



RESPONDING to **DOMESTIC VIOLENCE**

The Integration of Criminal Justice and Human Services

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5 EDITION



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Domestic Violence, Health, and the Health System Response

Chapter Overview

Abused women use health care more than any other resource, including criminal justice. They may visit a doctor's office, clinic, or hospital emergency department (ED). Their visit may involve injury, a secondary consequence of abuse such as depression or an unwanted pregnancy, or a problem with no apparent relation to abuse. In every encounter, the health professional can afford female patients the opportunity to identify abuse as a concern and, if identified, can open a window to the full spectrum of their experience, facilitate access to relevant information about their options, help plan for their immediate safety if needed, and incorporate an understanding of abuse into their ongoing care. Simply asking about abuse conveys its importance as a health issue. A successful strategy to manage or prevent abuse is inconceivable without an active role by the full range of medical, health, and mental health practitioners.

This chapter reviews evidence on the significance of domestic violence and coercive control for women's health and on the health-care response. We identify the physical, mental, and behavioral health consequences of abuse, emphasizing its impact on reproductive health and populations with special needs. Next, we outline the response of the health system to abuse and consider major challenges to reforming this response. These challenges include adapting an all-inclusive definition of partner abuse; distinguishing new from ongoing cases; deciding how best to screen for abuse; understanding what "clinical violence intervention" implies for traditional approaches to patient care; learning to look beyond violence to coercive control; and appreciating the pros and cons of mandated reporting. Meeting these challenges entails complementing the medical paradigm with a public health perspective consistent with rooting the health response in a broader coordinated community response, an approach we term "complex social prevention."

The Role of Health Service

The criminal justice system in the United States is part of a state bureaucracy and so is accountable to centralized administrative and policy directives. By contrast, the health system in the United States consists of an amalgam of private, nonprofit, and federal institutions that operate in a competitive market. There is no constitutional right to health care in the United States as there is to justice resources. As a result, health services are provided and must be accessed by individuals largely through contractual relationships financed by an eclectic mixture of fee-for-service, work-based insurance, and government funds. What some observers describe as the “dis-organization” of U.S. health care has meant that the health care response to abuse has been much more varied and piecemeal than the response by the legal or criminal justice systems. Despite the sharp reduction in the uninsured population brought about the 2012 Affordable Care Act, significant financial, cultural, and demographic barriers continue to constrain victim access to quality health care, let alone to health services designed for abuse victims.

An early glimpse at the significance of partner abuse for the health system was provided by two surveys in the early 1980s. A Kentucky Harris Poll showed that 17% of abused women had used emergency medical services because of violence and a Texas survey found that 385,595 women in that state had done so (Stark & Flitcraft, 1988; Teske & Parker, 1983). Meanwhile, the Yale Trauma Studies (YTS) conducted at Yale–New Haven Hospital demonstrated that domestic violence was the leading cause of injury for which adult women sought care and a major context for a range of other medical, behavioral, and mental health problems (Stark & Flitcraft, 1988). By 1992, the American Medical Association (AMA Council of Scientific Affairs, 1992) estimated that more than 1.5 million women nationwide sought medical treatment for injuries related to abuse annually. Subsequent research confirmed both the absolute and relative significance of abuse for women’s health, showing that victims of abuse make more visits to health-care providers over their lifetime than non-battered women, have more and longer hospitalizations, and are at greater risk for needing healthcare for a variety of problems than non-victims (Black, 2011).

Estimates of the costs of providing health care to abused women have grown alongside the growing awareness of its significance, escalating from approximately \$5.8 billion in 1995 to \$8.3 billion in 2003 to more than \$10 billion today. These estimates include both the direct costs for medical and mental health services and the indirect costs resulting from productivity lost due to abuse-related morbidity and mortality (Centers for Disease Control and Prevention, 2003; Max, Rice, Finkelstein, Bardwell, & Leadbetter, 2004). One response to abuse-related health costs was that 8 of the 16 largest insurers in the country either denied coverage to battered women or charged them higher rates (Fromson & Durborow, 2001), a practice known as “pink lining.” This form of discrimination was outlawed by the Health Care Reform Act (HCRA) of 2010.

PINK LINING

Discrimination risks are real. A woman from rural Minnesota was beaten severely by her ex-husband. After remarrying, she applied for health insurance and was told that she would not be covered for treatment relating to the abuse-related preexisting conditions of depression and neck injury. Studies by the Insurance Commissioners in Pennsylvania and Kansas revealed that 24% of the responding companies used domestic violence as an underwriting criterion when issuing and renewing insurance (Fromson & Durborow, 2001).

It may seem obvious why victims of violence would require health services in such large numbers. Media portrayals like the graphic video of NFL running back Ray Rice knocking out and then dragging his unconscious fiancée out of an elevator reinforce a widespread association of partner abuse with the types of injuries that would prompt any person to seek emergency care. But equating partner abuse with injurious violence captures only part of its significance for health—and not necessarily the most important part. Serious and even fatal injuries are all too common in abusive

relationships. In most cases of abuse, however, episodes of extreme violence are part of the larger pattern of coercion and control described in Chapter 4. The violence in this pattern is marked less by its severity than by its frequency, duration, sexual nature, and cumulative effects on a particular victim. As importantly from a health perspective, in a majority of cases, the effects of the violence are confounded by the consequences of the range of coercive and controlling tactics that complement physical assault. As a result, most health visits by battered women are to primary care rather than emergency medical sites and involve medical, behavioral, mental health, and psychosocial problems secondary to this pattern of coercive control. Indeed, clinicians or health systems that limit intervention to the ER or rely on injury to identify abuse miss the vast majority of battered women in their care and are likely only to identify victims after they have developed a complex clinical profile requiring extensive resources.

Some of what we say about female victims of male partners applies to male victims of female partner violence as well as to transgender victims and victims coupled with persons who share their gender identity. Although we have extensive survey evidence of female-to-male partner violence, few studies have compared the abuse-related health profiles of male and female victims and fewer still have differentiated health outcomes by the sexual orientation of offenders or victims. Many of these studies find that the modal pattern of violence is bidirectional, though even in these cases there are significant differences in the dynamics and outcomes of the abuse by gender.

Phelan, Hamberger, Hare, and Edwards (2000) compared men and women presenting complaints of injury at a level 1 trauma center for emergency medical services and who reported being in a currently violent or abusive relationship. In this study, men reported significantly higher rates of violence initiation than women did. One hundred percent of the men reported they initiated violence between 50% and 100% of the time. In contrast, fewer than 1 woman in 10 reported initiating violence more than 20% of the time. Even in situations where violence was bidirectional, the women in these relationships were significantly more likely than the men to be injured by partner violence, to be injured more severely, to seek health care, and to experience a range of negative health impacts, including clinically significant levels of depression and PTSD. Based on these findings, the authors concluded that male partner abuse of women is qualitatively different than female partner abuse, not merely different in the degree of violence deployed.

Devising an appropriate health system response is vital to any overall strategy to manage or prevent domestic violence. Moreover, the knowledge base exists to implement such a response. At a minimum, this response would build on the core values of medicine and public health, particularly their emphasis on beneficence and non-maleficence (to “do no harm”); their willingness to embrace prevention; their capacity to take a nonjudgmental, holistic, and historical approach to health issues; and their distinguished record of addressing problems that most people would prefer to keep under wraps. Understanding partner violence as the context for a range of women’s health problems would significantly improve intervention with all female patients regardless of their demographics. A medical/public health perspective offers a vantage point to understand partner violence that complements and goes beyond the criminal justice framework outlined in earlier chapters.

The Need for and Use of Health Services by Battered Women

Two things were clear by the late 1980s: (a) Battered women used health facilities of all types for a range of problems related to abuse; and (b) the health system’s response was woefully inadequate. For example, a study in a southwestern Michigan county found that 81.7% of victimized women identified by police had used the ER with a median of four visits each (Kothari & Rhodes, 2006). A more recent study of 993 abused women also found that 80% had used the ER, most with medical complaints. Although the women averaged just under 3.3 police incident reports each (total = 3.246) and 7 visits to the ER over the 4-year study period, only 28% of the women had been identified as abuse victims, and those largely because they had self-disclosed, were brought in by police, had filed a police complaint that day, or had mental health or substance abuse problems (Kothari et al., 2011). This section reviews the health dimensions of woman battering. The next section examines the health-care response.

Medical research on abuse focused on trauma care initially because it was assumed that battered women would primarily use emergency services for injuries caused by physical or sexual violence. Based on reviews in 1996 and

1998, the CDC reported that 40% to 60% of abused women were injured in the United States (National Center for Injury Prevention and Control, 2003). In a subsequent report, the CDC estimated that domestic violence resulted in approximately 2 million injuries to women and 600,000 injuries to men annually (Centers for Disease Control and Prevention, 2008).

The Significance of Abuse for Female Trauma

A conservative estimate is that battered women comprise 30% to 35% of female trauma patients (Boes, 2007). The earliest (and lowest) estimates come from the YTS—NIMH-funded multisite, multitier research conducted in the 1980s and based on reviews of women's medical records. Analysis of a year's sample of trauma patients in Yale's ED revealed the then startling finding that domestic violence was the most common source of injuries for which women sought medical attention. One female trauma patient in five (18.7%) was identified as a battered woman. Because battered women used the ED more often than non-battered women, they accounted for 40% of all injuries presented by the sample cohort. At the time, partner abuse was not officially recognized as a diagnosis, let alone as a major source of injury. Nevertheless, abused women presented almost four times as many injuries as auto accident victims (40% vs. 11%), although auto accidents were thought to be the most important cause of adult injury. As the availability of shelters and other services made it ethically appropriate to ask patients directly about their experience, researchers reported considerably higher prevalence rates. For instance, 54.2% of female patients disclosed a history of abuse in a multihospital study in Colorado (Abbott, Johnson, Kozial-McLain, & Lowenstein, 1995).

Most abused women have suffered one or more episodes of severe violence, including strangulation (commonly misnamed "choking"), burning, torture, and the use of weapons. In a British survey of 500 shelter residents, 70% had been choked or strangled at least once, 60% had been beaten in their sleep, 24% had been cut or stabbed at least once, almost 60% had been forced to have sex against their will, 26.5% had been beaten unconscious, and 10% had been tied up. Because of these assaults, 38% of the women reported permanent damage (Rees, Agnew-Davies, & Barkham, 2006). In a national survey conducted by the CDC, 10% of the women who identified themselves as abused reported they had been choked more than 11 times and another 5% reported they were choked more than 50 times (Black et al., 2011). An indication of the potential benefits that might accrue because of intervention with women injured by abusive partners was that 41% of women killed by abusive partners had used the health system for abuse-related injury in the year prior to the fatality (Sharps et al. 2001, as cited by Plichta, 2004).

Partner violence is an important cause of injury at each point in women's life cycle, accounting for 34% of the injuries to young women ages 16 to 18 years, for instance, as well as 18% of the injuries presented by women 60 years and older (McLeer & Anwar, 1989). Teens and older women often fall between the cracks of existing programs. Protective services for women who are abused in the context of age-related disability (elder abuse) are often seen as inappropriate and patronizing by the older battered woman who is capable of living independently, for instance, while going to a shelter may mean dropping out of school or leaving a supportive family network for teens. In response to evidence like this, some health systems have adopted a life-cycle approach to intervention, tailoring different identification and triage protocols for adolescent, adult, and elderly patient groups.

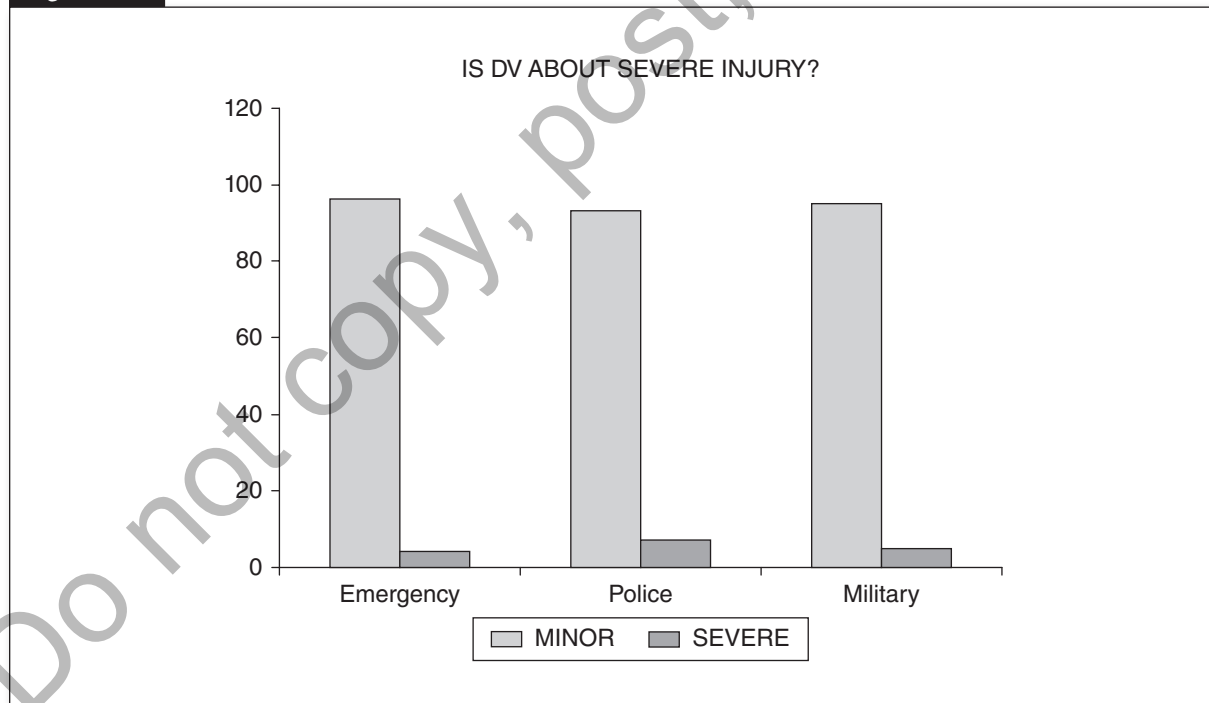
The Importance of Primary Care

Contrary to the popular association of partner abuse with emergent problems, the proportions of abused women among primary care patients is as high or higher than in the ED. In one primary care site, 21.4% of the 1,952 women surveyed had been physically or sexually abused by a male partner (Gin, Rucker, Frayne, Cygan, & Hubbell, 1991). Meanwhile, 38.8% of the women in a Midwestern community practice setting reported they had been abused (Hamberger, Saunders, & Harvey, 1986). Finally, 55.1% of 1,443 women seeking medical care in two university-associated family practice clinics in Columbia, South Carolina, had experienced some type of intimate partner violence in a current, most recent, or past intimate relationship (Coker, Smith, McKeown, & King, 2000). While 77.3% of the abused patients at the South Carolina family clinics experienced physical or sexual violence, 22.7% suffered the consequence of nonphysical abuse (Coker et al., 2000).

The Minor Nature of the Injuries Caused by Abuse

Another popular misconception is that serious injury is the most common outcome of partner violence. The vast majority of partner assaults involve pushing, shoving, grabbing, holding, shaking, arm twisting, hair pulling, slapping, choking, punching, kicking, and beating. While these acts can certainly cause serious harm, as when someone falls down the stairs as a result of being pushed, they do not generally result in medically significant injuries. Even among the battered women seen at Yale's surgical emergency service, 9% had no injury at all and the largest proportion of injuries (58%) involved "contusions, abrasions, or blunt trauma," "lacerations," and "sprains and strains." Only 2% of these injuries required hospitalization or major medical care, a rate that was no higher than among all other emergency service patients. Even when fractures or dislocations (9%), human bites (3%), and rapes (2%) were included, the data still showed that almost 90% of the injuries women presented would be classified as minor (Stark & Flitcraft, 1996). Ninety-two percent of the women in a community sample who had been assaulted at least once by a partner in the previous six months had sustained only cuts, scrapes, and bruises (though 11% had suffered broken bones and fractures; Sutherland, Bybee, & Sullivan, 2002). Even in the military, where the presence of weapons might lead us to expect the most severe assaults, only 7% of substantiated cases are serious enough to require more than one medical visit (Caliber Associates, 2002). The NCVS records incidents of abuse that respondents consider crimes. Nevertheless, between 1993 and 2004, fewer than 20% of abuse victims required medical treatment (Catalano, 2005). Among the abused women identified by a random population survey conducted by Harris Interactive for the Commonwealth Fund, no woman reported that she had been shot, stabbed, choked, or beaten up (Commonwealth Fund, 1999). This data is summarized in Figure 13.1.

Figure 13.1



Sources: Stark & Flitcraft, 1996; Caliber Associates, 2002.

It would be a serious mistake to assume that abuse is minor simply because most domestic violence is noninjurious. In fact, the hallmarks of domestic violence are its frequency, duration, sexual nature, and cumulative effects rather than its severity.

The Markers of Partner Violence in the Health System

In contrast to legal definitions of domestic violence as a discrete assault, health practitioners confront the consequences of abuse as a continuing course of conduct in which repeated physical assaults are combined with a host of other oppressive tactics. From this vantage, abuse more closely resembles a chronic health problem like diabetes or HIV than emergent problems such as a heart attack or the flu. The health problems presented by battered women are the cumulative outcome of all the abuse that has preceded the visit and only rarely of a single, isolated incident.

From the standpoint of the health system, the hallmarks of domestic violence are the frequency of the violence, the overlap of physical with sexual coercion, the duration of abuse, and its cumulative effects on victims' physical, mental, behavioral, and psychosocial health.

The Frequency of Abusive Assaults

It has been well known for decades that about a third of all offenders use force several times a week, so-called serial abuse, and many do so on a daily basis. Responding to the most recent CDC population study, the abused women reported experiencing the following types of assault between 11 and 50 times or >50 times: choked (10%; 5%); kicked (18%; 7%); "hit with a fist or an object" (19%; 10%); "beaten" (21%; 18%); and "slapped, pushed, or shoved" (22%; 21%; Black et al., 2011). In the shelter sample from the United Kingdom mentioned previously, the women reported they were "shook or roughly handled" (58%); pushed, grabbed, shoved, or held (65%); slapped, smacked, or had their arm twisted (55.2%); and kicked, bitten, or punched (46.6%) "often" or "all the time." Individual women are experiencing the cumulative effect of these assaults.

ONGOING VIOLENCE: FEMALE VICTIMS IN THE UNITED STATES

The frequency of abusive assault is reflected in the disproportionate use of emergency health resources for domestic violence victims. At Yale's inner-city hospital, non-battered women averaged 1.9 injury visits to the emergency medical service as adults. By contrast, abused women averaged 5.7 injury visits and almost one in five had presented to the emergency room 11 or more times with complaints of injury. Conversely, the YTS found that 80% of the adult women who had visited Yale's emergency room three or more times had been battered (Stark & Flitcraft, 1996). In a study of ED utilization by battered women in a southwestern Michigan county, almost all the victims identified by police utilized the ED (87%) over the 3-year study period with a median of 4 visits each (Kothari & Rhodes, 2006; Rhodes et al., 2011).

The Duration of Abuse

The frequency of assaults by partners takes its significance for health service use from the duration of abusive relationships. From the perspective of the health system, partner abuse has a low spontaneous cure rate. Some of the adult medical records reviewed in the YTS covered 40 years or more. Nevertheless, if a woman in the Yale sample had ever made a hospital visit related to partner abuse as an adult, there was a 72% chance she had presented at least one injury related to abuse in the last 5 years, the marker used to indicate that abuse might be a current concern. The average time span between the first abuse-related presentation to the hospital and the most recent was 7.3 years, which researchers called the "adult trauma history," a key window through which clinicians can assess abuse. Campbell and Soeken (1999) estimated that abusive relationships in their population-based sample lasted 5.5 years on average. Combining estimates of the frequency of abusive assaults with their average duration highlights a dramatic reality: that a significant proportion of victims have suffered dozens, and many have suffered hundreds, of assaults.

The Sexual Nature of Partner Violence and Coercion

Debate continues about the utility of viewing partner abuse through the lens of gender identity and sexual inequality. From the standpoint of the health system, however, the sexual nature of woman battering is reflected in both the physical nature of the injuries inflicted and in the frequency with which health visits by battered women are prompted by sexual coercion, including but by no means limited to rapes.

Most accident victims suffer injuries to their peripheries—their hands, head, and feet, for example. By contrast, the YTS reported that battered women were 13 times more likely than non-battered women to be injured in the breast, chest, face, and abdomen, physical sites that are identified with female sexuality.

The significance of partner abuse as a context for rape is well established by studies of both rape victims and battered women.

It is estimated that 14% to 25% of women in the general population experience intimate partner sexual assaults (McFarlane & Malecha, 2005). The YTS found that partners comprised 35% of the assailants in all rapes reported to the hospital and half of the assailants in cases where the victim was older than 30 years (Stark & Flitcraft, 1996). Fifty-one percent of the women who reported being raped to the CDC survey identified a present or former partner as the offender (Black et al., 2011).

A recent literature review concluded that between 43% and 55% of abused women are also sexually assaulted by their partner (Wingood, DiClemente, & Raj, 2000). Battered women using emergency shelter and domestic violence services indicate that between one third and one half have been sexually assaulted by their partners (Campbell, Sullivan, & Davidson, 1995; Bergen, 1996). In one well-designed study, 37.6% of female primary care patients were identified as victims of partner violence. Almost half of these abused women (18.1% of the total) also were sexually assaulted (Coker et al., 2000). Similarly, a study of rural battered women found that half had been raped by their partners (Websdale, 1998). A distinguishing characteristic of partner rapes is that they tend to be repeated. In a large sample of women in shelter, 27% reported they had been forced to have sex against their will often or “all the time.” The occurrence of sexual assault in abuse cases is a significant risk factor for a subsequent homicide. The Georgia Domestic Violence Fatality Review identified sexual violence in 23% of the femicide cases examined between 2004 and 2008 (Georgia Commission, 2009).

The Continuum of Sexual Coercion

Sexual assault in abusive relationships is typically part of a pattern of sexual coercion. Twenty-five to 30% of women who obtained protection orders reported that they had been subjected to a wide range of sexual abuse, exploitation, and assault (Logan & Cole, 2011). The most commonly reported forms of sexual coercion are sexual inspection; forced pregnancy (sometimes involving denial or sabotage of birth control); coerced sex with children, other family members, or strangers; sex trafficking; the use of pornography; and what may be termed “rape as routine,” where women comply because they are afraid. In a study of men in a batterer intervention program, 33% of those who sexually assaulted their female partners did so when the women were asleep (Bergen & Bukovec, 2006). Male abuse victims also report sexual coercion by male and female partners, though in far smaller numbers than women (Black et al., 2011).

❖ Donna Barnes, age 34, shot her husband Nick while he slept, called police to report the crime, then returned to the bedroom to retrieve the gun. Donna insisted she'd been beaten almost daily for five years. Apart from swollen fingers and some bruising on her legs, police had no evidence to support her claim. Indeed, they wondered, if assault had been so common why hadn't she called police or gone to the hospital? One medical visit involved a broken thumb, but Donna claimed this occurred when she had accidentally slammed the car door on her own hand. Fortunately for her defense, Donna had kept a diary in which she recorded more than 300 incidents of being assaulted. These assaults usually occurred just before bedtime and typically involved punching, kicking, and dragging her by the hair. Her fingers were swollen from protecting her head. Although none of the assaults had been life-threatening, their cumulative effect was to make Donna feel like a hostage in her own home. She returned to get the gun because she believed her husband could come after her even after he was dead. The belief that an abusive partner is omnipotent is common among battered women.

Whether or not sexual coercion consists of criminal acts, its co-occurrence with domestic violence is significantly more traumatic than either violence or sexual assault alone and provides the context for a range of physical and mental health complaints (Richie, 1996). The shame associated with sexual coercion can be a formidable barrier to disclosure and even if acknowledged at an initial interview (e.g., in response to questions such as “Has anyone made you do something of which you are ashamed?”) need not be explored until trust is established. The battered rape victim may feel uncomfortable with aspects of stranger rape hospital protocols that involve eliciting support from significant others or may approach the rape trauma apart from the larger context of coercion and control.

SEX AS ROUTINE

Shortly after they married, Donna was talking on the phone to Nick's uncle and laughed at one of his jokes. Nick quietly took the phone, hung it up and then punched Donna, telling her that her laughing meant she was flirting. He then demanded sex. When she demurred, saying she was not feeling well, he tied her hands behind her back and “had his way” with her. She never said no to Nick again when he wanted sex.

The Secondary Consequences of Abuse

After the onset of abuse, battered women are at an increased risk for a range of medical, behavioral, and mental health problems that distinguish them from non-battered women as well as from other classes of assault victims, including male and female victims of female partner abuse. Most battered women do not develop these problems, but

the proportions who do are sufficient to make partner abuse a major cause—and in the cases of female alcohol abuse, attempted suicides, and child abuse, *the* major cause—of these problems in the health system. The prevalence of these secondary problems largely accounts for the comparably high rates of health-care utilization by battered women and the fact that the annual costs of their care are 19% higher than for women without a history of abuse (Rivara et al., 2007).

Medical Problems

Battered women have an overall rate of physical health problems that is 60% higher than the rate for non-abused women (Campbell, 2002). Between 14% and 20% of these general medical problems are clearly related to assault or prior injury. These presentations include headaches from head trauma; dysphagia from being strangled; traumatic brain injury; joint, abdominal, or breast pain from assaults; and a range of problems linked to sexual assault. In comparison with non-abused women, meanwhile, abused women have a 50% to 70% increase in gynecological problems (such as STDs or urinary tract infections), central nervous system problems such as headaches or fainting, problems related to chronic stress (such as appetite loss), and viral infections (such as flu) as well as of HIV (Campbell et al., 2002).

The association between partner abuse and increased risk for HIV has been identified in multiple studies here and abroad (Coker, 2007; Wu, El-Bassel, Witte, Gilbert, & Chang, 2003). Women in abusive relationships are more than three times as likely to have HIV infection as women who are not suffering abuse (Sareen, Pagura, & Grant, 2009). In addition, 55.3% of American women with HIV/AIDS are abused, more than twice the national rate (Coker, 2007). Women with HIV who report recent trauma are more than four times more likely to fail their HIV treatment and almost four times more likely to engage in risky sexual behavior (Machtiger, Haber, Wilson, & Weiss, 2012). As a consequence, effectively addressing trauma in STD/HIV/AIDS treatment has the potential to enhance both recruitment and retention of battered women.

Battered women also seek help for a range of medical problems that reflect the chronic stress associated with ongoing abuse rather than the acute effects of abuse itself. These include functional gastrointestinal disorders, digestive problems, nutritional deficiencies, or central nervous system disorders. Up to 53% of female patients visiting pain clinics report physical or sexual abuse. Although many of these visits are clearly related to past and current injuries, battered women also are twice as likely as non-abused women to report chronic pain unrelated to injury, or “spontaneous” pain (Haber & Roos, 1985). They are also at greater risk for viral infections such as colds or flu (Campbell et al., 2002). Not surprisingly, battered women are far more likely than non-abused women to rate their general health as fair or poor (Kramer, Lorenzon, & Muellerm, 2004).

Behavioral Problems

The YTS demonstrated that the behavioral and psychosocial consequences of abuse are as important as its physical consequences. In a control comparison, abused women were 5 times more likely than non-abused women to attempt suicide, 15 times more likely to abuse alcohol, 9 times more likely to abuse drugs, 6 times more likely to report fear of child abuse, and 3 times more likely to be diagnosed as depressed or psychotic (Stark & Flitcraft, 1996). Indeed, one abused patient in five attempted suicide at least once, and many made multiple attempts, often on the same day or in close proximity to a hospital visit related to abuse and with the medicine they had been prescribed at their visit. An analysis of 16 published longitudinal studies involving more than 36,000 participants found that intimate partner violence increased the likelihood of suicide attempts as well as doubled depression among women (Devries et al., 2013). Binge drinking is also associated with victimization. A large California survey found that more than half of the victims subjected to recent violence reported engaging in binge drinking during the prior year, significantly higher rates than non-victims (Zahnd, 2011).

So common were secondary problems among abused women in the YTS that battering emerged as *the* major overall cause or context for female suicide attempts, child abuse, and alcohol abuse (Stark & Flitcraft, 1996). Importantly, with the exception of alcohol abuse, the incidence of these problems among battered women only became disproportionate against the background of ongoing abuse, indicating that battering rather than a preexisting vulnerability or addiction was their context, if not always their proximate cause. Battered women are also at sharply elevated risk for homelessness (Browne & Bassuk, 1997; Muelleman, Lenaghan, & Pakesier, 1998; Stark & Flitcraft, 1996). Once abused women develop these problems, they became more vulnerable to further coercion and control.

Mental Health Problems

Adapting to and surviving within abusive relationships can exact significant mental health costs. Research has failed to identify a particular problem or personality profile that makes certain women “violence prone.” However, after the onset of abuse, battered women report more symptoms and are diagnosed with psychiatric problems with greater frequency than non-abused women (Nicolaidis & Touhouliotis, 2006). The CDC estimates that mental health services are provided to 26.4% of victims of partner violence. Forty-eight percent of the abused women in a large random sample said they had needed help with mental health issues in the past 12 months (Weinbaum et al., 2010).

Abuse significantly increases a woman’s risk of developing PTSD, depression, anxiety disorders, hopelessness, psychosexual dysfunction, and obsessive compulsive disorder, perhaps by as much as 500% (Dutton et al., 2006; Golding, 1999; Follingstad, Brennan, Hause, Polek, & Rutledge, 1991). One abused woman in 10 identified in the YTS suffered a psychotic break. Other common psychiatric problems presented by abused women include panic attacks, sleep disturbances, and agoraphobia (Dutton et al., 2006).

Battered Woman Syndrome

One form of cognitive distortion widely thought to result from abuse is battered woman’s syndrome (BWS), which is a type of depression induced by repeated life-threatening violence. In a series of influential publications, psychologist Lenore Walker (1979) argued that victims experienced a “cycle of violence” consisting of a buildup of tension, an explosion of violence, and a honeymoon phase in which the abuser placated his victim with apologies, gifts, and the like. Women who stayed through at least two cycles developed learned helplessness; concluded that escape or turning to outside help was useless, even when it was available; and focused on survival instead. BWS seemingly explained two paradoxes that are important to health: the duration of abusive relationships (“why does she stay?”) and the reason why, if abuse is so common, case reports were so rare.

BWS has been discredited as a general account of battering and its effects (Dutton, 1996). Separations are common in abusive relationships. In response to supportive questioning, most victims are frank and accurate reporters

(Dutton, 1996). Meanwhile, the scope of controlling behaviors explains the durability of abusive relationships more accurately than psychological dependence (Stark, 2007). Finally, the dynamics in abusive relationships is typically ongoing rather than cyclical. Nonetheless, BWS affects an estimated 14% of abused women and is one explanation of why some women may be reluctant to disclose.

Post-Traumatic Stress Disorder

PTSD is another common outcome of partner violence. A meta-analysis across multiple samples of battered women, including those in hospital EDs and psychiatric settings, found a weighted mean prevalence of 48% for depression and 64% for PTSD (Golding, 1999). The NISVS found 22.3% of victimized women reported PTSD symptoms over their lifetime as did 4.7% of abused men (Black et al., 2011). Women who have been sexually assaulted or stalked as well as physically abused are at the highest risk for PTSD, a combination of behaviors that describes the experience of 37% of the abused women in the general population (Black et al. 2011).

The classic precondition for PTSD is exposure to an event that induces “intense fear, helplessness, or horror” (American Psychiatric Association, 2000). In partner abuse, the trauma is usually more diffuse, more prolonged, and less tangible than in the conventional model. Recognizing that the traditional model failed to capture “the protean symptomatic manifestations of prolonged, repeated trauma” associated with abuse, psychiatrist Judith Herman (1992, p.119) identified a pattern she called “complex PTSD” and applied it to victims of rape, incest, and partner assault. Complex PTSD is characterized by hyperarousal (chronic alertness), intrusion (flashbacks, floods of emotion, hidden reenactments), and constriction, “a state of detached calm . . . when events continue to register in awareness but are disconnected from their ordinary meanings” (Herman, 1992, p. 45). These symptoms are linked to a protracted depression not unlike that described by Walker as BWS. Several studies confirm that many battered women suffer from the symptoms of complex PTSD (as described by Herman) or classic PTSD (as outlined in the DSM-IV), particularly if they have been sexually and physically assaulted. Other studies suggest a higher than normal prevalence of psychosexual dysfunction, major depression, generalized anxiety disorder, and obsessive compulsive disorders among battered women, all of which are consistent with a PTSD framework (Dutton et al., 2006).

Explaining the Secondary Health Problems Associated With Partner Abuse

The profile of health problems exhibited by battered women is unique, distinguishing their experience from the experience of victims of stranger assault or of men assaulted by female partners. Abused women are five times more likely to require medical care than abused men (7.9% vs. 1.6%) as well as to experience symptoms of PTSD (22.3% vs. 4.7%; Coker et al., 2002; Catalano, 2006). With the exception of high blood pressure, abused women are at also at significantly greater risk than abused men for a broad spectrum of adverse physical, mental, and behavioral health outcomes (Black, 2011; Black et al. 2011). The distinctive health profile presented by battered women appears to reflect the unique nature of male partner abuse rather than personality factors or family history that might predispose certain women to enter abusive relationships. Male partner violence is much more frequent than female partner violence, for instance, and far more likely to be accompanied by sexual violence and stalking. Fifty-three percent of men arrested for domestic violence, but only 3% of women, have more than three similar police reports, for instance (Hester, 2013a). Meanwhile, the NISVS found that 37% of the abused women in the survey reported being raped or stalked as well as assaulted (Black et al., 2011). The cumulative effects of this abuse include high levels of fear and stress-related health problems as well as behavioral health problems such as substance abuse, which reflect victim attempts to self-medicate the effects of coercion as well as to numb anxiety, hyperarousal, and other symptoms of PTSD (Hein & Hein, 1998).

The nonviolent tactics that complement coercion in a majority of abusive relationships are another major reason why woman battering has distinctive health effects. Forty-seven percent of the women responding to the NISVS reported they had been subjected to psychological aggression, including such tactics as not being allowed to socialize with friends or to leave the house, having their money taken, and having their time and movements monitored. Combined with violence and intimidation, these and similar tactics designed to isolate, degrade, exploit, and regulate

victims comprise coercive control, the pattern described in Chapter 4. Control may extend to constraints on resources vital to health, such as medicines, food, personal hygiene supplies, and access to health providers. By depriving women of autonomy, liberty, and basic rights and resources, coercive control elicits an experience of entrapment that can make victims feel like hostages even when they are physically separated from the abusive partner. A study of 600 women aged 15 to 24 who were patients at a reproductive health center in New York found that two thirds experienced one or more episodes of controlling behavior. The types of controlling behavior included the male partner: (a) insisting on knowing the woman's location at all times (45.9%); (b) being angry if the woman spoke to another man (40.8%); (c) being suspicious of infidelity (40.5%); (d) attempting to keep the partner from seeing friends (26.5%); (e) ignoring or treating his partner indifferently (24.7%); (f) restricting contact with her family (6.3%); and (g) expecting his partner to ask permission before seeking health care (3.7%; Catallozzi, Simon, Davidson, Breitbart, & Rickert, 2011). Because control tactics deprive women of the means to escape abuse or effectively resist it, the level of control in a relationship is an important predictor of future risk, including a risk that the victim will be seriously or fatally injured.

STOCKHOLM SYNDROME

Laura was charged with embezzling more than \$350,000 from the company where she kept the books, although she had no criminal history and had been valedictorian of her class at Vassar College. Laura claimed she stole the money to prove her love for her boyfriend, Tony. After Tony was killed in a motorcycle accident, Laura made a suicidal gesture and was discharged from the hospital with a diagnosis of obsessive compulsive disorder. Laura continued to steal small sums, seemingly disproving her claim of innocence. When the forensic social worker hired by the defense asked Laura what she did that was "obsessive," she described numerous rituals, including color coding her clothes, vacuuming daily "till you can see the lines," and measuring each dish to precisely fit spaces in the frig. When she was asked when these behaviors began, Laura produced The List, a set of rules prepared by her boyfriend that itemized his expectations room-to-room, including how she cleaned, cooked, dressed, and so on. Tony rewarded Laura with sex or time out with her friends when she complied with the rules, but beat or humiliated her when she was "bad." Over time, Laura came to believe that pleasing Tony was the only way to stay safe and that his reality was the only one that counted, an example of Stockholm Syndrome. Because completing the rituals was the only way she knew to keep safe (and her only source of self-esteem), she continued the rituals after his death, including small thefts he had demanded.

The health consequences of partner abuse often outlast the battering. Studies have found that half of the women who experienced PTSD remained symptomatic even after they had been out of a violent relationship for 6 to 9 years (Woods, 2000). However, most victims do not experience these consequences. Thus, while abused women were three times as likely as non-victims to describe their mental health as "poor" to the NISVS, only 3.4% overall gave this assessment (Black et al. 2011). Meanwhile, many symptoms (such as depression or hypervigilance) may resolve once safety is restored or, as with substance abuse, be more responsive to treatment.

Populations at Special Risk

Pregnant Women and Reproductive Coercion

Battering has myriad and dramatic effects on reproductive health, particularly among adolescents and young women. What is termed reproductive coercion or reproductive control ranges from physical and sexual assaults during pregnancy to demanding unprotected sex, sabotaging birth control, threatening a partner if she has or does not have

an abortion, or engaging in high-risk sexual behaviors. A California study of abused 15- to 20-year-old women found that a quarter reported that their male partners were actively trying to get them pregnant against their will, for example, by manipulating or refusing condom use (Miller, Jordan, Levenson, & Silverman, 2010). The NISVS (Black et al., 2011) found that 8.6% of women reported having had an intimate partner who tried to get them pregnant by not wanting to or refusing to use a condom. A common aim of forcing an unwanted pregnancy is to increase a partner's dependence by forestalling education, employment, or other sources of independence. Reproductive coercion is also the context for much of the aforementioned prevalence of STDS and HIV among abused women (Decker et al., 2009). The proportion of abuse victims who seek abortion is higher than in the general female population and ranges from 20% in Canada (Fisher et al., 2005) to 31.4% in the United States (Evins & Chescheir, 1996) to 35.1% in England (Keeling, Birch, & Green, 2004).

Population-based estimates of the prevalence of physical abuse among pregnant women differ markedly from estimates based on hospital samples. Based on data from 15 participating states, the CDC's Pregnancy Risk Assessment Monitoring System (PRAMS) found rates of violence ranging from 2.4% to 6.6% (Lipscomb, 2000). By contrast, starting with the YTS, a number of studies have shown that between 21% and 78% of women using hospital obstetrical services are in abusive relationships and that abuse is the major cause of injury during pregnancy (Stark & Flitcraft, 1996; Datner, Wiebe, Brensinger, & Nelson, 2007). Women who are abused while pregnant have 30 times the risk for clinical pregnancy trauma and 5 times the risk for experiencing placental abruption compared with women who did not report domestic violence (Leone et al., 2010). Abuse has been identified in 45% of the homicides and 54% of suicides from pregnancy to a year after birth, dwarfing other causes of perinatal mortality (Palladino, Singh, Campbell, Flynn, & Gold, 2011). Battered pregnant women are younger and less educated than their non-abused counterparts, are less likely to be married, and are significantly more likely to have trichomoniasis, to report depressive symptoms, to report high levels of psychosocial stress, and to abuse substances.

Evidence on how pregnancy affects the onset, escalation, or de-escalation of partner violence is inconclusive. However, studies agree that if women are abused before becoming pregnant, the abuse is more likely than not to continue during pregnancy as well as after the birth (Saltzman, Johnson, Gilbert, & Goodwin, 2003). In addition to its significance as a source of injury and fatality, abuse during pregnancy is associated with adverse pregnancy outcomes such as preterm birth and having a low-birth-weight baby; higher rates of maternal morbidity such as low weight gain and anemia; depression and other psychological problems; and delayed entry into prenatal care (Amaro, Fried, Cabral, & Zuckerman, 1990; Parker, McFarlane, Soeken, & Torres, 1993). A number of studies have also shown a strong connection between partner abuse and post-partum depression (e.g., Woolhouse, Gartland, Hegarty, Donath, & Brown, 2011).

Women With Disabilities

Conclusions about abuse among persons with disabilities are notoriously suspect. Persons with disabilities are often excluded from research for a variety of reasons, including the presumption that they are incapable of intimate relationships. Studies that purport to capture their experience may fail to differentiate vulnerability by the type of disability or to include questions pertaining to the types of intimidation and control to which persons with disabilities are particularly vulnerable. A confounding issue is the extent to which partners, helping professionals, and even some victims rationalize violent and controlling behavior as protective or as otherwise necessary for "her own good."

Disabled women are many times more likely than disabled men to experience partner abuse (Rand & Harrell, 2009). However, evidence is inconclusive about whether they also face a higher risk of being physically abused than nondisabled women. The NCVS conducted by the Justice Department found that physical abuse was as common among disabled as among nondisabled women (27.3% vs. 24.1%; Harrell, 2011), though disabled women were twice as likely to report being raped or sexually assaulted. Similarly, the NVAWS found no evidence that disability increases one's risk of intimate partner violence (Tjaden & Thoennes, 2000). By contrast, drawing on much larger samples of women as well as of disabled women, the 2006 Behavioral Risk Factor Surveillance System Survey

(BRFSS) reached the opposite conclusion, reporting that the lifetime prevalence of physical abuse was considerably higher among women with disabilities than nondisabled women (37.3% vs. 20.6%) and that disabled women were twice as likely to report being threatened with violence (28.5% vs. 15.4% of women without a disability); hit, slapped, pushed, kicked, or physically hurt (30.6% vs. 15.7%); and to experience sexual coercion by an intimate partner (19.7% vs. 8.2%). The BFRSS also found strong evidence that women with disabilities who are abused have significantly more health problems than non-abused women with disabilities, reporting that the victims were 35% less likely to consider their health as good to excellent and 58% more likely to report an unmet health care need owing to costs than their disabled counterparts not experiencing partner abuse (Barrett, O'Day, Roche, & Carlson, 2009). Similarly, a meta-analysis of 26 prior studies that included some 21,500 people with a range of physical and mental disabilities from seven countries (Australia, Canada, New Zealand, Taiwan, the United Kingdom, United States, and South Africa) found that disabled adults are 1.5 times more likely to be a victim of intimate partner violence, sexual assault, or other physical violence than those without a disability. In particular, those with mental illness are nearly four times more likely to be victimized, with some studies concluding that 40% of women with mental health problems were abused (Armour, Wolf, Mitra, & Brieding, 2008). There is also some evidence that women who are hearing impaired are twice as likely to be abused as women without hearing impairments and suffer elevated rates of psychological aggression (Abused Deaf Women's Advocacy Service, 1997). Interestingly, the General Social Survey of Statistics Canada (GSS) in 1999 found that disabled and nondisabled women reported similar rates of abuse in the previous year, but much higher rates and much more severe violence during the previous five years. (Brownridge, 2006).

