

## Record: 1

**Title:** Invisible victims: Battered women in psychiatric and medical emergency rooms.

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**Source:** Bulletin of the Menninger Clinic; Winter96, Vol. 60 Issue 1, p1, 21p, 1 Chart

**Document Type:** Article

**Subject Terms:** ABUSED women -- Medical care  
WIFE abuse  
COUNTERTRANSFERENCE (Psychology)  
FAMILY violence

**Abstract:** Describes three main countertransferences that interfere with accurate identification of battered wives. Counter-identification; Countertransference rage; Countertransference helplessness.

**Full Text Word Count:** 8391

**ISSN:** 0025-9284

**Accession Number:** 9603112942

**Database:** Psychology and Behavioral Sciences Collection

### **INVISIBLE VICTIMS: BATTERED WOMEN IN PSYCHIATRIC AND MEDICAL EMERGENCY ROOMS**

Violence against women by their male partners is widespread and infrequently identified as a causal factor in multiple physical and psychological problems of female patients in medical and psychiatric settings. Three main countertransferences that interfere with accurate identification of battered women are described: (1) counter-identification, (2) countertransference rage, and (3) countertransference helplessness. Battering men and battered women are found in all levels of society, although younger, lower income, less-educated men who have observed parental violence in their own home are at higher risk of abusing their spouses. Additionally, antisocial personality disorder, depression, and/or alcohol and drug abuse increase the risk of male violence in the home. Contrary to popular belief, the husband-to-wife violence is usually motivated by his need to control her rather than a result of his loss of control. Battered women show no consistent prebattering risk markers, except for a history of parental violence in their family of origin. Violence against women by their male partners is a serious public health problem that has not been adequately addressed by the medical and psychiatric professions. Myths and clinical realities of battered women are described and detailed recommendations for clinical inquiry and evaluation of level of danger are given. (Bulletin of the Menninger Clinic, 60[1], 1-21)

The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma. (Herman, 1992, p. 1)

Wife battering is the largest cause of injury to U.S. women, resulting in a larger number of injuries than auto accidents, muggings, and rapes combined. Up to 4 million women per year are abused by their male partners, with as many as 2 million suffering serious injury and 2,000-4,000 suffering death at the hands of their husbands, boy-friends, or former partners. Retrospective chart reviews in hospital emergency rooms indicate that while 30-35% of women seen in the emergency room have symptoms or injuries secondary to battering, the cause of the problem is identified in only 5% of those cases (Randall, 1990). Researchers have found that at least 30% of men who batter their wives also batter and/or sexually abuse their children (cf. Gelles & Straus, 1988; Walker, 1979). Additionally, mothers who are battered by their male partners are more likely to abuse their children than mothers who are not battered (Pagelow, 1992). The psychiatric and medical sequelae of this abuse are enormous.

While the number of men and women who hit their partners is about equal, most women hit their male partners in self-defense (cf. Gelles & Straus, 1988). Additionally, 95% of serious injury resulting from marital violence is caused by husband-to-wife violence. For these reasons, I have focused on psychiatric and familial sequelae of abuse of women by their male partners. I will review the demographics of partner abuse and related child abuse, identify the myths and cultural attitudes about family violence that interfere with adequate clinical response to victims, and describe the countertransference pitfalls that contribute to ineffective and damaging clinical responses. A strong case for increased training and formal guidelines for recognition and assessment of the sequelae of battering that undoubtedly affect many of our female patients will be made. I conclude with recommendations for more adequate clinical protocols for identification and treatment.

### Who is being beaten?

An important point about violent men and the women they batter is that wife abuse, like child abuse, occurs across economic, racial, and social lines (cf. Burge, 1989; Hotaling & Sugarman, 1986). Abusers range from the stereotypical laid-off blue-collar worker who beats his wife up after drinking up his unemployment check, to the CEO of a large organization whose wife functions as a "super volunteer," hiding her bruises from her family and lying about her injuries to her physician (Gelles & Straus, 1988).

Gelles and Straus (1988) studied a national sample of 8,000 families and found that one eighth of the husbands had carried out one or more acts of physical aggression against their wives during the past year. Worse, more than 3 out of a 100 (1.8 million) wives had been severely injured by their husbands during the previous year. From 8% (Helton, MacFarlane, & Anderson, 1987) to 17% (McFarlane, Parker, Soeker, & Bullock, 1992) of pregnant women are battered during their pregnancy, resulting in birth defects, miscarriages, and high-risk deliveries with complications such as placental separation and pre-term labor (Saltzman, 1990).

