Health Care Barriers and Interventions for Battered Women

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Synopsis

Family violence is a major public health problem. Battered women present with multiple physical injuries in hospital emergency rooms, clinics, and personal physicians' offices. Yet, they are often not identified as battered and fail to receive appropriate treatment for the nonphysical effects of these events. Instead, only discrete physical injuries are identified.

The authors explore the literature to identify barriers in recognizing and treating battered women. These barriers are viewed as a microcosm of the larger public health problem in which battered women fear identifying themselves and often are not recognized by public health professionals. Some barriers pertain to the victims themselves; others can be attributed to the attitudes of medical care providers in emergency rooms, clinics, and private physicians' offices.

The many faceted needs of victims require a variety of interventions including medical models, criminal justice intervention systems, and social models for change. Some intervention strategies that are currently being employed in various programs in the United States are described.

HEALTH CARE is receiving a great deal of attention in the United States, especially in respect to the efficiency and cost-effectiveness of medical care. In the current reexamination of health priorities and strategies, it is crucial to explore the application of health care in cases of family violence.

Many victims are in dire need of medical care and community support. Health care providers, however, lack protocols and training in the recognition and intervention with this kind of violence. Furthermore, the problem of recidivistic injuries among battered women has not been effectively addressed. A clear and unified intervention approach also is lacking in respect to legal, social, and medical services for these victims, and no comprehensive strategy has been created to address crucial needs.

The Public Health Issue

Family violence results in a range of physical injuries that are treated in hospital emergency rooms, clinics, and personal physicians' offices. However, emergency room staff identify battering in only 5–10 percent of the total cases (*1*) that are subsequently found to involve battered women. In one sense, hospital emergency rooms are a microcosm of our society in that barriers interfere with the recognition and intervention on behalf of battered women.

Although physical injuries among battered women vary widely, they often include hematomas, lacerations, contusions, fractures, head injuries, dislocations, burns, and miscarriages (*2*). The site of the symptoms vary, such as choking sensations, hyperventilation, chest pain, gastrointestinal symptoms, pelvic and back pain, insomnia and fatigue, and nightmares (*3*). Flitcraft and coworkers, in an American Medical Association (AMA) publication, described numerous physical problems that may be associated with battering, such as abdominal and gastrointestinal complaints, palpitations, dizziness, atypical chest pain, fatigue, decreased concentration, and sexual dysfunction (*4*).

Thus, effective protocols are needed to identify battered women not only in hospital emergency rooms but also in private physicians' offices, clinics, and all other public health settings where battered women seek assistance. This assistance may include shelter, aid for children, financial assistance, clothing, and education. Health providers, educators, medical personnel, counselors, social workers, clergy, and others need to recognize and intervene effectively with battered women. Further exploration and model-

building are essential to reduce the public health dangers associated with family violence.

Physical Abuse

In most studies, women are considered battered if they have suffered one or more episodes of battery from a male partner or ex-partner (*3*). Lesbians also experience battering (*5,6*), as well as gay men (*7*). A range of behaviors that are defined as battering includes, but should not be limited to, slapping, kicking, punching, hitting, stomping, shoving, and sexual assault. From a medical perspective, a battered wife has been defined as a woman whose opposite-sex partner used violent physical force on her preceding her contact with the hospital emergency room (*8*). However, little attention has been focused on battered lesbians and gay men.

Warshaw (*9*) established a set of criteria for defining battering:

> . . . explicit mention of having been injured by a significant other; evidence of having been injured by an unnamed other; injuries described as accidental, self-inflicted, or undefined; mention of marital difficulties; vague psychosomatic complaints; abortion, miscarriage, or premature labor; substance abuse; suicide attempts; depression; anxiety; psychosis, panic disorder; and post-traumatic stress disorder.

In addition, Kurz (*10*) described a woman as battered if someone "heard the woman, or someone accompanying her, say that she had been injured by her husband or boyfriend" or if a staff member discovered that the woman had been injured by her boyfriend or husband.

