

## The Battered Woman

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### Definition

Domestic violence and spouse abuse are terms referring to violence occurring between partners in an ongoing relationship, regardless of whether they are married (1). A battered woman has been defined as any woman over the age of 16 with evidence of physical abuse on at least one occasion at the hands of an intimate male partner (2). The battered wife syndrome has been defined as a symptom complex occurring as a result of violence in which a woman has at any time received deliberate, severe, and repeated (more than three times) physical abuse from her husband, with the minimal injury of severe bruising (3). Richwald and McCluskey have categorized violent acts from the least to the most severe, from verbal abuse, threat of violence, throwing an object, throwing an object at someone, pushing, slapping, kicking, hitting, beating up, threatening with a weapon, and use of a weapon. Most definitions also incorporate concepts of intentionality and the repetitive nature of the assaults (4).

It can be seen from these definitions that violence is viewed most often as physical abuse. In most violent relationships, however, mental abuse and intimidation are an integral component of the abuse syndrome. Regardless of how it is defined or the form it takes, abuse represents a significant clinical problem that warrants further evaluation. In 1985, the Surgeon General of the United States sponsored a workshop on violence and public health in an effort to focus attention on this and similar problems, in the hope of helping to reduce the incidence of violence in society and providing more effective help for its victims (5).

### Incidence

It is difficult to ascertain the exact incidence of domestic violence. One estimate based on the work of several investigators has placed the annual number of cases of domestic violence in the United States at 1.5 million; it has also been estimated to occur in up to 50% of all familial relationships (1, 6, 7). A study performed at Yale University reported that 3.8% of women who came to the surgical services and 3.4% of women who came to the psychiatric services of the emergency department had been victims of battering (2). The U.S. Department of Justice's Bureau of Justice Statistics reports that 57% of 450,000 annual cases of family violence were committed by spouses or ex-spouses and that the wife was the victim in 93% of cases. In one-quarter of these cases, at least three similar incidents had been reported within the previous 6 months (8). Furthermore, it has been estimated that between one-third and one-half of all female homicide victims are murdered by their male partners (9). For a variety of social, emotional, and economic reasons, the incidence of battered women is probably severely underreported throughout the world.

### Public Health Impact

It is difficult to obtain statistics on the morbidity of battering. In the Yale study, 19% of the women in the series had received serious injuries to the head, 5% had lacerations requiring sutures, and 62% had contusions and soft tissue injuries (2). In all series, the areas most commonly injured in women were the

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head, neck, chest, abdomen, breasts, and upper extremities. The upper extremities were frequently fractured as the woman attempted to defend herself. Of the women injured in the Yale series, 84% had injuries that were severe enough to require medical treatment at least once, and 81% stated that the assailant had beaten them with the fists (2). In a study performed in England, 100 women evaluated at a women's aid hostel stated that they had been bruised at some time, and 44% of the cases were associated with laceration. All women reported having been hit with a clenched fist, 59 had been repeatedly kicked, weapons were used in 42 cases, fractures had occurred in 32, and nine women had been beaten and taken to a hospital after being found unconscious (10). Most studies of battered women demonstrate similar findings. Walker, in a

large and careful study of battered women, reported that three-quarters felt that the batterer would kill them in the relationship, and almost half felt that they might kill the batterer. Eleven percent of these victims stated that they had actually tried to kill the batterer, and 87% believed that they themselves would be the one to die if someone was killed. In addition, half of the batterers and about one-third of the women in the series had threatened to commit suicide (11). Walker states that in her and others' experience, batterers and their victims move easily from suicidal to homicidal intent. The suicide threats in a relationship on the part of either a batterer or a victim may be a warning that a homicide may actually occur (11, 12).

The cost to society of domestic violence is difficult to establish. It includes the emergency and long term care of the victims; legal expenses, including both police and court intervention; the expense of shelters and housing for abused women and their children; and the overall cost to the community for therapeutic services to the victim, the batterer, the children, and the family unit.

