

# Battered Women: A Health Care Problem In Disguise

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Women should have the right to move about within the confines of their homes among those persons with whom they share the most intimate, interpersonal relationships without fearing for their safety and well-being, for life itself. In general women accept and expect that right as a given; however recent studies cited by Davidson (1978) from the National Institute of Mental Health suggest that 50%-60% of all American marriages have experienced at least one incident of minor battering or assault upon the female in the relationship. Understated estimates report greater than three to four million American women are battered on more than one occasion each year (Iver, 1980; Stark, Flitcraft & Fraxier, 1979). The Crime Index of the Federal Bureau of Investigation (1980) reported the incidence of wife beating to be greater than that of rape, another act of violence that frequently goes unreported. The estimates of the Index project the incidence to be ten times more common than official figures indicated.

One of the myths surrounding battered women is that it is a lower socioeconomic phenomenon. This assumption interferes with the ability of middle-class and upper-class health care providers to confront the universality of the problem. Citing Fairfax County, Virginia, one of the wealthiest counties in the United States, Martin (1976) reported that during 1974 there were at least 30 assault warrants sought each week by Fairfax County wives, with police receiving approximately 400 family disturbance calls per month.

Lichtenstein (1981) echoed the beliefs of victims and many professionals when she stated, "Medical agencies usually only treat physical injuries and do very little to prevent the problem" (p. 241). A study done by Rounsaville and Weismann (1977-1978) revealed that battered women reflect 3.5% of the emergency room population. Tracking twenty women previously treated in an emergency room for injuries secondary to battering, only three medical records included any mention of abuse. Health care providers seem to be more comfortable accepting spurious explanations than probing for the truth. According to Martin (1976), "Even if they suspect that a woman's injuries are due to a beating they seldom want to risk personal involvement by asking questions" (p. 12). Parker and Schumacher (1977) emphasized the "long suffering inattention to battered women from social agencies and the health care system" (p. 760).

## Purpose of the Study

A limited clinical study was conducted to determine the feasibility of a full scale research project. The purpose of this embryonic study was to initiate a nursing profile of battered women interfacing with the health care system.

Nurses have a unique opportunity to become leaders in the multidisciplinary approach to controlling and reducing the malignant impact that the battered

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woman syndrome has on the individual, family, and society. A goal of this study for nursing was to provide a description that would enable clinical nurses to increase their knowledge and skills for identifying battered women in order to render improved patient care. Nurse educators could use this information for teaching students methods of assessing battered women and subsequent

nursing interventions specific to this syndrome.

The obligation to identify these women has implications that extend beyond the health needs of the battered woman. The nurse must be cognizant of the fact that service is not being provided for just a single individual but any children in the relationship are being accessed as well.

Gayford (1975) found that violence is passed on from generation to generation. Children who have experienced abuse or have witnessed maternal abuse exhibit a greater propensity to use violence in their adult relationships. Harris (1979) documented the fact that female children involved in domestic violence during their early formative years have three times a greater chance for being abused or battered within their marital relationship.

The approach a nurse takes toward defining the significance and implications that the battered woman phenomenon holds for nursing, and for oneself as a nurse, is partially determined by one's philosophy and definition of nursing. Yura and Walsh (1978) stated, "It is believed that the preservation of, the fostering of, the maintenance of, and the facilitation of the integrity of all human needs of the person (s) is the territory of nursing" (pp. 75-76).

### Definition of Terms

The battered woman or battered wife syndrome has been defined several ways. Most authors agree that when the term "wife," or "spouse" is used it also encompasses unmarried women involved in an intimate relationship with a male partner. Parker and Schumacher (1977) defined the battered wife syndrome as "a symptom complex of violence in which a woman has, at any time, received deliberate, severe, and repeated (more than three times) demonstrable injury from her husband with the minimal injury of severe bruising" (p. 760). A battered woman, according to Walker (1979), ". . . is a woman who is repeatedly subjected to any forceful or psychological behavior by a man in order to coerce her to do something he wants her to do without any concern for her rights. Battered women include wives or women in any form of intimate relationships with men. Furthermore, in order to be classified as a battered woman, the couple must go through the battering cycle at least twice. Any woman may find herself in an abusive relationship with a man once. If it occurs a second time, and she remains in the situation, she is defined as a battered woman, (p. xv)"

For the purpose of this preliminary clinical investigation the term "battered woman" was defined to be a female, aged 16 or more years, who has been the victim of a perceived intentional act of physical violence that occurred during the course of an interpersonal relationship with a spouse or male partner.

