# Casualties Of Violence

## Violence against Women: An Issue of Health

Conference Papers

**Women's Aid**

With support from the Department of Health and Children

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# Contributors

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**Dr Claudia Garcia-Moreno** is a Medical Doctor with a Masters in Community Medicine from the London School of Hygiene and Tropical Medicine. She has worked for over fifteen years in public health in Latin America, Africa and Asia, particularly in primary health care, and women' s health, including reproductive health. She was Chief of Women's Health in the World Health Organization from 1994 to 1998 and is now responsible for mainstreaming gender in the World Health Organization and for work on violence against women. In addition, she is co-ordinator of the World Health Organization Multi-country Study on Women's Health and Domestic Violence against Women.

**Dr. Evan Stark** was a founder of one of America's first domestic violence shelters, the New Haven Project for Battered Women. He has worked in direct service provision for victims of domestic violence, as an advocate for the rights and needs of victims and as a researcher. He co-directed the first major federal research programme on domestic violence in health-care settings and identified domestic violence as a leading cause of female injury and the context for multiple medical and mental health problems. Dr. Stark has written extensively on the issue of domestic violence and health and is co-author of *Women at Risk: Domestic Violence and Women's Health* (1996).

**Dr. Joan Zorza** is a Washington based attorney and has served as an advocate for women who are victims of violence for over 30 years. She has written extensively on topics related to violence against women, including: domestic violence and health, stalking, sexual assault, marital rape and, inter-state custody and domestic violence. Dr. Zorza is founding editor of both *Domestic Violence Report* and *Sexual Assault Report*, leading bi-monthly US publications covering legal developments, research and services in relation to violence against women. Dr. Zorza is a consultant to the International Association of Chiefs of Police and liaison to the American Bar Association's Commission on Domestic Violence. She served on the board of the (US) National Coalition Against Domestic Violence for 10 years and helped to draft sections of the original federal Violence Against Women Act.

# Introduction:
# Health and Domestic Violence in Ireland

## MARGARET MARTIN, MAY 2004.

In February 2002, Women's Aid hosted a conference to highlight the health consequences of domestic violence for victims, the impact of domestic violence on the health system and the important role medical personnel can play in responding to women experiencing violence in intimate relationships. The conference brought leading international experts in the field of domestic violence research together to highlight the health implications for women experiencing male violence and to explore the most effective models of professional and institutional practice in relation to the problem. The conference was the result of the many years that Women's Aid has spent working with both women experiencing domestic violence and health and medical professionals.

Research has shown that domestic violence is an issue for health care providers. According to a recent Irish survey of women attending general practices, 4 out of 10 women who had been involved in a sexual relationship with a man had experienced domestic violence (Bradley et al, 2002). In 1993 Women's Aid and St. James's Hospital carried out a joint research project on domestic violence in the Accident and Emergency Department. The research found that during a one year period there were 119 female admissions as a direct result of an assault by an intimate partner (Cronin and O'Connor, 1993). The types of injuries sustained included bruising, lacerations, fractures, loss of consciousness, attempted strangulation, broken teeth and sexual assault. Of these 119 admissions, 46 women disclosed that the assault was part of a long history of abuse.

According to the World Bank, rape and domestic violence emerge as significant causes of disability and death of women of reproductive age in both the industrial and the developing world (World Bank, 1993). Here, in Ireland, we are no strangers to the most serious consequences of domestic violence. 100 women have been murdered since 1996[1]. 68 of the women were killed in their own homes. Of the resolved cases just under half of the women were killed by a partner or ex-partner. In established market economies, gender based violence accounts for nearly one in five healthy years of life lost to women between the ages of 15 and 44 (World Bank, 1993).

Work on domestic violence and the health sector should not be limited to General Practise or Accident and Emergency Services. It is as relevant to areas such as Maternity Care and Mental Health Services. Pregnancy can be a time of considerable risk for women in abusive relationships. National research carried out by Women's Aid found that 34% of women who had experienced abuse had been assaulted during pregnancy (Kelleher Associates & O'Connor, 1995). Research conducted in the Rotunda Maternity Hospital over a three month period showed that one in eight women attending had been subjected to abuse during pregnancy (O'Donnell et al, 2000). These findings are in line

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[1] These figures relate to the period up to the end of May 2004.

with international research, which has found that pregnancy can be a time when women are at increased risk of abuse.

Mental Health Services must also be able to respond effectively to women experiencing violence in intimate relationships. Women who are experiencing abuse are more likely to suffer from depression and anxiety than non-abused women. In addition, the strategies used in mental abuse can affect the mental health of those experiencing domestic violence. Clearly, the health effects of domestic violence are both serious and wide-ranging, and have implications for health providers in a variety of settings.