### Relationship to Child Abuse

The relationship of spouse battering to child abuse is a strong one. One study showed that within the violent family's structure, 53% of men who abused their partners were also reported to abuse their children, and one-third of the batterers threatened to abuse their children. In the same relationship, 28% of the wives said that they had abused their children while living in the violent household, and 6% were threatening to abuse their children at the time they were evaluated (11).

Physical abuse in pregnancy has been referred to as prenatal child abuse. In one study, 81 of 742 patients visiting a prenatal clinic (10.9%) stated that they had been victims of abuse at some time in the past, and 29 of these women stated that the abuse had continued into the current pregnancy. Twenty-one percent reported an increase of abuse during pregnancy; 36% noted a decrease in abuse (13). Whereas battering in the nonpregnant state generally affects the regions of the head, chest, breasts, and arms, abuse during pregnancy is frequently directed at the abdomen (7).

### Recognition

Because obstetrician-gynecologists are often the primary care providers for many women, they play a vital role in detecting the woman who is the victim of abuse and in offering appropriate care. As with most psychosocial problems, the physician's ability to recognize the abused woman depends on his or her index of suspicion. For example, one study noted that only 5% of 107 victims of domestic violence seen in a metropolitan emergency department were identified as such by physicians on the emergency room report (1). It is important, however, to identify these individuals, as they are at high risk for further physical injury and death through suicide or homicide and because their children and the batterer himself are also at risk.

Viken has listed a profile of the characteristics of abused wives. These include a history of having been beaten as a child, raised in a single-parent home, married as a teenager, and pregnant before marriage. Sixty percent of battered women in one study became pregnant before marriage (10). These women have frequent clinic visits with a variety of somatic complaints, including headache, insomnia, choking sensations, hyperventilation, gastrointestinal symptoms, and chest, pelvic, and back pain. There is frequently noncompliance with advice and recommendations of the physician (14).

In visits to emergency rooms, the patient may appear shy, frightened, embarrassed, evasive, anxious, or passive and often may cry (15). Often the batterer accompanies the woman on such visits and stays close at hand so as to monitor what she says to the physician. The woman may be hesitant to provide information about how she was injured, and her explanation may not fit with the injuries observed. Many have made repeated visits to the emergency room, and some have been treated for drug or alcohol overdose in the past (see box). If the diagnosis is not appropriately made, a tranquilizer has often been prescribed.

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Somatic complaints in abused women:

- Headaches
- Insomnia

- Choking sensation
- Hyperventilation
- Gastrointestinal symptoms
- Chest, back, pelvic pain

Other signs and symptoms:

- Shyness
- Fright
- Embarrassment
- Evasiveness
- Jumpiness
- Passivity
- Frequent crying
- Often accompanied by male partner
- Drug or alcohol abuse (often overdose)
- Injuries

It is appropriate to ask patients directly whether they have ever been physically abused, particularly if there is evidence of injury. Questions such as "Has anyone at home hit you or tried to injure you?" and "Have you ever been physically abused, either recently or in the past?" are appropriate ways in which to introduce the subject. It is important for the physician to acknowledge the problem and to affirm that battering is unacceptable (16).

Physical examination by the physician may often show evidence for previous injury, either recent or remote. It is important for the physician to note such injuries and to ask the patient how she got them. If the woman is wearing sunglasses, it is appropriate to ask her to remove them, as she may be harboring an eye injury. Bruises to the breasts and abdomen of a pregnant woman should certainly be discussed.

Obtaining informed consent and collecting and processing specimens for physical evidence of abuse for legal and forensic purposes should be carried out as for other types of physical or sexual assault (17).

### *The Cycle of Battering*

Battering acts within a violent family seem to occur in cycles consisting of three phases (11). In the first phase, the tension-building phase, gradual escalation of tension is seen in discrete acts that cause family friction. These would include name-calling, intimidating remarks, meanness, and mild physical abuse, such as pushing. The batterer expresses dissatisfaction and hostility, but this does not occur in an explosive form. The woman attempts to placate the batterer in the hopes of pleasing him or calming him down. She believes at this point that she must avoid aggravating him further. She will try not to respond to his hostile actions and is often successful at first, which only reinforces her belief that she can control him. As the tension builds, she has more difficulty controlling his anger and frequently withdraws, fearing that she will inadvertently set off his explosive behavior. Her withdrawal may be the signal for the man to become more aggressive.

