Addressing Domestic Violence, Past and Present

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In September 1993, MedChi and the Maryland Alliance Against Family Violence (the “Alliance”) embarked upon a major family-violence prevention initiative that focused on education and training of health care professionals. Seed money for this initiative was donated by MedChi, and a Family Violence Task Force (the “Task Force”) was formed under the auspices of MedChi’s Public Health and Public Relations Committees co-chaired by Martin P. Wasserman, M.D. and Hiroshi Nakazawa, M.D.

With the theme “Unlock the Silence: Trust is the Key,” the Task Force undertook a statewide initiative to:

- develop protocols and educational materials for physicians and other health care providers on domestic violence, child abuse, and elder abuse
- offer educational conferences on family violence to hospital personnel and physicians and
- conduct a public education campaign.

The Task Force reviewed materials produced by the AMA and the Ohio Medical Association and produced three physician manuals, training modules, and a nurses’ manual. These materials were utilized not only for use by practicing physicians in their offices, but also to help Maryland hospitals meet a Joint Commission on Accreditation of Healthcare Organizations mandate to provide training to their medical staffs. In addition, the Alliance received a $35,000 Federal grant to develop informational materials to promote family violence as a public health issue to the general population.

The Task Force and Alliance developed materials for victims of family violence that included general information on family violence, a resource list, and a message encouraging victims to trust their physicians and turn to them for help. One of the key issues in the physicians’ handbook, and in the educational sessions with health care providers, involved the recognition of three types of abuse (physical abuse, emotional abuse, and sexual abuse) and the cycle of violence developed by Dr. Lenore Walker in 1979. This cycle explained the behaviors associated with domestic violence, noting
that there were three phases: the tension-building phase, the acute battering phase, and the loving contrition or "honeymoon" phase.

Since the development and recognition of the cycle, additional research has supported a progression of violence that can accompany this cycle. Although not all couples experience the cycle and progression of violence, in relationships where they exist, the longer the cycle is allowed to continue without intervention, the more constricted the cycle becomes, and the violence escalates in both frequency and severity.

The Task Force also utilized materials developed by the Domestic Abuse Intervention Project, including the power and control and equality wheel, the medical power and control wheel, and the empowerment wheel. The power and control wheel addresses how an abuser uses various methods to control the victim; and the advocacy wheel focuses upon tactics and behaviors that should be employed by individuals in the medical system to help empower a victim of domestic violence. The medical power and control wheel recognizes primary tactics and behaviors that individuals in the medical system may unknowingly use to establish and maintain control over a victim of domestic violence. Since these behaviors further victimize the patient and may place the patient in danger, the training stressed the importance of being familiar with behaviors that could further escalate the situation.

Examples of these behaviors are:

- **Violating confidentiality**? interviewing in front of family; telling colleagues issues discussed in confidence without the patient’s consent; calling the police without consent if not reportable
- **Normalizing victimization**? failing to respond to the disclosure of abuse; acceptance of intimidation as normal in relationships; belief that abuse is the outcome of non-compliance with patriarchy
- **Ignoring the need for safety**? failing to recognize the patient’s sense of danger; being unwilling to ask whether it is safe to go home; being unwilling to ask if there is a safe place to go to if the situation escalates
- **Not respecting the patient’s autonomy**? prescribing divorce, sedative medicines, going to a shelter, couples’ counseling, or law enforcement involvement; punishing the patient for not taking your advice
- **Trivializing and minimizing the abuse**? not taking the danger the patient feels seriously; expecting tolerance due to the number of years in the relationship or recent illness
- **Blaming the victim**? asking the patient what they did to provoke the abuse; focusing on the patient as the problem; asking why the patient doesn’t just leave, why they put up with it, why they allow themselves to be victimized.

Recognizing many of these ordinary responses and being able to adjust behavior became an important theme in educating physicians and other medical personnel. Also, being able to recognize patient and physician barriers was, and still is, important in developing an environment that is conducive to identifying domestic abuse. Examples of these barriers are highlighted below and merit
Patient barriers include:

- fear that revelation will jeopardize the patient’s safety or the safety of the children
- lack of funds to escape or re-locate
- shame and humiliation at the way the person is being treated
- thinking the person deserves the abuse and is not deserving of help
- feeling protective of the partner
- lack of awareness that physical symptoms are caused by the stress of living in an abusive relationship
- belief that injuries are not severe enough to mention
- beliefs grounded in cultural, ethnic and/or religious orientation that may limit a patient’s awareness or response to the abuse
- lack of transportation to seek medical intervention.