Women are overwhelmingly in the majority when presenting to health services with injury due to domestic violence. Research data from the US has shown that approximately 25% of all females presenting to Accident and Emergency Departments are experiencing abuse related injuries (Stark and Flitcraft, 1996). In Ireland, after a friend or relative, the person to whom a woman experiencing abuse is most likely to disclose to is her GP (Kelleher Associates & O'Connor, 1995). However, research carried out in doctor's surgeries indicates that few women are asked about domestic violence by their general practitioner (Bradley et al, 2002). This has obvious health implications. It also has implications for the woman's safety as this information can be crucial if she is accessing protection through the legal system. As violence is so detrimental to women's health, the health sector plays a key role in the service provision, protection and prevention.

The Women's Aid "Casualties of Violence" conference highlighted the need for integration of the work of the health system and the legal system. Through our work on the issue of domestic violence over the last 30 years Women's Aid know that many women experiencing abuse will access the health sector and later access protection through the legal system. In addition, most, if not all, women will access the health system at some stage during their lifetime - whether as a result of illness or injury to themselves, their children or for maternity care. For this reason, medical personnel are ideally placed to identify women who are experiencing abuse by a partner and to intervene to support women.

There have been a number of policy developments in relation to health and domestic violence. The report from the Government's Task Force on Violence against Women (1997) makes a number of recommendations as to how the health service must adapt to respond effectively to women experiencing male violence. *A Plan for Women's Health* (Department of Health, 1997) identified violence against women as a critical area for action. This plan, the first in Europe to consult with women about their experiences and requirements in relation to the health service, sets out a number of actions with regard to violence against women and the health service which mirror the recommendations of the Task Force. The Government's *Health Strategy* (2002) also named violence against women as a key issue.

Women's Aid has worked for a number of years to support health-care professionals in developing a response to women experiencing domestic violence. In 1997, the Women's

Aid Training Unit was formally established in response to the increasing demand for specialist training in relation to violence against women in intimate relationships. As health care providers are most frequently accessed by women experiencing abuse, work in this area was prioritised. We have developed training for staff in Accident and Emergency and Maternity, and for student doctors, public health nurses, and more recently, mental health practitioners.

In 1999, the Women's Aid Training Unit launched a specialist training manual for health professionals. Since then 74 hospital personnel have participated in one of these targeted training courses. As of February 2002, at least one staff member from 25 acute hospitals (of the 38 in the country) had attended. This accounts for 65% of the hospitals around the country who provide emergency medical assistance. All the major hospitals in the eastern, south-eastern and mid-western regions have now participated in these training courses. In October 2000, Women's Aid carried out an evaluation of the effectiveness of this training and the impacts on participating agencies. Two previous training courses were looked at and the evaluation found that participants had subsequently gone on to train approximately 900 other staff from a variety of disciplines within their own agencies.

The continuing work of Women's Aid with the health sector consistently highlights the key role of health professionals in relation to domestic violence and the real differences that individuals within the system can make to women experiencing violence. We have seen a commitment by the health sector to respond to the issue of domestic violence appropriately and we warmly welcome this. However, our work has also raised concerns about the many obstacles within the system which still exist in relation to women's safety such as institutional barriers; issues of confidentiality; documentation; appropriate referral; lack of policies and procedures and a lack of connection to the legal system.

"Casualties of Violence" provided an opportunity to address some of these issues and to examine how the health system can effectively respond to women experiencing violence in intimate relationships. The conference papers are a valuable contribution to our ongoing work to ensure that we respond effectively to women who are living daily with the consequences of domestic violence.

## Works Cited

Bradley et al (2002) 'Reported Frequency of Domestic Violence: Cross Sectional Survey of Women Attending General Practice*', British Medical Journal*. 324: 271-274.

Cronin & O'Connor (1993) *The Identification and Treatment of Women Admitted to an Accident & Emergency Department as a Result of Assault by Spouses/Partners*, *a research project*. Dublin, Women's Aid.

Kelleher & O'Connor (1995) *Making the Links- towards an integrated strategy for the elimination of violence against women in intimate relationships*. Dublin: Women's Aid.

O'Donnell S, et al (2000) ‘Abuse in Pregnancy – The Experience of Women’, *Irish Medical Journal.* Vol. 93, 8, Nov 2000.

Office of the Tánaiste (1997) *Report of the Task Force on Violence against Women*. Dublin: Government Publications Office Dublin.

Department of Health and Children (1997) *A Plan for Women’s Health*. Dublin: Government Publications Office.

Department of Health and Children (1997) *The Health Strategy*. Dublin: Government Publications Office.

Stark and Flitcraft (1996) *Women at Risk: Domestic Violence and Women's Health*. London: Sage Publications.

World Bank (1993) *World Development Report*. Washington: World Bank.

# VIOLENCE AGAINST WOMEN: THE RESPONSE OF THE HEALTH SYSTEM IN IRELAND

MONICA O'CONNOR

It is thirty years since the women's movement created the political climate in which women felt they could disclose the systematic physical and sexual violence they experienced at the hands of male partners. As rape crisis centres and refuges were set up in Ireland, the philosophy and politics of feminism and an understanding that men's violence is always about controlling women's public and private freedom, guided their principles and practice of work with individual women. Over the past thirty years, following campaigns and lobbying by women's organisations, there have been major improvements in the response from statutory agencies and in the State's willingness to accept responsibility for men's violence against women - whether it occurs in public or in private.