Although extensive literature exists on the psychological sequelae of abuse, the connection between a history of abuse and psychiatric disorders has not been adequately integrated into clinical practice. In 1980, Post and coauthors reported a 50% rate of domestic abuse in a sample of female psychiatric inpatients. Four

years later, Carmen, Rieker, and Mills (1984) studied the relationship between psychiatric illness and physical and sexual abuse. They found that almost 50% of the female patients studied had histories of abuse and 90% of the abused patients were abused by family members. Of their female abused patients, 51% had been abused by husbands or former husbands. Although diagnosis did not reliably discriminate between abused and nonabused patients, abused patients required 30% longer hospitalizations than nonabused patients across different diagnoses. Three years later, Jacobson and Richardson (1987) reported that 64% of female psychiatric inpatients had experienced major physical or sexual assault during adulthood. The majority of assailants lived in the home. All of these researchers make the point that, contrary to popular belief, abused women do report abuse when asked in a safe setting. All recommended the inclusion of specific questions about abuse in routine psychiatric interviews. Because victims of violence rarely volunteer information about the abuse, and we have not incorporated routine inquiry about family violence into our clinical protocols, crucial information that could lead to more accurate diagnosis and treatment is missed.

### **Who are they? Violent men/battered women**

Three kinds of research provide the information on battering men and battered women presented below: (1) clinical research on women who seek shelter, psychiatric attention, or medical aid; (2) recent research on men in mandatory treatment programs; and (3) research from large-scale, random population samples.

Until recently, researchers have focused almost exclusively on the women, searching for explanations based on the battered woman's personality. An analysis of the social and cultural beliefs about men, women, and relationships contributing to this almost exclusive focus is beyond the scope of this article. Suffice it to say that, while sexism has played a part in that exclusive focus, pragmatics have also played a part. Beginning with Snell, Rosenwald, and Robey's 1964 article, "The Wifebeater's Wife," researchers have found that the women are available to study while their husbands refuse to participate. The recent information on men who batter their wives is available because some cities have instituted mandatory arrest policies and developed diversion programs that result in something of a captive audience for research.

### **Myths and realities of battered women**

The most common myth about battered women is that they are masochistic. The implications of this belief are that she asks for it; she enjoys being beaten; it's her own fault; she can and should control the batterer's behavior; and, finally, if she doesn't like being beaten, why doesn't she leave? Clinical interest is focused on her presumed underlying psychopathology rather than on the question of why the batterer is beating her. The following summary of research will show that there is little or no substance to these myths.

Fifteen years of research have failed to confirm any psychological risk factor or predisposing personality to account for being victimized by husbands (cf. Burge, 1989; Gelles & Straus, 1988; Rosenbaum & O'Leary, 1981). There is no typical woman victim. As with battering men, women of all ethnic groups, economic classes, educational levels, as well as psychological states, and so on, are

battered. The only clear and universal risk factor is being female. In their review of research on husband-to-wife violence, Hotaling and Sugarman (1986) found only one factor that consistently discriminated between battered and nonbattered women: witnessing violence between parents as a child. However, the majority of those who witness parental violence do not go on to violent marriages (Emery, 1989). While younger women are more likely to be battered than older women (Hotaling & Sugarman, 1986), age is no protection. Battering of wives accounts for a significant amount of elder abuse (Arnold & Jeffries, 1983).

The effects of being battered bring women to the attention of clinicians for varied physical and psychological ills: Hilberman and Munson (1977-78) reviewed cases of women referred by the medical staff of a rural health clinic for psychiatric evaluation and found that 50% of those referred were being battered by their husbands. The battering history was known by the referring physician in only 4 of 60 cases. Reasons for referral ranged across a spectrum of psychiatric problems, from depression and anxiety to chronic tranquilizer and analgesic use. Almost all of their sample of 60 women had made frequent visits to physicians for somatic complaints, anxiety, suicidal behavior, and insomnia. Long-term effects of chronic violence and living in constant anticipation of violence include fear, confusion, and acute feelings of powerlessness. Chronic fatigue and tension, exaggerated startled reactions, and sleeping and eating disturbances are common.

A large-scale, random-sample research project confirmed the clinical findings. Women who are being beaten have much higher rates of depression, somatic complaints, and suicide attempts than women who are either normally adjusted or unhappy but not battered (cf. Gelles & Harrop, 1989). Women who are being beaten have a higher incidence of drug and alcohol abuse and dependence, secondary to battering (Burge, 1989). Women are frequently misdiagnosed with affective disorders, anxiety disorders, and personality disorders as the primary diagnosis because the trauma that causes the symptoms is unidentified. Posttraumatic stress disorder is likely to be the most appropriate primary diagnosis for battered women (Burge, 1959) even if other diagnoses are concurrent.

