceded by abuse (Heise, 1993). Unfortunately, many therapists are so focused on these symptoms, they forget that they may be the only ones who can help victims navigate the community systems they need to get safe. A therapist may be the only one to give the domestic violence victim the number to the local shelter.

Many mental health practitioners continue to employ contraindicated modalities, such as couples counseling, that do not address the victim's needs and may endanger her. Some still see domestic violence as a relationship issue much like many used to see rape as a sexual issue. The reality is that marital/relationship therapy endangers victims, does not address the behavioral problems of the abuser, and does not succeed in getting the violence to stop (Bograd, 1984). Many battered women report going into sessions with the abuser, making disclosures about the abuse in response to the therapist, and getting beaten on the way home from the session, sometimes while still in the counseling facilities. Victims are also routinely pulled into conjoint modalities in the context of chemical-dependency treatment for their abusive partners. While treatment of all family members is the norm in chemical-dependency treatment, it is a strategy that can undermine the safety of battered women. The aforementioned risks that come with disclosure occur here as well, and there is a danger she will be pulled into seeing him as having a "disease," and will consequently feel responsible to aid in his recovery. The tendency of some battered women to remain with, and feel responsible for, their chemically-dependent, abusive partners becomes less baffling to care providers in light of the common use of treatment strategies that support such feelings for abusers, no matter how much danger they may pose for the victim.

Many battered women continue to be labeled as addicted/codependent and put in a group for "women who love too much." As noted earlier, many battered women may display characteristics consistent with codependency theory. While many women who do these things are simply acting on overwhelming female socialization (Hagan, 1993), battered women also do them to survive. It is important for therapists to recognize client behavior within the context of real trauma. Domestic violence victims have no less desire to live than nonabused women. Their behavior is almost always strategic, albeit puzzling to outsiders. The real tragedy is to label compliance with the abuser as codependency, when, at least in that moment, it may be the only thing that kept this person alive long enough to get to the therapy office. These behaviors are survival-based while with a dangerous mate, and will need to be adapted once the survivor is safe. A strength-based therapy approach will help the domestic violence victim to see how skillful she was while in the unsafe situation, and will help her to adapt to behaviors more centered on her own needs later, when it is safe to do so. Walker (1994) refers to this approach as survivor therapy.

Finally, the area of psychological evaluation often poses formidable barriers to battered women. Standardized tests such as the MMPI are often administered on battered women in the context of custody evaluations by individuals who are not aware that victims of trauma will score false positives on some scales (Rosewater, 1985). Unfortunately, the results of these tests often lead psychologists to conclude and eventually portray to the court a victim who is angry, paranoid, psychotic, and/or highly conflictual. These conclusions are often the cornerstones of court decisions about whether her abuser gets custody of her children. As noted by Liss and Stahly (1993), the effect of abuse on an individual's ability to parent is rarely considered by courts when determining custody. Therapists conducting psychological examinations need to become familiar with the pitfalls of using standardized tests on both victims and abusers, and establish other means of assessment.

Physical and Cultural Accessibility to Shelters/Services

The system of protective shelter in the United States evolved beginning in the late 1970s. The groundswell of domestic violence victims who

now seek shelter continues to increase every year, while beds do not. Many domestic violence shelters, to the horror of those victims who finally muster the courage to leave, have waiting lists. Therapists need to have information about many different shelters in their state so that they can effectively link a client to a shelter in a crisis. Therapists may also want to consider the theoretical orientation guiding services at shelters to which they refer, as these will vary.

While this model may have a separate application for understanding the barriers to well-being faced by any person marginalized by physical abilities, ethnicity, or sexual orientation, within this application these factors pose additional concrete barriers to domestic violence victims. Accessibility, while potentially a barrier to all victims, is a larger concern for marginalized groups.

Discrimination. Often due to ignorance, certain victims encounter difficulty accessing shelter services. Some programs have policies that officially or unofficially do not admit prostitutes, HIV-positive victims, and women who have physically defended themselves. Chemically dependent and mentally ill victims are also often not admitted to shelters, either due to ignorance or inadequate staff resources for addressing these additional needs.

This also occurs with many lesbian victims who are often officially or unofficially unwelcome at some battered women's shelters by either staff, other clients, or both. Because the abuser is also female in these cases, many lesbian victims fear the abusive partner will get admitted to the shelter posing as a victim. Lesbian victims also face the choice of coming out, or lying about who the abuser is. Because coming out may pose the threat of loss of job, housing, family support, and child custody, many choose to lie about the gender and identity of the abuser, and forgo any protection the legal system might afford as a result.

