Development of the Woman Abuse Screening Tool

By

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Dissertation Approval Form

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Researchers reported that 25%-33% of female trauma victims had injuries caused by battering. More than one million women per year seek medical care for injuries caused by battering. Of those who seek medical care, only one in ten is officially identified as a battered woman. Women are routinely screened for a variety of problems, conditions, or medical disorders, but violence is not included. An important issue related to identifying battered women is the lack of an appropriate comprehensive screening tool.

The purpose of this study was threefold: (a) determine whether using a comprehensive abuse screening tool results in an increased identification rate of battered women greater than what has been reported in other studies; (b) identify if verbal/emotional abuse are precursors of physical violence; and (c) test specific psychometric properties.

The sample consisted of 438 women ranging in age from 18 to 78 years. Twenty-six percent of the women reported being in abusive relationships. The results of the paired-samples sign test indicated that verbal/emotional abuse are precursors of physical abuse at a .05 significance level.
The specific psychometric properties tested were internal consistency, content validity, and discriminant validity. The results of data analysis indicated that the WAST is highly reliable (Chronbach's alpha = .93 for physical abuse and .91 for verbal/emotional abuse). Factor analysis and examination of content by experts in the field suggest good content validity. The results of discriminant analysis indicated that the WAST is able to discriminate between battered and non-battered women. The analysis correctly classified 94.44% of the cases.

The results of this study may help health care professionals identify battered women and determine when women are at risk of being abused.
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Author's Signature
Dedication

To Michael and "Stash".
Acknowledgment

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Chapter 1

Development of the Woman Abuse Screening Tool

Introduction

Annually, millions of Americans nationwide are affected by domestic violence. Family violence can occur against males, but the majority of victims are women and children (Campbell & Humphreys, 1993; Sampselle, 1992; Sheridan, 1990; Okun, 1986). It is estimated that 3-4 million women are physically abused in their homes each year by an intimate partner (Koop, 1989; Stark & Flitcraft, 1988). One estimate reported that as many as 12 million women nationwide were involved in abusive relationships (Johnston & Koflanovich, 1991). This translates into a woman being beaten every 15 seconds in the United States (Bunch, 1992). Every country has reported intentional battering of women. Abuse of females crosses all social, racial, religious, ethnic, and national boundaries (Campbell & Humphreys, 1993; Koop, 1989; Stark & Flitcraft, 1988; Stacey & Shupe, 1983). Other studies have shown that black women are twice as likely to be abused as white women yet other authors reported that black women are twice as likely to report the abuse compared to white women (Stark & Flitcraft, 1991; Straus, Gelles, & Steinmetz, 1988). Lockhart (1985) and Cazenave and Straus (1979) found that the differences in husband to wife abuse between African/Americans and whites are related to social class. Some researchers reported that abuse is more prevalent in lower class families while others reported that there are no differences in prevalence rates of abuse between lower class families and middle to upper class families (Lockhart, 1985; Cazenave & Straus, 1979; Stark & Flitcraft, 1988; Hillard, 1985; Stacey & Shupe, 1983). In Fall 1985, Dr. C. Everett Koop, former surgeon general, declared domestic violence a major public health problem (Koop, 1985).
Straus, Gelles, and Steinmetz (1988) conducted a national survey which specifically measured violent acts among families or those living in the same household. The sample consisted of 2,143 individuals. Their results indicated that there are 3.9 million instances of spouse abuse every year. The Federal Bureau of Investigation (FBI) (1986) reported that 30% of female homicide victims were murdered by a husband or boyfriend (Reiss & Roth, 1990). It is difficult to gather accurate epidemiological data on domestic violence due to under-reporting, lack of uniform identification procedures, difficulty in defining domestic violence, and failure to record the abusive incident in the medical records of those seeking medical treatment for injuries sustained in an assault.

Statement of the Problem

Researchers reported that 25%-33% of female trauma victims had injuries caused by battering (Campbell, 1989; McLeer & Anwar, 1989; Stark, Flitcraft & Frazier, 1979; Goldberg & Tomlanovich, 1984). Stark and Flitcraft (1981) found that domestic violence accounts for more injuries to women than rapes, muggings and motor vehicle accidents combined. In general, it is believed that the severity of injury in domestic violence cases is greater than the severity of injuries sustained in stranger assault (Varvaro, 1989; Taylor & Campbell, 1992).

In 1980, the National Crime Survey (NCS) reported that 30,000 emergency room visits, 40,000 visits to physicians, 21,000 hospitalizations, and 100,000 days of hospitalization were associated with domestic violence (McLeer & Anwar, 1989; Varvaro, 1989). This survey further indicated that battering may be the foremost cause of injury to women. More than one million women per year needed medical care for injuries caused by battering (Koop, 1989; Deckstein & Nadelson, 1986).

Traumatic injuries from family violence range from mild to life-threatening. Injuries include, but are not limited to, bruises in various stages of healing, fractures, black eyes, ear injuries, abdominal injuries, miscarriages related to trauma to the abdominal area, stab wounds, gunshot wounds, head trauma, and suicide attempts.
Increasingly, domestic violence is seen as a life-long health problem beginning for some in utero. The cycle continues as child abuse, battering in adulthood, and finally culminating in elder abuse (Taylor & Campbell, 1992; Campbell & Sheridan, 1989; Varvaro, 1989; Helton, McFarlane, & Anderson, 1987; Stacey & Shupe, 1983).

It is difficult to determine the true incidence of battering during pregnancy but there is evidence to indicate that it is not a rare occurrence. Estimates based on recent studies of women who were battered while pregnant ranged from 3.9% to 8% (Hillard, 1985; Helton, McFarlane, & Anderson, 1987; Campbell, Poland, Waller, & Ager, 1992; Amaro, Fried, Cabral, & Zuckerman, 1990). In a study conducted by Hillard (1985) 742 women who attended an obstetrics clinic for prenatal care were screened for physical abuse during their first visit to the clinic. Eighty one (10.9%) of the 742 women were positive for physical abuse. Another 29 (3.9%) reported being abused during the current pregnancy. Twenty-nine (3.9%) of the 81 women reporting abuse were abused during their current pregnancy. Abuse during pregnancy increased for 21% of the 81 women who were positive for abuse. For 36% of the 81 battered women the abuse decreased during their pregnancy. There was no change for the other 43%.

Four of the women who were not abused when the initial screening took place subsequently reported being abused at a later stage of the pregnancy.

Helton, McFarlane, and Anderson (1987) conducted a study of 290 pregnant women in an attempt to determine the prevalence of women who were battered while pregnant. The participants were randomly selected from 6 public clinics and 2 private clinics. The 6 public clinics were randomly selected, the 2 private clinics were not. The authors reported that 68 (23%) of the 290 women reported being battered before or during their current pregnancy. Twenty-four (8%) women reported being battered during their current pregnancy and 44 (15%) reported battering prior to becoming pregnant. Another 7 (10.3%) of the 24 women reported that the physical abuse increased while they were pregnant (Helton, McFarlane, & Anderson, 1987).
addition, when questioned about abuse, 26 (9%) displayed behaviors indicative of battering as evidenced by crying, anxiety, and ambivalent statements such as "Don't all men hit?" (Helton & Snodgrass, 1987, p. 145).

A study of 1,243 pregnant women conducted by Amaro, Fried, Cabral and Zuckerman (1990) indicated that 92 (7%) of the participants reported experiencing physical or sexual abuse by an intimate partner while pregnant. Campbell, Poland, Waller and Ager (1992) reported that 7% of 488 pregnant women in their study reported being physically abused while pregnant. Another 1.2% reported being physically assaulted by someone other than their current partner while they were pregnant. This brings the total of women in this study who were physically assaulted while pregnant to 8.2%. However, the results of a study conducted by McFarlane, Parker, Soeken, and Bullock (1992) indicated that 17% of 691 women reported being physically and/or sexually abused during their current pregnancy. In an earlier study of 542 battered women from shelters in the Dallas-Fort Worth metropolitan area, 42% reported being battered while pregnant. Another 8% reported they had complications as a result of the physical violence (Stacey, & Shupe, 1983).

Injuries to pregnant battered women tended to focus around the abdomen, breasts, and genitals. Many of the injuries were caused by punches, kicks, or other types of blows. Many reported being sexually assaulted by their partners as well. Battering during pregnancy is associated with miscarriages, stillbirths, low birth weight infants, pre-term deliveries, substance abuse, as well as placental separation, antepartum hemorrhage, fetal fractures, and rupture of the uterus, liver, or spleen (Campbell, Poland, Waller, & Ager, 1992; Browne, 1991; McFarlane & Parker, 1991; Amaro, Fried, Cabral, & Zuckerman, 1990; McFarlane, 1989; Helton, McFarlane & Anderson, 1987).

The Surgeon General's Workshop on Violence and Public Health (1985) concluded that pregnancy put women at high risk for battering and suggested that all pregnant
women be routinely screened for abuse. Many women will not volunteer this 
information but will report it if asked. If the nurse discovers the presence of violence it 
is her responsibility to intervene. She can either refer the woman to someone who is 
familiar with abuse issues or, at a minimum, refer her to a community agency or 
shelter where she can get the help she needs. Intervention at this stage may help prevent 
future health problems or complications for both mother and baby.

Many battered women do not seek or require medical attention for their injuries. 
Of those who seek medical care, only one in ten is officially identified as a battered 
woman by nurses and physicians (Randall, 1990; Varvaro, 1989; Warshaw, 1989; 
Stark, Flitcraft, & Frazier, 1979). The identification and treatment of battered women 
by health care personnel may be a positive interaction, a negative interaction, or non- 
existent (Varvaro, 1989; Warshaw, 1989). A positive response may actually facilitate 
the battered woman’s decision to leave the abusive relationship. A negative response will 
only serve to re-victimize the woman and reinforce or condone her partner’s abusive 
evidence of inappropriate responses to battered women by the medical profession. Their 
findings indicated that in most cases the battering is denied by the health professional or 
its importance is diminished. They also found that battering was not a high priority for 
health care providers. Medical responses to battered women focused on physical 
injuries caused by battering and had a tendency to blame the victim for staying in the 
abusive relationship (Taylor & Campbell, 1992; Warshaw, 1989; Kurz & Stark; 
1988; Varvaro, 1989; Campbell, 1988; Rosewater, 1988).

Reasons for inappropriate responses or no response by the health care 
professional may stem from lack of knowledge or training in abuse issues, fear of 
offending the patient, time constraints (Sugg & Inui, 1992), myths, misinformation, 
sexist bias, the structure of the medical model (Warshaw, 1989; Tilden, 1989; Kurz, & 
Stark, 1988), and failure to believe the woman’s story (Hilberman, 1980). Pagelow
(1981), Mitchell and Hodson (1983), Walker (1984) and Varvaro (1989) postulated that any one of the above factors or a combination of the factors affected the battered woman's decision to leave or end an abusive relationship (Taylor & Campbell, 1992). Pagelow (1981) specifically states:

The fewer the resources, the more negative the institutional response; and the more intense the traditional ideology of women who have been battered, the more likely they are to remain in relationships with the batterers and the less likely they are to perform acts that significantly alter the situation in a positive direction (pg. 46).

It is important to treat not only the battered woman's injuries but to attend to her emotional needs as well. Nurses and physicians are in an ideal setting to identify, assess, and intervene with battered women. Battered women have increased health problems and make more frequent visits to health care facilities (Bergman & Brismar, 1991; Warshaw, 1989; Goldberg & Tomlanovich, 1984; McLeer & Anwar, 1987, 1989; Stark, Flitcraft, & Frazier, 1979, 1981). It has been reported that the development and use of written policy and protocols increased the identification of battered women by more than five-fold (McLeer & Anwar, 1989). Often the nurse or physician is the first person outside the home to discover that a woman is being brutalized by her intimate partner. Health care personnel play a vital role in breaking the vicious cycle of violence through identification, assessment and intervention with battered women (Taylor & Campbell, 1992).

The seriousness of domestic violence has largely been ignored in our society. This is partly due to the many myths and misconceptions surrounding domestic violence issues, denial of its existence by the health care practitioner, the shame and stigma attached to those involved in abusive relationships, and public policy which tends to preserve the privacy and sanctity of the family domain. Whether identified or not, battered women are found in almost all areas of the health care system (Bullock, 1989).
Stark and Flitcraft (1988) reported that the majority of battered women presented to general medical, behavioral, or psychiatric settings for treatment. They also found that only 8% of non-battered women compared to 19% of battered women were more likely to present with depression, anxiety, and/or marital, sexual, family problems. Only 3% of non-battered women presented with vague medical complaints compared to 12% of battered women (Stark & Flitcraft, 1988). Hillard (1985) reported that 17% of abused women compared to 3% of non-abused women in a sample of 742 pregnant women screened for physical abuse, were prescribed medication for "nerves". Forty-three percent of the abused women complained of problems with "nerves" compared to 5% of the non-abused group. Fourteen percent of abused compared to non-abused women in the sample had a history of depression. Fifteen percent of the abused women were hospitalized for "nerves" compared to 1% of the non-abused women. Suicide attempts were made by 20% of the abused women where as 3% of the control group attempted suicide. Additionally, 18% of the abused women reported alcohol/drug use compared to only 7% of the non-abused women. Domestic violence should not be viewed as a private event. It is clear that battering is a major public health problem and should be recognized as such. It is, therefore, of utmost importance that all women are assessed for abuse.

An important issue related to identifying, assessing, and treating battered women is the lack of an appropriate comprehensive screening tool. Several instruments are currently available to determine levels of anger/aggression of perpetrators; types of psychological abuse; and levels and intensity of violence. With one exception, none are specific to identifying women who are abused. Unless women are identified as abused, intervention and prevention are impossible. Sedlak (1988) stated "the need for screening arises primarily in medical, mental health, and general-purpose shelters, where clientele may seek services without referring to the problem of wife abuse" (p.
Women are routinely screened for a variety of problems, conditions, or medical disorders, but violence is not included in this screening process.

**Purpose**

One purpose of this study was to determine whether using the Woman Abuse Screening Tool (WAST), a comprehensive abuse screening tool, resulted in an identification rate of women in abusive relationships greater than has been reported in other studies. The second purpose was to determine whether verbal/emotional abuse are precursors of physical violence. The third purpose was to further test the internal consistency, content validity and discriminant validity of the WAST. The specific aim of the WAST is to enable nurses, physicians, and other healthcare professionals to identify women who are in abusive or potentially abusive relationships. Once identified, intervention and perhaps prevention of physical abuse is possible.

**Null Hypotheses**

H\(_1\) Incidence of self-reported physical, emotional, and sexual abuse will be < 30%.

H\(_2\) There will be no significant differences in the percentages of women reporting abuse based on race, education, marital status, or income.

H\(_3\) There will be no significant differences in the percentages of women reporting abuse based on geographic location or healthcare setting.

H\(_4\) Verbal/emotional abuse are not precursors of physical abuse.

H\(_5\) The WAST does not discriminate between battered and non-battered women.

**Definition of Terms**

The main terms used in this study are defined below. They were determined after conducting a thorough literature review. For the purpose of this study the term domestic violence was used as a general term to encompass the various forms of violence within the family or an intimate relationship including child abuse, child sexual abuse, woman/wife abuse, marital rape, and elder abuse. A battered woman was defined as any female who has been physically, verbally/emotionally, or sexually abused at least once
by an intimate partner. Physical abuse was defined as and included, but was not limited to, pushing, slapping, hitting, punching, kicking, biting, hair-pulling, hitting with an object, or using a weapon.

Verbal/emotional abuse was defined as, but was not limited to, verbal insults, forced isolation, threats to harm family or friends, intimidation, destruction of pets or property, sleep or food deprivation, name-calling, extreme possessiveness/jealousy, controlling one's freedom, humiliation or humiliating behavior, and mental degradation. Sexual abuse was defined as and included forcing a person to have sex or perform sexual acts against their will. Forced sexual acts included sex with others, sex with objects or animals, sexual dancing, or wearing certain types of clothing/items against one's will. An intimate partner was defined as a husband, ex-husband, boyfriend, ex-boyfriend, lover or ex-lover. An intimate partner can be either male or female.
Chapter 2

Theoretical Framework

There are many theories surrounding the issue of domestic violence. Literature on child abuse began to appear in the 1960s with the publication of Kempe’s "The Battered Child" (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962). Articles pertaining to spouse abuse did not appear until the 1970s. Following is a brief overview on the various domestic violence theories.

Psychoanalytic/Psychopathologic Approaches

Traditional psychoanalytic theories of domestic violence view the abuser, usually male, or the abused, usually female, as having personality flaws or characteristics that are pathologic in nature. This infers that intrapsychic, psychological, or biological aberrancies in women cause men to become violent toward them (Stordeur & Stille, 1989; Okun, 1986). A major tenet of psychoanalytic theory is that women are masochistic. Freud (1924/1961) described three types of masochism: erotogenic or primary, a feminine, and a moral masochism. Basically, erotogenic masochism is pleasure in pain. Moral masochism is seen as a sense of mostly unconscious guilt or the need for punishment. According to Freud (1924/1961), feminine masochism is based entirely on pleasure in pain or primary masochism. Masochism is viewed as a primary characteristic of a woman's personality. The satisfactions sought and found by women in their sex-lives and motherhood are considered masochistic. Psychoanalytic theory views little girls as having the desire to be castrated by their fathers. According to this theory, women secretly desire to be raped, gagged, bound, painfully beaten, whipped, mistreated, forced into obedience, and tainted. Mentally, they desire humiliation. Menstruation is considered as a masochistic experience. Masochistic satisfaction is also thought to be achieved through childbirth. Additionally, men who participate in
masochistic behavior are actually reflecting the wish to play the female role (Freud, 1924/1961; Deutsch, 1930; Rado, 1933; Horney, 1935).

Psychoanalytic theory implies the battered woman enjoys the abuse because of her masochistic personality and is responsible for provoking her partner to resort to violence in order to satisfy her masochistic nature (Okun, 1986; Stordeur & Stille, 1989; Campbell & Humphreys, 1984). From this perspective, it is implied that men batter because they have immature personalities, personality disorders, poor impulse control, low frustration tolerance, dependency, depression, developmental trauma, fear of intimacy, fear of abandonment, jealousy, substance abuse, or some psychiatric illness. It is also implied from this perspective that some of the reasons men batter women are because women are mentally ill, have personality disorders, are depressed, are too dependent, or are substance abusers (Stordeur & Stille, 1989).

The problem with this approach is that the abuser is not held accountable for his behavior since he is viewed as being "ill" or not in control of his actions. The woman is blamed for the abuse perpetrated against her. It is further inferred that she provokes her abuser and therefore, his violent response is justifiable. This reinforces the batterers denial that he chooses to be violent. Battering of an intimate partner is never justifiable. It is interesting to note that the prevalence of psychiatric illness is no greater in abusive men as non-abusive men. Of those who have a diagnosed psychiatric illness, a consistent pattern of psychopathology has not been established (Stordeur & Stille, 1989; Yllo & Bograd, 1989; Rosewater, 1989; Campbell & Humphreys, 1984). Hamberger (1993) refuted this statement. In an article commenting on the myth of psychopathology in woman battering he presented evidence from his research findings which indicated that 86% of a group of identified abusers had at least one personality disorder according to the Millon Clinical Multiaxial Inventory (MCMI). Three types of pathology were identified in the sample group: (a) schizoid/borderline; (b) narcissistic/antisocial; and (c) passive dependent/compulsive. However, Hamberger
(1993) reported that two other studies (Hamberger & Hastings, 1986; 1991) comparing abusive and non-abusive men showed no significant differences. Although his findings are contradictory, he stated the possibility of psychopathology in abusive men should not be ruled out as there may be important treatment implications for abuser treatment. Obviously, further research in this area is necessary.

Learning Theory

Some of the literature on battered women considers battering as a learned behavior. Much of this theory is based on Bandura's social-learning theory. Bandura (1978) postulated that aggressive responses are learned by observation, and refined through direct experience with positive reinforcement. Bandura also examined such social factors as violence in the media, and combat training of military personnel as contributing factors to learning violent behavior. He further stated that in cultures where violence and aggression are not condoned or tolerated, the people live in peace. The societies that value violence and aggression by attaching prestige to it and provide training in aggression to use "legitimately" are societies in which there is a great deal of threatening, fighting, maiming, and killing of people (Bandura, 1978). This hypothesis is supported in the literature due to the high prevalence of abusers, who as children, either witnessed their mothers being abused, were abused themselves, or experienced both (Okun, 1986). It is further supported in that violence in our society is acceptable, tolerated and condoned.

With the exception of one learning theorist, Lenore Walker, these theories address aggression and acts of aggression but do not specifically address the issue of violence among intimate partners. Using learned helplessness theory, Lenore Walker (1979) addressed the violent acts in intimate relationships. She specifically addressed the reason battered women stay in abusive relationships. Walker (1979) provided a poignant answer to the question of why women stay:
They were both beaten and then blamed for not ending their beatings. Told they have the freedom to leave a violent situation, they are blamed for the destruction of their family life. Free to live alone, they cannot expect to earn equal pay for equal work. Encouraged to express their feelings, they are beaten when they express anger. They have the same inalienable right to the pursuit of individual happiness as men do, but they must make sure their men's and children's rights are met first. They are blamed for not seeking help, yet when they do, they are advised to go home and stop the inappropriate behavior which causes their men to hurt them. Not only are they responsible for their own beatings, they also must assume responsibility for their batterer's mental health. If they were only better persons...they would find a way to prevent their own victimization (pg. 15 & 16).

Applying Walker's theoretical perspective, the woman's experience in the abusive relationship is the main focus. Walker believes though, that the way women are socialized to be passive may predispose them to violence in the future (Walker, 1979). Walker based her theory on the study of dogs conducted by Abramson, Seligman and Teasdale (1978) who randomly and at varied intervals shocked caged dogs using an electrical current. The dogs learned that no matter what they did they were unable to stop or control the shock. In the beginning the dogs tried to escape. Even when the dogs were taught they could escape and the cage door was left open they did not attempt to leave the cage or avoid the shock. Similar studies were performed on a variety of other species including birds, primates, fish, cats, rodents and humans. Some species learned to be helpless at a more rapid rate than others. Those animals learning helplessness at a faster rate became even more helpless across many situations. Yet others sense of powerlessness was evident in all their behaviors. The crux of the learned helplessness hypothesis is that motivational, cognitive and emotional deficits develop when it is learned that outcomes are uncontrollable. It is further postulated that simple exposure
to uncontrollability is not sufficient to cause helplessness. However, it is the organisms' perception that the outcomes are uncontrollable which render them helpless. The motivational deficit develops when the organism expects the outcome to be uncontrollable and is therefore, not motivated to initiate any response to escape. The cognitive deficit results because the organism has learned that an outcome is uncontrollable. It therefore makes it difficult to learn that responses will produce outcomes. Finally, the consequences of learned helplessness are a depressed affect (Abramson, Seligman, & Teasdale, 1978).

Walker draws a parallel between this study and the other animal and human studies that produced the same results to the plight of battered women. (Walker, 1979). That is, battered women are subjected to random and repeated beatings from which they feel they cannot escape.

They learn that their voluntary responses really don't make that much difference in what happens to them....It becomes extraordinarily difficult for such women...to believe their competent actions can change their life situation. Like Seligman's dogs, they need to be shown the way out repeatedly before change is possible (Walker, 1979, pg. 528-529).

Walker's theory has two distinct disadvantages. It fails to explain the influence of society and social factors which encourage women to preserve the family and/or relationship at all cost. Her theory also does not explain why some women are able to leave a violent relationship after being battered only a few times (Okun, 1986). A plausible explanation for this may be that the women who do leave an abusive relationship after one or a few beatings do not perceive the situation as uncontrollable. Since they do not perceive the situation out of their control they are motivated to respond by leaving or terminating the relationship. Walker freely admits that her theory only partially explains battered women's behavior.
Walker Cycle Theory of Violence

Walker also developed the Walker Cycle Theory of Violence. There are three phases associated with the cycle of violence theory. Phase I is the tension building phase. Phase II is the acute battering stage. Phase III is often termed the "honeymoon" phase. During Phase I tension begins to increase. The batterer may begin to show displeasure with his partner's actions or activities. He will call her names, tell her she is a terrible person, tell her she cannot do anything right, and express general hostility toward her. She will try and placate him by doing things she thinks will appease or calm him. For a short time she may be successful which gives her a false sense of her abilities to control his behavior. The tension will continue to escalate. Nothing she does appeases her abuser. At this point she may withdraw from the abuser fearing the inevitable. He senses this withdrawal and becomes more oppressive toward her.

As the tension becomes unbearable the second phase is entered at the time the battering incident occurs. Verbal abuse followed by physical abuse and often times sexual abuse are typical behaviors during Phase II. The woman may suffer minor to life-threatening injuries during this phase. Police intervention is often necessary during this stage. This phase ends when the battering incident ceases. His tension is reduced and his behavior is reinforced at this point because the violence has succeeded in reducing his tension.

Phase III, the "honeymoon" phase follows the battering incident. The abuser may apologize profusely promising never to use violence again. The abuser may actually be sincere for the moment. The woman wants to believe he will change and will usually give him another chance. His loving, contrite behavior provides positive reinforcement to her to remain in the relationship. This is a typical response early on in the relationship. Over time though, the abuse will increase in frequency and severity. The length of the "honeymoon" phase will decrease (Walker, 1984). Walker (1984) has shown that women are more willing to leave the abusive relationship as Phase I and II
increases and Phase III decreases. Her results suggested further research into the psychological costs and benefits of remaining in an abusive relationship.

Pagelow (1981) integrated such feminist concerns as health care professional's responses, available resources, and gender role stereotypes into social-learning theory. Historically, battered women have been labeled as mentally ill or having character disorders and this was the reason for their abuse. They have been labeled as masochistic, paranoid, or depressed. Study results suggest that health care providers have a tendency to ignore battering as a primary health problem and treat the symptoms related to the abuse (Pagelow, 1992; Campbell, 1989; Campbell & Sheridan, 1989; Varvaro, 1989; Tilden, 1989; Stark, Flitcraft, Zuckerman, Grey, Robinson, & Frazier, 1981). Rosewater (1988) stated "Professionals fail to distinguish the symptoms of victims of violence from the symptoms of the sufferers of mental illness or to understand their interplay." Battered women are referred for psychiatric treatment more frequently than non-battered women (Warshaw, 1989; Campbell, 1989; Campbell & Sheridan, 1989; Varvaro, 1989; Stark, Flitcraft, Zuckerman, Grey, Robinson, & Frazier, 1981).

Coercive Control Theory

Singer (1979) and Serum (1979) view the battering of women as a coercive control situation. Their theory is based on research involving brainwashing and coercive control used in concentration camps, thought reform prison programs practiced by the Chinese, hostage situations, and religious cults. This theory is best summarized by Serum (1979) who stated, "The battered woman syndrome represents the breakdown of the personality in the face of severe external threat." (cited in Okun, 1986, pg. 87). Following are ten common threads Serum found when comparing battered women to prisoners in German concentration camps:

1) guilt feelings, with an attendant sense of deserving the victimization; 2) significant loss of self-esteem; 3) detachment of emotion from incidents of
severe violence, and extreme reactions to trivial incidents; 4) failure to observe the controller’s rules because of the arbitrariness of punishment; 5) extreme emotional reactions; 6) difficulty planning for the future and delaying gratification; 7) fear of escaping the coercive control situation; 8) child-like dependency on the controllers, and identification with them; 9) imitation of controllers' aggressiveness, and adoption of their values; 10) maintenance of the hope that the controller is kind and just (cited in Okun, 1986, pg. 10).

Abusers use many of the documented brainwashing techniques against their intimate partners. Some of the techniques used by abusers against their partners include keeping their partners confined or imprisoned in the home; social isolation; beatings; torture or threats of torture; depriving them of food; randomly interrupting their sleep; threats of murder or actually murdering their partners; random and unpredictable leniency as well as random and unpredictable violent acts; humiliation; various forms of bondage; and coerced false confessions. Due in part to the isolation and fear the battered woman will try to behave as her batterer has dictated. This type of coercive behavior increases the woman's dependency on her abuser (Okun, 1986; Graham, Rawlings, & Rimini, 1989; Walker, 1979).