### [Why doesn't she leave?](#)

The mythology of battered women is that they do not leave violent relationships. In fact most battered women do eventually leave[a] (Okun, 1986). Campbell (1989) found that battered women and women experiencing serious problems, but not violence, in their relationships, took about the same length of time to end the relationship. She found that the battered women were deeply attached to their batterers and that they, like women ending unhappy but not violent relationships, went through a grieving process as they separated from the batterer. She concluded that the failure of researchers to compare battered women with an appropriate comparison group of maritally unhappy but not battered women has resulted in negative stereotyping.

Gelles and Straus (1988) found that wives who are hit make varied, frequent, and persistent efforts to stop the hitting. They leave, they talk to their husbands between violent episodes, they seek help from his family and friends, they call the police, they seek restraining orders, and they divorce.

Because researchers have considered the question "Why doesn't she leave?" more important than the question "Why does he hit?," we have a great deal of understanding of the realistic pressures on women to stay and the behavioral, emotional, social, and economic as well as physical safety issues involved in decisions to stay or to leave.

There are four classes of explanations of the battered woman's difficulties in leaving: (1) socialization to believe in her responsibility to preserve the family unit, to provide a father for her children, and to control her husband's behavior by pleasing him (cf. Pfouts, 1978); (2) lack of economic resources and independent ability to provide for herself and her children (cf. Gelles & Straus, 1988; Pfouts, 1978); (3) her often realistic belief, [b] based on previous experience of her husband's capacity for violence, that he will carry out his threats to kill her, himself, the children or all of them, if she does leave; and (4) the intensity of the traumatic bonding that occurs in these highly charged relationships with intense periods of violence interspersed with intense emotional bonding (Dutton & Painter, 1981). Any or all of these classes of explanation may account for an individual decision to stay in a violent relationship. However, such clinical research must be balanced by the research indicating that, in fact, battered women do make active and continued efforts to stop the violence, including leaving. [c]

### Characteristics of batterers

There is consistent support for some markers of risk for husband-to-wife violence in men, across both clinical and demographic studies. Younger, lower-income, less-educated men are more at risk for wife abuse (Gelles & Straus, 1988; Hotaling & Sugarman, 1986), although, as stated, wife battering occurs in all social and economic classes. Men who observe parental violence as children are more likely to hit their wives (cf. Gelles & Straus, 1988; Hotaling & Sugarman, 1986; Walker, 1979). Dinwiddie (1992) found that batterers have higher rates of antisocial personality disorder (ASD), alcoholism, and depression. When alcoholism coexists with either depression or ASD, the incidence of violence doubles from 50% with either alcoholism or ASD and 30% with major depression, to 80% (alcoholism and depression) and 93% (alcoholism and ASD) (Bland & Orn, 1986).

Walker (1979) and Hilberman and Munson (1977-1978) studied severely battered women and reported their husbands to be dependent, pathologically jealous, likely to abuse alcohol, to have low self-esteem, and to have poor impulse control. One study documented a high incidence of head injury in batterers as compared to nonbatterers (Rosenbaum & Hoge, 1989). Batterers are also likely to blame others for their behavior (cf. Harris & Bologh, 1985; Walker, 1979) and 30% of them are likely to sexually and/or physically abuse their children (cf. Gelles & Straus, 1988; Hilberman & Munson, 1977-1978; Walker, 1979) as compared to about 5% of the general male population.

Clinically, men who batter are reported using violence as an outlet for any unpleasant feelings, have unrealistic and extreme needs for attention and reassurance, are easily triggered into angry outbursts, and suffer from extreme fears of abandonment (Walker, 1983). Contrary to popular belief, the battering is rarely secondary to a loss of control. Rather, hitting is motivated and deliberate,

with the goal of intimidating and controlling the woman (Davidovich, 1990). Batters are described as histrionic, that is, as displaying emotion on the basis of the perceived social effect of that display (Davidovich, 1990). Parenthetically, some clinicians believe that the increased danger of lethal violence at the time of separation, as well as the increases in battering during a woman's pregnancy, are secondary to the extreme abandonment fears and infantile dependency of battering men (cf. Hanks, 1993).

The implications for psychiatric and medical emergency rooms are clear. Wife abuse is costly in human suffering and in larger costs to society. However, these implications have been made and reported and still we have not responded with training and with routine inquiry. In spite of repeated calls to action over the past 15 years, medical and psychiatric emergency rooms, as well as family physicians, have not established routine inquiry about family violence in medical and psychiatric interviews or added family violence training to residency programs ("Violence education," 1991).

### [Why aren't we asking? Countertransference resistance to identification of battered women](#)

Social and cultural issues play a part in the failure of clinicians to identify family violence, specifically the notion of the privacy of the family as well as residual beliefs about the male's primacy in the family. Acts that would be considered crimes if committed outside the family are considered private when committed against a family member, particularly against an adult woman. The boundaries of privacy have diminished in relation to children, with mandated reporting laws in all 50 states, but these boundaries still surround wives, elders, and siblings.