### Theoretical Framework

The use of the human need theory as a framework for the nursing process lends itself most harmoniously to the assessment and identification of the battered woman. Fulfillment of needs achieved in ascending order in Maslow's (1954) hierarchy of needs appears to disintegrate in descending order with the battered woman.

Specific to the battered woman, however, is the theory of the cycle of violence developed by Walker (1979) to explain the cyclical nature of violence operative in the battered woman syndrome (See Fig. 1). The cycle has three distinct phases; however, there are no data as yet to predict the length of time a couple will remain in any phase or how long it will take to complete the cycle. Straus, Gelles, and Steinmetz (1980) contend that the issue of battered women in 1980 has just reached the stage in which child abuse was in 1968. Currently, with the advent of treatment programs and efforts toward prevention and control of the domestic violence of which

battered women is a part, laws are being written and rewritten.

Understanding the cycle theory of violence is paramount for those persons interested in the identification and prevention of, and intervention to alleviate the battering of women. Helpers must learn to understand how the battered woman became victimized, how she learned helplessness behaviors, and especially why so many of these women do not attempt to escape their situation. Walker (1979) noted in the literature a lack of studies on the psychology of battered women even though sociological studies had begun to emerge. There is a parallel to Walker's 1975 observations of the paucity of extant nursing research studies in the literature today.

Walker (1979) began her study not knowing what questions to ask; thus the battered women were allowed to recount their stories as they chose. This methodology proved to be a tedious but effective way of gathering this particularly sensitive data. Previously, when these women had attempted to tell their stories they were interrupted by responses of disbelief when they reached the horrifying details, or they were told they had a deep psychological need to be battered that was reminiscent of masochism. Masochism as defined by Freud (1933) addressed the need of some person to experience pain, suffering, humiliation, and ill-treatment to achieve sexual satisfaction. By definition alone, battered women do not meet the criteria for masochism. Regrettably this myth continues to exist.

Using a methodology similar to the grounded theory approach of Glaser and Straus (1967) or Spradley's (1979) ethnographic process Walker collected data from detailed stories of 120 battered women, which was supplemented by more than 300 fragments of stories. Since her sample was not selected randomly but self-volunteered, she declined to use statistical analysis of her data. She was therefore reluctant to make statistical generalizations about her data, although the sample was representative of "all ages, races, religions (including no religion), educational levels, cultures, and socioeconomic groups" (p. 31). For example, the women were from 17 to 76 years of age and had experienced battering relationships for between two months and fifty-three years. Conclusions were formulated by Walker because they had been confirmed "repeatedly by all the available data so far." She is convinced that "battered women themselves are the best judges of whether or not they

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are being battered" (p. xiv). Therefore Walker's criteria for a participant's acceptance into her study was belief in the battered woman's perception that she had been physically or psychologically abused by her partner.

Midway through Walker's (1979) project a common theme emerged that was different from that of women involved merely in unhappy relationships. This common denominator of battered women proved to be the continuous experiencing of life-threatening events at the hands of her male partner.

### Cycle Theory of Violence Phase One

Phase one was labeled the "tension-building phase." During this time minor battering incidents occurred, for example, throwing dishes or food at the woman, shaking her too vigorously, or grabbing an arm too tightly. The female responded to the male by becoming

compliant, passive, obsequious, or withdrawn—anything to assuage his anger and reduce the risk of injury. Unfortunately, by responding in these ways the woman becomes an unwitting accomplice; she is in effect accepting partial responsibility for the abusive behavior. The woman commonly uses denial and rationalization as defense mechanisms in an effort to regain psychological equilibrium and a feeling of some control of the situation. She may even convince herself that she is slightly responsible and therefore deserving of the anger if not the abusive behavior. She rationalizes that perhaps she did overcook the dinner or failed to have the house clean enough. To minimize what actually did occur, she tells herself that things could have been worse.