It is interesting to note that prisoners (usually male) who have succumbed to brainwashing techniques are not labeled as masochistic or considered weak. On the other hand, women who have been subjected to these same techniques by an intimate partner are considered by many members of society to be weak, masochistic, and responsible for provoking the abuse. This stems in part from societal beliefs and expectations that women are responsible for the success or failure of a relationship, perceptions that females are immature and childish, and the custom of blaming female victims as is evidenced in attitudes toward rape survivors (Okun, 1986; Graham, Rawlings, & Rimini, 1989; Walker, 1979).
Coercion theory explains the similarities experienced by prisoners and battered women subjected to extreme treatment and draws a parallel between the two. This is an important theory in that it avoids any conclusions that blame women for being abused, for being masochistic, or provoking the violence. Also noteworthy is lack of evidence in the brainwashing literature of a predisposition in succumbing to brainwashing techniques. As with most theories this one is not without problems. Social and cultural influences on violent acts are not addressed by the coercive control theory; only vague criteria is given for what constitutes a coercive control situation; and this theory, as is true for most, does not apply well to abusive relationships that are ended quickly (Okun, 1986). The reason coercive theory may not apply well to abused women who quickly end their relationships may be due to the fact that they have not succumbed to any of their abuser's brainwashing techniques. The abusers coercive tactics increase over time. If the relationship is short in duration he has not had the time to use these tactics with any degree of success. The women may realize they have options and are therefore able to motivate and mobilize in order to escape.

**Sociological Theories**

Sociological theorists view violence as a family matter; they believe it is learned in childhood and transmitted into adult relationships (intra-generational); that it is culturally supported; and is provoked by social stresses such as unemployment, frustration, anger, and poverty (Stordeur & Stille, 1989; Okun, 1986; Stark & Flitcraft, 1985).

According to Straus (1976) it is sexist attitudes and practices which condone woman battering for the following reasons: (1) stress and frustration will cause some men to resort to violence in order to reinforce a position as head of the family, (2) antagonism between men and women may occur due to gender-role stereotypes and inequality, (3) it is difficult for many women to escape violent or abusive marriages due to the lack of alternative roles for women and family or societal pressure to remain
in the relationship for "better" or "worse", it is exceedingly difficult for women to obtain legal protection from abusive partners in the male-oriented criminal justice system (Straus, 1976).

One of the major contributions of sociological theory has been to increase our understanding of wife battering as related to the patriarchal nature of our society. We have been helped to understand how strict gender-role expectations and the power imbalances between males and females may lead to violence. Lastly, sociological theorists have informed us how the role of society's values in viewing violence against women as normal has sanctioned, condoned and tolerated these atrocities (Horsfall, 1991; Yllo & Bograd, 1989; Stordeur & Stille, 1989; Dobash & Dobash, 1979).

**Family Systems Theory**

Family Systems Theorists view the family as an open system operating as a whole. Theoretically, changing one part of the family causes change in the whole family system. In other words, the behavior of one family member influences the behavior of other family members and vice versa (Pressman, 1989; Bograd, 1884). According to Pressman (1989), Family Systems Theory is a theory interested in the "what" of a family situation or dysfunction and not concerned with the causes or "why's" of the situation or dysfunction. Systems theorists believe the cause will not usually assist in resolution, therefore, patterns of behavior should be the main focus for modification, since behavior patterns sustain problems (Pressman, 1989).

Family systems theorists view domestic violence as a symptom of a disturbed or pathological relationship. Basic to this theory is that all parts of a system play a role in maintaining homeostasis. The family constantly strives to maintain homeostasis even if this is accomplished through dysfunctional relationships. All family members participate in the system and are, therefore, responsible for the dysfunction. From this perspective all members of the family play a role in maintaining the batterers behavior and perpetuating the abuse (Hansen, Harway, & Cervantes, 1991; Pressman, 1989;
Stordeur & Stille, 1989). Systems theory does not take into account the historical, social, religious, cultural, economic and political circumstances involved in condoning and maintaining abusive relationships. Without considering these issues, effective treatment is not possible (Pressman, 1989).

Bograd (1984) criticizes family systems theory for bias against women. She believes systems theories hold women responsible for violence while exonerating the batterer for his behavior. This also serves to obscure the seriousness of violence. It is implied that women are also responsible for controlling their partner's feelings and actions, while ignoring size and physical strength differences between males and females (Hansen, Harway, & Cervantes, 1991; Pressman, 1989; Bograd, 1984). In cases of wife battering, even when the wife changes her behavior, her husband continues to be violent. Unless he is willing to get help and wants to change his behavior, he will continue to be violent regardless of his wife's behavior. Since Systems Theory views all members of the family as playing a role in the dysfunction, it is assumed the abused woman provokes, encourages, reinforces, and maintains her husband's abusive actions (Pressman, 1989).

Systems theories have a tendency to perpetuate gender-role stereotypes which may sanction some forms of violence against women (Pressman, 1989; Bograd, 1984). In our society, women are considered the weaker sex and as wives, are expected to be subordinate to their husbands. The institutions of religion, education, family, government, law, labor, and the media sanction and condone this dogma. Therefore, from this viewpoint, it is perfectly acceptable for a husband to beat his wife in order to maintain his position of authority and to keep her as his subordinate (Pressman, 1989).

Theorists, using a systems approach, encourage couples or family therapy as the best approach in dealing with the violence. Both the woman and the man have a tendency to minimize the violence when this approach is used. Women will minimize the violence during these sessions for fear of future abuse and as a mechanism of coping with an
intolerable situation. Another problem with this approach is that the therapist may focus on how the female’s behavior provoked the violence as opposed to holding the abuser accountable for his actions. This approach is placing the blame on the woman for being battered (Hansen, Harway, & Cervantes, 1991; Pressman, 1989; Stordeur & Stille, 1989; Bograd, 1984). It also implies that if the woman would only be a better wife or conform to the female role as socially defined, she would not be battered. This translates to the battered woman being told she needs to modify her demands, modulate her anger, and be more sensitive to the needs of her husband. This type of behavior is just what her husband expects and he resorts to violence when she does not comply (Bograd, 1984).

**Conceptual Framework**

The conceptual framework for the development of the Woman Abuse Screening Tool (WAST) and this study is derived from the feminist theories as discussed below. There are four feminist theoretical frameworks: liberal feminism, traditional Marxist feminism, radical feminism and socialist feminism (Bograd, 1984; Jaggar & Rothenberg, 1984). Each of the four theories attempts to describe and explain the causes and consequences of women’s oppression, repression, and suppression as well as strategies for equality and liberation (Tong, 1989).

Liberal feminists believe "that female subordination is rooted in a set of customary and legal constraints that blocks women's entrance and/or success in the so-called public world" (Tong, 1989, p.2). Liberal feminists further believe that women are not afforded the same civil rights and opportunities as men because of society's belief that women are mentally and physically inferior to men. The thrust of liberal feminism is equal opportunity for all citizens regardless of gender (Tong, 1989; Jaggar & Rothenberg, 1984; Donovan, 1991).

Marxist feminists believe the class structure of society and the introduction of private property is responsible for women's oppression because with privatization "the
wealth produced by the powerless many [usually males] ends up in the hands of the powerful few" [also male] (Tong, 1989, p.2). Therefore, it is felt that capitalism, not just the social structure where men are granted more privileges than women, is the main cause of women's oppression. Radical feminism considers the patriarchal system which is characterized by power, dominance, hierarchy, and competition to be the cause of women's oppression. In order for women to be liberated, radical feminists believe the family, legal, political and religious institutions as we know them must be eliminated.

Socialist feminists have attempted to weave together segments from the radical, Marxist, and liberal feminist theories. From this perspective, women's oppression is a result of the organization of capitalist ideologies, is also related to reproduction and sexuality issues, and women's socialization. The emphasis of social feminist theorists is to integrate all aspects which are believed to contribute to women's subordination and oppression into one unified theory (Tong, 1989; Donovan, 1991; Jaggar & Rothenberg, 1984).

The basic principles common to the four feminist theories are: gender equity and that male-female relationships are currently based on an unequal distribution of power determined by gender; that gender should not determine one's value in society; and that women should have the same rights over their bodies as has been granted to men. Gender equity proposes a partnership in human interaction as opposed to a traditional dominance or patriarchal model (Horsfall, 1991; Sampselle, 1990; Bograd & Yllo, 1989; Bograd, 1984). In our society men are the dominant class. Women are considered inferior and second rate. One of the most obvious and discernible forms of control used by men to wield power over women is violence whether in the form of battering, rape or both (Bograd, 1984). Feminists are concerned with changing the social systems which perpetuate gender inequality and with the personal growth of individuals (Bograd, 1984). Feminist theory promotes power-sharing as opposed to power-grabbing. Power-sharing promotes equality. Power-grabbing is described as wielding power over
others, keeping all the power to one's self, and taking power from another person to
increase one's own power base (Mason, Backer, & Georges, 1991). Feminist theory also
emphasizes respect of self and others, equality (Mason, et al, 191) and enabling one's
self to "be" or "become" (Heide, date unknown).

Feminist perspective views violence against women by their intimate male
partners as one of power and control. Men use violence or the threat of violence to
oppress and dominate women. Feminists believe violence against women is condoned and
sanctioned by society and perpetuated by political, social, and economic factors.
Feminists reject the notion of domestic violence, family violence, marital violence or
spouse abuse and emphasize the term woman-battering as another form of violence
against women. Most domestic violence experts agree that well over 90% of intimate
violence is perpetrated by males against females (Campbell & Humphreys, 1993;

Feminist researchers seek to understand why men use violence against women,
two statements are basic to feminist perspective; "(1) No woman deserves to be beaten,
and (2) men are solely responsible for their actions" (pg. 561). She further
emphasizes the following four values of feminist thought regarding violence against
women: (1) There is a difference between verbal expression of anger and physical
abuse; (2) men and women can control their behavior; (3) women and men have the
right to physical safety; and (4) blaming the victim only draws attention from the
patriarchal context of battering (Bograd, 1984). Feminist theorists are supportive of
measures aimed at teaching men nonviolence while at the same time increasing legal and
social consequences against men who batter.

Domestic violence is difficult to define due to the wide range of disagreements
about how to define and measure it. Definitions are not consistent in the literature
which makes it difficult to determine not only the prevalence of domestic violence but its
consequences. The terms battered woman, spouse abuse, wife battering, woman battering, abused woman, abused wife, domestic violence, interpersonal violence, and family violence are often used interchangeably. This can cause confusion depending on how each term is defined. Other terms associated with domestic violence and woman battering include violence, assault, battery, beating, violence, shock, trauma, intentional injury, and injury. In the discussion below, an attempt will be made to define the terms domestic violence and woman battering as well as explain the other associated terms.

Definitions of Domestic Violence

Definitions of domestic violence range from using any type of force in the family, this includes violence among siblings and spousal homicide, to only violent acts against wives (Stark & Flitcraft, 1988). Feminists object to the terms domestic violence and family violence. They regard the battering of women as a gender issue and feel the above terms mask the fact that most of the time the abusers are male and the violence is directed against women (Stordeur & Stille, 1989; Bograd, 1988). Stark, Flitcraft, and Frazier (1988) prefer to define domestic violence as any type of physical force among adult partners regardless of marital status or living arrangements.

Legal Definitions of Domestic Violence

Legal definitions of domestic violence vary from state to state. Assault and battery are terms that are often used synonymously. In legal terms the definition of assault is the threat of physical harm or violence while battery is carrying out that threat.

The following is the legal definition of abuse in the State of Illinois: "Abuse means physical abuse, harassment, intimidation of a dependent, interference with personal liberty or willful deprivation but does not include reasonable direction of a minor child by a parent or person in loco parentis" (Illinois Domestic Violence Act, 1986, p. 4).
Domestic battery as defined under the Illinois Domestic Violence Act (IDVA) of 1986 states: "A person commits Domestic Battery if he intentionally or knowingly without legal justification by any means: causes bodily harm to any family or household member; makes physical contact of an insulting or provoking nature with any family or household member" (p. 27).

Definitions of Battered Women

There are many definitions of the terms battered woman, spouse abuse, woman battering, abused woman, and abused wife. In 1985, C. Everett Koop, sponsored a workshop on violence and public health. Members of the Surgeon General's Task Force on spouse abuse made the following statement:

the phenomenon of spouse abuse includes physical, sexual, and psychological abuse and is found in all social, economic, ethnic, and racial groups. Spouse abuse is a crime perpetrated primarily against women, often causing them serious injury and premature death and affecting the psychological development of their children and/or other family members. (p. 71)

Feminists define violence against women and children as the use of force or threat of force to maintain an unequal power balance in the relationship (Bograd & Yllo, 1989; Stordeur & Stille, 1989; Stark & Flitcraft, 1988). Bograd and Yllo (1989) define woman battering as any physical force used by a male against his intimate partner. Force can range from pushing, to sexual assault, to the use of a gun or knife. This type of violence threatens not only the woman's safety but her bodily integrity as well (Bograd, 1988).

Varvaro (1989) defines a battered woman as "one who has been deliberately and repeatedly physically, emotionally, or sexually abused in her home by an intimate mate such as a husband, ex-husband, boyfriend, ex-boyfriend, or lover" (p.1). Sheridan (1990) defines a battered woman as "any woman aged 16 or older who is physically, emotionally, or psychologically abused by a husband or significant other" (p. 618).
**Associated Terms**

In many instances battering, abuse and violence are used interchangeably which may also cause confusion. Webster's defines the term violence as "physical force used so as to injure or damage; unjust use of force or power, as in deprivation of rights; to assault; great force or strength of feeling, conduct, or language; roughness in action" (Webster's New Universal Unabridged Dictionary, 1983). Abuse is defined by Webster's as "to use ill; to maltreat; to misuse; to use with bad motives or to wrong purposes; as, to abuse rights or privileges; to violate; to defile; to deceive; to impose on; to treat harshly; to use insulting, coarse, or bad language about or to; to revile" (Webster's New Universal Unabridged Dictionary, 1983). Battering is defined as "to beat with successive blows; to beat repeatedly with violence; to break to bits by pounding; to wear or impair, as by beating or by use" (Webster's New Universal Unabridged Dictionary, 1983).

Violence suggests use of physical force whereas abuse can suggest violence or nonviolence (Frieze & Browne, 1989; Stordeur & Stille, 1989). Browne and Frieze (1989) suggest that battering and beating be defined as "repeated, physically forceful actions". Sonkin, Martin, and Walker (1985) describe four types of violence: physical, sexual, destruction of property, and psychological. The balance of power in a relationship is altered dramatically when violence is used. This destroys trust and creates a threat, inequality, and loss (Frieze & Browne, 1989).

Trauma, shock, injury, and casualty are terms easily applicable to woman battering. Trauma can be intentional or accidental, physical and/or psychological. Dorland's Medical Dictionary defines trauma as "a wound or injury, whether physical or psychic." Traumatic is a term commonly associated with trauma and is defined by Dorland as "pertaining to, occurring as the result of, or causing trauma" (p. 1388). Halpern (1989) defines trauma as "a structural or physiologic alteration caused by an outside source of energy applied to the body. The external force may be in the form of..."
mechanical, chemical, thermal, electrical, barometric, or radiation energy” (p. 380). Intentional trauma is usually associated with an act of violence such as using a knife or gun, throwing an object at another person, pushing, grabbing, shoving, slapping, kicking, biting, hitting with a fist, hitting with an object, beating up, spitting, pinching, choking, or sexual violence. The abused woman may be in a state of shock or go into shock as a result of her traumatic injuries. She may even be a casualty.

Psychological violence includes but is not limited to threats of violence (assault), pathological jealousy, mental degradation, controlling one's freedom, suicide threats, controlling sleeping and eating patterns, threats to take or the harm children, and forcing degrading and/or humiliating behavior (Dutton, 1992; Walker, 1984). Bograd (1982) and Mitchell and Hodson (1983) report that women's psychological reactions to intentional battering by an intimate partner are similar to individuals who have been victims of physical trauma, psychological trauma or a traumatic event not perpetrated by a significant other. This should not come as a surprise because the battered woman has suffered trauma whether it was physical, psychological, or both. Many of the above behaviors are techniques used by kidnappers, terrorists, and some governments (Okun, 1986; Dutton, 1992). Violence in our society is either tolerated and condoned or considered a deplorable act depending upon the victim's status, the perpetrator, the particulars surrounding the violent act, and the extent of the injury suffered (Hanrahan, Campbell, & Ulrich, 1993).

The resulting psychological consequences of woman battering include but are not limited to feelings of anger, shock, disbelief, confusion, fear, anxiety, shame, humiliation, substance abuse, self-blame, helplessness, hopelessness, suicidal/homicidal ideation, decreased self-esteem, depressive symptoms, and social isolation from friends and family. Some of the physiological consequences of abuse include bruises, lacerations, abrasions, fractures, gunshot wounds, stab wounds,
contusions, concussions, head trauma leading to neurological impairment, coma, or even
death (Sheridan, 1990; Campbell & Sheridan, 1989; Varvaro, 1989).

Literature Review

Historical Perspective

Domestic violence is not a new phenomenon. It is not a result of modern society
and a breakdown of the family. Nor is it a type of pathology on the part of the victim,
usually female, or the abuser, usually male. A brief overview of the historical
perspective of domestic violence is necessary to enable the reader to fully understand
how the status of women throughout history in Western culture has condoned and
sanctioned the use of violence against women.

The roots of domestic violence can be traced back to Rome in 753 BC. when
Romulus established laws concerning marital and family relations (Gardner, 1991;
Hunt, 1990; Okun, 1986; Walker, 1984; Dobash & Dobash, 1979). He declared the
husband as the ruling authority over the household. A man's wife was considered his
property. Once married, a woman was no longer an individual. She and her husband
became one person in the eyes of the law. The laws of chastisement gave husbands the
legal authority to physically discipline their wives for any offense deemed appropriate.
It was perfectly legal and acceptable for a husband or father to kill his wife or daughter
for committing adultery, suspected adultery, or drinking wine. After all, they were his
"possessions" and he was to maintain control over them. Wives were not afforded
reciprocity if their husbands committed these same offenses (Gardner, 1991; Okun,
1986; Campbell & Humphreys, 1984; Dobash & Dobash, 1979). Well into nineteenth
century England a husband was permitted to kill his wife without fear of punishment. A
woman's role was to be that of wife and mother (Horsfall, 1991; Okun, 1986; Dobash &
Dobash, 1979). She was afforded few other choices with the exception of becoming a
priestess, harlot, or mistress. Unfortunately, this traditional role and status of women
took hold and was perpetuated in English common law and throughout Europe (Horsfall, 1991; Gardner, 1991; Okun, 1986; Dobash & Dobash, 1979).

The Roman laws towards women's rights and status began to ease around 202 BC. But the dawning of Christianity at about the same time period saw the re-establishment of a husband's domination and absolute authority over his wife and family. Over the next several centuries the Church, at various times, either sanctioned wife abuse or encouraged husbands to use some restraint and compassion when chastising their wives. Some priests were appalled at the way many of their parishioners treated their wives and encouraged them to be as kind and compassionate to their wives as they were to their farm animals (Horsfall, 1991; Gardner, 1991; Okun, 1986; Dobash & Dobash, 1979).

Throughout the Middle Ages and beyond, the double standard thrived and the Church continued to encourage and condone violence against wives (Dobash & Dobash, 1979). During the Middle Ages if a wife committed adultery, allowed herself to be sodomized, prostituted herself, had a miscarriage, masturbated, neglected her children, participated in lesbian acts, refused a priest, or disagreed with him she could be burned at the stake (Horsfall, 1991; Okun, 1986).

The status of women did not change much during the seventeenth, eighteenth, and nineteenth centuries. "Children, property, earnings, and even the wife's conscience belonged to the husband" (Campbell & Humphreys, 1984, pg. 83). Husbands were still permitted to commit violent acts against their wives whether in public or private with complete tolerance by the church and state (Horsfall, 1991; Okun, 1986; Dobash & Dobash, 1979). Another important point throughout history is that wives were not permitted to refuse sex with their husbands. Husbands had the right to demand sex regardless of their wives' moods or wishes. This gave married women fewer rights than English slaves because legally, the slaves could refuse their master's sexual advances (Okun, 1986). It was not until the 1970s that marital rape was even a consideration.
The first laws against marital rape were not passed until the 1980s. To date, not all states have laws against marital rape.

During the late nineteenth century laws in England and the United States regarding the treatment of wives slowly began to change. For example, women were granted divorces by the courts if they sustained life-threatening beatings at the hands of their husbands. It was no longer legal for a man to sell his wife and daughter into prostitution. Also, a husband could not legally keep his wife locked up as a prisoner in the home (Okun, 1986; Dobash & Dobash, 1979).

In the early part of the twentieth century, individual states began passing laws technically making it illegal for a husband to beat his wife. Enforcing the laws was a different matter. The courts maintained, and to some extent today, that "a man's home is his castle" and domestic matters are private. It was not until the women's movement and the civil rights movement in the 1960s that the issue of wife abuse became the focus of national attention. It is currently illegal for a man to beat his wife in this country but, the police and the courts commonly treat even the most severe injuries as misdemeanors as opposed to felonies due to the intimate relationship between the parties. Woman abuse is still trivialized by the police, the legal system, medicine, social workers and society at large. The attitudes toward a man's right to beat his wife and the double standard prevail throughout our society today as they did in ancient Rome (Horsfall, 1991; Hanmer & Maynard, 1990; Okun, 1986; Dobash & Dobash, 1979).

From this brief overview of history, it is obvious that domestic violence is not a new phenomenon nor is it due to pathology on the part of either partner. Throughout history, violence against women and children has not only been acceptable but encouraged. Violence or the threat of violence has been a method used by men for more than 2600 years (Okun, 1986) to maintain power and control over their "possessions" or "property". The roots of violence against women are found in society's attitudes about

Current Perspectives on Woman Battering

Battering of an intimate partner is a widespread everyday occurrence (Varvaro, 1989). Society has a tendency to look upon spouse abuse as a "private matter" or "love spat" that will soon be over. This is not the case. It is a rare occurrence for a violent episode between intimates to happen only once. Over time the violence usually escalates, becomes more frequent, and severity of injury increases (Pagelow, 1992; Varvaro, 1989; Campbell & Sheridan, 1989).

Battering is not restricted to married couples. Statistics indicate unmarried women, divorced or separated women are also at risk for battering. In fact, single, separated, or divorced women are at higher risk of assault by an intimate partner than married women (Stark & Flitcraft, 1985). Bullock, McFarlane, Bateman, and Miller (1989) reported that battering occurs in 12-22% of teenage dating relationships, and 38% of dating college students. These numbers may not reflect the true problem as the Justice Department estimates 43% of battering is not reported to the authorities (Bullock, et al 1989).

Research has failed to identify a consistent personality profile of the battered woman. Most studies have not found any significant differences in personality characteristics between battered and non-battered women. One exception is that battered women reported higher rates of alcohol abuse precipitated after the onset of abuse (Hudson, 1990; Rosewater, 1989; Stark & Flitcraft, 1985).

A range of personality characteristics of abusers have been identified. Abuser characteristics include vulnerable self-concept; low self-esteem; powerlessness or inadequacy, conflicts over dependency; traditional ideas of gender roles; pathological jealousy; fear of abandonment alternating with a desire to control women and children; lack of empathy, and lack of assertiveness. When comparing abusive men to non-abusive
men these features were not distinctive from the non-abusive men who were
experiencing marital discord (Stordeur & Stille, 1989; Stark & Flitcraft, 1985).

Myths

There are many myths surrounding spouse abuse. Some of the most common
myths are: violence is normal; battering is a rare occurrence; a woman's
psychopathology is the reason she is beaten; women are responsible for provoking the
violence; infrequent or mild physical abuse is a normal part of any marriage; the abuser
is sick, mentally ill, an alcoholic, or under stress and therefore not responsible for his
behavior; the woman is "bad" and deserves to be beaten; and if the woman would be
compliant, quiet, and good her partner would not beat her (Hilberman, 1980; Bograd,
1982). Believing in these myths can have a negative influence on the diagnosis and
treatment of battered women. Our society also views domestic violence as a private
family matter totally ignoring or minimizing the trauma associated with battering.
Stordeur and Stille (1989) have found that the majority of the abusers in their
treatment program have admitted that they intentionally meant to inflict injuries on
their intimate partners. Bograd (1983) has reported the same.

Risk Factors

With few exceptions, domestic violence research has failed to establish risk
factors that are conclusively linked to spouse abuse. A risk factor may not cause the
violence, just increase the likelihood of it occurring. Some researchers prefer to use
the term "vulnerability factors" in place of risk factors. It is thought these factors
interact with the domestic situation and if conflict is present, then exposure to the
vulnerability factors may increase the woman's chance of being abused (Stark &
Flitcraft, 1988).

According to Stark and Flitcraft (1988) the one factor that appears to
precipitate woman battering to a substantial degree is male violence. Other frequently
cited risk factors for abuse are age, race, income, occupation, substance abuse,
pregnancy, violence in family of origin, marital status, and social situation (Stark & Flitcraft, 1988). Lockhart (1985) found no differences in the incidence of husband to wife abuse based on race when she controlled for social class. She stated that before any conclusions based on race and abuse can be drawn, the researcher must control for social class (Lockhart, 1985). However, there is much controversy whether income, occupation, and social status increase a woman’s risk of abuse. In another study Hotaling and Sugarman (1990) found that high levels of marital conflict and lower socioeconomic status were consistent risk markers of abuse.

Single, separated, or divorced women were more likely to experience abuse than married women. Stark and Flitcraft (1988) reported that only 15.6% of all assaults among married women are perpetrated by a husband, however, 55% of assaults among separated women are by an intimate partner. Violence in the family of origin has been reported to increase the risk of a woman being abused or that a man will become abusive but no conclusive data are available to inconclusively establish this as a causal factor. In fact, the majority of adults who were abused as children are not involved in abusive relationships (Stark & Flitcraft, 1988).

Prevention

There are four factors directed toward preventing spouse abuse. They include: (1) protecting the battered woman; (2) stopping the violence; (3) expanding resources available to victims and perpetrators; and (4) early identification, community referrals, and public education. Programs available to protect battered women include shelters, hotlines, crisis intervention programs and counseling services. Shelters have been effective resources for battered women in that a high percentage do not return to their abusers. Sedlak (1988) reports 33% to as high as 80% of women staying in shelters do not return to the abusive relationship.

Counseling is available to battered women through shelters, community mental health clinics, women’s groups, and individual therapists. There is very little research
available to substantiate the effectiveness of counseling battered women. There are a few programs available to men who batter, although, services for battered men have been slower to develop. Programs for abusers are shown to have a high attrition rate and a very low success rate (Sedlak, 1988). According to Dutton (1988) abuser treatment groups have mixed results. Edleson and Tolman (1992) conducted a thorough literature review of evaluation studies for abuser treatment groups. The results of their search indicate a 53% to 85% success rate. Part of the problem in evaluating success of abuser treatment groups is how to define abuse, length of time the abuser is followed after treatment, and sources of data. Another important consideration is what constitutes success? Is treatment considered successful if there is a reduction in violence, or a complete absence of physical violence and for what time period? Is the treatment program effective if there is no longer any physical abuse but the abuser continues to be verbally/emotionally abusive (Edleson & Tolman, 1992)? These are some of the questions that need to be addressed when evaluating outcome. Clearly the need exists to continue to conduct research in this area and attempt to fill this gap. For a more in-depth discussion on abuser treatment issues see Edleson and Tolman (1992) and Dutton (1988).

Another resource for women is police and legal intervention. Law enforcement agencies have been heavily criticized for failing to protect battered women. Many law enforcement agencies and individual officers view domestic violence as a private matter rather than a criminal matter (Sheridan, 1990). Police intervention has been shown to be an effective deterrent to men who are abusive to their partners (Dutton, 1988; Stubbing, 1990; Edleson & Tolman, 1992).

Health care professionals can play a major role in preventing further abuse through the identification and intervention of battered women. Nurses and physicians need to be familiar with the common signs and symptoms of abuse. They should also be knowledgeable of community resources available to battered women. Domestic violence...
is a widespread problem in our society. It is important to educate the public that violence is not an acceptable way of conflict resolution and that violence against another person is a criminal act regardless of the relationship between the assailant and the victim.

### Identifying Battered Women

Since the mid 1970s five studies have been conducted to determine the prevalence of domestic violence victims utilizing emergency services. Hamberger, Saunders, and Hovey (1992) conducted a study to determine the prevalence of battered women in a family practice clinic. The results are discussed below.

Flitcraft (1979) conducted a one month study of 520 women who sought emergency treatment for any type of injury. Medical records for 481 of the women (92.5%) were analyzed for previous emergency visits, hospitalizations, clinic records, and social and psychiatric service notes. Every episode of injury was noted for a total of 1419 traumatic injuries. The incidence of traumatic injury ranged from 1 injury to more than 20 or more injuries per woman.

The women were classified using the Flitcraft Criteria for classification. Using this criteria, women were classified as positives, probable, suggestive, or negative. A positive category meant that at least one injury was recorded in the medical record as inflicted by a husband, boyfriend, or other male intimate. To be in the probable category, at least one injury resulted from a punch, kick, shot, or similar and intentional assault by another person, but the relationship of assailant to victim was not indicated. If at least one injury did not fit the history given, the woman fit into the suggestive category. The negative category included injuries that were adequately explained by the recorded etiology, such as muggings, or unknown assailant.