Denial of the existence of violence in the family also plays a role in the failure to identify wife battering. Violent families disturb our cherished notions of the family as a safe haven. These important social and cultural factors are covered extensively in the medical and psychological literature (cf. Finkelhor et al., 1983; Gelles & Straus, 1988; Symonds, 1979). The following discussion will describe the unconscious and conscious countertransference[d] reactions to victims of battering that interfere with the use of empathy to aid in identification and adequate treatment. While a full discussion of empathy as a tool in clinical evaluations is beyond the scope of this article, discussions of the clinical usefulness of identification combined with self-observation are briefly reviewed.

Reich (1960) viewed trial identifications, putting ourselves in the patient's place in order to achieve empathy, as the basis of empathy, with the crucial caveat that the therapist must be able to first observe his or her identification with the patient. Secondly, the therapist must adequately contain and process his or her own evoked response in order to achieve a therapeutic response rather than a countertransference enactment. Hausner (1993) describes the clinical utility of trial identifications that must be recognized and tolerated in order to achieve empathic understanding. Victims of violence evoke anxiety in the clinician, resulting in resistances to identification and reaction against identification (Hoppe, 1967). In addition, evaluation of a battered woman in any clinical setting has the elements of a crisis setting that conspire to create pressure on the professional to act rather than think (Hausner, 1993).

Clinical effectiveness depends in part on trial identifications, which are used by the clinician to increase empathy and understanding of the patient's experience. When faced with a battered woman, the clinician may be overwhelmed with conflicting sets of feelings and active resistance to identifying with her.

Additionally, common denial, minimization, and rationalization can interfere with offering adequate help. As with any complex and trying countertransference, the clinician's willingness to examine, understand, and manage his or her own responses is crucial to maintaining an adequate therapeutic stance. Three main countertransference responses that stand in the way of an adequate clinical response to family violence are described below: (1) Counteridentification, an unconscious and conscious rejection of identificatory impulses; (2) countertransference rage against the assailant; and (3) countertransference helplessness combined with anxiety heightened by the realistic danger to the patient. Each of these results in greater defensiveness and less capacity for containment of the patient's and the clinician's anxiety by the clinician.

### Counteridentification

Counteridentification, or the need to establish difference and distance between oneself and another, is a defense against identifications that evokes strong anxiety. Intense anxiety can be evoked within the clinician faced with a victim of violence when cherished unconscious beliefs about the degree of control one has over one's safety are challenged. M. Symonds (1975) describes the phenomenon of blaming the victim as stemming from a basic need for humans to find rational explanations for brutality. The most common form of counteridentification against battered women is the mistaken application of the label "masochistic" to her.[e] With one stroke, the violence has been explained by reference to the victim's personality, her psychopathology is seen as the cause of her victimization, and the anxiety evoked in the clinician by her suffering is reduced. A. Symonds (1979) finds two bases for the myth of masochism in battered women: first, the universal human tendency to reject and blame the victim, and second, Freud's theory of masochism in women. She described the myth of masochism as based on a dynamic explanation: Women are being beaten because they seek out violent men. They seek out and stay with these men because they derive satisfaction from suffering. This explanation ignores the extent of wife battering and the high likelihood that batterers have a history of violence prior to entering the relationship (A. Symonds, 1979). In addition, the use of the explanation of masochism has not been recognized as evidence of the clinician's defense against the human anxiety associated with facing a victim of an assault by an intimate family member (M. Symonds, 1975).

Because of advances in our understanding of the effects of traumatic events on victims of severe trauma, we now know that chronic abuse causes serious psychological harm. Therefore, we should not assume preexisting psychopathology in those who demonstrate severe psycho-pathology after severe trauma. "While some battered women clearly have major psychological difficulties that render them vulnerable, the majority show no evidence of serious psychopathology before entering into the exploitative relationship" (Herman, 1992, p. 116). Ordinary, psychologically healthy people can become trapped in prolonged abusive situations and suffer severe and crippling psychological consequences. For example, hostages are known to develop pathological

attachments to their captors.[f] Instead of conceptualizing the psycho-pathology of the victim as a response to an abusive situation, clinician's have frequently attributed the abusive situation to the victim's presumed underlying psychopathology. Locating the cause of the victimization in the battered woman enables us to maintain our self-protective belief that we can prevent such misfortune from befalling us. This defensive maneuver also allows us to avoid dealing with the questions raised by the extent and frequency of abuse of women by their male partners and husbands and by cultural complicity in the continuation of that abuse.