The woman externalizes the etiology of the event, which assists her in reinforcing her denial. Additionally she is relieved of the responsibility of doing anything about the situation. She reasons that when external events improve the abusive behavior will cease. Adversely, this kind of rationale provides the foundation for the second stage of the cycle—the acute battering incident. Women who do not become victims of battering respond more authoritatively during phase one. Accidentally burning dinner, spilling a drink, or some minor infraction or mistake may result instead in angry words being exchanged; however, qualitatively and quantitatively there is a major difference between the exchange of words and attack through violent behavior.

To control the terror she feels, a woman who previously has experienced the full cycle of violence will deny her situation even more strongly as a way of helping her to believe that she has some control over the batterer's behavior. Each minor battering incident adds to the mounting residual tension for both parties involved. Any control the woman may have felt she had slips away as she becomes more passive and compliant in an ultimately unsuccessful effort to control her own anger at having been treated in such a demeaning fashion. In reference to the need theory framework one can begin to see that the higher level needs are being compromised. The woman's needs for love and belonging are threatened; as a result she tries even harder to achieve fulfillment of these needs.

The fact that the batterer generally becomes violent within the confines of his own home lends credibility to the speculation that the batterer knows that he is behaving contrary to the norms of Western society. A man who beats his mate will view as unacceptable similar behavior in other men. Fearful that his behavior will cause the woman to leave, the batterer becomes increasingly oppressive and possessive in an effort to maintain control over her. Historically, prior to the recent advances to aid the battered woman, this approach was usually effective.

During phase one battered women take extraordinary measures to maintain the delicate and precarious equilibrium. Fearing this aggression may be unleashed on others close to their relationship, the battered women distance the couple from supportive persons with whom interpersonal closeness is usually maintained (e.g., grown children, parents, siblings, or close friends). This isolation provides the batterer with even greater leverage and control over the woman, thus jeopardizing her safety even further.

As the tension escalates the delicate balance becomes more difficult to maintain, and coping techniques begin to weaken. The tension mounts to the point it can no longer be contained. It is at this time that phase two erupts.

## Phase Two

Phase two is ushered in by an incident of acute battering, which is characterized by a volatile discharge of tension by the man. This phase is distinguished from phase one by major destructiveness and complete lack of control by the batterer. Although phase one was serious, the

battering behavior was consciously meted out. In the second phase the batterer is so consumed with rage that he loses touch with any conscious control. This consuming rage may be triggered by an unrelated, external event or precipitated by the battered woman herself because she can no longer tolerate the escalating tension, horror, wrath, and anxiety. If she has experienced the cycle previously she knows phase two is inevitable and, remembering that a period of calm will follow, she wants to get the explosion over with.

Phase two is the briefest of the three stages in the cycle, usually ranging from 2-24 hours. Occasionally women have reported that the terrorizing and beatings continued for one week. Historically a lack of predictability as to when the explosion will occur and total lack of control characterize this stage.

The psychological stress on the woman is unrelenting, contributing to such health problems as anorexia, fatigue, insomnia, tension headaches, gastrointestinal disorders, hypertension, allergic dermatitis, and palpitations. With ' lower level needs unmet she has no energy or motivation to strive toward fulfillment of her higher level needs. It is not inconsistent that low self-esteem is characteristic of the battered woman.

Walker (1979) reported that only the batterer is able to interrupt phase two. The woman can do little more than try to protect herself or find a safe place to hide. These options become more difficult and limited if the woman has children to care for. She cannot flee and leave the children in the hands of the batterer. It is not uncommon for the man to beat his children (or the children of his partner) if he cannot reach the woman or if the children get in his way. The children do not have immunity from the man who beats his mate.

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What finally terminates the batterer's outrage is unclear because few men report being able to recall this episode. Speculations are that he becomes physically and emotionally drained.

The best way to respond to the attacker is difficult to generalize. If the woman responds to the batterer's verbal abuse he becomes angrier; nonresponse enrages him further. Sounds of pain seem to serve the purpose of exciting the attacker, as it does some rapists. Injuries to the upper limbs are common if the female raises them to protect herself. Most women reported that they realized the man was out of control during the acute battering episode and concentrated their efforts on trying to protect themselves from further damage rather than trying to reason with the batterer.

The severe attack is followed by a period of shock, incredulity, and negation—not unlike the reaction experienced by the rape victim or victims of other catastrophes. Many women attempt to deal with the invasion inflicted upon them by verbally minimizing the damages. They try to explain away the attacker's behavior by understating the severity of the event.

