

Response: To the Victimization of Women and Children
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Nursing Network On Violence Against Women: Nursing and Battered Women

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The definition of nursing is “the diagnosis and treatment of human responses to actual or potential health problems” (American Nurses’ Association, 1980, p. 9). That the battering of women in intimate relationships is a significant health problem is evident in the number of women involved, the extent of injuries incurred, the psychological and physical risks to women of continued abuse, and the potential of homicide for both the women and their partners. The responses of women to battering are an appropriate concern of nursing, well within the scope of the definition above, and those responses are the central concern in attempting to prevent further health problems.

Much of the current literature on battering stresses the need for the medical system to become more aware of the problem and do more to alleviate the problems of battered women (e.g., Appleton, 1980; Attorney General’s Task Force, 1984; Davis & Carlson, 1981; Stark, Flitcraft, & Frazier, 1979). This emphasis is laudable and timely. However, it is frequently unclear whether terms such as “medical care” or the “medical system” are meant to refer to nursing as well as to medicine. The two fields are distinct disciplines, with separate bodies of scientific knowledge. It seems that either the authors lack knowledge about the differentiation or they consider nursing to be subservient to medicine. The traditional gender difference between the majority of nurses and physicians gives the latter possibility a sexist implication. In the study of wife battering, where feminist scholars have made such important contributions, continued failure to differentiate clearly within the health care professions is untenable.

Medicine is concerned primarily with the diagnosis and treatment of actual health problems. Thus, physicians can be expected to diagnose and treat the physical injuries associated with battering; nurses should have the primary responsibility for caring for the woman’s responses to those injuries and to the ongoing experience of being battered.

The research conducted to date concerning the health care system’s treatment of battered women demonstrates the inadequacy of the system in meeting the needs of battered women. Part of the problem can be addressed by increasing the awareness of physicians about the health problem of battering, but more could be accomplished by increasing the awareness and expertise of nurses. Nursing is historically, philosophically, and professionally in a unique position to provide important interventions to battered women.

Philosophical Origins and Theoretical Models of Nursing

The scientific basis for nursing was developed in the writing and practice of Florence Nightingale, in the mid- 1800s. Nightingale was a feminist, as well as a nurse and a scientist (Stark, 1979). Her essay, *Cassandra* (Nightingale, 1852/1979), reflected her anguished protest against the subjugation of women in Victorian times. By creating nursing as a new and respectable profession for women, Nightingale advanced both the empowerment of women and health for all human beings.

Nightingale’s (1860/1969) “laws” of nursing and health emphasized the concern of nursing

with prevention of disease, the importance of an environment conducive to health, and the ability of patients to heal themselves through a healthy environment. These central concerns of nursing have remained. They are relevant to the nursing care of battered women today as we advocate prevention of further injury from abuse, helping battered women to create a safer environment, and reliance on the women themselves to address the battering situation with assistance.

As nursing developed as a profession, the parallels between its subjugation to medicine and the decline of feminism after the 1920s are painfully clear (Ashley, 1976). Nursing has often been decried by feminists as the epitome of a group of women oppressed (e.g., Daly, 1978), but the struggles of the early nursing leaders to maintain autonomy for nursing have not often been described (Wheeler, 1985). Nursing perhaps has come late to the feminist movement, but there is clear recognition now by both nursing leaders and practicing professionals of the congruency between nursing and feminist issues and goals (Heide, 1982).

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As well as recognizing the influence of feminism in nursing, contemporary nursing theoretical frameworks reflect thinking especially useful for battered women. The holism of human beings is a strong thrust in nursing (e.g., Orem, 1985), 1984; Parse, 1981; Rogers, 1970). Thus, nursing sees women's physical, behavioral, emotional, and social responses to battering in a synergistic sense. In addition, Leininger (1978) has added a nursing framework with a person's culture as a core concept and stressed the importance of qualitative research methodology for nursing in order to emphasize individual experiences. In nursing, the uniqueness of each human being is considered, and the strengths of each individual are as important as her or his health problems.

The fact that constant, mutual interactions of human beings and their environments change in patterns of increasing diversity and complexity, is stressed by the nurse-theorist Martha Rogers (1970). Her theory predicts that battered women will change their responses over time. Research on battering has supported the notion of changes over time in both the pattern of abuse and the behavior and feelings of battered women (e.g., Bowker, 1983; Frieze, 1979; Giles-Sims, 1983; Walker, 1984).

The self-care model of Dorothea Orem (1985) emphasizes the ability of human beings to care for their own health. Viewing battered women as the primary agents in making decisions about their life and health avoids the paternalistic, dependency-fostering relationships characteristic of traditional medicine. In addition, the actions women take to avoid and/or minimize their abuse can be seen as self-care behaviors and recognized as a strength using the Orem framework (Humphreys, 1985). Orem also introduced the notion of "dependent care agency" to describe the activities of adults in caring for the health of those dependent upon them. In order to understand battered women, it is crucial to recognize their concerns for their children, and the Orem conceptualization offers a framework from which this can be done.