A blaming and/or rejecting response is likely to actively contribute to the stress and trauma of the battered woman, as she is simultaneously held responsible for her husband's violence and is helpless to prevent his assaults on her. These attitudes and defensive responses result in the clinician asking the victim judgmental questions such as, "Why did he do that to you?" or, "Why don't you leave?" Difficult as one might find it to believe, counselors and ministers (and physicians!) continue to advise women to keep a better house or make sure dinner is hot, urging them to understand why their husbands are so angry with them, or teaching them communication skills (S. Hanks, personal communication).

Clinical vignette: A 38-year-old married woman with two children went to her male physician with a broken and badly bruised arm. He asked her in an angry voice, "What did you do to make your husband so angry?" He then told her that "no man would do this to his wife without a good reason." (L. Morales, personal communication, 1994).

Statements such as this support the illusion that the woman controls her husband's or lover's violent behavior. She may agree with the mistaken belief that she is in control. As a result of intermittent reinforcement, she has been trained to believe she can control violent outbursts on his part. She is also motivated to believe in her control as a defense against petrifying terror. When she is seen in the emergency room or after a suicide attempt, her omnipotent illusions of control have been shattered and she is more open to accepting her inability to control her husband's or lover's violence. It is therefore very damaging to have a professional reassert her omnipotence by treating her in any way that implies her responsibility for the violent outburst.

The distance achieved by these defensive maneuvers restores the clinician's feeling of safety, but reduces his or her clinical effectiveness. By defending against trans identifications, the clinician loses a valuable tool for establishing a therapeutic alliance and empathic understanding of the patient.

### **Countertransference rage and helplessness: Projective identification in the evaluation of battered women**

Projective identification is a complex process with both interpersonal and intrapsychic elements. Ogden (1982) described projective identification as the patient's complicated and multifaceted projection of unacceptable personal aspects of himself or herself into the therapist, who then becomes unconsciously identified by both patient and therapist with those projected aspects of the patient. In addition, the patient acts in ways that bring subtle and not so subtle pressures

to bear on the therapist to enact the identificatory elements. The patient is relieved, for the moment, of the pressure of the projected experience while the therapist identifies with those projected aspects of the patient.

When we ask women if someone is hurting them, we may be outraged and horrified at the descriptions of the battering. Women are struck with hands, fists, and tools; are choked, slammed against walls, beaten in the abdomen and breasts, sexually assaulted, stabbed, shot, imprisoned, and forced to watch their children and pets being abused; and their property is destroyed. Many battered women exert fierce control over their own rage. They have seen and felt what uncontrolled rage can do, and are often terrified of their own rage toward the perpetrator. The woman may appear dispassionate or minimize what she is reporting, as we feel her rage via projective identification (Hanks, 1993). The clinician may feel overwhelmed by horror and rage against the assailant.

In a study of psychiatric inpatients, Carmen, Rieker, and Mills (1984) found that female victims of abuse directed aggression against themselves in overt as well as covert ways, but did not usually acknowledge rage against their abusers. The apparently passive or impassive battered woman may be warding off rage out of fear of losing control of her own violence, and may project her rage into the clinician.

Containing the rage and horror is essential to forming a therapeutic alliance with the battered woman. If the therapist acts out the patient's rage, the patient is left holding only her feelings of love, empathy, and protectiveness toward her abuser, whom she will view as needing protection from the enraged therapist. Hanks (1993) recommends that any therapists working with battered women balance their caseload with assailants, in order to avoid overidentification with either. (The converse is obviously necessary as well.)

Severely battered women can develop a sense of helplessness in the face of overwhelming and unpredictable violence. Similarly, clinicians faced with a battered woman who feels--often realistically--trapped by economic, emotional, social, and psychological circumstances may experience the same helplessness and hopelessness that the patient is feeling. Her fear may be read as passivity or ambivalence. She may be struggling to predict the consequences of "telling" and assessing her degree of danger, as the helping professional becomes impatient and frustrated with what is mistakenly labeled denial, lying, or protectiveness.

Paralysis resulting from the fear that any action may increase the danger is a common feature of victimization (cf. Herman, 1992; Hilberman & Munson, 1977-1978). Clinicians must be able to tolerate both the patient's and their own feelings of helplessness without becoming controlling or sadistic.

Overidentification with the patient can result in wishes to rescue her or to take over for her. Or, the opposite can occur if the therapist develops a sadistic countertransference to the battered woman's state of traumatic infantilism (M. Symonds, 1975) and harshly rejects her. This can occur if the clinician finds unbearable the combination of terror and helplessness that the battered woman experiences (Hilberman & Munson, 1977-1978) and inspires. Both overidentification and harsh rejection can prolong dependency, worsen the patient's experience of helplessness, increase her shame, and undermine the

development of a therapeutic alliance.