The severity of the injuries usually determines if and when the battered woman will seek medical attention. Like victims of natural disasters, it is not unusual for battered women to suffer psychological fragmentation and to exhibit symptoms of depression, malaise, withdrawal, and helplessness. Obtaining medical care may be delayed for a period from 24 hours to several days during which time she usually remains isolated and secluded. This postponed action syndrome is prevalent among various types of trauma victims as rape, battering, or catastrophically induced injuries. The battered woman may be under additional pressure not to seek help because the batterer fears that he will be exposed. Men in responsible positions (e.g., clergymen, lawyers,

physicians, teachers, law enforcement officers, or businessmen) fear that they will lose their jobs if the nature of their behavior is revealed. Her partner's possible loss of employment poses an additional threat to the woman, since loss of income jeopardizes fulfillment of other needs such as food and shelter. The well-being of her children may be threatened if her partner loses his source of income. Lichtenstein (1981) reported three primary reasons why battered women do not seek medical treatment: their partners would not allow it, they lack transportation, and they would be embarrassed.

### Phase Three

The woman's victimization is concluded in the third phase of the cycle. This phase is greeted with relief by the couple because it represents a movement from viciousness to a time of tenderness, love, and contrition. It is reminiscent of traditional perceptions of a honeymoon. The batterer realizes that the boundaries of acceptable behavior have been overstepped. His seduction of the female with behaviors antithetical to those just exhibited hooks her into the third phase of the cycle. The calm that is characteristic of the third phase follows almost immediately upon the heels of the storm of phase two. The tension built throughout phase one is heightened during phase two and is released in phase three, thus completing the cycle of violence (see Fig. 1). The man pleads for forgiveness, apologizes profusely, lavishes her with gifts whether or not they can be afforded, and tells her (and believes himself) that he will never again behave in such a manner. One reason that he believes this is that he feels the woman has undoubtedly learned her lesson and that he will never again have to demonstrate physically his control and authority over her. He professes to make right all of his errant ways from alcohol to drugs to infidelity—and says whatever else is propitious to say at the moment.

Walker (1979) reported that the ideal time for intervention is during the brief span between the end of phase two and beginning of phase three. It is during this time that the battered woman is most likely to seek health care. Since nursing personnel usually spend the most time with the patient who is seeking and receiving health care, they have an excellent opportunity to establish a relationship with the battered woman, the result of which might allow her to reveal the true nature of her sustained injuries.

Nursing intervention should include communicating to the battered woman that she has options other than being entrapped in a continuing cycle of violence. Awareness of these options would provide the nurse with the knowledge necessary to intervene or to make the appropriate referral. Additionally, the nurse can begin to offer support to the battered woman about her sense of worth as a human being. This is the crucial point of contact with the health care system; there may be no other opportunity for intervention, communication and support—until the cycle once again comes full swing following the next episode of acute battering.

When the third phase—the period of calm, with the overstated behavior of apologies, gifts, and promises—ensues, the woman wants desperately to reconfirm her original choice of that particular partner. Walker (1979) learned that, regardless of the reason for the original choice of a partner, most women see themselves as failures if they have to acknowledge having made a poor choice. A battered woman has real feelings of love for the man in spite of his behavior, and she wants to believe that love will prevail. She views the contrite, loving man as the controlling force and tries to dismiss his ugly personality characteristics and behaviors. The bonding that occurs during phase three is not unlike a symbiotic relationship. The couple experiences a sense of exaggerated dependence and reliance on one another.

The battered woman who has experienced previous cycles of violence may be aware that she

is allowing herself to become a partner to her own brutality. She accepts brief periods of calm, loving behavior in lieu of more permanent physical safety and psychological wellbeing. Such a trade-off undermines the woman's feeling of self-esteem. She experiences increased doubts, self-recrimination, embarrassment, shame, guilt, helplessness, and submissiveness. Walker's (1979) findings indicate that phase three lasts longer than phase two but is more brief than phase one, when the cycle of violence begins anew.

### Methodology

The methodology employed to develop a nursing profile of battered women was an ex po facto exploratory

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study using focused interviewing of a purposive sample of self-reported battered women. The setting used was an inner city shelter open to any woman and her children demonstrating the need for protection from a battering situation.