However, I would like to address two critical issues today. The first is the difficulty in bringing those feminist principles and philosophy into agencies which come from very different models of work. The second is the challenge of creating safer outcomes for abused women after disclosure within statutory institutions.

Women's Aid has worked closely for many years with nurses, doctors, GPs, social workers and police officers to try to create sensitive and safe responses to abused women. However, committed individuals are not the same as institutional change. In my experience those committed individuals often work within untransformed institutions in terms of power, inequality, attitudes to women and attitudes to holding men accountable for their violence.

Frontline staff in hospitals and police stations are struggling to create good practice with abused women whilst also being over-burdened, under valued and with little time-out for reflection, training or development. They rarely have an input into the management, policies, guidelines or framework of the institution within which they operate. Nor do they have the power to address the gender inequalities within their own workplace.

Policies in relation to confidentiality and recording are dictated by the agency and not the individual practitioner, regardless of their risk for women. Dr. Fiona Bradley's (2002) recently published research clearly demonstrates that women want to be given the opportunity to disclose and to have their injuries recorded. However, we also need to be aware that information is power and there needs to be a very careful introduction of any kind of mandatory recording or reporting without the woman's consent. Women's fears around confidentiality, privacy and controlling the intervention at every level must be considered. It is so critical that we do not attempt to take that control away from women as it is not only dangerous, but it is also likely to block her from being able to disclose.

We need to inform women where that information is going and who will have access to it.

So, even if women do disclose in a safe and sensitive environment, what happens next? Research tells us that for many women the levels of injury, violence, stalking, sexual assault, and even the risk of homicide, escalate after they try to get help or leave a violent partner. Women can be faced with the prospect of poverty, homelessness, endless court appearances, child access difficulties, and in some cases loss of their children. In 1999, 1,714 women sought refuge in the Eastern Regional Health Authority area and only 609 of those women were accommodated (Kelleher Associates, 2001). What is the point in us telling women to disclose if the most basic need of shelter was not there for over 1,100 women when they left?

Who this woman is and the circumstances of her life can also play as much a part in the reactions, attitudes and responses of agencies as the level of risk or violence that she is experiencing. Her economic or educational status, her sexual orientation, her ethnicity, whether she has a disability and her age are all factors which can create discriminatory practice that can impact on the outcomes for her in terms of accessing support and protective services.

The impact of years of abuse may be that women develop addiction or alcohol problems, suffer from depression and develop coping strategies which agencies regard as erratic and difficult behaviour. The danger then is that suddenly the woman herself and her mothering, not the violence or her abusive partner, become the problem and the focus of intervention.

The status of the perpetrator can also be a major factor in terms of how he is dealt with by the various institutions. Research commissioned by Women's Aid in 1999, illustrated that men are far more likely to be criminalised for domestic violence offences if they have criminal records for previous crimes (Kelleher and O'Connor, 1999). In addition, despite a relatively high arrest rate, only between 1 and 6 percent of those arrested for domestic violence incidents receive any prison sentence (Kelleher and O'Connor, 1999).

Finally, I would like to end with some of the challenges we all face. We need to demonstrate that our work is informed by the fundamental principles of the empowerment of abused women, the prioritisation of women's safety, accountability to these women and a strong commitment to anti-discriminatory practice. At each stage of intervention the power to tell or not and the power to act or not, must remain with her.

We also need to move towards minimum standards and minimum requirements an abused woman can expect as a right, from the minute she decides to tread that dangerous road of disclosure. We cannot encourage women to tell if we cannot guarantee them the basic right to protection and justice. In Ireland, we have a long way to go in terms of holding perpetrators accountable particularly where the victim is known to them. The fact remains that in too many instances women regret that they ever broke the silence surrounding their abuse due to the negative consequences and escalated violence they

experienced following disclosure. The challenge for all practitioners is ensuring that at least one outcome for women, following our intervention is a positive experience of increased support and safety.

## Works Cited

Bradley et al (2002) 'Reported Frequency of Domestic Violence: Cross Sectional Survey of Women Attending General Practice*', British Medical Journal*. 324: 271-274.

Kelleher Associates (2001) A *Framework for Developing an Effective Response to Women and Children who experience Male Violence in the Eastern Region*. Dublin: Eastern Regional Planning Committee on Violence against Women.

Kelleher & O'Connor (1999) *Safety and Sanctions: Domestic Violence and the Enforcement of the Law in Ireland*. Dublin: Women's Aid.

# IMPACTS OF VIOLENCE ON WOMEN'S HEALTH: A GLOBAL PERSPECTIVE

## DR. CLAUDIA GARCÍA-MORENO

Health professionals, social workers, police and all the many professions represented here have an important role to play in responding to the issue of domestic violence. I was asked to provide a global overview of the magnitude and nature of violence and its health consequences for women and children. There are many forms of violence against women. I am going to focus on intimate partner violence or domestic violence and sexual violence, which we know are the most common and the most universal forms of violence.

Over the last ten years we have seen violence against women getting increased international recognition. This is thanks to the advocacy and efforts of the women's movement in bringing this to the attention of the world as a human rights issue. We saw it first at the World Conference on Human Rights in Vienna where violence was recognised as a violation of women's human rights. This led to the UN adoption of a declaration on the elimination of violence against women. In 1996 the World Health Assembly (the governing body of the World Health Organisation which brings together Health Ministers from 190 countries) recognised and included violence against women and children as a public health concern.

The UN Declaration on the Elimination of Violence against Women provides a definition of violence against women as: "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to a woman, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life". It goes on to describe the many forms this can take, including country specific forms of violence, such as dowry related murder, female genital mutilation and other traditional practices. It also includes trafficking in women and forced prostitution. With many of these forms of violence we are all at the early stages in terms of understanding and compiling information on their magnitude and the forms they take.

We define intimate partner violence as a pattern of assaulting and coercive behaviours including physical, sexual and psychological attacks as well as economic coercion used by adults or adolescents against their current or former intimate partners. It can take many forms and we are getting better at capturing physical abuse and sexual abuse. However, we still have many problems in capturing emotional abuse, how economics can be used in violence and the use of children to control an adult victim.

I will move to the focus of my paper which is to provide an overview of the data on the magnitude and characteristics of the problem from a global perspective and to talk about the health consequences, particularly the sexual and reproductive health consequences. Much of what I am going to say is based on the work of Lori Heise and Mary Ellesberg, who completed a review of published and unpublished literature at the end of 1999 to

collate the information we have on violence against women and its health consequences worldwide[2].

When it comes to talking about the dimensions and the magnitude of the problem we have a lot of difficulty in comparing the results of studies across countries. Studies use different definitions of violence, they use different time spans to measure violence, they look at different samples of women. Some look at women who are married or partnered, some look at all women, some look at women who are currently in a relationship and others look at women of different ages. This also makes it very difficult to produce estimates as we do for other health problems. One of the areas that the World Health Organisation is working on is developing methodology to capture violence in a way that can be compared cross-culturally.

Reviewing some of the population based surveys, the figures we have for lifetime rates of physical abuse by intimate partners vary from 10% to over 50% of women, depending on the country that we look at. When we look at 12 month rates the variation is from around 3% of women, to much higher rates, 23%.

Sexual abuse in childhood is even harder to document and most studies ask adults about their past experiences of childhood sexual abuse. We find, like intimate partner violence, a wide variation in the prevalence rates depending on the methodology used. However, using studies reported in international journals during the 1990's, a mean lifetime prevalence rate of childhood sexual victimisation has now been estimated: women as girls 19% and men as boys 7%. We also know that women and girls experience violence particularly from people they know and within the boundaries of their home.

We know from studies on intimate partner violence that physical violence rarely occurs on its own. Usually, it is accompanied by sexual and emotional violence. Studies in the USA show that 40%-45% of physically abused women are also forced to have sex by their male partners. Forced sex is common in abusive intimate partnerships. When the International Centre for Research on Women did a qualitative study in 15 countries on women's HIV risk, respondents frequently reported being physically forced to have sex or to engage in types of sexual activity they found degrading. In a study in India, 29% of men admitted to forcing their wife to have sex against her will, and of these, 23% admitted to using physical force. Worldwide studies show that refusing a man sex is considered, by both women and men, to be one of the more commonly justified reasons for violence.

Focussing on adolescent sexuality and health, many studies show that a lot of young women report that their first experience of sex was forced or against their will. In a South African study of 191 teenage mothers attending an ante-natal care clinic, 32% reported that their first sexual intercourse was forced, 11% reported having been raped and 78% said that the consequence of refusing sex would be a beating.

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[2] Unless otherwise stated figures cited can be found in Heise, L, et al (1999) 'Ending Violence Against Women', *Population Reports*, Series L, No. 11, Baltimore: Johns Hopkins University School of Public Health.

What are the causes of violence? In the past there has been a tendency to try to find a cause such as alcohol or a family history of abuse. Nowadays we are working with more sophisticated models that allow us to look at several factors, not just for risk, but also factors that are protective at different levels: at the level of the individual, the relationship, the community, the society and also to look at the interaction among and across the many factors. In relation to the individual, we have factors such as witnessing marital violence as a child and being abused in childhood. In relation to the family we have factors such as male dominance in the family, male control of wealth and the use of alcohol. At the level of the community, we can look at levels of employment and crime, isolation of women in the family and the availability of services. And at the level of society we need to examine norms around male dominance, values and social norms of violence as a form of chastisement and male entitlement over women generally. All of these have been shown to have an impact either in protecting against violence or putting women at increased risk.

When we look at studies across the world, some commonalities that are emerge. One is that violence occurs in the context of jealousy and control. This has been documented in studies that are culturally diverse. Even in cultures where male control of female behaviour is the norm, violent husbands are found to be more controlling than non-violent men. Another clear commonality is that violence against women is a product of gender inequality. Certain issues are consistently associated with this violence: norms of male entitlement and ownership of women, male control of wealth in the family, notions of masculinity tied to male dominance and honour and male control of decision making.

There are clear differences in the meaning given by women and men to violence at the level of cultural acceptability. In large parts of the developing world wife beating is seen as an acceptable form of correction. Evidently, there is much work to be done on those social norms that condone violence. The attitude that beating is acceptable as long as it is for a just cause and that acceptability depends on who does what to whom is still very evident in the world. For example, there are studies in Egypt and Ghana, where 70% of women will say yes, it is acceptable for my husband to beat me if I don't do x, y or z.

So, why should we be looking at violence against women as a health problem? This is the question I had to answer when I started working in the World Health Organisation. We now have more and more evidence that gender-based abuse is a major cause of disability and ill health for women, and that health providers are uniquely placed to assist and provide support to victims. We also know that violence has a significant impact on health care services and on costs which are often unidentified. The field of public health and health promotion offers useful skills and learning from tackling other health problems. This can be helpful in the context of a multi-sector response. Although the World Health Organisation emphasises and focuses on the health sector, we are very clearly aware that no sector can deal with this problem alone and that it requires the intervention of a wide range of sectors in a co-ordinated manner.

Violence in the medical field was initially looked at in relation to injuries. We are trying to move away from that, to conceptualize violence as a risk factor rather than as a disease or a condition that needs to be identified or diagnosed. Compared to non-abused women, women who have been abused have reduced physical functioning, more physical symptoms, report worse subjective health, need more lifetime diagnosis and have higher healthcare utilisation. And this is not necessarily always related to the violent event, but over time and persisting, even after the violence has ended.

What are the health consequences of violence against women? There are fatal outcomes, including homicide, suicide, maternal death, death during pregnancy, and HIV related deaths. However, there are also a wide range of non-fatal outcomes from the violence, including physical and mental health problems for women that put them at risk, and there are significant consequences for women's sexual and reproductive health. There are also health consequences for the women's children. The violence can affect their emotional well being and result in behavioural difficulties, injuries, homelessness and low birth weight. While violence is an important cause of injury for women, injury is not the most important or the most predominant consequence of violence. Many of the other significant health consequences are often ignored or blurred by the focus on injury. So, yes, injury is very important, as it is with these injuries that women present to the services. However, there are many other health consequences of violence against women. If physicians, nurses and healthcare providers had violence as one of the risk factors, it might lead to a better response to the problem.

Violence has serious consequences for reproductive health. It leads to unwanted pregnancies, undermines contraceptive use, reduces women's sexual autonomy and contributes to adolescent pregnancy. The fear of violence can lead to a lack of discussion about family planning and use of contraception. In a study from Ghana, a woman said that she cannot even speak of family planning in passing to her husband. Whenever he hears people discussing family planning on the radio, he gets so angry, he fumes and shouts. She said that "if he can threaten a wireless, what would he do to me if I broached the topic". In that same study, 51% of women and 43% of men agreed that a husband is justified in beating his wife if she uses family planning without his permission. Violence reduces sexual autonomy. In an Indian study of 98 currently married women, 68% reported being coerced into sex by their husbands, and 31% reported being forced through beatings. In many parts of the world, marriage is interpreted as granting men unconditional rights to sexual acts with their wife - rights that they can enforce through violence if necessary.

Violence has also been associated with a wide range of gynaecological problems: vaginal bleeding, vaginal discharge, painful menstruation, sexual dysfunction, pelvic inflammatory disease, painful intercourse and chronic pelvic pain. And here again the role of health providers, particularly gynaecologists and obstetricians, needs to be worked on to identify violence as a risk factor. 3%-20% of women record being abused during pregnancy and the World Health Organization is now finding even higher rates in some areas. For many women this is a continuation of ongoing violence. However, for a group of women, between one third and one fourth, violence may only begin during pregnancy.

Violence has been associated with a wide range of adverse pregnancy outcomes, including late entry into pre-natal care, increased smoking and drug use, vaginal and cervical infections, premature labour, miscarriage, abortion, bleeding during pregnancy and low birth weight.

Given all that we have heard, it is not surprising that women who are abused tend to use health services more than non-abused women. International research has found that women who experience violence are more likely to go into hospital, more likely to have surgery and likely to have more outpatient visits than women who had not been exposed to violence.

So, what can we conclude from all this data? Physical and sexual abuse of women and girls affects a significant proportion of women around the world. A history of abuse increases a woman's risk of a number of negative outcomes and also impacts on the health of her children. The healthcare setting presents an important opportunity for intervention. However, having said that, there is balance to be struck between the health sector becoming more involved in the area and falling into the trap of medicalising the problem. I am constantly aware that while I want the issue to be more visible and I want people in all areas, whether it is mental health, HIV or reproductive health to take on this issue, we have to be very careful. We must ensure that we do not transform the woman into the patient and turn the problem, which is a social problem with many complexities, into a medical problem. We must not lead health providers to think that we alone can somehow solve the problem, as we are trained to do. As health providers we are trained to think that we need to solve people's problems and to find cures. However in relation to domestic violence we must find ways of contributing to the solution and supporting women, while also keeping her safety, empowerment and right to make her own decisions foremost in our minds.