During the study month, 14 battered women (2.8%) were positively identified by the ER physician. Another 72 (16%) fit into the probable and suggestive categories. A total of nearly 10% of the 481 women were positively identified as being battered at
least once from their medical histories. Another 15% had histories of trauma that pointed toward abuse (Stark, Flitcraft, & Frazier, 1979).

Physicians only identified 75 of the injuries as abusive incidents, although another 340 or 24% fell into the probable or suggestive categories. In summary, physicians only identified 1 out of 35 of the women they saw as battered. In reality the figure approaches 1 in 4. What physicians acknowledge as a rare occurrence is actually an epidemic (Stark, Flitcraft, & Frazier, 1979).

Tilden and Shepherd (1987) conducted a study to develop and test an interview protocol to be used by the emergency room staff nurses when assessing female trauma patients. The researchers wanted to determine whether using a systematic protocol that directly questioned women as to who caused the injury, would lead to an increase in the identification of battered women. They hypothesized that using such a protocol would increase the identification rate of battered women. The study was conducted in the emergency room of a large, urban, university hospital. Data were collected from the medical records of all female trauma patients from June 1983 to September 1983 prior to implementing systematic protocols in order to establish a baseline. Patients were categorized according to the Flitcraft Criteria. After nurses were exposed to the intervention data were again collected for the four-month period from June 1984 to September 1984. The same time period was used to control for seasonal fluctuations but history and mortality due to attrition of staff could pose threats to internal validity. The total N for the pre- and post-intervention was 72 and 74 respectively. The authors reported that post-treatment rate of identification was significantly higher (22.97%) than the pre-treatment rate of 9.72% (Tilden & Shepherd, 1987; Taylor & Campbell, 1992).

McLeod and Anwar (1987) reviewed the records of every fourth female trauma case during 1976 who presented to the ER of the Medical College of Pennsylvania. Females involved in motor vehicle accidents and natural disasters were excluded. A total
of 359 medical records were reviewed. The subjects were categorized using the Flitcraft Criteria. The results indicated that 5.6% were classified as positive, 10.9% were probable, and 9.2% suggestive of battering. A protocol containing questions eliciting a trauma history and whether someone was responsible for causing a woman's injuries was developed. The ER nurses were trained in the use of this protocol. After training and implementation of this protocol, the ER records of every fourth female trauma patient were reviewed for calendar year 1977 for a total of 412. The authors reported that positive identification for battering increased from 5.6% to 30% after implementation of staff training and use of protocols (McLeer & Anwar, 1987; Taylor & Campbell, 1992).

In 1986 McLeer and Anwar received funding to conduct a follow-up study of female trauma patients presenting to the same ER. The methodology and inclusion/exclusion criteria was identical to their previous study. The identification of battered women was significantly lower in 1985 than in 1977. The protocol introduced in 1977 was no longer in effect during the 1985 study. Also, there was no longer any policy or procedure used for identifying battered women or monitoring staff efficacy. Since the demographics of the population utilizing the emergency room had not changed, it was concluded that without a monitoring system to ensure continued use, introduction and implementation of educational programs and protocols are not sufficient for continued vigilance on the part of staff in identifying injuries sustained from battering (McLeer & Anwar, 1989; Taylor & Campbell, 1992).

Goldberg and Tomlanovich (1984) conducted a study using 492 males and females presenting to a general hospital emergency room. The purpose of their study was to obtain information on the extent and nature of domestic violence in this population. Data were collected through chart review and a self-administered questionnaire. The questionnaire contained questions about the type of violence in the relationship, the extent of the violence, and what services would be needed or helpful.
Every tenth person 15 years of age or older who presented to the ER was offered the questionnaire. The study was conducted from June to July and September to October 1981. The results indicated that 22% of the patients identified themselves as victims of domestic violence on the questionnaire but only 5% were identified as such on the ER medical record (Taylor & Campbell, 1992).

Hamerger, Saunders, and Hovey (1992) conducted a study from June 1, 1991, through July 31, 1991, to determine the prevalence of battered women in a family practice clinic. The family practice clinic was located in a Midwestern city with a population of 75,000. According to the authors, all racial, ethnic, and socioeconomic groups were represented in the clinic population. During the eight-week study period all consecutive female patients who presented to the clinic for routine appointments were asked to participate in the study. A total of 394 women participated in the study. However, 20 surveys had incomplete information and were excluded from the analysis which left a total of 374 participants. The participants ranged in age from 18 to 75 years who had been in an intimate relationship for at least six months. Other inclusion criteria included the ability to speak English and free of dementia.

The study included questions about demographic information, relationship status, history of physical abuse, and whether the participant's physician had asked about stress in the relationship and any type of abuse. In addition, participants were given the Conflict Tactics Scale (CTS) to assess verbal and physical aggression within the past twelve months or at any time during the relationship (Hamberger, Saunders, & Hovey, 1992).

Recently battered women were compared to non-battered women on demographic variables. The results indicated no significant differences on race and education. However, the results indicated \( p < .001 \) that the battered women were younger (28.9 years) than the non-battered women (37.8 years). The results also indicated
that the relationships of the battered women were shorter in duration (7.6 years) than the non-battered women (14.5 years) (Hamberger, Saunders, & Hovey, 1992).

A total of 85 women reported having been physically abused within the past year by an intimate partner. The incidence of physical abuse for the entire sample (374) was 22.7%. Women who were considered to be "at risk" were women who, in the past year, were in an intimate relationship and were recently separated or divorced. A total of 338 women were in this latter category. The incidence of physical abuse in this group was 25.1%. The incidence of all women in the study who had been injured within the past year as a result of physical abuse was 13.3% and 14.8% for the "at risk" group (Hamberger, Saunders, & Hovey, 1992).

Lifetime prevalence rates of physical abuse were based on the responses of 335 of the women because of incomplete data. A total of 130 of the women reported having been physically abused at some point during their lifetime by an intimate partner which produced a 38.8% prevalence rate for the total sample. The lifetime injury rate was based on the responses of 351 of the women which yielded a prevalence rate of 24.7%. Although the prevalence of abuse was high in this study, the authors reported that only 2% of the women reported that their physicians asked them about verbal abuse and 1.7% reported that their physicians asked about physical abuse (Hamberger, Saunders, & Hovey, 1992).

**Summary**

In summary, there have been five main objectives of the research literature on battering: (1) determine the incidence and prevalence of domestic violence; (2) determine and relate patterns of domestic violence and factors which contribute to the violence or its cessation; (3) investigate the influence of social factors on violent behavior and helping agencies; (4) furnish psychological profiles of the abuser and battered woman; and (5) answer the proverbial question "why do battered women stay?" (Okun, 1986). Instead of asking the question "why does she stay?", battered women's
advocates suggest we ask "why do so many men beat their wives?", and "what is preventing her from leaving?" (Campbell & Fishwick, 1993).

Domestic violence is a difficult issue to study. One of the major problems is in defining domestic violence. Another problem is the under reporting of family violence. Obtaining subjects to study battering is a serious problem. Most samples come from battered women's shelters or other agencies women turn to for intervention. This is problematic since battered women from shelters do not necessarily represent the general population. Using only battered women from shelters makes it difficult to use random sampling and find control groups. It is also difficult to study those women who are battered but do not seek some type of intervention.

The studies that have been conducted pertaining to the identification of battered women presenting to health care settings concluded that the prevalence is far greater than the number identified as such in their medical records. As a result battered women are not receiving adequate or comprehensive care necessary to meet their needs. It is clear from the literature that all women must be screened for abuse. The need exists to develop a comprehensive screening tool to assist the health care provider in performing this important task.

Review of Domestic Violence Instruments

Index of Spouse Abuse (ISA).

The Index of Spouse Abuse (ISA) is a 30-item scale designed to measure the severity or magnitude of physical and nonphysical abuse of a woman by her intimate partner. The instrument was designed for clinical use to monitor and evaluate progress in treatment. It specifically measures the changes in the severity of physical and non-physical abuse as perceived by the battered woman. Each question on the ISA represents some form of physical or non-physical abuse. Each item is weighted according to the severity of the abusive act. The ISA consists of two sub-scales. The first sub-scale is the ISA-P which measures the severity of physical abuse. The second sub-scale is the

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ISA-NP which measures the severity of non-physical abuse. Each sub-scale also contains a clinical cutting score. The clinical cutting scores on the two sub-scales each range from 0-100. A score above 10 on the ISA-P indicates that a person is probably a victim of severe physical abuse. On the ISA-NP sub-scale a score above 25 is indicative of severe non-physical abuse.

Three studies were conducted to test the validity and reliability of the ISA. In the first study there were 398 female graduate and undergraduate students from various departments within the University of Hawaii who were involved in some type of dating or marital relationship with a male. The average age was 22.8 years, 79.3% were single, 16.6% were married, 2.5% were separated or divorced, and 1.6% reported other marital status. This group was referred to as the Hawaii spouse Abuse Survey (HSAS) sample. The second group consisted of 188 graduate and undergraduate students as well as some faculty members at the University of Hawaii from the School of Social Work and the Psychology department. No demographic information was given on this group. The third group consisted of 107 women. Of this group, 64 were known victims of domestic battery and the remaining 43 were classified "...as being free of any clinically significant partner or spouse abuse." (Hudson & McIntosh, 1981, p.876). "Clinically significant partner or spouse abuse" was not defined. This sample was recruited from several social service agencies and battered women's shelters from Hawaii, Michigan, California, Arkansas, New Mexico, and Pennsylvania. The mean age of this sample was 29.9 years, 14.2% were single, 54.7% were married and 31.1% were separated or divorced. This group was referred to as the ISA Validation (ISAV) group.

The results of the studies indicated that the mean scores for the known battered women was 45.2 on the ISA-P and 58.9 on the ISA-NP as compared to 3.8 on the ISA-P and 8.3 on the ISA-NP for the non-battered women. The internal consistency of the ISA-P has an alpha range of .90 to .94 and .91 to .97 for the ISA-NP. The results indicated that the discriminant validity coefficient is .73 for the ISA-P and .80 for the ISA-NP
(Hudson & McIntosh, 1981). Although its reliability and validity are well established, the ISA was not specifically designed as a screening mechanism to detect battered women, it was designed to be used in clinical settings to monitor and evaluate any change in severity and degree of physical or verbal/emotional abuse. This therefore, limits the use of the ISA as a screening tool.

**The Conflict Tactics Scale (CTS).**

The Conflict Tactics Scale (CTS) is a scale which has been designed to measure intra-family conflict. The CTS has three sub-scales which measure three different tactics one family member may use to resolve a conflict with another family member. The three tactics measured for resolving conflict are reasoning, verbal aggression, and violence. There are three versions of the CTS: Form A, Form N and Form R. Form A was the original version. It was designed as a self-administered questionnaire. Form N is the revised version of Form A and was designed to be used in face-to-face interviews for a national survey on domestic violence. The other differences between Form A and Form N are that Form N focuses more on verbal aggression and violence rather than reasoning; the response range was increased by one; a "response card" was added; some responses were re-written; and a category was added so that if an act ever occurred it could be recorded (Straus, 1979; Straus, Gelles & Steinmetz, 1981). Form R added slightly different response categories as well as the acts of choking, burning and scalding. This version was used in the 1985 Family Violence Resurvey (Straus, 1990). The internal consistency reliability for Form A was computed through item analysis in order to determine the correlation of each item with the total score of the CTS. This sample consisted of 385 husbands and wives. The item-total correlation's for husbands on the reasoning scale ranged from .53-.82 with a mean of .74; the range for the men on the verbal aggression scale ranged from .47-.85 with a mean of .73; and the range for the men on the violence scale for the men ranged from .79-.91 with a mean of .87. The range on the same scales were similar for the wives. The range of item-total
correlation's for the wives on the reasoning scale were .52-.78 with a mean of .70; the range for the wives on the verbal aggression scale were .44-.81 with a mean of .70; and the range for the wives on the violence scale were .84-.91 with a mean of .88. Straus (1979) reported that data indicated a reasonable level of reliability.

To evaluate the reliability of Form N Chronbach's alpha was computed. This sample consisted of 2,143 participants. The alpha coefficient for Form N was .50 for husbands on the reasoning scale; .80 on the verbal aggression scale and .83 on the violence scale. The alpha coefficient on the reasoning scale for the wives was .51; .79 on the verbal aggression scale and .82 on the violence scale. The alpha coefficient for the combined coupled scores was .76 for reasoning; .88 for the verbal aggression scale and .88 for the violence scale. These data also indicated a reasonable level of reliability. As far as the validity of the CTS was concerned, Straus (1979) concluded that there was no definitive evidence to support its validity or lack of evidence to not support its validity. Form R has replaced Form N. No data regarding reliability and validity of Form R was reported.

As reported by Straus and Gelles (1990), the two disadvantages of the CTS are that the CTS does not measure violent acts in a non-conflict situation nor does it measure the consequences of violent acts. This limits its use in predicting abuse. Although the CTS reports good reliability and validity in measuring conflict within the family it was not designed specifically as a screening tool to detect women who are abused. Therefore, its use as a screening tool would be inappropriate.

**Wife Abuse Inventory (WAI).**

Lewis (1983) developed the Wife Abuse Inventory (WAI) to be used as a screening tool to predict women who are at risk of physical abuse by an intimate male partner. A pilot study was conducted on 11 battered women residing in a battered women's shelter. Lewis determined that the WAI should not be administered to battered women on intake as the information given by the battered woman may not be accurate.
The age range of the pilot sample was from 20-44 years. Eight of the women were white and three were black. With the exception of one woman all had been living with their respective partners. The length of their relationships with their partners ranged from 1 year to 25 years.

The pilot version of the WAI consisted of 40 items. If five or more participants responded positively to an item it was kept and included in the final version of the WAI. Item analysis determined that 34 of the items should be kept. The revised WAI consists of 34 questions focusing around the husband's self-image, the degree of social-isolation of the family, and how the couple resolves conflict. The WAI was administered to two groups of women in order to determine whether the instrument could differentiate between battered and non-battered women. The first group consisted of 30 known battered women who were living in a battered women's shelter. In the abused group 19 (86.4%) of the women were white, and 3 (13.67%) were black. Not all the demographic information was available according to the author (Lewis, 1987). Other demographic information such as age, marital status, and length of the relationship was not reported. Group two consisted of 35 non-battered women. Of this group, 21 (84%) were white and 4 (16%) were black. Twenty-five of the surveys from the battered group were considered usable. These were matched from the non-abused group using the variables of women's age, partner's age, length of relationship, and income. The mean composite scores on the WAI for the abused group were 88.72 and 62.24 for the non-abused group. The differences were highly significant $F = 59.29, p < .0001$. The results indicated that the WAI can discriminate between abused and non-abused women. Reliability estimates for the WAI are .90 for the alpha coefficient and .90 for split halves which are indicative of high levels of internal consistency.

The WAI was designed to determine women who are at risk for physical abuse. The WAI does not cover sexual or emotional issues. Lewis (1985) specifically states
that the WAI should not be used as a diagnostic tool. This limits its use in a clinical setting.

**Spouse Abuse Identification Questionnaire.**

Geffner and Pagelow (1989) developed the Spouse Abuse Identification Questionnaire. It consists of 40 items which were designed to "detect the level of intimidation of the victim and how free the abused spouse may be to express feelings and opinions openly." It was written from the victims' perspective. This tool is unpublished and has no established reliability or validity.

**The Brief Anger-Aggression Questionnaire (BAAG).**

The Brief Anger-Aggression Questionnaire (BAAG) was developed by Mauiro, Vitialiano, and Cahn (1987). This instrument was developed to rapidly screen violent-prone men for levels of anger and aggression. This questionnaire contains six items which measure the amount of anger and hostility of the perpetrator or potential perpetrator of intentional violence. Four studies were conducted to establish the reliability and validity of the BAAQ. The first study examined construct validity and used a sample of 137 men. The mean age of the men in this sample was 31.7 years. Sixty-nine percent of the men were white, 24% black and 7% Hispanic or Native American. Thirty-one percent of the men were married, 33% were separated or divorced, and 36% had never been married. A Pearson correlation coefficient was computed on the total scores of the BAAQ and the Buss-Durkee Hostility Inventory (BDHI). According to Mauiro, Vitialiano, and Cahn (1987), the BDHI is "the best known and most widely used measure of anger and hostility" (pg. 167). The scores were found to be significantly related with a Pearson r = .78, p < .001.

The second was undertaken to determine test-re-test reliability. The sample consisted of 44 participants. The mean age was 32.52 years; 75% were white, 19% black, 6% Hispanic or Native American. Twenty-eight percent of the men were married, 34% separated or divorced, and 38% had never been married. The alpha...
coefficient was .82 which indicated a decent level of internal consistency. A Pearson's r was calculated to determine test-re-test reliability which was $r = .84$. This also indicated a high level of reliability.

The third study measures criterion validity using a sample of violent versus non-violent men. The men were separated into one of three groups. Group 1 was the batterers group. This group consisted of 30 men who had physically abused an intimate partner. Group 2 was the general assaulters group. There were 26 men in this group who had assaulted people other than an intimate partner. Group 3 was the mixed group. This group of 37 men had assaulted both an intimate partner and someone else. A control group of 26 men was recruited with matching demographics. The mean age of this group was 32.13 years. Sixty-six percent were white, 28% black, 6% Hispanic or Native American. Thirty-one percent were married, 33% separated or divorced, and 36% had never married. Significant differences ($F = 13.17, p < .001$) were reported between the three violent groups and the non-violent control group. No significant differences were found between the three assaultive groups. The scores on the BAAQ were combined for all three assaultive groups since no significant differences were found between them and subsequently compared to the control group. Multivariate analysis of variance showed significant differences between the assaultive and non-assaultive groups ($p < .001$).

The fourth study also looked at criterion validity related to change as a result of therapy. This study was conducted to determine whether the BAAQ would be sensitive to psychological changes in the men who underwent anger control treatment. The 75 participants in this group were involved in an 18 week group therapy program for violent men. The mean age in the treatment group was 33.90. Seventy-one percent were white, 21% black, 8% Hispanic or Native American. Twenty-one percent were married, 43% separated or divorced, and 35% had never been married. The control group consisted of 26 violent men on the waiting list for the anger control treatment program. Their demographics were matched to the sample group. The control group was
on the waiting list for the same 18 weeks that the treatment group was in session. The BAAQ was given to both groups on a pre-test post-test design. The results of ANOVA with repeated measures during the "pre" and "post" periods revealed no significant differences between the two groups prior to treatment. However, there were significant differences ($F = 18.05, p < .001$) between the two groups after the 18 weeks of treatment. This data suggests that the BAAQ is significant to psychological changes in the men after treatment (Mauro, Vitialiano, & Cahn, 1987). The data support the BAAQ as a valid and reliable instrument to measure anger and aggression levels in violent-prone men. As it is not intended for use as a screening tool to identify battered women its use as such would be inappropriate.

**Psychological Maltreatment of Women Inventory (PMWI).**

The Psychological Maltreatment of Women Inventory (PMWI) developed by Tolman (1989) contains 58 items to assess the types of psychological abuse exhibited by battering men. There are two versions, one for the perpetrator and one for the victim. The PMWI was administered to 408 abusive men and 207 battered women. Seventy-six percent of the men were white, 15% were black, 5% were Hispanic, and 3% were Native American. The average age of the men was 31.9 years. The median income in the sample was from $10,000 to $15,000. The average time the men were in a relationship with their partner was 6.48 years. For the women in the sample the average age was 32.6 years. The racial mix of the women was 89% white, 5% Native American, 4% black, and 1% Hispanic. The average length of the relationship for the women with their partners was 6.9 years. A separate factor analysis was performed on the women's responses and the men's responses. The results from the women's data analysis revealed 13 factors with Eigenvalues greater than 1.000 and 14 factors for the men. Two factors emerged from this analysis. The first factor was a dominance-isolation factor and the second factor was an emotional-verbal factor. The men's data revealed similar loading on the same two factors. The total scores of the two sub-scales

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are highly correlated for both the men \((r = .7320)\) and women \((r = .7376)\). For the domination sub-scale the average scores for the men were 43.3 \((SD = 15.8)\) and 70.7 \((SD = 13.5)\) for the women. On the emotional-verbal sub-scale the average scores for the men were 51.7 \((SD = 15.7)\) and 79.4 \((SD = 17.9)\) for the women (Tolman, 1989).

Intracouple reliability was analyzed using Spearman's Rho. This sample used 28 couples from the larger sample. The results indicate a low rate of agreement between the men and women on both sub-scales. For each of the sub-scales intracouple reliability was analyzed. The scores for both the men and women were significantly correlated on the domination-isolation scale \((r = .4849, p = .007)\). The scores on the verbal-emotional scale were not significantly correlated \((r = .3025, p = .265)\). The alpha coefficients for the women on the domination-isolation were .9451 and .9292 on the emotional-verbal sub-scale. The men also had a high correlation of .9087 on the domination-isolation sub-scale and .9335 on the emotional-verbal sub-scale (Tolman, 1989).

As reported by Tolman (1989) the tool is in progress of refinement. He stated further that this tool is not intended for clinical use until its reliability and validity are further established. Although the PMWI will be a valuable tool in the future in determining treatment plans and outcomes it was not designed as a screening tool for identifying battered women and it would therefore, be inappropriate to use it as such.

**Abusive Behavior Inventory (ABI).**

Shepard and Campbell (1992) developed the Abusive Behavior Inventory (ABI). The ABI is designed to measure the physical and psychological abuse of women by their partners. The ABI is a 30-item instrument using a 5 point Likert-type scale which measures the frequency of abusive behaviors during a 6 month period. It contains two sub-scales: the physical abuse subscale and the psychological abuse subscale. There are two identical versions of this instrument, one for the batterer and one for the battered woman. The only difference between the two instruments is the use of pronouns. The
ABI was administered to 100 men and 78 females in order to test for reliability and validity. The men and women were divided equally into one of four groups: abusers/battered women and non-abusers/non-battered women. Ninety percent of the men were white, 97% of the women were also white. No other race was specified. The income levels of 43% of the women and 51% of the men was below $15,000. In the group of non-abusing men the average age was 40.1 years as compared to 35.9 years in the abuser group. The average age of the women in the non-battered group was 37.3 years compared to 32.9 years in the battered group. The average length of the relationship with their partners was 8.9 years for the women and 8.2 years for the men. No significant differences were reported for either the men or women in the abuse and non-abuse groups using the variables of race, income, or length of relationship.

The alpha coefficients on the physical abuse sub-scale for the four groups ranged from .80 to .92 and the alpha coefficients for the psychological abuse sub-scale ranged from .76 to .91. The standard error of measurement (SEM) ranged from .04 to .12. The low SEM is the desired result. Although the ABI has been shown to be valid and reliable its use as a screening tool is limited since it was developed to assist in the evaluation of abuser treatment programs and not the identification of battered women. Also, the ABI does not address issues concerning sexual assault or abuse by an intimate partner.

**The Abuse Assessment Screen (AAS).**

The Abuse Assessment Screen (AAS) has been developed by the Nursing Research Consortium on Violence and Abuse (1989) to detect the incidence, frequency, and severity of women battered during pregnancy and the relationship battering has on women seeking prenatal care (Parker & McFarlane, 1991). The AAS consists of five "yes-no" questions to be asked by the health care provider. Questions 2, 3, and 4 ask the woman about physical and sexual abuse and her relationship to the perpetrator. Question 1 asks "Have you ever been emotionally or physically abused by your partner or someone important to you?" Question 5 asks "Are you afraid of your partner or
anyone you listed above?" The severity of each physical incident is scored using a scale of 1-6 with one being threats of abuse to number 6 which is use of a weapon or resulting wound from the weapon. The AAS was evaluated by comparing it with the ISA, CTS, and Danger Assessment Screen (DAS). The sample for this comparison consisted of 691 white, black, and Hispanic pregnant women. After being assessed using the AAS all the women were administered the CTS and the ISA. Any identified battered women were given the DAS to identify their risk of homicide. Battered women scored significantly higher on these instruments than non-battered women. When compared to the CTS in this study the alpha coefficient was .80. When compared to the ISA as a whole, the alpha coefficient for the AAS was .95. When compared to the two sub-scales of the ISA the alpha coefficient for the AAS was .87 for the ISA-P and .93 for the ISA-NP. The assessed reliability of the DAS is .71 with a correlation of .75 with the ISA-P and .49 with the CTS sub-scale of severe abuse. The authors report their results are similar to those using research instruments which have been rigorously tested and validated (McFarlane, Parker, Soeken, & Bullock, 1992).

The problem with the AAS is that it is not comprehensive in scope and is designed to be administered by a staff member. This may limit its use in settings where staff are untrained in domestic violence issues, have time constraints, or are uncomfortable in addressing the issue of abuse. Another problem with the AAS is its use of the terms "emotionally or physically abused". Often, women who are in abusive relationships do not label themselves as being abused. Moreover, others do not realize they are being abused emotionally or physically. It is important to use specific terms without labeling.

Clinical experience with battered women has revealed that many do not perceive themselves as being battered. They will speak openly about the way their partner punches, slaps, or kicks them. They will talk about the abusive language he uses toward them and the names he calls them, but time and time again, the women will say "I am not abused or battered". This is why it is so important to develop an instrument that
incorporates the elements of verbal/emotional, sexual, and physical abuse without specifically labeling the acts in the general terms of battering or abuse. Helton (1985) stated "... it is clear that nurses assessing for battering must use more than one question to uncover abuse." (p. 22).

The need also exists for the prevention of violence. Anthropologists report that nonviolent societies exist. Characteristics of nonviolent societies include tendencies to be more egalitarian in terms of economics, power, sex-role expectations, and ethnic arrangements. The non-violent societies do not use corporal punishment to discipline their children; cooperation versus competition is encouraged and valued. Acknowledgment and understanding of non-violent societies and their characteristics are important in that they may be useful in developing primary prevention strategies against violence in our society (Hanrahan, Campbell & Ulrich, 1993). Primary prevention of violence requires societal level interventions, being able to identify women who are at risk of abuse, and nursing interventions with both the women at risk and their abusive partners (Campbell, McKenna, Torres, Sheridan & Landenburger, 1993). There is evidence that verbal (Campbell & Fishwick, 1993; Dobash & Dobash 1979; Walker, 1984) and/or emotional abuse usually, but not always, precedes physical abuse (Edleson, & Tolman, 1992; Shepard & Campbell, 1992; Tolman, 1989). Since evidence supports the notion that emotional abuse precedes physical abuse, there is a need to develop an instrument that may aid health care providers in not only identifying battered women but also detecting women who are at risk for physical abuse.
Methodology

**Woman Abuse Screening Tool (WAST)-Pilot Study.**

The Woman Abuse Screening Tool (WAST) (Taylor, 1991) was developed incorporating the above concepts. Not only can the WAST (Appendix A) be used as a general screening tool for women who are currently in abusive relationships, but it can be used for prevention as well. Women who are reporting high levels of verbal/emotional abuse in their relationships can be alerted to the risk of being physically abused by their partner. A discussion of the development of the WAST and the results of the pilot study are discussed below.

**Purpose.**

The purpose of the pilot study was to assess the stability, readability, and clinical utility of the Woman Abuse Screening Tool (WAST). This tool was designed to detect women who are currently being physically, emotionally and/or sexually abused by an intimate partner. The WAST was developed to be used as a general screening tool for abuse and is appropriate for use in any clinical setting. It can be self-administered or staff administered. The WAST was an 11 item questionnaire requiring yes-no responses and a comments section after each question. Questions 2, 6, 9b, and 10 were specific for detecting physical abuse. Questions 1, 4, 5, 7, 8, 9a, and 11 were written to detect psychological abuse. Question 3 was specific for sexual abuse/assault by an intimate partner. Demographic information such as race, age, type of insurance, occupation, marital status, date of birth, yearly income, level of education, number of children, clinical setting, and medical diagnosis, if applicable, were also collected.
Description of the Sample.

One hundred questionnaires were sent to each data collection site. The sample size for the pilot study was chosen based on Nunnaly's (1978) suggestion of using 10 subjects per item on an instrument. The sample consisted of 104 females ranging in age from 18 years to 86 years. Fifty five of the respondents were from Chicago, Illinois and 49 were from Green Bay, Wisconsin. These two sites were chosen for their differences in population size and racial diversity. It was of interest to compare the number of women reporting abuse in a large urban setting versus a more rural area. Additionally, there was a great interest to determine the number of women reporting abuse in a psychiatric setting versus the emergency department.

All eligible women from the selected units were approached by nursing staff, graduate nursing students, or the principal investigator and asked whether they would be willing to fill out the questionnaire. Excluded were any women who were in critical or life-threatening conditions. The study was explained to each potential participant. In Chicago, completed questionnaires (WAST) were given to the nurse who then placed them in an envelope for completed surveys. In Green Bay, the participants placed the completed surveys in a locked box at the nurses station. Each questionnaire was assigned a number beginning with number one through N in order to maintain confidentiality and anonymity.

