Battered wives—measures by the social and medical services

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Summary: The social files and medical records of 98 acutely battered wives who attended a surgical emergency department were studied. Although all women had been hospitalized during the decade preceding the present incident, wife battering was documented in the records in only 18%. The majority of the women (73%) were also known to the social services, but battering was documented in less than half of the cases in the social service files. The measures taken by the social services to help the battered women consisted mainly of economic support and psychotherapy. The cooperation between the medical and social services and the police in cases of wife battering was very limited or non-existent.

It is concluded that support given to battered women by the formal sources of aid is insufficient. The documentation of the cases is poor, there is a lack of practical measures and the cooperation between the authorities is limited. This study indicates that the social and medical services underestimate the importance of informal help sources like women's groups or shelters which often are the most valued resources by the battered women themselves. With improved cooperation between authorities and between formal and informal sources of aid the battered wives could be helped more effectively.

Introduction

Family violence has aroused increasing interest during the last two decades. The social situation of the battered wife has been described in a large number of studies.^{1–3} It has been claimed that the battered wife is a high consumer of both medical and social services.^{4,5} However, far from every battered woman makes use of these services. Not every battering episode will bring the woman to hospital. In a study made in Kentucky, USA,⁶ 79 assaults out of 882 were serious enough to require medical attention. In Gayford's study,⁷ only 11 out of 81 battered wives (14%) who left their partners, went to hospital. The corresponding proportion in Appelton's study⁸ of 219 battered wives was 12%. In that study relatives and friends were used as a source of aid by 62% of women, the police by 24% and the church by 8%.

A lot of criticism has been raised against the performance of the legal system and the social and medical services when dealing with battered wives.^{5,9,10} However, few studies of marital violence have examined the nature of the help received by battered wives and its effectiveness in reducing or eliminating the victimization.¹¹ In a national United States survey,⁵ covering about 1000 repor-

ting subjects, the police were the most often used source of help (53% of the battered wives had reported the incident to the police at least once). The second most common source of help was the social services and counselling agencies (50%), followed by lawyers (43%) physicians and nurses (39%), clergy (33%), women's shelters (26%), women's groups (21%) and district attorneys (14%). When asked to judge the effectiveness of these sources of aid the women's groups were judged to be very or somewhat effective by 60% and women's shelters by 56%. The corresponding figures for the other sources were lower.

In Sweden there are three formal sources of aid that meet battered wives in the acute situation: the police and the medical and social services. These resources are under society control. The informal help sources are privately organized. In Stockholm, as in other major cities there are women's groups and shelters. They sometimes receive economic support from society but are not under society control.

The formal and informal help sources are allowed to discuss cases only after permission by the client. Battered wives are free to choose either formal or informal help sources or any combination of these. To some extent each source of aid has its unique resources but some important measures, like supportive counselling, could be given anywhere.

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The aim of the present study was to describe the use of formal sources of aid by battered wives in Sweden and to describe the measures taken by the services and the co-operation between them.

Methods

During an 8-month period in 1983–84 all battered wives who attended the surgical emergency department at Huddinge Hospital with injuries due to battering were identified. The present study is based on register data on the total number of battered wives identified during the study period. Data regarding consumption of out-patient care by the battered wives and the controls during the 5-year period preceding the present battering episode were obtained from the Stockholm County Council computer files. Medical records were studied with regard to wife battering documentation and reports to the social services. Sociodemographic data were collected from the population register.

A medical social worker specially assigned to the research project studied the battered wives' social files at the social welfare offices to which the women were known. She studied the files covering the decade preceding the present battering episode regarding data on measures taken by the social services to help the battered women. Information about the women's social situation, ways of contact with the social welfare office and between the office and other authorities was also collected. Copies of police reports on family violence, which are generally sent to the social welfare office and included in the files, were studied. Finally data were collected from a more extensive social and psychiatric analysis, including interviews and tests, made on 49 of the battered women.¹²

Material

During the 8-month study period a total of 98 battered wives was identified. The assailant was their husband or steady partner. The mean age of the women was 33 years (range 18–63). The assailants were, on the average, slightly older: 36 years (range 19–59).

