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Battered Wives and Medical Service:

An Exploratory Study of Wife Assault Victims' Experiences in Nova Scotia Health Delivery Settings

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ABSTRACT

This essay examines the experiences of forty-eight wife assault victims within medical settings. Various qualitative features of the doctor-patient encounter were explored by using a closed-ended questionnaire. The survey data revealed that the physician's knowledge of the spousal abuse impacted little on the provision of physical examinations and the rate at which psychoactive drugs were prescribed. This paper postulates that discomfort with the subject of wife abuse, the frequency with which psychoactive drugs were dispensed, and some physicians' failure to inform patients of the side-effects of psychoactive drugs, impact negatively on the quality of care abused women received.

RÉSUMÉ

Notre étude porte sur les expériences de quarante-huit femmes mariées, toutes victimes d'une agression. Notre lieu de recherche était les cabinets des médecins responsables des soins médicaux. Notre démarche consistait à examiner, grâce à un questionnaire à questions ouvertes, certains des aspects qualitatifs du rapport entre le médecin et sa cliente. Notre sondage a démontré que la connaissance des circonstances influençait très peu le médecin quant à l'offre d'une consultation médicale et à la prescription de drogues psycho-actives. Nous soutenons que la qualité des soins que les femmes battues reçoivent est inversement affectée par le malaise des médecins à l'égard des femmes battues, la fréquence avec laquelle ces drogues sont prescrites, et le fait que les médecins ne préviennent pas toujours leurs clientes des effets indésirables de ces drogues.

Introduction

This essay explores, through survey interview data, the experiences of wife assault victims within medical settings. The medical settings to which we are referring here are, in order, the offices of general practitioners and, less commonly, hospital emergency and outpatient departments. The response of health delivery professionals, especially doctors, to battered women is very important since it is within this arena that the victims may first appear in public for treatment. It is hoped that in medical settings battered women will feel able to discuss the violence done to them, perhaps the first time, as a consequence of the degree of confidentiality assumed in the doctor-patient relationship (Lewis, p. 6). Opportunities for victim disclosure otherwise may be rare since, on the one hand, secrecy is an all-too-frequent aspect of abusive family relationships and, on the other hand, the victims' external, social and emotional support systems (e.g., family and friends) have been destroyed (Boulette and Anderson, p. 661). Our concern with battered women's experiences within medical settings arises, in part, from these factors.

Spousal assault, as defined by the Ministry of the Federal Solicitor General, involves the intentional use of verbal threats of physical injury or the actual infliction of physical injury by one spouse against another (Ellis, p. 158). Throughout this essay, the terms wife assault/wife battering are employed instead of the more benign expression spousal assault. Wife assault/wife batteri.ng are more accurately descriptive of what goes on than the term

"spousal assault." Women are much more frequently injured, much more seriously injured, and much more likely to be killed than are men in these relationships. Moreover, males as intimates/companions/husbands are generally the assailants (Ellis, 1987).

A central theme in the essay concerns the documentation and discussion of the extent to which doctors treated battered women's injuries and health concerns with various drugs, particularly those categories referred to as psychotropic or psychoactive. Psychotropic is a term normally used in reference to certain types of drugs, meaning that the substance exerts an effect upon the mind (*Dorland's Pocket Medical Dictionary*, p. 526). Psychoactive has a similar meaning in that it usually refers to drugs that affect the brain and influence behaviour (*Chambers Twentieth Century Dictionary*, p. 1085). These terms appear synonymously throughout this essay.

The essay opens with a brief note outlining our research methodology and procedures. This is followed by a description and analysis of our findings. The essay concludes with a discussion of the data presented relative to findings from other studies concerned with similar issues. Here, we also link this material to broader theoretical and conceptual issues regarding women and health delivery systems.

A Note on Methodology

The data in this study were derived from interviews with 48 victims of wife assault. All but four women in the sample were, at one point in time or another, residents of a safe-house and transition facility for victims of wife assault and their children. The aforementioned four cases were referred to the researchers by a satellite counselling service for battered women.

Between October 17, 1984, and January 28, 1988, the transition house has provided shelter for two hundred and sixty-six women. Of these, forty-nine have been documented as taking prescribed psychoactive drugs during their stay. Eighteen of these identified cases were interviewed, ten declined to be interviewed, and the researchers were unable either to contact or to locate the remaining twenty-one cases for reasons such as changes in place of residence and movement out of the region/province. Thirty additional interviews were obtained through a non-systematic selection of cases from the transition house files. None of these women had been identified as past or present users of prescribed psychoactive drugs.

The selection procedure intentionally over-sampled for women who were known to use prescribed psychoactive drugs. This was done since a central purpose of the study was to describe and examine the conditions and circumstances under which battered women were prescribed psychoactive drugs by attending physicians. Consequently, the sample is not systematically structured so as to be statistically representative of a larger population. Rather, it provides preliminary and exploratory information conducive to identifying patterns in women's experiences within health delivery settings.

