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Wife Abuse in the Medical Setting

An Introduction
for Health Personnel



national clearinghouse
on domestic violence

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Preface

This monograph is designed to help health professionals identify and respond to violence against women. Our research into the impact of battering on a large metropolitan hospital indicates:

- 21 percent of all women who use the emergency surgical service are battered;
- almost half of all injuries presented by women to the emergency surgical service occur in the context of abuse;
- battering accounts for 1 in every 4 suicide attempts by all women and half of all suicide attempts by black women;
- half of all rapes to women over 30 are part of the battering syndrome;
- a pediatric history of abuse is often followed by battering as an adult;
- battered women most frequently and disproportionately turn to nontrauma services for their health care, rather than services that primarily treat severe injury;
- using current diagnostic techniques, medical personnel diagnose 1 battered woman in 25; and
- the current pattern of medical response contributes to the battering syndrome.

Findings like these cannot really speak for themselves. Battering has been widely recognized since the early 19th century and our response, as a profession and as a society, has been inadequate. In addition to describing the battering syndrome, we must discover why we have responded so ineffectively.

The introduction and part I of this monograph provide an overview of the problem and analyze the major paradox uncovered by our research, namely that health professionals try to improve the health of battered women while they inadvertently reinforce the social relations that undermine it.

Part II describes the battering syndrome as an evolving process that includes, in addition to injury, a pattern of self-abuse, institutional abuse, and medical and psychosocial problems. This study addresses the following questions: How common is abuse? What sorts of injuries and psychosocial problems comprise the battering syndrome? Which medical services are used by battered women? Are the psychosocial problems associated with abuse its cause or its consequence? And finally, how do health professionals respond to battering?

Part III presents two modes of identifying battered women in the medical complex — a profile method that indicates high-risk presentations at various medical sites and a retrospective method that can be used to generate data on the prevalence of abuse.

Part IV describes the stages of the battering syndrome and relevant dimensions of the health professional's encounter with battered women. An annotated bibliography is appended for the health professional who wants to pursue these problems further.

The study research team includes a plastic surgeon and an internist, both deeply committed to emergency and community care; a clinical psychologist; a sociologist; and two researchers (one is an RN and the other has a liberal arts background). Members of the team continue to work closely with community-based battered women groups. The other key experience underlying this work is our routine encounter with hundreds of women trapped in violent homes who bring their escalating injuries to the attention of the health system.

In the final analysis, the accurate identification, effective treatment, and prevention of abuse require a willingness to question traditional diagnostic categories and to expand our understanding of a medically significant event to include the battered woman's definition of her "emergency."

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Introduction

Each year in the United States, 3 to 4 million women are beaten in their homes by their husbands or ex-husbands, boyfriends, or lovers. This includes approximately 1.8 million women living in couples and a third of the 6 million or so women who are separated or divorced. Another 3 to 4 million women have been beaten in the past and remain in abusive relationships (Straus, Gelles, & Steinmetz, 1980; Stark, Flitcraft, & Frazier, 1979).

The health implications of these statistics are staggering. A Harris poll of Kentucky housewives reported that 17 percent of those who had been battered used emergency medical services (Harris, 1979). This estimate represents almost 1 million women nationwide. Among a group of women living in a shelter, 50 percent had used emergency medical services and the rest admitted they required such service periodically but were afraid to report their problems (Star, 1978). Interviews conducted with abused women abroad reveal that 80 percent report their injuries at least once to medical personnel and 40 percent seek medical attention on at least five occasions (Dobash & Dobash, 1979). Again, those battered women who do not use the hospital are often prevented from doing so by their assailants. Untreated injuries for vicious attacks often result in permanent disfigurement. Were adequate protection available for battered women, virtually all would seek emergency medical care.

Even this understates the problem. Battered women comprise a significant percentage of rape victims, suicide attempts, psychiatric patients, mothers of abused children, alcoholics, and women who miscarry or abort. Finally — and this will be shown in detail — battered women make multiple visits to the medical and psychiatric service for general health problems that are as much a part of the battering syndrome as physical injury but are not recognized as related to assault. Indeed, our data indicate that battering accounts for more than one of every four visits by women to the emergency services.

The physician is often the first person outside the battered woman's family she turns to, if only because her injuries require both treatment and explanation. This fact, plus the figures on utilization, mean that *the medical system is a crucial point in the identification and prevention of abuse.*

Despite recent publicity, abuse remains virtually unrecognized by the medical system. Even in hospitals that have developed a protocol for battering, a relatively small percentage of the abused women using the medical facility are accurately diagnosed, probably fewer than 1 in 25. Moreover, virtually none of the physical, medical, or psychosocial sequelae of abuse are now identified as part of the battering syndrome. A recent medical article illustrates this assessment. The education director of a prestigious psychiatric institute describes a typical "crock."

Mrs. X came to this country from Eastern Europe in 1914 and worked as a domestic in Washington, D.C., until 1928 when she moved to a medium-sized university town in New England to marry. During the next 40 years (from 1928 to 1967) she saw 394 physicians (including 17 psychiatrists), averaging a visit a month or 424 visits overall (340 nonpsychiatric, 84 psychiatric). Despite an "unremarkable" history, Mrs. X repeatedly complained of problems to her head, eyes, ears, face, throat (12 times), chest, breathing, vagina, and so forth, in addition to ill-defined "pain all over." She did not receive elaborate workups, however, since her problems were apparently "transparent." As a consequence, she received almost no followup, most of her visits were unscheduled and no diagnosis was made, therapy suggested, or return visits scheduled. To the contrary, resentment of her psychosomatic disguise provoked psychiatrists to use labels for Mrs. X

(such as *crock*, immature personality, hysterical, emotional overlay, conversion reaction, etc.) and she was eventually committed to a State mental hospital for "punitive" reasons (Bauermeister, 1979).

In 1928, the same year Mrs. X began her history as an alleged *crock*, her medical record noted that her husband physically abused her on a regular basis. Her spouse was alternately described as aggressive and psychotic, but no link was made between the ongoing domestic violence, Mrs. X's multiple physical complaints, and her accompanying mental health problems. This monograph will demonstrate that the medical history of Mrs. X compels a diagnosis of *battering syndrome*.

Given its obvious prevalence and seriousness, and the frequency with which it is apparently reported, why is *battering* so rarely identified? One answer is personal bias. A growing literature shows how health professionals reinforce sexual, racial, and economic inequities through their individual attitudes and practices. The awareness of sexism among health professionals is relatively recent. However, the denigration of indigent patients has been common knowledge for almost a century. These biases may have less impact on the quality of treatment for standard medical problems than do time constraints, patient load, overwork, or inadequate resources, supervision, and training. But these attitudes clearly lead to bad medical practice where *battering* is concerned because they conceal fundamental dimensions of a pathological process that might express itself in multiple complaints and problems with no clear organic basis. Thus when staff at a neighboring medical service call their alleged *crocks* *TBP's* (total body pain) they provide a barely concealed rationale for dismissing abuse.

A more complex explanation for medical neglect is the medical paradigm that views disease as an occurrence in and to the body (which is understood to be an imperfect physiological mechanism) that is merely influenced by social factors. Medical history is considered important only if it bears on the present complaint (Turshen, 1977; Stark, 1977; Powles, 1973). By contrast, in the case of *battering*, the trauma history sets the terms for understanding the medical significance of the presenting complaint. The influence of the medical paradigm was described in Kempe's initial work on child abuse. Physicians in the early 1960's not only failed to recognize familial assault as the etiology of children's medical problems, but also tended to turn to extensive medical workups to discover blood and metabolic disorders that could explain an accumulating history of multiple bruises and fractures (Kempe, 1962). When unavoidable adult health problems are not reflected in physiological abnormalities, present practice often leads to punitive interventions, including labeling, inappropriate sedation, and institutionalization. Even well-intentioned professionals operating within narrow diagnostic categories tend to approach the victims of abuse as *crocks*.

A third explanation rests in the politics of medicine itself. At the turn of the century, hospitals in the United States faced a fiscal crisis which they met by providing inpatient beds and medical technology to private physicians. Outpatient and emergency care were reserved for those of the marginal strata — the poor, minorities, immigrants, and women (Rosenberg). Although emergency services remain the major source of primary care for the poor, emergency care emphasized high-technology interventions in increasingly life-threatening situations. From a medical perspective, an emergency is a proximate physiological event (often precipitated by an "accident") with life-threatening potential that can be directly observed. However, the battered woman views her social situation as an emergency regardless of physical evidence. This clash of expectations is dramatized when professionals label social ills "inappropriate," diagnostically fragment complex social problems into multiple, apparently discrete symptoms, and fail to interpret the emergency visit in relation to the recorded history the patient has accumulated in the same medical complex. The fact that many hospitals fail to integrate records of emergency visits into the general medical record or fail to follow emergency visits clinically reflects the same unwillingness to acknowledge the reality of medical service utilization by low-income individuals.

The alternative response involves considering expressed patient need as a basis for allocating scarce health resources. From this perspective, *battering* is clearly an acute emergency requiring greatly expanded investments of time and resources.

I. An Overview of the Problem

The distinctiveness of the battering syndrome lies in its systematic combination of physical injury and medical and psychosocial problems, its social consequences (which include the subordination of women in the home), and the fact that it is typically confined to women. Physical force and aggression are preconditions for the syndrome and, in any given case, the victim or assailant may be mentally disturbed. Still, battering has become widespread only because it is supported by diverse family and personality types and tolerated by those who govern community affairs, the courts, medicine, psychiatry, police, schools, and the church.

Because victims of the battering syndrome are typically women, it is linked to broader patterns of discrimination. Women may, of course, fight as hard as men. A recent national survey indicates that women attack men, often using lethal weapons, almost as frequently as they are attacked by men (Gelles, 1979). But fighting and battering are very different. While men injured in fights often use the emergency service, they rarely evidence the battering syndrome observed among women. In a random sample of Delaware households, Steinmetz found no cases to support her theory of husband battering (Steinmetz, 1977-78). The discrepancy between reported acts of aggression by men and women and evidence that women have been the victims of battering for centuries reflects the fact that even women who "win" fights at home are likely to suffer discrimination in the courts, schools, and hospitals. Historically, women who fight back have been denied the rights granted to "proper females." It is this combination of discrimination outside the home and physical force in the household that produces the battering syndrome.

In certain situations—wars, strikes, revolutions, sporting contests—fighting, and even violence, may contribute to highly valued personal or collective ends. Similarly, the acceptance of force, *per se*, to resolve disputes does not lead automatically to the abuse of women. Thus, although fighting may be common in poor neighborhoods, battering is not. The risk of abuse seems to be greatest when persons become isolated from supportive networks and locked into violent homes.

To ask why people hit one another and to explain why millions of women are beaten in their homes are two separate issues. Conversely, programs that try to reduce violence without confronting the inequities that produce battering will have little effect on the incidence of abuse.

Historical Perspective

The distinctiveness of battering lies in its links to broader patterns of sexual inequality, not in any immutable laws of nature, personality, or family life. In view of this linkage, however, what implications can be drawn from its remarkable continuity? For though the meaning of domestic violence differs from society to society, from class to class, and from region to region, the persistence of abuse is a sobering reminder that women's individual lives have not always improved as they achieved formal equality.

History offers no conclusive answer to the question: Is battering increasing? But history can help us understand a central paradox. Critics universally trace battering to the prerogatives of men as masters in traditional households, but they also agree that the modern state has usurped the family's traditional functions and power. Yet battering has persisted (Lasch, 1977; Parsons, 1955; Smelser, 1965; Zaretsky, 1979).

While the basis for the male's power in the family has clearly eroded, his authority is sustained by outside institutions, including the very laws and professions expected to protect women from abuse. Even where no male is physically present in the household, the services support a kind of dependence among women and children that makes them vulnerable. The services' very general commitment to the family becomes, in practice, a means of supporting traditional relations of authority in the home.

A striking feature of wife beating is the intermittent public concern it has received along with other aspects of family crisis. In instances of battering recorded since the 1830's, public benevolence has defended individual family members by supporting the traditional family structure. Despite talk of an invasion of family life by the state, the services continue to see reconstituted families as the solution to a myriad of health problems, including battering. Since support for traditional family relations as the solution to abuse merely aggravates it, policymakers have created a vicious cycle leading to calls for restrictive legislation for even more protection by the services.

An added problem with protection has been a distinction, made even by the most progressive feminists of the 19th century, between worthy and unworthy victims. For instance, although Frances Power Cobbe anticipated virtually every aspect of the current discussion of abuse in her essay, "Wife Torture in England" (1878), she separated women assaulted while performing their feminine role (wife-beating situation) from those "dreadful viragos" who fought, fought back, drank, or were promiscuous (Cobbe, 1878).

Community groups made similar distinctions, offering their protection only to women who remained dutifully bound to domesticity. Even the law openly distinguished "the gentle, fragile and submissive" woman whose abuse was unwarranted from the "amazon" woman who acted disobediently, countered violence with violence or, in the words of one judge, "chooses to unsex herself and forget she is female (Pleck, 1977)." These distinctions remain evident in current medical practice.

The reformers believed that as women were given the right to own property and work for wages, their subordination would disappear. But women were linked to property through their fathers and husbands and so were "free" only if they remained dependent within the family. And the separation of manufacturing from the household reduced the woman's status at home from junior partner to a wageless servant.

The great reforms of the Progressive Era (1890-1920), the Juvenile and Family Court, protective labor legislation for women and children, the "mother's pension" (ADC), and the family wage were designed to restore the traditional role of women. A woman's misery was alleged to result from the family's decline, not from her place in it, and battering was linked to the "peculiar" habits, particularly drinking, of immigrant or minority poor (Zaretsky, 1979).

In the modern period, wages that replace property as the source of personal independence offer women an alternative to full-time domestic work and undermine the personal power of particular men. But even as the lingering rationales for male authority evaporate, new supports are found. This is evidenced by the lower wages received by women and job segregation practices that maintain female dependence on and in male-dominated households (Hartman, 1976). Ironically, even professions that assume women's traditional responsibilities for health, education, and welfare manage the internal relations of family life both directly (by enforcing stereotypic role behavior among men, women, and children) and indirectly (by promoting a stable family as the best response to drink, divorce, delinquency, and mental illness) (Ewen, 1977; Ehrenreich and English, 1978; Foucault, 1979). While women in traditional societies confronted a patriarchal trinity of father-husband-priest, today's woman confronts an equally patriarchal alliance between business, government, and the service professions (Ewen, 1977). Modern medicine has not escaped this commitment to the traditional family.