Moreover, underlying control and power issues that are important in the violence of battering must also be recognized (*6*):

> For a woman being abused, physical violence is but one of the tools that her abuser uses to have power and control over many, or all, aspects of her life. Many formerly battered women who have even suffered life-threatening injuries say that the physical violence was nothing compared to the psychological and emotional abuse they endured.

Sexual abuse has also been noted as a particular concern in regard to its impact on battered women (*11*).

Stets and Straus (*12*) have described this problem as extending to the physical assault of men by women: "We find that Female Only violence is more common than Male Only violence in every marital status group." 'Female Only' violence is defined as including no violence from the male. Rather, only the female used minor or severe violence. The marital status groups included persons in various age ranges. In addition, couples were differentiated into 'dating,' 'cohabitating,' and 'married.'

Pagelow disputes the results of this research (*13*):

> There is a preponderance of evidence showing that the vast majority of victims of spouse abuse are females, and the vast majority of abusers are males. Studies of marital violence show that only a small percentage of abused husbands are found in any sample.

Extent of the Problem

According to the AMA report, nearly one-quarter of women in the United States (more than 12 million) are abused by a partner during their lives (*4*). Flitcraft and coworkers describe battered women as accounting for 22 to 35 percent of women who seek treatment in hospital emergency rooms.

The annual estimates for injuries from family violence are a total medical cost of $44,393,700: 21,000 hospitalizations, 99,800 days of hospitalization, 28,700 emergency department visits, and 39,000 physician visits (*14*). Identifying battered women and preventing recidivism are serious problems for medical personnel staffing surgical and medical hospital emergency rooms. Rounsaville and Weissman (*15*) found that during a 1-month period, 37 battered women presented at surgical and psychiatric services of Yale-New Haven Hospital emergency room located in New Haven and serving an urban and suburban population of 400,000. This number represented 3.8 percent of admissions in the emergency room of one hospital. The battered women often presented with contusions or other injuries to their heads and necks.

Kurz and Stark (*16*) have estimated that 40 percent of all injuries of women coming to emergency rooms occurred in abusive relationships. Stark and coworkers (*17*) found that 25 percent of emergency room visits of women were caused by battering. In fact, battering may be the major cause of injury to women—a greater total than automobile accidents, muggings, and rapes combined (*18*).

Battering is a serious problem among couples in the lesbian and gay communities (*19*); this kind of battering has generated little research. In a survey of

lesbians, 59.8 percent had been victims of battering (*20*). A second survey indicated that 52 percent of lesbians had been abused by female partners (*21*). Violence committed against lesbians and gays by stranger-perpetrators is also a problem (*7*). Lesbian and gay persons seek medical assistance in hospital emergency rooms, but emergency room staff are likely to assume that the batterer is an opposite-sex partner (*22*). When the victim is a lesbian injured by her partner, she may (*5*):

> . . . ultimately decide against telling her full story. By coming out, a lesbian's sexual preference may be included as a part of her permanent medical record, subject to review by unknown future insurers, physicians, nurses, and technicians.

Renzetti (*23*) found in her study that the few lesbian respondents who contacted police, attorneys, or physicians experienced negative responses.

The extent of battering encompasses more than a discrete injury of a battered woman. Rather, its full scope involves recidivism or repeated abuse. That is, the initial incident of battering characteristically is followed by repeated episodes of abuse, and studies have explored the impact of different intervention strategies on recidivism (*24–27*). It has been reported that 47 percent of husbands who physically abuse their wives do so three or more times a year (*4*).

A key aspect of this problem is battering during pregnancy; the extent of this abuse has been found to be considerable. Helton found that 21 percent of prenatal patients had a history of abuse, and in current pregnancies it has been reported to occur in 8.3 percent of prenatal patients (*28*). Outreach services to battered women during pregnancy is crucial.

Service Barriers to Health Care

Identifying service barriers is important in developing strategies for intervention. The emergency department is often the initial contact site for hospital services. It is important for battered women to be recognized, diagnosed, and treated upon this first entry to the hospital system.