Generally, anything can spark the hostile act, and the acute battering incident takes place. This is the second phase of the cycle, in which there is an uncontrollable discharge of tensions which have built up through the earlier phase. The batterer will attack the victim both verbally and physically, often leaving her injured. It is at this point that in self-defense the woman may actually injure or kill the batterer. In the approximately two-thirds of batterers who abuse alcohol, the violent event may be accompanied by a bout of heavy drinking. The victim often believes that the drinking is the cause of the beating, rather than its excuse. If law enforcement officials are called in at this point, often they also conclude that this is the case.

The third phase follows, in which the batterer apologizes profusely and asks for forgiveness. He may show kindness and remorse and shower the victim with gifts and promises. During this phase, the victim begins to hope that the relationship can be saved and that the violence will not recur. Since many batterers seem charming and are manipulative, the victim may actually believe that the problem has passed.

With repeated cycles, an increase in the first phase, a decrease in the third phase, and a tendency for the violence to become more acute and dangerous are seen. The batterer learns that he has controlled the victim and does not need to put much energy into obtaining forgiveness.

The victim, for her own part, is often so demoralized at this point that she finds it difficult to leave the situation, even if she has the means and the opportunity to do so (11).

### *Myths*

A number of myths about battered women are prevalent. Hofeller has listed a number of these and refutes them in the following fashion (18):

1. Battered women are always from lower socioeconomic groups.

Domestic violence is primarily reported in lower socioeconomic groups because they utilize emergency

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facilities more often than they see private physicians. These public facilities report such incidents, whereas private practices generally do not. Most studies, however, show that the condition occurs in all groups, regardless of race, religion, or socioeconomic category.

2. Battered women must enjoy the abuse; otherwise, they would take the children and leave. All studies have shown that battered women are not masochists. The reasons for their remaining in an abusive relationship are complex and multiple, but their lives in the battering situation are chaotic, frightening, and violent.

3. A woman who gets beaten probably provoked her partner.

The victim of abuse may believe that she deserves the battering at various periods in the relationship. The violence, however, resides within the batterer, and the circumstances that lead to the violence are often such that the woman accepts responsibility for the violence as a means of maintaining some sense of control over her situation. Believing that something in her actions may allow her to control the batterer and thereby prevent a future incident misleads her into a false sense of security.

4. The battered woman who is serious about solving the problem could have the batterer arrested and put in jail.

Women will not routinely resort to arrest to control the batterer for a variety of reasons, including loss of income, fear that the batterer will inflict more severe punishment after he is released, and the realization that the court system will probably play down her accusations and perhaps release the batterer within a short time. This perception has validity in light of the fact that most jurisdictions and law enforcement officers tend to minimize the significance of domestic violence, whereas similar episodes of violence between unrelated individuals are not treated as lightly.

5. If a battered woman remarries, she usually chooses another violent man.

Data show that a number of abused women remain single after leaving an abusive relationship. Many who do marry make a conscious effort not to marry a batterer and frequently find men who are not violent (18).

### *Counseling*

Efforts at counseling must take into consideration the dynamics of the battering relationship. In attempting to help the victim, the first step is to listen non-judgmentally and to attempt to assess the seriousness of the victim's circumstances. The victim should be made aware of the support services available in the community, such as shelters for battered women, community resources that can offer financial and emotional support for her and her children, and agencies that can make her aware of her legal rights.

### *Acute Intervention*

It is likely that the victim of abuse will not wish to leave the home situation because of economic concerns and a fear that the batterer may continue to pursue her. She may be advised of the possibilities of having the batterer arrested and served with a restraining order or, in some jurisdictions, having him produce a peace bond that will impose a fine should he break the restraining order. If the victim cannot be convinced to leave the home, she may be given phone numbers of resource agencies and the police and encouraged to use them in the event of another acute outbreak of violence.

