PATTERNS OF USE OF A SHELTER FOR BATTERED WOMEN IN NEWFOUNDLAND

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Patterns of Use of a Shelter for Battered Women in Newfoundland

by

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ABSTRACT

Wife battering is now recognized as a widespread problem with serious social, medical, and legal consequences. The literature on aggression and violence in general, and on wife battering in particular, is insufficient to explain this phenomenon adequately. It does indicate that battered women exist in all socioeconomic strata and that the theories on wife battering must address the cultural and political context in which it occurs. Hundreds of non-governmental services have been opened in response to the needs of these women. Shelters providing temporary accomodation are the most common. Little is known about how these services are used.

This study analyzed data collected by one shelter. Women admitted in the first three years because of spouse abuse (N=297) were included. Data on the sociodemographic characteristics, health status, history of abuse, and admission characteristics of these women as well as some details on the admission are presented.

The results indicate that this shelter was a much needed service which was well received by battered women. Women from a variety of backgrounds used the shelter. Although the women had many contacts with professionals from social, legal, and medical services, few were referred to the shelter by these services. It is clear that shelters are an important source of data for understanding the problems and needs of battered women. The data indicate that some

specialized training may be needed for staff of shelters and for professionals who are in contact with battered women. The issue of prevention should be addressed in order to aid battered women and to decrease demands on the health care system. The large number of children admitted to this shelter suggests a need for information on the children of battered women and their response to services designed for their mothers.

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Chapter 1

Aggression and Violence

1.1 Introduction

To have a better understanding of wife battering we will first briefly review various theories on the origins of aggression and violence. Such a review will illustrate the concepts that inform various professionals and disciplines on the behaviour of the aggressor - the husband. In some cases the conceptualization of the aggressor's behaviour also reflects a view of the role of the victim - the wife. Actually, there was little concrete data on wife batterers available (Martin, 1976; Ponzetti, Cate, Koval, 1982) with which to refute or support any explanation of their behaviour; the discussion, therefore, will be very general.

For the purposes of this discussion aggression will mean:

> An act carried out with the intention of, or which is perceived as having the intention of hurting another. The injury can be psychological, material deprivation, or physical pain or damage. When the injury is pain or damage, it can be called 'physical aggression' and is then synonymous with "violence...".(Gelles & Straus, 1979, p.554)

The study of aggression and violence in humans has been

infused with the "nature-nurture" controversy. Is aggression a fact of nature, an innate human characteristic, or is it a behaviour introduced into the human repertoire during the course of a life-time? A number of theories have been developed, promoted, or dismissed by scientists from every discipline involved in human research. The primary propositions and some major criticisms of each theory will be presented.

The first five groups of theories looked primarily at individual efforts to survive, achieve goals, and to respond to internal as well as external stimuli. These were biological, drive, personality trait, psychodynamic, and social learning theories. The last two groups also engaged in analysis of social institutions and purposeful behaviour of individuals acting for these institutions. The interactionism and stratification theories propose that individuals were heavily influenced by their society.

It will be evident that some theories overlapped; for instance, psychodynamic theories owe much to the work of Freud and other psychoanalytic theorists. More importantly, it will be illustrated that there was no one theory that accounted for aggression and violence in humans and that science has not been able to predict aggressive or violent behaviour with a high degree of certainty.

1.2 Biological Theories

Biological theories, which emphasized the genetic inheritance of a stimulus-response sequence in aggression, included ethological and psychoanalytic theories (Edmunds & Kendrick, 1980; Roberts, Mock, Johnstone, 1981) and sociobiology which applied principles of the evolutionary theory of human development to human behavior (Sayers, 1982).

1.2.1 Ethology

The basic tenet of ethology was that most animal and human behavior is instinctive. "For each bit of behavior, there is a blueprint stored away in the nervous system and passed on within the genes of that species" (Hunt, 1973, pp. 29,30). External stimuli serve to activate the instinctual response to a given situation (Hunt, 1973).

Ethologists compared species of animals both by observing them in natural settings and through experimentation. They believed that the study of animals will produce information useful in understanding human behavior (Roberts et al. ,1981).

Lorenz, the father of ethology, maintained that aggression was an innate trait in humans, phylogenetically determined, and apt to surface spontaneously despite experience and learning that would contradict such behavior (see Montague, 1973). He also concluded that males and females were equally aggressive but that females tended to

direct their aggression at other females (see Reid, 1978). Lorenz explained that this selectivity in choosing a target was based in the biological fact that men were larger and stronger than women. He believed that these biologically determined differences accounted for social hierarchies and differences in sex roles (see Sayer, 1982).

Social institutions and activities were explained in part by instincts. For instance, Morris concluded that beauty aids such as cosmetics were modern adaptations originating in the biological signals (such a changed colour or enlarged glands) employed by our animal ancestors to determine the sexual season (cited in Reed, 1978).

Many criticisms were made of the work of ethologists, in particular Lorenz. Some writers indicated that Lorenz' methods were fundamentally unscientific and his theory based on unsound judgment (Barnett, 1973; Schneirla, 1973). He was criticized for failing to distinguish between female aggression initiated to protect the young, a common phenomenon, and fighting for sexual access to males which was unknown. He was also criticized for making generalizations to women in modern society based on observations of exceptional phenomena in, for example, one breed of fish (Reed, 1978).

Ethological explanations for sex differences in behavior were questioned by the work of anthropologists such as Mead (1949) who concluded:

> But all human groups of which we have any

> knowledge show evidence of considerable variation in their biological inheritance. Even among the most inbred and isolated groups, very marked differences in physique and apparent temperament will be found, and despite the high degree of uniformity that characterizes the child-rearing practices of many primitive tribes, each adult will appear as more or less masculine, or more or less feminine according to the standards of that particular tribe. (p. 133)

The differences in behavior between sexes, excluding child bearing, were according to Mead usually attributable to social sanctions and ascribed roles.

Some critics suggested that the development of human culture made instinctive behavior useless. It followed from this, that such genes would have been negatively selected out of the human gene pool. If however, genetically ordained behaviors still existed they may have fallen almost completely under the control of learned responses (Montague, 1973). Others pointed out that ethologists attempted to explain too much of society by looking at instinct (Reid, 1978; Sayers, 1982).

1.2.2 Sociobiology

Sociobiology, which was closely related to ethology, applied the theory of evolution to social behavior which it proposed was primarily determined by genetic self-interest or the compulsion to ensure the survival of one's genes. Altruistic behavior was discounted as such and was explained on the basis of acts of self-interest (Sayers, 1982).

Tiger applied sociobiology to explain sex differences in aggression between men and women. He concluded that men

had a biologically determined ability to form bonds or attachments to other men. These male bonding patterns were established because of their essential role in primitive hunting patterns. This cooperative bonding was declared by Tiger to be the same trait as competitive aggression. Aggression was both cause and effect of the ties between men and was a predictable male trait, suppressed only at a psycho-social cost to men. War was described as a universal and all male enterprise, a bond situation involving power and force from which women were consciously and emotionally excluded. Women, according to Tiger, were innately inferior to men (see Reid, 1978).

Another sociobiologist explained relationships between men and women by looking at "parental investment". He determined that women were predestined to give more child care and males to be more sexually promiscuous based on their initial unbalanced investment in the zygote. The female egg provided more food reserves than the male sperm. In addition to this, a woman invests a nine month pregnancy to produce an offspring.

Since behavior was directed at maximizing the chances of one's genes surviving, each sex would try to get the other to invest more in existing offspring, thus leaving them free to produce and raise additional ones. A male's sexual promiscuity would pose a threat to the female's genes because it could result in his desertion of her and decreased investment in her offspring. Females, therefore,

evolved a counter-strategy of acting coyly. Coyness provided a period before mating to assess the likelihood of a male investing in offspring after they were born (Trevers as cited in Sayers, 1982).

Goldberg (1978) concluded that aggression was biologically determined and a male trait and that this predisposed society to a patriarchal structure. He maintained that differences in the socialization of males and females and in sex roles could be accounted for by trait of aggression. Differences in status in society were explained by the fact that women were ill equipped to win in competitive and aggressive ventures. Socialization and patriarchal structure derived naturally from the biological differences between men and women, thus ensuring that both could function well. Goldberg concluded that placing women in authority through artificial means (which he did not define) would cause instability and the end of democracy.

Sociobiology was criticized for basing evolutionary explanations on certain forms of social relationships that have not always existed and for not providing a thorough review of ethnographic and historical data. It was also stated that sociobiologists have failed to support their claims with their data (Hubbard, 1979; Reid, 1978; Sayers, 1982) and

> Like Social Darwinism, it [sociobiology] also relies on circular reasoning. It uses terms derived from present human society to characterize animal behavior and then uses this characterization to justify, in biological terms, the human society from

which that characterization was derived in the first place.[1] (Hubbard, 1979, p. 58)

Sayers (1982) pointed out that ethological and sociobiological theories reflected a "doctrine that individual success is the result of competition" (p. 65). They also, both explicitly and implicitly, assumed a continuity between different behaviors such as rough play, aggression, dominance, and political activity and then assumed that they have a common biological origin. This ignored the fact that a particular social behavior might meet a number of different needs.

Sociobiological theories continue to be popularized in high school and university undergraduate textbooks (Sayers, 1982).

1.2.3 Psychoanalytic

Psychoanalytic theories stand on the same basic principles as ethological theories, instinctivism and inevitability, but they were arrived at through different methods. The originator of psychoanalytic theory, Freud, used ideas gained from psychoanalytic treatment of his clients and through analysis of his own life (Roberts et al.,1981). Psychoanalytic study is a source of concepts for understanding human behavior (Elshtain, 1981).

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[1] See Sayer (1982) page 78 for an example of this.

The concept of aggression as a human drive with a biological motive became very popular through Freud and, with the support of ethological reports, became widely accepted in the fields of mental health, political science, and sociology. Freud conceived of aggression as "a rising pressure which had to be discharged periodically or diverted into other channels" (Singer, 1971, p.3; Zillman, 1979).

Freud (1933) believed that males and females both began with an aggressive instinct but that that there existed in females a stronger instinct towards passivity.[2] Freud (1933) said:

> Both sexes seem to pass through the early phases of libidinal development in the same manner. It might have been expected that in girls there would already have been some lag in aggressiveness in the sadistic-anal phase, but such is not the case. Analysis of children's play has shown our women analysts that the aggressive impulses of little gifls leave nothing to be desired in the way of abundance and violence. With their entry in to the phallic phase the differences between the sexes are completely eclipsed by their agreements. We are now obliged to recognize that the little girl is a little man. (p. 74)

The observed differences in sex roles were explained by the fact that the girl eventually discovered that she was not a man but was "castrated", without a penis. In realizing that her mother was castrated and then, that all women were castrated, she was able to make the "necessary" transition from attachment to her mother to attachment to her father.

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[2] See Williams (1977) page 154 for a similar argument.

> Her love was directed to her phallic mother; with the discovery that her mother is castrated it becomes possible to drop her as an object so that the motives for hostility, which have long been accumulating, gain the upper hand. This means, therefore, that as a result of the discovery of women's lack of a penis they are debased in value for girls just as they are for boys and later perhaps for men. (italics added, p.76)

The "ground for femininity" was smoothed by "passive instinctual impulses" which caused her to cease clitoral masturbation and other activity as well. Women being instinctively passive were also more narcissistic and more ashamed, than men. They had fewer social interests and less ability to sublimate their instincts than men.

Psychoanalytic theorists do not necessarily agree with all of Freuds conclusions and there was not total consensus within the field any more than within other fields of study. Psychoanalytic theory maintains, however, that there are biological roots to aggression and that sex differences can be explained through concepts such as the stages of development, identification, superego, etc. (Hyde & Rosenberg, 1980).

There were a number of criticisms of psychoanalytic theories. For one, the concept of channelling off aggression or catharsis was not supported by available evidence and, furthermore, aggression could not be viewed as a unitary phenomena (Berkowitz, 1973; Zillman, 1979). Other concepts, particularly those describing subconscious forces, could not be evaluated scientifically and much of existing work remained unfounded by research (Elshtain, 1981; Hyde &

Rosenberg, 1980). Finally, the explanations of aggression and sex differences in aggressive behavior did not pay sufficient attention to social learning and reinforcement (Williams, 1977) and reflected a biased "male-as-normative" model (Hyde & Rosenberg, 1980, p. 42; Chesler, 1971; Elshtain , 1981; Sayers, 1982).

1.3 Drive Theories

The drive theories postulated the existence of an aggressive drive that was stimulated by frustration and reduced only by an aggressive response. (Edmunds & Kendrick, 1980). These theories were the preoccupation of experimental researchers on human aggression for three decades (1940-1970) and their views that frustration was a necessary but not sufficient condition for hostility and aggression were widely accepted (Zillman, 1979).

Some theories proposed that frustration could build up over time, could erupt into aggression, or could be relieved by behaviors through a cathartic mechanism (Roberts et al., 1981; Zillman, 1979). Alternative explanations of the role of frustration were also offered. It is possible that the frustration-leads-to-aggression hypothesis may be viewed as a case where tension leads to an altered physiological state that increases the probability of aggression (Barchas, 1981). It is also possible to construct frustration as an aversive event.

Thus, insults, painful stimuli, and reductions in

> the level of rewarding conditions (eg. extinction) have one property in common - they are all physically or psychologically aversive to the organism. (Barchas, 1981, p. 37)

However, aversive events produce many different reactions ranging from aggression to apathy.

> Although most people do not use aggression as their primary response to aversive events, some people discover that aggression can be effective in terminating these experiences. (Barchas, 1981, p. 37)

The main criticism of drive theories was that research undermined its assumptions; for instance, levels of aggression did not correspond to levels of frustration; frustration failed to enhance or lead to aggressiveness; and the displacement of aggression was unsupported (Berkowitz, 1973; Roberts et al., 1981; Zillman, 1979). Finally, drive theories did not account for all types of aggression (Barchas, 1981).

1.4 Personality Trait Theories

Personality-trait models assumed that individuals would exhibit particular personality and behavioral characteristics across time, in a variety of settings and to the extent that probabilities for a behavior occurring could be established. Traits were considered the prime antecedents of behavior (Shah, 1981). These theories were clearly related to the psychodynamic and social learning theories.

Personality was defined by Allport as "the dynamic

organization within the individual of those psychophysical systems that determine his characteristic behavior and thought." (cited in Williams, 1977, p. 397). Williams (1977) distinguished temperament as "innate, largely hereditary predispositions to behave in certain ways" (p. 398) and included it with physique and intelligence as the raw material of personality. Each person's unique personality resulted from the interaction of predispositions and experiential history.

There was some agreement that three personality factors could be found to interact in a violent individual. These were: instigation to aggression - all the motivational factors leading to the act; inhibitions against aggression - these are changeable, vary over time and across situations; habit strength - the degree to which aggressive behavior has been positively reinforced. These three factors could be found in different combinations in violent individuals (Megargee, 1981).

Edmunds and Kendrick (1980) embarked on a major research project to validate a test of aggressiveness, identifying dispositional factors that would predict aggression. They stated in their preface that their results and subsequent work forced them to reassess the trait theory.

They were able to identify a stable personality factor which they called aggressiveness/hostility for both males and females, however stable personality dimensions of this

factor were only found in males. Even these were not correlated with actual aggression.

Williams (1977) raised a number of concerns regarding personality research. The research largely ignored studying individuals in order to understand how personality developed and operated; this weakened its ability to explain how personality affects behavior. Studies that did look at individuals generally looked at samples from a clinical perspective. Furthermore, there was a strong bias toward using male samples generally.

Part of the explantion for a predominance of male subjects was the fact that researchers often dropped female subjects when their performance questioned existing theory. This was the decision taken by Edmunds and Kendrick (1980) during their research on a personality trait of aggressiveness. After differences were found based on sex most of the remainder of the research was done on males.

Williams (1977) also questioned whether the empirical methods of personality research excluded certain experiences which were necessary in order to understand human nature. She stated that a broader scope of methodology, including longitudinal studies, was required in the field. She also questioned the practice of using a masculine model as a standard against which women were measured.

1.5 Psychodynamic Theories

Psychodynamic theories assumed that there was a personality core that predisposed certain behaviors (Shah, 1981). They borrowed from both Psychoanalytic and Personality Trait Theories. The theory of catathymia, for instance, described a multistaged thinking disorder which was precipitated by a traumatic experience (Stuart, 1981).

Psychodynamic theories were popular in explaining aggression and violence on the basis of psychological disorders. For instance, Stienmetz and Straus (1974) identified psychosis, psychopathic personality, alcoholism, masochism and sadism as Psychopathological Traits that act as antecedents to family violence . Characteristics that are related to aggression are not necessarily exclusive; for instance, Megargee (1981) identified both "chronically overcontrolled people" and "chronically undercontrolled people" as potential aggressors but he recognized that this did not delineate all aggressive types.

Psychodynamic theorists failed to identify and measure psychological factors that would predict violence (Stuart, 1981). Megargee (1981) concluded that the large number of patterns associated with acts of violence along with the shortage of measurement devises, would inhibit anyone from predicting violence in an individual. The psychopathological traits associated with aggression account for no more than a small percentage of aggression. In fact, most dangerous and aggressive people are not psychopaths (Hare, 1981).

1.6 Social Learning Theories

Social Learning Theory was distinguished by its emphasis on learning by observation. The other learning paradigms involved were instrumental learning through reinforcement of behavior and stimulus control where stimuli associated with positive or negative consequences become cues to behavior in similar situations (Zillman, 1979).

Under this theory aggression was learned and controlled by negative and postive reinforcement of behaviors and by environmental stimuli that became associated with an act.

Learning by observation introduced the concept of vicarious reinforcement; that is, seeing someone else's behavior rewarded or punished increased or decreased the likelihood of modelling that behavior.

The role of stimuli in the person's environment was shown to be one of facilitating the judging of the probable consequences of imitating a behavior. Those contingencies that were believed by an actor to prevail could, in fact, override the influence of actual contingencies. The role of stimuli, therefore, was not that of control as in the stimulus-response, classical conditioning paradigms (Zillman, 1979).

In addition to looking at the way in which aggressive behavior was learned, social-learning theory looked at activation and maintenance of learned aggression. The activators of instigators of aggressive behavior included: modelling influence which also affected the learning;

aversive treatment which increased arousal in the recipient; incentive inducements and instructional control which gave the expectation of positive consequences of an act; and bizarre symbolic control where an individual was provoked by a pathological condition such as a delusion.

Aggressive behavior was said to be maintained by external-, vacarious-, and self-reinforcements. Tangible rewards, social and status rewards, observations of others being rewarded, and feelings of self-worth and esteem all served to maintain the behavior (Roberts et al., 1981).

Bandura (1973a) also maintained that aggressive behavior was activated and controlled by cognitive control. He assumed that humans were capable of recognizing prevailing contingencies and of having insight into their application to other situations. It was also noted that humans store information in symbolic form and experiences can therefore guide behavior to a degree disproportionate to their initial reinforcement value. In short, humans are capable of rational thought and problem solving (Zillman, 1979).

Social-learning theory was criticized for being too rigorous in reducing everything to observable variables and therefore being mechanistic and off the mark of human experience. Much of the empirical work was focused on controlled experiments in laboratories and its relevance to the real world and to severe physical violence was questioned (Roberts et al., 1981). There also remained many

questions as to how the mechanisms of modeling actually worked. They appeared to operate in concert and may, in fact, have been indistinguishable. The role of reinforcers was also unclear. Furthermore, the assumptions about cognitive processes were often used post hoc as explanations and served only to obscure the subject.[3]

1.7 Situationism and Interactionism

The discussion of theory to this point identified theories that focused on characteristics of the individual actor in order to understand behavior. Other theories have been developed on the premise that behavior cannot be explained by looking at individuals alone as there are factors outside of an individual's control that act to produce human response; for example, prevailing social institutions; the structure of relations within the society; the setting in which events occur, and situational conditions (Barnhas, 1981; Collins, 1975; Shah, 1981).

Situationism developed out of this concern. It emphasized external stimuli in the setting as basic determinants of individual behavior. This was criticized because it tended to ignore or underestimate the effect of individual internal factors. (Edmunds & Kendrick, 1980; Limbardo, 1978). A related model, Interactionism, placed

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[3] See Zillman (1979) for a detailed review of literature on social learning.

more emphasis on the interaction of individual factors and situational factors. (Barchas, 1981; Edmunds & Kendrick, 1980; Hunt, 1973; Singer, 1971)

While it was recognized that certain people could have identifiable characteristics that appeared across situations and over time, for example, personality traits, it was also believed that social settings would vary as to the degree to which they promoted or inhibited certain behaviors (Shah, 1981). As Megaree (1981) stated, "It is clear, however, that a number of different personality patterns interacting with a vast array of situational factors may result in individual acts of violence" (pp.190-191).

Toch (1969) studied violent men (police officers, men who had assaulted police officers, prison inmates, and parolees) and was able to produce a ten-category typology of violence-prone men. He also suggested that two individual orientations were likely to produce violence: seeing others as a means to your ends and feeling vulnerable to manipulation yourself. However, these were not necessary conditions for violence. As he put it, "some situations can shatter selves of steel, while others cater to the lowest levels of maturity" (p. 188). He also referred to subcultures of violence where violence was part of a prescribed code. "The subculture of violence thus prescribes certain rules for the exercise of violence and also equips its members with motives, attitudes, and perceptions which produce the games in which these rules apply" (p. 193).

The primary criticism of these theories was that they were successful in generating descriptions of social realities and explaining the construction of such realities but they failed to produce a body of verifiable generalizations about the causes of variations in behavior (Collins, 1975).

Truzzi (1968) stated that sociologists were preoccupied with achieving insight which meant a loss in empirical support.

> For, to many sociologists, a major subjective insight into the social world (even if rather thinly supported by the validating measures of empirical research) may be perceived as more valuable than a trivial or truistic fact upheld by a mountain of researchers. In fact, it might be argued that this search for insights into social life is a primary motive for a majority of persons who choose to enter professional sociology. (p.4)

Subjective understanding or insight is gained when a researcher uses an empathetic process to see a social situation from the actor's perspective (Collins, 1975; Truzzi, 1968).

While the focus was taken off individual control there remained a neglect of the study of social structure and its relevance from both current and historical perspectives (Collins, 1975).

1.8 Stratification or Conflict Theory

Stratification or conflict theory resulted from the effort to describe and analyze social life and social order. Its roots were in the works of Machiavelli and Hobbes, Marx and Weber. According to Collins (1975), Marx proposed three basic principles related to conflict sociology: classes formed by division of property oppose each other in a struggle for political power or the means by which property is distributed and maintained; material contributions determine how well these classes can organize in their own interests (mobilization factors); and the means of mental production determine which classes will be able to control ideology, a powerful political force. To these Weber added the concept of emotional production or the means by which strong emotions about certain beliefs, and solidarity as a community are created.

Collins (1975) has criticized conflict theorists for creating simplistic hierarchies to explain complex social and personal relationships. He concluded that they have called upon causal agents that do not in fact exist. The resultant theories lacked a coherent vision of the world.

> The inadequacies of such models have been apparent for some decades now. Lifestyle does not always neatly line up with occupational class, nor does ethnicity, political behavior, personal associations, or parental background, although these divergences are probably more striking in twentieth-century America than elsewhere. There have been several reactions. One has been to regard variations as the result of methodological impurities, to be overcome by treating the different variables as

> indicators of a single underlying stratification position....The effort to salvage a unicausal model has tended to be supplanted by a second approach, roughly describable as pluralistic. (Collins, 1975, p. 50)

Collins produced a conflict theory of stratification "linking structural and interactional levels of analysis [casting] all structural variables in terms of actual differences in the experience of face-to-face encounters" (p. 45). In this way, he attempted to bring stratification theory in line with actual human experience. He proposed that conversation would provide the basis for a detailed description of the mechanisms of an explanatory theory of stratification. His approach to study would be that of ethology and phenomenology. This subjected his particular stratification theory to the same criticisms as those applied to ethological theories previously. The position that: "Humans beings are animals and human social ties are fundamentally based on automatically aroused emotional responses" (p. 155) was questioned by research into human response and behavior. Furthermore Collin's theory of sex stratification represented the weakness reflected by many in employing stratification to understand men and women and the violence that occurred between them. He had three basic propositions:

1. All human beings have strong drives for sexual gratifications...
2. Human beings all have the capacity for aggressive arousal, particularly in response to being coerced...

> 3. Males on the average are bigger and stronger than females, in the human species.... (p. 229-230)

Therefore, "men will generally be the sexual aggressors and women will be sexual prizes for men" (p. 230).

> Without this sexual complimentary on the genital level, it is hard to see why the whole apparatus of specifically sexual property and its surrounding ideals should have come about, why the family should have a structure independently of a sexual class domination. (p. 232)

Collins apparently missed the many alternative answers to his questions in contemporary writing on the subject by writers such as Mitchell (1973), Rowbotham (1973), and Reid (1971).

Furthermore, his three propositions were questioned as illustrated by previous points in this paper; for example, the role of social learning in providing differential contingencies for handling arousal; and the inconsistency between cultures in the domination by size theory.

Stratification theory, as proposed by Marx, Weber, and Engels in particular, was criticized by feminists for weaknesses in analyzing the positions of women in society. Firestone (1978) believed that an analysis of the means of production did not touch that level of reality in women's lives not stemming directly from economics. This was so even if reproduction was included in the analysis. It was stated that analyzing and changing the properties of a class society would not change the situation of women. The

weakness of such propositions was in considering relationships between the sexes in the same way as relationships between classes (Saffioti, 1978; O'Brien, 1979).

Acker (1973) pointed out problems of stratification theory that were recognized from disparate political vantage points. These involved assumptions about the social position of women: first that the family was the unit of stratification; and second, that males headed households and represented all member's status.

She recommended that a woman's own occupation (including that of homemaker) should be taken into account regardless of her marital status.

On this point, Delphy (1981) said:

> What these writers have done is to draw attention to inconsistencies in the criteria used in the classification of women, and in particular, to the use of a double standard: taking paid work into account for single but not for married women. But they have not examined what this inconsistency itself reveals. It is based on a double standard used in determining social class membership. Occupation, the universal measure of an individual's social class, is in the case of women and women alone, replaced by a completely heterogeneous criterion: marriage. (p. 116)

She went on to show how studies purporting to study the social class relationships between husband and wife have actually been studying those between husband and father-in-law.

When a woman is assumed to be of the same class as her husband because she does not have an occupation outside of

the home an essential variable is obscured - economic independence. Women with an outside occupation may be ranked distantly from their husbands while women without an outside occupation end up being closer to him. Delphy concluded that to be without an occupation was to be without "a place of one's own in the class structure" (p. 125). Women without an occupation outside the home were neither participants in the classically defined economics, a part of the "labor force" nor were they integrated into the theoretical modes of production. Their relationship to production was "the complementary part of a relationship constituting a specific mode of production, different from and parallel to the wage labour mode" (p. 126) and called patriarchal. Sociology relegated a woman to a class based on her dependence on her husband and then designated the relationship as one of class parity. By obscuring this variable sociology devised the "specific antagonistic relations of production between husband and wife" (p. 127) as well as the fact that these relations preceeded chronologically and logically the relations of industrial class. Therefore, the patriarchal class system overrides the industrial one (Delphy, 1981).

1.9 A Note on Sex Differences in Aggression

A complete understanding of violence against women cannot be reached without looking at the possibility that there are gender related factors in aggression. O'Leary (1977) stated:

> Perhaps the most consistent evidence for behavioral differences between the sexes has been obtained in studies of aggression. Whether aggression is defined as committing violent crimes, administering shocks, imitating a model hitting a doll, or playing rough and tumble in nursery school, males appear to be the more aggressive sex. (p. 61)

Edmunds and Kendrick (1980) and Buss (1971) also supported the existence of these differences. No explanation of the origin of these sex differences had conclusive support; furthermore, there was no consistent support of the idea that females were more passive or compliant than males (O'Leary, 1977). In the area of crime, however, crimes involving "elements of coercion and confrontation with the victim" were typically carried out by males. This changed little between 1934 and 1979 despite projections that women's gains in equality would see them masculinize their crime (Steffensmeier & Cobb, 1981).

Many writers claimed that male dominance in society was determined by men's innate aggressiveness. Others argued that, even if this dominance was not automatically the result of greater physical strength, it should exist because of this greater physical strength. Often such arguments, unsupported by evidence, were tautological or simply circular (Sayers, 1982).

We know too little about sex differences in aggresion and violence. Some researchers, for example Buss (1971) were so sure that aggression was a masculine trait that they omitted women from studies on the topic. Others too easily moved to equate men and women's behavior (see the discussion

on husband battering). This subject must be a part of studies on aggression if we are to understand and influence human behavior (Hyde & Rosenberg, 1980; Williams, 1977).

In summary, few studies have attempted to explain the behavior of wife batterers. Seven groups of theories from a variety of disciplines were identified which address aggressive behavior generally. None of these account for all aggression or make such behavior predictable. Each is subject to a number of criticisms not limited to those arising from feminist theory and analysis. One outstanding gab in knowledge of aggression is the paucity of knowledge on sex differences.

Chapter 2

Causes of Wife Battering

Explanations of the causes of wife battering drew on the six theories of aggression discussed above. A review of the positions taken by various authors on the subject of etiology showed that there was no consensus. Some authors borrowed from more than one theory to accommodate their beliefs about violence in the context of conjugal relationships. The most popular traditional theories for explaining this violence were the Psychodynamic and Social Learning theories; feminists, however, have developed an alternate stratification theory.

2.1 Biological Theories

The most commonly adopted Biological Theory was the Psychoanalytic variety. Rader concluded that man's impulse toward aggression was reinforced by social activities (such as war) and was directed at women because women had dominated, and therefore emasculated, the men in their childhoods (cited in Pogrebin, 1974). A later writer concluded that innate violent impulses were usually controlled by psychological barriers but that men could be desensitized to these barriers by such things as media

violence (Nias, 1979). Media violence as a mediator of behavior was supported by other writers (Medlicott, 1980; Donnerstein, 1980).

Neuberger (1982) assumed that humans had a predisposition to impute malevolent intent to our intimates. This was more likely to occur in families, he said, due to the undefined nature of rules governing behavior in that context. Kuchel and Kuhle (1981), on the other hand, stated that the impact of light, food, and color on the body and subsequently on behavior should be emphasized. "Generic man", they said "is a biological creature first" (p.1). Eysenck (1979) also believed violent behavior to be biologically rooted and subject to partial control by "Pavlovian" conditioning of a social conscience. The latter point appeared to be closely related to Social Learning Theories.

2.2 Drive Theories

Drive Theories were seldom presented in the wife abuse literature. In most cases stress and frustration were seen as triggers that activated psychological disorders which produced aggression; that is, they were part of a Psychodynamic Theory. These theories will be reviewed later. In two cases, however, stress and frustration were said to cause the eruption of violent behavior at home. The stress and frustration were seen to result from social structures that frustrated the development and progress of certain

people, particularly the "lower classes". (Gel cited in Miller & Miller, 1980; Petersen, 1980). Petersen (1980) also stated that personal stress could produce violence.

These positions resembled a Drive Theory in that they proposed a build up of frustration that could erupt as aggression and therefore be released. They did not, however, explicitly describe the existence of an innate aggressive drive in humans. In Petersen's (1980) case, he stated that violence was a learned behavior. This was closer to a Social Learning Theory.

At first reading one might have been tempted to place theories which addressed structural policies and practices such as discriminations, unemployment, poverty, etc. into the category of Stratification; however, neither author addressed these as stratification theorists would. Stratification theorists would see these as motivations for choosing conflict or aggression in order to change the situation or to maintain a certain status quo. In these cases, aggression was believed to relieve an emotional state.

2.3 Personality Trait Theories

The pursuit of particular personality and behavioral characteristics to identify batterers was popular in the literature. Bowden (1978) supported the Theory of Social Learning of violence but also quoted a study which identified three types of wife assaulters: the dependent-

passive, the dependent suspicious, and the type who were domineering bullies. Another author identified character deficits produced by inadequate mothering as the basis of violence (Blumberg, 1980). Similarly, Yelsma (1981) predicted measurable internal behavior or value orientations that would be antecedents to aggression. Stewart and deBlois (1981) identified four antisocial traits in batterers: aggressiveness, egocentricity, nonconformity, and irresponsibility.

2.4 Psychodynamic Theories

Psychodynamic Theories were common in the literature of both psychology and social work. Two authors saw origin of family violence in a psychological state produced by deprivation of physical pleasure (Prescott, 1975; Greenland, 1980). Two authors looked at specific dysfunctions: self-righteous rage (Horowitz, 1981) and minimal brain dysfunction (Elliot, 1982). Gillman (1980) concluded that the man's difficulty originated in his preoedipal relations with his mother.

Coleman (1980) concluded that batterers had intense feelings of dependency and inadequacy which they masked. A later writer, however, concluded that violence could result from a fear of independence or a fear of dependence; a lack of self control or excessive control; an inadequate ego structure; lact of trust; and underlying depression (Cantoni, 1981).

Weitzman and Dreen (1982) supported the concept of individual dysfunction as did Pizzey and Shapiro (1982). The latter concluded that children raised in a violent home bonded to pain and this bond became an addiction with a physiological component. This bond prevented the development of an independent self.

2.4.1 Alcohol Abuse

Alcohol abuse and alcoholism are commonly associated with wife abuse. It was generally accepted by researchers that the relationship between alcohol and violence was not causal (Fleming, 1979; MacLeod, 1980; Marjot, 1982; Moore, 1979; Spieker, 1980). Among many professionals and in the general public, however, the impression that alcohol causes violence continues to exist (Fleming 1981). The Research Group on Abused Women (1980) found that most police officers and some social workers mentioned alcohol as the cause of wife assault in Quebec. In another study 71% of the community resource people believed alcohol was generally involved in wife abuse (Anderson et al., 1975).

A study of actual police files in a Canadian city showed that 58% of the cases of "family disturbance" (where 92% of the complainants were women) did not involve alcohol use at all (MacEachern, Adler, Roland, 1980). Police records in two Scottish cities indicated a similar finding, only 30% of the men were described as intoxicated (Dobash & Dobash, 1979).

People who used agencies other than the police reported a much higher frequency of alcohol involvement in wife abuse. A family counselling project found that alcohol was "present" in one or both spouses at the time of the violence in 88% of their cases (Support Services for Assaulted Women, 1982). Hilberman (1980) found that drinking accompanied violence in 93% of her sample and in another study of health and social agencies the women reported that there had been drinking by one of both spouses prior to the assault in 82% of the cases (Anderson et al., 1975). These figures would justify the impression of social sevice workers that alcohol is usually involved; however, as Gelles (1972) pointed out, family members invoke alcohol as a causal factor in order to disavow the deviance of the violence to professionals.

A comparison of frequency of drinking of couples where there was violence and those where there was no violence found that self-reports of frequent drinking were more common in the violent couples; however, 63.3% of these did report no, infrequent, or occassional drinking. All couples were attending a marriage and family clinic (Coleman, Weinman, Hsi, 1980).

Reports from women admitted to shelters on spouses who were regularly drunk or drunk prior to assaults gave percentages more similar to those found in police records than the agency studies mentioned. MacLeod (1980) found that 50% of the men were reported to have been drinking prior to the disputes. One study stated that violence was regularly

associated with alcohol in 44% of cases (Gayford, 1975) and another that the men were regularly drunk in only 25% of the cases (Dobash & Dobash, 1979).

2.4.2 Alcohol Use by Batterers and Battered Women

Use of alcohol by the abusers was described similarly in studies: under 50% heavy drinkers (Pahl, 1979), 58% heavy drinkers (Speiker, 1980), 52% frequently drunk (Gayford, 1975) 29% moderate drinkers (Speiker, 1980; MacEachern et al., 1980) 59% abused alcohol (Fitch & Papantonio, 1983). In an inpatient alcoholic rehabilitation program, 69% of the men had abused their spouse (Powers, Schlesinger, Benson, 1983).

The reports on the drinking of the abused women varied but usually showed low numbers. Eberle (1980) cited a study showing a .24 correlation between the drinking of the battered women and their spouses and suggested that 4% of battered women had problems with drinking. Another study she cited said that only 8% of battered women used alcohol. This would imply a very high rate of problem drinking among battered women who do drink. A study of police records reported that 22% of the women in family disputes had been drinking (Byles, 1980) while 15% of battered women seen by one group of health and social service agencies had been drinking prior to the violence (Anderson et al., 1975). MacLeod (1980) stated that 20% of the women in her sample were drinking prior to the dispute. The highest percentage

of women described as "under the influence" were 52% of those admitted to hospital after the assault (Brisman & Tuner, 1982).

2.4.3 The Roles of Alcohol

These is no specific aggressive drive or instinct involved with alcohol (Marjot, 1982). Alcohol's effect may be determined by the social situation (Marjot, 1982; Fleming, 1981). As Marjot (1980) said:

> It seems to me that people use alcohol for one or more of a wide variety of effects. They have to 'learn' to obtain such an effect. The lore and tradition of the drinking society is passed on by precept and example - through family, friends, peer groups and workmates among others. (p.289)

Gelles (1972) agreed that "drunken deportment" was learned along with a complex of verbalizations explaining it.

Some authors speculated that women got beaten by men who had been out drinking with other men partially because of the support and encouragement men in such gatherings gave each other for their role as boss (Epstein, Ng, Trebble, 1978). Arguments over the man's drinking behavior and subsequent attacks on the wife often follow drinking bouts. Often these arguments are over the expenditure of money needed for housekeeping (Coleman et al., 1980; Dobash & Dobash, 1979; Gelles, 1972; Speiker, 1980). Elbow (1977) suggested that some men spend money on alcohol and

entertainment as a means of asserting their control.[4]

Alcohol is used for a number of effects: getting high, making socializing easier, passing time, getting energy, reliefing pain, sedation, relieving emotional distress, gaining courage to express feelings, or forgetting (Marjot, 1982). Some authors focused on the gaining of courage or loss of inhibitions as the effect for abusers (Epstein et al., 1978; Elbow, 1977). Others believed that the forgetting or tuning-out was the desired or claimed effect which provided a socially acceptable excuse or denial for the deviant behavior - battering (Elbow, 1977; Fleming, 1981; Gelles, 1972; Richardson & Campbell, 1980; Speiker, 1980). Alcohol is then a convenient alibi. Sociopaths are particularly apt to invoke this particular alibi (Forrest, 1983).

A popular theory is that alcohol disinhibits one's control of their behavior through a depressant effect on the brain. Adesso (1980) challenged this idea and concluded that drunken behavior was dependent on what one had learned to expect from drinking. The socially acceptable limits of drunken behavior are learned. "Thus drinking sets the occassion for a change in behavior" (p.141). After reviewing the research on alcohol and aggression, Adesso (1980) concluded:

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[4] This perception is shared by many of the women from Transition House who report that their spouses tell them during arguments over drinking that they'll spend their money as they want to.

> First, it is not simply the pharmacological effects of alcohol that induced aggression, at least at the moderate doses used in these studies. A combination of expectancies, situational factors, and individual differences contributes to the appearance of aggression after drinking. Second, the disinhibition and elicitation theories of alcohol's effects on behavior both seem inadequate to explain the results of the behavioral studies. (p. 143)

Often both the men and their wives disavowed the abuse and focused on drinking as the problem. The idea that drunk men don't know what they're doing is very pervasive in our society (Epstein et al., 1978) and provides an opportunity to explain the violence by something apart from the couple's relationship (Dobash & Dobash, 1979; Gelles, 1972).

Men who abuse alcohol do not always exhibit similar or consistent violent behavior (Spelker, 1980) and, of course, not all "drunks" are violent in the first place (Gelles, 1972; Powers et al., 1983). Men in an alcoholism rehabilitation program reported that they were drinking in over half of the episodes of slapping and pushing and just under half of incidents where there was hitting with fists or feet (Powers et al., 1983). Some abusers attending a family counselling project were able to stop their violence even though their drinking continued (Support Services for Assaulted Women, 1982).

Some authors pointed out that excessive use of alcohol increased the probability of violence (Anderson et al., 1975; Forrest, 1983). Many women in shelters have expressed the same belief. They are terrified when their spouse has been drinking or has gone out to drink and express a belief

in the increased likelihood of violence. Forrest (1983) concluded that "Sadomasochism[5] is a clinically significant factor in the development and maintenance of the addiction process" (p. 181). He described the "grossly inappropriate" behavior of alcoholics as "acting out" behavior and distinguished it from the behavior of sociopaths. Differential diagnosis of alcoholism and sociopathology is difficult but alcoholics are more likely to benefit from psychotherapy than sociopaths.

Zimberg (1982) called attention to the possibility that "Individuals who are violent when intoxicated may be experiencing a reaction to other drugs along with alcohol, may have coexisting functional or organic psychosis, or may have a neurological disorder that has been called episodic dyscontrol" (p. 59).

Prolonged alcohol abuse can result in brain damage. Acute brain damage, manifested by hallucinations and delirium tremors is reversible; alcoholic chronic brain syndrome (dementia) may cause sudden outbursts of anger and paranoid delusions and is usually not reversible.

> The onset of symptoms is usually gradual and insidious. The earliest symptoms may include fatigue, listlessness, loss of interest, depression, and sometimes anxiety or agitation. Personality changes such as irritability, social withdrawal,

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[5] "In this chapter, the process of chronically and pathologically inflicting emotional and physical pain upon self and significant others is defined as "sadomasochism" (Forrest, 1983, p. 181).

> inconsiderateness, petulance, or moral laxity may be noted. These symptoms may be present for months or years before any clear-cut confusion, disorientation, or recent memory defect...is noticeable to others. (Smith, 1977, p.146)

Eberle (1982) concluded from her study that women who use alcohol are more likely to be battered by men who abuse it. (Abuse means repeated excessive use.) These men were older than men who did not use alcohol. There was some indication that the most severe injury was inflicted by alcohol abusers. This is partially support by a study that reported 52% of the women admitted to hospital after abuse were alcohol users (Brismar & Tuner, 1982). The men in the alcoholism rehabilitation program reported alcohol associated with all of the incidents of "more severe violence", i.e. hitting with blunt objects, sexual abuse, or use of weapons (Powers et al., 1983). Powers et al. (1983) noted that the low rate of reported severe violence may have been due to a resistance to acknowledging such acts. The association of 100% of cases with alcohol could also be accounted for by the excuse, disavowal belief.

