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Nursing Network On Violence Against Women: Advocacy with Battered Women: The Role of the Emergency Room Nurse

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It has been over 10 years since the plight of battered women survivors emerged as an issue among the helping professions. However, the questions asked of battered women have not significantly changed. The battered woman is still asked, "What did you do that made him want to hit you?" "Why did you provoke him when he was drinking?" or, "Why do you stay with him?" If asked the source of these questions, many battered women service providers would say without hesitation, "the police!" While many police officers still use this victim- blaming language, the same questions have been asked by physicians and nurses in emergency room settings. Victim-blaming is not unique to any one group of professionals. However, throughout the country, many nurses are challenging the traditional medical system's treatment of battered women.

The concept of nurse as victim advocate is not new; however, the role cannot be overemphasized. Battered women survivors seek medical care in many health care settings, but frequently come to emergency rooms for treatment. Once in the emergency room, battered women are often misdiagnosed. In addition, health care workers generally consider her abuse to be an insignificant part of the victim's medical history (Stark, Flitcraft, & Frazier, 1979).

Nursing schools provide only minimal lecture and clinical instruction on family violence, the focus of instruction has been on caring for abused children. To be an effective advocate with battered women, the emergency room nurse must first acquire a working knowledge of family violence. This knowledge can be obtained from existing nursing, social science, and victimology literature.

For instance, nurses Campbell and Humphreys (1984) published a comprehensive text on the subject, The Nursing Care of Victims of Family Violence. Nurses also have prepared training manuals on identification and treatment of battered women (Braham, Furniss, Holtz, & Stevens, 1986; Sheridan, Belknap, Engel, Katz, & Kelleher, 1985). Nursing magazines and journals are increasingly a source of clinical and research articles on nursing interventions with battered women.

While it is quite common to see emergency room nurses reading recent articles on current treatment protocols for such conditions as myocardial dysfunction or autoimmune deficiency syndrome, it is rare to see a copy of journals like Response in the nurse's conference room. Nurse advocates must not only learn how to work with battered women, they must also share that knowledge with their colleagues. Advocacy also requires a working knowledge of state and local statutes, reporting requirements, crime victim assistance services, and community services.

Part of the process of becoming an educated advocate involves acquiring several basic personal beliefs about the nature of abuse. Among these beliefs are:

1. Abuse is a crime.
2. No one deserves to be beaten.
3. A woman has the right to choose what she wants to do about an abusive relationship.
4. Abuse is an outgrowth of a power imbalance between the abuser and abused.

The nurse must be prepared for a variety of reactions from colleagues ranging from ambivalence to open hostility. The nurse advocate is in the business of empowering battered women survivors. However, in their efforts to compete with physicians, some nurses have adopted the traditional medical practice model with its paternalistic overtones, and simply shunned nursing care models.

Fanslow (1986) has observed that efforts to share authority with physicians and hospital administrators have centered on acquisition of more power by nurses. She cautions the nursing profession that in striving for power it should not forget the power

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that nurses already have over patients. For example, telling a battered woman survivor that she must immediately leave an abusive relationship and go to a battered woman's shelter is an abuse of power (and usually impractical as an immediate step, since most shelters are over-crowded). The nurse who "prescribes" such a cure is likely to label the battered woman as "noncompliant," "masochistic," or "crazy" when she leaves the hospital hand in hand with her abuser. Instead of identifying her/his own effort as an inappropriate nursing intervention, the nurse is, in effect, further blaming the battered woman for her condition.

A more successful approach would provide the survivor with privacy and a temporary safe environment in the hospital emergency department. The woman and the nurse should then explore ways to break the cycle of violence. The battered woman may not believe that she has any choice but to endure the abuse. The nurse can help her identify choices and develop priorities. The survivor's options may include shelter, staying with a friend, pressing a criminal complaint or civil litigation, counseling, or simply returning home.

The nurse advocate should reserve her/his most active participation until after the survivor has made her choice of action. For example, if the survivor wants to file a police report, or if it is legally required, the nurse advocate should prepare the woman for the police interview and stay with her during the interview. The danger is that the police interview may actually become an interrogation. For this reason the survivor should never be left alone with the police unless she specifically requests it.

Inappropriate actions taken with the victim can produce anxiety and must be dealt with carefully. Challenging authority by questioning treatment of victims by police officers, physicians, or other nurses can produce professional and possibly employment- related conflict. Copp (1986) states that advocacy requires a serious commitment that involves risk and willingness to work with controversial and highly emotional situations. Willingness to take risks extends to the other nurses and physicians who treat survivors. Physicians, nurses, and police officers, to name a few, must realize that they are part of a team of service providers that can intervene effectively with battered women only if they work cooperatively.

Copp (1986) identifies distinct types of nursing advocacy including "human advocacy," "moral-ethical advocacy," "legal advocacy," "spiritual advocacy," and "system and political advocacy." Her article describes nursing advocacy with vulnerable patient populations. Battered

women are certainly vulnerable. Using Copp's paradigm, nurses can serve as advocates for battered women in many ways.

"Human advocacy" is possible if the nurse gets to know the survivor as a person with special needs who is in distress. "Moral-ethical advocacy" includes involving the survivor in the decision making process. That means in most instances advocating with rather than for the survivor. Advocating for the survivor is acceptable on a temporary basis but only when her injuries are so serious that she cannot take an active role.

"Legal advocacy" requires a working knowledge of appropriate statutes and related community service agencies and organizations. "Spiritual advocacy" involves awareness of and an understanding response to the survivor's religious beliefs (for instance, the belief that marriage is for life), and family member roles. Enlisting the support of the hospital chaplain in providing additional advocacy and resources is an option that the nurse should explore with the survivor.

"Political and system advocacy" can best be accomplished through existing nurse-directed political action groups, which are usually affiliated with state nursing associations. The nurse can work with such groups to make services for battered women a political agenda item. In addition, the nurse can write or telephone appropriate elected officials concerning additional services for battered women.

Nurses can undertake political advocacy on issues that concern treatment of battered women through membership in state and local coalitions against domestic violence and through becoming active members in the national Nursing Network on Violence Against Women. Membership in such organizations extends the political power of all battered women service providers and introduces nurses to multidisciplinary experts. Those contacts provide invaluable resources for referrals and information.

Advocacy does not necessarily mean that the nurse must agree with the survivor's choices. It is appropriate for the nurse to tell the battered woman that her decision to return to an abusive relationship may be fatal, and to share with the patient the various risk factors involved (Campbell, 1986). Instead of being angry that the woman is returning to an abusive home, the nurse should teach her additional survival tactics. Examples might include hiding money over time for emergency purposes and how to elicit prompt police response to a call for help.

The complex health needs of battered women are increasingly becoming a priority for all service providers. Throughout the country, efforts are under way to improve networking between community- based battered women agencies and local health institutions. Nurse advocates need to increase their outreach into the community and the community needs to search out concerned nurses. Together, they can be more effective in reducing the physical and psychological pain of family violence.

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Homeless Assistance Act

The Homeless Assistance Act of 1987 (HR 558) provides funding for services to the homeless. In January 1988, seven Texas battered women shelters were awarded grants under the act for shelter renovation projects. The fund is administered in Texas by the Department of Community Affairs. The legislation is available from the Congressional Document Room, (202) 225-3456. A summary can be obtained for $2 from Benedictine Health Resource Center, 400 E. Anderson Lance #636 Austin, TX 78752.

Elder Abuse Prevention Committee

A National Committee for the Prevention of Elder Abuse has been formed under the auspices of the Center on Aging of the University of Massachusetts Medical Center. The purpose of the committee is to explore ways to reduce and prevent elder abuse, neglect and exploitation. Contact Rosalie S. Wolf at the center, 55 Lake Ave. North, Worcester, MA 01605, (617) 856-3662.