The interview instrument consisted almost entirely of closed-ended questions; that is, questions requiring a yes/no response or a response from an all-inclusive choice set. However, in addition to several open-ended opinions and suggestions/recommendations type questions, the interviewer was encouraged to record, as directly as possible, the women's thoughts, descriptions and remarks regarding their experiences with medical services and health care delivery systems. This information, recorded on the interview questionnaire, was transcribed and used to put a "human face" on the medical setting experiences of battered women evident in the analysis of responses to the close-ended questions. This allows us to hear the voices of battered women and to remember that apparently sterile numbers describe lived experiences. The interviews were conducted between late fall 1987, and early winter 1988.[1]

The Findings

A. Background Characteristics

Forty-eight battered women were interviewed for this study. Table 1 outlines some background characteristics of the women interviewed. Sixty percent of these women were thirty years of age or older and all of them were at least twenty years of age. Forty-one of our respondents (85.5 percent) had achieved, at most, a high school level of education. Fully one in five (21 percent) reported having no more than a grade eight education. Only five (10 percent) had any post-secondary level education. Over seventy-seven percent of the women interviewed reported being unemployed. Of those employed (22.9 percent), most worked in low-paying part-time and/or seasonal jobs. In sum, the patterns evident in these three background characteristics suggest that the vast majority of the women interviewed are adult women with low levels of formal education, few job skills and little to no employment income. Minimally, for most of these women, this translates into material and personal dependency upon their

male companions. Such dependency places these women in a subordinate and vulnerable position relative to that of their copartners. Most of these women have few material and income support options other than their spouses. Consequences of this are amplified in several other background characteristics reported in Table 1.

Table 1

Background Characteristics by Selected Categories of Respondents

Characteristic	Categories		
Age	20-29 years 39.6%	30 years or more 60.4%	
Education	0-Gr. 8 20.9%	Gr. 9-12 64.6%	Post-secondary 10.4%
Employment Status	Employed 22.9%	Unemployed 77.1%	
Number Dependent Children	None 14.6%	1-2 45.8%	3 or more 39.7%
Saw Doctor After Last Assault	Yes 45.8%	No 54.2%	
Experienced Abuse Prior to Last Assault	Yes 87.5%	No 6.2%	
How Long Living with Partner/Spouse	1-5 yrs. 35.4%	6-10 yrs. 27.0%	More than 10 yrs. 35.4%

Notes: N=48, missing observations + row totals = 100.0%.

All of the women interviewed had been co-habitating with their male assailants for at least one year. Indeed, sixty-two percent of them had been living with their abusing spouse for six years or more. Moreover, all but seven of these abused women (85.5 percent) had at least one dependent child. Most had two or more. The presence of dependent children in a setting of domestic violence and abuse, particularly in those cases where the women/wife victims have little to no independent source of material/income support, commonly magnifies the woman's vulnerability to the male's violence. Analysis of selected background characteristics of women in the study suggest a positive association between the number of dependent children and the length of the abusive relationship. While the sample is small and not representative of a larger population, preliminary findings show that regardless of educational attainment, women with dependent children stay longer in abusive relationships.[2] Reliant on the male to provide income for the care and feeding of their children and themselves, these women are, by and large, trapped and immobilized in a straight-jacket of material dependency.

The extent to which they are immobilized is evident in the fact that almost eighty-eight percent of the women interviewed reported that they had been abused prior to seeking asylum at the shelter. Indeed, many of them had been abused repeatedly throughout their relationship with their male assailants.

Factors such as the accumulative effect of a history of abuse, the extremity of the most recent assault and the perceived threat to their children's welfare drove most of these women to seek help. Unfortunately, the decision to permanently leave the violent domestic situation means that they will in all likelihood become even more materially disadvantaged as a consequence of loss of access to cash, a drastic reduction in their standard of material life and direct dependency on government support programmes (e.g., welfare).

Given that the domestic circumstances from which these women fled was, in all likelihood, extremely damaging to their emotional and physical well-being, one would expect that the majority of the victims would have sought help from health service professionals. However, only twenty-two of the women interviewed (45.8 percent) reported seeing a doctor after their last assault. Fully fifty-four percent of our respondents (26 women) did not seek medical assistance. This is a curious and troubling pattern. After all, the expertise and authority of medical practitioners should prove invaluable to abused women, in terms of both providing immediate symptomatic relief for physical and emotional damage and, if needed, expert testimony in the event of a criminal or family court proceeding. When asked why they did not see a doctor after the last assault, the twenty-six women gave a number of reasons for their reticence (see Table 2). Fifty-four percent stated that they did not want anyone to know about their abuse, while forty-six percent cited embarrassment as a key factor. Family disputes are judged by many as intensely personal and private matters. Moreover, many women, raised to believe that, as care givers, they are responsible for

the management of domestic life, feel that public knowledge of their abuse, of their violation, will be interpreted as a testament to their failure at keeping a "good home" and "content family." In short, these women commonly feel that they will be held responsible and judged as incompetent or inadequate. Since the abusing relationship within the confines of the family already constitutes a damaging frontal assault on the victim's self-identity, many women feel that public disclosure, that is, revealing the reality of domestic violence to non-family, would confirm and, worse, reaffirm to themselves and others the extent of their failure as mothers, wives, and care givers. This process is also evident in the fact that about sixty-two percent of these women judged that their injuries were not serious enough to warrant medical attention. However, they sought asylum in the shelther following the last assault after, in all likelihood, having lived for years in a violent, abusive domestic situation. Moreover, most of the women interviewed, including these twenty-six, reported a past history of seeking relief through doctors, in one way or another, for the physical and emotional damage resulting from assaults. Only a few women indicated that factors such as their abusers, lack of access to transportation and lack of confidence in physicians prohibited them from seeking medical help after the last assault. These data suggest that, in addition to self-perceptions and personal embarrassment, many battered women do not seek medical attention and intervention immediately for reasons other than those discussed thus far. To further pursue this and other issues we now turn to a specific examination of battered women's experiences within medical service health delivery environments.

Table 2

Reasons Cited For Not Seeing Doctor After Last Assault

Reasons	Response Distributions %	
	Yes	No
Didn't want anyone to know about abuse	53.8	34.6
Injuries not serious	61.5	19.2
Mate wouldn't allow	3.9	80.8
Too embarrassed	46.2	38.5
No transportation	3.9	77.0

Notes: N=26, row totals + missing observations = 100.0%.

B. Battered Women's Medical Environment Experiences

Of the twenty-two women who saw a doctor after their last assault, fifty-seven percent reported they sought assistance for physical abuse while eighty-seven percent cited emotional abuse as the reason they sought treatment (see Table 3). Apparently, a number of these women sought medical assistance for both physical and emotional abuse. None of these women reported being sexually abused.

Table 3

Respondents Who Saw Doctor After Last Assault By Type of Abuse

Type of Abuse	Response Distributions %	
	Yes	No
Physical	56.5	43.5
Emotional	87.0	13.0

Note: N=22, row total + missing observations = 100.0%.

Table 4 profiles key qualities of the medical practice experienced by the twenty-two battered women. It should be noted that, in all cases, these battered women were not accompanied by their abusing male spouses. Furthermore, all of the victims reported they went to see the physicians unaccompanied by friends or relatives. None of these women reported that a nurse or female companion was present during the time spent with attending physicians, including the physician-patient interviews and physical examinations. In short, all of the battered women seeking medical attention after their last assault were unaccompanied by familiars when they entered the medical service environment and were alone throughout their contact with doctors. Notably, few of the women interviewed indicated any difficulty with this situation. Indeed, many reported that either they preferred to maintain the confidential qualities of doctor-patient relationships by being alone throughout the interview and examination process, or they had not imagined that any other arrangement was necessary and/or preferable.

We find this somewhat surprising, particularly given the emotional, psychological and physical trauma associated with violence in domestic settings and the battered woman's decision to seek medical assistance. We had anticipated that the victims of battering would feel the need for and welcome the presence of social-emotional support in the form of female familiars, family, female

advocates (e.g., transition house staff) and/or female health professionals. After all, battered women seeking medical assistance minimally undergo the triple trauma of physical/emotional injury, the realization of their vulnerability in the "haven," that is, the family, and the risk of making it all public by going to a doctor.

Table 4

Aspects of Medical Service Extended to Those Who Saw Doctor After Most Recent Assault

Characteristic of Service	Response Distributions %	
	Yes	No
Doctor asked about the source of the injury	60.9	34.8
Doctor asked if patient abused	21.7	56.5
Doctor did physical exam	8.7	78.3
Doctor prescribed psychoactive drug	59.2	33.3

Note: N=22, row total + missing observations = 100.0%.

Our information, however, does not affirm the contention that these women feel the need for or desire the presence of social-emotional support persons, at least within the medical setting. While a more sophisticated explanation of this would require further research, we suspect stereotypic perceptions of the necessity for doctor-patient confidentiality, reticence to challenge the physician's authority by requesting a supportive person accompany the victim, and lack of gender-based consciousness concerning the design and biases of medical services undermine, to a large extent, these victims' thoughts and feelings.

The twenty-two women who sought medical services after their last abuse were asked whether or not the examining doctor inquired about the source of their physical/emotional wounds. More than one in three (34.8 percent) reported that the attending physician did *not* ask how they had come to be injured. In slightly more than one in five of the cases (21.7 percent), doctors were reported to have specifically asked if the women had been abused. In nineteen cases, although the abuse was acknowledged during the doctor-patient consultation, the disclosure did not seem to impact profoundly on the sensitivity of physicians.

Some of the women interviewed gave accounts of the doctors' reactions when told by the victims about their abuse. For instance, one victim described how the doctor "looked down" when she was telling him about her abuse at home. This gave her the impression that he was uncomfortable hearing about this. Another abused wife reported that her doctor did not give the impression that he would be interested in talking about her "domestic" problems. In response to explaining the family situation to him, the battered wife reported that the doctor said, "You shouldn't have married him in the first place." Finding him insensitive and rude, thereafter she confined herself to discussing only physical ailments. Finally, another battered woman reported that, when her doctor saw a black eye, he remarked, "I hope the other guy is worse off," and, "Go home and give him one for me." On another occasion, when speaking to the victim and her abuser, the doctor was reported to have said, "You should take up something else, like sex."

So, physician knowledge of the fact that the injuries result from abusive situations does not necessarily translate into humane responses. Fortunately, not all doctors respond in such an inappropriate manner. For instance, one battered woman related an account of her physician's response when informed of the abuse. He immediately asked his office personnel to ensure that they were not disturbed, so that he could have uninterrupted time to discuss the situation with this woman. In the course of the conversation, this physician gave the victim the transition house telephone number. He also provided his home number, telling her to contact him day or night if she needed support.

However, our evidence indicates that far too many of the attending doctors were either disinterested in or insensitive to the circumstances of the injured women. At best, these physicians appear to have adopted a symptomatic rather than a causative/preventive approach in their assessment and treatment of physical/emotional injuries and complaints.

Fewer than nine percent of the women who sought medical assistance reported that they were given a physical examination by the attending doctor.[3] When asked, none of these women indicated that they had received a gynecological examination. The physicians' failure to provide physical examinations is more than curious given that fifty-five percent of the women sought medical assistance for physical abuse after the last assault, and that almost eighty-seven percent of the cases were identified as assault during the patient-doctor exchange. In fact, this failure is

potentially deeply concerning in terms of its implications for the quality and character of health care received by many battered women.

On the basis of this and previous data and discussion, it could be suggested that many of the attending doctors were not informed fully by these women. That is, many of the women are extremely embarrassed by their circumstances and, consequently, are not entirely candid with their physicians. Moreover, it could be said that many of the doctors are uninformed, at least partially, about the circumstances and characteristics of these women's physical/emotional wounds, because they have failed (intentionally or not) to inquire, when interviewing the patient, about the source of injury. Finally, it might also be argued that the emotional trauma of battered women seeking medical attention immediately on the heels of an assault is so intense that the physician is compelled to first settle their emotional/psychological condition before attending to any other than the most serious of physical injuries.

This last possibility appears supported by the fact that almost three in every five of the women received prescriptions for psychoactive/psychotropic drugs such as tranquilizers from their attending doctors (see Table 4). However, over eighty-seven percent of these women reported seeking medical assistance for emotional abuse. Apparently, while not all doctors respond by prescribing psychoactive substances when confronted with emotional trauma, many do. However, when it comes to the provision of physical examinations, the most common practice identified is *not* to examine. Perhaps many of these physicians simply did not know what they were dealing with; that is, they were inadequately informed due to acts of omission and/or commission.

As mentioned, nineteen of the twenty-two women who sought medical assistance after the last assault reported that they informed their doctor that their injuries were caused by spousal abuse.[4] Table 5 profiles the characteristics of medical service experienced by these women. These data reveal that physicians' knowledge of abuse only has a minor effect on the doctors' propensity to prescribe psychoactive drugs and to provide physical examination. Where spousal abuse was known to have occurred, doctors prescribed psychoactive drugs in more than one in every two of the cases, and conducted physical examinations for less than eleven per cent of the women.[5] Consequently, knowledge of the specific cause of injury appears to have little effect on the character and content of the physician's medical intervention and assistance.

Table 5

Aspects of Medical Service Extended to Cases Identified as Wife Assault

Characteristic of Service	Response Distributions %	
	Yes	No
Doctor did physical examination	10.5	89.5
Doctor prescribed psychoactive drug	52.6	47.4
Doctor suggested transition house	52.6	47.4
Doctor suggested mental health assistance	52.6	47.4
Doctor suggested he/she see partner/spouse	21.1	78.9
Doctor suggested patient leave domestic situation	31.6	68.4

Note: N=19, row total + missing observations = 100.0%.

As evident in Table 4, in general, physicians did not provide physical examinations. However, many physicians were reported to have recommended other courses of action to the women. In more than one in every two instances, the attending doctors were reported to have suggested that the women go to a women's shelter. Almost one in three specifically recommended that the women leave their domestic situation for the sake of their physical and emotional well-being. Only a few physicians suggested the police be contacted, and none of them recommended that arrangements be made to ensure the batterer be removed from the family home. Also, more than fifty percent of the women stated that the doctor suggested they seek further mental health assistance.

Due to the way in which questions were worded, it is unclear why further mental health assistance was recommended. Perhaps the doctors considered the women's emotional wounds to be so severe as to require more specialized intervention. Or, equally possible, is that the physicians attributed the blame and responsibility for the situation to the women. That is, at least some of the physicians may have concluded that the women needed to be straightened out and settled down in order for them to

fulfill their familial and domestic duties. These data all suggest that a bare majority (52.6 percent) of the battered women who sought medical assistance after their last assault were attended to by physicians responsive to the circumstances of battered women. Many of the doctors seem unconcerned about the special conditions and needs of battered women. Most appear negligent in providing physical examinations, while many are too ready to prescribe psychoactive drugs.