Battered women who have been arrested also face discrimination and difficulty getting into some shelters. As states adopt proarrest policies, some which require that one of the two parties be taken to jail, many battered women are being arrested for self-defense. This often occurs in choking/strangulation cases, where the victim has no visible injuries until later (and then only detectable by trained officers) and the real offender is often covered with scratches and marks inflicted by the victim while being choked. Police officers may also make arrest errors in cases where battered women defend themselves with weapons to offset size and power differences between themselves and their attackers, often resulting in serious injury to the primary aggressor. Programs in states with newly adopted mandatory/proarrest statutes report that primary aggressor assessments are difficult, and sometimes officers arrest the victim. Domestic violence agencies report that battered women are being arrested, sometimes even with visible injuries inflicted upon them, such as concussions, broken bones, and head injuries requiring stitches. Unfortunately, some shelters now have policies that refuse admission to victims who have been arrested, regardless of whether they were defending themselves. Therapists need to understand what the admission criteria are for shelters in their own community and perhaps engage shelter policymakers in a dialogue.

Language. Many police departments still respond without language interpreters to 911 calls from victims who are deaf or hard of hearing or nonEnglish speaking. Many social service agencies, including shelters, do not have TTY machines. Deaf and hard-of-hearing victims, and those who do not speak English, often find their children must serve as interpreters for them to call crisis lines and have intakes at shelters. This reliance on child interpreters poses problems beyond the obvious impact of exposure to all of the details of the abuse of their mothers and the responsibility placed on them. If children who translate for their mothers later disclose allegations of physical or sexual abuse, they are often suspected of being coached because of their advanced language skills. Therapists working with the children of such women need to explore how much responsibility has been placed on them due to the language barriers of their abused mothers, and consider their adult-like language in this context.

Battered women who do not speak English often have limited access to support groups or court because of the lack of interpreters. Depending on how rare the language requiring translation is in a particular community, the only translators available may be people the victim and abuser know, thus potentially impeding trust and possibly further endangering the victim. Therapists working with clients who face language barriers need to become familiar with translator resources and the dynamics of using them in these cases.

Physical barriers. Most domestic violence shelters in the United States opened in the late

1970s to early 1980s, often in old houses. Many are not accessible to victims in wheelchairs or those who need assistance getting around. Many use bunk beds to increase capacity. Even with the Americans with Disabilities Act, these and other agencies the victim may need are often not accessible to individuals with particular handicaps. While some shelters have contracted with local hotels or motels to provide access, many have not. For the victim in a wheelchair, or with an illness that requires care, often the choice is between an abusive caretaker and independence in substandard living conditions. Other resources, such as disability agencies, should be explored as potential referral sources as well.

Culture. Women of color, foreign-born women, and women who are not from the majority culture may be admitted to shelter programs only to find a monoculturally-based menu of services. Most domestic violence programs center around counseling (usually with a person from the majority culture), support groups (where the battered woman of color may be the only person of her ethnicity), and legal services. This last option ultimately relies on the police for enforcement of orders from the court. Many victims of color find their mistrust of the police not understood by shelter workers who see protection orders as the foundation of safety.

Immigration. Battered immigrant women face additional cultural barriers and legal barriers. Many of these women are undocumented. Because some shelters require that victims have a job or apply for public assistance, undocumented victims often face the choice of violence or temporary shelter followed by deportation. Therapists need to know the shelter policies before referring battered, immigrant women. Also, while federal immigration law has recently changed to increase protections for battered women, therapists working with this population should become familiar with local immigration legal resources.

Affordable housing. The lack of affordable and safe housing can be a barrier for domestic violence victims who often can only stay in shelters for 30–90 days, regardless of the availability of transitional or permanent housing. Many find the only affordable housing is in high-crime areas where they and their children face further trauma from strangers. One battered woman, counseled by the first author, was raped by a neighbor only weeks after leaving the shelter to move into a minimally secured apartment in a high-crime neighborhood. She reconciled with a very dangerous partner, explaining that the predictability and familiarity of his violence was preferable to unpredictable attacks by strangers.