It is probably reasonable to discuss an exit plan with the battered victim. The woman should

be prepared to leave if she anticipates a battering incident is about to take place, rather than wait until it has occurred. The following exit plan has been proposed for a woman who feels that she or her children are in danger from her male partner (19):

1. Have a change of clothes packed for herself and her children, including toilet articles, necessary medications, and an extra set of keys to the house and the car. These can be placed in a suitcase and stored with a friend or neighbor.
2. Cash, a checkbook, and a savings account book may also be kept with the individual chosen.
3. Identification papers, such as birth certificates, social security card, voter registration card, utility bills, and a driver's license should be kept available, since children will need to be enrolled in school and financial assistance may have to be sought.
4. Something special, such as a book or a toy, should be taken for each child.
5. If available, financial records, such as mortgage papers, rent receipts, or an automobile title, should be taken, and a plan of exactly where to go, regardless of the time of day or night, should be decided upon. This may be a friend or relative's home or a shelter for battered women and children.

If the woman is battered or injured, she is instructed to plan to go to an emergency room or, if badly hurt,

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to call an ambulance, the police, or a close friend or relative. She is advised to describe past and current battering incidents to the health care provider, to obtain a copy of the medical record for any treatment received for injuries in order to help the district attorney or police file charges, and to learn the name of the medications that the physician at the emergency room prescribes and what they are to be used for. The victims are advised to be wary of tranquilizers, since they will not solve the victim's problems, but these drugs are often sought by the distraught individual. Women in violent homes who have not decided to leave are instructed to practice these exit drills as if they were a fire drill in order to minimize confusion when they need to be utilized (19).

#### *Long-Term Aid and Referral*

Some battered women require little or no therapy once they have been placed in a violence-free setting. This is especially true if they have social and family support and a means of supporting themselves. The majority, however, require help from a therapy program. The first help might occur by group interaction in a shelter situation. The immediate goals of this therapy are to help her lessen her social isolation and rebuild her self-esteem. The next stage of counseling would depend on the patient's individual needs. Women with severe psychiatric problems who have anxiety, depression, or other pathology may need psychotherapy. Individuals with less severe psychologic problems may need to continue in individual or group counseling in order to rebuild their lives as single individuals or single parents. This may be accomplished under the guidance of a psychologist or a social worker.

Specific attention during this period must be given to obtaining appropriate legal aid and helping the individual to acquire reeducation or job skills and to make arrangements for child care. If the counselor perceives that the battered woman is considering returning to the batterer's household, the dynamics of the battering relationship should be reviewed and the available options discussed so that all alternatives are considered before a final decision is made (11, 20).

#### *Children of Abuse Victims*

Counseling for the child in the violent family situation must take into consideration the fact that the child may have been physically abused or may have witnessed abuse within the family. In any case, studies have shown that these children often have behavior problems at home and in school and may begin displaying aggressive behavior themselves.

Later in life their violent behavior pattern may place them into a violent family situation of their own. In shelter situations, children often withdraw but then may show destructive patterns of behavior. In many cases, supervised play therapy allows them to work through their feelings in the immediate post trauma period. They should be evaluated periodically to determine whether individual therapy is necessary to alleviate these destructive behavior patterns (20).

### *The Male Batterer*

To understand the counseling goals for the batterer, one must understand the batterer's personality. Most studies show that male batterers refuse to take responsibility for their behavior, blaming their victims for their violent acts. These individuals often have strong controlling personalities and cannot tolerate autonomy in their partners. They are rigid in their expectations of marriage and sexual behavior. They consider their wives or partners as chattel, and they wish to be cared for in the most basic fashion, as they were cared for by their mothers. They often make unrealistic demands and have low tolerance for stress. They may appear depressed or even make suicidal gestures. Their basic behavior pattern is aggressive and assaultive, and they often have used violence to handle their problems throughout their lives. They can be charming and manipulative, especially in their relationships outside the marriage. At the same time, they frequently exhibit low self-esteem, feelings of inadequacy, and a sense of helplessness that is accentuated by the possibility of losing their wives. Male batterers often exhibit contempt for women in their daily activities (14, 21, 22).

