# The Domestic Violence Coalition of Greater Chattanooga, Inc.

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## INTIMATE PARTNER VIOLENCE HEALTH CARE INTERVENTION PROTOCOL

### I. Definition of DOMESTIC VIOLENCE

**Legal:** According to Tennessee law, domestic assault has occurred when a family or household member causes or attempts to cause bodily injury to another family or household member. Legal definition of family or household member includes people living as spouses, people related by blood or marriage, people who have a child in common, people whose sexual relationship has resulted in a current pregnancy, people jointly residing in the same dwelling unit who are aged 18 years or older or who are emancipated and people who have or have had a dating relationship. Children under the age of 18 may be covered under protective orders taken by parents.

**Behavioral:** Behaviorally, family violence encompasses a much broader scope and includes behaviors that are physical, psychological, emotional or sexual; spousal or other intimate partner violence, elder and child abuse, dating violence and sexual assault or rape occurring within the context of intimate relationship

### II. Guidelines for Intervention

Though 92 percent of reported incidents of domestic violence involve males against females, it is not a gender issue. IT IS A HUMAN RIGHTS ISSUE and can occur as female to male or between same sexes. For the sake of brevity, victims are referred to as women in these protocols.

Domestic or family violence flourishes in an atmosphere of silence and isolation, so many victims will have great difficulty admitting that they have been injured by a family member and discussing this information. Providers must respect the decision of the victim, but can impart information about available resources with statements such as, "Should you find yourself or a friend in an unsafe situation, you may want to know..." Written materials should be made available to the victim, but she should not be asked to take them with her unless she elects to do so.

- Make credit card size or one-page safety plans available in your restrooms.
- Place posters with hotline numbers on them in restrooms so that patients can write them in an inconspicuous place.

**SCREENING:**

Family abuse may occur on a continuum from emotional abuse and verbal assault to severe physical assault. Each form of abuse is significant and places the victim at risk of injury - emotional and physical - including death.

- Every woman seeking care should be asked directly if anyone has ever physically or psychologically hurt her. Denial is a potent defense for both victim and perpetrator, so the victim may not be able to make the connection between certain behaviors and abuse, (i.e., pinching, pushing, being locked out, put out of moving car, etc.)

**SCREEN women carefully who present with the following problems:**

**ACCESS TO MEDICAL CARE:**
* **lack of access to care:** abuser may control or deny access to care, money, transportation, use of phone, etc.
* **failure to keep appointments** or **leaving before being seen** after arriving for appointment
* **failure to purchase / take prescribed medication** or show up for scheduled procedures
* **homelessness** is secondary to abuse and may prevent access to care and increase likelihood of victimization
* **partner insists on accompanying victim** in health care setting, overly solicitous of victim's health
* **partner answers provider=s questions** directed to patient; patient too intimidated to answer/speak
* **partner waits outside door** when asked to leave (trys to overhear what is being said)
* **partner attempts to intimidate victim or provider**, demands that victim leave before procedure completed
* **partner voices or displays signs of jealousy** of victim in relationship to provider
* **some abusers become threatening**, others appear to be very **charming**, **thoughtful, overly concerned**

□ **PHYSICAL SIGNS:**
* **injuries to face, neck, arms, torso, breasts or genitals** (abusers are skillful at injuring the victim in areas that will be covered by clothing or in ways that minimize bruising or overt injury)
* **contusions, abrasions, burns, lacerations, gun and puncture wounds**
* **rib fractures, missing teeth, broken jaw, perforated ear drum, hematuria, back injuries**
* **chest pain, fatigue, sexual dysfunction, UTI=s**.
* **bilateral distribution or injury to multiple areas**
* **multiple injuries in various stages of healing**
* **evidence of rape or sexual assault**, unplanned pregnancies, abortions, premature births, sexually transmitted disease, HIV infection.
* **pregnant women with abdominal bruising**, vaginal bleeding, spontaneous abortion or abruptio placenta.
* **inappropriate or inadequate dress** for weather conditions and generally poor self-care.

□ **PSYCHOLOGICAL SYMPTOMS**:

* **repeated visits to emergency rooms**
* **delay between time of injury or onset** of disease and presentation for medical care
* **explanation by victim or partner that is inconsistent** with type or severity of injury
* **vague, non-specific or multiple migrating** complaints
* **PTSD, psychological symptoms** - anxiety, depression, sleep or digestive disorders, suicidal ideation, panic attack, out of body experiences, dissociative ideation, overly protective of partner, lying to protect abuser.
* **hesitant/inconsistent, incomplete reporting of medical history**; incoherent or chaotic reporting, chronology of reporting does not match injuries or reported symptoms

□ **INTERVENTION:** (See intervention from Massachusetts Medical Society below)
* **R**- Routinely Screen Female Patients
* **A**- Ask Direct Questions
* **D-** Document your findings
* **A**- Assess Patient Safety
* **R**- Review Option/Referral
* ALWAYS, ALWAYS, ALWAYS, review the medical record
* establish an atmosphere for privacy, developing trust, concern and willingness to discuss abuse

* treat medical/mental health problems
* provide SAFETY PLAN and plan for follow-up care
* confidentiality essential; the patient's life could depend upon it

## RADAR: A DOMESTIC VIOLENCE INTERVENTION

(Developed by Massachusetts Medical Society)

### R ROUTINELY SCREEN FEMALE PATIENTS

Although many women who are victims of domestic violence will not volunteer any information, they will discuss it if asked simple, direct questions in a non-judgemental way and in an confidential setting. *Interview* the *patient alone.*

### A ASK DIRECT QUESTIONS

"Because violence is so common in many women's lives, I've begun to ask about it routinely":
"Are you in a relationship in which you have been physically hurt or threatened?' If no, "Have you ever been?"
"Have you ever been hit, kicked or punched by your partner?"
"I notice you have a number of bruises; did someone do this to you?"

