

IMPROVING THE HEALTH CARE RESPONSE TO DOMESTIC VIOLENCE:

A RESOURCE MANUAL FOR HEALTH CARE PROVIDERS



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DEDICATION

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

— Catherine de Hueck Doherty

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

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PREFACE

HOW THIS MANUAL WAS DEVELOPED

BY DEBBIE LEE

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

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

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

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

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

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

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

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

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



INTRODUCTION

BY PATRICIA R. SALBER, M.D.

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

The numbers are staggering. Close to 4 million American women are physically abused each year in this country (Straus,

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

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

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

IMPROVING THE HEALTH CARE RESPONSE

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

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

Mental health care providers see battered women for suicide attempts, anxiety and depression (American College of Obstetrics and Gynecology, 1989; Berrios & Grady, 1991; McGrath et al.,

1990; Stark & Flitcraft, 1988a). In one study, 64% of female psychiatric inpatients experienced physical assaults and 38% experienced sexual assaults as adults; these were largely due to abusive relationships (Jacobson & Richardson, 1987).

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

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

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

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

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

Despite the fact that health practitioners see many victims of domestic violence in their clinical practices and despite the fact that the impact on the health care system is enormous, many health professionals fail to recognize the problem because they don't routinely inquire about or document abuse as the cause of their patient's symptoms (Friedman, Samet, Roberts, Hulin & Hans, 1992; Goldberg & Tomlanovich, 1984; Hamberger et al., 1992; Helton et al., 1987; Kurz, 1987; McLeer & Anwar, 1989; Morrison, 1988;

Stark, Flitcraft & Frazier, 1979; Warshaw, 1989). This failure occurs even though many physicians believe questions about physical and sexual assault should be asked routinely (Friedman et al., 1992). Furthermore, studies document that most patients want health care providers to ask about abuse and would answer truthfully if asked (Friedman et al., 1992; Rounsaville & Weisimann, 1978).

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

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

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

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

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

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

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

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

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

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

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

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

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

This approach, however, is at odds with the second principle outlined above — respect for victims’ integrity and authority over their lives. Providers must understand that, unlike child abuse cases where the victims are vulnerable children, the victims of domestic violence are adults who have a right to make their own decisions. Victims almost always know far more about themselves and their abusers than the health care providers do. This knowledge helps the victim formulate a response to the violence. The health care provider can play an important role in the victim’s decision-making process by asking the right questions, providing information about the nature of domestic violence, giving

GUIDING PRINCIPLES

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

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

messages of support, and letting her know about resources in the health care setting and in the community which can provide an alternative to the violence. At times it will be appropriate for the health care provider to make recommendations about what to do, but only after understanding the full reality of the victim’s situation and

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

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

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

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

Holding perpetrators responsible for domestic abuse is not solely the responsibility of the criminal justice system. Health professionals can hold perpetrators responsible in a number of ways. They can refuse to continue in silent collusion with batter-

ers and start to accurately name the problem of domestic violence. They can tell victims that they do not deserve abusive treatment. They can cut through abusers' minimization, denial, rationalization, and blaming to insist that it is the abuser's responsibility, not the victim's, to stop his abusive behaviors.

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

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

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

These guiding principles form the heart of this manual. They are woven into the text and content of every chapter. The authors hope this manual will serve as the beginning of your education about domestic violence. Wherever possible, we have provided references and resources to further your knowledge about this crucial issue which so profoundly affects the health and well-being of so many of our patients. We also hope that you will use this educational experience to change the

way you view your role and responsibility to victims of domestic abuse. It is no longer acceptable to say that this is the role of some other type of service provider. It is everyone's responsibility. For that reason, we believe that you have an obligation to educate your peers about their role in domestic violence identification and intervention and help improve your practice's ability to respond to domestic violence. Therefore, we encourage you to share this manual with others and to freely utilize the resource materials contained in it. We hope you will become a teacher, an advocate, and a leader in the movement to improve the health care response to victims of domestic violence.

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