For the pilot study, a professional was defined as a physician, registered nurse, teacher, psychologist, upper level management/executive, attorney, social worker, librarian, dentist, or surgeon. White collar was defined as a skilled office worker, secretary, copywriter, lower to middle management, sales, or data entry. Blue collar was defined as a factory worker, laborer, nurses aide, or mechanic. The above categories were chosen based on responses from participants.
**Pilot Results.**

A total of 104 of the 200 questionnaires were returned. The psychiatric intensive care/geriatric units (ICU) in Green Bay, Wisconsin returned 18 of the 50 questionnaires given to them for a 36% return rate. The less acute unit from Green Bay returned a total of 31 of the 50 questionnaires for a 62% return rate. The emergency room in Chicago returned 55 of the 100 questionnaires for a return rate of 55%. The total return rate of both sites combined was 52% (Appendix B). The racial mix of Blacks and Whites were fairly evenly distributed. However Hispanic, Asian, and other racial groups were under-represented (Appendix B). More of the women were employed outside the home than those who were homemakers (Appendix B). The sample was fairly evenly distributed in relation to marital status (Appendix B) and income (Appendix B).

**Reading Level.**

The Fry Readability Scale (1978) was used to determine the approximate reading level of the WAST. According to Fry's (1978) scale the WAST is written at a seventh grade reading level. Fry's Readability graph was directly validated by interformula and comprehension scores and oral reading errors. Fry's Readability graph was also indirectly validated in studies conducted by Zingman, Dulin, Britton and Lumpkin. Fry reports the graph correlated .85 with Rauding technique and .81 with Bormuth level. He also reported correlation's of .95 with Flesch and .85 with Dale-Chall (Fry, 1978).

**Clinical Utility.**

Chi-square tests of association, at a significance level of .01, indicated one slightly ($p=.01930$) significant difference for question 6 and marital status. Question 6 asked whether you ever feel your life or safety is in danger because of your partner's behavior. Twenty of the 97 women who responded to this question answered yes. Only 15% who answered yes were single, the other 85% who answered yes were married.
(45%) or separated/divorced (40%). The accuracy of this statistic is questionable due to the small sample size (Appendix B). However, the high prevalence of physical and sexual abuse reported from the clinical areas indicated that the WAST has clinical utility.

**Summary of WAST Pilot Results.**

Healthy People 2000 (1991) reported that the majority of abusive incidents among intimates were caused by physical abuse, followed by emotional abuse, and sexual abuse. It is interesting to note, that even in this small sample, 33% of the women responded "yes" when directly asked about physical abuse. Another 14% reported sexual assault/abuse by their partners. The responses to questions eliciting emotional abuse were equally high. These figures were consistent with the rates of abuse reported in the literature and suggested that the WAST has clinical utility (Sampselle, 1992; Healthy People 2000, 1991; Campbell, 1989; McLeer & Anwar, 1989; Stark, Flitcraft, & Frazier, 1979; Goldberg & Tomlanovich, 1984; Stark & Flitcraft, 1985).

For each of the questions, a chi-square test of association was performed using the following demographic information: the name of the hospital/clinic, age, marital status, race, education level, number of years of college, type of college degree earned, and occupation. At a significance level of .01, there were no significant differences with the exception of Question 6 and marital status (Appendix B).

The most common method of determining stability of an instrument is the test-re-test procedure. An important step in the development of any proposed tool is to determine the consistency of the items on the tool to assess the content being measured (Strickland & Waltz, 1988). Since this was the first test of the WAST, it was not possible to determine its stability. Further testing is necessary to establish its stability, however the results indicated that the questions adequately addressed the behaviors consistent in abusive relationships.
Current Evaluation of the WAST

In the current study further development of the WAST was done. The specific properties assessed were internal consistency, content validity and discriminant validity. In the development of a new instrument it is necessary to determine minimal levels of reliability and validity (Norbeck, 1985). Nunnally (1978) stated that whenever a new instrument is developed it is of utmost importance to determine its reliability. Other terms associated with reliability are dependability, stability, consistency, predictability, and accuracy. In general terms, reliability refers to the accuracy or precision of an instrument (Kerlinger, 1986). More specifically, reliability is concerned with minimal measurement error and repeatable measurements with different persons at different times. It is important for a measurement to remain stable and dependable over time (Nunnally, 1978).

Internal consistency is concerned with reliability. It is based on the average correlation among items or questions within an instrument or test. Reliability is reported in the form of a correlation coefficient. The alpha coefficient is usually computed when estimating reliability based on the correlation (internal consistency) among test items (Nunnally, 1978). According to Nunnally (1978), the number of items and the average correlation among test items determines the size of the alpha (reliability) coefficient. In general, the higher the alpha the higher the reliability. In the majority of cases, the alpha coefficient is a good estimate of reliability (Nunnally, 1978). According to Nunnally (1978), an alpha of .70 is satisfactory for early stages of the research process and an alpha of .80 is suitable for basic research. A low alpha may be indicative of a test that is too short or that the test items are not related to each other (Nunnally, 1978).

In general, an instrument is considered valid if it measures what it is intended to measure (Nunnally, 1978). In order for an instrument to be valid it must be reliable. However, an instrument with high reliability does not automatically mean that it is valid.
There are many types of validity. This discussion will be limited to content validity and discriminant validity.

Content validity refers to the representativeness of the topic, the matter, or the substance that is being measured. In order to validate content, each item of the instrument must be analyzed and presumed to be representative of whatever property is being measured. It is generally a judgment made alone or in conjunction with others who are experts in that particular content area (Kerlinger, 1986; Nunnally, 1978). However, factor analysis plays an important role as well in determining content, construct and predictive validity. Factor analysis finds clusters of related variables. Each of the variables within a cluster are highly correlated with each other. In regard to content validity, factor analysis will help determine ways of improving and revising the instrument depending on which variables cluster together and are highly correlated and those which are unnecessary (Nunnally, 1978).

Discriminant validity is an important factor in construct validation. Discriminant validity is the ability to empirically distinguish which variables are correlated to a particular construct and how those variables are correlated to that construct. It is also the ability to determine which variables are not related to the construct (Kerlinger, 1986).

The current version of the WAST is slightly different from the version used in the pilot study. In the current version, the responses to the questions have been changed from a "yes-no" choice to a 5 point Likert-type choice (Appendix A). This method was chosen so as to obtain a more detailed account of how frequently the abuse, if any was occurring. This information will also enable the trained clinician to determine the woman's risk of injury and/or further abuse.

The questions have been re-ordered so that the least threatening questions are first, with the most threatening last. The questions are also grouped according to type of
abuse. The verbal/emotional abuse questions are first followed by the physical abuse questions, then sexual abuse. The demographic section follows the abuse questions.

The word "try" had been added to question 1. It now reads as follows: "When you and your partner argue, how often does your partner try to make you feel that you caused the argument?". This question was changed because no one can control how you feel any particular way, but they can try and make you feel a certain way through words or actions. The question "If yes, how long has your partner been doing this to you? ____ Years ____ Months" has been added after each question in order to know how long this has been happening to the woman and to predict whether verbal/emotional abuse is a precursor of physical abuse. Question 14 was added to determine the role of drugs/alcohol and in abusive relationships. Also added to this version are questions on battering and pregnancy, physical violence in front of other people, and whether the participant has ever talked to a healthcare professional about abuse. The information provided is much more comprehensive in scope and can add to the quality of care given to the client.

Research Design

This was a non-experimental, descriptive study. The first purpose of the study was to determine the incidence of self-reported verbal/emotional, physical and/or sexual abuse by an intimate partner among female clients presenting for treatment in a variety of clinical settings. The second purpose was to try and determine whether verbal/emotional abuse are precursors of physical violence. Thirdly, psychometric properties of the instrument were tested. The specific psychometric properties tested were internal consistency, content validity, and discriminant validity.

Data Collection Sites

Data were collected from a variety of settings. The sites chosen included: (a) Anchor-Central, a Health Maintenance Organization (HMO); (b) 6 Kellogg at Rush-Presbyterian-St. Luke's Medical Center, an in-patient obstetrical/gynecological unit;
(c) Rainbow House/Arco Iris and Apna Ghar, two battered women's shelters; (d) Boone County Health Department, a public health clinic; (e) a convenience sample of known non-battered women from throughout the state.

The HMO provided services in the areas of Family Practice, Internal Medicine, Obstetrics and Gynecology, and Pediatrics. The HMO and in-patient obstetrical/gynecological unit were located in the inner city of a large Midwestern metropolitan area and are part of a major medical center/teaching institution. The medical center was a 900 bed facility and tertiary care referral center. Both of the battered women's shelters were located in the same large, metropolitan area as the medical center. One of the battered women's shelters catered primarily to Asian battered women, however, any battered woman was eligible for their services. The public health department was located in a rural area in the Midwest. The sample of known non-battered women were recruited from a large Midwestern urban setting, its suburbs, and from more rural areas throughout the state. These particular sites were chosen in order to gather information on the incidence of self-reported abuse among women from different racial, cultural, educational, and socio-economic groups.

**Subjects**

The sample consisted of women 18 years of age or older presenting to the various clinical settings for treatment and who agreed to participate in the study. The WAST was also administered to a group of known non-battered women and a group of known battered women. The group of known battered women were recruited from two local battered women's shelters. The sample of known non-battered women was a convenience sample recruited by the principal investigator from a group of colleagues and personal contacts.

Exclusion criteria included any woman who presented in a critical, life-threatening condition or who was deemed mentally incapable of completing the questionnaire. For safety reasons women who were accompanied by another person to any of the clinical settings were not included. Also excluded from the study for safety reasons...
reasons were women on the in-patient obstetrical and gynecological unit whose partners were present.

Excluding women from the study whose partners were present or those who were accompanied to one of the clinical settings by a partner may have caused selection bias. Unfortunately, it was not known in which direction this may have biased the sample. For example, were women whose partners present more likely or less likely to have been in abusive relationships? This question could have been interpreted in one of two ways. One interpretation of this question would have been that women whose partners were present were less likely to have been abused because the partners presence would have been seen as loving and caring. However, a partners presence may have been interpreted as the overbearing, overprotective mate who was suspicious and jealous and making sure his abusive behavior remained a secret. Excluding these women from the study may have had an effect on the results of the study. The presence of a woman’s partner in the clinical setting raises issues of implementation of the WAST. For example, if a woman’s partner always accompanies her to her appointments, how and when to obtain an abuse assessment would be of concern. Also, if it were possible to have her partner wait in the reception area while she was in the exam room, would she feel safe to disclose the abuse.

Each setting (Table 1) was coded with a number. Each client was assigned an identification number beginning with number one through N in order to maintain confidentiality and anonymity. A total of 438 women participated in the study.

According to Nunnally (1978) it is not possible to determine in advance the number of participants necessary for item analysis. He suggested that there should be ten times as many participants as items on a test or questionnaire that is under development. However, this is not practical for an instrument with more than 70 items. If an instrument has more than 70 items a guideline for subject size is a minimum of five participants per item (Nunnally, 1978). Kerlinger (1986) suggested that the sample size be as large as possible in order to reduce measurement error. Kerlinger
further stated that data analysis on larger samples results in more accurate results. The total number of items on the WAST was 40. Therefore, based on the guidelines suggested by both Nunnally (1978) and Kerlinger (1986) an N of 400 was the sample size chosen.

Data Collection

Data were collected using the WAST (Appendix A). The WAST is a general screening tool with 26 questions. The WAST was designed to be self-administered or staff-administered. There was also a section for demographic information regarding age, race, educational level, marital status, occupation, and income. The total number of items on the WAST is 40. An in-service was given to the staff at each data collection site by the principal investigator. The purpose of the study was explained to staff. Also included in the in-service was an overview of the dynamics involved in abusive relationships. Staff were each given a copy of the WAST to review in order to become familiar with the items on the questionnaire. Staff were instructed on how to administer and collect the questionnaires. Any questions or concerns were addressed at that time. They were also given the telephone number of the principal investigator for any questions, concerns, problems or issues that they felt needed to be addressed. Client safety and anonymity were emphasized. It should be noted that it takes approximately 10 minutes to complete the WAST.

Data Analysis

Data were analyzed using the Statistical Package for the Social Sciences (SPSS™). The specific version of SPSS™ used was SPSS™ for Windows, Release 5. A significance level of .05 was used for analyses.

Factor analysis was performed in order to determine the relationship of the abuse screening questions to the dimensions of verbal/emotional abuse, physical abuse, and sexual abuse. Cronbach's alpha was computed to determine internal consistency. To determine content validity, the WAST was sent to experts in the field of domestic
violence for their analysis and input. Discriminant analysis was performed to test the hypothesis that the WAST does not discriminate between battered and non-battered women.

Descriptive statistics were computed to test Hypothesis 1, which stated that the incidence of self-reported physical, verbal/emotional, and/or sexual abuse will be < 30%. Chi square tests of association were performed to test Hypothesis 2, which stated that there will be no significant differences in the percentages of women reporting abuse based on race, education, marital status, or income. Chi-square tests of association were also performed to test Hypothesis 3, which stated that there will be no significant differences in the percentages of women reporting abuse based on geographic location or healthcare setting. Multivariate Discriminant analysis was performed to determine whether there were any similarities or differences with respect to abuse based on demographic information, geographic location, or healthcare setting.

To test Hypothesis 4, which stated that verbal and emotional abuse are not precursors of physical abuse, a paired-samples sign test was performed. Each question concerning the length of time physical abuse has occurred was paired with each question concerning the length of time emotional abuse has occurred. The sign test showed the number of times the occurrence of physical abuse preceded emotional abuse. To test Hypothesis 5, which stated that the WAST does not discriminate between battered and non-battered women, discriminant analysis was performed.

**Protection of Human Subjects**

Each of the participants received a written information sheet (Appendix A). The study was explained to them by either the principal investigator or a designated staff person at the shelter or clinical site. Any questions the participants had were answered at that time. They were told they could withdraw from the study at any time. The risks and benefits were explained to each participant. They were given the opportunity to stop at any time while filling out the questionnaire and talk about their feelings with either
the principal investigator or a designated staff person. Participants were also given telephone numbers of battered women's crisis lines, battered women's support groups, and battered women's shelters.

In order to protect the client's safety and anonymity, they were not required to sign any document stating they participated in this study. Participants were informed that none of the information would be placed or maintained in their medical records. Consent was assumed by the participant filling out the questionnaire. Completed questionnaires were placed in an envelope or box (depending on data collection site) marked "Completed Questionnaires".

This study was approved by the Human Investigation Committee of Rush-Presbyterian-St. Luke's Medical Center/Rush University.
Results

Description of the Sample

A total of 438 women participated in this study. Data were collected from two battered women's shelters (Rainbow House/Arco Iris and Apna Ghar), from a group of known non-battered women from throughout the state, and from the general population at three different clinical sites (Anchor-Central, Illinois Department of Health Clinic, and 6 Kellogg at Rush-Presbyterian-St. Luke's Medical Center). Nearly 50% of the participants were from Anchor-Central, 16% were from the battered women's shelters, 21% were from a public health clinic and in-patient maternal child unit, and 13% were a group of known non-battered women. See Table 1 for a description of the data collection sites and the number of participants from each site.

In the top, left-hand corner of the questionnaire was a section for the participants to mark whether they had been interviewed or whether they filled out the WAST without being interviewed. Three hundred ninety-five (90.2%) of the women completed the Woman Abuse Screening Tool (WAST) on their own. Fourteen women were interviewed and 29 did not specify whether or not they were interviewed. The women who were interviewed were Spanish speaking and were unable to read in either Spanish or English. The interviews were conducted by a bi-lingual (English-Spanish) nurse who worked in the public health clinic.

Four hundred-nineteen (95.7%) of the women completed the questionnaire based on a current relationship and 19 (4.3%) of the respondents based their responses on a former relationship. Two hundred-eight (47.5%) women were married (Table 2). The rest were either single, divorced, or widowed. The average number of years a woman was with her partner was 16.99 years, with a mode of 3 years and median of 7 years.
Table 1

Data Collection Sites

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total N = 438</td>
<td>438</td>
<td>100.0</td>
</tr>
<tr>
<td>Known non-battered</td>
<td>58</td>
<td>13.2</td>
</tr>
<tr>
<td>Rainbow House</td>
<td>48</td>
<td>11.0</td>
</tr>
<tr>
<td>Apna Ghar</td>
<td>22</td>
<td>5.0</td>
</tr>
<tr>
<td>Anchor-Central</td>
<td>218</td>
<td>49.8</td>
</tr>
<tr>
<td>IDPH</td>
<td>57</td>
<td>13.0</td>
</tr>
<tr>
<td>Ante-/post-partum unit</td>
<td>35</td>
<td>8.0</td>
</tr>
</tbody>
</table>

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Table 2
Marital Status of Respondents

<table>
<thead>
<tr>
<th>Status</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>208</td>
<td>47.5</td>
</tr>
<tr>
<td>Single</td>
<td>147</td>
<td>33.6</td>
</tr>
<tr>
<td>Separated</td>
<td>28</td>
<td>6.4</td>
</tr>
<tr>
<td>Divorced</td>
<td>37</td>
<td>8.4</td>
</tr>
<tr>
<td>Widowed</td>
<td>5</td>
<td>1.1</td>
</tr>
<tr>
<td>Missing</td>
<td>13</td>
<td>3.0</td>
</tr>
<tr>
<td>Total</td>
<td>438</td>
<td>100.0</td>
</tr>
</tbody>
</table>
The mean number of children per woman was 1.65. The number of children per woman ranged from 0 to 10 with a standard deviation of 1.613. The participants ranged in age from 18 years to 78 years. The mean age of the participants was 34.7 years, the mode was 37.0 years, and the median age was 33.5 years.

The sample consisted of African American (44.3%), white (34.0%), Hispanic (12.6%), Asian (4.8%), Native American (0.2%), and other (1.4%) women (Table 3). In response to race (question 32), one woman wrote, "What difference does it make?"

The total United States population in 1990 was 248,710,000. For the Chicago Metropolitan Area which includes the city of Chicago, Gary, Indiana, and Kenosha, Wisconsin, the total population in 1990 was 8,240,000. According to the 1990 population distribution figures the racial breakdown for the Chicago Metropolitan area was as follows: (a) African/American-19.0%; (b) White-66.8%; (c) Hispanic origin-10.9%, persons of Hispanic origin may be of any race; (d) Asian/Pacific Islander-3.1%; and (e) American Indian, Eskimo, Aleut-0.2% (Statistical Abstract of the United States, 1993).

In comparing the racial mix of the sample population to the racial mix of the Chicago Metropolitan area there is an over-representation of African/Americans by 25.3%, Asians by 1.7%, and Hispanics by 1.7% in the study population. There is an under-representation of Whites. The distribution of Native/Americans in the study is representative of the Chicago Metropolitan area.

Forty-three (9.8%) of the women reported having no health insurance, 46 (10.5%) had Public Aid/Medicaid, 268 (61.2%) belonged to an HMO/PPO, 8 (1.8%) were Medicare recipients, 61 (14%) had private insurance and 12 (2.7%) did not respond. Two hundred eighteen (49.8%) of the participants were from the HMO. This accounted for the high percentage of women who reported having an HMO as their insurance carrier. A question that came to mind was how does an HMO affect a battered
<table>
<thead>
<tr>
<th>Race</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>149</td>
<td>34.0</td>
</tr>
<tr>
<td>Black/African American</td>
<td>194</td>
<td>44.3</td>
</tr>
<tr>
<td>Hispanic</td>
<td>55</td>
<td>12.6</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>21</td>
<td>4.8</td>
</tr>
<tr>
<td>American Indian</td>
<td>1</td>
<td>.2</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>1.4</td>
</tr>
<tr>
<td>Missing</td>
<td>12</td>
<td>2.7</td>
</tr>
<tr>
<td>TOTAL</td>
<td>438</td>
<td>100.0</td>
</tr>
</tbody>
</table>
woman's access to healthcare if she must first call her primary care provider before seeking treatment in a non life-threatening situation?

Four questions pertained to work status. The questions moved from general to specific. Question 35 was: "Do you work?" Question 36: "Are you paid for your work?" Question 37: "Are you a housewife?" Question 38: "If you are not a housewife, what kind of job do you have?" Questions 35 through 37 were forced-choice yes or no answers. Although originally there was not a "not applicable" response category for questions 35 through 37, participants wrote in "NA" to questions 36, 37, 38, and 39, that a "NA" category was created for data analysis. Question 38 was an open-ended question that required respondents to write in their particular job title or occupation.

The participant's responses to the type of job held were coded into the following categories: (a) 0 = Unemployed; (b) 1 = Retired; (c) 2 = Professional; (d) 3 = White collar; (e) 4 = Blue collar; (e) 5 = Student; (f) 6 = Other; and (g) 7 = NA (not applicable). For the purposes of this study a professional was defined as a physician, registered nurse, occupational therapist, dietitian, architect, teacher, psychologist, upper level management/executive, attorney, social worker, librarian, dentist, or surgeon. White collar was defined as a skilled office worker, banker, real estate broker, secretary, copywriter, lower to middle management, computer supervisor, sales, or data entry. Blue collar was defined as a factory worker, laborer, construction worker, cook, waitress, nurses aide, or mechanic. The "Other" category included parenting, mothering, teaching assistant, self-employed, "do nails", china inspector, baby-sitting, electrologist, and travel agent. The above categories were chosen based on responses from participants.

Three hundred-six (69.9%) of the women stated they worked, 118 (26.9%) reported they did not work. Of the 420 women responding to the question, "Are you paid for your work?" (question 36), 298 (68.0%) said they were paid, 50 (11.4%) stated they were not paid, 72 (16.4%) responded with not applicable (NA). Only 383 of the
438 women reported income levels. Of those who reported their income, the average was $25,000 to $29,999 per year, with a median of $30,000 to $39,999 per year, and a mode of < $10,000 (Table 4).

Of the 399 women responding to question 37 which asked, "Are you a housewife?", 141 (32.2%) responded "yes", 257 (58.7%) responded "no", 1 woman responded with "NA". Of the 321 women responding to question 38 which asked, "If you are not a housewife, what kind of job do you have?", 19 (4.3%) were unemployed; 1 (.2%) was retired; 78 (17.8%) were professionals; 72 (16.4%) were white-collar workers; 22 (5.0%) were blue-collar; 8 (1.8%) were students; 36 (8.2%) were in the "Other" category; 85 (19.4%) responded with NA. Many of the women who worked outside the home also responded "yes" to "Are you a housewife". One woman who had responded that she was both a professional and a housewife made the following comment: "We women get to have two jobs, aren't we the special ones."

Question 34, "How much education do you have?" had the following response categories: (a) did not finish high school or get a GED; (b) high school; (c) GED; (d) Business/Technical/Vocational School; (e) Some College; (f) College Graduate; (g) Graduate School; or (h) Doctorate. More than 60% of the participants had some college education or more. Eighty-eight percent of the women were high school graduates. Thirty-four percent of the participants were college graduates. In addition, nearly 20% completed graduate degrees. The median education level for the 427 women who responded to this question was "some college" (Table 5).

Three hundred fifty-four (80.8%) women were not pregnant at the time they completed the WAST, 58 (13.2%) were pregnant, 5 (1.1%) did not know if they were pregnant, and 21 (4.8%) made no response. Two hundred-eleven (48.2%) of the women reported they were healthy, 124 (28.3%) of the respondents had a medical disorder (Table 6).
### Table 4

**Income**

<table>
<thead>
<tr>
<th>Income</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $10,000</td>
<td>71</td>
<td>16.2</td>
</tr>
<tr>
<td>$10,000-14,999</td>
<td>25</td>
<td>5.7</td>
</tr>
<tr>
<td>$15,000-19,999</td>
<td>25</td>
<td>5.7</td>
</tr>
<tr>
<td>$20,000-24,999</td>
<td>28</td>
<td>6.4</td>
</tr>
<tr>
<td>$25,000-29,999</td>
<td>24</td>
<td>5.5</td>
</tr>
<tr>
<td>$30,000-39,999</td>
<td>51</td>
<td>11.6</td>
</tr>
<tr>
<td>$40,000-49,999</td>
<td>61</td>
<td>13.9</td>
</tr>
<tr>
<td>$50,000-59,999</td>
<td>35</td>
<td>8.0</td>
</tr>
<tr>
<td>More than 60,000</td>
<td>63</td>
<td>14.4</td>
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<tr>
<td>Missing</td>
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<td>12.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>438</td>
<td>100.0</td>
</tr>
<tr>
<td>Education</td>
<td></td>
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</tr>
<tr>
<td>-----------------------------------------</td>
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</tr>
<tr>
<td><strong>Total N = 438</strong></td>
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<td></td>
</tr>
<tr>
<td>Did not finish high school</td>
<td>42</td>
<td>9.6</td>
</tr>
<tr>
<td>High school graduate</td>
<td>70</td>
<td>16.0</td>
</tr>
<tr>
<td>GED</td>
<td>13</td>
<td>3.0</td>
</tr>
<tr>
<td>Business/tech/vocational</td>
<td>21</td>
<td>4.8</td>
</tr>
<tr>
<td>Some college</td>
<td>132</td>
<td>30.1</td>
</tr>
<tr>
<td>College graduate</td>
<td>62</td>
<td>14.2</td>
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<tr>
<td>Graduate school</td>
<td>69</td>
<td>15.8</td>
</tr>
<tr>
<td>Doctorate</td>
<td>18</td>
<td>4.1</td>
</tr>
<tr>
<td>Missing</td>
<td>11</td>
<td>2.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>438</td>
<td>100.0</td>
</tr>
<tr>
<td>Medical Diagnosis</td>
<td>Frequency</td>
<td>Percent (%)</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-----------</td>
<td>-------------</td>
</tr>
<tr>
<td>None</td>
<td>211</td>
<td>48.2</td>
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<tr>
<td>Obesity/Eating Disorders</td>
<td>6</td>
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<tr>
<td>Respiratory System Dysfunction</td>
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<td>Cardiovascular System Dysfunction</td>
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<td>.7</td>
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<td>Nervous System Dysfunction</td>
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<td>1.8</td>
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<tr>
<td>Endocrine System Dysfunction</td>
<td>8</td>
<td>1.8</td>
</tr>
<tr>
<td>GI system Dysfunction</td>
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<td>Musculoskeletal System Dysfunction</td>
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<td>Reproductive System Dysfunction</td>
<td>4</td>
<td>.9</td>
</tr>
<tr>
<td>Mental Disorders</td>
<td>11</td>
<td>2.5</td>
</tr>
<tr>
<td>Other*</td>
<td>24</td>
<td>5.5</td>
</tr>
<tr>
<td>Missing</td>
<td>103</td>
<td>23.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>438</td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

*Multiple diagnosis reported
For those respondents answering affirmatively as to whether they had ever spoken to a healthcare professional about abuse, 46 (10.5%) also included written comments about what their healthcare provider said to them (Appendix C). Eighty-four (19.2%) women had additional written comments to Question 40 which asked "If there is anything else you would like to say, please write your comments below:" (Appendix D).

For the purpose of the following discussion, the abuse question responses were recoded from "Never", "A few times a year", "A few times a month", "A few times a week", and "Everyday", into the two groups of "never abused" and "abused at least a few times a year". For a complete summary of the responses to the abuse questions prior to recoding see Table 7. Questions 1 through 13, 15, 22, and 23 asked about behaviors that are considered to be various forms of psychological abuse. Psychological abuse includes such behaviors as threats of violence, instilling fear, controlling behavior, extreme jealousy, verbal and mental degradation, the abuser blaming others for his/her violence, enforced isolation, humiliation, intimidation, and economic abuse (Tolman, 1989; Campbell & Humphreys, 1993; Shepard & Campbell, 1992). Questions 16 through 18, and 20 pertained to physical violence. Question 21 asked about forced sexual activities. Question 14 asked about the woman's partner's use of drugs or alcohol.

A total of 434 women responded to question 1a which asked, "When you and your partner argue, how often does your partner try to make you feel that you caused the argument?" One hundred-four (23.7%) women reported never, 330 (75.3%) reported that this happened to them at least a few times a year. When asked "How often does your partner call you bad names?" (Q2a), 261 (59.6%) stated never and 176 (40.2%) indicated they were called bad names at least a few times a year.

In response to "How often does your partner say things to you to try and make you feel bad?" (Q3a), 196 (44.7%) of the participants responded never, 240 (54.8%) indicated their partners said things to try and make them feel bad at least a few times a
<table>
<thead>
<tr>
<th>Question</th>
<th>Never N (%)</th>
<th>A few times/year N (%)</th>
<th>A few times/month N (%)</th>
<th>A few times/week N (%)</th>
<th>Everyday N (%)</th>
<th>NA N (%)</th>
<th>Missing N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When you and your partner argue, how often does your partner try to make you feel that you caused the argument?</td>
<td>104 (23.7)</td>
<td>134 (30.6)</td>
<td>97 (22.1)</td>
<td>50 (11.4)</td>
<td>49 (11.2)</td>
<td>4 (0.9)</td>
<td></td>
</tr>
<tr>
<td>2. How often does your partner call you bad names?</td>
<td>261 (59.6)</td>
<td>79 (18.0)</td>
<td>42 (9.6)</td>
<td>30 (6.8)</td>
<td>25 (5.7)</td>
<td>1 (0.2)</td>
<td></td>
</tr>
<tr>
<td>3. How often does your partner say things to you to try and make you feel bad?</td>
<td>196 (44.7)</td>
<td>102 (23.3)</td>
<td>63 (14.4)</td>
<td>43 (9.8)</td>
<td>32 (7.3)</td>
<td>2 (0.5)</td>
<td></td>
</tr>
<tr>
<td>4. How often does your partner accuse you of being with other men/women?</td>
<td>300 (68.5)</td>
<td>57 (13.0)</td>
<td>30 (6.8)</td>
<td>25 (5.7)</td>
<td>24 (5.5)</td>
<td>2 (0.5)</td>
<td></td>
</tr>
<tr>
<td>5. How often does your partner try to keep you from seeing or talking with your family and friends?</td>
<td>324 (74.0)</td>
<td>36 (8.2)</td>
<td>27 (6.2)</td>
<td>19 (4.3)</td>
<td>30 (6.8)</td>
<td>2 (0.5)</td>
<td></td>
</tr>
</tbody>
</table>
Table 7

W.A.S.T. Responses (con't)

<table>
<thead>
<tr>
<th>Question</th>
<th>Never N (%)</th>
<th>A few times/year N (%)</th>
<th>A few times/month N (%)</th>
<th>A few times/week N (%)</th>
<th>Everyday N (%)</th>
<th>NA N (%)</th>
<th>Missing N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. How often do you feel that your partner tries to control your every move?</td>
<td>264 (60.3)</td>
<td>54 (12.3)</td>
<td>24 (5.5)</td>
<td>24 (5.5)</td>
<td>70 (16.0)</td>
<td>2 (.5)</td>
<td></td>
</tr>
<tr>
<td>7. How often does your partner say you are crazy?</td>
<td>253 (57.8)</td>
<td>75 (17.1)</td>
<td>36 (8.2)</td>
<td>31 (7.1)</td>
<td>34 (7.8)</td>
<td>9 (2.1)</td>
<td></td>
</tr>
<tr>
<td>8. How often does your partner withhold money?</td>
<td>298 (68.0)</td>
<td>38 (8.7)</td>
<td>35 (8.0)</td>
<td>19 (4.3)</td>
<td>45 (10.3)</td>
<td>3 (.7)</td>
<td></td>
</tr>
<tr>
<td>9. How often does your partner threaten to destroy your personal things?</td>
<td>366 (83.6)</td>
<td>26 (5.9)</td>
<td>12 (2.7)</td>
<td>15 (3.4)</td>
<td>17 (3.9)</td>
<td>2 (.5)</td>
<td></td>
</tr>
<tr>
<td>10. How often does your partner threaten to hurt your pets?</td>
<td>380 (86.8)</td>
<td>9 (2.1)</td>
<td>2 (.5)</td>
<td>10 (2.3)</td>
<td>3 (.7)</td>
<td>21 (4.8)</td>
<td>13 (3.0)</td>
</tr>
<tr>
<td>11. How often does your partner threaten to hurt your family?</td>
<td>379 (86.5)</td>
<td>22 (5.0)</td>
<td>14 (3.2)</td>
<td>5 (1.1)</td>
<td>11 (2.5)</td>
<td>7 (1.6)</td>
<td></td>
</tr>
<tr>
<td>12. How often does your partner threaten to take your children?</td>
<td>355 (81.1)</td>
<td>20 (4.6)</td>
<td>12 (2.7)</td>
<td>7 (1.6)</td>
<td>9 (2.1)</td>
<td>26 (5.9)</td>
<td>9 (2.1)</td>
</tr>
<tr>
<td>Question</td>
<td>Never N (%)</td>
<td>A few times/year N (%)</td>
<td>A few times/month N (%)</td>
<td>A few times/week N (%)</td>
<td>Everyday N (%)</td>
<td>NA N (%)</td>
<td>Missing N (%)</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-------------</td>
<td>------------------------</td>
<td>-------------------------</td>
<td>------------------------</td>
<td>----------------</td>
<td>-----------</td>
<td>--------------</td>
</tr>
<tr>
<td>13. How often does your partner threaten to hurt your children?</td>
<td>367 (83.8)</td>
<td>14 (3.2)</td>
<td>8 (1.8)</td>
<td>8 (1.8)</td>
<td>5 (1.1)</td>
<td>28 (6.4)</td>
<td>8 (1.8)</td>
</tr>
<tr>
<td>14. How often does your partner use drugs or alcohol?</td>
<td>179 (40.9)</td>
<td>71 (16.2)</td>
<td>68 (15.5)</td>
<td>74 (16.9)</td>
<td>38 (8.7)</td>
<td>6 (1.4)</td>
<td></td>
</tr>
<tr>
<td>15. How often do you feel your life and/or safety are in danger because of your partner's behavior?</td>
<td>326 (74.4)</td>
<td>38 (8.7)</td>
<td>15 (3.4)</td>
<td>11 (2.5)</td>
<td>45 (10.3)</td>
<td>3 (0.7)</td>
<td></td>
</tr>
<tr>
<td>16. How often is your partner violent to other people?</td>
<td>349 (79.7)</td>
<td>43 (9.8)</td>
<td>25 (5.7)</td>
<td>8 (1.8)</td>
<td>6 (1.4)</td>
<td>1 (0.2)</td>
<td>4 (0.9)</td>
</tr>
<tr>
<td>17. How often does your partner push, slap, hit or otherwise physically hurt you?</td>
<td>322 (73.5)</td>
<td>48 (11.0)</td>
<td>35 (8.0)</td>
<td>21 (4.8)</td>
<td>10 (2.3)</td>
<td></td>
<td>2 (0.5)</td>
</tr>
<tr>
<td>18. How often does your partner hit, slap, push, or otherwise physically hurt you in front of other people?</td>
<td>378 (86.3)</td>
<td>27 (6.2)</td>
<td>17 (3.9)</td>
<td>9 (2.1)</td>
<td>4 (0.9)</td>
<td></td>
<td>3 (0.7)</td>
</tr>
</tbody>
</table>
Table 7

W.A.S.T Responses (con’t)

<table>
<thead>
<tr>
<th>Question</th>
<th>Never N (%)</th>
<th>A few times/year N (%)</th>
<th>A few times/month N (%)</th>
<th>A few times/week N (%)</th>
<th>Everyday N (%)</th>
<th>NA N (%)</th>
<th>Missing N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. If you have ever been pregnant while with your current partner, how often does/did your partner physically hurt you while you are/were pregnant?</td>
<td>273 (62.3)</td>
<td>7 (1.6)</td>
<td>19 (4.3)</td>
<td>5 (1.1)</td>
<td>4 (.9)</td>
<td>115 (26.3)</td>
<td>15 (3.4)</td>
</tr>
<tr>
<td>21. How often does your partner force you to have sex or perform sexual acts against your will?</td>
<td>361 (82.4)</td>
<td>26 (5.9)</td>
<td>20 (4.6)</td>
<td>14 (3.2)</td>
<td>12 (2.7)</td>
<td>1 (.2)</td>
<td>4 (.9)</td>
</tr>
<tr>
<td>22. After you and your partner have an argument or physical fight how often does your partner promise never to hurt you again?</td>
<td>266 (60.7)</td>
<td>41 (9.4)</td>
<td>27 (6.2)</td>
<td>15 (3.4)</td>
<td>33 (7.5)</td>
<td>27 (6.2)</td>
<td>29 (6.6)</td>
</tr>
<tr>
<td>23. Does your partner appear to be wonderful and/or charming to the rest of the world but is a monster at home?</td>
<td>293 (66.9)</td>
<td>41 (9.4)</td>
<td>21 (4.8)</td>
<td>13 (3.0)</td>
<td>54 (12.3)</td>
<td>4 (.9)</td>
<td>12 (2.7)</td>
</tr>
</tbody>
</table>
year. One hundred thirty-six (31.1%) women indicated that their partners accused them of being with other men/women at least a few times a year (Q4a).

One hundred-twelve (25.6%) women felt that their partners tried to keep them from seeing or talking to family and friends at least a few times a year (Q5a). One hundred seventy-two (39.3%) of the women felt their partners tried to control their every move at least a few times a year (Q6a).

One hundred seventy-six (40.2%) of the participants reported being called crazy by their partners at least a few times a year (Q7a). One hundred thirty-seven (31.3%) women indicated that their partners withheld money from them at least a few times a year (Q8a). Destruction of personal property by an intimate partner at least a few times a year was reported by 70 (16.0%) of the women (Q9a).

Twenty-four (5.5%) women reported that at least a few times a year their partner threatened to harm their pets (Q10a). Fifty-two (11.9%) women stated that their partners threatened to hurt family members at least a few times a year (Q11a). Of the 429 women responding to the question, "How often does your partner threaten to take your children?" (Q12a), 48 (11.0%) stated their partners threatened to take the children at least a few times a year. Four hundred-thirty women answered question 13a which asks, "How often does your partner threaten to hurt your children?". Thirty-five (8.0%) of these women reported that their partners threatened to harm their children at least a few times a year.

Two hundred fifty-one (57.3%) women reported that their partners use either drugs or alcohol at least a few times a year (Q14a). One hundred-nine (24.9%) respondents stated they felt that their life/safety was in danger due to their partner's behavior at least a few times a year (Q15a).

Eighty-two (18.7%) participants stated that at least a few times a year their partners were violent to other people (Q16a). When asked about physical abuse (Q17a), 114 (26.0%) of the women stated they were physically abused at least a few times a year (Q17a).
times a year by an intimate partner. One of the women stated in response to this question (17a) that her husband never physically abused her but, "he has taken out the gun and shot up the house twice." Of the 438 participants, 57 (13.0%) reported that their partners physically abused them in front of other people at least a few times a year (Q18a). Thirty-five (8.0%) women also reported being physically abused while they were pregnant (Q20). Seventy-two (16.4%) of the women reported that they were forced to have sex or perform sexual acts against their will at least a few times a year by their partner (Q21a).

Of the 409 women who responded to question 22a which asked, "After you and your partner have an argument or physical fight how often does your partner promise never to hurt you again?", 116 (26.5%) stated their partners promised never to hurt them again at least a few times a year. One hundred twenty-nine (29.5%) women stated that at least a few times a year their partner was wonder/charming to the rest of the world but a monster at home (Q23a). One woman wrote the following comment next to this question: "They don't think he is a monster, they know he is a monster!"

**Chi-square Tests of Association**

Chi-square tests of association were performed to determine if there were significant differences in the percentages of women reporting physical abuse (question 17a) based on race, education, marital status, income, setting, and age. A chi-square test of association tests the hypothesis that the variables are not related. If this hypothesis is rejected it can not be concluded that there is a cause and effect relationship, only that there is an association between the variables tested (Shott, 1990). The responses to Question 17a (physical abuse) were recoded into two groups: never abused and abused at least a few times a year. It was necessary to recode question 17a (physical abuse) in order to determine whether there was any association between physical abuse and race, education, marital status, income, setting, and age because prior to recoding more than 20% of the expected frequencies were less than five.
A total of 424 cases were used to determine significant differences in the percentages of woman reporting physical abuse based on race. Since four of the 12 cells (33.3%) had an expected frequency less than five it was not possible to determine if there was an association between race and physical abuse in the entire study population. However, the percentages shown in Table 8 indicated that in this study African/American women reported higher rates of physical abuse than the other racial groups.

Another chi-square test of association was performed to determine significant differences in the percentages of woman reporting physical abuse based on race using only the participants from the HMO (Anchor), the public health clinic, and the inpatient obstetrical/gynecological unit. For this analysis race was collapsed into the following three categories: (a) white; (b) African/American; and (c) other. The results indicated a significant difference ($X^2 = 8.68432, DF = 2, p = .01301$) in the percentages of women who reported physical abuse based on race (Table 9). Twenty-eight (9.4%) of the African/American women reported that they had been physically abused at least a few times a year compared to 14 (4.7%) women in the "Other" category and 7 (2.3%) of the white women.

There is controversy whether race and physical abuse are associated. Very little is really known about the degree of physical abuse and ethnicity. In their study of 2,143 families, Straus, Gelles, and Steinmetz (1988) reported that husband to wife abuse was highest among African/American men (11%), followed by Other (5%), and White (3%). They reported that it was 400% more common in African/American families than white families (Straus, Gelles, & Steinmetz, 1988). However, Lockhart (1985) refuted the results of Straus, Gelles, and Steinmetz (1988). She stated that the 400% difference they reported was actually only a 5% difference. She further stated that the 400% figure was derived by dividing 11% by 3%. Another problem cited by Lockhart (1985) regarding the Straus, Gelles, and Steinmetz (1988) study results was that they
Table 8

Physical Abuse by Race Using the Entire Sample

<table>
<thead>
<tr>
<th></th>
<th>Never Abused</th>
<th>Abused</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Row %</td>
<td>Column %</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Column %</td>
</tr>
<tr>
<td>TOTAL N = 424</td>
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<td></td>
</tr>
<tr>
<td>White</td>
<td>N = 130</td>
<td>N = 18</td>
</tr>
<tr>
<td></td>
<td>87.8</td>
<td>12.2</td>
</tr>
<tr>
<td></td>
<td>41.8</td>
<td>15.9</td>
</tr>
<tr>
<td></td>
<td>30.7</td>
<td>4.2</td>
</tr>
<tr>
<td>Black/African American</td>
<td>N = 129</td>
<td>N = 64</td>
</tr>
<tr>
<td></td>
<td>66.8</td>
<td>33.2</td>
</tr>
<tr>
<td></td>
<td>41.5</td>
<td>56.6</td>
</tr>
<tr>
<td></td>
<td>30.4</td>
<td>15.1</td>
</tr>
<tr>
<td>Hispanic</td>
<td>N = 39</td>
<td>N = 16</td>
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<td></td>
<td>70.9</td>
<td>29.1</td>
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<tr>
<td></td>
<td>9.2</td>
<td>3.8</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>N = 8</td>
<td>N = 13</td>
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<tr>
<td></td>
<td>38.1</td>
<td>61.9</td>
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<td></td>
<td>1.9</td>
<td>3.1</td>
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<tr>
<td>American Indian</td>
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<tr>
<td></td>
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</tr>
<tr>
<td>Other</td>
<td>N = 5</td>
<td>N = 1</td>
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<tr>
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<td>83.3</td>
<td>16.7</td>
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<tr>
<td></td>
<td>1.6</td>
<td>.9</td>
</tr>
<tr>
<td></td>
<td>1.2</td>
<td>.2</td>
</tr>
<tr>
<td>Column Total</td>
<td>N = 311</td>
<td>N = 113</td>
</tr>
<tr>
<td>Total Percent (%)</td>
<td>73.3</td>
<td>26.7</td>
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<tr>
<td></td>
<td>White</td>
<td>African/Amer</td>
</tr>
<tr>
<td>------------------</td>
<td>-------</td>
<td>--------------</td>
</tr>
<tr>
<td></td>
<td>Row %</td>
<td>Row %</td>
</tr>
<tr>
<td>TOTAL N = 424</td>
<td></td>
<td></td>
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<tr>
<td>Known non-battered</td>
<td>77.6</td>
<td>19.0</td>
</tr>
<tr>
<td></td>
<td>30.2</td>
<td>5.7</td>
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<td></td>
<td>10.6</td>
<td>2.6</td>
</tr>
<tr>
<td>Rainbow House</td>
<td>11.1</td>
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<td>17.7</td>
</tr>
<tr>
<td></td>
<td>1.2</td>
<td>8.0</td>
</tr>
<tr>
<td>Apna Ghar</td>
<td>19.0</td>
<td>4.8</td>
</tr>
<tr>
<td></td>
<td>2.7</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>0.9</td>
<td>0.2</td>
</tr>
<tr>
<td>Anchor</td>
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<td>63.3</td>
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<td></td>
<td>25.5</td>
<td>69.3</td>
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<tr>
<td></td>
<td>9.0</td>
<td>31.4</td>
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<td>IDPH</td>
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<td>3.6</td>
</tr>
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<td></td>
<td>27.5</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>9.7</td>
<td>0.5</td>
</tr>
<tr>
<td>Ante-/post-partum</td>
<td>47.1</td>
<td>32.4</td>
</tr>
<tr>
<td>unit</td>
<td>10.7</td>
<td>5.7</td>
</tr>
<tr>
<td></td>
<td>3.8</td>
<td>2.6</td>
</tr>
<tr>
<td>Column Total</td>
<td>N = 322</td>
<td>N = 114</td>
</tr>
<tr>
<td>Total %</td>
<td>73.9</td>
<td>26.1</td>
</tr>
</tbody>
</table>
failed to report whether the difference found between the races was significant (Lockhart, 1985).

Lockhart (1985) conducted a study on husband to wife abuse with a sample of 307 black women and white women. Her results indicated that there were no significant differences between the races. She cited methodological problems as the issue involved in previous studies which have compared physical abuse and race. According to Lockhart (1985) the methodological problems included: (a) the use of clinical samples; (b) the use of data from criminal justice agencies; and (c) neglecting to control for social class.

It is thought that the differences in prevalence of woman battering found between the races may be associated with social class as opposed to race. Lockhart stated that researchers must control for social class before any major conclusions can be drawn between physical abuse and race (Lockhart, 1985). Although race has been cited as a risk factor for physical abuse, it has not been found with any consistency to increase a woman's risk for abuse (Stark & Flitcraft, 1988).

Chi-square tests of association suggested that in this study population education and physical abuse were associated (7 DF, $X^2 = 36.83429, p = .00001$). The results in Table 10 showed that women (38.9%) who had completed "some college" were more likely to be abused at least a few times a year compared to the women in the other education categories. The group who had not completed high school had the second highest percentage of women (20.4%) who had been abused followed by those who had completed: high school (13.3%), college (10.6%), business/technical/vocational school (5.3%), graduate school (5.3%), and doctorates (1.8%) respectively. This finding was supported by the research results of Straus, Gelles, and Steinmetz (1988). Incomplete degree completion may be associated with the presence of abuse.

The data indicated that there was an association between marital status and physical abuse (4 DF, $X^2 = 41.96145, p = .00000$). The percentages in Table 11 indicated that single women were more likely to experience some form of physical abuse.
### Table 10

**Physical Abuse by Education**

<table>
<thead>
<tr>
<th>Education Level</th>
<th>% Never Abused</th>
<th>% Abused</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=425</td>
<td>machinery</td>
<td>machinery</td>
<td>machinery</td>
</tr>
<tr>
<td>Did not finish high school</td>
<td>N =19</td>
<td>N = 23</td>
<td>N =42</td>
</tr>
<tr>
<td></td>
<td>Total %</td>
<td>Total %</td>
<td>Total Row %</td>
</tr>
<tr>
<td></td>
<td>6.1</td>
<td>20.4</td>
<td>9.9</td>
</tr>
<tr>
<td></td>
<td>4.5</td>
<td>5.4</td>
<td></td>
</tr>
<tr>
<td>High School Graduate</td>
<td>N = 54</td>
<td>N = 15</td>
<td>N = 69</td>
</tr>
<tr>
<td></td>
<td>Total %</td>
<td>Total %</td>
<td>Total Row %</td>
</tr>
<tr>
<td></td>
<td>17.3</td>
<td>13.3</td>
<td>16.2</td>
</tr>
<tr>
<td></td>
<td>12.7</td>
<td>3.5</td>
<td></td>
</tr>
<tr>
<td>GED</td>
<td>N = 8</td>
<td>N = 5</td>
<td>N = 13</td>
</tr>
<tr>
<td></td>
<td>Total %</td>
<td>Total %</td>
<td>Total Row %</td>
</tr>
<tr>
<td></td>
<td>2.6</td>
<td>4.4</td>
<td>3.1</td>
</tr>
<tr>
<td></td>
<td>1.9</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td>Business/Tech/Voc</td>
<td>N = 15</td>
<td>N = 6</td>
<td>N = 21</td>
</tr>
<tr>
<td></td>
<td>Total %</td>
<td>Total %</td>
<td>Total Row %</td>
</tr>
<tr>
<td></td>
<td>4.8</td>
<td>5.3</td>
<td>4.9</td>
</tr>
<tr>
<td></td>
<td>3.5</td>
<td>1.4</td>
<td></td>
</tr>
<tr>
<td>Some College</td>
<td>N = 88</td>
<td>N = 44</td>
<td>N = 132</td>
</tr>
<tr>
<td></td>
<td>Total %</td>
<td>Total %</td>
<td>Total Row %</td>
</tr>
<tr>
<td></td>
<td>28.2</td>
<td>38.9</td>
<td>31.1</td>
</tr>
<tr>
<td></td>
<td>20.7</td>
<td>10.4</td>
<td></td>
</tr>
<tr>
<td>College Graduate</td>
<td>N = 50</td>
<td>N = 12</td>
<td>N = 62</td>
</tr>
<tr>
<td></td>
<td>Total %</td>
<td>Total %</td>
<td>Total Row %</td>
</tr>
<tr>
<td></td>
<td>16.0</td>
<td>10.6</td>
<td>14.6</td>
</tr>
<tr>
<td></td>
<td>11.8</td>
<td>2.8</td>
<td></td>
</tr>
<tr>
<td>Graduate School</td>
<td>N = 62</td>
<td>N = 6</td>
<td>N = 68</td>
</tr>
<tr>
<td></td>
<td>Total %</td>
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<td>Total Row %</td>
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<td>19.9</td>
<td>5.3</td>
<td>16.0</td>
</tr>
<tr>
<td></td>
<td>14.6</td>
<td>1.4</td>
<td></td>
</tr>
<tr>
<td>Doctorate</td>
<td>N = 16</td>
<td>N = 2</td>
<td>N = 18</td>
</tr>
<tr>
<td></td>
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<td>Total %</td>
<td>Total Row %</td>
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<td></td>
<td>5.1</td>
<td>1.8</td>
<td>4.2</td>
</tr>
<tr>
<td></td>
<td>3.8</td>
<td>.5</td>
<td></td>
</tr>
<tr>
<td>Column Total</td>
<td>N = 312</td>
<td>N = 113</td>
<td>N = 425</td>
</tr>
<tr>
<td>Total %</td>
<td>machinery</td>
<td>machinery</td>
<td>machinery</td>
</tr>
<tr>
<td></td>
<td>73.4</td>
<td>26.6</td>
<td>100.0</td>
</tr>
</tbody>
</table>

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Table 11

Physical Abuse by Marital Status

<table>
<thead>
<tr>
<th></th>
<th>Never Abused</th>
<th>Abused</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Row %</td>
<td>Column %</td>
</tr>
<tr>
<td>TOTAL N = 423</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>N = 176</td>
<td></td>
</tr>
<tr>
<td></td>
<td>85.4</td>
<td>85.4</td>
</tr>
<tr>
<td></td>
<td>56.8</td>
<td>56.8</td>
</tr>
<tr>
<td></td>
<td>41.6</td>
<td>41.6</td>
</tr>
<tr>
<td>Single</td>
<td>N = 96</td>
<td></td>
</tr>
<tr>
<td></td>
<td>65.3</td>
<td>65.3</td>
</tr>
<tr>
<td></td>
<td>31.0</td>
<td>31.0</td>
</tr>
<tr>
<td></td>
<td>22.7</td>
<td>22.7</td>
</tr>
<tr>
<td>Separated</td>
<td>N = 10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>35.7</td>
<td>35.7</td>
</tr>
<tr>
<td></td>
<td>3.2</td>
<td>3.2</td>
</tr>
<tr>
<td></td>
<td>2.4</td>
<td>2.4</td>
</tr>
<tr>
<td>Divorced</td>
<td>N = 24</td>
<td></td>
</tr>
<tr>
<td></td>
<td>64.9</td>
<td>64.9</td>
</tr>
<tr>
<td></td>
<td>7.7</td>
<td>7.7</td>
</tr>
<tr>
<td></td>
<td>5.7</td>
<td>5.7</td>
</tr>
<tr>
<td>Widowed</td>
<td>N = 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>80.0</td>
<td>80.0</td>
</tr>
<tr>
<td></td>
<td>1.3</td>
<td>1.3</td>
</tr>
<tr>
<td></td>
<td>.9</td>
<td>.9</td>
</tr>
<tr>
<td>Column Total</td>
<td>N = 310</td>
<td></td>
</tr>
<tr>
<td>Total %</td>
<td>73.3</td>
<td>73.3</td>
</tr>
</tbody>
</table>
at least a few times a year than married, separated, divorced, or widowed women. This finding was consistent with reports from other researchers (Stark & Flitcraft, 1985; Bullock, McFarlane, Bateman, & Miller, 1989). Bullock, McFarlane, Bateman, and Miller (1989) found that 38% of dating college students reported they were in abusive relationships. However, these results need to be interpreted with caution as "single" may be confounded with race.

Chi-square tests of association showed a relationship between income and physical abuse (8 DF, $X^2 = 85.99749$, $p = .00000$). According to the percentages presented in Table 12, women with an income less than $10,000 per year were more likely to be physically abused at least a few times a year compared to women with higher incomes. This was an expected finding for this particular group because, of the 382 women who responded to the income and battering questions, 43 (11.3%) of the women reported incomes less than $10,000 per year. Of the 43 battered women with incomes less than $10,000 per year, 35 (9.2%) were from the two battered women's shelters which could have made a difference in the results. Income has been found to increase a woman's risk of abuse (Hotaling & Sugarman, 1990). However, social class was not controlled for and this may have confounded race and class.

An association was evident between setting and physical abuse (5 DF, $X^2 = 165.45492$, $p = .00000$). However, these findings may have resulted because a portion of the participants were recruited from two battered women's shelters. The data in Table 13 show the percentages of women from the various data collection sites who reported being physically abused at least a few times a year by an intimate partner. As would be expected the percentages of women in battered women's shelters reported higher rates of physical abuse than women from the clinical sites. Four of the women from the known non-battered group reported being physically abused by a partner at least a few times a year. Another finding was that four women from one of the battered women's shelter reported that they were not physically abused. The reason these four
Table 12

Physical Abuse by Income

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Never Abused</th>
<th>Abused</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total N = 382</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Never</td>
<td>Abused</td>
</tr>
<tr>
<td>Under $10,000</td>
<td>N = 28</td>
<td>N = 43</td>
</tr>
<tr>
<td>$10,000-14,999</td>
<td>N = 16</td>
<td>N = 9</td>
</tr>
<tr>
<td>$15,000-19,999</td>
<td>N = 16</td>
<td>N = 9</td>
</tr>
<tr>
<td>$20,000-24,999</td>
<td>N = 16</td>
<td>N = 12</td>
</tr>
<tr>
<td>$25,000-29,999</td>
<td>N = 22</td>
<td>N = 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income by Physical Abuse (cont')</td>
<td>Never Abused</td>
<td>Abused</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------</td>
<td>--------</td>
</tr>
<tr>
<td>N = 382</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>Row %</td>
</tr>
<tr>
<td>$30,000-39,999</td>
<td>N = 42</td>
<td>82.4</td>
</tr>
<tr>
<td></td>
<td>14.7</td>
<td>9.3</td>
</tr>
<tr>
<td></td>
<td>11.0</td>
<td>2.4</td>
</tr>
<tr>
<td>$40,000-49,999</td>
<td>N = 56</td>
<td>91.8</td>
</tr>
<tr>
<td></td>
<td>19.6</td>
<td>5.2</td>
</tr>
<tr>
<td></td>
<td>14.7</td>
<td>1.3</td>
</tr>
<tr>
<td>$50,000-59,999</td>
<td>N = 29</td>
<td>82.9</td>
</tr>
<tr>
<td></td>
<td>10.2</td>
<td>6.2</td>
</tr>
<tr>
<td></td>
<td>7.6</td>
<td>1.6</td>
</tr>
<tr>
<td>More than 60,000</td>
<td>N = 60</td>
<td>96.8</td>
</tr>
<tr>
<td></td>
<td>21.1</td>
<td>2.1</td>
</tr>
<tr>
<td></td>
<td>15.7</td>
<td>.5</td>
</tr>
<tr>
<td>Column Total</td>
<td>N = 285</td>
<td>74.6</td>
</tr>
</tbody>
</table>

Missing Cases = 56
<table>
<thead>
<tr>
<th>Setting</th>
<th>N</th>
<th>%</th>
<th>%</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Known non-battered</td>
<td>54</td>
<td>93.1</td>
<td>6.9</td>
<td>16.8</td>
<td>3.5</td>
</tr>
<tr>
<td>Rainbow House</td>
<td>4</td>
<td>8.3</td>
<td>91.7</td>
<td>1.2</td>
<td>38.6</td>
</tr>
<tr>
<td>Apna Ghar</td>
<td>5</td>
<td>22.7</td>
<td>77.3</td>
<td>1.6</td>
<td>14.9</td>
</tr>
<tr>
<td>Anchor</td>
<td>180</td>
<td>83.3</td>
<td>16.7</td>
<td>55.9</td>
<td>31.6</td>
</tr>
<tr>
<td>iDPH</td>
<td>47</td>
<td>82.5</td>
<td>17.5</td>
<td>14.6</td>
<td>8.8</td>
</tr>
<tr>
<td>Ante-/post-partum unit</td>
<td>32</td>
<td>91.4</td>
<td>8.6</td>
<td>9.9</td>
<td>2.6</td>
</tr>
<tr>
<td>Column Total</td>
<td>322</td>
<td>73.9</td>
<td>26.1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
women did not report physical abuse is unclear. Perhaps they were in denial. Another explanation could be that they wanted to present themselves in a socially desirable manner. Perhaps they were not physically abused but feared for their lives due to the threats or behavior of their respective partners.