### D DOCUMENT YOUR FINDINGS

Record a description of the abuse as she has described it to you. Use verbatim statements such as "the patient states she was...' If she gives the specific name of the assailant, use it in your record. 'She says her boyfriend John Smith struck her... Record all pertinent physical findings. Use a body map to supplement the written record. Offer to photograph injuries. When serious injury or sexual abuse is detected, preserve all physical evidence. Document an opinion if the injuries were inconsistent with the patient's explanation. In photographing injuries, remember that many injuries to do manifest themselves as well (some not at all) as immediately as in 24 to 72 hours after the injury.

### A ASSESS PATIENT SAFETY

Before she leaves the medical setting, find out if she is afraid to go home. Has there been an increase in frequency or severity of violence? Have there been threats of homicide or suicide? Have there been threats to her children? Is there a gun present in the home? (See Lethality Section)

### R REVIEW OPTIONS & REFERRALS

If the patient is in imminent danger, find out if there is someone with whom she can stay. Does she need immediate access to a shelter? Offer her the opportunity of a private phone to make a call. If she does not need immediate assistance, offer information about hotlines and resources in the community . Remember that it may be dangerous for the woman to have information about resources in her possession. Do not insist that she take them. *Make a follow up appointment to see* her.

### IF THE PATIENT ANSWERS *YES*:

***Encourage her to talk about it***

'Would you like to talk about what has happened to you?' 'How do you feel about it?" "What would you like to do about this?'

***Listen non-judgmentally. Validate her experience. Remember that victims are brainwashed to believe that abuse is their fault.***

This process begins the healing process for the victim and gives you information about type of referrals she may need.

"You are not alone." "No one has to live with violence" "You do not deserve to be treated this way. "You are not to blame." "What happened to you is a crime." "Help is available for you." "I am concerned for your safety and for that of your children."

### IF THE PATIENT ANSWERS NO, OR WILL NOT DISCUSS THE TOPIC:

***Be aware of any clinical signs that may indicate abuse:*** injury to the head, neck, torso, breasts, abdomen or genitals; bilateral or multiple injuries; delay between onset of injury and seeking treatment; explanation by the patient which is inconsistent with the type of injury; any injury during pregnancy, especially to abdomen or breasts; prior history of trauma; chronic pain; symptoms for which no etiology is apparent; psychological distress such as depression, suicidal ideation, anxiety and/or sleep disorders; a partner who seems overly protective, answers questions for her or will not leave the victim alone with others.

***If any of these clinical signs are present, ask more specific questions. Make sure she is alone***. "It looks as though someone may have hurt you. Can you tell me how it happened?" "Sometimes when people feel the way you do, it may be because they are being hurt at home. Is this happening to you?"

***If the patient denies abuse, but you strongly suspect it,*** document your opinion, and let her know there *are* resources available to her should she choose to pursue such an option *in* the future.

***Make a follow up appointment to see her.***

Source: Improving the Health Care System's Response to Domestic Violence, Family Violence Prevention Fund

**INTERVIEWING PATIENTS:** * Suggestions for interview process/questions
I routinely ask patients about their personal relationships. Has anyone close to you recently or ever hurt you physically? emotionally? sexually? Has your partner ever hit you?

Have you ever had medical treatment for injuries made by your partner?

If you could change two things about your partner, what would you change?

Has your partner ever scared you? What happened? Are you ever afraid of your partner?

What does your partner act like when he/she has been drinking? Using drugs?

During your relationship, have there been times when an argument has become physical?

How do you and your partner resolve arguments?

Is jealousy and issue with you and your partner?

Does your partner ever try to control what you do?

Does your partner eve lose his temper? Throw things? What happens when your partner loses his temper? Do you ever get scared?

Has your partner ever forced you to have sex when you did not wish to?

Have you ever been hit, slapped or kicked while you were pregnant? Has the abuse increased since you are pregnant?

Remembering the last time you were abused, mark the places on the body diagram where you were hurt.

Does your partner ever call you names or put you down?

Are your children affected by your partner's behavior? Have they ever seen him/her abuse you? What do your children say to you about the abuse?

Do you know where you could go if you were abused or worried about abuse?
*Adapted from a list by Annie Lewis O'Connor, MS, MPH, RN

## III. DOCUMENTATION:

* Obtain a complete history of abuse, reporting:
- victim's report of specifics of presenting condition (use verbatim descriptions when possible)
- date, time, location of all reported physical or verbal assaults
- victim's relationship to abuser
- mechanism of injury, use or threats of injury with weapons
- previous trauma
- relevant social history
* Document thorough physical examination:
- use anatomical drawing to illustrate injury sites
- use rape kit if appropriate
* Record your objective, professional observations about consistency of findings with victim's report of injuries.
* Document evidence when police are called including names, badge numbers, action offered or taken.
* Document discharge plan and plan for follow-up care.

*** Include photographs of injuries with consent of victim. Include HIPPA consent.

## IV. IDENTIFYING ADULT VICTIMS OF DOMESTIC VIOLENCE

It is often difficult for hospital staff to identify domestic violence victims. Abuse is often a pattern of behavior that escalates in frequency and severity over time. Victims may have been battered many times before they seek medical attention for their injuries and violence may be have become a long-established pattern in the relationship. Because of the coercive nature of the relationship and need to protect the abuser, victims may not give a true history and attribute injury to a cause other than abuse.

Staff should suspect domestic violence when the patient presents with any of the following:

1. Patient admits that physical abuse has occurred.

2. Patient presents with unexplained bruises, lacerations, fractures or multiple injuries in various stages of healing.

- Common injury sites are face, head, chest, breasts, abdomen and genitalia
- Injuries sustained during pregnancy (usually to breasts, abdomen or genitalia)
- Choking or strangling are favorite forms of abuse. Bruises not imminently visible
- Injury to torso or areas covered by clothing.
- Inappropriate attire.
- Fractures (ribs, extremities, skull), pattern burns, gunshots, stabbings.
- Contour reflects object used to inflict injury (hand, belt, rope, chain, cigarette, teeth)
- Broken jaw, missing teeth, perforated ear drums, hematuria
- Sleeping / eating disorders, anxiety, panic attack, fatigue, depression, sexual dysfunction

2. Old untreated injuries or fractures in varied stages of healing.

3. Extent or type of injury is inconsistent with explanation given by patient.

4. Substantial delay has occurred between time of injury and presentation for treatment.

5. HIV, STD’s, unplanned, unwanted pregnancies, multiple abortions or pregnancies, UTI's

6. There is no physical evidence to support patient=s complaints.

7. Partner accompanies and insists on staying near patient; answers questions for patient.

8. Irrational jealousy or possessiveness expressed by partner

9. Frequent, repeated use of emergency room. Medical records indicate history of suspicious injuries or frequent accidents.

