

DOMESTIC VIOLENCE

OBJECTIVES

When you complete this module, you will be able to:

1. Provide a definition of domestic violence.
2. List three reasons why women don't report domestic violence.
3. List three reasons why health care professionals don't report domestic violence.
4. Identify three screening tools used to detect domestic violence.
5. List three signs that may indicate domestic violence is taking place.
6. Provide a definition of the term RADAR.
7. Identify the three typologies of batterers

INTRODUCTION

Domestic violence is perhaps one of the least-publicized crimes in the United States, but it is far from being uncommon. The exact incidence of domestic violence is almost impossible to ascertain, for various reasons, but there is ample evidence that it is widespread.

- Police in the United States spend approximately 1/3 of their working hours responding to domestic violence calls.¹
- There is some evidence that between 4-15% of all visits by women to emergency departments are related in some way to domestic violence.²
- Each year, approximately 1.3 million women and 835,000 men in the United States are physically assaulted by an intimate partner.³
- Although domestic violence affects approximately 25% of the population, it has been estimated that only 2.5% to 15% of those who have been victimized report the problem.⁴

One of the issues in determining the exact incidence of domestic violence has been one of definitions. Traditionally, domestic violence has been defined as assaults against women. However, in recent years, it has become clear that domestic violence involves and affects teenagers, men, the elderly, and children. It has also become clear that domestic violence can involve isolated incidents of abuse, persistent patterns of abuse, psychological abuse, sexual abuse, physical and/or social isolation, deprivation and neglect, and stalking. For the purpose of this discussion, domestic violence will be limited to the physical, sexual, and /or psychological violence against women, and it will be defined as *victimization of a person with whom the abuser has or has had an intimate, romantic, or spousal relationship.*⁵

DETECTING AND SCREENING FOR DOMESTIC VIOLENCE

SCREENING TOOLS

Detecting domestic violence can be very difficult. As mentioned previously, only a small percentage of the victims of domestic violence seek help or report their problems, and there are many reasons for this.⁶ Women may feel shame or embarrassment, or they may fear being judged by a healthcare provider. They may fear losing a loved one or the only stable relationship they have in their lives, or they may fear that they will lose their children. They may also fear, for various reasons, police involvement, and that reporting domestic violence will escalate the problem and make it worse. Another reason is that victims of domestic violence are unfamiliar with, and afraid of the social services that are available to them. They may also feel disappointed in the response they receive if they had reported incidents of domestic violence in the past. As well, the people around those who are suffering from domestic violence are often unable or unwilling to report it.⁷

But regardless of the roadblocks that prevent women from reporting incidents or patterns of domestic violence in their lives, it is imperative that nurses be aware of this problem and educate themselves in the process of screening for domestic violence. Although there are many reasons why health care professionals do not report domestic violence (inadequate resources, lack of training, perceived lack of time, fear of making patients uncomfortable, fear of retaliation from the abuser, etc.), making the effort is important; the discovery rate of domestic violence goes up significantly when nurses are trained to be sensitive to its possible presence.⁸ There have been exhaustive attempts documented in the social science and psychological literature to find the optimum screening tool, and there are many available. Most should take into account physical violence, sexual violence, and psychological and/or emotional abuse.⁹ There are several that have proven to be valuable. The Women's Experience with Battering Scale (WABS) has been shown to be sensitive in detecting domestic violence. While many assessments for domestic violence focus on recent injuries, this scale identifies more domestic violence victims than those tools.¹⁰ The Women's Experience with Battering Scale consists of 10 questions to which the women will agree strongly, agree somewhat, agree a little, disagree a little, disagree somewhat, or disagree strongly.¹¹ The basis of the questions is: *how does your partner make you feel?*

- He makes me feel unsafe even in my own home.
- I feel ashamed of the things he does to me.
- I try not to rock the boat because I am afraid of what he might do.
- I feel like I am programmed to react in a certain way to him.
- I feel like he keeps me prisoner.
- He makes me feel like I have no control over my life, no power, no protection.
- I hide the truth from others because I am afraid not to.
- I feel owned and controlled by him.
- He can scare me without laying a hand on me.
- He has a look that goes straight through me and terrifies me.

Other valuable tools are the HITS (**H**urt, **I**nsult, **T**hreaten, **S**cream) screen, and the Women Abuse Screening Tool (WAST).¹² The HITS screen is a series of four questions that asks how often does your partner:

- Physically hurt you
- Insult or talk down to you
- Threaten you with harm
- Scream or curse at you

The WAST screen is a bit more complex and a bit longer.

- In general, how would you describe your relationship?
- Do you and your partner work out arguments, with great difficulty, some difficulty, or no difficulty?
- Do arguments ever result in you feeling put down or bad about yourself?
- Do arguments ever result in hitting, kicking, or pushing?
- Do you ever feel frightened by what your partner says or does?
- Has your partner ever abused you physically?
- Has your partner ever abused you emotionally?
- Has your partner ever abused you sexually?

SCREENING: THE INTERVIEW PROCESS

Screening tools can be useful, but there is no single tool that will reliably capture all instances of domestic violence against women. Also, as mentioned previously, there are barriers to the self-reporting of domestic violence, and there are also barriers to screening for domestic violence by health care professionals. But screening can make a difference, and although having a structured interview tool available is very important, it should be remembered that the female victim of domestic violence is most often in a very vulnerable and precarious emotional state. The victims have specific needs that must be addressed. In particular, female victims of domestic violence prefer that:¹³

- They are treated with respect and concern.
- They are protected.
- The abuse is documented.
- They are given some control in the process of detection and reporting.
- The response to the violence is immediate, not delayed.
- They are given options.
- There is good follow-up available.

The interview itself should be conducted in total privacy. This means that all other persons, children included, are separated from the interviewee. Make sure your nonverbal behavior communicates concern and compassion. Do not be judgmental. Tell the woman that what she says is confidential, and express concern for her safety. You can start the conversation with an open ended question such as, “Do you feel safe at home?”¹⁴ Follow this up with more questions; these can take the form of one of the screens mentioned earlier, or some less detailed and organized questions. Be sure to respect the woman’s right to refuse to answer. But regardless of the form that the interview takes, make sure

that the victim understands that her problem is considered by the staff to be serious, the violence is illegal and wrong, *and she is not responsible for it happening.*

SCREENING: PATTERNS OF INJURY

Domestic violence is common and has been associated with a range of health problems such as depression, substance abuse, chronic mental illness, chronic disease, and overall poor health.^{15,16} Along with the screening tools and the interview process, nurses need to be aware of common patterns of injuries that are associated with domestic violence, especially given the fact that many female victims of domestic violence will not willingly or openly report it. Several “red flags” can be hints or strong suggestions that domestic violence is taking place.^{17,18,19,20}

- Is the patient anxious, withdrawn, or depressed, especially when in the presence of her partner?
- Does the partner seem overprotective, does he try and dominate the interview and answer for the woman? Does he refuse to leave when asked?
- Does the patient appear malnourished?
- Does the patient have unexplained injuries to her breasts, rectum, or genitals?
- Are there unexplained injuries to the face, neck, or throat?
- Does the patient have bilateral, symmetrical injuries?
- Are there unexplained dental injuries?
- Are there obvious fingernail scratches, cigarette burns, or rope marks?
- Does the patient have subconjunctival hemorrhage(s)?
- Does the patient have injuries at multiple sites?
- Are there slap marks with the impression of fingers?
- Are there any bite marks?
- Does the patient have defensive injuries, e.g., to the wrists and/or forearms, or to the palms of the hand or the back of the head or neck (these can occur when the victim is crouching on the ground to avoid further attacks).

DOMESTIC VIOLENCE: THE ROOTS OF THE PROBLEM

The amount of literature that has been published regarding the cause of domestic violence against women – why men abuse their partners – is staggering. Witnessing parental violence during childhood has been shown in many studies to be strongly associated with influencing battering behavior.^{21,22} Substance abuse with drugs or alcohol has also been shown to have a strong correlation with battering behavior.^{23,24} Perhaps, given the amount of available information, the most useful way to understand why men abuse their female partners is to focus on three distinct root causes.²⁵

- **Psychopathology:** It has become clear that male batterers are not a homogenous group, and may differ considerably in the severity and type of violence they inflict, their alcohol use, level of anger, and level of depression. However, researchers have been able to identify distinct subtypes of male batterers.²⁶