MARIA AND "PERSPECTICIDE"

Domestic violence and coercive control may also cause a loss of physical and cognitive functions.

Maria's husband Thomas was arrested and charged with being part of a drug ring dubbed "the Pizza Connection" because it operated out of local pizza parlors. After the arrest, Maria received monthly deliveries of cash in paper bags at their Long Island home. Several months later, Maria was arrested. Local police and the FBI seized her home, which was sold at auction, and she was charged with crimes related to her allowing her home to be used for crime. She was also charged with tax fraud because she had signed returns claiming a tiny proportion of the income reflected in their yacht, her fur coats, and their expensive home and cars. At trial, a domestic violence expert testified that Maria suffered from "perspecticide," a condition in which victims of abuse or torture lose the ability to "know what they know." Because of her husband's 25-year history of physical, sexual, economic, and psychological abuse and the danger of even thinking of confronting her husband, let alone actually confronting him, about his law-breaking, Maria was unable to think for herself or to make the most basic logical connections. Indeed, it took two years of psychiatric care after her acquittal for Maria to regain the ability to tell time.

Defining Woman Battering in the Health Setting

The different aims of health and criminal justice and the longitudinal and multifaceted health consequences of partner abuse have led the health and justice systems to define and measure the problem in very different ways.

Because of its emphasis on discrete assaults, the criminal justice system generally ignores the elements of partner abuse that are key to its health outcomes—namely its frequency, duration, sexual nature, and cumulative effects. Many facets of coercive control that have devastating health consequences are either not criminal—such as taking a partner's medications, timing her coming and going, or setting rules for when and how she cooks, makes love, feeds the

children, or contacts outside professionals—or are criminal only when committed against a stranger, such as taking a partner's money or using a GPS to track her movements. Thus, the working definition of domestic violence in the health system must be far broader in scope than the criminal justice definition and must consider partner abuse as historical and multidimensional rather than as limited to discrete episodes of violence.

The contrasting definitions used by the criminal justice and health-care systems also reflect the very different consequences of mistakenly identifying someone as a victim in the two systems. Criminal justice adapts narrow definitions of crimes like abuse to maximize the likelihood that only “true positives” will be sanctioned, even if this means leaving many offenders outside the definition's scope (“false negatives”).

Since the aims of the health-care system are ameliorative rather than retributive and because the legal status of acts or the relational status of the parties are irrelevant to health consequences, clinical assessments of abuse must be all-inclusive and designed to identify as many victims of domestic violence or coercive control (“true positives”) as possible, even if this means questioning or offering services to many patients for whom abuse is not a current concern (“true negatives”). Therefore, the most effective operational approach to identification in health settings involves an inclusive notion of coercion and control, regardless of marital or living status, sexual orientation, the severity of injury, or whether the presentation involves injury, medical, behavioral, or psychological problems, or simply fear. Since the clinician's primary concern is future risk, the important distinction is between an anonymous assault, where ongoing problems are unlikely, and coercion and control by a partner.

Measuring Partner Abuse: Prevalence and Incidence

The historical, multidimensional, all-inclusive, and ameliorative definition that informs the health perspective on partner abuse also provides a unique, treatment- and prevention-oriented approach to measurement. Most crimes are narrowly circumscribed in time and space and so are rightly counted as discrete acts, even if the particular offender is well-known to police. From this perspective, the number of new cases, what is called “incidence” in epidemiology, is virtually identical to the total number of cases, or “prevalence,” and so the two terms are used interchangeably. If the crime rate drops, so does the burden of crime on the community.

Incidence and prevalence are also interchangeable for diseases like the flu, where the sentinel event is over quickly, much like a mugging. However, a large number of health problems are either chronic or last for a considerable period, like alcohol abuse. In this instance, the total burden on the community, or the prevalence (P) of a problem (discussed in Chapter 2), is calculated by multiplying its incidence (I) by its average duration (D) and is expressed in the simple formula $P = I \times D$. Note that a problem can continue to drain significant resources if it is long-lasting even if we reduce the number of new cases significantly, as has been the case with HIV/AIDS. Distinguishing incidence, duration, and prevalence is vital to determining whether we can expect to make the greatest impact on a problem from primary prevention (keeping new cases from developing), secondary prevention (ending ongoing cases), or tertiary prevention (shortening the duration or severity of a case).

We saw previously that researchers approximated the average duration of abusive relationships as between 5.5 and 7.3 years, making abuse more like a chronic than an acute health problem like the flu. This is why, in our discussion below, we emphasize health reforms that replace an acute-care model of intervention with a model that situates the management of abuse in the context of a patient's ongoing care. Meanwhile, the YTS estimated that the “institutional prevalence” of abuse among female trauma patients was approximately 15%. These were cases in which women had experienced at least one abuse-related visit in the past 5 years. When these values were plugged into the formula, Stark (2007) estimated the annual incidence (I) of domestic violence among female trauma patients was between 2% and 3%. This meant that domestic violence was a current concern for 15 of the 19 of every 100 female trauma patients who had “ever” been battered and that it was “new” for only 3 of these women, illustrating a very low spontaneous cure rate. Put differently, the fact that 79 to 86 of every 100 battered women in the hospital caseload are in long-standing abusive relationships suggests that effective early intervention (“secondary prevention”) could reduce the overall health burden associated with partner abuse by as much as 85%, freeing up considerable resources for other health needs, including primary prevention.

Even the broadest definition of abuse is unlikely to substantially improve the health response unless it is embedded in a strategy of professional education that helps providers appreciate how the knowledge of abuse informs the victim's diagnosis, intervention, and prognosis for recovery, including the likelihood that she will suffer a similar problem in the future and can comply with both treatment and follow-up care.

Medical Neglect

Domestic violence was virtually invisible to the health system when the first shelters opened. There is no reference to partner violence in a 1985 survey of Injury in America (Committee on Trauma Research, 1985) conducted under the auspices of the National Academy of Medicine and the National Research Council. Reported rates of accurate identification in abuse cases ranged from 1 in 15 in a rural clinic in North Carolina to 1 in 20 in the YTS (Hilberman & Munson, 1977/78; Stark & Flitcraft, 1996). At Yale, only 1 injury in 40 caused by abuse was linked to partner violence and these notations were mostly fortuitous. Clinicians would report unreflectively that a woman had been "beat up by boyfriend" or "kicked by foot" at one visit and then had "fallen at bank" at the next. Physicians found ways *not* to identify abuse even when they said it was their responsibility to do so. A study of four Philadelphia emergency rooms identified a propensity for physicians to discredit victims who disclosed domestic violence even after they had been trained to respond appropriately (Kurz & Stark, 1988). As late as 1991, only 20% of emergency departments in Massachusetts had a written protocol in place to identify domestic violence, and 58% reported that they identified five or fewer battered women a month, which represents a tiny fraction of research estimates (Isaac & Sanchez, 1994).

Some research suggested that the clinical response to abuse actually increased a woman's entrapment in the abusive relationship. After failing to identify partner violence, clinicians treated a woman's injuries symptomatically, which did little to address her underlying predicament. As abuse continued and she returned to the hospital, other problems began to appear on her medical record alongside injury—nonspecific pain, headaches, or somatic complaints, for instance. Typically, these problems were treated with sleep medications and antianxiety drugs; these medications were used subsequently by many in suicidal gestures or "cries for help." Sometimes, women's repeated help-seeking was mistaken for malingering. In these instances, physicians vented their frustration by applying pseudo-psychiatric labels, writing that the abuse victims were "frequent visitors," hypochondriacs, or "hysterics." The effect of applying these labels was to communicate to other clinicians that they should not waste valuable time on these women, which isolated them further from vital resources. This reinforced the same message the abusive partner was giving the victimized patient: She was the problem, not him. Since the pills were given to her, clearly she was the crazy one. Her partner also had told her this was true. Without proper medical assistance, many women attempted to self-medicate using alcohol or drugs to relieve the stress in the relationship. Now, a doctor or nurse might recognize that she was "beaten by boyfriend," but once a woman appeared with "alcohol on breath" or a similar issue, her behavioral adaptations were taken as the primary cause of any abuse-related injury rather than as the consequence of domestic violence. Thus, women were referred for psychiatric or behavioral treatment, often with their abusive partner as an identified caretaker. Given these realities, it was not surprising that women rated medicine the least effective of all interventions (Bowker & Maurer, 1987).

Reforming the Health System

As is true for reform in the societal response to abuse generally, so in health as well has reform been driven by a combination of grassroots activism, legislative initiatives, and changes in standards of practice (in this instance, those set by the professional associations to which health providers belong or by the associations that license hospitals and review their accreditation). Still, nothing we say in the following sections mitigates the influence of local markets, administrative decisions, and the ability to pay on the health system response to abuse. Despite trends toward more centralized ownership and administration of specialized medical practices, physicians—the critical decision makers at points of service—are still largely self-employed and, therefore, are not directly accountable for the quality of care provided by hospitals or the costs of care. Most mental health providers also are private practitioners with similar limits on accountability to central policy directives and cost restrictions.

The earliest medical responses to domestic violence relied on individual, hospital-based initiatives by nurses and social workers. In 1977, building on the success of hospital–community collaborations in establishing rape crisis teams, the Ambulatory Nursing Department of the Brigham and Women's Hospital in Boston formed a multidisciplinary committee to develop a therapeutic intervention for abuse victims. The intervention at Brigham, like a parallel program at Harborview Hospital in Seattle, relied on a social service trauma team composed initially of volunteer social workers who met weekly with nursing staff. Although these largely volunteer efforts proved difficult to sustain, during the next decade, clinician-advocates, who often worked closely with shelter or other women's groups in their communities, introduced freestanding domestic violence services at hospitals in Chicago, San Francisco, Philadelphia, Minneapolis, and many other cities.

