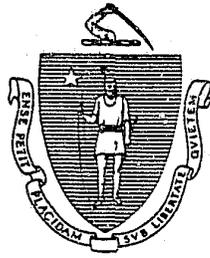


150715



Commonwealth of Massachusetts
Office of the Attorney General
Scott Harshbarger

and

The Dimock Community Health Center

Family Violence: The Health Provider's Role In Assessment and Intervention

150715

U.S. Department of Justice
National Institute of Justice

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**DOMESTIC VIOLENCE BACKGROUND
MATERIALS**

WHAT IS BATTERING?

Battering is a pattern of coercive control founded in violence. In our society, sexism teaches men that they have the right to be and ought to be dominant over women. Whether the batterer is male or female, his or her intent is the same: to feel superior and dominant in the relationship while making the partner feel subordinate, incompetent, worthless, and anxious.² Batterers will often explain their abuse with the cliché: "She needs to be taught who is the boss."

Battering can consist of:

- physical abuse, including punching, slapping, kicking, shoving, choking;
- verbal and emotional forms of assault and control such as intimidation, coercion, threats, or degradation;
- economic forms of control such as withholding or denying access to money or other basic resources; sabotaging employment, housing; or educational opportunities; forcing the partner to live beyond her means or misusing the partner's credit cards;
- sexual assault or coercion;
- social isolation by denying communication with friends and relatives or making communication so difficult that the woman chooses to avoid it; prohibiting access to the telephone or transportation; denying access to needed health care;
- failure to comply with immigration requirements, thereby making the immigrant spouse unable to work and vulnerable to deportation and loss of child custody.

Nonphysical forms of abuse can sometimes be more damaging than physical violence. Many women who have been battered say that while their physical injuries have healed, their emotional scars and diminished self-image remain.

Sexual Abuse

Sexual abuse is often a component of battering. The following definitions are from the Massachusetts Coalition of Rape Crisis Services:

Sexual assault is any kind of sexual contact that is forced or coerced. Obscene phone calls, indecent exposure, unwanted touching, sexual harassment, and pressure to have sexual contact are all forms of sexual assault. Sexual assault includes rape and incest. Anyone who experiences any forced or coerced sexual contact has been sexually assaulted.

² Adapted from Susan Schechter and Lisa Gary, "Understanding and Empowering Battered Women," in *Abuse and Victimization Across the Life Span*, M.B. Straus, ed. (Baltimore: Johns Hopkins University Press), 1988.

Rape is vaginal, anal, or oral penetration by a penis, finger, or object against the will of the victim through the use of force or threat of force. It is an act of violence using sex as a weapon. It is motivated by the desire to overpower and dominate the victim. Rape is often experienced as a life-threatening situation. **Acquaintance rape** refers to forced intercourse by someone the victim knows. **Marital rape** refers to forced intercourse by a spouse and can be prosecuted in Massachusetts.

According to Stark et al.:

Many rape crisis teams were developed in response to the notion of rape as an isolated event in the life of the unprotected housewife or coed and focus upon the legal aspects of evidence gathering, documentation, and prosecution. Such strategies do not address the emotional, medical, legal, or shelter needs of the woman who lives within a violent relationship in which rape is yet another incident of ongoing physical abuse. On the contrary, within the medical encounter where rape is presumed to refer to anonymous sexual assault, the abused woman is likely to feel that she is misunderstood and therefore respond with hostility, refuse to cooperate with police representatives, and fail to keep appointments with medical personnel and rape crisis counselors.³

Every woman who has been battered (regardless of her age) should be asked if the batterer has ever forced or attempted to force her to engage in sex against her will. She should be told that this is a form of battering. A woman who has been raped should be referred to a rape crisis center, listed in the "Referrals" section of this manual.

If the woman has been sexually assaulted or raped by her husband, inform her that this is a crime she can prosecute in Massachusetts. In all cases involving rape, evidence should be collected using the Massachusetts Rape Evidence Collection Kit.

Myths About Woman Abuse

Chris Butler

MYTH #1: "Battering" overstates the case. Few women get beaten, though maybe some get slapped around a little.

An estimated two to four million women are beaten in their homes every year in this country. In Massachusetts alone, the courts grant over 30,000 abuse prevention orders each year to women seeking

protection in the home. Although the first incident of violence may not be severe, once battering begins it tends to escalate in severity and frequency, sometimes leading to permanent injury or death.

What may begin as an occasional slap or shove will turn into a push down the stairs, a punch to the face, or a kick in the stomach. On average, four women are murdered every day by their husband or boyfriend in the United States. A Kansas Police Department study found that in 85% of domestic homicide cases, the police were summoned at least once before the killing occurred and in 50% of the cases, they had been called five or more times before the killing.

Battering brutally violates a woman's rights over her body, her mind, and ultimately her life. Battering is not just acts of physical violence. It involves a system of emotional and social control which batterers impose on a woman in an effort to maintain power and dominance. The violence is preceded by emotional abuse and humiliation, as the batterer tries to rob the woman of her sense of self worth. The abuser typically is extremely jealous and attempts to isolate the woman from friends and family. The batterer denies his acts and minimizes the violence, turning any discussion of his violence around to focus on blaming the victim.

MYTH #2: Battering is a family matter.

No act which can leave a

I got pregnant when I was seventeen. I figured I'd get married. He battered me from the beginning, from before we were married. He threw irons at me while I was pregnant. I almost had a miscarriage when he threw me down a flight of stairs.

A minister who had his Ph.D. from BU in theology was counseling us. He was the minister who married us. He tried to get me to leave because he had fallen in love with me. I had a relationship with him. He battered me also—he tried to kill me, he tried to drive me off the Mystic River Bridge and did all this crazy shit to me. So I was kissing him one day and I picked up a rock and whammo—I knocked him out cold and split. That was the only way I could get away from him. I had just turned 18.

woman permanently injured physically or mentally, or result in her death is a "family matter." Assault is assault, rape is rape, murder is murder, regardless of the relationship between the people. Arguing in such cases that the "privacy" of the family must be maintained can mean injury, death, or virtual imprisonment to many battered women. The same attitudes perpetuate the sexual and physical abuse of children.

There is a general reluctance to interfere in family relationships. Women have been encouraged to remain in violent homes in order to preserve the family unit. Or, alternately, battered women are viewed as defective for having "willingly put up with it," and treated almost as criminals themselves. In either case, the things which we know can help a woman—providing her with legal protection and/or a safe place to stay, giving her the support of other battered women, and changing the criminal justice system to hold the batterer accountable—are not provided and society looks the other way. It is the isolation and denial enforced by the abuser, combined with the community's isolation, denial, and neglect which trap a woman.

Shelter workers and other advocates have begun educating the law enforcement community and social service agencies about battering. However, this work is just beginning; many police officers, judges and therapists still blame the victim. The law enforcement system is still reluctant to

treat battering as seriously as any other violent crime. Lawsuits such as the million dollar *Thurman v. Torrington* case in Connecticut have convinced some police departments to treat battering more seriously for fear of being sued for negligence. Yet even in states with strong abuse prevention laws many police officers and judges continue to discount the criminal nature of the abuse. Until we stop separating violence within families from other violent crimes, we will force thousands of women to stay in an environment that may eventually kill them.

MYTH #3: Battering only happens in "problem" families.

Battering is too widespread to be considered the problem of a few "sick" families; it is the problem of a society which presents violence as a normal part of intimate relationships.

The concept of the "problem" or "dysfunctional" family is suspect since it presupposes the existence of non-problem or "normal" families. The image of the stable, happy family masks the reality of the large number of people whose family lives are a daily ordeal, ignores the rising number of people who do not live within nuclear families, and ignores the statistics on woman and child abuse. By encouraging male dominance and reinforcing stereotyped sex roles, our whole society and not just individuals or individual families is responsible for the violence.

The myth that only problem

families experience violence also encourages social service workers, police, and court personnel to look for "reasons" and family "problems" to explain away the violence. The notion that alcoholics or drug abusers batter because of their addictions is contradicted by the evidence that the battering does not always stop when the abuser gets help for his substance abuse. For years women have been encouraged to seek professional help for their partner's alcoholism, their failure to make a successful marriage, or their "paranoia" about being abused. More and more women are now rejecting such advice and recognizing that the abuser is the problem.

MYTH #4: Battering occurs only within low income or working class families, or within particular racial or ethnic groups.

Studies and our direct experience show that batterers and battered women are of every racial, social, ethnic, and economic background. Women have been battered by doctors, lawyers, dock workers, judges, school teachers, ministers, and cab drivers. Statistics dealing with woman abuse have been gathered primarily through public agencies such as city hospitals and social service agencies, and therefore sometimes erroneously suggest that only certain kinds of women are battered by certain kinds of men.

Since middle class and upper class women often have other options open to them, such as staying in a hotel, they are less

likely to seek assistance from public agencies, or from emergency shelters. Many middle class women also are afraid of damaging a successful husband's career, and are pressured by family, friends and others to keep up appearances. Others may have greater access to work and financial independence. Of the middle class women who do seek assistance from battered women's service groups, many have spent years working in the home and do not have marketable skills; they suddenly find themselves without any means of support except public assistance.

MYTH #5: Battered women constitute a particular and easily definable group of women.

The term "battered women" gives rise to the stereotype of a passive woman, between 20 and 35 years old, who is unemployed, has 2 or more children, and lives with her husband who is alcoholic. The facts, however, indicate that "the" battered woman is us—any of us. Battered women are as diverse as women are.

A battered woman may be elderly, teenaged, or middle aged. She may represent an upper, middle, or working class background and any race or culture. She may be a homemaker, or work as an administrator, teacher, prostitute, organizer, shelter worker, student or factory worker. She may have been in the relationship two weeks or twenty years. She fits no easily definable pattern or stereotype.

I've learned also that the doctors, the police, the clergy and friends will excuse my husband for distorting my face but won't forgive me for looking bruised and broken.

I called the police one time. They not only didn't respond to the call, they called several hours later to ask if things had "settled down."

Furthermore, just as there are diverse kinds of women who are battered, there are many different kinds of relationships in which abuse occurs. The term "wife abuse," although widely used, distorts reality. Women are battered not only by husbands, but also in dating relationships, or by lovers, relatives, and neighbors. Prostitutes are often battered by their pimps and johns, and the very nature of prostitution is a system of abuse of women and children. Some lesbians are subject to homophobic attacks by former husbands or family members and others are beaten by their lovers.

MYTH #6: She asked for it or she wanted it.

Of all the myths about battering this is probably the most degrading to women. Yet many battered women have been accused by abusers and others of asking for the violence. Anyone who asks "what did you do to provoke the violence?" reinforces this message. Many women stay with a violent partner for years thinking that the battering is their fault and they'll eventually find a way to make it stop.

Similar to the provocation theory is the suggestion that women like to be abused. This theory blames the woman for the violence rather than holding the abuser responsible. The fact that the woman is trying to avoid being hurt is ignored. Because of the prevalence of violence against women and children in this society, many women have been

taught to expect violence in their relationships. And periods of being showered with affection and attention make it hard for the woman to leave. It's not the violence a battered woman wants to preserve—it's the relationship.

MYTH #7: It can't really be that bad or she wouldn't stay.

Many women do leave. Every year in Massachusetts, 5000 women and children flee to shelters for battered women. However, some women stay because they have been threatened with worse harm if they leave or because they are economically dependent on their partners. An interview with eighty-one battered women in Duluth, Minnesota, found that 48% of those employed reported that they lost work time because of physical abuse, 43% were harassed at work, and 18% lost their jobs because of the abuse; 21% said that they were discouraged from going to school, and 14% were forbidden by the batterer from returning to school. The social and economic controls which a batterer places on a woman and the process of trying to tear down her spirit can immobilize her.

MYTH #8: Battering occurs because both partners come from violent families.

Many professionals and scholars explain battering as the result of a "cycle of violence," in which boys who are exposed to violence grow up to be batterers; girls, to be victims. What this theory fails to

No one has to "provoke" a wife beater. He'll hit when he's ready and for whatever reason he wishes. I may be his excuse but I have never been the reason.

address is the large number of batterers who come from nonviolent families and battered women who come from nonviolent families but become trapped in violent relationships. There is no question that observing violence towards their mother has a tremendous impact on children. But this does not mean that every child of a battered woman will batter or be battered as an adult.

Another facet of the cycle of violence theory is the suggestion that battered women batter their children. Because of this common belief, some battered women are afraid to mention their own abuse to social workers for fear of losing custody of their children. Battered women are no more likely to abuse their children than women who

have not been battered.

While the cycle of violence theory too rigidly stereotypes children of batterers, and puts blame on the woman, there is an important point to be understood about the role of victimization in a person's life. Being victimized by sexual abuse or beatings as a child or sexually exploited as an adolescent can teach a young woman bitter lessons about who she is and what she can expect from the world. People are often confused and disgusted by a woman who goes from one bad situation to the next and they blame her for the "choices" she makes. But often we can see that the lessons she learned as a child have set her up for later violence. For instance, one woman wrote about the



impact of having been raped repeatedly by her birth father as a very young child and sexually abused by a neighbor when she was seven:

I couldn't seem to heal. I kept being told I was a woman who loves too much, that I am a masochist, that I'm addicted to abusers. And I finally found the battered women's program in Des Moines, Iowa, and they told me differently. They told me I didn't seek out an abuser and that I'm not co-dependent. And instead they said I have one problem: I married a goddamned abuser.

He encouraged me to drink, to take drugs, to sleep with anyone who wanted me. He was constantly bragging that he was 'training' me...Eventually he started paying me, ten or twenty dollars here and there to assuage his guilt.

She writes of her experience as a twelve-year-old girl:

I don't remember how many men there were in the four years that followed. Most of them older, most of them vicious. All of them afraid for themselves that I might 'tell.' Some were more violent than others. Some were more guilty than others. Most of them were respected family men...The only thing that kept me sane was knowing that I was not the only one. One friend of mine, at fifteen years old, was sleeping with a married minister. One friend's father broke her arm. Another's brother raped her. 'That's life,' we used to say. 'Have another beer.'

MYTH #9: "Women who love too much" are the problem. These women get "addicted" to abusive partners and can't leave.

This myth is particularly powerful because it appeals to women who are starting to see their relationships as unsatisfying and abusive. Though the abuser is solely responsible for the abusive behavior, this myth instead places blame on women. The attempts made by women with abusive partners to save their relationships

and maintain a loving home environment for their children are not symptoms of an addictive personality. These reactions are normal and healthy. In fact, some of the supposed symptoms of addiction like "trying hard to be good" are actually survival techniques for the battered woman. Often one of the goals of the batterer is to belittle the woman's attempts to care for him and her children. The "women who love too much" theory compounds the battered woman's feelings of inadequacy and guilt by reinforcing the feeling that she is the problem.

MYTH #10: Lesbians don't get battered.

Lesbian battering occurs when a woman uses violent and coercive behavior to control her partner or lover. She may use the additional threat of exposing the abused partner's lesbianism—which could cause her to lose her job, her home, her children, or the support of her family. It is a myth that certain groups of lesbians batter and others do not. Whether a woman is a "bar dyke," identifies with "butch" or "femme" roles, considers herself a "feminist," is closeted or not, she is capable of battering or being battered. Lesbian battering crosses the lines of class, race, and culture.

Battered lesbians are often afraid to speak out about the battering. The fear of splitting the community keeps the battering a secret, and this allows the violence to continue. The fear of giving homophobic people fuel for their

At my job interview at the battered women's shelter they asked if I had any personal experience with battering and I said no. It wasn't until I'd been on the job for a few months that I realized the answer was really yes. Even though I'd been beaten and abused, as a lesbian I just never equated the word "battered woman" with what I was going through.

hatred of lesbians and gays keeps survivors of lesbian battering silent. The lesbian community as well as the battered women's movement needs to continue raising the issue of lesbian battering, validating the experiences of battered lesbians, and holding the batterers accountable.

MYTH #11: Just as many men as women are battered. Battered husbands just don't come forward as often.

The vast majority of battering occurs in heterosexual couples, with the man battering the woman. The Bureau of Justice Statistics estimates that 95% of serious domestic assaults are committed by the male. The fact that much of the literature goes to great lengths to use gender neutral terms like "domestic violence," "battering couple," and "spouse abuse" is profoundly misleading. Battering is integrally connected to

sexism and strongly rooted in our patriarchal history.

MYTH #12: Batterers just have a problem expressing anger. They need counseling.

One of the most common, and we believe mistaken, approaches to getting batterers to stop their abuse is to assume that they need to learn how to control their anger and solve disputes nonviolently. We believe this is a mistaken focus because batterers often can manage quite adequately not to beat their boss when they are angry or to terrorize their friends. The central focus of programs for abusers must be on challenging their belief that they have the right to control their wives and girlfriends. Battering, far from being an uncontrolled act, is imposed specifically to maintain the batterer's control over his or her partner.

Batterers are so wound up in denial. They'll say I didn't really hit her hard, or she made me do it, or it was the liquor talking, or things'll get better when the pressure's off at work, or when I get a job. The list is endless. The ironic thing is that the sociologists and the media collude in the denial because they're always talking about "Unemployment and Domestic Violence" or "Alcohol and Spouse Abuse."



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Domestic Violence Facts

- * In Massachusetts, on average, a woman was killed by her batterer every 22 days in 1990, every 16 days in 1991, every 13 days in 1992, and as of May 21, 1993, a woman was killed by her abuser every 14 days (Massachusetts Department of Public Health).
- * National surveys indicate that at least 2 million women per year are severely assaulted by their male partner (Straus and Gelles, 1990).
- * From 1976 through 1987, the deaths of approximately 38,648 people over the age of 15 resulted from one partner killing another. Of these deaths 61% of the victims were women killed by their husbands or boyfriend, and 39% were men killed by women partners (Browne and Williams, in press).
- * In a national survey over half of the males who were violent toward female partners also abused their children (Finkelhor, et al., 1983).
- * In the United States women are more at risk to be assaulted and injured, raped, or killed by a current or ex-male partner than by all types of assailants combined (Finkelhor and Yllo, 1985; Browne and Williams, 1989).
- * Abused women make up approximately 22 - 35% of women presenting with injury to hospital emergency rooms (Randall, 1990).
- * Police in Massachusetts estimate that 40 - 60% of their calls involve family violence (C.J.T.C. Domestic Violence Manual, 1986).
- * About 3 million children each year witness abuse of one parent by another (Robert S. Pynoos, M.D., U.C.L.A. School of Medicine).
- * Violence by intimate partners is the leading cause of injury for women, "responsible for more injuries than car crashes, rape, and muggy combined" (Stark and Flitcraft, 1980).
- * Abuse of pregnant women is the leading cause of birth defects and infant mortality (March of Dimes study).
- * In Norfolk and Walpole prisons, at least 80% of the inmates have been victims of or witness to family violence (Department of Social Services).

Domestic Violence Training Project

A Program for Health Professionals

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TABLE I

MISCONCEPTIONS ABOUT ABUSE AND THEIR CLINICAL CONSEQUENCES

MISCONCEPTION	CONSEQUENCE FOR ABUSE VICTIM	RESEARCH FINDINGS
Adult injury is accidental unless proved otherwise.	Problem is treated symptomatically. The source of injury is probed only if a medical dilemma is posed.	Abuse is a major source of female injury. Injury should be treated as social unless proved accidental.

APPROPRIATE PRACTICE REQUIRES THAT A FULL TRAUMA HISTORY BE TAKEN IN ALL INSTANCES OF ADULT INJURY.

Abusive injuries are typically life-threatening. Assessment should be based on severity of injury.	The majority of visits for abuse go unrecognized. The message is, "you will be helped when you are really beaten." Abuse victims are labelled as "crocks" and sent home with no followup.	The majority of abusive injuries do not require hospitalization. The majority of visits by abused women involve non-trauma and non-emergent complaints. Battering often presents with no discrete physical findings.
--	---	--

PATIENT COMPLAINT IS THE BEST BASIS FOR ASSESSING A WOMAN'S PREDICAMENT AND EMERGENCY. ABUSE SHOULD BE IDENTIFIED AT PRIMARY HEALTH CARE SITES AS WELL AS IN EMERGENCY SETTINGS. WOMEN WHO CARRY "LABELS" SHOULD BE CAREFULLY QUERIED ABOUT ABUSE.

Alcoholism, drug abuse, depression, and other psychosocial problems are the cause of battering.	Abuse victims are stigmatized, labeled, referred to psychiatry and blamed for the problem. Violence escalates unless it is stopped.	The psychosocial problems are typically consequences of battering and frustrated help-seeking. Victims are not typically "crazy."
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VIOLENCE SHOULD BE PROVEN AND TREATED AS THE BASIS FOR PSYCHOSOCIAL PROBLEMS SUCH AS ALCOHOL AND DRUG ABUSE, CHILD ABUSE, RAPE, ET AL. STOPPING VIOLENCE SHOULD BE THE CONTEXT FOR TREATING THE SECONDARY PROBLEMS SUCH AS ALCOHOLISM.

MISCONCEPTION	CONSEQUENCE FOR ABUSE VICTIM	RESEARCH FINDINGS
Abuse victims delay reporting, conceal the source of their problem and are reluctant to accept help. Victims should simply leave.	Victims are patronized, little help is offered and providers become impatient or angry at victims who stay in violent homes.	Victims report promptly, often and are responsive to supportive questions. Lack of resources and protection explain why women stay.

A FULL HISTORY OF ADULT TRAUMA SHOULD BE ROUTINELY TAKEN WITH WOMEN PATIENTS. OPTIONS SHOULD BE REALISTIC AND EMPOWERING.

Abuse is a problem for poor, black, and unemployed people.	Violence is "expected" in these groups, hence no help is offered. Abuse is not diagnosed in middle-class groups.	Abuse is found among all groups, occupations, etc.
--	--	--

ABUSE PROCEDURES SHOULD BE INITIATED WHENEVER A WOMEN PRESENTS VIOLENCE AS A COMPLAINT.

Abuse is a family problem. Abuse can be prevented when women learn to cope or parent more effectively.	Providers reinforce a woman's sense of failure. She is given false hope that if she changes violence will stop. Family therapy is used. Abuse is ignored among single, divorced and separated women.	Divorced, separated, and single women are at higher risk than married women. Violence is the assailant's problem.
--	--	---

ABUSE SHOULD BE PROBED AND RESPONDED TO REGARDLESS OF MARITAL OR COHABITANT STATUS. FAMILY SUPPORT SHOULD BE SUGGESTED ONLY AFTER THE VIOLENCE HAS STOPPED AND A WOMAN UNDERSTANDS THE CAUSES AND PROBABLE COURSE OF ABUSE AND THE ALTERNATIVES AVAILABLE TO HER, INCLUDING HER LEGAL OPTIONS.

**Domestic Violence Training Project
A Program for Health Professionals**

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Violence, Values, and Gender

"I want to do a study of battered women."
 "Fine. There are data from the rape crisis team in the ED that need to be pulled together."
 "No, not rape. I want to study battered women."
 "What's a battered woman?"

Dialogue between medical student and adviser
 New Haven, Conn. 1975

Violence epidemiology is still in its infancy. In our offices, clinics, and emergency departments we all see injury and its consequences, perhaps daily.

And yet, like a clinical Heisenberg's uncertainty principle, the more closely we focus on injuries, the less we seem to understand the violent relationships that culminate in these injuries. When we begin to make the connection between our patients' health problems and violence, we experience the same sort of epiphany that came with child abuse in the 1960s.

I was shocked into recognizing the complex interplay of poor health, injury, and violence during residency when I was called to the emergency department to admit a 35-year-old woman for yet another bout of acute pancreatitis. She was nearly blind, with wide scars over her left breast and shoulder, and multiple scars over her abdomen and flanks. Her several-volume medical record documented bilateral retinal detachments, burns over her torso from hot grease, a fractured jaw, multiple stab wounds to the abdomen, and a gunshot wound that required a partial hepatic resection. In the discharge summary for each hospitalization, house officers through the years had carefully noted "the patient is a 22-year-old . . . 25-year-old . . . 27-year-old . . . 31-year-old woman with a long and complicated history of trauma secondary to alcohol abuse."

The recurrent assaults were characterized as episodic injuries; alcoholism, not her violent relationship, became the prism through which we viewed this patient's life. In fact, of course, violence is more than the sum total of injuries, and optimal clinical intervention must address the social context in which violence occurs, not simply the pattern or severity of the resultant injuries.

Child abuse intervention programs initiated in the mid-1960s were the first to characterize violence within the context of ongoing social and familial relationships. Since then, we have extended the model to encompass protective services for abused elderly and handicapped individuals who are victims of abuse. With domestic violence—a major focus in this issue of *THE JOURNAL*—it is not age but gender that characterizes the experience of abuse.

When we¹ reported our findings that domestic violence was a leading cause of women's injuries, the initial response from the medical profession was to focus on emergency care. Yet a history of battering has proven important as a backdrop to many vexing issues in women's health care: alcoholism, suicide attempts, drug use and abuse, depression, and child abuse. It

is now evident that ambulatory and primary care facilities, mental health and substance abuse programs must provide services to address the sequelae of abuse and the medical problems that arise from women's isolation in violent relationships.

Through the Prism of Gender: The Adult Trauma History

The report from the American Medical Association (A.M.A.) Council on Scientific Affairs² reviews the epidemiology and clinical dimensions of rape, physical and sexual assaults in marital, cohabiting, and dating relationships, and the long-term effects of child sexual abuse—unveiling women's vulnerability to violence across the life span. The common denominator for women of all ages is that social partners—not strangers—pose the greatest threat of violence. In other words, the predominance of assaults on women occurs within ongoing familial, social, and domestic relationships. As a result, female victims of abuse present a distinct "adult trauma history" typified by recurrent injuries generally accompanied by sexual assault, threats, and verbal abuse.

The inescapable significance of women's vulnerability to violence is revealed in the article by Marzuk et al³ on the epidemiology of murder-suicide. Their intent was to unify and classify data on homicide-suicide episodes, a unique class of violence. But they discovered that the most common type, representing fully one half to three fourths of all murder-suicides in the United States, typically involved a male between the ages of 18 and 60 years who physically abused his girlfriend or wife, feared her infidelity or estrangement, murdered her, and committed suicide, usually by a firearm. The importance of this work perhaps lies less in its typology of murder-suicide, than in its identification of possible predictors of lethal domestic violence and emphasis on the role of firearms in homicide and suicide.⁴

The Challenge in Clinical Practice

McFarlane and coworkers⁵ demystify the problem of identifying women involved in abusive relationships. They highlight the importance of routine assessment for abuse in non-emergent settings, particularly prenatal care. Using three straightforward questions in a safe, confidential, and interpersonal encounter, they found that 17% of pregnant women in their public health clinic population were abused, 60% of whom reported recurrent episodes of violence within the index pregnancy. Abused women were twice as likely not to begin prenatal care until the third trimester, suggesting that domestic violence may limit women's utilization of early prenatal care.

These authors use a scale that gave a "severity of physical abuse" score according to the severity of the resultant injury. For instance, "threats of abuse, including use of a weapon" are ranked as the least violent of abusive acts. Consequently, black women appeared to experience fewer episodes of violence compared with their Hispanic and white counterparts. Homicide data suggest that this is not the case.⁶ Is it intuitively obvious that the severity of abuse parallels the severity of injuries? Consider for a moment the woman who, when asked whether

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the violence is escalating, responds, "Yes, I mean no. No, I guess it's better. He doesn't hit me anymore, but he sleeps with a gun under his pillow." An alternative interpretation may be that severity of abuse differs little across ethnic groups and that threats with and access to a weapon should be ranked in a category with a high probability of significant injury, predictive of severe abuse. Thus, outright violence and coercive control, introduced by Jones and Schechter,⁷ undermine a woman's capacity to design and implement proactive safety plans.

The report from the AMA Council on Ethical and Judicial Affairs⁴ highlights beneficence and nonmaleficence as the principles to guide physicians' intervention in domestic violence. Importantly, our responsibilities extend to "participation in efforts to secure a safe place, including offering hospitalization if necessary for patients when there are no available shelters." But having emphasized safety, the report's distinction between child abuse and woman abuse becomes crucial. In the case of woman abuse, protective services (the basis of child abuse intervention) are replaced by informative and interpretive encounters that facilitate patient empowerment and autonomy.⁹

Consequently, "[s]pouses, partners, or other third parties, including the police, should not be notified of an abuse diagnosis without the expressed consent of the patient." Nor, I would add, should we contact these parties to confirm or substantiate a patient's report of abuse. Again, in contrast to policy in cases of suspected child abuse, "It is not evident, however, that mandatory reporting of domestic violence [by physicians] would contribute to the safety of battered women or would facilitate their access to appropriate resources." When we are addressing the abuse of competent adults, "[o]verriding a patient's refusal violates the ethical principle of respect for patient autonomy." The tenets of beneficence, nonmaleficence, confidentiality, and patient's autonomy provide a strong foundation for the development of an appropriate and empowering medical response to domestic violence. When women who have been abused are given the power to act, they are able to regain control of their lives and are more likely to make the decisions necessary to ensure a safe future.

As physicians organize to address domestic violence, we join forces with others who have been dedicated to eliminating this problem, forging relationships across institutional and disciplinary lines. The interagency child death review team described by Durfee et al¹⁰ exemplifies a kind of institutional morbidity and mortality conference that can identify problems, gather data, and generate more effective intervention strategies. Adaptation of this model to review incidents of both fatal and nonfatal domestic assaults may facilitate cooperation between health care organizations, community-based services for battered women, and the complex array of legal, law enforcement, and social services vital to violence intervention and prevention efforts.

Personal and Professional Values

In medical practice, knowledge, skills, and attitudes are recognized as the necessary elements of clinical expertise. However, attitudes can be at odds with practice skills and knowledge. As discussed by Orentlicher,¹¹ corporal punishment remains legal in most states' public schools despite strong positions against it by the AMA, the American Academy of Pediatrics, the American Psychiatric Association, and American Public Health Association. Results from the study by McCormick¹² demonstrate the considerable confusion among physicians on the advisability of corporal punishment in the home. Widely

differing definitions of corporal punishment prevent meaningful comparison of these two articles, but policymakers, physicians, and parents share the frustration that knowledge transforms behavior only when appropriate skills and values converge in the right political climate. Deep ambiguities persist on the societal and community levels regarding the difference between caretakers' legitimate authority and abusive behavior.

Fortunately, there is no longer legal ambiguity with respect to the use of force in intimate relationships between adults. State laws have established partner or spouse abuse as a criminal act. Legislative actions vary by state, but include mandated arrest when police are called to intervene in domestic violence cases. Policies developed in recent years urge judges to grant battered women child custody, mandate court-assigned treatment programs for batterers, and provide for more than a thousand community-based shelter and advocacy programs for victims of family violence. We have witnessed a profound change in the public response to domestic violence over the past 15 years.

Nevertheless, informal social norms and stereotypic gender roles still legitimate control of one partner over the other and may allow us to rationalize abuse in adult relationships. Sugg and Inui¹³ in their survey of primary care physicians' attitudes about domestic violence conclude that "physicians found exploring domestic violence in the clinical setting analogous to 'opening Pandora's box.'" In the face of domestic violence, physicians experience fear and a sense of powerlessness and they perceive a loss of control, all of which parallel the feelings of the abused patient. But the physicians' strategies—denial, rationalization, and minimization—echo the voices of the abuser who neither identifies nor accepts responsibility for his violent behavior.

Interpersonal abuse was not foreign to the physicians interviewed by Sugg and Inui, nor is it foreign to many of us. Fourteen percent of male physicians and 31% of female physicians had been victims of abuse at some point in their lives. Yet only two physicians had been able to address violence with their patients; one of the physicians had sought counseling to cope with his own history of abusive behavior.

As the medical profession participates in violence prevention and intervention efforts, advances in knowledge, skills, and attitudes are bound to follow. This change will prompt a deeper understanding of the abuse of control and authority in our own professional—and personal—lives.

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Identifying the Assaultive Husband in Court: You Be the Judge

by David Adams, M.Ed.

David Adams is Co-founder and President of Emerge: A Men's Counseling Service on Domestic Violence. He is a nationally known expert on counseling assaultive husbands.

stereotypes and learning to ask the right questions. Court officers must be especially careful to ask plaintiffs whether they fear potential reprisals from the defendant in reporting domestic assaults.

As frightening as domestic abuse is, the experience of publicly disclosing it has been compared to stepping off a cliff. Disclosure not only puts the battered woman at greater risk for retribution from her abuser but it also severely jeopardizes her social and economic security. Research shows that, far from being irrational, these fears are well-founded. Women are most likely to be murdered while attempting to report abuse or to leave an abusive relationship (Sonkin, 1985; Browne, 1987). Many battered women report that their husbands have repeatedly threatened to kill them if they call the police or attempt to leave. Those who treat the abusive man confirm that the violence often escalates once the woman attempts to end the relationship. The abuser's threats of continued physical abuse are often accompanied by economic threats. These commonly include threats to withhold child support and to sabotage her job plans. Some men make threats that are specific to the children, exploiting their wives fears of losing the children once they report domestic abuse.

Most battered women's fears about calling the police or seeking court protection are logical reflections of her past experience with her abusive spouse. What appears from the outside as an irrational pattern of "crying wolf," becomes much more understandable when one identifies the specific scare tactics of the abuser. These, combined with inconsistent and sometimes hostile responses from the criminal justice system reinforce the battered women's fears that there is no real escape from the abuse.

Characteristics of the Abusive Husband

The following descriptive profile of the abusive husband is provided to help criminal justice workers become more sensitive to the concerns of battered women and more knowledgeable (and hence, less vulnerable) to the manipulation patterns of the abusive man. The profile is drawn not only from victim accounts and research findings but also my twelve year experience as a counselor of abusive men at Emerge: A Men's Coun-

seling Service on Domestic Violence, in Cambridge, Massachusetts. Founded in 1977, Emerge was the first program of its kind in the nation. Each characteristic listed has implications for all those who are in a position to identify abusive behavior and prescribe solutions.

1. Discrepancy in public versus private behavior

Men who batter their wives often do not come across to those outside the family as abusive individuals. Often, the abusive man maintains a public image as a friendly, caring person who is a devoted "family man." This good reputation often leads neighbors and friends to conclude that his wife is exaggerating when she reports physical abuse. Police responding to these reports may be swayed by the calm demeanor of the perpetrator. By contrast, his wife may seem more agitated and hysterical, leading police officers to conclude falsely that she is the more aggressive party. This false picture is often repeated in court. Dressed in a suit and accompanied by counsel, the male defendant frequently comes across more credibly than the female plaintiff. This is especially true when the perpetrator is a professional man. In such a case, the picture the plaintiff paints of her husband's behavior may seem inconsistent with his stature in the community. Approximately one-third of the men counseled at Emerge are professional men who are well respected in their jobs and their communities. These have included doctors, psychologists, lawyers, ministers, and business executives. Police and court officers must look beyond the popular image of the abusive man as an easy-to-spot brute. While some abusers bear some resemblance to this stereotype, most do not.

2. Minimization and denial

Living in a society that undervalues domestic life, abusive men do not expect their abusive behaviors toward women to be taken seriously. One man said it had never occurred to him that he could be arrested for such a "minor thing." This man's attitude that men's ill-treatment of women doesn't belong in the public sphere, does not exist in a social vacuum. It is mirrored by recent public debates about the relevance of how public men treat their wives, particularly when allegations of wife abuse or infi-

delity are made. It is reflected by the historical reluctance of police and courts to intervene in "domestic disturbances" (Roy, 1977).

Few, if any, abusive husbands characterize themselves as men who beat their wives. A recent informal poll of clients at Emerge revealed that few men, even the most severe abusers, had thought of themselves in those terms. The abuser's tendency to minimize problems is comparable to the denial patterns of alcohol or drug abusers. Problem drinkers minimize their drinking by favorably comparing their own consumption pattern to "worst case" alcoholics — those who drink bottles of hard liquor on the street. Many battering husbands similarly minimize their violence by comparing it to "brutes who beat their wives every day." Besides spurning the "wife beater" label, most abusive men underreport their violence. Research studies of violence-reporting patterns among husbands and wives have found that husbands are more likely than wives to underreport their own violence (Szinovacz, 1983; Browning & Dutton, 1986). For instance, husbands are more likely to count even severe acts of violence (e.g., choking, punching, beating someone up) as self-defense rather than violence (Brygger & Edleson, 1984). Frequently, what abusers report as self-defense is in reality violent retaliation. While some men rationalize their violence, other merely lie about it. The previously mentioned poll of Emerge clients found that many had lied about their violence when asked by neighbors, relatives, and police.

3. *Blaming others*

Perhaps the most common manipulation pattern of the abusive man is to project blame for his violence onto his wife. In treatment programs for abusers, statements like "she drove me to it," "she provoked me," "she really knows how to push my buttons" are common. Statements like these reveal the abusers attempt to divert attention away from his own behavior and choices. Abusers in the early stages of treatment resist self-criticism by projecting responsibility for their violence onto others (Adams, 1988). This is similar to the alcoholic's tendency to blame other people, things, and circumstances for his drinking. The abusive husband, like the alcoholic, pre-

sents himself as a victim.

Too often, interveners get caught up in talking about the victim's behavior. This is a disservice to the abuser because it reinforces his denial of responsibility. When the topic of discussion shifts to his partner's behavior, the abuser is prevented from recognizing that he has choices in how he responds to her, and that some choices are more constructive than others. Often, the abuser manipulatively seeks allies in his attempts to monitor and police his wife's behavior. Abusers in later stages of treatment are able to critically identify this as a lack of respect for their partners. One man said "I could never accept her the way she was; I always felt I had to 'correct' her. And it was easy to find other people to agree with me." (Emerge, 1989).

4. *Controlling behaviors*

Advocates for battered women have pointed out that wife abuse is more than isolated acts of physical violence. It is a cohesive pattern of coercive controls that include verbal abuse, threats, psychological manipulation, sexual coercion, and control over economic resources (Dobash & Dobash, 1979; Schechter, 1982). The co-existence of these other controlling behaviors serve to remind the victim subliminally of the potential for physical abuse (e.g., yelling, threats, angry sulking) and to undermine her independence. The abuser's frequent criticisms of his wife erode her confidence in her own abilities. One abusive husband said he constantly tore down his wife's self-confidence because "I felt threatened whenever she felt good about herself." This man's wife said that it was only when she got support and validation from others that she began to trust that she could make it on her own. Social isolation is another tactic used by abusers to undermine their wife's autonomy (Walker, 1984). Accusations of infidelity or of "neglecting the family" serve to manipulate the woman into curtailing her contacts with friends, co-workers, and relatives.

5. *Jealousy and possessiveness*

Many battered women report that their husbands make frequent jealous accusations. For some abusers, this jealousy has an obsessive quality. These men constantly monitor their wife's whereabouts. Their surveillance activities often con-

tinue (and escalate) when their wives leave or attempt to end the relationship. These may include following her around, interrogating the children, eavesdropping on telephone conversations, and making frequent telephone calls to monitor her activities.

It bears repeating that pathological jealousy of this kind is not evident in all men who abuse their wives. Its presence should be seen as a significant indicator of potential homicidality (Sonkin, 1985). Closely related to this is extreme possessiveness which is often manifested by the abuser's unwillingness to accept the end of the relationship. Women who leave this type of man are subjected to ongoing harassment and pressure tactics, including multiple phone calls, homicide or suicide threats, uninvited visits at home or work, and manipulation of the children.

6. *Manipulation of children*

There is considerable variation among abusive husbands on whether their violence extends to the children. While child abuse is as frequent or more frequent than wife abuse for some abusive husbands, others have strong prohibitions against hitting their children. Regardless of whether children are directly abused, children are adversely affected by being exposed to wife abuse (Kalmuss, 1984). Children exposed to abuse are more insecure, more aggressive, and more prone to depression. Children in this situation commonly feel divided loyalties between their mothers and fathers. Research shows that childhood exposure to wife abuse is a significant predictor of future wife abuse (Hotaling & Sugarman, 1986).

Courts are often asked to decide custody and child visitation issues when battered women file for protective orders. Judges must be wary of the manipulation patterns of the abuser in making these decisions. For instance, abusive husbands commonly misuse child visitations as a way of gaining access to their wives. Abuse of child visitations not only compromises the battered woman's safety but also has an adverse emotional impact on the children. Some abusers use their children as emissaries who are responsible for spying on mom's activities or for convincing mom to "let Dadd come home." Some abusers contest cu-

body or child support agreements as a bargaining tactic designed to coerce their partners to reconcile or to drop criminal complaints. Prosecutors and judges should routinely encourage battered women to seek modification of child visitation agreements if such agreements are being abused, or if the child's or woman's physical safety is being jeopardized.

7. Substance Abuse

Research studies have varied findings about the degree of overlap between spouse abuse and substance abuse. One study found 70% of men arrested for domestic battery showed evidence of alcohol or drug abuse (Roberts, 1987). A survey of women who sought refuge in shelters for battered women, found that 48% reported that their abusive husband abused alcohol. This variation in findings is attributable to the use of differing criteria in assessing the batterer's use or abuse of substances. There is also evidence to suggest that police are more likely to arrest a batterer when there is also evidence that he is under the influence of alcohol or drugs (Kantor & Straus, 1986).

Despite the high correlation, experts in the domestic violence field agree that alcohol or drug use does not cause men to batter their wives (Coleman & Straus, 1983). Acting as a socially approved disinhibitor, alcohol use becomes a convenient excuse for some men to hit their wives. The battering husband who abuses alcohol has two problems for which he must take responsibility. Alcohol or drug treatment alone will not stop the batterer's abusiveness. Recovering alcoholics exhibit high rates of abusive behavior. Despite this, one study found that courts in one state refer most alcohol/drug abusing batterers to alcohol or drug treatment programs only — without also referring to specialized batterer treatment programs (Roberts, 1987). Because probation officers and judges have been more sensitized to alcohol and drug problems, there is a danger of focusing exclusively on the substance abuse when the substance abuser is also abusive toward his wife. When the problems co-exist, it is critical for the individual to be evaluated for both kinds of treatment.

8. Resistance to change

Like substance abusers who are still in

the denial stage, most abusive husbands lack internal motivation to seek counseling or to change their behavior. It is estimated that less than 1% of men who batter are referred to specialized treatment programs for abusers. Approximately 20% of Emerge clients are court-ordered to attend the program. Though the rest, technically, are self-referred, most of these have sought counseling only once it became clear that their relationship will not continue unless they attend. For most of these men, the problem as they see it is that their wives have left them, not that they have been violent. Initially, the abusive man bargains with his wife to change as little as possible (Adams, 1989). For instance, he may agree to attend one week of counseling in exchange for returning home or having criminal charges against him dropped. Fifty percent of Emerge clients drop out of treatment within the first month, a figure that is consistent with other programs. Some drop out as soon as they reconcile with their wives. Others drop out as soon as it becomes clear that a reconciliation isn't possible. The typical battering man, like the alcoholic, brings a 'quick fix' mentality to counseling. His desire to restore the status quo outweighs his desire to change.

Summary

For court workers to become aware of abusive behavior patterns does not condemn the abuser's chances for change. On the contrary, this insight helps interveners resist the abuser's manipulation patterns and more realistically appraise his suitability for rehabilitative efforts. Clearly, some perpetrators pose too great a danger to their wives for the courts to release them into the community. Assessments for potential lethality should be made in every spouse assault case. In my experience, the men who do make significant changes are those who accept legal sanctions and persevere with counseling. These men respect their wife's decisions concerning the amount and nature of contact she wishes to have with him. He learns to focus on his own rather than her behavior. Much depends on the public sanctions that the abuser encounters along the way. Courts have a critical role to play in this. They determine whether the abuser attends a treatment program, how long he stays in the

program, and whether the victim's safety is ensured while he attends the program.

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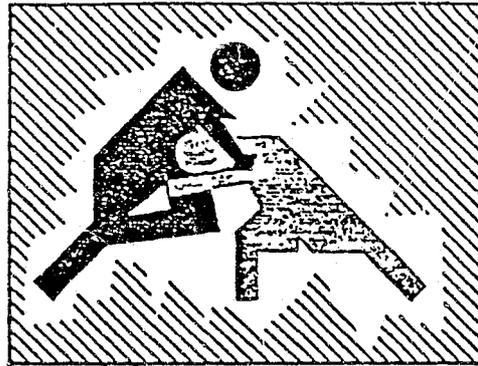
FACTS ON ALCOHOL, DRUGS AND DOMESTIC VIOLENCE

Robert Mackey, M.A., C.A.S.

Statistics on the correlation between domestic violence and addiction range between forty-four percent according to the New Jersey Uniform Crime Report of 1989, to more than eighty percent in some research studies. According to the National Woman Abuse Prevention Project in Washington, D.C., alcoholism and battering share the following characteristics: Both are inter-generational, both involve denial and minimization of the problem, and both involve isolation of the family. Considering this, any intervention with either of these problems should consider the implications and presence of the other.

The topic of domestic violence and its association with addiction has received increased attention over the past decade. In a report by Schuerger and Reigle, personality and background data were obtained on two-hundred and fifty men enrolled in a group treatment program for spouse abuse. The major conclusions of this investigation verified the prevalence of alcoholism, drug abuse, and violence in the family of origin of abusive men. Fitch and Papantonio found violence between the batterer's parents, abuse of the batterer as a child, alcohol and drug abuse, and economic stress to be highly correlated to spouse abuse. Lehmann and Krupp cited several striking statistics on drinking and wife abuse. Data from the New York based program, *Abused Women's Aid In Crisis*, indicate that alcohol abuse on the part of the husband was a factor in over eighty percent of their cases. Another interesting point cited by these authors was the survey conducted by Scott, who interviewed 100 wives of alcoholics who had identified themselves as victims of abuse. Seventy-two percent of these women indicated they had been threatened physically, forty-five percent had been physically attacked, and twenty-seven percent had experienced "potentially lethal" attacks. None of these women had sought help as victims of battering, suggesting that alcohol abuse is not

only a factor in many cases of domestic violence, but that wife battering may be very common in families of alcoholics.



Lehmann and Krupp carried out their own survey of 1500 cases of women calling a hotline for abused women in Philadelphia. Fifty-five percent of these women said that their husbands became abusive when drinking. They asserted that although the association between alcoholism and domestic violence is clear, "most existing research supports the conclusion that alcohol abuse does not cause domestic violence." A final portion of this research involved interviews with ten alcoholism counselors and ten workers specializing in the field of domestic violence. Contrary to the research literature, workers in both fields believed that alcoholism was in fact the primary cause of the violence. These findings support the need for collaboration between the fields of addiction treatment and domestic violence as well as professional training on the subject.

In summary, the literature on alcohol abuse and domestic violence makes it clear that men with drinking problems are at high risk to be abusive toward their spouses. However, it is also clear that many men who have drinking problems do not abuse their wives and that some men who don't have drinking problems do abuse their

wives. Therefore, the conclusion that there is no direct causal relationship between drinking and spouse abuse, a position supported by most of the researchers in this area, appears irrefutable.

There are a few salient points to consider when intervening with the problems of alcohol abuse and domestic violence. First, there is no causal relationship between the two, therefore recovering from one of the problems does not assure resolution of the other. Treatment of the addiction should precede treatment for the battering; however in many cases, counseling for battering can be initiated concurrently or can be instituted initially to assist in confronting the denial of the addiction. In either case, the violence must be addressed immediately, if not through counseling then through legal sanctions and restraints to assure the safety of the victim(s). Victims of domestic violence, where alcoholism is involved or not, should receive the benefit of counseling and education concerning the cycle and dynamics of battering. Victims should also be afforded the opportunity to investigate family-of-origin issues, beliefs, behavioral patterns, and role expectancies that increase vulnerability to abusive types of relationships through disempowerment. The goal of intervention is to assure safety and to empower both victim and abuser to act in their best interest independently. While family therapy is an important aspect of addiction recovery, it is contraindicated in the presence of domestic violence. Early recovery where both problems exist should focus on individual self-management and should incorporate marital or family treatment as an adjunct therapy later in the therapeutic process. Domestic violence creates an extreme imbalance of power in the relationship prohibiting effective negotiation. This disempowerment requires a reasonable degree of resolution before the effective assertion of the victim's needs can be realized.

The following components are recommended to be incorporated in treatment programs for battering, in order of priority:

1. Instruct/support the alcoholic batterer to abstain from alcohol use and violence through direct appeal and appropriate treatment modalities (if necessary, through legal or formal sanctions such as restraining orders, job jeopardy, etc.).
2. Confront denial/minimization and projection of responsibility.
3. Incorporate recovery programs for addiction concomitant with anger management/self-control techniques.
4. Address potential relapse issues common to both problems such as resentment, self-pity, and cyclical self-defeating patterns of behavior.
5. Teach assertive communication skills.
6. Educate all parties on the techniques of effective problem-solving, thereby empowering each individual in the system to behave in his or her personal best interest.
7. Address the needs of the entire family system. These are inter-generational problems, and prevention is a primary objective.

Suggestions for Abusers

1. Seek help from people with specific knowledge of addiction and/or aggression control. This may require involvement in appropriate 12-step meetings and in anger management counseling. Remember, addressing one problem will not necessarily resolve the other.
2. Understand that both battering (physical and psychological) and addiction are progressive. The longer you deny the problems, the more dangerous they become.
3. Resentment, denial, self-pity, and loss of control are characteristic of alcoholism and battering. Be willing to get honest.
4. Alcoholism and family violence tend to be inter-generational; be prepared for longer care. Be supportive and encourage help for your children and family.
5. You can't avoid influencing others, but you can't afford to control anyone but yourself.
6. Stop losing control of yourself to try to gain control of others.