Since the interviewer did not have access to objective data—except that which could be directly observed, such as black eyes or other physical characteristics—the study was conducted on the assumption that the subjects were telling the truth as they perceived it. Walker (1979) has suggested that anyone working with battered women in any capacity approach them with this assumption.

The women were asked to tell the investigator what had happened during the battering situation. Each woman was asked if she had sought health care following the most recent battering event or after any previous episodes. If the woman responded affirmatively she was asked whether she had been identified within the health care system as a battered woman and if so by whom had she been identified. The available choices were identification through self-report, by a health care provider, others (family, friends, or law enforcement), or not identified. If she had been identified by someone other than herself she would have had to confirm or deny the report. If she confirmed the report she was considered by the investigator a “self-reported battered woman.” If she denied the report she was regarded as an “unconfirmed suspected battered woman.” This information should have been noted in the medical record, however, medical records were not available. With the exception of immediate family members, the health care provider may be the only external person to see the battered woman during the transition from phase two to phase three, at which time her health needs are usually greatest and most obvious.

If the woman reported she had not been identified in the health care system as a battered woman she was asked whether or not anyone had inquired specifically, or raised the possibility, that her injuries might be a result of a battering incident. If she was not identified as a battered woman she was asked to reveal how she had explained the etiology of her injuries. She was finally asked to discuss her feelings and reasons for not identifying herself as a battered woman.

### Sample

The sample of the study consisted of 12 women—5 Caucasians and 7 blacks. Of the 12 women, 8 were seen within the confines of the shelter; 4 were residing outside the shelter. The age range was 19 to 38 years old, with a mean age of 26.7 years. In general, the black women represented the youngest women in the sample. Two women were married, two were divorced,

and eight were involved in a living arrangement with the male partner who beat them. The divorced women had been battered within the marital relationship. The women had been involved in their interpersonal relationships from 2-14 years, with a mean of 7.3 years. The mean number of years within a relationship was inflated by the women in the higher socioeconomic group. None of the women at the shelter were married to or had been with their male partners longer than five years. Four of the women were in the middle to upper socioeconomic status — \$25,000 or above. Eight of the women were receiving, had received, or were applying for public assistance. Seven of the women involved with public assistance were black; one was caucasian.

Present or former occupations included factory worker, file-clerk, household domestic, realtor, social worker, housewife, college professor, lawyer, doctorally prepared nurse, and never employed. Of the women, 11 women were Protestant and one was Catholic; 11 had children ranging from 8 months to 13 years of age.

It was impossible to establish a statistical mean for the number of times the women had been battered within a relationship. It was not unusual to receive answers like “So many times I can’t count.” “I lost track a long time ago.” “Who counts anymore?” or “It happens so much I just can’t remember.” Only two women were able to respond to frequency ranges offered—“More than 5 times,” “More than 10 times” “Between 10 and 20 times,” or “Greater than 30 times.”

Interview Responses Question 1:

I would like you to tell me what happened during your relationship with your husband (boyfriend) that relates to the battering events.

All the answers were similar. The stories went as follows. The relationship I began (except in one case) much as | most female-male relationships begin. The two individuals were attracted to each other for a variety of reasons physical appearance, love, mutual needs, or convenience. After they established themselves within the relationship it proceeded until such time when verbal disagreements began. The length of time varied from “from the beginning” to “a couple of years.” The verbal disagreements deteriorated into “Bad arguments” or “Screaming matches.” The verbal attacks assumed the position of minor physical altercations:

- “He slapped me around a little bit.”
- “He smacked me sometimes. Maybe I needed that.”
- “He was okay till he got drunk, then sometimes he’d get mad and hit me or throw things at me. I’d get mad with him right back though.”
- “He stuffed raw hamburger up my nose once when I threw a dishrag at him because he was making fun of me.”
- “Sometimes he’d take my shoulders and shake me real hard so I’d have to listen to him.”
- “He used to push me out the door / and lock it. Then I’d have to beg to I get in. Sometimes I’d be in my nightgown and people would see me.”

Once the physical barrier had been I violated, with resulting capitulation or compliance from the female, the situation degenerated further—sometimes slowly, but always surely. As one woman explained, “The first time it happened I could feel it coming. I just knew, he was gonna blow, but I didn’t know how bad till afterwards. Then he was real sorry. He promised me he’d never hurt me again. He told me it was an accident, that he couldn’t help it. You know, I loved him and thought it would be okay. Huh, little did I know!”