One study investigated the way that alcohol involvement affected the attribution of blame by observers to abuser and/or victim and/or situational factors. It was found that when a man was drunk he received less blame and situational factors received more blame than when he was sober. When the woman/victim was drunk she also received more blame than if sober and amount of blame ascribed to the man decreased while situational factors remained constant (Richardson &

Campbell, 1980). A similar process is instituted when women are blamed for "inadvertently" contributing to their abuse (Coleman et al.,1980) or said to "provoke their husbands" (Speiker, 1980) with arguments or nagging about drinking. Many women make the same attributions and accept that they provoked the abuse (Dobash & Dobash, 1979). The implication is that if a woman remained silent she would not be abused and that she is behaving irrationally to defend her rights or to verbalize her feelings or concerns. One author asserted that women could be "unconsciously" responsible for their own death by "unconsciously" exhibiting behavior threatening to thier husbands. (Mushanga, 1983).

2.5 Social Learning Theories

Social Learning Theories were very popular in the literature on wife abuse. In particular, the intergenerational transmission of violence was widely accepted, that is, the learning of violence in the family of origin. Carroll (1979) produced some support for this theory but noted that there was little solid research support up to that point. Several other authors expressed support for this theory (DeLorto, 1980; Fagan, Stewart, Hansen, 1983; Pizzey 1974; Ulbrich & Huber, 1981). In Pizzey's (1974) words, "violent men are bred by violent men" (p. 74).

Some writers supported the Social Learning Theory in conjunction with other theories (Bowden, 1978; Eysenck, 1977; Petersen, 1980). Medlicott (1980) asserted that

violence resulted from attempts by males to establish masculinity and that boys required a stable father figure to respect.

The Social Learning Theory was also used to account for subcultures of violence or to predict differences in prevalence between, for instance, classes (Gelles, 1974; Petersen, 1980).

Media violence was seen as both a teaching mechanism and a maintainer of violent responses (Medlicott, 1980; Donnerstein, 1980).

2.6 Interactionism

The interaction of individual internal factors and situational factors was not frequently adopted as a theory of wife abuse in the literature. Brandon's (1977) was the earliest paper to specify individual predispositions (eg. constitutional makeup, current affectional bonds, role certainty) that interacted with situational factors (eg. current state of health, opportunity, family and other supports or restraints) to cause wife abuse.

Interactionism can produce different explanations based on the selection of relevant individual and situational factors. Whereas Brandon (1977) considered alcohol and drugs to be situational "disinhibiting" factors to aggression. Ponzetti, Cate, and Koval (1979) considered alcohol or drug dependence to be one internal factor that interacted with external factors to produce aggression.

Other supporters of interactionism included Barnhill (1980) and Bern (1982).

2.7 Stratification or Conflict Theories

These theories were not common in the literature but were supported by some of the best known writers in the field, for example, Steinmetz and Straus (1974)and Straus and Hotaling (1980).

Steinmetz and Straus (1974) wrote that conflict and violence between people are natural and necessary for individual growth and social development. Willingness and ability to use physical violence may be resources which could be used to maintain or advance one's position in a system like the family. To explain the apparent antagonism between the sexes, the authors posited a psychodynamic theory of identity conflict in boys originating in and also perpetuating the isolation of women and young children.

MacLeod (1980) also stated that violence was an integral part of family interactions and of society. Some violence against wives was condoned and enforced a particular form of the family. Straus and Hotaling (1980) referred to "the sexist organization of society and the family system" as primary in causing wife-beating and Straus (1980) went on to explain that husbands maintain their traditional authority with violence and that "The cultural norms and values permitting and sometimes encouraging husband-to-wife violence reflect the hierarchical and

male-dominant society typical of the Western world" (p. 87). He also noted that rape was similarly an act of power and degradation. Petersen (1979) referred to rape as "social coercion".

Saville, Wilkinson, O'Donnell and Colley (1981) also supported a conflict theory based on class and sexual inequality.

Gelles and Straus (1979) identified twelve different theories developed between 1971 and 1979 to account for intrafamily violence. In addition they explored 3 conceptual frameworks which they thought would be useful in theoretical development. These theories and conceptual frameworks were primary drive, psychodynamic, social learning and conflict theories.

Gelles and Straus classified the 15 theories as follows:

Intraindividual Theories:

1. Psychopathology
2. Alcohol and drugs

Social Psychological Theories:

1. Frustration-aggression
2. Social learning
3. Self-attitude
4. "Clockwork Orange"
5. Symbolic interaction

6. Exchange theory
7. Attribution theory

Sociocultural Theories:

1. Functional
2. Culture of violence
3. Structural
4. General systems
5. Conflict
6. Resource. (pp. 560-61)

The authors then proceeded to draw out the "most distinctive" contributions of each theory which complemented each other and to produce a complex diagram representing an "Integrated Theory of Family Violence". The two explanatory principles identified as common to 13 of the theories ("Clockwork-Orange" and General System were excluded from the integration) were:

1. the set of relationships and processes embodied in the social learning and symbolic interaction theories
2. a causal relation between frustration or stress and aggression...

> Implicit in figure 212 [the integration of the 13 theories] is the idea that cultural norms and values arise out of the enduring patterns of social interaction and in the long run tend to remain as part of the culture only if these cultural elements continue to reflect the actual interactional structure of the society. (pp.570-571)

The authors noted that many variables were omitted from

their chart because it would have been unreadable. In addition they did not diagram negative or positive feedback, causal relationships, or "cybernetic" process and predicted that such a diagram would be useless in its complexity. They stated, "In our opinion, the only adequate unified representation of such a general systems theory integration of these partial theories is likely to be in the form of a computer simulation" (p. 575).

As noted in the review of theories on aggression and violence a causal relationship between frustration or stress and aggression cannot be assumed; furthermore, the relationships of the processes of social learning and behavior are not fully understood. Clearly, we are not close to having a workable integrated theory.

2.7.1 the Role of Social Class

Nine published studies of original data were identified which took positions on whether battering was associated with socioeconomic status. (Whitehurst 1971; O'Brien, 1971; Gelles, 1972; Carlson, 1977; Walker, 1979; Dobash & Dobash, 1979; MacLeod, 1980; Petersen, 1980; Fagan et al., 1983). Only one of these used a random sample which consisted of women in one state who were or had been married to or cohabiting with a man. The author gave his bias at the beginning: "that middle-class norms reject violent behavior and not just the admission of such behavior" (Petersen, 1980 p. 394). This assumption was disputed by many (Fleming,

1979; Stark & McEvoy, 1970) and remains part of the unresolved debate over class differences. Petersen also decided to measure class through the husband because "it is primarily his that determines the family's social class and because it is the man who inflicts the abuse" (p. 395). This is at best a tautologic explantion of this choice of method. One of the major weaknesses of this paper, however, was the fact that 40% of his sample did not or could not provide information on the husband's income, and another 5% are unaccounted for in the data on income. Furthermore, no level of significance was calculated on the data. Despite these limitations the author concluded: "The data indicate that wife abuse is very concentrated in certain segments of society and is not distributed fairly evenly across all strata of society, as feminist explanation predicts" (p. 401). On closer examination of his data, this conclusion was not clearly indicated; for instance, while 44% of abused women's husbands earned less than $10,000 another 41% earned from $10,000 to $20,000 and 15% earned over $20,000. While 33% of abused women's husband's had less than Grade 11, another 44% were high school graduates and 13% had some college education.

The most well known study concluding that "violence is more likely to occur in families located on the lower rungs of the social ladder" was done by Gelles (1972, p. 188). The interviews were done with a sample of 20 agency referred cases, 20 police blotter cases (from another city) and a

neighbour of each family. Sixty-six wives and 14 husbands were interviewed about themselves and their spouses. Again, the data were not conclusive; for intance, husbands with the lowest education were more likely to abuse their wives but violence was more frequent when the husband had a least high school. Husbands with medium occupational status were more likely to abuse their wives than husbands of low or high status jobs (Gelles, 1972). This study had been criticized on a number of points (Dobash & Dobash, 1979; Wardell, Gillespie, Leffler, 1983) but the greatest restriction was provided by the author.

> Because of the nature of the sample, great care must be taken in inferring that the incidence data reported on violence are applicable to any population other than the 80 individuals interviewed. (Gelles, 1972, p.191)

This study was subsequently cited as evidence that abuse occurs in all classes (Moores, 1979).

O'Brien's (1971) study of families who had been involved in a divorce action also concluded that abuse was more likely when "the husband was not achieving well in the work/earner role and where the husband demonstrated certain status characteristics lower than those of his wife "(p.697). We found that the husband's status was compared to that of his wife on education and on the wife's father's occupational status. The family's social status was measured by the husband's job, source of income and education. The author accepted that there was a greater incidence of

violence among the poor and offered the explanation that this might have been due to a greater incidence of husband's underachieving in their role. He suggested that public policy to bolster the "achievement ability" of husbands would reduce family violence and provided no counter to the anticipated charge of discrimination by feminists (O'Brien, 1971). This author failed to explain the violence of the 56% of husbands who were not seriously dissatisfied with their jobs and the 44% who were not less educated than their wives. We can, in fact, interpret his data to say that violence is common in middle and upper class couples who seek divorce. This is supported by Whitehurst, Booth and Hanif (1983) who studied recently separated or divorced couples in Ontario.

Another study of court cases involving husband to wife violence classed the participants as "working-class" but did not provide the criteria for doing so. The author did not conclude from this non-random sample that violence was a lower class phenomenon; instead, he suggested that middle-class people have ways of avoiding the courtroom (supported by Snell et al., 1964) and that middle-class violence goes "unseen" as a means of maintaining the image that "deviance" belongs to the lower classes (Whitehurst, 1971). There were a number of indications that battering is not a lower class phenomenon. Statistics Canada reported that domestic homocide occurred in above average proportions in white collar occupational categories and a family service

used mainly by middle-class clients found that nearly 20% of their clients were assaulted wives (cited in MacLeod, 1980). Walker (1979), whose sample was drawn from a private psychotherapy practice concluded that "Most battered women are from middle-class and higher-income homes" (pp.18-19).

Four studies of battered women's services found their clients to be predominantly lower class. Three used husbands' and wives' employment status, education and income as indicators of class (Carlson, 1977; Dobash & Dobash 1979; MacLeod, 1980) and one, a description of the batterers, discussed these men's education and employment status only (Fagan et al., 1983). All of these studies, however, maintained that battering occurred at all socioeconomic levels. They recognized the nongeneralizable nature of their data and the evidence which contradicted a socioeconomic explanation of causation: for example, batterers with higher educational achievement inflicted more severe injuries (Fagan et al., 1983), battered women came from homes where financial resources were not a problem (Carlson, 1977), middle-class women often phone but don't stay in shelters (MacLeod, 1980).

One other presentation of original data was a study of the prevalence of violent behavior in general in the U.S. In a random sample, these authors found that the middle class were likely to engage in physical violence just as often as other classes. One fifth of the population approved of slapping one's spouse and this approval increased with

income and education (Stark & McEvoy, 1970). A more recent study found a similar percentage in agreement with slapping one's spouse but found no relationship between this attitude and socioeconomic variables (Greenblat, 1983).

The debate over prevalence and socioeconomic status is not over. Authors of reviews of information and other papers continue to present conflicting opinions. Consider the following quotations:

> The characteristics of relative deprivation are important, since a poor environment and unemployment appear to contribute to family violence.... (Bowden, 1978, p.14)

> For battering is a societal crime, cutting across all classes, regions, ethnic groups, races and religions. (Fleming, 1979, p.375)

> Batterers represent all ages, all educational levels, all religions, all socioeconomic classes, and all regions of the country and city. (Moore, 1979, p.15)

> Wife beating, which formerly was associated primarily with certain ethnic or lower socio-economic groups, has increased dramatically. (Lesse, 1979, p.190)

> Wife beating occurs all over the U.S., in all socioeconomic classes. (Miller & Miller, 1980, p.27)

and in the same paper

> Policies in our society which result in poverty, discrimination, unemployment and illness serve to stunt the development of some people, causing stresses and frustrations that can erupt as domestic violence, he [Dr. Gil] asserts. (Miller & Miller, 1980, p.28)

> Some of the available research, for example, shows that the type of family situation in which one kind of abuse occurs is also the type of family situation in which other abuse occurs: For example, all forms of abuse appear to be higher in the lower socioeconomic strata. (Finkelhor, 1983, p.21)

2.7.2 Problems Associated with the Issue of Class

It was argued that women of lower socioeconomic status are more liable to intervention and documentation by public agencies, while middle and upper class families are better able to preserve their privacy (Freeman, 1980; Hilberman, 1980; Jackson & Rushton, 1982; Martin, 1976; Walter, 1979). Lower class women often cannot turn to their equally impoverished extended family (Fleming, 1979). Middle and upper class victims (Gayford, 1978; MacLeod, 1980; Speiker, 1980) and even public agencies (Snell et al., 1964; Hutchins & Baxter, 1980) are more likely to redefine the abuse so that it is kept private. The appearance of greater help seeking in lower classes could be a distortion created, in part, by these factors and by the fact that the records of private agencies, which middle and upper class families might use, rarely contain detailed statistics (Martin 1976; Moore, 1979). Where such statistics were available, distribution by class was almost equal (Rounsaville, Lifton, Belber, 1979) or was biased towards the upper classes (Walker, 1979).

A distortion of perception of distribution might also arise because victims themselves repeatedly underestimate the prevalence of this problem and associated it exclusively

with the lower classes (Rounsaville, 1978; MacLeod, 1980). In addition, middle class women often fear that, because of their husband's position in the community, they will not be believed if they tell their story, will not be able to get help, or may face immediate publicity and public humiliation. They may also risk their husband's career and, subsequently, their own social standing (Walker, 1979). In smaller communities, like St. John's, it would be very close to a breach of confidentiality for a shelter to release the fact that they had admitted or talked to wives of men in certain occupations with limited membership; therefore, such evidence of class distribution would have to be repressed.

One of the theories positing a greater prevalence of violence in the lower classes (the social structural approach) proposed that violence was a response to stress and frustration or to threats to one's identity. It went further to say that families of lower socioeconomic status were more likely to encounter stress and have stressful family relations (Gelles, 1972; Bowden, 1978). This is connected with two other theories, cycle of deprivation and intergenerational transmission: violence as a response is learned and children in different social positions will be exposed to more violence in a variety of situations (Gelles, 1972). Posing one set of social problems as precursors of another set has been called "social genetics" (Stark & Flitcraft, 1983).

There were a number of problem with these theories

identified in the literature , the foremost being evidence that frustration levels do not correspond to levels of aggression and frustration fails to enhance or lead to aggression (Zillman, 1979; Roberts et al., 1981). In addition, a person's values and ideology will help determine what becomes a source of stress (Marecek, 1978). We cannot assume consistency of values among and within classes. Also, as Martin (1976) pointed out a good education does not guarantee a stress free job nor does money shield one from stressful events in life. Finally, this theory did not account for sex differences in use of violence unless one accepted without evidence that women experienced significantly fewer stresses, frustrations, and threats to their identity than men.

The intergenerational transmission of violence was posed as an explanation for the behavior of both batterers and their wives: put simply men learn violence as a response, women learn the victim role (Fagan, Steward, Hansen, 1983; Straus, 1980; Star, Clark, Gaetz, O'Malia, 1979). The difference in sex role learning is never fully explained. Why, for instance, don't women "learn" to use physical violence, as an "ultimate" resource more often? [Fagan, Steward, and Hansen (1983) attempted to explain this in a footnote by defining "patriarchy" as a "structural dimension of the social learning environment" (p.66).]

The findings on exposure to violence in childhood varied. Often researchers interpreted inconclusive data as

supporting the intergenerational theory: in one 8 men and 29 women had witnessed assault between parents but 7 men and 18 women had not, more women than men (the abusers) had been abused as children (Anderson et al., 1975); in another, 23% of assaulted women and 51% of their husbands had been exposed to models of violence in their childhood (Gayford, 1975a); another study of abusers found that 57% had been exposed to some form of violence as children (Fagan et al., 1983). Other studies interpreted similar statistics as counter to the intergenerational theory: in one 48% of the women said there had been violence in their or their husband's parental home but another 20% said there had been none (30% give no answer and 2% felt there had been violence in their husband's home but he had always denied it) (Women's Research Centre and Vancouver Transition House, 1980); and in another, 41% of the men and 71% of the women had had no experience of violence in their parental home (Dobash & Dobash, 1979).

Childhood experience is only one way that children are taught to accept wife battering (MacLeod, 1980) and the lesson is not always fully accepted; many who were exposed to domestic violence during childhood expressed dismay and shock when it happened to them (Dobash & Dobash, 1979; Women's Research Centre and Vancouver Transition House, 1980).

Another explanation supporting class differences in family violence was the resource theory. This defined

resources as those things that one spouse can use to attain their goals. In the absence of "legitimate resources", a spouse may resort to "illegitimate resources" (ie. violence) to maintain his or her power in a relationship (Allen & Straus, 1980; Huaser 1982). Allen and Straus found low but consistent correlations supporting this theory but the correlations were stronger in the "working class families".[6] They explained this difference by postulating that lower class and middle class battering are different phenomena; the former was labelled "instrumental", a means to an end with less severe sanctions against it than for the middle classes who used "expressive" or "creative" violence, a means of catharsis (Allen & Straus, 1980). Hauser (1982) also tested the resource theory and failed to support it.

Walker (1979) reported on a study in England that found most wife beating to be by men with successful careers, affluence, prestige and power in the community. She considered the resource theory a myth. Similarly, a Canadian shelter found wife beaters disproportionately represented among police and doctors (cited in MacLeod, 1980) whose wives would hardly be expected to have more resources or power.

Related to the resource theory was the expressed belief that unemployment (in the man) contributed to wife battering

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6 These families were not defined but it was implied that husband's occupational status determined their class.

(Pogrebin, 1983; Finklehor, 1983; Martin, 1981). Again, there was conflicting evidence. Walker (1979)[7] found that the rate of violence appeared to rise with unemployment (1979) while Gelles (1972) found less violence in families where the husband was unemployed than in families where he was employed in a low or medium status occupation. An alternative to the explanation that the husband's loss of resources or his increased stress result in violence or more violence is that his opportunity for violence has simply increased. If he is at home he is spending more time in his wife's presence. He may also be doing more drinking, not necessarily out of frustration but perhaps as a popular pass time. In addition, the fact of unemployment, may make the family more subject to exposure to public agencies and the previously mentioned increased likelihood of documentation. Clients often must answer questions about their lives in areas that do not connect, for them, with the problem or need presented (Morris, Cooper, Byles, 1973).

One of the earliest papers on wife abuse addressed the issue of the public perception of class differences. A psychiatric clinic recognized that a disproportionate number of the men charged with assaulting their wives were being

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[7] Walker (1979) is one of the few to mention unemployment in both men and women. Her statement on unemployment can only be interpreted, however, due to a confusion in verb tenses: "There is no doubt that as unemployment <u>becomes</u> more chronic for both men and women, the rate of violence between them <u>appeared</u> to rise." (p. 132, italics added)

sent by the judges and probation officers for psychiatric assessment as compared to the number of men sent who had been charged with other offences. All of the wife assaulters were middle-class. The authors felt that this reflected "a general community feeling that 'There must be something wrong with a man who would beat his wife," especially when he has a good job, a nice home, children and an outwardly stable family' (Snell et al., 1964, p .107). The arguments pointing to poverty and culture as sources of wife battering revealed race and class biases, according to Fleming (1979), who found that racism, classism, sexism, and negative reactions to gay people ran deep in our culture.

A bias towards believing in the moral superiority of the middle class was reflected by Petersen (1980). A sexist bias was presented by another author who maintained that we are living in a matriarchal society where women have become "I" oriented and husbands "we" oriented and women are encroaching on traditional male prerogatives "without giving anything in return" (Lesse, 1979). There is much evidence pointing to quite an opposite conclusion about the relative statuses of men and women (Fitzgerald, Guberman, Wolfe, 1982).

The involvement of social science and the helping professions in the issue of wife battering is a recent phenomenon. This has resulted in a different interpretation of the problem(s) than offered by the political activists who initiated the concern (Morgan, 1981; Stark & Flitcraft,

1983; Wardell et al., 1983). By focusing on abuse as one of many social problems, rooted in individual actors or family constellations we take it out of the political context and call upon medicine, psychiatry, and social work to intervene and "treat" the deviants. By adopting the study of conflict in families from the perspective of deviance and/or failure to adapt, social scientists can maintain the paradigm of the conventional, middle class, successful family and develop intervention strategies for families who have failed to establish this ideal:

> By organizing the facts about domestic violence into a problem (the cycle of deprivation) whose solution seems to be in an expanded caretaking role for the welfare state, science helps conceal the contradictory nature of that state and, more immediately, the ways in which its patriarchal benevolence converges with client/female dependence. (Stark & Flitcraft, 1980, p. 345)

Public, political issues thereby become depoliticized into personal pathologies. It is not necessary, therefore, to look at structural roots or class interests in the problem or solutions (Morgan 1981). Domestic violence becomes "an apparently self-constituting form of irrationality" (Stark & Flitcraft, 1983, p.333) and social welfare legislation continues to treat its symptoms rather than broader societal issues (Morris et al., 1973).

Some maintained that this was an appropriately non-interventionist role for government. MacKinnon (1983) argued, however, that government maintenance of the ideology of privacy through jurisprudence and social policy does not

mean that it is absent from any area of social life. "Rather, this leaves the balance of forces where they are socially, so that governments' patterns of intervention mirror, and magnify, thus authorize, the existing social divisions of power" (p. 27).

2.7.3 The Theory of Patriarchal Society

This theory was developed by feminists who studied violence against women including rape and wife battering. A feminist theory on aggression and violence in general was not identified. Schecter (1982) gave a summary of the theory:

> Woman abuse is viewed here as an historical expression of male domination manifested within the family and currently reinforced by the institutions, economic arrangements, and sexist division of labor within capitalist society. Only by analyzing this total context of battering will women and men be able to devise a long-range plan to eliminate it. (p. 209)

It was this theory that was developed by Dobash and Dobash (1979) in their book Violence Against Wives: A Case Against the Patriarchy. These authors move from the experience of violence by wives in specific families to a general theory accounting for wife battering. Gelles (1980) acknowledged this as the most "macro-level approach" taken to understand wife battering. While some authors (Straus & Hotaling 1980; Straus, 1980; Saville, Wilkinson, O'Donnell, Colley, 1981) looked at sexism and inequality as factors in wife beating others looked at possible historical and social purposes

behind battering which belonged to a patriarchal society (Committee on Violence Against Women, 1982; Research Group on Abused Women, 1980; Freeman, 1980; MacLeod, 1980; see also Sayers, 1982).[8]

Straus (1976) listed nine ways in which a male-dominant structure of society created and maintained a high level of wife beating. These included: defense of male authority; stress on the masculine identity; economic and occupational discrimination against women; the sexual division of the labour of child care; the idea that children cannot be succesfully raised by one parent; establishment of the wife role as prominent for women; the negative image of women; continuance in law and culture of the concept of women as children; and the male orientation of the legal system.

2.7.4 Summary

While a great deal of theoretical work on wife battering and family violence in general has been done it is apparent that there were large differences between theorists and that no consensus had been reached. A larger problem with theories of causation was that there was little empirical evidence to support any one (Stahly, 1977-78; Saunders, 1977; Gelles, 1980; Schumm, Martin, Bollman,

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[8] This theory also informed the focus of the feminist "peace movement" (Leghorn, 1982; McAllister 1982; Roberts, 1982) and the movement against pornography (Barlow, 1984; Dworken, 1979).

Jurich, 1982). Even where associations between variables had been found, these were small (Gelles, 1980). It appeared that some variables gained in significance, not through empirical testing or observation, but through the "Woozle Effect". This happened when subsequent writers quoted an author's findings without the qualifications that author had attached to those findings. Such findings can be so widely cited as to become generalized "truths" (Gelles, 1980; Schumm, Martin, Bollman, Jurich, 1982).

Schumm, Martin, Bollman, Jurich (1982) decided to test the factors cited by Gelles (1980) as related to both child and spouse abuse: experience of violence in the family of origin; socioeconomic status; family stress accompanying the employment — status of the father; and social isolation. They surveyed a random sample of adolescents. Discriminant analysis of their data revealed that no variable was significant. The author's speculated that the variables were "marker" variables rather than causal.

The theory of causation that one adopts appears to be related to one's experience and personal perspective. Hickey and Douglas (1981), in studying elder abuse found a significant relationship between the occupational perspective and caseload characteristics of professionals and the notions of causality they adopted. Moore and Pepitone-Rockwell (1979) found that only women participants at a conference believed that male superiority in society affected battering. In a summation to another conference O'Brien (1979) made the following comments:

> One theme which I think must force itself on our minds as we listen to a discussion of violence is this, how far do we human beings who are subject to the emotions and pressures that produce violence know what we are doing when we think we are discussing violence? How far and in what level are we influenced by our own unconscious drives? (p. 132)

Schecter (1982) identified several areas that must be addressed in building theories about wife battering. For instance, little is known about the effect of economic and social changes in the past century or more; what significance battering in lesbian relationships brings to the discussion; or the effect of class and race factors. We found little evidence on the interconnections between class, gender, and race or dominant personality structures and how these evolve. These are only a few of the areas in which we need more understanding.

Chapter 3

Responses to Victimization

A victim was defined as someone whose life changed as the result of a particular negative event (Janoff-Bulman & Frieze, 1983). In the last decade researchers began to focus attention on the victim; however, most efforts were made to identify the victim's contribution to the violence (Bard, 1974; Symonds, 1975). Those studies which focused on victim response tended to look at female victims, psychological research in particular looked at victims of rape. Janoff-Bulman and Frieze (1983) speculated that this pattern reflected the view of victims as weak and helpless and prototypically female.

The victim of wife battering is distinguished from other victims because the violence occurs at the hands of someone with whom they are very intimate and because the victimization is usually repeated. These factors make their experience unique and this must be understood in order to understand their reactions and responses to the situation (Miller & Porter, 1983). An adequate explanation of victimization must also include an analysis of the economic, social, and physical bases for sex roles (Egger & Crancher, 1982).

3.1 The Context of Battered Women's Lives

3.1.1 Marriage and Love

In modern Western cultures marriage is highly valued and divorce is considered unfortunate and a social problem (Ferraro & Johnson, 1983; Valcourt, 1980; Straus, 1976). The terms marriage and husband will be taken here to include cases of cohabitation. Women are generally identified by their relationships with other people; a woman's husband is a prime source of her identity, whereas men are usually defined first by their occupation outside the home. Housewife may, in fact, be a woman's career (Riddington, 1977-78; Worell & Garret-Fulks, 1983). Nurturance and the care of others is fundamental to the female identity:

> More strongly expressed, a lack of ambition - or a professed lack of ambition, or a sacrificial willingness to set personal ambition aside - is virtuous proof of the nurturant feminine nature which, if absent, strikes at the guilty heart of femaleness itself. (Brownmiller, 1983, p. 221)

Women in general take more responsibility for the maintenance and continuation of the marital relationship. Its failure, while causing grief for both partners, is taken personally by women (Riddington, 1977-78; Dobash & Dobash, 1979; Worrell & Garret-Fulks, 1983). One clinician stated her expectations of the wife explicitly: "if she wants the marriage to continue she is the one who must make the greatest effort". The battered woman should pamper her husband, avoid asking his help to discipline the children,

and not show that she favors the children over him (Shaines, 1977; p. 118).

Girls learn that their primary objective is to marry; boys learn to achieve independence and a career. by adolescence girls have difficulty imagining themselves in any other role (Dobash & Dobash, 1979; Hyde & Rosenberg, 1980). Battered women have stated that wife and mother are the only acceptable role for women (Gelles, 1978). Women, in fact, rarely deny this but accept a two-career role - homemaker and career outside the home (Deckard, 1975). They find themselves unprepared and feel incompetent for the "single" role when widowed or divorced (Worrell & Garret-Fulks, 1983).

Dobash and Dobash (1979) saw a pattern in the descriptions battered wives gave of the history of their relationship with their husband. During the courtship stage each person led a separate life and the couple spent time together. As their commitment to each other increased the women tended to limit their social contacts to those that could leave no doubt in their boyfriends' minds that they were not seeing other males. The men made no such adaptation. As the couple got closer to marriage the men increased their efforts to establish control over the womens' activities and friends and to assert possession of them. This pattern became more pronounced after marriage.

> When a woman becomes a wife, she must give up most of her activities and aspirations and adjust her identity. She must schedule her work and

> pastimes around the work and leisure of other family members. She must fit herself into the nooks and crannies which are left after everyone else has been cared for, cleaned, served, fed, and nurtured. The woman becomes increasingly isolated and segregated as her husband's sense of possession grows and as household tasks mount and demands for service become greater. These demands are heavily laced with the ideas of duty and morality and they take on an almost religious character. The husband's and wife's expectations may not be in accord and rarely are they truly negotiable. (p. 93)

Worell and Garret-Fulks (1983) specified four specific female roles associated with marriage that made it difficult for "single-again" women to cope with their new status. These were:

"(1) economic dependence on a male, (2) subordination to male power, (3) reliance on a husband for social identity, and (4) investment in the supermom/superwife roles (p. 205)." this is comparable to Straus' (1979) ways in which a high level of wife beating was maintained.

Often women have married believing in the "Cinderella" myth. Marriage was seen as an escape from an unhappy family life or an otherwise unsuccessful past (Riddington, 1977-78). Many found the period before marriage "the best time of life". They received the attention of a man who loved them, they were freed from parental control but not yet under a husband's control, they had no domestic duties, and had reasonable social life (Dobash & Dobash, 1979, p.85). Many women bought the myth of the egalitarian marriage (Eichler 1981; Gillespie, 1971). Battering husbands, on the other hand, have stated explicitly that they did not want their wives equal to them (Gelles, 1978).

A multibillion dollar advertising industry seeks to convince young women to buy their aids to achieving sex appeal and love. Girls as young as ten have absorbed the idea that they must wear tight jeans and have small buttocks or they "lose". Essentially what they would lose is status on a male-defined scale of desirability (Dobash & Dobash, 1979; Hyde & Rosenberg, 1980: Landsberg, 1982). Sarsby (1983) found this to be true in research with adolescents in Britain: "the girls were worried about how to be loved, and about not coming up to the glossy standards of desirability which the boys wanted" (p. 132).

Sarsby concluded that the ideal of 'romantic love' (to be distinguished from the emotional process of "falling in love with", or experiencing love for another) is supported by various social and economic forces. This ideal may serve different purposes designed on the needs of a capitalist economic system and translated through custom and socialization. It helps to regulate sexuality and procreation and the raising of children. It is also the idiom through which women's dependence on men is expressed, it "lends grace to what is too plain to be spoken", a reality that is difficult to accept and rationalize in a culture articulating the ideals of equality (Sarsby, 1983: p. 110; Eichler, 1981; Dobash & Dobash, 1979).

3.1.2 Social and Psychological Isolation

The social and psychological isolation of battered women play a significant role in their victimization (Dobash & Dobash, 1979). Friends and relatives provide social and psychological support, a source of identity, information, and beliefs.

Disruptions in friendship and kinship ties change the demands in a marital relationship. A move, therefore, can disrupt a woman's life and lead to greater isolation and dependence on the husband. This accounts, in part, for suburban families being more husband-dominant (Gillespie 1971). Children further restrict a woman's mobility and outside interests thus contributing to her dependence on her husband (Deckard, 1975).

The ideology of the privacy of the family and the home (MacKinnon, 1984) is linked with an "ethic of loyality" toward the marriage which stops women from discussing abuse (Gillespie, 1971; Dobash & Dobash, 1979). The desire not to betray this loyality is part of what creates 'masked isolation'. 'Masked isolation' exists when violence is hidden from a network of friends and family which is often the case for women employed outside of the home (Tidmarsh, 1976).

The conscious decision not to tell, fed by guilt, shame, and humiliation is distinguishable from the denials of victimization that a woman may employ. In some cases women decide not to tell because they cannot see what help

could be gained (Tidmarsh, 1976). In fact, friends are seldom able to provide practical help (Egger & Crancher, 1982; Bograd, 1982; Dobash & Dobash, 1979). Usually, people outside the marriage share the privacy ideology and view this as none of their business. Most neighbours, those not defined as 'friends', consider it unacceptable to display marital disharmony in public and maintain a social distance, partially managed with the gossip mill (Dobash & Dobash, 1979).[9]

When battered women do reveal the abuse they are usually looking for emotional support. The response is often sympathetic advice but nothing which seriously questions the continuation of the marriage or the hierarchy in the home (Dobash & Dobash, 1979; Valcourt, 1980). In fact, the woman who has not accepted the victimization may reject criticism of her husband or the marriage (Rounsaville et. al. 1979).

Such support while not ending the violence may prevent severe reactions to the victimization. Studies in other areas have shown that positive social support can help maintenance of self-esteem, recovery from posttraumatic stress, and prevention of depressive illness, and alcoholism (Janoff-Bulman & Freize, 1983).

In some cases the husband systematically restricts his wife's contacts and outings until her whereabouts are

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[9] For more comments on the family see Weak Understanding of the Family in chapter eight.

totally under his control. One woman revealed that she never left the house; her groceries were delivered and she shopped from catalogs. Another woman was not allowed to hang clothes outside unless her husband was present. He spent so much time off work checking on her whereabouts that he lost jobs. In some cases this is related to morbid or delusional jealousy; in others it is simply an exercise of power. A woman is expected to find total fulfillment in her marriage, home, and family. She is expected to center her life around her husband's (Deckard, 1975). Some men expect a more total commitment than others.

Where there is severe isolation, the battered woman's choices are limited. "Knowledge control is an important part of keeping a person dependent" (Eichler, 1981). The isolated woman does not see how other couples handle conflict or share resources, she doesn't gain a new perspective. She has no one with whom she can check out her perceptions, her hopes, her needs, or her view of herself, her husband, or her marriage (Chan, 1983).

Elbow (1977) divided abusers into 4 personality characteristics: the controller, the defender, the approval seeker, and the incorporator. In each case the men demanded the total attention of their wives and controlled their activities. The controller maintained control in all aspects of his life and discounted other people's needs; the defender felt he had to guard against his wife hurting him while at the same time needing to rescue and protect her;

the approval seeker saw rejection everywhere and his wife had to bind to him to reassure him; finally, the incorporator saw his and his wife's egos as fused and feared she would be taken from him. While the explanations were somewhat different, the final result was the same isolation.

The consequences of isolation for a family were theorized to be a decrease in both actual resources and models of potential coping resources and the potential for the development of negative and fatalistic attitudes towards society in general. The consequences for the battered woman, however, were seen as worse than those for the victimizer (Chan, 1983).

3.1.3 Pregnancy and Children

Pregnancy or the arrival of the first child were identified in two studies as the factors that precipitated violence in the relationship (Gayford, 1978; Women's Research Centre and Vancouver Transition House, 1980). One shelter reported that 80% of the women had been beaten during pregnancy (MacLeod, 1980). Anderson et al. (1975) found that 60% of the women were assaulted during pregnancy while Miller's (1980) figure was 30%. Some reports indicated that the incidence and severity of violence increased during pregnancy (Wetzel & Ross, 1983; Colorado Association for Aid to Battered Women, 1980; Sammons, 1981; Fagan et al., 1983).

Some authors suggested that the stress of realizing the

responsibilities that a child brings is what precipitates violence during pregnancy (Gayford, 1975; Sammons, 1981). Other suggestions were that jealousy of the coming child and the loss of the wife's total attention was the motivation (Women's Research Centre, 1980; Sammons, 1981). The possibility that this battering is actually inutero child abuse was also raised (Gelles, 1975; Pugh, 1978). Such abuse sometimes resulted in miscarriage (Fagan et al., 1983) and this may have been the intent (Sammons, 1981; Gelles, 1975). The most prevalent explanation offered by battered women was quite different.

Battered women reported that the pregnancy frustrated their husband's desire to have absolute control over their behavior (Women's Research Centre, 1980). This was somewhat in contradiction to MacLeod's (1980) analysis that it was the perceived dependency and enforced isolation of the pregnant woman that defined her as an appropriate victim to the abuser .

Fagan et al. (1983) determined that violence during pregnancy was associated with victims who had been most seriously injured. Elbow's (1977) description of the Incorporator included the fact that his children threatened his equilibrium and signified alienation from his wife over whom he must have total control. This type of man was described as very dangerous which was consistent with Fagan et al.'s assessment.

Mothers are seen as and see themselves as primarily

responsible for the children. In the modern nuclear family, children contribute to a woman's isolation (Dobash & Dobash, 1979; Deckard, 1975). There was no systematic research, however, on the role of children in violent marriages or their effect on the battered woman (Ferraro & Johnson, 1983). It was clear that not wanting to leave the children was a common reason for remaining with the husband (Anderson et al., 1975; Lichstenstein, 1981; Iyer, 1980) as was the belief that children needed their father no matter what his qualifications turned out to be (Lowenberg, 1977). However, the economic and social responsibilities of single parenthood were some of the greatest restraints on battered women (MacLeod, 1980).

Children sometimes turn against their mothers and contribute both psychologically and physically to the abuse (Ferraro & Johnson 1983; MacLeod, 1980; Valcourt, 1980). This adds greatly to the woman's loss of self-esteem, sense of failure in her roles, and self blame (Miller & Porter, 1983). On the other hand, some children defend their mothers and become very protective (Ferraro & Johnson, 1983). It is often the intervention by children during the violence or the effects on the children that spur a woman to take remedial action.

Children living in homes where there is marital violence have been deemed at risk or in need of protection under Child Welfare acts in Newfoundland and Labrador, New Brunswick, and Prince Edward Island (Canadian Association of

Social Workers, 1981). There was evidence that such children are at risk of developing health problems (Price & Armstrong, 1978; Westra & Martin, 1981; Valcourt, 1980) and emotional or psychological problems (Daniels, 1977; Gayford, 1975; Hilberman, 1980; Pfouts, 1978). There was also a great deal of support for the theory that such children are at greater risk of becoming batterers or victims in adulthood (Fagan et al., 1983; Gayford, 1975; Roy, 1977). However, most studies can be criticized for lack of methodological rigor and lack of appropriate comparison groups. Using standardized measures of child behavior and two comparison groups, one in which there was nonviolent marital discord and one where there was no marital discord, researchers found no significant difference in behavior or personality problems among the children. The children from violent homes did show a trend toward having more conduct and personality disorders. It should be noted that these researchers studied only male children closest to the age of ten (Rosenbaum & O'Leary, 1981b).

Since many abusers view their children in the same way they view their wives, as property; they attempt to extend their control over the children. The children are often another means of control over the wife through threats to harm them, to deprive her of access to them, or by limiting the quantity and quality of care she is allowed to give them.

In this context, a woman's response to victimization

depends on a number of factors: her basic assumptions about the world (Riddington, 1978); the coping resources she has at her disposal; the severity and frequency of the violence (Gelles, 1977; Janoff-Bulman & Frieze, 1983); whether self-blame is involved (Miller, Porter, 1983); whether she weighs the benefits of taking action as greater than the benefits and risks of not (Pfouts, 1978) and whether there are outside resources available to her (Gelles, 1977). As one would expect, victims vary considerably in their response (Janoff-Bulman & Frieze, 1983).

3.2 Rationalization or Search for Meaning.

Battered women often do not identify themselves by this label (Bograd, 1982; Prescott & Letko, 1977). There were a number of possible explanations for this offered in the literature. One source of explanation was the internal consequences of acceptance of one's victimization: a sense of loss of one's beliefs, loves, and plans; feeling a loss of control over one's life; a loss of self-esteem; and acceptance for oneself of what is perceived as a negative label. In relation to the latter, victims realize that the response to victims is generally ambivalent at its best and hostile at its worse. In an effort to avoid negative reactions, victims will keep their status secret (Taylor, Wood, Lichtman, 1983).

In the case of battered women another factor emerged. It has only been in the last decade that there was any

publicity on or definition of a social problem called wife beating. Many women could not apply this label because they did not know it existed. What happened to them was viewed as either normal or as the result of individual pathology. We do not know how well known it is today; certainly women still appear at shelters, expressing the surprise they felt when learning that such a specialized service existed and that the problem was widespread.

Also, the role of helping agencies in denying or redefining the victimization must be considered. Often the violence is considered secondary to other diagnoses. In some cases the victimization is denied and blame ascribed to the victim. The victims then come to see themselves as the victimizers.

Taylor et al. (1983) proposed two explanations for victim blaming. The non-victim derogates the victim in order to maintain the perception that their own success is based on their internal qualities. The victim's failure is assessed as a personal failure and to materially or psychologically compensate victims would be too close to criticizing the very social system that affords themselves benefits. In a related explanation, the non-victim derogates the victim is order to maintain a "just world" belief. An image of the victim as someone who deserved to be victimized eliminates the fear that recognition of random and uncontrollable victimization would engender. People wish to maintain their own sense of invulnerability (Perloff, 1983).

Women commonly state something like, "If my husband ever hit me, I'd be out the door, bags in hand". They do not believe this could ever happen to them under any circumstances. Other see victims as losers and fear guilt by association (Janoff-Bulman & Frieze, 1983; Symonds, 1975). Some prefer seeing wife abuse as an interactional problem, with equal (or more) responsibility going to the wife. This mediates the necessity of analyzing the inherent problems in the roles of men and women within the institutions of the marriage and the family.

Ferraro and Johnson (1983) attempted to explain how battered women rationalized or made sense of the violence over a long period of time instead of leaving the marriage. They found that battered women used one or more of six types of rationalizations. In the first, an "appeal to the salvation ethic", the woman claimed to be committed to her husband and to seeing him through his pathology. This was used especially often by wives of husbands who had alcohol or drinking problems. In the second type the battering is presented as beyond the batterer's control and therefore his intent to do harm is denied. Thirdly, the woman may also deny that she was hurt or define the injury as tolerable or, fourth, she may ascribe blame to herself, accepting the denigrations and accusations of the abuses. Out of the belief that she will not be able, either practically and/or emotionally, to succeed on her own the battered woman may deny that there any options to the abusive relationship.

Finally, the woman may invoke an "appeal to higher loyalities" such as religious beliefs, the needs of the children, or the sanctity of a marriage. Her commitment to an ideal is stronger than her reaction to the violence.

The same authors then described six catalysts that may motivate a woman to redefine the abuse as victimization that warrants a response. These were: a sudden increase in the relative level of violence; an increase in resources; a worsening of the overall marital relationship; a loss of hope for improvement; increased visibility of the violence; and a redefinition of the relationship by someone outside.

Silver, Boon, and Stones (1983) discussed the search for meaning in victimization by victims who want to make sense out of the world. Victims generally (Janoff-Bulman & Frieze, 1983) and battered women have their basic assumptions about the world shattered. Women assume that their home is a haven from crime and violence and that their marriage, based on love, will be one of joy if not simply contentment (Riddington, 1977-78). The violence done to them by someone they love, and who loves them, must be rationalized. This is particularly true since, as we have seen in the discussion of marriage, that women derive part of their identity from their marriage. Silver, Boon, and Stones (1983) theorized that efforts to make sense of their experience may be common to victims and that this may be especially difficult to achieve for those experiencing chronic victimization at the hands of someone whom they

cannot control. The rationalizations described by Ferraro and Johnson (1983) could also be attempts by battered women to give meaning to their lives. Once the catalysts shatter even this meaning, action must be taken to redefine the battering relationship. The action that follows will depend on the number of personal and social resources the woman has available.