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Suggestions for Battered Persons

1. Attempt to define yourself as a survivor of violence rather than a victim; it's more empowering.
2. Reach out to support groups; isolation is one of your greatest enemies.
3. Trust that ultimately you know what's in your best interest; act accordingly.
4. You are not the cause of another's behavior, so you cannot change someone else; focus on yourself.
5. Develop a safety plan for you and your children in the event that you need to act quickly. A local domestic violence service can assist you in developing your options and advise you of your rights. In New Jersey, the state-wide hotline number is: 1-800-572-SAFE.

Domestic violence and addiction can be a

lethal mix. The loss of control and effects of alcohol and drug abuse contribute significantly to the severity of beatings in abusive relationships. FBI statistics indicate that thirty percent of female homicide victims are killed by their husbands or boyfriends.

Battering, unlike the disease of addiction, is a socially learned behavior which can be reversed if the motivation for change is realized. Techniques and social skills can be re-learned to eliminate the violent behavior, just as life manageability can be attained through a commitment to recovery. Where abstinence of the drug alone is insufficient for true recovery, elimination of the violence is just the first of many steps toward breaking the cycle of domestic violence. The process of recovery ultimately benefits other significant people.

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The New Jersey Alcohol/Drug Resource Center and Clearinghouse serves institutions of higher education, state agencies, communities and school districts throughout the state of New Jersey by providing technical assistance, training, and resources in alcohol and other drug abuse education and prevention. For more information on the Clearinghouse, call or write to:

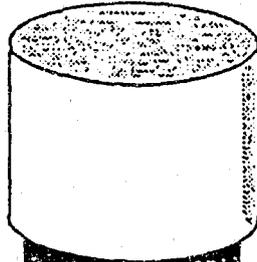
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Smithers Hall-Busch Campus
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CLEARINGHOUSE FACT SHEETS MAY BE REPRODUCED IN ANY QUANTITY FOR EDUCATIONAL USE

Is Danger Ahead In Your Relationship ? Take This Test And Find Out

*Alcohol is a drug.
If you're pregnant
don't drink or take
drugs -- they can
hurt your baby.*



*These drinks all have the
same amount of alcohol:
* 1 beer * 5 oz. of wine
* 1 shot of hard liquor
* 1 wine cooler*

Warning Signs of Alcohol or Other Drug Addiction

Are you going out with someone who ...

- Is hard to get along with when drinking or using other drugs.
- Drinks or takes drugs because they're "depressed."
- Drinks or takes drugs to calm their nerves or deal with other pressures.
- Can use a lot of alcohol or other drugs without seeming to be drunk or high.
- Gets into trouble at work, school, or at parties because of alcohol or drug use.
- Forgets things they say or do when under the influence of drugs or alcohol.
(Also called blackouts.)
- Wants you to drink or take drugs with him.
- Tries to hide or lie about drinking or drug use.
- Is scary when drinking or using drugs.
- Gets violent or yells or insults you when drinking or using drugs.
- Uses drinking as an excuse for hurting you with words or actions.
- Gets mad when you try to talk about drinking or drug use.
- Has trouble with money because of spending too much on liquor or other drugs.
- Apologizes later or tries to make up for things after drinking or drug use.
- Has been arrested for driving "under the influence," or been in any other trouble with the law due to drinking or drugging.
- Says they'll stop drinking if you have sex, or do other things for them.

Do you keep trying to "make things better"? Do you blame yourself? Do you feel trapped? Don't know what to do?

There is hope and help. Call the Mass. Drug and Alcohol Hotline 1-800-327-5050

**THE LEGAL RESPONSE TO DOMESTIC
VIOLENCE**

The Abuse Prevention Act: A Summary Outline

A. Purpose

Provide victims with a range of remedies by conferring powers and imposing obligations on the police and the courts to prevent and respond to domestic violence.

B. Population Protected

"Family or Household Member": covers persons regardless of sex or age who:

1. are or were married;
2. are or were related by blood or marriage;
3. have a child in common, whether they ever lived together or were married;
4. are or were living together in the same household;
5. are or were in a substantive dating or engagement relationship. The existence of the relationship to be determined by the court based on:
 - (i) length of time of relationship;
 - (ii) type of relationship;
 - (iii) frequency of interaction between the parties;
 - (iv) if relationship terminated, length of time that has elapsed since termination. G.L. c. 209A, §1.

C. Conduct Prohibited

"Abuse": occurs when a family or household member:

1. attempts or actually causes physical harm;
2. places another in fear of imminent serious physical harm; or
3. causes another to engage involuntarily in sexual relations by force, threat or duress.
G.L. c. 209A, §1. See Commonwealth v. Gordon, 407 Mass. 340, 348-349 (1990).

D. Orders

1. Jurisdiction:

Superior, District, Boston Municipal or Probate.
G.L. c. 209A, §§ 1,2.

2. Venue:

Place where victim resided at the time abuse occurred, or where the victim resides if he/she left the residence where the abuse occurred.
G.L. c. 209A, §2.

3. Emergency Restraining Order

- a. may be granted telephonically through a police officer when the court is closed for business. G.L. 209A, §5.
- b. when there is a "substantial likelihood of immediate danger of abuse." G.L. 209A, §§ 4,5.
- c. victim must appear next business day in court to file a complaint. G.L. 209A, §5.
- d. Notice:
 - i. the order may be entered without notice to the defendant as deemed necessary by the court to protect the victim from abuse, but
 - ii. immediate notice must be given to the defendant once the order is issued, and
 - iii. the defendant must be given an opportunity to be heard on the question of continuing the order no later than 2 court business days after the order is entered. G.L. c. 209A, §4.

4. Temporary Orders

- a. Filing:
 - i. complaint must be filed before the court with jurisdiction (G.L. c. 209A, §4) and can be done pro se (G.L. c. 209A, §9).
 - ii. no filing fee is required. G.L. c. 209A, §3.
- b. Procedure:
 - i. restraining order may be granted ex parte without notice to the defendant
 - ii. when there is a "substantial likelihood of immediate danger of abuse."
 - iii. the defendant must be given immediate notice once the order is issued and an opportunity to be heard within 10 court business days.
 - iv. if defendant does not appear at the 10-day hearing, the temporary order continues in effect.
G.L. c. 209A, §4.
- c. Duration:
 - i. order can last for a fixed period of time, not to exceed one year.
 - ii. court may modify the order upon either party's motion.

- iii. court may extend the order upon the victim's motion for such additional time as it deems necessary to protect the victim or any child in her custody from abuse. G.L. c. 209A, §3.

E. Police Intervention and Responsibilities

1. An officer shall use all reasonable means to prevent further abuse whenever he/she has reason to believe that a family member has been abused or is in danger of being abused, including:
 - a. remaining on the scene to protect the victim.
 - b. assisting the victim in obtaining medical help.
 - c. assisting the victim in locating and reaching a safe place.
 - d. providing verbal and written notice of G.L. c. 209A in English or the victim's native language whenever possible.
 - e. assisting the victim in accessing emergency judicial help when the court is closed.
 - f. informing the victim that the abuser is eligible for bail and release.G.L. c. 209A, §6.
2. Any person will be subject to arrest, criminal sanctions and a criminal complaint if:
 - a. a law officer witnesses or has probable cause to believe the person has violated a temporary or permanent vacate, restraining or no-contact order or judgment under G.L. c. 208, §§34B, 34C; G.L. c. 209A, §§3,4,5; G.L. c. 209 §32; or G.L. c. 209C, §§15 or 20.
 - b. When no order is in effect, arrest is the preferred response if the law officer witnesses or has probable cause to believe the person has committed:
 - i. a felony;
 - ii. a misdemeanor involving abuse under G.L. c. 209A, §1;
 - iii. an assault and battery, G.L. c. 265, §13A.G.L. c. 209A, §6.
 - c. Violations of other conditions are enforceable through civil contempt proceedings. G.L. 209A, §7.

3. The victim shall be provided a copy of the full incident report at no cost upon request to the appropriate police department. G.L. c. 209A, §6.

F. Remedies and Criminal Penalties

1. Remedies

The victim may file a complaint requesting protection, including orders to:

- a. refrain from abuse. G.L. c. 209A, §3(a).
- b. refrain from contact. G.L. c. 209A, §3(b).
- c. vacate the household. G.L. c. 209A, §3(c). See Commonwealth v. Gordon, 407 Mass. 340, 345-348 (1990).
- d. award temporary custody of minor child, G.L. c. 209A, §3(d).
- e. award temporary support for victim or child if defendant has legal obligation to support. G.L. c. 209A, §3(e).
- f. compensate for losses as a result of the abuse, including medical and moving expenses, lost earnings, and reasonable attorney fees. G.L. c. 209A, §3(f).
- g. impound the victim's address. G.L. c. 209A, §§3(g), 8.
- h. refrain from abusing or having contact with victim's child. G.L. c. 209A, §3(h).
- i. recommend that the defendant attend batterer's treatment program. G.L. c. 209A, §3(i).

2. Exclusions

- a. No order may affect title to real property.
- b. Custody and support orders or judgments from prior, pending or subsequent Probate Court proceedings supersede custody and support orders under G.L. c. 209A.
- c. Mediation between the parties may not be compelled.
G.L. c. 209A, §3.

3. Criminal Penalties for Violation of Court Order

- a. fine of not more than \$5000 or
- b. imprisonment in a house of correction

- for not more than 2 1/2 years, or both.
- c. if defendant has no prior record of any crime of violence, the court may order appropriate treatment.
 - d. criminal remedies are not exclusive and "do not preclude any other civil or criminal remedies."
- G.L. c. 209A, §7.

4. Civil Remedy

- a. Each court may "enforce by civil contempt procedure a violation of its own court order." G.L. c. 209A, §7. See Commonwealth v. Mahoney, 415 Mass. 278, 287 (1993).

209A § 1

Definitions

As used in this chapter the following words shall have the following meanings:
"Abuse", the occurrence of one or more of the following acts between family or household members:

- (a) attempting to cause or causing physical harm;
- (b) placing another in fear of imminent serious physical harm;
- (c) causing another to engage involuntarily in sexual relations by force, threat or duress.

"Court", the superior, probate and family, district or Boston municipal court departments of the trial court, except when the petitioner is in a dating relationship when "Court" shall mean district, probate, or Boston municipal courts.

"Family or household members", persons who:

- (a) are or were married to one another;
- (b) are or were residing together in the same household;
- (c) are or were related by blood or marriage;
- (d) having a child in common regardless or¹ whether they have ever married or lived together; or
- (e) are or have been in a substantive dating or engagement relationship, which shall be adjudged by district, probate or Boston municipal courts consideration of the following factors:

(1) the length of time of the relationship; (2) the type of relationship; (3) the frequency of interaction between the parties; and (4) if the relationship has been terminated by either person, the length of time elapsed since the termination of the relationship.

"Law officer", any officer authorized to serve criminal process.

"Vacate order", court order to leave and remain away from a premises and surrendering forthwith any keys to said premises to the plaintiff. The defendant shall not damage any of the plaintiff's belongings or those of any other occupant and shall not shut off or cause to be shut off any utilities or mail delivery to the plaintiff. In the case where the premises designated in the vacate order is a residence, so long as the plaintiff is living at said residence, the defendant shall not interfere in any way with the plaintiff's right to possess such residence, except by order or judgment of a court of competent jurisdiction pursuant to appropriate civil eviction proceedings, a petition to partition real estate, or a proceeding to divide marital property. A vacate order may include in its scope a household, a multiple family dwelling and the plaintiff's workplace. When issuing an order to vacate the plaintiff's workplace, the presiding justice must consider whether the plaintiff and defendant work in the same location or for the same employer.

209A § 2.

Venue

Proceedings under this chapter shall be filed, heard and determined in the superior court department or the Boston municipal court department or respective divisions of the probate and family or district court departments having venue over the plaintiff's residence. If the plaintiff has left a residence or household to avoid abuse, such plaintiff shall have the option of commencing an action in the court having venue over such prior residence or household, or in the court having venue over the present residence or household.

Remedies; period of relief

A person suffering from abuse from an adult or minor family or household member may file a complaint in the court requesting protection from such abuse, including, but not limited to, the following orders:

(a) ordering the defendant to refrain from abusing the plaintiff, whether the defendant is an adult or minor;

(b) ordering the defendant to refrain from contacting the plaintiff, unless authorized by the court, whether the defendant is an adult or minor;

(c) ordering the defendant to vacate forthwith and remain away from the household, multiple family dwelling, and workplace. Notwithstanding the provisions of section thirty-four B of chapter two hundred and eight, an order to vacate shall be for a fixed period of time, not to exceed one year, at the expiration of which time the court may extend any such order upon motion of the plaintiff, with notice to the defendant, for such additional time as it deems necessary to protect the plaintiff from abuse;

(d) awarding the plaintiff temporary custody of a minor child;

(e) ordering the defendant to pay temporary support for the plaintiff or any child in the plaintiff's custody or both, when the defendant has a legal obligation to support such a person. In determining the amount to be paid, the court shall apply the standards established in the child support guidelines;

(f) ordering the defendant to pay the person abused monetary compensation for the losses suffered as a direct result of such abuse. Compensatory losses shall include, but not be limited to, loss of earnings or support, costs for restoring utilities, out-of-pocket losses for injuries sustained, replacement costs for locks or personal property removed or destroyed, medical and moving expenses and reasonable attorney's fees;

(g) ordering the plaintiff's address to be impounded as provided in section nine;

(h) ordering the defendant to refrain from abusing or contacting the plaintiff's child, or child in plaintiff's care or custody, unless authorized by the court;

(i) the judge may recommend to the defendant that the defendant attend a recognized batterer's treatment program.

No filing fee shall be charged for the filing of the complaint. Neither the plaintiff nor the plaintiff's attorney shall be charged for certified copies of any orders entered by the court, or any copies of the file reasonably required for future court action or as a result of the loss or destruction of plaintiff's copies.

Any relief granted by the court shall be for a fixed period of time not to exceed one year. Every order shall on its face state the time and date the order is to expire and shall include the date and time that the matter will again be heard. If the plaintiff appears at the court at the date and time the order is to expire, the court shall determine whether or not to extend the order for any additional time reasonably necessary to protect the plaintiff or to enter a permanent order. When the expiration date stated on the order is on a weekend day or holiday, or a date when the court is closed to business, the order shall not expire until the next date that the court is open to business. The plaintiff may appear on such next court business day at the time designated by the order to request that the order be extended. The court may also extend the order upon motion of the plaintiff, for such additional time as it deems necessary to protect from abuse the plaintiff or any child in the plaintiff's care or custody. The fact that abuse has not occurred during the pendency of an order shall not, in itself, constitute sufficient ground for denying or failing to extend the order, of allowing an order to expire or be vacated, or for refusing to issue a new order.

The court may modify its order at any subsequent time upon motion by either party. When the plaintiff's address is impounded and the defendant has filed a motion to modify the court's order, the court shall be responsible for notifying the plaintiff. In no event shall the court disclose any impounded address.

No order under this chapter shall in any manner affect title to real property.

No court shall compel parties to mediate any aspect of their case. Although the court may refer the case to the family service office of the probation department or victim/witness advocates for information gathering purposes, the court shall not compel the parties to meet together in such information gathering sessions.

209A § 3 (Cont.)

A court shall not deny any complaint filed under this chapter solely because it was not filed within a particular time period after the last alleged incident of abuse.

A court may issue a mutual restraining order or mutual no-contact order pursuant to any abuse prevention action only if the court has made specific written findings of fact. The court shall then provide a detailed order, sufficiently specific to apprise any law officer as to which party has violated the order, if the parties are in or appear to be in violation of the order.

Any action commenced under the provisions of this chapter shall not preclude any other civil or criminal remedies. A party filing a complaint under this chapter shall be required to disclose any prior or pending actions involving the parties for divorce, annulment, paternity, custody or support, guardianship, separate support or legal separation, or abuse prevention.

If there is a prior or pending custody support order from the probate and family court department of the trial court, an order issued in the superior, district or Boston municipal court departments of the trial court pursuant to this chapter may include any relief available pursuant to this chapter except orders for custody or support.

If the parties to a proceeding under this chapter are parties in a subsequent proceeding in the probate and family court department for divorce, annulment, paternity, custody or support, guardianship or separate support, any custody or support order or judgment issued in the subsequent proceeding shall supersede any prior custody or support order under this chapter.

209A § 4

Temporary orders; notice; hearing

Upon the filing of a complaint under this chapter, the court may enter such temporary orders as it deems necessary to protect a plaintiff from abuse, including relief as provided in section three. Such relief shall not be contingent upon the filing of a complaint for divorce, separate support, or paternity action.

If the plaintiff demonstrates a substantial likelihood of immediate danger of abuse, the court may enter such temporary relief orders without notice as it deems necessary to protect the plaintiff from abuse and shall immediately thereafter notify the defendant that the temporary orders have been issued. The court shall give the defendant an opportunity to be heard on the question of continuing the temporary order and of granting other relief as requested by the plaintiff no later than ten court business days after such orders are entered.

Notice shall be made by the appropriate law enforcement agency as provided in section seven.

If the defendant does not appear at such subsequent hearing, the temporary orders shall continue in effect without further order of the court.

209A § 5.

Granting of relief when court closed; certification

When the court is closed for business, any justice of the superior, probate and family, district or Boston municipal court departments may grant relief to the plaintiff as provided under section four if the plaintiff demonstrates a substantial likelihood of immediate danger of abuse. In the discretion of the justice, such relief may be granted and communicated by telephone to an officer or employee of an appropriate law enforcement agency, who shall record such order on a form of order promulgated for such use by the chief administrative justice and shall deliver a copy of such order on the next court day to the clerk-magistrate of the court having venue and jurisdiction over the matter. If relief has been granted without the filing of a complaint pursuant to this section of this chapter, then the plaintiff shall appear in court on the next available business day to file said complaint. Notice to the plaintiff and defendant and an opportunity for the defendant to be heard shall be given as provided in said section four.

Any order issued under this section and any documentation in support thereof shall be certified on the next court day by the clerk-magistrate or register of the court issuing such order to the court having venue and jurisdiction over the matter. Such certification to the court shall have the effect of commencing proceedings under this chapter and invoking the other provisions of this chapter but shall not be deemed necessary for an emergency order issued under this section to take effect.

209A § 6

Powers of police

Whenever any law officer has reason to believe that a family or household member has been abused or is in danger of being abused, such officer shall use all reasonable means to prevent further abuse. The officer shall take, but not be limited to the following action:

(1) remain on the scene of where said abuse occurred or was in danger of occurring as long as the officer has reason to believe that at least one of the parties involved would be in immediate physical danger without the presence of a law officer. This shall include, but not be limited to remaining in the dwelling for a reasonable period of time;

(2) assist the abused person in obtaining medical treatment necessitated by an assault, which may include driving the victim to the emergency room of the nearest hospital, or arranging for appropriate transportation to a health care facility, notwithstanding any law to the contrary;

(3) assist the abused person in locating and getting to a safe place; including but not limited to a designated meeting place for a shelter or a family member's or friend's residence. The officer shall consider the victim's preference in this regard and what is reasonable under all the circumstances;

(4) give such person immediate and adequate notice of his or her rights. Such notice shall consist of handing said person a copy of the statement which follows below and reading the same to said person. Where said person's native language is not English, the statement shall be then provided in said person's native language whenever possible.

"You have the right to appear at the Superior, Probate and Family, District or Boston Municipal Court, if you reside within the appropriate jurisdiction, and file a complaint requesting any of the following applicable orders: (a) an order restraining your attacker from abusing you; (b) an order directing your attacker to leave your household, building or workplace; (c) an order awarding you custody of a minor child; (d) an order directing your attacker to pay support for you or any minor child in your custody, if the attacker has a legal obligation of support; and (e) an order directing your attacker to pay you for losses suffered as a result of abuse, including medical and moving expenses, loss of earnings or support, costs for restoring utilities and replacing locks, reasonable attorney's fees and other out-of-pocket losses for injuries and property damage sustained.

For an emergency on weekends, holidays, or weeknights the police will refer you to a justice of the superior, probate and family, district, or Boston municipal court departments.

209A § 6 (Cont.)

You have the right to go to the appropriate district court or the Boston municipal court and seek a criminal complaint for threats, assault and battery, assault with a deadly weapon, assault with intent to kill or other related offenses.

If you are in need of medical treatment, you have the right to request that an officer present drive you to the nearest hospital or otherwise assist you in obtaining medical treatment.

If you believe that police protection is needed for your physical safety, you have the right to request that the officer present remain at the scene until you and your children can leave or until your safety is otherwise ensured. You may also request that the officer assist you in locating and taking you to a safe place, including but not limited to a designated meeting place for a shelter or a family member's or a friend's residence, or a similar place of safety.

You may request a copy of the police incident report at no cost from the police department."

The officer shall leave a copy of the foregoing statement with such person before leaving the scene or premises.

(5) assist such person by activating the emergency judicial system when the court is closed for business;

(6) inform the victim that the abuser will be eligible for bail and may be promptly released; and

(7) arrest any person a law officer witnesses or has probable cause to believe has violated a temporary or permanent vacate, restraining, or no-contact order or judgment issued pursuant to section eighteen, thirty-four B or thirty-four C of chapter two hundred and eight, section thirty-two of chapter two hundred and nine, section three, four or five of this chapter, or sections fifteen or twenty of chapter two hundred and nine C. When there are no vacate, restraining, or no-contact orders or judgments in effect, arrest shall be the preferred response whenever an officer witnesses or has probable cause to believe that a person:

(a) has committed a felony;

(b) has committed a misdemeanor involving abuse as defined in section one of this chapter;

(c) has committed an assault and battery in violation of section thirteen A of chapter two hundred and sixty-five.

The safety of the victim and any involved children shall be paramount in any decision to arrest. Any officer arresting both parties must submit a detailed, written report in addition to an incident report, setting forth the grounds for dual arrest.

No law officer investigating an incident of domestic violence shall threaten, suggest, or otherwise indicate the arrest of all parties for the purpose of discouraging requests for law enforcement intervention by any party.

No law officer shall be held liable in any civil action regarding personal injury or injury to property brought by any party to a domestic violence incident for an arrest based on probable cause when such officer acted reasonably and in good faith and in compliance with this chapter and the statewide policy as established by the secretary of public safety.

Whenever any law officer investigates an incident of domestic violence, the officer shall immediately file a written incident report in accordance with the standards of the officer's law enforcement agency and, wherever possible, in the form of the National Incident-Based Reporting System, as defined by the Federal Bureau of Investigation. The latter information may be submitted voluntarily by the local police on a monthly basis to the crime reporting unit of the criminal history systems board.

The victim shall be provided a copy of the full incident report at no cost upon request to the appropriate law enforcement department.

When a judge or other person authorized to take bail bails any person arrested under the provisions of this chapter, he shall make reasonable efforts to inform the victim of such release prior to or at the time of said release.

When any person charged with or arrested for a crime involving abuse under this chapter is released from custody, the court or the emergency response judge shall issue, upon the request of the victim, a written no-contact order prohibiting the person charged or arrested from having any contact with the victim and shall use all reasonable means to notify the victim immediately of release from custody. The victim shall be given at no cost a certified copy of the no-contact order.

Court orders; service; enforcement; violations

Whenever the court orders under sections eighteen, thirty-four B, and thirty-four C of chapter two hundred and eight, section thirty-two of chapter two hundred and nine, sections three, four and five of this chapter, or sections fifteen and twenty of chapter two hundred and nine C, the defendant to vacate, refrain from abusing the plaintiff or to have no contact with the plaintiff or the plaintiff's minor child, the register or clerk-magistrate shall transmit two certified copies of each such order and one copy of the complaint and summons forthwith to the appropriate law enforcement agency which, unless otherwise ordered by the court, shall serve one copy of each order upon the defendant, together with a copy of the complaint, order and summons. The law enforcement agency shall promptly make its return of service to the court.

Law enforcement officers shall use every reasonable means to enforce such abuse prevention orders. Law enforcement agencies shall establish procedures adequate to insure that an officer on the scene of an alleged violation of such order may be informed of the existence and terms of such order. The court shall notify the appropriate law enforcement agency in writing whenever any such order is vacated and shall direct the agency to destroy all record of such vacated order and such agency shall comply with that directive.

Each abuse prevention order issued shall contain the following statement: **VIOLATION OF THIS ORDER IS A CRIMINAL OFFENSE.**

Any violation of such order shall be punishable by a fine of not more than five thousand dollars, or by imprisonment for not more than two and one-half years in a house of correction, or by both such fine and imprisonment. Where the defendant has no prior record of any crime of violence and where the court believes, after evaluation by a certified or provisionally certified batterer's treatment program, that the defendant is amenable to treatment, the court may, in addition to any other penalty, order appropriate treatment as specified in this section. If a defendant ordered to undergo treatment has received a suspended sentence, the original sentence shall be reimposed if the defendant fails to participate in said program as required by the terms of his probation.

When a defendant has been ordered to participate in a treatment program pursuant to this section, the defendant shall be required to regularly attend a certified or provisionally certified batterer's treatment program. To the extent permitted by professional requirements of confidentiality, said program shall communicate with local battered women's programs for the purpose of protecting the victim's safety. Additionally, it shall specify the defendant's attendance requirements and keep the probation department informed of whether the defendant is in compliance.

In addition to, but not in lieu of, such orders for treatment, if the defendant has a substance abuse problem, the court may order appropriate treatment for such problem. All ordered treatment shall last until the end of the probationary period or until the treatment program decides to discharge the defendant, whichever comes first. When the defendant is not in compliance with the terms of probation, the court shall hold a revocation of probation hearing. To the extent possible, the defendant shall be responsible for paying all costs for court ordered treatment.

In each instance where there is a violation of an abuse prevention order, the court may order the defendant to pay the plaintiff for all damages including, but not limited to, cost for shelter or emergency housing, loss of earnings or support, out-of-pocket losses for injuries sustained or property damaged, medical expenses, moving expenses, cost for obtaining an unlisted telephone number, and reasonable attorney's fees.

Any such violation may be enforced in the superior, the district or Boston municipal court departments. Criminal remedies provided herein are not exclusive and do not preclude any other available civil or criminal remedies. The superior, probate and family, district and Boston municipal court departments may each enforce by civil contempt procedure a violation of its own court order.

The provisions of section eight of chapter one hundred and thirty-six shall not apply to any order, complaint or summons issued pursuant to this section.

209A § 8

Address of plaintiff; exclusion from court documents; confidentiality of records

Upon the request of the plaintiff, the court shall impound the plaintiff's address by excluding same from the complaint and from all other court documents which are available for public inspection, and shall ensure that the address is kept confidential from the defendant and defendant's attorney.

The records of cases arising out of an action brought under the provisions of this chapter where the plaintiff or defendant is a minor shall be withheld from public inspection except by order of the court; provided, that such records shall be open, at all reasonable times, to the inspection of the minor, said minor's parent, guardian, attorney, and to the plaintiff and the plaintiff's attorney, or any of them.

209A § 9.

Form of complaint; promulgation

The administrative justices of the superior court, probate and family court, district court, and the Boston municipal court departments shall jointly promulgate a form of complaint for use under this chapter which shall be in such form and language to permit a plaintiff to prepare and file such complaint *pro se*.

**BATTERED WOMEN IN CLINICAL
SETTINGS**

IDENTIFYING BATTERED WOMEN IN CLINICAL SETTINGS

This section gives general guidelines for identifying battered women, based on the stages of battering model presented below. The guidelines are applicable for health care providers practicing in various settings, including emergency rooms, community health centers, private practitioners' offices, obstetric and gynecological clinics, family planning centers, psychiatric emergency services, chiropractors, pain clinics, and dentists' offices.

Although many people envision battered women seeking help in emergency medical facilities, research shows that nontrauma treatment sites are the major source of medical care for abused women (Flitcraft, 1977). Because clinicians in these facilities may see the woman on a number of occasions, it is crucial that they be familiar with the battering syndrome (particularly its secondary manifestations) and methods of intervention, and that they be acquainted with the shelters and other resources for battered women in their community.

Stages of Battering - A Medical Perspective⁵

The battering syndrome may be thought of as developing in stages of increasing medical complexity and severity.

From a medical perspective, these stages of battering are a chronologically organized syndrome often beginning with repeated physical injuries or psychological injuries (resulting from repeated threats of injury or death) and followed by illnesses and emotional problems resulting from ongoing abuse. Battered women often try to use multiple social and medical services to prevent future threats or violence and ameliorate the physical and emotional damage resulting from the battering. If the abuse continues without effective intervention, women are at risk of serious problems including attempted suicide, mental illness, and substance abuse.

The progression of this syndrome and the subsequent effects on the patient evolve as a result of both the abuse experienced by the patient and the negative responses of the institutions from which she has sought help.

Injuries

Types of Physical Injuries

The physical injuries sustained by battered women typically include one or a combination of the following:

- central injuries, specifically to the face, head, neck, chest, breasts, abdomen, or genital areas;
- bilateral distribution of injuries or injury to multiple areas;
- contusions, lacerations, abrasions, ecchymoses, stab wounds, burns, human bites, fractures (particularly of the nose and orbits), and spiral wrist fractures;
- complaints of acute or chronic pain without tissue injury;

⁵ Adapted from *Identifying and Treating Adult Victims of Domestic Violence*, pp. 9-12.

- sexual assault (which includes unwanted sexual contact by a husband);
- injuries or vaginal bleeding during pregnancy, spontaneous or threatened miscarriage (Note: If a pregnant woman presents with injuries to her breasts and abdomen, it is almost certain that her injuries are the result of a beating. Physical battering often begins when the woman becomes pregnant. The isolation that is usually part of battering may make it difficult or impossible for a pregnant woman to get prenatal care);
- multiple injuries (such as bruises, burns, and scars) in different stages of healing;
- substantial delay between the time of injury and presentation for treatment.

Demeanor

Is the patient hesitant or evasive when describing the cause of injuries? Does she appear to be embarrassed, ashamed, frightened, disoriented, or depressed? Does patient's distress appear to be disproportional to her injuries; i.e., excessive distress over a minor injury or little visible emotional response to a serious injury? All victims can be expected to experience traumatization from the events surrounding their injuries and from their relationship with the batterer. A patient who has no apparent physical injuries may be seeking help for psychological abuse. Suspect battering if the woman reports being homeless; homeless women are frequently homeless because they left a battering situation.

Explanation of Injuries

Do the injuries match the story? For example, a black eye may be caused by bumping into a door, but the bump would not result in bruises about the neck and forearms.

Illnesses

The following symptoms frequently have been reported by battered women as resulting from the violence itself or from the stress of living with repeated abuse:

- headaches, migraines;
- musculoskeletal complaints (such as neckaches, backaches);
- malaise, fatigue;
- insomnia;
- chest pain, palpitations;
- hyperventilation;
- gastrointestinal disorders (such as diarrhea, abdominal pain, colitis, ulcers);
- eating disorders (such as anorexia, bulimia);
- gynecological problems (including infections, dyspareunia, etc);
- chronic pain;
- depression;
- anxiety;
- sexually transmitted diseases, especially repeated episodes, or HIV infection.

Isolation

If their abuse is not identified and followed by effective intervention, many women develop a history of repeated and frustrated help-seeking attempts. Such "well-known" patients are often met with skepticism and provided symptomatic treatment with analgesics or minor

tranquilizers. Little or no effort is made to identify and alleviate the patient's underlying problem. Instead, well-known patients are frequently labeled. Common labels used by medical professionals for battered women include: TBP (total body pain), hysteric, hypochondriac, and immature personality.

Labeled patients may be hostile or reticent because they have frequently sought help and not received it, or received inappropriate responses such as being told that their emotional abuse wasn't so bad, or being advised to "work harder at the relationship and give in more." The patient may become involved inappropriately in the mental health care system where the symptoms are seen as evidence of a mental health problem. If battering is identified at this time, it is often seen as secondary to the mental health issues. What many practitioners do not know is that in most cases, psychological symptoms disappear once the abused woman is safe from her abuser and able to think clearly. Thus, institutional insensitivity combined with the ongoing violence may leave the patient at risk of a variety of serious psychosocial problems, the final stage in the battering syndrome.

Serious Psychosocial Problems

If battering continues over time, there will often be an increase in the severity and frequency of the violence, as well as an increase in the woman's isolation and fear. These dynamics, combined with the lack of outside intervention and assistance, then bring an increased risk of psychosocial problems such as:

- drug abuse or addiction;
- alcohol abuse or addiction;
- suicidal ideation or suicide attempts;
- severe depression.

Through substance abuse and suicide attempts, the woman tries to escape from the abuse, either temporarily or permanently.

The patient now manifests multiple problems which must be treated; however, the root cause, the battering, still may not have been identified. Although the health care professional must treat the problems discussed above, they need to be examined in light of the patient's battering history. For example, an alcoholic patient should be offered detox and referred to a battered women's shelter. Alcoholism did not cause the battering (although the battering may have caused the alcoholism), nor will the violence disappear when the patient is sober.

Although battered women who are currently using alcohol or drugs cannot be admitted to most shelters, there are a few that can accommodate them; see the subsection on "Resources for Battered Women with Substance Abuse and/or Mental Health Problems" in the "Referrals" section of this manual. Alcohol and drug users can still call any shelter hotline for support and attend weekly support groups at any shelter as long as they arrive sober. This is often the place where battered women who are substance abusers can get helpful information from other women who have been in the same situation.

The progressive nature of woman battering and the escalation of physical and emotional risks over time underscore the importance of identifying battered women early in the abusive relationship.

REVIEWING THE PATIENT'S HISTORY

An unexplained delay in seeking treatment and/or previous visits for trauma should make the provider suspect abuse.

In attempting to identify abuse or to confirm suspected abuse, it is important to diagnose and treat not only the immediate presenting injuries but also to review the patient's medical record for a history of injuries or illnesses which may be indicative of battering, or written remarks from practitioners who suspected but could not confirm abuse. Finding no record of past injuries does not mean that they have not occurred; many battered women seek treatment from numerous physicians not familiar with their histories.

The Role of Primary Care Facilities and Community Health Centers In Identification and Intervention

Clinicians at primary care and community health care centers may see the same patients over time and are therefore in a good position to detect battering. As complaints are written into the patient's record, the cluster of symptoms associated with battering may become apparent. In addition, a patient who has an ongoing relationship with a clinician may be more willing to trust and confide in him or her. Because a battered woman will often have contact with her primary health care provider before she experiences the type of crisis that takes her to a hospital emergency room, the provider may have the opportunity to intervene in the early stages of battering, before serious injury occurs. Many women will not seek help voluntarily before they are seriously injured because help-seeking may be seen by the abuser as a betrayal and cause more violence. Others may be physically prevented from seeking help.

A question about abuse should be incorporated into the routine health assessment. Every female patient should be asked about violence in her life. "Does your partner ever hurt you?" or "Have you ever been physically hurt by anyone?" are two ways that this might be phrased. Explaining that every patient is asked this as a matter of course (just as every patient is asked about smoking, sexual behaviors, and drug use) should prevent anyone from feeling singled out or offended by the question. For those women who have not been abused, the question provides the practitioner an opportunity to heighten their awareness of the widespread nature of the problem in our society, and will let them know that they can turn to the clinician if abuse becomes a problem in the future. For those women who are experiencing abuse, this may be the first time that anyone has given them the opportunity to discuss it in a confidential, supportive atmosphere.

Recurrent sexually transmitted diseases may indicate that the patient is experiencing sexual abuse. The health care provider should discuss with the patient how she became infected and whether sex was coercive. Batterers frequently refuse to practice safer sex, placing battered women at increased risk of HIV exposure.

The occurrence of self-abusive behavior (abuse of alcohol or drugs, suicide attempts) after a cluster of seemingly unrelated complaints over a period of time can indicate to the clinician that sporadic incidents of battering may have escalated into a pattern of abuse in which change or escape seems impossible.⁶

⁶ Anne Flitcraft and Evan Stark, "Woman Battering: A Prevention-Oriented Approach," in *Post-Traumatic Therapy and Victims of Violence*, ed. Frank M. Ochberg (New York: Brunner/Mazel, 1988), p. 68.

When a patient mentions that she is using alcohol or other drugs, the clinician should ask her why. A mention of her partner's use of alcohol or drugs also provides an opening to ask about battering; the clinician should inquire about the partner's behavior when he or she is drunk or high. Substance abuse by either partner is also a recognized risk factor for HIV infection.

An inquiry about depression and suicide attempts should be included in every initial evaluation of a patient. Because of the high correlation between suicide attempts and woman battering, a positive response should suggest to the clinician the possibility of battering.

Whenever possible, the health care facility should address battering in an interdisciplinary manner, making use of all available resources. Some hospitals and primary care facilities have social service providers who are trained in domestic violence intervention. See the section in this manual on "The Role of the Social Worker" for more information. Even when there is a social services department, it is not sufficient for social workers alone to be knowledgeable about basic safety advice and referrals, for the battered woman may be unwilling to confide in a second person after she has told the nurse or primary health care physician about the battering. Every member of the staff should be able to provide emergency information.

Posters and informational pamphlets on battering that include a list of shelters and other resources should be placed in the waiting area. If possible, additional copies should be placed in the women's restroom, where a woman can take one unobserved by her partner. The information should be available in the languages most commonly spoken in the community.

Within some families, the normalcy of hitting to resolve conflicts is taken for granted. Many women are not aware that it is illegal for a man to hit his wife or partner. The primary health care provider needs to let the woman know that violent behavior is unacceptable and that it is not just a personal family matter.

The Role of the Emergency Department

Many of the issues addressed in the section above are relevant to emergency room settings (e.g., asking about violence, seeking the root of self-abusive behavior, and displaying informational material on battering). Emergency department personnel may feel hindered in identifying and treating battered women because of their high-pressure caseloads and crisis orientation. They will often see a battered woman without having access to her medical record, and thus will not be able to rely on a history to provide clues about battering. As noted in the section below, ancillary staff can be very helpful in identifying battered women and the emergency department should make full use of this resource. Close collaboration with the social services staff is also invaluable.

The Role of the Ancillary Staff

Because the emergency department or health center secretary is often the first person to observe the patient, he or she plays an important role in noting signs indicative of battering. The batterer may accompany the woman to the medical facility, remaining close by her side, being very solicitous and answering questions for her. When the secretary asks why she wishes to be seen, the woman may seem anxious or glance at her partner before saying that

she has been accidentally injured, or her partner may answer for her. The secretarial staff should be trained to pick up on these cues and to alert a nurse or physician when battering is suspected.

It is essential to involve the security department in your facility's response to battering. Work with security personnel to develop a protocol for responding to potentially dangerous situations in which the suspected batterer has accompanied the woman to the facility. The secretary or health care provider should notify security immediately if a suspected abuser is exhibiting threatening behavior.

GUIDELINES FOR INTERVIEWING SUSPECTED BATTERED WOMEN⁷

Creating the Right Atmosphere for Interviewing the Patient

Women who have been abused come to health care facilities for help. Only if they feel safe, physically and emotionally, will they be able to respond to staff outreach and consider alternatives.

Interview the patient in private. Ask any family members or friends who accompanied her to wait in the waiting area. State matter-of-factly that it is hospital policy to interview the patient in private. **Don't assume that any female who has accompanied her is safe to talk in front of; that "friend" may actually be her abuser.** If the woman came with her children, ask one of the staff to babysit. If the suspected abuser is not cooperative, have a medical provider ask to talk to him or her alone while the woman is being interviewed by another provider. Call security only as a last resort, since this may increase the possibility of a violent retaliation against the woman later. If security is called, discuss the possible repercussions during risk assessment and safety planning.

The situation must be handled with particular care when the patient is disabled and accompanied by a personal care attendant (PCA) or other support person. A disabled patient has the legal right to be accompanied in the treatment area by her PCA (support person) if she so desires. However, if you suspect that the PCA (support person) may be her batterer, ask the patient **privately** if she wishes to be accompanied in the treatment area by the PCA (support person). This minimizes the possibility that the patient will feel coerced into being accompanied.

If necessary, provide the patient with an appropriate interpreter from your facility. The interpreter should be a female member of your organization who is familiar with the patient's cultural background and will respect the confidential nature of the interview. Never ask the person accompanying the woman to serve as an interpreter; he or she might be the batterer or be interested in protecting the batterer.

All patients should be greeted with warmth and respect and treated as adults. Unless she asks you to use her first name, refer to the patient as "Ms." or "Mrs. Jones," not as "Sally."

Assure the woman that anything she tells you about her personal situation will not be disclosed without her written consent, but **be sure to explain the confidentiality limitations placed upon you as a mandated reporter of child abuse, elder abuse, and abuse of certain persons with disabilities.**

Guilt or shame can be countered with repeated assurances that no one has the right to hurt another person. Assure the woman that by coming forward and frankly discussing the situation, she has done the right thing. Acknowledge that it is probably difficult for her to talk about what has happened. Let her know that she is not alone; share some statistics about the number of women who are battered and speak from your experience with women in similar situations.

Acknowledge your understanding of the woman's anger if she expresses it, but do not express your own anger at the batterer. This can humiliate and alienate her.

If time is available, let the woman talk herself out. **Do not** encourage her to talk if you don't have the time to listen; this will add to feelings of rejection and isolation. **Do** find someone who is sensitive and knowledgeable about battering who has the time and refer the woman to that person immediately.

Remember that it is not your job to rescue the woman. She is a survivor who has asked for help. Praise her repeatedly for the strengths she has demonstrated; let her know that she is a survivor. Help her to recognize the personal resources that will enable her to escape permanently from the abusive situation. **Never** tell her what you think she should; give her options and let her decide what is best.

How to Ask about Abuse

A direct or indirect approach may be used to ask a patient about abuse. Some experts suggest starting with direct questions and switching to indirect questions if direct questioning is not productive. Others feel that it is best to start with indirect questions because many abused women are very guarded and may be put off by direct inquiries. Unless the woman seems eager to discuss the battering, it is probably better to ease into the discussion gradually by asking general questions about her home life and relationship. Some examples of questions that you can ask are given below.

Remember that "abuse" and "battering" are terms to which patients may react very negatively. A patient who admits that her partner hits her is still unlikely to identify herself as "a battered woman" and may not trust you if you use this expression.

It isn't easy to ask a woman about violence in her life, but practitioners must ask many very personal questions and learn to do so straightforwardly and sensitively, without causing or experiencing embarrassment. **Don't be afraid to ask; evidence shows that battered women generally respond positively to sensitive questioning from a concerned professional.**

Indirect:

- How are things going in your relationship?
- You mentioned that your partner loses his (her) temper with the children. Can you tell me more about that?
- You seem to have some special concern about your partner. Can you tell me more? Does he (she) ever act in a way that frightens you?
- You mentioned that your partner uses alcohol (drugs). How does he (she) act when he (she) has been drinking (taking drugs)? Does his (her) behavior frighten you? (Note: See section on "Alcohol Abuse and Battering.")
- Couples have different ways of resolving their conflicts. How do you and your partner deal with your conflicts? What happens when your partner doesn't get his (her) way?

Direct:

- Have you ever been in a relationship in which you were punched, kicked, hit, or hurt in any way? In which you were threatened or forced to do things you didn't want to do? Are you in such a relationship now?
- Are you afraid of your partner?
- Has there been any time in your relationship when you and your partner have physically fought?
- I notice you have some bruises. Could you tell me how they happened? Did someone hit you?
- Many patients come to me with injuries like yours and tell me that they have been beaten. Is this happening to you? Have you been beaten?
- Has your partner ever forced or attempted to force you to have sex when you didn't want to? (Note: Some women may not know that forced intercourse by a husband is marital rape and can be prosecuted in Massachusetts. See section on "Sexual Abuse" for more information.)

If She Is Unwilling to Talk

If a patient denies that she was battered or refuses to talk, do not feel that your efforts have been wasted. Many women have been socialized to believe that they cannot escape abuse; they may not be ready to admit needing outside help. It is possible that her past attempts to obtain help were futile. Language and cultural barriers may also prevent her from being able to confide in you.

Tell the patient your suspected diagnosis. You can say something like: "I see many women with injuries like yours, and they seldom happen accidentally. Usually they come from someone intentionally hurting them" or "I work with many women who are fearful of their partners and I know that when someone with injuries like yours has delayed getting medical treatment, they are usually living in fear." These openings may encourage the woman to discuss her situation.

Even if she is not ready to talk, you can still help by giving information and by letting her know that she is not alone, that many patients have come to you with the same kinds of problems. Let the patient know that battering is widespread, that it occurs at all levels of society, and that education, race, ethnicity, or religion make little difference.

This may help the woman to realize that she is not alone and not to be blamed. Reiterate that many survivors of abuse from all backgrounds and in all conditions have received help and have gone on to make new lives for themselves.

EXAMINATION AND MEDICAL RECORDS⁹

Conduct a thorough physical examination, including any indicated X-rays or laboratory procedures. You should examine the woman's entire body to reveal hidden injuries or evidence of old injuries.

Medical records are important in cases involving battering for two reasons: records of past traumas can help you identify battering, and careful recording of the present injury will be helpful to the woman should she choose to prosecute.

Medical records can be subpoenaed for evidence, so the following two points are crucial:

Avoid subjective interpretation of data. If a patient presents abuse as the source of injury, state this on her chart. Preface the patient's explanation with "patient stated . . ." and then note who injured whom with what. Use her own words as much as possible. This protects both you and the patient.

You cannot be held liable for recording a patient's statement, medical facts, or your expert medical opinion. If the woman denies that she has been battered, you cannot state that the injuries are the result of battering, but you can note that battering was suspected, or that the patient's explanation does not fit her injuries. It will be easier to identify the possibility of abuse on the patient's next visit if your suspicions are recorded.

Recorded information should be as precise and detailed as possible. A future court case may rest on the evidence contained in your records. (Careful recording can also eliminate the need for a court appearance by hospital personnel.) Inadequate or imprecise data may be misinterpreted.

Use a body injury map like the one on the next page to mark the location of the injuries. It is important to relate physical findings to the type of instrument or weapon used. Record any reference the patient makes to the object that caused her injury, and note whether the injury was consistent with the alleged object (an iron burn will leave a distinctive mark, as will a rope burn, a blow with a belt buckle, a human bite, etc.) If the pattern of injuries is inconsistent with the patient's explanation, it is important to document this.

Do not include information that is extraneous to medical fact or expert opinion, for example, the circumstances leading up to the injury. ("He was drunk, demanded I get up and cook dinner for him, and then threw his plate against the wall.") Although this type of information is not admissible in court, it could hurt the woman's case if your recorded statement is inconsistent with the testimony given in court.

⁹ Adapted from *Domestic Violence: A Guide for Health Care Professionals*, p. 16.

COLLECTION OF PHYSICAL EVIDENCE

Physical evidence of abuse must be collected carefully so that it will be admissible in court if the woman chooses to prosecute her assailant. Unless you are required to report the incident (see the section in this manual on "Reporting the Incident to the Police"), assure the woman that no police report will be filed unless she gives her permission.

Place torn or blood-stained clothing in a sealed envelope or bag. Label the envelope with the patient's name, date, and the name of the person who placed the items in the envelope. If the patient has any object that was used to inflict the injuries (belts, electrical cord, screwdrivers, and similar household objects are frequently used as weapons), it should be handled in a similar manner and placed in a separate envelope. The envelopes should be stored in a locked drawer until they are given to the police, prosecutor, or patient's lawyer.

Because the prosecutor must show that these items were not tampered with, they should be handled by as few people as possible. If possible, the same person should remove the items (or witness their removal), place them in the envelope, secure the envelope in a drawer, and turn the items over to the police.

If sexual assault has occurred, use the Massachusetts Rape Evidence Collection Kit to collect the necessary physical evidence.

REPORTING THE INCIDENT TO THE POLICE

Although battering is a crime, medical personnel are not required in Massachusetts to report cases of abuse to the police or other state agencies **with the following exceptions:**

- Cases involving gunshot wounds, powder burns, or burns covering five percent or more of the body must be reported to the Department of Public Safety, and cases involving stabbings must be reported to the local police authorities.
- Cases involving rape or sexual assault must be reported to the Commissioner of Public Safety and to the police of the town where the incident occurred **without** identifying the victim. (See the sample "Provider Sexual Crime Report" following this section, which can be reproduced on your facility's letterhead and used to report these cases.)
- Cases involving suspected abuse, neglect, or financial exploitation of an adult age 60 or over must be reported to the Elder Protective Services Program. (See the section in this manual on "Battered Elders.")
- Cases involving the suspected abuse of a minor (under age 18) by her or his guardian or caretaker must be reported to the Department of Social Services. (See the section in this manual on "Reporting to the Department of Social Services.")
- Cases involving the suspected abuse or neglect of certain persons with disabilities between the ages of 18 and 59 must be reported to the Disabled Persons Protection Commission. (See the section in this manual on "Abuse of Persons with Disabilities.")

A woman who has been injured or threatened should be informed that she can contact the local police or district attorney's office to request that charges be filed against the abuser. Victims may also file for a restraining order, a document that prohibits the abuser from further harming or threatening the victim.

Hospital and health center staffs should develop a working relationship with the local police agencies to facilitate the handling of battering cases seen by health care providers.

Unfortunately, a restraining order is merely a piece of paper that the abuser can choose to disregard. Filing charges may enrage the batterer, and the woman will likely bear the consequences. The woman is the best judge of whether reporting the incident will enhance or diminish her safety. **By reporting a suspected incident of abuse to the police or any other agency without the patient's consent, you may be further endangering her safety. Always trust the patient's judgement with regard to her safety and respect her wishes.**

Provider Sexual Crime Report

TO: Department of Public Safety
Boston, MA 02215

FAX NUMBER: (617) 566-6945

FROM: Name of attending physician and hospital, clinic, sanatorium, or institution where treatment was sought:

Name of physician, manager, superintendent, or other person in charge making this report:

Name (please print)

Title

Signature

Date

N.B.: THE VICTIM'S NAME, ADDRESS, OR OTHER IDENTIFYING INFORMATION SHOULD NOT BE INCLUDED IN THIS REPORT.

Type of crime being reported (check all that apply):

- rape by a stranger
- rape by acquaintance
- attempted rape
- indecent assault
- male assault on female
- male assault on male

- female assault on female
- female assault on male
- male assault on child
- female assault on child
- other _____
- unknown

LOCUS: Municipality where offense occurred, including: street name; highway name or number; neighborhood (e.g., Weymouth Landing, Revere Beach); or geographical landmark (e.g., Brimfield State Park, Mt. Greylock). **DO NOT USE VICTIM'S ADDRESS.**

Date of Offense _____ Time of Day _____ AM/PM

RISK ASSESSMENT AND SAFETY PLANNING^{11 12}

Assessing the Woman's Risk

Regardless of the severity of the presenting complaint or injury, the best indicator of danger is a patient's assessment. Frequency and severity of previous attacks are good guides to current danger. Threats are as important as the actual injury, however, and the presence of weapons in the home is an additional risk factor.

It is important to remember that battered women are most likely to be killed when they are in the act of leaving or after they have left their abuser; the woman will have the best sense of when it is safe for her to flee.

The following assailant behaviors and situations, especially if they occur in a cluster, tend to indicate increased danger to the woman:

- threats and fantasies about homicide and suicide, a history of homicide or suicide attempts;
- placement of new injuries in more visible location (such as the face) when earlier assaults focused on areas of the body generally concealed by clothing;
- violent sexual behavior;
- depression and situational stresses, such as job loss, that exacerbate a depression;
- history of mental illnesses;
- weapons possession or past use of weapons;
- obsession about the partner ("I can't live without her") and centrality of the woman to the abuser's life;
- rage over her leaving;
- drug and alcohol consumption in a state of fury and depression;
- access to the battered woman;
- hunting or stalking the woman and continually harassing her;
- escalation of the abuser's threats and violence;
- harming or killing a pet, or hurting or destroying anything that has value to the woman.

¹¹ Adapted in part from Susan Schechter, *Guidelines for Mental Health Practitioners in Domestic Violence Cases* (Washington, D.C.: National Coalition Against Domestic Violence, 1987).

¹² Adapted in part from Flietcraft and Stark, "Woman Battering: A Prevention-Oriented Approach," pp. 69-71.

Overnight hospitalization (when feasible) should be considered in any instance where a clear or present danger exists. It should be explained clearly to the woman that the hospitalization is being used as a means of protecting her and does not imply that she has a psychiatric disorder. The possibility of spending the night with a friend or relative, or at a battered women's shelter if space is available, should also be discussed with the woman.

Educating the Patient about the Probable Course of Battering

In the vast majority of cases, unless violence is stopped it will continue, possibly escalate, and put children as well as the woman at high risk of serious injury and even death. Even if the children are not directly involved in the violence, exposure to violence in the home can cause lasting emotional and psychological damage to children. The patient should be fully acquainted with these dangers, as well as the psychosocial problems associated with abuse. A clear account of the health dimensions of abuse is particularly important in those cases where the assailant becomes contrite and loving immediately following an abusive episode (the so-called "honeymoon phase"). The fact that the assailant--and not the woman--is responsible for the violence should be repeatedly emphasized.

Counseling the Patient about Her Options

The goals of intervention are to ensure the woman's safety, empower her, and stop the violence. Preventive measures available to the woman include:

- Pressing criminal charges against the abuser.
- Obtaining a restraining order. Restraining orders may prohibit future contact and access to the woman's home and/or children, and provide for criminal or civil penalties if these prohibitions are violated. The police are mandated to arrest any person who violates a restraining order.
- Talking to other battered women in a support group.
- Initiating divorce proceedings.
- Securing emergency shelter.
- Using protective overnight hospitalization.
- Identifying an ongoing social support system, including friends and relatives with whom the woman and her children may stay, neighbors who will inform authorities in case of subsequent trouble, and friends or other advocates who will support a woman through the criminal justice process. Since battering is an ongoing problem, a woman needs ongoing help in addition to emergency relief.
- Developing a safety plan. The woman should hide in a safe place copies of important documents (birth certificates, passports, immigration documents, etc.), essential medications, a change of clothing for herself and her children, extra keys for the house and the car, cash and personal passbooks or checks (if she has been able to set up these accounts) in the event that she must flee quickly. A trusted neighbor could be asked to store these for her.

- Discussing the woman's immediate safety needs. Ask her where she will go when she leaves the facility, and who is waiting for her outside. Ask if she feels safe. If she is not returning to the batterer, be sure she has a plan of action and a list of emergency numbers. If necessary, arrange for her to leave through a less visible exit. Be especially cautious if it was necessary to call security to restrain her assailant.

The key to service for abused women is the battered women's shelter, which is typically a community-based facility operated by a largely volunteer staff. The shelter provides immediate protection from harm and also offers the support of other battered women and staff with extensive experience in the area. Shelters can refer women to other services and advocate effectively for their needs. Shelters are not appropriate for all battered women, however, and the clinician should be familiar with the entry requirements, capacity, and operating procedures of the local facility, as well as that of other local services to which abused women may be referred. (See the "Referrals" section in this manual.) Every health care provider should be able to refer patients to shelters and other resources for battered women.

A Word of Caution about Prescribing Tranquillizers

Emergency room doctors are more likely to prescribe tranquilizers and pain medication to battered women than to non-battered women.¹³ Primary care physicians may also prescribe tranquilizers, believing that they may help and cannot hurt. Tranquilized women are far less able to understand their options or make the decisions necessary to protect themselves. The prescription of tranquilizers may also give the abuser another emotional weapon to use against the woman: "See, I told you that you were crazy--now they've given you the medication that proves it." Unnecessary use of tranquilizers can be dangerous to the battered woman and should be discouraged.

Protecting the Confidentiality of Your Discussion¹⁴

Written discharge instructions, which might be seen by the batterer, should not directly state the cause of the woman's injuries. If the woman is fearful of bringing any written information home, phone numbers of shelters or hotlines can be written inside her shoe.

The Role of the Social Worker¹⁵

When there is a social services department in the health care facility, the social worker may be seen as the key respondent in battering cases. She or he must know how to assess the safety of the battered woman and her children and know what resources in the community are available to her.

Generally speaking, it is best if the woman is not interviewed more than once. If she accepts a referral to the social services department, the nurse or physician should brief the social worker about her case to spare the woman from having to repeat her story and to make her feel that the health care provider and the social worker are working as a team.

¹³ Stark, et al., *Wife Abuse in the Medical Setting*, p. 8.

¹⁴ From Boston City Hospital Emergency Department's "Acute Management of Battered Women/Adolescents," December 1991, p. 3.

¹⁵ Thanks to Lisa Gary, who wrote portions of this section.

It is not sufficient for the social services staff alone to be knowledgeable about basic safety advice and referrals, for the battered woman may be unwilling to confide in a second person after she has told her story to the nurse or physician. Every member of the staff should be able to provide emergency information.

The social worker can assume the sensitive role of helping other staff members to understand violence against women. For example, when a woman presents with serious injuries but is not ready to leave the battering partner, the social worker can help the staff to understand that the woman is not staying with her abuser because she enjoys or accepts being battered but because of fear of retaliation, concerns for the safety of the children, or financial dependency.

The social worker will also take part in the discharge and safety planning process. Knowing the resources available and the battered woman's history, she can assist the medical staff in helping the woman plan creatively.

Why Battered Women Stay¹⁶

Often health care professionals feel frustrated or angry at the battered woman if she does not leave her batterer or returns to him after leaving for a short period of time. An understanding of the main reasons why battered women stay can help the provider deal with these feelings and better serve the woman. Every woman has her own reasons for staying, and although the health care provider should help the woman explore all her options, he or she should not disparage her reasons or her decision.

Financial Considerations: Many battered women and their children are economically dependent on the batterer. If she has no marketable skills, her meager income and/or inadequate public benefits will not be enough to cover the costs of rent, utilities, child care, food, clothing, etc. The battered woman may feel that appeasing the batterer is the only way to provide for the children. The number of children and their ages affect the woman's mobility.

Isolation: Many batterers systematically destroy their partner's friendships and family ties. Often people feel uncomfortable around the abuse and avoid contact with the woman. The woman may choose to stop having contact with her friends and family because of the emotional and physical violence that occurs afterwards. The resulting isolation can leave the woman psychologically dependent on the batterer as her only support system.

Low Self-Esteem: Many battered women feel they are failures as wives, lovers, mothers, and women because they do not know how to avoid or stop the abuse. Their batterers often tell them that they are to blame, and so they spend almost all their time concentrating on ways to appease the batterer, leaving them with little time to address their own needs. They may have been convinced that they are unable to live on their own, and that the abuser is the best or only partner they will ever have.

Fear: Fear of reprisal for calling the police or going to court is not unfounded: **MORE BATTERED WOMEN ARE MURDERED WHILE ATTEMPTING TO FLEE THE ABUSER THAN AT ANY OTHER TIME.** Often the batterer's extended family and friends will join

¹⁶ Adapted from Harvard Law School Battered Women's Advocacy Project Training and Resource Manual, Draft #6 (Cambridge, MA: February, 1991), pp. 47-48.

him or her in threatening, harassing, intimidating, and harming the woman for seeking help. Immigrant women may be threatened with deportation by their partners. Some women may feel paralyzed by fear of the unknown or of change.

Guilt: Like victims of rape and incest, abused women often believe that they are in some way responsible for the crime. Thus, they may feel guilty for not figuring out a way to stop the violence themselves.

Promises of Change: It is easy for the woman to believe the batterer when he or she tells the woman that he or she is sorry and the abuse will not recur. The woman may still love the batterer and believe that if she is patient enough, her partner will stop being violent.

Denial and Minimization: If the batterer denies or minimizes the abuse, it can be dangerous for the woman to contradict him or her and report the injuries as intentional. The woman may accurately perceive that denial of the abuse is the only way to protect herself. The abuser may have also convinced her that she is crazy and that the abuser's account is accurate.

Sense of Responsibility or Loyalty to the Abuser: The woman may be reluctant to leave a partner who has a physical, emotional, or psychological problem and is dependent upon her for care or support.

Social and Professional Concerns: The woman may fear that she will lose social and professional connections, or that her private business will become public knowledge within her social or professional circle.

Lack of Prior Serious Intervention: In the past, the woman may have attempted to obtain help from friends, health care providers, police and/or courts, to no avail. Based on this inadequate response, she may now assume that no one will treat the abuse seriously. Thus, the woman may be reluctant to keep calling the police or going to court unless she sees serious, consistent intervention.

Wanting to Keep the Family Together/Fear of Losing Custody: The woman may believe that the children will fare better in a two-parent family, especially if she can figure out how to stop the abuse. Additionally, since the *Massachusetts Supreme Judicial Court Gender Bias Study* (1989) reports that fully 70% of the men who attempt to gain custody are successful, the mother has very valid fears of losing her children should she try to protect herself through the legal system.

Religious Beliefs: The woman's religion may discourage or prohibit separation or divorce.

Inability to Use Support Services: The woman may feel she is unable to use support services because of language or cultural barriers, lifestyle issues, disabilities, etc. Women with active substance abuse problems are not admitted to most shelters.

Exhaustion: The strain of dealing with abuse day to day may have left the woman unable to make any major decisions or changes.

WHILE SOME BATTERED WOMEN WANT THE RELATIONSHIP TO CONTINUE, THEY ARE CLEAR ABOUT WANTING THE VIOLENCE TO STOP.

When a Woman Chooses to Stay^{17 18}

If the woman chooses to stay with the batterer for now, the health care provider is not powerless to help. Without being judgmental or blaming the woman, there are many constructive things the health care provider can say:

"I am afraid for your safety."

"I am afraid for the safety of your children."

"The violence will get worse unless there is serious intervention and your partner is forced to stop the violent behavior."

"Would you find a restraining order helpful? Do you know how to have it enforced?"

"If you sense that the violence might escalate, can you leave for a few days? Do you have a place to go and phone numbers for shelters?"

"Have you hidden a set of car keys and some extra money?"

"Can you run to a neighbor's house or work out a signal so that the neighbor will call the police?"

"Can you get involved in a support group at the local shelter?"

"I understand that you may not choose to leave now, but I will be here to help when you are ready." (Note: Of course, you can say this only if you will be available to help the woman in the future, and if she will be able to initiate contact with you. This continuity is ideal, but institutional realities may make it impossible. If you can't be certain of these conditions, it would be best to say that someone, either at your facility or at one to which you have referred her, will be available to help her.)

Very often you will be the only person with whom the battered woman has contact who offers helpful, supportive comments. Though she may not be able to act on your advice now, in many cases your support can be instrumental in her decision to leave later on.

If you measure your success as a provider by whether the woman leaves the batterer, you may become frustrated and blame the woman. If you measure your success by how well you counseled her about her safety options and respected her right to self-determination, you can feel assured that you did your job well.

¹⁷ Adapted in part from Harvard Law School Battered Women's Advocacy Project Training and Resource Manual, p. 49.

¹⁸ Adapted in part from Schechter, *Guidelines for Mental Health Practitioners in Domestic Violence Cases*, p. 12.

WORKING WITH POPULATIONS WITH SPECIAL NEEDS

Cultural Diversity²³

Specific attention must be paid to issues of cultural diversity when addressing woman abuse. Awareness of cultural values and norms will assist the health care provider when listening to women, giving them information, and assisting them in making decisions and safety plans. While cultural differences must be considered when dealing with battering, they must never be used to deny or excuse the violence. The attitude that certain cultures or socio-economic groups are inherently more violent than others is not only uninformed, it helps to create a climate where violence toward women is considered "normal" or minor and hence, unimportant and invisible.

To empower battered women, women of all races, classes, ethnicities, ages, religions, sexual orientations, and physical abilities must have access to the information and services required to ensure safety. However, what feels safe and validating differs from culture to culture. The following are some guidelines for enhancing your effectiveness in dealing with abused women from cultures different from your own.

Racial oppression: Stereotypes that the dominant culture holds about communities of color affect the type of help a woman can expect to receive, thus making it more difficult for women of color to escape from abusive situations. It is imperative to examine your own stereotypes toward others and remember that the woman before you is a unique individual.

Health care setting: Every organization has its own cultural atmosphere which makes it accessible and comfortable to some communities and alienating to others. Health care settings can be particularly threatening to newly arrived refugees and immigrants as well as to linguistic minorities. Take stock of your particular setting and the atmosphere it projects. Does it feel alienating to those who are not part of the dominant culture and if so, what can be done to make it feel more welcoming?

Family and community values: When working with an individual woman it is helpful to know what the customary family and sex roles are in her community. This includes how divorce is perceived, how single mothers are treated, and whether the role of family members is confronting or protecting the batterer. In some communities, there is strong emphasis placed on keeping the family together. Divorce and separation are frowned upon and the blame is generally placed on the woman, who may be socially ostracized. The challenge in this situation is to help the woman begin to think about personal empowerment in the context of the family or community.

Shame: All battered women experience some degree of shame which usually arises from the belief that the violence is a result of their behavior. Cultural values and religious beliefs can heighten this sense of shame to the point where some women take the ultimate step in ending the violence by taking their own lives. To reduce the self-blame that accompanies battering, it is important to remind the woman of the cultural and religious values emphasizing compassion, respect, patience, and responsibility that are being violated by the

²³ Excerpted in part from:
Cathy Barber and Elba Crespo, "Understanding Diversity and Accessibility," in *For Shelter and Beyond*, pp. 49-54, and
Laura Crites, "Cross Cultural Counseling in Wife Beating Cases," *Response*, 77(13), no. 4, pp. 8-12.

batterer. It may also be helpful in some cultures to focus on the relationship between parent and child, since greater shame will result if the woman fails to protect her children from the destructive influence of violence.

Help-seeking behaviors: It is important to know how the woman's community views seeking help from outsiders. Is it acceptable or is it considered a betrayal? Cultural norms such as these may be related to a reluctance to seek a restraining order or contact a battered women's shelter. Helping the woman to identify these values and her fears about betraying them may assist in her decision-making process.

Language: What is the woman's primary language? If English is a second language, don't assume that she "doesn't mind" speaking English. If she doesn't speak English it is important to use an **appropriate** interpreter; i.e., someone from your facility, preferably a woman, who is trained in medical interpretation and who will honor confidentiality. Remember to address the woman when you speak, not the interpreter. It is not appropriate to expect the woman to bring along a friend or relative to interpret, since that person may be the batterer or someone sympathetic to the batterer, and it is **never** appropriate to use a child as an interpreter. In an emergency situation, when no interpreter is immediately available at your facility, use your best judgment. Try contacting one of the shelters in the "Referrals" section that lists a bilingual or multilingual staff.

Legal options: It is important for all women to know their legal options. In many immigrant communities, it is not widely known that battering is a crime. Refugee and immigrant women may choose not to take legal action or seek protection from their abusers because they fear using a legal system they are unfamiliar with and do not trust.

Shelters: Shelters may not represent safe haven for women and children who do not speak English. The shelter's rules may seem very alien and the inability to communicate increases the sense of isolation. Before referring women to shelters, you should describe as fully as possible what shelters are like, what resources they offer, and how they function. Check the "Referrals" section of this manual for shelters with bilingual or multilingual staffs.

Immigration Issues: For a woman from an immigrant group, the history of migration is important in understanding her situation. Did her people leave their country of origin by choice or did they flee from war? How closely do community members adhere to cultural traditions? Are there conflicts between generations? What was her life like in her country of origin? What were her resources? Refugee and immigrant women may be afraid of getting help for fear of losing their immigration status. Abusers who are citizens often threaten to report the woman to the Immigration and Naturalization Service or to discontinue sponsorship of a spouse who currently has conditional permanent resident status. In these cases, the woman may be able to gain legal status without the spouse's continued sponsorship by obtaining a waiver of the joint filing requirement. The woman should be referred to an immigration lawyer or to one of the legal services listed in the "Referrals" section of this manual. If the woman is fearful, an advocate can consult the lawyer without revealing the woman's identity. A restraining order that grants her temporary custody and child support may be especially helpful for the woman who does not want to terminate her marriage because of concerns about her conditional permanent resident status. A restraining order also provides documentation in any future custody, divorce, criminal, or

immigration proceeding, which may help a conditional permanent resident seeking a waiver of the joint filing requirement.²⁴

Undocumented immigrants face perhaps the most frightening situation of all battered women, and should be dealt with very gently. They are often too terrified of being deported to call the police or get a restraining order. A battered woman requesting police protection or filing for a protective order in Massachusetts should never be asked about her citizenship, but undocumented immigrants may have a legitimate fear of calling the police in areas where police are known to check immigrant status and cooperate with the INS. If the police inquire about the woman's immigration status or place of birth, she has the right to remain silent.²⁵ The woman should be told that a restraining order will not endanger the batterer's status if he is undocumented unless he violates the order.

Women who come from countries with dictatorial or terrorist regimes may have trouble believing that the police will not harm them and that getting a restraining order is a civil rather than a criminal matter. The best way to help these women is to have someone from their culture who is experienced in working with undocumented immigrants explain their legal rights to protection and reassure them that they are in a safe environment and can trust the health care providers. If there is no one on your staff who can do this, check the "Referrals" section of this manual to see if the woman's language is spoken at any of the shelters listed, or call the Massachusetts Battered Women's Hotline.

Body language: What are the traditions in the woman's community for speaking about personal problems? Many people will not speak directly about problems, but begin by talking about other less personal issues. A woman's body language may also be different from yours. She may avoid direct eye contact if it is a sign of disrespect in her culture. Sitting close or far away, smiling after every comment, talking loudly or softly, getting angry quickly, gesturing emphatically--all of these behaviors may be related to a woman's culture and its way of communicating. To avoid misunderstandings, ask the woman to tell you, in her own words, what she understands from her meeting with you and what her plans are.

²⁴ Ted Chiappari, "Remedies of Battered Immigrant Women in the Commonwealth of Massachusetts," unpublished paper, Harvard Law School, Cambridge, MA, April 10, 1992, pp. 30-31.

²⁵ *Domestic Violence in Immigrant and Refugee Communities: Asserting the Rights of Battered Women* (San Francisco: Family Violence Prevention Fund; Coalition for Immigrant and Refugee Rights and Services, Immigrant Women's Task Force; and National Immigration Project of the National Lawyers Guild, Inc., 1991), pp. VIII-7 - VIII-8.

Woman Battering

A PREVENTION-ORIENTED APPROACH *

Anne H. Flitcraft
Evan Stark

THE MEDICAL RESPONSE

The tendency for health providers to alternately neglect, stigmatize, and even punish abuse victims has been documented from both medical records,² and direct observation in emergency departments.¹⁸

Neglect, inappropriate medication, labeling, and punitive referrals often characterize the ongoing care of women who present with abusive injury.

Table I indicates how misconceptions about the origins of abuse and the experience and personality of abuse victims can lead the PA to errors in clinical judgment and practice. It also includes notes to guide the PA to appropriate clinical judgment and practice.

Appropriate Clinical Practice

Appropriate practice requires that the adult trauma history is routinely taken as a part of the medical history of every patient and the trauma history is reviewed in all instances of adult injury.

Patient complaint is the best basis for assessing a woman's predicament and emergency. Abuse should be identified at primary health care sites, as well as in emergency settings. Women who carry "labels" should be carefully queried about abuse.

Violence should be probed and treated as the basis for psychosocial problems, such as alcohol and drug abuse, child abuse, rape, etc. Stopping violence should be the context for treating the secondary problems such as alcoholism.

Abuse procedures should be initiated whenever a woman presents violence as a complaint. Options should be realistic and empowering.

Abuse should be identified and responded to, regardless of marital or cohabitant status. Family support should be suggested only after the violence has stopped and a woman understands the causes and probable course of abuse and the alternatives available to her, including her legal options.

* This is an abbreviated version of "Woman Battering - A Prevention-Oriented Approach", by Anne H. Flitcraft and Evan Stark.

PREVENTION

Woman battering is one of a number of major health problems for which social and psychosocial factors are key. Unfortunately, attention to psychosocial factors in health is often slighted in many education programs, a gap that may lessen effectiveness, particularly in the family practice and primary care settings in where large numbers of PAs work. The prevention strategy outlined here requires a broad social approach to the causes and dimensions of health problems as well as to intervention.

The following sections, Current Interventions and a New Health Perspective, outline the current response to abuse. The remaining sections describe the potential role of PAs in a multidisciplinary strategy to prevent or substantially reduce battering.

CURRENT INTERVENTIONS

The PA's response to abuse takes place in the context of a broader social commitment. As we have seen, a woman's risk of violence is the outcome of multiple and complex social processes over which neither the abuse victim nor the clinician has much control. Preventing spouse abuse requires that (a) victims be identified; (b) protection be provided; (c) the violence be stopped; and (d) the underlying causes of battering be addressed, primarily by expanding the resources and options available to victims and assailants. The PA can make an important contribution to each of these processes. To do so, however, the PA should understand the current response from various sectors of society.

Federal and State Responses

Thus far, the response by federal and state lawmakers is designed to facilitate shelter for victims and police and legal action against assailants.

Federal and state action on abuse is a direct response to the battered women's movement. In the effort to prevent domestic violence, the battered women's movement is unique in its community base, the importance of abused women in its development, and in its political commitment to empower women as well as provide them with shelter and counseling.¹⁹ The emergence of more than 700 shelters for battered women in the United States constitutes the single greatest pressure on local institutions to take cognizance of, and act on, the problem.

State responses emphasize legal reform, shelter funding, and the redirection of protective and human service resources. By 1981, only South Dakota had failed to improve the civil and criminal remedies available to abuse victims, and 28 states now mandate some form of reporting from protective and/or health services. Several states have formed state-level commissions (New York) or agencies (New Jersey) to oversee action on domestic violence. While community initiatives have been more limited, the recently formed Council on Family Violence (under the auspices of the United States Conference of Mayors) plans to develop comprehensive family violence prevention and treatment programs at the local level. In several cities, close working relations between the prosecutor's office, courts, police, mental health services, and local shelters have resulted in community-wide coalitions to coordinate action on the problem.

The federal response has emphasized primarily technical assistance and research, though current legislation offers direct support to shelters for abused women. From 1974 until its termination, the Law Enforcement Assistance Administration supported some direct services (including several shelters) and court mediation programs for battered women. And Housing and Urban Development (HUD) revisions in the Community Development Block Grant guidelines permitted community groups to purchase shelters and other direct services.