Family-only batterers are men who restrict their violent behavior to the immediate family. Their violence is generally less severe, they usually do not have severe psychopathology, and they are not in legal trouble outside of the home. *Dysphoric/borderline batterers* may not restrict their violent behavior to the family, and their abuse may be sexual and psychological as well as physical. There is a chance that they may have serious psychopathology such as borderline personality disorder or schizoid personality characteristics, and drug and alcohol abuse may be a problem. *Violent/antisocial batterers* engage in moderate to severe violence, including psychological and sexual abuse. They may have an antisocial personality disorder or be psychopaths, often have substance abuse problems, and are violent outside of the context of the family. The reasons for the behavior of these three subtypes may be genetic (e.g., impulsivity and an irritable temperament are both associated with domestic violence and may be inheritable), it may be due to early childhood experience and learning (e.g., witnessing violent behavior in the home, being abused), or it may be due to peer experiences (e.g., association with deviant peers). Other reasons for violent behavior towards a spouse may be attachment problems, a high degree of impulsivity, and poor social skills. For example, the dysphoric/borderline batterers may have a pathological attachment and dependency on their wives. As well, a batterer may have deficient social skills that make solving interpersonal conflicts difficult.

- Cognitive distortions and deficiencies: Some researchers have postulated that there is a significant difference in the cognitive processes between violent and non-violent men.²⁷ What is of interest is the cognitive content of the violent male, how he arrives at that given cognition, and how the cognitive process relate to the violent behavior. It has been consistently shown that martially violent men believe that marital conflicts are caused by actions of the wife, and this has been called a problem with attribution.²⁸ They tend to view their wives with mistrust and suspicion and attribute hostile intent to their words and actions, e.g., they believe that the wife was trying to publicly embarrass them, make them jealous, or reject them. It has also been shown that violent husbands have attitudes that are skewed to predispose them to violent behavior towards their female partner. They appear to believe more strongly that violence within an intimate relationship is acceptable and that traditional roles of male and female behaviors, responsibilities, etc., are acceptable and desirable.
- Social skills deficiencies: There is a reasonable amount of evidence that men who abuse their female partners have social skills deficiencies, particularly as regarding the ability to constructively solve conflict and deal with interpersonal tension.²⁹

Obviously, the reasons why a man becomes violent towards his partner are many and complex. But it does appear that many men who abuse their female partners have witnessed violence in their own families while growing up or were subject to it themselves. It also appears that abusers have poor social skills available to them for solving conflict³⁰, and drugs and alcohol often play a part. They are suspicious and mistrustful of their wives and accept violence as a legitimate and acceptable means of

conflict resolution. They often have low self esteem, lack of impulse control, and antisocial tendencies.³¹

DOMESTIC VIOLENCE: ANSWERS TO THE PROBLEM

Intervening when a woman reports domestic violence is critical; it can encourage the woman to leave an abusive relationship and improves their health status.³² The first step is to make sure, if your patient is indeed a victim of domestic violence, to listen in a nonjudgmental manner and assure the victim that what has happened to them is both wrong and illegal. Following that, a useful approach is to use a guide developed by Alpert.³³ The guide is called RADAR and has five steps: **R**emember, **A**sk, **D**ocument, **A**ssess, and **R**eview.

The first two steps have been discussed: Always remember that domestic violence is a possibility and don't forget to ask if there is a suspicion that it has occurred. Documentation is especially important as these cases will eventually enter the legal system. As well, documenting alerts other healthcare providers to the presence of domestic violence in the victim's life, it provides objective data that the injuries sustained were not accidental, and it helps to determine the actual rate of screening. Be objective in your documentation, use the woman's own words, and if possible, take photographs. Following the documentation, make a thorough assessment of the safety of the victim. The following have been identified as risk factors for significant danger, e.g., possible serious injury or homicide, to a female victim of domestic violence:³⁴

- There are weapons in the house.
- The violence has been increasing in frequency and intensity.
- The abuser uses drugs and/or alcohol to excess.
- Weapons have been used to abuse and injure.
- Abuse has resulted burns, broken bones, etc.
- Being forced into sex or into unwanted sex acts.
- Threats to kill.
- Killing of pets.
- Threats of suicide.
- The abuser is violent towards children.
- The abuser is violent outside the home.
- Abuse during pregnancy.

