Improving the Health Care Response to Domestic Violence:

A Resource Manual for Health Care Providers

Authors
Carole Warshaw, M.D.
Anne L. Ganley, Ph.D.

Editors
Debbie Lee
Nancy Durborow, M.A.
Patricia R. Salber, M.D., F.A.C.E.P.

Contributing Author
Patricia R. Salber, M.D., F.A.C.E.P.

Contributing Editors
Candace Heisler, J.D.
Patrick Letellier, M.A.
Barbara Hart, M.S.W., J.D.

PRODUCED BY
The Family Violence Prevention Fund
IN COLLABORATION WITH THE
Pennsylvania Coalition Against Domestic Violence

THIS MANUAL WAS MADE POSSIBLE BY A GRANT FROM THE
Conrad N. Hilton Foundation

WITH SUPPORT FROM THE
U.S. Department of Health and Human Services, Sierra Health Foundation, William Randolph Hearst Foundation, Henry J. Kaiser Family Foundation

2nd Edition, Revised March 1996

Permission to Reprint or Adapt the Contents of "Improving the Health Care System's Response to Domestic Violence."

The contents of this publication may be adapted and reprinted with permission of the Family Violence Prevention Fund. Any adaptation or reprinting must be accompanied by the following acknowledgement:

> This material was adapted from the publication entitled, "Improving the Health Care System's Response to Domestic Violence: A Resource Manual for Health Care Providers," produced by the Family Violence Prevention Fund in collaboration with the Pennsylvania Coalition Against Domestic Violence. Written by Carole Warshaw, M.D. and Anne L. Ganley, Ph.D., with contributions by Patricia R. Salber, M.D.

Any adaptation or reprinting of any part of the manual must also include the name of the author of the section being reprinted.

Family Violence Prevention Fund
383 Rhode Island St., Suite 304
San Francisco, CA 94103-5133
phone: (415)252-8900
fax: (415)252-8991

Dedication

With the gift of listening comes the gift of healing, because listening to your brothers and sisters until they have said the last words in their hearts is healing and consoling. Someone once said that it is possible "to listen a person's soul into existence."

— Catherine de Hueck Doherty

We honor the many survivors of domestic violence who have taught us both about courage and survival. We thank them for their leadership.

Table of Contents

Chapter Three: Health Care Responses to Perpetrators of Domestic Violence

ACKNOWLEDGEMENTS

The completion of this manual is a credit to the tireless efforts of many dedicated individuals and organizations who have generously shared their expertise, rich experiences and time.

The major credit goes to the Conrad N. Hilton Foundation for its insight in first funding this work in 1992. We commend Marge Brownstein and Donald Hubbs for their vision and commitment to the National Health Initiative of which this manual is a part. The Hilton Foundation's dedication to the prevention of domestic violence continues to make a real impact in the lives of the millions of American women and children living in violent homes.

Deepest appreciation goes to Carole Warshaw, M.D. and Anne Ganley, Ph.D. who are the principal authors of this manual.

Dr. Warshaw has made an important contribution to changing the way in which the health care system responds to battered women. Her work helps guide institutions in examining their approaches to domestic violence and has played an integral role in this project's success. Her devotion to the voice of survivors is present throughout this manual.

Dr. Ganley's vision and expertise were invaluable throughout this project. Her extensive knowledge of the educational process contributed greatly to the development of this manual. She is a talented trainer and was key in the development of the pilot test training and this manual's outline and format.

A special thanks goes to Patricia R. Salber, M.D. who has dedicated tireless hours to the health care work of the FUND since its inception. Her vision and enthusiasm have provided a strong foundation for the manual, as well as the FUND's National Health Initiative.

To my Pennsylvania Coalition Against Domestic Violence (PCADV) counterpart and colleague Nancy Durborow, I express my sincerest appreciation. The dedication and leadership of PCADV within the domestic violence movement and to this project has been tremendous. Special thanks to Judy Yupcavage, Trish Patterson, Bonnie Fowler and Susan Kelly-Dreiss, Executive Director.

We are particularly grateful to the FUND's National Health Initiative Advisory Committee. This stellar group of professionals representing the major health care organizations, professional associations and domestic violence experts who have been leaders in the field gave generously of their time, expertise and enthusiasm. This diverse and multi-disciplinary group of individuals spent many meetings debating issues and critiquing drafts. Their comments and suggestions for improvement were valuable contributions to this manual.

A very special thanks goes to the emergency department teams of the 12 California and Pennsylvania hospitals who participated in the pilot test of this manual — providing thoughtful feedback to this project and an enthusiasm that was infectious. Their work symbolizes a multi-disciplinary approach that should be a model to the health care system. They were truly an inspiration to all of us involved in this project.

The assistance and guidance by the many individuals who participated on the California and Pennsylvania State Advisory Committees played an integral part in this project's success. These Advisory Committee members guided the initial planning of the pilot test project and chose the pilot test hospital sites. They provided us with the foundation of knowledge which helped us to capture much of the experience of health care practitioners.

We are extremely grateful to the contributing editors: to Barbara Hart for her invaluable insights and extensive reviews/critiques, and to Candace Heisler for her meticulous reviews and generous advice. Their dedication and care were deeply appreciated. A special thanks goes to Patrick Letellier for his thoughtful and insightful editing, and for the skill and clarity with which he did it.

Particular credit must be given to Elizabeth McLoughlin of the San Francisco Injury Center for Research and Prevention and Trauma Foundation, who has been an invaluable advisor to the health work of the FUND. The Trauma Foundation's technical assistance with research and citations is reflected throughout this manual. Thanks to Robin Trembly-McGraw, Elvira James, Julieta Carillo, and Gregory Nah.

