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The Development and Implementation of a Hospital Protocol for the Identification and Treatment of Battered Women
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The Development and Implementation of a Hospital Protocol for the Identification and Treatment of Battered Women
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This monograph is dedicated to Andrew G. Jessiman, M.D. who encouraged and supported us in all our efforts and whose concern for the person is a constant inspiration to us all.

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I. Background: Brigham and Women's Hospital Program on Domestic Violence

In 1977, the Ambulatory Nursing Department of the Brigham and Women's Hospital (formerly Peter Bent Brigham) met to discuss the phenomenon of domestic violence. This discussion was the result of many factors that had brought the issue of domestic violence to the foreground as a major problem.

Family violence had long been recognized as a problem but the focus had been on child abuse and neglect. Many Boston hospitals had responded by developing programs to care for the abused children and their parents. These programs helped the staff to realize that there was another victim of family violence—the battered woman.

Developing the Program

A program for victims of sexual assault had been established at the Peter Bent Brigham Hospital in 1974. It provided intensive crisis intervention for the victim at the time of the initial emergency. A core group of interested emergency services nurses received intensive preparation in counseling and crisis intervention techniques for the victim of sexual assault. This core group became concerned about the plight of these women and the inexcusable behavior and attitudes of the police, physicians, and others (even women) with whom they had to interact. At first the nurses accompanied the victims to court, learning as they went along. They later began counseling, guiding, and preparing the victims for the legal ordeal ahead. Simultaneously, they developed programs for employees, physicians, police, and others to help dispel myths and change attitudes and behaviors toward the victims.

These concerned nurses also participated in police training programs and assisted the police and legal authorities in case preparation and testimony. They discussed the writing of rape laws with legislators. Throughout this development process, a protocol of care for the victim of sexual assault was developed and refined. This protocol addressed all aspects of the care of the rape victim and outlined the responsibilities of those involved in her care and treatment. It was this successful, still operational program that was used as a model for planning services to care for victims of domestic violence. Although male victims of family violence occasionally sought care, the majority of the victims were female and so they became the focus of the new domestic violence program.

Establishment of the Multidisciplinary Committee

It was determined during the early stages of the domestic violence program that it should be located in the emergency services department since this was the point of entry for most victims into the hospital system. The staff of the emergency services realized that the battered woman, like the rape victim, had needs other than attention to physical injuries. It was also realized that the issues were very difficult and more complex than with the rape victim. The hospital's social service department was contacted and a multidisciplinary group was formed to examine the problem and to propose effective action.

After extensive reading and discussion, the committee group felt they had sufficient background information to take definitive steps toward establishing a program for victims of domestic violence seeking medical care.

The first step in the program development was the organization of a multidisciplinary committee chaired by the nursing coordinator for ambulatory and emergency services. Membership on the committee was comprised of nursing, social service, and emergency services administration representatives, since members of these departments would necessarily be involved in interactions with the battered woman (see Figure 1). The committee began its work by reviewing and discussing current literature about the issue and identifying relevant community services. It also reviewed films and video materials about the problem. Meetings were then held with representatives of grass roots and community social service agencies. These led to the development of a protocol for the identification/care, and referral of battered women (see Appendix I). During this same period, the social services department established and implemented a 24-hour trauma unit while they and other members of the group offered workshop programs and seminars on domestic violence to interested lay and professional groups, and developed educational programs for, noncommittee staff members. Several committee members also became active on various nonhospital committees on domestic violence and worked on domestic violence legislation. A brochure was developed explaining the hospital program and local community services. The committee was also responsible for the development of a guideline for recording the victim's injuries.

The multidisciplinary committee also took into account State laws regarding domestic violence and legal provisions for aiding its victims. This knowledge of what protections were afforded the victims of domestic violence played an important role in how Brigham and Women's developed their program.

Satisfied that they had explored all options open to those seeking help, the committee moved the domestic violence program into the next logical phase--implementation through therapeutic intervention.

Figure 1

Organization of Multidisciplinary Committee

Nursing, Committee Chairman, Emergency Services Administration, Social Services, Multidisciplinary Committee

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II. Therapeutic Interventions

Victim Profile

Before a community or program such as that established at Brigham and Women's Hospital can be sensitive to the needs of the victim, it is important to understand why she may choose to remain in the home with the abuser. Many theories have been proposed to explain this reluctance on the victim's part to leave a violent situation—most are controversial and none are totally conclusive. Most often, however they include: 1) the frequency and severity of abuse; 2) the victim's acceptance of the abuse; 3) the victim's financial dependence upon her spouse; 4) the victim's low self-esteem; 5) the victim's feelings toward the abuser; and 6) the victim's sense of shame about the abusive situation.

The Frequency and Severity of the Abuse

Incidents of domestic abuse tend to escalate in both frequency and severity. Unless she has never been exposed to violence before, a woman may overlook the early isolated events. She may make excuses for her mate's behavior as incidents increase failing to realize that she has become part of a set pattern. The abuse may at first be infrequent and injuries minor. But the very fact that the abuse was started or repeated should indicate that something is going wrong.

The Victim's Acceptance of the Abuse

Victims often blame themselves for causing abusive situations, and feel that they "deserved it." They may gradually find themselves unconsciously accepting more responsibility for the increasing violence, and feel that they only need to meet some set of nebulous expectations in order to earn the abusers' approval and avoid their violence. They are, in effect, accepting the abuse.

The Victim's Financial Dependence on Her Spouse

The husband often controls all of the material assets of the family. The woman may not be employed outside the home and may have several dependent children. Even a woman who is employed realistically feels she cannot support the family on only one income. How can she possibly do justice to raising her children when earning the only income? This financial dependency, and feelings of guilt that she will not be able to do enough for her children if she leaves, will often keep a victim in an abusive situation.

The Victim's Low Self-Esteem

Even women with marketable skills can feel worthless and unable to compete in a larger environment. As the violence escalates, so may the family's isolation. The woman has fewer chances to talk, to regain perspective or—being hurt—to test whether she is really at fault and without value. She may have been constantly belittled and made to feel inferior by the very person closest to her. - With her self-esteem lowered, a woman can feel emotionally unable to be alone and incomplete without a mate.

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The Victim's Feelings Toward the Abuser and Their Home

Early in the relationship the woman probably had positive feelings toward her mate. She may even feel that she loves him during the abusive situation. He may be contrite and very loving after an incident of violence. In fact, these post-abuse periods are often the best times in their relationship and she may be unwilling to lose these pleasant moments. Often a woman has a surprisingly insightful understanding of the motivation behind her man's violence. Consequently, she feels she can excuse the violence because she understands its roots.

Closely tied to the victim's reluctance to leave the abusive situation are her feelings about her home. The decision to leave one's home is a major one and cannot be undertaken easily by any individual. Most likely the woman has done most of the work in creating the home, acquiring possessions, and conveniently arranging all the necessities of life. This home is part of her life. Her children were born or raised here. Their heights are measured on the closet door. The violence must be very bad indeed to cause her to leave. She is much more likely to initially attempt other means of stopping the violence. For this reason, programs that envision only shelters as an alternative are quite good starting points, but not nearly help enough to compensate for her loss.

The Victim's Sense of Shame About the Abusive Situation

Often the woman is reluctant to discuss the fact that she is being beaten. She does not want to be asked why she puts up with it, why she allows him to get away with it. She sees other women in relationships where there is no beating and this may reinforce her feeling of "it must be me." She withdraws from friends and family out of this sense of shame and the fact that "they know."

If there has been no verbal recognition of the family violence, it can be treated by the victim, the abuser, even the family and the neighbors as though it did not exist—at least temporarily. The significance of the interview in the emergency services is that it does

break through the isolation concealment. It forces a woman to confront her feelings and the situation as it really is. Even though the violence has been observed by others and documented in hospital charts, a woman cannot mobilize her energies for change until she has admitted to the cause of her injuries and decided she wants to do something about it.

Abuser Profile

In order to help the victim of abuse, some knowledge is needed regarding the abuser. Many theories have been advanced that give insight into the reasons for this behavior. Here again, these theories have not been proven but reflect documented patterns of abuse. Primary among these patterns of abuse are: (1) projection of blame for the abuse on the victim; (2) failure by the victim to conform to the abuser's definition of her role; (3) transference of anger engendered by nondomestic sources; and (4) violence around sexual issues.

The domestic violence program at Brigham and Women's does not deal with the abuser and there is not a lot of hard data that could be called conclusive. There certainly are many myths and, as Richard Gelles states, "Our research has unveiled a continued series of paradoxes and contrasts between the image of the family and the actual behaviors which goes on behind the closed doors of American households."³

Early writings proposed that psychological disorders and illness were responsible for causing abuse. Others proposed that class, economic status, or stress levels were the cause. Later research has pointed out that no single factor can be proven causative. Violence is found at all levels of society.

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Is it in fact more common among the poor and the so called lower class? No one can say for sure but many believe that more than class, or education, or anything else, it is learned behavior that is the most influencing factor. American society tolerates, and in many instances condones, violent behavior.

Situations exist in society that make persons feel their only hope to be heard or to make change is through aggressive and, if need be, violent behavior. Women and other minorities are continually faced with problems of inequality. To many blacks, past and even current injustices make true justice seem a privilege of the white and moneyed.

All of these factors lead to the realization that there is not one, but many things that influence and precipitate violent behavior. It seems logical that if we have learned by example and experience to solve our problems by violent means, either individually or socially, then that will remain an alternative.

Projection of Blame

It is not unusual for the offender to feel that hitting the victim was justified. "If she would do what she was told, I wouldn't have to hit her" and "she asked for it" are two commonly expressed "reasons" for abuse. The abuse is legitimate in the eyes of the abused.

Victim's Failure To Conform to Abuser's Definition or Ideas of Her Role

The idea of male supremacy is still prevalent in American society. The very climate of the times, however, seems to challenge this long-held belief. There is a burgeoning awareness among women

— and even some far-sighted men — that the old order must be altered just to survive. Changing social values, better educated women, and spiraling inflation have shown that a woman's place is no longer primarily in the home. And women's rights movements, such as ERA, have gathered a momentum that would be difficult, perhaps even impossible, to stop.

More and more women are joining the work force and increasingly entering occupations and professions that were once predominantly or exclusively male. There is a demand for equal pay for equal work. Women are deciding when and if they will have children and how many. They are no longer willing to accept and forgive a man's infidelity and sexual indiscretions and attribute them to "just the way men are." The old double standard no longer applies.

The sexual revolution of the last decade or so has resulted, and continues to result, in a set of circumstances that has drastically changed male-female relationships and heightened the feeling of loss of control for men. Men harbouring such notions are primary candidates for spousal abusers.

Transference of Anger Engendered by Nondomestic Sources

Researchers have often argued that conjugal violence is more likely to occur in families in the lower levels of society.⁴ Lack of money, power, or prestige often result in frustration, bitterness, and anger that culminate in domestic abuse. A man who feels less than his neighbors or coworkers may try to compensate by demanding to be the king of his castle, or master of his wife.

Sex Related Violence

Much sex related violence is due to jealousy and revolves around issues of flirting, infidelity, or sexual disinterest on the part of one spouse. There are often long-standing, heated arguments full of accusations and interrogations of the suspected partner. Cultural and social conditions have led to a general acceptance of violence in such situations. The psychological maneuverings involved are often completely subconscious.

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Whether true or not, the sex act has often been viewed as a tool used by the married woman as a method to reward or punish her partner. She has seemingly learned by watching and listening that sex is very important to men, that they "have to have it." This supposed power can help her obtain things that might otherwise not be available to her. Cleopatra used her sexuality to great advantage to rule and protect her land. Delilah used hers to gain revenge. Many other women, famous and infamous, have used their sexual wiles to achieve their own ends.

Woman has learned to control her sexuality to the point that she will not be aroused if she does not want to be. The time, place, and conditions for sex will be what she determines. This can be infuriating to the man who is in such a situation and decides that he wants sex here and now. If the woman is forced, her lack of response or cooperation with the effort may infuriate him further and cause violence. Although the man might be physically more powerful than she, the woman may take some satisfaction in knowing that she is in control in this situation. This might be particularly important to the woman who is unable to exert much influence, power, or control over other things in her life.

Sexual violence is also precipitated when one or both partners are unable to fulfill the expectations of sexual expressions and performance. Verbal attacks occur when one denigrates the other's ability to perform. Frigidity, impotence, or outright refusal to perform certain acts are frequent causes of arguments between partners. The refusal of a woman to have sex with a drunken partner can also lead to his beating her. Gelles reports that the bedroom is where most homicides or nonlethal violence occur.⁵

Alcohol, Drugs, and Other Influencing Factors

The Brigham and Women's experience is that alcohol is a precipitating factor in much domestic violence. Oddly enough, it is a problem shared by both victim and abuser. In a sample of 70 battered women, 31 percent admitted to having difficulty with alcohol, and 20 percent said they had been drinking at the time of the violence. These women said that 51 percent of the batterers had habitual difficulty with alcohol and 36 percent were under the influence of alcohol at the time of the incident. Eight women and 7 men were reported to have difficulty with drugs, and 3 men were reported to be under the influence of drugs at the time of the beating.

The Crisis

The battered woman who most commonly comes to the hospital emergency services has suffered bruises and contusions but is not critically injured. Unlike the physician or the nurse on duty who has identified her as a victim of domestic violence, she may well have no other thought than getting medical treatment for herself. She is "in crisis."

Crisis is usually seen as an upset in the individual's equilibrium. The person can no longer use previously successful methods to cope with the current situation. The authors' assumption, supported in the literature by Lvdia Rapaport, is that "A little help, rationally directed and purposefully focused at a strategic time is more effective than more extensive help given at a period of less emotional accessibility."⁶ Indeed, the battered woman's own pain and feeling of inability to cope with her situation adequately make it possible for her to look again, perhaps see things differently, and consider new reactions or ideas that she might previously have thought impossible. Whether life-threatening violence, verbal threat, or some other hazardous event in her home has caused her to seek help from an emergency service, this period is crucial for her; this is the best time for her to mobilize her energy to create a "second chance" for herself.⁷ Successful management of the current crisis may well result in increased ability to cope with future crisis.

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Entering the System

The first person the client sees when she enters the hospital is the emergency services secretary. The patient is greeted and asked why she wishes to be seen. Since the batterer often accompanies the victim, it is not unusual for the patient to say that she has fallen or has had some sort of accident. The secretarial staff has been prepared to pick up on cues and to alert a nurse immediately when battering is suspected. The secretary then proceeds to assist the patient in filling out forms, in requesting previous medical records if any, and in obtaining written consent for treatment at the hospital. At the end of the emergency visit, the secretary assists in making whatever followup appointments may be necessary.

The Nurse and the Crisis Situation

It is the responsibility of the examining nurse to approach the patient in an open and sensitive manner. He or she may be the first person to raise the question of abuse being the cause of the injuries. Techniques of crisis intervention, familiar to all nurses, are employed at this time to calm the woman and assure her that she will be helped. If the patient admits that she has been battered, she is offered the services of a counselor. If she denies battering or refuses to see a counselor, she is told that help is available to her in the future if she desires it and told how and where to call to talk with someone. Usually when asked, however, the woman says she would like to talk to "someone" and a social worker is introduced to her. In a gentle, compassionate way, the social worker uses the woman's own feeling of need at the moment to heighten her awareness of the violence in her life and the need for her, ultimately, to get it stopped.

The Social Worker

Before the intervention begins, the social worker talks to the referring emergency room staff members to learn the extent of the patient's injuries, plan of treatment, and possible time involved. For example, will she need x-rays, lab work? How long will that take? What are the medical concerns? Women are often anxious about their injuries but also quite concerned about the length of time they are in the emergency room. Perhaps they have children at home, or are concerned about angering their mate further by an extended absence. To help allay the patient's anxiety, the social worker must understand what is happening medically. By talking with medical providers, the social worker learns what the patient has already shared about what precipitated her injuries and how she appears to be handling it emotionally.

In addition to preparing for the interview, the worker also needs to continue to cooperate with medical staff and to understand the followup plan. The social worker not only reviews the woman's inpatient and outpatient records for similar past injuries and use of emergency services, but looks for past use of mental health intervention or possible long-standing relationships with health providers. It is then possible to encourage the woman to come back for the followup interview. The worker can also offer to reconnect her with medical personnel who may have been meaningful or helpful in the past.

The Victim/Social Worker Interview

The interview usually begins with the social worker listening to the woman's version of the incident that brought her to the emergency room. Ideally, she will have already completed her medical and surgical workup so that she is free to go with the social worker to a more private family interviewing room. Often, however, the woman and the social worker find themselves in a medical examining room—the only privacy provided by curtains — with many interruptions from medical personnel still attending the woman's physical complaints. Although this may initially prove a hindrance in the interview, the setting of the interview has been found to be secondary to the social worker's ability to focus on the woman's story thus making her feel heard, accepted, and safe.

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As the victim describes the situation that brought her to the hospital, the social worker tries to determine how she feels about the injuries she has sustained.

- Is she angry? Perhaps she can use the energy of her anger constructively to make changes in her life situation.
- Is she passive? The woman who shows very little emotion at the time of an emergency room visit causes the worker greatest concern as she seems to accept her hurt and to offer little opportunity for intervention.
- Is she depressed? Although the use of tranquilizers can be abused, if the extent of her depression appears to be severe, perhaps a physician should prescribe medication.

The worker also asks questions aimed at helping the woman to focus on and clarify her present life situation through her answers.

- Where does she live?
- With whom is she living?
- Are there children in the home?

- Who is aware of the violence there?
- Has this sort of thing happened before?
- Has it happened with this particular mate, or with other persons in the past?

The social worker eventually focuses the victim's attention on her immediate situation.

- Is it safe for her to return to her home?
- If her assailant is in the home, does she feel that he will harm her further?
- If there are children, are they safe? Where are they now?

Natural Support Systems

The social worker's next step would be an attempt to determine what sort of natural support system the woman has. For instance:

- Does she have family members in the area, and how does she get along with them?
- Are they aware of the violence in the victim's household?
- Could she go to them for shelter in an emergency—briefly, or for a longer period of time?
- Do her neighbors know what's going on?
- Would they offer her any safety?
- How about friends in a different part of town (if geography was a factor with neighbors)?

If the victim answers yes to some of these questions, the social worker tries to help her think through what her assailant's response would be. Would he bother her in her emergency haven or harass her friends (or relatives) for taking her in?

When a woman has a source of help in a relative, friend, or neighbor but still hesitates to seek help, the social worker tries to encourage her to call on the natural supports already available to her. Women are often reluctant to face the fact that they are victims of violence in their own homes and are ashamed to admit such a fact to friends and relatives.

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The majority of women seen in the Brigham and Women's emergency services respond to the crisis interview by recognizing the resources they have within their existing support system of family, friends, and neighbors. Forty-seven women out of a sample of 70 reported having a supportive network who were aware of the abuse. For the most part, these family members or friends had tried to intervene by calling the police, offering the woman shelter, or giving verbal support.

Existing relationships for shelter and support are the most adaptable and enduring resources for the victim of domestic violence and are bedrocks of safety when working well. We have come to realize what a difference it makes in a woman's feeling of mastery to perceive that she can use her own natural network to prevent or protect herself from violence. It, in turn, can be supplemented by other professional counselors, legal advocacy, or women's groups. Many cities have such resources available and organizations wishing to set up domestic violence programs should find out which ones are in service in their areas.

Sheltering

If a woman does not feel she can return to her own home or go to relatives or friends after a battering incident, the worker may review available shelters for women (and children) in the areas. In a review of 70 cases seen in emergency services at the Brigham and Women's Hospital in 1979, only 4 women went to such shelters. Most were able or willing to return to their own homes or the homes of relatives or friends. Those, women who did go to shelters were clearly the most seriously, and frequently, injured by their spouses.

Community Sheltering

There are a number of shelters available to battered women in the Boston area. Several shelters were already well established at the time Brigham and Women's initiated the domestic violence protocol. Brigham and Women's contacted each shelter, asking to meet with a representative in order to obtain a thorough understanding of their admission policy and the programs offered. There was no institutionalized relationship with any shelter. Instead, the program relied on the establishment and maintenance of good personal working relationships.

The most well-established refuge, in a suburban community adjacent to the hospital, provides shelter for those women who are clearly motivated to make a major change in their lives. This shelter's strict admission policy supports its use as the agent of transition for such women and does not usually provide respite care or emergency short-term services.

Another shelter offers services primarily to minority women living in a particular section of the city. This group has established a small additional shelter very near the hospital and is able to provide a counselor who can come to the emergency services to meet the patient and accompany her to the shelter.

Private and Short-Term Sheltering

One neighborhood women's group has organized a network of private homes willing to take a woman in crisis. Most of these homes are those of women who were previously abused themselves.

The City of Boston also has at least two public shelters for homeless women available for a night's lodging. They do not provide services for battered women and are very clearly short-term refuges. We usually do not suggest that a victim of domestic violence go there unless there is no other resource.

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Legal Resources

The legal definition of domestic violence accepted in the State of Massachusetts is:

The occurrence of one or more of the following acts between family and/or household members:

1. Attempting to cause or causing physical harm;
2. Placing another in fear of imminent serious physical harm; and
3. Causing another to engage involuntarily in sexual relations by force, threat of force, or duress. A "family or household member" is defined as a "household member, a spouse, or their minor children or blood relative."⁸

Provisions of the Law

Over the past few years, most States have made changes in their laws in recognition of the problem of family violence. These laws vary from State to State and should be obtained and understood by anyone involved in establishing programs for the treatment of victims. It may even be possible, in some instances, to get involved in expanding existing laws or developing new ones that will result in better protection for the abused. Most of the changes in the laws came as a result of the hard work, perseverance, and cooperation of many individuals and agencies involved with the identification and treatment of the victims of domestic violence.

Under the provisions of the Massachusetts law, a person suffering abuse may seek a court order to provide protection from the abuse. This might include directing the defendant to stop the abuse, vacate the house, pay temporary support for the victim or any child in the victim's custody or both, if it is the abuser's legal duty to support such persons and to pay the victim's compensation for losses caused by the abuse. The court may also issue an order awarding custody of minor children to the abused person. Petitions for these protective orders may be brought to district, private, or superior courts. A district court judge is available on weekends, evenings, and holidays to issue temporary emergency orders. No fees are charged for filings. Prior to the enactment of this law, the only person who could seek court orders relating to the abuse were spouses who had filed complaints for divorce or separate maintenance.

Putting Teeth in the Law

The law provides that a violation of a vacate or restraining order issued by the probate court and a violation of any of the orders of the new additions to the law is a misdemeanor punishable by a fine of not more than \$1,000 or imprisonment for not more than 2-1/2 years in a house of correction, or both. A law officer is required to use every reasonable means to enforce such orders, and the abuser may be arrested without a warrant. The violator may also be held in contempt and punished by the court.

Obligations of the Police

Under the law, if the officer has reason to believe that a family or household member has been abused, the officer shall use all reasonable means to prevent further abuse. This may include remaining on the scene as long as there is danger to the physical safety of the abused, assisting in obtaining medical treatment, or making an arrest. These obligations apply whether or not a court order has been obtained.

It is very often the counselor or other helping person who is the first to inform the victim of her rights under the law. The average person is ignorant of what the legal process is or how to go about using it.

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It has been the experience at Brigham and Women's that the police, courts, and legal authorities are more than willing to cooperate with those caring for the battered and abused by providing educational sessions, liaison, and other services that will assist in alleviating their plight.

The social worker details the legal resources prescribed by law in the State that are available to the victim during the course of their discussion about the woman's future safety. In order to use this law in emergencies that occur after usual business hours, the worker should have a thorough understanding of how it normally operates and have some contact with the court system in the neighborhood. When this mechanism breaks down, the worker has the responsibility for reporting incidents in which the system fails to be responsive.

After discussing the resources available to the woman under Massachusetts Law 209, the worker explains how each option might work in the situation. Sometimes a woman feels that any of these would pose an even greater threat than her present situation. The social worker explains to the victim the availability and limits of police protection, and stresses the need for her to inform the police if her assailant again approaches or enters the house in violation of a restraining order. In some of the more severe cases, where an assailant has either already been arrested or is being sought on charges of felonious assault or assault and battery, the worker tries to maintain close contact with police to determine the man's whereabouts out of concern for the woman's safety in returning home.

The Brigham and Women's Hospital is fortunate to have the services of a court clinic available to us, one that has psychiatric services as well as legal counseling. In addition, the clinic provides a liaison person to be available to our program. Any patient needing further exploration of the legal system and assistance in negotiating the legal and court process can be directly referred. Although court clinics vary, this particular clinic is also available to women who are undecided about wanting to press charges but need ongoing counseling to cope with their situations and up-to-date information about available legal resources.

During a 12-month period (5/78-5/79) the court clinic received at least one referral per week from Brigham and Women's. Half of these were women who followed through with a personal interview at the court clinic. Another 25 percent were telephone contacts, following the initial referral. Twenty women received ongoing services at the court clinic, 10 filed charges against their husbands, 9 separated from the man, 6 made use of women's counseling and 4 women received short and/or long-term counseling with their children.

As part of protocol, Brigham and Women's offers a woman the opportunity to have her picture taken in order to document visible injuries for further court purposes. Two written forms are available to her: one giving permission to photograph, another denying permission (see Figures 2 and 3). Should she give permission, the worker explains that these photographs will be kept in a sealed envelope in her medical record, available only to her or to her attorney to be used in court for verification of her injuries.

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Figure: Sample Right To Photograph Form

Hospital

I hereby grant to the Brigham and Women's Hospital the right to make photographs/ films/tapes of me or my child

(Name)

and the right to use any or all of said photographs, films or tapes in which such likeness appears. Usage of said photographs/films/tapes is hereby understood to include exhibit, display, printing, or publishing of the same or any other lawful use whatsoever.

Date photographs/films/video tapes made

Signed

Address

Photographer Address

Figure: Sample Refusal To Consent To Photograph Form

Hospital

I request that no photographs of me or my body be taken. It has been explained to me that photographs are usually requested to be taken of all patients presented with my history.

Patient's Signature, Date

Patient's Parent or Guardian, Date

Street Address
City, State, Zip
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Impact on Family

If there are children in the household, as there are in the great majority of cases, the worker tries to encourage the woman to consider the possible effects of a violent household—both physically and emotionally—on the children. Certainly their safety, and their sense of safety as a norm, is threatened. Children learn and tend to repeat what they observe, taking for granted the sex roles and family interactions they see.

In the sample of 70 cases, 47 women reported that they were living with children in the household. This totaled 128 children ranging in age from infancy through adolescence. Thirty-three women reported that the children had observed this battering incident and 27 reported that the children had observed battering in the home.

In asking open-ended questions, the worker tries to suggest the impact of violence on the whole family.

- How does the woman feel about the children—how are they doing?
- Do they have difficulty separating from her?
- Are there temper tantrums?
- Do they have problems getting along with children their own age?
- Are they constantly in some sort of conflict with their peers?
- Does a child tend to hurt other children?
- Are they doing reasonably well in school?
- Does a child have irrational fears, of the dark or of animals, for example?
- Does the victimized mother see one or more of her children as having a problem?

Such questions are designed to sensitize the mother to possible areas of difficulty and the long-range effects of domestic violence on the children involved. Nevertheless, it is not always appropriate to pursue this detailed agenda. A woman may feel so needy herself that she would react negatively to extensive concern about her children. Still, what the worker asks reflects a natural concern for the safety of the children and for their attitude and response to violence, it is our impression that the woman finds this helpful in seeing that abuse in the home is never limited to the couple's relationship with each other.

Although Brigham and Women's Hospital does not offer any services to children, a list of referral agencies is maintained to help a woman initiate services for her children if this is indicated. In our experience, the children seldom accompany the patient, so that we are not able to observe behavior or interaction. It is the worker's responsibility to determine the safety of children, but we base our assessment and possible intervention solely on the mother's statement.

If the worker feels from the woman's responses that children may be endangered, then it is the responsibility of the social worker, with the knowledge of the physician in emergency services, to file a report with the State requesting the State worker investigate the home situation to assess the safety of the children. If such a decision is made, the worker shares it with the woman. Although at first this may seem like a threat to her, the worker tries to help the woman see this action as a way to use the authority of the State to control the behavior of the spouse. It can also, of course, create a conflict if the woman feels she must choose between her spouse and her children. Instead of leaving the woman in conflict, the social worker makes every effort to take advantage of a parent's universal and basic desire to provide a good home for her children. It may be possible that resources of the State Child Welfare Department can be used to benefit the family by assisting them to resolve (or to control) their ongoing conflict. The desire to ensure the children's well being is a strong motivation for change in most parents.

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Maria is a case illustrating the beneficial use of a child abuse report. Maria was cut by her husband during a violent argument on the street of an inner city housing project. The police who brought Maria to the hospital reported that her husband was known to have a gun and was observed acting quite bizarre. Because of Maria's hysterical crying and a language difficulty, the interview with Maria was quite difficult. The worker was finally able to determine that Maria was concerned about her son, who was with his paternal grandmother. Her husband had said he would not allow her to have the boy. Maria felt the boy was safe that night but did not want him further exposed to his father's violence. Although the worker suggested that Maria go to a shelter for her safety, she insisted she would be safe at the home of a friend. The worker explained her legal options—not at all sure Maria was understanding—and arranged an appointment to see her the next day.

Maria arrived early for the scheduled appointment, neatly dressed and asking for help in obtaining a restraining order. The worker made arrangements for her to be seen at the court clinic. The worker also explained the need to file a report of child abuse and neglect with the State. The worker called in the report in Maria's presence and Maria supplied all the details for the written report. The child was subsequently returned to his mother and they left the State, relocating near Maria's family.

Because it is known that there are often earlier, unresolved conflicts when domestic violence occurs, the worker asks about the woman's past experiences. The worker helps the woman to review previous relationships with men, events earlier in this relationship, and what the woman experienced in her own home as she was growing up. The worker tries to help the woman identify her expectations of a relationship and of herself as a woman. Although not all interviews can go so far in such a volatile situation, sometimes a woman can begin to see the long-range goals (or lack of them) that she has had for her life.

It is also possible to assume that the pattern of violence in the woman's family might be so taken for granted as a part of life that she sees things in terms of hurt or be hurt. This may lead the woman to turn to violence out of a feeling of frustration and anger and a belief that this is her only alternative. By focusing on her interest and concern for her safety and the safety of her children, the Brigham and Women's DV team hopes that the woman will be able to recognize other alternatives available to her in dealing with her dilemma of violence.

Review of Victim's Plans After Leaving Hospital

The interview concludes with a review of the woman's immediate plans when she leaves the hospital. Does she understand what community agencies are prepared to provide the needed followup and counseling services. Therefore, our intervention is usually a comprehensive crisis interview at the time of the emergency services visit. Most of the women do not maintain contact with the hospital social worker.

Brigham and Women's protocol also considers the possibility that children accompanying a woman to emergency services may need placement if the woman is admitted, or if there is not room for all of them in the shelter if that is where she goes. In 2 years of operation, there has never been a need to place children in foster care because of their mother's injuries. Particularly when children are involved, the woman is always urged to use the natural support system of family or neighbors. Placement in a foster home after a traumatic incident seems unduly frightening for children and should be considered only as a last resort. Still, contact is maintained with a children's service agency that has 24-hour foster placement. We have also set up a referral plan with a neighboring children's hospital if there is a need for a child to be examined. With the mother's permission, the social worker would accompany the child to the other emergency room for the examination.

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Social Service Trauma Team

The domestic violence program at the Brigham and Women's Hospital began initially with a small team of volunteer social workers who were to be on call in the emergency services on nights and weekends. This group, identified as a Social Service Trauma Team, met on a regular basis to read articles, discuss crisis theory, and accumulate a knowledge of community resources prior to the actual implementation of the protocol. Once the protocol was implemented in February 1978, the team met weekly with nursing administrators and emergency services nurses to do a weekly review of cases, along with regular psychiatric consultation.

Psychiatric Consultation

Psychiatric consultation is available to the emergency services at all times. Although a psychiatrist is not in the house after usual office hours, one is always on call to consult or to come to the hospital to evaluate a patient.

The focus of the psychiatric consultation was to develop interviewing techniques for working with women in crisis and identifying areas for further exploration. The purpose was to help women to begin to plan for their immediate safety, and to try to enable them to see their lives from a somewhat larger perspective. From case presentations, program health providers shared interviewing style and techniques and learned how to make the best use of legal resources. Meetings afforded an opportunity to exchange information on community resources. Representatives of various shelters and support groups came to team meetings to share their working philosophies and outline types of situations in which they felt they could be most helpful.

Countertransference issues

In retrospect, these regular team meetings were explicitly helpful in dealing with countertransference issues. In the early months, for instance, the domestic violence team was anxious to see women take legal action and be more vigorous in their efforts to encourage them to go to shelters, perhaps out of a need to feel that the women were doing something to keep themselves safe. It is especially important to recognize countertransference issues, so that providers do not knowingly push a woman to act when she is not ready, thereby adding to her sense of failure and powerlessness when she fails to do as they suggest.

In fact, the interview at the emergency services may be the first time the woman has broken out of her isolation to admit to herself or to others that there is a pattern of violence in her life. Cindy, for instance, came to us severely beaten, saying this time her boyfriend had gone too far. She could not continue to accept her previous excuse for him that he "really didn't mean it." She wanted to prosecute. The worker and medical team took pictures, submitted reports to the police and courts on her behalf and prepared her to go to court. Cindy, an alcoholic, chose to go to a halfway house for alcoholics instead of the more straightforward shelter. Encouraged to talk about her feelings, and develop her own plan, Cindy surprised the worker by improving her situation in her own way. She left the shelter without informing anyone, secured a new apartment in a city suburb, and managed to get her old job back. When the worker called her old apartment, she managed to get the message and returned the call the following day. Her solution to the problem was to drop the charges, have no further contact with her assailant, and instead to concentrate on more productive aspects of her life. Yet somehow, Cindy felt the medical team and worker had been helpful to her.

The woman may use the interview with the social worker to accumulate information that may be used at the time of another incident, or prior to it. It may be a series of contacts, perhaps in other settings as well, that will lead to the accumulation-of strength to make a change. If battering is identified in the medical record, other medical providers can take note and act accordingly.

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Early in the program's development, most workers felt an inability to accept and work with some women, for example, prostitutes. As the trauma team's interviewing skills developed and they became more emotionally comfortable with the violence in the lives of some patients, they realized they were seeing some prostitutes and that they were able to be of the same help to them that they were to other women. The availability of regular team meetings allowed for the development of a safe group in which individual workers could face their own prejudices and stereotypes and readjust their own preconceived agenda of intervention and value system as they grew professionally.

The Boston area is particularly rich in resources for battered women. Massachusetts has a comprehensive domestic violence law that provides at least "paper protection" for the abuse victim. Still, no law or court order can provide a woman with 24-hour protection. It is her ability to look at the violent relationship differently and to mobilize her own personal resources in a new way that actually does provide her with protection and precipitated change. Changes in her own perception, as well as new information and the ability to use it effectively, are most significant for the woman in crisis. Fortunately, intervention leading to changes of this sort can be accomplished in any setting, regardless of community resources.

Effects of Domestic Violence Program

Since Brigham and Women's protocol was implemented in February of 1977, 211 women have been identified as having been battered and were referred to a social service for counseling. An additional eight percent were identified in the emergency services but made the choice not to see a social worker at that time. Prior to the implementation of this program, very few women were identified or referred for counseling.

It is true that a wealth of community resources helps the worker to feel more secure in a crisis and does provide critical services for more severe situations. Nevertheless, we at Brigham and Women's hope that our experience will encourage other communities, with or without sophisticated community resources, to implement a program of crisis intervention for the victims of domestic violence.

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Appendix I

Protocol for the Identification and Treatment of Victims of Domestic Violence

This protocol was developed by a multidisciplinary team to meet the special needs of abuse victims in crisis. The team was comprised of registered nurses, social workers, unit managers, and administrative staff members.

Process and Responsibilities

Unit Management—The unit management staff provides the managerial and clerical components of the emergency services. It is comprised of administrative personnel who are responsible for maintaining the level of prepared secretarial staff and who participate on the multidisciplinary team to evaluate and update services as indicated.

Secretarial Staff — The secretarial staff fulfills the primary function of facilitator to the patient in crisis. The secretary greets the patient as she enters the emergency services and alerts the nursing staff if the patient says she has been beaten or if the secretary suspects that the patient may be a victim of abuse. She records demographic information on the emergency/triage report and obtains the patient's written consent to treatment. At the end of the patient's emergency services stay, scheduling of followup appointments or other testing are expedited by the secretary.

Since it is the secretary who has the first contact with the patient, it is important that the people in this position be familiar with the problem of abuse and that they pick up on cues the patient may present when registering at the desk. For this reason, effective utilization of inservice programs that provide sensitivity training must be of primary concern to management staff.

Nursing Staff — It is the responsibility of the nurse to approach the patient in an open and sensitive manner in an effort to determine whether injuries are a result of physical abuse. She records the nature and extent of the patient's injuries prefixed by the word "alleged" or "alleges" when referring to an assault, and documents whether the patient has accepted referral to a counselor either during that visit or as followup.

The nursing staff is comprised of registered nurses who, in addition to their basic educational preparation, have developed expertise in crisis intervention and counseling techniques through their involvement with the department's sexual assault victim counseling program. They have learned to be alert to cues which may indicate that abuse has occurred. The patient may be evasive or hesitant in talking about her "accident." As the nurse is assessing the patient's condition, bruises may become apparent in places usually covered by clothing, for example, the buttocks or thighs. When the patient is asked how things are at home, both her verbal and body language responses are carefully noted.

As the examination continues, the woman will be asked directly if she has been beaten or abused. When this occurs, the woman is often relieved and may immediately respond in the affirmative. It may be that the nurse is the first person to express awareness and concern for the woman's plight. The woman may take the opportunity to vent and listening is important.

The woman often needs a lot of emotional and psychological support at this time. She may also be very uncomfortable physically as a result of the battering. The nurse must be sensitive to the victim's fears and concerns and understand that she may not yet be ready to make a change in her life situation.

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The woman's priorities must be determined and addressed. If she has been accompanied to the hospital by the batterer, which is often the case, she may be frightened and feel vulnerable and unsafe. She may be greatly concerned for the children at home and need assistance in determining what she should do at the moment. She needs assurance that she is safe and that she will be accompanied to her home by the police if she so requests. The police will stay with her while she collects her belongings or children.

Nurses in the emergency services have developed close working relationships with the police. This relationship has developed and strengthened over the last several years as a result of the rape program and the fact that the nurses have participated in police training and education programs and the police have participated in employee and community education programs with the nurses. They have also followed rape victims together throughout the often long court process. It has been satisfying to see the results of this mutual sharing and to realize that what both groups have learned from each other has carried its effects over into the domestic violence program.

In order for the nursing staff members to carry out their responsibilities to the battered woman effectively, they must have an understanding of the issues involved in domestic violence. Cultural and philosophical orientations effect behavior and attitude. Personal feelings must be discussed and the staff must be aware of myths, fallacies, and stereotypes and be familiar with research done in the field. All of this is essential if they are to interact with the victim in a nonjudgmental, helping way.

Recording and Followup

When the nurse completes the assessment, he or she records the findings on the emergency triage report and prepares the victim for examination by the physician. The findings are then communicated to the physician—an appropriate approach to the patient is discussed. The counselor is called if the patient has agreed or has shown ambivalence about discussing her problem with someone. If the patient refuses to speak with a counselor, the nurse logs the patient's name and hospital number and leaves the information in the social service mailbox in the area. In addition, the nurse offers the patient written materials regarding community resources for counseling, emergency shelter, and legal aid. It has been Brigham and Women's experience that some women will take advantage of these resources at a later time.

Physician Responsibilities — The physician is called to evaluate and treat any injuries. It is important that the physician be oriented to the protocol and be familiar with the problem and issues of domestic violence. Many emergency services are staffed by interns and residents and they may be uncomfortable in discussing these issues with a patient. The nursing and social service staff can be helpful to the physician in this regard and someone must have the responsibility for seeing that all new physicians are oriented to the protocol and the problem.

In some instances it is the physician who first identifies that the patient is a victim of abuse. It then becomes the responsibility of the physician to involve nursing and/or social service in the treatment and followup of the patient.

After examination and treatment of any physical injuries, the physician records all findings in the patient's hospital record including a plan for any necessary medical followup.

Social Service Responsibilities — When the program was initially developed, an on-call social service trauma team was developed. The social service staff took voluntary unpaid call to provide 24-hour crisis intervention for victims of domestic violence. The need has since been defined for full time availability of social services in the emergency department and the hospital assumes the cost of two social workers to work exclusively in the department. They rotate late night and weekend calls. These are master's degree prepared people. Services are also available to Spanish speaking women by a bilingual social worker.

The intervention is crisis theory-based and has the following purposes:

1. To provide an opportunity for the woman to vent her feelings and discuss her situation. While this occurs her affect and emotional state are noted by the counselor.
2. To allow the counselor an opportunity to assess the woman's total situation: resources, support network, finances, family structure, physical safety, previous abuse are all included.
3. To familiarize the victim with the options available to her. (She is made aware of legal action she may take—shelters, community resources, and the availability of ongoing counseling.) An evaluation of physical safety and emotional health of any children is done. A research questionnaire is completed.

The counselor is responsible for recording the patient's circumstances in a cursory manner in order to respect the patient's privacy. A clear, concise description of the incident is recorded. The patient's emotional state and affect is noted. Any identified support network is included in the note. A plan of intervention and/or followup is documented.

Other Considerations

Photography — All patients with visible injuries must be offered photography. Cameras, flashbulbs, "confidential" stickers, and envelopes are kept in a designated place in the area. Consent and refusal forms for photography must be signed, witnessed, and then placed in the patient's record. Pictures are taken by the social worker or nurse. All pictures contain an identifying feature of the patient, for example, the face or hand. Each picture is dated and signed by the patient, the photographer, and one witness. The pictures are put in an 8x11 envelope, perforated to fit in the chart, and placed in the back of the patient's record. The envelopes have "confidential" stickers on the front and back with an additional handwritten statement that reads, "to be used only by patient for litigation purposes."

Psychiatric Liaison — The psychiatric liaison to the program is available 24 hours a day to the counselors for consultation. If a patient is in need of emergency psychiatric care, the psychiatrist on call is summoned to the emergency services. The details of social service intervention will be discussed in the next chapter.

The protocol of care has proved to be a useful and effective tool. It clearly delineates the roles and responsibilities of all staff who interact with the victims of abuse. It is a tool with which new staff can be oriented and it has been used to help others provide services to victims of domestic violence. Its development provided the opportunity for a multidisciplinary group of health care providers to learn to work together to identify, treat, and offer alternatives to those women physically abused by the men with whom they share a close relationship.

Previous to the development of this protocol and the subsequent consciousness raising of the emergency services staff, many of these victimized women were unidentified and returned to their same violent environment without having discussed their problem with anyone and often not knowing that they had any recourse.

All new staff are introduced to this protocol as part of their orientation. The nursing staff takes responsibility for orienting new physician staff to the protocol and familiarizing them with the problem of domestic violence.

Appendix II

Implementing a Domestic Violence Program

Administrative Support — The first step in implementing a program is developing some data to show that need exists. Data may be collected in several ways. The local police department should have statistics to determine the number of women in the area who seek public protection from physical abuse each month. Find out what facilities or agencies in the community might be involved in providing counseling, shelter, or other services for victims of family violence.

The support of hospital administration is essential in the development of new programs. Speak with an appropriate administrative representative and put forth a proposal. Be prepared with supportive data.

Task Force Development — A small, select task force comprised of representatives from medicine, nursing, social services, and administration should be called together. A maximum of six people is recommended. These people should be interested in the issue and eager to provide an interdisciplinary approach to the problem. Much time will be saved if the following information is collected prior to the first meeting:

1. **An Updated Bibliography** — Be sure that it is not biased. All viewpoints should be included. There are many sources that can be used and more articles are being published all the time. One recent search produced over 500 citations. Local women's groups, university and professional school libraries, and local libraries are excellent sources of materials.
2. **Law** — Obtain a copy of the latest laws referring to family violence in the State. Contact the Attorney General's office or any women's law group. There is much movement nationally in this area. The Office on Domestic Violence has current information on relevant activities in the Congress and Senate.
3. **Additional Information** — The Attorney General's office has information on instructions given "to police departments and the general public regarding police responsibilities and victim's rights. Usually there will be published information describing the legal process victims must follow for such things as vacate orders, the names of district judges, and the availability of legal aids to assist victims through the court process.

At the first meeting, collected materials should be distributed to each person. An important thing to remember is that not all health care providers will be comfortable with the material they will read. It is therefore advisable to do the following:

1. Divide the bibliography among the task force members and have each one read a dozen varied articles.
2. Ask each person to take notes on each article and make copies for the other members.
3. Allow 2 to 3 weeks for circulation among the members.
4. Ask each person to read all law and "additional information" materials.
5. Reconvene the group about a month after the initial meeting.

The second meeting is a discussion and venting session. It will focus on discussion of the written materials reviewed and the individual feelings of group members. Usually at this point one or two members drop out because they feel uncomfortable with the issues. They can still be a great moral support, however, and their feelings should be respected.

Program Implementation — Decide what will be done—the choices and requirements.

1. Develop and implement a full program for crisis intervention, initial counseling, ongoing counseling or referral to supportive counseling services or support groups.

Requirements:

- a. An adequate staff of psychiatric nurse clinicians and/or psychiatric social workers who will take calls 24 hours a day, 7 days a week.
 - b. An educated and sensitive secretarial, nursing, and physician staff.
 - c. A hospital approved protocol which states philosophy and objectives and defines the actual procedure to be followed. '
 - d. The provision of ongoing program evaluation through staff meetings, chart review, literature review, and meetings with representatives of refuges and community support groups.
 - e. The willingness to participate with State, local, and other agencies for public education and legislative programs.
 - f. The development of printed materials for information on the availability of resources and agencies.
2. Develop a program for crisis intervention and referral to community agencies, support groups or refuges.

Requirements:

- a. A comprehensive orientation program for new emergency services employees that includes secretaries, nurses, and physicians.
- b. An educated and sensitive secretarial, nursing, and physician staff.
- c. Printed material for patients on available outside resources.
- d. Meetings with representatives of refuges and support groups to whom you will refer women to establish communications systems.

Active Involvement — Consider the best sources of information or relevant services that could possibly affect or aid your program in the future. Get involved. Introduce the program.

1. Contact local women's groups and State agencies and get on mailing lists.
2. Participate in programs for lay and professional groups.
3. Attend local Emergency Department Nurses' Association meetings to encourage them to start a program of their own. Volunteer to help.
4. Go to neighborhood health centers in the catchment area, familiarize the staff there with the hospital's program, and present a program to aid in the understanding of the victim's dilemma and what the provider of care can do to help.
5. Put on a program for the employees in the hospital. (Rent a good film, but be sure to preview it first.)
6. Have the hospital public relations department put together, publish, and circulate a pamphlet for patients and visitors. Make it available with other teaching materials.
7. Keep data. It will be necessary in grant writing, research, and publication.
8. Publicize the program through newspapers, radio, television, health fairs, conventions, and meetings.

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Appendix III

Recommended Outline for Emergency and Ambulatory Service Personnel Educational Seminar

Once a program becomes known and recognized, it is inevitable that the agency will be contacted to participate in various programs and speak to different groups regarding the issues of domestic violence and the particular agency's program. It might be decided to designate a spokesperson for the domestic violence program to provide general information and answer questions about the program. Speaking engagements should be shared by a core group of interested and articulate program members since most of the members have full-time positions as caregivers. These engagements are a good opportunity for hospital people to meet the community and enhance their public speaking skills while educating the public and marketing the domestic violence program.

Approximately 1-1/2 to 2 hours should be allowed for the presentation depending on the size of the group and how vocal it is. The actual didactic information can be given in about 30-45 minutes but it is helpful to stop after each section for group discussion and questions. People will not remember questions until the end of the program, and an unanswered question can frustrate participants to a point where they will no longer listen carefully to the remaining information.

The program is given in outline with cue words or phrases for assistance. Each presenter should develop a style and be prepared to adapt his or her presentation to suit the audience.

It is important to remember that when a victim flees to a refuge she has usually made a decision to change her life. She is ready to be in transition. She has recognized and admitted to herself that she is indeed a victim. When a woman comes to a clinic for a routine visit, or to an emergency ward because of injuries, she may not be at all close to transition. It cannot be assumed that she has even recognized her predicament. At best, it may only be possible to plant a seed in her mind—let her know that she can make decisions, be supportive of her, let her know who is available to her in the community or in your institution if she decides to make a change. These points must be reinforced throughout the seminar.

The following is a sample outline. Many others might be developed and used.

I. Introduction

- A. What is domestic violence? (Use the legal State definition where one exists.)
- B. Introduce seminar topic, for example, "This seminar concentrates on spousal abuse, but it must be remembered that the apparent victims are not just abused spouses but the whole family including the children."

II. Theories Re: Personality Characteristics of the Abuser. Resource article: Elbow, M. "Theoretical Considerations of Violent Marriages" Social Casework (November 1977).

A. Outline most frequently cited reasons for abuse given by or observed in abuser.

1. Projection of Blame for Marital Strife

- "I wouldn't have gotten drunk if my wife weren't such a nag."
- "I wouldn't have hit her if she'd done what she was supposed to."

These people usually won't accept counseling because "there's nothing wrong with me"

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2. Disallowance of Autonomy

- Mate must conform to his definition of her role.
- He expects to depend on his mate almost as an extension of his own ego.

3. Mate As A Symbol

- Doesn't relate to his mate as a person, but as a symbol of a "significant other."
- Great tendency to compare the battered wife to a parent.
- Conflict between hostility toward wife and dependence on mother.

4. Rigid Adherence to Expectations of Marriage

- Demands change within his mate to meet those expectations.

5. Sexual Relationships

- Sex is imposed. Wife is criticized for lack of sexual response. No sexual satisfaction is achieved by wife. Wife is often humiliated verbally or required to perform humiliating acts.

III. Factors That Contribute to Wife's Reluctance to Leave

A. Outline most frequently cited reasons for victim's failure to leave abusive situations.

1. Frequency and severity of abuse.
2. Victim of violence as a child.
3. Degree and power of resources (financial, family, etc.).
4. Personal feelings:

- Low self-esteem
- Sense of shame
- Fear of reprisal
- Love for abusive husband.

IV. How to Recognize Immediate and Long-Term Needs of the Victim. Resource articles: (1) Hendrix, M. et al. "The Battered Wife." American Journal of Nursing (April 1978); (2) Lieberknecht, K. "Helping the Battered Wife" American Journal of Nursing (April 1978).

A. Provide guidelines for recognizing and aiding abused wife.

1. Provider must be alert to cues:

- Physical symptoms of abuse (bruises).
- Bruises in places usually kept covered, such as buttocks, thighs, breasts. (The skilled batterer hits in spots not seen, especially if wife is employed.)
- Hesitant, embarrassed, or evasive about circumstances surrounding "accidents." ® Comments such as, "I've had a tough time lately" "Things have been difficult."

2. Provider must be helpful and supportive:

- Ask directly if woman has been abused. She may be relieved.
- You may be the first to express awareness and concern.
- Listen, support, encourage. She may feel "trapped."
- Don't tell her what she "should" do.
- Don't judge her.
- Support her ability to make decisions. (Know the alternatives to offer her.)

V. Personal Issues for the Provider

A. Provide guidelines to aid providers in recognizing their own prejudices.

1. Some biases that destroy ability to help:

- "They're asking for it."

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- "I'd get out even if I didn't have any money."
- "Only poor people get beaten."
- "Only minorities have this problem."

VI. What To Write in the Hospital Record

A. Provide guidelines for recording patient/victim information.

1. Be careful of subjective data that might put the victim in a poor light.
2. Be short and concise with objective data. Always preface statements with "patient states...."
3. Describe injuries carefully. Visible signs may be gone if and when victim goes to court. (See "photograph" statement in sample protocol.)

VII. Explore and Coordinate Service Providers

A. Provide listings of statewide programs.

1. Police protection
2. Protective laws
3. Counseling services
4. Shelters
5. Others

B. Outline facilities or program guidelines that can be established in your own hospital.

1. Current stage in development
2. Protocol
3. Involvement with outside agencies
4. Date and time of regular committee meetings (Are they open meetings?)

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