The literature on victims explicitly recognizes that those who have been traumatically victimized must be able to make decisions if they are to combat the paralysis resulting from terror. This helps reduce shame, self-blame, and learned helplessness (cf. Herman, 1992). A harsh, rejecting stance can increase the patient's self-blame and increase the sense that the batterer is the only secure (though highly dangerous) object, while an omnipotent, controlling stance can further deplete the patient's sense of agency and self-esteem.

By thinking about and understanding these reactions rather than acting on them, one can be in a better position to understand both the realistic dangers to the woman and the psychological interference with her capacity for self-protective action. Consultation and the support of a working group are also very helpful in preventing burnout and/or loss of perspective (Hanks, 1993). Also crucial is information and understanding of the causes and effects of abuse as well as familiarity with community resources (Council on Scientific Affairs, 1992; Feldman, 1992) and a firm, expressed conviction that violence is an unacceptable solution to family problems.

### Dangers to the children

Children who witness violent assaults on their mothers are at greater risk for cognitive problems, social problems, behavior disorders (boys), depression and increased aggression (boys), and higher likelihood of suffering violent assaults (girls) (cf. Rosenbaum & O'Leary, 1981). Those children who are also attacked by their fathers or their mothers' male partners are at even higher risk for psychological, academic, and social problems (cf. Hughes, 1988). Additionally, children exposed to marital violence are more likely to both consider violence an appropriate means of solving conflict and to use violence themselves (Jaffe et al., 1989).

The developmental stage and the gender of the children who witness marital violence influence the effects of the violence (Jaffe et al., 1990). Infant witnesses are characterized by "poor health, poor sleeping habits, and excessive screaming" (p. 40). Preschoolers display hiding, shaking, and stuttering, as well as excessive irritability and yelling. Younger children in shelters have more somatic symptoms as well as behavioral regressions, such as loss of toilet training (Jaffe et al., 1990). Fantuzzo and coauthors (1991) reported that conduct problems and emotional problems were associated with verbal and physical violence in the home; when the families were in shelters, presumably with a group of children exposed to higher levels of violence toward their mothers, the children were also found to have lower levels of social functioning.

By the time these children enter primary school, gender-related differences surface. Boys are more disruptive, more aggressive, and throw severe temper tantrums. Girls are more likely to become withdrawn, passive, and clingy, as well as to display a wide array of somatic symptoms. As girls mature, they are more likely to be victims of physical violence from boys they date than are girls from nonviolent homes. Boys are more likely to be physically violent to the girls they date and later marry.

Older children and adolescents have learned to accept and expect violence. They may blame their mothers for the violence and resist her efforts to leave. In shelters, teenagers have been noted to exert pressure on their mothers to return home. Aggression may be the adolescent's main problem-solving strategy, and many have been known to join their fathers in beating their mothers after years of witnessing violence. Anxiety symptoms such as nail-biting and hair-pulling are common, and adolescents from violent families often run away.

Pregnancy is no protection against being battered by male partners. In fact, pregnancy appears to increase the risk of battering. Saltzman (1990) found that 154 out of 1,000 women were assaulted during the first four months of a pregnancy, and 170 out of 1,000 were assaulted by their partners during the fifth through ninth months (cf. Gelles & Straus, 1988).

The negative effects on children from violent homes are likely to be multifactorial. Mothers are generally the primary parents in U.S. families. Battering by husbands has serious negative consequences, physical and psychological, for the female victims. Depression, dissociative states, anxiety, and somatic symptoms are common secondary consequences of marital violence. There is a significant body of research in child development that documents the negative impact of mothers' depression on the development of their children (cf. Kochanska, 1991). The children depend on their mother's ability to buffer them from the negative effects of violence. As both her physical and psychological suffering increases, her ability to shelter her children decreases.

### **Inquiry about abuse in clinical interviews**

For a variety of reasons, including fear of the perpetrator, fear of intervention by authorities in the family, and shame, women rarely volunteer information about violent assaults on them by their husbands or boyfriends. Because of constraints imposed by shame and fear, inquiry about domestic abuse requires the same tact and delicacy that clinicians practice with regard to other sensitive and anxiety-provoking matters, such as child abuse or suicidal ideation. As in any clinical interview, the patient's perceived safety will determine the degree of openness and cooperation with the interviewer. And the issue of safety has even greater relevance for a woman who is being beaten at home. First, any inquiry regarding injuries or assaults must take place outside of the presence and bearing of the possible assailant. Second, the type of question asked and the tone of the questions will influence the possible responses. It is essential to maintain an open, nonblaming stance when inquiring about family violence. For example, the question "Is your husband beating you up?" may elicit a protective or denying response, while an empathic comment such as "You seem frightened. Is anyone being hurt at home?" may elicit a more open response. Medical research clearly demonstrates that, contrary to popular belief, when asked in a nonjudgmental and empathic way, in a safe environment, women will disclose abuse (cf. Stuart & Campbell, 1989). One must not mistake her fear and the necessity for her to assess the risk to herself and her children for neurotic anxiety or ambivalence.