There are so many individuals who have contributed to this project. In particular we would like to thank Susan Schechter, author and activist; Dr. Jaqueline Campbell, Johns Hopkins University; Ariella Hyman, San Francisco Neighborhood Legal Assistance Foundation; Dr. Ronald Chez, American College of Obstetrics and Gynecology; Dr. Wanda Filer, York Hospital, PA; Dr. Barbara Herbert, Boston City Hospital; Physicians for a Violence-Free Society; Bill, Celi, Matt and Dov; as well as Dr. Anne Flitcraft and the Domestic Violence Training Project, the American College of Obstetricians and Gynecologists, the Nursing Network on Violence Against Women, Susan Hadly, WomanKind, MN, and the many advocates of the Battered Women's Movement for their pioneering work in this field.

This manual could not have been produced without the hard work of Laura Valles and Kevin McCulloch. Their editing and word processing are much appreciated. Appreciation goes to Ces Rosales of ZesTop Publishing for designing and typesetting the content and to Jill Davey for the cover design. Appreciation also goes to Janet Nudelman and Valerie Sheehan, the other health team staff at the Family Violence Prevention Fund for their support and invaluable contributions. My gratitude goes to both Esta Soler, Executive Director, and Janet Carter, my fellow Associate Director, for their support and wisdom at many points.

In addition to the Conrad N. Hilton Foundation we wish to express our deepest appreciation to all the funders of the FUND's National and California Health Initiatives: the U.S. Department of Health and Human Services, Sierra Health Foundation, William Randolph Hearst Foundation, and Henry J. Kaiser Family Foundation.

DEBBIE LEE
Associate Director
FAMILY VIOLENCE PREVENTION FUND
JUNE, 1995

National Health Initiative Advisory Committee/Experts Panel

Marjorie Braude, MD
American Medical Women's Association

Ann Brown, MD
American Association of Women Emergency Physicians

Jacquelyn Campbell, BSN, MSN, PhD
Academy of Nursing/American Nurses Assn

Ronald Chez, MD
American College of Obstetricians and Gynecologists

Allison Clifford, RN
New York State Office for the Prevention of Domestic Violence

Courtney Esposito, CSW, DVS
Center for the Study of Violence, Albert Einstein Medical Center

Wanda D. Filer, MD
Department of Family Practice, York Hospital

Susan Hadley
WomanKind

Richard Jones, MD
American College of Obstetricians and Gynecologists

Robert McAfee, MD
American Medical Association

Elizabeth McLoughlin, ScD
San Francisco Injury Center for Research and Prevention

Cynthia Newbille
National Black Women's Health Project

Mary Pittman, DPH
American Hospital Association

Dianne Reese
West Virgina Coalition Against Domestic Violence

Charlie Robbins, DSW
Society for Social Work Directors in Healthcare

Linda E. Saltzman, PhD
National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

Susan Schechter, MSW
University of Iowa, School of Social Work

Carol Jack Scott, MSED, FACEP
American College of Physicians

Fred Schiavone, MD
American College of Emergency Physicians

Wendy Taylor, DNSc, RN
Emergency Nurses Association

Sara Torres, PhD, RN
Nursing Network on Violence Against Women and Hispanic Nurses Association

Beverly J. Wilkins
Mental Health and Social Services, Indian Health Services,

Staff

Family Violence Prevention Fund

Debbie Lee
Janet Nudelman
Laura Valles
Valerie Sheehan

Pennsylvania Coalition Against Domestic Violence

Nancy Durborow
Judy Yupcavage
Trish Patterson

California State Advisory Committee

Penny Ablin, M.D.
Sonora Community Hospital

Deidre Anglin, M.D.
LA County/USC Med. Ctr.

Carol Arnett
L.A. Domestic Violence Council

Larry Bedard, M.D.
CA Medical Society

Pat Chase, M.D.
Dept. of Health Services

Dr. Susan Harris
California Association of Hospitals & Healthcare Systems

Ariella Hyman
San Francisco Neighborhood Legal Assistance Foundation

Eira Klich-Heartt
Santa Rosa Community Hospital

Linda Mahoney
California Assn. of Public Hospitals
Fairmont Hospital

Elizabeth McLoughlin, Sc.D.
San Francisco Injury Center for Research and Prevention

Gregory Nah
San Francisco Injury Center for Research and Prevention

Joanne Powell
Golden Gate Nurses Assn.

Maureen Rezac
YMCA - Marjoree Mason Ctr.

Karen Roberson
Visiting Nurse Association of L.A.

Michael Rodriguez, M.D.
Pacific Center for Violence Prevention

Patricia Salber, M.D.
American College of Emergency Physicians

Pam Seay
CA Medical Society

Alice Washington, LCSW
Highland General Hospital

David Lee

Pat Felten
Department of Health Services

Kim Yeager, M.D., M.P.H.
Department of Health Services

Pennsylvania Medical Advisory Committee

Senator Allyson Schwartz
Senate P. O.

Donna Wenger
Pennsylvania Blue Shield

Barbara Spaar, R.N., B.S.N
Health Care Coordinator

Gloria Martin-Payne
Pennsylvania Department of Health

Debra Feldman, M.D.
The Mercy Hospital of Pittsburgh

Ed Nielson
Pennsylvania Academy of Family Physicians

Pat Wood
Pennsylvania Academy of Family Physicians

Julia Cox
Pennsylvania Chapter American Trauma Society

Mary Beth Brady, M.S.W.
Pennsylvania Society for Hospital Social Work Directors

Pat Bruno, M.D.
Pennsylvania Medical Society

Kathy Kovalik, R.N., M.P.H.
Pennsylvania Nurses Association

Joan Boben
Hospital Association of Pennsylvania

Ellen Marshall
American College of Physicians

Pat James
Fellowship Farm

Wanda Filer, M.D.
Thomas Hart Family Practice Center/York Hospital

Linda Snyder, R.N., M.S.N., C.R.N.P., C.E.N.
Pennsylvania Council of Emrgency Nurses Association