The women recounted stories of being battered, followed by promises from the batterer to reform, coupled with obsequious



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behavior. Ambivalent feelings about the batterer were prevalent. They felt “hate” and “loathing” for the man who beat them, but stated that they continued to love the man. In general the women claimed responsibility for the man’s behavior toward them, feeling that the beatings may have been justified even though they could not identify any logical reasons.

### Question 2:

“What injuries have you sustained from the episodes of battering?”

Injuries about the head and face dominated the list. Injuries reported (listed in order of frequency of mentions) included:

1. Fractures (14): nose (5), ribs (4), jaws (3), and arms (2).
2. General reports of being “sore all over my body” related to having been hurled, shoved, pushed, or thrown across a room or to the floor. (12).
3. Battered while pregnant (11). This figure represented 100% of the women in the sample who had ever been pregnant.
4. Multiple contusions on body, primarily on arms, chest, neck and abdomen (11).
5. “Black eyes” (9).
6. Head and facial lacerations (7).
7. Hair pulled out (7).
8. Lacerations from knives and broken bottles (6).
9. Burns in various places on body (5).
10. Spontaneous abortions within ten days of a battering incident (5). \*
11. Head injuries described as “concussions” and “clot on my brain” (4).
12. Dislocated jaws (3).
13. Loose or knocked out teeth (3).
14. “Broken cartilage in nose and ear” (1).

Some of these answers could be merged into fewer categories for purposes of coding, in subsequent, more extensive studies; however, to familiarize a reader unaware of the severe damage that can be inflicted, it is important not to lose the vivid picture of injuries.

\*This occurrence does not establish a cause-effect relationship, but is reported as a finding.

### Question 3:

Did you seek health care for your injuries the last time you were battered?

Of the 12 women, 8 had sought health care following their most recent battering event. The only woman who had never sought health care was a nurse who managed each time to care for herself. She had had extensive experience as a trauma nurse and had access to supplies and medication.

### Question 4:

Tell me about times when you did seek health care for your injuries as a result of being battered.

One of the women sought psychiatric care after having been battered over a period of time. When battered while pregnant she would schedule herself for additional obstetrical visits, giving some fictitious reason. She stated that her obstetrician was never aware that she was being battered. Such information was not volunteered and the obstetrician never inquired. Ten of the women entered the health care system via emergency rooms. The women did not always return to the same health care facility for fear of arousing suspicion or because they lived in different locations at the time.

No women reported positive feelings about the health care received. They felt they were treated impersonally, insensitively, and received minimal to no support from the providers. One lady recited an incident of waiting in an examining room with her small child and girlfriend while the hospital staff “watched the football game on T.V.” Health care was obtained from within hours after receiving the injuries to four days later.

Question 5:

What was your reason for not seeking health care for injuries resulting from the most recent or previous events of battering?

Reasons presented for not seeking health care after a battering event were:

1. Felt that the sustained injuries were not severe enough to warrant health care.
2. Had no money to pay for the health care visit.
3. Was not allowed by the male partner to seek health care.
4. Had no means of transportation.
5. Felt ashamed and embarrassed and didn't want to be seen by anyone.
6. Felt dissatisfaction with previous health care following a battering event.

The women used a combination of the above rationales following battering events. No woman expressed a single reason. The reason employed depended somehow on the nature of the episode.

Question 6:

Have you been identified in the health care system as a battered woman or as a victim of abuse?

Only two women reported having been identified in the health care system as battered women, both through self-report. One of the two women sought psychiatric care and identified herself as a battered woman to the psychiatrist but not to her obstetrician. The other of the two women was asked by a health care provider if she had been raped. She responded negatively to the rape question, but volunteered that she had been beaten.

Question 7:

By whom were you identified as a battered woman?

As noted in the response to the previous question, the only women acknowledged within the health care system to be battered were both identified by self-report. Since this writer did not have access to the medical records there was no documentation for this kind of data. It is possible that some women were identified without their knowledge. Another possibility is that health care providers might have recognized the battered women syndrome but might not have validated it with the woman.

Question 8:

If you were not identified, did anyone ask you specifically if you had been beaten, abused, or battered?