The United States Commission on Civil Rights held hearings on battered women in 1978. One outgrowth was the formation of the Nation Coalition Against Domestic Violence (NCADV), first designed to support shelter legislation and subsequently to coordinate shelter-oriented education and advocacy nationwide. Another outgrowth was the establishment of the Office of Domestic Violence (in Health, Education, and Welfare) to collect and disseminate information to service providers. Within the National Institutes of Mental Health (NIMH), divisions on "Rape" and Violent Anti-Social Behavior" supported

research on battery, including a national survey of spouse abuse. Most recently, the Attorney General's Task Force on Domestic Violence issued an impressive report focusing on the need for a nationally coordinated criminal justice response to spouse abuse. Funding to implement the recommendations of the Task Force may soon be available through the Justice Department.

Three consecutive attempts to pass the Domestic Violence Assistance Act failed (1978, 1979 and 1980), in part because of counter-pressure from extreme conservatives, but a revised bill passed both houses in 1984 and awaits appropriation of the \$6 million mandated. Some states can now fund shelter programs through federal victim compensation legislation.

The Medical Response

In the early 1970's, emergency service nurses in many hospitals established protocols to provide intensive crisis intervention for sexual assault victims. Building on this base and following the lead of the Ambulatory Nursing Department of the Brigham and Women's Hospital in Boston, several hospitals introduced a domestic violence protocol into emergency service. Meanwhile, New York and New Jersey have developed model protocols for hospitals and major training conferences have been directed at nursing, social service, and emergency medical staff. On the whole, however, and by contrast with the response from the shelter movement and the criminal justice system, the response from the medical field lacks a focus, coordination, and national leadership. In October 1985, C. Everett Koop, Surgeon General of the United States, convened a national conference to study violence as a public health issue. Such national efforts may herald a change in which medicine is mandated to develop a constructive response to domestic violence.

A NEW HEALTH PERSPECTIVE

The knowledge base exists for a coordinated response to abuse by the health care community. As we have seen, however, the current medical response may even contribute to the problem. Traditional medical training does not prepare the PA to cope with complex psychosocial problems such as woman battering. A prevention-oriented approach to battering requires going beyond the medical model of disease and interventions based on this model. The traditional model is inadequate in a number of respects.

(1) It misses or greatly undervalues the psychological and social costs of abuse. Only when these costs are considered, along with the costs of injury, can the full importance of battering and spouse abuse be appreciated.

(2) In its emphasis on biology, personality, or at-risk behaviors, the traditional medical model underplays the complex social origins of spouse abuse. The "political" model of spouse abuse—which emphasizes the use of violence to enforce inequality—finds stronger support than alternative explanations highlighting individual pathology, at-risk behaviors, or stress. Closing what Carmen, et. al. (1985) call the "gender gap" in medical and psychiatric services requires that PAs base identification on patient self-assessment, that discreet presentations be seen in the context of a woman's entire history, and that clinicians stop blaming abuse on its victims.

(3) Traditional methods of screening for susceptibility and/or managing at-risk behaviors have little bearing on abuse, particularly in the family practice and primary care settings where PAs work. Instead, interventions must target social behaviors and the social environment; the PA must form working relationships with community-based service providers (such as shelter workers) and the disciplines outside health (including social science); and an emphasis should be placed on nonmedical policies and interventions that can reduce violence and improve health. We term this approach "complex social prevention."

The following sections outline a multilevel and multidisciplinary strategy to prevent battering and substantially reduce abuse. The first section on Care Identification in Medical Settings describes case identification in a number of major clinical settings where PAs work. The function of early identification is primary prevention, that is, intervention in cases of abuse before a pattern of victimization is established. The second section on Complex Social Prevention extends this discussion, focusing on the battered woman as patient and on the link between an accurate prognosis and an awareness on the PA's own feelings and responses to abuse. The first and second sections are also relevant to secondary prevention: minimizing the

consequences of battering when a pattern of abuse has already been established. In the final section, we address complex social prevention, the broad changes needed to reduce the underlying causes of violence against women.

CASE IDENTIFICATION IN MEDICAL SETTINGS

For those involved directly in service delivery, identification methods begin with the patient encounter but may extend to a complete review of the patient's medical records to understand the history and extent of abuse as well as the patient's previous attempts to find aid.

This section describes the medical presentations and problems associated with abuse as they are seen within the various medical and surgical clinics of a major medical center. Practitioners who work in family practice, more integrated facilities, or in community health centers will have to identify the specific sites where each high-risk presentation is likely to appear, given the triage and referral patterns of that particular facility.

The Surgical Setting

Traditionally, when health care professionals ask patients how a particular injury occurred, they are seeking specific technical information to alter the approach to injury-repair. A broader interpretation of how a particular injury occurred is necessary to identify abused women. Batterings should be part of the differential diagnosis of every encounter with an injured client. By classifying the etiology of the presenting complaint into one of the following categories, the health professional can determine the relative risk of abuse and, therefore, the appropriateness of the follow-up questions about battering.

1. Positive incidents: Those cases in which the injury is directly attributed to a spouse, boyfriend, or significant male intimate.

2. Probable incidents: Those cases in which injury could only have been sustained in an assault; that is, the patient was kicked, stabbed, choked, shot, etc., but the injury was not sustained in a mugging, street assault, or robbery.

3. Suggestive Incidents: Those cases in which the immediate alleged etiology does not account for, nor is consistent with, the injury sustained, e.g., falling downstairs and suffering two black eyes or sitting on a steak knife and suffering deep hip lacerations.

4. Negative incidents: Those cases, including anonymous assaults and muggings, where the alleged etiology is consistent with the pattern of injuries sustained.

The direct questions, "Has someone done this to you?", "Are you safe at home," and, "Have you been injured before?" are appropriate in all cases of injury. Aspects of the event itself (discussed below) should heighten the clinician's "index of suspicion" and should prompt frank discussion with the client about possible problems with domestic assault.

1. Multiple injuries: There are relatively few ways of sustaining injury to more than one anatomic site and fewer ways of sustaining bilateral injuries, regardless of the etiology. Frequently cases that might be dismissed as multiple abrasions or contusions are actually domestic assault.

2. Site of injuries: Most accidents involve the extremities, especially the hands and feet. Deliberate assault carries a different body map so that any incidents involving injury to the face, neck, chest, breasts, or abdomen ought to prompt careful attention to rule out intimate assault.

3. Rape: Regardless of the legal definition, a woman who seeks medical aid after forced sexual contact with a male intimate will say she has been raped — there is no other word to describe the experience. Many rape crisis teams, developed in response to the notion of rape as an isolated event in the life of the unprotected housewife or coed, focus on the legal aspects of evidence gathering, documentation, and prosecution, and urge counseling, often including the woman's significant other. Such strategies do not address the emotional, medical, legal, or shelter needs of the woman who lives within a violent relationship (or marriage), in which rape is yet another incident of ongoing physical abuse. On the contrary, within the medical encounter where rape is presumed to refer to anonymous sexual assault, the abused woman is likely to feel that she is misunderstood and therefore respond with hostility, refuse to cooperate with police, and

fail to keep appointments with medical personnel and rape crisis counselors.

4. Severity of injury: Contrary to widely publicized reports of battering, severity of injury (in strictly medical terms) is a relatively poor indicator of domestic assault and an unreliable way of identifying abuse in the medical setting. In fact, the presentation of medically insignificant trauma to the emergency service ought to alert providers to the possibility that ongoing assault and impending danger constitute the real emergency for which a woman is seeking aid.

5. Pregnancy: Abused women are more likely to be beaten when pregnant. The risk to both the mother and unborn child is reflected in the higher rates of miscarriage among abused women. The coincidence of trauma and pregnancy represents an extremely high-risk prevention that may demand emergency medical and social service intervention.

6. Trauma history: When treating even the most insignificant injury most clinicians briefly investigate a patient's medical history to elicit complete information about the last tetanus shot, allergies, daily medications, history of diabetes, and previous major hospitalizations. In the case of joint injury, the provider may ask about previous injury to the same site. There is no pathophysiology that establishes logical continuity between episodes of adult trauma. As long as injury is seen as a relatively confined anatomical breach, there is no imperative to elicit a history of previous trauma as a routine step in the evaluation of any injured patient. In screening and identifying abused women, eliciting a history of previous trauma (the trauma history) is the most important step in patient evaluation. If a trauma history is obtained routinely, regardless of current clinical presentation, abused women can be identified within the larger population of patients with unintentional or accidental injuries. Furthermore, the routine use of the trauma history in medical and psychiatric settings circumvents the tendency to identify abuse only in those situations where the extent and nature of the injuries make the diagnosis obvious — situations representing only the severest injuries.

The Medical Setting

Battering includes the development of multiple medical and psychosocial problems, as well as repeated episodes of injury. Health professionals need identification skills not only in the acute trauma setting, but also in nontrauma settings that form the predominant medical structure that provides on-going care to abused women. Active identification efforts in these settings help assure that women need not be beaten again before the problem is recognized. In addition, given the high-tech and crisis orientation of emergency medicine — and the well-known limitations of the emergency surgical service as a primary care facility — the nontrauma clinical setting may provide a more suitable environment where patient-provider interviews are less distorted by time constraints or preconceived notions about the types of complaints that are "appropriate." Social service providers are usually more accessible in clinic settings.

Although intervention at nontrauma settings is important in any detection and prevention effort, health professionals at these sites frequently fail to identify abuse and inappropriately label complaints associated with battering. Throughout the health care system, one clue to abuse is a patient's accumulation of quasi-medical labels such as "hysterical," "hypochondriac," or "patient with multiple vague complaints." Although the labels express the frustration of a provider who is unable to answer a patient's chief complaint in traditional therapeutic modes, they also signify to other practitioners (most painfully) that future complaints may also be less serious (or real) than initial evaluation might suggest.

Medical Emergency Service

In the medical emergency service, presenting complaints indicating abuse include:

1. "old" injuries, particularly to the back, neck, and ribs;
2. complaints of trauma without anatomic "evidence of injury", complaints of headache, abdominal pain, muscle aches, or nonspecific pain;
3. sleep disorders, anxiety, dysphagia, hyperventilation, or other problems symptomatic of the stress associated with living in a violent environment; or
4. problems associated with late stages of battering, e.g., alcohol or drug abuse.

The PA working in an emergency setting must recognize that the emergency of the abused woman is frequently not evident in laboratory tests, x-rays, or physical examinations. To reiterate: abuse can only be recognized if the practitioner accepts that a legitimate emergency may not be accompanied by serious anatomic or physiologic pathology.

Medical Clinics

The variety of complaints for which abused women visit the medical clinic are similar to those presented to the medical emergency service. However, medical clinic records are kept more consistently than in emergency settings, and the PA in this setting — as well as in family practice — is likely to have access to a woman's entire clinic history. Clues that warrant specific review of the trauma history include:

1. persistent visits with vague complaints and symptoms without evidence of physiologic dysfunction;
2. frequent use of minor tranquilizers and sleep medication; or
3. increasing reliance on alcohol or abuse of licit or illicit drugs.

The astute PA can review a patient's clinical history and locate clusters of seemingly unrelated complaints emerging over time, followed by evidence of incipient self-abusive behaviors that may indicate the point at which sporadic incidents of violence have settled into patterns of abuse from which change and escape seem impossible.

Obstetrical and Gynecology Clinics

Abused women in the obstetrical case-load constitute a higher percentage than in any other trauma or nontrauma population (with the exception of mothers of abused children), approaching 25%. In gathering information about a woman's obstetrical or reproductive history, the PA should select data immediately relevant to the care/repair of the present clinical problem. The PA also should ask the patient about previous pregnancies, deliveries, and births, primarily to anticipate anatomic or physiological problems that may emerge during the current pregnancy. The following histories should prompt the PA to include a full trauma history in the review of systems:

1. self-induced or attempted abortions;
2. multiple therapeutic abortions;
3. miscarriages; or
4. divorce or separation during pregnancy.

Persistent gynecological complaints, particularly abdominal pain and dyspareunia in the context of normal physical and laboratory exam, frequently are overlooked as manifestations of domestic violence.

Mental Health Services

Ideally, problems requiring social services, community mental health services, or medically oriented psychiatry would be clearly distinct. However, it is common practice in the busy emergency room to refer patients who appear "emotionally upset" to psychiatric personnel. Such "dumping" is particularly common in cases of battering. Emergency psychiatric staff generally accept a medical model of mental illness, and, regardless of their personal philosophy, are certainly not skilled community social workers.

The relative overutilization of emergency psychiatric services by abused women is so startling that one could argue that every psychiatric interview ought to include a full trauma history. Beyond this, before initiating a mental health referral, it is mandatory to rule out battering in cases of:

1. alcohol abuse;
2. drug abuse (particularly of licit substances);
3. suicide attempts (regardless of the degree of potential lethality);
4. attempted suicide during pregnancy;
5. suspected child abuse;
6. vague and nonspecific complaints of anxiety, depression, or anger, often associated with a moderate degree of impaired function and tangential reference to marital conflict; and
7. paranoid tendencies, sometimes associated with fears of falling asleep or losing control and inflicting violence.

THE BATTERED WOMAN AS A PATIENT

Ideally, having identified abuse, the PA will triage to appropriate social or community services. Unfortunately, both hospital and community-based social services are often closed during the hours when battered women need them; the quality of service varies greatly; and a patient may refuse referral because she is simply not ready because of past experiences with health care services. Even when the patient cooperates fully, however, and adequate preparation for referral has been made — such as the development of a hospital protocol — the PA must complete the interview, clearly explain the appropriateness of any referral or policy, and help the patient become aware of her future prospects and options.

The Interview Setting

Whether the patient is seen in a family practice setting, hospital emergency service, or clinic, the interview should be conducted in a place that is private and from which it is possible to exit safely.

Assailants often accompany victims. Because the assailant fears exposure, he may insist on being present during all medical interviews, appear over-solicitous in seeking help for the abused woman, and respond to questions about the incident directed to the patient. In a firm but unthreatening manner, the PA should ask the man to remain in the waiting room (or return home). Since the PA may be the first person to whom the woman has talked frankly about her abuse, it is imperative that sufficient time be allotted for a woman to tell her story.

The Interview

The following guidelines should help make the interview effective:

- Establish whether abuse is the context of the immediate complaint.

Experience suggests that abuse victims respond positively to supportive questioning. Abuse and battering are clinical terms. The patient who denies she is “a battered woman” may frankly admit her husband or boyfriend hits her when they argue. Direct questions such as “has somebody done this to you?” are best. But eliciting information about abuse sometimes means assuring the patient that “many women such as yourself come here with problems caused by their husbands or boyfriends.” Since abuse often arises from struggles involving male dominance, if direct questioning is not productive, it may help to ask “What happens when he doesn’t get his way?”

- Locate the presenting problem in the patient’s history of adult trauma and psychosocial problems.

Taking a complete history of adult trauma supplemented by a review of the patient’s medical history provides a general picture of an ongoing abusive relationship. Previous notes indicating abuse (“positives”), repeated visits for “accidents,” assaults, or vague complaints with no evidence of medical disease, and presentations for which the recorded explanation seems inadequate should prompt the PA to inform the patient that her history suggests abuse. The psychosocial sequelae of abuse should be explored by identifying possible links between violence and the onset and development of psychosocial problems.

- Listen supportively to the patient’s story.

Once a preliminary diagnosis of abuse or battering has been made, the most important thing to tell a woman is that she has done the right thing in sharing her story, that no one has the right to hurt her, and that she can be protected and the violence made to stop. A simple statement such as “tell me about it” is usually sufficient to elicit a detailed account.

In listening to her story, the PA should refrain from being judgmental and attempt to keep personal biases and reactions under control, including anger at the assailant. The woman should be helped to identify her feelings, including her anger, and allowed to describe her beliefs about the situation, no matter how transparent they may seem. Even the feeling that “a wife should stay with her husband, no matter what,” may be a source of security and pride. However powerless or dependent the patient may seem, she has survived and has come for help. She does not need rescuing, but rather, help in recognizing her own strengths and resources.

- Keep a record, including photographs, of the patient's injuries and complaints.
- Assess the seriousness of the problem.

Regardless of the severity of the presenting complaint or injury, the best indicator of current danger is a patient's assessment. Frequency, spacing, proximity, and severity of previous attacks are good guides to current danger. Threats may be as important as actual injury, however, and the presence of weapons in the home is an additional risk factor. Overnight hospitalization should be considered in any instance where a clear or present danger exists.

- Acquaint the patient with the probable course of battering.

In the vast majority of cases, unless violence is stopped, it will continue, possibly escalate, and put children, as well as the present victim, at high risk of serious injury and even death. The patient should be fully acquainted with these dangers, as well as the psychosocial problems associated with abuse. A clear account of the health dimensions of abuse is particularly important in those cases where the assailant becomes contrite and loving immediately following an abusive episode (the so-called "honeymoon phase"). The fact that the assailant — and not the victim — is responsible for the violence should be repeatedly emphasized.

- Acquaint the patient with her options.

The goal of intervention is to stop the violence and to empower the victim. Preventive measures available to the victim typically include criminal charges, emergency court orders restraining assailants, emergency shelter, and protective institutionalization (e.g., overnight hospitalization). Restraining orders may prohibit future contact, access to the victim's home and/or children, and provide for severe criminal or civil penalties if these prohibitions are violated. Ameliorative measures range from initiating divorce proceedings through family counseling. In many communities, the assailant may be ordered or may voluntarily enter programs for abusers. Violence must be dealt with directly and independently of whatever other problems assailants present.

In either case, the PA should help the victim identify possible sources of ongoing social support, including friends and relatives with whom the woman and her children may stay, neighbors who will inform authorities in case of subsequent trouble, and friends or other "advocates" who will support a woman through the criminal justice process. Since battering is an ongoing problem, a woman needs ongoing help in addition to emergency relief. The PA should help the victim develop a plan of action and review progress on the plan in subsequent health visits.

The key to service for abuse victims is the battered woman's shelter, typically a community-based facility operating on a shoe-string budget and with a largely nonprofessional staff. The shelter provides immediate protection from harm. But it also offers the support of other resident victims and staff with extensive experience in the area. Shelters can refer women to other relevant services and advocate effectively for their needs. Shelters are not appropriate for all victims, however, and the PA should be familiar with the entry requirements, capacity, and operating procedures of the local facility, as well as of other local services to which abuse victims may be referred.

The experience of abuse victims often includes a history of frustrated help-seeking. The PA should be sensitive to the limits of services for the poor and to the distrust many low-income persons justifiably feel towards professions that expect and reinforce dependency. The PA should be as realistic as possible in explaining what existing services have to offer and the difficulty of always getting what is promised. Direct contact and follow-up with an existing service provider is often needed to ensure an appropriate response.

The Attitude of the Physician Assistant

Battered women may be "unattractive" patients. Bruises may leave permanent physical or psychological scars, and uncontrolled rage, apparent self-pity, and a range of behavioral sequelae of abuse (such as alcoholism) may mask the underlying cause — the violence. Despite relevant training, the PA may continue to picture battered women as pathetic or helpless, conceive of assault as a consequence of behavioral or environmental problems, or insist on an unequivocal commitment by the victim to the course

of action the PA believes is necessary. If he or she comes from a different economic, cultural, or racial background, the PA may not fully appreciate how limited are the resources available to most abuse victims. And, perhaps most important, the PA is often uncomfortable with violence.

Coming to terms with your own attitudes, experiences, and reactions to violence is an important part of appreciating abuse, and it also minimizes the possibility that defensive anger at the assailant will not be misdirected at patients who express ambivalence towards their situation. Dealing with dependence is another problem. It is difficult to remember that behind the momentary dependence evoked by crisis is a woman who has faced daily risks that would intimidate less courageous people. A common feeling is that there are no limits to the patient's dependence — if you let her depend on you now, she will demand more and more of your precious time and energy. One response to this feeling is to present the cold front of the medical expert, a particular problem for clinicians such as PAs whose status as professionals may be somewhat ambiguous. An alternative response is to take over the problem of problem-solving from the victim, telling her what to do (and feel) rather than fostering her own decision-making. Both responses reinforce a feeling of helplessness among victims.

Evaluating the Encounter

Despite our best efforts, violence often continues. The services to which abused women are referred often do not work. Many women remain vulnerable and others voluntarily return to abusive situations, sometimes after only a brief absence. This may reflect a woman's failure to appreciate the seriousness of her situation, a problem that more complete patient education can sometimes remedy. Or a woman may return because she truly cares for her partner, although she does not like being beaten. Or she may return because she thinks it is best for the children. But the decision to stay in, or return to, abusive relationships is also the result of the larger problems women experience: the scarcity of well-paying jobs, even for women with skills; the absence of daycare; unequal legal protections; the difficulty of maintaining an active social life without a man; and persistence of cultural norms which emphasize a woman's domestic obligations.

The fact that a battered woman returns home does not mean the PA has failed. Violence against women is rooted in the most fundamental political features of our society — remedies for some of which are addressed below — and will not change overnight. The patient encounter may be considered a success if battering has been identified, its sequelae described, and the patient has been made aware of existing resources and of the PA's willingness to support her in utilizing these resources. Research indicates that most abuse victims do eventually leave their assailant, though it may be many months before they act on the options the PA has presented. Even in most cases where no change is visible to the PA, identification and support are important therapeutically.

COMPLEX SOCIAL PREVENTION

This section formalizes the primary and secondary means to prevent battering discussed in previous sections. In addition, it addresses the more basic causes of violence against women by proposing interventions designed to change social, cultural, and physical contexts of violence. However important the identification and referral of individual patients, nonmedical policies and practices may have the greatest impact on prevention.

1. Establish and Implement Model Protocols for the Early Identification and Referral of Abuse Victims in Health Settings.

Activities that might eventually reduce the prevalence of abusive injury by 75% and dramatically impact the incidence of female alcoholism, child abuse, female suicide attempts, and mental illness include: the creation of multidisciplinary intervention teams; the implementation of identification and referral protocols at major nontrauma and nonemergency, as well as emergency, settings; supportive education about available options for victims and assailants; speedy referral to community-based services and aggressive follow-up; and the creation of support services (including shelter) where none are available. PAs and their associations should play a major role in the design, promotion, implementation, and evaluation of model protocols.

2. Introduce Model Units on Spouse Abuse into the Professional Education, Training, and Continuing Education of Health and Social Service Providers.

In an effort to close the "gender gap" in medical and mental health education, relevant materials on spouse abuse should be introduced into the regular professional training of the PA, including Continuing Education Series programs. Such a model unit should emphasize elements of "the new health perspective" required to understand and sensitively respond to the problems raised by abuse.

3. Support the Development of Spouse Abuse Protocols in Secondary Treatment Sites Dealing with Sexual Assault, Alcohol and Drug Abuse, Suicide Prevention, Emergency Psychiatric Problems, Child Abuse, and the Homeless.

Programs dealing directly with the major sequelae of battering, such as alcoholism, attempted suicide, homelessness, or child abuse, rarely if ever select male violence as a primary target for intervention. PAs working in, or making referrals to, such programs should urge local providers of these services to develop spouse abuse identification and treatment protocols.

4. Extend the Range of Options Available to Battered Women.

As the first-line of protection for abuse victims, community-based shelters should receive all possible support from PAs and their associations. In addition, the need for emergency housing and other vital resources should be met by providing "safe wards" in local health institutions; ensuring priority status for abuse victims in public housing; helping to establish "second stage housing" during the transition from shelter to independent living; making abuse victims automatically eligible for disaster relief, disability pensions, and other public assistance programs; and giving victims priority status in Head Start and job-training programs.

5. Increase Our Knowledge of the Causes of Spouse Abuse and Which Interventions Most Effectively Prevent It.

Knowledge of what causes spouse abuse or why woman abuse typically leads to battering is far less extensive than knowledge of the scope and impact of domestic violence. There is a need for critical evaluation of existing services and interventions and for controlled comparisons of various interventions, such as the Minneapolis police experiment.²⁴

6. Give National Recognition to the Criminal Nature of Spouse Abuse with Particular Emphasis on its Health Consequences for Women.

PAs should insist that the national organizations in which they participate or which represent them recognize that the physical integrity of social partners is a basic health right. Awareness must be heightened of the psychosocial costs of violence against women in particular.

7. Decrease the Cultural Acceptance of Violence Against Vulnerable Groups.

There is widespread tolerance for violence among and against certain disadvantaged or vulnerable groups (women, blacks, teenagers, children) based on theories of diminished responsibility for impulsive behavior. These attitudes are shared by many health professionals, including many PAs. Public health education should target beliefs that view interpersonal violence as a legitimate response to jealousy or economic hardship, as well as explanations that blame or otherwise denigrate the victims of violence.

8. Support the Empowerment of Women by Expanding Their Social and Economic Options.

Millions of women become entrapped in violent homes because of limited social and economic opportunities. And many victims of abuse are denied effective access to resources, including health care, to which they are legally entitled by discrimination based on race, income, educational deficits, or gender. PAs must work to ensure equity in existing services and to expand community-based support for abuse victims to include job training, income maintenance, housing, day-care, and special educational components. This support is particularly important during the abuse victim's transition from a shelter to independent living.