Janet Scott
Women's Center and Shelter of Greater Pittsburgh

Barbara Woodmansee
ACCESS-York

Val Ford

Courtney Esposito
Albert Einstein Medical Center

Sylvia Beck, M.D.
Medical College of Pennsylvania

Arnold Cohen, M.D.
Women's Healthcare/US Healthcare

James Withers, M.D.
The Mercy Hospital of Pittsburgh

Peg Sikora, R.N., C.A.R.N.
National Nurses Society on Addictions

David Houseal
ADVANCE/Lutheran Social Services

Lisa de Mello
Philadelphia Health Management Corporation

Sandy Dempsey
Physicians for Social Responsibility

Linda Dyer
Montgomery County Women's Center

CALIFORNIA HOSPITAL TEAMS

SONORA COMMUNITY HOSPITAL
SONORA, CA
Penny Ablin, MD
Pat Cervelli, MSW, VNA/Hospice
Nancy Drews, RN
Nancy Jackson, RN
Susan Troy, RN

KAISER PERMANENTE HOSPITAL
SACRAMENTO, CA
Anne Brennan, MD
Gail Gilbert, RN
Joyce Hildebeck, *WEAVE*
Kathy Miles, RN
Leslie Pratt

VALLEY MEDICAL CENTER
FRESNO, CA
David Boyd, RN
Jim Comes, MD
Socorro Rios, MSW
Maureen Russell, LCSW, *YWCA Marjaree Mason Center*
Tom Schultz, MD
Tom Stoeckel, RN

SAN FRANCISCO GENERAL HOSPITAL
SAN FRANCISCO, CA
Doreen Dare
Madeleine Daley, RN
John Fazio, RN
Beth Kaplan, MD
Wenny Kasuma, *La Casa de las Madres*
Ed Kinchley, MSW
Nancy Von Bretzel, MSW

L.A. COUNTY/USC MEDICAL CENTER
LOS ANGELES, CA
Carol Adolf, MSW
Deirdre Anglin, MD
Ann Evanilla
Idella Hill, RN
Carrie Korn, RN
Gabriella Neuberger, MSW
Monica Serna, MD
Lynne Ticson, MD
Dolores Velasquez

SCRIPPS MEMORIAL HOSPITAL
LA JOLLA, CA
Linda Conforth
Martin Griglak, MD
Linda Hodges
Dwayne Kusler, RN
Diane McGrogan, LCSW
Lori Riggio, MA, *YMCA*

PENNSYLVANIA HOSPITAL TEAMS

ALBERT EINSTEIN MEDICAL CENTER
PHILADELPHIA, PA
William Dalsey, MD
Betty Brennan, RN
Courtney Esposito, *AEMC Center for the Study of Violence*
Bobbie Rothman
Janet Bradley
Carol Ray, *Women Against Abuse*

MAGEE WOMEN'S HOSPITAL
PITTSBURGH, PA
Pamela Dodge, RN, MSN
Carol Simmons, MD
Lee Ann Raneiri, RN, BSN
Kathy Reed, LSW
Janet Scott, *WC & S of Greater Pittsburgh*

TRI-STATE TRAUMA SYSTEMS
ERIE, PA
Nancy Bennett, *St. Vincent Health Center*
Russell Beinick, MD, *St. Vincent Health Center*
Linda King, *Hospitality House*
Kelly Knaus, *Hamot Medical Center*
MaryAnn Koslowski, DO, *Hamot Medical Center*
Sherri Maxwell, RN, *Hamot Medical Center*
Kathleen Randall, RN, MSN
Diane Derr
Mary Ann Anderson
Shelly Solvedt, RN, MSN, *St. Vincent Health Center*
Dennis Evans

GEISINGER MEDICAL CENTER
DANVILLE, PA
Harold Smith, MD
Trish Brent, RN
Louisa Weber
Laurita Carlton, RN
Gail Lynn, RN
Terry Jacques, *Women's Center, Bloomsburg*

CENTRE COMMUNITY HOSPITAL
STATE COLLEGE, PA
Cay Greil, RN
Judy Pleshonko, RN
Tedd Ziff, MD
Nancy Mutch, RN
Donna Hastings, *Centre Co. Women's Resource Center*

FULTON COUNTY MEDICAL CENTER
MCCONNELLSBURG, PA
James Rintaul, MD
Myreta Elvey, RN
Cindy Cutshall, RN
Linda Sowers
Karen Johnson, *Women In Need*
Lisa Johnson, *Women In Need*

PREFACE

HOW THIS MANUAL WAS DEVELOPED

BY DEBBIE LEE

This Resource Manual was produced by the Family Violence Prevention Fund (FUND) in collaboration with the Pennsylvania Coalition Against Domestic Violence (PCADV) as a component of the National Health Initiative on Domestic Violence funded by the Conrad N. Hilton Foundation.

The development of the Manual took place in four phases. During the first phase, hospital emergency department surveys were conducted in California, Pennsylvania, and nationally. The purpose was to collect baseline information on the existing emergency department response to domestic violence and to gauge the use of clinical protocols and training programs. Survey respondents were asked to send protocols, training curricula and educational materials to the FUND where they were analyzed and catalogued. Furthermore, ED respondents were asked if they would support the development of model resource and training materials on domestic violence. The materials gathered, baseline data collected and overwhelmingly positive directive to move forward with the production of a resource manual on domestic violence for health care providers concluded the first phase of this project.

Meanwhile, State Advisory Committees (SAC) were formed in both California and Pennsylvania to oversee the California and Pennsylvania State Health Initiatives on Domestic Violence. A National Advisory Committee (NAC) representing major medical and health associations and domestic violence coalitions was recruited to coordinate the FUND's National Health Initiative and guide its health-related program and policy activities. These influential committees made up of physicians, nurses, insurance and health care administrators, policymakers, batterer treatment providers, and medical social workers working in emergency department, ObGyn and primary care settings, as well as domestic violence experts, created the overall vision for the resource manual. In addition, the SACs coordinated the CA and PA emergency department surveys and also assisted with the design of the Model Emergency Department Domestic Violence Program and the selection of the twelve implementation sites. A 1993 NAC meeting in San Francisco and SAC meetings held in California and Pennsylvania laid the foundation for the substance and focus of the Resource Manual.