Appropriate therapy, whether individual or with a group, for these individuals focuses on finding ways to help the batterer understand that violence is not the appropriate means of solving his problems. Later, when basic attitude changes have been achieved, family therapy may be helpful for the couple in helping them define means to work out their daily problems. Often it is necessary to utilize the courts to get the batterer into a therapeutic situation (11).

### *Community Resources*

A number of community resources are available in most localities. The acute situation can be helped by the police department, crisis hotlines, rape relief centers, domestic violence programs, legal aid services for abused women, hospital emergency rooms, and shelters for battered women and children. For counseling and follow-up care, there are individual counselors who specialize in the care of battered women and their spouses and children. These may

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include social workers, psychologists, psychiatrists, and other mental health workers; community hospitals with mental health departments; and community mental health services. Some cities sponsor private, nonprofit organizations that offer group counseling and supportive therapy to individuals and couples. The goals are to make the resources accessible and safe; to give the topic of the battered woman syndrome strong, positive publicity; and to enhance support for victims who are unsure of their options.

### *Legal and Emergency Issues*

Evidence of child abuse must be reported to police or specified social agencies in all 50 states and the District of Columbia. Failure to do so in most states makes the physician an accomplice and liable for prosecution. In the case of the battered woman, physician liability may be recognized if suicidal or homicidal intentions are not addressed by therapy or reported to a responsible public agency (23). Most such serious consequences are preceded by several acts of violence, many of which have involved police intervention.

Legislative initiatives have been slow in coming in most jurisdictions. Most states have passed laws that protect the battered wife and allow arrest of the batterer, and 36 states and the District of Columbia have passed laws that regulate the removal of the abuser from the home, place restraints on continuing the abuse, and mandate requirements for counseling and the payment of restitution (24). If police are called to the scene and there is evidence of battering, an arrest may be made even though the victim refuses to press charges. This is encouraged in specific training of the police to identify domestic violence. In states where this initiative has been implemented, the jails have frequently been overcrowded, particularly on weekends and holidays, when domestic violence is more likely to occur.

A few interesting initiatives have been seen in various parts of the United States. One such program is the San Francisco district attorney's Family Violence Project. This has made it possible to place chronic spouse abusers into a treatment program. The offender is required to complete an educational workshop in nonviolence prior to beginning other counseling treatment therapy. In most jurisdictions, milder forms of spouse abuse are considered misdemeanors.

Recently a California penal code amendment has made wife abuse a felony. In most jurisdictions where serious physical harm is proven, felony charges may be brought (11). Other communities are developing diversion programs for the batterers and victim advocacy programs (18).

### Summary

Wife battering is a common problem that affects the family unit in particular and society in general. It occurs in all segments of society and reflects the violence that is a part of the behavior of many. Physicians can learn to detect its presence in their patients and to offer ways in which the victims can find help. Such help may include counseling for the victims, the batterer, and their children or a constructive plan for the woman to exit the relationship and rebuild her life in safety. While public attitudes have changed very slowly in appreciating the extent and seriousness of this problem, legislative initiatives have begun to address remedies for this potentially damaging and lethal situation.

Physicians should attempt to identify individuals who are the victims of abuse and to help them understand the dynamics of their relationship and the dangers faced by themselves and their children. Information about available community, social, and legal resources, their rights under the law, and a plan for dealing with the abusive partner should be made available to these women (25). The physician must remain caring and supportive of the victim as she works through these crises, even if she chooses to follow advice or courses of action other than leaving the relationship.

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#### Suggested Resources For Abuse Victims

American College of Obstetricians and Gynecologists: *The Abused Woman* (ACOG Patient Education Pamphlet AP083). Washington DC, ACOG, 1989

National Coalition Against Domestic Violence. A 24-hour hotline providing support and referrals for abused women: 1-800-333-SAFE

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The American College of Obstetricians and Gynecologists, 409 12th Street, SW, Washington, DC 20024-2188

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