Age was recoded into groups of ten year increments with the exception of group one. Group one included women from 18 years to 29 years of age. Even after recoding, it was not possible to determine whether there was an association between age and physical abuse because 5 of 14 (35.7%) cells had an expected frequency of less than 5. However, the age group 18 - 29 years had the highest number of abused women (46) followed by the 30-39 year old group in which 38 of the 407 women reported being abused at least a few times a year. Stark and Flitcraft (1988) found abuse to be more common in couples under the age of 30 years. As the age of the women increased the number of women reporting abuse decreased. Eighteen of the women in age group 40-49 reported abuse, 2 women in the 50-59 year age group reported abuse and none of the women over age 60 reported being abused.

Reliability Analysis

Chronbach's alpha is the reliability coefficient that is most commonly calculated. Cases with missing values on any variable are not included in the analysis (Norusis, 1992). A Chronbach's alpha was computed to determine the internal consistency of the WAST. A total of 360 cases met the criteria for inclusion and were used for the physical abuse scale analysis.

Of the 22 items on the physical abuse scale 16 had corrected item-total correlation's above .60, one item above .50, and five items had a corrected item-total correlation below .50. The variables with corrected item-total correlation's above .60 were: (a) physical abuse-17a = .8527; (b) feeling life/safety are in danger-15a = .8252; (c) partner appears wonderful/charming but is a monster-23a = .7943; (d) call you bad names-2a = .7785; (e) keeping from family/friends-5a = .7717; (f)
control moves-6a = .7680; (g) say things to make you feel bad-3a = .7522; (h) threaten to destroy personal things-9a = .7135; (i) partner accuse you of being with other men/women-4a = .6801; (j) force you to have sex-21a = .6762; (k) threaten to hurt your family-11a = .6688; (l) partner withhold money-8a = .6639; (m) partner make you feel you caused the argument-1a = .6420; (n) physical abuse in front of others-18a = .6270; (o) partner says you are crazy-7a = .6194; and (p) partner violent to other people-16a = .6191.

The one variable with a corrected item-total correlation between .50 and .60 was question 22a which asked "After you and your partner have an argument or physical fight how often does your partner promise never to hurt you again?" The corrected item-total correlation was .5265.

Following are the five items with corrected item-total correlation's below .50: (a) partner uses drugs or alcohol-14a = .4426; (b) threatens to hurt your pets-10a = .4174; (c) threatens to take your children-12a = .3782; (d) threatens to hurt your children-.3078; and (e) pregnant physical abuse-20 = .1851. These results may be artifact due to method variance. The above five items would not apply to all women and the "NA-not applicable" response may have resulted in the low correlations.

The behaviors with the highest correlation's on the physical abuse scale were consistent with the various forms of psychological abuse that have been reported to occur in physically abusive relationships as discussed in the literature review (Dutton, 1992; Walker, 1984; Tolman, 1989). However, it was an interesting finding that substance use, threats to harm the children and pets, threats to take the children, and pregnant physical abuse had much lower corrected item-total correlation's given that substance use, threats of harm and pregnant physical abuse have been reported with some consistency to occur in physically abusive relationships. The results may be due to artifact of some people not having children or pets, and having never been pregnant. The alpha for the physical abuse scale was .93.
For the verbal/emotional abuse scale a total of 363 cases met the criteria for inclusion and were used for the analysis. Of the 19 items on the emotional abuse scale 13 items had corrected item-total correlation's above .60, one item above .50, and five items had corrected item-total correlation's below .50.

The variables on the verbal/emotional abuse scale with corrected item-total correlation's above .60 were: (a) 15a-feeling life/safety are in danger because of partner's behavior = .8089; (b) 23a-partner appears to be wonderful/charming but is a monster = .7913; (c) 2a-calls you bad names = .7658; (d) 5a-keeps you from seeing family/friends = .7648; (e) 6a-controls your every move = .7601; (f) 3a-says things to try and make you feel bad = .7446; (g) 9a threatens to destroy personal things = .6957; (h) 4a-accuses you of being with other men/women = .6688; (i) 11a-threatens to hurt your family = .6615; (j) 8a-partner withhold money = .6532; (k) 1a-make you feel you caused the argument = .6128; and (m) 16a-violent to other people = .6016.

The variable on the verbal/emotional abuse scale with a corrected item-total correlation above .50 was: 22a-after an argument/physical fight your partner promises never to hurt you again = .5230. The five items which had corrected item-total correlation's below .50 were: (a) 14a-substance use = .4391; (b) 10a-threatens to hurt your pets = .4188; (c) 12a-threatens to take your children; (d) 13a-threatens to hurt your children = .3082; and (e) 20-pregnant physical abuse = .1806.

The behaviors with the greatest corrected item-total correlation's on the verbal/emotional abuse scale were consistent with the various forms of verbal/emotional abuse such as controlling behaviors, isolation, humiliation, degradation, and economic abuse. It was interesting that 15a (feeling life/safety are in danger) had high correlation's on both scales. However this was an understandable finding because a woman's partner's behavior may have put her life or physical well-being at risk of abuse which would account for the high correlation on the physical abuse.
scale. Alternatively, his behavior could affect her psychological well-being in the form of intimidation which would account for the high correlation of the verbal/emotional abuse scale. The reason that threatening to hurt her pets and children, and threatening to take her children did not correlate higher on the verbal/emotional abuse scale may be due to methodological artifact in that not all women have children or pets. The alpha for the verbal/emotional abuse scale is .91. The large alpha on both scales indicated that the WAST has good reliability.

**Content Validity**

In order to examine content validity a group of five experts in the field of domestic violence were asked to review and evaluate the final version of the WAST. Questions were reviewed for content, completeness and clarity. One reviewer suggested that the number of items on the questionnaire be reduced in order to make it shorter. A second reviewer commented that the WAST is "excellent, well phrased, not inflammatory, and comprehensive". The third expert wrote, "I read through the entire patient information questionnaire and there are no changes that I would make. I think this questionnaire is very good and I think the right questions are asked. Very good Job!!!!"

The fourth expert stated that "in general the instrument captures most of the major assessment questions that exist in other screening tools (Index of Spouse Abuse, Danger Assessment, Psychological Maltreatment of Women Inventory, Abuse Assessment Screen). Questions 24 and 25 are unique in that they assess women's use of the health care system. All-in-all this instrument has clinical utility as is, but could have better utility if the B-response was eliminated." This individual suggested the following revisions: (a) Add a NA (not applicable) response selection to the questions that ask about pets, children and pregnancy since not all women have pets, children, or have been pregnant. (b) Separate the two concepts "life and/or safety" in question 15a since they can have two very different meanings. (c) Consider adding a question asking about
threats, use, or presence of a weapon. (d) Consider weighting the responses to the questions so that they would have more clinical significance. For example those who checked "everyday" would be at greater risk than those who checked "never" or "a few times a year". (e) Change the term "housewife" (question 37) to "homemaker". It was also discussed that the WAST is too long as an initial screening tool for all women. It was suggested that the Abuse Assessment Screen (AAS) be used as the primary screening tool for all women. If there was a positive response to abuse then the WAST could be used to perform a more comprehensive and in-depth assessment.

The fifth domestic violence expert felt that the WAST was too long for busy clinicians to use as a routine screening tool but stated it would be very useful for a more in-depth assessment. It was suggested to try to pull some key questions from the WAST to use initially. Then those women who were suggestive of abuse or who were reporting abuse could be given the entire instrument. For a more in-depth assessment this expert suggested adding more dimensions to questions 20, 21, and 39. Question 20 asks about pregnant physical abuse. It was suggested to ask in conjunction with this question whether the abuse increased, decreased or stayed the same. Question 21 asks about sexual abuse by an intimate partner. The panel member suggested adding sub-parts to this question asking about condom use, multiple partners, IV drug use and other high risk behaviors. Question 39 asks about income. It was suggested to ask if the women's income was greater than her partner's income and how is this related to physical abuse. It was also suggested by this expert to separate Hispanics into categories of Mexican, Puerto Rican, Cuban, and other Hispanic origin.

The fifth expert on domestic violence thought the WAST asked appropriate questions but was too long to be used routinely by busy clinicians. A one page assessment was thought to be more useful. This person stated it was very useful to be administered by an advanced practice clinician in a primary care setting for more in-depth evaluation of a woman's situation. The clinician could then think about patterns, intensity, and
frequency and assist the battered women to understand these trends as well. It was also stated that the WAST would be good as a learning tool for medical students.

**Discriminant Analysis**

The direct method discriminant analysis was performed to determine whether the WAST was able to discriminate between battered and non-battered women. The questions were recoded into two groups. Group 1 was comprised of women who reported never being abused. Group 2 was comprised of women who reported being abused at least a few times a year.

Any cases which had missing information for the variable (17a-physical abuse) that defined the groups or for any of the predictor variables was excluded from the analysis (Norusis, 1992). A total of 360 cases fit the inclusion criteria and were used in the analysis. The results of discriminant analysis are as follows: Eigenvalue = 2.6625; canonical correlation = .8526; Wilks' lambda = .273040, chi-square = 451.102, 21 DF, p = .0000. The canonical correlation is representative of the proportion of the total variance attributable to differences among the groups (Norusis, 1992). Wilks' lambda "...is the proportion of the total variance in the discriminant scores not explained by differences among groups..." (Norusis, 1992, pg. 17). A small lambda is associated with functions that have much variability between groups but very little variability within groups (Norusis, 1992). The analysis correctly classified 94.44% of the cases. The results of discriminant analysis demonstrated that the WAST has a high canonical correlation and a low Wilks' lambda, indicating much variability between groups, as well as a high classification rate; the WAST was able to discriminate between battered and non-battered women.

The stepwise procedure of multivariate discriminant analysis was performed to determine whether there were similarities or differences with respect to abuse based on setting, race, age, marital status, education, work status, income, and occupation.
Predictor variables are one of the desired end-products of discriminant analysis. Stepwise selection method is commonly used to select the variables (Norusis, 1992).

"...[T]he first variable included in the analysis has the largest acceptable value for the selection criterion. After the first variable is entered, the value of the criterion is reevaluated for all variables not in the model, and the variable with the largest acceptable criterion value is entered next. At this point, the variable entered first is reevaluated to determine whether it meets the removal criterion. If it does, it is removed from the model.

The next step is to examine the variables not in the equation for entry, followed by examination of the variables in the equation for removal. Variables are removed until none remain that meet the removal criterion. Variable selection terminates when no more variables meet entry or removal criteria." (Norusis, 1992, pg. 21).

A total of 278 cases met the inclusion criteria and were used in the analysis. Computation ceased after step 4 because the other selected variables were not eligible for inclusion. The four variables remaining were income, setting, race (Table 14), and work status. In this particular study, discriminant analysis suggested that there was a difference with respect to abuse based on income (Wilks' lambda = .77504, p = .0000); setting (Wilks' lambda = .74197, p = .0000); race (Wilks' lambda = .72858, p = .0000), and employment status (Wilks' lambda = .71536, p = .0000). The canonical discriminant functions were: Eigenvalue = .3979; canonical correlation = .5335, Wilks' Lambda = .715360; Chi-square = 91.782, 4 DF, p = .0000). It is important to note that although Wilks' lambda is statistically significant, it does not provide much information about how effective the discriminant function classifies cases among the groups. Wilks' lambda only tests the null hypothesis that the population means are equal (Norusis, 1992). The discriminant analysis procedure correctly classified the cases.
<table>
<thead>
<tr>
<th></th>
<th>Never Abused</th>
<th>Abused</th>
<th>Row Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Row %</td>
<td>Column %</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TOTAL N = 298</td>
<td>Column %</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Row %</td>
<td>Column %</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TOTAL N = 249</td>
<td>Column %</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TOTAL N = 298</td>
<td>Column %</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Row %</td>
<td>Column %</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TOTAL N = 298</td>
<td>Column %</td>
<td></td>
</tr>
</tbody>
</table>

White

- N = 87
- 34.9
- 92.6
- 29.2
- N = 94
- 31.5

Black/African American

- N = 117
- 47.0
- 80.7
- 39.3
- N = 145
- 48.7

Other

- N = 45
- 18.1
- 76.3
- 15.1
- N = 59
- 19.8

Total Percent (%)

- 83.6
- 16.4
- 100.0
75.60% of the time. However, this predicted group classification is not much better than chance.

The stepwise procedure of multivariate discriminant analysis was also performed only using the data from the three health care settings to determine whether there were similarities or differences with respect to abuse based on income, health care setting, race, and work status. A total of 268 cases met the inclusion criteria and were used in the analysis. Computation ceased after step 1 because the other selected variables were not eligible for inclusion. Income was found to be significant (Eigenvalue = .0421, Wilks' lambda = .959562, $X^2 = 10.959$, DF = 1, $p = .0009$). These results are supported in the literature which found income to be a risk marker of physical abuse (Hotaling & Sugarman, 1990).

Factor Analysis

Factor analysis was performed to determine the relationship of the abuse screening questions to the dimensions of verbal/emotional abuse, physical abuse, and sexual abuse. A principal components analysis produced two factors with Eigenvalues greater than one. The Eigenvalue for Factor 1 = 10.46060 which accounted for 47.5% of the variability. The Eigenvalue for Factor 2 = 1.95126 and accounted for 8.9% of the variability. A scree plot also indicated that two factors were appropriate. The first factor which emerged was an abuse factor which included physical, sexual, verbal/emotional abuse factors and controlling behaviors. The second factor was more of a threat factor. Most of the variables loaded on Factor 1. This may have resulted because rather than women experiencing one type of abusive behavior they are experiencing a combination of verbal/emotional, physical and sexual abuse.

On Factor 1 seven of the variables had a factor loading of .80 or above, six had factor loadings of .70 to .76, three variables had a factor loading of .60 to .68, and one factor had a factor loading of .56. The other five factors had a factor loading below .50. Only two factors had a factor loading above .50 on Factor 2.
The variables with factor loadings on Factor 1 of .80 and above were questions 17a (physical abuse), 15a (feel life/safety are in danger because of partner's behavior), 2a (partner call you bad names), 23a (partner appears wonderful/charming but is a monster at home), 6a (partner tries to control your every move), 5a (partner keeps you from seeing/talking with family/friends), and 3a (say things to try and make you feel bad). Questions 9a (partner threatens to destroy your personal things), 4a (partner accuse you of being with other men/women), 21a (forced sex), 8a (partner withhold money), 1a (make you feel you caused argument), and 11a (partner threatens to hurt your family) had factor loadings of .76 to .70 respectively. Factors loadings of .68 to .67 included questions 7a (partner says you are crazy), 18a (physical abuse in front of others), and 16a (partner violent to other people). Question 22a (partner promises never to hurt you again) had a factor loading of .56.

Those questions with factor loadings less than .50 on Factor 1 included 14a (substance use), 10a (threat to hurt pets), 13a (threat to hurt children), 12a (threat to take children), and 20 (pregnant physical abuse). Question 10a (threat to hurt pets) was difficult to interpret because it had a very similar factor loading on both Factors 1 and 2.

On Factor 2, the threat factor, questions 13a (threat to hurt children) and 12a (threat to take children) had factor loadings of .85 to .81 respectively. Question 10a (threat to hurt pets) had a factor loading of .40 and question 20 (pregnant physical abuse) had a factor loading of .35 on Factor 2. The results of the factor loadings are presented in Table 15.

The Varimax rotation method was used to achieve a more simple structure. Rotation helps to interpret the variables which in turn permits differentiation between the factors. Rotation changes the factor matrix but does not change the communalities and the percentage of total variance explained. What does change is the variance...
<table>
<thead>
<tr>
<th>Question</th>
<th>Factor 1</th>
<th>Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. How often does your partner push, slap, hit or otherwise physically hurt you?</td>
<td>.89747</td>
<td>-.09335</td>
</tr>
<tr>
<td>15. How often do you feel your life and/or safety are in danger because of your partner's behavior?</td>
<td>.86555</td>
<td>-.00086</td>
</tr>
<tr>
<td>2. How often does your partner call you bad names?</td>
<td>.83505</td>
<td>-.18603</td>
</tr>
<tr>
<td>23. Does your partner appear to be wonderful and/or charming to the rest of the world but is a monster at home?</td>
<td>.82734</td>
<td>-.02725</td>
</tr>
<tr>
<td>6. How often do you feel that your partner tries to control your every move?</td>
<td>.81945</td>
<td>-.12354</td>
</tr>
<tr>
<td>5. How often does your partner try to keep you from seeing or talking with your family and friends?</td>
<td>.81248</td>
<td>.00241</td>
</tr>
<tr>
<td>3. How often does your partner say things to you to try and make you feel bad?</td>
<td>.80964</td>
<td>-.20154</td>
</tr>
<tr>
<td>9. How often does your partner threaten to destroy your personal things?</td>
<td>.76226</td>
<td>.04267</td>
</tr>
<tr>
<td>Question</td>
<td>Factor 1</td>
<td>Factor 2</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-----------</td>
</tr>
<tr>
<td>4. How often does your partner accuse you of being with other men/women?</td>
<td>.74258</td>
<td>-.11521</td>
</tr>
<tr>
<td>21. How often does your partner force you to have sex or perform sexual acts against your will?</td>
<td>.72416</td>
<td>.03732</td>
</tr>
<tr>
<td>8. How often does your partner withhold money?</td>
<td>.72410</td>
<td>-.04978</td>
</tr>
<tr>
<td>1. When you and your partner argue, how often does your partner try to make you feel that you caused the argument?</td>
<td>.71315</td>
<td>-.28759</td>
</tr>
<tr>
<td>11. How often does your partner threaten to hurt your family?</td>
<td>.70592</td>
<td>.18540</td>
</tr>
<tr>
<td>7. How often does your partner say you are crazy?</td>
<td>.68248</td>
<td>-.14769</td>
</tr>
<tr>
<td>18. How often does your partner hit, slap, push, or otherwise physically hurt you in front of other people?</td>
<td>.67828</td>
<td>-.04282</td>
</tr>
<tr>
<td>16. How often is your partner violent to other people?</td>
<td>.67647</td>
<td>-.09317</td>
</tr>
<tr>
<td>Question</td>
<td>Factor 1</td>
<td>Factor 2</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>22. After you and your partner have an argument or physical fight how</td>
<td>.56478</td>
<td>.07540</td>
</tr>
<tr>
<td>often does your partner promise never to hurt you again?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. How often does your partner use drugs or alcohol?</td>
<td>.48738</td>
<td>.11380</td>
</tr>
<tr>
<td>10. How often does your partner threaten to hurt your pets?</td>
<td>.42507</td>
<td>.39627</td>
</tr>
<tr>
<td>13. How often does your partner threaten to hurt your children?</td>
<td>.27748</td>
<td>.85369</td>
</tr>
<tr>
<td>12. How often does your partner threaten to take your children?</td>
<td>.35292</td>
<td>.81092</td>
</tr>
<tr>
<td>20. If you have ever been pregnant while with your current partner,</td>
<td>.18822</td>
<td>.34767</td>
</tr>
<tr>
<td>how often does/did your partner physically hurt you while you were</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pregnant?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
accounted for by each of the factors. The varimax method strives to minimize the number of variables that have high loadings on a factor (Norusis, 1992).

Once rotated, the factor loadings on Factor 1 (physical abuse) changed somewhat. Questions 17a (physical abuse), 2a (call you bad names), 3a (say things to make you feel bad), 15a (feel life/safety in danger) and 6a ((control your every move) had factor loadings of .88 to .82. Factor loadings for questions 23a (appears wonderful/charming but is a monster at home), 5a (keep from seeing/talking to family/friends), 1a (make you feel like you caused argument), 4a (accuse you of being with other men/women), 9a (destroy personal things), and 8a partner withhold money) ranged from .797 to .705. Questions 7a (say you are crazy), 21a forced sex), 16a (partner violent to others), 18a (physical abuse in front of others), and 11a (threat to hurt your family) had factor loadings on Factor 1 from .695 to .617. Questions 22a (promise never to hurt you again) and 14a (substance use) each had factor loadings of .51598 and .42204 respectively on Factor 1.

After varimax rotation (Table 16) the same four variables (13a-threat to hurt children, 12a-threat to take children, 10a-threat to hurt pets, & 20-pregnant physical abuse) loaded on Factor 2 (verbal/emotional abuse). However, after rotation the factor loadings for the variables on Factor 2 were higher than prior to rotation. Factors 13a (threat to hurt children) and 12a (threat to take children) had factor loadings of .89762 and .87951 respectively which was a slight increase than before they were rotated. Variables 10a (threat to hurt pets) and 20 (pregnant physical abuse) increased their factor loadings on Factor 2 from .39627 to .50573, and from .34767 to .38818 respectively.

**Paired Samples Sign Test**

A paired-samples sign test was performed in order to determine whether verbal/emotional abuse are precursors of physical abuse. Each question concerning the length of time physical abuse occurred was paired with each question concerning the
Table 16

**Factor Structure After Varimax Rotation**

<table>
<thead>
<tr>
<th>Question</th>
<th>Factor 1</th>
<th>Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. How often does your partner push, slap, hit or otherwise physically hurt you?</td>
<td>.88401</td>
<td>.18079</td>
</tr>
<tr>
<td>2. How often does your partner call you bad names?</td>
<td>.85235</td>
<td>.07363</td>
</tr>
<tr>
<td>3. How often does your partner say things to you to try and make you feel bad?</td>
<td>.83277</td>
<td>.05119</td>
</tr>
<tr>
<td>15. How often do you feel your life and/or safety are in danger because of your partner's behavior?</td>
<td>.82577</td>
<td>.25940</td>
</tr>
<tr>
<td>6. How often do you feel that your partner tries to control your every move?</td>
<td>.81868</td>
<td>.12854</td>
</tr>
<tr>
<td>23. Does your partner appear to be wonderful and/or charming to the rest of the world but is a monster at home?</td>
<td>.79726</td>
<td>.22275</td>
</tr>
<tr>
<td>5. How often does your partner try to keep you from seeing or talking with your family and friends?</td>
<td>.77416</td>
<td>.24657</td>
</tr>
<tr>
<td>1. When you and your partner argue, how often does your partner try to make you feel that you caused the argument?</td>
<td>.76662</td>
<td>-.05989</td>
</tr>
</tbody>
</table>

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Table 16
Factor Structure After Varimax Rotation (con't)

<table>
<thead>
<tr>
<th>Question</th>
<th>Factor 1</th>
<th>Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. How often does your partner accuse you of being with other men/women?</td>
<td>.74286</td>
<td>.11337</td>
</tr>
<tr>
<td>9. How often does your partner threaten to destroy your personal things?</td>
<td>.71416</td>
<td>.26986</td>
</tr>
<tr>
<td>8. How often does your partner withhold money?</td>
<td>.70557</td>
<td>.17022</td>
</tr>
<tr>
<td>7. How often does your partner say you are crazy?</td>
<td>.69530</td>
<td>.06432</td>
</tr>
<tr>
<td>21. How often does your partner force you to have sex or perform sexual acts against your will?</td>
<td>.67944</td>
<td>.25331</td>
</tr>
<tr>
<td>16. How often is your partner violent to other people?</td>
<td>.67318</td>
<td>.11451</td>
</tr>
<tr>
<td>18. How often does your partner hit, slap, push, or otherwise physically hurt you in front of other people?</td>
<td>.65978</td>
<td>.16308</td>
</tr>
<tr>
<td>11. How often does your partner threaten to hurt your family?</td>
<td>.61752</td>
<td>.38905</td>
</tr>
<tr>
<td>22. After you and your partner have a physical fight how often does your partner promise never to hurt you again?</td>
<td>.51598</td>
<td>.24171</td>
</tr>
</tbody>
</table>

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Table 16

Factor Structure After Varimax Rotation (con't)

<table>
<thead>
<tr>
<th>Question</th>
<th>Factor 1</th>
<th>Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. How often does your partner use drugs or alcohol?</td>
<td>.42204</td>
<td>.25236</td>
</tr>
<tr>
<td>13. How often does your partner threaten to hurt your children?</td>
<td>.00799</td>
<td>.89762</td>
</tr>
<tr>
<td>12. How often does your partner threaten to take your children?</td>
<td>.09279</td>
<td>.87951</td>
</tr>
<tr>
<td>10. How often does your partner threaten to hurt your pets?</td>
<td>.28627</td>
<td>.50573</td>
</tr>
<tr>
<td>20. If you have ever been pregnant while with your current partner, how often does/did your partner physically hurt you while you are/were pregnant?</td>
<td>.07499</td>
<td>.38818</td>
</tr>
</tbody>
</table>
length of time verbal/emotional abuse occurred. Participants were asked to write in the space that was provided the number of years or months a particular incident occurred. However, this caused confusion because many of the women put a check mark or "X" next to the "years" or "months" response choices instead of writing in a specified length of time. This made analysis impossible. Therefore, "length of time" responses ("b" questions) were recoded as follows: 1 = < 1 year; 2 = 1-5 years; 3 = 6-10 years; 4 = 11-20 years; 5 = 21-30 years; 6 = > 30 years; 7 = number of years not specified; 8 = number of months not specified; 9 = NA (not applicable).

The results of the paired-samples sign test are shown in Table 17. Questions 1b (try to make you feel you caused argument), 2b (call you bad names), 3b (say things to make you feel bad), 6b (control your every move), 7b (say you are crazy), 9b (destroy personal things), 10b (threat to hurt pets), 11b (threat to hurt family), 12b (threat to take children), 13b (threat to hurt children), 14b (substance use), and 16b (violent to others) were statistically significant at the .05 level indicating that these variables occurred prior to the physical abuse. In the literature the one risk factor that has been shown with any consistency to precipitate woman battering was male violence toward other people (Stark & Flitcraft, 1988). However, Hotaling and Sugarman (1990) found that the only consistent risk marker for husband to wife abuse was low socioeconomic status. Questions 4b (accuse you of being with other men/women), 5b (keep you from seeing/talking to family/friends), 8b (partner withhold money), 15b (feel life/safety are in danger because of partner's behavior), 22b (partner promise never to hurt you again), and 23b (appears wonderful/charming but is a monster at home) were not statistically significant at the .05 level.

The verbal/emotional abuse questions that were significant included: the abuser making the woman feel as though she caused their arguments; name calling; saying hurtful things; controlling behaviors; telling her she's crazy; destroying her personal
<table>
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<tr>
<th>Question 17b with:</th>
<th>Cases</th>
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<tr>
<td>1b (argument)</td>
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</tr>
<tr>
<td>2b (bad names)</td>
<td>396</td>
<td>5.1111</td>
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<tr>
<td>3b (feel bad)</td>
<td>370</td>
<td>8.8387</td>
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<td>5b (isolation)</td>
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<td>6b (control)</td>
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<td>9b (destroy property)</td>
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<td>10b (threaten pets)</td>
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<td>22b (broken promises)</td>
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<td>23b (appears charming)</td>
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property; threatening to hurt her pets, family, or children; threatening to take her children; using alcohol or drugs; and the abuser being violent to other people. The results of these findings are supported by the findings of other researchers (Tolman, 1992; Tolman, 1989; Shepard & Campbell, 1992). Verbal and emotional abuse have been found to be harmful. It is also known that verbal and emotional abuse are usually accompanied by physical abuse (Tolman, 1992; Tolman, 1989; Shepard & Campbell, 1992). Therefore, the behaviors that were significant as precursors to physical abuse can be seen as warning signals to the clinician and patient.