## Works Cited

Heise, L, et al (1999) 'Ending Violence Against Women', *Population Reports*, Series L, No. 11, Baltimore: Johns Hopkins University School of Public Health.

UN General Assembly Resolution 48/104, *Declaration in the Elimination of Violence against Women*, 20 Dec 1993.

# The Response of Health Systems to Violence against Women: Lessons Learned and Models of Good Practice

## DR. EVAN STARK

I want to start, with a case to recreate some of the dilemmas we are facing. This woman's name was Terry Trafficonda. We had what is called a Wrongful Death Suit against the city brought by Terri Trafficonda's sister and I was an expert in the case. A Wrongful Death Suit means that something the police could have or should have done that evening would have made a difference and perhaps saved Terri's life. In my investigation what I found out was that for a week before the killing Terri had not been allowed access to the upstairs bedroom. She had not been allowed access to food except for a couple of slices of cold pizza. She had not been allowed access to her son. She was not allowed to go to work. She was not allowed to go to the upstairs bathroom and the downstairs bathroom had no toilet paper. She was not allowed to access the phone. There was evidence in the autopsy report, based on injuries on her legs etc, that there had been previous assaults so this was not an isolated incident. The lawyer for the town asked what the police could have done differently. His point was, and it struck me and I hope it strikes you, that until he shot his wife that night, Nick Trafficonda had not committed a serious crime in my State of Connecticut or any state in the United States, or this country, or Western Europe or virtually any country in the world.

And that is where I want to begin, because we need your help in health, just as we need your cooperation in justice. We will work with you collaboratively to close the gap between what battered women experience and what the law defines as the crime of domestic violence.

First of all, I do not want to in any way under-play the incredible achievements we have made over the last thirty years, in the area of domestic violence. But, to a certain extent, our domestic violence revolution has stalled and, as you saw, even though so many men are being arrested, virtually no one is going to jail. So if you believe that the deterrence depends on giving men the message that they will be held accountable for their act, what message are we sending them when only one out of a hundred calls actually results in any kind of significant sanction?[3]

One of the questions we have to ask ourselves today and think about together is whether we want to think about the woman in the poster with the black eye and the broken nose as a typical victim. Or are we going to understand the regime of terror that is created by constant physical intimidation even if there are no broken bones. One of the lessons I

[3] See Kelleher & O'Connor (1999), p.7 for information on arrest and conviction rates in Ireland referred to here.

hope you take away today is that if you wait for physical injury to walk in the door of your general practice or into your emergency room or your obstetrical setting, you will miss 99% of all physical abuse in your practice.

We do not have time here today to talk about the issues, at least in the detail that they deserve, involving domestic violence and children. I want to report a very frustrating outcome: the removal of children from victims of domestic violence has increased, not decreased. While many battered women have now been freed from prison or acquitted in trials where they responded justly to assaults on themselves, the fact is that thousands of battered women are still going to jail and are still losing custody of their children. So the domestic violence revolution has stalled, in some sense.

Domestic violence is a crime not so much against women's bodies but against women's freedoms and independence and autonomy. You cannot get involved in women's health without getting involved in the politics of sexuality. This simply means recognising the strengths of the women we are dealing with, how those strengths are so often quashed and crushed and also recognising that unless we emancipate these strengths our nation suffers. Because without 50% of our nation contributing as fully independent autonomous human beings in every area of their life, 50% of our quality as a people is lost.

Let me back up a little bit and give you some sense of where we have come from, at least in the health area. Thirty years ago, Dr. Flitcraft and I went into the emergency room at Yale New Haven Hospital and we started to read medical records - thousands of medical records. When a woman walked in with an injury in our community thirty years ago, the assumption was that unless she said that she had been mugged or assaulted, she had been injured accidentally. Let us assume that every health problem women bring to us is political in origin unless they prove it. So if the medical records said that she had been kicked by foot, or punched by fist, or stabbed with knife, we assumed that there was somebody at the end of that foot or weapon. We put those things back into context. We discovered that domestic violence was the leading cause of injury for which women sought medical attention. This was significant because up until that time it was widely believed that auto accidents and other kinds of accidents were the major causes of women's injuries. Now we saw that women's injuries had to be located in women's lives and in the politics of sexuality in their lives.

So we began to think more about these issues and began to look at the women's medical histories. We found 18% of the women in our sample were battered and, if you look at the 1995 study in Ireland, 18% of the women were identified as victims of domestic violence (Kelleher and O'Connor, 1995). Why are these statistics important to you? What is important is that you set that statistic as a goal standard for you in your own practice; that you go back and when you start asking you think "if there are 18% in Dublin wouldn't there be 18% in, say, Carlow?". The way I started was with every record that had "hypochondriac", or "well known complainant". Almost every woman, about 85%, who had that label turned out on inspection to be a battered woman.