In contrast to the history and philosophy of nursing, the origins of medicine were in classical Greece and emphasized rationality and objectivity (Cassell, 1976). Physicians were taught to disregard the patient's descriptions and interpretations of her or his physical state as mere

opinion. Descartes added the philosophy of a mind-body dichotomy. His influence on the shape of medicine continues in the separation of psychiatry and physical medical practices. Medicine has also emphasized the commonalities of human anatomies and physiologies rather than the uniqueness of each human being.

The 1800s saw the beginnings of the scientific search for causality, and the early 1900s began the era of cure (Cassell, 1976; Starr, 1982). Medical research and practice have continued to be centered around pathology rather than strengths. The primary objectives of (1) studying disease using the traditional rational or scientific method and (2) effecting cures continue to be the essence of medicine today. The worth and efficacy of these objectives are not challenged, and it is recognized that the medical community has members who are feminists, who practice holistic medicine, and who are more concerned with the patient than the disease. However, there clearly are differences between the philosophy, theories, and purposes of medicine and those of nursing.

Research on Battered Women in the Health Care System

Research which has explored battering within the health care system has been conducted by medicine, nursing, and other disciplines. Several basic assumptions, inconsistent with both nursing and feminist approaches to battered women, underlie the majority of this research. The first of these is that battering is a medical (including psychiatric) diagnosis which should be applied to any woman who is abused. "Battered spouse syndrome" has been suggested as an appropriate medical diagnosis to use in cases of wife abuse (Appleton, 1980). Since medical diagnostic categories generally are used to describe pathology, the implication is that all battered women are sick simply because they are battered.

Many of the characteristics of battered women can be seen as strengths or "survival strategies" as documented by Kelly (1984) and Hoff (1983) when viewed without the assumption of pathology. In addition, research has not consistently shown significant differences between battered and "normal" women (e.g., Arndt, 1981; Campbell, 1987). Wardell, Gillespie, and Leffler (1983) have argued convincingly that the scientific approach of differentiating between battered and "normal" women is a sexist and stigmatizing practice in research. The same can be said in the health care of battered women.

The second problematic assumption is built upon the first. If battered women are sick, it follows that they automatically need medical intervention beyond caring for wounds. The general assumption is that they always need psychiatric care. Once referred to psychiatry, a battered woman will be given a psychiatric diagnosis because that is the nature of the process. It is the only way her therapist can receive any kind of third-party payment. She becomes officially "mentally ill."

The third basic assumption prevalent in the literature on battered women by health care professionals is that interventions needed for battered women can be suggested without a thorough study of the response to battering. Except for Lenore Walker's (1984) application of learned helplessness to battered women, no theoretical explanations of the responses to battering have been tested by research. Even the testing of that model has not been replicated as yet and cannot be said to explain all of the experience of battering. The suggested health care interventions found in the literature are based on medical, nursing, and social work clinical experience rather than theory and research.

From this overview of nursing and medicine, it can be seen that nursing has the philosophy and theory more in

keeping with the principles of the battered women's movement. In the past, nurses have been found to be blaming or indifferent to battered women, but these attitudes are changing. Hundreds of nurses are involved in providing health care in shelters, serving on shelter boards of directors, and being advocates for battered women in the health care policy arena. I would like to see more of a partnership between nurses and the battered women's movement in building knowledge through research and in advocacy. Such a partnership has the potential to be a powerful alliance for social change!

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Nursing Network on Violence Against Women

The Nursing Network on Violence Against Women (NNVAW) is an organization of nurses interested in preventing all forms of violence against women and diminishing the effects of such violence upon its survivors.

Since 1985, NNVAW has provided a forum for nurses and other health care providers involved in the various areas of violence against women to meet, share knowledge and ideas, and gain support for our work. The major vehicles used to accomplish our objectives include: (1) a mailing list of NNVAW members and resources which can be used by nurses and others needing a nursing contact with expertise in the field; (2) communication with members and other interested parties through the NNVAW column in *Response*; and (3) a national conference held biannually. NNVAW is a user friendly organization.

NNVAW will hold its next national conference in San Francisco in April 1989. Abstracts of proposals for conference papers should be sent to Laura Smith McKenna, Battered Women's Alternatives, P.O. Box 6460, Concord, CA 94924.

Other NNVAW projects include compilation of listings of manuals for training nurses to work with battered women and protocols used by shelters to provide health care which have been developed by or with the help of nurses. To add to this compilation, which will be published in a later NNVAW column, contact B. Parker, School of Nursing, University of Maryland, Baltimore Campus, Catonsville, MD 21228. To propose material for future columns or suggest additions to the list of training manuals, contact Jacquelyn C. Campbell, Wayne State University College of Nursing, Detroit, MI 48103.

For information about conference participation, membership in NNVAW, and membership listing, contact C. King at the address given above. For a copy of the mailing list, send name and address, area of expertise, and \$10 to defray duplication and mailing costs.

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