Those questions that were not significant as precursors to physical abuse included jealousy, isolation from family or friends, withholding money, feeling as though her life/safety were in danger because of her partner's behavior, her partner promising never to hurt her again, and her partner being wonderful/charming to the rest of the world but is a monster at home. Typically, the behaviors that were not found to be significant, and therefore not precursors of physical abuse in this study population, would not occur early on in the relationship. This type of behavior would begin to evolve after the relationship had been established for some period of time and the woman was more deeply engaged in the relationship.

Results of Hypothesis Testing

Hypothesis One.

Hypothesis one stated that the incidence of self-reported physical, verbal/emotional, and sexual abuse will be < 30%. The data indicate that the total percentage of women in this study who reported physical abuse was 26%. Of the 216 women from Anchor, 16.7% reported abuse. Of the 57 participants from a public health clinic 17.5% reported abuse. Of the 35 women were from the in-patient obstetrical/gynecological unit 8.6% reported abuse. These results supported the hypothesis that self-reported physical abuse was < 30% and it was therefore not possible to reject hypothesis one. However, most of the research on the prevalence of
battering has been conducted in emergency departments. A small number of studies have
been conducted in primary care settings.

The prevalence of battering found in emergency departments ranged from 20% to
33% (McLeer & Anwar, 1987; Tilden & Shepherd, 1987; Stark, Flitcraft & Frazier,
1979; Goldberg & Tomlanovich, 1984). Hamberger, Saunders and Hovey (1992)
conducted a study to determine the prevalence of battered women in a family practice
clinic. Their results indicated that 22.7% of 394 women had been physically abused
within the past year by an intimate partner. The lifetime rate of abuse among the
participants was 38.8%. The other studies that were conducted in primary care settings
reported that the prevalence of battering in their female clientele ranged from 3.9% to
8% (Hillard, 1985; Helton, McFarlane, & Anderson, 1987; Campbell, Poland, Waller,

The number of women who reported sexual abuse was 16.4% which also
supports hypothesis one. The percentage of women who reported verbal/emotional abuse
was greater than 30% for questions 1a (make you feel you caused argument), 2a (call
you bad names), 3a (say things to try and make you feel bad), 4a (accuse you of being
with other men/women), 6a (control your every move), 7a (say you are crazy), and 8a
(partner withhold money), but not for questions 5a (keep you from seeing/talking with
your family/friends), 9a (threat to destroy your personal things), 10a threat to hurt
pets), 11a (threat to hurt family), 12a (threat to take children), 13a (threat to hurt
children), 15a (feel life/safety are in danger because of partner's behavior), and 22a
(promise never to hurt you again). The results are presented in Table 7. Therefore,
hypothesis one was rejected by seven of the verbal/emotional abuse questions and
supported by eight of the verbal/emotional abuse questions.

**Hypothesis Two.**

Hypothesis two stated that there will be no significant differences in the
percentages of women reporting abuse based on race, education, marital status, or
income. Chi-square tests of association suggested that in this study population there were differences in the percentages of women reporting abuse based on education ($p = .00001$), marital status ($p = .00000$), and income ($p = .00000$).

A chi-square test of association was performed to determine significant differences in the percentages of women who reported physical abuse based on race using only the participants from the HMO (Anchor), the public health clinic, and the inpatient obstetrical/gynecological unit. The results indicated a significant difference ($X^2 = 8.68432$, $DF = 2$, $p = .01301$) in the percentages of women who reported physical abuse based on race (Table 9). Therefore, hypothesis two was rejected based on race, education, marital status, and income.

The results of discriminant analysis indicated significant differences ($p < .05$) between the women who reported physical abuse based on income and race (Eigenvalue = .3979, canonical correlation = .5335, Wilks' lambda = .715360, Chi-square = 91.782, 4 df, $p = .0000$) but not on education or marital status. However, when discriminant analysis was performed using only the health care settings income was found to be significant ($p = .009$).

**Hypothesis Three.**

Hypothesis three stated that there will be no significant differences in the percentages of women reporting abuse based on geographic location, or healthcare setting. Chi-square tests of association, using only the three health care settings, suggested that there were no significant differences in the percentages of women reporting abuse based on setting ($p = .44594$). Since there were no significant differences hypothesis three can not be rejected based on chi-square analysis. The results indicated that battered women are present in areas of the health care setting other than the emergency department. The results are supported by the findings of other researchers (Hamberger, Saunders, & Hovey, 1992; Bullock, 1989; Stark & Flitcraft, 1988).
The results of discriminant analysis, using all of the data collection sites, indicated a significant (p < .05) difference with respect to abuse based on setting (p = .0000). Based on the results of discriminant analysis hypothesis three was rejected. The results of discriminant analysis suggested that the WAST was able to discriminate between battered and non-battered women.

**Hypothesis Four.**

Hypothesis four stated that verbal/emotional abuse are not precursors of physical abuse. The results (Table 17) of the paired-samples sign test (p < .05), suggested that the WAST questions pertaining to certain types of verbal/emotional abuse such as degradation, humiliation, mind-games, violence toward others, and intimidation were precursors of physical abuse. Therefore, hypothesis four was rejected. The six verbal/emotional abuse questions that were not significant such as economic abuse, jealousy, isolation, broken promises and threats to harm others were consistent with the types of verbal/emotional abuse that would occur after the physical abuse had begun. This is consistent with behaviors reported by Tolman (1992).

**Hypothesis Five.**

Hypothesis five stated that the WAST does not discriminate between battered and non-battered women. The results of discriminant analysis (p = .0000) indicated that the WAST was able to discriminate between battered and non-battered women. Therefore, hypothesis five was rejected at the .05 significance level.
Conclusions and Recommendations

Summary of the Findings

The purpose of this study was threefold. The first purpose was to determine whether using a comprehensive abuse screening tool would result in an increased identification rate of women who are in abusive relationships than has been reported in other studies. The second purpose was to try and determine whether verbal/emotional abuse are precursors of physical violence. The third purpose was to test specific psychometric properties of the WAST.

The specific psychometric properties of the WAST that were tested included internal consistency, content validity, and discriminant validity. As internal consistency is concerned with reliability (Nunnally, 1978), a Chronbach’s alpha was computed on the physical violence scale and the verbal/emotional abuse scale. According to Nunnally (1978) a high alpha is indicative of good reliability. The alpha coefficients were .93 and .91 respectively, indicating that the WAST is highly reliable.

A good instrument must be valid as well as reliable (Nunnally, 1978). Content validity was tested using five individuals who are considered experts in the field of domestic violence. The experts were asked to examine each item on the WAST and determine how well each question represented the various forms of abuse (physical, verbal/emotional, and sexual).

In general, the panel of experts felt that the items were representative of the various dimensions of abuse and that the WAST has good clinical utility. Minor revisions were suggested. Suggested revisions included: (a) reduce the number of items on the WAST to make it shorter; (b) add "NA-not applicable" responses to the items pertaining to children, pregnancy, and pets; (c) separate the concepts "life and/or safety" in
question 15a since they do not mean the same thing; (d) consider weighting the responses; (e) add questions asking about threats, use, or presence of weapons; (f) add more dimensions to the questions pertaining to forced sexual activities and battering during pregnancy; (g) distinguish between substance use and abuse; (h) change the term "housewife" to homemaker; and (i) separate Hispanic categories into Mexican, Puerto Rican, and Cuban. Three of the five domestic violence experts felt the WAST was too long to be used as a screening tool, and that it should be used as an assessment tool once abuse was discovered.

It can also be argued that the WAST is appropriate as a screening tool for all women especially if one wants to use it as a primary prevention tool. If used as a prevention tool then women reporting high rates of verbal/emotional abuse may be at risk of physical abuse sometime in the future. Intervention at this point may prevent the physical abuse from occurring by alerting the woman to the danger signs. She could then be informed of her rights, and other options available to her. Once given the necessary information she could decide whether or not to take action appropriate to her needs and circumstances.

Factor analysis also plays a role in determining content validity. Two factors emerged as a result of factor analysis. The two factors were an abuse factor (Factor 1) which included verbal/emotional abuse, physical abuse, sexual abuse and controlling behaviors; and the second factor was a threat factor (Factor 2).

Following is a list of the variables with factor loadings greater than .50. The variables are listed from highest to lowest factor loadings (the question number is in parentheses following a description of the variable): physical abuse (17a); the woman feeling her life/safety are in danger because of her partner's behavior (15a); being called bad names (2a); her partner is wonderful/charming outside the home, but is a monster at home (23a); her partner controlling her moves (6a); her partner keeping her from seeing/talking with family or friends (5a); her partner saying things to try
and make her feel bad (3a); her partner destroying personal property (9a); her partner accusing her of being with other men/women (4a); forced sex (21a); partner withholding money (8a); trying to make her feel as though she caused their arguments (1a); threatening to hurt her family (11a); saying she is crazy (7a); being physically abusive to her in front of other people (18a); her partner being violent to others (16a); and promising never to hurt her after an argument or physical fight. Factor loadings less than .50 in absolute value will be re-evaluated and possibly removed from the questionnaire since these are small factor loadings and may not be particularly meaningful to either of the two factors. Variables that have large coefficients in absolute value on a factor are closely related to that factor (Norusis, 1992). Therefore the behaviors described above with factor loadings above .50 in absolute value are closely related to factor 1, the abuse factor.

Before and after varimax rotation only questions 14 (substance use) and 20 (pregnant physical abuse) had factor loadings less than .50. Substance use verses substance abuse may have caused confusion and accounted for the low factor loadings. This question (14a) needs revision and clarification between the terms use and abuse. The "NA-not applicable" response may have caused some confusion on question 20 (pregnant physical abuse) because it is not clear whether the response choice means the respondent was never abused or never pregnant. This question will be revised in the next version of the WAST.

Factor analysis showed that the variables with the highest factor loadings pertain to physical abuse, jealousy, isolation, control issues, verbal abuse, sexual abuse, and various forms of emotional abuse. The results are consistent with the findings reported by Tolman (1992) Stark and Flitcraft (1988), Hillard (1985), Campbell (1989; 1988; 1986) and Campbell and Fishwick (1993). The results are also consistent with the dynamics of an abusive relationship as discussed in the literature review. Since the results of this analysis are similar with the results of previous research, there is a
strong indication that the questions are representative of the various forms of abuse and
the WAST can therefore be considered to have good content validity.

Discriminant analysis was performed to determine whether the WAST was able to
discriminate between battered and non-battered women. The results were significant (p
= .0000) indicating that the WAST was able to distinguish between the two groups. The
groups were correctly classified 94.44% of the time.

Discriminant analysis was also performed to determine whether there were
similarities or differences with respect to abuse based on demographic information.
Significant differences (p = .0000) with respect to abuse based on income, setting,
race, and employment status were found when using all the data collection sites.
However, when discriminant analysis was performed using only the three health care
settings only income was significant (p = .0009). According to Hotaling and Sugarman
(1990) socioeconomic status was a consistent risk marker of battering. The WAST
demonstrated its ability to discriminate between battered and non battered women, and
demonstrated good content validity.

Using the WAST did not result in a higher percentage of women reporting abuse
than has been reported in previous studies from emergency departments. The total
percentage of women who participated in the study who reported abuse was 26% which
was consistent with the percentages reported from the emergency department studies
(Campbell, 1989; McLeer & Anwar, 1987 & 1989; Varvaro, 1989; Stark, Flitcraft &
Frazier, 1979; Goldberg & Tomlanovich, 1984; Tilden & Shepherd, 1987). The
percentages of women who reported abuse from the three health care settings was
consistent with the rates of abuse found in primary care settings as reported by other
researchers (Hamberger, Saunders & Hovey, 1992; Hillard, 1985; Helton, McFarlane,
& Anderson, 1987; Campbell, Poland, Waller, & Ager, 1992; Amaro, Fried, Cabral, &
Zuckerman, 1990). Based on the results of this study the WAST appears to be clinically
useful. One of the strengths of this study was that primary care settings and not only emergency departments were used for data collection.

The paired-samples sign test was computed to determine whether verbal/emotional abuse were precursors to physical abuse. The results suggested that fourteen of the questions pertaining to various forms of verbal and emotional abuse are precursors to physical abuse at a significance level of .05. These findings are supported by other researchers who have reported that verbal and psychological abuse usually, but not always precedes physical abuse (Campbell & Fishwick, 1993; Dobash & Dobash 1979; Walker, 1984; Edleson, & Tolman, 1992; Shepard & Campbell, 1992; Tolman, 1989). Although these findings are preliminary with regards to the use of this instrument in predicting physical abuse, nurses should be aware that verbal and emotional abuse are precursors of physical abuse.

Finally, comments written by the participants supported the need for educating nurses, physicians, social workers and other health care professional as to the issues and dynamics involved in abusive relationships.

Limitations of the Study

This tool is limited in that it is a self-report measure. Self-report instruments are vulnerable to the perceptions of the respondents as well as respondents wanting to present themselves in a socially desirable manner. Social desirability is a complex phenomenon. According to Nunnally (1978) social desirability should be viewed in terms of three hypothetical components: (a) the actual state of adjustment of the participant; (b) knowledge about their own personal characteristics; and (c) willingness to reveal what they know. Generally, people tend to say more good things about themselves than bad things (Nunnally, 1978). Some of the women in this study may have wanted to present themselves in a socially desirable manner and therefore denied or minimized the abuse which would help to explain the lower than expected percentages of women who reported abuse.
Another limitation of this study was that the participants were a non-random sample. Other limitations were that the sample was predominantly from an urban area, and only one Mid-western state was sampled. Control for response rate was not attempted for this particular study. Controlling for response rate should be incorporated into future research on the WAST.

Lack of cultural diversity was another limitation. There was an over-representation of African/American women. Cultural practices and values are varied and in order to provide comprehensive care and meet the needs of all battered women effectively, more studies using a culturally diverse group need to be undertaken. This study was limited to women who were able to read and comprehend English or Spanish. Because of only one geographic location, mainly an urban setting, and under-representation of racial and ethnic groups, this study was limited. Another limitation related to race was failure to control for social class.

The lack of privacy and time at Anchor may have limited some women from participating in the study. Several women who declined to participate stated they did not feel they had enough time to complete the WAST prior to being called in to the exam room. Participants were told they could take the WAST into the exam room with them if they preferred more privacy or needed additional time. An empty office was also made available to those participants needing more privacy, however, no one chose this option. The majority of the Anchor participants completed the questionnaire in the reception area while waiting to be called in for their appointments. In addition, women who were accompanied by a male partner were not asked to participate in this study because of the lack of privacy and obvious safety issues involved. This limited the number of women who were able to participate. Excluding these women may have biased the study in one direction or another. This may have been one of the factors that resulted in the lower than expected percentages of women who reported abuse.
Significance to Nursing

Annually millions of Americans are abused, with the majority of the abuse victims being women and children (Campbell & Humphreys, 1993; Sampselle, 1992; Sheridan, 1990; Okun, 1986). This physical violence often results in physical or psychological trauma. The injuries and/or the psychological sequelae are the reasons many women enter the health care system. The results of this study demonstrated that battered women are found in all areas of the health care arena. Therefore, it is necessary that nurses understand the dynamics of abusive relationships and become familiar with the physical and psychological signs and symptoms of domestic violence. The WAST was developed to aid nurses and other health care professionals identify women who are being battered either psychologically, physically, or sexually.

Using the WAST will aid nurses and other health care professionals not only in identifying battered women, but identifying women who are at risk of abuse. It provides a comprehensive assessment of verbal, emotional, physical, and sexual abuse. Using the WAST can facilitate the assessment process and guide the intervention.

One aspect of primary prevention is the ability to identify women who are at risk of abuse. The results of this study indicated that the WAST is valid, reliable, and able to distinguish between abused and non-abuse women. Verbal put-downs, name-calling, controlling behaviors, intimidation, isolation, jealousy, threats of harm, violent behavior toward others, substance use, and blaming others for violent behavior were found to correlate highly with abuse in this study. The behaviors that were identified as risk factor or predictors of physical abuse were consistent with what has been previously reported by other researchers (Campbell, McKenna, Torres, Sheridan & Landenburger, 1993; Edleson & Tolman, 1992; Shepard & Campbell, 1992; Tolman, 1989; Varvaro, 1989; Taylor & Campbell, 1992; Campbell & Fishwick, 1993).

Therefore, when nurses or other health care providers observe these types of behaviors
in clients or have clients intimating that a partner is displaying such behaviors should alert the clinician to the possibility of a client who is involved in an abusive relationship.

If the patient is not in an abusive relationship but is indicating that her partner is verbally/emotionally abusive this should alert the practitioner to the risk of physical abuse in the future. In either case an intervention would be appropriate at this point. For those clients who are not physically, emotionally, or sexually abused discussing the abuse issues with them will alert them to the warning signs and possibly prevent abuse from occurring. Having discussed abuse with non-abused clients will make them feel more comfortable in discussing the issue in the future should it become necessary.

As a teaching tool, the WAST can be used for orienting new staff so they become familiar with the signs and symptoms of abuse and make the appropriate intervention. It can be used for staff education and development initially and then as refreshers once or twice yearly or as needed depending on staff turn-over.

The WAST can also be used in conjunction with other teaching methods as a learning tool for undergraduate and graduate nursing students. Using the WAST in the classroom or skills laboratory should help the students become more comfortable with the topic. They can then transfer this knowledge and comfort level to the patient care setting thereby providing a more comprehensive and holistic approach to patient care.

**Implications for Clinical Practice**

Although the findings are preliminary, the WAST demonstrated that it is clinically useful. Nursing care interventions based on the research findings of this study should begin with assessment of all women for abuse regardless of presentation or health care setting. If it is safe for the woman, she could complete the WAST on intake when she completes the other required forms or in the waiting area while waiting to be called for her appointment. If it is not safe or there is no privacy, the woman could be given the
WAST once she is in the exam room and while she waits to be seen by the nurse, physician, or other health care professional.

Once the woman has completed the WAST, the healthcare provider should discuss the woman's responses with her. Thorough assessment is needed to determine the proper treatment plan. If a woman is abused, nursing care may include: (a) physical examination; (b) x-rays if indicated; (c) photographing injuries if appropriate; (d) notification of authorities as appropriate; (e) thorough documentation of physical exam; (f) written information about abuse issues; (g) referrals to appropriate community agencies; (h) safety plan; and (i) follow-up care. Only after identification and assessment can an appropriate care plan be implemented. Using the WAST will aid the health care professional in the identification, assessment, treatment, and planning the care of battered women and women who are at risk of abuse.

**Recommendations for Future Research**

Although the results of this study suggest that the WAST is valid and reliable, further testing needs to be conducted. The first step is to revise several of the questions based on the results of data analysis, comments from the experts, and comments from the study participants. Question 14a asks about drug or alcohol use. These are two separate concepts and will be separated in the revised version. There may also have been confusion surrounding the terms use verses abuse which may have affected the results.

It was also suggested by one of the experts to separate question 15a since life and safety are two different concepts. The words "and/or safety" will be removed so that the questions reads, "How often do you feel your life is in danger because of your partner's behavior?" The woman's response to this question will then give the health care practitioner a better idea of the degree of risk to the woman's life which will help guide the intervention strategy.

As suggested by study results, participants, and one of the experts, a "not applicable" response will be added to questions 10a, 12a, and 13a. These questions
pertain to women with children or who have pets. Not all women have children or pets, therefore, a "not applicable" response is a more appropriate answer than "never".

Question 19, which asked, "Have you ever been pregnant while with your current partner?" may be eliminated because it is somewhat redundant with question 20 and question 30. Question 20 asked, "If you have ever been pregnant while with your current partner, how often does/did your partner physically hurt you while you are/were pregnant?" Question 30 asked, "Are you pregnant?". Although question 20 had low factor loadings on Factors 1 and 2, as well as a low correlation with the discriminant function (physical abuse, Q17a) it will not be removed from the WAST until further testing of the instrument has been completed. The findings may have been a result of artifact. Clearly, the response to this question is clinically useful to the health care professional in planning and implementing pre-natal and post-partum care.

It was suggested to change the response choices to question 23 (wonderful/charming) from never, a few times a year, a few times a month, a few times a week, and everyday to yes or no. The current response choices do not fit the question.

It was suggested by one of the expert panel members and many of the study participants to change the term "housewife" in question 38 to "homemaker". Women's reactions to this term included: "What does housewife mean?"; "This word is outdated"; "Housewife is an old-fashioned word and no longer appropriate"; and "What is a housewife?"

Another suggested revision which will be incorporated into the next version of the WAST will be to weight the responses. The responses will be weighted as follows: 0 = Never; 1 = A few times a year; 2 = A few times a month; 3 = A few times a week; and 4 = Everyday. After a woman has completed the WAST her score would be totaled. Women with high scores would be considered to be at greater risk of harm or death than those with low scores. However, the total score would need to be interpreted with caution.
since some of the questions are more indicative of abuse than others. Therefore, each response would need careful examination.

The "B" questions which ask, "If yes, how long has your partner been doing this to you?" obviously confused the study participants. They had a choice of writing in the number of years or months this had been happening to them. It was not possible to get an accurate account of the number of years a particular behavior had been happening to them because many of the women put either an "X" or check mark next to "years" or "months" instead of writing in a number. In order to include this information in the analysis two other categories had to be created. The first category was "years check but number of years not specified. The second category created was, "months check but number not specified. One of the experts on domestic violence stated that the "b" questions were not appropriate for every question and suggested either eliminating the "b" questions entirely or only using them on those questions for which length of time the incident occurred was necessary to know.

If the "b" questions are to remain in the questionnaire, another suggestion to alleviate the confusion by forcing a choice would be to group time responses as follows: less than 1 year; 1 - 5 years; 6 - 10 years; 11 - 15 years; 16 - 20 years; more than 20 years. In a future study, both methods could be incorporated and tested on different groups to determine the best solution.

Future research should also include: (a) Establishing construct validity. This could be accomplished by administering the WAST concurrently with other instruments such as the Index of Spouse Abuse (ISA), Abuse Assessment Screening tool (AAS), the Danger Assessment (DA), and/or the Conflicts Tactics Scale (CTS); (b) Testing the WAST in a variety of geographic locations throughout the United States as well as urban, suburban, and rural settings; and (c) Testing for cultural sensitivity by using a racially and ethnically diverse group of women; (d) Collecting the data over a longer period of time in order to obtain more accurate numbers of women reporting abuse and to
determine whether any trends emerge related to time of year, time of day, special events or historical events; and (e) analyzing the qualitative data collected from the participant comments.

**Summary**

The overall purpose of this study was to determine whether using a comprehensive screening tool resulted in an identification rate of battered women greater than has been reported in previous studies; identify if verbal/emotional abuse were precursors to physical abuse; and test the reliability, content validity and discriminant validity of the WAST.

Using the WAST did not result in a higher identification rate of battered women than has been previously reported. However, the percentages of battered women were consistent with the percentages reported from studies conducted in emergency departments and with the percentages reported from studies conducted in primary care settings.

The WAST was found to be highly reliable with an alpha of .93 overall, and an alpha of .93 on the physical abuse scale and .91 on the emotional abuse scale. Results of factor analysis and analysis by family violence experts indicated that the WAST has good content validity. Finally, the results of discriminant analysis indicated that 94.44% of the time the WAST was able to distinguish between battered and non-battered women.
Studies have shown that a lot of women are being hurt in their relationships. The purpose of asking the following questions is to help find out whether your partner is hurting you. Answering the following questions will help us to help you.

The risk to you is that it may be upsetting to talk about your relationship. You may stop and talk about your feelings at any time. Crisis counseling is available by calling the Family Violence Program at (312) 942-2873 or one of the programs listed below. If you are having trouble with your partner, answering these questions will let us help you. If you are not having problems with your partner, you will be helping nurses and doctors to know when help is needed for others.

You do not have to answer these questions. You may stop answering the questions at any time. If you do not answer the questions it will not affect your treatment. There is no way you can be identified with the information you provide us. It should take you about 15 minutes to answer the questions. Thank you for your participation.

For counseling you may also call:
Mujeres Latinas en accion (312) 226-1544
Rainbow House/Arco Iris (312) 762-6611.

THIS TOP SHEET IS FOR YOU TO KEEP. IF IT IS NOT SAFE FOR YOU TO KEEP THIS PAGE, THROW IT AWAY.

For further information about this study contact:
Wendy Taylor, M.S., RN
Coordinator
Family Violence Program
Questionnaire

INSTRUCTIONS: Please answer the following questions. Place an "X" or check mark (\(\checkmark\)) in the blank space to the left of the response that best describes you. There are no right or wrong answers. NOTE: A partner can be a husband, ex-husband, boyfriend, ex-boyfriend, lover, or ex-lover. A partner can be either female or male.

1a. When you and your partner argue, how often does your partner try to make you feel that you caused the argument?

   ______ NEVER
   ______ A FEW TIMES A YEAR
   ______ A FEW TIMES A MONTH
   ______ A FEW TIMES A WEEK
   ______ EVERYDAY

   b. If yes, how long has your partner been doing this to you? _____Years _____Months

2a. How often does your partner call you bad names?

   ______ NEVER
   ______ A FEW TIMES A YEAR
   ______ A FEW TIMES A MONTH
   ______ A FEW TIMES A WEEK
   ______ EVERYDAY

   b. If yes, how long has your partner been doing this to you? _____Years _____Months

3a. How often does your partner say things to you to try and make you feel bad?

   ______ NEVER
   ______ A FEW TIMES A YEAR
   ______ A FEW TIMES A MONTH
   ______ A FEW TIMES A WEEK
   ______ EVERYDAY

   b. If yes, how long has your partner been doing this to you? _____Years _____Months

4a. How often does your partner accuse you of being with other men/women?

   ______ NEVER
   ______ A FEW TIMES A YEAR
   ______ A FEW TIMES A MONTH
   ______ A FEW TIMES A WEEK
   ______ EVERYDAY

   b. If yes, how long has your partner been doing this to you? _____Years _____Months
5a. How often does your partner try to keep you from seeing or talking with your family and friends?

- NEVER
- A FEW TIMES A YEAR
- A FEW TIMES A MONTH
- A FEW TIMES A WEEK
- EVERYDAY

b. If yes, how long has your partner been doing this to you? _____Years _____Months

6a. How often do you feel that your partner tries to control your every move?

- NEVER
- A FEW TIMES A YEAR
- A FEW TIMES A MONTH
- A FEW TIMES A WEEK
- EVERYDAY

b. If yes, how long has your partner been doing this to you? _____Years _____Months

7a. How often does your partner say you are crazy?

- NEVER
- A FEW TIMES A YEAR
- A FEW TIMES A MONTH
- A FEW TIMES A WEEK
- EVERYDAY

b. If yes, how long has your partner been doing this to you? _____Years _____Months

8a. How often does your partner withhold money?

- NEVER
- A FEW TIMES A YEAR
- A FEW TIMES A MONTH
- A FEW TIMES A WEEK
- EVERYDAY

b. If yes, how long has your partner been doing this to you? _____Years _____Months

9a. How often does your partner threaten to destroy your personal things?

- NEVER
- A FEW TIMES A YEAR
- A FEW TIMES A MONTH
- A FEW TIMES A WEEK
- EVERYDAY

b. If yes, how long has your partner been doing this to you? _____Years _____Months
10a. How often does your partner threaten to hurt your pets?

___ NEVER
___ A FEW TIMES A YEAR
___ A FEW TIMES A MONTH
___ A FEW TIMES A WEEK
___ EVERYDAY

b. If yes, how long has your partner been doing this to you? ____Years ____Months

11a. How often does your partner threaten to hurt your family?

___ NEVER
___ A FEW TIMES A YEAR
___ A FEW TIMES A MONTH
___ A FEW TIMES A WEEK
___ EVERYDAY

b. If yes, how long has your partner been doing this to you? ____Years ____Months

12a. How often does your partner threaten to take your children?

___ NEVER
___ A FEW TIMES A YEAR
___ A FEW TIMES A MONTH
___ A FEW TIMES A WEEK
___ EVERYDAY

b. If yes, how long has your partner been doing this to you? ____Years ____Months

13a. How often does your partner threaten to hurt your children?

___ NEVER
___ A FEW TIMES A YEAR
___ A FEW TIMES A MONTH
___ A FEW TIMES A WEEK
___ EVERYDAY

b. If yes, how long has your partner been doing this to you? ____Years ____Months

14a. How often does your partner use drugs or alcohol?

___ NEVER
___ A FEW TIMES A YEAR
___ A FEW TIMES A MONTH
___ A FEW TIMES A WEEK
___ EVERYDAY

b. If yes, how long has your partner been using drugs or alcohol?
____Years____Months
15a. How often do you feel your life and/or safety are in danger because of your partner's behavior?

___ NEVER
___ A FEW TIMES A YEAR
___ A FEW TIMES A MONTH
___ A FEW TIMES A WEEK
___ EVERYDAY

b. If yes, how long have you been feeling this way? _____Years _____Months

16a. How often is your partner violent to other people?