Initial reform efforts emphasized developing domestic violence policies and protocols within hospitals and medical departments, primarily in emergency services, providing guidelines for practitioners at these sites and training health practitioners to respond more appropriately. In 1986, under its Family Violence Prevention and Response Act, Connecticut established the Domestic Violence Training Project at the University of Connecticut's Health Center, which was one of the first publicly funded projects established to train health professionals in domestic violence intervention. Other states hosted similar projects, including Minnesota, Pennsylvania, Alabama, Colorado, New Jersey, and Wisconsin. In 1990, through its Office of Domestic Violence Prevention, New York became the first state to require that licensed hospitals establish protocols and training programs to identify and treat victims of domestic violence. The New York office also placed domestic violence advocates in all New York City hospitals. In 1994, Florida passed legislation requiring 1 hour of instruction on domestic violence as a condition of licensing and recertification for health providers. Shortly afterward, California mandated that hospitals and clinics screen all patients for domestic violence and required health personnel to report individual cases to authorities. In the wake of these changes, the San Francisco–based Family Violence Prevent Fund (renamed Futures without Violence or FUTURES) and the Pennsylvania Coalition Against Domestic Violence selected six hospitals in California and six in Pennsylvania to test a new domestic violence resource manual for providers. Each hospital formed multidisciplinary teams (including a domestic violence advocate) and was given technical assistance to implement a comprehensive response. With funding from the Commonwealth Fund, the Domestic Violence Training Project (DVTP) mounted a similar initiative in Connecticut's 11 federally qualified community health centers.

As the knowledge base about the significance of abuse developed, local initiatives with hospitals were supplemented by attempts to mobilize the public health system and private practitioners. An unprecedented Surgeon General's Workshop on Violence and Public Health was convened by C. Everett Koop in 1985. This was followed by regional conferences on the same theme, as well as by a conference convened in Washington, DC, by the American Medical Association (AMA) and cosponsored by 50 medical, nursing, legal, and social service organizations. Working with the CDC's National Center for Injury Prevention, Dr. Koop identified the unique importance of a health-care response. He wrote:

Identifying violence as a public health issue is a relatively new idea. Traditionally, when confronted by the circumstances of violence, the health professions have deferred to the criminal justice system. . . . Today, the professions of medicine, nursing, and health-related social services must come forward and recognize violence as their issue. (Koop, 1991, p. v)

The workshop also emphasized the economic and social costs of violence and focused specifically on violence against women and children.

To the extent that private practitioners in the United States have responded to domestic violence, they have done so under the auspices of their professional associations. After a series of studies in Texas demonstrated that battering was a problem for many pregnant women, the American College of Nurse Midwives and the American College of Obstetricians and Gynecologists mounted national campaigns to educate their members. In 1991, the AMA followed suit, developing and disseminating diagnostic and treatment guidelines on child abuse and neglect, sexual abuse, domestic violence, as well as elder abuse and neglect. By the end of the 1990s, virtually

every organization representing health professionals in the United States had identified domestic violence as a priority, some moved to action by advocacy groups within their profession. For instance, the American Nursing Association was pressured to adapt domestic violence as an issue by a newly formed National Nursing Network on Violence Against Women.

Many additional professional health organizations also took initiatives, including representatives for army medics, emergency medical personnel, psychiatrists and psychologists, dentists, pediatricians, and surgeons working with traumatic brain injury. Under the leadership of the AMA, a National Coalition of Physicians Against Family Violence was formed with institutional membership from more than 75 major medical organizations. The AMA's initiatives also emboldened state medical societies and groups in Colorado, Connecticut, Ohio, Maryland, and several other states to distribute diagnostic, reporting, and intervention guidelines to their membership. Illustrating these initiatives was a Physicians' Campaign Against Family Violence launched with a special issue on domestic violence by the Maryland Medical Journal. With seed funding from the state medical society, the Maryland program produced training materials, a physicians' manual, and patient information brochures, and the program stimulated legislation to develop onsite victim advocacy programs at four diverse hospitals.

In 1992, the AMA Council on Ethical and Judicial Affairs suggested that domestic violence intervention be rooted in the principles of beneficence and non-maleficence. In the same year, the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) required emergency and ambulatory care services to develop domestic violence protocols. In 1996, the standards were upgraded to include objective criteria to identify, assess, and refer victims of abuse. The JCAHO standards provided a significant boost to training. McFarlane and her colleagues (McFarlane, Christoffel, Bateman, Miller, & Bullock, 1991) found that the implementation of a program for health professionals in a Texas obstetrical service resulted in a statistically significant gain in knowledge of domestic violence. Of those who completed training, 86% stated they intended to assess for signs of abuse among pregnant women. More importantly, at the 6-month follow-up, approximately 75% of the participating health service centers were assessing pregnant patients for signs of battering. The combination of community outreach, public education, and health professional training was linked to a noted increase in calls to information centers by battered women who had been referred by a health provider. When nurse interviews replaced reliance on patient self-reports, identification of domestic violence increased 20%. Other studies reported as much as a 600% increase in identification after an initial training of health providers (McLeer & Anwar, 1989). In part, these gains reflected the sorry state of awareness when training began. Without an ongoing institutional commitment to provide resources of clinical intervention with domestic violence victims, the initial gains from training were hard to sustain.

Medical education was another arena that was vital to reforming the health system response. By 1993, 101 of the 126 US medical schools responding to a survey had incorporated material on domestic violence into required course material (Alpert, Tonkin, Seeherman, & Holtz, 1998). Other critical pieces of the health response included (a) major commitments to health research in rape and domestic violence by the NIMH; (b) the establishment of regional Centers for Injury Prevention and Control with funding from the CDC to conduct translational research on violence prevention, including domestic violence prevention; (c) major funding commitments to domestic violence research and health interventions by private foundations such as the Commonwealth Fund and the Hilton Foundation; and (d) the designation of the San Francisco FUND (now called FUTURES) as a national center to disseminate information on domestic violence-related health issues under VAWA in 1994. Although the CDC had traditionally limited its role to surveillance, reporting, and epidemic control, in 1996, it launched a program to support Coordinated Community Responses to Prevent Intimate Partner Violence in several communities. Health-care institutions played a vital role in these collaborations.

For fiscal year 2000, \$5.9 million was appropriated to support 10 projects administered by the CDC. In 2005, the reauthorized VAWA specifically targeted health professionals for support. VAWA recognized that,

Because almost all women see a health-care provider at least once a year, the health-care system is uniquely positioned to proactively reach out to women who are or have been victims of domestic or sexual violence. Health-care providers, if trained and educated, can find safety long before she can turn to a shelter or call the police. (National Task Force, 2005, p. 5)



In 2000, a joint task force headed by the US Attorney General and the Secretary of Health, Education, and Welfare issued an Agenda for the Nation on Violence Against Women. Among the 15 areas of focus, the health-care system was prominent. A 10-point summary of the Health Care Systems section of the Agenda is outlined as follows:

1. Conduct public health campaigns
2. Establish national task force on health and mental health care systems' response to sexual assault
3. Educate all health-care providers on violence against women
4. Create protocol and documentation guidelines for health-care facilities and disseminate widely
5. Protect victim health records
6. Ensure that mandatory reporting requirements protect the safety and health status of adult victims
7. Create incentives for providers to respond to domestic violence
8. Create oversight and accreditation requirements for domestic violence and sexual assault care
9. Establish health-care outcomes measures
10. Dedicate increased federal, state, and local funds to improving the health- and mental health-care systems' response to violence against women



Title V of the Act sought to strengthen the health system's response with programs to train and educate health-care professionals about domestic and sexual violence, promote family violence screening for patients, and study the health ramifications of partner abuse.

Improvements in the health response to partner abuse over the last decade have mainly resulted from the dissemination and normalization of earlier initiatives in professional education, training, and patient inquiry. For example, it is standard practice in thousands of health facilities for patients to be asked some variation of "Are you safe at home?" or "Is someone hurting you or controlling what you do?" at all points of service. Another example is the Domestic Violence Health Care Partnership (DVHCP) in California. Operated through a partnership between FUTURES and the Blue Shield of California Foundation, DVHCP funds 19 teams comprising local domestic violence organizations and health facilities to develop policy and clinical responses to domestic and sexual violence and to help advocates connect survivors with health services. Although primarily concerned with improving the criminal justice response, particularly to underserved populations such as immigrants and Native Americans, the latest reauthorization of VAWA (2013–2014) provided special support for medical and nursing examinations in sexual assault cases and funding through CDC, DOJ, HHS, and the Department of Education for research on best practices to combat and reduce domestic violence and to encourage "a comprehensive approach that focuses on youth, children exposed to violence, and men as leaders and influencers of social norms (SMART Prevention grants)."

The omnipresence of abuse victims across the spectrum of health services highlights the importance of rooting intervention in primary care. Primary care is predicated on longitudinal responsibility for patients regardless of the presence or absence of specific diseases, and the integration of physical, psychological, and social aspects of health into a holistic understanding of a patient's needs. Apart from the specific issues raised for health care by abuse, we should remember that utilization by battered women is shaped by the same factors that shape utilization of health services generally, including local demographics and the physical, financial, and cultural accessibility of health care.

NATIONAL HEALTH RESOURCE CENTER ON DOMESTIC VIOLENCE

Created by the VAWA in 1994 and operated under the auspices of the San Francisco–based FUTURES, The National Health Resource Center on Domestic Violence (The Center) is funded to improve health care's response to domestic violence.

The Center offers:

- Personalized, expert technical assistance via email, fax, phone, postal mail, and face-to-face at professional conferences and meetings around the nation. Contact us at health@futureswithoutviolence.org or call 415-678-5500.
- An online toolkit for health-care providers and DV advocates to prepare a clinical practice to address domestic and sexual violence, including screening instruments, sample scripts for providers, and patient and provider educational resources.
- A free e-Bulletin highlighting innovative and emerging practices in addition to well-documented and rigorously evaluated interventions.
- A free webinar series with expert presenters and cutting edge topics.
- A biennial National Conference on Health and Domestic Violence—a scientific meeting at which health, medical, and domestic violence experts and leaders explore the latest health research and programmatic responses to domestic violence.
- Online access to the Health Material Index.