10. Patient is reluctant, embarrassed or evasive when describing circumstances of accident.

11. Use of tranquilizers.

12. Multiple migrating complaints; complaints of chronic, somatic pain, chest pain, A choking sensation.

13. Suicidal ideation; previous suicide attempts.

15. Anxiety about time (may be allotted only a short time away from home).

16. History of substance abuse or psychiatric history in patient or partner.

17. Frequently missed appointments.

## V. REPORTING:

*Tennessee does not have a mandatory reporting law, but physicians are requested to voluntarily report domestic violence injuries (T.C.A. 36-3-601).
See Voluntary Domestic Violence Screening/Statistical Form for return to Tennessee Department of Health.

## VI. THE IDENTIFIED BATTERED WOMAN

* If a patient self-identifies or discloses battering to you, provide her with extra time. She may desire to remain in a private area, especially if she is in a decision-making phase, attempting to decide whether to return to her male partner. If her male partner is in the waiting area, ask ***her if*** she ***feels*** safe at this time. Her options are:

a. immediate access to shelter
b. shelter information and access at later date
c. access to counseling
d. returning to the male partner, with follow-up appointment
e. referral to prosecutorial or police agencies, especially if injuries are apparent

* Use empathetic, active listening skills if a victim discusses a battering incident with you. Allow her l over the conversation. Encourage discussion of immediate safely needs using questions like "Do you feel you are safe now with your partner?" or "Does your partner have a gun in the house or threaten you with a weapon?" or "Do you have plans for help if he hits you again?"

Battered women evaluate their own safety or danger potential, however the health care provider should encourage realistic discussions of the battering situation to encourage informed decision making..

* Educate her about signs of escalating physical danger, which include: (see lethality assessment)
a. Availability or access to weapons
b. Assaults or threats with weapons
c. Extension of his assaults, or threats of assaults to children, pets or extended lamily members.
d. Surveillance of woman at work, increasing isolation of woman
e. Extreme jealousy, accusations of infidelity

f. Forced sexual encounters
g. Battering during pregnancy
h. Decrease or absence of remorse expressed by the batterer

* Particular attention should be paid to postpartum women experiencing emotional or physical abuse. Observe for extended postpartum blues in the mother, feeding problems in the infant and poor communication between the couple. Be alert for postpartum women reporting coercive sexual patterns from male partners. Battered women report that sexual assault occurs during postpartum period.

## VII. SUMMARY OF PREVENTION OF BATTERING STRATEGIES FOR ALL WOMEN

Empowering Victims: safety and self-care

- Assess all female patients for battering.
- Provide written referral information to community resources.
- Assess for battering in a private location, away from partners and children.
- Use nonjudgmental, empathetic responses when assessing for abuse.
- Observe for signs suggestive of battering, such as:

* injuries inconsistent with explanation,
* vague or multiple physical complaints,
* complaints of "problems with husband" or "problems at home",
* crying, sighing, laughing at abuse assessment questions,
* no eye contact or searching, engaging eye contact when assessing for battering,
* fear when discussing battering, or
* ambivalent statements about battering.
* Document assessment, teaching, photographing, referrals, statements or threats from batterer.
* Provide the patient with copies of her health record related to battering incident to enable her. to file charges with law enforcement or the courts
* Self care increases with information, positive reinforcement, shared health goals and decision-making between provider and patient.
* Sometimes, despite all efforts, a patient may continue to feel her only option is to remain with the abuser. However, your empathetic responses may assist her toward self-help, and the referral information you give her may be utilized at a later date.

## III. PROVIDING PRACTICAL SUPPORT TO WOMEN AFFECTED BY PARTNER

**VIOLENCE:**

Patience is crucial. Many victims of violence have not talked about their abuse.   Allow her to tell her story and express her feelings.

Let her know that she does not deserve to be treated this way.  Even if she changes,  the abuse will not.

Respect that values will differ from culture to culture.  Individual values may affect how a victim behaves and the choices that will be made.

Let her know that help is available, and even though she may not be ready now, you will be there when she is ready.

Let her know that you are concerned for her safety and the safety of her children. Discuss with her the impact that violence has on children who witness violence and explore alternatives to safety.

Understand her ambivalence  about leaving. Remember that making a change is a process and that many women are in greater danger when they leave. Trust her decisions and support her; giving her choices and letting her decide.

Recognize that many women feel embarrassed and ashamed about the abuse. Many women feel that have contributed to the abuse and that they are equally responsible.   Work with the women to help dispel the myths.

Reinforce to her that she is not alone. The feeling of being alone makes her feel isolated.

Share with her the incidence and prevalence rate for domestic violence. Share with her (confidentially) information about other cases. Discuss the options of individual counseling and or victim=s support groups.

Building a rapport and trusting relationship may entrust a victim to confide in you and work towards taking steps that keep her (and her children) safe and free of violence.

Keep in nlind that victims living in violence possess amazing survival skills. Often when a crisis occurs, a victim may experience difficulty making decisions.  Such difficulty is part of the post traumatic stress syndrome.   A clinician's most effective support would be to discuss the choices available and support her choice.

Source: Adapted from  writings by Annie Lewis O'Connor, MS, MPH, RN, cs, Conference of Boston Teaching Hospitals= Domestic Violence Task Force

**X.  EMPOWERING RESPONSES**

You do not deserve to be hit or injured. No one deserves to be treated badly by a partner. No matter what, it is not OK for your partner to hurt you. It is wrong and it is against the law.

You deserve to be treated decently. Violence and threats of violence that make you afraid are wrong.

I'm concerned for your safety. I'm concerned about the safety of your children. I'd like to talk to you about making a safety plan in case you need to leave quickly. (Go over safety plan or refer to someone who will do this.)

You may not want to do anything right now, but I would like to tell you about the services that are available. (Make a referral, give information and/or hot line number).

No matter what you decide to do, I am still your doctor and I want you to know that we will work together on all of your health problems and continue to talk at your appointments about how things are at home. If things get worse or you would like to talk to me again about this, please call me.

Many women are in violent relationships. It is a very common problem. You are the one who decides what to do and when. I will support the decisions that you make, even though I will encourage you to consider all of your options.

Your medical record is confidential, and cannot be released without your written permission.  You do need to know that I am required by state law to report any gunshot or knife wound, if you are seriously burned, or if children are being abused at home.
If both you and the children are being hurt, it is possible to help all of you together.

Source:  Eleanor Hobbs, MD, Conference of Boston Teaching Hospitals= Domestic Violence Task Force

## WHAT IS ABUSE?

Abuse is defined as intentional, repeated acts which cause physical or emotional harm inflicted by an intimate partner and frequently occurring in a cyclic pattern.

**ARE YOU A VICTIM OF ABUSE?**

If you have been the subject of such behaviors as those listed below on more than one occasion during your relationship, you are a victim. Does your partner

___ slap, shake, punch or push you?
____ bite, pinch, tickle you excessively or pull your hair?
___ make fun of your feelings, call you names to put you down, humiliate you in public
___ throw objects, destroy items that are special to you, put holes in walls or furniture?
___ drive dangerously to frighten you, throw you out of the car, abandon you in dangerous places?
___ accuse you unjustly of flirting or going out with another, continually criticize or ignore you?
___ lock you out of the house, destroy or threaten your pets or property?
____ manipulate you by telling lies, play mind games, blame his/her abusive behavior on you?
____ isolate you or limit your time with friends or family?
____ threaten you, your child(ren) or your family or friends?
____ kick, beat or stab you, hold you at gun point?
____ use sexual names to put you down, force you to perform unwanted sexual acts?
____ delay or deny you medical treatment?
____ cause you to lose a promotion or your job, cause you to drop out of school?

**Studies show that if your partner abuses you on just two occasions, he/she is likely to continue to abuse you.**
If you are unclear on whether you are abused, take the following quiz. If you answer yes to no more than two or three of the following questions, you are a victim of abuse.

Yes No
___ ___ I am afraid of my partner.
___ ___ I cannot express my feelings or opinions without being afraid of my partner's reaction.
___ ___ I have to ask permission from my partner to see my family or friends.
___ ___ I have to ask permission to spend money or buy something for myself.
___ ___ I constantly try to make things "just right" to please my partner.
___ ___ I try and try to please my partner, just to get criticized again.
___ ___ I sometimes feel that my partner is two people (Dr. Jekyll/ Mr. Hyde).
___ ___ My partner seems to see our relationship in a whole different way than I see it. I am confused about the relationship. I don't know what my partner feels most of the time.
___ ___ I am beginning to believe all the terrible things my partner says about me. I'm not sure what is real anymore. Maybe I am going crazy.
___ ___ I feel responsible for my partner=s behavior. It is up to me to make our relationship work.
___ ___ I feel that my partner watches everything I do.

*****FOR MORE INFORMATION OR HELP**:
**call the Domestic Violence Hotline (answered 24 hours) at 423-755-2700**
**or the Domestic Violence Coalition during business hours at 423-875-0120**

## THE PATTERN OF DOMESTIC YIOLENCE

**HE TELLS YOU:** "You're not so bad off. We have a good life."

"You are really asking for it when you make me crazy like this. I don't get this way with anyone else. It's your fault."

"Give me another chance. I'll change."

"If you leave, I'll find someone else who is better than you."

"You're so fat (or dumb or uneducated), I'm the only one who would put up with you. You could never get another man."

**YOU TELL YOURSELF:** "I can handle this, because a lot of the time he's ok."

"He's nice to everyone else. It must be my fault. If I can learn to do things he won't get mad."

"He'll change. He means it this time. I'm going to give him another chance."

"It's the drink (or drug) that makes him behave this way."

"I'm so ugly (or stupid), no one else could love me. He's the best I can do. Being alone would be worse."

**THE TRUTH IS:** The way he treats you is despicable. It is not normal to be abused. He's going to keep beating on you as long as you permit it.

He doesn't abuse others, because it isn't safe. Nobody else would put up with it. You are the only one he can knock around.

Abuse is slow death. You may have been abused when you were young, so his cruelty may seem normal. It is not normal. It is a hideous way to live.

He will never change until you make it clear that you will no longer put up with his abuse. Separating from him may make him get professional help.

He hits you, because he is a coward and a bully. If he drinks or uses drugs, that's another problem. It is not the reason he beats up on you.

When an abuser is faced with losing his victim, he will try to hang on any way he can. Threats and promises are his best weapons. Don't fall for these tactics but plan carefully so that you can leave safely.

The typical abuser tries to separate his victim from outside support - family, friends, people at work. Keeping you isolated is an effective ploy.

An abuser tries to destroy the victim's self-esteem and make her believe she can't live or survive without him. Counseling by a qualified therapist can help you to understand what has happened to you.

The most loving thing you can do is hold your abuser responsible for his behavior. Separation is the only way to demonstrate that you will no longer put up with it. As long as you stay with an abuser, he will continue to dish it out, and this will go on until you are a total wreck - or dead.

Source: Adapted from FDR Publications

**National Coalition Against Domestic Violence**
P.O. Box 34103, Washington, DC 20043-4103, 202/638-6388

## A Proposed New Diagnosis

1. A history of subjection to totalitarian control over a prolonged period (months to years). Examples include hostages, prisoners of war, concentration-camp survivors, and survivors of some religious cults. Examples also include those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse, and organized sexual exploitation.

2. Alterations in affect regulators, including
   + persistent dysphoria
   + chronic suicidal preoccupation
   + self-injury
   + explosive or extremely inhibited anger (may alternate)
   + compulsive or extremely inhibited sexuality (may alternate)
3. Alterations in consciousness, including
   + amnesia or hyperamnesia for traumatic events
   + transient dissociative episodes
   + depersonalization / derealization
   + reliving experiences, either in the form of intrusive post-traumatic stress disorder symptoms or in the form of ruminative preoccupation
4. Alterations in self-perception, including
   + sense of helplessness or paralysis of initiative
   + shame, guilt, and self-blame
   + sense of defilement or stigma
   + sense of complete difference from others (may include sense of specialness, utter aloneness, belief no other person can understand, or nonhuman identity)
5. Alterations in perception of perpetrator, including
   + preoccupation with relationship with perpetrator (includes preoccupation with revenge)
   + unrealistic attribution of total power to perpetrator (caution: victim's assessment of power realities may be more realistic than clinician's)
   + idealization or paradoxical gratitude
   + sense of special or supernatural relationship
   + acceptance of belief system or rationalizations of perpetrator
6. Alterations in relations with others, including
   + isolation and withdrawal
   + disruption in intimate relationships
   + repeated search for rescuer (may alternate with isolation and withdrawal)
   + persistent distrust
   + repeated failures of self-protection
7. Alterations in system of meaning
   + loss of sustaining faith
   + sense of hopelessness and despair

SOURCE: HERMAN, JUDITH LEWIS. TRAUMA AND RECOVERY. NEW YORK: BASIC BOOKS, 1992.

## WHY WOMEN STAY WITH THEIR ABUSERS

THE QUESTION SHOULD NO LONGER BE: WHY DO WOMEN STAY IN ABUSIVE RELATIONSHIPS? INSTEAD THE QUESTION SHOULD BE: WHAT ARE WE AS MEMBERS OF A COMMUNITY, SOCIETY, and GOVERNMENT DOING TO ENABLE HER TO LEAVE AND REMAIN SAFE AND WELL IN THE LONG TERM?

# WHY SHE STAYS, WHEN SHE LEAVES

Many people not involved with an abusive partner say that if their mates ever harmed them they would leave. Many battered victims remember the same resolve. Why do they stay? Why might they go back? Why do some permanently separate from their abusers?

There are serious factors which weigh on the battered woman's decision to leave. This is the man she loves, or has loved. The abuser may be the father of her children. Ending an intimate relationship is very difficult. Even more so when self confidence has been destroyed by the batterer. Battered women report the following reasons for staying with the barterer or leaving him.

**HOPE FOR CHANGE:** Many abusive mates become remorseful after inflicting violence. This contrite behavior may include promising never to hit her again, agreeing to seek counseling if the victim does not leave, reminding the victim of how hard the perpetrator works, pointing out the incredible stresses under which he operates, acknowledging the wrongfulness of his violence to the children and asking their help in stopping it, and demonstrating his love for her in meaningful ways. Since battered women are often committed to their relationships and have often built their lives around them, they hope for change. When the batterer acknowledges the error of his ways, breaks down and cries in despair and concedes the need for dramatic change, hope is often born anew for battered women.

**ISOLATION:** Many battered women lose their support systems. Their batterers have isolated them. For example, a batterer may prohibit the victim from using the phone; humiliate her at family gatherings; insist on transporting her to work; censor her mail, etc. Batterers are often highly possessive and excessively jealous. They believe that they own their victims and are entitled to their exclusive attention and absolute obedience. The batterer knows that if the truth is told about his conduct, support persons will urge the victim to leave or seek assistance. Therefore, batterers quickly isolate their victims in order to sustain the power of their violence.

**SOCIETAL DENIAL:** Abused women fear that no one will believe that their partners beat them. Batterers often are very ingratiating and popular men who keep their terrorizing, controlling behaviors within the family behind dosed doors. The battered woman knows this, and it compounds her fear that no one will believe her. Battered women discover that many people and agencies in the community trivialize the impact of violence (e.g. doctors prescribe Valium for coping; ministers recommend prayer and more accommodating behaviors; therapists advise better communications with the perpetrators. etc). For good reasons, she believes that no one understands that she feels like a prisoner who might be severely injured or die at the hands of her jailer. She concludes that since they don't understand the seriousness of the violence, they will not support her disruption of the family.

**BARRICADES TO LEAVING:** Even when a victim decides to leave, the abuser puts up many barricades. He may threaten to seek custody of the children, withhold support or interfere with her employment. He may advise her prospective landlord that she is not credit-worthy; try to turn the children or family against her; threaten to kill her or other family members if she leaves; threaten retaliatory suicide or escalate his violence in other ways to hold her in the relationship.

**BELIEF IN BATTERER=S INTERVENTION:** Abused women are reluctant to leave when their partners are in treatment. They believe the treatment will motivate them to make the profound changes necessary to stop their abuse. Therefore, it is very important that victims are referred to domestic violence programs that offer full information about treatment programs for batterers and evaluate whether they programs are likely to effect the change that will make life safe for them.

**DANGERS IN LEAVING:** The abused woman may believe that leaving is not necessarily going to make her life or the life of her children safer. Seventy five percent of the homicides or serious injuries to victims occur when they are attempting to leave the relationship, so leaving may be a dangerous process. Many abusers escalate their violence to coerce their victims into reconciliation or to retaliate for separation or departure. Leaving requires strategic planning and comprehensive legal intervention to safeguard victims and their children.

**ECONOMIC AUTONOMY:** But battered women do leave. The most likely predictor of whether a victim will permanently separate from her abuser is whether she has the economic resources to survive without him. Therefore, it is important that victims obtain support awards in protection orders and are referred to battered women's programs where they can learn about other economic supports, job training and employment opportunities.

**LEAVING IS A PROCESS:** Most victims leave and return several times before permanently separating from the abuser. Leaving is a process. The first time a victim leaves may be a test to see whether he will actually get some help to stop his terrorism. When he is violent again, she may leave to gain more information about resources available to her. She may reconcile and start to get some economic and educational resources together in case she has to leave later. She may next leave to try to break out of the isolation in which the abuser has virtually imprisoned her. Most battered women eventually leave.