Isolation and financial factors. Social, physical, and financial isolation results from the control exerted on the lives of battered women by their batterers (*3*). Battered women are often prevented from going out alone, and they may have limited use of a telephone or outside resources to escape from the situation. Families may not know how to offer emotional comfort and other types of support. In fact, battered women frequently hide the battering from their families (*29*). Even if their families are aware of the abuse, they may not know about community resources. Battered women who experience this isolation often can be identified by such statements as (*30*): "My husband won't let me." "He won't give me any money."

Battered women may be constrained by economic considerations. That is, the presence of children in the home, added to her financial dependency and lack of job skills, can increase the difficulties for the battered woman (*31*). Isolation and financial control can be barriers to seeking medical help.

Interview questions. Another barrier is the failure of emergency room staff and personal physicians to question and validate information regarding the violent context of the battered woman's injury. Rather than ascertaining (*a*) the cause of the woman's injury, (*b*) her feelings, and (*c*) her terror of the total living situation, triaging is often reduced to questioning and recording that focus only on the discrete injury (*17*).

For example, Warshaw (*9*) describes an interview in which a nurse records that a woman was "hit on upper lip, teeth loose and with dislocation. Happened last night." The discharge diagnosis was "Blunt trauma face." Warshaw acknowledges that

> The nurse's note does not mention who hit her, what her relationship to this person was, what the circumstances of the attack were, or why she waited five hours to seek medical help.

This antiseptic manner of objectifying the person results in frequent failures to recognize the violent origin of the injury, which must also be diagnosed and treated in order to impact fully on current and future injuries.

Thus, the failure to ask specific, validating, and battering-directed interview questions precludes making a contextual diagnosis and results in a barrier to effective intervention, such as referral to a battered women's shelter. The void in referrals leads to nonuse of other, crucial health care systems. In addition, this lack of validation discourages the battered woman from seeking additional curative and preventive help.

The absence of direct and accepting language in interviewing battered women is another barrier to their receiving adequate health care. Warshaw (*9*) explains that few among the medical staff studied

asked direct questions that allow for comprehensive interventions. For example, one physician asked a patient, "Did someone hit you?" when the physician identified redness about the patient's ear. The patient responded that indeed she had been hit by her boyfriend. When the physician asked why she had not previously revealed this, the patient said that the former physician had not asked. In fact, he had asked if there had been any trauma. The patient, not knowing the meaning of trauma, was not able to answer this question accurately. Bohn (*3*) suggests that it is important to question injured women privately, thereby giving them the opportunity to reveal the truth in the absence of the abuser who may accompany her to the emergency room.

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Blaming battered women. Blaming battered women for their situations is another barrier to effective health care. Blaming results from negative attitudes of the medical staff, such as the belief that some women marry men who abuse them before the marriage (thereby choosing the role of victim) and that some women invite the beatings they receive (*30*). Some medical staff hold a battered woman accountable for the battering. The woman is perceived as being in control of and responsible for her situation (*17*). Battered women fear being demeaned and blamed for an attack (*2*), and this fear discourages them from seeking health care services.

Trauma symptomatology. Deterrents to identifying battered women include the difficulty experienced by emergency room staff in recognizing trauma symptoms. Like hostages of violent crimes (*32*), these women may appear evasive and depressed (*17*). Depression is characteristic of the post-traumatic stress disorder (*33*). Other trauma symptoms include terror, fear, shock, psychogenic amnesia (inability to recall an aspect of the traumatic event), difficulty concentrating, flashbacks, and intrusive thoughts (*33*). They are attached to their batterers with traumatic bonding (*34*), a type of obedience and terrified clinging for fear of being harmed by the batterer. In the battered woman syndrome, the victim experiences helplessness, never knowing when the next attack will occur since the batterer builds up tension, explodes with rage, and then goes through a honeymoon period of apologies (*35,36*).