Of course, not all doctors pursue even this line of intervention. One woman reported that her doctor merely recommend she go home and take a hot bath. Other women related accounts of similar "treatment," involving such advice as "getting out more" and "needing a break from the kids." The implications of these points are developed in more detail in the analysis/discussion segment of the essay. Now, we turn to a specific examination of these battered women's experiences with prescription drugs, especially psychoactive substances.

C. Prescription Drugs

As reported earlier, almost sixty percent of the women reported receiving a drug prescribed by the attending doctor. Forty percent of these indicated that they asked the doctor for a prescription, mostly to settle their "nerves," to help them sleep and to assist them in coping with anxiety and depression. With few exceptions, the drugs prescribed by the doctors were tranquilizers (i.e., psychoactive or psychotropic drugs) of one sort or another. It should be noted that the doctors occupied a position of authority, judgement and power in the practitioner/patient relationship, especially when it comes to diagnosis and determination of appropriate treatments. Regardless of whether or not a patient requests a prescription for "nerves," depression, anxiety or other reasons, the physician is the only player in the relationship empowered to prescribe, presumably after completing the diagnostic assessment essential to determining appropriate treatment. Apparently, many of the physicians treating the battered women judged that psychoactive drugs were, at least in part, an appropriate treatment.

Table 6 profiles the particular psychoactive drugs, as reported by the women who could recall specifics, prescribed by attending physicians. All of these drugs are commonly prescribed for management of anxiety and acute emotional problems. Notably, they all can be physiologically and/or psychologically addictive if consumed over prolonged periods of time. Indeed, the precautions for these substances specify that reassessment should occur after a brief period of time; that these drugs are rarely intended for long-term use because the prescribing physician runs the risk of creating a patient's dependency on the drug (*Compendium of Pharmaceuticals and Specialties*, 1986).

Table 6

Psychoactive Drugs Prescribed After Last Assault

Name of Drug	Prescribed %
Atarax	4.5
Ativan	18.2
Lectopam	18.2
Serax	18.2
Valium	13.6

Note: N=22, Column total + missing observations = 100.0%.

Table 7 describes the length of time prescription drugs were reported to have been taken by the women who had seen a doctor after their last assault. One in two of these women reported that they had been taking their prescription for at least one month. Thirty-six percent stated that they took prescribed drugs for more than one year. Given the predominance of psychoactive drug prescriptions, the data suggest that many of these women are at risk of forming psychological if not physiological dependencies.

Table 7

The Length of Time Prescription Drugs Were Taken By Respondents Who Saw Doctor After Last Assault

Length of Time	Response Distributions %
Less than one month	40.9
Greater than one month, less than one year	13.6
Greater than one year	36.4

Note: N=22, vertical column + missing observations = 100.0%.

Table 8 outlines the battered women's recollection of whether or not the doctor informed them about the rea-

sons for being prescribed the drug, as well as the side-effects attributed to those drugs. Almost one in five reported that the prescribing physician did *not* tell them what the drug was for. Moreover, in excess of three in every four of the battered women stated that the doctors did *not* explain the possible side-effects of the prescribed drugs to them. In other words, this information indicates that many of the women were, at best, inadequately informed while regularly consuming, over lengthy periods of time, psychoactive drugs with the power to alter significantly their psychological, emotional and physiological well-being. Given the potency of these drugs, surely a fundamental characteristic of competent and responsible medical practice should be clear communication of the reasons for and possible side-effects/risks of prescribed drugs, followed by periodic assessments. This legitimate expectation of responsible professional practice is not evident in these data. Far too many of the women interviewed demonstrated an essential lack of concern and understanding regarding the character and risks of the psychoactive drugs they commonly consumed.

Table 8

Medical Service Experienced by Respondents Who Were Prescribed Psychoactive Drugs

Characteristic of Service	Response Distributions %	
	Yes	No
Doctor told what drug was for	76.2	19.0
Doctor explained side-effects of the drug	19.0	76.2

Note: N=22, row totals + missing observations = 100.0%.

One respondent told of the ease with which she obtained prescriptions, frequently double-doctoring, that is, obtaining psychoactive drug prescriptions from two or more doctors within the same period of time. She had become addicted to the drugs. Another woman told us that she "pressured" her doctor to renew prescriptions, which he did, although he warned her of the consequences. After a friend's intervention and support, this battered woman freed herself from her addiction. Upon informing the prescribing doctor that she was no longer taking the drugs, he reportedly said, "I was wondering when you would stop." The prescribing physicians must, at least in part, assume some responsibility for these situations, their risks and outcomes.

The reported prescribing practices of doctors were examined in relation to several of the background characteristics of the battered women interviewed (see Table 9). Those women with a previous history with prescribed psychoactive drugs were five times more likely to have received prescriptions than were women reporting no previous history with such drugs (45.5 percent as compared with 9.1 percent). The data suggest that either battered women's previous experience with psychoactive drugs predisposes doctors to re-prescribe similar treatment, and/or battered women with previous drug experience influence physicians to prescribe such treatment. Regardless of the particular factors involved here, the doctors occupy the determinant position insofar as they are the only participants in the relationship with the right to prescribe treatment, presumably following professional diagnosis. The data suggest that many of the physicians who treated the battered women interviewed for this study were, in one way or another, more influenced by the previous history of their patients than responsive to a diagnosis of women's current status. Indeed, given the characteristics of and risks with these drugs, one would think that patients with a previous history of use would be less likely to receive prescriptions. Diagnosis of battered women's current situation, coupled with their previous history of use, indicates that treatment with psychoactive drugs does not address the problem successfully. For many physicians a reverse conclusion appears to be the case.

Table 9

Psychoactive Drugs Prescribed After Most Recent Assault by History with Prescribed Drugs and Education

	Prior Drug Use		Education		
Psychoactive Drugs Prescribed (Last Assault)	No History of Prescribed Drugs	History of Prescribed Drugs	Gr. 0-8	Gr. 9-12	Post Sec.
Yes %	9.1	45.5	18.2	31.8	4.5
No %	18.2	13.6	0.0	22.7	9.0

Note: N=22, Cell totals + missing observations = 100.0%.

The educational background of battered women also appears, in part, to predict physicians prescription practices. The data presented in Table 9 report that every one of the battered women with less than a grade nine formal education received a psychoactive drug prescription. Women with senior matriculation or at least some high school education were *more* likely than not to receive a psychoactive drug prescription. However, women with at least some post-secondary education were *less* likely to be given such a prescription by their attending physician. While the small number of cases involved here require that interpretative caution be exercised, these data indicate that the socioeconomic background characteristics of battered women, as predicted by level of educational attainment, influences many of the doctors' diagnostic and treatment predispositions. Certainly, those women of lower socioeconomic status appear much more likely than other women to receive psychoactive drug prescriptions as treatment for their injuries.[6] While further research is necessary to establish concretely the breadth and character of the practice, this pattern is very disturbing in terms of its implications for the professionalism of physician diagnostic and treatment practices, and for the quality of medical services experienced by many battered women.

D. Battered Women's Perceptions of Medical Treatment

While the preceding information and discussion might suggest that the battered women interviewed for this study are negatively predisposed towards physicians, the response distributions concerning the women's perceptions of the doctors' attitudes toward them during treatment indicate otherwise (see Table 10). These data reveal that as many as three in every four to as few as three in five of the women believed their doctors were caring, interested, friendly, understanding, respectful and patient, and did not blame or act condescendingly. As few as one in ten and as many as one in three reported that they found their attending physician's attitude and comportment to be unacceptable. For instance, almost thirty percent found their doctors to be aloof and more than one in ten reported they felt their physicians to be uninterested. By and large, the battered women interviewed were quite positive in their assessment of doctors' deportment and attitudes. This is further supported by the perception of attribute indices presented in Table 11. Regardless of whether or not the battered women saw a doctor after their assault, over eighty-five percent of them rate the professional/personal qualities of their attending physicians as moderate to high in positive attributes. In short, the vast majority of the women interviewed were very positive in their feelings about and assessment of physicians. It is apparent that most of the women did not have any particular "axe to grind" concerning the delivery of medical services.

Table 10

Battered Women's Perceptions of Doctors' Attitudes Toward Them During Treatment

Characteristics	Response Distribution %	
	Yes	No
Caring	68.8	16.7
Blaming	10.4	66.7
Interested	62.5	25.0
Condescending	16.7	70.8
Friendly	75.0	14.6
Aloof	29.2	60.4
Understanding	70.8	18.8
Uncaring	12.5	72.6
Respectful	70.8	10.4
Uninterested	14.6	66.7
Impatient	14.6	72.9
Distracted	18.8	66.7

Note: N=48, horizontal row + missing observations = 100.0%.

Table 11

Battered Women's Perceptions of Personal/Professional Attributes of Doctor by Whether Respondent Did/Did Not See after Last Assault[1]

Personal/Professional Attributes	Did Not See Doctor %	Saw Doctor %
Low	14.2	11.8
Moderate	28.5	35.2
High	57.2	53.0
	100.0	100.0

Note: N=48

[1] Missing observations = 17, notably, in any of these missing cases are accounted for by women refusing to rate their doctors.

However, when asked about what they would recommend doctors do to improve service, many of the women responded affirmatively to a number of items presented (see Table 12). About nine in every ten thought that

doctors should directly ask women whether or not they had been battered, refer battered women to appropriate agencies and/or counsellors, and explain fully the purpose and effects of prescribed drugs. About four in every five thought that the attending physician should offer/advise a physical examination and should offer/provide a nurse during physical examinations. Finally, from two in every three to seventy percent of the women indicated that they thought doctors should provide, in addition to medical treatment, information and explanations concerning battered women's legal and human rights. About seventy percent of respondents believed that doctors should take the initiative and contact the police and/or other authorities when an assault is suspected.

Table 12

Battered Women's Suggestions Concerning Doctor's Treatment

Suggestions	Response Distributions	
	Yes	No
Ask about abuse	87.5	6.3
Refer to agencies	91.7	0.0
Fully explain purpose and effects of drugs	89.6	2.1
Offer/advise a physical examination	83.3	8.3
Offer/provide availability of nurse during physical examinations	77.1	4.2
Explain law	83.3	8.3
Explain rights	72.9	25.0
Take initiative to contact police and/or other authorities	70.8	16.7

Note: N=48, horizontal columns + missing cases = 100.0%.

