Domestic Violence: Are Nurses Hiding the Facts?

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Abstract

Domestic violence (DV) is a huge public health problem affecting up to 4 million women each year in the United States. Research studies estimate that a woman is beaten every seven seconds and 4 die each day. The cycle of violence is perpetuated by parental modeling of violence, society's acceptance of battering, and by failures of healthcare systems and providers. Consistently seen with domestic violence is a behavior pattern of coercive control, isolation, intimidation, and physical, sexual, or psychological assaults. It is estimated that about 15% to 32% of abused women are seen in primary care clinics. Advanced Practice Nurses (APN), like other primary care providers, have an obligation to advocate for women against abuse. This article will review barriers to screening, risk factors for violence against women, and offer practical strategies for uncovering the facts.

INTRODUCTION

DOMESTIC VIOLENCE: A SIGNIFICANT HEALTH PROBLEM

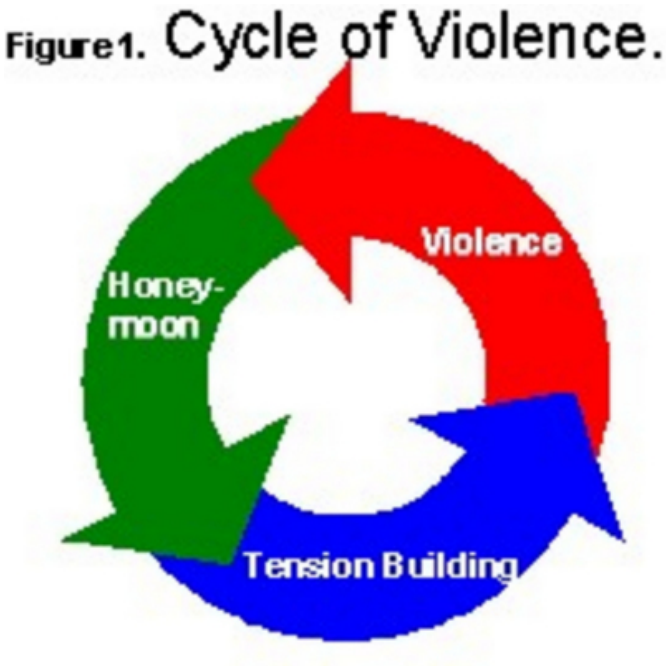
Domestic violence (DV) is defined as violence inflicted upon adults by their intimate partner. Consistent with domestic violence is a behavior pattern of coercion, isolation, intimidation, and physical, sexual or psychological assaults.[1,2] Ninety to ninety-five percent of the time, domestic violence is enacted by men against women.[3] Research studies estimate that a woman is beaten every seven seconds and some die—four women a day.[4,5] More than a 1,000 women a year are killed by the fists, stabs, or bullet wounds of their intimate partners in the United States.

Femicide (homicide of a woman) is the major cause of death for African American women ages 15 to 34 and the seventh leading cause of premature death of all women in America.2 The criminal justice system alone can not protect these women from their abusers. Police and healthcare providers alike are swayed by societal prejudices.[6] Police are less quick to respond to calls for help involving a “private or marital matter”, than those committed by a stranger.[7] When perpetrators are arrested, 90% are never prosecuted.[8] Half (48%) of all battered women keep silent about their abuse out of fear of retaliation from the abuser for having “called the police”.[9] They fear for their lives. Victims feel isolated and powerless with little choice but to stay in the abusive relationship.[10]

An estimated 3.3 to 4 million children witness domestic violence each year, and half of these children are either physically or sexually abused.[11,12] Children who witness violence are a thousand times more likely to become abusive adults themselves. Young males that witness violence are 24 times more apt to rape and 6 times more likely to commit suicide. A son frequently comes to the aid of an abused mother. Sixty-three percent of adolescents (ages 11-20), who are convicted of homicide, killed while defending their mother from another slap, punch, or gunshot wound. 11 These boys see and use violence as a coping mechanism, which adds to the escalation of abusive and destructive behavior in our society. These youth perpetuate the continuance of this behavior pattern to the next generation.

The cycle of violence was first described by Walker in 1962 (see figure 1).[13] The cyclic behavior begins with a time of tension building arguments, progresses to violence, and settles into the honeymoon phase. [14] The latter phase is a making-up or calm time. With time, this cycle increases in frequency and severity as it is repeated over and over again. Children learn this cyclic behavior pattern not only by parental modeling, but also by society’s ostensible acceptance of batters. They learn from the media and cinema a type of romanticized violence against women which legitimizes abuse and battering.

Figure 1



IMPACT OF VIOLENCE ON HEALTH CARE

Even when femicide does not occur, violence against women still imparts a tremendous amount of morbidity. This violence is likely to be the precursor of chronic disease, substance abuse and mental health problems, which affects all ethnic and socioeconomic levels of women.[15] Suicide is a desperate method of escaping battering and is at the root of 25% of all suicide attempts, with half of the attempts made by African American women.10 All those who experience or witness abuse suffer psychological consequences; some are so traumatized they develop post-traumatic stress disorder.[16]

Half of the women assaulted are injured and one-fourth (about 1 million a year) seek medical care. 10 As many as 22% to 35% of women visiting the emergency room received their injuries from an ongoing abusive relationship.[17] Of women needing emergency surgery, 20% are battered.10 Abuse during pregnancy occurs at rates of 9% to 20%.13 McFarlane and colleagues reported a 60% recurrence of abuse among battered pregnant women.[18]

Domestic abuse accounts for half of all rapes of women over 30 years old.10 Murdoch and Nicholand found that one in four women in the military under age 50 had been physically abused within the past year. Thirty-one percent of abused victims had been forced to have nonconsensual sex.[19]

The epidemic of violence is not only felt by hospital emergency room staff, but also by primary care providers. Neufeld reported that 23% of women seen in a family practice setting had experienced domestic violence within the past 12 months.[20] Others show rates for abuse from 14% to 32% of ambulatory care practices. 6,[21] Of women seeking prenatal care, abuse rates range from 4% to 17%.21 All this domestic violence adds up to 100,000 days in the hospital, 30,000 emergency room visits, and 40,000 healthcare visits each year.5 Communities and healthcare systems aware of the financial burden of domestic violence, $3 to $5 billion annually, are developing strategies and services to address the needs of abused women and children.12 Unfortunately, some women with insurance who have received healthcare for abuse are being subjected to discrimination. The high medical costs have become the impetus for insurers to use domestic violence as an underwriting criterion to deny victims insurance coverage.[22]

Even with the spawning of violence awareness, shelters, and services, there are limited social services available. Assisting the woman is especially difficult if she is impoverished or pregnant, a teenager, a minority or an immigrant. [23] A lack of coordination exists among agencies. Presently, victims are not safe. Too few providers screening, too few shelters for refuge, and too few intervention protocols are in place. The services are limited by lack of funding, inequitable access, and health professionals who are not putting domestic violence knowledge into practice. 6

BARRIERS

SCREENING BARRIERS

In 1991, the federal government strengthened its research and prevention programs for violence with the establishment of the National Center for Injury Prevention.2 Subsequent studies showed that health professionals occupied key positions in violence prevention, but were ill equipped for their roles.2 Healthcare providers lacked knowledge of the extent, impact, and symptomatology of violence. [24] [25] [26] [27] Providers often held the same prejudices as society by considering domestic violence a “private or legal” matter and ignored the facts.13 Providers were afraid of offending their patients by asking about domestic abuse.26 They were not sure how to ask about battering and what resources were available.6 Others were frustrated by the cyclic nature of abuse—seeing a woman coming back again and again with repetitive and often more serious injuries, instead of leaving the battering environment. Some health professionals were pressured by the time constraints within the healthcare delivery system.26 They feared to ask about abuse because it might open “Pandora’s Box” and take a long time to assess

for danger and to design a safety plan.16 Even though healthcare providers are legally mandated to document abuse, some providers may be reluctant to chart the abuse for fear that the woman would lose her insurance coverage.

The profession of nursing, largely women, are impacted by violence on several fronts. Many nurses have been the recipient of abuse or have witnessed abuse, either at home, work, or in the military. They may have suffered abusive behavior and sexual harassment by controlling physicians, administrators and patients. Not until the 1960s did women even have a forum to express the nature and extent of this violence. Additionally, women who have been abused make up a large proportion of the nursing and caring professions.13 Some nurses may have the barrier of personal abuse blocking them from responding to their abused patients.26

BARRIER OF TRADITION: THE MIND SET OF AMERICA

Social and psychological views on the role of women in society feeds the epidemic of domestic violence. Throughout the history of the United States, notions regarding the institution of male domination have led to battering of women, which the Anglo-American common law allowed (e.g., chastisement, U.S. Marital Property Act, etc.).[28] These embedded views persist and support the continuation of battering and violence by husbands and boyfriends.

Public health education efforts should reach every citizen, but especially children and young adults, because they are the largest cohorts of victims and perpetrators of domestic violence. The myth of male dominance has been present for centuries and will not disappear on its own. Education can change societal views and empower individuals with conflict resolution skills.[29] High profile health promotion campaigns similar to those on childhood immunizations and HIV/AIDS are crucial to changing the attitudes of society. Healthcare provider barriers to violence prevention can be removed by understanding why women stay in an abusive relationship and how to identify “red flag” behaviors.

RISK FACTORS

WHAT ARE THE BEHAVIOR CLUES OF AN ABUSER? WHY DOESN’T SHE LEAVE?

Battering is more than an isolated case of the husband or boyfriend “blowing up”. It is a process of deliberate intimidation intended to coerce “his” woman to do his will.10 Battering is enacting behavior which shows an established set of control skills. So, in reality, the man who abuses his wife and children is not “out of control”, conversely, he is very much “in control”. The perpetrator enforces control in a way that compares to the brainwashing techniques used on the American prisoners of war by the Chinese in Korea or the Nazi’s methods of controlling prisoners in the death camps.10,15 For this reason women’s shelters teach about coercion techniques (see figure 2).10 These techniques are used to setup a regulating situation for domestic violence. Isolation of the woman from her support systems makes her solely dependent on her partner. 10 Women frequently say, “he moved me away from my friends, he didn’t want me to go anywhere unless he was with me, or he would eavesdrop on my telephone conversations”. The second technique is monopolization of perception which is expressed by “I was always scared he’d blow up”. The controller’s wishes monopolize her thoughts forcing the victim to concentrate on the immediate situation, be introspective, and decrease competing input. All actions that do not comply with the wishes of the controller frustrate him. 10

Figure 2. “Red Flags” of Coercion

Isolation

no family to help with the children

Monopolization-perception

has no future plans

Induced debility & exhaustion

X-ray shows denied Fx, fatigued - no clinical reason

Threats

must hide fact she’s visited the clinic or has medicine

Occasional indulgences

brags of travel, flowers or jewelry

Omnipotence

physical battering, missed appointments, suicidal

Degradation

low self-esteem, not sure of her abilities

Trivial demands

partner wants her to dress, cook,or clean a certain way

Induced debility and exhaustion can be dictated by—keeping the woman awake at night by starting fights, or by not allowing her to see a healthcare provider for injuries received from battering. 10 The exhaustion or physical condition weakens the woman's ability to resist the will of the controller. Additionally, he can use threats which induce anxiety and despair—he said, "he'd take the kids" or "find me if I left, no matter where I went". 10 The fifth method used that hooks the feminine heart and search for hope is the giving of positive motivation for compliance to his wishes by occasional indulgences (e.g. flowers, a vacation). 10 Because the victim is so isolated, these occasional indulgences may be the only signs of kindness or love she receives.

Physical signs of abuse often comes with the demonstration of his omnipotence and seems to prove to the victim the total futility of resistance. 10 The abuser beats her up, or in the case of a women with a disability, the abuse may come by withholding her food, assistance with personal care regimens, or her mobility—her wheelchair or braces. [30] During pregnancy the slaps, punches, and kicks are focused to the areas of the breasts and abdomen.18

Still another tactic used by the controller is that of degradation. 10 Degrading words and actions beat the woman down in spirit and self-confidence, leaving a person who has an eroded sense of self-worth and non-belief in her personal capabilities. Lastly, he enforces trivial demands—"You'll wear your hair long or else!" 10 This technique develops the habit of compliance. A behavioral pattern of obedience because every victim knows what "or else" means in their relationship. Male dominance has remained an undertone from our patriarchal society's past. Male dominance supports tenets like "a man's castle is his home" and "I'm the boss of you and don't ever forget it". The victim is obedient, isolated, and has low self-esteem. She is restricted emotionally, as well as usually being restricted socially and financially. She is fearful that if she leaves, the threats will be carried out against her and possibly her children. The victim fears for her life!

The health professional should NOT ask "Why don't you leave?", but should instead ask about abuse (see Table 1). Obtaining a thorough social history will reveal the "red flags" of domestic violence. Rodriguez and colleagues surveyed women who had suffered abuse, as to what they wanted from their healthcare provider. The victims wanted to be asked direct questions about abuse, listened to with an empathetic ear, and supported in their decision to stay or leave their relationship.21 Battered women are usually in a better position to assess their safety than are healthcare providers.

Table1. Commonly Asked Questions.

Questions that help the Nurse screen for domestic violence.

- Has anyone ever hit, slapped, restrained or hurt you physically? Or emotionally?**
- At times, are you afraid of your partner? Previous partner?**
- Have you ever felt unsafe in your home situation?**
- Does your partner* like to boss you around?
- If he doesn't get his own way, how does he act?
- Have you been forced to have sex or do sexual things you are uncomfortable doing?
- When arguing with your partner, does he threaten to hurt you or the children?
- Has your partner ever stopped you from leaving home, visiting family or friends,
- going to work or school?
- Do you have a say in how to spend money?
- Are any of these things going on now?
- *partner or spouse or boyfriend or ex-husband or old boyfriend
- **quick screening questions

PRACTICAL STRATEGIES

NURSING: EDUCATION, PRACTICE, AND RESEARCH

The healthcare system needs reform that addresses the problem of domestic violence. The responsibility of several key steps rest with the nursing profession. Action is needed in nursing education, practice, and research.

EDUCATION

Of paramount importance is education of both professionals and the public. Nursing schools, whose standard curriculum includes domestic violence, need to facilitate knowledge to

practice by offering opportunities for reinforcement in clinical settings.24 Experiential learning sites like women's shelters, the district attorney's office, or batter rehabilitation programs aid the learning process.

Studies show that if physicians and nurses ignore the problem of a woman's abusive experience, their act of silence is often psychologically damaging and is a factor in the development of subsequent psychopathology.10 The provider who knows about the abuse, but remains silent, magnifies the patient's anxiety, feelings of hopelessness, fear, and shame. Each professional nurse should seek further education on the prevalence, assessment, and care of abused persons.

Many nursing organizations have supported ending domestic violence with continued education (CE) conferences or journal CE offerings (e.g., Journal of Nurse-Midwifery).[31] Florida's Board of Nurse Examiners mandates continued education on abuse, as other states have mandated continued education on the public health issue of HIV/AIDS. Nursing supervisors should require staff training to respond to victims of abused as is recommend by hospital accrediting agencies.

PRACTICE

Advanced practice nurses (clinical nurse specialists and nurse practitioners) are in prime positions to impact staff development, research, and daily practice of domestic violence prevention and screening. Nurse practitioners can attend to the primary care needs of 80% of the ambulatory patients and already have health prevention as a strong component of their practice (e.g., safety, immunizations, cancer screening). Screening each patient every year for domestic violence would identify those women who are victims and begin empowering them. For those women who were past victims of physical, mental or psychological abuse—it can begin the healing process. Asking non-abused women about domestic violence would be a step in primary prevention—awareness.

Advanced Practice Nurses can insure that clear protocols for identifying and treating domestic assault victims are in place in their healthcare facilities (e.g., when negotiating practice protocols, clinical research, or committee work). APNs must address violence as a primary prevention issue by recognizing the use of control tactics as a risk factor for domestic violence. A clinical example may be in helping a teenager recognize coercion behaviors in a dating relationship.

The nurse's therapeutic counseling goals include victim empowerment, emotional support, and problem solving for material assistance (e.g., food, clothing, shelter, lawyers, money, etc.). APNs need to validate the woman's experiences and feelings, help her make a safety plan and give her referrals to community resources. Printed screening tools and protocols for intervention may be obtained for use with or for adaptation of an existing standardized patient intake form (see Table 2). Universal screening for domestic violence using as few as three questions has been shown to detect two-thirds of abused women coming to an emergency department (see Table 1).[32]

Figure 2

Table 2. Resources: Domestic Violence Screening Tools

Organization Materials Telephone Number		
March of Dimes	Screening tool, body map	1-888-663-4637 Web Site: http://www.modimes.org
Family Violence Prevention Fund	Screening & documentation form: screening, body map, referrals, safety planning & progress notes	To order a screening packet: 1-800-313-1310 Web Site: http://fvpf.org/fund/
American Medical Association	RADAR screening, charting tool	312-464-4671 Web Site: http://www.ama-assn.org
National Domestic Violence Hotline	Crisis Hotline	1-800-722-SAFE(7233) or 1-800-7873224 (TDD)

As a community citizen and patient advocate, the nurse can lead the campaign for guaranteeing the rights of women to be free from bodily harm. APNs can make sure that the family violence issue is addressed by churches, schools, and city counsels. Being cognizant of relevant current political and legal debates would keep the nurse poised for action. Nurses must loudly voice their views on the press or the entertainment industry's legitimization of violence. The victim can never be blamed for the abuse. Another avenue the APN could use to foster ending domestic violence is by donations of money or more importantly, time to women's shelters.

RESEARCH

The nursing profession, as a key member of the

interdisciplinary team, can help answer those important research questions about violence—its cause, prevention, effects, and best therapeutic regimen. APNs could answer life saving questions unique to their nursing practice. What do battered women want from their APN? What survival skills can be taught by the APN in a single visit? What agencies are the best referral for women immigrants of various ethnic origins? Does play therapy heal the wounds of witnessing mother's abuse? Utilizing clinically based research, nurses would gain knowledge by working with and for abused women. The impact of domestic violence could be drastically lowered by primary prevention interventions, thereby, eliminating the need for crisis management and emergency care.23

SUMMARY

Domestic violence is a public health problem with great consequences. The abused woman suffers physical, mental, and emotional pain. Her children may also be sexually abused and battered. As the result of witnessing violence, children are likely to become abusers themselves. The economic cost of this epidemic is felt by the healthcare industry, the legal system, and business communities. Health economists calculate that violent crime costs the United States $192 billion per year—three times that of the AIDS epidemic.[33]

Advanced Practice Nurses have expertise in the skills of case finding, prevention counseling, case management, and knowledge of resources and referrals. These skills position the APN as an essential provider of domestic violence prevention and screening. Because of the complexity of domestic violence, the implementation of an interdisciplinary community plan is necessary. This plan for domestic violence prevention needs nursing leaders, educators, researchers, and practitioners to help design, develop, and implement. Only then will nursing uncover the facts about domestic violence.

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