When friends, family and helping agencies such as police, shelters, clergy, courts, health care providers, educators and therapists, lend substantial and concerted efforts to assist abused women in the leaving process, they are more likely to leave and secure protection for themselves and their children. Therefore, when abused women stay, we as a community should look to see what we are doing to hinder the leaving process and make changes to facilitate leaving safely.

*Leaving must be done in a way that does not further jeopardize the victim's safety.*
*It is important for law enforcement to refer victims to domestic violence programs to develop plans to leave safely.*

Source: Barbara J. Hart, Esq. Pennsylvania Coalition Against Domestic Violence

Abused women give many reasons for staying with batterers:

**1. "I'm afraid he will kill me if I leave."**

A batterer often threatens to hurt or kill his partner, the children or her family members if she tries to leave him. Unfortunately, many follow through with the threat. Women who leave their batterers are at 75% greater risk of being killed by the batterer than those who stay. More victims are murdered after obtaining a protective order or while in the process of leaving than at any other time. (National Coalition Against Domestic Violence, 1988).

**2. "I can't afford to leave him."**

Abusers often control the household money, and the psychological abuse so damages the victim=s self-esteem that she comes to doubt her ability to support herself and her children financially. This issue is especially problematic for women who have never worked outside the home.

**3. "It must be my fault."**

When relationships do not work, victims often feel totally responsible, despite any evidence to the contrary. This tendency reaches dangerous proportions when they feel guilty, i.e., "If only I were a better partner, he wouldn't hurt me." Unfortunately, the batterer, and sometime the victim=s friends, family, and even clergy members reinforce this attitude by telling the victim she must have done something to cause the abuse. The victim then turns herself inside out trying to change her behavior to stop the violence. Many victims say they stay because there is society pressure and they want their children to be raised in a two-parent family.

**4. "He says it won't happen again."**

Batterers often apologize, shower the victim with affection, and promise never to be violent again. Many victims feel sorry for the batterer, especially if he cries, and convince themselves they can help him. Unfortunately, not only does the violence happen again; it often escalates to the point that the victim is injured so badly she has to seek medical care.

**5. "I don't know where to turn."**

The abuser may forbid the victim to use the telephone or drive the car. Unable to communicate with friends and family, she is then psychologically dependent on the batterer as her sole support. Until recently, few places existed where victims could seek help.

Most states do not provide enough money for a victim to support herself and her children until she can put her life together on her own. Many shelters only offer services for 30 days. That is not enough time for a person who has experience the trauma that leads to Post-Traumatic Stress Syndrome to be able to recover enough to survive without some assistance.

Some batterers are life-endangering. While it is true that all batterers are dangerous, some are more likely to kill than others and some are more likely to kill at specific times. Regardless of whether there is an order of protection in effect, police, prosecutors, probation counselors and advocates should evaluate whether an assailant is likely to kill his partner, other family members and br criminal justice system personnel and take appropriate action.

It is important that responding officers conduct an assessment at every call, no matter how many times an officer has responded to the same household. The dispatcher and responding officer can utilize the indicators described below in making an assessment of the batterer's potential to kill. Prosecutors, probation counselors and advocates should, likewise, make an assessment during each interview with a battered woman.

Assessment is tricky and never full-proof. Considering these factors may or may not reveal actual potential for homicidal assault. But, the likelihood is greater when these factors are present. The greater the number of indicators that the batterer demonstrates or the greater the intensity of indicators, the greater the likelihood of a life-threatening attack.

The evaluation should use all information available about the batterer. Reliable information cannot be obtained from an interview conducted with the victim and perpetrator together. Furthermore, information obtained from the victim is significantly more reliable than from the batterer.

### *THREATS OF HOMICIDE OR SUICIDE*

The batterer who has threatened to kill himself, his partner, the children, her relatives or others such as police officers, must be considered extremely dangerous.

### *FANTASIES OF HOMICIDE OR SUICIDE*

The more the batterer has developed a fantasy about, who, how, and/or where to kill, the more dangerous he may be. The batterer who has previously acted out part of a homicide or suicide fantasy may be invested in killing as a viable "solution" to his problems. As in suicide assessment, the more detailed the plan and the more available the method, the greater the risk.

### *WEAPONS*

Where a batterer possess weapons and has used them or has threatened to use them in the past in his assaults on the battered woman, the children or himself, his access to those weapons increases his potential for lethal assault. The use of guns is a strong predictor of homicide. If a batterer has a history of arson or the threat of arson, fire should be considered a weapon.

Source: Nashville Metropolitan Police Department: Domestic Violence Division

***NOTE:*** We have assumed that the victim is a woman and the abuser is a man. It may be that the victim is a man and the abuser a woman or that the abuser and the victim are the same sex. Assessment is basically the same despite these gender differences. The only additional indicator to be assessed in a lesbian or gay relationship is whether the abuser has been firmly closeted and is now risking exposure as a lesbian or gay person in order to facilitate their severe, life-threatening attacks. When a person has been desperately closeted, losing the protection of invisibility in order to abuse potentially suggest great desperation and should be included in the assessment.

### *"OWNERSHIP' OF THE BATTERED PARTNER*

The batterer who says *"Death before Divorce!"* or *"You belong to me and will never belong to another!",* may

be stating his fundamental belief that the woman has no right to life separate from him. A batterer who believes he is absolutely entitled to his female partner, her services, her obedience and her loyalty, no matter what, is likely to be life endangering.

### *CENTRALITY OF THE PARTNER*

A man who idolizes his female partner, or who depends heavily on her to organize and sustain his life, or who has isolated himself from all other community, may retaliate against a partner who decides to end the relationship. He rationalizes that her "betrayal" justifies his lethal retaliation.