But what was interesting about injury, and what contradicts the model of the woman with the black eye on the poster is that the battered women's injuries tended to be much less severe than the injuries of non-battered women when they came in. The typical battered woman's injury was not medically significant. What is remarkable about abuse is that although it does cause serious injury and death, there is no question about it, what is typical about the injury pattern in battering is that it tends to be repetitive and relatively minor.

That does not mean that having your hair pulled and being slapped and pushed is a minor activity, but it is not something that is going to impress you in an emergency room and it is not something that is going to impress the police. So, again, if you wait for injury, if you wait for visible injury or even complaints of injury you are going to miss it all until you have the long history and the complicated history. The other remarkable thing about the injuries was that they tended to be sexual in nature, not just because rape or sexual assault was accompanying the battering, but because the pattern of injury - the breast, the abdomen, the mouth - all talk to you about the politics of sexuality in that home: he was trying to shut her up, he was trying to hurt her baby, he was trying to stifle her sexuality. 40% of the women we are talking about are assaulted two and three times a week, in many cases over several years, sometimes five and ten years.

We began to look at these patterns, in the emergency room because we had the mistaken belief that battering was a crisis, an emergency. What we have found since is that the rates of abuse presenting at primary care settings are actually higher than the rates we discover in the emergency room. The most recent Irish study shows 39% of women visiting general practice had experienced domestic violence, which is about twice as high as what we see in the emergency room (Bradley et al, 2002). The next and most important step we took was talking not only about physical injury, but looking at a range of medical problems. We talked about the chronic pain syndrome, the headaches, the twisting injuries, the kind of things they cause, but what we also discovered was that battered women in our case load had a highly disproportionate risk of a range of psychosocial and behavioural problems.

In our studies, abused women were five times more likely to report child abuse, fifteen times more likely to report substance abuse or alcoholism, nine times more likely to abuse drugs than non battered women and six times more likely to attempt suicide. When we first discovered these statistics the obvious explanation was that these were multi-problem women. So we asked the question which came first, the battering or this disproportionately high risk of psychosocial problems. The answer is that the risk only followed the first presentation of an injury to our hospital and in that case the battering may have been going on for some years. We discovered that 45% of female alcoholics we studied had a history of domestic violence. When we looked at all the women who attempted suicide in our hospital we found that almost 30% had a history of domestic violence.

When a woman developed alcohol or drug abuse we were inverting cause and effect. You can find a long history of domestic violence on a woman's medical record and then at the bottom a carefully written note that it is secondary to alcohol abuse. In other

words, instead of seeing the violence as the cause of the substance abuse, the substance abuse or the mental health problem was seen as the framework for everything else. Then, what we were doing was referring to psychiatry or referring to alcohol or drug treatment. More often than not we were referring her to some form of family or group treatment in which her abuser was being enlisted as her caretaker. So we were completing the cycle of entrapment which the batterer had started and for which the women came and sought our help to relieve.

I want to sum this up in a question. Think about men who are assaulted. Even men who are assaulted by women. How many of the men that you see in your practice who have been assaulted attempt suicide, or develop alcohol problems, or drug problems, or become psychotic or depressed, as a result of the assault? In fact, there is no chronicled description of a male population who, as a result of violence, end up developing these problems, except war veterans. In the States we have a theory called "learned helplessness". It says that women get hit on the head so often that eventually they stop seeking help. They blame themselves, they withdraw, and they become passive. That was all well and good until you looked at the evidence that they were pouring into the general practices and into the shelters and into the emergency rooms. If anything, we had learned helplessness, not them.

Battered women are not simply being physically violated. In the spaces between these episodes of abuse we are now learning that there are patterns of coercion and control which create an almost hostage-like situation in which the most fundamental liberties are being violated, in the most comprehensive and fundamental ways. Even though the law defines domestic violence as episodic, women report their experience of abuse as ongoing. What makes a battered woman is not the violence. What makes a battered woman is the constructive inability for her to escape and that is what we have to start understanding when we interview, when we assess.

First of all let us talk about isolation. You rarely have domestic violence without a woman being isolated. What we mean when we say isolation is that she is isolated from the moorings of social identity, isolated from work, isolated from mates at school, isolated from friends, isolated from family and isolated from you. When a woman comes to see you she is coming against the odds. It is an opportunity to begin to look at her whole life through the prism of that single visit as just the tip of the iceberg. Isolation is a systematic problem and self-isolation is a big part of it which makes battered women feel guilty. She is trying please him so she quits the job or she comes home directly and does not go out with her friends or she does not go to school. So it seems like she, in fact, is dependent or infantilising herself when, in reality, she is merely accommodating the threats and the abuse. Often isolation is the first sign long before there is violence.

