Violence in the Family:
Issues in the Counselling of Battered Women

Teresa Angless

The continuing violence in South Africa leaves no-one unaffected. Women are additionally vulnerable to violence in the form of sexual harassment, rape and battering. Many women are more likely to be injured or hurt inside the family than outside. Battering occurs in up to 50% of American and British marriages, whereas in South Africa at least one in four women are regularly beaten up by their male partners.

With this high rate of occurrence, all health workers are likely to deal with women who are battered. Professionals often add to the problems of battered women through a lack of specific training and an absence of a comprehensive policy to address battering. Health workers often adhere to damaging myths which hold women responsible for the battering and blame them for their own abuse. Some of these myths include the notion that women enjoy it, that they provoke it and that only sick men batter etc. Many battered women are repeatedly not believed. They are blamed and thereby left feeling guilty and helpless.

Analysis of Battering

Health workers need to understand battering as a social problem. They need to take into account an analysis of power relations in the broader society and how these impact on gender relations. Battering is an extreme form of the accepted dominant-submissive roles that men and women, respectively, are socialised to play. Battering is a frequently condoned way for men to re-establish control and maintain dominance. An analysis of battering which takes cognizance of these power relations should inform counselling relationships in which the main aim is the empowerment of battered women, helping them to regain access to their own strengths and skills.

Uncovering Battering in the Health Setting

Because of societal attitudes which blame women, much shame surrounds the issue of battering. Women in modern culture are largely held responsible for the success

of their relationships and so may feel bound to cover up the presence of battering.

The increasingly privatized nature of the family serves to keep much battering hidden. All too often health workers collude in this silence. The tremendous pressure of time, feelings of discomfort and helplessness as well as health workers' own prejudices can lead them to avoiding the issue, thereby sending women back to life threatening situations unaided. Women are all to readily prescribed anti-depressants and tranquillisers to 'help them cope'. These often tend to dull women's capacity to make choices and institute changes. Many battered women have gone for years without receiving help. Eventually they believe that help is not available. Health workers need to make space for battering to be disclosed and openly discussed in an accepting and non-judgemental climate. The battered women's experience needs to be validated and the complexity of the situation acknowledged. Realising someone else accepts the situation as real helps women feel less crazy and may encourage them to take steps in changing the situation.

Moving at the right pace

Working from within a medical model may create a tendency to expect instant cures. Dealing with battering requires much patience and time. The action to be taken may seem obvious to an outsider who then gives advice or dictates what should be done. Leaving a life-partner is no easy task. A woman may feel duty bound to remain with an abusive partner, especially where children are involved. Messages from family and society may reinforce this with the result that some women feel too guilty to even contemplate leaving. Women are socialised into believing that they need a man and must be dependent on him. Economic dependence and the lack of resources for single women, such as employment opportunities and child care facilities, are a real constraint. The diabolical housing shortage makes finding alternative accommodation often impossible.

Hearing about the abuse may be difficult for health workers who need to deal with their own feelings about violence, the woman and her batterer. It is important not to allow our feelings and judgements to cloud the counselling relationship. Witnessing the effects of the abuse on women may make it difficult for health workers to appreciate the tremendous ambivalence experienced by the battered woman. It is important to realise that many women may still love their partner, especially where the violence is intermittent and interspersed with good times. For all battered women there is always the hope that things will improve - letting go of this hope is perhaps one of the biggest losses battered women must face.

As with all social problems a danger of generalising is present. It is necessary to recognise the unique meaning of the relationship for each particular woman and

Health workers need to take their cue from the woman, because she is the best expert of her own situation. *Photo: Ismail Vawda*

to explore this with her. This would allow health workers to better appreciate the mixed feelings and huge loss implicit in leaving the relationship, albeit violent. Space must be provided for battered women to explore the full range of their feelings and to accept that they need to return to the relationship several times before arriving at a final decision to leave. Health workers need to take their cue from the woman, because she is the best expert on her own situation.

One effect of exposure to violence, especially verbal and emotional abuse, is a lack of trust in oneself and one's ability to make decisions. An essential component of the empowerment process is to demonstrate confidence in the woman and her ability to make the best decisions for herself.

Presenting Options - Making Choices

Health workers need to be knowledgeable on the options available to battered women and to present them in a clear and unbiased way.

Previous options made and avenues of help sought can be explored to see what has worked in the past. Options may range from staying in the home, divorce or moving suburbs and cities. Conjoint (couple) counselling should only ever be considered on the women's own request and recommendation.

Given the present socio-economic conditions and tremendous lack of resources for women, leaving a relationship permanently may not be an easy option. Avenues of protection for the woman then need to be explored. Health workers should be insisting on adequate police protection for battered women and access to interdicts should be facilitated. Community resources need to be mobilised to provide protection and emergency shelter for women and their children.

Health workers need to network with other services available to battered women and to become familiar with appropriate referral sources. Local women's organisations could be used as support networks but additional and improved state provided services need to be lobbied and fought for constantly. A policy of referral to social workers should be adopted wherever possible, and liaison with social workers should be encouraged. Battered women need advocates for legal aid and police protection. The availability of housing for single women, in general, also needs to be improved.

Perhaps the most immediate and severe service shortage is the lack of safe shelter for battered women. Presently there are only two shelters for battered women in South Africa, yet these are needed in every city and town. Other possibilities such as safe-houses or the utilisation of clinic or day hospital facilities as emergency shelter need to be explored.

Keeping accurate medical records which may expedite criminal charges is a further way in which health workers can assist. The health setting itself needs to become a place that takes battering seriously, raising awareness of the issues through in-service training, displays, posters and campaigns. Battering is a life-threatening situation which health workers cannot afford to send women back into unassisted.

Teresa Angless works for the School of Social Work
at the University of Cape Town.