___ NEVER
___ A FEW TIMES A YEAR
___ A FEW TIMES A MONTH
___ A FEW TIMES A WEEK
___ EVERYDAY

b. If yes, how long has your partner been violent to other people?

_____Years _____Months

17a. How often does your partner hit, slap, push or otherwise physically hurt you?

___ NEVER
___ A FEW TIMES A YEAR
___ A FEW TIMES A MONTH
___ A FEW TIMES A WEEK
___ EVERYDAY

b. If yes, how long has your partner been doing this to you? _____Years _____Months

18a. How often does your partner hit, slap, push or otherwise physically hurt you in front of other people?

___ NEVER
___ A FEW TIMES A YEAR
___ A FEW TIMES A MONTH
___ A FEW TIMES A WEEK
___ EVERYDAY

b. If yes, how long has your partner been doing this to you? _____Years _____Months

19. Have you ever been pregnant while with your current partner?

___ YES
___ NO
20. If you have ever been pregnant while with your current partner, how often does/did your partner physically hurt you while you are/were pregnant?

- NEVER
- A FEW TIMES A YEAR
- A FEW TIMES A MONTH
- A FEW TIMES A WEEK
- EVERYDAY
- DOES NOT APPLY TO ME

21a. How often does your partner force you to have sex or perform sexual acts against your will?

- NEVER
- A FEW TIMES A YEAR
- A FEW TIMES A MONTH
- A FEW TIMES A WEEK
- EVERYDAY

b. If yes, how long has your partner been doing this to you? _____Years _____Months

22a. After you and your partner have an argument or physical fight how often does your partner promise never to hurt you again?

- NEVER
- A FEW TIMES A YEAR
- A FEW TIMES A MONTH
- A FEW TIMES A WEEK
- EVERYDAY

b. If yes, how long has your partner been doing this to you? _____Years _____Months

23a. Does your partner appear to be wonderful and/or charming to the rest of the world but is a monster at home?

- NEVER
- A FEW TIMES A YEAR
- A FEW TIMES A MONTH
- A FEW TIMES A WEEK
- EVERYDAY

b. If yes, how long has your partner been this way? _____Years _____Months

24. Have you ever talked to your doctor, nurse, social worker, or other healthcare worker about physical or emotional abuse?

- YES
- NO
- DOES NOT APPLY TO ME

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25. If you answered yes to question 24, what did your doctor, nurse, social worker, or other healthcare worker say to you? Please write your answer below:

25. What medical problems, if any, do you have?

26. How old are you? ________ years

27. Are you now:
   ___ Married
   ___ Single
   ___ Separated
   ___ Divorced
   ___ Widowed

28. How long have you and your partner been together? _____ Years _____ Months

29. Are you pregnant?
   ___ No
   ___ Yes

30. How many children do you have? ______

31. What is your race?
   ___ White
   ___ Black/African American
   ___ Hispanic
   ___ Asian/Pacific Islander
   ___ American Indian
   ___ Other (Please specify) ________________________________

32. What kind of health insurance do you have?
   ___ No insurance
   ___ HMO/PPO
   ___ Blue Cross/Blue Shield
   ___ Public Aid/Medicaid
   ___ Medicare
   ___ Other (Please specify) ________________________________
33. How much education do you have?

___ Did not finish high school or get a GED
___ High School
___ GED
___ Business/Technical/Vocational School
___ Some College
___ College Graduate (BA, BS)
___ Graduate School (MA, MS, MFA, etc.)
___ Doctorate (MD, Ph.D., DNS, DDS, etc.)

34. Do you work?

___ YES
___ NO

35. Are you paid for your work?

___ YES
___ NO

36. Are you a housewife?

___ YES
___ NO

37. If you are not a housewife, what kind of job do you have? ______________________

38. What is the total income for everyone who lives with you?

___ Under $10,000
___ $10,000-14,999
___ $15,000-19,999
___ $20,000-24,999
___ $25,000-29,999
___ $30,000-39,999
___ $40,000-49,999
___ $50,000-59,999
___ More than $60,000

39. If there is anything else you would like to say, please write your comments below:
### Appendix B: Results from Pilot Study

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<thead>
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<th>Number of Respondents: Urban vs Rural Setting - Pilot Study</th>
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<td>N (104)</td>
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<tr>
<td>------------------------------------------------------------</td>
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<tr>
<td>Urban</td>
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<tr>
<td>Rural</td>
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<tr>
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<td>ICU</td>
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### Race-Pilot Study

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<td>Black</td>
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<tr>
<td>White</td>
<td>47</td>
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<td>Hispanic</td>
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<td>Asian</td>
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### Occupation-Pilot Study

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<tr>
<td>Unemployed</td>
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<td>4.3</td>
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<tr>
<td>Retired</td>
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<td>2.9</td>
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<tr>
<td>Homemaker</td>
<td>13</td>
<td>18.8</td>
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<tr>
<td>Professional</td>
<td>8</td>
<td>11.6</td>
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<tr>
<td>White Collar</td>
<td>23</td>
<td>33.3</td>
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<tr>
<td>Blue Collar</td>
<td>13</td>
<td>18.8</td>
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<tr>
<td>Student</td>
<td>4</td>
<td>5.8</td>
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<tr>
<td>Other</td>
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<td>4.3</td>
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<th>Marital Status-Pilot Study</th>
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<tr>
<td>Married</td>
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<tr>
<td>Single</td>
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<td>Separated</td>
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<td>11.2</td>
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<td>Divorced</td>
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<td>9.6</td>
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<td>Widowed</td>
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<td>2.9</td>
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<td>Income-Pilot Study</td>
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<td>%</td>
</tr>
<tr>
<td>-------------------</td>
<td>---</td>
<td>----</td>
</tr>
<tr>
<td>Under $10,000</td>
<td>29</td>
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<td>$10,000-14,999</td>
<td>14</td>
<td>15.9</td>
</tr>
<tr>
<td>$15,000-19,999</td>
<td>16</td>
<td>18.2</td>
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<tr>
<td>$20,000-24,999</td>
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<td>2.3</td>
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<td>6.8</td>
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<td>$40,000-49,999</td>
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<td>4.5</td>
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<td>$50,000-59,999</td>
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<td>2.3</td>
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<tr>
<td>More than 60,000</td>
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<td>4.5</td>
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Question Responses-Pilot Study

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<th>Question</th>
<th>No</th>
<th>Yes</th>
<th>Missing</th>
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<tbody>
<tr>
<td>1. Has your relationship with your partner kept you from seeing or talking with your family and friends?</td>
<td>85</td>
<td>82.5</td>
<td>18</td>
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<tr>
<td>2. Have you ever been hit, slapped, pushed or otherwise physically hurt by your partner?</td>
<td>69</td>
<td>67.0</td>
<td>34</td>
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<tr>
<td>3. Does your partner ever force you to have sex or perform sexual acts against your will?</td>
<td>89</td>
<td>86.4</td>
<td>14</td>
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<tr>
<td>4. Do you feel that your partner tries to control your every move?</td>
<td>79</td>
<td>76.7</td>
<td>24</td>
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<tr>
<td>Question</td>
<td>(N)</td>
<td>%</td>
<td>(N)</td>
</tr>
<tr>
<td>----------</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>5a. Does your partner ever threaten you with things like: withholding money?</td>
<td>42</td>
<td>40.8</td>
<td>17</td>
</tr>
<tr>
<td>5b. saying you are crazy?</td>
<td>42</td>
<td>40.8</td>
<td>20</td>
</tr>
<tr>
<td>5c. taking your children?</td>
<td>46</td>
<td>44.7</td>
<td>11</td>
</tr>
<tr>
<td>5d. hurting your children?</td>
<td>46</td>
<td>44.7</td>
<td>5</td>
</tr>
<tr>
<td>5e. hurting your pets?</td>
<td>46</td>
<td>44.7</td>
<td>6</td>
</tr>
<tr>
<td>5f. hurting your family?</td>
<td>45</td>
<td>43.7</td>
<td>6</td>
</tr>
<tr>
<td>5g. destroying your personal possessions?</td>
<td>44</td>
<td>42.7</td>
<td>15</td>
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<tr>
<td>5h. other</td>
<td>41</td>
<td>40.2</td>
<td>3</td>
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*Assumed to be a "no" answer but not marked due to directions given which were to check the responses that applied*
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<tr>
<th>Question</th>
<th>No</th>
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<th>Missing</th>
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<tbody>
<tr>
<td>6. Do you ever feel your life or safety is in danger because of your partner's behavior?</td>
<td>82</td>
<td>79.6</td>
<td>21</td>
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<tr>
<td>7a. Do you feel that you always cause the argument?</td>
<td>80</td>
<td>80.8</td>
<td>19</td>
</tr>
<tr>
<td>7b. Does your partner make you feel that you always cause the argument?</td>
<td>48</td>
<td>60.8</td>
<td>31</td>
</tr>
<tr>
<td>8. Is your partner very jealous or suspicious?</td>
<td>66</td>
<td>64.7</td>
<td>36</td>
</tr>
<tr>
<td>9a. Does your partner appear to be wonderful and/or charming to the rest of the world but is a monster at home?</td>
<td>80</td>
<td>78.4</td>
<td>22</td>
</tr>
<tr>
<td>9b. Is your partner violent outside the home?</td>
<td>94</td>
<td>92.2</td>
<td>8</td>
</tr>
<tr>
<td>10a. After you and your partner have an argument or physical fight does your partner promise never to hurt you again?</td>
<td>65</td>
<td>71.4</td>
<td>26</td>
</tr>
<tr>
<td>10b. If yes, do you believe him?</td>
<td>48</td>
<td>87.3</td>
<td>7</td>
</tr>
<tr>
<td>11a. Does your partner call you names?</td>
<td>72</td>
<td>71.3</td>
<td>29</td>
</tr>
<tr>
<td>11b. Does your partner say things that make you feel bad?</td>
<td>60</td>
<td>60.6</td>
<td>39</td>
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</tbody>
</table>
Appendix C: Participant Comments to Question 25

Client ID 25. If you have ever talked to your doctor, nurse, social worker or other healthcare worker about physical or emotional abuse, what did they say to you?

NB-1 "Offers support to take care of myself, detach from emotional abuse"
NB-3 4 "History of abuse"
NB-4 8 "Psychologist helped me deal with my husband."
NB-5 2 "I eventually terminated the relationship. Although I often have trouble not seeing this person."
NB-5 7 "Counsel was sought; assistance provided regarding DIVORCE. Provided protection for children and myself."
NB-5 8 "Here is a phone # of a couple who do couples counseling, when you're interested."
RH-6 2 "(Human Service) Told me to try and get family counseling and just said I'm sorry and that was her response."
RH-6 6 "Doctor said she would find resources for me but didn't."
RH-7 8 "Go and get some help from a counselor (sic)."
RH-8 4 "Report it or leave"
RH-9 1 "They send (sic) me to the clinic to get follow-up"
RH-9 4 "(Doctor) That you probably got it from (sic) some one that used to beat you when you were little."
RH-9 5 "Advised me to make a police report, seek counseling. Asked me has the person a mental disorder I didn't answer them I didn't know"
RH-1 0 3 "That I need to seek counseling for me and my children"
RH-1 0 4 "She talked to me. She asked me what I wanted to do."
Participant Comments to Question 25 (con't)

Client ID 25. If you have ever talked to your doctor, nurse, social worker or other healthcare worker about physical or emotional abuse, what did they say to you?

RH-107  "Leave"

AG-109  "After that happen I was in other shelter and counselling (sic) went for few times and that's all!"

AG-110  "They tell me it's good to talk about it, and get it of(sic) my chest, and put in the back of my head. They incurrage (sic) me to take counseling or just to talk with someone."

AG-113  "(Doctor) She couldn't come to conclusion, she was quiet by hearing the situation, and said it was a personal affair, has to be settled by mutual understanding"

AG-115  "(To Apna Ghar) -helped me in many ways-Could come back to the U.S. because of Apna Ghar(AG)-I have custody of my daughter because of AG"

AG-117  "They listen-No comment"

AG-118  "to leave him, stop pursuing any kind of relationship, keep the children away from him. Report his actions to DCFS."

AG-125  "They make me think back, sometime, from, that time."

IDPH-166  (This client was interviewed by a staff person) "Go to WAVE and she did also call police and she did"

IDPH-178  (Client interviewed) "Hand-out with referral in spanish (sic)."

ANCH-240  "Can't remember"

ANCH-244  "Never to break away from my family and do more for me."
Participant Comments to Question 25 (con’t)

Client ID 25. If you have ever talked to your doctor, nurse, social worker or other healthcare worker about physical or emotional abuse, what did they say to you?

ANCH-249 "To get legally separated because he isn’t ready for marriage yet. (We’re married)"

ANCH-256 "Get a divorce and I did"

ANCH-260 "Weigh the pros & cons of the relationship! If the bad out weighs the good this relationship must not be good for me"

ANCH-313 "That I have to learn to tell my husband how I feel because I always want to protect his feelings."

ANCH-320 "I went to a counselor-He helped me through the emotional detachment and gave me a sheet on being a caretaker and how to love myself."

ANCH-326 "I only went once, and we didn’t get that far. I didn’t feel comfortable with him, so I decided to try someone else."

ANCH-330 "we went for marital counseling-I had to decide if I wanted to continue living with an alcoholic"

ANCH-355 "Seek help"

ANCH-402 "I went to a private psychotherapist who suggested that I begin to like myself and to trust my instincts. He suggested that I look at my accomplishments and start living my life and stop living life thru someone else."

ANCH-411 "Abuse should not be accepted, leave the person alone-"

ANCH-395 "He never offered advice because I didn’t continue treatment."
<table>
<thead>
<tr>
<th>Client ID</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANCH-433</td>
<td>&quot;Emotional abuse does not apply I just talk to my therapist about how relationships affect my panic disorder&quot;</td>
</tr>
<tr>
<td>ANCH-440</td>
<td>&quot;take care of myself&quot;</td>
</tr>
<tr>
<td>ANCH-444</td>
<td>&quot;Leave him. So I got a divorce&quot;</td>
</tr>
</tbody>
</table>

**NOTE:** The comments are direct quotes from participants. Therefore, spelling, grammar and punctuation were not corrected.

NB=Known non-battered  
RH=Rainbow House  
AG=Apna Ghar  
IDPH=Public Health Clinic  
ANCH=Health Maintenance Organization
Appendix D: Participant Comments to Question 40

Client ID 40. If there is anything else you would like to say, please write your comments below:

NB-9  "I was a very independent person when I married at age 30, having dated since age 14. Of the many relationships I had, not one partner verbally or physically abused me. My parents did not fight, either verbally or physically, and seldom argued. They have been married 50 years-My siblings are still married to their original spouses."

NB-15  "I don't know if I'm in the unusual category. But I am very happily married to a wonderful man. Our 'argument' or disagreement is mostly about our kid's social functions or activities. And deciding what to do on house renovations."

NB-26  "I question if an abused person would willingly answer some of these questions with much detail. I believe that the abused person would feel doubly threaten (sic) just by taking this survey (& admitting reality) & second being possibly found out."

NB-31  "It was easy to give the answer to the question but time frame was too hard to try and figure out"

NB-37  "Earlier in our marriage, I made it clear what behavior was acceptable and what was not."
"I would like to get my life back and get my babyie (sic) back, and get a job and get a place of my own like a c.H.A. (sic) need to talk about trying to get a C.H.A. or something & try to go back to school-g.E.D. (sic)"

"I need to start thinking about what my wants & my needs are in life, and stop trying to please anyone but myself."

"I would like to live in peace in my own place and raise my presious (sic) daughter whom I love deeply. My abuser is stalking me thru using my daughter."

"Help!"

"Please help me to be who I was."

"I answered these questions to the best of my ability. The frequencies of abuse as stated are not accurate because things don't usually happen a few times per week, month or year, but usually once per week, month or year."

Comments are in written in Spanish

"My name is (intentially left blank) I would like to say the reson (sic) I can't work is because I have a Hemophilliac (sic) son, and I have to stay close around him, because he can become ill very easily."
"Thank you for helping me and may god bless all of you"

"I believe that I would've left the first time after the abuse if the person I told would've believed me and said we'll maybe you did something."

"I had to elaborate (sic) on most of my answers because my situation is a little different. I have been a victim of abuse all my life and most of my adult years so when I am faced with a situation I become passive and can't tell the difference feel if I just put it aside the quicker it will be over. I have a tendency to keep hurt to myself and feel I can handle it or deal with it. Why do I keep getting into situations like this? I am tired of being a door mat for men, family, and anyone who wants to dump on me. I need help and counseling where I won't spend the next 10 years of my life in the same situation. Thank you."

"In all these questions the B question is not clear to a not so sharp person. First of all in ?A there is no Yes, So one would have to assume that if they answered any of ?a other than the Never, would be a yes response to answer B."

"I was not only physical abused, but also emotional, sexual, mental abused"

"Keep up the good work."
AG-109  "I do not know much about this (or your project) but you are doing
great thing. Asian Indian women need to be educated more about
everything. There should be some kind of organization or club for those
women so at least they can go out and meet other (people) or women.
There should be a literature for Asian-Indian women and should be
available also. There should be advertisement for a guideline. Thank
you!"

AG-111  "I endured alot of emotional, physical and sexual abuse at the hands of
my ex-husband. My daughters also endured the same abuse. But! I got
out and I have learned that I will never go back to that way of life. My
only concern now is to protect my son from the same kind of abuse
because my ex-husband knows no other way of life and also more
important feels he has the right to treat people any way he wants
because it's all about what ever gives him pleasure or personal
satisfaction and the Hell with everyone (sic) else."

AG-112  "I want justice. My problem is this (sic) right now I don't have a visa
& work permit. I came here from India for justice. Because my
husband is a bigamist. I am trying my best to get justice. I need your
help."

AG-114  "These questions are not specific enough. Every situation is different it
was hard to answer."

AG-115  "I have received counseling (sic) and help from Apna Ghar."
AG-116 "I think the laws should be more help towards the women-as it stands now they are favored to the men. Laws need to be make (sic) stronger. An order of protection should be more than a pieace (sic) of paper. Maybe more women would come forward and report abuse if it was easier & safer."

AG-117 "I could never go back to him. FEAR of my life."

AG-118 "Even though I do not see him except for supervised visitation he has with his son, I am still aftaid of his anger and retaliation. He always blamed me for his outbursts and his own problems with handling past failures in jobs, money, kids or our relationship.

He did things at work to people who suspected him of stealing, and told me he would do anything to stay out of jail, especially if people found out what he did to my son, our dog and me. I will always be afraid he is watching me or looking for an opportunity to hurt me. He even told me that he would kill his ex-wife if he could get away with it, because of all the problems she caused him."

AG-124 "Loving their own reputation is the biggest weak point for women. Such as trying to open up their secret love story to the community when one person feel uncomfortable to be with their partner. What I mean is using their secret love that she's trying to hide from the community to threat (sic) her to live under his will when she couldn't stand living under it. That can cause a woman to feel very low about herself."
AG-125  "I do not think, my husband, in anyway, is sorry, about my laceration.  
he does not admit, doing it to me."

MC-134  "I do not have any kind of an abusive relationship. and pray to God I 
ever will."

MC-137  "Yes I would love to be treated like a wife my husband stay out at night
Never hit me or anything like that just not caregiving or anything.  
Sometime I wish I could leave and never look back. I mean that the kid 
(sic) are grown 26-23 no baby but he tell me this is his house. You 
know I don't like that."

MC-142  "I have never been in an abusive relationship and would not tolerate 
being in one. I am probably not a good candidate to answer this 
questionnaire. As my past relationships could not be considered abusive 
in the sense of physical or emotional abuse. Rather normal 
relationships with usual problems, disappointments, etc., and finally 
incompatibility ending the relationship."

MC-148  "I really have a lovely husband & a wonderful marriage---and I would 
certainly feel free to say otherwise if it weren't true."

MC-152  "I consider myself very lucky to have my husband. (Even my friends 
tell me how lucky I am)"
MC-155 "Now I think it needs to be known in some study that Spanish are very overprotective, tend to drink alot and keep wifes (sic) at home away from friends."

IDPH-166 (Interviewed)"Belvidere does not have services locally have to go to Rkfd--Diff for children enrolled in school. Belvidere has no transportation to Rkfd.--Must leave son with mother in Belvidere so he can to to school. Mother willing to do this. City police not supportive--did not offer to take her to WAVE. WAVE had said police would bring her to WAVE. After first beating in April-did not talk to anyone. Spouse promised not to do it again. Second beating-July-Police talked her out of filing charges. Couple was in counseling 6 mos before marriage and 6 mos after marriage. Husband has history of sexual abuse by father. Husband also refuses to use condom during sexual intercourse. Current wife feel you are scapegoat for anger toward ex-wife."

IDPH-179 "I do not like the term "housewife" in this survey. I work both inside and outside my home. What exactly does "housewife" mean? If I am employed outside the home, am a wife and homeowner, am I not a housewife? This question is far too open to interpretation and the term is outdated."

IDPH-187 "The answers were all never due to the fact that I have had only a few boyfriends & not for very long."
"Yes. After answering all these questions, I realized my husband is a Saint!"

"Good questions-Not intimidating or confusing"

"Good luck on this research project! An important topic"

"I have been married a long time, my relationship with my husband has changed greatly over this time as stresses in our lives changed. If I had answered this survey in the early years of my marriage, when we were both emotionally immature, our children were young, and financial pressures were there (sic) highest point-my answers would have been different."

"-A man who hasn't stood up for you before, even though he agreed you are right, never will --He tries to hit at my self-esteem. Sometimes in public--I'm frustrated"

"I was never a battered wife"

"Mine was mental--Multiple affairs. Divorce left me with no credit, lots of debt."

"I am fortunate not to have an abusive partner. But please help those who do and try to get them to see the life they can have without the abuse"
ANCH-278 "We tend to argue, but never are physical. Also they are just everyday little squabbles. Nobody is perfect."

ANCH-291 "1. My husband is not really a monster until I go somewhere and he can't get in touch with me. He wants to know where I am always. Until he gets over his anger, sometimes he won't talk to me for at least a week. After he's over his anger, instead of apologizing he'll ask if I want to go shopping or call and ask what's for dinner. He'll act as if nothing has ever happened. 2. My husband doesn't try to keep me from my family. He will try and keep me from some of my friends. He feels that some of them are a bad influence on me.

ANCH-298 "My boyfriend is abusive in ways this form does not touch on. The greatest abuse was when told me to get a abortion....I was only 22 yrs old at time he was 37 yrs old. I wanted to stay with him so I did it, much to regret I did. I never stop thinking of this child. I never told any one other than this form today...thanks for asking me to fill out this form. Happy Thanksgiving to the people doing this survery. and Pray for me alot. If you want to know how to help other girls/women tell them never have a abortion unless they choose to have one. I listened to him because I love him so much. I also was only making $24,000 in ---when I got pregnant today,--- I make $70,000 Make girl/women (sic) understand thing don't stay the same. Now I make enough for my baby but its dead. So we must inform girls/woman (sic) don't listen to what men say about our lifes....I suffer alot because of the way I have been treated all my life."
ANCH-307  "I am a single parent. One is 18, other 15 month. I did go through all of the abuse with my first husband, but I've been divorced for 13 years. The only 2 real arguments my boyfriend and I had were when I got pregnant & when he had to move to Texas."

ANCH-313  "I come from a dysfunctional family where there was sexual abuse from a relative & my mother never believed my sister or I. Nothing was ever done. As a result our family is torn apart because of this because to this day my mother cannot accept that my stepfather sexually abused my 3 nieces and my stepfathers brother sexually abused my sister, brother and I. I had counseling for 2 years and it helped me very much. Women are ashamed to speak of what happens. They need lots of support and someone who is non-judgemental to talk to."

ANCH-320  "I feel that there's such a thing as sulte (sic) abuse. For years I put up with very minor problems and disagreements. I wasn't aware that my marriage was even having difficulty. Once something was discussed and resolved I let go of it. My ex-husband harbored lots of anger. It wasn't until after the separation and divorce that I realized how inconsiderate my spouse really was. Most of our finances, were spent to benefit his needs. ex-dentist, clothing, cars, food."

ANCH-326  "I've been looking for somewhere to go, and you found me. Thanks! I intend to call one of the numbers listed on the information sheet."
"I'm not having any problems, but I am aware of so many, and have often used referral services for women. I also know what signs to look for. Good luck with your program!"

"I'm off drugs now, my relationship with my husband is very pleasant (sic). We have typical argument, but other than that things are fine."

"I hope this has help (sic) you! I thank the good Lord my husband is not abusive to me!"

"We get along fine other than his drinking being a problem-this gets better sometimes-but I feel will not stop."

"This only happen (sic) 3 years ago, now I am recovery (sic) well. Thanks to God and my Christian friends. I only wish I had of heard of this before. Because families goes through a great deal living in this kind of fear. I hope this program can help some people. It take (sic) great effected (sic) on your children life and yourself, you must be a fighter and willing to stand, and just prayer (sic) your way out of it. Before someone really gets hurt. I am at a point now I can talk about it with others. It was a day to day process, and women can you raise your children alone, it (sic) hard when children use (sic) to having two parents and now only one and let (sic) with memories of the hurt, bitter, and pain. I know your program will help someone. Thank God for this program."
"I hope that when I call the people can help my family & me."

"Husband is an alcoholic is in AA program and I attend Ala-non 12 step program which has helped me to understand the disease."

"I hope this survay (sic) helps women in troubled relationships"

"I think that this was a good ideal (sic) this survey. We womens (sic) do need help from our jealous husband, boyfriend cause abuse is going on. Mentally & physically you got to know when to get out before your (sic) dead."

"Thank God I'm divorce (sic) now. I don't live with anybody this questions (sic) was during my marriage live (sic)."

"I believe that women that are in abusive relationships (physical, sexual, emotional) are lacking in self-esteem. I also believe that no one likes being abused, and there is help for everyone. People need to know that they are no along (sic). I am fortunate to be in a non-abusive relationship. I love my child and myself to (sic) much to let something like this destroy our lives. People fail to realized (sic) that an abusive relationship also affects the children that are in the environment."
ANCH-390  "We were together for six years. The first few years were great. The last few were hell. It was emotional abuse; when it changed to physical abuse I left. The shooting up the house caused me to walk away. My husband refused to sign for the divorce for another six years. During that time we communicated by telephone only. I feel many women need help with the legal side of a relationship."

ANCH-392  "I didn't all of the questions because I don’t have a current partner and I am separated from the one that was physical (sic) & mentally abusing me. I am very concerned about those women who are still in that type of relationship. I want to tell them that they can make it. They do not have to take that kind of abuse. That man may say he loves you but he doesn't love hisself (sic) how can he love you? There is someone better. Get out while you can!"

ANCH-398  "The way I have been hurt lately is in a (sic) emotional way not physically. However my partner is not with me anymore, but last month I just found that he just play a game with me."

ANCH-406  "I am very happy in my relationship-although my husband does drink too often I know he feels the same way about the smoking--We are in our first year of marriage (after dating 3 yrs) and have been adjusting to each other. We have short arguements & both make up. I should have filled this out 5 years ago when I was single & dated an ------for 10 years!"
ANCH-410  "These answers reflect a present relationship. I've had an abusive relationship and felt that I was in the bad relation as a form of self punishment for many reasons. I'm happy to have broken my chain of self destructive (sic) behavior. I'm a better and much happier person today!"

ANCH-416  "These are good questions. I will never forget them. My finance (sic) applies to none. He's a great guy so far. Some women need these questions. I know a few."

ANCH-428  "Good luck with your survey."

ANCH-431  "Jesus is the answer. I went through some of these things before I started living a life for Christ, Lord Jesus. My encouragements are to pray and seek the Lord. For He is good and His mercy endure (sic) for ever. This questionare (sic) are somewhat helpful for a person to feel free to answer where is help. Jesus"

ANCH-433  "I would not stay in a physically abusive relationship. My present partner hurts my feelings but my therapist suggests I over react and should change my reaction or response."

ANCH-434  "While my current relationship is not abusive I was in an abusive relationship for 5 years while in high school."
ANCH-439  "I been dating my friend for only 5 months he's nice to me he dont fight he likes to go out with me alot he takes me to dinner all the time and I really like him a lot not for anything he got but just how he treat me and respect me and thats all in having a relationship is respect."

ANCH-444  "Such a questionnaire should be given to males too confidentially."

ANCH-441  "This was a very excellent questionnaire."

**NOTE:** The comments are direct quotes from participants. Therefore, spelling, grammar and punctuation were not corrected.

NB=Known non-battered
RH=Rainbow House
AG=Apna Ghar
IDPH=Public Health Clinic
ANCH=Health Maintenance Organization
References


Heide, W. S. (Unknown). *Feminism: Making a difference in our health*. Framingham, MA.