### *SEPARATION VIOLENCE*

When a batterer believes that he is about t loose his partner, if he can't envision life without her or if the' separation causes him great despair or rage, he may choose to kill. In many cases this is where stalking begins. When the abuser loses control of the victim, stalking puts him back in control. These are often some of the characteristics of a **"Domestic Stalker":**

a) will poison or kill the victim's pets
b) will telephone anonymous threats
c) will harass
d) will wage a psychological warfare against the victim
e) will exhibit hyper macho exterior to hide feelings of inferiority
f) insist on male dominance
g) seems to believe that a tortured relationship is better than no relationship
h) comes from an abusive childhood
I) cannot take responsibility for their actions
j) actions are shrewd and often untraceable
k) is a control freak
I) is easily stressed

### *ESCALATION OF BATTERER RISK*

A less obvious indicator of increasing danger may be the sharp escalation of personal risk undertaken by a batterer; when a batterer begins to act without regard to the legal or social consequences that previously constrained his violence, chances of lethal assault increase significantly.

### *HOSTAGE - TAKING*

A hostage-taker is a risk of inflicting homicide. Between 75% and 90% of all hostage taking in the U.S. are related to domestic violence situations.

### *DEPRESSION*

Where a batterer has been acutely depressed and sees little hope for moving beyond the depression, he may be a candidate for homicide and suicide. Research shows that many men who are hospitalized for depression have homicidal fantasies directed at family members.

### *REPEATED OUTREACH OF LAW ENFORCEMENT*

Partner or spousal homicide almost always occurs in a context of historical violence. Prior calls to the police indicate elevated risk of life threatening conduct.

### *ACCESS TO THE BATTERED WOMAN AND / OR TO A FAMILY MEMBER*

If the batterer cannot find her, he cannot kill her. If he does not have access to the children, he cannot use them as a means of access to the battered woman. Careful safety planning and police assistance are required for those times when contact is required, e.g. court appearances and custody exchanges.

### *DRUG AND ALCOHOL CONSUMPTION*

Consumption of drugs or alcohol when in a state of despair or fury can elevate risk of lethality. Studies indicate that substance abuse is not the reason for spousal abuse but certainly aggravates the situation.

If you conclude that a batterer is likely to kill or commit life-endangering violence, extraordinary measures should be taken to protect the victim and her children. This may include providing transportation and conducting meticulous follow-up. The victim should be advised that the presence of these indicators may mean that the batterer is contemplating homicide and that she should immediately take action to protect herself and should contact the local shelter or police department to further assess and develop a safety plan.

### *ASSESSMENT BY BATTERED WOMEN*

It is important that advocates and criminal justice personnel help each battered woman assess the threat that her batterer poses to her life and safety. Often a professional's confirmation of a battered woman's suspicions impels her to implement her most careful safety plan, and she may go into hiding or flee.

Source: Nashville Metropolitan Police Department - Domestic Violence Division

During on-scene investigations officers should conduct a lethality assessment of present or past incidents. Using a calendar, asks the victim to mark the approximate dates during the past year (if possible) when they were beaten by their abuser. Write on the date how long each incident lasted in approximate hours and rate the incident according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts and/or continuing pain
3. Beating Up, severe contusions, burns, broken bones
4. Threat to use weapon; head injury, internal injury, permanent injury
5. Use of weapon; wounds from weapon

*(1f **any** of the descriptions for the higher number apply, use the higher number)*

1. Has the physical violence increased in frequency over the past year?
2. Has the physical violence increased in severity over the past year and/or has a weapon or threat with a weapon been used?
3. Has your abuser ever tried to choke you?
4. Is there a gun in the house?
5. Has he/she ever forced you to have sex when you did not wish to do so?
6. Does he/she use drugs? Such as "uppers" or amphetamines, speed, angel dust, cocaine, crack, street drugs, heroin or mixtures?
7. Does he/she threatened to kill you and/or do you believe he/she is capable of killing you?
8. Is he/she drinking every day or almost every day?
9. Does he/she control your daily activities? For instance, does he/she tell you who you can or cannot be friends with, how much money you can take shopping, or when you can take the car?

   ___If the abuser has attempted this control and the victim has resisted, check here
10. Have you ever been beaten by your abuser while you were pregnant?
11. Is your abuser violently and constantly jealous (For instance does he say, "If I can= t have you, no one else can?)
12. Have you ever threatened or tried to commit suicide?
13. Has your abuser ever threatened or tried to commit suicide?
14. Is your abuser violent toward your children?
15. Is your abuser violent outside the home?
16. Does your abuser have a criminal record? For what?______________________________
17. Have you ever had your abuser arrested for assaulting you in the past?
18. Have you decided to leave your abuser?
19. Have you left your abuser and then returned?
20. Has your abuser made threats toward the police?
21. Has your abuser stalked you?
22. Has your abuser attempted to or destroyed your household pets?
23. Has your abuser shown signs of depression or is he/she on medication for depression?
24. Has your abuser used or threatened to use arson as a weapon?

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**OFFICER** **DATE**

Source: Used by permission: Nashville Domestic Violence Unit

**DOMESTIC VIOLENCE AND CHILDREN**

IN THE PROCESS OF BATTERING THEIR PARTNERS, PERPETRATORS OF DOMESTIC

VIOLENCE OFTEN TRAUMATIZE AND TERRORIZE CHILDREN:

1. *By intentionally injuring the children as a way of threatening and controlling the victim.* For example, a child may be used as a physical weapon against the victim by being thrown at the victim, or a child may be physically or sexually abused as a way to coerce the victim to do certain things.

2. *By unintentionally injuring the children during the attack on the abused parent when the child gets caught in the fight or attempts to intervene.* For example, an infant may be injured when the mother is pushed against the wall while holding the child or a small child may be kicked when trying to stop the perpetrator's attack against the victim.

3. *By creating an environment where children witness the abuse or its effects.* Research reveals that children who witness domestic violence are affected in the same way as children who are physically and sexually abused. In spite of what perpetrators may say, children have often either directly witnessed the physical and psychological assaults or have indirectly witnessed them by overhearing the episodes or by seeing the aftermath of the injuries and property damage.