The Major Challenge Ahead: Screening and Clinical Violence Intervention

The interrelated components of reforming hospitals and other health institutions include routine questioning about abuse, triage to patient-specific services if requested, in-house champions to oversee the response, and ongoing provider trainings that address the importance of looking beyond violence, providing information regardless of observed risk, culturally sensitive and nonjudgmental support, addressing patient safety and documentation. With funding from the Commonwealth Fund, the DVTP completed a demonstration project that showed how a “training-the-trainer” strategy could implement this model with or without outside technical assistance from advocacy groups at Connecticut’s 11 federally qualified community health centers (Stark, 2010). One of the most successful comprehensive programs is Project Connect, a collaboration initiative operated by 11 Grantees and administered by FUTURES that has trained health providers to assess for and respond to domestic and sexual violence in more than 80 clinical settings. An evaluation by researchers at the University of Pittsburgh suggests that Project Connect reduces the risks for unplanned pregnancy, poor health outcomes, and further abuse.

Barriers to Identification

Despite extensive and often well-funded efforts to incorporate domestic violence into the professional education and training of health providers, widespread resistance remains to making the identification and management of partner abuse and its consequences—what we term “clinical violence intervention”—a part of routine patient care. One result is that the proportion of true positives who are appropriately cared for has lagged far behind investments in reforming the health response to abuse.

The limited progress in identification is not hard to understand. Some abused women are too frightened or too ashamed to admit their partner is hurting them. Moreover, many clinicians are reticent to ask about or confront abuse for the same reasons police were traditionally arrest-averse in domestic violence cases: They believe relationship

violence is a private matter that falls outside their purview, that asking about relationship violence will open a Pandora's Box, and that it is pointless to confront abuse because they can do little to stop it.

These explanations are unsatisfactory for several reasons. First, most abused women report they would welcome inquiries about abuse from clinicians and are forthright when asked in a confidential setting (Caralis & Musialowski, 1997). Second, although issues of patient confidentiality must be handled delicately, physicians and nurses frequently elicit accurate information about other personal matters such as sexual activity or parenting practices. Finally, physicians routinely screen for problems for which no effective therapies exist.

Another explanation for low rates of identification highlights the discomfort physicians and public health practitioners feel about intervening in abuse. Some clinicians believe intervention to help battered women means discounting the competing rights of husbands or involves them inappropriately in the politics of family life. Research confirms that abused women may not seek health care or disclose their abuse when they encounter providers who appear "uninterested, uncaring, or uncomfortable" about domestic violence (Campbell, Pliska, Taylor, & Sheridan, 1994). A recent study among women seeking healthcare in UK primary care surgeries who had experienced physical and sexual abuse from a partner or ex-partner in the previous year found they wanted their doctors to ask them about partner abuse and refer them to help, but not demand they leave their abusers before they are ready (Malpass, Sales, Howell, Johnson, & Agnes-Davies, 2011). Identification rates remain low where questions about abuse are posed in a perfunctory way with little sensitivity to the context or risk involved in disclosure or no information is provided about what can be done if the patient reports abuse (O'Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011).

The implied involvement with the criminal justice system or child protective services also makes some clinicians uneasy about clinical violence intervention. Nursing, social work, public health, and the allied health professions embrace more holistic concepts of health but are no less wedded to stereotypes that attribute blame to victimized individuals and preclude public advocacy where the roots of problems lie in politically charged issues such as sexual inequality.

Other obstacles to change are the status structure of medicine, its traditional male bias, its commitment to a narrow disease paradigm that minimizes so-called social problems, and the belief that partner abuse is such an ingrained facet of poverty that nothing can be done. Even when victims have financial access to health services, capitation arrangements and pressure for primary care providers to serve as gatekeepers can aggravate concern that asking about abuse will occupy more clinical time than these cases merit. Other challenges involve the absence of strong federal leadership in primary care or public health and the large number of families without adequate health coverage even after recent expansions of coverage under the Affordable Care Act. Taken together, it is easy to explain why a health problem that affects 20% or more of the adult female population has elicited a medical response that is uneven at best, even from those practitioners specializing in injury.

Screening

Health advocates hoped to sidestep resistance to identification by individual clinicians by making screening for partner abuse an official part of patient care. Routine screening has been endorsed by many associations of health professionals such as the AMA and American Nursing Association, as well as by JCAHO. Moreover, it seems an eminently sensible approach given the high prevalence of abuse, its significance for a range of health problems, the reluctance of doctors to identify the problem on their own, evidence that early and effective intervention could lead to dramatic cost savings, and the low probability of harm caused by screening.

Although it may seem surprising, proposals for routine, universal patient questioning about domestic violence continue to excite controversy. Organizations such as the US Preventive Services Task Force, the UK National Screening Committee, the WHO, and the Canadian Task Force on Preventive Health Care have either withheld support for such recommendations or opposed them. The reasons given for their opposition range from the claim that domestic violence is not a disease per se to the fact that its risk factors are complex. However, the key criticisms are that there is a paucity of evidence that screening tools are accurate, that their application improves health outcomes for abused women, or that the services to which identified victims are referred have been proved effective.

Since doing nothing about abuse violates the ethical imperative to inform all patients about the risks and available resources, most studies have compared screening to other types of intervention, such as questioning based on risk profiles or simply providing all patients with information about abuse. Another approach has been to assess health and service utilization before and after questioning about abuse. A 2012 review of 15 studies undertaken by the US Preventive Services Task Force that evaluated the accuracy of screening found that (a) screening instruments designed for health-care settings can accurately identify female abuse victims; (b) screening women for abuse can reduce violence and improve health outcomes (noting that there are important limitations in effectiveness studies); and (c) screening had minimal adverse effects on women, although some women experienced “discomfort, loss of privacy, emotional distress, and concerns about further abuse” (Nelson, Bougatsos, & Blazina, 2012). By contrast, another survey of existing studies concluded that (a) although routine screening greatly increased identification, improvements waned with time; (b) asking one question was as beneficial as asking many; and (c) there was no evidence that improved identification led to better outcomes for victims (Ramsay, Richardson, Carter, Davidson, & Feder, 2002). One of the few randomized studies available reported that victims whose positive screen results were communicated to their physicians had no better outcomes than women who were simply given a referral card (MacMillan et al., 2009). Unfortunately, evidence is rarely provided in these studies about whether physicians actually used the information they got from the screen or how they did so. Moreover, the retention rate in the randomized study was too low to support its general conclusion: that many of those identified as abused were already aware of and using services and a debatable statistical method was used that neutralized the reduction in harms that were found. One major and unanticipated effect of the screen was that more than four times as many abuse victims who were questioned discussed violence with their physicians than abuse victims who were not screened (44% vs. 10%). If supported by other research, this finding suggests that routine questioning is a sound basis for the ongoing care of abused patients. None of these studies measured outcomes linked to health costs such as whether victims who were referred for support were more or less likely than those not questioned or referred to reduce their overall use of health services.

Universal screening presents a shift in clinical practice from the more familiar professional norm of targeted screening, which involves asking only those individuals perceived by clinicians as high risk, the approach favored by many critics of routine inquiry, including the WHO. However, abuse is the context for so broad a range of health problems that the list of risk factors is virtually identical to women’s major complaints, particularly at sites serving poor or disadvantaged populations, making it far easier and more cost effective to take a generic rather than a risk-based approach to questioning. Moreover, an approach that relies on risk factors is unlikely to pick up early onset abuse or cases in which nonviolent coercive control tactics are the major means of oppression or those characterized by frequent but low-level violence.

If the weight of evidence supports the introduction of a universal screen for partner abuse, opponents of screening have raised two important issues: (a) the appropriate measure of success, and (b) the limits of a screening protocol that is not complemented by sensitive case management, referral, and accountability.

Many female patients are comforted when their abuse is acknowledged, some are newly made aware of service options, and some will see questioning about abuse as opening a door through which they can escape. In general, however, given the low spontaneous cure rate of partner abuse, the complex problem profile it elicits in a significant minority of victims, the comprehensive nature of the oppression involved (particularly in cases of coercive control), and the limited efficacy of available interventions in ending abuse, it seems extremely unlikely that routine inquiry will result in major changes in women’s short-term health status, let alone end abuse. Clinicians routinely question patients about a family history of heart problems or other diseases as well as about a range of behaviors such as smoking or sexual activity. These questions often have no immediate benefit for patients or, as is the case with asking about smoking, have not been shown to lead to beneficial outcomes. The principal function of these questions is to broaden the frame within which clinicians understand a patient’s complaints, risks, and test results. Similarly, knowledge of abuse bears on how clinicians interpret and respond to a myriad of problems secondary to abuse, as well as to patient behaviors within the medical context—such as frequent visits, missed appointments, or reluctance to discuss the source of injury—to which they might otherwise apply stigmatizing labels. Thus, measuring how screening affects patient care is as important as assessing its impact on domestic violence. Domestic violence screening is a form of patient and

clinician education; this fact is illustrated by the dramatic increase in physician–patient discussions about abuse in the Canadian study. It also provides an institutional data set to help administrators allocate scarce resources and a baseline against which to judge the efficacy of intervention. Perhaps more importantly, although significant harm reduction might not result from hospital screening, compelling evidence suggests that not asking about or responding to domestic violence leaves victimized women at risk and elicits inappropriate and often harmful responses to the secondary effects of abuse from medical care.

Critics make a convincing case that routine inquiry in itself may function as a form of disguised betrayal unless it is embedded in a comprehensive program of clinical violence intervention. A recent review of major studies concluded that screening can be “very effective and more patients can be helped” if the program has institutional and senior administrative support, questions are standardized, patients are questioned privately, and the identification of partner abuse prompts services or referrals (O’Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011).

Illustrating this approach, the San Francisco–based FUTURES developed and helped establish screening guidelines in diverse settings as part of a National Health Initiative demonstration project. Among several dozen other initiatives by state medical societies, hospitals, and local nonprofits, two stand out as exemplary—Woman Kind in Minnesota and DOVE, which is known as Developing Options for Violence Emergencies, in Akron, Ohio. Successful screening programs had links to such support services as mental health care, safe shelters or transitional housing, health care, employment assistance, and legal services (O’Campo et al., 2011). The provision of support services is another important outcome measure in screening research.

Complementing generic screening at primary and emergency care sites are programs that add questions, education modules, and safety planning about partner violence to protocols to prevent behavioral problems associated with abuse. For instance, based on evidence about the importance of partner abuse as a context for female suicide attempts, Kaiser Permanente of Northern California, an HMO with more than 3 million members and 20 medical centers, has added questions about partner violence to a new program of suicide prevention for patients who are not involved in mental health clinics (Sederer, 2011).