### **Clinical example**

A 39-year-old Caucasian married woman was referred for individual treatment following one year of couples therapy with an experienced psychologist. The couples' therapist informed the individual therapist that the couple had intractable

difficulties in communication that had brought the treatment to a halt. She felt that they could not improve their relationship without making changes individually. They were described by the referring therapist as disagreeing about family finances and child-rearing style.

In the initial interview with the patient, the therapist noted her flat affect and slumped posture. Also prominent was a quality of circumspection in her report of her marital difficulties. She informed the therapist that she was afraid of her husband because he gets so angry and that he had convinced a prior couples therapist that she was abused as a child and that is why she is afraid of him. She does not feel she was abused. She reported that their couples therapy had not been helpful because all she could do was cry and her husband was articulate and convincing. She felt she could not adequately represent her concerns to the couples therapist. When asked what she was afraid of, she reported that her husband gets really angry and yells and that he gets "in my face, yelling at me that I shouldn't be afraid of him." She described him in a very loving way as having been abused as a child, having had a disrupted childhood, and having been treated very badly by his own mother. At this point, the therapist noted her depressed appearance, her protectiveness toward her husband, her description of possible rage attacks on his part, and the implication from her description that he was responding with rage to fearfulness on her part. The next question was, "Has your husband ever hurt you?" She quickly responded, "He has never hit me." The therapist pursued the issue by softly asking again, after nodding in response to her protective statement, "But, has he ever hurt you?" She became anxious and slightly agitated and told the therapist that he had hurt her a couple of times. As this information was further explored, with gentle questions asking for details, the information about the abuse was slowly articulated. He had pushed her against walls, slammed her down on furniture, bruised her arms and breasts, stood on her toes to hold her close while yelling at her, and held her next to him as he raged with threats that he would kill her if she moved. Eighteen months prior to this interview, she had called the police when he was abusing her. They had not reported any of this abuse to the couples therapist, and she claimed that she had not been asked about abuse, in spite of the red flags that were apparent to the individual therapist. This was verified by the couples therapist, who was surprised and dismayed to learn of the violence. The therapist came to understand through her work with this patient that the patient had tried to clue in the couples therapist to the violence at home, but had not directly informed her, both because of her fear of the consequences at home, should she tell, and because of her protectiveness toward her husband.

It is up to clinicians to help patients communicate directly and to be attuned to anxiety about disclosure of uncomfortable issues. We don't leave it up to patients to inform us without help about suicidality, and we should not leave it up to them to inform us about family violence. When we suspect violence, we have to ask about it persistently and gently. In addition, we have to raise our index of suspicion in response to information about the ubiquitousness of family violence in the clinical histories of our female psychiatric patients.

Jacobson and Richardson (1987) recommend that all psychiatrists develop their own set of routine questions regarding family violence to be included in any clinical interview. Following are examples illustrating the necessary points to

cover:

Ask first about circumstances. Who, what, where, when, and how long are reasonable, specific, and concrete questions.[g]

Ask about perceived effects. Were you frightened, were you hurt, and did you tell anyone?

Ask about specific levels of assault, including sexual assault,[h] keeping in mind that our patients, like ourselves, are not likely to define violence at home in the same language as violence between strangers. For example, if you ask a woman if her husband has raped her, you are less likely to get accurate information because most people do not define forced sex between marital partners as rape. If you ask her first, "Have you ever had sex with your husband when you didn't want to?" and then, if she says yes, follow that with the question, "Were you physically forced to have sex[i] or to perform sexual acts against your will, or by threats of harm?" more accurate data will result.

When any violence in a family is identified, it can be considered a risk factor for other forms of family violence, and must lead to further assessment.

When abuse is occurring, it is appropriate to aid the woman in assessing the level of danger to herself and her family. Stuart and Campbell (1989) recommend informing abused patients about risk factors that have been associated with eventual homicide in wife-battering relationships, including: controlling behavior such as forbidding the woman to have friends or to visit family; sexual jealousy; threats of suicide by the partner; and murder/suicide threats.

### **When should we be asking? The case for routine inquiry**

While the focus of this article is on emergency medicine in psychiatric and medical emergency rooms, the guidelines for inquiries about family violence presented below are applicable to any medical practice, from family practice to psychiatry, psychology, and social work.