The second phase of development involved preparing a first draft of the Resource Manual for review by the NAC, clinical experts in the field and the hospitals participating in

the Model ED Domestic Violence Program. A December, 1994 meeting of the NAC involved a chapter-by-chapter review examining both content and format. In addition, national experts from a variety of health settings and disciplines reviewed the manual for its adaptability to a diversity of health care settings and applicability to the full spectrum of health care providers that would be using it.

During the third phase, the manual was evaluated for its "useability" through the six month Model ED Domestic Violence program in twelve CA and PA hospitals. Intensive two-day training sessions based on information contained in the manual were held in San Francisco, CA and Harrisburg, PA. The conferences were attended by multidisciplinary teams made up of an ED physician, nurse, social worker, administrator and community domestic violence expert from each of the twelve participating pilot test hospitals. The emergency department program evaluated the resource manual's content, gauged the effectiveness of its implementation strategies and tested the manual's adaptability to a variety of hospital settings.

The Resource Manual was then further revised and finalized based on feedback from the test-sites during the final phase of development. A team of skilled editors sifted through and incorporated the guidance received by national experts throughout the country. A comprehensive appendix was constructed using model materials collected and created to facilitate the ease of developing a health-facility-based domestic violence program. And finally, because so many voices were incorporated into the final document, a resource manual that is truly reflective of the diverse needs and circumstances of health care providers was developed.

Because of generous underwriting from the Conrad N. Hilton Foundation, as well as the U.S. Department of Health and Human Services, the Sierra Health Foundation, the William Randolph Hearst Foundation, and the Henry J. Kaiser Family Foundation, the FUND is able to make the Resource Manual available at cost.

We invite you to send us your thoughts and feedback regarding the manual and share with us any materials you think would be useful to further guide efforts to strengthen the health care response to domestic violence.

INTRODUCTION

BY PATRICIA R. SALBER, M.D.

Until recently, domestic violence was considered to be primarily a social or criminal-justice problem and therefore not in the purview of the health professional. Unfortunately, in many areas of the country, this attitude continues to prevail despite the fact that victims of domestic violence are routinely seeking care for medical complaints related to battering. Lacerations are sutured, broken bones are set, and emotional problems are medicated without an attempt to uncover or address their underlying cause. As a result, the medical community misses the opportunity to intervene in many hundreds of thousands of cases of domestic violence — and many, many victims continue to suffer the adverse health consequences of physical and emotional abuse.

The numbers are staggering. Close to 4 million American women are physically abused each year in this country (Straus, Gelles & Steinmetz, 1980; *Violence Against Women*, 1990). Many of these women seek care in health care settings, often repeatedly (Berrios & Grady, 1991; Bowker & Maurer, 1987). One study conducted in an urban emergency department found that 24% of women seen for any reason had a history of domestic violence (Goldberg & Tomlanovich, 1984). Another study of injured women seen at an inner-city emergency department found that 30% of female trauma victims were injured due to battering. The number increased to 42% in the age range of 18-20 year-olds (McLeer & Anwar, 1989). Physical injuries due to battering can range from relatively minor bruising and abrasions to injuries requiring hospitalization, major surgical intervention, or death (Berrios & Grady, 1991; Federal Bureau of Investigation, 1993).

Emergency departments are not the only health care setting in which victims of domestic violence seek care. Twenty-eight percent of women surveyed in three university-affiliated ambulatory care internal medicine clinics had experienced domestic

---

The section on "Guiding Principles" (pages 4 to 6) was contributed by Anne L. Ganley, Ph.D.

violence at some time in their lives; 14% were currently experiencing abuse (Gin, Rucker, Frayne, Cygan & Habbell, 1991). One Midwestern family practice clinic reported that 23% of women clients had been physically assaulted by their partners within the last year and 39% had experienced physical abuse at some time in their lives (Hamberger, Saunders & Hovey, 1992).

Obstetrical health providers have an especially important role in identifying battered women. Studies indicate that between 10-32% of women seeking care from prenatal health care providers have a past history of domestic abuse (Campbell, Poland, Waller & Ager, 1992; Helton, McFarlane & Anderson, 1987; Hillard, 1985; Parker, McFarlane, Soeken, Torres & Campbell, 1993; Stewart & Cecutti, 1993) and 4-8% of women are battered while pregnant (Amaro, 1990; Berenson, Stiglich, Wilkinson & Anderson, 1991; Campbell, et al., 1992; Helton, et al., 1987; Hillard, 1985; McFarlane, Parker, Soeken, & Bullock, 1992; Stewart & Cecutti, 1993). One recent study surveyed a sample of new mothers for a history of domestic violence in the 12 months preceding the birth of the index child — between 4-7% reported having been physically hurt by their husband or partner (Vandecastle, et al., 1994). Furthermore, battering during pregnancy jeopardizes the pregnancy. In one study of poor women, 24% of pregnant teens and 20% of pregnant adults entered prenatal care in the third trimester compared to 9% and 11% respectively of non-abused teens and adults (Parker, McFarlane, Soeken, Torres & Campbell, 1993). Abused women have a higher rate of miscarriage, stillbirths, premature labor, low birth weight babies, and injuries to the fetus, including fractures (Berrios & Grady, 1991; Bowker & Maurer, 1987; Bullock & McFarlane, 1989; Saltzman, 1990).