Given the incongruity between continued male privilege at home and growing opportunities for female independence, family conflict is inevitable. Women are frequently hit when they demand money or the right to work, assert sexual independence, or refuse to be the sole providers of child

care, food preparation, and housework. These issues all derive from current changes in male-female status at home. Unfortunately, even those who accept traditional authority face profound problems at home. But the question remains: Is the decline of the traditional family the real crisis or is the problem in the defense of traditional authority? The answer to this question may determine how effectively medicine responds to abuse.

Psychological and Psychiatric Perspectives

History shows that the helping professions often supported patterns of family authority that fostered abuse. It sheds little light, however, on the interpersonal dimensions that cause battering in one family but not in another. Family fights occur over issues such as feelings of sexual displeasure, the raising of children, or even cleaning house. Psychology explains how women "learn" that proper resolution of these issues are appropriate sex-role behaviors that meet their normal needs. Unfortunately, this attitude has done more to support the stereotypic behaviors that lead to abuse.

The theory of learned helplessness, originally developed by Seligman to explain the submissiveness of animals subjected to excessive stress, was extrapolated by Walker to explain why women in abusive situations appear indifferent to their victimization, stay in abusive homes, fail to report their problems, and are generally depressed, defeated, and resigned (Walker, 1977-78). However, Walker has been unable to verify her theory (Nielsen, et al., 1979). Battered women divorce frequently, seek counseling, and report their attacks and injuries to friends, relatives, police, clergy, physicians, and social workers—apparently without evoking much concern. This failure to have battering accepted as a serious issue explains its absence from medical and police records.

Battered women periodically leave home or fight back when force is threatened. Unfortunately, neither divorce nor an appeal to the helping services presently offers much hope for protection. Battered women rarely have much money, have negative experience with the helping services, and carry labels for the secondary problems associated with abuse (e.g., alcoholism) that make it difficult to find work. Until real alternatives exist, explanations for battering based on a woman's failure to act decisively shift attention from the lack of available resources to the victim herself. Such alleged symptoms of helplessness as attempted suicide or depression are often pleas for help. The fact that battered women make the best out of a bad situation is far more relevant to an assessment of their present capacity for change than their supposed resignation. The same argument applies to the theory that female masochism leads to the acceptance of repeated abuse (Symonds, 1979).

Another largely untested psychological theory is that family violence is transmitted intergenerationally, from battered children who become battered or battering adults (Gelles, 1972; Parker & Schumacher, 1977; Van Stolk, 1976; Wasserman, 1967; Renvoize, 1978).

Although research shows that child abuse is often accompanied by family conflict, the reverse is far less frequently true. Battered women report an abnormal incidence of child abuse, and wife-battering may cause insomnia, chronic anxiety, and other health problems for children (Hilberman & Munson, 1977-78). But when a private practitioner identified a history of wife abuse among his patients by taking careful histories, he concluded that child abuse was rare, although the children showed the effects of parental violence (Levine, 1975).

To date, no studies have followed abused children into adult life. Retrospective evidence linking male violence with the abuse of these males as children is based either on the childhood experience reported by small samples who have committed violent crimes or on subjective interviews in which battered women recount the childhood experiences of their assailants (Faulk, 1977; Strauss, Gelles, & Steinmetz, 1980; Walker, 1979). Evidence linking child abuse by women to the abuse of these women by their parents is similarly inconclusive.

There is, however, a significant association between child abuse and eventual victimization as an

adult woman. Our research shows that battered women are far more likely than nonbattered women to have a pediatric history that includes severe trauma or abuse, a finding that is consistent with theories that link early dependence on the helping institutions to subsequent isolation, secondary deviance, and adult victimization. Thus, child abuse must be considered a factor in a small but significant number of abuse cases.

Female suicide attempts and family conflict have been associated in the psychiatric literature, but the link has been explained by predisposing traits such as rigid personality or general hostility that make these women unable to cope with family tension (Vinoda, 1966; Birchnell & Alarcon, 1977; Weissman, Fox, & Lerman, 1973). However, battering is the most frequent precipitating cause of female suicide attempts when family conflicts are present and probably precipitates depression and general hostility as well (Stark, Flitcraft, & Zuckerman, 1979). The battered woman's suicide attempt is less a failed suicide than a complex response to battering that may even help protect her physically by removing her from the home.

Other psychiatric research fails to see the appropriateness of observed responses in abusive situations and supports sex-role stereotypes. There is a tendency to blame battered women whether they fulfill or resist traditional expectations. Star and associates label women "immature," for instance, for traits that reflect prevailing norms, such as accepting male authority (Star, et al., 1979). In contrast, another research team blames a woman who is "hostile, domineering, and masculine" because she fights back when hit and refuses to sleep with her husband when he is drunk (Snell, Rosenwald, & Robey, 1964).

Battered women comprise a significant number of those women referred to the psychiatric emergency service, institutionalized in psychiatric facilities, or referred to rural psychiatric clinics (Post et al., 1980; Hilberman, 1977-78). Here too the battering remains invisible. Nevertheless, these women whose fear of abuse is often accompanied by severe symptom formation are frequently labeled and tranquilized.

Efforts to aggregate personality characteristics into portraits of typical victims and assailants have been largely unrewarding. The number and variety of participants are too great to fit the expected profiles of victims as alternately helpless or "masculine" and of batterers as either compensating for a passive personality or being habitually strict and overbearing.

Sociological Perspective

Contradictory findings in the psychological and sociological literature suggest that battering has diverse causes and expressions, particularly when the focus is on individuals and families rather than institutions. In one case it may be precipitated by child abuse, in another by psychiatric disorder, in still another by alcoholism or female rebellion. Although women are beaten for a variety of reasons, the battering syndrome uniformly grows out of and reinforces the unequal power relations between men and women. Social factors intervene to organize the various motives and expressions of abuse into the uniform syndrome we observe in the medical records.

Battering can be linked to the business cycle, to class, to cultural differences, to race, and to stages in the life-cycle. Some think unemployment creates the frustration that leads to escalating assault and homicide rates (Martin, 1977; Brenner, 1977). Others identify violence with the peak in business, arguing that family tensions are increased by the stress of an expansive market (Eyer, 1977; Henry & Short, 1964). Studies linking battering to economic status argue that the occupational environment, not wage levels alone, contributes to abuse and that, although black women who are abused turn to the helping services more frequently than whites, class is a more important predictor than race (Chester & Streather, 1972; Lystad, 1975; Steinmetz, 1974). Other studies show that abuse increases slightly with income, that it is as common in wealthy as in poor communities, and that middle and working class parents use force equally (Harris, 1979; Flitcraft, 1977; Connecticut Task

Force on Abused Women, 1977; Strauss, 1971; Walker, 1979). Lachman (1978) believes that battering peaks when economic and family pressures coincide, (for example, the birth of the second child). However, these economic arguments do not explain why sex rather than ability or some other factor is the key to power in our society.

Cultural explanations for battering highlight important subjective factors. Violence may be stimulated by the ineffectualness felt by men trying to fulfill popular expectations of how "real" men should behave (Martin, 1977; Sennett & Cobbe, 1973; Rubin, 1976; Piotrkowski, 1980). Violence among the poor has been tied to cultural values which lead them to pursue immediate gratification, even if it means striking out impulsively against kin (Lewis, 1965; Levy, 1974). We find, however, that poor women exhibit patterns of deviance and self-abuse often identified with the "culture of poverty" only after the first incident of abuse, usually when they are isolated from support networks (Flitcraft, 1977). The common cultural argument that "violence is as American as apple pie" misses the fact that violence is punished only under certain conditions in our society. Moreover, medicine and other institutions appear to encourage violence indirectly, as a byproduct of its support for institutional dependence and traditional sex stereotypes.

Feminism called attention to battering in the late 1960's by arguing that sexism unified women's oppression in this society and that the sexual division of labor and opportunity, like woman's role at home, merely reflected male chauvinism. Physically more powerful than women, men are trained to use force while women are taught to passively accept their status as male property. To this extent, battering is the domestic counterpart of rape (Martin, 1977; Strauss, Gelles, & Steinmetz, 1980; Gelles, 1979; Gingold, 1976; Abrams, 1978).

While gender remains an important basis for inequality, this approach does not identify the social basis for sexism itself, making it seem almost a natural attitude for men or else an immutable part of the social fabric. Women are unquestionably influenced by an avalanche of propaganda to behave "properly," particularly when this behavior is a prerequisite to equal protection. And this view of women as generally passive helps win support for the victims of abuse. In fact, women's aggressiveness in refusing to accept subordination is as frequently associated with abuse as is their resignation to their appropriate sex-role (Dobash & Dobash, 1977-78).

As women enter the wage market in larger numbers, competition between the sexes intensifies. The reflection of this competition in domestic violence against women is not a consequence of women's new freedom, but rather of the limitations placed on them by unequal wages, lack of full political equality, and continued dependence in the home. Women with money or decent jobs are more likely to take advantage of available services than unemployed women. The importance of community-based shelters for abused women as part of a comprehensive health response to battering lies precisely here. By providing collective support for women in trouble, shelters reduce a woman's isolation and dependence, hence her subsequent vulnerability to abuse. This is particularly true if support continues after she leaves the shelter. The woman's support network permits a victim to negotiate her future family relations on a new and more equal basis. Community-based shelters and support groups are therefore crucial to programs that aim to provide aid to abused women and prevent battering.

II. The Research Report

The research reported in this section was motivated by the need for accurate data on wife abuse and its impact on medicine. The results of a pilot study conducted by Flitcraft (1977) suggest that battering is a syndrome that could be adequately understood only if viewed historically and in relation to the medical and psychosocial problems that accompanied physical injury. The authors' present study seeks to identify the battering syndrome to: (1) determine whether it is the context of abuse or its sequelae, and (2) determine the patterns of medical resource utilization and medical response that distinguish abused from nonabused women. Although results are preliminary, they are statistically significant unless specifically indicated to be otherwise.

A Description of the Battering Syndrome

The study analyzed the trauma histories of 2,676 women treated in an Emergency Surgical Service (ESS) of an urban hospital and found that 21 percent were at-risk for abuse. Among those patients whose first visit injuries were traced to an assault by a male intimate, only a small percentage were identified as battered and referred to appropriate aid.

A review of the medical records of these women indicates that battered women can be distinguished from nonbattered women by the type, anatomic location, and frequency of injury (the trauma history); reproductive history; psychosocial problems; pediatric medical history; and sociodemographic backgrounds. Though battered women are not specifically identified, the medical response to this group distinguishes it from the nonbattered group.

Battered women were injured three times as much and used the service twice as long as nonbattered women. The physical site of battering injuries differs from those resulting from other causes. Injuries to multiple anatomic sites or to the head, face, neck, throat, chest, and abdomen tend to result from battering. In contrast, injuries to the extremities or hip area are not generally associated with domestic assault.

The at-risk women are more likely to have a pregnancy terminated by abortion or miscarriage and are more likely to be pregnant when they are injured.

At-risk women use three nontrauma medical sites frequently and disproportionately—the Medical Emergency Service, the Psychiatric Emergency Service, and the Obstetrics and Gynecology Service. The data indicate that nontrauma sites are the major source of medical care for abused women.

In terms of psychosocial problems, the battered woman is more likely to have attempted suicide at least once and to be diagnosed as an alcoholic or drug addict. These problems typically occur after the onset of abuse. With the possible exception of suicide attempts, these diagnoses may be used as punitive labels rather than as accurate assessments of psychiatric or psychosocial problems.

In the study subsample of women with available pediatric records, abusive injuries, major injuries, and psychiatric problems in childhood are associated with battering in adulthood. Also, at-risk women are more likely to be younger, nonwhite, and Protestant. At the time of their battering injury, they are as likely to be divorced, separated, or single as nonbattered women and are more likely to be isolated from next of kin.

The types of injury also differ significantly. Battering injuries are likely to be abrasions and contusions, or pains for which no physiologic cause can be determined. Nonbattering injuries are

more likely to be sprains or strains. Fractures, dislocations, and lacerations occur with similar frequency to battered and nonbattered women.

In addition to receiving punitive labels, battered women are more likely to receive prescriptions for analgesics and minor tranquilizers. A small minority of at-risk women were referred to services for battered women, and battered women were only slightly more likely to be referred to social services or psychiatric services than nonbattered women. Overall, the data suggest that the medical personnel at the ESS tend to ignore battering as a primary problem and treat the complaints associated with abuse symptomatically.

Prevalence and Dimensions of Battering

How common is battering among women in the emergency medical population? Estimates of the proportion of abused women range from 1 percent to 50 percent in the medical and social science literature. Moreover, there are different ways to assess the impact of abuse on the Emergency Surgical Services (ESS).

Data on the impact of abuse should be viewed from several perspectives to better illustrate the magnitude of abuse as it confronts a medical system with no adequate means to identify or respond to it. Of the 2,676 women in this study, 6.4 percent (171) presented injuries during the sample year that were attributed to assault by a male intimate. Though medical personnel rarely described such incidents as battering, these cases are usually catalogued as positive instances of battering in the research design. These are only the most obvious cases. A more skeptical evaluation of current patient visits shows an additional 5.1 percent (136) of the women sought aid during the sample year for injuries that were the result of an assault (i.e., they were hit, punched, kicked, stabbed, shot, etc.). But these incidents were not described as anonymous assaults, muggings, or robberies. They were instead called "probable" instances of battering. A still more skeptical approach identifies another 2.3 percent (63) of the women whose explanations were inconsistent or inadequately explained their anatomic injuries. Such cases were classified as suggestive of domestic violence.

TABLE 1
Incidence of Battering Among Women Patients

Category	Risk at Most Recent Visit	Risk During Last 5 Years	Risk-Historic Prevalence (based on entire med. record)
Positive Women	171 (6.4%)	218 (8.1%)	295 (11.0%)
Probable Women	136 (5.1%)	185 (6.9%)	201 (7.5%)
Suggestive Women	63 (2.3%)	64 (2.4%)	68 (2.5%)
Nonbattered Women	<u>2,306 (86.2%)</u>	<u>2,209 (82.6%)</u>	<u>2,112 (79.0%)</u>
	2,676	2,676	2,676

Even this figure underestimates the number of abused women treated in the emergency service since domestic violence is an ongoing problem that can be seen through analysis of a woman's trauma history rather than through the single injury episode of the sample year. This ongoing situation is defined as *present active prevalence* or that percent of patients who have evidenced abuse—whether positive, probable, or suggestive injuries—during the preceding 5 years. As shown in table 1, a significant percentage of these women (17.4 percent) appeared to be involved in abusive intimate relationships at some point during that period.

Finally, the historic prevalence of abuse, based on all the available medical records in the research sample, shows that 21 percent of the women who used the Emergency Surgical Service during the year have a history of abuse (see table 2). The overwhelming majority (88 percent) of this group (496 of 564 women) were in the high-risk positive and probable categories. A simple comparison between historical prevalence and active prevalence reveals that only 17 percent of the cases of abuse were either resolved or no longer reported in the medical records. Therefore, 83 percent of the women in this caseload who had ever been abused still appear to be in violent relationships. This indicates that abuse is typically an ongoing problem rather than a single incident, and that medical intervention has little impact. Interestingly, although some estimates of abuse (based on self-selected samples) diverge from our findings, these historic prevalence estimates are similar to estimates made by Harris and Anwar (Harris, 1979 & Anwar, 1976).

A Statistical Profile of At-Risk Women Using the Medical System

To compare battered and nonbattered women in the medical population, 591 of the nonbattered women in the study were randomly selected to serve as a control group.

Trauma Histories

Battered women clearly use the ESS in larger numbers than previously suspected. They also use it more frequently than nonbattered women. To determine the use of the ESS by battered women, trauma-induced visits by battered women and by controls were compared. The average number of trauma visits made per woman in each of the two groups was also compared.

TABLE 2
Visits to the Emergency Surgical Service

Category Totals	Sample (%)	No. of Visits	Total Visits (%)	Mean No. of Visits	Women With Only One Trauma Visit
Positive Women—295	25.5	2,088	46.2	7.01	48 (15.8%)
Probable Women—201	17.4	983	22.0	4.89	43 (21.4%)
Suggestive Women—68	5.9	268	6.0	3.94	16 (23.5%)
Total At-Risk Women—564	48.8	3,319	74.1	5.88	105 (18.8%)
Nonbattered Women—591	51.2	1,158	25.9	1.98	318 (53.8%)

The sample of 1,155 women made a total of 4,477 visits to the ESS. The battered women account for far more of these visits (3,319) than would be expected by their representation in the sample. While the abused women apparently use the ESS on an ongoing basis (positives have an average of seven trauma incidents), most of the nonbattered women (54 percent) had only one trauma incident that was treated at this hospital. Although positive women account for 26 percent of the research sample, they account for almost half (46 percent) of all visits to the ESS. Nonbattered women, comprising 51 percent of the sample, present only 26 percent of the injuries.

Table 2 shows the number and proportion of trauma visits made by the women in each risk group. The at-risk women not only have more at-risk incidents but more nonabusive incidents as well. For example, the positive women represent 26 percent of the sample and obviously account for all the positive incidents. But they also account for more than half of the probable and suggestive incidents and a little more than a third of the negative incidents reported in the medical records. It has not been determined whether this represents a conservative reading of the medical record by the research team or whether women abused at home are more likely to have genuine accidental injuries.

The large number of visits to the ESS made by battered women also reflects the fact that the at-risk women use the ESS on a longer term basis. The average at-risk woman has a trauma history of approximately 7 years, compared to only 3.7 years for nonbattered women.

How many of these abusive incidents did medical personnel actually associate with battering? Of the 435 positive trauma incidents presented in the sample, only 67 (15 percent) resulted in a diagnosis of physical abuse. In other words, using present identification techniques and symptomatic diagnoses, medical personnel trace a very small proportion of injuries reported by abused women to battering.

Location and Type of Injury

There is no substitute for a thorough medical history that employs both records and interviews to identify battered women. However, understanding the type and location of the injuries incurred by battered women can help medical personnel develop an index of suspicion. While most people seek emergency room attention for discrete injuries at a discrete location, victims of deliberate physical assault, like victims of automobile accidents and falls, suffer injuries at multiple sites.

The most frequently recorded locations of injuries are presented in table 3 and on shaded areas of the injury map. While 8 percent of the at-risk injuries are described as multiple (more than three sites), only 2 percent of the negatives are. The negative incidents are likely to be associated with injuries to the elbow, knee, or hip area, whereas at-risk injuries cluster significantly around the head, neck/face/throat, chest, and abdomen. For example, 36 percent of at-risk injuries are to the neck, face, or throat compared with only 14 percent of negative injuries. Similarly, 15 percent of at-risk injuries are to the head and 7 percent to the chest, compared with 7 percent and 3 percent, respectively, of the negative injuries. In contrast, 29 percent of negative injuries are in the elbow/hand/forearm area and an additional 29 percent are to the knee, leg, or foot, compared with only 13 percent and 6 percent of at-risk injuries. Overall, the nonabusive injuries tend to be to the extremities, whereas the abusive injuries tend to be central (face and torso).

INJURY MAP

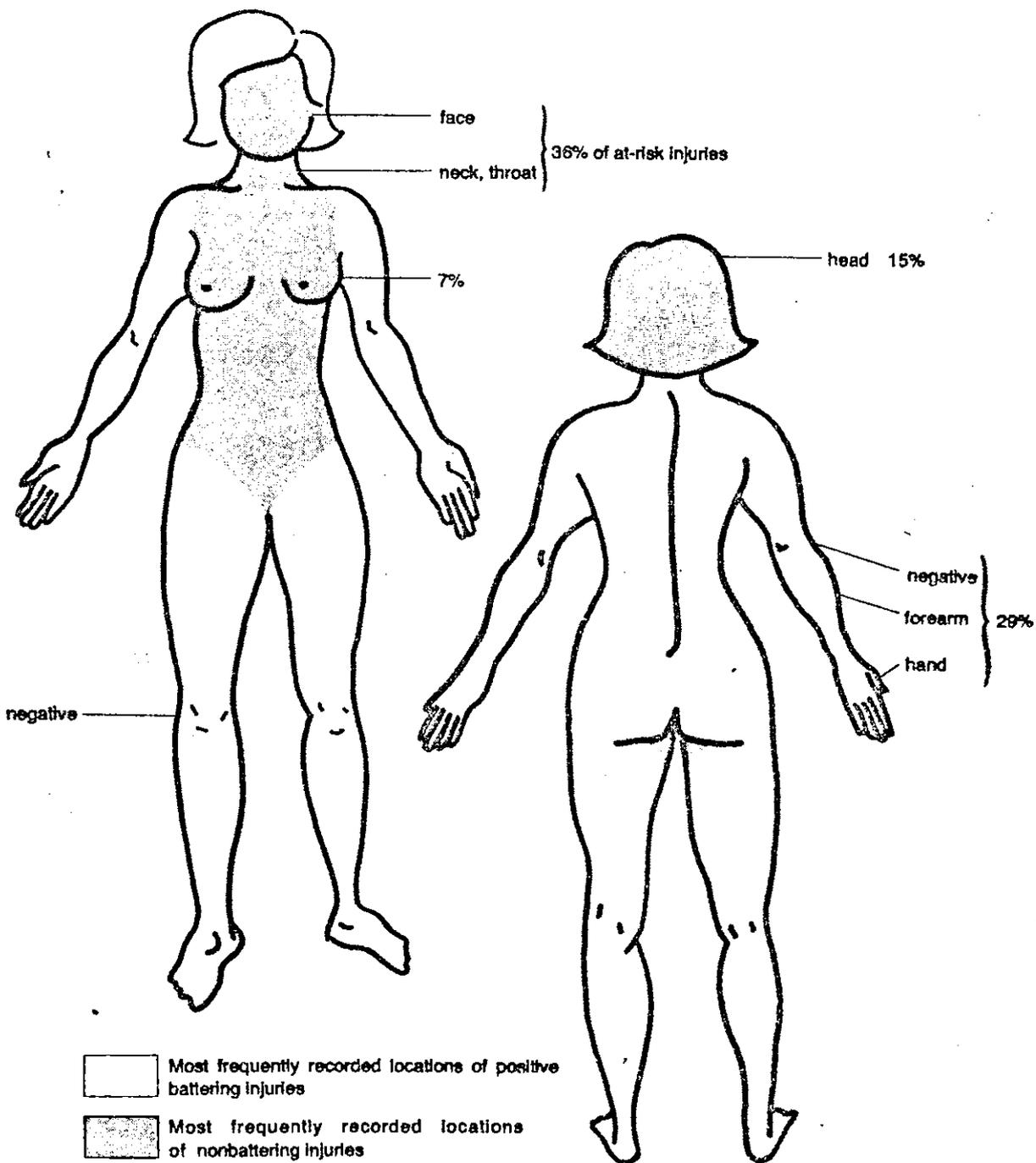


TABLE 3
Injury Sites

Injury Sites	At-Risk Battered Women (%)				Women With Negative Incidents (%)	Total No. With Injury At This Site
	Positive Incidents	Probable Incidents	Suggestive Incidents	Total At-Risk Incidents		
Head	16	23	12	51	49	292
Neck, Face, and Throat	15	30	13	58	42	823
Shoulder, Scapula, Clavicle, and Upper Arm	16	12	8	37	63	187
Elbow, Hand, and Forearm	5	8	6	18	82	1,102
Chest, Breast, Abdomen, and Perineum	20	25	13	59	41	310
Upper Back	10	13	8	31	69	205
Low Back, Hip, and Thigh	5	8	9	23	77	285
Knee, Lower Leg, and Foot	2	4	4	10	90	1,048
Multiple Sites (more than 3)	29	18	14	61	39	181
Total Injuries	10	14	8	32	68	100 %

Comparisons of the types of at-risk injuries and negative injuries are presented in table 4. The at-risk presentations are more likely to involve abrasions/contusions (56 percent compared with 34 percent), or pains that have no apparent physical cause (6 percent compared with 3 percent). The negative injuries are more likely to be sprains or strains (23 percent versus 5 percent). There are no significant differences in the proportion of lacerations, fractures, or dislocations. Although the number of rapes or human bites is very small, most of these injuries occur to battered women. The statistics for rape are consistent with a previous study of 174 rape victims who had used the same ESS over a 2-year period. Almost one-third of the rape victims had documented histories of battering. Among the victims over the age of 30, 58 percent were battered (Roper & Frazier, 1977). Again, since rape is viewed as an event that can be isolated from a woman's previous medical history, battering was rarely, if ever, identified as its context.

TABLE 4
Type of Injuries

Documented Injuries	At-Risk Battered Women (%)				Women With Negative Incidents (%)	Total No. With This Type of Injury
	Positive Incidents (n = 426)	Probable Incidents (n = 621)	Suggestive Incidents (n = 364)	Total At-Risk Incidents (n = 1,411)		
Abrasions, Contusions, Blunt Trauma	15	18	9	43	57	1,589
Lacerations	8	17	8	32	68	1,028
Fractures, Dislocations	6	13	9	29	71	408
Sprains/Strains	3	3	5	11	89	807
Human Bites	12	50	15	77	23	52
Animal Bites, Burns	0	2	2	5	95	232
Complaints with Negative Phy. Exam	16	17	20	53	47	218
Rape	27	14	11	52	48	58

Demographic Background

The at-risk women who come to the ESS are significantly different from controls in age, race, and religion. On the average, positives are 3 years younger than negatives (33.1 and 36.2), while probables and suggestives are still younger. This reinforces an earlier suspicion that many suggestives, and perhaps probables, are in earlier phases of the abusive relationship than positives.

Nonwhite women, primarily blacks, comprise 37 percent of our sample. However, over half of the nonwhite women in the sample have a trauma history that is at least suggestive of abuse, compared with about a third of the white women (see table 5). This may mean that nonwhites are more likely to be battered than whites, or it may reflect the fact that nonwhite women are twice as likely as whites to report abuse (Ridington, 1977-78). Although nonwhite women comprise 54 percent of the positives and 59 percent of the probables, the largest portion of suggestives (66 percent) are white. This may mean that whites are less explicit than nonwhites about the source of their injuries, or it may mean physicians more readily acknowledge or record abuse as a problem for nonwhites.

TABLE 5
Race As a Predictor of Battering

Category	Whites	Non Whites
Positive Women	136 (46%)	159 (54%)
Probable Women	82 (41%)	118 (59%)
Suggestive Women	45 (66%)	23 (34%)
Nonbattered Women	465 (79%)	128 (21%)

Religion also figures significantly in abuse statistics. Thirty-four percent of the nonbattered sample were Protestants as opposed to 56 percent of the at-risk women. By contrast, 51 percent of the negative sample are Catholic, compared with 34 percent of the at-risk women. A possible interaction between race and religion has not been yet assessed.

Financial independence has frequently been cited as a factor that contributes to abuse (because it threatens male privileges) but it may help a woman escape future battering. The women treated for positive trauma are only slightly less likely to be employed than those treated for negative trauma (31 percent versus 32 percent). However, women with probable or suggestive injuries are much less likely to be employed. Combining the three at-risk categories shows that 22 percent of the women with at-risk injuries are employed compared with 32 percent of the women treated for negative injuries. The higher employment among women with positive injuries (compared with probable or suggestive injuries) suggests that women who are more financially independent may be more willing to report abuse.

TABLE 6
Employment and Welfare Status as Predictors of Battering

Category	Employed	Welfare
Positive Incidents	80 (28%)	198 (57%)
Probable Incidents	81 (18%)	379 (72%)
Suggestive Incidents	50 (22%)	174 (58%)
Combined At-Risk Incidents	211 (22%)	751 (84%)
Nonbattering Incidents	743 (32%)	1,240 (48%)

A large proportion of the visits to the ESS were paid for by welfare, whether the incidents were caused by battering or not (see table 6). However, treatment cost for at-risk visits was more likely to be paid by welfare than treatment for negative injuries. Of the payments that were made and reported in the medical records, 36 percent of the at-risk visits and 52 percent of the negative visits were paid for by the individuals themselves or by insurance. Random surveys and other studies indicate that physical abuse does not occur disproportionately among the poor. The overrepresentation of welfare recipients among the sample of battered women may reflect a heavier dependence on the Emergency Medical Services for ongoing care among the low-income population rather than any actual preponderance of abuse among the poor.

Although battered women are often assumed to be married, 73 percent of the battered women in the sample were single, divorced, or separated. This suggests that survey data based exclusively on intact couples are of limited utility and, conversely, that separation or divorce present viable options to continued abuse only in combination with other, rarely employed, protective strategies. Clearly too, the fact that an injury victim is separated or divorced is no reason to reject battering as a possible diagnosis (see table 7). However, the battered woman is apparently more isolated than the nonbattered woman. Eleven percent of the women treated for at-risk trauma list no next of kin on their medical records, compared with only 7 percent of the women treated for negative trauma. Similarly, women treated for at-risk injuries are somewhat less likely to live at the same address as their next of kin than those treated for nonbattering trauma. It is therefore difficult to state whether isolation is the cause or consequence of physical abuse (table 7).