4. *By using the children to coercively control the ab used partner while the victim is living with the perpetrator and when the partners are separated* The intent is to continue the abuse of the adult victim, sometimes with little regard for the damage this controlling behavior has on the children.

EXAMPLES OF THE PERPETRATOR'S BEHAVIOR THAT TRAUMATIZES AND TERRORIZES CHILDREN INCLUDE BUT ARE NOT LIMITED TO:

I. Asserting that the children's "bad" behavior is the reason for the assault on the victim;
2. Isolating the children along with the abused parent (e.g., not allowing the children to enter peer activities or friendships);
3. Engaging the children in the abuse of the other parent (e.g., making the child participate in the physical or emotional assaults against the adult);
4. Forcing the children to watch the violence against the abused parent;
5. Threatening violence against the children, pets, or other loved objects. Attacks against any loved objects are particularly traumatic for young children who often do not make a distinction between themselves and the object. Consequently, the perpetrator's attack is experienced by the children as an attack against themselves;
6. Interrogating the children about the abused parent's activities;
7. Forcing the abused parent to always be accompanied by the children;
8. Taking the children away after each violent episode to ensure that the adult victim will not flee the perpetrator;
9. Holding children hostage or abducting the children in efforts to punish the victim or to gain the victim's compliance;
10. Using lengthy custody battles as a way to continue abusing the other parent;
11. Engaging in long tirades aimed at the children about the abused parent's behaviors that "caused" the separation;
12. Demanding unlimited visitation or access by telephone.

CONSEQUENCES OF DOMESTIC VIOLENCE ON CHILDREN

Children may be physically, emotionally, and cognitively damaged as a result of domestic violence, and the effects are both short- and long-term. Consequences of the violence vary according to the age and developmental stage of the child. During infancy, the crucial developmental task is for the child to develop emotional attachments to others. Being able to make attachments to others provides a foundation for healthy development. Domestic violence not only interrupts the infant's attachment to the perpetrator, but it can also interrupt the child's attachment to the victim. The perpetrator may directly interfere with the victim's care of the young child. The perpetrator's violence may not permit bonding between either parent or the child. This results in difficulty for the child in forming future relationships and blocks the development of other age appropriate skills and abilities.

The primary tasks of children between ages five and ten are role development and cognitive development. The perpetrator's violence and pattern of control can impede or derail both of these tasks. For example, a child may have difficulty learning basic concepts in school because of his or her anxieties about what is happening at home.

The central developmental task of teenagers is to become autonomous. This task is achieved as teens separate from relationships with parents and establish peer relationships. Often what is learned in family relationships is duplicated in peer relationships. Consequently, for teens living in violent homes, there is no positive model for learning the skills necessary for establishing mutuality in healthy adult relationships (e.g., listening, support, non-violent problem-solving, compromise). The teenager will sometimes side with the abusive parent, viewing that parent as the one who is more powerful.

Children often express the fear generated by domestic violence in symptoms such as:

+ eating or sleeping disorders;
+mood disorders such as depression and emotional neediness;
+over compliance, dinginess, withdrawal;
+aggressive acting out or destructive rages;
+detachment, avoidance, a fantasy family life;
+somatic complaints;
+finger biting, restlessness, shaking, stuttering;
+school problems;
+suicidal ideation.

The child's experience of domestic violence also results in changes in perceptions and problem solving skills. Young children often incorrectly see themselves as the cause of the perpetrator's violence. They will use either passive behaviors such as withdrawal or aggressive behaviors such as verbal abuse rather than assertive problem solving skills to cope with the problem.

CHILDREN, PARENTING, AND DOMESTIC VIOLENCE

In the face of overwhelming odds, battered women do many things to protect their children from perpetrators: intervening in the perpetrator's violence directed at the children, sending the children to others when they are in danger, teaching the children safety plans, reminding the children that they are not responsible for domestic violence, and being very loving and engaged with the children. Sometimes the victim cannot effectively protect the children from the violence because she is relatively powerless to protect herself.

Many children are not harmed irreparably by experiencing domestic violence in their families. A caring, supportive network can lessen the negative effects to children, helping them rebuild their sense of self as caring, competent beings. Once they are safe, they can return to normal developmental tasks.

Source: Improving the Health Care System's Response to Domestic Violence

## *CHILDREN AND THE EFFECTS OF DOMESTIC VIOLENCE*

Often, the first physical assaults in a relationship occur when the victim becomes pregnant. At this time, she is

more vulnerable and the abuser senses that he will lose his place as the focal point in her life. Abusers often experience children as extensions of themselves. Their focus is narcissistic and they are often unable to provide the nurturing and care that a child needs and are unable to put the needs of the child before their own.

**PRE-NATAL**
increased miscarriages due to increased beatings and/or mother's stress
poor health due to mother's stress and lack of proper nutrition
infants are battered before they are born while in the mother=s uterus

**INFANTS**
crying and irritability
sleep disturbances
digestive problems

**TODDLERS AND PRESCHOOL**
poor social skills,
isolation from peers
failure of one or more grade levels
low self esteem
general aggressiveness, identification with aggressor
violent outbursts of anger
bullying or withdrawn,
dependent or more aggressive than other children or
more withdrawn than other children
impaired cognitive abilities,
physical signs of abuse
delays in verbal development
poor motor abilities, inappropriate dress, poor self care
general fearfulness, anxiety, hyper-reactive
stomach aches, headaches
nightmares, sleep disorders
lack of bowel and bladder control over 3 years old
lack of confidence to begin new tasks

**SCHOOL AGE:**
poor grades, or in special classes
bed-wetting
nightmares
digestive problems, ulcers
headaches (not related to eye strain or sinus)

**TEENAGERS**
poor grades, failure in school, quits
low self esteem
refuses to bring friends home
role reversal / feels responsible to take care of home and mother
runaway / stays away from home or
violent outbursts of anger, destroying property
immaturity, poor judgment, irresponsible decision making
unable to communicate feelings
withdrawn, few friends
nightmares
ulcers, digestive problems
bed-wetting
headaches
severe acne
dating violence: males hitting girlfriends
females being hit by their boyfriends
joining in on abuse of mother