An age-matched group comprising 98 women from the same sociodemographic region was selected from the population register as a control group. The total group of controls was studied by register data regarding marital status, birth place and consumption of in- and out-patient care. Forty nine controls underwent a more extensive psychosocial analysis with interviews and tests.

One third of the 98 battered wives had more severe types of injury (fractures, concussion, eardrum perforation, thoracic or abdominal trauma).

Half of the battered wives were admitted to the department of surgery, sometimes on medicosocial grounds. Eleven of them were referred to the department of psychiatry after termination of surgical care. Three developed paranoid psychotic conditions.¹²

The battered wives also showed a significantly higher consumption of in-patient care during the preceding 10-year period. This was the case both regarding psychiatric and somatic hospital care. The most common reasons for hospitalization were undefined somatic and psychiatric disorders, suicide attempts, and abuse of alcohol and drugs. These findings have been reported previously.⁴

Results

Sociodemographic data

The battered wives constituted 8% of all the women who attended the surgical emergency department for injuries during the 8-month study period. There were more foreign-born women in the battered group (49% versus 18%). There were also more divorcees among the battered wives (42%) than among the controls (13%).

The more extensive social and psychiatric analysis made, concerning half of the battered wives and controls, revealed some interesting differences (Table I). Thus there were no great differences concerning children living at home, occupation or housing conditions between the battered wives and the controls. The unemployment rate was lower among the latter, however. The history of battering was dramatically different in the two groups with 94% of the battered wives being battered repeatedly compared to 6% of the controls. There was a correlation between repeated battering and heavy alcohol consumption by husband or partner, a greater number of previous male cohabitants and a lack of close friends. These findings have been extensively discussed in previous reports.^{4,11,12}

Previous contacts with the medical and social services

The battered wives had a significantly higher consumption of out-patient care during the 5 years preceding the present battering episode, compared to the controls (Table II). This was true regarding both primary health care and treatment in out-patient departments. In the hospitals, the women's need for surgical care was most pronounced. One quarter of the total number of out-patient attendances by the battered wives were emergency ones.

All the battered wives had been in contact with the medical care service on at least one occasion

Table I Sociodemographic characteristics and history of battering in battered wives and controls

	<i>Battered wives (n = 49)</i>	<i>Controls (n = 49)</i>
Age	33	33
Children living at home < 18 yr	28 (57%)	28 (57%)
Occupation	30 (62%)	30 (62%)
unemployed	11 (22%)*	3 (6%)
others, not gainfully employed (students, house-wives etc)	8 (16%)	16 (32%)
Housing		
own, permanent	38 (78%)	40 (82%)
temporary, institutional lodging etc	11 (22%)	9 (18%)
Battered at some time	49 (100%)*	12 (24%)
Battered repeatedly	46 (94%)*	3 (6%)
Husband/partner heavy consumer of alcohol	43 (88%)*	3 (6%)
Number of previous male cohabitants (range)	2,3 (1–7)*	1,2 (0–3)
At least one friend	25 (51%)*	41 (84%)

* $P < 0.05$; *** $P < 0.001$ **Table II** Number of attendances at out-patient care services by battered wives and controls during the 5 years preceding the present assault

<i>Out-patient care services</i>	<i>No. of atten- dances by bat- tered wives (n = 98)</i>	<i>No. of attendances by controls (n = 98)</i>
Primary health care	205* (27%)	91 (46%)
Hospitals		
Psychiatry	87* (11%)	14 (7%)
Surgery	296* (39%)	39 (20%)
Medicine	94* (12%)	25 (13%)
Gynaecology	84* (11%)	27 (14%)
Totals	766* (100%)	196 (100%)
Emergency visits	189 (25%)	45 (23%)
Visits per woman	7.8*	2.0

* $P < 0.001$

during the 5-year study period. Wife battering was documented in the medical records of 18 of these women (18%). Seventy-two of the battered wives (73%) were known to the social services and wife battering was documented in 43% of the social

service files (Table III). The women had generally been in contact with the social services on repeated occasions over several years. Further problems documented in the files were alcohol abuse, which appeared in one third of the battered wives, and drug abuse, which appeared in one tenth (Table IV). According to the social service files, child abuse was very unusual (3%)

Measures by the social services

Acute Thirty-one women were known to have been battered according to the social files. The acute measures taken by the social services included supportive counselling (25 women), referral to a hospital emergency department (9 women), arrangement for temporary housing (8 women) and report to the police (2 women). Thus some women figured in several measures.