In relation to the decision making process Pfouts (1978) offered a theory that battered wives, either consciously or unconsciously, weighed the total benefits of the marriage against the costs and compared this level of satisfication with what they thought they could achieve from the best available alternative.

Both Ferraro and Johnson (1983) and Pfouts (1978) addressed the function of social role expectations in the battered woman's assessment of her options. All of the rationalizations proposed by Ferraro and Johnson are strongly reinforced by society through its institutions, policies, and laws. Pfouts, for instance, found that the abuse of the wife was seldom a concern in the management of the "child abuse" cases in which she identified battered women. She described the community context as "a vacuum of nonresponse" (p. 367).

Other authors proposed a theory called Selective Evaluation. They proposed that victims use five cognitive mechanisms to "de-victimize" themselves, that is to avoid the negative attributions that they themselves ascribe to

victims and that they think others would ascribe to them. The five mechanisms include:

1. making social comparisons with others less fortunate than yourself. This may make one feel better off than some others thus restoring self-esteem. It also has the potential of providing role models of coping
2. controlling the selection of attributes to be compared so that one emerges looking better off
3. creating hypothetical worse worlds - This may either accommodate the first two functions or it may minimize the current situation
4. construing benefit from the event such as finding meaning in the experience, and
5. manufacturing normative standards of adjustment. In this case the victim recognizes the victimization and establishes what a "normal" response to it would be so that their own response looks good (Taylor et al., 1983).

It has been noted earlier that many battered women do not identify themselves (see p.73). Some authors have suggested middle class women are particularly adverse to the label "battered wife" because it connotes lower class phenomenon. It is possible that they are employing the first and/or second mechanisms mentioned above to avoid the victim label. The process of making comparisons and of deciding one is "better off" than so and so is one that continues in shelters. It would also not be difficult for battered women to imagine worse worlds; for instance, they sometimes realize they could have been killed. They often fear extension of the violence to other relatives, the children, or friends. Some battered women, wishing to establish a

normative response may be influenced by recent media coverage of battered wives who have killed (see Zwarun, 1984). They may consider their own coping responses as more morally acceptable. Finally, looking at the last proposed mechanism, battered women do sometimes construe benefit from the victimization; for instance some women said it had made them more independent (Dobash & Dobash, 1979).

Miller and Porter (1983) looked at theories of self-blame and found three ways of accounting for it. One account suggested that victims assume blame as a means of maintaining a belief that they can control their lives. A second suggestion was that self-blame maintains the concept of a just world where negative things don't happen to one unless they are deserved. Finally, it was suggested that self-blame is a means of imposing meaning on the event.

Victims may ask themselves why the violence occurred - the cause, or why they were the target - the occassion. Battered women are unlikely to question themselves as their husband's target so they question the existence of the violence and their role in causation. Knowing that there are many battered women may be irrelevant to battered women who are questioning the cause of their own victimization.

As perceived severity of the victimization increases for battered women they are less likely to self-blame and more likely to lay the blame on their husbands. The relationship of duration of violence to self-blame is not as clear. It appears, however, that if a woman believes she

should be able to alter her husband's behavior and, over a long period of time, is unable to do so she may blame herself for this failure as well as for tolerating the marriage.

The traits in herself to which a woman attributes the blame and her feelings about these traits may affect how well she copes. A woman who attributes the abuse to a trait which she dislikes and still feels is a part of her may experience depression. A woman who feels the trait belongs to a "former self" may be more optimistic. Thus the degree of threat of the abuse to the woman's self esteem may be influenced by her explanation of the causes. One study of women who blamed their abuse on "permanent" character defects within themselves also found over 50% to be clinically depressed (Rounsaville, Lifton, Breber, 1979).

Other factors may determine the experienced effect of a victimization more directly than causal attributions. For instance, a battered woman's self-esteem may be determined by her causal attributions but if she has just taken her children and gone to a shelter other concerns may play a larger role in her emotional life; such as safety and her economic future (Miller & Porter, 1983).

3.3 The Battered Woman's Emotional Career

The initial psychological response to victimization is usually immediate and may be shock, fear, anxiety or depression (Janoff-Bulman & Frieze, 1983). The first

assault on a battered woman is usually not as severe as subsequent ones but is the most shocking and most quickly forgiven and forgotten (Dobash & Dobash, 1977-78; Ferraro & Johnson, 1983). However, even some women (less than half) who had been struck once in their marriage sought help or tried to leave their husbands (Gelles, 1977).

Johnson and Ferraro (1983) referred to a battered woman's feelings as an "emotional career". This career is influenced by the cultural, political, and interactional structure in which the woman lives. A woman's initial reaction is probably shock and betrayal - her assumptions about marriage and her husband have been betrayed. Because of her greater responsibility for the success of her marriage, and because her husband tells her she caused the event she feels guilt and shame (Ferraro & Johnson, 1983; Prescott & Letko, 1977), disparaged (Valcourt, 1980), and inferior (Ferraro & Johnson; 1983; Prescott & Letko, 1977). Early in the relationship these feelings may not be lasting. The woman may employ a rationalization that gives meaning to the event or she may make changes in line with her husband's demands. She still feels hope for the marriage and affection for the man.

As the violence continues and her efforts fail, the woman may exhaust rationalizations and fail to find any meaning in the violence. She will probably seek help (Gelles, 1977). Her chances of receiving help depend largely on the agency or individual professional that she contacts

(Dobash & Dobash, 1979; Walker, 1979; Roy, 1978). Failure to receive help may be a "secondary victimization". If friends and relatives respond negatively to the woman, it may be as distressing as the original abuse (Janoff-Bulman & Frieze, 1983). We have no measure of the effects on the woman of judgmental and help - denying responses from professionals. In some cases, where there is police inaction or clerical callousness, her assumptions about the world may again be damaged.

If the woman is successful in getting help her fear may subside. This, of course, depends on the type of help.

3.3.1 Learned Helplessness and Depression

Battered women who experience their situation as life-threatening, feel a "penetrating fear" (Ferraro & Johnson, 1983, p.334). "Emotionally, they are petrified of their mates" (Lowenberg, 1977, p.10) and they believe there is no escape (Ferraro & Johnson, 1983; Lowenberg, 1977).[10]

Battered women who stay in a marriage without hope of seeing an end to the violence often experience depression (Ferraro & Johnson, 1983; Bograd, 1982; Valcourt, 1980; Prescott & Letko, 1977; Lowenberg, 1977). One study found

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[10] Resick (1983) proposed that these women may respond as hostages in other situations have: grateful to their captor for giving them life and bonded to them because of this. Invoking the "Stockholm Syndrome" to explain the response of battered women, however, seems unnecessary given the explanatory value of other social and psychological factors.

over 50% of the battered women, most of whom had left the marriage, clinically depressed (Resick, 1983). Others have found 46% (Gayford, 1975a), 53% (Rounsaville et al., 1979), and 36% (Steward & deBlois, 1981) of the battered women diagnosed as depressed.

Walker (1979) introduced a theory of learned helplessness to account for the passivity of battered women. She proposed that battered women perceive that they have no control over what happens to them, become passive, and then "allow things that appear to them to be out of their control actually to get out of their control". She also proposed that women try to control the events of the abuse even though they feel helpless to control the occurrence of abuse. These efforts were described as attempts to ward off depression and "not to feel totally helpless" (pp. 47,50).

Peterson and Seligman (1983) stated that the causes, symptoms, and cures of learned helplessness and depression were often parallel. They added an attribution component with three dimensions to the theory of learned helplessness. The first dimension was attribution of cause to something about the person (internal) or about the situation (external); the second dimension was time (stable or unstable attribution); and the third was the pervasiveness of attribution (global or specific to one type of event). The causal attribution made will depend in part on the nature of the victimization; the more severe the victimization the less likely a woman is to blame herself

(Miller & Porter, 1983). One's causal interpretation may also determine one's reaction. A passive reaction may occur because one interprets the cause of the violence to be stable across time and global in its effect.

The authors acknowledged several difficulties in applying the learned - helplessness theory. The perceived uncontrollability of events is difficult to separate from other traumatic aspects, such as fear, which may account for passivity; furthermore, the theory does not account for individual beliefs about the consequences of uncontrollable events or ability to cope with these. Little is known about the difference between "procedural control" and "outcome control".[11]

Symonds (1979) offered a theory similar to learned helplessness called "traumatic psychological infantilism". This reaction was posited to come after the initial shock and denial and before the third phase of depression. Traumatic psychological infantilism results from the terror of the abuse combined with the discovery that there is no outside help, that she is isolated. The physical and psychological abuse that many battered women receive between periods of calm and affection and in the context of social isolation was compared to brainwashing methods. These methods result in the passivity and cooperation of the recipient and the isolation is a necessary factor.

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[11] Walker (1979) mentioned procedural control as a depression preventer.

Depression and passivity may also be explained as one stage in a grieving process. Loss results in grief which has 5 stages. After denial, anger, and bargaining, depression is the fourth stage, followed by acceptance. A battered woman who remains with an abusive husband may be caught in a "web of chronic grief". Chronic grief is paralyzing (Flynn & Whitcomb, 1981).

In some cases, a woman caught in learned helplessness, clinical depression, or perceiving her real isolation and helplessness - "may feel that she has no choice but to commit suicide" (Lowenberg, 1977. p. 13).

The literature was not clear on how likely suicide attempts were; however, the incidence appeared to be very high. One study of women from a shelter and a psychiatric clinic found that 42% had attempted suicide (Gayford, 1975a, 1975b). A study of a similar sample found that 50% had "considered" suicide (Star et al.,1979). Another study of mothers of children referred to a psychiatric clinic found that 27% of the abused mothers and only 5% of the nonabused mothers had attempted suicide (Stewart & deBlois, 1981). Back, Post, and D'Arcy (1982) found the highest rate of suicide attempts by battered women in their sample of patients of a psychiatric hospital (77%); however, they found no significant difference in history of suicide attempts when an age matched, non-battered control group of patients was compared to the battered women.

Stark (1981) predicted that battering was the most

significant precipitant of suicide among women. Of women who attempted suicide, 25% were battered but this rose to 45% of those who made multiple attempts and 50% of the women were black (Stark, 1981).

3.3.2 Overassessment of Pathology

Peterson and Seligman (1983) cautioned victimization researchers not to interpret all reactions to victimization as pathological. They noted a tendency in research on rape to "overdiscover" self-blame and guilt; often anger and outrage were more appropriate descriptions of what was observed.

Stark (1981) made the same point for an interpretation of a battered woman's passivity. He interpreted some battering as a consequence of the women's feminist struggle to refuse the absolute dependency and powerlessness demanded by their husbands. The women, who probably were not aware of the political demands of the women's movement, were nevertheless refusing their personal total subordination. Every attempt at getting help can be viewed as an act of courage and "resistance".

> Even the sense of helplessness that results in multiple suicide attempts, alcoholism, and depression should be viewed, as Fanon illustrates in his work on the psychopathology of oppressed peoples, as the consequence of woman's putting her selfhood at risk, hurling it in a futile but nonetheless political gesture at the attempt to keep her in a subordinate status in private life. The strong possibility that helplessness is the result including dependence on helping institutions, must be considered in each and every therapeutic encounter. (p. 18)

There is a tendency to generalize the powerlessness of battered women. A victim may be helpless "in the face of victimization" but not helpless in the recovery process.

> "People can be helpless in preventing their own victimization, while powerful in coping with it." (p. 13)

Similarly the battered woman must take some responsibility for the solution to her situation which should not be construed to mean that she is responsible for, or in control of, the cause of it (Janoff-Bulman & Frieze, 1983).

Battered women often stay in a marriage out of a believe that the children are better off. This belief is supported by many professionals and institutions. It has been suggested that women are particularly good at coping in order to support others' needs even though this may be detrimental to them (Wortman, 1983).

A battered woman who enters a shelter will usually feel a great release of fear.[12] The fear is replaced by anger as her betrayal becomes vivid. Since anger is "unfeminine", coping with it is difficult and if it is suppressed it may turn into depression. Expression of anger can lead to joy and exhilaration. Eventually, however, the woman in a shelter will express confusion over her conflicting responses to her situation (Ferraro & Johnson, 1983).

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[12] Often, however, the women are justifiably afraid that their husband will break into the shelter or otherwise get to them. Some women do not leave the shelter for days, even weeks due to this fear.

3.3.3 Grief Reactions

Symonds (1975) noticed that the reaction of victims of stranger-crime were similar to the reactions of people who had experienced a loss:

> The first response is shock and denial. When attempts at denial fail the person becomes frightened, and this fright is usually accompanied by clinging behavior. Very frequently he finds himself compulsively talking and obsessively ruminating. This phase is followed by apathy with periods of recrimination and inner-directed rage. There are occassional outbursts of outer-directed resentment and anger until resolution occurs through either replacement or restoration of the lost object. (p.24)

It has been proposed that battered women must go through the stages of grief in order to resolve their situation (Ferraro & Johnson, 1983; Flynn & Whitcomb, 1981; Weingourt, 1979). As she loses her self-esteem and her traditional values fail to have meaning the battered woman experiences "reactive grief". The potential loss of her health, marriage, children, home etc. causes "anticipatory grief" (Flynn & Whitcomb 1981). Riddington (1977-1978) noted that women in shelters experience a great deal of grief .

Weingourt (1979) proposed a three-stage model of "grief work", for the battered woman who has left her husband. Grief was described as both a psychological and a social process of filling the emotional and social spaces left by the loss of the husband.

The first stage called "ambivalence" was characterized by fear and subsequently guilt. In the safety of the

shelter, the woman may experience the self-blame and begin to see herself as a deserter. The husband may be telling her that he can't live without her and she doubts if she can live without him. The children may feel the same or may contribute to her guilt by pitying their father and missing him and their home. The woman may bargain within herself to negotiate acceptable limits on her possible return. She may also bargain directly with her husband, (Flynn & Whitcomb, 1981). Usually, anger is not overtly expressed but is passive and displaced onto the shelter rules or staff or her children or other residents. At this point the woman is still in the "role of the helpless victim".

If the woman moves out of the victim role she enters the second stage called Awareness of Impact in which she becomes aware of her role in shaping the past and responsibility for the future. This is the stage in which she experiences depression and faces the reality of her situation. As she deals with the idea that she let the victimization happen and the accompanying anger and guilt, she also recognizes that she can choose not to let it happen again.

The final stage, Acceptance of Loss, is entered when a woman is able to realistically assess her past relationship and to begin major changes. The tasks to be accomplished in this stage are revamping her thoughts about herself and others, considering new patterns of behavior, and testing these patterns (Weingourt, 1979). Of course, many factors,

particularly social ones, will influence the "grief work" that a woman attempts in a shelter. In part it will depend on the other residents and also on the relative skills of the staff she deals with. In addition, the social and psychological adjustments may conflict; not being able to find a home, for instance, can create a feeling of hopelessness.

The stages as described by Weingourt (1979) do not preclude returning to the husband as a result of successful "grief work". The woman may pass through the stages until she comes to the stage of testing new patterns. She may wish to test a different kind of relationship with her husband but having realistically assessed the past and successfully buried her old dreams, she may have a contingency plan if things don't work out.

Most battered women remain optimistic about future relationships with other men (Ferraro & Johnson, 1983); however, some develop a general distrust of men and of marriage (Prescott & Letko, 1977). Some battered women have reported that their husband's violence discouraged them from having children (Prescott & Letko, 1977).

Battered women identified the long-term psychological effects of the violent relationship as the most difficult things to be overcome (Egger & Crancher, 1982). Psychiatry refers to severe psychological reactions as the "posttraumatic stress disorder".

Apart from the existence of a recognizable

stresser, diagnostic criteria for this disorder include:

1. re-experiencing the trauma via memories, intrusive thoughts, or dreams
2. numbing of responsiveness demonstrable by feelings of detachment from others, constricted affect or diminished interest in significant activities
3. other symptoms including exaggerated startle response, sleep disturbance, guilt, memory impairment or trouble concentration, and phobias about the activities triggering recollection of the event. (Janoff-Bulman & Frieze, 1983, p. 2)

The incidence of this disorder in battered women is not known, although symptoms are exhibited by women and their children in shelters.

Whereas studies on aggressive behavior have often ignored women, studies of victims of violence initially focused on women. To understand the responses of battered women to victimization we must look at the social and political context in which the violence occurs and a response is generated. This includes looking at the effects of repeated victimization, role expectations, what is explicitly or implicitly supported by society, as well as, individual psychological and social circumstances. Students of victimization are cautioned not be overly quick in attributing victim responses to pathology. More knowledge is needed about posttraumatic stress disorder among battered women.

Chapter 4
Other Issues

4.1 Rural Women

There was evidence in the literature that wife abuse is as common in rural areas as in large cities. This was the finding of a national survey in the United States (Straus, Gelles, Steinmetz 1980). Another U.S. study of intact long term marriages found similar rates of spousal violence, as reported by an adolescent, in both rural and urban families (Schumm, Martin, Bollman, Jurich, 1982). Both studies used the same instrument to assess the violence.

The question of rural vs. urban wife abuse had received little recognition in published research. Three reviews of the literature did not mention the issue directly (Breines & Gordon, 1983; Gelles, 1980; Lystad, 1975) and an overview of the Canadian situation also neglected this subject (Small, 1982).

One study suggested that rural spouses sought outside help after verbal conflict and, therefore, sooner than urban spouses who did so after physical violence. The authors proposed that rural informal helping networks may result in early identification and less stigmatization of problems as

compared to formal urban services. It was also suggested that there may be social norms against family violence in rural areas. (Schumm et al., 1982). Kuhle (1981) argued the opposite: that rural areas are typically conservative, accept stereotyped roles and approve a man's right to beat his wife. This along with the lack of services and lack of anonymity makes it next to impossible for women to seek help or to acknowledge abuse. (Kuhle, 1981; Crist, 1982). Lewis (1971) also found rural students to be more conservative, conforming, and to evidence authoritarian personalities which entail accepting traditional values in social relations, politics, and religion. Two social workers described rural cultures as male dominated where a husband's use of force is sanctioned and reinforced by his male peer group (Bagarozzi & Giddings, 1983).

A U.S. police department serving a small population (less than 6000) reported receiving "domestic dispute" calls every day. A second department reported that these calls were second only to car accidents in frequency (Martin, 1981). A police force serving a small Canadian city and several outlying rural areas, however, reported that 96.4% of their domestic disturbance calls came from the city (Fleming, 1975). Crist (1982) made the point that police responses are often inconsistent and depend on which office is called. Due to the smallness of their operation, rural police officers may not be able to take time to provide concrete assistance to the woman (eg. transportation). If

they are hostile to repeat calls, they may decide not to respond to her call at all. In many areas the police officers know both parties personally and women are reluctant to call them (Kuhle, 1981).

Rural women may initially present a problem different than battering to helping agencies when they do seek help (Claerout, Elder, Janes, 1982). This is not unusual for battered women in general (Dobash & Dobash, 1979; Gelles, 1972). Rural women do use shelters when they are available (Dobash & Dobash, 1979). Shelters exist in rural, surburan, and urban areas in the U.S. (Roberts, 1981). A Canadian study found 19 shelters in areas with less than 50,000 population (27% of the total number of shelters), 6 of these (8%) were in areas with less than a 15,000 population (MacLeod, 1980). In 1980, however, 45% of Canadian women lived in areas where there were no shelters (Lewis, 1982). In Quebec, women outside of large cities tended to hear about rural shelters through the media or other persons whereas in the cities women were referred to shelters by social workers (Valcourt, 1980). This could be explained by the lack of other services in rural areas or by the desire of rural women to remain anonymous to social agencies. It could also, as suggested by the authors, reflect a greater amount of personal contact in small areas (Valcourt, 1980).

Women in rural areas deal with a totally different society than that in cities. This presents many problems for battered rural women. Her isolation may be intensified

by great distances between her and neighbours or services. Transportation may not be available or may be impossible due to weather and/or road conditions. Should she decide to leave there are few resources to help her and few options for employment or housing in her community. As a single person she may be ostracized in a couple orientated setting. Rural women also face the local "gossip mill" and lack of anonymity in local services and small motels. This may reinforce a need to conceal the violence. People who work in social services in rural communities are often seen as outsiders and unapproachable (Kuhle, 1981; Crist, 1982). Accepting their help may be another stigma.

Women in rural Newfoundland and Labrador have expressed that wife abuse is a problem (Sherrard & Fouillard, 1982). Wife abuse was a serious concern at the 1983 Labrador Native Women's Conference in Nain Labrador. All of the problems mentioned above can be applied to the situation of rural women in Newfoundland and Labrador. In addition, there are specific problems for northern women and women in communities without roads to other communities.

It is relatively easy to develop a list of difficulties that are imposed on a battered woman by her rural environment. It is not so easy to identify social characteristics such as degree of male domination, which distinguish rural, urban, and surburban societies. It was proposed, for instance, that surburan women were more isolated and more dependent on their husbands because the

move to the suburbs disrupted friendship and kinship ties (Gillespie, 1971). However, at the same time it is suggested that people with close ties in rural areas may support the right of a husband to dominate through violence (Bagarozzi & Giddings, 1983). We do know that rates of divorce are lower in rural areas in Canada (Boyd, 1983). This may indicate that it is more difficult for rural women to leave a marriage.

The issue of rural vs. urban wife abuse is important in a country with both types of communities and varied geography. Urban and rural life appear to impose different restrictions on battered women. The differences need to be better understood in order to effectively address the problems of battered women.

Chapter 5

Shelters

5.1 History of Development

The first sanctuaries for women were religious, charitable or governmental affiliates which offered women in extreme crisis a temporary or permanent refuge. These included convents, hospitals, asylums, poor houses, etc. which did not actually exist for that purpose. In the Middle Ages, convents were particularly popular for women wishing to escape the realities of married life and of male violence (Hutchins & Baxter, 1980).

The shelters of today came from quite different origins. The shelter which most often is considered the first of its kind is Chiswick's Women's Aid, opened in England in 1971 (Pizzey, 1974; Dobash & Dobash, 1979). The first U.S. shelter opened in Arizona in 1972 or 1973 (Hutchins & Baxter 1980; Johnson, 1981) the first Canadian shelter opened in British Columbia in 1972 (MacLeod, 1980).[13]

There were two versions in the literature as to the

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[13] Since 1971 the number of shelters and services for battered women has increased rapidly.

impetus behind the majority of shelters. Some believed that the majority of these services were the result of efforts by feminist groups. Women's centers, rape crises centers, consciousness-raising groups and other sevices springing out of the women's movement were repeatedly receiving requests for help from women battered in their homes (Pizzey, 1974; Weir 1977; Colorado Association for Aid to Battered Women, 1980). Volunteers began taking women into their private homes but this proved inadequate and the concept of shelters was developed (Fleming, 1979; Colorado Association for Aid to Battered Women, 1980).

Other believed that feminist connections did not exist for the earliest shelters in the U.S. The earliest shelters were promoted by Al-Anon, professional women's groups and YWCAs and feminist organizations began sponsering shelters in 1975. In 1981, less than half the U.S. shelters were directly related to feminist ideology or groups; 25% were started by churches and 25-30% by YWCA or other local organizations (Johnson, 1981).

In the U.S. two major philosophical trends in shelter development were identified. At one end of the spectrum were shelters, often affiliated with religious organizations, which viewed abuse as a temporary marital crisis and reconcilation as inevitable and desirable. On the other side of the spectrum were those shelters with a feminist orientation that viewed battering as rooted in sexism and believed that victims needed protection and help to make life changes (Hutchins & Baxter, 1980).

5.2 Philosophy and Program

The differences in philosophical base produce important organizational, program, and policy differences. The more traditional shelters focus on individual counselling or therapy and marital counselling. They view the problem as individual and their operations and programs resemble traditional social services. The feminist shelters view the problem as structural and social. Their programs stress recognition of how the social system oppresses the individual woman and how she can achieve independence from the violent relationship (Johnson, 1981; Bograd, 1982).

> Transition houses represent a support approach to wife battering, rather than a treatment approach and so reflect the women's own perceptions of their major needs. Most houses do more than protect the woman from physical harm. They attempt to make her aware of her options and attempt to strengthen her ability to follow through on her decisions. They reflect an attempt to increase the real choices for women who have been battered in the face of a whole society which is structured to limit their choices. (MacLeod, 1980, p. 52)

Leghorn (1978) asserted that it was the feminist ideology that made shelters effective and popular.

> Grassroots groups, in their very structure and the nature of their services, have said clearly to battered women: It is not you that is sick. It is our society which is responsible, in its structure of sexual domination, for condoning and perpetuating this behavior and the institutions that sustain it. (p. 447)

This position was also taken be Riddington (1977-78). The actual establishment of a shelter by a women's group

underlines that women can help themselves and each other. The promotion of self-help, which is endemic to feminism, also gives women independence and increases her sense of control (Weir, 1977, p. 115) and personal improvement (Leghorn, 1978).

There was no literature comparing evaluations of traditionally orientated to feminist orientated shelters (Johnson, 1980). We read however that most shelters had to turn away clients at some point (Macleod, 1980; Barr & Carrier, 1978) and that some traditional agencies have rethought their policies and practices in relation to abused women because of feminist work (Pfouts &, Renz 1981).

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Also, one survey of battered women found, of those who used a shelter, 71% said it had been helpful. Shelters were the only services reported by these women to provide emergency accomodation and, additionally, psychological support (Egger & Crancher, 1982).

Whatever, the ideology of the sponser, shelters were initiated locally, by community groups and not by government plan or impetus (Colorado Association for Aid to Battered

Women, 1982). Their numbers - 300 services in the U.S. (Fleming, 1979), about 230 in Canada (S.T. Gilman, National Clearinghouse on Domestic Violence, personal communication, December 13, 1985), and over 150 in England (Johnson, 1981) make them a significant social service.

5.3 Services Offered

Lowenberg (1977) identified 4 primary supportive services for women wanting to escape battering: 1) one to one counselling on the decision, 2) transportation, 3) temporary shelter, and 4) food. Lynch and Norris' (1978) list differed only slightly. They specified that the initial counselling be by someone in a position to offer immediate and effective help. The second need cited was safety followed by shelter, food, clothing and medical supplies. Finally, they concluded that the woman's emotional needs must also be considered from the beginning.

Many professionals from traditional services were surprised that women from all strata would use a feminist service (see Carlson, 1977). The explanation for this lies in the fact that all shelters respond to the most critical needs of battered women (Leghorn, 1978; Colorado Association for Aid to Battered Women, 1980; Valcourt, 1980).

Fleming (1979) defined a shelter as much more than temporary refuge:

> A shelter is a sanctuary where a woman who has suffered a loss of self-esteem and self-confidence can find people who are committed to rebuilding the

> positive self-image necessary for her to regain control of her life. A shelter can be a place where a woman who has lived in fear and isolation can find security and safety as well as the love and support of other women who are struggling to rebuild lives shattered by domestic violence. A shelter can and should serve as protective community to which residents and former residents can turn for confidential support, encouragement, and assistance. (pp. 354-355)

Roberts (1981), in a national survey in the U.S. ,found that shelters typically had a separate facility (usually a house) which was indistinguishable in the neighbourhood. They usually had a 24 hour crisis telephone service in the house and kept their address confidential. Security was prime concern for all shelters.

Generally shelters had a board of directors, a director, and other staff and/or volunteers. They established house rules on use of alcohol and non-prescription drugs, nonviolence, the sharing of household chores (cooking, cleaning, etc.) and the responsibility of mothers to supervise their children.

The main problems faced by shelters were lack of secure funding and loss of staff and volunteers . Funding was also a major problem for Canadian shelters (MacLeod, 1980).

Inevitably, shelters provide much more to the women they serve and to the community than short-term refuge. Shelters usually get involved in public and professional education programs, police training, research, services to children, follow-up services, and support groups (Roberts, 1981; MacLeod, 1980; Fleming, 1979).

NiCarthy (1982) in "Getting Free" had this to say to battered women about shelters as a source of help:

> The first week you're on your own will be stressful and possible filled with fear and anxiety, but you can use those feelings to get your life reorganized. The scope and details of your immediate problems will vary depending on how badly you were hurt, whether your relationship was short or long or whether you have children. It will make a big difference whether you're unemployed or have marketable skills. Where you stay right after you leave the man will have an impact on how you feel, how you interpret your situation and how you start planning your future.
>
> A stay in a shelter for battered women may be your best protection from the dangerous man, as well as from your own temptation to go back to him. You'll be surrounded by people who immediately understand why you had to leave. You'll get support for not contacting the man, and he may not be allowed to call or visit at all if the location of the shelter is kept secret from the public.
>
> There will be someone in the shelter nearly all the time to help you sort out practical problems related to money, school or work, childcare and finding reliable professional help. Many shelters also have counselors available to talk to, and public assistance workers often make regular calls so you won't have to spend a day standing in the public assistance line alone. Talking with other women in similar situations will help reduce your loneliness and fears. Women who would ordinarily never meet because of differences, interests and lifestyles can be marvelously helpful to each other when they have the problem of a battering man in common. If you have children, it can be a great relief to get help in caring for them while you arrange to reorganize your life. some shelters have full-time childcare, others have occasional volunteers. If it's not available on a regular basis, you can always trade childcare with other women in the shelter.
>
> A shelter may have the disadvantages of lack of privacy, crowded conditions, too many children and too much stress in small quarters. But you may not have time to ask, or care, about those conditions if you're escaping from an immediately dangerous situation. Even if you think you won't choose to stay in a shelter, it would be a good idea to get information now about the services they offer and how to arrange for housing in case you need it in an emergency.

> There are also other kinds of shelters available, usually run by churches, the Salvation Army or YWCA's. These provide temporary housing to men, women and children who have no place else to go, and while they offer some of the same advantages of shelters specifically designed for battered women, they lack the special community feeling that often develops among people whose situations are similar. If you have to wait a few days to get into a shelter for battered women, this other kind of shelter is a good option. (pp. 161-162)

5.4 Community Support

In most places efforts to establish shelters were met with opposition from some circles (Weir, 1977; Fleming, 1979; Hutchins, Baxter 1980). Petton (1978) maintained that provision of such concrete services was "less glamorous professionally than psychologizing about the poor". He believed that many helping professionals viewed the support and practice of psychodynamic theories as a higher status endeavor (p. 613).

Barr and Carrier (1978) located the lack of support for such services in a historical confusion over whether the primary concern of these social agencies was with the children or the maintenance of the family. Where the law was clear, primary concern was with the family; hence, agencies would not aid a woman and her children until she had already conclusively left her husband. "In practice local authorities are very reluctant to offer housing to a woman and her children unless and until she has conclusively left her husband - irrespective of whether the existing home is a place of continued violence" (p. 340).

Johnson (1981) stated that another concern of existing agency personnel was that shelters would "invade other agency's bureaucratic turf". This turf is defined by the geographical area served, the classification of the service - mental health, health, addiction, social, and the types of service provided (p. 837).

5.5 Concerns for the Future of Programs

Prior to 1970, wife battering received, at best, selective inattention. Currently it has reached the status of a recognized social problem (Pfouts & Renz, 1981) and there is a social movement, a movement against wife beating, in existence. The movement achieved enormous gains in a decade because it operated from the base of established organizations, it was flexable and adaptive in its approaches, and it interacted successfully with the media which found the topic particularly useful (Tierney, 1982).

Once this intense level of interest and support has waned or moved onto another problem, what will become of the movement? Pfouts and Renz (1981) offer 4 possibilities: it will fade into oblivion; continue at the current (and inadequate) level; be taken over by traditional government run agencies; or the present programs may receive adequate, permanent funding and remain independent. The outcome will depend on political trends, public opinion, and the resources of the agencies to plan and organize for their long-range future (Pfouts & Renz, 1981; Schecter, 1982).

It should be noted that Johnson (1981) pointed out that achieving funding has resulted in program cooptations. Schecter (1982) also raised this issue.

It appeared from the literature that feminist programs were in the most danger of extinction. Some have indicated a shift towards the traditional approach of individualizing the problem and offering "therapy" to the battered woman. Such trends will result in the problem of wife abuse becoming increasingly professionalized, medicalized, and de-politicized (Tierney, 1982).

Shelters for battered women have become a significant part of the social service system. Some of these were sponsered by traditional groups while others were started by feminist organizations. The roots of a shelter produce its philosophical base and thus, its policies and programs. Shelters have been well accepted by battered women as desireable and effective services but they have not easily gained the support of other social agencies. There is some concern that shelters may become less effective if they move toward individualizing the problem of wife abuse.

Chapter 6

Context and Background of Shelter Under Study

The shelter under study is situated in a unique city and province. Cultural and geographic factors have influenced the development and operation of this program. In order to place the data presented in this study in context, this chapter will give a brief geographical sketch of the province and city in which this shelter is located and a brief account of the history of the development of the shelter.

6.1 Geographical Context

Newfoundland and Labrador is the most easterly province in Canada. It is one of four Atlantic provinces. The island of Newfoundland is separated from Labrador and the rest of Canada by the Atlantic ocean. There are car ferries between Nova Scotia and Newfoundland which take from twelve to eighteen hours to make the crossing.

The island has approximately 6,000 miles of heavily indented coastline which is dotted with small fishing communities. Some communities are accessible only by dirt roads, others are accessible only by water. The population of the island is roughly 536,000 with 42% living on the

Avalon Peninsuala. A sizeable french speaking population lives on the west coast of the island. The most notable group of Native people on the island lives in Conne River on the South Coast.

The distance from St. John's, the capital city on the east coast of the island, to Corner Brook, the only other city which is on the west coast, is approximately 689 kilometers (Personal Communications, Department of Transportation, March 19, 1985).

Labrador is almost three times as large as the island. The population is approximately 31,000 of which 5% are Innuit, 3% Naskopi Innu, 32% Settlers, and 60% immigrants. With the exception of those between the towns of Wabush, Labrador City and Sheffield (a Quebec town), and those connecting some of the communities in the southern Straits region, there are no roads that connect communities. Travel is done by boat in the summer and by small plane or skidoo in the winter (Women Health Education Project, 1984).

St. John's, the capital, is located on the Avalon Peninsula. It is the oldest city in North America and the most easterly. The provincial government building and most department headquarters are located in this city.

The harbour of St. John's is a haven for fishing vessels from countries such as Russia, Poland, Greece, Japan, and Portugal.

The St. John's Census Metropolitan Area (CMA) is the fastest growing centre east of Toronto and this trend is

expected to continue. The 1981 census gave St. John's (CMA) a population of 155,000 and indicated that people are moving from the city core to surrounding suburban areas.

Newfoundland had an unemployment rate of 19% in 1982 while the rate for St. John's was 12%. (The Canadian rate was also 12%). (Statistics Canada as cited in St. John's, 1982). In 1982, the top 10 companies in terms of employment in the province included fishery, mining, and forestry companies plus the telephone and power companies.

The Memorial University of Newfoundland is located in St. John's with six faculties (Arts, Science, Education, Engineering, Medicine and Business Administration) and four schools (Nursing, Social Work, Physical Education, and Graduate Studies). St. John's also has the School of Nursing at St. Clare's Hospital, the College of Trades and Technology, and the College of Fisheries. Numerous other specialized training faciities exist in the city (eg. computer training colleges) (St. John's, 1982).

Newfoundland is one of the few provinces where a denominational school system operates.

In the last six years (1979-1985) in particular the province has been experiencing the effects of offshore oil development. The social impact of this economic development as yet to be assessed. A study was carried out and will be subject to public hearings in 1985 (Hibernia Development Project, 1985).

For a map of the province see Appendix A, 318.

6.2 The St. John's Status of Women's Council

The St. John's Status of Women's Council (SJSWC) was known as the Newfoundland Status of Women's Council prior to a name change in 1984. The SJSWC was founded in 1972 by an ad hoc group of women in St. John's in response to the Royal Commission Report on the Status of Women. The aims of this new organization were concluded to be: to raise the consciousness of women (on women's equality), to improve the status of women, and to work towards the implementation of the Recommendations of the Royal Commission Report on the Status of Women.

In 1977 the SJSWC purchased a three storey house which became the first self-supporting Women's Centre in Canada. Rent from apartments in the house payed the mortgage and upkeep costs. This centre included an office for a Rape Crisis 24-hour crisis telephone line.

The SJSWC is an incorporated non-governmental organization. Throughout its history it has had between 200 and 300 members. A small membership fee entitles one to receive a newsletter, to vote at membership meetings and annual meetings, and to run for one of the executive positions. Elections for the executive are held at the annual meeting.

The executive of the SJSWC meets at least monthly. This body oversees the affairs of the organization and directs its activities. Several committees may be established to deal with specific aspects of the work.

The SJSWC has been an influential lobby for women's rights in Newfoundland and Labrador. It had significant impact on the passage of a Matrimonial Property Act in the province and on the establishment of the government Advisory Council on the Status of Women. It presented numerous briefs to governments and commissions on subjects ranging from the Juror's Act to the health care system.

The SJSWC also sponsored, with the Newfoundland and Labrador Women's Institutes, a three year Women's Health Education Project which was provincial in scope. This project held meetings and workshops with approximately 2000 women who came predominately from rural areas of the province. Topics ranged from coping with stress and violence against women, to development of political skills.

Some of the publications of SJSWC have included: Women and the Law in Newfoundland and Labrador, a Do-It-Yourself Divorce Kit, Working for Our Future: Opportunity for Women in Resource Development , and Women and Aging (NSWC, 1982).

6.3 Transition House

The establishment of a shelter for battered women was one of the major accomplishments of the SJSWC. SJSWC is the sponsor of Transition House and owns the house "in right of the Queen for Newfoundland".[14]

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[14] This phrase means the shelter cannot be sold to profit the sponsor but funds must be returned to the government or to another organization with the same objectives.

A board of directors of Transition House is appointed by the SJSWC executive every year; thus, the Board of Transition House, while authorized to oversee the operations of the shelter, is legally a committee of SJSWC. One of the positions on the Board of Transition House is Liason with SJSWC.

Transition House was the result of two years of intensive lobbying and political activity. For many years, SJSWC volunteers (and in later years staff) at the Women's Centres (offices were rented prior to the purchase of the current centre) had received calls from women who had been beaten by their husbands and who wanted help. On occasion volunteers took women and children home with them.

SJSWC members were aware of shelters in other provinces of Canada and in other countries. SJSWC had repeatedly since 1972 recommended to government the establishment of a shelter in St. John's. In 1979 the executive of SJSWC decided to make establishment of a shelter a priority goal.

A first step was development of forms to better document the calls received at the Women's Centre. It became clear that the Centre received between 30 to 50 calls a year from battered women even though it was not advertised as a service to battered women. In the summer of 1979 a grant obtained by SJSWC and the Newfoundland Association of Social Workers produced an internal discussion paper "Transition House in St. John's: Need and Model" (Herzberg & O'Brien, 1979). This research provided confirmation from

social service providers and the justice system that wife battering was a widespread problem in St. John's.

The SJSWC produced a position paper on transition houses in October 1979. It stated that a service offering crisis interventions and a transitional period should be provided for battered women and their children.

> The initial and paramount goal is to save their lives. In addition, such a service should allow her the opportunity to reflect on all options available to her and to enable her, through counselling and interaction with other women, to see her problem as a common occurrence in a male-dominated society, rather than as a personal fault. Hence, the concept of mutual aid will be an important factor in the delivery of service. (NSWC, 1979, p.2)

In the winter of 1979, SJSWC requested the opposition party of Newfoundland and Labrador to submit a written question to the Minister of Health, asking for an estimate on the prevalence of battered women in the province. Despite the fact that a written question allows time for research, the Minister of Health responded that the government had no such estimates. In addition, there was laughing and joking in the House of Assembly, a preview of similar behavior by members of Parliament in the House of Commons in 1982.

SJSWC expressed outrage at the behavior of House of Assembly members, as did other groups in the province. The premier was written and the media provided with interviews. In addition, SJSWC provided the government with the data that it had gathered. After these events the government

decided to sponsor a seminar on family violence. SJSWC agreed to organize a day-long conference which was funded by the federal and provincial Departments of Justice. In May 1980, representatives from women's groups, police forces, social work departments, public health programs, etc. attended the session which received extensive media coverage. From nine separate workshops the overriding recommendation was that shelters were necessary to intervene in battering cases.

As a result of the media coverage received by SJSWC an individual offered an appropriate house to SJSWC at a very reasonable price. SJSWC then negotiated with the federal Department of Employment and Immigration, Canada Community Services Project and the provincial Department of Social Services for complementary operational grants. During this period a grant to write a needs assessment was received from Canada Mortgage and Housing Corporation (Lucy, 1980).

In December 1980, the Department of Social Services announced it would fund the Transition House for three years in conjunction with Canada Employment and Immigration. In June 1981, Transition House was officially opened. Staff had been in training for one month and renovations required by fire and safety regulations had just been completed. The house was soon operating at capacity.

Transition House was licenced under a Boarding House bylaw for 14 beds. It is an older attached house with 5 bedrooms, 2 bathrooms, a kitchen, a dining room, a living

room and a finished basement. It has an extremely small office and a small back yard. It is located in the downtown and is therefore near schools, hospitals, courts, social services, and the police.

Transition House began in 1981 with four shift workers, one children's services worker, one administrator, one administrative assistant, and one fund raising and resource person. In January 1984 it operated with a similar complement of staff, the only change being in the position of fund raiser/resource person which became counselling coordinator.

Transition House operates a 24-hour emergency line and is staffed 24 hours a day. The following is the "mission statement" of Transition House:

> Transition House provides battered women and their children a shelter from violence and an opportunity to consider choices and alternate life styles in a nonjudgemental setting. Transition house promotes equality for women in a violence free society, provision of responsive services, unity among women and a feminist working environment. (Volunteer Manual, 1983)

6.3.1 Transition House Admission Policies

The Transition House admission policies are as follows:

1. ADMISSION PRIORITIES

1. Women with children in an emergency situation.
2. Women without children in an emergency situation.

3. Women with children in a planned admission.

4. Women without children in a planned admission.

5. Women with numerous previous admissions to the House.

2. SCREENING OF WOMEN

1. Women - not battered either physically or emotionally by partner or family member.

2. Women who clearly require treatment in a psychiatric setting.

3. Active Alcoholic or drug addicted women who are not involved in a detox programme.

4. Women who do not follow the cooperative living guidelines of Transition House.

5. Women who are identified as inappropriate after admission will be asked to leave.

3. CHILDREN

1. Children to be accompanied by an adult.

2. Female: From infancy to 16 can be admitted to the House.

3. Male: From 13 to 16 a decision to be made on an individual basis.

(House Policies and Procedures, 1985)

A battered woman may contact Transition House herself or be referred through a professional. In most cases the woman herself is interviewed in person or over the telephone before admission.