In addition to the years of recommendations from the American Medical Association for routine inquiry about family violence, since January 1992, emergency rooms have been required by Joint Commission on Accreditation of Health Care Organizations (JCAHO) to have protocols for inquiry about domestic violence. As of January 1994, hospitals in California are legally required not only to routinely inquire about family violence, but also to report domestic assault to the district attorney.[j]

A list of symptoms that may occur in women who are being beaten by their husbands is presented in Table 1. As is evident, almost any complaint that women bring to their physicians, psychiatrists, and emergency-care practitioners can be an indicator of abuse. Ranging from unexplained traumatic injuries, to affective and anxiety disorders, to somatic problems, sleep disturbances, drug or alcohol abuse, and chronic pain, the list is so inclusive that one rapidly reaches the conclusion that it makes sense to inquire about domestic violence as part of every routine clinical exam.

### **Once you know, then what?**

Most importantly, the physician must not expect to be able to solve the problem and must not be discouraged from offering aid by the realization that the problem

is unlikely to be solved in any rapid, clear way. Given this reality, physicians can take certain steps that will help:

The physician can validate the woman's experience and sequelae by providing information about the frequency of victimization, the negative effects, the danger to her children, and the physician's professional opinion that, "no matter what," people should not be hurt and afraid in their homes. When the victim excuses her husband's violence, it can be very helpful for a physician, in a nonpunitive and nonjudgmental way, to empathize with her feelings for the batterer and to firmly state that understanding does not equal justification for his violence.

Treatment of acute symptoms and/or injuries can be initiated.

Documentation of the abuse will facilitate future interventions as well as provide support for legal measures, should the woman choose to pursue those.

The patient must be aided in assessing and planning for her own safety and for her children's safety, whether her immediate plan is to leave or to go back.

Appropriate referral information should be available in all clinical settings, including community resources for legal aid, emergency shelter, children's services, and support groups for battered women.

Legal requirements regarding reporting of abuse in the respective states and communities must be met (cf. Council on Scientific Affairs, 1992; Feldman, 1992; Hendricks-Matthews, 1992; Randall, 1991).

While the most appropriate model of intervention may not be one of control, but of increasing the patient's ability to protect herself and her children, the physician may be constrained by legal requirements and/or concern for the physical safety of the woman and her children. Flitcraft, in an interview with Randall (1990), noted that "the very acknowledgment that domestic violence is going on and that you and she agree it is a serious problem, is a very powerful and therapeutic first step" (p. 943). One of the most important questions a physician can ask a woman who is being beaten is, "Are you safe at home?" All of us must begin asking.

a In any case, the woman leaving solves her problem, but not his. He will go on to batter another woman.

b For a review of lethal outcomes of wife battering, see the Council on Scientific Affairs (1992).

c For a thorough discussion of the application of attachment theory and a grief model of marital separation to battered women, see Campbell (1989).

d For the purposes of this article, I will be using countertransference to mean the whole of the therapist's attitudes and behavior toward the patient, including those in consciousness. For a lengthier discussion of the history of the concept and current usage, see Tyson (1986).

e Snell and coauthors (1964) wrote a classic article called "The Wifebeater's Wife: A Study of Family Interaction," illustrating the use of the concept of masochism to blame the victim of battering for her husband's violence. They considered her improved when she no longer sought protection from his violence and when she submitted to demands for sex under any circumstances, including the husband's drunkenness and/or violence.

f For detailed discussions of the similarity of battered women to concentration camp victims, hostages, and prisoners of war, see Herman (1992).

g Giving in to our wish to ask why is a manifestation of countertransference. To ask her, "Why is he hitting you?," places the onus on her to explain his violence and will interfere with the development of a therapeutic alliance.

h Studies of battered women have demonstrated that the incidence of sexual assault is very high (22-50%).

i For a detailed analysis of rape in marriage with case examples, see Finkelhor and Yllo (1983).

j Anecdotal suggest that the requirement to report in the absence of safeguards has had a chilling effect on female victims, who have become reluctant to seek treatment for injuries.

### **Table 1. Clinical indicators of abuse**

1. Depressive symptoms
2. Suicidal ideation or attempts
3. Anxiety symptoms
4. Chronic pain in back, pelvic region, chest, or neck
5. Unexplained traumatic injury
6. Fractures in various stages of healing
7. Somatic disorders, such as sleep disturbance, appetite disturbance, and gastrointestinal problems
8. Alcohol or drug abuse
9. Chronic use of pain medication or sleeping pills
10. Child abuse, by either parent
11. Alcohol abuse or depression or antisocial personality disorder in husband
12. History of abuse in either partner

Sources: Feldman, 1992; Hendricks-Matthews, 1992; Veltkamp & Miller, 1990.

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