Long-term The long-term measures taken by the social services on behalf of the entire group of 72 battered wives known to them mainly involved economic support (85%) and psychotherapy (50%) (Table V). Less common measures were

Table III Knowledge and documentation of wife battering by the medical and social services concerning the battered wives ($n = 98$) who attended the surgical emergency department

	<i>Medical services</i>	<i>Social services</i>
Battered wives known to the services	98* (100%)	72 (73%)
Wife battering documented in the files/records of the services	18* (18%)	31 (43%)*†

* $P < 0.001$; † percentage calculated on $n = 72$.**Table IV** Assaults on the battered wives known to the services, child abuse in the family and substance abuse by the wife and husband

<i>Documentation in social service files concerning:</i>	<i>Battered wives (n = 72)</i>
Wife battering	31 (43%)
Child abuse	2 (3%)
Alcoholism in woman	21 (29%)
Alcoholism in man	7 (10%)
Drug abuse in woman	6 (8%)
Drug abuse in man	4 (6%)

Table V Measures by the social services to help the battered wives known to the services during the 5 years preceding the battering incident in question

Measures	Battered wives (n = 72)
Financial support	61 (85%)
Psychotherapy or counselling	36 (50%)
Practical arrangements (women's hostel, day nursery, housing)	21 (29%)
Treatment in institution for woman (family care, treatment home, etc)	18 (25%)

The same woman may have figured in several measures

different practical arrangements, such as helping the women to move to a new flat or to arrange day care for their children (29%). One quarter of the women had been referred to a treatment home. The main reason for this was alcohol and drug abuse by the woman. Fifty-four of the 72 battered wives (75%) known to the social services had children under 18 years of age living at home. In 17 of these families (31%) the social services had initiated an investigation of child neglect or abuse which resulted in a temporary placement in a foster home in eight cases (15%). The reason for this measure was intraparental violence (five cases), mental insanity in the parents (two cases), child abuse (three cases), and behavioural disorders in the child (two cases).

Ways of contact with and between authorities

Fifty-three (73%) of the women known to the social services had initiated the contact themselves. The remaining 19 (27%) had got in contact with the service after a report from other authorities, neighbours or relatives. These women had been reported on a total of 35 times. The police authorities were responsible for twelve reports, relatives for nine reports, neighbours for eight reports, day nurseries for four reports and a social service in other parts of the city for two reports.

The flow of information between the medical and social services and the police authorities is illustrated in Figure 1. Thus, in only two of the 18 cases when wife abuse was documented in the medical records had the medical service reported the situation of the women to the social service. The social worker, on the other hand, had accompanied the battered woman on nine occasions to the hospital emergency department and helped her to report the incidents to the staff. The police had made 12 reports to the social services and in two cases the latter had reported the incident to the police. There had been no contacts between the medical service and the police.

Figure 1 Number of reports between the police, social and medical services on wife battering involving the battered women (n = 98) during the five years preceding the battering episode in question

Discussion

In the 1970s the community organizations that traditionally provided assistance to the general public—such as the police and the medical and social services—were considered to have a limited interest in family violence. Violence within the family was often regarded as a 'private event' and battered wives were generally not given proper protection. During the last decade the awareness of the problem has increased tremendously. Women's shelters and women's groups have been established, and in Sweden and in other countries there has been a reformation of the legislation in this field and social workers have become increasingly engaged in the problem. It was during this period of dynamic changes that this study was made.

The high consumption of in-patient medical care by the battered wives in this study has been described in a previous report.⁴ The same pattern was seen in out-patient care concerning both general practitioners and hospitals. The battering was documented only to a very limited extent, however, in the medical records and probably was unknown to most doctors. There is a considerable risk that doctors and nurses will not see the underlying problem that brings the battered wife to the consultation. With an increased awareness of wife battering the medical staff could probably improve their charge of the patients.^{14,15} Almost three quarters of the patients were known to the social services, which is a much greater proportion than expected. Other studies indicate that 10–20% of Swedish women of comparable ages have been in contact with the social welfare services.¹⁶ There are, however, no official statistics on the proportion of women known to the social services in Sweden. Compared to the national US survey⁵ in which 50% of the battered wives had sought help at the social services, the figure in the present study is higher but not incompatible. However, battering was documented in less than half of the social service files. This might of course reflect the fact that battering was not the only reason for the women to contact the social services. It might also indicate that documentation is incomplete, i.e. the social worker knows about the battering but does not document it. In some cases the battered wives probably did not reveal the abuse to the social worker. In these cases the social worker was

prevented, like the medical staff, from taking the most appropriate measures for the woman.