There is no charge for staying at Transition House and no limit on the number of admissions for one woman. The

suggested maximum length of stay is 6 weeks but this can be extended. Male children from 14 to 16 years of age are not automatically admitted as are all other children under the age of 16 years. Children 16 years of age and older are encouraged to find other accommodation (House Policies and Procedures, 1985).

This chapter has described some of the characteristics of the shelter under study and its geographical location. It is located in Atlantic Canada in an urban setting but also serves a large rural population. It was established in 1981 by a feminist organization and accomodates 14 women and children.

Chapter 7
Women in Other Shelters

In this chapter we will review the data on shelter users provided by eleven studies. These studies took place in Scotland, England, the United States, and Canada but similiarities exist in the findings. These will provide comparative data for the findings of the present study.

7.1 Social Class

To summarize what has alrady been discussed about social class, wife abuse has been reported in all income, educational, and occupational levels of women and of abusers (Colorado Asociation for Aid to Battered Women ,1980; Gelles, 1972; Mac Leod, 1980; Straus et al., 1980) but some evidence suggests that it is more prevalent at lower socioeconomic levels (Straus et al., 1980; Hilberman, 1980). Comparisons of finding on class are made difficult because different criteria are used. In addition, it can be argued that women of lower socioeconomic status are more liable to intervention and documentation by public agencies while middle and upper class families are better able to preserve their privacy (Freeman, 1980; Hilberman, 1980; Jackson & Rushton, 1982). The appearance of greater help seeking in

lower classes could be a distortion created by the fact that the records of private agencies, which middle and upper class families might use, rarely contain detailed information on violence and class. Where these were available, distribution by class was almost equal (Rounsaville et al., 1979). A distortion of perception of distribution might also arise because victims repeatedly underestimate the prevalence of this problem and associate it exclusively with the lower classes (Mac Leod, 1980; Rounsaville, 1978). Middle and upper class victims aided by professionals, friends, and neighbours (Jackson & Rushton, 1982; Morgan, 1981; Speiker, 1980), are more likely to redefine the abuse so that it is kept private.

The literature was not clear on the social class of battered women using shelters. MacLeod (1980) and Morgan (1981) have indicated that middle and upper class women generally do not use refuges for battered women; however, Moore (1979) disagreed noting that middle class women were in shelters and could be studied there. A Quebec study of women in shelters found no class differences between these women and the population of Quebec women as described by Statistics Canada (Research Group on Abused Women, 1980). Drake (1982) reported that 33% of the women in one shelter were middle to upper class.

7.2 Age

Research disagrees as to which age bracket has the highest rates of wife abuse; couples with one member under 30 (Straus et al., 1980) or couples with ages 41 to 50 (Gelles, 1972). In 5 studies (Drake, 1982; Gayford, 1975; Mc Danal & Seigle, 1978; Snyder & Fruchtman, 1981; Star, Clark, Goetz, O'Malia, 1979) where a mean age of women was determined, shelter residents were on average 26 to 32 years old. Four other studies also showed the majority to be under 35 years (Womens Research Centre & Vancouver Transition House, 1980; Chan, 1978; Dobash & Dobash, 1979; Mac Eachern, Adler, Roland, 1980) This would appear to support Straus, Gelles and Steinmetz (1980). The age range, however, was from the teens to over 40 years (65 being the top range) in 6 of these 9 studies, (Womens Research Centre & Vancouver Transition House, 1980; Dobash & Dobash, 1979; Mac Eachern et al., 1980; Gayford, 1975; Snyder & Fruchtman, 1981; Star et al., 1979) and in 3 others (Ferraro & Johnson, 1983; Mac Leod, 1980; Menzies, 1977, as cited in MacLeod, 1980).

7.3 Education

The effect of educational status on shelter use is unclear from a review of studies. Two studies indicated that less than 10% had lower than high school education (Ferraro & Johnson, 1983), 3 found between 27 and 36% to have less than high school (Womens Research Centre & Vancouver Transition House, 1980; Gayford, 1975; Snyder & Fruchtman,

1981), and only one of these indicated residents (3%) with no formal education (Womens Research Centre & Vancouver Transition House, 1980). The range of percentages with high school or above was great, 33% to 93%, (Chan, 1978; Star et al., 1979) no doubt reflecting geographical differences.

7.4 Occupation

Residents' occupations covered every category and type - professional to unskilled, waitress to college professor. As would be expected from the demographics of the labour force, the majority of women were in the lower paid occupations (Womens Research Centre & Vancouver Transition House, 1980). The percentages of homemakers ranged from 5 to 54% (Womens Research Centre & Vancouver Transition House, 1980; Chan, 1978; Drake, 1982; Ferraro & Johnson, 1983) of skilled to semi-skilled occupations from 16 to 27% and of unskilled occupations from 19 to 32% (Chan, 1978; Saville, Wilkinson, O'Donnell, Colley, 1981; Snyder & Fruchtman, 1981). Only one woman was described as retired (Womens Research Centre & Vancouver Transition House, 1980) while between 8 and 84% were described as unemployed or not working (Ferraro & Johnson, 1983; Saville et al., 1981; Snyder & Fruchtman, 1981).

7.5 Source of Income

Few studies addressed the issue of residents' sources of income. Where data was available from 14 to 31% listed employment (Womens Research Centre & Vancouver Transition House, 1980; DeLorto & LaViolette, 1980; MacEachern, Adler, Roland, 1980; Mac Leod, 1980; Saville et al.,1981; Snyder & Fruchtman, 1981), 30 to 37% their spouse (Womens Research Centre & Vancouver Transition House, 1980; Mac Eachern et al., 1980), and 2 to 67% public assistance (Womens Research Centre & Vancouver Transition House, 1980; Drake, 1982; Ferraro & Johnson, 1983; MacEachern et al.,1980; Snyder & Fructman, 1981). Only one study from Canada provided information on source of income for all of its sample as follows: 26% Public Assistance, 14% Employment, 30% Spouse, 2% U.I.C., 8% Pensions, Savings, or Family, 6% No Income (Womens Research Centre & Vancouver Transition House, 1980).

7.6 Children

The vast majority (64 to 100%) of shelter users had children (Womens Research Centre & Vancouver Transition House, 1980; Drake, 1982; MacEachern, et al., 1980; Pahl, 1979; Saville et al., 1981; Snyder & Fruchtman, 1981) and family size was usually around 2 children (Chan, 1978; Dobash & Dobash, 1979; Ferraro & Johnson, 1983; Mc Danal & Siegle, 1978; Snyder & Fruchtman, 1981). The children ranged in age from newborns to 16 years (Womens Research Centre & Vancouver Transition House, 1980; Chan, 1978;

Drake, 1982; Gayford, 1975; Pahl, 1979). Three studies indicated the majority of children in shelters to be "quite young" or under 6 years (Womens Research Centre & Vancouver Transition House, 1980; Chan, 1978; Gayford, 1975).

7.7 Marital Status

Resident users may be legally married to, cohabiting with, or living separate from the abuser. Legally married women were usually the majority in shelters, comprising from 59 to 85% of residents as compared to 9 to 28% residents who were cohabiting (Womens Research Centre & Vancouver Transition House, 1980; Gayford, 1975; MacEachern et al., 1980; Mac Leod, 1980; Snyder & Fruchtman, 1981; Star et al., 1979). In one study cohabiting women outnumbered single and legally married women 67% to 34% (Drake, 1982). It was not uncommon for residents to be single, divorced, or separated yet still victims of abuse and in need of refuge. These women comprised from 10 to 24% of residents in some shelters (Drake, 1982; MacEachern et al., 1980; Mac Leod, 1980; Snyder & Fruchtman, 1981).

7.8 ~~Length of~~ Relationship and Abuse

In some cases, shelter users had had only a short relationships with the abuser but the majority appeared to have had a long term relationship, marked by abuse from an early point. The length of the relationship with abusers ranged from months to 40 years (Womens Research Centre &

Vancouver Transition House, 1980; Drake, 1982; Gayford, 1975; MacEachern et al., 1980; Mac Leod, 1980; Saville et al., 1981; Star et al., 1979) and means, where calculated, ranged from 7.3 to 8.8 years (Drake, 1982; Gayford, 1975; Snyder & Fruchtman, 1981). The number of years in which abuse occurred was not provided; however, three studies (Womens Research Centre & Vancouver Transition House, 1980; Dobash & Dobash, 1979; Star et al., 1979) indicated that, for the majority of residents, abuse had started within one year of the beginning of the relationship. Most residents (46 to 86%) had left the abuser before (Womens Research Centre & Vancouver Transition House, 1980; Gayford, 1975; Mac Leod, 1980; Pahl, 1979; Snyder & Fruchtman, 1981).

7.9 Medical Care

It is unclear from the literature whether shelter users are likely to have used a medical service at some time. In two studies few residents (less than 20%) indicated that they had received medical attention after abuse (Dobash & Dobash, 1979; Snyder & Fruchtman, 1981). In other cases 50 to 67% had done so (Womens Research Centre & Vancouver Transition House, 1980; Drake, 1982; Star et al., 1979). Evidence shows that few of these women are identified by doctors, nurses, or social workers as battered women and offered assistance for this problem (Freidman, 1977). Often not even known cases are recorded in hospital records (MacEachern et al., 1980) and women find the response of

physicians unhelpful. They explained that anti-depressants and tranquillizers were the only assistance offered (Pahl, 1979). Chronic health problems, mentioned in one study, existed in 18% of one sample in which 9% had also been taken to hospital after beatings (Gayford, 1975).

7.10 Psychotropic Drug Use

The literature pointed to a disproportionate rate of prescription of tranquillizers and other psychotropic drugs to battered women. In two studies 71% of the women had been prescribed tranquillizers (Gayford, 1975; Hebert, Leith, Pepall, 1979) and in another battered women outhumbered other women in chronic tranquillizer use (Stark, 1981). Two studies of shelter residents indicated rates of psychotropic drug use of 11 to 40% (Womens Research Centre & Vancouver Transition House, 1980; Dobash & Dobash, 1979).

7.11 Types of Abuse

Studies on battering have used disparate definitions of abuse, often choosing criteria — such as obvious bruising, based on the expediency of empirically identifying a case (Finkelhor & Yllo, 1982; Moore, 1979; Pagelow, 1979). The primary effort at operationalizing wife abuse produced the Conflicts Tactics Scale which does not deal with psychological or sexual abuse, does not differentiate attacks by consequence or context (Gelles, 1980; Martin, 1978; Straus et al., 1980) and therefore does not present a complete description of the abuse (Breines & Gordon, 1983).

Public policy planners may wish to delineate a specific group of clients by a number of criteria (Benjamin & Adler, 1980), shelters, on the other hand, usually rely on a victim's identification of a battering syndrome or professional referral and only set admission eligilibity criteria not related to the abuse (eg. absence of a drug problem) (Fleming, 1979; Mac Leod, 1980; Martin, 1978; Roberts, 1981). Evidence suggested that women can be relied upon to accurately report the abuse they received and their reason for seeking admission (Mac Leod, 1980).

Battering may be physical (including sexual) or psychological. Physical abuse ranges from slaps to attacks with weapons. The consequence may be no physical damage, serious injury, disability, or death (Womens Research Centre & Vancouver Transition House, 1980; Colorado Association for Aid to Battered Women, 1980; Greenland, 1980).

Sexual abuse includes forced sexual activity which may involve other men, objects, life threatening situations, or threats (Colorado Association for Aid to Battered Women, 1980; NiCarthy, 1982).

Psychological abuse includes threats, denigration, and forced isolation (Womens Research Centre & Vancouver Transition House, 1980; Hilberman, 1980; Rounsaville et al., 1979). The result may be a "paralyzing terror" (Berkman, 1980), depression, or somatic illess, (Hilberman, 1980). Many shelter residents who only identify psychological abuse as their reason for seeking admission have also been

physically abused in the past (Womens Research Centre & Vancouver Transition House, 1980).

Studies involving shelter residents indicated that physical abuse was most common; from 81 to 100% of the women had been physically abused (Womens Research Centre & Vancouver Transition House, 1980; Dobash & Dobash, 1979; Gayford, 1975; MacEachern et al., 1980; Snyder & Fruchtman, 1981; Star et al., 1979), 35 to 57% were sexually abused (Womens Research Centre & Vancouver Transition House, 1980; MacEachern et al., 1980; Snyder & Fruchtman, 1981), and 11 to 85% were psychologically abused (Womens Research Centre & Vancouver Transition House, 1980; MacEachern et al., 1980; Snyder & Fruchtman, 1981; Star et al.,1979). Two studies indicated that from 32 to 54% of the women had children who were also abused (Gayford, 1975; Star et al., 1979).

7.12 Alcohol Problems

Alcohol is often associated with wife abuse, however, shelter residents varied greatly in declaring it a part of the problem in the marriage - 6 to 50% (Dobash & Dobash, 1979; Mac Leod, 1980). It is generally accepted that alcohol, while commonly involved in incidents of violence, is not a causative factor (Fleming, 1979; Mac Leod, 1980; Marjot, 1982; Moore, 1979; Speiker, 1980).

7.13 Financial Problems

Frequently it is assumed that finances are a problem that creates stress and friction. In one shelter nearly all the women articulated problems such as husbands accumulating debts or refusing housekeeping money (Womens Research Centre & Vancouver Transition House, 1980). In two studies gambling was mentioned as a significant problem (Womens Research Centre & Vancouver Transition House, 1980; Gayford, 1975). Financial problems may not be related to socioeconomic status of the family.

7.14 Social or Legal Services Used

Battered women frequently contact other services before they approach a shelter. Gayford (1975) found that 32% had called in the police, 57% contacted a social service, and 10% a lawyer. Thirty-two per cent of residents in another sample contacted these three services (Womens Research Centre & Vancouver Transition House, 1980). Often these services, like medical and health services, do not identify the abuse as a major problem and do not provide the woman with what she requires (Dobash & Dobash, 1979; Mac Leod, 1980).

The literature on shelter users does not present a consistent picture; it appears that shelter use is not restricted to any one group of battered women. There is not trend in reports on social class, education, or source of income of residents or in reports of prior use of medical

services and problems with alcohol or finances. Residents of most shelters came from a wide range of ages but the majority appeared to be between 25 and 35 years of age, legally married, and to have children. Abuse had occurred for several years for most residents. Physical abuse was the most commonly reported, followed by psychological and sexual abuse.

Chapter 8

Problems with the Literature

8.1 General Context

8.1.1 Describing Wife Abuse

The apparent bias in most family violence literature against certain cultures and classes was superseded by the all encompassing bias against battered women and women in general (Wardell et al., 1983; Stark & Flitcraft, 1983). This will be illustrated by following the lead of Wardell et al. in looking at the general context in which studies were done, the tendency of writers to blame the victim, and the way in which subsequent proposals for intervention were formulated.

Wife abuse is often obscured by the terminology adopted by social scientists and the helping professionals. Battered women were called domestic violence program clients (Morgan, 1981), victims of domestic family or intrafamily violence (Bard & Zacker, 1971; Barnhill, 1980; Cantoni, 1981; Garfinkle, 1974), victims of conjugal violence (Bagarozzi & Giddings, 1983; Lowenberg, 1977), or victims of spouse abuse (Benedek, 1981; Bern, 1982; Glascow 1980, Loeb, 1983). They were also called a surgical problem (Brismar & Tuner, 1982),

and a syndrome (Appleton, 1980; Bern, 1982; Goldstein & Page, 1981). In part this occured because battered wives were being considered synonymous to other victims of abuse. (This will be addressed later). In a larger way, it masked the fact that husbands were beating wives and that the relationship between victim and aggressor and the sex of victims was significant to understanding the issue (Committee on Violence Against Women, 1982; Morgan, 1981).

Wife abuse is further masked by those who present it as a problem secondary to other historical or individual problems in the family. A case history of a family, for example, may trivialize the abuse (Stark & Flitcraft, 1983). One author described a woman whose husband beat and threatened to kill her and her children. She had been afraid to go into an agency for two years, even though she had contacted them by phone. This was given as an example of someone who, because of defective relationships with her parents, was threatened by and in fear of treatment rather than her husband. In another case, a woman admitted that her husband had threatened to kill her and the whole family if she had an affair. She described his rage and jealously; their child's enuresis; the fact that she was having an affair; and she said that she wanted to divorce her husband. The worker could find no basis for intervention until Mrs. B stopped "her incessant talk and admit[ted] multigenerational problems of sexual and physical violence" (Cantoni, 1981, p. 9).

In hospitals and doctors' offices this process of focusing on secondary problem produces labels for the patient which can be used to explain seemingly unrelated accidents and injuries. The woman becomes a drug abuser, depressed, emotionally unstable, "this explains not only why she had had so many injuries but also why she occassionally appears to have had 'fights' or why she had such a poor self-image" (Stark, Flitcraft, Frazier, 1979, p. 473). The therapeutic approach taken then ignores the determining feature of her current situation; the latter had become vague in the picture of a multiproblem family.

> The problem is explained simply by juxtaposing it to other problems and, in the process, its organizational principle, its sex specificity is lost. So is any possibility of genuine redress. Once labelling, misdiagnosis, callous indifference and punitive treatment have helped to make Mrs. McShane the "victim of circumstances" the image of her violent past suggest she was from the start, the opacity of her situation is projected onto her. She is withdrawn, not the hospital. (Stark, 1981, p. 15)

One study sought to "illuminate" the involvement of women with batterers who drink by studying the women's childhoods. The women were subsequently classified in three typologies of family of origin. In one group, the fact that some women described themselves as tomboys was attributed by the researcher to their having identified with the aggressor (their father) in order to avoid his wrath towards women. (Rosenbaum, Adams, Scott, Renson, Tinklenberg, Hanks, 1981). This is a classic example of going far beyond the immediate context of the problem to explain what, to the authors, is irrational behavior.

The authors suggested that the findings had implications for treatment: if a woman was unwilling or unable to terminate the relationship she could protect herself by altering her behavior during angry encounters; if the woman did want to end the relationship, she needed an understanding of how her early life influenced her behavior in combination with supportive concrete services (Rosenbaum et al., 1981). The suggestion is unsatisfactory because it implies that knowledge of your childhood alone doesn't help you decide to end a battering relationship, in fact, concrete services are needed. It also suggests that the woman who is "unwilling or unable" to terminate such a relationship, should be the focus of treatment rather than the batterer. The woman is then expected to protect herself from irrational violent attack. The professional thus avoids dealing with the factors that make her unable or unwilling to leave.

Wife battering had no sooner become a focus of attention for social science when it was linked with other forms of family violence - child abuse, sibling abuse, elderly abuse, husband abuse (Gelles, 1972; Steinmetz, 1977-78; Straus et al., 1980). Aggregating these problems obscures their differences and all forms must be better understood separately before similarities can be described with confidence (Breines & Gordon, 1983) despite the argument that studying them separately will obscure these similarities (Dibble & Straus, 1980).

One difficulty with treating all violence in the family as one phenomenon is that it encourages conceptualization of weaknesses in the social order. This avoids an examination of the roles of various violences in maintaining a particular social order. This happens, in part, because researchers have a weak understanding of family, of gender, and of power (Breines & Gordon, 1983) and partly because researchers do not recognize male domination in society (Wardell et al., 1982). One researcher, in fact, insisted that we are in a matriarchal society (Lesse, 1979). Another wished to study the analogy between "animal battering" and wife battering (Moore & Pepitone-Rockwell, 1979). Analogies between wife abuse and other family violence are often made without distinguishing the nature of the abuse, the situation in which it occurred, and the expectations attached to certain roles (Wardell, et al., 1982), for instance, the expectation that mothers are primarily responsible for the upbringing of their child.

Flanzer (1982) introduced his book on family violence by stating that each pair in the family system has "built-in potential for conflict" and went on to describe the general characteristics of such violence (p. 4). Some of the general characteristics that he omitted to mention were: victims of child sexual abuse are predominantly girls attacked by men they know (MacFarlane, 1978); women predominantly appear in hospitals and doctors' offices with repeated severe injuries (Hilberman, 1980; Appleton, 1980; Barman, 1981); women get

battered when pregnant (Gelles, 1972), often because they are pregnant; men predominantly express pathological jealousy of their wives (Bowden, 1978); elderly abused parents are predominantly women (Freeman, 1979). This is not an exhaustive list. Having thus generalized about types of violence Flanzer (1982) went on to generalize the characteristics of abusers and of victims in lists of 5 and 4 items respectively. While his book's title, The Many Faces of Family Violence, implies a differentiation, his theories project a single phenomenon.

Part of the trend in treating all violence as the same thing has been the development of a Conflict Tactics Scale (CTS) to measure reasoning, verbal and physical aggression (Straus, 1979). Items on the scale range from "Discussed the issue calmly" to "Used a knife or gun" and number of times used ranges from "never" to "more than 20 times". The "violence index" includes successful and unsuccessful attempts to make physical contact; the "severe violence index" drops throwing things, pushing, grabbing, shoving and slapping (Straus et al., 1980). This scale is the most popular one in use in research and was used in a major US national study (Straus et al., 1980) as well as in other studies. Breines and Gordon (1983) outlined the major criticisms of the CTS:

> [It] categorizes violent acts on a continuum from least to most severe, treats male and female acts equally, and makes no allowance for the power context within which violence occurs. The CTS assumes that all violent acts are comparable and can

> be ranked; that violence can be ordered linearly; and, implicitly, that any pushing, hitting, or throwing is worse than any amount of verbal or emotional expression, no matter what pain the latter inflicts. (p. 511)

It also assumes that pushing and slapping are less than severe violence. Since the scale does not deal with outcomes or injuries a push is a push whether it resulted in a fall downstairs or a stumble; whether it was done in front of the children or not; whether it was part of a public humiliation or not. While this suits the empiricist demands of some researchers, the date fail to describe reality (Breines & Gordon, 1983).

A further consequence of this type of strictly empirical method is that battered women are eliminated from study. Since acts and consequences of psychological abuse are difficult to quantify, some studies chose to discount the victims of such abuse (Hartik, 1982; Bach et al., 1982; Price & Armstrong, 1978; Wiggins, 1983). The results, analyses and subsequent recommendations were, therefore, skewed. A message was also transmitted: battered women are those women who are victims of physical attacks beyond slapping or shoving. Gayford (1979) has even created a category "Pseudo-battered wife" for those who cannot present direct evidence of violence. Other writers, however, recognized that psychological, sexual, and social abuse are serious and can be life threatening (Women's Research Centre & Vancouver Transition House, 1980; Berkman, 1980; Moore, 1979; Pfouts, 1978).

Some studies went even further in limiting who would be studied (see Hartik, 1982; Mahon, 1981; Coleman, 1980; Saravanapavahanthan, 1982). One, for instance, defined a "chronic battered wife" as one whose husband inflicted injuries requiring doctors care on ten or more occassions. An "acute battered wife" was one who required doctors care only one to nine times. Those women "occassionally slapped, bumped, accidentally pushed, and the like, were not included in the study" (emphasis added, Peretti & Buchanan, 1978, p. 64).

Failure to identify battered women is often connected to a bias against them. It is linked to victim blaming, to the focus on secondary problems, and to the lack of understanding of family politics, gender, and power. It is also related to the question of whose definition of battered woman is used. "Victims are made, not born: like deviants and saints, they are subject to examination and classification before being publicly acknowledged." (Jackson & Rushton, 1982, p.23). Myths about battering abound (Walter, 1979) but one persons myth may be another's yardstick. Since the description of a victim relies substantially on "ideological definition", failure to identify will never be an easy problem to resolve (Jackson & Rushton, 1982; Freeman, 1980). MacLeod (1980) illustrated how battered women may be defined away by the legal system in When is Proof not Proof? (p. 42). Another study reported that wives and girlfriends appeared to take pleasure in a

certain amount of "thumping". The conclusions were based on what the men involved had told the authors (Renvoize, 1978).

Other authors stated that violence is a "social construction" (Freeman, 1979; Stark et al., 1979), that is some acts are considered legitimate and others unacceptable or illegitimate. Straus (1980) believed that some violence was "normal" or "ordinary" and that this and "wife-abuse" formed opposite ends of a continuum. He went on to say:

> The point on the continuum at which the violence becomes "abuse", and the rates of such abuse, are primarily a reflection of social definitions of what is ordinary, or normal, rather than of psychopathology. It has varied widely from one historical period to another. (p.7)

Several problems with this position arise: it is never explained who arrives at this social definition nor how it is maintained and transmitted; and it does not address whether rates vary with social definition and, therefore, over historical periods.

8.1.2 Lack of an Historical Context

A lack of historical context in the literature was noted by Breines and Gordon (1983) who saw family violence as an historical phenomenon. Child abuse and wife abuse as social problems have very different histories. An understanding of the issues involved as antecedents of wife abuse requires an understanding of the historical roles of gender and the family in relation to government and social structure (Davidson, 1970; Dobash & Dobash, 1979, 1981;

Freeman, 1980; MacLeod, 1980; Morgan, 1981; Pogrebin, 1983; Stark, 1981).

Absence of an historical context has encouraged personalization of this problem and the neglect by researchers of an analysis of cultural and social sanctions affecting men and women. There is little doubt that wife beating has been a common feature of British and North American culture for centuries (Dobash & Dobash, 1981; Freeman, 1979;) and is not a consequence of the twentieth century feminist movement as some would have us believe (see Lessie, 1979; Medlicott, 1980; Research Group on Abused Women, 1980). Rather, it was the feminist movement that began the most recent campaign against wife abuse. Goldman (1978) pointed out that women were historically physically and economically the chattel of their husbands and ascribed less authority than men under the law. Thus, for centuries husbands were completely free from judicial restriction on wife beating. In addition, decades elapsed between periods of legislator interest in the topic. These facts must be examined to understand the role of individuals and of institutions in the dynamics of wife beating and to ground conceptualization and development of theory in a more complete understanding of the world (Dobash & Dobash, 1981, 1983; Morris, Cooper, Byles, 1973). Obscuring the history of wife beating may be also serve the ideology of those who wish to avoid the social analyses that feminism has produced and which they find threatening (Breines & Gordon, 1983; Freeman, 1980; Schecter, 1981).

Overt rejection of feminism was common in the literature on wife abuse (Lessie 1979; Gabbard & Larson, 1981; Benjamen & Adler, 1980; Pogrebin, 1974; Medlicott, 1980; Peterson, 1980). The covert, more subtle, and not necessarily deliberate rejection was seen by some as more damaging to the cause of eradication of violence against women . This rejection is reflected in the way that writers and researchers treat the family and its functions (Stark & Flitcraft, 1983; Wardell et al., 1983).

8.1.3 Weak Understanding of the Family

The family, a popular topic in the 1980's has had its passing mourned and its security called for by many. The family that is meant in such discussions is inevitably a heterosexual, male headed couple with children (Pogrebin, 1983; Barrett & McIntosh, 1982). Some have argued, however, that the family is not weaker but that society is more "familialized" than ever (Michele & McIntosh, 1982).

The rise of scientific interest in wife abuse in the 1970's brought a new focus on family life. It became clear that the family was the context of many social problems, however, the family as an institution and its role in wife battering was only minimally addressed in the literature. The roles of gender and power are often ignored (Briénes & Gordon, 1983).

The cultural definition of appropriate roles for men and women affect their contract in marriage (Rice, 1978) and

are reflected in law and social policy. The social changes which separated land ownership and economic power (limited liability laws) relegated the home to the private sphere. At the same time, the role of women in the home was integrated into an understanding of feminity. Women were defined as delicate and as especially equipped for home and child care. Men were defined as natural protectors (Freeman, 1980; Sachs, 1978). The domain of women is still perceived to be the home. Their obligations have a moral nature which means everyone can expect certain things from them (Dobash & Dobash, 1979). Many women are employed outside the home; for these women a dual role is the predominant, if not only, model (Hyde & Rosenberg, 1980; Rice, 1978).

The rationalizations for these beliefs about women's roles can be expected to continue as they serve the self-interest of people in positions of power: women continue to provide many services at home and they do not become competitors in the paid work world (Sachs, 1978) or persons for whom society must provide services. The need for reconceptualization of the roles of women and men in society and concomitant policy changes is avoided.

The unequal distribution ~~of~~ power both within and outside the family and the way that male dominance works and is maintained must be understood to understand wife beating (Wardell et al., 1983).

Rather than question the role of the current family structures in society, social scientists focussed on

"deviant" families. The family continued to be epitomized as the natural and desirable form of social organization; however the upsurg in publicity over violence made it clear that it was not to be idealized as peaceful. Social science could have adopted a questioning stance towards the family structure and social structure in which battering was so common; instead, it defined wife beating and families in which it occurred as deviant. The family could thus be maintained ideologically as the proper sphere for discipline and control and the role of government in maintaining the subordination of women in the family need not be examined. Furthermore, if society was defined as violent, the family became an amorphous institution susceptible to influence and in need of regular protection and intervention. Social Services, therefore, did not have to address issues such as role change and redistribution of power but could focus on containing reconstituting, or stabilizing the 'inevitable' violence (Leffler, 1983; Stark & Flitcraft, 1983; Wardell et al., 1983). Flanzer (1982) , for instance, maintained that "family violence, no matter what form, is still family violence" and proposes a "family systems orientation" with a single treatment approach to all forms. "A single member of the family can change the family system. Violence against any family member will stop when the family unit agrees to disallow it" (p. 8) Similarly, Straus (1980) spoke of "families" as though they were autonomous individuals. "Families are expected to provide adequate food", families

bring up children. Ironically, he follows this with a discussion of sex role inequality in families. Straus believes that "most violence in families reflects a combination of normal process and situations" and he lists eleven "causal factors", none of which addresses the role of the family as an institution in society. He goes on to recommend that we study families longitudinally to determine what causes them to be violent (pp. 23-25). Such discussions disembody the victims and imply that the experience is the same for everyone (Pogrebin, 1983).[15]

There has been a great deal of concern expressed about the decline of the family. An examination of our society, however, reveals it to be more "familialized" than ever (Barrett & McIntosh, 1982). In reaction to feminism's questions about the effect of the traditional family on women both right (see Pogrebin, 1983) and left (see Barrett & McIntosh 1982; Hoshchild, 1983) writers from the political spectrum have called for the return of the patriarchal family. Family violence researchers have an "ideological affinity" with such proposals in their search for "private" causes and solutions to the problem (Stark & Flitcraft, 1983). The literature reiterates sexist depictions of the family rather than presenting alternatives (Wardell, et al., 1983). Some authors go so far as to blame violence on the

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[15] Barnhill (1980) also speaks of the family as single unit.

denigration of the male authority role by feminists and promote father headed households as preventative measures (Medlicott, 1980). Most people are not as forthright in their support of male dominance, however, and mask their ideology as "pro-family". Anyone opposing their positions automatically becomes "anti-family". The family that such people support is not variable or flexable, it is clearly "traditional", that is ordered and patriarchal (Pogrebin, 1983). There is no room for the "flexible notions of family constellations" called for by feminist family systems therapists (Libow, Raskin, Caust, 1982).

While many writers agree with feminists on various issues (e.g. the need for child care services) they generally fail to describe the role of patriarchy in setting the context for violence against women (Breines & Gordon, 1983; Morgan, 1981). One of the ideologies that keeps women isolated and vulnerable is that of privacy. The laws of privacy, by staying out of marriage and the family, are intended to protect individual "bodily integrity, personal exercise of moral intelligence, and freedom of intimacy" (MacKinnon, 1983, p. 27). In fact, the right to privacy has included the right of men to do what they want in their own homes. The private is defined as a "sphere of equality and choice" but in reality these do not exist for women (MacKinnon, 1983). In effect, the right to be left alone exists for men (Bard & Zacker, 1971). People acting within the family are practically immune from the law (MacLeod,

1980); belief in the private nature of family interactions is reflected in the actions and statements of police officers in cases of wife battering (Fleming, 1975) and the exoneration of perpetrators of child sexual abuse (Breines & Gordon, 1983). More explicitly, the laws are designed to preserve the traditional family and to discourage the ending of marriages. The institutions of the family and marriage take precedence over the needs or wishes of individuals (Dobash & Dobash, 1979; Goldman, 1978). While some laws are being amended to give women more equality and security, women are still uncertain about their legal rights and status (Walker, 1979) and about which expectations placed on them are prescribed by law and which by traditions.

One area which has not been examined is the role of social networks, relatives or friends, in setting the limits on violence and controlling the response of women (Breines & Gordon, 1980). Social agencies have been systematically examined and it has been shown that they protect the existing social order and reflect the ideology of patriarchy (Becker & Abel, 1978; Dobash & Dobash, 1979, 1981; Field & Field, 1973; Freeman, 1980; Goldman, 1978; MacLeod, 1980; Stark et al., 1979). Even the press obscure wife beating in their coverage (Weaver, 1984).

Many myths about wife battering exist because of the subordinate view of women (Collier, 1982) but also in order to maintain this view. It is in the collective interest of men who have power that women remain subordinate (Breines &

Gordon, 1983; Sachs, 1978). The balance of power in marriage and the family lies with men (Collier, 1982). They are given the right to possess and to dominate women (Dobash & Dobash, 1979, 1981) even if this right is not put into practice. In this context it is different for women to see themselves as autonomous beings (Freize, 1978; Hyde & Rosenberg, 1980; Muehhenhard, 1983), ultimately, women individually and collectively are controlled (Freeman, 1979; Schecter, 1982), their economic dependence is ensured (Committee on Violence Against Women, 1982; Dulude, 1984; MacLeod, 1980) and they ensure that men continue to participate in the economy (Freeman, 1979; Pogrebin, 1983).

In short, the leaders in a patriarchal society are willing to overlook and condone wife battering, in fact, they must do so. The alternative is fundamental changes in the social structure and organizations which contribute to the problem. Peterson (1977) asserted that political freedom depends on freedom of bodily movement and concluded that women, as a group, were not protected and that the state was, in fact, a "male protection racket" (1977, p.360).

8.2 Victim Blaming

8.2.1 Battered Women as Deviant

A great deal of attention is paid to finding differences between battered and nonbattered women. This is partially motivated by the need to believe that this violence is not random and that individuals can control

whether or not they become victims. It allows a believe that our social structure and organizations are functioning reasonably well and that responsibility lies with individuals (Symonds, 1975). In the search for differences, however, battered women become deviant (Hilberman, 1980). Any differences that are found are assumed to explain why violence began and why it continued. The data collected is often correlational and differences may, in fact, be the result of the violence (Stark et al., 1979) or may reflect self-perception or the result of being an official victim or nonvictim. Finally, if enough data are compared, eventually differences will appear (Wardell, et al., 1983).

Back, Post and D'Arcy (1982) compared women in a psychiatric hospital whose chart indicated "deliberate, severe and repeated" physical injury to women whose chart did not report a history of physical abuse. Many records were excluded from study because information on the relationships with men was not available; obviously, there may have ben battered women in this sample as well as in the "official" nonbattered sample as no one had been instructed to ask patients about physical abuse. It can justifiably be asked, "Who is being compared to whom?".

Despite the fact that clinical diagnoses in the "battered" group (83% with personality disorders compared to 45% in the "nonbattered" group) was "surprisingly homogeneous" and did not correspond to MMPI findings and did raise questions for these researchers such as, do

personality attributes result from abuse or clinician bias these writers held to the hope that "clinical diagnosis appears to be another factor that might be potentially useful as a predictor of victimizations" (p. 23). In other words, your personality profile may result in someone else beating you.

Another study sought to delineate the psychological makeup of battered wives. The subjects were referred by acquaintances of friends or were contacted through ads in the newspapers and women's restrooms. "Battered" wives were those who had been physically beaten more than once so that results were visible or required medical attention. It is not clear how the author contacted "nonbattered" wives but, presumably discounting medical personnel, no subject had received "professional" help for problems in their marriage (Hartik, 1982). Again we can ask, Who is being compared with whom?.

Comparing 11 battered women (those physically injured two or more times) referred by a victim advocacy program to an unspecified "general population" of women one researcher found significant differences in only five of sixteen possible variables. These particular battered women were more "reserved, detached, critical, and cool", "more concrete in their their thinking", "more easily upset", more inclined to be "sober, prudent, serious, and taciturn", "more persevering", and had "a greater tendency toward self-sufficiency". In a classic twist of interpretation

these very limited findings about battered women's "reserved" and "cool" characteristics along with their "self-sufficiency" are used to explain how battered women fail to accept blame for their husband's behaviour, become isolated from others, and cause the battering "scene" (Mahon, 1981, pp. 151-152).

In an effort to determine if battered women provoked violence against themselves with hostility Price and Armstrong (1978) compared two groups of women referred by social agencies, one consisting of women identified as battered. They found no difference between groups on hostility scores. The authors concluded:

> Most of the decisive predisposing differences between our groups are to be found in the father-related items... [and] underscore the specific importance of a poor relationship with the father as predisposing to abuse from the husband in later life. (p. 46)

According to these authors, the women were responsible in any case, they either "provoke their consorts" or "pick out more violent men to marry". If the husband was an alcoholic, the significant factor was not his potential for violence when she married him but whether she was critical of his drinking.

Other studies attempted to set apart battered and nonbattered women on various characteristics: psychosocial characteristics (Star et al., 1979; Star, 1980; Novak, 1979); conflict predispositions (Yelsma, 1981); marital status (Yllo & Straus, 1981). All have produced

nongeneralizable data of questionable theoretical and practical use and/or have failed to find any differences.

Another trend in the literature, is the creation of typologies of battered women and comparisons of various types (Snyder & Fruchtman, 1981). These typologies often suggest the victims' responsibility for the violence; for example, "Inadequate Wife", "Highly Competent Wife", "Provocative Wife" (Gayford, 1979). Peretti and Buchanan (1978) arbitrarily assigned women who required a doctors attention 10 times or more the label chronic and those requiring such attention one to 9 times acute. (The dropped any other women from the study). They then proceeded to search for differences in psycho-social variables between the two groups which helped "the wives sustain and endure the battered wife role" (p. 64, emphasis added). Cristall (1978) compared battered women who had left and battered women had not left the violent relationship. Her conclusions on androgyny and self-actualization as factors in this decision were not discussed in terms of services, resources, or other factors which would affect such a decision. She implied that the women who did not leave were mentally unhealthly and participating in maladaptive behaviors.

The latter type of research was based on the assumption that sex role stereotypes have "taught women to be the victim" (Cristall, 1978, p. 65). This implies that these women mindlessly accept the ideology of appropriate roles and that these beliefs in some way contribute to the

violence. There are questions as to whether childhood or adult socialization affects behavior and, in fact, whether attitudes or beliefs actually precede or cause behavior. Dibble and Straus (1980) concluded that actions towards a person had more impact on their behavior than their own attitudes. The literature had not substantiated that battered women are more stereotyped than nonbattered women (Wardell, et al., 1983). Some writers, in fact, maintained that the woman's nontraditional beliefs in an egalitarian marriage caused the violence against her . As Martin (1981) explained, sex role stereotyping is enforced in concrete ways by our society. Women are told that they are responsible for making a marriage work and are offered few alternatives to a traditional marriage. This is only one of many factors contributing to why victims stay in abusive relationships but is not offered as a cause of the abuse.

One of the psychological explanations of a battered woman's behavior is that she responds out of "learned helplessness". The essence of this theory is that whether or not women have control over the outcome of events they will respond as though they believe they do not. They become passive, submissive, and thus "allow" things to actually get out of their control. Learning is interferred with and "battered women become blind to their options" and "cannot think of alternatives". Their "emotional well-being becomes precarious" and they are "prone to depression and anxiety" (Walker, 1979, p. 45-51).

In explaining how women learn helplessness Walker (1979) points out that

> feelings of helplessness among humans tend to spread from one specific aversive situation to another. A battered woman therefore does not have to learn that she cannot escape one man's battering, but rather that she cannot escape men's coercion. (p. 48)

Rather than explain how battered women develop "learned helplessness" this poses the question of why all women don't suffer from it. Also, if women display learned helplessness with their husbands but not in their careers what psychological mechanism permits this contradiction?

There are a number of problems with the learned helplessness theory: firstly, feelings and beliefs of helplessness may be quite valid and may be rational assessments of the situations; secondly, failure to use options may have nothing to do with psychology but may reflect errors of judgment, a common enough event, or the actual absence of viable options (Wardell, et al, 1983; see Chapter Three for earlier discussions of learned helplessness.)

The personal resource theory of battering proposed that men batter their ~~wives~~ because violence is the final resource with which they can maintain their superior status and control (Allen & Straus, 1980; Hauser, 1982). Others maintained that lower-income men use violence as a means of control because their role as provider is not up to the expectations of other family members (Dibble & Straus, 1980;

Goode, 1974). Presumably if other family members, particularly the wife, lowered their expectations the wife would not be beaten.

This means of victim blaming is possible only if wife battering is considered outside a general societal context. Power in a marriage is related to the concepts of social worth and the social structure that acknowledges, rewards, or denigrates one's resources. Men's and women's work receives different values both conceptually and practically in terms of salaries. Women with children do not gain power (though one would assume children to be a marvellous resource); they lose it by virtue of our social system (Pogrebin, 1983) and they lose control over their bodies, their name, their money and their place of residence (Gillespie, 1971; Luxton, 1982).

In this context, one would not expect to find a large number of wife-dominant families. In order to do so, one must operationalize the term to be "a contest the husband can lose" (Wardell, et al., 1983). He may be compared to her father (O'Brien, 1971); his power may be assessed on one dimension such as family income (Dibble & Straus, 1980) or occupational status and compared to other men, his neighbours (Gelles, 1974); or he may be compared to his wife on many dimensions but if he loses on one (eg. education,

Gelles, 1974) he loses the contest.[16] in calculating the wives' score.)

> Or he may be compared to her expectations of what an ideal husband should be. If he falls short in her mind, it becomes stressful and he hits her. On the deficient husband may be compared to his own expectations—of what an ideal husband or ideal man should be. (Notice, incidentally, that earlier we learned if she falls short of his expectations concerning perfect wives, that's stressful and he hits her.) In other words, if anyone falls short of anyone's expectations, it's all her fault and we can see why he hits her. (Wardell, et al., 1983, p. 77)

Personal resource theory has not been developed beyond a victim blaming perspective.[17]

8.2.2 Provocation and Masachism

Explanations that women provoke battering are often linked to a theory of masochism. While some maintained that masochism was "a pervasive human quality" promoting "unconscious collusion" between aggressor and victim (Gabbard & Larson, 1981, p.533), others maintained that, given gender socialization, sex discrimination, and external restrictions the concept of masochistic choices was irrelevant (Hilberman, 1980; Wiggins, 1983). The proposed

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16 In assessing the Mean Occupational Status Score for husbands and wives, Gelles included men with no jobs in the husbands' score but excluded women with "no jobs or housewives" (58% of the sample of wives

17 For an example see Symonds (1978) page 220 and for other criticisms of the resource theory see Chapter Two.

indicators of masochism may be so pervasive as to encompass all of us at some time:

> Expecting, and demanding, respect for oneself as a person is an important aspect of psychological health. The failure to achieve this, to dare to throw the spotlight back upon the other person when he or she aggresses, is the major interactional problem of the masochistic person, based upon feelings of badness, guilt, unworthiness - all creating fear. (Sharpness, 1979, p.187)

For the battered woman fear is probably a rational and correctly assumed response to her situation (Symonds, 1979). Casting the spotlight may result in further injury and insult resulting in her being labelled masochistic by the clinician and/or provocative by the researcher.