Mental health care providers see battered women for suicide attempts, anxiety and depression (American College of Obstetrics and Gynecology, 1989; Berrios & Grady, 1991; McGrath et al., 1990; Stark & Flitcraft, 1988a). In one study, 64% of female psychiatric inpatients experienced physical assaults and 38% experienced sexual assaults as adults; these were largely due to abusive relationships (Jacobson & Richardson, 1987).

Orthopedists, orthopedic nurse practitioners and physician assistants see battered women with fractures and other musculoskeletal complaints caused by domestic violence. These women seek care from specialists in "head and neck" medicine for perforated eardrums, nasal fractures, dislocated mandibles, and septal hematomata. Dentists see battered women with fractured teeth, "bad bites," and broken jaws. Ophthalmologists and other eye care professionals see battered women with subconjunctival hematomata, retinal detachments, orbital blow-out fractures and lid lacerations. Practitioners who specialize in chronic pain syndromes, such as headache, chronic pelvic pain or functional gastrointestinal disorders, also see battered women (Domino & Haber, 1987; Drossman et al., 1990; Follingstad et al., 1991; Haber & Roos, 1985). Some HIV-positive women or women with AIDS may have contracted the virus from coerced sexual activity in the context of a battering relationship (Zierler et al., 1991). Health care providers who see abused children also see battered women because child abuse and spousal abuse frequently co-exist (Bowker & Maurer, 1987; McKibben, DeVos & Newberger, 1989; Stark & Flitcraft, 1988b; Walker, 1979).

Battered women have a decreased subjective sense of their physical and mental well-being, an increase in reported symptoms across a wide variety of organ systems, particularly gynecologic symptoms, and an increased utilization of medical resources (Follingstad et al., 1991; Jaffe, Wolfe, Wilson & Zak, 1986; Kerouac, Taggart, Lescop & Fortin, 1986; Koss, Koss & Woodruff, 1991; Rodriguez, 1989). In one study, the frequency of abuse was a strong predictor of the number and severity of reported symptoms (Follingstad et al., 1991).

Battered women also have a higher incidence of injurious health behaviors such as smoking, drug and/or alcohol abuse, and poor dietary habits (Amaro, 1990; Koss, Koss & Woodruff, 1991; Rodriguez, 1989; Root & Fallon, 1988; Stewart & Cecutti, 1993).

While the research cited above refers to the tremendous impact of battering on heterosexual women, domestic violence is not an exclusively heterosexual phenomenon. Lesbians and gay men also suffer the adverse consequences of abuse in their relationships, and present with injuries and trauma in many of the same medical settings as heterosexual battered women. The few studies that have been conducted on lesbian battering indicate that it happens at approximately the same rate as heterosexual battering (Renzetti, 1992). In the absence of empirical research on gay male battering, we must look to anecdotal evidence and expert opinion, both of which indicate battering as a serious and widespread problem among gay men (Letellier, 1994).

Although it is difficult to know the true dollar costs for providing direct medical care to victims of domestic violence, it is estimated to be in the range of $1.8 billion per year (Miller, Cohen & Wiersema, 1995). When other factors are added in, such as days of work missed, decreased productivity at the workplace due to emotional, psychiatric and medical sequelae of abuse, and loss of young individuals from the workforce due to early death or disability, the financial toll is huge.

Despite the fact that health practitioners see many victims of domestic violence in their clinical practices and despite the fact that the impact on the health care system is enormous, many health professionals fail to recognize the problem because they don't routinely inquire about or document abuse as the cause of their patient's symptoms (Friedman, Samet, Roberts, Hulin & Hans, 1992; Goldberg & Tomlanovich, 1984; Hamberger et al., 1992; Helton et al., 1987; Kurz, 1987; McLeer & Anwar, 1989; Morrison, 1988; Stark, Flitcraft & Frazier, 1979; Warshaw, 1989). This failure occurs even though many physicians believe questions about physical and sexual assault should be asked routinely (Friedman et al., 1992). Furthermore, studies document that most patients want health care providers to ask about abuse and would answer truthfully if asked (Friedman et al., 1992; Rounsaville & Weisimann, 1978).

The reasons why health professionals have failed to appropriately respond to victims of domestic violence are myriad and complex, but crucial to understand if we are going to improve the response of the health care system to domestic violence. A thorough discussion of the barriers to identification of domestic violence victimization can be found in Chapter Two. Briefly, they include a lack of training about domestic violence (Holtz, Hanes & Safran, 1989); providers' misconceptions about who is affected by domestic violence, biases and/or prejudices (Burge, 1989; Kramer, 1993; Langford, 1990); and current or prior experiences with domestic violence outside of the health care setting (Sugg & Inui, 1992; Warshaw, 1993). Health professionals may not want to inquire about domestic violence because of the fear of opening a "Pandora's box" and/or because of concerns about time constraints (Sugg & Inui, 1992; Warshaw, 1993). Some may not inquire because of concerns about privacy (Jecker, 1993; Kurz & Stark, 1988; Sugg, 1992) and/or confidentiality — especially in states where mandatory reporting laws exist.[1] Others may feel that inquiry and intervention are not appropriate roles for them and should be the responsibility of social workers and mental health professionals. Still others may become frustrated with battered individuals who are "difficult" or intoxicated or have vague but recurring and seemingly undiagnosable symptoms that lead the professional to

[1]See Appendix N for a full discussion of the implications of mandatory reporting of domestic abuse by health professionals.

apply labels such as "crock," "hysteric," "somatization disorder," or "self-defeating personality disorder" to the patient (Stark et al., 1979).

Health providers, however, are uniquely situated to be effective in helping reduce the tragedy of domestic violence. As already described, they frequently encounter battered women in their clinical practices. The special nature of the provider-patient relationship offers a unique opportunity to intervene in this serious problem.