In summary, most battered women face several, but usually not all, of the barriers outlined here. The presence of these barriers requires that the therapist working with battered women be willing to step out of the therapy role to educate herself or himself about public policy and law, provide information, case management and advocacy for her or his clients, and become a force for systems change when it is required for the safety of clients.

Layer 2: Barriers Due to Family/Socialization/ Role Expectations

In working through this layer of barriers, several factors within the battered woman's life need to be considered including: female socialization in patriarchal culture, individual and societal values and attitudes, personal identity, religious beliefs, and rules learned within one's family of origin. First, consider the impact of female socialization in the context of patriarchal culture.

Values/Beliefs about Relationships

The psychology of women has provided important examples of how women's relationships, behaviors, attitudes, and beliefs are shaped by the demands and threats of the dominant patriarchy in which women live (Debold, Wilson, & Malave, 1993). Gilligan, Rogers, and Tolman (1992) have suggested that when adolescent girls encounter this wall of patriarchy, they learn to give up parts of themselves in a compromise for safety and acceptance within society. This compromise often results in girls and women looking to men to validate their own personal authority (Young-Eisendrath & Widemann, 1987). As a result, many women have been socialized to believe that they need a man to have value. Minimally, women learn to develop their identity in the context of relationships; few role models exist for the autonomous development of female identity. To survive in this system of dominance (Hagan, 1993), many women learn to put themselves last. They learn to sacrifice their needs for those of their partners or their children. For battered women who have made this compromise, asking them to leave their abuser is asking them to leave that which they may believe they need to survive.

Identity

All women struggle to form healthy identities in a patriarchal society. Forming a sense of personal identity is often an even more daunting challenge for battered women. Attempting to placate an abusive mate often requires one's full attention. Little time is left to be introspective about one's own wants, needs, or dreams for the future. Indeed, doing so often only serves to remind battered women of the sharp contrast between their dreams and the harsh reality of abuse.

In addition, the well-noted isolation battered women experience often forces them out of the workplace, out of old friendships, and away from alternate sources of support. As a result, the victim's relationship with the abuser may be the only significant relationship in her life. Many battered women have been brainwashed for years by the abuser to believe they are incapable of surviving on their own, mirroring potent cautionary messages in the culture about the ability of any woman to survive on her own. Asking a battered woman to give up that relationship may be asking her to do what feels impossible. These ingrained messages about needing to be in a relationship and needing male protection represent examples of barriers experienced in the second layer.

To be most effective in removing the barriers battered woman face as a result of their socialization, care proviers are encouraged to explore the following areas: What does this client believe about living without a partner?; What does she believe she can accomplish on her own?; What does she believe about putting herself first, before what her abuser or her children want?; and finally, Who does she believe she is, or can be, if she is not in this relationship? The answers provided by clients to these questions allow care providers to gain insight into how to work with this client to overcome these barriers stemming from socialization.

Values/Beliefs about Abuse

Another crucial area of exploration in Layer 2 is the client's own values and beliefs about violence. One result of socialization into American society is a desensitization to violence. Meidzian (1991) articulates the concern that American society accepts, and in fact, encourages violent behavior in men and boys. She contends that though it is known that most acts of violence are committed by men, this knowledge is often taken for granted because it is so much a part of our mental landscape. Contemporary culture also romanticizes jealousy and obsession, even naming women's colognes after these concepts. As a result, many women believe that a certain level of jealousy or obsession is merely confirmation of their desirability and an indication of their partner's commitment. Therefore, it is likely that battered women have come to expect abuse, in some form, in their lives. The following questions need to be considered: What does this woman believe about violence?; Does she perceive it to be a normal part of a relationship?; Is it acceptable as long as her mate does less damage to her than her father did to her mother?; Is jealousy from a mate validation that she is loved and desired or a sign of danger?; Is divorce wrong?; and Are children better off with any father, even a violent father, rather than no father?

Religious Values/Beliefs

Deeply held religious beliefs also enter the picture when working with women through the barriers found in this layer. For many, religion provides guidance, reassurance, and hope. Battered women may benefit from strong ties within a church, synagogue, or temple. Care providers who are able to align themselves with these built-in support systems are likely to increase their effectiveness with this population. Unfortunately, patriarchal beliefs are often reinforced in religious institutions that tell women to obey their husbands as their husbands obey God, and refuse to sanction divorce despite knowledge of abuse within the family. Part of moving through this layer of barriers means exploring the following religious beliefs: Is it ever acceptable within this woman's faith to end a marriage?; Does she believe God expects her to love, honor, and obey her mate despite the violence?; and Does she believe God would never give her more to deal with than she could take?