While physicians may be ethically and legally circumscribed when providing non-medical advice and intervention, the majority of the battered women are unequivocal in their recommendation that physicians take more initiative when providing medical services for the victims of assault. This is understandable, particularly given the negative self-identity and emotional trauma associated with domestic violence. These women, in very difficult personal situations, look to physicians for initiative and assistance. In such circumstances, the quality and character of the medical assistance battered women receive will be determined, in no small measure, by the degree to which the physicians become proactive in providing treatments sensitized to the victim's situation. That is, competent and effective medical assistance will be provided to the extent that doctors come to recognize the particularities of the battered woman's circumstances and, thereafter, act accordingly. The women interviewed are suggesting that, for this to occur, physicians must assertively probe for information about the causes and outcomes of injuries, document physical and interview evidence, initiate comprehensive physical examinations and consider the victims' "greater picture" in their diagnosis and treatment. Certainly, the evidence provided here indicates that physician propensity to treat with prescriptions of psychoactive drugs is inadequate at best, and incompetent at worst. Treating with prescriptions is also potentially damaging — if not actually so —to the personal, social and health interests of battered women.

Conclusions

While the exploratory and preliminary qualities of this research require that caution be used in order not to overgeneralize from the evidence presented, the patterns and practices identified here share much in common with findings reported from other studies. By itself, the family, domestic and intimate setting within which the violence occurs tremendously complicates battered women's medical experiences. Many studies have shown conclusively that abused women seek help outside of the home usually only after having experienced systematic violence for years (Cape Breton Transition House, 1988; Chambers and Smith, 1988; Kerouac et al., 1986; Stark et al., 1979). The fact that this happens within the family setting and is perpetrated by an intimate demobilizes most women. In an attempt to dismiss what is happening to them, abused women commonly think of each assault as a situational event. That is, they generally do not recognize violence as part of a behavioral pattern on the part of the male, or as part of a lifestyle forced on them. In addition, many abused wives, feeling they are responsible for maintaining "domestic bliss," blame themselves for the violence, concluding that something must be wrong with them, otherwise the attacks would either not happen or would stop. Consequently, battered wives have been described as experiencing low self-esteem and a sense of low self-worth (Chambers and Smith, pp. 230-233). Along with battering the victim's body and sense of worth, the emotional-psychological fallout from systematic verbal and physical assaults experienced is expressed by the victims in non-specific embarrassment, depression, anxiety, sleeplessness, nervousness and the like. Often these outcomes are *not* directly associated in the victims' minds with their abuse.

So, battered wives seeking medical attention frequently enter health delivery environments completely traumatized by their experiences, scared of consequences, and uncertain of causes. As noted earlier, many turn first to medical services for relief —doctors in particular — or, as some might argue, for rescue. In these settings, many hope to find answers for their "private" problems and "treatment" for their ailments (Lewis, 1982). In order to respond with any degree of effectiveness, health care professionals must be familiar with the facts of abuse and their likely expression in victims. Unfortunately, evidence does not indicate that health care professionals and doctors in particular have been adequately responsive to this situation (Corea 1985, pp. 89-93; and Stark et al., 1979).

It has been reported elsewhere that doctors frequently do not ask victims if their physical injuries or emotional complaints are associated with or caused by domestic violence (Lewis p. 5). Our research has identified a similar pattern. By failing to do this, doctors disable themselves in regard to diagnoses and, even more troubling, increase the likelihood that they will engage a treatment that will increase, rather than decrease, the battered women's jeopardy.

The literature indicates that the location and type of physical injuries sustained by battered women mask their causes (Klingbeil and Boyd, 1984). For example, many male assailants attack their victim's body (e.g., breasts, abdomens and spines) so as to inflict pain while leaving little or no readily apparent sign of injury when the woman is clothed (Martin, p. 249). Moreover, sexual assaults, particularly rapes, are reported to be a common characteristic of wife abuse (Corea, p. 90; Stark et al., pp. 466-469). This is also "invisible" injury to the doctor looking across a desk at the battered woman. Professional diagnosis, thorough documentation and the recommendation of competent treatment require that physical examinations be an ordinary procedure in the delivery of medical service to battered women. But, as ours and other studies have shown, doctors rarely provide such a service.

From the above, we can conclude that many doctors, as a result of (a) not probing for the cause of injury during their patient interviews, and (b) not completing physical examinations, do not conduct a competent diagnosis. However, this does not appear to prohibit them in any way from prescribing treatment, usually in the form of psychoactive drugs.