To be effective in combatting domestic violence, however, professionals must rethink the traditional medical approach. They must develop a fuller understanding of the effect of all of the circumstances of an individual's life on his/her health. This requires the consideration of social conditions, such as domestic violence, when trying to determine the etiology of a patient's symptoms. It also mandates a consideration of therapeutic options beyond prescriptions, such as giving patients messages like "There is help available," and "You don't deserve to be beaten." It involves giving victims information which can help them confront and, hopefully, eliminate the violence in their lives.

Individual personal health practitioners must move closer to the practice of traditional public health providers by studying the health of the populations they serve and designing population-based strategies which ameliorate the adverse health consequences of identified factors. It is only by utilizing such strategies that health professionals can begin to be truly effective in illness prevention and health promotion.

In the area of domestic violence, this means helping to make the health care system more responsive to victims of domestic violence. There are a variety of ways in which individual practitioners can make a difference, including educating colleagues, implementing domestic violence protocols, setting up hospital-based advocacy programs, and establishing interdisciplinary domestic violence committees.

It is also crucial that health care providers work with local domestic violence experts. They have been at the helm of the domestic violence field — carrying out community education and prevention activities, educating law enforcement, prosecutors, the judiciary and elected officials, as well as health care providers. Domestic violence programs have shaped laws at local, state and national levels protecting battered women and their children.

Since the mid 1970's, community groups and formerly battered women have responded to the needs of battered women by establishing over 1,200 domestic violence programs throughout this country. The keystone of domestic violence services has been safe shelter for battered women and their children. While shelter is only a temporary stop-gap, it is a life saving one. However, as public education and awareness has grown, the supply of shelter beds has been unable to keep up with the demand, which can sometimes leave victims and providers frustrated.

Many other services are an integral part of the empowerment and advocacy offered by domestic violence programs. These include: crisis counseling, legal advocacy, job training, assistance with welfare and housing, counseling for children, relocation assistance, bilingual services and a variety of other services. This comprehensive approach to service delivery is unique among human services programs. It is important for the health care community to become familiar with the domestic violence program(s) in their own communities. Collaboration with domestic violence programs can result in developing more appropriate services to victims of domestic violence and their families.

Effective domestic violence prevention also requires going beyond the clinical setting and out into the community where the roots of violence are pervasive. Health professionals can provide leadership in domestic violence prevention by participating in public education, victim advocacy, and political action. The role of the health

provider in health systems and community change is discussed in detail in Chapter 4.

This manual was developed to give physicians, nurses, medical social workers and other health care personnel a wide range of information and other tools, including model protocols, patient education materials, practitioner guides and resource information, necessary for becoming more effective in domestic violence identification, intervention and prevention. The authors of this manual believe that all health care providers should be guided by certain principles when designing and implementing strategies for improving responses to victims of domestic violence. These principles are:

GUIDING PRINCIPLES

1. Regarding safety of victims and their children as a priority.
2. Respecting the integrity and authority of each battered woman over her own life choices.
3. Holding perpetrators responsible for the abuse and for stopping it.
4. Advocating on behalf of victims of domestic violence and their children.
5. Acknowledging the need to make changes in the health care system to improve the health care response to domestic violence.

It almost goes without saying that safety for victims and their children is a top priority in any health care intervention. Once health professionals understand the serious health risks posed by domestic violence, they are usually aggressive in their response (e.g., "I will save her life by making her to go to the shelter right now").

This approach, however, is at odds with the second principle outlined above — respect for victims' integrity and authority over their lives. Providers must understand that, unlike child abuse cases where the victims are vulnerable children, the victims of domestic violence are adults who have a right to make their own decisions. Victims almost always know far more about themselves and their abusers than the health care providers do. This knowledge helps the victim formulate a response to the violence. The health care provider can play an important role in the victim's decision-making process by asking the right questions, providing information about the nature of domestic violence, giving messages of support, and letting her know about resources in the health care setting and in the community which can provide an alternative to the violence. At times it will be appropriate for the health care provider to make recommendations about what to do, but only after understanding the full reality of the victim's situation and

with the understanding that, ultimately, the victim must make her own choices.

Respecting victims' authority over their own lives is important for another reason. At the core of domestic abuse is the batterer's desire to control the victim's life, including her ability to make decisions for herself. When health care providers insist that victims obey their "prescription" to leave their abusers and go to a shelter immediately, they reinforce their lack of self-determination and victimize them further. Providers need to understand that the decision to leave — or stay — is the victim's to make and theirs to respect.

There are ambiguities and tensions involved in developing responses which are in keeping with both the safety and autonomy principles. Some providers may give more weight to the safety principle and be influenced by a desire to "protect" the patient and therefore demand that she leave the situation or go to a shelter. Other providers may place greater emphasis on the principle of self-determination and therefore fail to help the patient develop a safety plan because of an erroneous belief that the patient could just leave the situation in order to protect herself. This manual will help readers develop strategies that recognize and incorporate both principles into their response to domestic violence.

The purpose of the third principle is to hold the perpetrator, not the victim, responsible for the abuse. Abusers alone determine when, where, why and toward whom they will be violent. This is important to keep in mind whether the health provider's contact is with a victim or a perpetrator. Health professionals can avoid overt or covert victim-blaming by remembering that, no matter what the circumstances, there is no excuse for domestic violence.

Holding perpetrators responsible for domestic abuse is not solely the responsibility of the criminal justice system. Health professionals can hold perpetrators responsible in a number of ways. They can refuse to continue in silent collusion with batterers and start to accurately name the problem of domestic violence. They can tell victims that they do not deserve abusive treatment. They can cut through abusers' minimization, denial, rationalization, and blaming to insist that it is the abuser's responsibility, not the victim's, to stop his abusive behaviors.

The fourth and fifth principles, commitments to provide advocacy and to improve the health care system's ability to respond to victims of domestic violence, require fundamental changes in the ways that health providers approach domestic violence. They require changes in individual practice patterns and changes in institutional structures. They also require "institutionalization" of these changes. Moreover, a truly effective response requires an interdisciplinary approach involving physicians, nurses, social workers, health educators and other allied health personnel.