Who should do the questioning when, where, and with what questions are other issues in screening. Physician-oriented educational seminars do not seem to improve identification rates significantly, even when the annual physical is the setting selected for questioning (Soglin, Bauchat, Soglin, & Martin, 2009). By contrast, when nurses ask patients about abuse at check-in, the documentation of lifetime abuse improves substantially, although current abuse is often not reported. In a Canadian study, Thurston and colleagues (2009) found that 39% of all patients were screened on average and that the screening rate had risen to 52% during the last month of the 1-year study. Importantly, 16% of those screened acknowledged abuse, which is approximately the expected rate. In part, the improvement over time was a result of increasing comfort among nurses with questioning. A large-scale study found that patients preferred written and online questionnaires to questioning from doctors or nurses. While patients provided more information on the self-administered questionnaires, however, there were no differences in the overall prevalence of abuse reported (MacMillan et al., 2006). Another alternative is the audio-based questionnaire. If they are interviewed, however, women express a preference for a female screener of their own race and for screeners who are in their age range, although age does not seem to concern older patients (Thackeray, Stelzner, Downs, & Miller, 2007). Only 7.9% say they would be angry or offended if they were questioned by their health-care provider about intimate partner violence. Within particular services, screening can help identify high-risk subgroups. For instance, in the pediatric setting where screening is readily accepted, mothers who miss their well-child appointments have been identified as at a risk for abuse (Phelan, 2007). However, victimized middle-class mothers might overuse well-baby services, reflecting the demands of a controlling partner.

Recent work on screening suggests that questioning patients only about physical violence might exclude many victims of coercive control, with approximately one in four women who present with the effects of being abused having never been physically assaulted (Lischick, 2009). Few screening tools contain specific questions about these broader dimensions of abuse and the few that have been tested in a health setting seem to screen out non-abused women more effectively than they identify victims. Asking women general questions about whether they feel “safe at home,” for instance, does not help identify women who experience low levels of physical violence at home. (Zweig, Schlichter, & Bur, 2002).

TEN STEPS TO ELICITING ACCURATE INFORMATION OF PARTNER ABUSE: WHAT FEMALE ABUSE VICTIMS TELL US

1. *Provider is non-judgemental*
2. *Some type of protection is available*
3. *Injuries and other forms of abuse are documented*
4. *There is an immediate response*
5. *The complexity of the situation is acknowledged*
6. *They feel they control the encounter*
7. *Options are provided (but not dictated)*
8. *Disclosure is discretionary*
9. *Questioning occurs at each visit*
10. *There is an open-door policy that makes help available as needed*

Mandatory Reporting

Another challenge is whether health providers should be required to report in abuse cases. Hoping to use reporting requirements to improve accountability and induce hospitals to invest in training, Connecticut and Minnesota required their hospitals to compile monthly statistics on their census of battered women. Connecticut and Minnesota quickly abandoned these requirements, however, the former because reported statistics were embarrassingly low and the latter because of the implication that reporting implied a state obligation to protect victims. US states mandate that clinicians report child abuse as well as injuries caused by gun shots, stabbing, or other violence to police. California, Colorado, and four other states specifically extend this mandate to include partner violence while Oklahoma, New Hampshire, and Pennsylvania specifically exempt clinicians from reporting such injuries. Supporters of mandated reporting believe they facilitate prosecution of batterers, encourage clinicians to identify abuse, and improve data collection. Opponents argue that such policies reduce patient autonomy, compromise patient confidentiality, can increase women's danger, and can lead to a reluctance on the part of some victims to discuss abuse with their clinicians. Interestingly, no increase in medical reports of domestic violence followed the introduction of California's mandated reporting requirement, possibly because neither clinical identification nor compliance are standardized or monitored. Current mandated reporting requirements foster the mistaken equation of partner abuse with severe injury and increase the reluctance of some clinicians to ask about abuse. After a review of existing practices for FUTURES, Ariella Hyman (1997) concluded, "the implications of mandatory reporting for patient health and safety as well as ethical concerns raised by such a policy argue against its general application" (p. 11).

Clinical Violence Intervention

Whatever kept individual clinicians or hospitals from responding appropriately to battered women in the past, experience suggests that health providers are willing to take violence as their issue when required behavioral changes are incremental and consistent with existing values, practices, and skills. The three major aims of clinical violence intervention are to: (a) convey the importance of partner abuse as a health issue to *all* patients;

(b) incorporate an understanding of partner abuse into treatment and patient management strategies; and, (c) through patient education and referral, prevent the progression of partner abuse by restoring a woman's sense of access to and control over her material resources, social relationships, and physical environment. This process is referred to as empowerment.

The introduction of a brief screen into the basic interview with all female patients avoids the problem of relying on severe injury before identifying abuse. In one primary care setting, when a single question, "At any time has a partner ever hit you, kicked you, or otherwise hurt you?" was added to a self-administered health history form, domestic violence identification increased from 0% (with discretionary inquiry alone) to 11.6% (Freund, Bak, & Blackhall, 1996). Adding questions that tap elements of coercive control as well as physical or sexual violence helps identify victims of coercive control, some of whom may not have been physically assaulted. Such questions might ask whether someone is "controlling what you do," "stalking you," "doing things that make you afraid," "taking your money" or "making you feel like a servant or slave." After identification, a confidential assessment of service needs can progress from validating a woman's concern to taking a careful history of adult trauma. In addition to getting at the history of abuse-related violence, the trauma history extends to the dynamics in the relationship that increase a woman's vulnerability to injury and other problems such as patterns of control, isolation, degradation, exploitation, and intimidation. It would also include a review of medical, behavioral, or mental health problems that might be associated with abuse, and consideration of risk to children in the home. The assumption throughout is that that observed behavioral or health effects of abuse are the cumulative result all that has come before as well as of the current situation and a legitimate focus for ongoing patient management.

The strategy of supportive empowerment, which emphasizes expanding a woman's options and facilitating individual choices, contrasts markedly with the protective service approach taken to abused children or victims of elder abuse, as well as with the strategies used to resolve family conflicts such as parenting education or couples' counseling. Supportive empowerment guides the health provider to safety planning *with* as opposed to *for* the victim, proceeding from how she has managed so far to what she views as the next step. Common interventions available involve shelter or other emergency housing, legal services, police involvement, treatment for substance abuse, ongoing physical therapy, job counseling, continuing education, and welfare or other emergency assistance. The overall strategy of managing the abuse as well as planning for safety should be re-evaluated at each visit.

As assessment tools are developed to help clinicians distinguish new from ongoing cases of partner abuse, it will be possible to evaluate which approaches to clinical management are most helpful. For instance, one study showed that three counseling sessions with pregnant and postpartum women led to greater reductions and violence exposure and improvements in overall maternal health than simply providing victims with a card identifying local services (Parker, McFarlane, Soeken, Silva, & Reel, 1999; McFarlane, Soeken, Reel, Parker, & Silva, 2007). Even more impressive results have been reported for home-visitation programs that incorporate a domestic violence component. Thus, a Hawaiian study of more than 600 new mothers found those who received weekly in-home visits from counselors after giving birth were less likely to report being physically abused by current or former intimates compared to mothers who did not have home visits. The mothers trusted the counselors and the relationship provided social support and decreased isolation (Bair-Merritt et al., 2010). While a significant reduction in violence persisted beyond the termination of the home visits, there was no comparable reduction in verbal or other forms of nonviolent abuse, possibly because strategies for dealing with coercive control have yet to be developed. Similarly, there is some evidence that coordinating or integrating substance abuse treatment with referrals to BIPs reduces partner violence more significantly than stand-alone or serial referrals to these services (Stuart, 2005).

At the institutional level, clinical violence intervention builds on two principles: mainstreaming, or making clinical violence intervention part of routine care, and normalization, or building on the skills and patient education techniques clinicians successfully employ in other medical or behavioral health areas.

We have long understood that changing one facet of the system's response to domestic violence without changing others does little to help victims of partner violence and might even make things worse. An outstanding issue in

moving the health response forward is how to broaden the traditional perspective of health care to recognize the strengths of parallel systems with alternative and even contradictory perspectives while maintaining its core values and commitments. In practical terms, this issue is addressed through collaboration with shelters, police, and other community groups in a coordinated community response.

❖ SUMMARY

This chapter has reviewed the health consequences of domestic violence as well as the history and status of the health-care response. In contrast to the criminal justice system, which recognized domestic violence early on even if it minimized its significance, the health-care system failed to identify the problem. Early research on the health consequences of abuse emphasized its importance as a source of female injury. However, it gradually became clear that abused women suffered disproportionate rates of a range of medical, mental health, and behavioral problems in addition to injury and that these problems typically emerged in the context of frequent, but generally low-level, violence combined with other tactics designed to isolate, intimidate, and control a partner. A major challenge today is how to expand the medical response to domestic violence to incorporate the dynamics and consequences of coercive control.

From early interventions mounted by volunteer teams of nurses and doctors in the hospital emergency room, the health response expanded to include virtually every major organization of medical, nursing, and public health professionals; the incorporation of domestic violence into the education and training of health professionals; and the development of protocols to identify, assess, and refer victims of partner abuse in hundreds of hospitals and other health-care organizations. These reforms have been supported by federal laws such as VAWA, state policies, initiatives by state and national professional organizations of health-care providers, and technical assistance from nonprofits such as FUTURES.

Despite these reforms, the health system faces many challenges. These include how to look beyond violence by implementing all-inclusive definitions of partner abuse that extend to coercive control; how to normalize and mainstream screening for partner abuse in ways that lead to demonstrable improvements in patient care; how to discriminate new from ongoing cases of partner abuse and adapt patient management strategies accordingly; and how to hold all providers accountable for considering women's safety and autonomy at home and in relationships as part of their well-being. Understanding what it means to treat patients in the context of violence—clinical violence intervention—remains elusive.

Reforming the health response requires that we come to grips with what it means to treat health problems in the context of partner violence by incorporating clinical violence education into the education and training of health professionals. Screening tools and intervention protocols must be put in place that reflect practice shown to be efficacious. However, as with policing, reforming the health response involves much more than merely mandating that health providers change their behavior. It extends to confronting an institutional culture that has been shaped by many of the same sexist beliefs about women held by society generally, as well as a practice paradigm (in this case the medical model) that views societal problems through the narrow prism of their biomedical, behavioral, and mental health manifestations, making it hard to address root causes. Although the health system has much to learn from partnering with criminal justice and community-based services, it also has much to teach, particularly about what it means to take a holistic and all-inclusive approach to a problem such as domestic violence.

❖ DISCUSSION QUESTIONS

1. Describe the health needs of battered women.
2. Why is injury a poor marker of abuse? Which markers are more appropriate?

3. Compare the appropriate definition of partner abuse in a health setting with the legal and criminal justice definitions of domestic violence.
4. Why is screening for domestic violence not sufficient, in itself, to improve patient care?
5. How should the effectiveness of routine inquiry about partner abuse be measured?
6. What does it mean to “normalize” and “mainstream” clinical violence intervention?

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