Litchfield (1981) in reviewing masochism as a component of the feminine psyche could only conclude that not enough was known to defend existing viewpoints. Nevertheless, the response of women in battering relationship is often interpreted as masochistic (Snell et al., 1964; Peretti & Buchan, 1978) even by those not equipped to do psychoanalysis, such as social workers (Nichols, 1976). That women "like to be slapped around" or "enjoy rough sex" is a popular stereotype used to justify the aggressor's behavior both by himself and others. That sadomasochism exists cannot be denied but it apparently plays an insignificant role in wife battering.

In the 1970's a new science, victimology, evolved in order to focus at least equal attention on the victim. Generally, this has meant determining how the victim

contributed to the violence (Bard, 1974; Symonds, 1975). Whitehurst (1971) was one of the first to assert that wives "cannot ever be exonerated very completely from their own culpability in the development of the violent scene" (p. 686). Gayford (1979) adopted this theme with enthusiasm. A "Provocative Wife" is generally "vivacious and energetic" (hardly qualities one would expect to be negative) but she finds one of "the many ways in which women can be provocative and so cause friction" (p.502). In a typical no win situation the provoking factor may be either her inadequacy or her overcontrol. The provocation may be anything a woman does (or does not do) "through the ongoing actions and counteractions of their daily lives" (Goode, 1971, p. 631). According to the literature, women may "unwittingly" ignite the violence (Rosenbaum & O'Leary, 1981b; Coleman, Weinman, Hsi, 1980) may "passively" provoke (Gayford, 1978; Weitzman & Dreen, 1982) may be "fully aware" of her contribution (Chimbos, 1976). (In the latter case, the author was referring to victims of homocide. How she determined the dead person's view on their contribution was not explained.) Other authors pressed for the study of "mutual coercion" which results in violence (Bagarozzi & Giddings, 1983).

What evolves from explanations of provocation is that it is equivalent to whatever the attacker reports he did not like, after the attack. He can thus assign blame to his victim (Wardell et al., 1983).

Verbal aggression or nagging was particularly popular in assigning responsibility for provocation (Gelles, 1972; Goode, 1974; Coleman et al., 1980). Wardell, Gillespie and Leffler (1983) dismissed this on 4 counts: men are more verbal than women; there has been no significant differences found between men and women on verbal violence; correlations between verbal and physical aggression that have been found do not differentiate sex of subjects or address causality; and, finally, it is not clear what the relationship of nagging and abuse would be.

Studies of provocation have not addressed the right of a wife to voice a grievance against her husband (Wardell et al., 1983) for instance, she may be justified in complaining about his drinking (Coleman et al., 1980; Martin, 1981) or his treatment of the children.

Several authors expressed a lack of support for the notion of provocation (Anderson et al., 1975; Research Group on Abused Women, 1980; Price & Armstrong , 1980; Rosenbaum & O'Leary, 1981b). Some qualified this by saying most women were nonprovocative (Pizzey, 1974).

Unfortunately, whether substantiated or not, the notion of provocation is popular. There was evidence of this in Berkman's (1980) description of a battered wife who killed her husband. The case was described in terms of a brutal unpredictable and ruthless man and a woman who felt guilty and terrified and who had not been helped by lawyers, police, or a hospital. She was assessed after the killing as

having borderline personality disorder, in other words, "she gave the superficial appearance of being psychologically healthy, but her inner psychological resources were absent, regressed or truncated" (p. 613). This was assumed to have contributed to her victimization but, relevant to the present discussion, with no evidence presented for such a conclusion the author stated,

> Stephanie's own provocativeness and passive aggressiveness must certainly have stimulated or triggered some of the abuse she experienced (p. 614, emphasis added)

[18] Greenblatt (1983), in studying emotional relationships in early marriage interviewed men and women about appropriate circumstances for spouses hitting each other. She found that when the subject was a husband hitting his wife, men and women both pointed to the victim's behavior as an explanation. Men did so more often than women. When the topic was a wife hitting her husband, victim blaming was less frequent and the model explanation became the wife's feelings.

> In other words, when women are hit, they are often described as responsible; when women hit, again they are responsible. Thus it is not a simple case of blaming the victim, but of blaming the female. (p. 245)

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[18] Ironically, victim provocation is arising as a legal defense for women who kill their battering husbands (Wolfe, 1979; Haines, 1981).

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8.2.3 Relationships as Deviant

In a manner similar to the way that scientists have attempted to identify the deviancy in the victim (and the batterer) which cause the violence, they have sought deviant or violence prone marriages. Invariably this approach is based on the assumption that women play as much a role in the violence as the men (Jackson & Rushton, 1982).

Pelton (1982) asserted that the "violent family" was a "pathologic triangle" in which the participants had interchangeable roles (p. 165). Gemmill (1982) believed that men and women each brought a need to "fuse with one another" to the marriage and that the violence began when one attempted to "differentiate" from the other.

Others believed a "drive addiction" kept the violence going in a relationship where the members were attracted to violence or were violent (Dunn & Pizzey, 1979). Gayford (1979) stated that violence was the result of men with low frustration levels pairing with women who were highly provocative.

It was said that we must look at the interpersonal relationship to understand violence (Ponzetti, Cate, Koval, 1982) and that violent marriages have an unusually rigid and

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19 See also Jackson and Rushton (1982).

inflexible rule system, approved by each spouse (even if its unwittingly) and then struggled over until violence erupts (Weitzman & Dreen, 1982).

Most of these reports were based on clinicians' assumptions after working with a few "violent couples". All of them seemed to ignore that in violent marriages it was the husbands who were most violent. They also ignored the socio-structural characteristics of marriage and the differences for men and women. Finally, Steinmetz (1980a), who actually expressed preference for the term "violence prone family" made a statement which was very critical of the concept:

> Experiencing violence during childhood was found to be characteristic in the backgrounds of murderers, assault and batterers, rapists, political assassins, and individuals who commit suicide. Thus none of us are immune from the effects of violence in the family. We experience violence directly within our family or indirectly by having to reside in a violent society caused, in part, by violent socialization practices. (p. 262)

8.2.4 Mother Blaming

Placing the blame for adult male behavior on their mothers is not new (Pogrebin, 1974) and it has not passed out of favor (see Boulding, 1978, p. 808). Blumberg (1980) asserted that battering men had received inadequate loving in their childhoods; Cantoni (1981), that the boys were sexually abused by their mothers; Gillman (1980) that the men's behavior stemmed from pre-oedipal relations with their mothers; Eysenck (1979) that an atmosphere of general

permissiveness when growing up harmed adult batterers. In other words,

> Humanity would be free of war and strife if only men's mothers did a decent job of raising them. (Pogrebin, 1974, p. 50)

Pogrebin (1983) pointed out that the role of the father in encouraging negative characteristics in children was by no means disproved. She quoted studies indicating that preschool children preferred the TV to their father and that for children aged 7 to 11 the person they feared the most was their father.

Mother blaming was assessed as useful only as a diversion from the responsibility of a patriarchal society (Jackson & Rushton, 1982; Caplan, Hall-McCorquodale, 1985).

8.2.5 Catch-22

Women are sometimes given the blame in a Catch-22 fashion. Pizzey (1974) adopted Catch-22 to describe the situation where women who stay are assumed to like the violence and are therefore blocked from finding alternatives. Gayford (1979), for example, asserted that the relationship is intense "with both parties striving to keep it alive ..If this were not so, there would simply be a separation between the two parties" (p. 504, italics added). Similarly, others described the process by which a battered woman's experience is interpreted as a sign of her helplessness, even sickness. Under this interpretation her

efforts to save the marriage, protect the family image, survive the beatings or help her husband are perceived as symptoms of her illness rather than indices of her strength and courage (Stark et al., 1979). A good example of this is the psychologists assessment of Ruth, a battered wife, whose husband, we are told in the case history, lied to her about his profession and background; was a martial arts and weapons expert; threatened to kill her if she ever left him; and moved them to a small rural community where they were completely isolated and where he watched her every move. Ruth contacted a minister there but his response was to offer marriage counselling. Ruth, we are told "became involved in a self-destructive process partly out of a need to rescue a man"; "was caught up in a obsession that he needed her, that he could (sic) not live without her - an obsession which she invented"; "let this dependency, which passed for love, overcome her better judgement. That led her down the path to her own destruction" (Thorman, 1980, p.114). Another example is the creation of the concept of a "drive addiction" to a noradrenaline high to explain why 'couples' create violence (Dunn & Pizzey, 1979).

Gates (1978) called the process of implying that women contributed to or deserved the criminal assaults they received a "second victimization". Some would interpret this as an effort by Gates to shift the blame onto individual professionals but Gates called for an indictment of "our value systems, social organization, and institutions" (Gates, 1978, p. 10; see also Stark, 1981).

8.2.6 Focus on the Men

Rather than focus attention on society as a whole, many search for deviance in the abuser alone, or as already discussed, along with the victim or marriage. Many explanations of why a man would hit his wife implied understanding or tolerance and reduced his responsibility. They often described him as "out of control" of his behavior (Greenblatt, 1983; MacLeod, 1980). Sometimes any explanation seems acceptable, as in the following quotation:

> Often a family fight erupts and family members demean each other. The fighting escalates, and the contestants feel increasingly pushed, until one or more of them reacts with blind rage. At other times, however, the violent outburst seem to come from nowhere. Sometimes it is possible to recognize the build-up of many frustrations, so that the final stress is the proverbial straw that broke the camel's back. Sometimes stress on the job may be taken out on a spouse. Sometimes it is possible to recognize an anniversary reaction to past loss. Often an apparently innocuous event triggers memories of old pain, and today's victim is merely a stand-in for yesterday's attacker (Cantoni, 1981, p. 8, emphasis added).

8.3 The Batterer

8.3.1 Mental Illness

Snell, Rosenwald and Robey (1964) noted a disproportionate number of wife assaulters being referred for psychiatric assessment by the courts. This reflected, they believed, the community belief that "There must be something wrong with a man who would beat his wife", (p.

107).[20]

Pizzey (1974) also adopted this believe to the point of recommending compulsory psychiatric treatment for batterers to be followed, if this failed or "if psychiatry can't cope", by imprisonment. Greenblatt's (1983) study revealed a tendency for the public to describe a battering husband as mentally ill. Anderson et al. (1975) found that a majority of the battered women they interviewed, who had been selected by community agencies, believed their husbands to be in some way mentally incompetent, that is mentally retarded, psychologically or emotionally immature, or extremely paranoid. These believes served to excuse or explain away their husband's behavior.

The evidence, however, does not support that mental illness or psychopathology explains wife battering (Straus & Hotaling, 1980; MacLeod, 1980; Research Group on Abused Women, 1980).

> The sheer amount as well as the patterned variation in rates of intrafamily violence amont various social groups, belies an explanation anchored in the abnormalities of individual members (Straus & Hotaling, 1980, p. 8).

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[20] The authors reflect another "community belief" in their follow-up. Because the men resisted psychiatric "contact" these professionals "moved into direct interest in exploring the wives roles in the marital strife" and engaging them in long term therapy. The one woman who refused to express regret over taking action against her husband was labelled "the most masculine" (p.111).

Incidents of organic brain damage, acts classifiable as temporary insanity, or psychosis, are rare (MacLeod, 1980; Cantoni, 1980). In a study of 33 abusers, who were self referred for psychotherapy, Coleman (1980) found that 4 had been hospitalized for a psychiatric illness, another 4 had a psychiatric history; only one was related to violence, however, the other were mental exhaustion, heroin withdrawal, and combat fatigue.

8.3.2 Jealousy

Intense jealousy of their spouse is characteristic of battering husbands. Often this jealousy is so extreme as to be described as morbid jealousy (Bowden, 1978; Dobash & Dobash, 1979; Women's Research Centre, 1980; Cobb, 1979).

> The clinical form that obsessive-delusional jealousy takes is quite consistent. The central dominating symptom is a preoccupation with the conviction that the spouse is sexually unfaithful. Two accessory symptom patterns are generated from the source.
>
> First, there is an almost constant harassment of the spouse, which takes the form of meticulous observations and reflects a watchful vigilance for any sign of the suspected infidelity....
>
> Second, there is an alternating cycle of rage and remorse. Actual physical assault is not unusual, homocide is a real risk, and physical destructiveness of one form or another tends to be the rule...The patient is contrite and sorrowful and begs forgiveness. (Docherty & Ellis, 1976, p. 679)

The jealousy is often linked to a view of women as promiscuous when not under constant surveillance (Coleman, 1980) and may reflect a projection onto the wife of the man's own sexual fantasies or extramarital activites

(Whitehurst, 1971). The public often reflect the believe that infidelity by a woman does give a man a right to hit her (Greenblatt, 1983). Whitehurst (1974) offered the opinion that men had no choice but to become irrate if their wives were unfaithful because this was the norm. This author has been offered this point of view by various individuals on several occassions. The wives of batterers, on the other hand, are not allowed this privledge of jealousy, misplaced or otherwise, and may be beaten for what is then called nagging or for challenging their husband's authority (Dobash & Dobash, 1979).

8.3.3 Response of Batterer

The response of batterers to their behavior is also to externalize the responsibility and blame. They blame, their wives, their loss of control, alcohol, and other external forces (Star, 1980; Flanzer, 1982; Coleman, 1980). They often will not admit that their behavior is unacceptable (Moore, 1979) or will totally deny or discount the seriousness of their behavior (Wetzel & Ross, 1983; Daniels, 1977; Foreman & Frederick, 1981; Coleman, 1980). At best they are ambivalent about accepting counselling or other help for themselves (Jaffee & Burris, 1981; Snell et al., 1964; Moore, 1979). In the view of their wives, only 6 or 33 men saw their assaults as a problem requiring help, 14 "definitely did not view it as a problem", and the opinion of 13 husbands were unknown (Anderson et al., 1975, p. 26)

Indications of the remorse of battering husbands were rare in the literature. In Cantoni's (1980) experience, the attacker goes into a "post-attack depression" after the violence and identifies with the victim (p. 8). Usually, however, any show of contribution is linked to a real threat of or the actual occurrence of the wife leaving and does not contain any acceptance of responsibility for the events (Behrman, 1975; Pizzey, 1974). As Pizzey (1974) reported, husbands go to great lengths to make their wives feel guilty for leaving and are convincing to the inexperienced with their remorse, innocence, and bafflement over what went wrong. "Bizzare conversations" with professionals advocating the wife's early return to her "poor husband", dispute the real danger involved (Pizzey 1971, p. 88), and are not uncommon.

Coleman (1980) also reported remorse in 78% of the 33 men she studied; however, some of the statements reported to denote remorse were equivocal; for example, "I feel bad that I get this way. I cry on her shoulder; why does she make me do this?" (p. 209, emphasis added).

8.4 Husband Battering

Steinmetz's (1977-78) article The Battered Husband Syndrome was followed by both extremely negative and extremely positive reviews (Pleck, Pleck, Grossman, Bart, 1977-78; Fields & Kirchner, 1978; Fleming, 1979). Steinmetz claimed that the percentage of wives having used physical

violence exceeded that of husbands and that wives more frequently committed such acts. The table that showed this was, however, ambiguous. In 16 cases husbands exceeded wives in percentage having used a particular form of violence; in 9 cases wives exceeded husbands; in 6 cases the percentages were equal; and in 9 cases there was no data. She also used studies of pre-1958 comic strips to support a high incidence of husband battering, assuming that comic strips emulated family life and reinforced family behavior. Later she accused comic strips of perpetuating a myth of family behavior. Steinmetz' study has been severely criticized (Breines & Gordon, 1978; Colorado Association for Aid to Battered Women, 1980; Fields & Kirchner, 1978; Gelles, 1979; Pleck, Pleck, Grossman, Bart, 1977-78). In addition, others who supported her contention that wives were violent raised a number of important issues which downplayed the point: underreporting their violence is more common for husbands than wives; husbands are higher in the most dangerous forms of violence; husbands repeat acts more often than wives; wives are beaten when pregnant; women are more likely to be seriously injured; and finally, we do not know what proportion of wives acted in self-defense (Straus , 1980b). Most studies of health and social services reported less than 3 percent of male victims assaulted by females (Saville et al., 1981; McDanal, 1978; Egger & Crancher, 1982; Colorado Association for Aid to Battered Women, 1980; Masselli, 1978). A special 3 year counselling project in St.

John's did not mention any cases where husband abuse was the presenting problem (Gorman, 1983) but they did not break their tables down by sex so we can only determine this from the narrative. In addition, literature on groups for batterers and characteristics of batters has not raised the concern that some of these men may also be victims of their spouse's violence. One author, having reviewed criminological studies and women's roles in the military and police forces, concluded that

> In spite of increasing levels of physical training and prowess, women are still far more the victims than the victimizers when it comes to violence. (Boulding, 1978, p.810)

Nevertheless, the point to be made here is that the discussion of battered husbands has not, to date, addressed the social context of gendered and hierarchical social relations (Breines & Gordon, 1983). Steinmetz (1977-78) sought to establish that all family violence was rooted the same. This corresponded with the desires of many individuals and institutions to ignore social and political factors in wife beating (Pleck et al., 1977-78) and played into the hands of those who resented special services to battered women (Oswald, 1980, Petro, 1978; Sane, 1978). It is very common, for example, for shelter representatives to be chastised for not providing services to battered husbands and to be accused of taking the wife's side by people who believe the husband is probably just as much a victim of abuse (see Davidson, 1977, p. 225).

Breines and Gordon (1983) warned that an absolute condemnation of violence might lead to the assumption that victims must be nonviolent to warrant support. They called for increased attention to the "gestalt of the conflict" rather than the enumeration of discrete and specific acts. Such a view would, for example, show Steinmetz's conclusion to be misleading (p. 152).

8.5 Proposals

Proposed solutions to the problem of wife beating generally reflect a bias toward individualizing it and to placing responsibility with the woman. Most continue the view of wife battering as a horrible event that occurs only in deviant families (Wardell et al., 1983). People concentrate on treating symptoms of wife abuse even when they have recognized that there are broader issues (Morris, Cooper, Byles, 1973; Wardell, et al., 1983, see Davidson, 1978, p. 235). Where wider issues are not recognized, strategies are primarily treatment orientated, advocating therapy, referral, and the training of professionals to treat wives and, less frequently, husbands (Weir, 1977).

The goals of such therapy vary widely with the orientation of the therapist. Gemmill (1982) recommended "teaching the woman about the functioning of emotional systems"; directing her to establish a "person-to-person relationship" with each of her parents; and getting her to identify her part in triggering the violence. While Gemmill

said, "The therapist must be careful not to ask the woman what she did to cause the beatings, as this assumes that she is to blame." What she recommended essentially made the same assumption. It is proposed for instance, that the woman's "fantasies or fears" may "spark" the violence and, if she can control these there will be no violence (p. 37). Weitzman and Dreen (1982) who adopted a psychological orientation similar to Gemmill's (1982), with blame divided equally, recommended that therapy be directed to, among other things, decrease sex roles.

Krain (1982) took the position that "the ultimate control of family violence lies in structural manipulation to provide checks on the use of violence" (p. 67). In other words, families must be open for greater surveillance and an audience must be provided in violence-prone families. The helping professions are left to design the nature of the audience. Krain indicated that a wife who has a confidante to whom she reveals any abuse is less likely to be beaten.

Flanzer (1982) decided that increasing the public's awareness of the shame of the family violence would decrease the amount of violence. (In fact, this could increase family violence by making self-referral and early interventions less likely.)

The tendency to view problems as individual and to produce solutions for individuals is often accompanied by the tendency to see problems as either social or legal but not both. In part this dichotomy occurs because

professionals tend to erect rigid barriers that distinguish them from other types of professionals and from the general public. It also comes from viewing the social structures as though they were not entwined.

On the individual level the overlap of social and legal aspects of a problem may mean, as is often the case with battered women, that the trauma of the situation overrides legal concerns and makes strict legal intervention inappropriate or, at best, seen as not helpful.

On the social level, legal problems experienced by individuals are often rooted in social structural inequalities. If the social and legal aspects are addressed separately, the belief is supported that there are certain problems clearly to be dealt with by a lawyer and the legal system remains fundamentally unchanged. The outcome is that:

> Too often, legislation which is specifically designed to alleviate problems and to improve the quality of life has in the practice complicated the situation for the individual. It also seems likely that in endeavoring to redress imbalance, much legislation has succeeded only in maintaining the status quo: the social structure and social values have remained unchanged. (Morris et al., 1973, p. 319)[21]

An example of this is the recent events in Ontario where policies were introduced mandating police officers to lay charges in cases of wife assault instead of leaving this

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[21] See also Freeman (1980).

to the wife. One presumably unforeseen outcome of this had been the arrest and jailing of wives who refused to testify against their husbands (see Hemmons (1981) for a U.S. example). Similarly, a rape complainant was jailed seven days for refusing to testify in Ontario (Staff and Special, 1983).

The outcome of arresting husbands was not clear. A study in Ontario showed that most men tried for assaulting their spouses were placed on probation and that judges did not agree on how such cases should be handled (Lipovenko, 1984).

Remedies that do not recognize the ideology upon which the legal structure is built "are often of little more value than a sticking plaster is to a broken leg" (Freeman, 1980, p. 401) or are severely limited in their ability to meet their goals (Bard & Zacker, 1971). In a situation where the government is less than willing to assume responsibility for aiding battered women (Schecter, 1981) it is unlikely that they will enact a coordinated effort of legal and social reform striking at fundamental inequalities as called for by many authors (Field & Field, 1973; Freeman, 1980; Hemmons, 1981; Schecter, 1981; Morgan, 1981). The attitudes and actions of professionals in legal and social services will continue to reflect this lack of change (Wilson, 1975).

> To counteract "institutional projection" and respond effectively to abuse it is necessary to view the problem historically, locate it in the material context (and struggles) of family life, recognize the political framework of authority that shapes

> this context (and these struggles) and develop therapeutic modalities which break the current alignment of helping services and patriarchal authority at a number of points.
>
> Suffice it to say that to transcend victim-blaming paradigms we must recognize that the multiplicity of problems abused women present derives from the repeated, deliberate and criminal use of violence to enforce a system of domination and authority which, in the present period at least, would be unthinkable without the use of force. However irrational any individual act of brutality may appear, violence against women flows from the logic of patriarchal domination, a logic which many of those with and for whom we work find perfectly rational, no matter how vehemently they rail against "the brutes". (Stark, 1981, p. 17)

8.6 Summary of Literature Review

Although aggression and violence are common in our society we know too little to be able to predict them (Edmunds & Kendrick, 1980). Some authors focused on the characteristics of individuals in order to understand aggressive behavior (Bandura, 1973b; Roberts et al., 1981) but others, while not discounting these, emphasized the influence of situational factors (Barchas, 1981; Collins, 1975). A review of the literature indicated that sex differences in violent behavior are not clearly understood (Hyde & Rosenberg, 1980; Williams, 1977).

Writers trying to explain wife abuse have borrowed from the various theories on causes of aggression, particularly the psychodynamic theories (Cantoni, 1981; Coleman, 1980). Research has shown that many of the popular beliefs about wife abuse are exagerated; for instance, the belief that alcohol abuse causes wife abuse (Fleming, 1981; Marjot,

1982; Speiker, 1980). Similiarly, evidence suggested that wife battering is not only associated with the lower classes or the unemployed (Walker, 1979; Rounsaville, et al., 1979) but that it may be kept private by middle and upper class victims and the services they approach (Snell et al., 1964; Hutchins, Baxter, 1980). We clearly need to know more about individual cases of wife abuse including the political and social context in which they occur (Wardell et al., 1983) in order to develop appropriate programs. Although this is clearly a widespread phenomenon (MacCleod, 1980), because of the variety of services that victims of wife abuse use and because of the low rates of identification we will probably never be able to arrive at an accurate estimate of the prevalence of this problem.

Wife abuse has serious social and personal costs; for instance, social and psychological isolation of the victim (Dobash & Dobash, 1979); depression, loss of self- esteem, and alcoholism (Janoff-Bulman & Frieze, 1983); debilitating injuries and illness (Gayford, 1975). It often results in marriage breakup (Chan, 1983) and in behaviorial and psychsomatic problems in children (Hershorn & Rosenbaum , 1985). Wife abuse also results in death for some women through murder or suicide (Lowenberg, 1977). Clearly wife abuse contributes to increased costs for our legal, health care, and social service systems.

Battered women often need help to reveal abuse (Tidmarsh, 1976) and to acknowledge the victimization in the

face of feelings of fear, guilt, humiliation, or shame, (Janoff-Bulman & Frieze, 1983). The literature indicated that professionals have often blamed the victim of wife abuse and/or failed to provide help (Stark et al., 1979; Schecter, 1983; Hilberman, 1980).

In response to these problems shelters for battered women have emerged in the last decade as a separate social service system linked with existing social and legal services (Schecter, 1983). They exist in large numbers (there are approximately 230 in Canada), yet because they are primarily oriented to direct service little is recorded about how they are used and by whom (MacCleod, 1980; Roberts, 1981). The literature on shelters is very sparse. The numbers of shelters and the numbers of women and children that they serve make them significant to an understanding of wife abuse.

This study is important for a number of reasons. It will contribute to the scant research on battered women and on shelter users in particular. Students of violence will be interested in comparing this preliminary data from a different culture with that currently available in other places. This study could provide the basis for more indepth analyses of the factors associated with the battered women's situation in Newfoundland and Labrador.

Those currently operating a shelter or wishing to start a similiar or related service will find the study useful for program planning and evaluation. It will also be applicable

to staff training and education, to secondary prevention or outreach to battered women, and to public education on this sensitive and important subject.

Chapter 9

Methodology

9.1 Introduction

In this chapter we will examine the source of the data, the definition of terms used, and specific procedures used in the study. The problems and limitations associated with methodology will also be addressed.

9.1.1 Source of Data

The data were abstracted from the routine records of the shelter. These records consisted of five forms: (1) Emergency Admission Form (EAF), (2) Additional Intake Information (AII), (3) Medical Form Woman (MF), (4) Information on Departure (IOD), (5) Distress Call Sheet (DCS) (See Appendix B, page 320, for samples of the forms.), the Intake Record Log, and the recordings in individual files. Data were recorded for the first three years of the operation of the shelter as follows: June 15,1981 to June 15, 1982; June 16, 1982 to June 15, 1983; and June 16, 1983 to June 1, 1984.

9.1.2 Sample Selection

All 320 admissions made from June 15, 1981 to June 1, 1984 were recorded in the Intake Record Log. The sample was reduced to 297 as 23 cases were discovered to be either admissions not caused by abuse from a spouse or the relationship of the resident to the abuser was not given. The purpose of this study was to look at victims of spouse abuse.

In 6 of the 23 cases the reason for admission was that the woman had no other place to go for accommodation; in other words, her problem was a lack of housing. Four of these women had been residents of the shelter previously because of abuse from their spouse. Fourteen other admissions were the result of non-spousal abuse. The relationship to the abuser was cited as Father in 7 cases and Family (Unspecified) in 2 others. Brother, Father and Mother, Stepfather, Son, and Daughter were each cited once. The relationship was unrecorded in 3 cases (see Table 5-1). The characteristics of this group are described in Appendix C, "Characteristics of Ineligible Cases", page 329.

It is important to note that it was the policy of the shelter that all informaton was voluntarily supplied by the residents. No one was compelled to answer questions in order to obtain admission. In addition, some information was shared with the staff after forms were completed. This information was not added to the forms but was recorded in notes in the subjects file.

Table 9-1: Characteristic of Ineligible Cases

Characteristic	Number	Percent (N=320)
a)Relationship (n=17)		
Father	7	2.2
Stepfather	1	.3
Father and Mother	1	.3
Son	1	.3
Brother	1	.3
Daughter	1	.3
Family (Unspecified)	2	.6
Unrecorded	3	.9
b)Nonabuse Cases (n=6)		
Housing problem	6	1.9

9.2 Pilot Study

Prior to conducting the study the feasibility of the project was tested with a pilot study. A random sample of 20 (20%) of the 100 admissions for the calendar year 1983 was selected. Data sheets completed on these admissions revealed that all five forms were available for 90% of the cases and that data were provided for each item on the forms at least 60% of the time.

9.3 Availability of Forms

Table 5-2 shows the availability of the five shelter forms for the 297 cases under study. Two hundred and thirty-one (78%) cases were first time admissions to the shelter; 66 (22%) cases were second to sixth admissions. The AII (Additional Intake Information) and the IOD (Information on Departure) were both lengthened during the period under study. The earlier and shorter versions of both forms were labelled -A and the later versions -B. AII-B came into use in approximately August 1982; between August and December of that year the AII-A was used twice. The IOD-B came into use in approximately April of 1982 but the IOD-A continued to be used almost as often as IOD-B . Twenty-four IOD-A were used between April and November 1982. The IOD-B was available in 45% of cases. (The differences in numbers of variables from these forms will be indicated in following sections .)

As can be seen in Table 5-2 there was similarity between first and multiple admissions in the availablity of

forms except for the AII-A which was available twice as often for first admissions. Overall the AII-B was available in only 53% of cases and The EAF, MF, and DCS were each readily available (98%, 96%, and 81% respectively).

The policy of the shelter was that the AII could be filled out after the actual admission had taken place and the family had settled into the shelter. Table 5-2 indicates that this policy contributed to a lower availability of AII-A and AII-B as compared to the EAF. The increased length of the AII-B form did not contribute to a reduced rate of completion. The AII for a specific admission was, however, completed less often in cases where there had been more than one admission. In these cases most information required to complete this form was available from previous admission records. Overall an AII was available in 91% of the cases being studied; 38% (112 cases) were AII-A and 53% (157 cases) were AII-B. It was the policy of the shelter that the IOD form could be self-completed by women immediately prior to leaving the shelter. This coupled with the length of the form clearly contributed to a poor completion rate. Single admissions were more likely than multiple admissions to complete this form (70% compared to 59% respectively).

Table 9-2: Availability of Forms by Type of Form and Type of Admission

Type Admission	Type of Form						
	EAF	AII -A	AII -B	MF	IOD -A	IOD -B	DCS
One (n=231)	228	98	122	222	56	106	182
%n	99	42	53	96	24	46	79
>One (n=66)	62	14	35	63	10	29	58
%n	94	21	53	95	15	44	89

9.3.1 Completion of Forms

The forms under study could have been completed by either regular permanent staff of the shelter or by relief staff. Relief staff were those who covered for permanent staff during the absence of the latter. There were approximately 15 different relief staff used during the period studied. Three relief staff completed more than half of the 74 admissions made by relief staff. This would indicate that in approximately half of the cases the relief staff were experienced with the use of the forms.

Table 5-3 includes the three forms on which staff names could be recorded and the type of staff completing each form. It appears from this table that relief staff were more likely than regular staff to complete both the EAF and the AII forms. Also, in proportion to the number of admissions that they completed (25%) the relief staff were more likely to sign the IOD than regular staff who made 75% of the admissions.

9.4 Availabilty of Data

9.4.1 The Intake Record Log

The Intake Record Log was a hardcover book which served as a master list of admissions to the shelter. The shelter used a numbering system for filing and the Intake Record Log recorded names and corresponding file numbers. Women were assigned a file number on their initial admission. This file

Table 9-3: Number of Forms Completed by Type of Staff

Staff	Type of Form (N=297)		
	EAF	AII	IOD
Regular	216	175	47
%n	73	59	16
Relief	74	66	29
%n	25	22	10
Missing	7	56	221
%n	3	19	74

number was used for any subsequent admissions. The Intake Record Log was used by the shelter to calculate monthly occupancy statistics.

Information on the following ten variables was abstracted from the Intake Record Log:

1. Date of This Admission
2. Date of Departure
3. Length of Stay
4. Number of This Admission
5. Number of Admissions in Year 1
6. Total Days Stay in Year 1
7. Number of Admissions in Year 2
8. Total Days Stay in Year 2
9. Number of Admissions in Year 3
10. Total Days Stay in Year 3

Data were available in all 297 cases for all ten variables.

9.4.2 Emergency Admission Form (EAF)

The Emergency Admission Form (EAF) was one of two forms that it was shelter policy to complete through a personal interview with the woman immediately at the time of admission. The EAF remained unchanged over the three year period. Table 5-4 lists the ten variables available from this form and their respective numbers of valid and missing cases. The availability rates for data from this form were very high.

The EAF was available for 97% of the cases included in this study. For the 9 admissions for which an EAF had not been completed the information required was recorded from a previous admission or from notes in the file. As Table 5-4 indicates, data for 7 of the 10 variables was available for at least 98% of the cases. Overall, data was readily available on the variables covered by the EAF.

9.4.3 Additional Intake Information (AII)

At the beginning of the study an Additonal Intake Information (AII) containing 11 items was in use. During the course of the study, in approxmately August 1982, a more detailed 41 item form was introduced. In the next five months the earlier form was used twice more. The earlier version was labelled AII-A and the longer AII-B.

Later, in approximately February 1983 additional minor modifications to the longer version were made: Region of Province was requested rather than Town of Residence and an item on the Number of Times Hospitalized was added. Fortunately, Region of Province could be inferred from Town of Residence and these could be treated as one variable. The number of forms containing the new item was not recorded.

In addition, the variables Problems of Alcohol Abuse and Problems of Drug Abuse on form AII-B were expanded to further clarify Problems of Alcohol Use and Problems of Drug Use by a woman or her spouse. The number of cases in which

Table 9-4: Availability of Data for Variables Abstracted from Emergency Admission Form

Variable (N=297)	# Valid Cases	# Missing Cases	% Completion Rate
Staff Indicated on EAF	261	36	88
Time of Admission	290	7	98
Agency Referring	242	55	81
Individual Referring	235	62	79
# Female Children in Family	297	0	100
# Male Children in Family	297	0	100
# Female Children Accompanying	297	0	100
# Male Children Accompanying	297	0	100
Total # Children in Family	297	0	100
Total # Children Accompanying	297	0	100

these variables occurred was not recorded; however, the number of missing cases was high on each of these variables.

Table 5-5 shows the availability of data for each variable included on AII-A and/or AII-B. Some variables have a low availability because the data was available only from an AII-B; for example, Spouse's Age, Highest School Grade, or Occupation. Other variables have a low availability because the data was never recorded, for example, Other Training, Times Hospitalized, and Response from Personnel.

9.4.4 Medical Form-Woman (MF)

The Medical Form - Woman (MF) was the second form that shelter policy specified should be completed immediately upon admission. As Table 9-2, page 184, indicated these forms were available in 96% of cases under study. The same MF was used in the three years studied. There were 12 missing forms and the completion rate for 7 of the 8 variables on the MF listed in Table 5-6 was 96%. In the case of pregnancy data were available in 287 cases because of notes in case files.

Prescriptions were listed directly from the MF and later classified in 5 categories indicated according to the Compendium of Pharmeceuticals and Specialties (Hughes, 1983). The five categories were established by Van Praag (1978).

Table 9-5: Availability of Data by Variable on Additional Intake Information Forms

Variable (N=297)	# Valid Cases	# Missing Cases	% Completion Rate
Date on AII	182	115	61
Staff AII	241	56	81
Woman's Age	292	5	98
Spouse's Age	158	139	53
Woman, Prov. Res.	297	0	100
Spouse, Prov. Res.	296	1	100
Region of Prov., Woman	293	4	99
Urban or Rural Residence	287	10	97
Relationship to Abuser	297	0	100
Woman, Highest Sch. Gr.	162	135	54
Spouse, Highest Sch. Gr.	131	166	44
Woman-Other Training	65	232	22
Spouse Other Training	65	232	22
Woman-Occupation	190	107	64
Spouse-Occupation	150	147	50
Woman-Source of Income	199	98	67
Spouse-Source of Income	170	127	57
Length Relationship	280	17	94
Length Abuse-Woman	262	35	88
Children Abused Previous Two Weeks	297	0	100
Length Abuse-Child	233	64	78
Type Abuse-Woman	293	4	99
Type Abuse-Child	297	0	100
Most Recent Abuse-Woman	252	45	85
Most Recent Abuse-Child	252	45	85
Med. Attention Required	211	86	71
Times Med.Att. Required	106	191	36
Hospitalization Required	170	127	57
Times Hospitalized	45	252	15
Injuries	219	78	74
Cause Reported	101	196	34
Response From Personnel	53	244	18
Prob. of Alcohol Abuse	115	182	39
Prob. of Drug Abuse	34	263	11
Prob. of Lack of Money	149	148	50
Prob. Alcohol Use-Woman	64	233	22
Prob. Alcohol Use-Spouse	173	124	58
Prob. Drug Use-Woman	65	232	22
Prob. Drug Use-Spouse	65	232	22
Times Left Before	203	94	68
Sought Help Before	252	45	85
How Heard Shelter	171	126	58

Table 9-6: Availability of Data for Variables Abstracted from Medical Form

Variable (N=297)	# Valid Cases	# Missing Cases	% Completion Rate
Date	285	12	96
Number of Chronic Medical Problems	285	12	96
Pregnancy	287	10	97
Prescriptions: Major Tranquillizers or Lithium	285	12	96
Minor Tranquillizers	285	12	96
Sedative/Hypnotics	285	12	96
Anti-depressants	285	12	96
Other	285	12	96

9.4.5 Information on Departure (IOD)

The Information on Departure (IOD) was also lengthened during the period under study. The earlier and shorter version (11 variables) was designated IOD-A and the longer more recent version (15 variables) IOD-B. As with the AII, there a short period of overlap during which both forms were in use. The second form came into use at approximately April 1982. There were almost twice as many IOD-B as there were IOD-A.

The availability of data for each variable was not high. Table 5-7 lists the variables available and indicates which were only on IOD-A or on IOD-B and which were on both types of form. The two last variables were coded on the basis of a follow-up address or telephone number recorded in the case file. These two therefore have a high availability rate of 92%. Other variables available on both types of forms have availability rates ranging from a low of 44% to a high of 75%.

Looking at the variables available only on IOD-A (n=66), (see Table 9-2) we can see that items on these forms were completed from 98% to a low of 59% of the time. In some cases the availability rate is lower because certain items did not apply to all women; for instance, items referring to children; however, this does not account for the poor availability rate.

Where availability rates were low it was noted in the analysis. In some cases data were excluded because of a poor availability rate.

Table 9-7: Availability of Data by Variable on Information on Departure Form

Variable (N=297)	# Valid Cases	# Missing Cases	% n
Date	188	109	63
X[22] Staffer	76	221	26
*[23] Found Stay Beneficial	61	236	20
* Felt Helped	64	233	22
Found Stay	136	161	46
Found Staff	197	100	66
Found Other Residents	196	101	66
* Condition Improved	65	232	22
* Children Were Helped	47	250	16
* Helpful Children's Program	39	258	13
X Affect Feelings About Self	131	166	44
X Stay Helpful Children	100	197	34
X Stay Helpful Parent	103	194	35
Residence After Departure	222	75	75
X Other Services Used	157	140	53
Means Financial Support	185	112	62
X Areas Would Like Help	87	210	29
Desires Follow-up	132	165	44
Address Left	274	23	92
Telephone Number Left	275	22	92

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[22] Variables indicated by an X were available only on the IOD-B of which there were 131

[23] Asteriks indicate variables only available on the IOD-A of which there were 66.

9.4.6 Distress Call Sheets (DCS)

The Distress Call Sheet (DCS) is a form used to record each call to the shelter. A record of distress calls was kept by the shelter for statistical purposes. During the period under study all DCS on an individual would be pulled from the DCS file and placed in their file on admission to the shelter. As we saw in Table 9-2, page 9-2, approximately two thirds of admissions (62%) had at least one DCS in their file.

If there was no DCS on file it was assumed that the date of the admission was the date of the first distress call to the shelter; thus, there was a high rate of availability of data on these variables (see Table 5-8).

9.4.7 Missing Data

In order to evaluate the extent of missing data a score was calculated based on the number of missing values per case for the following 26 variables from the AII:

1. woman's age
2. spouse's age
3. relationship to abuser
4. highest school grade - woman
5. highest school grade - spouse
6. other training - woman
7. other training - spouse
8. occupation - woman

Table 9-8: Availability of Data by Variable on Distress Call Sheet (DCS).

Variable (N=297)	# Valid Cases	# Missing Cases	% Completion Rate
Date 1st DCS	297	0	100
# of DCS	297	0	100
Disposition of 1st DCS	297	0	100
Agency Referring	182	115	61
Individual Referring	181	116	61
Date Last DCS	239	58	80

9. occupation - spouse
10. source of income - woman
11. source of income - spouse
12. type of abuse - woman
13. type of abuse - child
14. most recent abuse - woman
15. most recent abuse - child
16. medical attention required
17. injuries
18. hospitalized
19. reported cause
20. response from personnel
21. problems alcohol use - woman
22. problems alcohol use - spouse
23. problems drug use - woman
24. problems drug use - spouse
25. problems lack of money
26. sought help before

These variables were selected because a perusal of the data suggested that they were most likely to be unrecorded. They were scored 1 if missing; 0 if recorded.

The possible range of scores was 0 to 26. As we can see in Table 5-9 scores ranged from 0 to 22; in no cases was data missing on all 26 variables. Forty-seven of cases had no missing data on these variables and, in fact, 95% of cases have 13 or less variables missing data.

It appears that certain regular staff people were more

Table 9-9: Frequency Distribution of Scores for Missing Data

Frequency	Number Cases (N=297)[25]	Percent	Cumulative Percent[24]
0	140	47	47
1	1	.3	47
2	2	1	48
3	5	2	50
4	14	5	55
5	7	2	57
6	15	5	62
7	21	7	69
8	21	7	76
9	17	6	82
10	17	6	88
11	13	4	92
12	8	3	95
13	2	1	96
14	1	.3	96
15	2	1	96
16	2	1	97
17	1	.3	97
18	1	.3	98
19	3	1	99
20	1	.3	99
21	2	1	100
22	1	.3	100

[24] Because of rounding off the Cumulative Percentages do not increase as would appear correct.

[25] N=297

likely to complete all items than others. In Table 5.10 we can see that staff members A, B, C, and D, scored 0 on all the admissions that they had completed; that is data were available in 100% of cases. These staff were responsible for 14% of the admissions; on the other hand, G who had no cases with a score of 0 did 4% of the admissions. Of the four remaining staff, E and F were more likely to complete the forms, having 56% and 71% of their admissions with a score of 0. E and F completed 20% of the admissions.