9. Make Spouse Abuse Prevention a Major Priority for all Human Resource and Public Health Funding.

Health and Human Services discretionary grant funds, funds for Community Mental Health and Neighborhood Health Centers, and the public health components of the block grant are important sources of direction for local health and human resource efforts. Innovative efforts supported through these programs should include community-wide (or institution-based) surveillance of spouse abuse; programs to reduce the isolation of female heads of household, as well as the isolating effects of tax, assistance, and social service policies; campaigns against misogyny in the media, efforts to provide meaningful social roles for those without salaried work; the provision of better communication and conflict-resolution skills for men (and teenage boys); model school curricula focusing on nonviolent conflict management; support for neighborhood-based mediation programs; and increased living option, particularly for women with children.

10. Focus Patient Education on the Negative Health Consequences of the Traditional Male Role.

Traditional male values and behaviors have been associated with a number of health problems as well as self-destructive behaviors. It is now clear that this role is also a major source of morbidity for women and children. PAs should educate male patients in private, clinic, and hospital settings to the health consequences of their behavior and encourage new models of role flexibility, shared decision-making, and nonviolent means of self-expression.

11. Expand the Options Available to Violent Men.

Health and social services in this country are largely used by, and oriented towards, women. The fact that most interventions to prevent spouse abuse target the victim rather than her assailant reflects the larger issue of creating services with which men identify. While the evidence is far from conclusive, abusive males appear to respond well to behavior-oriented counseling (particularly as an alternative to jail) where they must take responsibility for their violent acts and learn nonviolent means of responding to interpersonal tension. PAs should support and encourage the development of such programs.

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ANNE FITCRAFT, MD

Battered women in your practice?

Domestic violence is a common health problem among women, but the health care professions have a poor record of identifying its victims. Here's how to recognize abuse—and help the patient—in your office.

EXPRESS STOP

Recognizing victims of domestic violence: The problem is widespread in this country, but few health professionals identify or deal with this issue in their practices. The single most important step physicians can take is to incorporate the subject into their routine history for all women. Begin with an acknowledgment that many women experience some kind of violence at home, and reassure the patient that you feel comfortable talking about it. Next, ask an open-ended question such as "What happens when you fight at your house?"

At least 4 million—and perhaps as many as 8 million—women in this country each year suffer physical abuse inflicted by their spouse or partner.* Domestic violence appears to cause more injuries to women than automobile accidents, mugging, and rape combined. The problem occurs with little variation in prevalence in all regions of the country, in all cultural and socioeconomic groups, and among unmarried as well as married couples.

In most cases of domestic violence, women are the victims; however, violence may be a component of any domestic relationship whether male-female, male-male, or female-female, and either partner may be the victim.

VII WOUNDING COURSE/1991

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If domestic violence is so prevalent, you may wonder why you are not seeing it in your own practice. Indeed, the medical profession on the whole has a poor record of recognizing the battered woman; health professionals identify perhaps as few as one victim in 20. Reports are now beginning to appear in the medical literature, but for the most part the problem has been brought to public attention by the women themselves. They have set up shelters, established a nationwide hot-line network, and lobbied for protective legislation. Physically abused women also seek medical care and may be seen in a physician's office, an emergency department (ED), or other facility. Almost 20% of women visiting an ED with injuries received those injuries from a husband or boyfriend. Of patients visiting an obstetric clinic, 25% had been battered.

The discrepancy that exists between the prevalence of domestic violence and what physicians see in their practices occurs in large part because physicians do not routinely ask women if they are in a violent relationship. Just as a thorough history should include inquiries into such life-style issues as smoking, alcohol and drug use, and sexual practices, it should also include questions about violence in the home. And such ques-

tions should be asked of all women patients, not just those presenting with injuries or fitting a certain risk profile. Attempts have been made to delineate a risk profile for domestic violence, but such profiles have been too insensitive to be reliable. Simply asking the patient directly is much more time- and cost-effective than trying to calculate each woman's risk.

Some physicians are concerned about offending patients by asking them about sensitive subjects like domestic violence. But such questions will not seem out of place in an open doctor-patient relationship where all kinds of information are readily exchanged. Too often the physician avoids sensitive issues in an effort to protect the patient's feelings, and the patient tries to protect the physician by not revealing what she considers disturbing information.

You may find it helpful to broach the subject with a statement acknowledging that relationships between adults are sometimes violent. Use specific words like hurt, hit, or threaten rather than a generality like family conflict. Reassure the patient that you feel comfortable discussing family violence and that you may have some suggestions for what she can do about it. Follow this acknowledgment with an open-ended question instead of one that can be answered with a simple yes or no.

For example, you might begin by saying, "We all fight at home. Fighting is part of living together, and sometimes it involves physical violence. What happens when you fight at your house?" Follow up the patient's responses with more open-ended questions. For instance, if the reply is, "We yell at each other a lot," next ask, "And then what happens?" If her reply indicates that the relationship is violent, continue with more open-ended questions that are designed to let the

story unfold, and this will help you initiate the process of exploring the situation.

Sometimes a patient will answer your question by saying something along these lines, "Abuse is not a problem for me, but it is for my neighbor, so please give me the information." You may not be sure who is using the information, but at least you know you are contributing to someone's understanding of this issue.

EXPRESS STOP

Injuries and other manifestations: Although injuries from domestic violence range from minor bruises to homicide, hospitalization is not usually necessary. The central areas of the body are affected more often than the extremities. Multiple injuries and a history of frequent trauma are common. Psychological and sexual abuse are part of the domestic violence spectrum. Other complaints such as low-back pain, sleep disorders, and headache are common as are secondary problems such as alcoholism, drug abuse, suicide attempts, and child abuse.

The extent of injuries in domestic violence ranges from those leaving no mark on the body through homicide. Most of them do not necessitate hospitalization, however. Contusions, lacerations, and abrasions are most common and usually affect the central part of the body—the head, the face, the neck, the breast, and the abdomen. If the patient has multiple injuries, domestic violence is more likely to be the cause than if she has only one injury. Yet it is important to keep domestic violence in mind when you find any evidence of trauma.

Because domestic violence is rarely an isolated occurrence, ask about previous injuries. Physical examination may show evidence of past injuries such as scars or a deviated septum. The medical history may include several ED visits for trauma. A woman not involved in a violent relationship

may be seen in the ED only 2-3 times in her life; the one in a violent relationship may have been seen 2-3 times within the past year. Even when the injury is relatively minor, she may seek treatment in an ED because it is a safe environment.

In cases where a history of frequent injury suggests domestic violence, avoid focusing on the specific circumstances of each incident. Rather, as suggested earlier, reassure her that you feel comfortable dealing with the issue, and ask directly whether violence is a part of her home life.

The office-based physician is especially likely to see manifestations of domestic violence other than physical injury. The stress engendered by a violent relationship can bring a woman to your office with any of a variety of complaints, such as musculoskeletal pain, low-back pain, headache, chest pain, abdominal complaints, sleep disorders, eating disorders, anxiety, depression, and chronic pain syndrome. While symptomatic treatment of these problems may sometimes be necessary, the underlying problem of domestic violence must be identified and acknowledged.

Domestic violence includes a spectrum of experiences including injury, threats of injury, rape or sexual abuse, and psychological abuse. An underlying principle is that domestic violence uses injury and the threat of abuse or injury to control the victim's behavior. Some patients experience the whole abuse spectrum, others just one or two parts of it.

Secondary problems associated with domestic violence include alcoholism and drug abuse. In addition, 10% of battered women attempt suicide—many of them doing so more than once—so it is important to evaluate these patients for depression and feelings of hopelessness.

EXPRESS STOP

Assessment of immediate needs: Tell the patient you are glad she told you about her problem, assure her that help is available, and assess her immediate safety needs. Make sure she has the hot-line number. Other indications of risk of serious injury are the introduction of weapons, violence to the children, threats against the patient or her children, and pregnancy. Ask if she is safe tonight; if not, explore options for refuge, referring her to a shelter if necessary. Establish a working relationship with a nearby shelter ahead of time.

Once a victim of domestic violence has been identified, you must decide how far along in the assessment and intervention process you are able to proceed and when you want to refer. At a minimum, acknowledge her problem, assess her immediate needs for safety, and let her know help is available. Make sure she has the hot-line number for victims of domestic violence (see "Toll-free hot line"), as well as any local hot-line number. Since you may be the first medical professional with whom she has shared this information, let her know that you are glad she told you about it because now you can provide better care for her. Tell her that no one has the right to hurt her and that assault is against the law.

To assess her immediate need for safety, find out the extent of the violence. There is

Toll-free hot line

The National Coalition Against Domestic Violence operates a hot line that provides information, confidential conversation about options and safety, and referrals to state and local programs.

- The number of this national domestic violence hot line is (800) 333-SAFE.
- For the hearing impaired it is (800) 873-6363.

no hard-and-fast rule that domestic violence begins at a minor degree and gradually escalates. The best indication of whether the patient is at risk of serious injury is her answer to the question, "Are you safe tonight?" Also inquire about the safety of any children in the home. If there are indications of child abuse, initiate the reporting process as required by law, in addition to providing for the safety of the battered woman and her children.

As part of your assessment of the patient's safety, ask if there are weapons in the home and if the abuser has ever used or threatened to use a weapon against her. Homicide data indicate that domestic violence involving weapons is more likely to lead to serious injury or death. Other warnings of escalat-

ing violence are the extension of violence to include the children, verbal threats to kill or seriously injure the children or the woman herself, and sexual abuse.

Pregnancy clearly tips the scales. The imposition of a new family member causes an imbalance in any stressful relationship. In a violent relationship, this imbalance generates more violence. Some women report the violence diminishes during pregnancy, but escalates after delivery. Others report that the violence begins or escalates during pregnancy.

Although a negative answer is rare to your questions about immediate safety, be prepared to help the patient who says she is not safe. Do not question her sense of danger or try to minimize or rationalize the dan-

Some dos and don'ts of treating family violence

DO ...

- Ask all women patients about violence in the home.
- Tell the patient you feel comfortable discussing family violence and may have some suggestions for what she can do about it.
- When you suspect violence, assess the patient's and children's safety, let her know help is available, and discuss options for refuge
- Make sure suspected victims of abuse have the toll-free hot-line number.
- Establish a working relationship with the local women's shelter.
- Know your state laws, inform patients of them, and direct patients to the agencies that can help.
- Assess the situation at each visit.
- Use neutral but descriptive language in the medical record; consider making a sketch of the body and marking injury sites with x's.

DONT ...

- Avoid sensitive issues in an effort to protect the patient's feelings.
- Ask questions that can be answered yes or no.
- Forget that such symptoms as low-back pain, abdominal complaints, sleep disorders, headache, anxiety, and depression may be manifestations of family violence.
- Question the patient's sense of danger if she says she is not safe.
- Recommend couples therapy if the woman is battered.
- Insist that the patient terminate the relationship—she alone can make that decision.
- Use such words as alleges in the patient's record; it may suggest you don't believe her.

ger. Help her explore options such as staying with friends or relatives. Ask what she has done in the past to find safety and what happened then. Did her partner follow her and threaten her?

If a woman in danger has no place to go, if leaving home escalated the violence in the past, or if she is afraid to leave because she thinks it will escalate the violence or her partner will follow her, the situation is a crisis and generally too big to handle in your office. You will be prepared for this eventuality if you have established beforehand a working relationship with a nearby shelter for battered women. Shelters can be found in many communities; they usually have such words as shelter, domestic or family crisis or violence, or battered women as part of their names. Personnel at the agency will help you plan the steps you should take when a woman comes to you in need of immediate protection.

EXPRESS STOP

Further assessment and intervention: Explore the domestic situation and its effects on the patient and children. Discuss and provide information about options such as shelter organizations and legal avenues. Do not recommend family therapy. Remember that terminating the relationship is the patient's decision, not yours. Ask about the problem at each subsequent visit. Use neutral language in medical records, and include sketches or photographs of injuries.

If the patient says it is safe for her to go home, help her examine her situation or refer her to someone who can. Questions to facilitate the assessment include, "How has the problem changed over the years? How do you feel about yourself now compared with when you first married? How do you feel about your future? How is the violence affecting your children? How have you managed to control the violence? Have you ever

called the police? Have you talked with a member of the clergy?" If she describes changes in her behavior as attempts to avoid violence, ask her if these strategies have worked.

Next help the patient explore her resources such as shelter organizations and legal avenues. Even if she does not want to leave the relationship immediately, encourage her to contact a local shelter organization. Among the resources provided by shelters are self-help groups, which provide the opportunity for her to talk with others in similar situations. Shelters are also of benefit to children, who even if not physically abused are observers of the domestic situation.

Assault is against the law in every state, and most states have specific laws regarding domestic violence that provide victims with resources such as temporary restraining orders.* Inform the patient about your state laws, and direct her to the agencies that can give her the information and assistance she needs.

Couples counseling or family therapy is rarely appropriate as an initial approach. Couples counseling is an option only when the man acknowledges the problem and expresses a desire to change his behavior, when the woman feels safe, and when both partners have a strong desire to maintain the relationship. Most often, however, she is ambivalent about staying, and he denies the problem or expresses no desire to change. In such cases, joint counseling, even if the man agrees to attend the sessions, can be detrimental if the batterer uses the information and feelings that the woman shares in counseling sessions against her. Counseling may

*No state has mandatory reporting requirements for domestic violence between adults as for child abuse. In some states, however, you are obligated to report it for statistical purposes, so it is important to be familiar with your state's laws.

become an adjunct to the violence in such circumstances.

When the issue of domestic violence arises unexpectedly during an appointment made for another reason, you may be concerned about the effect on your schedule if you give the problem all the time and attention it needs. Once you have ascertained that the patient and any children involved will be safe, explain your situation. Spend a few minutes to let her know that you realize the importance of her problem and that it not only affects how she feels about herself but also threatens her health and well-being. Encourage her to make an early appointment to return so you can discuss the problem fully. Again, make sure she has the hot-line number.

Although the patient may find resources outside your office to help her cope with or change her situation, it is important to assess domestic violence at each subsequent visit. Sometimes the violence escalates in spite of efforts to end the relationship, and she may need help exploring other options, such as moving to a shelter.

Keep in mind that terminating the relationship is a decision the woman, not the physician, makes. Physicians often become frustrated when patients do not handle situations promptly. In such cases, the physician may "prescribe" changes that the woman "should" make and thus may subtly mimic the domestic dynamics.

Instead, your role is to help her assess the relationship and recognize when it is time to initiate change. Each woman tries a series of strategies to deal with her situation and in the process continually evaluates the issues in the relationship and her own sense of self. If the patient stays in a violent relationship, at each visit focus on her strategies for avoiding and minimizing violence,

review a safety plan, and assess for changes in danger.

When making an entry about domestic violence in the patient's medical record, be mindful that you are putting together a data base that may be used in court. When bruises and abrasions heal, your record is all the evidence that remains. Use neutral but descriptive language. Avoid using words like alleges that imply you do not believe what the patient says. Consider making a sketch of the body and marking injury sites with x's. If your practice is set up for photography, include photos of the injuries. □

PREPARED BY REBECCA SKINNER BORGATTI

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Some dos and don'ts of treating family violence

DO . . .

- Ask all women patients about violence in the home.
- Tell the patient you feel comfortable discussing family violence and may have some suggestions for what she can do about it.
- When you suspect violence, assess the patient's and children's safety, let her know help is available, and discuss options for refuge.
- Make sure suspected victims of abuse have the toll-free hot-line number.
- Establish a working relationship with the local women's shelter.
- Know your state laws, inform patients of them, and direct patients to the agencies that can help.
- Assess the situation at each visit.
- Use neutral but descriptive language in the medical record; consider making a sketch of the body and marking injury sites with x's.

DON'T . . .

- Avoid sensitive issues in an effort to protect the patient's feelings.
- Ask questions that can be answered yes or no.
- Forget that such symptoms as low-back pain, abdominal complaints, sleep disorders, headache, anxiety, and depression may be manifestations of family violence.
- Question the patient's sense of danger if she says she is not safe.
- Recommend couples therapy if the woman is battered.
- Insist that the patient terminate the relationship—she alone can make that decision.
- Use such words as alleges in the patient's record; it may suggest you don't believe her.

ANNE FITCRAFT, MD

Battered women in your practice?

PATIENT CARE / OCTOBER 15, 1990

Domestic Violence Training Project
A Program For Health Professionals

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ABUSED WOMEN AND CHRONIC PAIN

BY JOEL D. HABER

A patient who had had surgery for reflex sympathetic dystrophy was referred to my colleagues and me at The University of Alabama in Birmingham Hospital (UAB) Pain Service. After many medical evaluations and treatments (including psychiatric consultation), she continued to see several physicians for relief of pain. During a supportive, nonthreatening interview, she revealed extreme fear and embarrassment concerning her marriage. After acknowledging her feelings and assuring her that we would keep her problems confidential, we told her that we knew she was suffering from some type of trauma. Although she had seen over 30 different physicians, this was the first time that she had admitted that her husband severely abused her both physically and sexually. Later, we found that gentle but persistent questioning helped many other women to admit traumatic histories of abuse.

To investigate the problem of abuse in women with chronic pain, we questioned all women who made initial visits to the UAB pain service between October 1983 and May 1984 about abuse as part of their psychological evaluation(1). Women who were abused one time were eliminated from the study at this point, and both those who were clearly abused and those who were not abused were then categorized by location of pain: low back pain, headache, abdominal pain, and "other" pain (for example, leg pain or multiple site pain). Eighty-two percent of the subjects in our sample fell into the "low back pain" and "other" categories, which contained approximately equal numbers of abused and non-abused women.

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The results of this study revealed that 53 percent of the 150 women who presented to our hospital-based chronic pain center showed a history of physical and/or sexual abuse. Surprisingly, the large majority of these women (78%) were first abused during marriage. The mean number of years women were abused was 12. In the sample, 100 percent of the pain problems followed incidents of abuse; however, it should be noted that a clear causal link cannot be established between abuse and chronic pain until more research is conducted.

Although the majority of abused women with pain problems in our sample sought medical attention repeatedly, most had never discussed their abuse with a health care professional, friends, or family. These women reported that health care professionals never asked whether abuse was a problem for them. When women were questioned, they often denied previous problems, and their embarrassment or fear was evident. In fact, the abused women were much more likely than the non-abused women to deny psychological distress, which made detection of abuse that much more difficult. As a result, social and psychological factors had never been examined in relationship to their chronic pain problems.

The large percentage of women in our sample with chronic pain who reported a history of abuse suggests

that this same phenomenon may be found in similar proportions at other pain services. Many professionals have indeed reported to us that they have identified abuse in women experiencing chronic pain, but have not documented the extent of this problem or systematically evaluated it. Further, the abused women in our study demonstrated more health problems than the non-abused women, and are probably seeking other types of health care services.

Because of the continuity of care they provide, nurses are in a position to provide information critical to understanding problems of abuse. Thus, they may be able to help patients break a chronic chain of seeking health care. The nurse can create an atmosphere of trust and confidentiality so the patient may be less afraid to reveal embarrassing information.

When asking about trauma, it is important to tune in to facial expressions or vocal hesitations that may suggest a problem. As psychologists, we tell each woman that many women with pain problems have had serious difficulties either in their childhoods with abusive parents or during their marriages with abusive spouses. This may help to allay the woman's fear that her problem is unique. The health care professional can then try to trace the link between trauma and the development of health problems. The more time the nurse spends developing rapport with a patient, the greater the chance that the patient will continue to see a caring health professional.

We need documentation of this phenomenon of abuse in pain patients as well as in patients with other health problems. Future research should address experimental techniques for eliciting basic information about the victim as well as about the perpetrator of abuse. The point, though, is that chronic pain is a real event, involving both physical and psychosocial elements.

**PROTECTING MOTHERS; PROTECTING
THEIR CHILDREN**

Identifying and Helping Battered Pregnant Women

Because battering during pregnancy is a frequent occurrence, nurses must routinely assess women for injury during prenatal visits.

BY BARBARA PARKER/JUDITH MCFARLANE

Numerous studies document battering and injury to American women. In 1980, for example, one in three women were found to have experienced intentional injury in the form of battering by their male partner (1). Moreover, studies of battered women report that 40 to 60 percent of these women were abused during pregnancy (2,3). Abuse during pregnancy includes blows to the abdomen, injuries to the breast and genitals, and sexual assault. Many battered women report miscarriages, stillbirths, and preterm deliveries (1,4). Among 542 battered women interviewed in a Dallas shelter, 42 percent said they had been battered while pregnant and 8 percent had complications (5). Battering was reported by most to become more acute during the pregnancy and the child's infancy.

A national telephone survey of 8,002 households in 1986 revealed that the risk of pregnant women having experienced violence during the previous year was 60.5 percent greater than the risk of women who were not pregnant (6). Similarly, men with pregnant wives or partners more often reported being violent toward their partners than did men whose wives were not pregnant at the time of the interview.

Although most reports on battering during pregnancy have been secured from battered women in shelters, two reports are notable exceptions (7,8). In both studies pregnant women were interviewed in public and private clinics. In one study, 290 women were interviewed (7). The women ranged in age from 18 to 43 years and the majority were married. Battering during the current pregnancy was reported by 8 percent (one

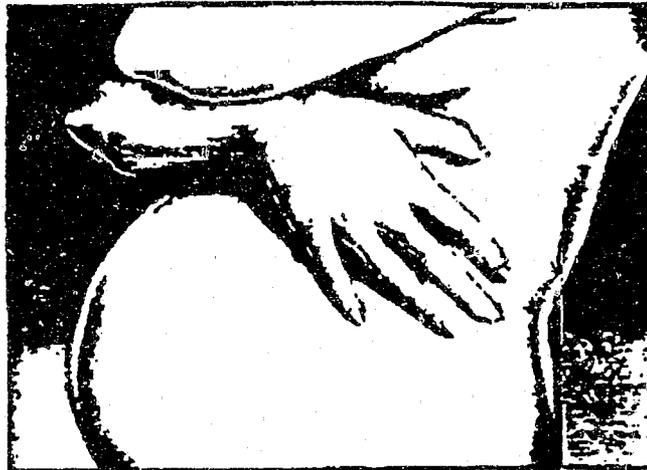
out of 12) of the women interviewed. An additional 15 percent reported battering before the current pregnancy. One-third of the women battered during pregnancy sought medical attention for injuries; 29 percent reported that abuse increased after their partner learned about the pregnancy.

In the second study, 742 prenatal patients were screened (8). Reports indicated that 10.9 percent of the women were abused during their present or a past relationship and that 3.9 percent were abused during their current pregnancy. The difference in prevalence revealed in the two studies may be due to the interview process: Anne Helton and her associates in the study of 290 women asked nine questions; Paula Hillard in the study of 742 asked one abuse-focused question.

Pregnant teenagers also report battering. Indeed, surveys record a higher prevalence during adolescent pregnancy than during adult pregnancy. A survey done in two schools for unwed pregnant teenagers revealed that 26 percent of the young women had male partners who were physically abusive. Among the pregnant teens who were

abused, 40 to 60 percent stated that the intentional injury had either begun or escalated since the partner became informed of the pregnancy. In addition, 65 percent of the women had not talked with anyone about the abuse, and one had reported injury to law enforcement agencies (9, 10).

Because birth weight is the most important determinant of infant survival and healthy growth and development, a study was done to determine if battering before or during pregnancy affects infant birth weight. During random interviews with 589 postpartum women in private and public hospitals, mothers were asked if they had been physically abused (10). In the private hospitals 17.5 percent of the women who said



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they had been battered delivered low-birth-weight (1,500 grams) infants, compared with 4.2 percent of the women who said that they had not been battered. The study documented a statistically significant association between battering and low birth weight.

An Approach to Assessment

Pregnancy is one of the few times that healthy women routinely interact with the health care system. Because women may not volunteer information regarding abuse, assessment for abuse must become incorporated into routine prenatal assessment. Nursing assessment of abused women must be conducted privately with assurances of confidentiality. A nonjudgmental, gentle approach is essential, but at the same time, questions must be direct. (See Abuse Assessment Screen.)

Women who have been battered often feel responsible for the violence. They may also have feelings of shame and embarrassment and use denial as a means of coping. For that reason, rapport between the nurse and the survivor of abuse is essential.

If during assessment a woman states that battering has occurred, the nurse's responsibility is to intervene. At a minimum, all agencies should have referral sources available as well as information about legal and criminal

options. A nurse must be familiar with state reporting procedures and be available to assist a woman if she wishes to file a report. Information about local laws and ordinances can be determined, for example, by contacting shelters or intervention programs in the area. Most programs welcome the opportunity to provide continuing education classes for nurses, because they recognize that many referrals are initiated by nurses.

Occasionally, women report violence but attempt to minimize its frequency or severity. They blame themselves or the use of alcohol by themselves or their partner, or they assert that the violence was temporary aberrant behavior caused by family difficulties or unemployment. "Forgetting" and minimizing have been noted to be effective coping strategies, especially if sexual abuse is involved (11). For example, if a woman believes that others will not define her problem as seriously as she does, minimizing the event in her own mind will make her feel less alienated from others (12).