The treatment of battered women with psychoactive drugs is one of the more commonly reported findings in the research literature (Corea, p. 91; Gregory, p. 17; Lampert, p. 267; Lewis, p. 5). One study found that,

> Though physicians often failed to identify battered women, they did treat them differently than other women. They prescribed minor tranquilizers or pain medications to nearly one in four battered women ... but to fewer than one in ten of non-battered women (Corea, p. 91) [who are two times more likely than men to be prescribed tranquilizers in any case. (Verbrugge, p. 667)]

This occurs, some argue, because doctors are biased by both their training and the patriarchal quality of society, in general, to view women's health ailments as more likely psychosomatic than those of men (Weisman and Teitelbaum, p. 194-195; Stark et al., p. 477 ff). The rate at which psychoactive drugs were prescribed for the abused women, as reported in our study, indicates that the "it's largely in their heads" diagnosis has possibly been a regular characteristic of these women's medical service experiences.

Of course, this approach to serving battered women, aside from never looking much beyond symptoms,

> ...can be dangerous, ... for battered women after attempt to kill themselves by overdosing on these medications. [In one study], battered women were 5 times more likely to have attempted suicide than non-battered women and 16 times more likely to have done so more than once. The practice is also dangerous because these medications may be contraindicated by the head and abdominal injuries prevalent among battered women. (Corea, p. 91)

Treating the ailments of battered women with psychoactive drugs also increases their jeopardy by reducing the ability of these women to pursue a proactive posture. Psychoactive drugs deaden feelings, impair thinking and reduce physical reaction times. Consequently, women partaking in such treatment may be further disabled in terms of either protecting themselves and their children from assaults and/or acting to change their domestic situation (Corea, p. 92). Also, one can only wonder what role tranquilized minds and behaviours play in stimulating onset and escalation of the violence, predictably resulting in more serious and permanent injuries.

> When women are regularly assaulted, they *do*, in fact often become depressed, attempt suicide and try to suffocate their sorrows in alcohol and drugs. Battered women *do* suffer these and other major psychosocial problems far more frequently than non-battered women, but only *after* the onset of abuse and of mistreatment in a medical setting (emphasis in original). (Corea, p. 92)

For those women encountering insensitive and irresponsible doctors, pursuit of medical assistance frequently leads to further impairment and victimization. As a result, battered women, although they are found over time in health delivery environments more often than in other service settings, report medical treatment to be one of the least effective interventions in terms of ending abuse and improving their well-being (Chambers and Smith, p. 233). While not all battered women's medical experiences result in such outcomes, the services delivered to many women are minimal, inadequate, and potentially and dangerously incompetent. Surely the vast majority of physicians do not intend outcomes such as these. Some argue that doctors, working within a curative medical model, get frustrated and, as a consequence, unresponsive when repeatedly confronted with the chronic physical and emotional injuries of wife assault victims (Corea, pp. 91-92; Popper, pp. 259-261; Swartz, pp. 318-319; Stark et al., pp. 469-477). Others argue that doctors are unresponsive intentionally. As one Cape Breton Transition House staff person has insisted,

> I believe the medical profession don't ask questions because they're afraid to get answers. When a woman comes in with bruises, they very rarely ask ... To get a doctor just to look at it is hard. They don't want to get involved with Court. They very rarely ask because they don't know how to deal with the answers. (Cape Breton Transition House, p. 24)

We would prefer, at this junction, to think that the vast majority of inadequate medical service and medical mistreatment originates in health professionals' fundamental ignorance concerning battered women's social, psychological, emotional and physical situation. Surely, most doctors, if informed and sensitized, would not practice potentially lethal medicine. Once knowledgeable of the characteristics and consequences of wife battering, we would hope that most physicians would adjust their interpersonal, diagnostic and treatment procedures.

NOTES

1. One limitation of questionnaire design involved the use of all inclusive choice sets to measure such background characteristics as educational attainment, number of dependent children, length of time in abusive relationship, etc. Providing only ranges within which respondents fell, such as having 1-2 dependent children, 3-4, etc., some relationships could not be adequately explored. Specific responses indicating the number of children and their ages would have provided finer measure of these background characteristics. Copies of the research instrument are available on request.
2. This finding is worthy of more research, especially that which links educational attainment to levels of available employment. Presumably in regions where employment opportunities for women exist, educational attainment will play an intervening role in the relationship between number of dependent children and duration of the abusive relationship.
3. The term "physical examination" was used by the researchers to mean an overall physical assessment of injury, rather than only the site of complaint. Since this term may have caused some confusion on the part of the respondents, the phrase "complete physical examination" is preferable in further research of this sort.
4. In these 19 cases, some women disclosed the source of injury when directly queried by the doctor while others did so voluntarily, at the onset of the consultation. While not dealt with by this study, the latter may have done so at least in part because they had decided to leave the violent domestic situation and hoped to use the medical setting as an official record of the incident.
5. The likelihood of prescribing psychoactive drugs to battered women who have sustained head injuries or might be pregnant strongly exists where physical examinations have not been completed.
6. Educational attainment as a predictor of potentiality for employment was used as an indicator of socioeconomic background. Results show a negative association between educational attainment and propensity to be prescribed psychoactive drugs. Further research with a larger, more representative sample employing more precise measures of educational attainment such as specific grade completed rather than a range (e.g., between grades 9-12) is warranted to explore this important relationship completely.

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