The proportion of alcohol abusers among the battered wives was quite considerable according to the social services files. Alcohol and drug abuse was probably over-represented among the battered wives known to the social services. This finding is in contrast with most American studies which indicate that fewer than 10% of battered wives abuse alcohol and drugs.¹⁷⁻²⁰

Child abuse was very rare according to the social service files. However, previous studies have shown that at least one third of the children of battered wives are battered too. In most cases the batterer is the same man who batters the woman but in some cases the battered woman herself beats her children.^{21,22} Some of the battered wives in the present study probably concealed the information about child abuse from the social worker. The reason could be that this type of information might initiate an investigation into child abuse and neglect in the family and that the woman's adequacy as a keeper of the child is called into question. In some cases the social worker might even choose to leave this information out of the files in order to be less restricted in her action.

Although child abuse was documented very rarely, the social services had initiated an investigation into child abuse or neglect in one third of the cases of women with children. The reason for this was generally found in the parental generation and less frequently in behavioural disorders of the child. However, several studies have indicated that children who witness intraparental violence are damaged psychologically even if they are not battered themselves.²⁴⁻²⁶

The most common acute measure taken by social workers when they encountered a battered wife was to talk to her. She was probably given moral support and practical advice. More seldom, however, the social worker helped her with practical matters like temporary housing and reporting to the police. The possibilities for the social welfare system to give acute assistance are limited, however, since most cases of wife battering occur during the night and weekends.^{22,23} The long-term measures taken by the social services consisted mainly in giving support, both through psychotherapy and through financial assistance. It should be observed, however, that these measures were not only prompted by the fact that the women had been battered. In most instances they probably had very little to do with the maltreatment and are rather indicators of these women's generally unfavourable social situation. Another indicator of the vulnerable position of these women was that one quarter of them had been sent to a treatment

home, generally because of alcohol or drug abuse.

Most women had contacted the social service themselves, which is the normal mode of contact in Sweden. A minority, however, had been reported on repeated occasions by other authorities, neighbours or relatives. These women probably represented an even more socially handicapped group with ongoing alcohol and drug abuse.

The batterer was very seldom contacted by the medical or social services. If the male is informed that his wife or partner has pleaded for help from any external help source the risk for repeated violence will increase. For that reason, the battered women themselves very often prohibit the authorities (as well as medical and social services) from contacting the batterer.

In some cases the batterer himself contacted the services and wanted to initiate supportive counselling together with his wife. Generally, however, these men are uninterested in support. They often trivialize the battering and do not regard it as a crime. The batterer's psychosocial and biochemical characteristics will be discussed in future reports.

Battered wives receive help from a large number of sources. In an inascertainable number of cases, however, their need for help is not met by the authority or service to which they turn. This study has elucidated the situation in Sweden concerning the formal sources of help organized by society. Cooperation between different authorities is very limited. Even more obvious than the lack of cooperation between these authorities is the total absence of recommendations concerning informal help, such as women's groups or shelters. These resources are of great value and are considered by many battered women to be the most effective means of stopping the battering.⁵

The idea of special shelters for women living with violent men is quite new. The first one, Chiswick Women's Aid, was founded by Erin Pizzey in 1972. From Chiswick the idea spread all over England and the rest of the world. These positive experiences have been documented by Pizzey^{27,28} and the situation of battered women staying in Chiswick's Aid has been described in the scientific works by Gayford.⁷ However, in the present study there was no documentation in the files or records indicating that women's shelters had been discussed.

The division of help sources in the community being both formal and informal might be a potential for the battered women but it is necessary that services, authorities and women's shelters have knowledge of and trust in each other. A proper cooperation would improve the general situation of battered wives seeking support in their vulnerable situation.

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