Some physician barriers to identifying domestic violence include:

- lack of awareness of the prevalence or severity of the problem
- lack of recognition of the social and psychological costs of abuse
- thinking that the patient may have provoked the abuse
- believing that identification of abuse and referral for services is not part of the physician’s role
- not knowing how to intervene or help
- blaming the patient or feeling frustrated or angry if the patient doesn’t leave the situation
- disbelief because the alleged assailant is present and seems very concerned and pleasant
- concern that discussing psychosocial issues will take an overwhelming amount of time
- difficulty in dealing with the feelings evoked by listening to the victim
- personal involvement in domestic violence as either a victim or a perpetrator.

Effective intervention begins by gathering patient information, and that begins with routine screening of all patients. An opening supportive statement, such as: “Because violence is so prevalent in our society, I have begun to ask about it routinely. This would be an effective way for health care providers to show their concern, and it sends the message that they recognize that battering is a possibility. This opening statement as well as any follow-up questions should be presented to the patient when the patient is alone with the provider. Follow-up questions should be non-judgmental and in the provider’s own words. Some suggested questions to open a dialogue with patients include:

- Are you in a relationship in which you have been physically hurt or threatened by your partner?
- Have you ever been in such a relationship?
- Are you, or have you ever been in a relationship in which you felt you were treated badly?
- In what ways?
- Has your partner ever destroyed things that you cared about?
- Do you feel safe in your current relationship?
- Have you been hit, kicked, punched, or otherwise injured by someone?
- If so, by whom?
- Has your partner ever prevented you from leaving the house, seeing friends, getting a job, or continuing your education?
- Do you have weapons in your home?
- Has your partner ever threatened to use these weapons when angry?

Beyond asking questions, a physician is in a unique position to assess a patient through an examination and recognize clinical clues that could link to domestic violence. For example, other than obvious physical injuries, a physician’s assessment of chronic pain, physical symptoms related to stress, anxiety disorders, depression, gynecological problems, frequent use of prescribed tranquilizers or pain medications, and frequent visits with vague complaints or symptoms, may lead to a connection to domestic violence.

After identification, health care providers are always faced with addressing how to appropriately intervene in a domestic violence situation. Beyond medical intervention, there are experts who can address patient safety issues and advise victims of their options. All health care professionals should become familiar with the resources that are available in every county in Maryland. For physicians, MedChi and the local medical societies can provide the names and telephone numbers of agencies that are prepared to respond quickly.

In 1998, with the Physician’s Campaign winding down, the Maryland Health Care Coalition Against Domestic Violence (the ?Coalition?) was formed to provide leadership and to promote a proactive and effective response to domestic violence through screening, identification, education, intervention and treatment of domestic violence victims. The membership of the Coalition includes doctors, nurses, social workers, and victim advocates and supports routine screening of all patients for domestic violence. In 2001, the Coalition finalized ?Domestic Violence Policy Guidelines: A Model for Maryland’s Health Care Community.? The eight-page document was endorsed by the Maryland Department of Health and Mental Hygiene and is available from the Coalition.

In addition, the Coalition has produced other educational materials that focus on the health consequences of domestic violence. Building upon the foundation laid by the Family Violence Task Force, the Coalition acts as a model for other state coalitions and is recognized for its capacity to address the needs of health care providers as they relate to abating the epidemic of family violence throughout Maryland.

MedChi and the state have come a long way from the beginning of the Physicians’ Campaign in 1993. Legislative initiatives, hospital-based domestic violence programs and protocols, and physician awareness have greatly increased a victim’s chances of being appropriately identified and referred for services. Even so, it is important for health care providers never to become complacent but to continue to be ever-vigilant in screening and referring patients for domestic violence. Through the diligent efforts of physicians and other health care professionals, lives will be saved, further injury will be prevented, and we will succeed in unlocking the silence.
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References:
