INTRODUCTION AND ACKNOWLEDGMENTS

INTRODUCTION

This woman abuse protocol was developed to provide health care professionals with information and resources to assist them in responding to the health care needs of women who have been abused by an intimate partner. The protocol is not specific to individual areas of health care, but rather, is focussed on providing a general overview of appropriate health care responses to the needs of abused women. The London Abused Women's Centre is committed to both the ongoing development of specific protocols and ongoing training opportunities for the health care profession.

ACKNOWLEDGMENTS

The manual, *Responding to Woman Abuse: A Protocol for Health Care Providers,* was prepared for the London Abused Women's Centre by Ms. Christine Reynolds, RN and Dr. Ann Schweitzer, RN, PhD of the School of Nursing, University of Western Ontario. The individual and professional commitment of these women to the development of this comprehensive educational tool for health care professionals will contribute significantly to the long term goal of ending woman abuse. Their efforts are deeply appreciated.

Recognition is also extended to the staff of the London Abused Women's Centre who generously donated their time and expertise to ensure that the final product best reflected the realities of women who are abused.

Finally, The London Abused Women's Centre thanks and honours the thousands of abused women who have so courageously walked through our doors with the hope of ending the violence in their lives. Ending the atrocities experienced by these women must remain the collective goals of society.

The health care profession has a responsibility to effectively respond to the health care needs of abused women. It is my hope that the protocol manual will assist with this responsibility.

Sincerely,

Megan Walker
Executive Director
London Abused Women's Centre

RESPONDING TO WOMAN ABUSE: A PROTOCOL FOR HEALTH CARE PROVIDERS

The goal of developing a protocol for health care providers is to create an educational tool that demonstrates ideal practices for health care providers and assists the health care community to respond effectively to woman abuse. This document was compiled from a variety of resources that address the issues of woman abuse and the response of health care providers to women in violent relationships.

While each health care provider and practice setting has its own specific needs and requirements that need to be considered, this document is a resource for those involved to develop protocols for identifying and responding effectively to women who experience abuse in their intimate relationships. Development of effective woman abuse protocols helps to give women the opportunity to disclose abuse, and to access information and resources which will assist them in taking control of their lives.

Recognition of the issue of woman abuse and supporting the programs that assist women who have been abused sends a message from the health care community that violence in any relationship is not acceptable in society, that it is regarded as a serious health issue, and that help is available. While violence in other situations and relationships is serious and also requires a health care response, this protocol is specific to woman abuse.

As health care practitioners, we look for results, and mostly for positive results from our care. We are constantly being asked to validate our practice with outcomes. It is easy to decide that a woman returning to an abusive partner is not a positive outcome from our intervention. The more difficult, but better thing to do, is to see the abused woman's situation as she sees it, the possibilities as she believes them to be. Benner and Wrubel (1989) point out that making right/wrong judgements about people's actions denies them the personal meaning that makes their decisions right for them, if not necessarily good for them. Our task then is to become facilitators and coaches, creating new possibilities and potentially new decisions.

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1998

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UNDERSTANDING

WOMAN

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UNDERSTANDING WOMAN ABUSE

Woman abuse is a social issue that impacts the health of women and children. Abused women will come in contact with a health professional for treatment of acute injury. They may also attend with symptoms developed from long-term emotional, mental or physical abuse. Abused women and their families are the largest consumers of health care services (Heise, 1994). It is not unusual for women to be treated for health complaints or injuries, without having the underlying cause - woman abuse - discovered.

Women often do not volunteer information about being abused, and health care providers often do not ask the question. Many women leave after treatment to return home to the situation that caused their injury/illness without information about resources that are available to help them and without a plan to assist them in case the abuse happens again. Abuse follows a predictable pattern, and the more skilled practitioners can become at recognizing the pattern in its early stages, the more opportunity there will be to provide women with knowledge and resources.

Early intervention may prevent illness, complications during pregnancy, injury, and even death by increasing the victim's safety and reinforcing the fact that the abusers are accountable for their coercive and violent behaviour.

Women who may not disclose or seek help from police or others may disclose abuse when questioned gently and privately by a supportive health care provider (Heise, 1994). Health care providers have a responsibility to identify and respond to woman abuse, and when possible, to respond to prevent further abuse regardless of age, socioeconomic status, culture, race, or sexual orientation. In order to respond effectively, it is important to question personal and societal attitudes surrounding the inequality between men and women and the dynamics of power and abuse within relationships.

DEFINING WOMAN ABUSE

> ...the intentional and systematic use of tactics to establish and maintain power and control over the thoughts, beliefs, and conduct of a woman through the inducement of fear and/or dependency. The tactics include, but are not limited to, emotional, financial, physical, and sexual abuse, as well as, intimidation, isolation, threats, using the children and using social status and privilege (adapted, the Domestic Abuse Intervention Project, 1993). Woman abuse includes the sum of all past acts of violence

and the promise of future violence that achieves enhanced power and control for the perpetrator over the partner (Hart, 1986). Abusive behaviour does not result from individual, personal or moral deficits, diseases, diminished intellect, addiction, mental illness, poverty, the other person's behaviour, or external events (McGrath & Zubretsky, 1997; Heise, 1994).

Abuse can be manifested in many ways. All forms of abuse result in the loss of dignity, control, safety and personal power. Abused women change their behaviour, preferences, and/or choices because they fear the consequences or reprisals of their abusive partner.

- **Physical Abuse**
  Hitting, punching, kicking, pushing, burning, biting, use of weapons and objects, restraining, withholding food/medical attention. It can, and sometimes does, result in death (Rogers, 1994).

- **Psychological/Emotional Abuse**
  On-going criticism, degradation, humiliation, possessiveness, threats, control of activities, social isolation, purposeful destruction of property and/or pets.

- **Economic Abuse**
  Withholding/restricting money, preventing the woman from getting/ keeping a job, taking her money, denying her independent access to money, excluding her from financial decision-making.

- **Sexual Abuse**
  Any forced sexual activity or malicious withholding of sex, demeaning the woman sexually by jokes and/or name calling, unwanted touching, excessive jealousy, sexual accusations, restricting her choice related to pregnancy, birth control and/or abortion, exposure to HIV and STD's.

Woman abuse is perpetrated by adults or adolescents against their intimate partners in current or former relationships. Women in lesbian relationships are not immune to violence and abuse, and its prevalence may be as high as in heterosexual relationships (Champagne, Lapp, & Lee, 1994). Abuse occurs in families of all socioeconomic, educational and cultural backgrounds and is found in both rural and urban settings. It can be manifested in many ways, but most frequently it involves a repeated, escalating pattern of incidents. Abuse typically escalates in frequency and/or severity and once abusers use physical violence, they are likely to intensify their assaults and increase the woman's risk of harm and serious life-threatening injury.

Tactics of control can begin very slowly as coercive tactics that may not be

criminal in nature but makes it very difficult for the woman, as well as friends, family, or professionals to recognize it as abuse. Women identify the emotional and psychological consequences of abuse as more damaging than the physical assaults (Jerzierski, 1994; Heise, 1994). While emotional abuse does occur in the absence of physical abuse, the two occur together in the majority of cases.

ABUSE INTIMATE RELATIONSHIPS "POWER AND CONTROL"

Woman abuse in adult relationships is generally defined as: The intentional and systematic use of tactics to establish and maintain power and control over the thoughts, beliefs, and conduct of a woman. The tactics can include, but are not limited to, the examples below.

Using Isolation:

- controlling what she does, who she sees and talks to, where she goes, limiting her outside involvement
- using jealousy to justify actions
- sabotaging of friendships, new relationships

Using Emotional Abuse:

- putting her down, calling her names, making her feel badly about herself
- playing mind games, making her think she is crazy
- humiliated her in front of friends and/or co-workers

Using Children:

- using visitation (access) to harass her
- using children to relay messages telling them bad things about her
- threatening to take children away
- making her feel badly about her parenting

Using Intimidation Coercion & Threats:

- making her afraid by using looks, actions, gestures
- smashing things
- threatening to report her to welfare, immigration, etc.
- purchasing or displaying weapons
- abusing pets or destroying cherished items

Minimizing, Denying & Blaming:

- making light of the abuse
- saying the abuse didn't happen
- saying the woman caused the abuse
- blaming stress as the problem

Physical Abuse:

- hitting, slapping, punching, biting, kicking, pushing or harming woman in any way
- confining, holding or preventing woman from leaving
- withholding/preventing a woman's access to physical care, food or medication

Using Social Status & Privilege:

- reinforcing control over her by the use of gender, race, class, sexual orientation, immigration status, age, occupation, wealth, physical or developmental ability
- using institutions to reinforce power or privilege

Using Economic Abuse:

- preventing her from getting or keeping a job
- taking her money
- making her ask for money or an "allowance"
- not allowing her to participate in financial decision making

Sexual Abuse:

- any sexual activity that is unwanted or coerced
- sexual name calling or accusations
- uninformed sexual activity, i.e. non-disclosure of STD/HIV status
- forced pregnancy or termination of pregnancy

COMMON MISCONCEPTIONS ABOUT WOMAN ABUSE

Myths and stereotypes about woman abuse often isolate abused women and prevent them from accessing and receiving appropriate services.

Misconception: Is woman abuse a private family matter?

Fact: Many forms of woman abuse including physical and sexual abuse, threats and stalking are crimes punishable by law. Woman abuse is a widespread societal problem that has devastating effects for individual victims, their children, and their communities. It is not a private matter. By keeping woman abuse private, it only serves to condone the behaviour of the perpetrator of abuse and does not protect the women and children who are subjected to this atrocity.

Misconception: Is woman abuse a new problem?

Fact: Woman abuse is a chosen act against a chosen victim. The abuser intends to seek compliance from, or control over, the victim. It is an act which has been condoned by society for centuries. In 18th century England, laws gave husbands the right to "discipline" their wives. One law, the Rule of Thumb, gave men the right to whip their wives with a switch no thicker than their thumb (Langley & Levy, 1979). Until 1965, in Canada, a husband would not be charged with assaulting his partner unless the woman could prove sufficient bodily harm (Dobash and Dobash, 1979). Moreover, it was not until 1983 (Bill C-127) that a man could be charged with sexually assaulting his wife. The historical unequal power relations between men and women have led to domination over and discrimination against women by men.

Misconception: Does woman abuse only happen to poor or uneducated women?

Fact: Women from all ages, socioeconomic, ethnic, cultural, educational, occupational and religious groups are abused. Perpetrators of woman abuse can be found in all age, cultural, socioeconomic, educational, occupational and religious groups.

Misconception: Is woman abuse a rare occurrence inflicted upon only a few women?

Fact: Woman abuse is often referred to as an epidemic in our society. In 1993, Statistics Canada found that three in ten married or common-law women reported experiencing abuse where criminal

charges were warranted (Rogers 1994). These statistics do not include women in dating relationships or non-criminal behaviours such as emotional abuse or isolation tactics. In Canada, an average of 78 women is killed each year by their current or former abusive partners (Johnson, 1996).

Misconception: *Is a "Domestic Dispute" a dispute/argument which has gone too far?*

Fact: Woman abuse is not a dispute which has become out of hand. It is the intentional action of one individual to gain and maintain power and control over another. It is about gaining control over an individual, not losing one's control. Abusers are making choices about their actions even when they are claiming that they "lost it" or were "out of control." Many women who seek service at the London Abused Women's Centre report that if the abuser becomes angry outside of the home, i.e., in the grocery store, the abusive partner waits until they are home before abusing her. Also, women report that when the abusive partner smashes things in the home, it is usually something belonging to her, rather than the abuser. These are just two examples that show the intentionality and decision making of the abuser and not the escalation of anger and out of control behaviour.

Misconception: *Can an incident of woman abuse be a minor, isolated incident?*

Fact: Woman abuse is rarely an isolated incident but rather a repeated pattern of tactics used to gain and maintain power and control over a woman. Woman abuse includes a wide range of coercive tactics that can include physical, sexual and emotional abuse as well as threats, intimidation, and use of the children. Abused women report that often the tactics of control increase in severity over time. Woman abuse causes serious and sometimes permanent injuries including death. Emotional abuse can also be as debilitating as physical abuse and as psychologically damaging as other types of abuse (Heise, 1994).

Misconception: *Do women provoke abuse in most cases?*

Fact: No one deserves to be abused. Provocation is an excuse that places responsibility and blame for violence on the victim rather than on the perpetrator. This misconception fails to hold abusers responsible and accountable for their own actions. It also clearly fails to protect the victim. Clients of the London Abused Women's Centre identify that they often deliberately alter their own

behaviours, choices, or decisions in order to avoid negative reprisals from their abusive partners and not provoke them.

Misconception: Are abusers sick or mentally ill?

Fact: Woman abuse is too widespread to be explained by mental illness. It is a learned behaviour that is intentional. It is also observed and reinforced in society. Woman abuse is not caused by genetics or illness (Bandura, 1973; Dutton, 1988). The socially sanctioned belief that men have the right to control women in relationships and the right to use force to ensure that control is reinforced by society's major institutions such as social, legal, religious, educational, mental health, medical, entertainment/media, and the family (Ganley, 1989). These institutions facilitate the use of violence as a legitimate means of controlling women.

Misconception: Do drugs or alcohol cause abuse?

Fact: While it is sometimes true that abusers may be under the influence of drugs or alcohol during abusive incidents and that these substances may contribute to the severity of the abuse, drugs and alcohol do not cause the abuse (Health Canada, 1993). Abused women often say that their partners are also abusive when sober. Stopping the substance abuse will not end the violence. Both issues must be addressed.

Misconception: Is woman abuse really spousal abuse? Both partners can be abusive.

Fact: Some people suggest that woman abuse is really spousal abuse because both parties have been abusive. Careful assessment must be undertaken in these situations to determine who is the primary aggressor and who is the victim. Often this assessment will reveal that one person starts the violence while the victim's violence is used in self-defence. To help assess this situation, two questions should be asked, "who is afraid of the other?" and "who changes their behaviour for fear of negative reprisals?"

Misconception: Does witnessing woman abuse harm children?

Fact: Yes. Studies have shown that children often experience symptoms associated with witnessing woman abuse such as nightmares, flashbacks, anxiety, and fear. Children who witness woman abuse or who are exposed to woman abuse are also at greater risk for behavioural problems such as outbursts of anger and aggression and conflict with the law. In fact, the level of emotional and

behavioural problems found in children who either witness, or are exposed to, woman abuse is similar to that of children who are themselves directly physically abused (Jaffe et al, 1985).

Misconception: Do women stay because they like the abuse?

Fact: There are many very real reasons why women stay. The primary reason given by victims for staying with their abusive partner is the fear of escalating violence and the lack of real options to be safe with their children. The fear of violence is realistic. Abusers will often threaten the woman's safety or that of her family's if she leaves the relationship. Strong societal and cultural messages create barriers for women who seek safety for themselves and their children. Some of these messages include, "you made your bed, now lie in it," or "it is a woman's responsibility to make the marriage work," and "children need two parents in the home." Statistics also show that women who do leave an abusive relationship experience an escalation in abuse, sometimes resulting in serious injuries or death (Crawford, Gartner & Dawson, 1997).

ABUSE AS CONTROL

All forms of abuse are attempts to control. Traditional attitudes and hierarchical structuring of society have supported the dominance of the male and the subservience of the female. Violence in general is accepted and condoned by society. Anger and aggressiveness are considered appropriate modes of conflict resolution. The message is that intimidation and violence against women are acceptable ways of dealing with conflict. Social and legal traditions have also allowed woman abuse to be treated as a private matter within the family home. These traditions, combined with the effects of the abuse, may cause an abused woman to:

- Believe she provokes her partner's abuse and that she did something to deserve it.
- Believe that if she changes what she does or says her partner will stop the abuse.
- Feel guilty about the violence.
- Deny her terror and the anger she feels.
- Be very concerned with keeping her family together and supporting her partner and her children.
- Be ashamed of her injuries, and try to hide the fact that this is happening in her home.
- Believe that this happens only to her and to no one else.
- Believe that no one can help her.
- Underestimate her ability to do things, not believing that she can take

care of herself.

C Demonstrate incredible endurance in surviving.

C Try to appease the abusive partner.

C Believe the myths about abuse.

UNDERSTANDING ABUSERS

Abusive behaviour does not result from individual personal or moral deficits, diseases, diminished intellect, addiction, mental illness, poverty, the other person's behaviour, or external events (McGrath & Zubretsky, 1997; Heise, 1994). Perpetrators act from a set of beliefs and attitudes about how men and women should relate in intimate relationships. They generally believe that they have the right to enforce their will on the female partners. In Ontario, 87% of those charged with domestic assault are men.

Abusive behaviour is the sole responsibility of the individual abuser. The abuser's choice to use violence is completely independent of the actions of the victim. There are no acceptable excuses for abusive behaviour. The criminal justice system, health care providers and the broader community must hold abusers accountable for their behaviour.

STATISTICS ABOUT WOMAN ABUSE (Rodgers, 1994)

C 25% of Canadian women who have been married or lived common-law have been assaulted by their partner. Newer marital relationships (<2 yrs.) had the highest rates.

C The rate of abuse for the age group 18-24 is four times the national average.

C Women with disabilities are at higher risk when compared to the total female population.

C In the majority of cases the abuse is not an isolated event. Violence occurred more than once in 2/3 of the reported cases.

C Violence against women occurs at any point in a relationship:

ÿ 16% of abused women report experiencing abuse before marriage (higher in common-law relationships).

ÿ 40% of abused women report that the abuse began during pregnancy.

ÿ 21% of abused women report that the abuse continued during

pregnancy.

- Approximately 20% of abused women report that the abuse occurred or increased in severity after the relationship ended or during separation.
- 39% of abused women report that their children witnessed the violence against them.

- Women rely mostly on friends and neighbours (44%) and family (45%). Only 25% tell a doctor.

- 25% of abused women use some formal social service agency with the most frequently used service being individual counselling.

- Children who grow up witnessing woman abuse are more likely to be in violent situations and relationships when they grow up.

- The risk of being an abuser is three times higher for men who witnessed violence by their fathers against their mothers. These men tend to inflict more frequent and severe violence on their partners.

IMPACT OF ABUSE ON WOMEN'S HEALTH

IMPACT OF ABUSE ON WOMEN'S HEALTH

Forty-five percent of woman abuse cases result in physical injury (approximately 40% of these injuries were severe enough to require medical attention). The psychological effects of this can be far reaching: 85% of abused women indicate that they have experienced some type of negative emotional effect - anger, fear, becoming less trusting, suffering from lowered self esteem, depression, anxiety, shame, and guilt. In order to combat these effects, 25% of these women report having used alcohol, drugs or medication (Day, 1995).

HEALTH CONSEQUENCES OF GENDER-BASED VIOLENCE (Heise, 1994)

Non-fatal Outcomes:

Physical Health Consequences

" STD's
" Injury
" Pelvic inflammatory disease
" Unwanted pregnancy
" Miscarriages
" Chronic pelvic pain
" Headaches
" Gynaecological problems
" Alcohol/drug abuse
" Asthma
" Irritable bowel syndrome
" Injurious health behaviours,
i.e., smoking, unprotected sex
" Partial or permanent disability

Mental Health Consequences

" Post traumatic stress disorder
" Depression
" Anxiety
" Sexual dysfunction
" Eating disorders
" Multiple personality disorder
" Obsessive-compulsive disorder

***Fatal Outcomes*:**

· Suicide
· Homicide

COSTS OF WOMAN ABUSE

There is a measurable price paid both socially and economically for violence

against women (legal costs, health care, shelter and support services). There are also hidden and unmeasurable costs. From 1994 data, Day (1995) found that 34% of abused women reported they could not work the day following an assault, which resulted in a loss of net income. Justice, health and social services incur costs for children who suffer long-term damaging effects of witnessing or experiencing violence in their homes. There are other social and financial costs to society as abused women isolate themselves in fear. Abused women withdraw from taking part in society by not volunteering or helping in schools, and they affect the economy when they are prevented from working, attending school, or controlling their own finances.

The Canadian estimates of medical/health costs of violence against women range from $408,357,042 to 1.5 billion annually (Day, 1995). Including the cost to social services/education system, criminal justice system, and labour and employment, the estimated cost of woman abuse is more than 4 billion dollars annually (Day, 1995).

The highest costs are born by the women who suffer the abuse. There are 200,700 women in legal or common law marriages who are abused in Canada each year (Day, 1995). From 1991-1994 an average of 40 women were killed each year by current or former legal spouses, common-law spouses or boyfriends, accounting for 75% of all female homicides. Of these women, 40% were living apart from their partner when they died, and nearly one third had some prior police intervention because of violence in the relationship. In some cases, children were also killed or were witnesses to the killing of their mothers. The majority of the deaths occurred in the victim's own home. The risk of being killed by one's intimate partner is five to six times higher for women living common-law or separated from their partners (Crawford, Gartner, & Dawson, 1997).

BARRIERS TO LEAVING

Society has traditionally placed the accountability for violence on the victim rather than on the abuser. Women tend to blame themselves because they have been blamed by others. "It is an ironic expectation that battered wives stop the abuse and escape death itself . . . take up the role of fugitive, along with continued responsibility for children, while assailants often go on with life as usual" (Hoff,1990 in Hoff, 1994).

- 43% of women leave their partners after an assault
- 29% never return home (Hoff, 1994).

Almost three quarters of women eventually return home, most commonly because:

- They are concerned about the disruption of their children's lives, and about maintaining a continuity in their environment and schools.

- Abusive partners threaten to abduct children, refuse economic support or fight for custody.
- Abusers threaten to kill their partners, to commit suicide, or to harm children, pets or other family members.
- They care about and have made a commitment to their partners, and want to give the relationship another chance.
- The abusive partner promises to change their behaviour.
- They are economically dependent upon their abusive partners, lacking their own money for housing and food.
- They lack accessible resources, a situation which is more pronounced for women with disabilities and special needs, and those with language and cultural barriers.

(Rodgers, 1994)

BARRIERS TO DISCLOSURE

Women who have been abused identify many reasons for not disclosing the abuse they experience to their families, friends or professionals. The reasons include their need for privacy, isolation, a lack of knowledge about agencies, difficulties with agencies from prior experiences, cost, consequences of approaching an agency, (i.e., fear of losing children), not wanting to have charges laid against the partner, blaming oneself for the abuse, hoping that things will get better, fearing that the partner will find out about the disclosure and inflict punishment (Burkell, 1993). Women who are in abusive lesbian relationships face the risk of being stigmatized by revealing their identity as a lesbian (Champagne, Lapp & Lee, 1994). Women with disabilities worry they will be seen as less credible because of their disability and won't be believed. They also fear losing their caregiver or losing attendant services and are at more risk of losing their children.

BARRIERS TO ACCESSING HEALTH CARE

A woman may feel unable to disclose to her family physician. Her partner may be seeing the same physician or they could be personal friends resulting in the fear that any disclosure may be revealed. Another fear is that health care providers may not understand the issue of woman abuse, may not take the woman's concerns seriously, or may blame her for the abuse. Women often hear from the very professionals with whom they seek help, i.e., clergy, counsellors, nurses and physicians, that they should go back home and try again (Sullivan-Wilson, 1994).

Access to health care institutions also creates barriers that make disclosure difficult. A woman may be unable to drive herself due to her injuries, she may not have access to a car, or her partner may refuse to take her. In rural areas, she may live far away from facilities and not have access to transportation. Once in a health care facility, abused women have privacy concerns, i.e. being in waiting rooms where they may encounter people who know them and may therefore discover why they are there. If an abused woman encounters an impersonal approach by a health care provider, she may feel that there is an unstated message that the person does not want to get "involved" (Burkell, 1993). Increasing pressures due to a lack of time and the conveyer belt approach that often characterizes busy health care settings today, are not conducive to the development of trusting relationships (Metcalf, 1996).

THE ROLE OF HEALTH CARE PROVIDERS

THE ROLE OF HEALTH CARE PROVIDERS

To provide an effective response, health care providers need to recognize the magnitude and significance of the problem of woman abuse and their own ability to make a significant difference in these women's lives. All health care providers are in strategic positions to prevent violence, to detect the risk and victimization of vulnerable women, and to provide services to survivors of abuse.

Abused women may attend with an emergency situation or for a consultation for herself or her children. Abused women and their assailants are encountered more frequently in certain health care settings, i.e., emergency departments, family practice, obstetrics and gynaecology, paediatrics and psychiatry. Practitioners who are most likely to encounter abused women are those in maternal/child, women's health, midwifery, medical-social work, child welfare and community health (Hoff, 1994).

As abused women rarely identify abuse as their initial problem, practitioners in a wide range of specialties may see women with a variety of injuries and in various settings:

Dentists - Treat women for broken teeth, oral injuries.

Gastroenterologists - Functional gastrointestinal disorders (women with these complaints are much more likely to report a history of physical or sexual abuse as an adult or in childhood).

Gerontologists - Treat abused elderly.

Gynaecologists/Obstetricians - Chronic pelvic pain with no identifiable organic cause, pregnant women with vaginal bleeding, threatened abortion, pre-term delivery. Gynaecologists often see women who have a significant history of past or present abuse.

Neurosurgeons - Serious head injuries: skull fractures, subdural/epidural haematoma or spinal cord injuries.

Nurses - Provide nursing care to abused women and are able to identify victims of abuse in various practice settings including maternal/child, community health, school health, mental health, occupational health, nursing homes and institutional care settings, acute care, primary health care, and academic settings.

Opthamologists - Retinal detachments and orbital blow-out fractures.

Otolaryngologists/Maxillofacial Surgeons - Facial lacerations and fractures of the nose, jaw and perforated tympanic membranes.
Paediatricians -Treat abused teens and care for children who have witnessed abuse.

Psychiatrists - Acute manifestations such as suicide attempts, as well as chronic manifestations such as anxiety, depression and post traumatic stress disorder.

Public Health Nurses - The major contact for isolated women and their children for health services.

Rehabilitation Practitioners, Occupational Therapists/Physiotherapists - Treat women recovering from a variety of injuries.

Social Workers - Provide counselling to women, who are referred for problems other than identified abuse, crisis counselling.

(Adapted from - Education Wife Assault Fact Sheet: How Physicians Can Help an Assaulted Woman, 1997).

PROVIDING CARE FOR ABUSED WOMEN

Health care professionals, like all other members of society, are influenced by traditional beliefs about women, marriage, the family and violence. Health care providers need to examine their own personal feelings which may contribute to a judgmental attitude which would negatively affect their interaction with a victimized woman. This may result in denying the abuse, blaming the victim, or minimizing the effects of the violence. The influence of biomedical frameworks often results in reducing the lived experiences of abused women into standard diagnostic categories or problems that can fit into a set treatment plan (Warshaw, 1993). This usually results in the labelling or diagnosis of the woman without addressing her personal reality as a victim or the accountability of the assailant.

The complexity of an abusive relationship precludes a single, or immediate solution. The foundations for successful interventions with abused women include:

- Demonstrating a basic understanding of the issues.
- Expressing genuine interest and concern.

- Responding with the skills that create a safe environment.
- Asking appropriate questions.
- Developing liaisons with other professionals and community groups for referral and collaboration.

Successful intervention with abused women also requires setting realistic expectations for the outcome. ***Success does not necessarily mean having the woman leave the relationship*.** Leaving may not be a viable option when considered in light of the risks that an abused woman may have to cope with as a result. Women need to be empowered to care for themselves and make their own decisions. Success results from conveying information and providing resources that will acknowledge her strengths and identify her options. Success is based on what the provider does in following an effective plan, rather than on the actions that the woman does or does not take.

PERSONAL REACTIONS IN RESPONSE TO THIS WORK

The experience of working with women who have been abused can generate strong emotional reactions. It is not unusual to feel angry, overwhelmed, vulnerable and/or helpless. Health care providers have high expectations of themselves and tend to have little tolerance for their own feelings of helplessness and professional inadequacy when they cannot fix the problem or believe they lack the skills (Warshaw, 1993). The disclosure of abuse may force providers to confront attitudes they were not aware of, or which cause them distress if they have been witnesses to, or are victims of, abuse themselves.

Recognizing these strong feelings is important in remaining calm and not inadvertently giving the woman messages that she is not doing the right thing or is to blame for her situation. It is important, then, for providers to examine their feelings and raise their self-awareness about their own strengths and limitations. Peer support and a team approach are valuable tools to debrief and problem-solve personal reactions.

Increasing their own knowledge is another way providers can come to terms with their feelings. By clearly understanding that the role of the health care provider is not to rescue the woman from her abusive relationship, interactions can be based upon empowering a woman to achieve her goals. It is important to recognize that interventions are multi-disciplinary, multidimensional and take time. One may never know when an interaction will be a part of the process that allows a woman to break free from an abusive partner.

SCREENING FOR ABUSE

Routine screening has been shown to be effective in identifying abused women (Grunfeld et al. 1994). Studies have suggested that a standard set of questions be used to ask all women patients about abuse as part of the routine social history/general health history questionnaire, regardless of their age or chief complaint. Not all women will recognize their situation as one of abuse and questions must be direct and specific with examples given if necessary. Some guidelines recommend intensive screening for high risk populations including pregnant and suicidal women. In one study 89% of women indicated they would feel comfortable in disclosing abuse to health care professionals if asked (Hayden et al., 1997).

High risk factors, injuries or the following conditions should raise the suspicion of abuse. Common presentations include:

- A recurrent trauma history, frequent use of emergency departments (typically between 10:00 p.m. and 5:00 a.m.).
- Injuries to head, neck, torso, breasts, abdomen, or genitals.
- Presenting physical injuries that are multi-site, that indicate sexual assault.
- Bilateral injuries that do not normally occur in accidents and/or signs of old untreated injuries.
- Unexplained injuries or injuries that are inconsistent with the explanation given.
- Delay between the occurrence of the injury and seeking of medical treatment.
- Physical injury during pregnancy, especially on the breasts and abdomen.
- Behavioural cues such as depression, suicidal ideation, anxiety and/or sleep disorders, panic attacks, symptoms of post traumatic stress disorder, and alcohol/substance abuse problems, heart palpitations, or chronic headaches.
- Chronic pain symptoms for which no etiology is apparent.
- A partner that seems overly protective, controlling, or who will not leave the woman's side.

(Family Violence Protection Fund, 1996)

ESSENTIAL ELEMENTS OF SCREENING

Screen in a safe environment.

- Separate the woman from the accompanying person to avoid putting her at additional risk. If this is not possible, postpone the screening. When a woman is accompanied by another woman, it cannot be assumed she

is a friend, she could be the partner.

C Use a private space.

C Use a non-threatening and non-judgmental manner.

C Inform the woman of the extent and limits of confidentiality, the mandated reporting of child abuse, and the need to act in cases where she expresses the intent to do harm to herself (suicide) or others.

Use questions that are direct and easy to understand.

C Indirect questioning will rarely bring disclosure of abuse (Jerzierski, 1994). Questions need to be direct. The actual abuse may need to be described in the questions, i.e.,

  ÿ "Have you ever been hurt or hit by someone close to you?"
  ÿ "I am concerned that your injuries have come from someone hurting you, is this what happened to you?"
  ÿ "Does your partner try to control everyday routines in your life such as whom you can see or when you can leave the home?"

C If the woman does not speak English, do not use family members or a person known to her. Use a professional interpreter or another health care professional fluent in her language. Be sure that the interpreter is aware of issues of confidentiality.

C Use the word "partner" if the abuser's gender is not known.

C Respect that she may refuse to give information or receive help.

C Focus attention on the woman, not on the paperwork, to build trust and rapport.

Document that abuse screening was done.

C Record that screening was initiated and include the response from the woman. Record if it is suspected even when the woman denies it.

a) *When there is no disclosure*: Screening is not a failure. A supportive approach such as the following will provide the woman with information about where to find a source of support when she is ready.

  ÿ "If this were to happen to you, or to someone you know, would you know where to go?"
  ÿ "Please return if you need someone to talk to."

b) *When there is a disclosure*: The health care provider's response to a

disclosure of abuse sets the stage for both the current intervention, and for future interactions with health care providers. A negative response, showing disbelief or blaming, will often result in the deliberate avoidance of health care services in the future. A positive response demonstrating concern, support and information can begin the process of the woman's examining her views of the relationship with the abuser and her options (Fishwick, 1995).

Most women are very vulnerable at the time of disclosure. They may be fearful, embarrassed, or can be in a state of emotional shock. They may be indecisive and show low self-esteem. During this time many women are overly compliant with suggestions and may later blame their care-giver for giving advice. It is important for the health care provider to listen, to allow time for the woman to ventilate her feelings, to offer emotional support and to avoid telling the woman what to do (CNA, 1992). The provider's role is to support the woman in making decisions, not to solve the problem for her.

ASSESSMENT

Depending upon the practice setting in which an abused woman presents, she may first require attention to her immediate medical/physical needs. When abuse has been disclosed, or suspected, in addition to medical/health care, an assessment of her injuries and the effects of the abuse is required. This should include the following categories:

1. *A history of her present complaint.*

   Record the description of the abuse that caused her injuries as she herself describes it. Use her own words, and be as specific as possible.

2. *A thorough physical examination.*

   Request that she disrobe and examine her for evidence of further injuries and/or evidence of old injuries. Use a body map to record as much detail as possible, including areas of tenderness that may indicate internal injuries that are not visible. Specific signs to look for include:

   - Injuries found on the head, face, throat, chest, breasts, back, abdomen, genitals (multiple sites are often involved).
   - The following types of injuries - abrasions, bruises, burns, dislocations, lacerations, bites, fractures (jaw, fingers, ribs, clavicle), strangulation.
   - Suspicious behaviour, such as the abused woman providing a description which is inconsistent with the type of injury, tense

interactions with her partner, her affect, patterns in her medical history, any unexplained delay in seeking help or any unusual manner of communication, i.e., she says nothing, minimizes the injury and situation, avoids eye contact, is anxious about a minor injury.

C Her partner's behaviours, i.e., note whether the partner hangs around, answers for her, seems overly concerned.

(Education on Wife Assault Sheets, 1997)

3. An assessment of her safety.

C Is there an immediate risk? How safe is the woman if she returns home now?

C What is her state of mind toward the situation and toward a possible change?

What assistance does she want?

ÿ What changes would she like to make for herself/children?
ÿ What would help her to make these changes?
ÿ What action is she ready to take now?

C How has the abuse affected her and her health?

C How does she cope with the abuse, and what works for her?

C What support systems does she have or not have?

C Safety strategies:

ÿ What does she currently do to protect herself/children?
ÿ Has she sought outside assistance? If so, from where and by whom?
ÿ Has she ever tried to leave? If so, what happened as a result?

C Suicidal ideation:

ÿ Has she ever attempted suicide, or thought about how she would do it?

4. Assessment of the children's safety.

C Have her children shown any sign of physical injuries or sexual abuse that could be related to the partner's abuse such as eating or sleeping disorders, somatic complaints, bad dreams, aggressive behaviour, school problems, depression?

- How often have they witnessed abuse?

DOCUMENTATION

The purpose of creating and using a documentation tool is to both record the injuries/condition of the abused woman, and to guide the user through the steps needed for effective intervention. It should be noted that this record may be required for court purposes as a legal medical document, therefore dates, times and statements by the woman are important. Proper documentation is beneficial to the woman in the event that she lays charges or is pursuing legal custody and access issues.

A thorough record should include the following:

- A description of abuse history, including:
  - Present complaint or injuries, including dates, times and locations of incidents.
  - Past experiences and frequency.

- A description of injuries including the type, location, size, colour and age, (documented on a body map).

- The name, address and relationship of the person identified as the abuser.

- A description of other health problems, both physical and mental, that may be related to the abuse.

- A description of all clinical findings.

- Photographs of the patient's injuries if possible (after obtaining written consent). Inform the woman of the legal benefits of medical documentation of injuries if charges are laid. The witnessing signature should be of someone other than the person taking the photographs. If photographs are taken, include:
  - One full body shot (an orientation photo to link injuries with patient).
  - One mid-range to show torso injuries.
  - Close-ups of all wounds and bruises.
  - An article to be used as a measure, i.e., a coin or ruler, to give perspective of size.
  - Two sets of photographs, one to be offered to the woman.
  - Your signature on the back of each Polaroid photo, along with the

woman’s name and the date the photos were taken.

If visible signs of injury are likely to appear after some time (i.e., bruising), request that the woman return for more photographs to be taken.

Preserve any physical evidence that could be used for forensic evidence if the decision has been made to take legal action. Evidence should be collected and labelled in the appropriate manner to ensure that it is useful to her case. Contact a police or emergency department or a sexual assault team concerning specific protocols for collecting evidence. Evidence can also be collected even if the decision has not yet been made to pursue charges. Remember, a comprehensive documentation of injuries will help in the future to indicate if there is a recurring pattern of violence.

SAFETY PLANNING

A safety plan is composed of strategies which can increase the immediate safety of the woman, and help her to be prepared in advance for the possibility of further violence. All health care providers should assess danger levels and develop, with the woman, short-term safety plans for various aspects of her situation, i.e., a crisis, assault, continuing to live with her partner, and weighing the risks associated with separating from her partner. An initial safety plan in the health care setting will most likely deal with the immediate situation and a more comprehensive safety plan may be developed at a later time. The role of the health care practitioner is to inform the patient of her options, affirm the survival skills that she has already employed and respect the decisions that she makes regarding the abusive situation.

Safety interventions should reflect the realities that there are risks attached to every decision an abused woman makes. The safety planning should be designed to evaluate the risks and benefits of different options and to identify ways to reduce the risks (Heise, 1994). Seeking help, getting an order of protection, or deciding to leave an abusive partner only makes sense to a woman when, on balance, it reduces the overall risks that she and her children are subjected.

The safety plan is a valuable tool to:

- Identify, with the woman, the reality that she does not control her partner’s violence.
- Explore, with the woman, the options she has in increasing her safety and the safety of her children.
- Identify strategies to assist her in seeking safety for herself and her

children.

- Make it clear that a safety plan does not guarantee that the violence will end given it is the abuser who is responsible for the violence and for ending the violence. (Canadian Nurses Association, 1992; London Abused Women's Centre, 1996).

The most comprehensive plan will not guarantee that a woman will be safe. It is a strategy, not a solution. Any plan must be the abused woman's plan, not the health care provider's. The role of the health care provider is to help identify options the woman may not have previously considered, to weigh the potential benefits and drawbacks, and to utilize all possible resources needed to implement the plan. The goal is to prevent further harm by the abusive partner, but also to protect the woman from further re-victimization by "the system" by affirming her right to self-determination.

More extensive, complex and detailed plans are needed in non-crisis situations. These plans can incorporate step-by-step goals that the woman can accomplish over an extended period of time, increasing her range of free choice and action, strengthening her economic independence, building her support network and improving her emotional and physical health. These plans are best developed by the woman together with a provider who has training and expertise.

CREATING A SAFETY PLAN

(adapted from San Francisco Domestic Violence Health Care Protocol)

- *The woman should be asked:*
    - What does she want to do? (Inform her of her legal rights.)
    - Can she stay with friends/family, or does she want to go to a woman's shelter?
    - Does she want emergency protection, i.e., a restraining order or a peace bond?
    - Does she want legal assistance? Does she need help with custody or visitation issues?
    - Does she want immigration assistance?
    - Does she want someone to discuss a safety plan further?

- *Contacting police:*
    - Does she want police intervention now?
    - Does she want the health care provider to remain with her during the police interview?
    - Have you ensured that she is in a safe place while waiting for

police?
- ÿ Have you documented in the medical record that a police contact/report was made, including the officer's name and identification?

C *Safety in the health care setting:*

- ÿ Set a procedure in place for notification of security or police in the event that the partner becomes abusive in the health care setting.

C *An emergency escape plan:*

- ÿ If the woman is returning home, problem-solve with her to attain a level of safety if she chooses to stay in the relationship with her partner.
- ÿ Suggest that she gather the following items and keep them in an accessible, hidden place or at a friend's home in case she has to leave in a hurry:
  - C Important documents, i.e., identification documents for herself and children (birth certificates, passports, social insurance card, drivers' licence, protection-order/documents, mortgage/lease papers, medical records, health cards, school/vaccination records).
  - C Some money, a credit card, bank books, cheque book.
  - C Clothing for herself and children.
  - C Keys - house, car, office.
  - C Medication.
  - C Children's favourite toy/blanket.

Remind her to take only what she can safely gather.

C *Other measures to take in anticipation of, or response to, a violent episode:*

- ÿ Plan possible escape routes.
- ÿ Teach children to call 911.
- ÿ Alert a supportive family member or friend of her situation.
- ÿ Have a neighbour call 911 on her behalf.

C *Assist her with obtaining help to carry out her personal safety plan:*

- ÿ Provide her with emergency phone numbers, a list of resources and brochures (be prepared if she needs these in a language other than English).
- ÿ Assist her if she chooses to seek immediate safety, i.e., calling a

shelter, hostel, supportive family/friends (consider accessibility and transportation issues).

ÿ In the acute care setting, consider admission or delay discharge if there is a serious concern for her safety.

SUPPORT AND REFERRAL

(adapted from San Francisco Domestic Violence Health Care Protocol)

1. Treat women with dignity, respect, compassion, and with sensitivity to differences in age, culture, ethnicity, and sexual orientations, while recognizing that violence is unacceptable in any relationship.

The first thing that the abused woman needs to hear is that the violence is not her fault, that no one has the right to control her by threats, coercion, physical intimidation or by any other misuse of power. It may be the first time anyone has told her this. It is important to validate her experience by believing what she says and empathizing with her. Positive messages will counter the victim-blaming messages she has heard from her abuser and/or others. Be sure to condemn the abuse and not the abuser, as often the woman still loves the abuser and only wants the abuse to stop. Express your concern and share information about abuse, pointing out that most violence continues over time and increases in frequency and severity. Offer support, and acknowledge the strength in any steps she makes, however small.

Social, economic, political, cultural and religious factors influence the woman's behaviour and choices, and have an impact on the outcome of intervention. Many options may not be viable for women because of their socio-economic status, race, ethnicity, sexual orientation, age, religious affiliation, physical and mental disabilities, immigration status, education, employment status, location and marital status (Gabinet, 1996).

2. Respect the integrity and authority of women's life choices.

Women are the experts in their own lives and usually make decisions that they perceive are best for themselves. Women may decide not to leave their abusive partner and this may often be the most rational action to keep her safe. All interventions should be structured to affirm the women's strengths and survival skills and to enable her to be a full participant in the process. In supporting her efforts to protect herself and her children, it is important not to make decisions for her or make personal judgements about her actions. It is not realistic to expect women to comply with recommended treatments that would require

them to do things that directly or indirectly endanger them. At times, the legitimate survival and safety strategies utilized by the abused woman may conflict with recommended treatment and follow-up care and put them at risk of being labelled by health care providers as resistant, or noncompliant with treatment. Recognize that the abused woman is making very difficult decisions in difficult situations.

Care must be taken to maintain the woman's ability to use her coping strategies. The prescription of tranquillizers and pain medication for management of real medical needs must be balanced against maintaining her ability to react to dangerous situations. These medications may deaden the pain and cloud her judgement, which can prolong an abusive relationship and make it difficult for a woman to assess danger or her options to take action to flee from a violent attack, or otherwise respond to a potentially life-threatening situation.

3. Recognize that the process of leaving a violent relationship is often a long and gradual one.

Do not expect immediate results from an intervention. Abuse can be a pattern extending over a period of years and a woman will have developed strategies that have helped her cope with the situation in her own way. The options that women confront in changing are not risk-free. Women can face an escalation of violence or retaliation at the time of separation which increases their risk of harm and possible life-threatening injury. Whether the woman chooses to continue in the relationship or not, the goal of intervention is to maximize safety. It is important to focus on helping her explore and evaluate all options so she can make informed decisions and design a personal safety plan that reflects her stated needs and goals. Do not expect a single solution that can be applied to all women in abusive situations.

4. Attempt to engage women in long term continuity of care within both the health care system and the larger community, in order to support them through the process of attaining greater safety and control.

Effective response to abused women needs to be grounded in collaborative approaches to promote better understanding of the issues, ensure comprehensive services and better use of resources (CNA, 1992). No single provider can offer all services needed to an abused woman. Keeping an updated list of professional and community services in all practice areas will help provide continuity of care. These lists should include professional and community agencies and resources. Information materials about abuse and sources of help

should be available and easily accessible to all women. Pamphlets in office examining rooms where they can be looked at/taken without being seen by others (such as the partner) are helpful. Make them available in small pamphlets or wallet-sized cards that can easily be concealed. Resources should include:

- Police - 911 Emergency Services
- Hospitals - Emergency Departments, Women's Health Centres
- Sexual Assault Centres
- Counselling/Support Centres for Abused Women
- Crisis Lines/Hotlines
- Safety from Abuse -Shelters/Safe Houses/Transition Houses
- Housing - Long Term
- Referral Agencies - Children's Aid Society
- Public Health Unit
- Parental Relief Programs
- Treatment Programs - Drugs/Alcohol
- Legal Aid/Advice
- Financial Aid
- Victim Assistance Services/Programs
- Family Service Agencies
- Programs for Children
- Women's Groups/Centres
- Immigration Services (multicultural services, services serving specific population groups)
- First Nations Services
- Services for Abused Seniors
- Crown Attorney's Office

Depending on the practice setting, this may be your only contact with the abused woman. It is essential that information regarding available services be given during this contact, and at any subsequent visits. Provide a written list of resources at every visit. Determine whether it is safe for her to take written materials home and recognize that she may require resources produced in her first language. Providing information carries more impact if it is presented explicitly by explaining whom to contact and how. If she is willing, provide the woman with assistance in making calls during health care visits. Assure her that she can always call back or return for support or more information.

Just as an abused woman needs the opportunity to disclose, she needs appropriate referral and follow-up of her situation at every subsequent interaction. Ongoing support and active interest in her well-being affirms her worth as a person and reinforces her options to continue to protect herself, improve her quality of life, and to explore her options for self-development.

At each visit:

- ÿ Ask about history of violence since last visit.
- ÿ Ask about her mental health.
- ÿ Ask about her coping strategies, i.e., has she used any counselling services? Has she called a support line? Has she told any family members and/or friends? Has she attempted to leave?
- ÿ Ask about her children.
- ÿ Reassess the level of danger that the woman is in, particularly during times when the woman has taken active steps toward leaving the relationship or involving the legal system or other professionals.

Referrals should not routinely be made to services that require cooperative participation by the woman and her abuser such as couple, marriage, and family counselling services, or alternative dispute or mediation services. These services operate on the grounds that both parties are on equal footing. Joint services also reinforce the idea that the abused woman has some responsibility for solving the problem of her partner's behaviour. These strategies also increase the risk to the woman who may be threatened or assaulted for what she may have said at these sessions. When a woman specifically asks for these types of services, explore with her the reasons for her request and her need for safety in these circumstances.

LEGAL ISSUES

Woman abuse is a crime. It is a criminal activity in the same way that threatening or harming any person is a crime. Because it is also a health issue, practitioners who treat abused women may find themselves involved in the legal proceedings when an abuser is charged. Since the 1980's, police lay charges in all cases when they have reasonable and probable grounds to believe that an assault has occurred, rather than leaving the decision to lay charges with the victim of the assault. This has resulted in a higher percentage of charges, from 3% in 1979 pre-policy, to 89% in 1990 (London Family Court Clinic, 1991). It has been reported that there is a significant reduction in the level of violence after police intervention and a higher use of available resources. Women are also more likely to follow through on charges laid by police. Emphasis on abuse as a crime, short term protection, and swift definitive action by the courts clearly demonstrates the criminal nature of assaults against women to the larger community (San Francisco Domestic Violence Health Care Protocol: A Guideline for Practitioners).

For various reasons the majority of incidents of woman abuse are not reported to the criminal justice system and women need to be respected for their choice to not report. Women fear retaliation by their partner, don't understand their rights or the process of the legal system, fear that they won't be believed, that they will be blamed for the abuse, fear racism or discrimination from the police/courts, want privacy, or feel it is too minor. They may believe that the police can't do anything, or they have called before and nothing was done. Women are twice as likely to report abuse to police if their children witness it. The reporting rate also increases with the severity of the abuse and the number

of occurrences. On average, women are beaten 35 times before they call the police (London Family Court Clinic, 1990). If a woman has gone through the criminal justice system and does not feel that justice has been served, she can be counselled toward civil litigation. While she may never receive financial compensation from her abuser, civil action may help her to obtain a sense of closure.

MEDICAL RECORDS

Health care providers have a responsibility to meet professional standards in medical records. The process of identification and accurate, detailed documentation of abuse is very important for women who may charge their partners in court. Once records have been released to the court, defence attorneys often use case records to exploit misconceptions about abuse and victim-blaming ideologies. It is critical that the medical record not support ideas such as the women are hysterical and unstable, and therefore not credible witnesses. Medical records that reflect the injuries a woman has sustained can be essential in the court process or in determining eligibility for priority public housing and/or other services.

These records may also be requested for a variety of other proceedings. Once charges are laid, women may be required to attend more than just the Criminal Court. These may include:

- Family Court - for restraining orders, separation, divorce, custody, visiting rights, maintenance and property division
- Immigration Tribunals
- Social Benefits Tribunal
- Criminal Injuries Compensation Board Hearings

(Ontario Women's Directorate, 1993)

In some cases, health care providers may also be subpoenaed to appear in court to support their documentation.

RELEASING MEDICAL RECORDS

Disclosure of abuse typically occurs with high expectations and promises of confidentiality and privacy. Legal proceedings may require that medical records be released. While the medical record is considered confidential, it can be released with the woman's consent (Ferris, 1997). If a release is requested, it is important to inform the woman of the issues related to file disclosure so that she can make an informed decision. Release of medical records can have serious consequences for the woman.

Records should not be released directly to defence counsel. This allows the alleged perpetrator access to them through his defence lawyer, who could use the woman's personal records against her in court. If records are not turned over, a subpoena or a summons can be served that compels the release of the

medical record, or the appearance of a witness to attend a proceeding on a given date. Subpoenas are not search warrants and therefore do not need to be handed over immediately. The record can be taken to the court in a sealed file and be presented directly to the Court for review on the date recorded on the subpoenas. The judge will then review the file to determine if the disclosure of documents is relevant to the proceedings (London Coordinating Committee to End Woman Abuse, 1996).

QUICK REFERENCE

FOR

APPROPRIATE RESPONSE

QUICK REFERENCE FOR APPROPRIATE RESPONSE

- In any setting, if you are working with women, you are working with some women who have experienced abuse in their intimate relationships.

- Do not judge the success of your intervention by the woman's response or actions. By recognizing and supporting the woman, and by making the appropriate referrals, you have made an impact. Leaving an abusive relationship can take a long time and can potentially place the woman at the greatest risk of serious injury or even death.

Five aspects of care should be provided: Identification/screening; assessment/examination; documentation; safety planning; and referral and support (Gabinet, 1996; McGrath & Zubretsky, 1997).

IDENTIFICATION/SCREENING

While women may not volunteer information about the abuse, they may disclose if asked simple and direct questions in a safe, confidential and a non-threatening manner. **An abused woman should never be questioned in the company of her partner.** The following comment, followed by direct questions, may assist the health care professional in opening up the dialogue:

- "Because violence is so common in the lives of so many women, I've begun to ask questions about it routinely. Has your partner at any time hit, kicked, or otherwise hurt or frightened you?"

ASSESSMENT/EXAMINATION

If the woman denies abuse:

- Be aware of the clinical findings that may indicate abuse.
- If clinical signs are present, ask more specific questions, such as, "It looks like someone has hurt you, can you tell me what happened?"
- If the woman denies the abuse, but you continue to strongly suspect it, inform her that you can help and provide referrals in the event that she may decide to follow up at some point in the future.

If the woman reports abuse:

- Encourage her to talk about it - what has happened, how she feels, what she would like to do about the situation.
- Listen in a non-judgmental way, with concern and respect.
- Validate her experiences (many women fear they will not be believed). Simple statements can express the practitioner's support, concern and respect.

You might say:	Do Not:
"I believe you. . ."	Blame or shame the woman.
"You are not to blame. . ."	Ask why she doesn't leave.
"You are not crazy. . ."	Minimize her experience.
"There is help available."	Ignore disclosure of abuse.
"You do not deserve this. . ."	Align yourself with the abuser.
"This is a crime . . ."	Make decisions without her consent.
"You are not alone . . ."	Expect immediate changes.

DOCUMENTATION

Include:
- The presenting complaint, symptoms.
- The medical and trauma history, relevant social history.
- Injuries in detail, including type, size, number, location, resolution.
- Whether the injuries are consistent with explanation given.
- Photographs (with the woman's consent).
- The involvement of police (if any).

SAFETY PLANNING

Assess:
- The status of the woman's immediate safety.
- Her level of fear, and her appraisal of her immediate and future safety.
- Whether there has been an increase in the frequency/severity of assaults.
- Whether there has been an increase in the threats of suicide/homicide by the partner.
- Whether there have been threats to her children.
- Whether a firearm is present or available.

***These are indications of escalating danger, and under these circumstances it is important to develop a safety plan with her*.**

REFERRAL AND SUPPORT

An appropriate response includes:
- Treating injuries as required.
- Considering whether prescriptions may hinder her ability to protect herself or flee the abusive relationship.
- Determining, if the risk of danger is high, if there is somewhere else she can stay, i.e., friends, family. Help her to get access to shelter services.
- Offering written information about shelters and community resources (assess if it is safe for her to keep written materials).
- Planning for follow-up, continuity of care.

LONDON AGENCIES
AND
COMMUNITY RESOURCES

LONDON AGENCIES AND COMMUNITY RESOURCES

Across Languages (Interpretation Services) 642-7247
At^lohsa Native Family Violence Services Inc.
24 Hour Crisis Line 432-0122
. . . . (toll free) 1-800-605-7477
Changing Ways - Male Abusers' Program 438-9869
Children's Aid Society of London and Middlesex 455-9000
After Hours 432-5987
Family Service London
Counselling - Heterosexual, Gay/Lesbian, Individual/Couples 433-0183
Kid's Helpline 1-800-668-6868
Lawyer Referral Service 1-800-268-8326
London and District Distress Centre
Distress Line 667-6711
Youth Line 660-4357
London Abused Women's Centre 432-2204
London Police Family Consultants 661-5636
Madame Vanier Children's Services 433-3101
Rotholme
Women's and Family Shelter 673-4114
S.O.S. Femmes - Francophone Services 1-800-387-8603
St. Joseph's Health Centre
Sexual Assault/Domestic Assault Treatment Centre . . . . 646-6100 ext. 4224
Salvation Army Family Services 434-1651
Second Stage Housing - Longer Term Safe Housing 642-3003
Sexual Assault Centre London - 24 Hour Crisis/Support Line . 438-2272
Sisters of St. Joseph - Shelter for Women without Children . . . 679-9570
Victim/Witness Programme 660-3041
Women's Community House
24 Hour Abused Women's Helpline and Emergency Shelter
. . . . 642-3000 / 1-800-265-1576
Zhaawanong First Nations Women's Shelter 432-2270

REFERENCES

REFERENCES

Bandura, A. (1973). Aggression: A Social Learning Analysis. Englewood Cliffs, NJ: Prentice Hall.

Benner & Wrubel. (1989). The Primacy of Caring: Stress and Coping in Health and Illness. California: Addison-Wesley Publishing Company.

Burkell, J. (1993). Huron County Voices: A Rural Community Responds to Woman Abuse. Huron County, Ontario, Canada: Stop Woman Abuse Now (SWAN) Coordinating Committee Against Woman Abuse - Huron County.

Canadian Nurses Association. (1992). Family Violence: Clinical Guidelines for Nurses. Ottawa, Canada: National Clearing House on Family Violence.

Canadian Panel on Violence Against Women. (1993). Changing the Landscape: Ending Violence Achieving Equality. Ottawa: Ministry of Supply and Services Canada.

Champagne, C., Lapp, R., & Lee, J. (1994). Assisting Abused Lesbians: A guide for Health Care Professional and Service Providers. London, Ontario: London Abused Women's Centre.

Crawford, M., Gartner, R., & Dawson, M. (1997). Woman Killing: Intimate Femicide in Ontario 1991-1994, Vol. 2. Toronto, Ontario: Ontario Women's Directorate.

Day, T. (1995). The Health Related Costs of Violence Against Women in Canada, The Tip of the Iceberg. London, Ontario: Centre for Research on Violence against Women and Children.

Dobash, R., Dobash, R. (1979).Violence Against Wives: A Case Against the Patriarchy. New York: Free Press.

Dranoff, L. (1977). Women in Canadian Law. Toronto: Fitzhenry and Whiteside.

Duluth Domestic Abuse Intervention Project. (1993). Power and Control Wheel. Minnesota: Minnesota Program Development Inc. National Training Project.

Dutton, M.A. (1992). Empowering and Healing the Battered Woman.

New York: Springer.

Education Wife Assault. Fact Sheets (1997). How Nurses Can Help an Assaulted Woman. How Physicians Can Help an Assaulted Woman. Toronto Ontario: Author.

Family Violence Prevention Fund. (1996). Strengthening the Health Care System's Response to Domestic Violence. Health Alert, 4, 1.

Ferris, L., McMain-Klein, M., & Silver, L. (1997). Documenting Wife Abuse: A Guide for Physicians. Canadian Medical Association Journal, 156, 1015-1022.

Fishwick, N. (1995). Nursing Care of Domestic Violence Victims in Acute and Critical Care Settings. AACN Clinical Issues, 6(1), 63-69.

Gabinet, I. (1996). St. Joseph's Health Centre Woman Abuse Protocol. Toronto, Canada: Woman Abuse Advocacy and Education Project.

Ganley, A. (1989). "Integrating a Feminist and Social Learning Analysis of Aggression: Creating Multiple Models for Intervention with Men Who Batter." In Treating Men Who Batter: Theory, Practice, and Programs, ed. P. L. Caesar and L. K. Hamberger. New York: Springer.

Hayden, S., Barton, E., & Hayden, M. (1997). Domestic Violence in the Emergency Department: How do Women Prefer to Disclose and Discuss the Issues? The Journal of Emergency Medicine, 15,(4), 447-451.

Health Canada. (1993). Family Violence and Substance Abuse from The National Clearinghouse on Family Violence. Cat. H72-22114 - 1994E: Canada.

Heise, L., Pitanguy, J., & Germain, A. (1994) Violence Against Women: The Hidden Health Burden .World Bank Discussion Papers. Washington D.C.

Hoff, L. A. (1994). Violence Issues: An Interdisciplinary Curriculum Guide for Health Professionals. Ottawa, Ontario: Mental Health Division, Health Services Directorate, Health Canada.

Jaffe, P.G., Wolfe, D. A., Wilson, S.K. & Sluscarck, M. (1985). Similarities in Behaviour and Social Maladjustment Among Child Victims and Witnesses to Family Violence. American Journal of Orthopsychiartry, 56, 142 - 146.

Jerzierski, M. (1994). Abuse of Women by Male Partners: Basic Knowledge for Emergency Nurses. Journal of Emergency Nursing, 20, 361-368.

Johnson, H. (1996). Dangerous Domains: Violence Against Women in Canada. Scarborough, ON: Nelson Canada.

Langley, R. & Levy, R. (1979). Wife Beating: The Silent Crisis. New York: Pocket Books.

London Abused Women's Centre (1996). Personalized Safety Plan for Abused Women. London, Ontario: Author.

London Abused Women's Centre. (1996). Volunteer Training Manual. London, Ontario: Author.

London Abused Women's Centre. (1997). How to Help Someone Who is Being Abused. London, Ontario: Author.

London Coordinating Committee to End Woman Abuse. (1996). Report from The Ad Hoc Working Group Responding to Subpoenas of Confidential Records (revised). London, Ontario: Author.

London Family Court Clinic. (1991). Wife Assault as a Crime: The Perspectives of Victims and Police Officers on a Charging Policy in London, Ontario from 1980-1990. London, Ontario: Author.

Metcalf, B. (1996). Women's Stories of Intimate Relationship Harassment. Unpublished Thesis, University of Western Ontario.

McGrath, C., & Zubretsky, T. M. A Framework for Intervention With Survivors of Domestic Violence: New York State Office for the Prevention of Domestic Violence. http://www.serve.com/zone/profinfo/intvsurv.html.

Ontario Women's Directorate. (1993). Fact Sheets: Wife Assault. Toronto, Ontario: Author.

Rodgers, K. (1994). Wife Assault: The Findings of a National Survey. Juristat. Cat. 85-002, 14(9), Canadian Centre for Justice Statistics. Ottawa, Ontario: Statistics Canada.

San Francisco Domestic Violence Health Care Protocol: A Guideline for Practitioners. Http://www.fvpf.org/fund/healthcare/protocol.htm#introduction.

Sullivan-Wilson, J. (1994). Guidelines for the Care of Abused Women: The Least We Can Do. Home Health Care Nurse, 12(4), 47-53.

Warshaw, C. (1993). Domestic violence: Challenges to Medical Practice. Journal of Women's Health, 2(1), 73-80.

APPENDIX A

HEALTH SERVICE ORGANIZATIONS WITH INFORMATION ON WOMAN ABUSE

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Association of Ontario Health Centres
5233 Dundas Street W., Suite 410
Etobicoke, ON M9B 1A6
www.aohc.org
email: mail@aohc.org
416-236-2539

Education Wife Assault
427 Bloor Street West, Box 7
Toronto, ON M5S 1X7
416-968-3422
www.interlog.com/~ewa
email: ewa@interlog.com

Ontario Women's Directorate
Mowat Block, 900 Bay Street, 6th Floor
Toronto, ON M7A 1L2
416-314-0300
www.gov.on.ca/owd

Ontario Ministry of Health
800-268-1154
www.gov.on.ca/health

Ontario Medical Association
www.oma.org
email: webmaster@oma.org

The College of Physicians and Surgeons of Ontario
80 College Street
Toronto, ON M5G 2E2
416-967-2600 / 800-268-7096
www.cpso.on.ca

Ontario Nurses' Association
85 Grenville Street, Suite 400
Toronto, ON M5S 3A2
www.ona.org

National Clearinghouse on
Family Violence, Health Canada
Health Promotion & Programs Branch
Jeanne Mance Bldg., Tunney's Pasture
1918C2 18th Floor, Ottawa, ON N1A 1B4
www.hc-sc.gc.ca
800-267-1291 / 613-957-2938

APPENDIX B

CASE STUDIES

APPENDIX B - CASE STUDY

Narrative 1

Bob and Karen have been in an intimate relationship for nine years. Bob is a forty-five-year-old, white man who is a ten-year veteran of the police force. Karen is a thirty-eight-year-old woman of colour, who has been working for two years in a social service agency for adolescents. Karen has recently been having difficulty managing her full-time work hours because of her chronic arthritic condition which has recently worsened.

As Karen has increasingly been able to do less work around the house, as well as at her place of employment, Bob has become more and more critical of her. Bob has been making comments that imply Karen is not worth anything and that she is not able to contribute equally to the relationship.

Once, when Karen tried to discuss the problems in their relationship, Bob threw a vase across the room and hit her in the back. The vase had been a gift to Karen from her grandmother. Without any concern that she may have been injured, Bob demanded that Karen clean up the broken glass and told her that the house was beginning to resemble a pig-sty. Bob then left for several hours not telling Karen where he was going. In addition to Bob's verbal and emotional abuse of Karen which was escalating, this was the first time he had assaulted her.

Karen is unsure about what actions to take. On the one hand, she is afraid to seek police intervention as Bob is an officer and she fears she may not be believed or supported. Karen also fears that if her place of employment learns that she is being abused, this would undermine her credibility with her clients. However, if they are not told, Karen fears she may be at risk of dismissal because of the negative impacts of the abuse she is experiencing (i.e., loss of concentration, mobility restrictions).

On a recent visit to her family doctor, Karen reported feeling depressed. The doctor also noted that many of Karen's arthritic symptoms had worsened since her last check-up. The doctor inquired about how work was going and asked whether this was a source of stress. Both Karen and Bob have been seeing this doctor for nine years, and her doctor assumed that the couple were very happy. Karen's doctor once even told her that she was lucky to have a partner who was a police officer.

Karen's doctor suggests that to reduce the stress, she should consider decreasing her work hours. The doctor also suggests that she write Karen a prescription for anti-depressants.

Some thoughts and questions about this situation*:*

1. Why is it assumed that Karen's stress comes from work rather than from a personal situation?

2. It is important to understand that women like Karen are vulnerable to abuse for many different reasons, e.g., age, isolation due to disability and racism.

3. Women with disabilities often report feeling unbelieved by professionals when they disclose that they are being abused, especially if the abuser is non-disabled and a respected member of the community. Abused women with partners in the police force often report that they feel afraid and unsupported in calling the police.

4. Many times, women receive prescriptions for psycho tropic drugs without an appropriate consideration of abuse. Prescribing drugs deals with the symptoms, not the root causes of the problem and reinforces to abused women that something is wrong with them - not their lives. Some medications can also impair a woman's ability to protect herself.

5. Did you know that abuse often magnifies existing medical conditions or disabilities?

Narrative 2

Therèse and Maxine are two white women who live together in a medium sized city in Ontario. Both women are in their early thirties. Maxine has participated in many athletic activities since high school. Currently, she plays on a city ball league. Maxine has just recently lost her job as a driver for a courier service. Therèse works as a child care worker at a day-care centre; she is not involved in any community, cultural or sports activities outside of the home. Only a few close friends know that Therèse and Maxine have an intimate relationship.

One particular summer evening, Therèse accompanied Maxine to the hospital because Maxine believes she may have broken a couple of fingers. Max, (she prefers to be called this) is dressed in her ball uniform because she was scheduled to play that evening. During the admitting process, the admissions clerk notices that Therèse seems really concerned, and often answers many of the questions for Max. Max appears to be withdrawn, and does not seem to mind that her friend is assisting her. While in the waiting room Therèse is extremely attentive to Maxine, who remains withdrawn and quiet. Therèse asks Max if she wants her to accompany her into the examining room. Maxine does not object.

After a nurse finishes the preliminary questions, Max is seen by the doctor who asks her if she hurt her fingers at the ball game. Maxine responds in an unusually nervous way that she thinks so, and Therèse jokingly remarks that Max might have to miss the rest of her playing season. Maxine is taken, without Therèse, to x-ray(Therèse returns to the waiting room). While on the way to x-ray with the nurse, Maxine discloses that she has been sexually assaulted during the evening, and wishes to speak to a doctor, alone.

After being x-rayed, Max is taken to the examining room and the doctor returns after having been informed of Max's disclosure to the nurse. The doctor expresses great concern and asks if the assailant was known to Maxine. Max reports that it was her partner, with whom she lives. The doctor expresses concern about Max's safety and asks if there is someone she could stay with this evening. Max responds that she does not know where she could go.

The doctor explains some options available to Maxine, such as laying a criminal charge, and tells Maxine that the police could come directly to the hospital to take a statement. The doctor also explains the use of the sexual assault kit in gathering evidence. After outlining these options and resources, the doctor notices that Maxine becomes very quiet and non-responsive. At this point, the doctor asks Max if she would feel more comfortable if her friend, waiting outside, was present during the examination and while the police took her statement.

Some thoughts and questions about this situation:

1. Is it always safe to assume that someone accompanying a patient, especially of the same sex, is a " friend" or actually supportive?

2. How can we make it possible for all potential victims of assault to disclose in safety?

3. Why do we ignore the possibility that sexual assaults can be perpetrated by same-sex offenders?

4. What can we do about a rape kit that largely ignores the possibility of lesbian sexual assault?

5. Does the doctor's resource list include services/options for lesbians?