Family of Origin Values/Beliefs

Finally, it is important to consider the impact of rules learned in the battered woman's family of origin. According to Debold et al. (1993), important information on values, ethics, and the world in which we live is passed on from one generation of the family to the next. Few would argue the contention that the family provides the stage for socialization into society. Therefore, care providers working with battered women must understand the family rules from which women

are operating. What rules from her upbringing will she be breaking if she leaves this partner? What will the consequences be from her family of origin if she prioritizes her safety above her marriage? By exploring these rules, care providers can work with, rather than against, these long-held beliefs.

In summary, even once the barriers in the environment (Layer 1) are removed, battered women face countless obstacles due to family, socialization, and role expectations. While advocacy, case management, and social action are required to address the barriers in the first layer, this second layer of barriers requires alliances, support systems, and consciousness raising. Care providers may best facilitate movement through these barriers by assisting battered women's efforts to link, both formally, in the form of support groups, and informally, by reaching out to neighbors and friends, with other survivors of abuse. In addition, care providers may wish to align themselves with progressive religious leaders in the community to establish community-based support for women trying to escape violence, for whom spiritual guidance is important. Most importantly, care providers need to be patient and nonjudgmental while working through this layer of barriers. Beliefs that have taken a lifetime to develop do not change in one session or after one assault. Many may also be culturally based, making them more ingrained and intrinsic to identity, and more difficult to let go of in a time of crisis.

Layer 3: Barriers from Psychological Consequences of Violence

Defense Mechanisms

Domestic violence victims exposed to high levels of trauma experience terror. A number of complex defense mechanisms can develop in response to terror, most commonly minimization of danger and denial. While these defense mechanisms allow the victim to psychologically survive terror, they act as barriers by impairing her ability to judge how much danger she is in. Dissociative responses such as numbing also play this role.

Physical/Somatic Results

Victims often report sleep deprivation resulting from the abuser keeping them up all night with assaults and arguing, or from ongoing vigilance on the victim's part in preparation for anticipated assaults. Victims in advanced battering situations are often injured for long periods of time, with several injuries in various stages of healing. Some develop stress-related illnesses. Others suffer barriers related to serious head trauma such as memory impairment. Victims who experience ongoing injury lose touch with their physical being, often resulting in their not seeking needed medical treatment. All of these experiences drain the victim's physical resources and become barriers to her having the kind of energy needed to manage escape and safety. Therapists working with severely battered women can enhance the therapy process by helping the victim focus on her physical needs to heal and rest.

Psychological Consequences

Walker (1994) described a host of typical psychological consequences of ongoing battering. Most common are anxiety, depression, self-doubt and self-blame, eroded self-esteem, and memory impairment. Many victims report feeling as if they are "going crazy," often resulting from the batterer's use of emotional abuse tactics geared to undermine her sense of herself. Victims also report feeling crazy as a result of mixed messages from helping professionals. Those experiencing years of abuse may begin to live long periods of their lives in a crisis state. Others develop chemical-abuse or dependency problems in attempts to numb the terror or other overwhelming feelings. Almost all survivors of ongoing abuse have minimal emotional resources left by the time they need them the most: when they are trying to escape for good.

Isolation

Many battered women lose family ties and friendships as their relationships progress. It is not uncommon for abusers to be hypercritical of potential supporters, discouraging or even forbidding that the victim see them. Sometimes, the people who care about her do not understand why she is with the abuser or they are afraid of him. Sometimes, the abuser is so charismatic that they do not believe her. Over time, especially if friends and family have supported earlier separations, contact stops or becomes minimal. Eventually, the victim becomes emotionally isolated from others. Sometimes, no one knows how dangerous the abuse has become. Therapists need to understand the key role isolation plays, and work with the victim to get involved in a support group with other battered women as an adjunct to individual therapy work.

Brainwashing

An overview of Amnesty International's documentation on brainwashing and Biderman's Chart of Coercion (NiCarthy, 1986) gives a quick understanding of the complexity of barriers created by the nonphysical abuse many victims experience. A number of tactics are common such as humiliation/degradation, trivial demands, demonstration of power and threats, exhaustion, occasional indulgences, emotional distance, and "crazy-making." In addition to the cognitive and psychological effects of brainwashing, isolation often ensures there is no other source of information that will contradict these messages. Therapists need to assess the severity and forms of emotional abuse that occurred and help the victim answer the confusing messages she may believe about the abuse and about herself.