The most important consideration in the initial assessment of a woman who is battered is determining her safety. Because both the frequency and severity of violence usually escalate over time, the potential for a lethal outcome is a frightening reality. The majority of female homicide victims in this country are killed by a hus-

ABUSE ASSESSMENT SCREEN

1. Have you ever been emotionally or physically abused by your partner or someone important to you?

YES NO

2. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?

YES NO

If YES, by whom _____

Number of times _____

3. Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?

YES NO

If YES, by whom _____

Number of times _____

Mark the area of injury on body map.

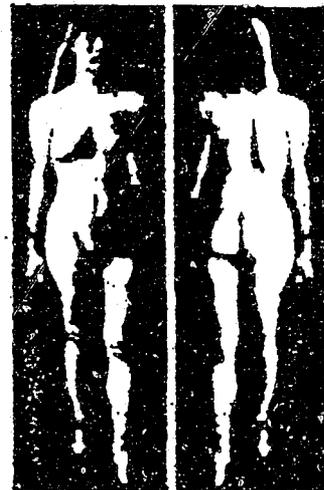
4. Within the last year, has anyone forced you to have sexual activities?

If YES, who _____

Number of times _____

5. Are you afraid of your partner or anyone you listed above?

YES NO



*Developed by the Nursing Research Consortium on Violence and Abuse of which both authors are members. 1989. Readers are encouraged to reproduce and use this assessment tool.

DANGER ASSESSMENT

Several risk factors have been associated with homicides (murder) of both batterers and battered women as a result of research that was conducted after the killings took place. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of severe battering and for you to see how many of the risk factors apply to your situation. (The "he" in the questions refers to your husband, partner, ex-husband, ex-partner or whoever is currently physically hurting you).

Please circle YES or NO for each question below.

- | | | |
|---|-----|----|
| 1. Has the physical violence increased in frequency over the past year? | YES | NO |
| 2. Has the physical violence increased in severity over the past year and/or has a weapon or threat with a weapon been used? | YES | NO |
| 3. Does he ever try to choke you? | YES | NO |
| 4. Is there a gun in the house? | YES | NO |
| 5. Has he ever forced you into sex when you did not wish to do so? | YES | NO |
| 6. Does he use drugs ("uppers" or amphetamines, speed, angel dust, cocaine, "crack," heroin, mixtures, or other street drugs)? | YES | NO |
| 7. Does he threaten to kill you and/or do you believe he is capable of killing you? | YES | NO |
| 8. Is he drunk every day or almost every day? (In terms of quantity of alcohol). | YES | NO |
| 9. Does he control most of your daily activities? For instance, does he tell you who you can be friends with, how much money you can take shopping, or when you can take the car? | YES | NO |
| 10. Have you ever been beaten by him while you were pregnant?
(If never pregnant by him, check here.) | YES | NO |
| 11. Is he violently and consistently jealous of you?
(For instance, does he say, "If I can't have you, no one can.") | YES | NO |
| 12. Have you ever threatened or tried suicide? | YES | NO |
| 13. Has he ever threatened or tried suicide? | YES | NO |
| 14. Is he violent toward your children? | YES | NO |
| 15. Is he violent outside the home? | YES | NO |

Total YES answers _____

THANK YOU. PLEASE TALK TO YOUR NURSE, ADVOCATE, OR COUNSELOR ABOUT WHAT THE DANGER ASSESSMENT MEANS IN YOUR SITUATION.

Reproduced from CAMPBELL, J. Nursing assessment for risk of homicide in battered women. ANI 6:38-51, 1988. Used with permission.

band, lover, ex-husband, or ex-lover. Moreover, a battered woman is in more danger of being killed by her abusive partner if she leaves him or makes it clear to him that she is ending their relationship (12). Risk factors of homicide include a handgun in the house, substance abuse, extreme jealousy, and battering during pregnancy.

An instrument has been developed to use in assessing the potential for homicide (see Danger Assessment). The instrument lists risk factors that are statistically associated with homicides of both battered women and batterers. Although it is currently unknown if some items indicate more risk than others (research is currently being conducted to help make those determinations), the instrument may be used to assist a woman to objectively evaluate the safety of her current relationship.

Intervening with survivors of abuse can be difficult. Women who are battered have as much difficulty terminating a relationship as women who have not experienced abuse (13). A woman, therefore, will often remain in an abusive relationship, especially if her partner is remorseful or promises to change his behavior. Such a woman requires as much, if not more, support and counseling.

It may be necessary for a nurse to assist a woman in objectively evaluating the strengths and limitations of her relationship with her partner. The nurse will need to employ problem-solving and decision-making skills when a woman is experiencing intense confusion or feeling conflicting loyalties. One approach is for the nurse and the survivor to brainstorm various options; for example, remaining in the home and seeking help for herself and/or her spouse, or remaining in the home and attempting to anticipate the violent attacks in order to protect herself and her children, or leaving the relationship either temporarily or permanently. When a complete list of options has been generated, the nurse and client together can determine the positive and negative consequences of each option and select the best alternative. If a woman decides to remain in the relationship, intervention will then focus on ways to recognize imminent violence and how to protect herself and her children.

Planning to Leave

When a woman decides that her situation is not going to change, she may be ready to make long-term decisions. With the nurse's assistance, the woman will make decisions such as when she should leave, where she will go, and which of her possessions she will take. The practitioner can discuss available resources and perhaps supply a list of shelters for abused women. Information about police protection and legal resources is also important for the woman to have. In many states, for example, an abused woman can obtain a restraining order from the police or have police protection while she is removing her belongings from the home. Once again, it is critical for nurses to be familiar with local laws and services. The nurse also needs to be aware that the most dangerous time for a woman is after she has left her abuser (12). Therefore, plans need to be carefully made to avoid

having to make last-minute crisis decisions.

Often the plan for leaving a violent relationship includes staying at a shelter for battered women. Every state has shelters where temporary housing and counseling are available. A national toll-free telephone number (1-800-333-SAFE) may be called to get information regarding abuse and the telephone numbers of local shelters.

The nurse needs to inform the woman who is planning to leave her home about the limitations of shelters. Because most shelters for abused women are overcrowded and have a "waiting list," a woman cannot wait until a crisis and expect to immediately find space in a shelter. Before she leaves home, a woman must contact a shelter and place her name on a waiting list. If her home is too dangerous to remain in, she might need to make temporary arrangements with a friend or relative or stay in a shelter for homeless people. Then it will be necessary to call the shelter for battered women every day to determine whether space is available.

A Matter of Routine

The Surgeon General recommends routine assessment for physical and sexual abuse during the prenatal period (14). Nurses have developed assessment tools for this purpose and protocols of care, and now must make assessment for battering an integral part of the routine nursing history (10,15,16). Therapeutic nursing interventions are the key to preventing further abuse and promoting the health and well-being of the mother and the child.

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THE CHILDREN OF BATTERED WOMEN¹⁹

Children of battered women have often witnessed terrifying acts of violence and violent threats against their mothers. For some children, the emotional effects of observing one's mother being battered are similar to the effects of being abused directly. A high percentage of children of battered women have themselves been victims of violence and sexual abuse. A 1980 study of battered women conducted by the U.S. Department of Health, Education, and Welfare found that half of the women interviewed reported that their children were either physically or psychologically abused by their fathers.

It is commonly assumed that battered women take out their anger and frustration by battering their children. However, there is no evidence to suggest that a large percentage of battered women abuse their children.

For many women, the batterer's violence toward her children is the catalyst that motivates her to seek assistance and refuge. For others, violence against the children tightens the batterer's control over the woman. Batterers frequently threaten that the woman will be blamed for the child abuse and lose custody of the children if she seeks help.

If the child is being abused, follow the medical protocol for examining, treating, and reporting to the Department of Social Services (see the following two sections). If the child is not being abused but has witnessed the abuse of his or her mother, he or she may need to talk about it with a trained counselor. If the woman is going to a shelter, encourage her to explore the services the shelter offers for children. If the woman is not ready or able to use a shelter, encourage her to seek outpatient counseling for the child in her community. If the woman believes the batterer will be amenable to attending a batterer treatment program, the children may benefit, as part of the treatment program compels the abuser to identify and discuss the effects of violence on the children.

Identifying Battered Women through Their Children²⁰

Battered women may indirectly seek help for their situation by presenting with their children. It is crucial that mothers of children presenting for actual or suspected abuse be interviewed **in private** about the circumstances of the child's abuse or neglect as well as about any abuse that the mother herself has experienced. Identification of woman battering has tremendous potential to help both the mother and the children. Blaming the mother for the abuse will probably prevent her from trusting and confiding in you.

The following situations should make the pediatric provider suspect woman abuse:

- frequent pediatric visits;
- visits for seemingly insignificant or vague complaints;
- late evening or night visits;

¹⁹ Adapted in part from Liz Roberts and Rachel Burger, "The Politics of Supporting Children," in *For Shelter and Beyond: Ending Violence Against Battered Women and Their Children* (Boston: Massachusetts Coalition of Battered Women Service Groups, 1990), pp. 93-113.

²⁰ Adapted from Boston City Hospital Emergency Department's "Acute Management of Battered Women/Adolescents," p. 10.

- concerns about the child's behavior;
- mother's partner is hypervigilant, controlling and verbally abusive, accuses the mother of neglect or incompetence;
- mother has obvious injuries.

Because the child's father, who is potentially the batterer, has access to the child's medical chart, it is critical that documentation of the mother's injuries appears in her own chart, not in the child's.

Reporting to the Department of Social Services ²¹

When the battered woman has children, the clinician must decide whether or not to file a report (51A) to the Department of Social Services (DSS). The decision to file can have a tremendous impact on both the mother and the child and is usually not clear-cut. When there is reason to believe that a child is seriously at risk either because the mother is abusive or because she is planning to return to a batterer who also abuses the child, you are required to file a 51A. Filing is also mandatory in cases in which the child has sustained injuries as a result of the battering.

Many battered women are adequately protecting their children, so it is important to do a careful assessment before involving DSS. For less clear-cut cases, the following questions will help the mother and the health care provider assess the child's safety:

- Does the batterer have access to the children?
- Are there weapons available to the batterer?
- Is the batterer or the mother abusing drugs or alcohol?
- Has the batterer threatened homicide or suicide?
- Has the batterer ever threatened to hurt or kill the child?
- Has the batterer ever removed or threatened to remove the child from the mother's care?
- Has the child ever witnessed the batterer abusing the mother, either physically or verbally?
- Has the batterer hit the child with belts, straps, or other objects which have left marks, bruises, welts, or other injuries?
- Has the batterer ever touched or spoken to the child in a sexual way?
- Has the child tried to intervene to protect the mother from the batterer? Was the child injured as a result?
- Has the child tried to run away?

²¹ A portion of this section was adapted from Boston City Hospital Emergency Department's "Acute Management of Battered Women/Adolescents," p. 11.

- Has the batterer ever assaulted the woman when she was holding the child?
- Has the child ever been unintentionally harmed when objects were thrown or weapons used in the home?
- Has the child ever tried to hurt him/herself or pets, or destroyed possessions?
- Is the child anxious or fearful upon leaving the mother (beyond the age at which this reaction is considered normal behavior)?
- Does the child's teacher, babysitter, or day care provider complain about the child's behavior (fighting, destroying property, not paying attention, withdrawing)?
- Has the mother attempted to protect her children by formulating a safety plan, seeking help, and utilizing services?

You should discuss your concerns about the children with the mother. In all cases the focus should be on keeping the child safe and enabling the woman to get real and appropriate help.

If you decide that a 51A report is warranted, call the DSS Hotline at 1-800-792-5200 to make a verbal report and obtain instructions on how and where to file a written report. Tell the DSS worker on the hotline about the battering and danger to the woman as well as to the children.

Tell the woman you are filing a 51A and ask the following questions as a guideline for risk assessment and safety planning:²²

- Ask the mother how she thinks the father will respond.
- Ask if this situation has happened in the past (i.e., any prior 51A filings or other outside agency involvement) and what the father's reaction was.
- Ask her whom she would like to inform the father about the filing (does she want to do it, would she like the hospital staff to do it, does she want to be present when he is told?).
- Encourage her to call you (or someone on your staff whom you know will be available) if any problems arise.

Follow through with the full risk assessment and safety planning protocol discussed in Section 10.

²² Adapted from "Guidelines for Safety Planning" developed by Advocacy for Women and Kids in Emergencies (AWAKE), Children's Hospital, Boston, MA.

Violence

U P D A T E

A Monthly Newsletter Dedicated to the Continuing Education of Professionals in the Field of Interpersonal Violence

FEATURE

Impact of Spouse Abuse on Children of Battered Women

Implications for Practice

by Honore M. Hughes
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Literature regarding children of battered women is sparse, with the results from research primarily accumulated over the last 10 years. Many people do not realize that when spouse abuse occurs in a family, the children are also very likely to be negatively affected. The most accurate description of these unwilling observers—the “unintentional victims”—is that they are emotionally abused. Recently, critiques and summaries of this area have begun to appear, and much of the following article is based on two reviews by Hughes (1, 2).

At this time, investigations in this area have progressed beyond the descriptive and clinical anecdote stage. Researchers working actively in this area are using standardized instruments and appropriate comparison groups. However, the samples of families studied have been mostly limited to low-income families and to those who sought refuge from violence at shelters for battered women or who have requested treatment for marital violence.

Prevalence

To briefly review, researchers' best estimates regarding the prevalence of spouse abuse range from 10% to 30% of couples. Even with the most conservative estimates, 10% to 15%, it is clear that a substantial number of children live in violent homes. When investigators ask women who have been beaten where their children are while they are being assaulted, in 90% of the cases the children are either in the same room or in the next room.

Impact

Although the data base regarding the impact of observing spouse abuse is relatively small, there is sufficient evidence to state that for children, being exposed to parental violence is a traumatic experience. On standardized behavior problem checklists, mothers describe high levels of problematic

behavior in their children. Consistent differences between children of battered women and comparison children in both internalizing (e.g., depressed, anxious) and externalizing (e.g., aggressive, dis-

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obedient) behaviors have been found, with both behavioral and emotional problems significantly higher in the children of battered women. Other difficulties that have been reported include (a) an increase in somatic symptoms, (b) lower cognitive skills and school achievement, (c) difficulties with social problem solving, and (d) tendencies to be more external in locus of control.

Focusing more on personality development, clinicians have also discussed the disruption that occurs in personality development when developmental stages are interrupted by violence in the family. For many, Erik Erickson's psychosocial stages of personality development have been helpful in understanding the problems experienced by violent families. His first and most basic stage, that related to the development of trust in other people, is the one most frequently mentioned by clinicians as being disrupted by family violence.

Severity of Impact

Other than high mean scores, another way to examine the impact of spouse abuse on the children is to look at the proportion of children who are reported to exhibit more severe difficulties, problems that are beyond those of the normative group for the measure. The Child Behavior Checklist (CBCL), one of the most commonly used instruments, provides T-scores and percentiles for age

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and gender; thus shelter children can be compared with the normative sample on extent of problems.

Several researchers have investigated the percentage of children in shelter samples who have CBCL scores above the cutoffs that indicate a need for clinical services. Depending on the gender of the child, the type of violence experienced, and the T-score used as the cutoff, the percentages reported indicate that from 25% to 65% of shelter children receive scores above that clinical level. On the average, approximately 35% to 45% of shelter children fall above that cutoff.

Mediating Variables

In terms of factors that influence the psychological adjustment of individual children, investigators in this area have stressed the importance of identifying variables that mediate the impact of domestic violence on the children. The list of potential mediators has been adapted from a number of sources (1, 2) and includes both child and situational/contextual factors (see box). The variables that have received the most in-depth examination are past experience with violence, and gender.

Type of Violence Experienced

Researchers in the area of family violence have quite consistently found that the co-occurrence of different types of violence is rather high, with estimates in the 40% to 60% range. As an example, available evidence from shelters and treatment programs indicates that 50% to 60% of the observers of domestic violence have also been physically abused themselves. Thus, in violent homes, chances are about 1 in 2 that if child abuse is present, spouse abuse is also likely to be occurring, and vice versa.

Based on research I conducted, results indicate that past experience with different types of violence does seem to make a difference in psychological adjustment: The more types of violence children are exposed to, the less well adjusted they will be. Thus type of violence experienced seems to be an important mediator in children's adjustment.

Gender

A differential impact on the psychological adjustment of children in shelters based on gender seems to appear in a manner that is inconsistent with previous literature on influences of gender on psychopathology. Most researchers in this area find that both shelter boys and shelter girls receive high mean scores on both internalizing and externalizing behaviors. Moreover, when severity of impact is investigated using clinical level cutoffs based on those same behaviors, again both boys and girls are high on both types of problems. It is interesting to note that this pattern is contrary to the traditional gender-role-related pattern of behavior

problems, wherein boys showed externalizing type — and girls exhibited internalizing-type difficulties.

Mechanisms by Which Conflict Exerts an Impact

In terms of a framework for understanding the impact of spouse abuse on children and the influence of mediating variables, my adaptation of Gryc and Fincham's (3) discussion of marital conflict and children's adjustment suggests that we look at direct and indirect mechanisms. Under *direct mechanisms* fall (a) modeling of aggressiveness and (b) stress in the family.

Regarding the fact that both boys and girls exhibit internalizing and externalizing symptoms, the aggressiveness on the part of both genders likely has been acquired through modeling. Their fathers are strong, powerful models who obtain what they want through aggressiveness. In contrast, the children's anxiety and depressive-type symptoms are apt to be a result of the stress the children feel from the spouse abuse. Jaffe, Wolfe, and Wilson (4) point out that many of the signs of distress in children of battered women are very similar to posttraumatic stress disorder (PTSD) symptoms.

Indirect mechanisms of influence include (a) characteristics of the parent-child relationship (for example, quality of attachment or emotional availability) and (b) disciplinary practices (e.g., those that are exceedingly negative, harsh, inconsistent, and so on). Related to the former, the parent-child relationship can be influenced by many factors, but one of the most important is the mental health of the mother. A common effect of being beaten is depression, with the result being that the abused woman is often emotionally unavailable. Thus the quality of attachment and the parent-child relationship are at risk for being negatively affected.

The second indirect mechanism of influence concerns disciplinary practices. Again, many variables can enter into this equation, depending on the length of time there has been physical violence between the parents, whether violence has been directed at the child, how much parenting is done by either parent, and the effectiveness of the parenting. Inadequate parenting in the form of very inconsistent and/or harsh discipline puts children at especially high-risk for behavioral and emotional problems.

Research Questions

Because so little empirical research has been conducted with children of battered women, there are multiple subareas that need extensive investigation. It is clear that, in addition to searching for variables that mediate the impact, empirically testing the proposed model for the mechanisms of influence, and studying more diverse samples, the

major task for researchers is to examine the effectiveness of different treatment approaches.

Intervention with children of battered women is the area in which there is probably the smallest amount of literature available. Most of the information is based on clinical experience; therefore we have little empirically tested information to guide our clinical work. The few interventions that have been published have assessed outcome informally, although the results look promising. More types of treatment, including crisis intervention, need to be evaluated, and in a more formal, standardized manner.

Several clinical descriptions of interventions have been published (e.g., 4), with the majority of them developed for school-age children using a time-limited group format. Jaffe et al. have informally evaluated their group approach from the children's, mothers', and clinicians' perspectives and recommended it as appropriate for mild problems. In addition, they suggested the group be used

Points to Remember

1. Spouse abuse is emotional/psychological abuse to observers. Don't overlook the children.
2. The more types of violence a child is exposed to, the worse the child's psychological adjustment is likely to be.
3. Ask about the presence of violence in the homes of your clients and attend to the response. Provide information about safety and shelters if necessary.
4. Behavioral/emotional difficulties that we see most frequently are aggressiveness and anxiety among both boys and girls.
5. Intervene by actively disapproving of the use of violence and by teaching children new interpersonal and problem-solving skills.

as a general educational format for any child who has been exposed to parental violence.

Some of the issues covered in the groups include (a) labeling feelings, (b) dealing with anger, (c) safety skills, (d) social support, (e) social competence and self-concept, (f) responsibility for parent violence, (g) understanding family violence, and (h) wishes about family (see 4 and 5 for more details).

Implications for Practice

Child- and Parent-Focused Intervention

When we see any member of a family in our centers or clinics, the most important thing to do is to ask about violence between the adult partners. Our acknowledgment of the possibility of violence conveys to a mother that this experience is important to discuss and has a detrimental impact on her children as well as on her.

As clinicians, we need to be advocates for the child and mother. Put the family in touch with domestic violence projects or social workers if necessary. In addition, work with teachers and the school. Basically, help the woman to do what needs

Mediating Variables*

1. Child factors

temperament, self-esteem, cognitive abilities, coping abilities, attributional style, gender, age, cognitive developmental abilities

2. Situational/contextual factors

(a) more or less stable factors related to the child (e.g., past experience with violence; perceived emotional climate of the family)

(b) marital conflict factors (e.g. frequency, intensity, duration, content, resolution, overt, covert, age at onset)

*Adapted from Grych & Fincham, 1990; Hughes et al., 1991; Hughes & Fanuzzo, in press; Moore & Papler, 1990.

to be done to stop the violence and keep herself and her children safe.

Child Focus

Research findings indicate that we must intervene with both behavioral difficulties (especially aggressiveness) and emotional problems (e.g., depression, anxiety, other PTSD-type symptoms). Empirical evidence from other areas of family violence suggests that intervention with aggressiveness is a major priority; one important and effective approach to treating aggressiveness is teaching anger control (e.g., 6). In addition, children of battered women often show difficulties in social problem solving. Improving those abilities would be helpful, as this would allow the children an opportunity to establish peer support systems. Teaching children how to get along better with peers, along with enhancing their empathy skills, has the additional benefit of reducing aggressiveness as well (5).

We must also attend to the emotional symptoms in both girls and boys. Research suggests that a cognitive-behavioral approach to treating both anxious and depressive symptoms would be helpful. Treat negative cognitive errors and other characteristic thought patterns that seem to be conducive to depression (e.g., attributions and locus of control). Working on the skills deficits that are seen in the areas of social problem solving can also help with low self-esteem and feelings of lack of competence. Play therapy (either nondirective or more focused) to deal with interpersonal and intrapersonal issues is also likely to be beneficial (7).

In addition, consider intervention for academic deficits as well as behavior problems. Success with school can be a strengthening and buffering experience for the children.

Parent Focus

Research from other areas of family violence and the model presented here suggests that we need

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to focus on parenting in two ways. One is to help a mother decrease her discipline problems. She can be a much more adequate parent with more effective discipline, and she will feel empowered by her effectiveness in her role as a mother. Second, we need to attend to and treat women's depression. Doing so will also improve a mother's ability to be attached to her children and meet their emotional needs.

Comprehensive, Extensive Approach

It is important to remember that effective treatment needs to be extensive, that is, lasting long enough to have an impact. With physically abusive families, research suggests that comprehensive (i.e., both child- and mother-focused) intervention lasting from 7-18 months after the violence has ended is necessary. Follow-up contacts—perhaps monthly—after the intensive intervention can be very effective.

Health Care Professionals

Intervention from health care professionals can be extremely beneficial to the children and their families. Several studies indicate that a battered woman is most likely to seek help from the medical community, whether it is from her physician, pediatrician, or a hospital's emergency room. Often, depending on her financial and emotional resources, her first attempt to obtain help is from the ER. An informed physician or nurse can be very effective in assisting the children. Many good recommendations are contained in an article by Wildin, Williamson, and Wilson (8). Essentially, they urge that the health care person ask about violence in the family and respond to the woman's answers. With

the children, acknowledge how scary violence and give the woman information about how to keep safe. If a referral seems to be in order, refer the family to a social worker rather than a psychiatrist.

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(A full list of related references may be obtained by writing to the publisher)

Point/Counterpoint

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programs to deny admission to pregnant women on the basis of pregnancy. Today, treatment programs are less likely to refuse services to a pregnant woman but are still unable to offer many of the special services pregnant women need. Many pregnant, addicted women already have young children. The availability of child-care services in both residential and outpatient treatment settings is still very rare.

Over the last five years, medical, public health, child health and welfare, and civil rights organizations have developed policies about pregnancy and addiction. States have organized multidisciplinary task forces to study and develop plans to address perinatal addiction. National organizations that have issued statements in opposition to criminal prosecution of pregnant, drug-dependent women for their drug use include the National Council on Alcoholism and Drug Dependence, the American

Society on Addiction Medicine, the American Medical Association, the American Academy of Pediatrics, the American Public Health Association, the American Nurses Association, the National Association of Public Child Welfare Administrators, the American Psychological Association, the Child Welfare League of America, and the American Civil Liberties Union. State task forces from Oregon to Ohio have rejected criminal prosecution in favor of measures to expand and coordinate a range of health and social services accessible to drug-dependent women and their families.

Advocates for both women and children have reached a clear consensus against prosecution. It is time to end this punitive practice and this debate and get on with the work of helping families recover from addiction.