After the assessment, review the options available to the victim. Encourage her to make a safety plan. Make sure she has the appropriate emergency numbers readily available at home, e.g., police, shelters, emergency rooms, and helpful friends and/or relatives available. Encourage her to have money, clothing, and important documents pre-collected and have a clear idea as to where she would go if the abuse reoccurs. Have the numbers of local organizations involved in helping victims of domestic violence. It is also helpful to have the telephone numbers and websites of national organizations that deal with domestic violence. Several helpful ones are:

- The National Coalition Against Domestic Violence. www.ncadv.org 303-839-1852. The website contains a state by state listing of all the national chapters along with their 1-800 numbers.
- National Violence Domestic Hotline. 1-800-799-7233
- Family Violence Prevention Fund. www.fvpf.org 415-252-8900

Despite abuse, it may be that the woman will decide that she does not want to leave her partner. It may be that she has developed “learned helplessness,” she may have internalized her partner’s view of herself as less than worthy, staying with the partner may be a social norm, she may feel that she hasn’t tried hard enough to make the relationship work, or she may feel that important needs (financial, social, psychological) cannot be met without her partner.³⁵ If the woman decides she is going to leave her partner, make sure she is prepared; breaking off a relationship with an abusive partner can be very dangerous. Encourage her to:

- Change her phone number.
- Screen calls.
- Avoid being alone.
- Change locks.
- Only meet the partner in a public place.
- Vary the daily routine.
- Get legal help.
- Make sure she has collected all important documents and papers, e.g., social security cards, birth certificates, marriage license, leases or deeds, checkbook, and any documentation (police reports, photographs, ER records) of the abuse.

Legal help may involve obtaining a *personal protection order*. These are especially useful if the victim has decided to take steps to end the abuse, but does not want to, or can’t, file criminal charges (e.g., she may perceive the personal protection order as something that will terminate her relationship with the abuser, and many abused women do not want to do that). A personal protection order is a court-ordered injunction that prohibits the abuser from contacting the victim, and it is designed to end the abuser’s use of violence, threats and/or intimidation.³⁶ They are typically issued for an effective period of 1 to 2 weeks. After that, both parties appear before a judge who decides if the order should be continued, for how long, or if it should be stopped. If the abuser violates the condition of the personal protection order, he can be incarcerated. It should be remembered, however, that the requirements for filing a personal protection order (e.g., some states require that the victim pay filing fees, which can be a significant obstacle if the victim is financially dependent on her abuser) and who can file for one (some states may not recognize relationships other than traditional male-female marriage) vary from location to location, and some states require that criminal charges be filed along with the petition for the personal protection order – and again, this can be a big deterrent for many women.

Requirements to report domestic violence vary, and it is not universal throughout the United States. In addition, the exact definition of domestic violence varies depending on location. However, The Joint Commission on Accreditation of Healthcare Organizations

(JCAHO) does require that all healthcare facilities address the issue of domestic violence by having policies in place for the identification, evaluation, management, and referral of domestic violence victims.³⁷ Again, as the laws vary from state to state, it is the duty of nurse to familiarize herself/himself with her/his hospital's policy.

INTERVENTION PROGRAMS FOR BATTERERS

Obviously, prevention of domestic violence is far preferable to treating victims, and it is generally accepted that treating the batterer is crucial. Battering intervention programs for male offenders have been in place for many years, and most states mandate attendance if a man is determined to be abusive. The programs are usually one of two types: The Duluth model, which is a feminist-based intervention, stresses examination of sexist attitudes towards woman and the patriarchal nature of society. Proponents of this approach feel that abusive patterns are learned and can be unlearned. The cognitive behavioral therapy approach assumes that the men lack the practical social skills to control their anger and resolve conflicts peacefully, and these skills are taught.

However, although programs are widely used, there still controversy over whether or not they work. Some authors have found that these programs do not decrease the incidence of battering;^{38,39} it may be that the batterer only stops the abuse while involved in the program. Other authors have reported success⁴⁰ but this is the exception.

Why are these programs unsuccessful? It is known that many men who abuse their female partners minimize their actions or deny them completely. They feel they have been forced to attend a program that unfairly punishes them, especially if they feel their partner initiated the violence or their partner was violent towards them. It is possible that treatment tailored to the individual, substance abuse counseling, and couples therapy may improve their effectiveness and decrease recidivism.

CONCLUSION

Violence against women is an enormous health care problem, both in the amount morbidity and suffering it causes as well as the enormous expenditure of monetary, judicial, and societal resources. Most nurses will, sometime in their career, care for a woman who has been battered, and they need to be conversant with the process of screening, interviewing, and intervening in these situations. Nursing diagnoses that may apply to the situation of domestic violence include violence risk, social isolation, situational self-esteem disturbance, rape trauma syndrome, family process alteration, denial, and chronic low self esteem disturbance.

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