TABLE 7
Marital Status and Next of Kin

Category	Married (%)	No Next of Kin Noted (%)	Next of Kin at Same Address (%)
Positive Incidents*	36	11	61
Probable Incidents	18	10	51
Suggestive Incidents	30	12	65
Combined At-Risk Incidents	27	11	57
Nonbattering Incidents	28	7	64

*Due to incomplete records, the number of women representing each incident risk group differs for each variable. The smallest sample is for address of next of kin: positive—363; probably—530; suggestive—310; negative—2,659.

Reproductive History

The at-risk women in our sample had an average of 2.7 children, a figure similar to that of nonbattered women (see table 8). However, the at-risk women were more likely to terminate pregnancies by abortion or to suffer miscarriages. Twenty-two percent of the at-risk sample had at

least one abortion, compared with only 8 percent of the nonbattered women. In addition, frequency of miscarriage among the high-risk women was approximately twice that of nonbattered women; 15 percent of at-risk women had at least one miscarriage compared with 8 percent nonbattered women.

TABLE 8
Reproductive History

Category Totals	Minimum of One Abortion (%)	Minimum of One Miscarriage (%)	Mean No. of Children*
Positive Women—295	22	18	2.73
Probable Women—201	24	14	2.74
Suggestive Women—68	13	9	2.43
Combined At-Risk Women—564	22	15	2.70
Nonbattered Women—591	8	8	2.58

*For the mean number of children the samples are smaller because of incomplete records: positive women—283; probable women—182; suggestive women—61; nonbattered women—548.

Previous research demonstrates that battered women are frequently injured when they are pregnant (Gelles, 1977). In our study as well, the women treated for at-risk injuries were more likely to be pregnant at the time of their visit than the women who were treated for nonbattering injuries (8 percent compared with 5 percent). Abuse during pregnancy may contribute to the greater proportion of identified miscarriages among at-risk women and could possibly account for their frequent abortions as well.

Although their number of children may not differ, battered women are generally younger and have an overall rate of pregnancy (live births plus abortions and miscarriages) that appears higher than that of nonbattered women. This suggests an important familial pressure that may lead to, as well as derive from, abuse.

Medical Resource Utilization

Battering is frequently identified with severe physical abuse. This assumption initially pointed to the ESS as the most likely site to discover battering. However, the battering syndrome includes multiple medical and psychosocial problems in addition to repeated injury so that battered women frequently and disproportionately utilize nontrauma medical resources as well.

In our sample, 765 of the 1,155 women used the Emergency Medical Service. At-risk women accounted for 78 percent of the total visits to this service. Moreover, of those women who used this service, at-risk women used it almost twice as often, averaging 1.79 visits per year prior to their first recorded battering incident and 1.95 visits per year after their first identified incident of abuse. Nonbattered women averaged 1 visit each year. The number of visits to the Emergency Medical Service is presented in table 9.

TABLE 9
Service Visits By All Women In Sample

Medical Resource	Visits of Negative Women (5,837)	Prebattering Visits of Combined At-Risk Women (5,472)	Postbattering Visits of Combined At-Risk Women (9,321)	Total Visits
Medical Emergency Service	1,901 (22%)	2,528 (29%)	4,179 (49%)	8,608 (100%)
Psychiatric Emergency Service	129 (17%)	192 (25%)	442 (58%)	763 (100%)
Women's Clinic	686 (24%)	1,060 (37%)	1,143 (40%)	2,889 (101%)
Medical Subspecialties	931 (33%)	674 (24%)	1,191 (43%)	2,796 (100%)
Surgical Clinic	1,088 (37%)	485 (16%)	1,385 (47%)	2,958 (100%)
Medical Clinic	1,014 (46%)	404 (18%)	791 (38%)	2,209 (100%)
Social Services	66 (23%)	92 (32%)	132 (46%)	290 (101%)
Psychiatric Clinic	16 (17%)	19 (20%)	58 (82%)	93 (99%)

Five times as many abused women as nonabused women used the Psychiatric Emergency Service. The at-risk women accounted for 83 percent of the sample visits there (see table 9), and averaged 0.52 visits per year before the first identified incident of battering and 0.69 visits per year afterwards, compared with 0.32 visits per year for nonbattered women.

Of the 2,889 visits made to the Women's Clinic, 77 percent were made by at-risk women. The at-risk women averaged 1.10 visits per year before the first battering incident, but only 0.85 after the first battering. However, this figure is still greater than that for nonbattered women.

Ironically, abused women do not seem to use the ongoing, continuing care clinic or the surgical (injury) followup clinic. The at-risk women made only 54 percent of the sample visits to the Medical Clinic (primary care clinic) averaging 0.92 visits per year compared with 0.77 for controls. The at-risk women made 63 percent of the sample visits to the Surgical Clinic for followup care, averaging 0.78 visits per year prebattering and 0.88 visits per year postbattering, compared with 0.90 visits per year for nonbattered women.

These findings indicate that battered women use the Medical Emergency Service, the Psychiatric Emergency Service, and the Women's Clinic frequently and disproportionately. These sites, which treat nontrauma medical and psychosocial problems, provide most of the health care for abused

women. Since this utilization pattern distinguishes battered women from controls, it must be understood as part of the battering syndrome and considered when developing the site or procedure in protocol dealing with abuse. Not surprisingly, the medical personnel at these clinics appear to be oblivious as ESS staff to the issue of battering. Medical records at these sites do not reflect awareness of clients' trauma histories or battering.

Psychosocial Problems and Mental Health

Researchers have traditionally associated family conflict with child abuse, primarily by an assailant (Strauss, Gelles, & Steinmetz, 1979; Walker, 1980). This study indicates that only a small number of battered women appear to be mothers of abused children. However, less than 1 percent of the nonbattered women are mothers of abused children compared with 5 percent of the positives and 3 percent of the probables (see table 10).

TABLE 10
Psychosocial Problems

Category	History of Suicide Attempt (%)	Mother of Abused Child (%)
Positive Women—295	14	5
Probable Women—201	11	3
Suggestive Women—68	4	0
Combined At-Risk Women—564	12	4
Nonbattered Women—591	1	0.5

Alcohol abuse has been discussed primarily as a stimulus to battering. It appears from the data that alcoholism is also a problem for the victims of abuse. Our study of clinic records of at-risk women prior to the first identified incident of abuse shows that alcoholism is no more common among battered women (3 percent) than nonbattered women (2 percent). After the first reported incident however, alcohol abuse climbs to at least 15 percent among the battered women suggesting that alcoholism is a consequence of abuse and an important psychosocial dimension of the battering syndrome.

Although very few sample women were diagnosed as drug addicts, these diagnoses trebled after the first identified battering incident (see table 11). Seventy percent of these diagnoses for battered women were made *after* the onset of abuse as initially presented in the emergency services.

The study also indicated an increase in several other diagnoses after the first recorded instance of battering. The authors created a general diagnostic category consisting of vague medical diagnoses that include diagnoses such as hysteria, neurosis, hypochondriasis, and psychosomatic disorders.

These comparisons indicate that at-risk and nonbattered women receive very similar diagnostic and nontrauma medical facilities prior to the onset of abuse. They also indicate that the mental health and psychosocial problems of at-risk women increase markedly with the onset of abuse. Abuse, therefore, appears to be the context for many of these secondary problems, rather than the reverse.

Although several studies of battering report that battered women are at significant risk for attempted suicide, the psychiatric researchers typically point to specific personality traits that predispose women to both family conflict and self-destruction (Gayford, 1975; Walker, 1979). In the current study, 12 percent of the at-risk women have been treated for at least one suicide attempt, compared with only 1 percent of the nonbattered women (table 10). Moreover, 40 percent of the positive and probable women who attempted suicide reported that their attempt was related to being battered.

A previous study more closely examined the relationship of battering and attempted suicide (Flitcraft, Zuckerman et al., 1979). From a sample of 91 women who came to the emergency service after suicide attempts, 28.6 percent were battered. Fifty-six percent of the black female suicide attempters were battered. Among the positive women, 43 percent had attempted suicide the same day that they were battered, and 71 percent attempted suicide within 6 months of the abusive incident. Eighty-five percent of the battered women who attempted suicide had been treated at this Emergency Surgical Service for at least one injury identified as the result of abuse. There is a 75 percent chance that if a woman mentioned a family conflict or "lovers' quarrel" as a precipitant of her suicide attempt, she had episodes of previous trauma revealing that she was battered. Battering should be regarded as a frequent precipitant of female suicide attempts, and conversely, women who attempt suicide are likely to have a history of domestic violence.

Only 5 percent of the nonbattered women in the sample were pregnant at the time of their suicide attempt compared with 20 percent of the battered women. This indicates the importance of identifying a history of abuse among patients at the Women's Clinic and of cooperation between the Women's Clinic and the Psychiatric Emergency Service.

Pediatric History

According to one theory, the "cycle of violence" is perpetuated across generations from the father to the daughter of origin. However, researchers have identified only a small proportion of battered women who experienced or witnessed violence as children (Stark, Flitcraft, Zuckerman et al., 1979). Although the percentage of all at-risk women experiencing childhood abuse may be small, it appears from the current sample that the percentage of abused children who are eventually battered as adults may be extremely significant.

Two hundred and twelve women in the sample had pediatric records at this hospital. At-risk women had no more pediatric medical problems than nonbattered women (see table 12). However, 20 percent of the nonbattered women had a childhood record of abusive injuries compared to 15 percent of the positives, 15 percent of the probables, and 11 percent of the suggestives. Similarly, 14 percent of the at-risk women had experienced major injuries as children, compared with only 2 percent of the nonbattered women. Conversely, all but three of the sample women who suffered major injuries as a child — 92 percent of this group — were battered as adults.

There were 184 child psychiatric records in the sample. Five percent of the controls had child psychiatric problems as children compared with 20 percent of the at-risk women. In fact, almost 50 percent of the at-risk women whose childhood records were available had major or minor psychiatric problems as children, compared to a little less than a quarter of the nonbattered women.

As would be expected, psychiatric problems in childhood were more prevalent for those who experienced major injuries or abusive injuries as children (table 13).

TABLE 12
Pediatric History

Category	Major Medical Problems	Major Injuries	Abusive Injuries	Minor Psych. Problems	Major Psych. Problems
Positive Women	10 (16%)	7 (12%)	9 (15%)	14 (24%)	12 (20%)
Probable Women	7 (18%)	6 (15%)	6 (15%)	7 (22%)	8 (25%)
Suggestive Women	1 (7%)	3 (17%)	2 (11%)	4 (31%)	1 (8%)
Combined At-Risk Women	18 (15%)	16 (14%)	17 (15%)	25 (24%)	21 (20%)
Nonbattered Women	11 (12%)	2 (2%)	1 (1%)	15 (19%)	4 (5%)

The next step was to determine whether psychiatric problems in childhood and pediatric injuries predict battering as an adult independent of demographic variables, such as race and religion, or adult history variables (abortions, miscarriages, number of visits to the ESS, etc.). These variables were included in a logistic regression analysis that found that major or abusive injuries as children predicted adult battering independent of demographic background or adult history. Childhood psychiatric history predicted adult battering only in conjunction with pediatric injury suggesting that child abuse was the context for childhood psychiatric problems (see table 13).

TABLE 13
Interaction Between Psychiatric Problems and Trauma in Pediatric History

	Pediatric Injuries	Major Psychiatric Problems in Pediatric History %
At-Risk Women	Normal Injuries—61	10
	Major Injuries— 9	22
	Abusive Injuries— 9	44
Negative Women	Normal Injuries—70	4
	Major Injuries— 0	0
	Abusive Injuries— 0	0

The Medical Response

We have already noted the failure of the medical services profession to identify abuse or to specify its determinant role in the etiology of a myriad of secondary problems. Although physicians fail to officially record battering, they do treat battered women differently as a group. The prescription of medicine is an important aspect of the physicians' response to the women who use the Emergency Surgical Service. Comparisons of the medicine prescribed for at-risk incidents and negative incidents indicate that analgesics are prescribed for 16 percent of at-risk incidents and 12 percent of negative incidents (see table 14). This difference is modest but statistically significant. The prescription of sedatives, tranquilizers, and antidepressants did not differ for the two groups.

TABLE 14
Medical Prescriptions By Treatment Area

Prescribed Medication	At-Risk Incidents (n = 1,437) (%)	Nonbattering Incidents* (n = 3,129) (%)	Prescriptions Nonbattered Women	Prebattering Prescriptions At-Risk Women	Postbattering Prescriptions At-Risk Women
Analgesics	16.0	12.0			
Medical E.S. Surgical Clinic			93 (29%)**	152 (40%)	174 (47%)
Medical Clinic			5 (2%)	8 (6%)	20 (8%)
Subspecialties			7 (7%)	5 (5%)	10 (10%)
Women's Clinic			0	8 (5%)	24 (12%)
			5 (4%)	10 (7%)	18 (9%)
Sedatives	0.3	0.2			
Medical E.S.			5 (2%)	17 (5%)	22 (6%)
Psych. E.S.			2 (5%)	2 (2%)	6 (5%)
Medical Clinic			5 (5%)	1 (1%)	5 (4%)
Minor Tranquilizers	2.0	2.0			
Medical E.S.			33 (10%)	48 (12%)	87 (23%)
Psych. E.S.			3 (8%)	14 (18%)	24 (19%)
Psych. Clinic			1 (10%)	1 (1%)	0 (38%)
Surgical Clinic			4 (2%)	1 (1%)	8 (3%)
Medical Clinic			17 (16%)	13 (12%)	18 (13%)
Subspecialties			3 (2%)	1 (1%)	8 (4%)
Women's Clinic			4 (3%)	3 (1%)	9 (4%)
Major Tranquilizers	0.5	0.3			
Medical E.S.			0	6 (2%)	10 (3%)
Psych. E.S.			5 (13%)	8 (9%)	9 (7%)
Psych. Clinic			0	0	3 (19%)
Medical Clinic			0	2 (2%)	2 (1%)
Antidepressants	No Statistic Available	No Statistic Available			
Psych. E.S.			0	5 (6%)	3 (2%)
Psych. Clinic			0	0	2 (13%)
Medical Clinic			4 (4%)	4 (4%)	2 (1%)

*These figures represent the percentage of clinic visits that result in the types of prescriptions listed.

**These figures represent the proportion of women who received the types of prescriptions listed. Some women received no prescriptions; some women received several prescriptions.

It was expected that battered women would be more likely to be referred to psychiatric services, social services, or services specifically designed for battered women. Although several women were referred to the local battered women's shelter or to counselors for victims of violence, these figures are unimpressive compared to the prevalence of abuse. Similarly, the proportion of battered women referred to other psychiatric or social services is only slightly higher than the proportion of nonbattered women referred to these services. These statistics are presented in table 15.

TABLE 15

Primary and Secondary Dispositions of Women Using the Emergency Surgical Service

Suggested Disposition	Percent Positive Incidents (n = 420)	Percent Probable Incidents (n = 808)	Percent Suggestive Incidents (n = 358)	Percent Combined At-Risk Incidents (n = 1,388)	Percent Negative Incidents (n = 2,950)
Home	48	49	53	49	59
Followup Clinic	25	43	38	38	34
Admit to Hospital	5	2	2	3	2
Psychiatric Emergency Service	6	1	2	3	1
Counselor for Battered Women (Emerg. Surg. Serv.)	8	1	0	3	0
Social Services	5	1	0	2	0
New Haven Project for Battered Women	4	0	0	1	0
Patient Walks Out	2	4	7	4	3

Overall, these data suggest that the symptoms and psychosocial problems resulting from battering are treated with medication rather than with psychotherapy or social services.

III. Methods of Identification

Identification of abused women within the medical setting is important both clinically and epidemiologically. For those involved directly in the delivery of services, identification methods begin with the patient encounter but may extend into a complete review of the patient's medical record to understand the history and extent of abuse as well as the patient's previous attempts to find aid within the medical complex. A review of patient medical records may provide a data base for those interested in establishing and evaluating programs of aid. A medical record review of a given caseload can be used to estimate the number of abused women using the services of a particular clinic or medical center, the number of recognized battering victims, and the major medical and psychosocial problems of this population. In addition, it reveals the current response in a given medical complex to both recognized and unrecognized victims of domestic assault.

The section on clinical settings describes the medical presentations and problems associated with domestic assault as they are seen within the various medical and surgical clinics of a major urban medical center. Practitioners who work in more integrated facilities or community health clinics may find that the specific medical sites (medical, surgical, or psychiatric emergency service; medical, primary care, or obstetrics and gynecology clinics) are not relevant to their situation. In this instance, clinic staff should discuss and identify the site where each high-risk presentation is likely to appear given the triage and referral patterns of that particular health care facility.

A preliminary word of caution. Accurate epidemiological data on domestic assault are difficult to gather. Since physicians do not record abuse, epidemiological investigations based upon physician case reporting methods seriously and consistently underestimate the magnitude of the problem. On the other hand, a critical review of medical records permits the trained researcher to identify both abused women and women whose medical histories certainly suggest domestic violence. In the second section, an approach to the medical record as a research tool is outlined. Though laborious, this method provides valuable data for those involved in the development of services for abused women.

Clinical Settings

Abused women have sought medical aid in numerous health care settings for generations. Yet rarely have clinicians publicly supported the movement to identify and respond politically to domestic assault. Because care providers are sentinels who oversee the complaints and disorders of everyday life, it seems paradoxical that battering remains outside the medical purview. Why should this be?

The answer has already been suggested. The contours of medical perception are inseparable from the broader cultural commitments of society and are bound by the logical categories of medicine. Health professionals approach patients to establish a diagnosis (not, for instance, to meet a need) and by so doing are impelled toward particular therapies, more or less scientifically based. The present diagnostic catalogue presumes an anatomical or physiological basis for disease. Events that cannot be explained in these categories appear to resist medical logic, do not lead easily to therapeutic intervention, and consequently confuse medical perception. Surprisingly, patients who present these events are often defined as "resistant". The interpretation of the medical record suggested here derives from a belief that the social origins of apparently discrete health problems radically alter understanding and improve response to the problems of particular patients. This mode of reinterpretation clears the way for following battering through its primary presentations at various medical sites.

The Surgical Setting

Traditionally, when patients are asked how a particular injury occurred, specific technical information is being sought to alter the approach to injury-repair. For example, a laceration sustained on a clean knife may be cleaned and sutured rather quickly whereas a smaller laceration sustained on ceramic fragments may require laborious exploration, and even X-rays, to locate retained fragments. A broader interpretation of *how a particular injury occurred* is necessary to identify abused women. Battering is a part of the differential diagnosis of every encounter with an injured client. By classifying the etiology of the presenting complaint into one of the following categories, the health professional can determine the relative risk of abuse and, therefore, the appropriateness of the followup question: Are you battered?

1. **Positive Incidents:** Those cases in which the injury is directly attributed to a spouse, boyfriend, or significant male intimate.
2. **Probable Incidents:** Those cases in which the injury could only have been sustained in an assault, that is the patient was kicked, hit, stabbed, choked, shot, etc., but the injury was not sustained in a mugging, street assault, or robbery.
3. **Suggestive Incidents:** Those cases in which the immediate alleged etiology does not account for or is inconsistent with the injury sustained—e.g., falling downstairs and suffering two black eyes, sitting on a steak knife and suffering deep hip lacerations.
4. **Negative Incidents:** Those cases, including anonymous assaults and muggings, where the alleged etiology is consistent with the pattern of injuries sustained.

Aspects of the event itself should serve to heighten the clinician's "index of suspicion" and prompt supportive frank discussion with the client regarding possible problems of domestic assault:

1. **Multiple Injuries:** There are relatively few ways of sustaining injury to more than one anatomic site and fewer ways of sustaining bilateral injuries regardless of the etiology. Frequently cases that might be dismissed as multiple abrasions or contusions are actually domestic assault.
2. **Body Map:** Most accidents involve the extremities, especially the hands and feet. Deliberate assault carries a different body map so that any incidents involving injury to the face, neck, chest, breasts, or abdomen ought to prompt careful attention in order to rule out intimate assault (see body map).
3. **Rape:** Regardless of the legal definition, a woman who seeks medical aid after forced sexual contact with a male intimate will say she has been raped—there is no other word to describe the experience. Many rape crisis teams were developed in response to the notion of rape as an isolated event in the life of the unprotected housewife or coed and focus upon the legal aspects of evidence gathering, documentation, and prosecution. Such strategies do not address the emotional, medical, legal, or shelter needs of the woman who lives within a violent relationship in which rape is yet another incident of ongoing physical abuse. On the contrary, within the medical encounter where rape is presumed to refer to anonymous sexual assault, the abused woman is likely to feel that she is misunderstood and therefore respond with hostility, refuse to cooperate with police representatives, and fail to keep appointments with medical personnel and rape crisis counselors.
4. **Severity of Injury:** Contrary to widely publicized press reports of battering, severity of injury (in strictly medical terms) is a relatively poor indicator of domestic assault and an unreliable way of identifying abuse in the medical setting. Abused women are no more likely to require hospitalization for medical treatment of injuries than nonabused women. In fact, the presentation of medically insignificant trauma to the emergency service ought to alert providers to the possibility that ongoing assault and impending danger is the real emergency for which a woman is seeking aid.

5. **Pregnancy:** Abused women are more likely to be beaten when pregnant. The risk to both the mother and unborn child is reflected in the higher rates of miscarriage among abused women. The coincidence of trauma and pregnancy represents an extremely high-risk presentation that may demand emergency medical and social service intervention.
6. **Trauma History:** Most clinicians briefly investigate a patient's medical history when treating even the most insignificant injury to elicit the most complete information about the last tetanus shot, allergies, daily medications, diabetic history, and major hospitalizations. In the case of joint injury, the provider may ask about previous injuries to the same site. There is no pathophysiology that establishes logical continuity between episodes of trauma. So long as injury is seen as a relatively confined anatomic breach, there is no imperative to elicit a history of previous trauma as a routine step in the evaluation of any injured patient. In screening and identifying abused women, however, the trauma history is the most important step in patient evaluation. If a trauma history is obtained routinely, regardless of the current clinical presentation, then it is possible to identify abused women within the larger population of patients with genuine accidental injuries, such as those due to motor vehicle accidents. Furthermore, the routine use of the trauma history interview circumvents the tendency to identify abuse only in those situations where the extent and nature of the injuries make the diagnosis obvious—situations that require extensive and emergency social service intervention at the height of intrafamilial crisis.

The Medical Setting

Battering is a syndrome that includes not only repeated episodes of injury but also the development of multiple medical and psychosocial problems. Identification skills should be extended beyond the acute trauma setting and into those nontrauma sites that actually form the predominant medical structure which provides ongoing care to the population of abused women. Active identification efforts within these settings have the advantage that women need not be beaten again before medical personnel recognize the problem. In addition, the organization of emergency medical services is increasingly oriented toward the medical disaster, the life-and-death injury, or illness that demands the intervention of technology and medical subspecialists. Given the limitations of the emergency surgical service as a primary care facility, the clinic setting may provide a more suitable environment where patient-provider interviews may be less distorted by time constraints or preconceived notions of "appropriate" complaints. Moreover, social service providers are likely to be more accessible in clinic settings. Although intervention at nontrauma sites can play an important role in the early detection and prevention of the syndrome, health professionals at these sites frequently fail to identify abuse and inappropriately label complaints associated with battering.

The accumulation of quasi-medical labels such as hysterical, hypochondriac, or patient with multiple vague complaints occurs throughout the medical complex. Although the labels express the frustration of a provider who is unable to answer a patient's chief complaint in traditional therapeutic modes, they also signify to other practitioners (most painfully) that future complaints may also be less serious (or real) than initial evaluation might suggest. Thus labels protect both medicine and providers from the very patients who may need services most. Labeling is a way of telling patients that, "whatever the problem, it is certainly not anything that I can help you solve." From the abused woman's perspective, this encounter minimizes her problem, discourages access to social resources, and reinforces her sense of isolation.

Medical Emergency Service

Abused women use medical emergency services more frequently than those who are not abused. Presenting complaints may be:

- associated with old injuries, particularly to the back, neck, and ribs;

- reflecting diffuse trauma that does not leave anatomic "evidence" but results in such complaints as headaches or nonspecific muscle pain;
- symptomatic of the stress associated with living in a violent environment such as sleep disorders, anxiety, dysphagia, or hyperventilation; or
- associated with relatively late stages of battering, e.g., alcohol or drug abuse.

Generally practitioners within the emergency setting must recognize that the emergency of the abused woman is frequently not evident in laboratory tests, X-rays, or physical examinations. For instance, of a group of 36 women who went to the emergency service alleging drug overdose by ingesting pharmacologically insignificant amounts of material (several aspirins, two Darvons, etc.) 22 percent had previous histories of domestic assault. In these cases, the abused woman can be recognized if the practitioner accepts the legitimacy of an "emergency" without anatomic or physiologic pathology.

Medical Clinics

The variety of complaints for which abused women visit the medical clinic are similar to those presented to the medical emergency service. However, medical clinic records are maintained more consistently than those of the emergency service and practitioners in this setting are likely to have access to a woman's entire clinic history. Clues that warrant specific review of the trauma history include:

- persistent clinic visits with vague complaints and symptoms without evidence of physiologic dysfunction;
- frequent use of minor tranquilizers or sleep medications; and
- increasing reliance upon alcohol or abuse of licit and illicit drugs.

The astute clinician can review a patient's clinical history and locate clusters of seemingly unrelated complaints emerging over time, followed by evidence of incipient self-abusive behaviors that may indicate the point at which sporadic incidents of violence have settled into a pattern of abuse from which change and escape seem impossible.

Obstetrics and Gynecology Clinics

In gathering information about a woman's obstetrical or reproductive history, data immediately relevant to the care/repair of the present clinical problem are selected. The patient is asked about previous pregnancies, deliveries, and births primarily to anticipate anatomic or physiological problems that may emerge during the current pregnancy. The following are examples of histories that ought to prompt the clinician to include a full trauma history in the review of systems:

1. self-induced or attempted abortions
2. multiple therapeutic abortions
3. miscarriages
4. divorce or separation during pregnancy

Persistent gynecological complaints, particularly abdominal pain and dyspareunia in the context of normal physical and laboratory examinations, are frequently overlooked manifestations of domestic assault.

Psychiatric Emergency Services

Emergency psychiatric services are a necessary component of all federally funded community mental health centers and serve, in part, as the outpatient adjunct in the deinstitutionalization of

mentally ill patients. Ideally problems requiring social services, community mental health services, or medically oriented psychiatry would be clearly distinct. However, within the busy emergency room, any patient who is "emotionally upset" is likely to be referred to psychiatric personnel. Rapid assessment of a patient's previous psychiatric history, present symptoms, and speedy disposition are rewarded in a setting where nonpsychiatric staff are overworked and unable to provide support to nonemergency cases, where senior psychiatric staff are in little evidence, and where there is intense competition for scarce resources. For instance, it is more difficult to admit a patient to some psychiatric facilities after 4 p.m., when downstaffing occurs.

Many facilities (especially private ones) simply advise holding a patient in the emergency service until the next morning. Emergency psychiatric staff generally accept a medical model of mental illness and, regardless of their personal philosophy, are certainly not skilled community social workers. Abused women within the emergency psychiatric service therefore are perceived through the prism of the differential diagnoses of mental illness. Two stereotypes emerge:

1. An abused woman's anger at her assailant is transferred into the therapeutic milieu where she is faced with the task of extricating herself from presumed illness. The hostility toward the provider initiates a process during which the practitioner may think he or she "understands" how a man might become so frustrated as to abuse this woman. Too often, this implicit identification with the assailant leads to punitive interventions such as involuntary hospitalizations, or passive-aggressive superficial evaluations without referral to further resources.
2. The patient who "accepts" the prism of mental illness as an appropriate vantage from which to view her crisis is likely to appear as excessively passive and withdrawn. She is without what some might deem "appropriate affect" in this situation, much like the victim of the rape trauma syndrome. Unlike the woman who fights against the diagnostic process, this woman observes, internalizes, learns the role of one who is emotionally hampered. In so doing she comes to accept responsibility for her own abuse and victimization and maintains the illusion that by altering her behavior she might protect herself from further assault. The results of such encounters may be characterized as caretaking with repeated visits to outpatient facilities and maintenance on a variety of minor psychoactive medications.

The relative overutilization of emergency psychiatric services by abused women is so startling that one could argue that any psychiatric interview ought to include a full trauma history. However, in the following situations such a history becomes mandatory:

- alcohol abuse;
- drug abuse (particularly of licit substances);
- suicide attempts, *regardless* of the strictly medical seriousness of the suicide gesture;
- attempted suicide during pregnancy;
- concern about ongoing or impending abuse of children;
- vague and nonspecific complaints of anxiety, depression, or anger, often associated with a moderate degree of impaired function and tangential references to marital conflict; and
- paranoid tendencies sometimes associated with fears of falling asleep or of losing control and inflicting violence.

Using the Medical Record

The use of hospital medical records as a source of information has both advantages and disadvantages. The optimum record is an integrated one that includes, in chronological order, every encounter between an individual patient and the service institution (*all* inpatient and outpatient visits).

Such a unit record system includes all visits to the Emergency Service, noninjury as well as injury complaints. Together they form the basis of the most reliable method for identifying abused women from medical records.

The methodology employed in the sample research is a retrospective review of the full medical records of adult women (aged 16 and older) who presented with injuries to an urban hospital's Emergency Surgical Service from July 1978 to July 1979. The full medical records were secured and analyzed for a random sample of 2,676 women. Identification of abuse depended upon careful and critical review of each woman's trauma history, that is, the sequential review of all episodes of trauma that she had presented to this emergency service during her adult life to date. Each injury episode was assigned to one of the following groups:

- **Positive:** record states that the patient's injury was inflicted by a male intimate or family member.
- **Probable:** record states that the patient was the object of blows — she was hit, kicked, beaten, stabbed, etc., but no personal etiology was indicated (muggings, anonymous assaults on street, robberies were not included in this category).
- **Suggestive:** alleged etiology did not appear to account for either the location of the injury or its severity.
- **Negative:** the pattern of injury was adequately explained by the recorded etiology. Injuries suffered in assaults described as muggings or anonymous assaults were included in the category.

When each trauma episode in the medical record had been classified into one of the above categories, the woman was assigned to a battering risk group on the basis of her trauma history. The definition of the battering risk groups are derived from the categories of trauma episodes as follows:

- **Positive:** at least one episode in the woman's trauma history was attributed to assault by a male intimate.
- **Probable:** at least one episode in the trauma history was an assault but no personal etiology was indicated (note that muggings, anonymous assaults were not included in this category).
- **Suggestive:** at least one episode in the trauma history was not well explained by the recorded alleged etiology.
- **Negative:** all episodes in the trauma history were well explained by the recorded injury, including those sustained in muggings, anonymous assaults, etc.

For purposes of further analysis, the women assigned to the positive, probable, and suggestive groups were considered to be at-risk for battering.

If medical records are organized into a total unit system, it is possible to estimate the number of abused women at any site by adapting this methodology. For instance, a sample of women could be gathered from the Women's Clinic. Reviewing the trauma histories of each, the clients could be categorized into appropriate battering risk groups, thereby estimating the percentage of the sample who are at-risk for abuse and, by extrapolation, the number of abused women who use the Women's Clinic.

What follows is a list of problems and descriptions frequently associated with abuse on the medical record. These clues have been organized by hospital site as well as by presentation because it is the *clustering* and *repetition* of presentations and complaints, rather than isolated events, that are significant. These clusterings will appear in a variety of sites so that one may have to review a woman's entire medical history in order to understand the role violence has played in determining her present situation.

Cluster Graph

	Surgical Emergency Service	Medical Emergency Service	Psychiatric Emergency Service and Clinic	Primary Medical Clinic	Medical/Surgical Clinic and Subspecialties	OB/Gyn. Clinic	Hospital Admissions	Social Service	
Self-Identified									'My (husband, boyfriend) (kicked, stabbed, etc.) me.'
Injuries									History of trauma, at-risk injuries. Body map traces inconsistent etiology.
Anxiety									Dysphagia — choking sensation, swallowing difficulty, and hyperventilation systems.
Gynecology									Dyspareunia, Miscariage, frequent abortions, and young motherhood.
Alcoholism									Addiction: (1) with frequent injury and (2) with marital conflict.
Social Problems									Unemployment (patient and/or male partner), financial difficulties, and isolation.
Suicide Attempts									With marital conflict in nonpsychotic women.
Psychiatric Labels									Depression, paranoia, psychosomatic/functional complaints, and drug dependency (nonstreet drugs).
									Headaches; back pain—vague, cause unknown, and complaints with negative workup.

Emergency Surgical Service

History, location, and context of injury should be examined when the woman requests treatment without the specific complaint of battering. Does she have facial, chest, or abdominal bruises, fractures, or lacerations? Was she punched, kicked, or in a fight? Does she tell a "funny" story about the context of her injury? Are there multiple visits for treatment of injuries? Is she pregnant? The suspicion of battering should be raised in any of these circumstances. The ESS admission report includes information relative to marital status, payment, usual care source, next of kin, ambulance and police involvement. Use of alcohol or drugs, alleged etiology and history of injury, and injury description are contained in both physician and nursing notes in the emergency service report, while additional information about the injury may be found in X-ray reports or requisitions. Medications prescribed and disposition data are located in the physician notes in this report.

Hospital Admissions: If the injury is severe enough to warrant hospitalization, results of a more complete physical examination, medical history, and psychosocial history are placed in the physician's admission reports. Social service and/or psychiatric referrals found in the physician's note section are informative and give an idea of the overall context of the complaints. Laboratory and X-ray reports are especially important when related to an injury or when battering is suspected. The nursing notes can provide insight into the patient's emotional state, her support network, and her relationships with visitors.

Medical Emergency Service (MES) and Medical Clinic (including Medical Subspecialties): Peculiar to the MES and medical clinics are a host of psychosocial, psychosomatic, and functional complaints by the woman who is battered. Anxiety symptoms, dysphagia, choking sensation, repetitious visits with vague medical complaints, and symptoms with no apparent physiological dysfunction are clues to abuse, especially when compounded with a suspicious injury or a history of old injuries.

Again, there are physicians' notes pertaining to clinical presentations, findings on physical examinations, diagnostic summaries, treatments, prescriptions, and disposition plans.

Primary Care Center: Many hospitals now have primary care centers to provide continuity of care for patients who use the hospital as their regular source of medical treatment. Because of the possibility for more holistic care at these centers, they are valuable in uncovering battering. Social factors in patients' complaints are likely to be discussed and, most importantly, written into the record. Patients who see the same clinician more than once are more likely to develop trust and speak more openly of their situation. Clinicians are also able to see "clusters" of symptoms emerging over time and probe into those they find particularly worrisome.

OB/Gyn Clinics: Of interest in this section of the record is the patient's reproductive history, especially high-risk pregnancies, miscarriages, therapeutic abortions, attempted abortions, premature deliveries, and the patient's age and marital status at the time of each pregnancy. The gynecology notes may include a history of frequent visits with complaints of dyspareunia and/or abdominal cramps or pain. In such cases one should be suspicious of abuse, especially when the diagnostic workup for these symptoms is negative. Clinic visit reports for both gynecology and obstetrics are completed by physicians, nurse-midwives, and nurses. Supplementary data are provided by the nutritionist and social services. Social service notes frequently give more insight into the woman's living conditions, social isolation, finances, family relationships, and current stresses in her life.

Psychiatric Emergency Service: The Psychiatric Emergency Service report completed by physicians includes current complaint/problem, description of the family of origin and significant male partners, social history, previous psychiatric history, diagnosis, prescription, and referral. Positive identification of battering, as well as reference to marital and family conflict, is likely to appear in the Psychiatric Emergency Service report. This part of the record may be the most thorough but should be approached with caution and a degree of skepticism. The psychiatrist may not recognize battering as the basic or most significant problem but may instead focus on the patient's depression, psychosis, or alcoholism, overlooking the possible abuse factor buried in her history.

Pediatric History: The patient's pediatric history, if available, should also be considered. Pediatric notes can reveal abuse of the woman as a child and thus provide further insight into her life pattern. Sexual abuse, incest, and family violence are often implied and sometimes explicitly recorded in this section of the medical record. Again, historical perspective is important, for it was not until the early 1960's that child abuse was recognized as a serious medical and social problem. At that time, reporting became compulsory in many States.

The medical record, while cumbersome, is an important source of information. It can be used alone or in conjunction with an interview to verify and determine the extent of abuse. It also provides insight into the nature of the battered woman's experience with particular medical institutions. Using medical records as outlined above is a laborious process but one that can prove valuable to health personnel in the day-to-day treatment of battered women and the development of improved protocols and services.

IV. The Medical Response

The Stages of Medical Perception

Medical records may also be used to reconstruct the stages through which the battering syndrome develops. Focus is placed on the extent to which the clinical response actually contributes to this developing syndrome. The battering syndrome can be divided into three stages, each of which includes a specific pattern of medical response. The first stage is characterized by symptomatic treatment primarily for physical injury and relatively minor medical and/or mental health complaints and problems. During stage two, labeling is used to describe the more serious psychosocial problems that accompany the proliferation of physical injuries, heightened complaints, and psychiatric referrals. In the final stage, when physical injury may be less pronounced than behavioral problems, such as multiple suicide attempts or severe medical and mental health problems, punitive interventions are typical.

Whether or not the staging process describes a particular case it provides a framework to understand the clinical presentations of and response to abused women at numerous medical sites. Successful medical training can improve services by altering the medical response at each stage and thereby forestall the emergence of the full syndrome of battering from initial incidents of trauma.

Stage I: Symptomatic Treatment of Multiple Injuries

At first, the battered woman's discrete individual injury is considered the only appropriate object for medical care. The fact that the injury was caused by a punch is no more significant than that it resulted from a fall and, if the cause is recorded, there is no comment. For example:

Monica N. came to the emergency service with multiple complaints of pain. She had a negative examination. The diagnosis was "beaten up, mild contusions, etc. Plan home. No followup needed."

The woman's history is consulted only if it can help resolve an apparent diagnostic dilemma. For instance, if confusion is caused by the coexistence of abdominal pain and a broken arm, the physician might ask the woman if she was also hit in the abdomen.

Denise O. was in a car accident resulting in multiple fractures including a compression fracture of her spine. She came to the emergency service within a month after "falling" on her fractured arm, and within 3 months after "falling down the stairs." She was readmitted to the hospital four times in the next year for continued pain. After a year of relatively unsuccessful physical therapy, her therapist noted, "Denise is aware of counseling at the center for beaten wives." Her abuse was never mentioned again.

Thus the official record more nearly reflects the number of pragmatic problems abuse has posed to medicine than the actual incidence of battering in the medical population.

Both the medical model and the limited repertoire of interventions at the physician's disposal limited the perception of what is wrong with the woman. The purely medical definition of the situation displaces any alternative definition a woman may offer. The repeated injuries appear as a series of unfortunate accidents. No apparent physiological event links one visit or injury to the next. But these accidents do not stop. Within 1 year, Charlene M. separately reported: (1) kicking at "something" and falling downstairs; (2) sustaining a gun-shot wound to the thigh; and (3) accidentally sticking a toothpick half an inch into her temple. The toothpick was still there after 3 weeks. She also came to the medical emergency service complaining of headaches.

Stage II: From Injury to Self-Abuse

The symptomatic treatment of abuse does nothing to prevent subsequent injury. Gradually, the accumulation of injuries is supplemented by physician notes about "vague medical complaints." A complex set of problems is recognized (trouble with neighbors, alcoholism, drug abuse, attempted suicide, depression, fear of child abuse, or a variety of alleged mental illnesses), but they appear disproportionately on the medical records of abused women only after the initial reported incident of assault. In medical terms, however, the actual sequence of events is reversed.

By recording the woman's secondary problems, medicine acknowledges what the patient also recognizes, that symptomatic relief is ineffective against her condition. The patient's persistence, reflected on the medical record by the aggregation of incongruous injuries, forces the physician to recognize that this collection of trauma has been borne by a particular woman. From a medical standpoint, the patient's persistence suggests a "failure of the cure" and poses problems of cooperation and "inappropriate demand." Suddenly the solution to the problems the patient has appears to lie in the problem the patient is. Secondary problems developed in the course of treatment afford medical providers a way to organize histories of otherwise unrelated accidents. She is, after all, an alcoholic, or she is suffering from a "female disorder" such as depression, hysteria, or hypochondria. This explains why she has had so many injuries and why she occasionally appears to have had fights. Even if recognition of the actual source of the patient's repeated injuries becomes unavoidable, it is explained as a consequence of her "more basic" problem (her alcoholism or her "rigid personality" for instance). These diagnoses are labels because they persist in the absence of evidence that they are either accurate or therapeutically relevant.

Audrey C. had a long history of accidental injuries. After a suicide attempt precipitated by her boyfriend's threat to leave her, she was sent to the State mental hospital. The nurse at the hospital insisted that Audrey was never psychotic or delusional during her hospitalization there. Nevertheless, she was diagnosed as a schizophrenic and put on Trilafon. She came to the emergency service with her boyfriend who claimed she was crazy (a fact proven by her hospitalization) and had stabbed him (the record notes a microscopic wound). The diagnosis was "no mental disorder." She was discharged to the police who arrested her. Three months later, she returned to the emergency service with a lacerated eyebrow suffered in an altercation.

It is impossible to separate the familial etiology of physical abuse from etiological factors that result from institutional neglect and symptomatic treatment. A patient's symptoms may include headaches or other suffering directly attendant upon repeated beatings or the isolation that leads victims of abuse to turn anger inward. They may also result from prior medical attempts to control a woman's complaints with classic psychiatric methods. Thus, battered women frequently attempt suicide by taking an overdose of the medication provided to ease their secondary problems. For the woman, the sociopathic symptom signals entrapment within a predictable syndrome associated with battering. For the physician, the symptom also suggests a solution, a cognitive and therapeutic strategy for comprehending otherwise unintelligible medical events.

As the depth of the family crisis generates "accidents" at rates that overwhelm the piecemeal therapeutic response, physicians apply cultural labels that permit them to treat victims of abuse as stereotypic females. These women, who complain of frequent headaches, bowel disorders, painful intercourse, and muscle pains, often have X-rays and laboratory tests that are normal and so they are labeled "neurotic," "hysterical," "hypochondriac," or "a well-known patient with multiple vague complaints."

The impact of the label cannot be underestimated. Abused women are often labeled at the height of their vulnerability, during a particularly severe crisis for instance, when the signs of their outward collapse suggest the problems implied by the label. This label can easily be read by the victim as an alternative interpretation of her situation. She, as well as her physician, may now come to see her life with an abusive male as a symptom of her more general pathology and dependency. She is now urged to think that it is she who is sick, perhaps even requiring the help of the assailant.

Stage III. From Self-Abuse to Battering

Whatever physicians intend their interventions to accomplish, their consequence is to reduce the victims' capacity to understand, to respond adequately, or to resolve her crisis by leaving the violent home or struggling against the malevolent other. If the woman's attempts to escape from the most painful aspects of her situation through self-abuse are defined as her primary problem, the cure typically involves the reimposition of traditional female role behavior and is often within the same violent context in which she is being beaten.