Denial and other attitudes of emergency room personnel. An additional barrier to identification and treatment of the ongoing violence experienced by battered women includes denial by the emergency room personnel (*2*). The denial surrounds the physical and emotional violence they experienced. Medical staff use denial in an attempt to distance themselves from the violence. The goal of distancing is to avoid feeling vulnerable and overwhelmed (*2*). It is very difficult to view the cruel injuries inflicted on these women, including broken bones, miscarriages, severe wounds, and burns on breasts and genitals. Without support, it seems understandable that rushed and caring emergency room staff would find it difficult to break through their own denial and recognize these horrors.

Other attitudes of emergency room personnel, along with their possible lack of training, may deter identification of and intervention with battered women. Their own discouragement about achieving a successful outcome with battered women (*10,17*) may lead to the staffs' giving up in their attempts to solve the large problem. Instead, staff members may seek rational reasons to explain the event in order not to feel vulnerable themselves. One example involves believing that abused women are responsible for what befalls them (*2*).

The staff may believe that asking about the cause of a patient's injuries is prying, and therefore it falls outside the purview of medicine (*2*). Direct questions about injuries may also be perceived as being intrusive (*16,37a*), out of place, and inappropriate (*9*).

Furthermore, the staff may see battery as a social or legal difficulty, rather than a health care problem (*2*). The emergency room personnel may believe myths, such as that battered women like being battered since they do not leave the battering situation (*2*). Lastly, the staff may be deterred by stigmatizing qualities such as alcohol on the breath of some battered women seeking help in hospital emergency services (*2,10,16*). This statement is not meant to imply that alcohol causes battering or that all

battered women abuse alcohol; rather, some victims of abuse may use alcohol to self-medicate and to cope with their pain and depression (*38*).

There may be feelings and an attitude of discouragement among emergency room staff when they learn that a battered woman has returned to an abusive relationship (*39*). And the hurried pace can be important when the staff feels overworked and burdened (*37b*): "Many viewed completing the protocol as an additional burden when they were already overworked."

Victim-Related Barriers to Care

Reluctance to identify themselves. Women are often reluctant to admit that they have been battered for a number of reasons (*2*). First, they feel ashamed (*3*), they blame themselves for the actual battering (*40*), and their fear of retaliation inhibits disclosing the source of their injury (*3,29,31*). Thus, they hesitate to ask for help, even when their injuries are substantial.

Traumatic bonding resulting in the lack of perceived options. Other barriers include traumatic bonding (*34*) and perceived lack of options (*2*). Traumatic bonding involves severe anxiety in which a woman clings to her abusive partner, hoping that he will change as he often promises, although his emotional and physical abuse are unchanging and intermittent during the cycle of abuse (*36*).

Anxiety causes clinging and a search for human comfort (*41*). Clinging is a normal response to trauma, and clinging characterizes the experience of emotionally and physically battered women (*38*). Further, the batterer's repeated promises to change and cease his violence add to the hope of the battered woman (*36*).

When a victim is traumatized, she does not perceive any available options. Thus, staying in the battering relationship seems like her only alternative.

Psychological trauma. Trauma is a barrier to seeking medical help (*3*). The "shock-like state" after being battered is "similar to that seen in disaster victims" (*3*). This, plus many other factors, can cause a victim to wait days before seeking medical assistance. Bohn (*3*) affirmed that this shock and numbness can be followed by "rationalization, self-blame, denial, or repression," any of which are barriers to promptly seeking medical assistance for injuries sustained in a battering incident.

Learned helplessness. Learned helplessness is the belief of the abused woman that she has no control over events in her life (*36*). Victims of trauma have been identified as experiencing learned helplessness (*41*). However, Herman (*42*) does not view battered women as experiencing learned helplessness; rather, she describes them as having learned that

> . . . every action will be watched, that most actions will be thwarted, and that she will pay dearly for failure. To the extent that the perpetrator has succeeded in enforcing his demands for total submission, she will perceive any exercise of her own initiative as insubordination. Before undertaking any action, she will scan the environment expecting retaliation.