In the realm of individual practice changes, providers must become more aware of domestic violence, begin to actively and routinely inquire about abuse, and have the knowledge and skills to assess safety and refer appropriately. It is equally important that they understand and embrace the concept of advocacy as a crucial health care response. Advocacy includes activities which take place in the health care setting (e.g., involving the victims in the decision-making process, providing knowledge and support as the patient goes through the medical encounter, and working to make the health care system more responsive to victims of domestic violence). It also involves activities which go beyond the health care setting and into the community, such as involvement with the local shelter, community education about domestic violence, and the formation of domestic violence consortia to coordinate otherwise fragmented services and to share resources (Langford, 1990). Advocacy means political activities such as involvement in organized medicine, nursing or other professional organizations. It also means active involvement in

shaping legislation and regulations which affect battered women and their children (Salber & Taliaferro, 1995; Sheridan, 1987). The need for these changes and model intervention strategies are described in more detail in Chapter 4.

These guiding principles form the heart of this manual. They are woven into the text and content of every chapter. The authors hope this manual will serve as the beginning of your education about domestic violence. Wherever possible, we have provided references and resources to further your knowledge about this crucial issue which so profoundly affects the health and well-being of so many of our patients. We also hope that you will use this educational experience to change the way you view your role and responsibility to victims of domestic abuse. It is no longer acceptable to say that this is the role of some other type of service provider. It is everyone's responsibility. For that reason, we believe that you have an obligation to educate your peers about their role in domestic violence identification and intervention and help improve your practice's ability to respond to domestic violence. Therefore, we encourage you to share this manual with others and to freely utilize the resource materials contained in it. We hope you will become a teacher, an advocate, and a leader in the movement to improve the health care response to victims of domestic violence.

REFERENCE LIST

Amaro, H. (1990). Violence during pregnancy and substance use. *American Journal of Public Health*, 80, 575-579.

American College of Obstetrics and Gynecology. (1989). *The battered woman* (Technical Bulletin No. 124). Washington, DC: Author. Available from The American College of Obstetricians and Gynecologists, 409 12th Street, SW, Washington, DC 20024-2188.

Berenson, A., Stiglich, N. J., Wilkinson, G. S., & Anderson, G. D. (1991). Drug abuse and other risk factors for physical abuse in pregnancy among white non-Hispanic, black and Hispanic women. *American Journal of Obstetrics and Gynecology,* 164, 1491-1499.

Berrios, D. C., & Grady, D. (1991). Domestic violence: Risk factors and outcomes. *Western Journal of Medicine,* 155, 133-135.

Bowker, L. H., & Maurer, L. (1987). The medical treatment of battered wives. *Women and Health,* 12, 25-45.

Bullock, L., & McFarlane, J. (1989). The birthweight/battering connection. *American Journal of Nursing,* 89, 1153-1155.

Burge, S. K. (1989). Violence against women as a health care issue. *Family Medicine*, 21, 368-373.

Campbell, J. C., Poland, M. L., Waller, J. B., & Ager, J. (1992). Correlates of battering during pregnancy. *Research in Nursing and Health*, 15, 219-226.

Domino, J. V., & Haber, J. D. (1987). Prior physical and sexual abuse in women with chronic headache: Clinical correlates. *Headache*, 27, 310-314.

Drossman, D. A., Lesserman, J., Rachman, G., Zhiming, L., Gluck, H., Toomey, T. C., & Mitchell, C. M. (1990). Sexual and physical abuse in women with functional or organic gastrointestinal disorders. *Annals of Internal Medicine*, 113, 828-833.

Federal Bureau of Investigation. (1993). *Uniform crime reports for the United States*. Washington, DC: United States Department of Justice.

Follingstad, D. R., Brennan, A. F., Hause, E. S., Polek, D. S., et al. (1991). Factors moderating physical and psychological symptoms of battered women. *Journal of Family Violence*, 6, 81-95.

Friedman, L. S., Samet, J. H., Roberts, M. S., Hulin, M., & Hans, P. (1992). Inquiry about victimization experiences: A survey of patient preferences and physician practices. *Archives of Internal Medicine*, 152, 1186-1190.

Gin, N. E., Rucker, L., Frayne, S., Cygan, R., & Habbell, F. A. (1991). Prevalence of

domestic violence among patients in three ambulatory care internal medicine clinics. *Journal of General Internal Medicine*, 6, 317-322.

Goldberg, W. G., & Tomlanovich, M. C. (1984). Domestic violence victims in the emergency department: New findings. *Journal of the American Medical Association*, 254, 3259-3264.

Haber, J. D., & Roos, C. (1985). Effects of spouse abuse and/or sexual abuse in the development and maintenance of chronic pain in women. In H. L. Fields, et al. (Eds.), *Advances in pain reserach and therapy IX* (pp. 889-895). New York: Raven Press.

Hamberger, K., Saunders, D. G., & Hovey, M. (1992). Prevalence of domestic violence in community practice and rate of physician inquiry. *Family Medicine*, 24, 283-287.

Helton, A. S., McFarlane, J., & Anderson, E. T. (1987). Battered and pregnant: A prevalence study. *American Journal of Public Health*, 77, 1337-1339.

Hillard, P. J. (1985). Physical abuse in pregnancy. *Obstetrics and Gynecology*, 66, 185-90.

Holtz, H. A., Hanes, C., Safran, M. A., et al. (1989). Education about domestic violence in US and Canadian medical schools: 1987-1988. *Morbidity and Mortality Weekly Report*, 38, 17-19.

Jacobson, A., & Richardson, B. (1987). Assault experiences of 100 psychiatric inpatients: Evidence of the need for routine inquiry. *American Journal of Psychiatry,* 144(7), 908-912.