When Betty P. became pregnant at the age of 16, her father literally jumped on her and beat her so that she would lose the baby. After the baby was born, she came to medical clinic where she reported that her husband drank and beat her. The diagnosis was reactive depression, and the treatment Seconal. Betty went home and overdosed on the Seconal. This time the diagnosis was postpartum depression and she was sent to the State mental hospital. Within 2 months she went to the Domestic Relations Bureau to see if she could get support. According to the medical record, the bureau was making every effort to reconcile the couple.

The Battered Woman as a Patient

The health professional may identify battering on the basis of a woman's medical history, immediate problem(s), or information provided during the initial interview. Ideally, the patient will then be triaged to appropriate social service personnel. Unfortunately, social service departments are often closed during the hours when many battered women need them, the quality of service varies greatly and a patient may refuse a referral, sometimes with good reason. Even where an adequate protocol is in place and the patient cooperates fully, the health professional must complete the interview, explain and justify hospital policy, and stress the importance of the diagnosis and referral. The health professional should be guided in this encounter by the following considerations.

- Carefully determine the seriousness of the problem by assessing the threat of future violence, not simply the immediate level of injury;
- Accept the patient's assessment of her situation in so far as this seems plausible;
- Focus the consultation on the patient and her real situation;
- Fully acquaint the patient with the multiple health consequences of abuse;
- Refrain from being judgmental and attempt to keep personal biases and first impressions under control;
- Provide a realistic picture of the services to which the patient is being referred;
- Base ongoing support on the patient's capacity for independent and courageous action, not her immediate and apparent dependence;
- Help the patient identify and use existing social support networks;
- Evaluate the encounter on the basis of successful identification of abuse and the successful transmission of information about the course of the problem and existing alternatives; and
- Follow the patient's subsequent experience, insofar as this is possible.

The Objective Seriousness of the Patient's Medical, Physical, or Psychosocial Problems

Although battered women often have severe problems requiring emergency treatment or hospitalization, the majority of their medical visits involve nontrauma complaints at nonemergency sites. Once battering has been identified as the context of the immediate complaint, the next step is to

determine the degree of emergency (the present danger to the woman regardless of physical symptoms). The health professional should ask, "What will happen if the woman returns home?" Evidence linking the number of prior abusive assaults to the eventual murder of the abused woman suggests that the frequency, proximity, and severity of the attacks to which the patient has been subject are good predictors of her immediate danger (Lachman, 1978). Threats may be as important as actual injury; the patient's assessment of her current risk is crucial. There is a clear and present danger, and overnight hospitalization should be considered.

The Subjective Dimensions of the Medical Encounter

Health professionals have developed a variety of styles to avoid the significance of abuse. Their discomfort with social or emotional problems leads them to cut such discussion short. By making encounters physician-centered, physicians prevent the patient from revealing abuse, sometimes for years. This generates the "by the way" syndrome, in which a patient mentions abuse only toward the end of the encounter in an off-handed manner. Conversely, the patient may refer to her domestic situation repeatedly, but never focus explicitly on abuse. Physicians often fear such comments because they think that if they probe they may uncover deep problems that will occupy too much of their important time. Ironically, at least in the case of battering, failure to probe or listen insures frequent return visits (Dobash & Dobash, 1979; Byrne & Lang, 1976).

A patient-centered encounter is not always sensitive. The health professional may encourage the woman to report her abuse but fail to respond in a way that shows it is considered an important health issue. The health professional may focus on issues other than the health consequences of the abuse for the woman, such as the assailant's problems, the details of a given episode of assault, or the woman's secondary problems. The Dobashes report an encounter that illustrates this point (Dobash and Dobash, p. 187).

- D: Come in. What can I do for you?
P: Well, I have got flu, Doctor. I have got all pains in my arms.
D: When did you start to feel not so well?
P: The weekend. It started Saturday afternoon, shivering with cold. . . . I came mostly about my head, it is paining me a lot. My husband. . . with a shoe, it cut me there, I couldn't comb my hair or touch my hair.
D: When was this?
P: Saturday night.
D: How come?
P: He came home drunk as usual. He has hit me in the past but not for a long while. . . causing trouble. . . people next door banging on the walls and it is getting on my nerves.
D: Does he drink much during the week?
P: Not so much during the week, but at weekends, Saturday and Sunday.
D: Does he drink beer or spirits?
P: . . . It is a young couple next door. . . disturbing them. . . banging on the walls and this is affecting my nerves.
D: Does he drink at all during the week?
P: Well, maybe once or twice.
D: Does he get druk then?
P: Not bad.

A woman's decision to report her abuse may be related to a number of factors other than sex injury, even when injury has been frequent. The last straw may be an emotional insult. This is illustrated in one case in which a victim's husband flew into a jealous rage whenever he returned.

home after several days absence and abused her. The woman left home for help, however, only when her husband insisted that she stop attending church. Moreover, evidence of minor mental health problems should not lead the health professional to disregard the patient's interpretation of events. Because women with a history of abuse and institutional neglect frequently behave inappropriately in administrative settings, it is often easy to dismiss the very real danger they are in.

Jane Doe was a 66 year-old white woman living with her husband of 40 years on Social Security in low-rent Federal housing. Her husband once served a prison term for murder and, just 3 months ago, cut off a portion of her finger in an argument. Mrs. Doe decided to seek a divorce. Also, she wanted to keep the apartment—she felt she worked to pay for it—so she went to the Legal Aid Society seeking an "emergency" divorce and an eviction order for which battered women judged to be in immediate danger are eligible in Connecticut. The legal intake worker, however, refused Mrs. Doe the divorce, justifying her decision by arguing that the situation was not an emergency and that Mrs. Doe was in no immediate danger. When the facts of the case were pointed out, the intake worker revealed that the real reason for her decision was that Mrs. Doe was "crazy," as evidenced by the fact that when she, the legal worker, left the room, Mrs. Doe continued to talk to herself. The local women's shelter advocate did not help when she volunteered her opinion that Mrs. Doe seemed to be talking to herself even when the legal worker was in the room.

Battered women are understandably skeptical about referrals that have not been clearly justified. The health professional should acknowledge the limits of the service response. Health professionals should also be sensitive to the distrust low-income persons feel toward professions that stand in a dependence-inducing relation to the poor.

The health professional should realistically discuss with the patient the long waits, the bias of social service staff, and the tendency to treat abuse as a personal problem, even in community mental health centers. Finally, the patient should be reminded that she can return to the hospital if the referral is inadequate and that the health professional will personally remain advised of the case. This response takes precious time but is necessary to insure effective aid.

The Professional's Attitude Toward the Abused Woman and the Possibilities for Change

Battered women are frequently pictured as pathetic victims—trapped, depressed, helpless, and vulnerable—with little self-confidence, a completely damaged ego, and little or no capacity to act decisively to change their lives without extensive counseling. Indeed, one guide to counselors suggests that before they can be helped, battered women must accept their "nothingness" (Ridington, 1977-78). The derogatory labels commonly affixed to indigent patients reflect physician bias that the problems of the poor reflect weakness in their character. Even seasoned community physicians may accept physical assault as a natural consequence of certain lifestyles. Women whose visits have been precipitated by an assault may well fulfill the stereotypic expectations that physicians have of victims.

The result of this approach is that the health professional communicates despair to the woman while tending to her physical symptoms. The health professional may actually reinforce the woman's anger by first demanding that she leave her assailant immediately and then dropping the protectionist pose if she hesitates or becomes defensive. In such instances the professional may become judgmental, even angry, at the patient. In both instances, the physician's insecurity, not the battered woman's needs, directs the physician's response. He or she sees the woman's life from the vantage of her abuse, forgetting that her other needs (e.g., for love or support) have not changed and must still be met. The professional seems to need an admittance of helplessness as a prerequisite to helping. The alternative is to accept the woman's ambivalence about her situation (e.g., "It is easy to see that

you love this man as well as hate him") while helping her assume responsibility for events. Meaningful help begins with an understanding of the victim's fragile sense of dignity and independence.

The health professional should acknowledge that under the immediate surface, the woman who has been injured is enormously courageous. She has reported her abuse despite threats, withstood a level of abuse few of us could, and often accepted physical injury to herself as the unfortunate consequence of standing up for her rights as a parent or for those of her children. Even the secondary problems accompanying abuse, such as suicide attempts or alcoholism, may be read as ways of coping with situations that might have led others to total breakdown or suicide. Only by treating the battered woman's vulnerability as a temporary condition can the professional help her find the self-confidence she needs to escape the danger she is in.

The Social Support Available for the Woman

Battered women will typically be offered preventive and/or therapeutic interventions. Preventive measures include emergency court orders restraining assailants, emergency shelter, protective institutionalization, and bringing criminal charges against the assailant (Eisenberg and Micklow, 1977). Therapeutic or ameliorative measures typically include counseling, family therapy, and ongoing assistance from a social caseworker (Resnick, 1976). Although ameliorative measures are clearly less disruptive than preventive interventions, both strategies may mean sudden and dramatic changes in the victim's life. The social support available to a woman from family members, friends, and neighbors may determine which option a woman selects. Shirley C. is an example of someone for whom positive support from family, friends, and medical professionals was crucial.

Shirley C. was married for 3 years before her husband's first assault. Initially she was shocked and ashamed and did not seek medical attention for her injuries. However, the second time he beat her, he did so in the presence of her sister who immediately brought her to the emergency service. She specifically stated that she had been beaten, was counseled by the social worker, and subsequently divorced her husband. Although still suffering from shock and disbelief, she had strong support and was able to remove herself from a dangerous situation, evaluate it, and take appropriate action.

The health professional should help the victim determine possible sources of support such as relatives with whom she and any children may stay, neighbors who will inform authorities during subsequent family crises, and friends who will accept the victim's point of view. Since the battering syndrome is an evolving process, it requires ongoing help, not simply emergency relief. Hence, any strategy of crisis intervention must be supplemented by the long-term support a woman can find in her own environment. Such support begins when the health professional assures the battered woman she is not alone.

Evaluating the Encounter

A woman's desire for emergency shelter often reflects the severity of recent assaults. Although shelter, divorce, a restraining order, or a criminal complaint are designed to prevent ongoing abuse, in many cases they do not succeed. Many women remain vulnerable and others voluntarily return to abusive situations, sometimes after only a brief absence. The persistence of abuse may reflect a woman's failure to recognize and act on the seriousness of her situation. It is crucial that she understand that medical and/or mental problems she may think are unrelated arise inevitably from the physical injury to which she has been subjected. But the decision to stay in an abusive relationship is often the result of the larger problems women experience in society—the scarcity of jobs, even for women with skills; the difficulty of maintaining social contact in certain communities without a man; the absence of adequate day care facilities; unequal protection before the law, etc. Battering often isolates women from the supportive networks they require to use resources that do exist. To this extent, battered women return to violent homes because they have no choice. In some

instances they return because they fear for their children or because they care for their partners, although they do not like being beaten.

The fact that a battered woman returns home does *not* mean the health intervention has failed. The health professional is operating against many of the same limits battered women face. The encounter should be considered a success if battering is accurately identified, its sequelae described, and the patient made aware of existing resources and support. The case of Adele M. reveals how important it can be for health professionals to identify multiple, vague medical complaints as part of the battering syndrome.

Adele M. has a 20-year history of treatment at the medical center that includes more than 100 visits to one of the medical clinics. Although she does not appear to have had any physical injury early in her medical history, she is routinely followed in the medical clinic. She was initially described as a "passive, little woman of seemingly low intelligence." By contrast, her husband was an "antagonistic, aggressive person." No connection was made between her husband's aggressive character and her multiple visits. Her complaints of choking sensations were attributed to emotional problems. Early in her history, she was committed to the State mental hospital for "paranoid delusions" and "agitated and unpredictable behavior." Then, in 1979, a physician treating her husband discovered her bizarre history of abuse over the last twenty years. Apparently, her son had also begun to abuse her. It was only *after* her abuse was recognized by a physician who discussed it with her that she made her first visit to the surgical service to report injuries sustained at home. Now the physician is following her case in the clinic and talking with her regularly about her abusive situation. Although she refuses outside intervention, the physician has succeeded in referring the husband and son to the local mental health center for outpatient treatment.

Recognition of the problem has not yet led to its termination. But the identification of battering *has* made a difference. Identifying abuse in the medical population will also play an important role in generating the resources needed to eventually prevent it. A problem that has rarely been recognized or responded to over the centuries cannot be corrected overnight because health professionals have suddenly acknowledged its importance.

When health professionals are asked why they have so persistently failed to identify or respond to abuse, their inevitable reply is "But what can I do?" Until recently, this was a reasonable response.

Today, there *are* alternatives to symptomatic treatment, labeling, and punitive interaction. Most large cities now have shelters where battered women can stay for brief periods in relative safety. In many places, police have been officially instructed to enforce the laws against domestic assault. Legal remedies have been strengthened. While social service agencies generally give priority to victims of abuse, these resources are not available everywhere, nor are they always effective. But the alternatives are sufficiently numerous to offer health professionals a real choice wherever they work.

This study does not outline a specific program. But it does suggest a certain orientation: understand the problem, learn how to identify it, and provide sympathetic and supportive intervention. If the resources exist, use them. If they do not, help in their development.

Battered women are not only abused by violent men, they are also abused by the social services. They need political support, not simply professional help. Allowing women to maintain their dignity and independence in the health care system is as much a part of the needed response to battering as temporary safety. For health is not simply a life without unnecessary injury. It is also the equality and self-esteem that permit a woman to enjoy such a life.

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Appendix

Annotated Bibliography

Appleton, Warren. "The Battered Woman Syndrome," *Annals of Emergency Medicine* 9.

Using questionnaires completed by female patients at a large medical emergency service, the author describes the physical and psychiatric sequelae of abuse, including the frequency and seriousness of injury and of psychiatric complaints. He compares acutely battered women with women who have previously suffered physical abuse and identifies the times during which abusive incidents are most often presented.

Bard, Morton, and Zacker, Joseph. "The Prevention of Family Violence: Dilemmas of Community Intervention," *Journal of Marriage and the Family* 33:677-682.

The authors describe an intensive training program for 18 officers in New York City to help them deal with family violence. During the study period, there were a decreased number of homicides related to family violence, a decreased number of injuries to the unit members, and an increased number of interventions for family complaints. The authors discuss the problems pertaining to the role of the police as peacekeepers rather than law enforcers and the right of the family to refuse help.

Bass, David, and Rice, Janet. "Agency Responses to the Abused Wife," *Social Casework* 60:338-342.

The authors interviewed 21 counselors and caseworkers, representing nine social service agencies in an urban community. They conclude that most of the people interviewed did not know of the community resources available to assist the abused wife. The authors speculate that, by dealing with wife abuse as a family problem and by directing counseling toward family interaction, the staff avoid agencies that deal specifically with wife abuse. Interagency competition as a factor may also bias the counselor's perspective. The authors call for an integration of all agencies to provide comprehensive treatment for the abused wife.

Carlson, Bonnie E. "Battered Women and Their Assailants," *Social Work* 22:455-460.

This study is based on a sample of 101 women who asked for assistance. The data include: source of referral, marital status, children, race, age, education, employment, alcohol and drug abuse, previous actions taken, and incidence of assault. The author concludes that financial and interpersonal stresses lead to domestic violence more often than intrapsychic factors. The article ends with a discussion of the types of support and interventions needed by battered women.

Cohen, I. "The Battered Woman," *Emergency Medicine* 11:24-42.

The author stresses the importance of identification in the medical setting and encourages shelter referral. It is noted that women rarely admit to having been abused, and the author suggests the following areas of suspicion: repeated injuries, particularly to the head, neck, and breasts; psychosomatic symptoms or emotional complaints; and injuries that do not agree with their alleged etiologies. The author advocates the use of shelters, but focuses responsibility on the clinician in terms of both identification and followup. The relationship between wife abuse and child abuse is also discussed. The article includes an extensive list of shelters and other services for each State.

Dobash, R. Emerson, and Dobash, Russell P. *Violence Against Wives*. New York: Free Press, 1979.

The authors present a lengthy theoretical and historical overview of wife abuse and an excellent critical summary of existing approaches and evidence. They trace the victims of abuse from childhood socialization through marriage into the violent relationship, capturing the concrete texture of battering incidents without losing sight of their broader basis in a sexist society. The critical discussion of the helping services and of medicine, in particular, is unique.

Ehrenreich, Barbara, and English, Deidre. *For Her Own Good*. New York: Anchor Doubleday, 1978.

The authors provide a critical overview of the changing cultural prescriptions concerning female health. They detail the extent to which models of health are inseparable from models of appropriate sex role behavior and link these behavioral imperatives to the changing status of women and the special interests of the helping professions.

Eisenberg, Sue E., and Micklow, Patricia L. "The Assaulted Wife: 'Catch 22' Revisited," *Women's Rights Law Reporter* 3:138-161.

The authors discuss wife abuse in terms of historical perspective and its prevalence in the United States today. They review the myths about battered women and the responses of law and medicine. In the final section, they discuss more effective nontraditional interventions. This is the best single introduction to the legal obstacles that confront abused women.

Emerson, Charles D. "Family Violence: A Study by the Los Angeles County Sheriff's Department," *The Police Chief* 46:48-50.

The author describes research concerning family disputes handled by the Los Angeles police during a 2-month period in 1978, as part of the Los Angeles Task Force on Domestic Violence. The survey, based on 1,446 cases, provides data concerning alcohol and drug factors, visibility and seriousness of injuries, utilization of emergency medical treatment, and resolution of disputes.

Farber, John M. "Emergency Department Social Work: A Program Description and Analysis," *Social Work in Health Care* 4:7-18.

In this report on the development of a social work component in the emergency room of a community hospital, the rationale for this expanded service and the objectives of the program are examined. Documentation by the coordinator of social work services demonstrated that 60 percent of the cases involved individual or family problems, including child and spouse abuse. The author maintains that early identification of problems and crisis intervention are best handled by social workers rather than emergency room staff because of the volume of patients the latter see and the acute nature of medical treatment. Statistical analysis of the first 2 years of service is presented in terms of the sex and age of patients seen by social workers in the emergency room and the types of problems they present.

Fonseka, S. "A Study of Wife-Beating in the Camberwell Area," *The British Journal of Clinical Practice* 28:400-401.

Based on the success of child abuse diagnosis through radiology, a study was done to attempt to diagnose wife battering the same way. The study included 55 women who were treated following assault. Although no definite radiological pattern emerged, facial trauma was the most common injury. A body map was used to illustrate this pattern. The article also includes statistics regarding abusive history and treatment for depression.

Gayford, John J. "Battered Wives," *Medicine, Science and the Law* 15(4):237-245.

The author reports the findings from a comprehensive survey of 100 battered women resident in a British shelter. The findings include patterns of injury, the social background of both partners, and data on family of origin, education, employment, alcohol, and arrests among both the women and their assailants. The emotional impact of violence on children is discussed, as are the psychological implications and social problems of battering.

Gelles, Richard J. "Violence and Pregnancy: A Note on the Extent of the Problem and Needed Services," *The Family Coordinator* January 1975:81-86.

The author cites the research reported in his 1974 book regarding the association between pregnancy and wife abuse. In this paper, he examines this phenomenon and discusses policy implications for those providing family services.

Haller, J.S., and Haller, R. *The Physician and Sexuality in Victorian America*. Urbana, Illinois: University of Illinois Press, 1974.

The authors demonstrate the extent to which the modern medical subspecialties responsible for women's reproductive health developed as a means to control individual and collective efforts at female independence. The widespread punitive use of surgery is particularly well documented and enormously relevant to understanding the current medical response to abused women.

Hartmann, Heidi. "Capitalism, Patriarchy and Job Segregation by Sex," *Signs* 1(3;2):137-169.

The author documents her argument that job segregation by sex is the primary mechanism in our society that enforces the power of men over women. She shows how female dependence on men in the family is reproduced by the low wages and unequal status of women in the job market and the extent to which male trade unions support this discrimination.

Higgins, John G. "Social Services for Abused Wives," *Social Casework* 59:266-271.

The author provides a very brief overview of services available to battered women in the United States and Canada. He includes emergency and transition services, such as crisis lines, police, emergency rooms, victim aid centers, shelters and PMD, clergy, attorneys, and counseling. Interviews with 20 counselors who work with violent spouses and their victims suggest there are two phases in the sessions: the initial phase, in which the clients ventilate their feelings, and the second phase, in which they choose alternatives for action. The weakest feature of wife abuse counseling is the small number of men requesting help.

Hilberman, Elaine, and Munson, Kit. "Sixty Battered Women," *Victimology* 2(3-4):460-470.

In a 12-month period, half (or 60) of all women referred by the staff of a rural health clinic for psychiatric evaluations were the victims of marital violence. However, only four of the victims had been accurately identified. The authors examine the family background of the women, their isolation, socioeconomic status, experience with alcohol, their reproductive histories, and the effect of domestic violence on their children. There is an interesting discussion of the role of abuse in causing paralyzing symptom formation and a checklist to help physicians identify battered women.

Lieberknecht, Kay "Helping the Battered Wife," *American Journal of Nursing* 78:654-656.

The author provides a brief practical guide for persons who plan to work with battered women. She discusses misconceptions about battered women and then constructs a process of help—accepting the battered woman's perceptions and feelings without contradicting her, expressing concern, encouraging the development of her awareness, and using a problem-solving approach.

Lynch, Catherine, and Norris, Thomas. "Services for Battered Women: Looking for a Perspective," *Victimology* 2:553-562.

The most formidable problems facing a service program for battered women are critically examined. The victims' needs, the stereotypes surrounding the abuse situation, and the corresponding programmatic responses are analyzed. The resources needed for the functioning of any such program are reviewed in detail. The diversity of agencies and orientations originating or supporting programs for battered women is discussed as a source of strength or disunity. Finally, the authors look to the future and call for steps to be taken to ensure that current attention to this problem is not merely a passing fad but becomes a permanent interest of society.

Martin, Del. *Battered Wives*. New York: New Glide Publications, 1977.

The first and still the best general introduction to the problem of abuse, this book includes excellent critical summaries of the legal and political status of battered wives and the extent to which their immediate predicament must be understood in broad political terms.

McShane, Claudette. "Community Services for Battered Women," *Social Work* 24:34-39.

Based on her experience as director of Sojourner Truth House, a shelter for battered women in Milwaukee, Wisconsin, the author identifies existing legal, medical, and social services for these women. She breaks down the problems of these services into four major categories: fragmentation, discontinuity, inaccessibility, and nonaccountability. She outlines a three-part strategy for improving services and concludes that a primary goal of service groups for abused women should be to heighten the consciousness of those in traditional agencies in order to alter and improve these services.

Menzies, Ken S. "The Road to Independence: The Role of a Refuge," *Victimology* 3:141-148.

The author describes a sample of 35 women who lived in a refuge for battered women in Ontario. The role of the refuge is examined in light of an understanding of the women's helplessness caused by the nature of their physical, psychological, social, and cultural dependencies on the offender. Statistics on abuse, isolation, helplessness, and financial problems are presented. The author states that the refuge fosters development of strong, independent women who feel worthwhile and confident about themselves.

Pahl, Jan. "The General Practitioner and the Problems of Battered Women," *Journal of Medical Ethics* 5:117-123.

The author discusses the responsibility of general practitioners who treat battered women. The paper describes a study of 50 women who were interviewed at a refuge for battered women. The author suggests three possible ways of explaining assault: as an individual problem; as a family problem; and as a social problem, the consequence of women's position in society. These differing explanations point to different ways in which general practitioners can approach the problem. Using the women's experiences, the author offers suggestions on what "good practice" might be.

Petro, Jane A.; Quann, Patricia L.; and Graham, William P. "Wife Abuse: The Diagnosis and Its Implications," *Journal of the American Medical Association* 240:240-241.

The authors present five case studies of battered women who were seen in the plastic surgery outpatient department. The authors claim that women will rarely admit abuse and that suspicion of abuse should be aroused if there is (1) a substantial delay between time of injury and presentation for treatment, (2) evidence of repeated injuries to the face and neck, or (3) a previous history of abuse. The authors conclude that physicians should actively intervene to prevent future abuse.

Pfouts, Jane H. "Violent Families: Coping Responses of Abused Wives," *Child Welfare* 57:101-111.

The author presents a theoretical schema to analyze the forces that influence the way women cope with abuse. The usefulness of the schema is tested on a sample of 35 violent families who had come to the attention of the welfare department because of suspected child abuse or neglect. The three coping responses are: self-punishment, aggression, and disengagement from the relationship. She concludes that the wife's coping responses depend on her cost-benefit analysis of the marriage and its alternatives.

Pizzey, Erin. *Scream Quietly or the Neighbors Will Hear*. Middlesex, England: Penguin Books, Ltd., 1974.

The inspiring story of Chiswick House, the first shelter for battered women in Great Britain and the model for many shelters here and in Europe. Pizzey's theories are particularly important because she has been so influential. Of particular interest are her views on the daily operations of the shelter, overcrowding, male children, the housing context for shelter development, and the importance of remaining in the public arena.

Rounsaville, Bruce; Lifton, Norman; and Bieber, Margo. "The Natural History of a Psychotherapy Group for Battered Women," *Psychiatry* 42:63-78.

Free followup appointments were offered to battered women using the surgical and psychiatric emergency services of an urban hospital and a community mental health center. Of the 75 battered women, 31 came for a followup interview, but only 10 of these attended more than one psychotherapy group session. The authors describe the sociodemographic background and abusive history of the sample. They discuss the changes resulting from therapy and the treatment problems encountered. Based on these results, the authors suggest therapeutic interventions for battered women.

Stahly, Geraldine Butts. "A Review of Selected Literature of Spousal Violence," *Victimology* 2:591-597.

The author reviews the social science literature on spouse abuse, emphasizing empirical data concerning the frequency, demography, and interpersonal processes related to abuse. She also discusses several theoretical papers that consider spousal assault in a social structure context. She concludes that more data are needed to test the theories that have been developed and specifies the types of research that are most crucial.

Stark, Evan; Flitcraft, Anne; and Frazier, William. "Medicine and Patriarchal Violence: The Social Construction of a Private Event," *International Journal of Health Services* 9(3):461-493.

The authors describe the battering syndrome as a pattern of physical abuse, medical and psychosocial problems, and punitive medical interventions that escalate over time. Various theoretical approaches to abuse are critically analyzed. The argument is that the medical response, which includes neglect, labeling, and the prescription of antidepressants, actually contributes to the development of the syndrome and derives from a fundamental convergence between medical and "patriarchal" logic. The authors trace battering to the contradictions inherent in women's status, particularly those that surround their importance as laborers and as housewives. The role of indigenous networks of support in protecting women against abuse is stressed.

Straus, Murray A. "Sexual Inequality, Cultural Norms, and Wife Beating," *Victimology* 1:54-70.

The author discusses society's acceptance of wife beating and the failures of the police and prosecutors to discourage battering. He briefly discusses social science research indicating that physical abuse is generally tolerated in male/female relationships. The societal norms regarding male dominance, economic discrimination against women, women's devalued role, and other factors reflecting sexual inequality are discussed in terms of wife abuse. He concludes that women's liberation and men's liberation are necessary if wife beating is to be decreased substantially.

Straus, Murray A. "Wife Beating: How Common and Why?" *Victimology* 3:443-458.

The author presents the results of a nationwide study of over 2,000 couples representative of all American couples. A Severe Violence Index and a Wife Beating Index were constructed for this study, and the extent of abuse of both husbands and wives is reported. The causes of spouse abuse are identified and examined, including (1) high levels of family conflict, (2) high levels of violence in U.S. society, and (3) the physical punishment of children as a model for the use of violence by family members.

Symonds, Alexandra. "Violence against Women — The Myth of Masochism," *American Journal of Psychotherapy* 33:161-173.

The author states that the theory of female masochism has long hampered the understanding of wife abuse, since it has been the tendency to blame the victim for her misfortune. The author contends that most abusive men have a long history of violence, including the fact that many of these men were beaten as children. In attempting to understand the dynamics of wife abuse and why these women stay in abusive relationships, comparisons are made to victims of other crimes and catastrophes.

Weingourt, Rita. "Battered Women: The Grieving Process," *Journal of Psychiatric Nursing and Mental Health Services* 17:40-47.

✓ This article is directed at people working with battered women who have left their husbands and are living in shelters. Using the model of Kubler-Ross's stages of grief, the author proposes an outline of intervention for each stage that will help increase the women's self-esteem and enable them to leave their husbands permanently. She focuses on the women's feeling of guilt, responsibility, and loss, as well as the problems presented by their children's attempts to cope with the changing family situation.

Wilson, Elizabeth. "Battered Wives: A Social Worker's Viewpoint," *Royal Society of Health Journal* 95:294-297.

The author discusses two reasons for the failure of social workers to deal with the issue of battered women. First, social workers are trained to maintain the family because of its importance in socializing children. Second, social workers are the guardians of the scarce resources of the state, and family breakdown is expensive, particularly with regard to housing resources. The author also discusses the problem in terms of an overall sexism of British society and concludes that social workers' attitudes toward battering will change slowly unless society's view of marriage changes.