With the exception of the one woman who was asked by a nurse if she had been raped, none was specifically asked if she had been battered or abused. In no case was the explanation offered by the woman to explain her injuries overtly challenged.

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Question 9:

What did you say to the health care providers (nurse or doctor) to explain how your injuries occurred?

The women presented various explanations to describe the etiology of their injuries. The most frequently offered explanation was a fall; seven reported either falling down the stairs or stumbling over an object. Three reported that they had been in automobile accidents. Others stated they had “bumped” into various objects, hit their heads on something around the house, burned themselves while cooking or ironing, or “just had an accident.” Most women had more than one excuse, which they used on different occasions. Some of the explanations given to specific situations were quite elaborate and creative.

Question 10:

What reasons or feelings prevented you from identifying yourself as a battered woman?

The question was specifically stated in this way because this interviewing technique lends itself to eliciting answers to questions that might be difficult to answer. Communication barriers are avoided with this specific approach.

The most common response was, “No one ever asked me.” The women did not interpret questions from health care providers about the etiology of their trauma as reason to reveal the true nature of their injuries. All of the women expressed feelings of embarrassment, shame, and guilt at having been battered. One woman said that she never admitted to battering within the health care system because she would have been too embarrassed to tell anyone. The guilt experienced in connection with being battered was a confusing feeling for these women. “He used to accuse me of things I know I didn’t do, but I still felt guilty.” “Even though he was the guilty one, he used to make me feel like I had done something wrong.” “I never knew why I felt so ashamed and guilty. He’s the one who should have felt that way.”

“Trapped” was a specific word used by 9 of the 12 women. “I just can’t explain it. I just felt trapped. It’s like he had control over my mind.” This statement came from a woman who was one of the few to not be trapped financially in the relationship. She had other sources of income available to her which gave her options not shared by most of the women. “He had me so trapped I couldn’t do anything on my own . . . He wouldn’t even let me see a doctor when I needed to, and I was too trapped to get out on my own.”

Expressed feelings of low self-esteem were abundant:

- “He told me I should just be glad I had him. Nobody else would want me. I guess he’s right.”
- “I’d get so depressed because I’d feel so bad about myself. Look at me. Who’d want someone like me?”
- “I knew there must be something wrong with me for somebody to do that to me.”

Feelings of fear were common.

- “I knew if I left my old man would come after me. Then I’d get it worse yet.”
- “I was scared they’d (the health care providers) tell my boyfriend and he’d beat me up for telling.”
- “He’d get me so scared I couldn’t do nothin’.”

Question 11:

What could the nurse or doctor have said or done to help you discuss your situation as a battered woman?

There were numerous and potentially helpful answers to this question:

- “It always seemed like the doctors and the nurses were too busy to listen. They would be rushing in and out. It was hard to talk. I wish they’d have had more time.”
- “I’d be where other people could hear me. I didn’t want to tell anybody what happened in front of other people.”

- “Most of the time they (the health care providers) acted like they couldn’t be bothered. The doctors and nurses were all in another little room watching the Redskins football game. Everybody had to wait for a long time.”
- “The doctor and the nurse would be talking to each other. They wouldn’t be payin’ no attention to me.”
- “Nobody ever asked me. I was too scared. If I knew they wasn’t gonna tell my old man, I think I might have told them.”
- “What could I say in front of my husband? I knew what he’d do when he got me home if I told.”
- “I just wish somebody would of come right out and asked me. I always hope they’ll do that. Then it wouldn’t really be like me tellin’ on nobody. I’m scared to tell first.”

The responses focused on the client’s perceived attitudes about the health care providers, issues of privacy, issues of trust, and fear of retaliation from the male partner. This writer’s perception is that some of the women would have been more receptive and honest in discussing their plight if the health care providers had demonstrated more sensitivity. Gentle probing about battering has the potential for eliciting more accurate data. When approached in a matter-of-fact manner and with empathy the women were eager and relieved to have the opportunity for the catharsis that “telling” brought about.

One woman, admitted directly to the hospital from the shelter after suffering a spontaneous abortion, was beaten by her boyfriend while in her hospital bed. The agency response was to have security escort the boyfriend from the hospital and quickly discharge the patient. She received no instructions for post hospital care; nor was she given an appointment for a follow-up visit.