Jaffe, P., Wolfe, D. A., Wilson, S., & Zak, L. (1986). Emotional and physical health problems of battered women. *Canadian Journal of Psychiatry*, 31, 625-629.

Jecker, N. S. (1993). Privacy beliefs and the violent family: Extending the ethical argument for physician intervention. *Journal of the American Medical Association*, 269, 776-780.

Kerouac, S., Taggart, M. E., Lescop, J., & Fortin, M. F. (1986). Dimensions of health in violent families. *Health Care Women International*, 7, 413-426.

Koss, M.P., Koss, P.G., & Woodruff, W. J. (1991). Deleterious effects of criminal victimization on women's health and medical utilization. *Archives of Internal Medicine*, 151, 342-347.

Kramer, A. (1993). Attitudes of emergency nurses and physicians about women and wife beating: Implications for emergency care [Abstract]. *Journal of Emergency Nursing*, 549.

Kurz, D. (1987). Emergency department responses to battered women. *Social Problems*, 34, 69-81.

Kurz, D., & Stark, E. (1988). Not-so-benign neglect. In K. Yllo & M. Bograd (Eds.), *Feminist perspectives on wife abuse* (pp. 249-265). Newbury Park, CA: Sage Publications.

Langford, D. R. (1990). Consortia: A strategy for improving the provision of health care to domestic violence survivors. *Response to the Victimization of Women and Children*, 13, 17-18.

Letellier, P. (1994). Gay and bisexual male domestic violence victimization: Challenges to feminist theory and responses to violence. *Violence and Victims*, 9(2), 95-106.

McFarlane, J., Parker, B., Soeken, K., & Bullock, L. (1992). Assessing for abuse during pregnancy: Severity and frequency of injuries and associated entry into prenatal care. *Journal of the American Medical Association*, 267, 3176-3178.

McGrath, E., et al. (Eds.). (1990). *Women and depression: Risk factors and treatment issues*. Washington, DC: American Psychological Association.

McKibben, L., DeVos, E., & Newberger, E. H. (1989). Victimization of mothers of abused children: A controlled study. *Pediatrics*, 84, 531.

McLeer, S. V., & Anwar, R. (1989). A study of battered women presenting in an emergency department. *American Journal of Public Health*, 79, 65-66.

Miller, T. R., Cohen, M. A., & Wiersema, B. (1995). *Crime in the United States: Victim costs and consequences*. [Final Report to the National Institutes of Justice.] Washington, DC: The Urban Institute and the National Public Services Research Institute.

Morrison, L. J. (1988). The battering syndrome: A poor record of detection in the emergency department. *Journal of Emergency Medicine*, 6, 521-526.

Parker, B., McFarlane, J., Soeken, K., Torres, S., & Campbell, D. (1993). Physical and emotional abuse in pregnancy: A comparison of adult and teenage women. *Nursing Research*, 42, 173-177.

Renzetti, C. (1992). *Violent betrayal: Partner abuse in lesbian relationships*. Newbury Park, CA: Sage.

Rodriguez, R. (1989). Perception of health needs by battered women. *Response to the Victimization of Women and Children*, 12, 22-23.

Root, M. P., & Fallon, P. (1988). The incidence of victimization experiences in a bulimic sample. *Journal of Interpersonal Violence*, 3, 161-173.

Rounsaville, B., & Weisiman, M. (1978). Battered women: A medical problem requiring detection. *International Journal of Health Service*, 9, 461-493.

Salber, P. R., & Taliaferro, E. (1995). *A physicians guide to domestic violence*. Volcano, CA: Volcano Press.

Saltzman, L. E. (1990). Battering during pregnancy: A role for physicians. *Atlanta Medicine*, 64, 45-48.

Sheridan, D. J. (1987). Advocacy with battered women: The role of the emergency room nurse. *Response to the Victimization of Women and Children*, 10, 14-15.

Stark, E. & Flitcraft, A. (1988a). Violence among intimates: An epidemiological review. In V. Hasselt, R. L. Morrison, & M. Hersen (Eds.), *Handbook of family violence* (pp. 293-318). New York: Plenum Press.

Stark, E. & Flitcraft, A. (1988b). Women and children at risk: A feminist perspective on child abuse. *International Journal of Health Services,* 18, 97.

Stark, E., Flitcraft, A., & Frazier, W. (1979). Medicine and patriarchal violence: The social construction of a "private" event. *International Journal of Health Services*, 9, 46.

Stewart, D. E., & Cecutti, A. (1993). Physical abuse in pregnancy. *Canadian Medical Association Journal*, 149, 1257-1263.

Straus, M., Gelles, R., & Steinmetz, S. (1980). *Behind closed doors: A survey of family violence in America*. New York: Doubleday.

Sugg, N., & Inui, T. (1992). Primary care physicians' response to domestic violence: Opening pandora's box. *Journal of the American Medical Association*, 267, 3157-3160.

Vandecastle, M., et al. (1994). Physical violence during the 12 months preceding childbirth — Alaska, Maine, Oklahoma and West Virginia, 1990-1991. *Morbidity and Mortality Weekly Report*, 43(8), 132-137.

The Violence Against Women Act of 1990: Hearing before the Committee on the Judiciary, S. Rep. No. 101-545, 101st Cong., 2d Sess. (1990b).

Walker, L. E. (1979). *The battered woman.* New York: Harper & Row.

Warshaw, C. (1989). Limitations of the medical model in the care of battered women. *Gender and Society*, 3, 506-517.

Warshaw, C. (1993). Domestic violence: challenges to medical practice. *Journal of Women's Health*, 2, 73-80.

Zerler, S., Feingold, L., Lawfer, D., Velentgas, P., Kantrowitz-Gordon, I., & Mayerk, K. (1991). Adult survivors of childhood sexual abuse and subsequent risk of HIV infection. *American Journal of Public Health*, 81, 572-575.