If the batterer accompanies the victim to the emergency room, she may feel terrified, traumatized, helpless, and unable to reveal the cause of her injury. Thus, it has been suggested that the woman should be interviewed alone in cases where battering is suspected (*3,4,11*).

Intervention Strategies

Intervention strategies have been developed to address recidivistic abuse and to prevent and intervene in battering. These strategies include medical models for identifying and treating abuse, criminal justice intervention systems, and social models for change.

Medical models. Medical models for prevention and intervention attempt to address the high cost of medical care for those who are battered, the problem of recidivism, and the difficulty in recognizing battered women. Physicians have been identified as important sources for medical care sought by injured, battered women (*31*); they include hospital emergency room staff (*4,9,10,15,17,18,43,44*), physicians in public and private clinics (*28*), and personal physicians (*4,45*). While medical care is important, identification and appropriate referrals for battered women have not been effective (*9,10*). In 92 percent of domestic violence cases, physicians did not give referrals or followup assistance to battered women (*9*). Physicians and other emergency room staff in one study (*10*) identified and viewed as legitimate cases of battering only 11 percent of the women, in 49 percent they offered only a partial response to the battering, and in 40 percent there was no appropriate response from the staff.

A proposed comprehensive intervention strategy (*11*) incorporates suggestions for medical and surgical services for battered women. Specific questions about

battering would be important, as well as providing linkages to battered women's services. From the time that a woman discloses that she is battered, she would quickly be placed in contact with an advocate or social worker (*11*):

> . . . who would provide her with information about protection, legal rights, and when needed, shelter. In the course of the initial contact, an assessment would be made of the level of violence in the home, the availability of weapons, and the woman's previous experience with court and police interventions. A safety plan would be developed with the woman.

Services would include housing advocacy, taking the victim to court when necessary, referrals for legal and medical care, and referrals to counseling resources.

In addition, it has been suggested by Helton and Snodgrass (*46*) that intervention and prevention strategies should include a discussion of battering as a community health issue, rather than a private, shameful problem. Furthermore, they urge medical personnel to

> . . . observe for patterns of injury (bruising, lacerations, sprains, or swellings) in any pregnant woman. Consider if the explanation for the injury is logical. For instance, bumping into a door would likely produce a bump on the forehead or bruising on the extremity, but not a full black eye or swelling of the jaw.

Also, recommendations include observation of the behavior of couples in childbirth education or parenting classes, watching for patterns of abuse. Followup is stressed when a woman's safety is in question.

Other models of medical intervention call for changes in medical school curriculums to include education about domestic violence (*47*). In addition, a clinical assessment screen has been suggested for use by health care providers (*48*). Moreover, the Council on Scientific Affairs of the AMA has recommended (*49*):

> That training on interviewing techniques, risk assessment, safety planning, and procedures for linking to resources be incorporated into undergraduate, graduate, and continuing medical education programs.
>
> That the American Medical Association collect and disseminate protocols on identifying and treating victims of violence and develop, in conjunction with other relevant organizations, guidelines for treatment in which protocols are absent.

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Protocols for Treating Battered Women

The American Medical Association has developed "Diagnostic and Treatment Guidelines on Domestic Violence" (*4*) as part of its campaign against family violence. The first crucial response is recognition of abuse by the physician. It is suggested that physicians become familiar with the range of behaviors considered to be abusive. In addition (*4*):

> Domestic violence and its medical and psychiatric sequelae are sufficiently prevalent to justify 'routine screening' of all women patients in emergency, surgical, primary care, pediatric, prenatal, and mental health settings.

While women may not initiate a discussion or explanation regarding abuse, specific questions by the physician will often elicit this information. These questions need to be "simple, direct questions in a nonjudgemental way and in a confidential setting" (*4*). The patient should be seen alone (*4*).

These questions include asking whether the woman is in a relationship in which she is threatened, forced to have sex, or physically hurt (*4*). The physician is encouraged to provide an experience in which the woman feels respected, is informed that she "doesn't deserve to be abused," and is supported in that her safety and decision-making are important (*4*).

Diagnostic criteria are provided to assist physicians in appropriate responses to battered women. These include observing that injuries are repeated as well as the exacerbation and difficulty in the control of chronic illnesses such as asthma, arthritis, hypertension, and heart disease. These consequences result in increased medical costs for exacerbated and uncon-

trolled chronic illnesses. Prevention and appropriate medical responses to abuse can reduce this expense.

Physicians are advised to watch for behavioral signs exhibited by battered women which often include fear, shame, evasion, embarrassment, taking responsibility for her partner's violence, being accompanied by the partner who insists on staying close and answering questions, reluctance to disagree in the presence of her partner, reports of jealousness or possessiveness by the partner, denial or minimization of violence (by the patient or the partner), and self-blame (*4*).

It has been suggested that misdiagnosis of abuse may result in responses and treatment that are potentially harmful (*31*). Physicians frequently prescribe pain medications or mild tranquilizers for battered women, and Kurz and Stark (*16*) have suggested that this medication is contraindicated because abuse victims are at risk for suicide and drug or alcohol abuse. Continued abuse and increased battering may occur when physicians do not diagnose abuse (*31*).

Crisis intervention theory is an important aspect of protocols for intervening with battered women (*50*):

> Assessment of patients' immediate resources is an inquiry common to any crisis intervention process. In terms of battered women, this means inquiring about family and friends, job or supervisory support, finances, child care, assistance from school personnel, and general safety in the home.

There is opportunity for change when a battered woman is in crisis (*37b*):

> At this point of maximum discomfort, when the woman perceives the pain and torment as unbearable, she is in an active crisis state. During this time there is an opportunity for change and growth.

Effective protocols for battered women in crisis must include a recognition of the important role of advocacy services. In one study, battered women (*50*):

> . . . needed the very resources hypothesized to increase their chances of escaping their assailants (employment, legal assistance, housing, transportation, childcare). The current findings corroborate that this lack of resources serves to trap women in their abusive relationships. It is very realistic for many women to feel that they have no options available to them.

When battered women leaving a shelter were offered advocacy services on a one-to-one basis with trained paraprofessionals for a 10-week period, these women reported being more effective in accessing resources (*52,53*). The resources included health care, education, social support, employment, and child care (*53*). The relationship between resource acquisition and advocacy suggest an important protocol in program planning for battered women.

At the Dekalb Medical Center in Atlanta, GA, a patient representative is called by nurses in the emergency room when battering is suspected (*54*). The representatives interview possible abuse victims, refer them to community resources like shelters, and offer to call family members when appropriate. Nurses at this center report that the patient representatives can spend more time with the patients than is possible for nurses, who have many other responsibilities. In addition, the nurses receive feedback from the representatives and thereby gain confidence that the battered women receive the best possible treatment.

WomanKind (*44*) began as a nonprofit corporation contracting with a hospital site. It was later purchased by the Fairview Hospital System in Minnesota. WomanKind provides advocacy services, such as support, information, education, and community resource referrals for battered women in crisis. The advocate assists the woman in making community contacts. If a battered woman chooses to continue in the abusive relationship, then the advocate helps to develop a protection plan and follows up with the woman. Other services include ongoing education and inservice training for medical staff in such areas as identifying battered women, documenting injuries (in part through taking pictures), domestic abuse statutes, restraining orders, characteristics of the abuser, and such community resources as shelters.

The Advocate Program at the Harriet Tubman Battered Women's Shelter in Minneapolis has a contract with Hennipen County Medical Center to provide advocacy. Since only 20 percent of the battered women contact the hospital through the emergency room, the advocate makes rounds in other services to speak directly with medical staff. In M.L.'s (one of the authors) September 1993 interview with Beverly Dusso, director of the shelter, Dusso described the advocate as a link with medical staff to ensure that the battered woman receives appropriate medical care, as well as providing assistance (*a*) to locate the whereabouts of the batterer, (*b*) to obtain needed legal protection, and (*c*) to proceed with assault charges when appropriate. The advocate helps the woman to recover her children and belongings, as

well as assisting with long-term educational and vocational goals and training. In addition, trained volunteers are on call for night emergencies so there is 24-hour coverage.

The AWAKE (Advocacy for Women and Kids in Emergencies) Program at Children's Hospital, Boston, MA, provides crisis intervention and advocacy services for battered women in need of help. These women are identified as experiencing domestic violence by hospitial staff who assist the women to disclose information and to access AWAKE assistance.

Janis Sallinger, director of AWAKE, pointed out in an interview with M.L., in September 1993, that a lack of followup (after the battered woman has disclosed the source of her injury) leaves her at risk of more serious injury or murder during the dangerous time of separation. Safety planning, advocacy, and support are the focus of the AWAKE Program and of the participants of the Health Care Providers Group, a meeting of health personnel in Massachusetts. These medical staff share support and information regarding domestic violence. A severe problem faced by the AWAKE Program in trying to assist battered women to move to safety is the lack of space in local shelters. Nine out of 10 women are turned away from shelters.

Experiments with different protocol models and intervention plans for battered women are needed, according to Susan Schechter, author and battered women's advocate, Iowa City, IA (interview with M.L., September 1993). Regardless of the setting, all health care providers should use indicators of battering in history-taking. Battered women may present with headaches, backaches, or stomachaches although, even with mulitiple testing, the battering frequently goes undetected. Other risk factors include child abuse, suicide attempts, and substance abuse; substances can be used to self-medicate. Many battered women want to disclose their battering, but are fearful of doing so because of past experiences with disclosure to health care professionals, family, friends, clergy, mental health professionals, and police. These past attempts may have been met with minimization and denial, or even blaming of the victim. Thus Schechter concluded, "Battering is a hidden problem."

Criminal Justice Intervention Systems

Legal interventions are important aspects of dealing with battering. Even when battered women leave the abusive partner, they are still at risk of physical harm and need legal protection. In one study, more than one-fourth of the women who were no longer involved with their assailants experienced physical abuse, contradicting the assumption that leaving the abusive partner would make the victim safe (*55*). Furthermore, legal protection is needed when battered women experience recurrent injuries. Flitcraft (*56*) has described assaults on women as "typified by recurrent injuries generally accompanied by sexual assaults, threats, and verbal abuse".

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Murder-suicide is part of the broad spectrum of violence against women. One-half to three-fourths of murder-suicides in the United States involved a male who abused and murdered his girlfriend or wife and then committed suicide (*57*).

However, the legal response to battering has been a subject of controversy. The prevailing assumptions of the Minneapolis experiment (*58*), that arrest is the most effective prevention for recidivistic battering, have been challenged in the Omaha replication (*59*). That is, arrests were not found to be more effective in reducing recidivistic battering than were mediation and separation remedies (*25*). Battering reoccurred among large numbers of the perpetrators in this study between the 7th and the 12th months of followup even though they had been arrested at the time of the initial incident (*59*).

In the Milwaukee study (*26*), it was found that "arrest not only deters some groups; it also escalates other groups into far higher frequency of domestic violence." As with the Omaha study, the Milwaukee study researchers found that the arrests were a deterrent only for up to 6 months. Two groups were differentiated (*26*):

> . . . arrest has variable effects on criminal careers, depending upon the social marginality of the offenders. At least for the offense of misdemeanor domestic battery—or harassment, in the case of Colorado Springs—arrest appears to deter less marginal persons and to escalate the frequency of violence among more marginal persons.

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It is suggested that "those with high stakes in social conformity, experience a deterrent effect from both versions of arrest, while those with low stakes in conformity show no such effect" (*26*). On the other hand, Frisch argues that the arrest period is a crucial time during which "victims may for the first time, with appropriate assistance, be able to get to safety." Frisch suggests that protection is important for the battered woman during the abuser's arrest (*27*):

> . . . taking account of the escalation effect of short arrest, as described in the Milwaukee study, one might give priority to safety of the victims who are likely to be at increased risk of additional violence as a result of the batterer's arrest.

In addition, Bowman (*24*) suggests that, rather than reducing arrests, a more effective intervention strategy might involve enhancing the comprehensive services for the victim, such as community support services when the battering is detected in addition to the arrest.

Social Models for Change

Because violence is viewed as a public health problem (*60*), planners are beginning to advocate for comprehensive efforts to design, implement, and fund anti-violence initiatives. A public health approach to violence has been suggested. There would be "health event surveillance, epidemiologic analysis, and intervention design and evaluation focused unwaveringly on a single, clear outcome—the prevention of a particular illness or injury" (*60*).

The Centers for Disease Control and Prevention has focused attention on injury prevention and the study of violence and has received from an appointed panel a recommendation for the creation of a "national system or infrastructure for preventing violence" (*60*). This infrastructure would involve a Federal commitment of finances and coordination.

Access to lethal weapons has been an additional concern related to violence. It has been suggested that owners of firearms be legally required to meet certain criteria (*61*). Deviance from any criterion should result in the loss of the right to own or operate firearms (*61*). Family-intimate assaults involving firearms has been estimated to enhance the probability of death twelvefold (*62*). Thus, reducing access to firearms and reducing the gun's lethality through redesign have been recommended as important aspects in violence intervention (*62*).

In addition, there is a focus on alternative followup strategies, thereby integrating the social-community support systems, the legal system, counseling, medical care, and a multidisciplinary team approach in the hospital setting. The Department of Social Work at Harborview Hospital in Seattle, WA, has designed a complex and comprehensive "Adult Abuse Protocol," with components of varied systems that bring comprehensive services to battered women. The protocol includes obtaining consent for photographs of the injuries, a detailed description of the batterer and the incident, and legal alternatives and actions (*50*), thereby integrating medical and legal systems.

Another comprehensive social change intervention targets both health care professionals and the community-at-large to enhance the identification of battered pregnant women and increase their utilization of resources (*63*). A range of methods was described by authors affiliated with the Houston, TX, March of Dimes, including increased education for health care providers working with pregnant women. Brochures were designed to inform the public about the impact of battering during pregnancy, and public service announcements were developed for the media.

The increased focus on health care may encourage insurance companies to join the effort to identify, assist, and reduce the health costs for battered women experiencing recidivistic injuries. Some problems associated with such interventions are (*a*) concerns about violating the confidentiality of patient-physician communication and (*b*) the large numbers of claims being processed, up to 160,000 at a given time, which may create difficulty in focusing on one person's injuries (M.L.'s interview with Evonne Yancey of Kaiser Permanente, September 1993).

It may be easier, however, for health maintenance organizations to identify and reach out to help battered women. For example, in the Cigna Health Plan of Georgia (M.L.'s interview with Judy Hadjian of the Cigna Health Plan of Georgia, September 1993) three service programs (Precertification Serv-

ices, Case Management Program and Claims Review, and Quality Assurance Program) track recidivistic injuries among women who are needing an unusual amount of services. When battering is suspected, the primary care physician is alerted in a confidential communication.

Conclusion

Family violence is an important public health problem in the United States. Physical battering of partners results in repeated use of hospital emergency rooms, clinics, and personal physicians. The costs—both in terms of health care and human suffering—are considerable, and barriers to effective intervention are numerous. It is important to coordinate medical, criminal justice, social, and community systems to provide comprehensive services for battered women.

Comprehensive coordinated intervention is crucial; strategies must encompass needs for housing, child care, economic stability, physical and emotional safety, counseling, legal protection, career development or job training, education regarding family violence, ongoing support groups or peer counseling, and health care. Thus, effective intervention must address barriers and strategies not in a piecemeal fashion, but with comprehensive inclusiveness.

Intervention in the national crisis regarding the health care of battered women must include many social changes. At the macro-level, they require establishing an infrastructure to do national planning and education of the public through the communication media, and at the micro-level, education of the medical staff and the victims about appropriate interventions.

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