Compliance Strategies/Stockholm Syndrome

Victims exposed to severe and life-threatening abuse, combined with acts of kindness can develop complex reactions described as Stockholm syndrome (Graham & Rawlings, 1991). Victims experiencing such abuse dynamics, in addition to many of the barriers outlined above, can become hypervigilant on behalf of the abuser, adapting his world view as their own as a strategy to emotionally and physically survive. Even victims not showing full Stockholm symptoms can experience abuse so severe that they become locked into compliance as a strategy to survive. The abuser often blames the abuse on her, by saying she's too fat, too thin, not smart, dinner was late, the kids are too loud, she spent too much money, and so on. This litany of complaints and blaming is reinforced with trivial demands and physical assaults. The title of an early film about domestic violence in the 1980s called *Too Much Salt in the Beans*, underscores this dynamic. As a result of this constant criticism, the victim engages in strategies to change these factors that have been identified as the cause of the abuse. These excuses that blame the victim always change, keeping her busy trying to fix herself until she eventually sees that the abuse does not originate with her. Therapists working with domestic violence victims must address the general misplacement of responsibility that is so common with this population.

Posttraumatic Stress Disorder (PTSD)

Posttraumatic stress reactions occupy a great deal of emotional energy. Victims suffering this complex response to severe trauma are often emotionally depleted by nightmares, intrusive recollections of violent assaults, and so on. Posttraumatic Stress Disorder (PTSD) is both an effect of domestic violence and a barrier to escaping it; managing PTSD symptoms takes energy, skill, and often the support of a skillful therapist with expertise in this area.

Layer 4: Barriers from Childhood Abuse and Neglect Issues

Childhood trauma or neglect sets the stage for, and increases the power of, the barriers in each of the other three layers.

Early Messages about Abuse and Safety

As noted previously, it is within the family that children first learn what to expect from people, how to communicate, and how to handle emotions (Debold et al., 1993). As Burstow (1992) explains, family members are trusted figures. When these trusted figures abuse children in their care, children assume that anyone is capable, and perhaps entitled, to abuse them. Children experiencing abuse within their own homes or in the homes of trusted individuals learn that there is no escape. They learn that danger is always present (Burstow, 1992). Our clinical experience tells us that children most often have small worlds. They are surrounded by a limited number of people and have had few experiences. When a child's tiny world betrays her, teaching her that she is unsafe and her emotions do not count, she has no other reality to counteract that lesson. For survivors of childhood trauma, adult partner violence merely confirms an already suspected world view.

Care providers working with battered women who have histories of childhood trauma are likely to notice that these women often have an impaired ability to judge the trustworthiness of others. Often the internal radar system of these women has quit functioning; in cases of early abuse it may have never developed. Care providers are encouraged to explore the following areas: Was her abuse or neglect as a child such that she never learned how to perceive danger from others?; Does she need concrete help in recognizing when the abuse is escalating?; and Can she see when people pose a threat to her children?

Psychological Consequences

A wide array of long-term effects have been associated with childhood abuse and trauma, including: de-

pression, anxiety, eating/body image issues, sexual dysfunction, dissociative reactions, personality disorders, posttraumatic stress reactions, and substance abuse (Read, 1997). Clearly, women who enter into adult relationships carrying these effects of childhood trauma are vulnerable to further abuse. When old trauma is unresolved and new trauma is occurring, the victim's childhood feelings can magnify the current emotions about abuse. Events in the present that are similar to old trauma can trigger overwhelming emotional responses to current abuse that can become immobilizing for the survivor.

Additional effects of childhood trauma that may be interfering with the woman's abilities to stay safe include dissociative reactions and long-standing mental health problems stemming from early abuse or neglect. For victims who have had a life of abuse, the moments of love, tenderness, and attention from this abusive mate may be the first in her life. She may need these so deeply that the need outweighs the possible risk, if she is able to perceive the risk at all. This becomes particularly powerful if the level of abuse in the current relationship is not greater than earlier abuse she has survived.

Thorough understanding of these issues involves considering the following questions: Is the interaction between old and current abuse so overwhelming that she is dissociating?; Was the abuse so severe or perpetuated so many times by so many abusers that she knows nothing but abuse?; Is she so eroded by her old abuse experiences that she will risk her life for the small episodes of love and tenderness she receives from this mate?; and Was her childhood abuse so severe that it resulted in long-term mental health problems (e.g., depression, anxiety, or personality disorders) that have now created a second presenting problem and a serious barrier to her ability to escape?

Care providers working with this population of battered women need to carefully assess several areas in helping them secure lasting safety. For example: Are old experiences with abuse and terror compounding and magnifying this woman's responses to similar events as an adult?; Are childhood messages about her worthiness and value impairing her ability to expect anything different from adult partners?; and Did childhood abuse or neglect experiences interfere with her development of skills she now needs to escape this abuser?

Battered women with histories of childhood abuse and neglect are often extremely challenging for care providers. Assessing all of these areas helps care providers appreciate the complexities of the barriers faced by this population. Intervention aimed at the barriers in Layer 4 is best facilitated by working alliances among the victim, her advocate, her therapist, and other reliable people within the victim's support system. Therapists should also consider the potential positive benefits of getting the client involved in an adults-abused-as-children group with peers who share her abuse experiences. When evaluating such resources for clients, therapists should note that some such treatment groups construe the effects of childhood trauma as codependency, that may undermine the victim's ability to benefit.

Discussion

As with most contributions to feminist theory, this model was developed in practice before theory. The authors are in the preliminary stages of considering how this theory might apply to other marginalized populations, specifically, people of color, sexual minorities, and economically deprived individuals. As pointed out by Brown (1994), all forms of oppression within a patriarchal structure are linked at the root. The authors believe that this model contributes to an integrated analysis of oppression (Brown, 1994; Kanuha, 1990) that may be useful in working with a wide variety of marginalized individuals.

The Barriers Model presents an alternative conceptual framework for understanding and working with battered women and therapeutic strategies to best address their needs. By moving the initial therapeutic focus away from psychological factors to an analysis of primary environmental barriers, this model helps therapists understand the behavior of battered women previously attributed to more pathological factors such as depression, tendencies toward self-defeat, codependency, and clinical resistance. The model takes into account the whole of the battered woman's experience, including community barriers as well as more internal factors such as female socialization, family of origin, psychological consequences of trauma and unresolved childhood abuse and neglect issues (see Figures 1 and 2). This model is based on a foundation that asserts that even these more internal barriers have their roots in an external cultural and social context.

The training we receive to prepare us for helping individuals through emotional problems rarely includes information specific to the phenomenon of domestic violence, sexual abuse, and trauma in general. Yet, a significant portion of any private prac-

Layer 1: Barriers in the Environment

Information/misinformation
Batterer
Money
Transportation
Police assistance
Criminal justice system
Attorneys
Religious counseling/guidance
Mental health system
Physical and cultural accessibility to shelters/services
  Discrimination
  Language barriers
  Physical barriers
  Cultural barriers
  Immigration issues
Affordable housing

Layer 2: Family/Social/Role Expectations

Values/beliefs about relationships
Identity
Values/beliefs about abuse
Religious values/beliefs
Family of origin

Layer 3: Psychological Consequences of Violence

  Defense mechanisms
  Physical/somatic results
  Psychological consequences
  Isolation
  Brainwashing
  Compliance strategies/Stockholm syndrome
  PTSD

Layer 4: Childhood Abuse/Neglect Issues

  Early messages about abuse and safety
  Psychological consequences of childhood abuse/neglect

Figure 2. Summary of Layers in The Barriers Model

tice, or general, public mental health agency services will be provided to individuals living with the current or residual effects of these problems. Because we are trained within a model that emphasizes the inner psychological structure of the client, we are trained to look away from that which must be focused on in these cases. Until we can place the victim of interpersonal trauma within a social, economic, and political context, we are forever limited to a disease-model approach.

The Barriers Model poses a challenge to those therapists working with this population in that it presents a call for a paradigm shift. Not only does the model present an alternate view of the battering and escape process, it presents an alternate model for therapy. Full use of The Barriers Model requires therapists to expand their role beyond traditional definition, to become educated about local public policy and law in the area in which they practice, to engage in interdisciplinary intervention, to provide information, linkage, case management and advocacy for battered clients, to help build a coordinated community response through participation on local task forces, and to become a force for change in their own communities.

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