### Implications for Practice

Nurses must approach the nursing assessment of a battered woman with an unbiased conduct of inquiry. The client may not be identified initially as such, but the nurse should obtain enough information to recognize the fact that some crisis of an unpleasant nature has occurred.

Lichtenstein (1981) urges: “Violence against women has been ignored by social institutions, and the degree of physical and psychological injury incurred has been minimized. Many women fail to seek help; therefore screening is an important nursing function. To prevent abuse nurses must be active case finders and stimulate change in societal attitudes toward women that perpetuate the tolerance of family violence.” (p. 237)

She also advocated the use of the Drake nurse self-assessment tool, which assesses one’s feelings and attitudes toward helping families to cope,

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as an applicable tool for the nurse working with battered women. The focus to the extent to which the nurse is meeting her own needs or those of the patient and the appropriateness of the nurse’s feelings, coping behavior, and beliefs about the patient’s strengths, resources, and abilities.

Using the data collected the investigator decided to explore the possibility of there being a linkage between the data and extant nursing diagnoses in an effort to derive a more specific nursing profile of the battered women. Employing Kim and Moritz (1982) as a guide the

following accepted nursing diagnoses were found to be or to have been present in every person in the sample:

1. Thought Processes, alteration in
2. Comfort, alteration in: pain
3. Coping, ineffective individual
4. Coping, ineffective family; disabling
5. Fear
6. Self care deficit, specific (would have to be specified for each individual battered woman).
7. Injury, potential for
8. Knowledge deficit, specific (would have to be specified for each individual battered woman)
9. Parenting, alteration in: actual\*
10. Parenting, alteration in: potential\*
11. Self-concept, disturbance in

\*The only subject from whom these were excluded as part of the profile was the childless woman who had never been pregnant.

It is this writer's belief that this approach to establishing a profile and ultimately a nursing diagnosis of battered women could be refined through additional research. There were other nursing diagnoses exhibited by some of the women that would need to be identified in an individual assessment, but they were not generalizable to the profile derived from this particular sample. "Alteration in nutrition: less than body requirements" for example, was a nursing diagnosis that was specific to several of the battered women.

This investigation supports the need for consciousness raising among nurses and other health care providers to be alert for a covert health problem that is estimated to be effecting at least 4 million women per year. Inquiry focused on abuse as a possible cause of injuries has become a standard part of the history-taking process in the Plastic Surgery Outpatient Department at Hershey Medical Center in Pennsylvania, as reported by Petro, Quann, and Graham (1978). Hospital admission or other safe shelter should be arranged for those women who have been battered to provide them and the health care team with the time to institute some planning for effective intervention.

### Implications for Research

The cycle of violence theory, developed and empirically tested by Walker (1979), has not been challenged or refuted in the literature. Even though the theory is supported empirically, the studies that have tested it through a rigorous, scholarly approach have not been numerous. Two of the major problems in securing such data have been (a) difficulties in establishing control groups, and (b) obtaining women at risk rather than retrospectively identified victims.

A productive study would be one in which the investigator assesses the nurse-patient interaction for congruency of perceptions about health care offered following a battering event. There are additional factors that appear to be common themes within the stories of the battered women; these should be investigated using a larger sample, preferably with a control group. Some of these are alcohol and/or drug use in the batterer and the battered woman, extreme vulnerability during pregnancy, and history of abuse in the family of origin of the male and female.

## Summary

This writer recommends that scholarly research studies be conducted on the topic of battered women, children of battered women, and the batterers with the hope that effective interventions can be developed or identified for use by nurses and other members of the health care team working to help these damaged human beings. A goal is to gain and test new knowledge which would contribute to an expanding body of nursing science. The ultimate goal of this work is succinctly stated by Maslow (1968): "Improving individual health is one approach to making a better world" (p. 6).

[Domestic Violence escalation chart] Walker's Cycle Theory of Violence of Battered Women, Three phases varying in time and intensity for the same and different couples

Phase I: Tension Building —Limited Control

Minor incident, External Influences, Minor incident, Phase II: Explosion No control

Honeymoon Phase III: Calm, Loving, Respite; Longer than Phase II but shorter than Phase I

Figure 1. cycle theory of violence

Information source: Walker, L. E. *The battered woman*. New York: Harper & Row, Publishers, 1979.

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