9.4.8 Operational Definitions

In most cases data was coded as it was recorded in the routine records of the shelter. The following operational definitions will clarify some of these variables as well as others defined by the researcher:

- Date Departed - the day the woman moved out of the shelter or the day she informed staff she would not be returning; as recorded in the Intake Record Log.
- Length of Stay - the number of days of occupancy of shelter beds including the day admitted and the day departed; as recorded in the Intake Record Log.
- Year 1 - the first year of operation from June 15, 1981 to June 15, 1982
- Year 2 - June 16, 1982 to June 15, 1983
- Year 3 - June 16, 1983 to June 1, 1984
- Time of Admission - as recorded on the EAF, to the nearest hour
- Children Accompanying - the numbers and sex of children admitted to the shelter as recorded on the EAF

Table 9-10: Score on Missing Values by Staff Person

Staff Person[26]	Score				
	0	11-20	21-30	Total	Percent
A	17	0	0	17	6
B	13	0	0	13	4
C	8	0	0	8	3
D	4	0	0	4	1
E	14	11	0	25	8
F	25	10	0	35	12
G		12	0	12	4
H	17	20	0	37	12
I	2	22	0	24	8
Relief	10	56	0	66	22
K	30	23	3	56	19
Total	140	154	3	297	

[26] K=Unidentified

- Agency Referring and Individual Referring - the referral source recorded on the EAF was coded in terms of a broader group or agency such as "hospital" and then, if possible, in terms of a specific department or professional in that agency (eg. doctor or nurse).

- Type of Abuse - coded as recorded on the AII. Staff recorded this data from interviews with women. The following definitions of abuse were taken from the volunteer training manuel with which the staff would have also been familiar: Abuse is

> ...violent attacks to control through pain or fear. This abuse can take different forms: physical (eg. punching, burning); emotional (eg. verbal attacks, threatening motions), sexual (eg. rape, derogatory sexual comments), and social (eg. isolation, lack of control over family funds). (Pennell, 1983, p.6)

- Prescriptions - prescriptions recorded on the MF were classified in 5 categories according to the Compendium of Pharmeceuticals and Specialties (Hughes, 1983). The five categories were established by Van Praag (1978) as follows:

1. major tranquillizers and lithium
2. minor tranquillizers
3. sedative hypnotics
4. antidepressants
5. other

- Chronic health problems - as recorded on the MF

- Age - the ages of women, spouses, or children were coded to the nearest year at the time of admission; in cases where a birthdate was recorded the age was calculated to the nearest age at the time of admission

- Region of Province - the AII listed seven regions which closely approximate the census divisions of Statistics Canada. Where towns or villages were

recorded they were coded according to the region in which they were located.

- Urban or Rural - Woman living in St. John's or Corner Brook were coded as urban; all others were classified as rural

- Occupations - occupations recorded on the AII were coded according to categories established by Statistics Canada (See Appendix D, 334.)

- Problem of Alcohol or Drug Abuse and Problem of Alcohol or Drug Use - if the AII-A recorded whether the spouse or woman had a Problem of Alcohol or Drug Abuse then Problem with Alcohol or Drug Use was also coded

- Disposition of First DCS - as recorded or in cases where there was no DCS on file it was assumed that the date of the admission was the date of the first distress call to the shelter.

- Regular Staff - permanent full-time employees of the shelter

- Relief Staff - all other staff recorded on the records of the shelter

9.5 Data Sheets

Data sheets were completed for each admission. Data from shelter records was transferred to precoded data summary forms for keypunching. (See Appendix E, page 337, for a sample of the coded data forms.) The researcher transferred data from the 320 admissions onto data sheets.

Data were analyzed using the SPSSX[27] data analysis system on a Vax 11/785 running VMS.

Where appropriate the significance of associations between variables was tested by a Chi square test. When

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[27] SPSSX is a trademark of SPSS, Inc.

group size was too small or when the collapsing of categories would have obscured differences trends were reported as frequencies, means, or percentages.

9.6 Interrater Reliability

An issue of central importance to researchers is the likelihood that two persons making the same assessment will assign the same code. This is an important measurement of reliability.

In this study the issue of interrater reliability was addressed by randomly selecting 50 cases and having data sheets coded by a second person. The second person had a similiar length of experience working in the shelter as the primary researcher.

Before the data sheets were scored for the second time the policy of the shelter on storage of DCS was changed; these were removed from individual files and filed separately. Thus the last six variables were not readily available and were discounted from this part of the study.

The interrater reliability was found to be 89%. Overall, neither researcher left more questions unanswered than the other. The average number of blanks per case was 5.06 for the primary researcher and 5.02 for the second. See Appendix F, 345 for a summary of these results.

9.7 Validity

No validity checks were run on the data.

9.8 Confidentiality

Strict confidentiality was maintained throughout the study. Each admission was given a study number and a master list was maintained by the researcher who also extracted the data from the files. No individual user of the shelter is identifiable on the data sheets or in the final report.

The 50 admissions recoded for interrater reliability were done by a staff person of the shelter. She was bound by the strict rules of confidentiality which were terms of her employment.

9.9 Problems with the Methodology

The main difficulty with a research project such as this is that it relies on records that were not designed with research as a priority and that were completed, to varying degrees, by several people. The problems of access to data and information as described by Chan (1978) were avoided by this researcher who had the cooperation of the agency and complete access to files; however, in many instances there simply was no recorded information. Some information was withheld by women admitted to the shelter; some was not available to them (eg. spouse's schooling); and some was simply not requested or not recorded by the staff.

In the sections, Availability of Forms and Availability

of Data we noted that certain staff were more likely to complete forms. In order to assess whether the completion of forms by staff was related to their length of employment the proportion of AII that they had each completed in relation to the total number of weeks that staff had worked at the shelter was calculated. This was compared to their scores on the number of missing values on 26 variables as described in the section Availability of Data. The score does not appear to be related to the number of admissions done or to the proportion of AII to weeks worked. It appears that certain staff were more likely to complete forms. We note, however, that there were 19% of AII with staff unidentified (see Table 5-11).

Changes in forms during a study period create the obvious problems of lack of consistency in data collection. In the case of this study it appears that the result of the change in form and of the policy of unsupervised completion of the IOD was that few data were available on these evaluative variables. Thus most of these variables were excluded from the analysis.

Several possible solutions to these problems come to mind: firstly, any shelter could revise its forms to meet research needs and could impress upon its staff the importance of research and of good data collection. Research would then become a priority of the shelter.

The above proposal would not compensate for the lack of voluntary participation by women in the interviews but a

Table 9-11: Score on Missing Values and Proportion of Weeks Worked to Number of AII by Staff Person

Staff Person	Score					Proportion AII/Weeks Worked
	0	11-20	21-30	Total	Percent	
A	17	0	0	17	6	.26
B	13	0	0	13	4	.20
C	8	0	0	8	3	.44
D	4	0	0	4	1	.03
E	14	11	0	25	8	.24
F	25	10	0	35	12	.22
G		12	0	12	4	.13
H	17	20	0	37	12	.23
I	2	22	0	24	8	.29
J[28]	10	56	0	66	22	
K[29]	30	23	3	56	19	
Tot.	140	154	3	297	99	

[28] It was not possible to establish a figure for relief staff as they worked irregularly.

[29] Unidentified

properly administered coding system would differentiate missed from refused information. It would not be ethical to make admission to a crisis service dependent on willingness to divulge details of one's life that were not immediately related to the request for admission; therefore, participation of women must remain voluntary. In the long run, I propose, participation by women would not account for the greatest lack of data as most women are willing to be interviewed by regular staff of the shelter, after admission and with confidentiality assured. The most imposing obstacle would continue to be the practice of making research a shelter priority and the compliance of staff with form completion. Most shelters are short staffed and underfunded; that is, they function with minimal numbers of both direct service and administrative staff and with funds that barely (or not at all) meet service program requirements. There are many direct service needs (eg. counselling, advocacy, follow-up) that staff would justifiably be more committed to than research. (See Research Group on Abused Women, 1980)

As an alternative to use of shelter records one could turn to individual research orientated interviews with women admitted to the shelter. This would mean fewer cases and less data per case unless the rsearcher could gather data over a long period of time. It was the experience in the shelter under study that women recalled their experiences over a period of time as they talked with other residents

and with staff. One interview, unless conducted later than the admission would therefore not provide all information. If one waited until the woman was ready to depart one would probably miss her altogether as evidenced by the low return of IOD's.

A third possibility would be to combine information from records with data collected from one or more interviews with shelter staff. The interviews could be done as a group or individually. Most shelter staff meet regularly as a group to discuss the events in the shelter and resident cases and plans. If the staff had been brought together as a group for the purposes of this study they would have been able to add data to many of the cases. It would be important to talk to all staff because different staff might know more about different residents. (In part this would result from a shift work schedule.) Such an endeavor would have required a substantial amount of the staff's time and the researcher would have had to address the issues of compensation and motivaton in order to hold such meetings.

9.9.1 Validity

There were no validity checks run on the data in this study. The central question addressing validity would be how truthful were the women when answering the questions posed to them by the staff. This researcher proposes that some women who were upset upon admission would be more likely not to be able to answer some questions which is

different than providing invalid responses. Whether upset or not some women would provide invalid answers to questions around the abuse because thay had forgotten incidents and details. Often, women would recall events or would recognize other events as significant only after a period of discussion and reflection. For instance, some women only recognized that marital rape had occurred after discussions on sexuality had raised the topic. The information provided by women might be considered to have high face validity; that is, it represented the way women perceived their situation at the time of admission. Crisis theory states that at a point of crisis, such as this, the mechanisms of repression and denial are weakened. It was the conclusion of Dobash and Dobash (1979) that abused women could be relied upon to convey valid and accurate information about their lives. Dibble and Straus (1980) cite a study (Bulcroft, Straus 1975) in which reports of wives on the incidence of their husband's violence corresponded to self-reports by the husbands. Eberle (1982) found a high validity in wive's reports of husbands' alcohol use. Coleman, Wineman, and Hsi (1980) accepted reports of marital violence from couples but validated reports of no violence by checking medical charts. One would expect that a sympathetic and confidential interview such as that done on an admission to the shelter would increase validity of responses (Chimbos, 1976). In addition, no shelter policy promoted the need to falsify information or to exaggerate;

that is, there were no requirements based on financial need or frequency of abuse to gain admission. It is the reseacher's conclusion that there is a high degree of validity in the data presented; however, it is recognized that this is not proven.

Chapter 10

Results

Data will be presented in eight sections. First we will look at the demographic characteristics of the sample and the trends over the three years of operation of the shelter. Comparisons to Statistics Canada's census figures will be made. Data reflecting on the circumstances surrounding the abuse experienced by the women, their admission to and stay at the shelter, and their health status will then be examined. Finally, the characteristics of women with more than one admission will be studied.

10.1 Demographic Characteristics of the Sample

Table 10-1 contains a summary of the demographic characteristics of the sample. Most of the women admitted to the shelter were from the Avalon Peninsula. Five women (2%) were from outside of Newfoundland and Labrador. Most women were between 20 and 39 years of age, were married, and had 1 to 4 children. The average age of the women was 32 years with an age range of 18 to 60 years.

Most women had completed between grades 9 and 13 ; 59% were in the official labour force; 43% were homemakers; and 9% were unemployed.

Demographic data were more available for women than for their spouses. For instance, the availability rates of information on occupations[30] for Years 1, 2, and 3 were for women 57%, 65%, and 68% and for their spouses were 22%, 53%, and 71% respectively. Where availability rates fell below 50% data was excluded from the analysis.

As might be expected the women tended to be younger than their spouses who had an average age of 34 with a range of 18 to 62 years. A comparison of the ages of women and spouses for Year 3 (the Year with the highest availability rate of data on spouses' ages) illustrates the age differences (see Table 10-2). Spouses were more likely than the women to be unemployed (16%).

For a detailed breakdown of data on demographic characteristics see Tables G-1 to G-9 in Appendix G, page 347, "Detailed Characteristics of the Study Population".

10.2 Three Year Trends in the Data

As Table 10-3 indicates women admitted in Year 2 tended to be younger and to have fewer children than women admitted in other years. More women aged 25 to 29 were admitted in Years 2 and 3.

Over the three years it appears that more of the women admitted were in the official labour force and more were

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30 See Appendix D, page 334 , "Definitions of Occupations by Statistics Canada's Major Occupational Groups" for a list of occupational categories.

Table 10-1: Demographic Characteristics of the Study Population

Characteristic	n	Distribution %
Region	(n=263)	
Avalon Peninsula		88
Other		12
Age of Woman	(n=297)	
Less than 20		2
20 -39		78
More than 39		20
Age of Spouse	(n=153)	
Less than 20		2
20 -39		73
More than 39		25
Marital Status	(n=297)	
Married		94
Other		6
Number of Children	(n=297)	
0		11
1-4		81
More than 4		9

Table 10-1, Demographic Characteristics of the Study Population, continued

Characteristic	n	Distribution %
Education of Women	(n=159)	
Less than Grade 9		34
Grade 9-13		66
Education of Spouse	(n=127)	
Less than Grade 9		37
Grade 9-13		63
Occupation of Woman	(n=190)	
Clerical		10
Service		20
Fishery		5
Other		15
Homemaker		43
Unemployed		9
Occupation of Spouse	(n=129)	
Administration		10
Service		10
Fishery		11
Construction		25
Production		12
Other		16
Unemployed		16

Note:1) Categories with 5% or more were listed individually.

Table 10-2: Distribution of Women and Spouses by Age Group for Year 3

Age	Spouses (n=107) %	Women (n=126) %
15-19	3	3
20-24	8	19
25-29	17	30
30-34	12	16
35-39	13	10
40-44	11	10
45-49	5	3
50-54	5	5
55-59	6	2
60-64	1	0
65+	0	0

unemployed. The unemployment rate was highest in Year 2 and dropped again in Year 3. The differences between Years 1 and 2 can partially be accounted for by the lower return rate for Year 1; however, as we have seen, the ages of the women admitted did drop over the three years which would make it more likely for women in Years 2 and 3 to be in the labour force. There were more women in clerical and service occupations in Years 2 and 3; in addition, the numbers in administrative occupations increased over the three years.

The unemployment rate of spouses also dropped in Year Three.

The percentage of women admitted who were married decreased slightly over the three years with a corresponding increase in the numbers who were separated and single. In the latter cases the abuser was a noncohabitating boyfriend.

Detailed breakdowns of data over the three years are available in Appendix G, page 347, "Detailed Characteristics of the Study Population".

10.3 Comparison of Data to 1981 Census

Table 10-4 provides a comparison of summary study population statistics to the 1981 census.[31]

Women admitted to the shelter were twice as likely to be from the Avalon Peninsula and from the city of St. John's

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[31] All census figures were obtained from Statistics Canada (1984).

Table 10-31 Characteristics of Study Population Over Three Years

Characteristic	Year 1 %	2 %	3 %
Region	(n=95)	(n=72)	(n=126)
Avalon Peninsula	86	84	89
Other	12	14	12
Age of Woman	(n=92)	(n=75)	(n=125)
Less than 20	2	1	3
20-39	70	92	75
More than 39	26	7	20
Age of Spouse		(n=46)	(n=107)
Less than 20		0	3
20-39		80	70
More than 39		18	28
Marital Status	(n=96)	(n=75)	(n=126)
Married	96	93	92
Other	4	6	8
Number of Children	(n=96)	(n=75)	(n=126)
0	9	13	10
1-4	75	86	80
More than 4	16	0	10

Table 10-3, Characteristics of Study Population Over Three Years, continued:

Characteristic	Year 1 %	2 %	3 %
Education of Woman		(n=50)	(n=109)
Less than Grade 9		32	34
Grade 9-13		66	66
Education of Spouse		(n=39)	(n=88)
Less than Grade 9		33	39
Grade 9-13		67	61
Occupation of Woman	(n=55)	(n=49)	(n=86)
Clerical	2	8	16
Service	16	18	22
Fishery	0	8	6
Other	8	12	18
Homemaker	69	14	8
Unemployed	5	14	8
Occupation of Spouse		(n=40)	(n=89)
Administration		10	10
Service		12	9
Fishery		5	14
Construction		28	24
Production		5	16
Other		19	15
Unemployed		19	15

as women reported on in the 1981 census.[32]

The distribution of ages of women appears at first to be markedly different from that provided by the 1981 Census. The expectation was, however, that most admissions to a shelter would be over 20 and under 60 years of age since these are the women most likely to be cohabitating with a man. If we adjust the census figures for this expectation we find that the admissions are representative of the population of the province aged 20 to 59 years.

In line with this expectation the study population exceeded the census in number of women married and numbers with 1 to 4 children.

As with the women admitted to the shelter, if we adjust the census figures for a population of men aged 20 to 59 years we see that the spouses are representative of this age group with one exception: there were nearly twice as many aged 30 to 34 years as would be expected (see Table 10-6). The median age of men in the census was 25 years while for the study population it was 32 years.

In comparing Statistics Canada figures on occupations with the study figures we must keep in mind that Statistics

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[32] The Statistics Canada census divisions for Newfoundland and the seven regions designated by the shelter were closely matched. Tables G-1 to G-9 in Appendix G provide census figures for both the province and Division 1, the Avalon Peninsula. There are few differences between these figures so it was decided to present just provincial census figures in this section.

Table 10-4: Study Population Characteristics with Comparison to 1981 Census

Characteristic	Census %	Study %
Region		
Avalon Peninsula	43	88
Other	57	12
Age of Woman		
Less than 20	11	2
20-39	32	78
More than 39	28	20
Age of Spouse		
Less than 20	11	2
20-39	31	73
More than 39	27	25
Marital Status		
Married	44	94
Other	27	6
Number of Children		
0	21	11
1-4	72	81
More than 4	7	9
Education of Woman		
Less than Grade 9	29	34
Grade 9-13	71	66
Education of Spouse		
Less than Grade 9	29	34
Grade 9-13	68	63
Occupation of Woman		
Clerical	30	10
Service	17	20
Fishery	.3	5
Other	47	15
Unemployed	19	9
Occupation of Spouse		
Administration	11	10
Service	8	10
Fishery	9	11
Construction	14	25
Production	19	12
Other	41	16
Unemployed	17	16

Table 10-5: Comparison of Women and 1981 Census for Women Aged 20 to 59 Years

Age (Years)	Census	All (N=297)
20-24	20	20
25-29	18	25
30-34	16	16
35-39	12	16
40-44	9	8
45-49	8	4
50-54	8	4
55-59	8	2

Table 10-6: Comparison of Spouses and 1981 Census for Men Aged 20 to 59 Years

Age	Census	All (N=153)
20-24	18	10
25-29	18	19
30-34	16	31
35-39	13	13
40-44	10	9
45-49	8	5
50-54	8	5
55-59	8	5

Canada includes both employed and unemployed persons in each occupation while unemployed people in the study are not broken down by occupation. The category of Homemaker was not included in the occupational categories of Statistics Canada. These women were not included among those considered to be employed and were not considered to be in the labour force by the census takers.

The women studied here do not match the census report on occupations as more were in the labour force and fewer were unemployed. Approximately 42% of Newfoundland women over 15 years of age are in the labour force and 19% of these are unemployed according to Statistics Canada.[33] The official unemployment rates for married women vary by age group; 21% in the 15-24 age bracket and 14% in the 25-64 age bracket are unemployed on the Avalon Peninsula. Excluding Homemakers and Students 58% of the women in this study considered themselves in the labour force and only 9% of these were currently unemployed. The professions of Teaching, Medicine, and Sales were slightly (6-8%) underrepresented while Clerical and Other were more underrepresented (20% and 13%). Service and Fishery occupations were slightly overrepresented among shelter residents.

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33 The distribution of occupations of women in the 1981 census did not differ markedly between the Avalon Peninsula and the province. The main difference was that there were more women employed in medical and clerical occupations on the Avalon Peninsula. This is to be expected since there are more hospitals and businesses in that region.

The occupations of Teaching, Clerical, Sales, Production, and Other were underrepresented among the spouses in Year 3 while the occupations associated with Service and Fishery were slightly (2%) overrepresented. Occupations associated with Construction were overrepresented to a greater degree (11%). This distribution was very similiar to that of the women when Production was included under Other.

Spouses had a higher rate of participation in the official labour force than the census population. According to Statistics Canada (1984) 72% of Newfoundland men aged 15 years and over are in the labour force; 17% of these men are currently unemployed. In Year Three 98% of the spouses were in the labour force, 12% of these were unemployed and 2% (students) were out of the labour force. As with the women the higher than normal participation of spouses in the labour force might be accounted for by the fact that they were younger than the general population.

10.4 Abuse

10.4.1 Type of Abuse

The majority of women (77%) admitted had experienced more than one of the 3 types of abuse which were recorded: physical, psychological, and sexual. Information was available on the type of abuse in 99% of the cases (see Table 10-7).

Women reported the following combinations of abuse:

- physical 14%
- physical and psychological 62%
- physical and sexual 1%
- physical, sexual, and psychological 13%
- psychological and sexual 1%
- psychological 9%

The number reporting sexual abuse increased from 8% to 22% over the three years.

10.4.2 Length of Abuse and of Relationship

Table 10-8 indicates that the majority of women were abused for less than 10 years. The length of time abuse occurred was available in 88% of cases and ranged from less than 1 year to 35 years.

There appears to be a trend over the three years in which longer relationships have had longer periods of abuse. Relationships tended to have been shorter in Year 2; 35% were less than 6 years in length. There were more women (4%) in Year 3 from relationships over 31 years in length (see Table 10-9). There was an increase of 15% of women abused for 1 to 5 years in Year 2 and a subsequent decrease of 20% in Year 3 (see Table 10-8). Interestingly the numbers reporting "several" years of abuse almost doubled by Year 3.[35]

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[35] It was not clear where the category "several" fell in relation to other values on this item. Staff recorded answers in a blank on the shelter form.

Table 10-7: Type of Abuse Reported by Year of Admission

Type of Abuse	Year 1 (n=94) %	2 (n=74) %	3 (n=125) %	All[34] (N=293) %
Physical	96	89	90	90
Sexual	8	12	22	15
Psychological	85	81	87	85

Table 10-8: Number of Years Abuse Occurred by Year of Admission

Number of Years	Year 1 (n=84) %	2 (n=66) %	3 (n=112) %	All (N=262) %
<1	6	2	0	2
1-5	38	53	33	40
6-10	21	17	22	21
11-15	10	9	12	11
16-20	7	3	7	6
21-25	4	2	2	2
26-30	4	0	2	2
31+	1	0	4	2
several	10	15	18	14

[34] Figures show percentage of responses; therefore totals equal more than 100%.

Table 10-9: Length of Relationship Between Woman and Spouse by Year of Admission

Number of Years	Year 1 (n=92) %	2 (n=71) %	3 (n=117) %	All (N=280) %
1-5	27	35	27	29
6-10	24	28	27	26
11-15	22	14	15	17
16-20	10	8	9	9
21-25	8	3	5	5
26-30	5	1	1	2
31+	1	0	4	2
several	3	10	10	8

Table 10-10: Type of Abuse Reported by Women Who Were Abused Throughout Relationship by Year of Admission

Type of Abuse	Year 1 (n=18) %	2 (n=7) %	3 (n=23) %
Physical	94	100	87
Sexual	17	14	17
Psychological	94	100	91

Table 10-11: Length of Relationship for Women Who Were Abused Throughout Relationship by Year of Admission

Length in Years	Year 1 (n=18) %	2 (n=7) %	3 (n=23) %
10-15	45	56	53
17-20	23	29	17
21-25	12	14	8
28-35	23	0	21

In some cases (16%) women reported that the length of time that abuse had occurred equalled the length of the couple's relationship. These women tended to have come from longer relationships (over 10 years) and to have experienced both physical and psychological abuse. They reported sexual abuse more often than other women except those in Year 3 (see Table 10-10). These relationships ranged from 10 to 35 years in length while the average length was 18 years. The average age of these women was 39 years as compared to 32 years for the whole sample (see Table 10-11).

Table 10-11 indicates that relationships such as these were longer in Year 1 than in Year 2. In Year 3 the majority were of shorter durations but again several were quite long.

10.4.3 Injuries

Most women (74%) listed one or more injuries that had resulted from the abuse. In Years 1 and 2 the availability rates of information on injuries were lower than for Year 3 (68% and 69% respectively as compared to 81%). There was no evaluation of the severity of these injuries although logically some appear more serious than others (for example, injuries requiring stitches compared to bruising). Some of the most serious injuries were coded as Other, for example, miscarriage, concussion, and hearing loss (see Table 10-12).

The trends in reporting of injuries indicate that longer relationships result in more injuries. There were more injuries classified as stitches, emotional, swelling,

sprains and other in Year 1 than in Years 2 and 3. The numbers dropped in Year 2 and rose again in Year 3 but not to the original levels. The numbers who reported bruising dropped between Years 1 and 2 but rose even higher in Year 3. Those women abused throughout their relationships exceeded the total sample in all forms of injury except bruising and other.

Table 10-13 indicates that the majority of injuries were reported by women aged 26 to 40 years. Women over 40 years of age were less likely than younger women to report all injuries except stitches.

10.4.4 Medical Attention

Longer relationships seem to result in more medical attention and more hospitalizations required due to abuse. This was similiar to the pattern observed for injuries in general. The number of women reporting that the consequences of abuse required them to seek medical attention was highest in Year 1 (92%) the year in which the most injuries were reported; however, it must be noted that the availability rate was low (50%) for Year 1 (see Table 10-14). The numbers seeking medical attention dropped steadily over the 3 years rather than dropping in Year 2 and rising in Year 3 as the number of injuries did. Women abused throughout their relationship were the most likely to require medical attention due to the abuse.

Of women who required medical attention the majority

Table 10-12: Type of Injury Reported by Women Who Were Abused Throughout Relationship by Year of Admission

Injuries	Year 1 (n=65) %	2 (n=52) %	3 (n=102) %	All[36] (N=219) %	A[37] (n=36) %
Bruising	71	69	78	74	72
Burns	5	6	6	6	11
Fractures	11	23	21	18	25
Stitches	17	4	10	10	17
Emotional	82	52	62	65	81
Swelling	25	14	7	14	17
Sprains	6	0	1	2	6
Other	17	8	12	12	11

Other Injuries Specified (n=27)

	%		%
Concussion	7	Eye injury	18
Broken teeth	22	Miscarriage	4
Hearing loss	4	Dizziness	8
Hair loss	11	Back/Neck	4
Stomach	4	Pain	4
Scratches	4	Unknown	11

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36 Figures show percentage of responses so the totals do not equal 100%.

37 Women abused throughout relationships.

Table 10-13: Injuries from Abuse by Age of Women

Injury	Age[38]					
	A	B	C	D	E	All
	n=53	n=126	n=9	n=22	n=5	N=215
	%	%	%	%	%	%
Bruising	25	59	4	10	2	74
Burns	8	92	0	0	0	6
Fractures	20	65	5	0	0	19
Stitches	9	66	0	26	0	11
Emotional	22	59	4	14	1	64
Swelling	27	57	10	7	0	14
Sprains	40	60	0	0	0	2
Other	27	53	3	6	10	14

[38] A=15 to 25 years
B=26 to 40 years
C=41 to 45 years
D=46 to 55 years
E=56+

required it more than once, 4% did so more than 10 times (see Table 10-15).

The reports on whether abuse resulted in hospitalization were similiar to those on medical attention (see Table 10-16).[39] There was a slight decrease (2%) in the numbers who required hospitalization from Year 2 to Year 3. Also those women abused throughout their relationship were more likely than the general sample to report that they had been hospitalized. Table 10-15 indicates that approximately half of the women who required hospitalization were hospitalized more than once. More women in Year 2 required hospitalization only once.[40]

10.5 The Admission

10.5.1 Circumstances Prior to Admission

10.5.1.1 Distress Calls

Distress call sheets were completed on 81% of the admissions. Distress calls were specific calls requesting assistance of some kind. Calls made for friendly chats or for follow-up were not recorded by the shelter staff as distress calls. The number of admissions with distress call sheets dropped over the three years from 84% in Year 1 to 78% in Year 3.

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[39] Only Years 2 and 3 are included in Table 10-16 because the return rate for Year 1 was only 25%.

[40] The availability rate for Year 2 was 54%.

Table 10-14: Need for Medical Attention by Year of Admission and by Women Abused Throughout Relationship

Needed	Year 1 (n=48) %	2 (n=49) %	3 (n=114) %	All (N=211) %	A[41] (n=36) %
Yes	92	65	54	65	72
No	8	35	46	35	28

Table 10-15: Frequency Medical Attention Required by Year of Admission

Times	Year 1 (n=27) %	2 (n=22) %	3 (n=54) %	All (N=103) %
1	22	27	39	32
2-5	4	23	39	26
6-10	0	4	4	3
>10	0	4	6	4
Several	52	41	13	29
A few	22	0	0	6

[41] Women abused throughout their relationships.

Table 10-16: Hospitalization For Abuse by Year of Admission and by Women Abused Throughout Relationship

Hospitalized	Year 2 (n=46) %	3 (n=100) %	All (N=146) %	42 A (n=26) %
Yes	28	26	27	38
No	72	74	73	62

Table 10-17: Number of Hospitalizations by Year of Admission

Times	Year 2 (n=7) %	3 (n=23) %	All (N=30) %
1	71	43	50
2-5	29	35	33
6-10	0	9	7
>10	0	4	7
Several	0	9	3

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42 Women abused throughout their relationships.

More women in Years 2 and 3 then in Year 1 had more than one distress call to the shelter; however the women with the highest number of recorded distress calls were in Year 1 (2% had 5 recorded calls), (see Table 10-18).

10.5.1.2 Disposition of First Distress Call

Over the three years, increasing numbers of women were admitted within 24 hours of their first call ; however, fewer women were admitted within one week. The numbers placed on a waiting list for admission were approximately 8% in Year 1 and climbed to 13% in Year 2.[43]

More than 25% of the women calling the shelter were not admitted within one week of their call. Of these, 1% were considered inappropriate for the shelter at their first call, and 2% decided to look for alternative services rather than be placed on the waiting list. Three percent of the women were not seeking admission to the shelter on their first call. These women may have wanted information about the shelter, or about other services, or advice on their problem (see Table 10-19).

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[43] If there was no distress call recorded for a case it was assumed that the date of admission was the first call to the shelter; therefore, disposition of the first distress call was available for 100% of the cases.

Table 10-18: Number of Distress Calls by Year of Admission

Number	Year 1 (n=81) %	2 (n=60) %	3 (n=78) %	All (N=240) %
1	90	80	82	84
2	7	15	15	12
3	0	5	3	2
5	2	0	0	1

Table 10-19: Disposition of First Distress Call by Year of Admission

Disposition	Year 1 (n=96) %	2 (n=75) %	3 (n=126) %	All[44] (N=297) %
Admitted -24 Hours	55	64	67	62
-1 Week	17	11	10	12
Waiting List	8	13	8	10
Seeking Alternative	3	3	1	2
Not Seeking Admission	4	3	3	3
Not Appropriate	0	1	1	1
May Call Back	14	11	6	10
Other[45]	8	1	10	7

[44] Table shows percentage of responses so totals do not equal 100%.

[45] Included a referral to AlAnon, went to friend, went to family, no show for intake interview, appointment made to meet, and will be admitted, time unspecified.

10.5.1.3 Most Recent Abuse

Admission to the shelter seemed to be precipitated by recent abuse; however, there was movement away from this trend by year 3. The women admitted to the shelter were asked when the most recent abuse had occurred. This information was available on 85% of the women admitted. For 67% of the women the most recent abuse had occurred within one week prior to their admission. In Year 1, 70% of the women had been abused within one week prior to their admission and 82% within the two prior weeks. The number abused within the previous two weeks dropped over the next two years (75% and 72% for Years 2 and 3 respectively). Notably between Years 1 and 2 the numbers almost doubled for those admitted who had not been abused for the previous eight weeks (see Table 10-20).

10.5.1.4 How Women Heard of the Shelter

The data suggest that friends and family play a large role in telling battered women about the existence of the shelter. Information on how women had heard about the shelter was available for only 58% of the sample. In Year 3 it was available for 86% of women and in Years 2 and 1 for 65% and 17% respectively; Year 1 was therefore dropped (Table 10-21.

Between Years 2 and 3 the number of women who had heard of the shelter through publicity, the Department of Social Services and through the police dropped while more women

Table 10-20: Time Period in Which Most Recent Abuse Occurred by Year of Admission

Time Period	Year 1 (n=85) %	2 (n=67) %	3 (n=100) %	All (N=252) %
1 Week	70	63	68	67
1-2 Weeks	12	12	4	9
2-4 Weeks	4	7	11	8
4-6 Weeks	5	2	0	2
6-8 Weeks	1	2	2	2
>8 Weeks	8	15	15	13

heard about the service from friends, hospitals, and private social services.

Friends and family informed 32% of the women about the existence of the service. Legal services including the Unified Family Court, Legal Aid, private lawyers, and the police accounted for 13% of women hearing about the shelter and hospitals and private doctors informed 17% of the women about the existence of the service. Approximately 13% of the women heard about the shelter from more than one source.

10.5.1.5 Referrals to the Shelter

At the time of admission women were asked if they had been referred to the shelter. This information was scored by type of agency making the referral and, if possible, by the type of professional or the department from which the referral originated. The agency type was available in 82% of cases and the type of professional or department in 79%. Women were more likely to refer themselves to the shelter than to be referred by a professional.

Twenty-nine percent of the women said they alone were responsible for their seeking admission. Hospitals referred 15% of the women and private doctors another 4%. Notably, the Unified Family Court which has a Family Crisis Project and counsellors on staff accounted for 7% of the referral by department, while the provincial court, which has no social service arm, was never mentioned as a referral source (see Tables 10-22 and 10-23.

Table 10-21: Source of Information on the Shelter by Year of Admission

Source	Year 2 (n=49) %	3 (n=109) %	All[46] (N=174) %
Publicity	20	13	18
Unified Family Court	4	3	4
Legal Aid	2	2	2
Dept. Social Services	20	11	14
Private Social Service	4	11	9
Hospital	6	15	12
Clergy	2	1	1
Family	8	6	7
Friend	16	30	25
Private Lawyer	2	0	1
Private Doctor	6	6	5
Police	8	4	6
Other[47]	10	10	9

[46] Figures show percentage of responses so totals do not equal 100%.

[47] Other included Memorial University, Women's Centre, AlAnon, Public Health Nurse, exresidents, YMCA, Human Rights Association.

Table 10-22: Referrals by Agency and by Year of Admission

Agency	Year 1 (n=88)	2 (n=59)	3 (n=95)	All (N=242)
	%	%	%	%
Self	27	20	37	29
Family	5	7	4	5
Friend	10	3	8	8
Hospital	15	10	18	15
Private Medical	3	5	4	4
Legal Service	17	20	10	15
Government Social Services	11	22	6	12
Private Social Service	6	8	7	7
Other[48]	7	7	5	6

[48] Other included telephone operators, public health nurses, AlAnon members, the Salvation Army, YWCA, Human Rights Association, and a stranger who gave a drive.

Table 10-23: Referrals by Profession or Department by Year of Admission

Individual	Year 1 (n=88) %	2 (n=53) %	3 (n=94) %	All (N=235) %
Nurse	78	85	76	79
Doctor	5	8	7	6
Social Worker	15	6	12	12
Psychiatry	52	43	66	56
UFC[49]	10	9	3	7
Private Lawyer	2	0	0	1
Prov.Court	0	0	0	0
Police	4	11	3	6
Legal Aid	1	0	3	2

[49] Unified Family Court

10.5.1.6 Help Seeking

The women were asked whether or not they had sought help from other places before coming to the shelter. Information on this was available in 85% of the cases. It would appear that the longer the shelter was established the less likely women were to try and get help from another source.

Table 10-24 indicates that 87% of the women had sought help elsewhere before being admitted to the shelter. The number that had sought help elsewhere decreased over the three years from 95% in Year 1 to 79% in Year 3.

In addition to seeking help, 89% of the women had left their spouse on occassion before this admisson to the shelter. As Table 10-25 indicates, 13% had left from 5 to 9 times before. This was not available for Year 1 because it was not recorded on the forms primarily in use at that time. In the section titled "Multiple Admissions" we will examine the data on women who had more than one admission to the shelter. These women were more numerous in Years 2 and 3 which would partially account for the decrease over the three years in the number of women who had never left before.

Table 10-24: Help Previously Sought from Other Sources by Year of Admission

Response	Year 1 (n=77) %	2 (n=59) %	3 (n=116) %	All (N=252) %
Yes	95	92	79	87
No	5	8	21	13

Table 10-25: Frequency of Marital Separations Before Admission by Year of Admission

Frequency	Year 2 (n=55) %	3 (n=113) %	All (N=168) %
None	13	11	11
1	34	20	25
2	16	23	21
3	13	17	15
4	2	4	3
5	4	4	4
6	7	6	6
7	2	2	2
8	2	0	1
Several	2	12	9
Few	5	2	3

10.5.2 The Actual Admissions

10.5.2.1 Month and Week of Admission

Women were admitted on a fairly regular basis across months and weeks. The only apparent trend was in the time of day that admissions were made. The month that an admission was made was available in 100% of the cases. If the admissions were evenly distributed over the 12 months we would expect approximately 8% in each month. Only July and April varied more than 2% from the expected 8% (see Table 10-26).

The day of the month that an admission was made was available in 100% of the cases. Table 10-27 shows the number of admissons made in each of the first 4 weeks of a month and in the last 3 days where applicable. If we weight the scores for the last three days by 2.3 we see that the whole sample varied only slightly by the time of month of admissions. In Year 1, however, there were fewer admissions made in the last few days of the month and in Year 3 the third week had fewer admissions. These scores do not seem to be part of any trend.

10.5.2.2 Time of Day

The time of day that an admission was made was recorded for 80% of the cases. These were scored on a 24 hour clock to the nearest hour. The availability of this information decreased over the three years.

Table 10-26: Month Admission Occurred by Year of Admission

Month	Year 1 (n=[illegible]6) %	2 (n=75) %	3 (n=126) %	All (N=297) %
June	6	11	4	6
July	14	9	10	11
August	7	13	10	10
September	6	7	9	7
October	12	3	7	8
November	6	9	5	6
December	5	15	10	9
January	12	3	11	9
February	9	7	9	8
March	12	7	12	10
April	5	5	3	4
May	5	12	12	10

Table 10-27: Time of Month of Admission by Year of Admission

Time Period	Year 1 (n=96) %	2 (n=75) %	3 (n=126) %	All (N=297) %
1st Week	21	17	26	22
2nd Week	26	28	21	24
3rd Week	26	24	19	23
4th Week	23	17	25	22
29th-31st	4	13	10	9
(X 2.3)	9	30	23	21

Table 10-28: Time of Day of Admission by Year of Admission

Time	Year 1 (n=89) %	2 (n=65) %	3 (n=107) %	All (N=261) %
0100-0400	4	6	6	6
0500-0800	0	0	0	0
0900-1200	17	15	12	14
1300-1600	18	28	25	24
1700-2000	38	29	36	35
2100-2400	22	22	20	21

No women were admitted between 4:30 and 8:00 a.m.. The majority of admissions (56%, 57%, 61% for Years 1, 2, and 3 respectively) were made between 1 p.m. and 8 p.m. Six percent of the admissions were made between 1 and 4 a.m.. There was a decrease over the three years in admissions made from 9 a.m. to noon with these being done from 1 p.m. to 4 p.m. in Year 2 and from 1 p.m. to 8 p.m. in Year 3 (see Table 10-28).

10.5.2.3 Number of Children Admitted

Most women took children to the shelter. The data indicated that smaller and younger families were more likely to be admitted together. Older children (14 to 16 years), especially boys, were less likely to accompany their mothers. The number of children included in each admission was available in 100% of cases. Table 10-29 indicates that 52% of the women admitted took one or two children with them to the shelter. In Year 1, more (14%) took 3 children to the shelter than in Years 2 and 3 (9% and 10% respectively).

Table 10-30 indicates the number of daughters and sons in each family and the number actually admitted with their mother. Generally, mothers were more likely to have all of their daughters with them than all of their sons.

Table 10-31 further breaks down the numbers of boys and girls admitted by age group. Girls 14 to 16 were more likely to accompany their mothers than boys in this age group. There was not a great difference between boys and

Table 10-29: Number of Children Admitted with Mother by Year of Admission

Number	Year 1 (n=96) %	2 (n=75) %	3 (n=126) %	All (N=297) %
0	28	31	29	29
1	24	24	26	25
2	26	29	27	27
3	14	9	10	11
4-6	8	7	7	7

Table 10-30: Number of Children in Family by Sex and by Number Admitted with Mother

Children	Number Admitted (%) 0	1	2	3	4-6
0 Girls (n=86)	100				
0 Boys (n=87)	100				
1 Girl (n=107)	18	82			
1 Boy (n=109)	22	78			
2 Girls (n=67)	25	12	63		
2 Boys (n=69)	38	7	55		
3 Girls (n=22)	45	14	18	23	
3 Boys (n=18)	28	11	11	50	
4-6 Girls (n=15)	60	7	20	7	7
4-6 Boys (n=14)	86	7	7	0	0

girls in the 11 to 13 age bracket; in the 0 to 10 age bracket girls were more likely to accompany their mothers.

10.6 Stay

10.6.1 Length of Stay

The length of stay guideline[50] was often exceeded but at a decreasing frequency over the three years. The length of stay at the shelter was recorded in number of days for 100% of the cases. Sixteen percent of the women exceeded the six week limitation on length of stay. Exceeding the suggested maximum length of stay occurred most often in Year 2 and least often in Year 3.

It appears that the lengths of stay were generally shorter in Year 3 (see Table 10-32); 82% of the women stayed 3 weeks or less compared to 73% for the whole sample.

10.6.2 Other Services Used

Detailed information on what occurred during the stay was often not available. Information on other services used indicated that legal and medical services and financial services were important to the residents. Women were asked to record on the Information on Departure form what other services they had used during their stay at the shelter.

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[50] Six weeks was a guideline for length of stay but decisions regarding length of stay were made on an individual basis.

Table 10-31: Number of Children by Age and Sex and by Number Admitted with Mother

Children	Number Admitted 0 %	1 %	2 %	3 %
Age 0-10				
0 Girls (n=154)	100			
0 Boys (n=150)	100			
1 Girl (n=103)	10	90		
1 Boy (n=100)	22	78		
2 Girls (n=36)	8	6	86	
2 Boys (n=38)	5	3	92	
3 Girls (n=4)	0	50		50
3 Boys (n=8)	50			50
6 Boys (n=1)		100		
Age 11-13				
0 Girls (n=263)	100			
0 Boys (n=253)	100			
1 Girl (n=29)	24	76		
1 Boy (n=35)	37	63		
2 Girls (n=5)	40	0	60	
2 Boys (n=9)	44	11	44	
Age 14-16				
0 Girls (n=226)	100			
0 Boys (n=238)	100			
1 Girl (n=32)	69	31		
1 Boy (n=32)	81	19		
2 Girls (n=18)	61	22	17	
2 Boys (n=13)	100			
3 Girls (n=14)	71	7	21	
3 Boys (n=7)	100			
4-5 Girls (n=7)	86		14	
4-5 Boys (n=7)	86	14		

Table 10-32: Length of Stay at Shelter by Year of Admission

Stay	Year 1 (n=96) %	2 (n=75) %	3 (n=126) %	All (N=297) %
1 or 2 days	22	17	25	22
3 days-1 week	26	32	32	30
8 days-3 weeks	21	16	25	21
22 days-6 weeks	14	15	6	10
43 days-8 weeks	5	4	8	6
>8 weeks	12	16	5	10

Other recordings also provided some of this information, nevertheless it was available for only 53% of the total number of cases; 56% in Year 2 and 58% in Year 3 (see Table 10-33).

The services used most often were legal services with the Unified Family Court (53%) being the most frequently used of all services.[51] Social Assistance which provides financial aid was the second most used service (34%) followed closely by doctors (32%).

The numbers using the services of Newfoundland and Labrador Housing Corporation (providers of subsidized housing) dropped by almost half from Year 2 to Year 3. The numbers using the services of Social Assistance also dropped by more than half during that time period. This corresponds with the fact that more women in Year 3 were employed.

10.6.3 Departure Information

10.6.3.1 Plans for Accomodation

In this study younger women with smaller families seemed more likely to go to relatives or friends after the shelter unless second stage housing was available. Older women seemed more likely to return to their spouse. Where a woman planned to live after leaving the shelter was recorded in 75% of the sample. For Years 1, 2, and 3 it was recorded

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51 Department of Social Services, Government of Newfoundland and Labrador

Table 10-33: Frequency of Use of Other Services by Year of Admission

Service	Year 2 (n=42) %	3 (n=73) %	All (N=157) %
Legal			
Legal Aid	31	20	31
Private Lawyer	17	10	12
Provincial Court	5	10	6
Unified Family Court	48	55	53
Medical			
Hospital Services	26	33	29
Psychiatric	5	14	12
Doctor	38	25	32
Dentist	2	0	1
Child Related			
School	24	11	17
Day Care	7	6	5
Child Welfare [52]	7	15	12
Financial			
Social Assistance	57	27	34
Employment			
Shelter Employment Project [53]	0	1	1
Canada Employment Centre	10	7	10
Support			
AA	0	4	2
AlAnon	2	4	3
Womens Centre	12	8	7
Shelter Support Group	38	12	17
Housing			
Newfoundland &Labrador Housing Corporation	36	19	27
Other	10	10	16

[52] Child Welfare and Social Assistance are services of the Government of Newfoundland and Labrador

[53] This project began in the fall of 1982

in 65%, 84%, and 77% of cases respectively (see Table 10-34).

More women returned to their husbands in Year 1; by Year 3 the numbers of women returning to their husbands had dropped considerably so that in Years 2 and 3 64% and 65% respectively had plans for accomodation other than returning to their husbands.

Only 30% of the women actually planned on moving into their own home or apartment separate from their husbands. The remaining 33% were going to live with relatives, friends, in a boarding house, or with other exresidents in Kirby House.[54] The number of women planning to go to relatives more than doubled in Year 2 and remained at 14% in Year 3. There were no admissions to Kirby House in Years 1 and 2 because it had not yet opened (see footnote).

Sixty-seven percent of the category "Other" was accounted for by admissions to a hospital, while one woman (11% of Other) was transferred to a shelter outside the province.

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54 Kirby House was second stage housing for exresidents of the shelter. It was a cooperative living arrangement where up to 24 women and children could share a house for up to 6 months. It opened in the spring of 1984.

Table 10-34: Plans for Accomodation on Departure by Year of Admission

Accomodation	Year 1 (n=62) %	2 (n=63) %	3 (n=97) %	All (N=222) %
With Spouse	55	36	35	41
Own Home or Apartment	27	30	32	30
Boarding House	2	5	2	3
With Relatives	8	19	14	14
With Friends	3	6	3	4
Kirby House	0	0	9	4
Other [55]	5	3	4	4

[55] Other for Year 1 included hospiital and jail; Year 2 included hospital and out of province shelter; Year 3 included hospital and hotel.

10.6.3.2 Means of Support

The data suggest that social assistance is more likely than participation in the labour force to enable women to live independently after staying in the shelter. Women returning to their spouse were twice as likely to be dependent on wages or unemployment insurance than on social assistance. Most women returning to their spouse were at least partially dependent on him for financial support. The means by which women would support themselves after leaving the shelter was available in 62% of the cases (72% in Year 2 and 71% in Year 3. As the question was asked of a small number in Year 1 the availability for that year was 43% (see Table 10-35).

While 41% of the women were planning to return to their husbands, only 24% reported their spouse as their means of support.. As was expected, since more women were in the labour force in Year 3 more listed paid employment (31%) than in Year 2 (26%) and fewer listed social assistance (37% for Year 3 compared to 59% for Year 2); however, more women in Year 3 than Year 2 listed their spouses as their means of support.

Approximately 11% of the women listed more than one means of support. Child Support from the spouse was seldom given as a means of support (1%).

When we compare information on plans for accomodation and means of support after departure we see that women who were dependent on social assistance were more likely than

other women to be going into their own home or apartment. The next most likely groups of women going into their own home were those with other means of support followed by those with paid employment (see Table 10-36).

Seventy-seven percent of women dependent on their spouse were going to be living with him. Women going to live with their spouse and women going into separate accomodation were more likely than other women to have more than one means of support.

Data on children suggest that young women with no children, older women whose children have left home, and women with young children are more likely to return to their spouses. Table 10-37 compares information on plans for accomodation after departure and number of children who had accompanied the woman to the shelter. It was assumed that these children would remain with their mother after leaving the shelter.

Women with no children or with 1 or 2 children were more likely to return to their husbands than women with 3 or 4 to 6 children. This was especially noticeable in comparing women with no children to those with 4 to 6 children. Conversly, the women with 4 to 6 children were more likely to go into their own private accomodation than to go with their husbands or to go to relatives. A higher percentage of women with no children went to relatives than women from any of the other groups with children.

Table 10-35: Means of Financial Support After Departure by Year of Admission

Means of Support	Year 2 (n=54) %	3 (n=90) %	All (N=185) %
Social Assistance	59	37	42
Paid Employment	26	31	30
Unemployment Insurance	7	12	10
Spouse	13	27	24
Child Support	2	1	1
Other[56]	2	2	3

Table 10-36: Plans for Accomodation on Departure by Means of Financial Support on Departure

Plans	Means of Support: Paid Employ. (n=49) %	Social Assist. (n=78) %	UIC (n=18) %	Spouse (n=44) %	Other (n=6) %
With Spouse	43	20	39	77	17
Own Home	35	53	22	9	67
With Relatives	14	12	6	11	0
Other[57]	8	15	33	2	17

[56] Other included pension, training allowance, financially independent, and unspecified.

[57] Other includes boarding house, Kirby House, and friends.

Table 10-37: Plans for Acomodation on Departure by Number of Children Admitted with Mother

Plans	Number of Children Admitted				
	None (n=55) %	1 or 2 (n=120) %	3 (n=28) %	4 to 6 (n=19) %	All (N=222) %
With Spouse	44	42	39	26	41
Own Home	16	32	39	47	30
With Relatives	22	11	14	10	14
Other	18	15	7	16	15

10.6.4 Feedback from Residents

The Information on Departure form was designed to provide feedback to the shelter from the residents. As described earlier it had a low completion rate: however, when residents provided feedback on the services it was very positive. Sufficient information for reporting was available on only 6 variables . These variables were: "How did you find the staff, the other residents, and the stay?" and "How did the stay affect your feelings about yourself?", "Would you like follow-up?", and whether a follow-up address was left on file.

Most women gave very positive feedback; most wanted follow-up; 91% reported that the staff were very helpful and 85% found other residents to be very cooperative or cooperative. Women returning to their spouses were less likely to leave a follow-up address (see Tables 10-38 to 10-43). It must be kept in mind that women who did not complete a departure form may not have had positive feedback to give.

10.7 Health Status

The data bearing on health that were presented in previous sectons suggested serious health problems for battered women and increased costs for the health care system. Most women admitted to this shelter (77%) had experienced more than one kind of abuse; 90% had experienced physical abuse. Seventy-four percent of the women listed

Table 10-38: Requests for Follow-up by Year of Admission

Request	Year 1 (n=37) %	2 (n=39) %	3 (n=56) %	All (N=165) %
Yes	89	92	85	89
No	11	8	15	11

Table 10-39: Record of Follow-up Address by Plans for Accomodation on Departure

Record	Plans for Accomodation: With Spouse (n=90) %	Own Home (n=67) %	With Relatives (n=30) %	Other (n=29) %	All (N=216) %
Yes	48	66	67	66	58
No	52	34	33	34	42

Table 10-40: Reported Effects on Selfesteem by Year of Admission

Effect	Year 2 (n=51) %	3 (n=78) %	All (N=129) %
Improved	92	94	93
No Change	8	6	7

Table 10-41: Evaluation of Stay by Year of Admission

Evaluation	Year 2 (n=52) %	3 (n=79) %	All (N=131) %
Very Helpful	85	89	85
Helpful	10	10	10
Satisfactory	6	1	3

Table 10-42: Evaluation of Staff by Year of Admission

Evaluation	Year 2 (n=61) %	3 (n=81) %	All (N=142) %
Very Helpful	95	91	93
Helpful	2	6	4
Satisfactory	3	1	2
Not Helpful	0	1	1

Table 10-43: Evaluation of Other Residents by Year of Admission (%)

Evaluation	Year 2 (n=60) %	3 (n=79) %	All (N=139) %
Very Cooperative	62	60	60
Cooperative	22	25	23
Satisfactory	15	11	15
Uncooperative	0	1	1
Very Uncooperative	2	1	1
Other	0	1	1

one or more injuries as the result of this abuse. Sixty-five percent of the women reported that medical attention was required after abuse and 27% were actually hospitalized. Fifteen percent of those listing a referral agency designated a hospital and an additional 4% listed a private doctor. Three percent of women leaving the shelter were admitted to a hospital.

10.7.1 Health Problems

Most women (71%) did not report health problems when they were admitted; however, a quarter had at least one problem. Some of the problems reported could have been caused by the abuse; most could be exacerbated by stress. Health problems were listed on a medical form completed on each woman at admission. More women had health problems in Year 1 and more had several problems than in other years (see Table 10-44). Over the three years increasingly more women were pregnant although the numbers who thought they could be stayed at about 3% (see Table 10-46).

10.7.2 Prescriptions

There was a trend towards women having fewer prescriptions over the 3 years with younger women having the least. Women who had prescriptions usually had more than one. The number of prescriptions for tranquillizers seemed to be declining in this population. The numbers of prescriptions in both psychotropic and other categories

Table 10-44: Number of Health Problems by Year of Admisson

Number	Year 1 (n=89) %	2 (n=74) %	3 (n=122) %	All (N=285) %
1	25	26	17	22
2	6	4	2	4
3-5	6	3	3	4
None	64	68	78	71

Table 10-45: Distribution of Problems by Type

	Percent (N=285)
Anxiety	4
Back or Spine Problems	3
Diabetes	3
Heart Problems	2
Asthma	2
Dizzy Spells or Fainting	2
Stomach Problems	2
Headaches or Migraines	1
Epilepsy	1
Rheumatism or Arthritis	1
Gynecological	1
Kidney	1
Pain	1
Hearing	1
Bronchitis	1
Sinus	1
Cerebral Palsy	1
Thyroid	1
Bowel	1
Lung	1
Middle Ear	1
Eczema	1
Unknown	1

Table 10-46: Numbers Pregnant by Year of Admission

Pregnant	Year 1 (n=91) %	2 (n=74) %	3 (n=122) %	All (N=287) %
Yes	1	4	6	4
Maybe	3	3	2	3
Not	96	93	92	93

indicate many interactions between the women admitted to the shelter and health care professionals, particularly doctors.

Forty-five percent, 28%, and 38% of women respectively for Years 1, 2, and 3 had at least one prescription with them when they were admitted. These figures do not correspond with the numbers who reported health problems in each year; they are higher in Years 1 and 3 and slightly lower in Year 2.

Over the three years the percentage of women with prescriptions for major tranquillizers dropped; the numbers with minor tranquillizers dropped by more than half; and the numbers with prescriptions for sedative/hypnotics dropped sharply in Year 2 but rose again in Year 3. The number of women with antidepressants also dropped sharply in Year 2 and rose again in Year 3. The number with other prescriptions dropped over the three years (see Table 10-47).

10.7.2.1 Combinations

Women seldom had only one type of prescription (see Table 10-48). Major tranquillizers were carried alone 25% of the time; minor tranquillizers were carried alone 29% of the time; and sedative/hypnotics 14% of the time. Antidepressants were never carried alone.

Several combinations show unusually high numbers of prescriptions for psychoactive drugs: for example, 2 major tranquillizers with one antidepressant; 2 minor

Table 10-47: Distribution of Prescription by Type and by Year of Admission

Type & Number	Year 1 (n=89) %	2 u(n=74) %	3 (n=122) %	All (N=285) %
Major Tranquillizer/ Lithium				
1	4	1	2	2
2	0	1	0	<1
Minor Tranquillizer				
1	19	8	9	12
2	3	1	2	2
3	1	0	0	<1
Sedative Hypnotic				
1	15	4	10	10
3	0	0	1	<1
Antidepressant				
1	12	4	5	7
2	0	0	2	1
3	0	0	1	<1
4	0	0	1	<1
Other				
1	11	8	3	15
2	9	7	3	7
3	3	0	2	2
4	3	0	2	2
5	1	0	0	1
6	1	0	1	1

tranquillizers with 3 sedative/hypnotics; 1 minor tranquillizer with 2 antidepressants and 1 with 4 antidepressants; 2 minor tranquillizers and 1 antidepressant; 1 sedative/hypnotic and 2 antidepressants. All of these occurred in less than 1 percent of the sample but these multiple combinations represent 12% of the prescriptions for major tranquillizers; 10% of the prescriptions for minor tranquillizers; 3% of sedative/hypnotic prescriptions; and 16% of prescriptions for antidepressants.

10.7.2.2 Other Prescriptions

Twenty-seven percent of the women had 1 or more nonpsychotropic prescriptions (see Table 10-49). Thirty-five percent of these were for pain; 21% for antibiotics; 16% for vitamins or iron; and 14% were diuretics.

10.8 Second and Multiple Admissions

10.8.1 Distribution

Nearly a quarter (22%) of the admissions made to the shelter were second to sixth admissions.[59] As would be expected, by Year 3 more admissions were in this category than in previous years. Fifth and sixth admissions (1%) occurred only in Year 3.

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[59] Third to sixth admissions will be referred to as multiple admissions.

Table 10-48: Distribution of Prescription Combinations

Combination			(n=107)
			%
1 Major Tranquillizer	&	2 Minor Tranqs.	2
1 Major Tranquillizer	&	1 Sed./Hypnotic	1
1 Major Tranquillizer	&	1 Antidepressant	1
2 Major Tranquillizer	&	1 Antidepressant	1
1 Major Tranquillizer	&	2 Other	1
1 Major Tranquillizer	&	4 Other	1
2 Minor Tranquillizer	&	1 Sed./Hypnotic	2
1 Minor Tranquillizer	&	1 Sed./Hypnotic	5
2 Minor Tranquillizer	&	3 Sed./Hypnotic	1
1 Minor Tranquillizer	&	1 Antidepressant	4
1 Minor Tranquillizer	&	2 Antidepressant	1
1 Minor Tranquillizer	&	4 Antidepressant	1
2 Minor Tranquillizer	&	1 Antidepressant	1
1 Sedative Hypnotic	&	1 Antidepressant	3
1 Sedative Hypnotic	&	2 Antidepressant	1

Table 10-49: Breakdown of Nonpsychotropic Prescriptions by Type

Type	Percent (n=76)
Anorectal Therapy	1
Antiarrhythmic	1
Antibacterial	3
Antibiotic	21
Anticonvulsant	8
Antidiarrheal	1
Antihistimine	12
Antiinflamatory	5
Antivert	1
Asthma Inhaler	1
Birth Control	13
Bronchodialator	1
Cough Syrup	1
Decongestant	3
Depo Provera	1
Diuretic	14
Gravol	3
Headache Therapy	3
Hyperthyroid Therapy	3
Insulin	5
Laxative	6
Muscle Relaxant	6
Nitroglycerin	3
Pain Relief	33
Vitamins or Iron	16
Weight Control	3

The number of women abused throughout their relationship (23%) who had multiple admissions was not substantially different from the whole sample (see Table 10-50). As compared to first and second admissions, multiple admissions were more likely to be in their twenties or over 45 years of age. It appears that women admitted more than twice were predominately in the 25 to 29 and over 45 year old ranges (see Table 10-51). The percentage of women aged 18 to 29 years increased among second admissions and dropped to about the same level as first admissions among the multiple admissions group.

It appears that battered women who separate from their husbands may still require the services of a shelter. Women admitted more than once to the shelter were more likely to be separated from the abuser than women admitted for the first time. They were also more likely to be cohabitating rather than formally married. No women whose status was that of divorced or for whom the abuser was a boyfriend were admitted more than once (see Table 10-52). The data suggests that multiple admissions had older children who were relatively independent from their mother. Women admitted more than once were more likely than first admissions to have larger families (4 to 11 children) (see Table 10-53).

Women in second or multiple admissions brought smaller numbers of children with them to the shelter (see Table 10-54). There was no clear trend in the income at admission

Table 10-50: Number of Admission by Year of Admission

Type	Year 1 (n=96) %	2 (n=75) %	3 (n=126) %	All (N=297) %	60 A (n=48) %
First	85	89	66	78	77
Second	12	8	22	15	17
Third	2	3	8	5	4
Fourth to 6th	2	0	4	2	2

Table 10-51: Age of Women by Number of Admission

Age	Number of Admission First (n=226)	2nd (n=45)	Mult. Adm. (n=21)	All (N=292)
15-19	3	2	0	2
20-24	20	27	10	20
25-29	24	24	38	25
30-34	19	11	10	17
35-39	18	13	0	16
40-44	8	13	0	16
45-49	4	2	10	4
50-54	3	4	10	4
55-59	2	2	0	2
60+	0	2	10	1

60 Those cases where length of abuse equalled length of relationship.

Table 10-52: Marital Status by Number of Admission

Status	Number of Admission			
	First (n=231) %	2nd (n=45) %	Mult. Adm. (n=21) %	All (N=297) %
Married	83	64	62	78
Cohabitating	14	20	19	15
Separated	2	16	19	5
Other[61]	1	0	0	1

[61] Other includes noncohabitatng boyfriends and divorced.

Table 10-53: Number of Children in Family by Number of Admission

Children	Number of Admission			
	First (n=231) %	2nd (n=45) %	Mult. Adm. (n=21) %	All (N=297) %
None	11	9	10	11
1	19	20	19	19
2	32	27	33	32
3	17	13	5	16
4-11	21	31	33	23

Table 10-54: Number of Children Admitted by Number of Admission

Children	Number of Admission			
	First (n=231) %	2nd (n=45) %	3rd to 4th (n=21) %	All (N=297) %
None	27	33	43	30
1	23	21	29	25
2	29	20	29	27
3	13	4	0	11
4-6	7	11	0	7

of single versus multiple admissions. Women admitted for the second time were more likely than women in first or multiple admissions to be on social assistance (36% compared to 24% and 23%). Women in multiple admissions were more likely than others to be in the official labour force (paid employment or unemployment insurance); they were also more likely than others to be reliant on their spouse. While the same number of women among first admissions as among multiple admissions were in the labour force fewer were dependent on their spouse (see Table 10-55).

10.8.2 Abuse

The data suggest that multiple admissions may have been made on the basis of threatened rather than actual abuse. Women in multiple admissions may have sought admission as a preventative measure. Women with multiple admissions were less likely to report either physical, sexual, or psychological abuse than other women (see Table 10-56). They were also less likely to report requiring medical treatment or hospitalization (see Tables 10-58 and 10-57).

Second admissions were more likely to report all three categories of abuse, to have required medical treatment, and to have been hospitalized due to abuse. They reported more injuries including more burns and stitches than either of the other groups (see Table 10-59) as well as more health problems (see Table 10-60). Second and multiple admissions reported more bruising and more injuries classified as

Table 10-55: Source of Income on Admission by Number of Admission

Source	Number of Admission			
	1st. (n=154) %	2nd (n=33) %	Mult. Adm. (n=13) %	All[62] (N=200) %
Paid Employ.	30	21	23	28
UIC	12	21	23	14
Social Assist.	24	36	23	26
Spouse	34	21	38	32
Other	5	3	8	5

[62] Figures show percent of responses so totals do not equal 100%.

other; however, multiple admissions reported overall fewer injuries than second admissions and only 3% more than first admissions.

10.8.3 Knowledge of the Shelter

Women in multiple admissions were more limited in both sources of knowledge of and sources of referral to the shelter. Friends were most likely (53%) to inform these women of the service. It appears that most multiple admissions were referred for one or more admissions by a psychiatric nurse; at other times they were self-referred (89%). A similiar situation is indicated for second admissions (see Tables 10-61 to 10-63).

10.8.4 The Stay

It appears that women in multiple admissions stayed longer at the shelter because alternative accomadation was difficult to find. Multiple admissions exceeded other admissions in all lengths of stay above one week (see Table 10-64).

Second admissions were more likely to stay under three weeks (80%) than first admissions (70%) but the only services they used substantially more often than the other women were hospital services. Multiple admissions used the Department of Social Services slightly more often than second admissions for social assistance but less often than first admissions (see Table 10-65).

Table 10-56: Type of Abuse by Number of Admission

Type	Number of Admission: 1st (n=227) %	2nd (n=45) %	Mult. Adm. (n=21) %	All (N=293) %
Physical	90	91	86	90
Sexual	14	22	5	15
Psychological	84	93	76	85

Table 10-57: Need for Hospitalization by Number of Admission

Response	Number of Admission: 1st (n=126) %	2nd (n=30) %	Mult. Adm. (n=14) %	All (N=170) %
Yes	31	40	29	32
No	69	60	71	68

Table 10-58: Need for Medical Attention by Number of Admission

Response	Number of Admission: 1st (n=154) %	2nd (n=39) %	Multi. Adm. (n=18) %	All (N=211) %
Yes	66	67	56	65
No	34	33	44	35

[63] Women could report more than one type of abuse so totals exceed 100%.

Table 10-59: Injuries by Number of Admission

Type	Number of Admission			
	1st (n=163) %	2nd (n=36) %	Mult. Adm. (n=20) %	All (N=219) %
Bruising	69	86	85	74
Burns	6	8	0	5
Fractures	19	17	15	18
Stitches	10	14	10	10
Emotional	65	64	55	64
Swelling	14	14	15	14
Sprains	2	3	0	2
Other	12	17	20	14

Table 10-60: Number of Health Problems by Number of Admission

Number	Number of Admission			
	1st (n=231) %	2nd (n=45) %	Multi. Adm. (n=21) %	All (N=297) %
1	22	22	5	21
2	2	9	0	3
3	3	4	0	3
4-5	1	0	0	1
None	71	64	95	72

Table 10-61: Source of Knowledge of Shelter by Number of Admission

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Source	Number of Admission			
	1st (n=122) %	2nd (n=32) %	Mult. Adm. (n=17) %	All (N=171) %
Publicity	20	12	13	18
Unified Family Court	4	3	0	4
Legal Aid	2	0	0	2
Dept. Social Services	12	19	13	14
Private Social Services	10	6	7	9
Hospital	12	9	13	12
Clergy	1	3	0	1
Family	9	3	0	7
Friend	20	28	53	25
Private Lawyer	1	0	0	1
Private Doctor	4	6	7	5
Police	4	9	13	6
Other	10	12	0	9

64 Figures indicate percentage of responses.

Table 10-62: Agency Referrals by Number of Admission

Agency	Number of Admission			
	1st	2nd	Mult.	All Adm.
	(n=182) %	(n=41) %	(n=19) %	(N=242) %
Self	14	68	89	29
Family	7	0	0	5
Friend	9	5	0	8
Hospital	13	7	0	15
Private Medical	4	5	0	4
Legal Service	18	7	5	15
Government Social Services	15	2	0	12
Private Social Service	8	5	0	7
Other[65]	8	0	5	6

[65] Other included telephone operators, public health nurses, AlAnon members, the Salvation Army, YWCA, Human Rights Association, and a stranger who gave a drive.

Table 10-63: Professional or Department Referrals by Number of Admission

Individual	Number of Admission			
	1st (n=175) %	2nd (n=41) %	Mult. (n=19) %	All Adm. (N=235) %
Nurse	76	85	95	79
Doctor	7	5	0	6
Social Worker	14	7	0	12
Psychiatry	47	78	89	56
UFC[66]	9	3	0	7
Private Lawyer	1	0	0	1
Prov.Court	0	0	0	0
Police	6	5	5	6
Legal Aid	2	0	0	2

[66] Unified Family Court

Table 10-64: Length of Stay at Shelter by Number of Admission

Length of Stay	Number of Admission			
	1st (n=231) %	2nd) (n=45) %	Mult. Adm. (n=21) %	All (N=297) %
Up to 1 week	52	56	10	52
1 to 3 weeks	18	24	33	21
3 to 6 weeks	12	7	24	10
6 to 8 weeks	7	4	28	6
>8 weeks	11	9	5	10

Table 10-65: Other Services Used During Stay by Number of Admission

Type	Number of Admission[67] 1st (n=128) %	2nd (n=22) %	Mult. Adm. (n=33) %	All (N=157) %
Legal				
Legal Aid	33	23	14	31
Private Lawyer	13	0	14	12
Provincial Court	3	23	14	6
Unified Family Crt.	52	54	43	53
Medical				
Hospital Services	30	18	57	29
Psychiatric	12	14	0	12
Doctor	31	36	28	32
Dentist	2	0	0	1
Child Related				
School	19	5	14	17
Day Care	6	0	0	5
Child Welfare	9	27	14	12
Financial				
Social Assistance	36	23	28	34

[67] Figures show percentage of responses.

Table 10-65, Other Services Used During Stay by Number of Admission, continued:

Type	Number of Admission 1st (n=128) %	2nd (n=22) %	Mult. Adm. (n=33) %	All (N=157) %
Employment				
Shelter Employment Project	0	4	1	1
Canada Employment Centre	11	4	0	10
Support				
AA	2	0	0	2
AlAnon	3	4	0	3
Womens Centre	8	4	0	7
Support Group				17
Housing				
Newfoundland /Labrador Housing Corporation	30	18	0	27
Other	18	4	14	16

[68]

[68] Figures show percentage of responses.

10.8.5 Plans on Departure

Women from second and multiple admissions were less likely to return home to their husbands. While women from second admissions were more likely than others to go into their own home or apartment. Multiple admissions were more likely than others to go to boarding houses, with relatives, or to Kirby House (see Table 10-66).

Women from multiple admissions were more likely to be dependent on paid employment and on their spouses than women from second admissions. First and multiple admissions were similiar in their means of support with fewer multiple admissions having paid employment (4% fewer) and an almost equal number (5% more) receiving social assistance. Second admissions were predominately reliant on social assistance(52%) (see Table 10-67).

Table 10-66: Plans for Accomodation on Departure by Number of Admission

Plans for Accomodation	Admission			
	1st (n=182) %	2nd (n=29) %	Mult. Adm. (n=11) %	All (N=222) %
Home with Husband	42	38	27	41
Own Home or Apartment	29	38	27	30
Boarding House	2	3	9	3
With Relatives	15	7	18	14
With Friends	4	3	0	4
Kirby House	3	7	18	4
Other	4	3	0	4

Table 10-67: Means of Support After Departure by Number of Admission

Means of Support	Admission 1st (n=149) %	2nd (n=25) %	Mult. Adm. (n=11) %	All (N=185) %
Social Assistance	40	52	45	42
Paid Employment	31	24	27	30
Unemployment Insurance	9	12	9	10
Spouse	25	16	27	24
Child Support	1	0	0	1
Other [69]	3	4	0	3

[69] Other included pension, training allowance, financially independent, and unspecified

Chapter 11

Discussion

This study clearly illustrates that wife abuse in Newfoundland and Labrador is not limited to the unemployed or to lower socioeconomic groups. More women and their spouses reported on in this study were in the labour force and fewer were unemployed than usual for the province. Approximately 8% of the women and 16% of their spouses were in the professional occupations. Both groups were distributed on educational level similiarly to the provincial population. We have not established a measure of social class for the study group but it appears that a variety of classes use the shelter. This concurs with reports by Moore (1979) and others.

Women from 18 to 60 years of age used the shelter. The average age was 32 years which is consistent with findings from other shelters (Gayford, 1975; Mac Eachern et al., 1980; Women's Research Centre and Vancouver Transition House, 1980). The women using the shelter closely resembled the population of women in Newfoundland and Labrador over 15 years of age. This is similiar to findings of a Quebec study for that province (Research Group on Abused Women, 1980).

In this study women in professional occupations tended

to be underrepresented. Since the study only provides informaton on women actually admitted to the shelter we cannot determine where professional women go , if, in fact, they do leave abusive husbands and why they do not go to the shelter. Is the lack of use due to pressures from children? Do children from these homes have higher expectations for their standard of living, for instance, which would make it difficult for them to adapt to a crowded shelter? Are they being asked to leave behind more than other children when they leave home? Is it harder for the women to leave when they have established a high standard of living?

One possible reason that more professional women do not use the shelter is that they can afford alternatives such as a new apartment which usually requires a damage deposit plus the first months rent. Another possible reason is that other professionals to whom they might turn do not refer them to that service. Doctors , lawyers, and the clergy, for instance, were seldom mentioned as the source of information on the service or as referal sources. In addition, the number of referrals from the Unified Family Court declined over the three years of the study. Whether more professionals use the Unified Family Court has not been documented but it does have the advantage of being in an elegant old house in a prestigious neighbourhood. It is also an arm of the Department of Justice rather than the Department of Social Services, which in this province is associated with "being on the welfare".

Possibly these women are more heavily constrained from admitting abuse. Anecdotal information indicates that many family members and professionals in St. John's still believe a woman is "stupid" to give up a nice home, a husband's income, and the children's father if beatings or psychological abuse aren't "really serious". In addition, the common belief continues to exist that abuse occurs most commonly in families with an unemployed alcoholic husband. Women are encouraged to be nurse, psychologist, and social worker for their abusive husband by helping him overcome whatever stressors are "causing" the problem behavior. It would be informative to study the distress call sheets on women not admitted to the shelter to determine if the professional women underrepresented in the study show up with more frequency as nonresidential clients.

Wife abuse is clearly not an urban phenomenon. Fifty-seven percent of the women using the shelter were from St. John's; 31% were from smaller surrounding communities and approximately 12% were from off the Avalon peninsula. Three percent actually travelled long distances from the west coast of the island and from Labrador. It was often difficult for women to get to St. John's. During the period of study there were two flights a week from Labrador to St. John's, weather permitting. On the island one had in some situations the choice of taking a bus or a private taxi service to St. John's; in others both services might be necessary; in others no public transportation was available.

There are several indications that the shelter was a successful and accepted service for battered women. For instance, most women reported that that their feelings about themselves had improved. This is an important finding given the low self-esteem of battered women described in the literature. Items on the Information on Departure form indicated that women were pleased with the services of the shelter.

Apparently the fact that women came from a mixture of socioeconomic backgrounds did not interfere with their ability to function cooperatively in the shelter. Interresident cooperation would be important to the comfort of residents and the smooth running of the shelter; for instance, women had to share rooms, meal preparation, and child care. This ability to interract successfully in a new social situation could also contribute to improved self-esteem. Most women (83%) reported that they had found other residents to be cooperative.

Another indication of the acceptance and approval of the shelter by residents was the fact that women returned to the shelter; 23% of the admissions were second to sixth admissions. We must keep in mind, however, that women had few, if any, alternatives for affordable and safe emergency shelter in this city. In 1984 another shelter opened in this city however it was reported by the study shelter that women were still returning when the need arose.

Women did not appear to reject the shelter on the

grounds of its association with a status of women's council or its feminist philosophy. This is indicated by the crosssection of women represented in the admissions to the shelter.

Although it is recognized that abuse occurs in lesbian relationships (Schechter, 1982) none of the women admitted reported that they were leaving an abusive lesbian relationship. No studies were found which reported on whether these women would see a shelter as an appropriate service available to them.

These evaluative indicators are just sign posts and cannot tell us what aspects of the program worked and for whom. What aspects did residents consider helpful and what gaps did they perceive? We also do not know how much this feedback was fuelled by gratitude rather than critical judgement.

The women liked some aspects of the service provided by the shelter but this study could not rate them on the basis of either importance or usefulness. It is not unusual for a new service such as Transition House to lack clearly defined program objectives and evaluation techniques. The literature provides few examples of even modest efforts at evaluation (see Salasin, 1981). Fields (1981, p.58)) states:

> The crisis in knowledge is that we do not know whether there are appropriate services for victims and if there are, what services are appropriate or utilizable by what victims.

What this study indicates is that shelters are appropriate

services for battered women and will be utilized by all age groups and socioeconomic strata, and victims of different types of abuse.

Women who believe they must leave an abusive relationship may have to wait for a bed in a shelter. Even if abused women from regions other than the Avalon could afford transportation to St. John's, arrange it, overcome anxiety about going into the city, and convince their children to relocate, they might well have difficulty getting a bed in the shelter under study. Thirteen percent of women who called the shelter in one year had to be placed on a waiting list.

The number of women placed on a waiting list at the time of their first distress call to the shelter is a cause for concern. Crisis intervention theory points out that immediate response to a request for help is important in maintaining an impetus for change. Since we only studied women who were admitted we do not know how many women placed on a waiting list subsequently stayed in an abusive relationship . Nor do we know if this action discouraged women from calling the shelter again. An examination of distress calls that did not result in admissions might provide information on this point. On the other hand, results of the present study may point to a weakness in crisis intervention theory as it applies to battered women. Battered women seem prepared to wait for shelter services. While 10% of women were placed on a waiting list 12% waited

more than 24 hours for admission and were admitted within a week of their call.

There are clearly not enough shelter beds in the province and, more particularly, in St. John's. Since this study a second shelter has opened in Corner Brook, a city approximately 689 kilometers away, and that shelter is reportedly operating at capacity (24 beds). Very few (1%) of the women in the present study came from Corner Brook, indicating that during the study period there had been a large gap in service to women in that area. This suggests that there are other regions of the province (for instance Central Newfoundland) in which battered women do not have access to a shelter. Since so few admissions were from outside the Avalon peninsula, however, it is unlikely that the opening of shelters in other regions will solve the problem of lack of beds in St. John's.

The waiting list existed at roughly the same level in Year 1 as in Year 3. It remains to be documented whether the opening of another shelter in the city of St. John's[70] has substantially improved this problem. Conversations with staff of the study shelter indicate that even after the other shelter had been in operation for 8 months a waiting list still existed.

The reports on previous attempts to get help by women admitted to the shelter indicate that the opening of the

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[70] The Haven of Hope opened in November 1984.

shelter did not create the demand for that type of service. Eighty-nine percent of women reported that they had left their spouse before.[71] This is a higher percentage than reported in a Vancouver shelter (Women's Research Centre and Vancouver Transition House (1980). Eighty-seven percent of the study sample had sought help elsewhere before admission. Unfortunately, where women went for help and what type of help they were looking for at that time was not recorded.

The majority of women had children and brought some, if not all of them to the shelter. This is consistent with other studies (Chan, 1978; Drake, 1982; Gayford, 1975; Women's Research Centre & Vancouver Transition House, 1980).

This study does not address the problems of the children in the shelter; obviously, their problems would impact upon their mother's decisions and her adjustment to the shelter. The problems of children and how they affect their mothers are areas that have not been documented. Although only 11% of the women had no children (approximately half as many as the population of Newfoundland and Labrador), 29% were not accompanied by children on admission. Only 50% of women with 3 children under 10 years of age were admitted with all three children. We do not know where the other children were staying. This would certainly influence the woman's stay, participation in

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[71] The availability rate for this question was 57% overall and 90% in Year 3.

programs, and decisions. It does appear that younger women with one or two children and older women with no children were more likely to return to living with their spouses. Possibly these women saw their options as more limited than other women.

The large numbers of children admitted to this shelter indicates that they should receive more attention from researchers. Even though thousands of children have stayed in shelters across the country we do not know what impact a stay in a shelter has on children. Approximately 430 children were admitted to the shelter during the study period. They ranged in age from newborns to 16 year olds. Fourteen to sixteen year olds were far less likely to accompany their mothers. In the case of boys aged 13 to 16 years admission was not automatic; that is, the shelter had a policy of deciding on admission in each individual case based on the mother's assessment of probable behavior and the need for him to accompany her. This probably accounts for the fact that fewer boys than girls in this age group accompanied their mothers.

Hershorn and Rosenbaum (1985) cite studies which suggest that viewing marital violence increases the incidence of psychopathology, anxiety disorders, and psychosomatic disorders among children. Their own study found a significant difference in occurrence of behavioral problems in children from satisfactory marriages as compared to violent or discordant marriages. This supports the

conclusion of the government of Newfoundland and Labrador, expressed in the Child Welfare Act, that children in violent homes are in need of protection.[72] However, the role of child protection services in cases is not clear; Child Welfare in the Department of Social Services was listed in 12% of cases as another service used during the stay at the shelter.[73]

The data on injuries, use of medical services, and hospitalization indicate that wife abuse increases costs of health care in this province. A higher percentage (72%) of women in this study required medical attention after abuse than did women in other studies (Drake, 1982; Star et al., 1979; Women's Research Centre & Vancouver Transition House, 1980) A higher proportion were actually hospitalized (Gayford, 1975). Consistent with other studies physical abuse was the most common form of abuse reported (Dobash & Dobash, 1978; Gayford, 1975; Women's Research Centre & Vancouver Transition House, 1980) . Sexual abuse was reported by fewer women in this study than in other studies (Mac Eachern et al., 1980; Snyder & Fructman, 1981; Women's Research Centre & Vancouver Transition House, 1980). This may reflect a difference in the interviewing and recording habits of the staff in shelters.

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72 It also raises the question of why children from homes where marriages are discordant are not also covered by Child Welfare Legislation.

73 The availability rate was very low (53%) on Other Services Used.

As stress and anxiety are known to increase the incidence of health problems these women are at risk, as are their children, of illness. In fact, many health problems were reported by the women and these could be exacerbated if not caused by physical and psychological abuse. More women in this study reported health problems than in the study of (Gayford, 1975) which examined this aspect. It appears that there are gaps in services to battered women in the existing health care system. To treat health problems without dealing with the social condition of the patient would seem an inadequate approach yet this often occurs. Few women were referred to the shelter by medical services and this is consistent with other reports (Friedman, 1977; MacEachern et al., 1980) despite the fact that many women required medical attention several times.

Public health nurses accounted for only 1% of referrals to the shelter despite the extensive public health system in this province . At least 4% of those admitted to the shelter were pregnant and 89% already had children. Public health nurses visit every newborn and its mother and could be trained to recognize wife abuse. Gelles (1975) found abuse of pregnant women to be common. The public health nurse could be an important source of referral and of followup and support after women leave the shelter.

We have already noted that wife battering increased costs to the health care system in this province. There is also evidence that wife battering places increased demands

on the social service and legal systems. For instance, it appears that in order to establish a residence separate from their spouse many women had to rely on social assistance.

The literature describes the debilitating social and psychological consequences of wife abuse for women and children (Ferraro & Johnson, 1983; Hershorn & Rosenbaum, 1985). With the large numbers and the cross section of the population represented by this study there is added support for the belief expressed by several groups that this is a widespread and serious problem in this province (Newfoundland Status of Women's Council, 1980; White, 1982).

Administrators and planners in other agencies and government who are interested in saving costs should be encouraged by the data in this study to examine their roles in secondary, if not primary prevention of wife abuse. For instance, the data showed that women who stayed in a relationship where abuse started early reported more injuries than other women. They were more likely to have required hospitalization. Ninety-four percent of women abused throughout their relationship were in the group with the highest rates of physical, sexual, and psychological abuse. Sixty-three percent of the sample had experienced abuse for more than six years. Eighty-seven percent had sought help before but less than 55% were referred to the shelter through an agency. Repeated violence resulted in repeated use of the most expensive health services: by Year 3 fifty-seven percent of women who had been hospitalized for

abuse had been hospitalized more than once; 9% more than 10 times. Of those requiring medical attention, 62% required it more than once.

Professionals can play an important role in secondary prevention of wife abuse. It was noted in the review of the literature that one of the catalysts for a women to define abuse as victimization that warranted a response was a redefinition of the abuse by someone outside the relationship (Ferraro and Johnson, 1983). The essence of secondary prevention is for professionals to make this redefinition as soon as mental or physical cruelty is observed. This will not only require that they understand wife abuse but will probably require attitudinal changes as well.

There is need for more careful attention to the issue of primary prevention of wife abuse; for instance, some writers believe that class struggle and the emergence of socialism per se would decrease the incidence of wife abuse. This study does not support that argument as it indicates that wife abuse cuts across socioeconomic classifications. What remains to be addressed is the function of the family structure and the relationships between men and women within this framework.

Primary prevention of wife abuse is integrally linked with secondary prevention; wife abuse is not a discreet illness that once contacted runs a predictable course. A woman may have an arm broken by her spouse early in the

relationship; years later she may be choked near death; she may even be killed. The earlier injury will be treated by a physician; the second may never be related to anyone; and the third event is viewed as a criminal matter unrelated to anyone outside of that husband-wife dyad. Both possibly could have been prevented from ever occurring by early identification of the Battered Wife Syndrome. Swanson (1985) said that this would require "straight-forward, non-threatening, open-ended questions" by the physician (p. 823). The more battered women are enabled to put a stop to abuse early in a relationship the more likely that abuse will become an unacceptable behavior for spouses. Additionally, the efforts of the health care field through professional training and continuing education to set aside the myths of wife battering and to promote appropriate intervention protocols will affect professional and public attitudes. Since many women are involved in health care this will also encourage secondary prevention, for instance, at least one hospital in St. John's has included sessions on wife abuse in its workshops on the employee assistance program.

Primary prevention is also linked with other social reforms and is a hidden benefit from such programs as affirmative action, equal pay legislation, day care provision, and removal of sexist educational practices. These reforms are important in improving the options of women currently in shelters and of preventing others from becoming victims who need such services.

Swanson (1985) recommends psychotherapy as the tertiary prevention route for a family physician. I believe this is a roadblock for the family physician and as suggested by Stark, Flitcraft, and Frazier (1979) inappropriately focuses on the psychological illness of battered women. Family physicians, not trained in this specialty and without the time to do psychotherapy are faced with a dearth of options of where to refer women for this type of treatment. It would not be perceived as helpful to refer every battered woman to a psychiatrist. It is more helpful for the family physician to view wife abuse as a social problem which the woman must identify and come to understand. A number of options from which the woman could choose are then available: referral to a shelter for residential or nonresidential services; marriage counselling; seeing a lawyer; going to family court; or government or private counselling services. In any case whoever makes a referral should be cautious not to send a woman to someone who is likely to promote self-blame or stay-at-any-cost solutions. As physicians become more informed about the issues and the available services they will be able to make better recommendations to women. As with any other syndrome or health problem compliance with professional advice will vary among patients; nevertheless, the physician should continue treating the patient without labelling her stupid, masochistic, or unworthy of her or his professional time.

All that has been said for the family physician can

also be applied to nurses, social workers, and professionals in general.

A problem exists for those health care professionals who wish to refer a battered woman: if the woman requires shelter there simply may not be a bed available to her. The health care professional can join with others in advocating that this service be increased to meet the need; in the meantime, most shelters will work with a referral agent to find alternative accomodation in emergency situations or to establish whether other options exist for the woman (for example, legal action). It has not been documented but it seems likely that shelter beds are much more cost efficient than hospital beds for which there already exists a greater demand than can be met in this province. Reports from this shelter indicate that women have been kept in hospital until a shelter bed was available.

There appears to have been a decline in the rates at which psychotropic drugs were prescribed in this region of the province. The rate of psychotropic drug use reported in this shelter (26%) is midway between the 40% reported by Dobash and Dobash (1979) and 11% as reported by the Women's Research Centre and Vancouver Transition House (1980). During the three years of the study the numbers of prescriptions for major and minor tranquillizers reported by residents dropped by half. Prescriptions for antidepressants also declined despite data indicating an increase over the three years in those referrals most likely

to require psychotropic medications, that is, referrals from psychiatric services. During the study period a Province wide education program on psychotropic drug use by women was sponsored by Health and Welfare Canada; we have no way of knowing if this affected prescription rates.

The data from this study supports Reudy's (1978) call for improved drug monitoring in general. Some of the combinations of prescriptions which women brought to the shelter appeared to be of limited medical value. This was most likely to involve major and minor tranquillizers. Either women accumulated prescriptions from one or more doctors because they wanted more than was prescribed, they did not understand that drugs were being replaced not increased by the prescribing physician, or physicians overprescribed to them.

Jacob (1979) and Cooperstock (1978b) question the cost to the health care system of "medicalized social problems". There is debate over the effect of psychotropic drugs: Cooperstock points out that single moderate dozes of benzodiazepines (minor tranquillizers) in a laboratory study created deficits in cognitive functions such as attention, vigilance, and decision making; other studies question this conclusion. Jacob makes a number of recommendations for the prevention of physical and psychological dependence on psychoactive agents. He warns that these drugs may interfere with the development of more successful solutions to a patient's problems. His first recommendation to the physician prescribing benzodiazepines is:

> Determine the cause of or precipitating factors in insomnia and anxiety, and treat the primary problem...Decide if the drug is necessary. (P. 719)

Hebert et al. (1979) found that battered women took drugs to cope with the abuse and tension at home and that drugs may have interfered with the women's abilities to make decisive changes. The only notable difference between first, second, and multiple admissions is that the percentage with prescriptions for antidepressants more than doubled between first and second admissions. This could indicate that some women became depressed after they had returned to their husband. The return of these women to the shelter indicates that decision making was possible at some level; however, we do not know how they fared in the final outcome as compared to women going through the program without drugs. Perhaps there were women who came to need drugs after returning to their husbands but who never returned to the shelter.

It is encouraging that the percentage of battered women with prescriptions decreased over the three years. We are left wondering, however, what effect tranquillizers had on the women (13% in Year 3) who were using them. Information on the difference in drug use between admission and departure was not available.

Data on health related issues indicate that shelter staff should have specific training on drugs and which combinations are possibly dangerous and when to seek consultation from a doctor. Such training would enable them more appropriately to refer women with several prescriptions

back to their doctor or to a doctor serving the shelter. Also, staff would need a basic knowledge of clinical depression and an understanding of suicide prevention. The shelter policy of safekeeping drugs in the office in a locked cabinet is obviously in keeping with the numbers and kinds of drugs brought to the shelter and the numbers of children.

Since neither the program objectives for outcome nor the individual's stated objectives for her stay were recorded we cannot compare these to written policies of the shelter. The percentage returning is an indicator of program success assuming that one objective of the program was that women would no longer need this accomodation. About 80% of women did not return for subsequent admission; an indication of very good success. We must keep in mind that the return of some women is more reflective of the lack of success of other programs (eg. enforcement of "Peace Bonds", counselling of the husband) than on the shelter program. This is indicated by the readmission of separated and divorced women.

Several process evaluations of the service are possible from the data. For instance, how appropriate were admissions, how available was the service, how long did women stay, and how did women hear of the service? Few women admitted (1%) had at the time of their first call been considered inappropriate for admission. It appears that appropriate clients are calling the shelter or are being

referred there and that staff are consistent in their assessments. This is supported by the fact that 93% of all admissions made during the period of study were women abused by their spouse; only 7% who had other problems.

We saw from the times of admission that women took advantage of the service on nearly a 24 hour basis. The fact that no women were admitted between five and eight in the morning may indicate that in cases where the precipitating crisis immediately preceeded admission it was most likely to occur before 3 or 4 a.m. In other cases the women would wait until morning or later to be admitted. Again we do not know how often the service was used in this time period for telephone counselling. The provision of 24 hour service was in keeping with the acceptance of referrals from other 24 hour emergency services such as hospitals and police departments which made the highest percentages of agency referrals.

It appears from the data on month of admission and length of stay that part of the difficulty with lack of beds is accounted for by some residents staying longer than the six week guideline. This occurred most often in Year 2, the year with the fewest admissions. In Year 3 when the average length of stay was less more admissons stayed under 3 weeks there was a greater number of admissions.

A subtle shift in service from strictly crisis intervention services towards a combination of these and more long-term counselling, intervention, and follow-up

services is indicated by the data. The shorter lengths of stay in Year 3 may be partly explained by the fact that approximately a third of admissions were multiple admissions. It is reasonable that women in subsequent admissions would need less time than women in first admissions to decide how they wanted to proceed and what their goals were. The consequence of longer lengths of stay appears to be that fewer first time admissions can be made. This issue should be addressed by the service in program planning and evaluation.

Since the number of children admitted with a women did not vary substantially from year to year this did not seem to affect length of stay or availability of beds.

The fact that 30% of women admitted were self-referrals points to the importance of a general publicity campaign. Women need to know that the service exists and how to contact it. Eighteen percent of women heard of the shelter through publicity and 25% through friends. Women also need to be able to identify themselves as someone who could use the service. Such a publicity campaign would be less time consuming for the shelter in its outreach efforts than doing such things as professional training. The responsibility for education in other agencies and/or professions aimed at increasing referral rates would have to be carried by government and appropriate associations (eg. provincial

medical or social work associations).[74]

This study indicates that there is a need for better record keeping and evaluation techniques in this shelter. Unfortunately the only form apparently designed with program evaluation as a goal (the IOD) was used very little during the period of study; however, the items that were completed often enough to warrant reporting indicated that, upon departure, residents were generally pleased with the help provided to them by the staff and had found their stay helpful.

The shelter should examine the departure and evaluation processes. We noted that the Information on Departure form was unavailable for many women and incomplete for most others. This form is the only form left for women to complete themselves. This could indicate that staff do not spend much time with residents discussing their departure and their feelings about the stay, the program, and their future plans. It could also mean that this form is inappropriate for use during or after such a session. It is designed for quick completion (multiple choice) and does not lend itself to individual responses. Also, on the face of it, this form would appear to be of little direct benefit to the woman.

Keeping in mind the waiting list and the demand for

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[74] See Chelimsky (1981) for a discussion of how some agencies resist change towards serving victims.

crisis service it is possible that once a woman decides to leave the shelter and has alternative accomodation arranged she moves quickly and her departure is overshadowed by the current crises of other residents and of new admissions. The handing out of a form on departure as compared to the administration of admission forms by staff implies that this form is less important; perhaps it gives the women the same message about her daparture. A shorter and simpler Information on Departure form could record plans for accomodation and follow-up information; another system more in keeping with the shelters other procedures could be established to record individual feedback and concerns.

The results of this study point to the need for follow-up and support programs for women after they leave the shelter to ensure that they know how to use the social service system successfully. Of the 7% admitted because of other problems about a quarter had problems due to a lack of housing and the majority of these admissions were former residents of the shelter who had previously been admitted because of spousal abuse.

Future evaluations of shelter services should examine the impact on women and their children of being denied crisis housing immediately when it is requested. This shelter provided space on distress call sheets for an answer to the question "When is it safe to call?" because women often said not to call them at all because their husband would retaliate with violence if he found out that they had

made such a contact. What kind of stress and other problems does being on a waiting list create for a woman? Does she tell her children to prepare for a quick move or hide the information for fear they'll let it slip? Does she live with the anxiety that "her" bed will be given away if she doesn't get to a phone on a certain day? Is she, in fact, placed in greater danger of abuse? We can surmise answers to some of these questions but we need information from the women themselves on this issue.

The importance of the role of second stage housing in preventing repeated admissions to shelters must be studied. Kirby House which opened in Year 3 appears to account for the difference in numbers of first and of multiple admissions who return to their spouses. This raises an interesting question: If second stage housing was available to first and second admissions, would they be less likely to need subsequent admissions? In other words, do women return to spouses (and to unchanged relationships) because the support associated with other alternatives is low. The main alternatives are a separate home or living with relatives. In the first case, women, besides being lonely, are vulnerable to break-ins and attacks from their estranged husbands. They must deal with all of the daily problems associated with single parenthood on their own. In the latter case conditions may be crowded or the family may impose their ideas of appropriate plans or behavior on the women.

One paper on second stage housing was located in the literature. This paper points out

> Protection from continued assaults by their husbands, even after the women have left home, has been determined to be most crucial need facing battered women, according to many researchers and Transition House workers... Unfortunately, lack of protection has also been recognized as a major shortcoming of law enforcement and legal services in Canada. The experience of one resident offers further evidence of this fact: in order to be safe she had to move to Vancouver and Munroe House[75] from a city in eastern Canada. In this case and others, peace bonds and restraining orders were not effective - they were ignored - according to several residents. Clearly, transition houses and second stage housing will be essential sources of safety and security until protection through legal action is a reality.
>
> Time to plan for the future, to "get used to being alone," and to deal with the practical aspects of "a new beginning," was a reason many residents gave for wanting to come to Munroe House. Women also said they needed time to "get stronger," relax, and re-establish their relationships with their children. (Women's Research Centre, 1980, pp.21-22)

To summarize, we have identified a number of areas where we have insufficient information to make program or policy recommendations for battered women; for instance, we do not know where professional women who are abused go if they do not use a shelter. We also do not know what sources of help the women admitted to the shelter had used before and whether they received the help they requested. If they did not, was that part of the process that led them to the

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[75] Munroe House is a second stage house in Vancouver. The study reported that another woman was transferred to an Ontario shelter.

shelter? And, if women are placed on a waiting list, a common occurrence in shelters across the country, what impact does this have on their lives? Is there a difference in application of crisis intervention theory to battered women; for instance, do some battered women make long range plans for change after a crisis has occurred and appear in the meantime to be indecisive? What services do battered women use if they do not use the shelter?

Improved recording techniques would provide a data base that would be helpful in understanding wife abuse and in planning and evaluating services. There are currently four shelters operating in this province and a fifth is scheduled to open in the winter of 1985/86. It would be desireable for each shelter to collect similiar data so that regional comparisons could be made. Experience from this study indicates that data collection is not a priority of shelter staff nor are forms well suited to evaluation or research. This is understandable considering the numbers of women and children served and the myriad problems addressed; however, as the issue of wife battering and provision of shelter beds loses its status as headline news, shelters and groups wishing to provide such services are going to need documentation which will help them in the competition they will face with other groups demanding scarce government and private funds. Already, there are demands for services to the batterers even though the studies used to support these demands question the efficacy of the services (see "Therapy programs", 1985; "Violent men suffer", 1985).

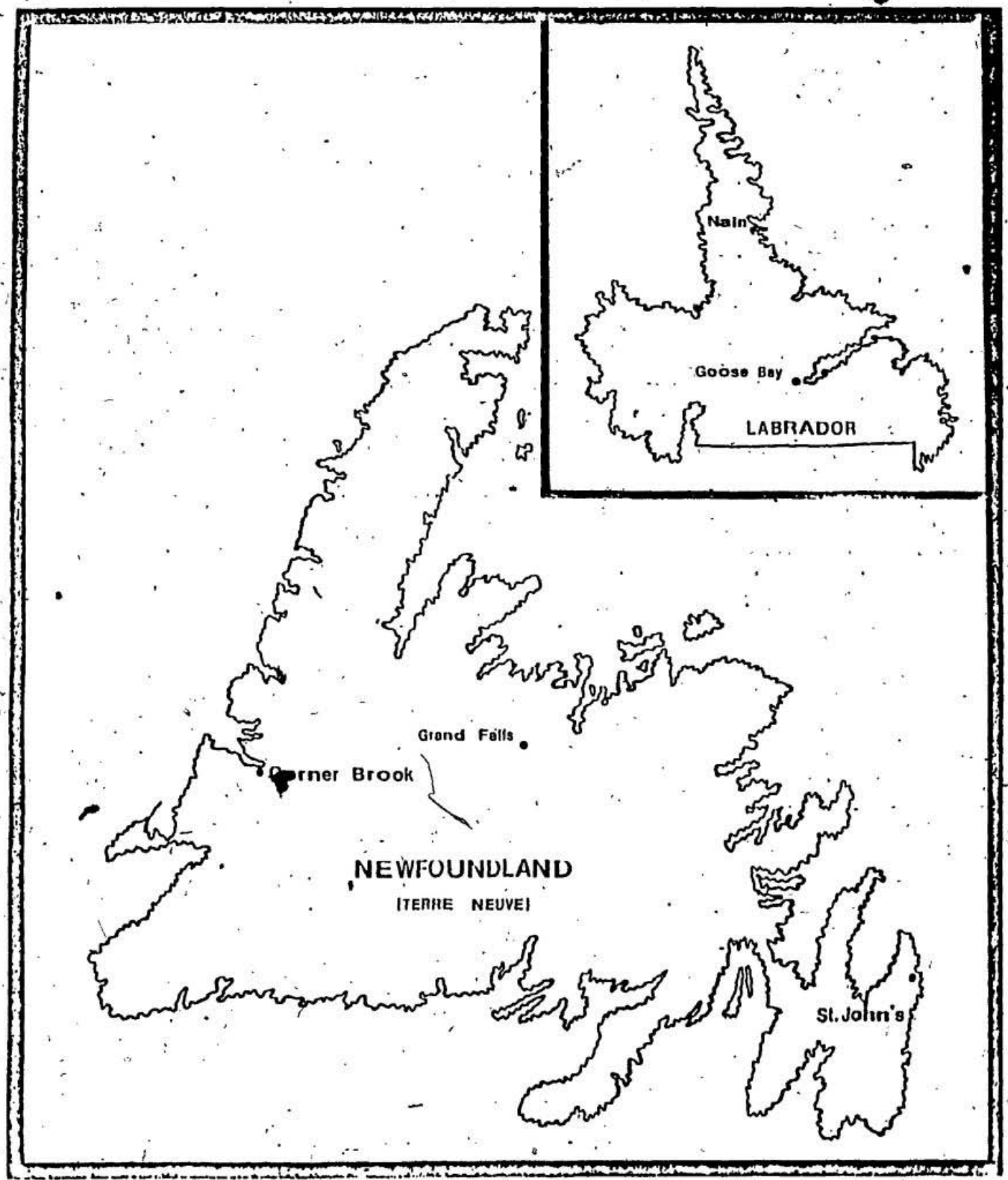
The Canadian Hospital Association and its provincial counterparts should be concerned with the response of the agencies they represent to primary, secondary, and tertiary prevention of wife abuse. For example, they might ask how many hospital emergency departments are effective in identifying wife abuse and do they have protocols for dealing with these cases? Governments should be concerned with reducing hospital and other medical care costs through early identificaton of wife abuse and appropriate intervention. Information is needed on why professionals make so few referrals to shelters; do they fail to identify battered women; do they see a medical response as most appropriate; do they not see a shelter as a professional service; or are they simply unaware of the service?

Finally, we do not know what causes battered women to identify abuse and to take action to prevent it from happening again. Do prescription drugs interfere with this process or does the need for these drugs and the contact with a doctor contribute to a woman seeking help? How can we encourage health seeking and health maintaining behavior in battered women? What impact would this have on the family as a whole and on the extended family?

Answers to these questions will help us to deal more effectively with this important and costly social problem.

Appendix A

Map of Newfoundland and Labrador


Nain
Goose Bay
LABRADOR
Grand Falls
Corner Brook
NEWFOUNDLAND
(TERRE NEUVE)
St. John's

Appendix B

Shelter Forms

B.1 Emérgency Admission Form

EMERGENCY ADMISSION FORM

Name:_____ Date:_____
Time:_____
Staffer:_____

Referred by:_____

Children	With Mother Now or Where Placed	Legal Status (ie. Foster, Stepchild)	Boy or Girl	Age

Persons to Call in Case of Emergency:_____
_____

Brief description of circumstances leading to admission (include witnesses):_____
_____
_____

Have children experienced any physical abuse in last 2 wks?
Describe briefly:_____
_____

Name of doctor who treated woman and children at time of admission to Transition House:_____

B.2 ADDITIONAL INTAKE INFORMATION

ADDITIONAL INTAKE INFORMATION

Date Completed:_____
Staffer:_____

1. Age: Woman_____ Spouse_____

2. Citizenship: Woman_____ Spouse_____

3.a) Province of Most Recent Residence: Woman_____
Spouse_____

b) (If Nfld.)Town of Most Recent Residence: Woman_____
Spouse_____

c) (If Nfld.)Region of Province - Woman:

Avalon Peninsula	_____	South Coast & Burin Pen.	_____
Central	_____	Eastern	_____
West Coast	_____	Northern Pen.	_____
Labrador	_____		

4. Relationship to Abuser: Married_____ Common Law _____
Divorced _____ Other(Specify) _____

5. Formal Education Status:

	Woman	Spouse
School Grade Achieved	_____	_____
Other Training(Specify)	_____	_____
Occupation	_____	_____

6. Main Source of Income Prior to Admission:

	Woman	Spouse
Paid Employment (Type)	_____	_____
Unemployment Insurance	_____	_____
Social Assistance	_____	_____
Financially Independent	_____	_____
Spouse Supported	_____	_____
Other (Specify)	_____	_____

7. Length of Time in Present Relationship_____

8. Length of Time Abused: Woman_____ Child_____

9. Major Problems in Relationship:

Woman - Physical Abuse	_____	Child - Physical Abuse	_____
Sexual Abuse	_____	Sexual Abuse	_____
Psychol. Abuse	_____	Psychol. Abuse	_____

10. How Recently Abused: Woman _____ Child _____
Comments:_____
_____

11. Woman:
Has abuse ever necessitated medical attention? _____
How many times? _____
Has it resulted in Bruising_____ Burns_____ Fractures___
Stitches_____ Other(Specify and include emotional)____
_____
Have you ever been hospitalized?____ How many times?___
Did you give information about the cause of injury at that time? Yes_____ No_____
Response from this doctor/hospital _____

12. Child:
Has abuse ever necessitated medical attention? _____
How many times? _____
Has it resulted in Bruising_____ Burns_____
Fractures_____ Stitches_____ Other(Specify and include emotional)_____

13. Did lack of money cause conflict in your relationship?
Yes_____ No _____

14. Were there problems due to alcohol use? Yourself_____
Spouse_____
Due to drug use? Yourself_____ Spouse_____

15. Have you left this relationship before? _____
How many times? _____

16. Have you sought help from other agencies or individuals before T.H.? Specify_____

17. How did you hear about Transition House?
a) Publicity
b) Agency (Specify)
c) Professional (Specify)
d) Friend
e) Other (Specify)

6/14/83

B.3 MEDICAL FORM

Medical Form - Woman

Date:_____

Name:_____
Birthdate:_____
MCP Number:_____

1. Have you experienced physical abuse within the last two weeks? Describe briefly:

2. Describe any current or chronic medical problems (diabetes, rashes, etc.)

3. Are you or could you be pregnant?

4. Prescription and/or nonprescription drugs (list and note if you have them with you).

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

5. Any allergies to drugs or other things?

_____ _____
_____ _____

6. Name of current doctor or specialist: _____

7. Next of Kin:_____

Staffer:_____

Update: (Staff - Initial Entries)
1. Any medical treatment required and/or received during stay:_____
2. Any changes in prescriptions:_____
3. Any consultation on medical needs:_____

6/14/83

B.4 DISTRESS CALL SHEET

DISTRESS CALL SHEET

PHONE #:_____ DATE:_____

SAFE TO CALL?_____ TIME OF CALL:_____

WHEN?_____ LENGTH OF CALL:_____

STAFFER:_____

NAME:_____ AGE:_____

ADDRESS:_____
_____
_____

NUMBER OF CHILDREN:_____ NAME AND AGE:
_____
_____
_____

IMMEDIATE SITUATION:_____
_____
_____
_____
_____

THIS WOMAN IS APPROPRIATE FOR OUR SHELTER_____
_____WILL BE COMING
_____WE HAVE NO ROOM
_____IS ON WAITING LIST
_____IS SEEKING ALTERNATIVE
SHE IS NOT APPROPRIATE. REASON_____
SHE MAY CALL BACK FOR SUPPORT_____

RESULT/ACTION PLAN:_____
_____
REFERRED BY:_____
OTHER COMMENTS:_____

B.5 INFORMATION ON DEPARTURE

INFORMATION ON DEPARTURE

NAME:_____ DATE:_____

STAFFER:_____

1. HOW DID YOU FIND YOUR STAY AT TRANSITION HOUSE?

VERY HELPFUL _____
HELPFUL _____
SATISFACTORY _____
NOT HELPFUL _____

2. HOW HELPFUL DID YOU FIND THE STAFF?

VERY HELPFUL _____
HELPFUL _____
SATISFACTORY _____
NOT HELPFUL _____

IF HELPFUL, IN WHAT WAYS?_____

IF NOT HELPFUL, IN WHAT WAYS?_____

3. HOW DID YOU FIND THE OTHER RESIDENTS?

VERY COOPERATIVE _____
COOPERATIVE _____
SATISFACTORY _____
UNCOOPERATIVE _____
VERY UNCOOPERATIVE _____

4. HOW DID YOUR STAY AT TRANSITION HOUSE AFFECT YOUR FEELINGS ABOUT YOURSELF?

IMPROVED _____
NO CHANGE _____
WORSE _____

GENERAL COMMENTS:_____

5. HOW HELPFUL WAS YOUR STAY AT TRANSITION HOUSE FOR YOUR CHILDREN?

VERY HELPFUL _____
HELPFUL _____
SATISFACTORY _____
NOT HELPFUL _____

6. HOW HELPFUL WAS YOUR STAY AT TRANSITION HOUSE FOR YOU AS A PARENT?

VERY HELPFUL _____
HELPFUL _____
SATISFACTORY _____
NOT HELPFUL _____

IF HELPFUL, IN WHAT WAYS:_____

IF NOT HELPFUL, IN WHAT WAYS FOR YOU AND YOUR CHILDREN?_____

7. WHERE WILL YOU STAY AFTER YOU LEAVE?
   - HOME WITH HUSBAND_____
   - OWN HOME OR APT _____
   - BOARDING HOUSE _____
   - WITH RELATIVES _____
   - WITH FRIENDS _____
   - OTHER (SPECIFY) _____

8. WHICH OTHER SERVICES WERE CONTACTED BY YOU DURING YOUR STAY AND WERE THEY HELPFUL? (YES OR NO)
   - LEGAL AID _____
   - LAWYER _____
   - UNIFIED FAMILY COURT _____
   - PROVINCIAL COURT _____
   - SOCIAL ASSISTANCE _____
   - CHILD WELFARE _____
   - DOCTOR _____
   - N.L.H.C.- HOUSING _____
   - PSYCHIATRIST _____
   - HOSPITAL(NAME) _____
   - ALCOHOLICS ANON. _____
   - AL-ANON _____
   - CANADA EMPLOYMENT _____
   - CANADA IMMIGRATION _____
   - SCHOOL _____
   - WOMEN'S CENTER _____
   - DAY CARE _____
   - TH EMPLOY. PROJECT _____
   - TH SUPPORT GROUP _____
   - OTHER (SPECIFY) _____

9. HOW WILL YOU SUPPORT YOURSELF FINANCIALLY NOW?
   - PAID EMPLOYMENT _____
   - SOCIAL ASSISTANCE _____
   - UIC _____
   - FINANCIALLY INDEPENDENT _____
   - SPOUSE _____
   - OTHER (INDICATE) _____

10. AREAS YOU WOULD LIKE HELP WITH IN THE FUTURE;
    - PHYSICAL HEALTH PROBLEMS (SPECIFY)_____
    - MENTAL HEALTH PROBLEMS (SPECIFY)_____
    - DRUG ADDICTION_____
    - ALCOHOL ADDICTION_____
    - PARENTING PROBLEMS_____
    - LEGAL MATTERS_____
    - ADJUSTING TO LIVING ON YOUR OWN_____
    - MARRIAGE COUNSELLING_____
    - OTHER (SPECIFY)_____

11. FOLLOW-UP? YES _____ NO_____ BY WHOM?_____
IF YES, WHAT ARE CONVENIENT TIMES AND PREFERRED WAYS TO MAKE CONTACT?_____

12. WHERE CAN BE REACHED?
PHONE NUMBER: _____ ADDRESS: _____
_____

3/14/83

Appendix C.

Some Characteristics of Ineligible Cases

Table C-1: Region of Newfoundland

Region	Frequency	Percent
Avalon Peninsula	21	96
Eastern	1	4

Missing Cases=1

Table C-2: Age

Age (Years)	Frequency	Percent
15-20	6	26
21-25	6	26
26-30	5	22
31-35	1	4
36-40	2	9
46-50	2	9
61+	1	4

Mean 26-30
Missing Cases=0

Table C-3: Number of Children

Number	Frequency	Percent
0	11	49
1	5	22
2	2	9
3	4	17
11	1	4

Missing Cases=0

Table C-4: Source of Income

Source	Frequency	Percent
Paid Employment	2	11
UIC	1	6
Social Assistance	9	50
Spouse	2	11
Other	4	22

Missing Cases=5

Table C-5: Educational Level

Grade	Frequency	Percent
6	1	6
7	3	17
8	3	17
9	3	17
11	7	39
12	1	6

Missing Cases=5

Table C-6: Occupation

Type	Frequency	Percent
Social Service	1	6
Clerical	2	12
Homemaker	4	24
Fishery	4	24
Construction	5	29
Production	1	6

Missing Cases=6

Table C-7: Other Training Received

Source	Frequency	Percent
Trades College	1	12
Some University	3	38
University Degree	1	12
Professional Training Course (Unspecified)	1	12
Some (Unspecified)	1	12

Missing Cases=15

Table C-8: Type of Abuse

Type	Frequency	Percent
Physical	13	72
Sexual	4	22
Psychological	15	83

Missing Cases=5

Table C-9: Injuries from Abuse

Injury	Frequency	Percent
Bruising	6	50
Emotional	11	92
Swelling	2	17
Other	1	8

Missing Cases=11

Table C-10: Referral Agency

Referral	Frequency	Percent
Hospital	1	14
Legal Service	1	14
Private Social Service	4	57
Other	1	14

Missing Cases=16

Table C-11: Number of Children Admitted

Number	Frequency	Percent
0	19	83
1	2	9
2	1	4
3	1	4

Missing Cases=0

Table C-12: Length of Abuse

Length (Yrs.)	Frequency	Percent
1-5	2	18
6-10	3	27
11-15	1	9
21-25	1	9
26-30	2	18
several	2	18

Missing Cases=12

Table C-13: Length of Stay

Length	Frequency	Percent
1 or 2 days	8	35
3 days to 1 week	3	13
8 days to 13 days	1	4
2 to 3 weeks	3	13
22 days to 6 weeks	4	17
43 days to 8 weeks	2	9
57 days to 10 weeks	1	4
71 days to 12 weeks	1	4

Missing Cases=0

Appendix D

Definition of Occupations by Statistics Canada's Major Groups of Occupations

Administrative

- 11 Managerial, administrative and related occupations
- 21 Occupations in natural sciences, engineering and mathematics

Social Service

- 23 Occupations in social sciences and related fields

Teaching

- 27 Teaching and related occupations

Medicine

- 31 Occupations in medicine and health

Clerical

- 41 Clerical and related occupations

Sales

- 51 Sales occupations

Service

- 61 Service occupations

Farming

- 71 Farming, horticulture and animal husbandry occupations

Fishing

- 73 Fishing, hunting, trapping and related occupatons

Production

- 77 Mining and quarrying including oil and gas field occupations
- 81/82 Processing occupatons
- 83 Machining and related occupations
- 85 Product fabricating, assembling and repairing occupations

Forestry

- 75 Forestry and logging occupations

Construction

- 87 Construction trades occupations

Other

- 25 Occupations in religion
- 33 Artistic, literary, recreational and related occupations
- 91 Transport equipment operating occupations
- 93 Materials handling and related occupations
- 95 Other crafts and equipment operating occupations
- 99 Occupations not elsewhere classified

Appendix E

Data Sheets

WOMAN'S CODE _____
FORMS = EAF _____
AII-A _____
-B _____
MF _____
IOD-A _____
IOD-B _____
DCS _____

(DATA SHEET)

PROPERTY OF:
W. THURSTON

COMMUNITY MEDICINE

HEALTH SCIENCES CENTRE

POD-B, 737-6693

	(1-3)	THI
Woman's Code	(4-6)	_____
INTAKE BOOK(Intake Record Log)		
1) Date Admitted (D/M/Y)	(7-12)	_____
2) Date Departed (D/M/Y)	(13-18)	__/__/__
3) Total Days Stayed	(19-21)	_____
4) Number of this Admission	(22-23)	_____
5) Number of Admissions in Year 1	(24)	_____
6) Total # days in Year 1	(25-27)	_____
7) Number of Admissions in Year 2	(28)	_____
8) Total # days in Year 2	(29-31)	_____
9) Number of Admissions in Year 3	(32)	_____
10) Total # days in Year 3	(33-35)	_____
EAF		
11) Time of Admission	(36-37)	_____
12) Staffer	(38-39)	_____
13) Referred by - Agency	(40-41)	_____
14) Referred by - Individual	(42-43)	_____
15) # Female Children 0-2	(44)	_____
3-5	(45)	_____
6-10	(46)	_____
11-13	(47)	_____
14-15	(48)	_____
16+	(49-50)	_____
Age Not Given	(51-52)	_____
16) Total # Female Children	(53-54)	_____
17) # Male Children 0-2	(55)	_____
3-5	(56)	_____

6-10	(57)	_____
11-13	(58)	_____
14-15	(59)	_____
16+	(60-61)	_____
Age Not Given	(62-63)	_____
18) Total # Male Children	(64-65)	_____
19) Total # of Children (16+18)	(66-67)	_____
20) # Female Children Accompanying 0-2	(68)	_____
3-5	(69)	_____
6-10	(70)	_____
11-13	(71)	_____
14-15	(72)	_____
16+	(73)	_____
Age Not Given	(74)	_____
21) Tot. # Fem. Child. Accomp.	(75-76)	_____
22) # Male Children Accompanying 0-2	(77)	_____
3-5	(78)	_____
6-10	(79)	_____
11-13	(80)	_____
	(1-3)	TH2
WOMAN'S CODE	(4-6)	_____
22) Cont. 14-15	(7)	_____
16+	(8)	_____
Age Not Given	(9)	_____
23) Total # Male Children Accompanying	(10-11)	_____
24) Tot. # Child. Accomp. (21+23)	(12-13)	_____
25) # Children Abused Within 2 Weeks	(14)	_____

AII

26) Type of AII	(15)	_____
27) Date on AII (D/M/Y)	(16-21)	_____
28) Staffer	(22-23)	_____
29) Woman's Age	(24-25)	_____
30) Spouse's Age	(26-27)	_____
31) Woman-Prov. Most Recent Residence	(28)	_____
32) Man-Prov. Most Recent Residence	(29)	_____
33) Woman - Region Nfld.	(30)	_____
34) Woman- St. John's or Corner Brook	(31)	_____
35) Relationship to Abuser	(32)	_____
36) Woman-Highest School Grade	(33-34)	_____
37) Spouse-Highest School Grade	(35-36)	_____
38) Woman-Other Training	(37-38)	_____
39) Spouse-Other Training	(39-40)	_____
40) Woman-Occupation	(41-42)	_____
41) Employed by/Running Bus. w/ Spouse	(43)	_____
42) Spouse Occupation	(44-45)	_____
43) Woman-Source Income	(46-47)	_____
44) Spouse-Source Income	(48-49)	_____
45) Length Relationship	(50-51)	_____
46) Length Abuse-Woman	(52-53)	_____
47) Length Abuse-Child(ren)	(54-55)	_____
48) Type Abuse-Woman	(56-58)	_____
49) Type Abuse-Child(ren)	(59-61)	_____
50) Most Recent Abuse-Woman	(62)	_____
51) Most Recent Abuse-Child(ren)	(63)	_____

52) Required Medical Attention	(64)	_____
53) # Times Med. Attention Required	(65-66)	_____
54) Resulting Injuries	(67-74)	_____
55) Was Hospitalized	(75)	_____
56) # Times Hospitalized	(76-77)	_____
57) Gave Information	(78)	_____
	(1-3)	TH3
WOMAN'S CODE	(4-6)	_____
58) Response from Doctor/Hospital	(7-10)	_____
59) Woman Indicated Dr./Staff Asked	(11)	_____
60) Are There Problems Alcohol Abuse	(12)	_____
61) Are There Problems Drug Abuse	(13)	_____
62) Conflict Due to LAck of Money	(14)	_____
63) Problems Alcohol Use-Woman	(15)	_____
64) Problems Alcohol Use-Spouse	(16)	_____
65) Problems Drug Use-Woman	(17)	_____
66) Problems Drug Use-Spouse	(18)	_____
67) # Times Left Before	(19)	_____
68) Sought Help Before	(20)	_____
69) Heard About Transition House	(21-26)	_____
IOD		
70) Type of IOD	(27)	_____
71) Date on IOD (D/M/Y)	(28-33)	_____
72) Staffer	(34-35)	_____
73) Found Stay Beneficial	(36)	_____
74) Felt Helped	(37)	_____
75) How Found Stay	(38)	_____

76) How Found Staff	(39)	_____
77) How Found Other Residents	(40)	_____
78) Feel Condition Improved	(41)	_____
79) Feel Children Were Helped	(42)	_____
80) How Helpful Children's Program	(43)	_____
81) Affect Feelings About Self	(44)	_____
82) Stay Helpful For Children	(45)	_____
83) Stay Helpful as Parent	(46)	_____
84) Stay After Leaving	(47)	_____
85) Other Services Contacted	(48-62)	_____
		_____
86) Means Financial Support	(63-64)	_____
87) Areas Would Like Help	(65-72)	_____
88) Would Like Follow-up	(73)	_____
89) Address Left	(74)	_____
90) Telephone Left	(75)	_____
	(1-3)	TH4
WOMAN'S CODE	(4-6)	_____
MF		
91) MF Date (D/M/Y)	(7-12)	_____
92) # Chronic Medical Problems	(13)	_____
93) Pregnant	(14)	_____
94) Prescriptions.		
1. Major Tranq./Lithium	(15)	_____
2. Minor Tranq.	(16)	_____
3. Sedative/Hypnotic	(17)	_____
4. Anti-depressant	(18)	_____
5. Other	(19)	_____

DCS

95) Date First DCS (D/M/Y) (20-25) _____

96) # Distress Calls (26) _____

97) Date Last Distress Call (27-32) _____

98) Disposition, First DCS (33-34) _____

99) Referred by-Agency (35-36) _____

100) Referred by-Individual (37-38) _____

Appendix F

Summary of Results of Interrater Reliability Check

Average No. of different scores per case (Range: 6 - 31)	14.06
Average No. of cases with different scores per variable (Range: 1 - 45)	5.33
Average No. of blanks per case	
- Primary Researcher (Range: 0 - 21)	5.02
- Second Researcher (Range: 0 - 16)	5.06
Average No. of blanks per variable	
- Primary Researcher (Range: 0 - 25)	1.84
- Second Researcher (Range: 0 - 45)	1.92

Note: There were 50 cases and each case required 122 scores. Total number of scores over 50 cases equalled 6100.

Appendix G

Detailed Characteristics of Sample

Table G-1: Distribution of Study Population by Region of Province and by Year of Admission with Comparison to 1981 Census

Region	Census	Year 1 (n=95)	2 (n=72)	3 (n=126)	All (N=293)
AP[76]	43	86	84	89	88
SC/BP	10	0	4	2	2
WC	13	2	0	1	1
C	17	3	3	4	3
E	8	1	1	3	2
NP	4	0	0	0	0
L	5	4	3	1	2
OP		2	3	1	2

[76] AP=Avalon Peninsula; SC/BP=South Coast & Burin Peninsula; W=West Coast; C=Central; E=Eastern, Excluding above; NP=Northern Peninsula; L=Labrador; OP=Outside of Province

Table G-2: Distribution of Women By Age and by Year of Admission with Comparison to 1981 Census

Age	Census		Year			
	77 A	78 B	1 (n=92)	2 (n=75)	3 (n=125)	All (N=292)
15-19	11	11	2	1	3	2
20-24	9	10	16	27	19	20
25-29	9	17	15	29	30	25
30-34	8		17	17	16	16
35-39	6	11	21	19	10	16
40-44	5		10	3	10	8
45-49	4	8	5	4	3	4
50-54	4		5	0	5	4
55-59	4	8	2	0	2	2
60-64	3		3	0	0	1
65+	8	10	0	0	0	0
Range			18-60	19-47	18-56	18-60
Mean			35	29	31	32

77 Province

78 Division 1, Avalon Peninsula

Table G-3: Distribution of Spouses by Age and by Year of Admission with Comparison to 1981 Census

Age (Years)	Census [79] A	Census [80] B	Year 2 n=46	Year 3 (n=107)	All (N=153)
15-19	11	11	0	3	2
20-24	9	9	13	8	10
25-29	8	9	24	17	19
30-34	8	8	30	32	31
35-39	6	6	13	13	13
40-44	5	5	4	11	9
45-49	4	4	6	5	5
50-54	4	4	6	5	5
55-59	4	4	2	6	5
60+	10	12	0	1	1
Mean [81]			33	35	34

[79] Province

[80] Division 1, Avalon Peninsula

[81] The range of scores for Year 2 was 22 to 58; for Year 3 it was 18 to 62.

Table G-4: Distribution of Women by Occupation and by Year of Admission with Comparison to 1981 Census

Occupation	Census 82 A	83 B	Year 1	2	3	All
n=			(55)	(49)	(86)	(N=190)
Administration	4	5	0	2	8	4
Soc. Services	1	2	0	2	1	1
Teaching	8	7	2	0	2	2
Medicine	9	11	0	2	1	1
Clerical	30	34	2	8	16	10
Sales	10	9	0	4	6	4
Service	17	16	16	18	22	20
Homemaker [84]			69	39	29	43
Fishery	.3	.1	0	8	6	5
Student			2	0	0	1
Unemployed	19	19	5	14	8	9
Other [85]	15	13	4	2	0	2

[82] Province

[83] Division 1, Avalon Peninsula

[84] Homemaker and Student were not included in Statistics Canada's list of occupations.

[85] Includes the categories of Religion, Artistic, Farming, Forestry, Production, Construction, Transport, Material Handling, Other Crafts, and Not Elsewhere Specified.

Table G-5: Distribution of Spouses by Occupation and by Year of Admission with Comparison to 1981 Census

Occupation	Census 86 A	87 B	Year 2	3	All
n=			(40)	(89)	(N=129)
Administration	11	15	10	10	10
Soc. Services	1	1	0	0	0
Teaching	4	4	0	0	0
Medicine	2	3	2	2	2
Clerical	6	8	1	1	1
Sales	7	8	0	0	0
Service	8	9	12	9	10
Farming	1	1	0	0	0
Fishery	9	5	5	14	11
Construction	14	15	28	24	25
Production	19	15	5	16	12
Forestry	3	.2	2	2	2
Student			0	2	1
Other[88]	17	16	15	8	10
Unemployed	17	17	20	12	16

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[86] Province

[87] Division 1, Avalon Peninsula

[88] Includes the categories of Religion, Artistic, Transport, Material Handling, Other Crafts, and Not Elsewhere Specified.

Table G-6: Number of Children in Family by Year of Admission with Comparison to 1981 Census

Number Children n=	Census Nfld.	89 A	Year 1 (96)	2 (75)	3 (126)	All (N=297)
0	21	23	9	13	10	11
1	24	24	16	24	18	19
2	26	28	29	32	33	32
3	15	14	15	17	15	16
4	7	6	15	13	14	14
5	3	2	6	0	5	4
6	2	1	4	0	4	3
7	1	.4	1	0	0	.3
8+	1	.2	5	0	1	2
Mean			3	2	2	2
Range			0-11	0-4	0-8	0-11

89 Divison 1, Avalon Peninsula

Table G-7: Educational Level of Women by Year of Admission With Comparison to 1981 Census

Grade	Census	Year 2 (n=50) %	3 (n=109) %	All (N=159) %
<Grade 9	29	32	34	34
9-13	71	66	66	66

Table G-8: Educational Level of Spouses by Year of Admission With Comparison to 1981 Census

Grade	Census	Year 2 (n=39) %	3 (n=88) %	All (N=127) %
<Gr.9	32	33	39	37
9-13	68	67	61	63

Table G-9. Marital Status by Year of Admission with Comparison to 1981 Census

Marital Status n=	Census	Year 1 (96) %	2 (75) %	3 / (126) %	All (N=297) %
[90] Married	44	96	93	92	94
Separated	1	4	5	6	5
Divorced	1	0	1	0	.3
Widowed	6	0	0	0	0
[91] Single	19	0	0	2	1

[90] Included cohabitating couples.

[91] 15 years and over

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