Violence is about power and control. What we understand is that control is the primary means of inflicting battering, not just the end, but the means. We are talking about control that extends to everything. From the basic: sex, where, how, when, with whom, how often; food; driving. To the most trivial: the TV changer; how you wear your hair; how you dress. I will give you an example. Lisa is a graduate of a very prestigious

organisation. And when I interviewed her she had a diagnosis of obsessive compulsive. I asked Lisa what she did that was obsessive and compulsive. She told me that she colour coded all her clothes in the closet, she alphabetised her CDs, she vacuumed until you could see the line. I asked Lisa if she had been like this as a teenager. She had not been - as a teenager she was a complete slob. When I asked her when it started she reached into her briefcase and took out what her boyfriend calls "the rules". She then described how he gave her this list of rules while going from room to room and detailing how the bedcovers had to be so many inches above the ground, the food had to be in such size dishes etc. The rules, to me, symbolised that the very infrastructures in which some women live their lives are as significant and as comprehensive as any regime of physical abuse or terror and which combined with isolation and intimidation create a framework within which ongoing physical abuse is almost inevitable.

As long as we maintain an injury definition of domestic violence, namely thinking that the more severe the injury the more severe the battering, I believe that we will continue to see the low rates of arrests and identification that we currently see. Something we have to watch out for is the tendency to misidentify and to see these women as inappropriate users of services or as people who are over using the services. And the tendency to respond to that by using the labels we all use as nurses, as social workers, as physicians to distance ourselves from these women. The labels do not so much describe the women as give us a kind of protection and they have another function particularly when we write them down. Namely to isolate women from services. Each of those steps, the failure to identify, the misidentification and the labelling reproduce what the batterer himself is doing in the home and reinforces the entrapment we are talking about.

Many of the symptoms are not specifically identified with a physical act but, again, can be tracked back to strategies of intimidation, isolation or control. I want to reiterate that in these cases, control occurs in such basic areas of women's lives that they are invisible. Women who bring symptoms of coercive control have no easy way to talk about what is part of their normal lives with men. Most men can easily identify with a helpless woman who was victimised by domestic violence, a judge can take pity on her when he sees the bruises and the injuries. It is much more difficult for men, or even women, to see coercive control as an extension of the normal prerogatives that most men continue to exercise in our communities.

We can provide a million trainings and give you all kinds of diagnostic tools, but in the end it is just going to be a question of whether you are going to turn to a woman who is in front of you and ask her if there is anybody in her life who is making her afraid, or controlling what she does, or hurting her. And those three questions about fear, control and physical injury are intimately related or correlated. If a woman answers "yes" to any of those three questions you have to start thinking about services, thinking about enhanced advocacy and moving to intervention. We are simply giving women permission and words to talk about experiences which are very difficult to articulate within the context of what I would call normal pathology, because these things are so normal that, again, I think they are largely invisible.

Let me now turn to talking about identification or, at least, the clinical encounter. Clinical violence intervention is not just a skill or a question; it is a whole framework within which to practice health care once violence has been identified as an issue by a patient or a client. And the secret, I believe, to successful intervention and healthcare is to normalise and mainstream. I believe that the skills you already possess are sufficient for you to do the job. You do not need some great new secret skill - maybe just a different question or two.

Mainstreaming refers to making clinical violence intervention part of routine patient care. It is part of what patients expect when they come to see us. That is when they walk in the door they should see their face on the wall. When they walk into the restroom, when they walk into the waiting room, when they are triaged, when the nurse is giving them the initial forms to fill out, they should recognise that this is a place where it is appropriate to talk about domestic violence. The literature should be available and the conversation should be part of the environment. Mainstreaming also means integrating sensitivity to partner abuse into the clinical response, through a whole spectrum of medical and behavioural problems that can be caused and aggravated by battering. So it means that you are talking about domestic violence when you are talking about substance abuse, when you are dealing with homelessness, when you are dealing with STDs, when you are dealing with child abuse.

Identification relies on an inclusive definition of coercion and control. We find that if a woman's fear level is high, even if her level of injury is low or non-existent, then that is an extremely dangerous situation. A woman's fear level is the single best predictor of the danger she is in, even more powerful than whether there is a gun in the house or whether she has had a previous hospitalisation from an assault. Even if the woman says "no", routine questioning underlines the fact that violence is a concern for health.

So asking the question is not just designed for identification, but it is patient education and it is part of our community responsibility in health to do that assessment. The key to assessment, from the point of physical violence, is what we call the adult trauma history. That means you need to take a comprehensive assessment of all the injury visits the woman has had as an adult to any health facility. One way to do that if there have been lots and lots of these is to do the first, the most serious and the most recent assault and then you can continue to review that history with each subsequent visit. I tend to use very open-ended questions about coercive control in talking about relationships. What you are talking about is a man who has selected his control tactic for this particular woman and, unless you provide an open-ended opportunity for women to talk about what it means to them, you will never get her story.

An important predictor of danger in this situation is a change in the routine. Something new has happened. He has violated an order of protection, he has introduced a weapon into the house. Safety planning means building on the skills and strategies that women have already used. It involves regular feedback through primary care settings and visits and following up with each subsequent visit to see if the things you talked about have worked, if the situation has changed.

This is a chronic situation. Domination is not going to go away tomorrow. It is being dealt with at a whole range of levels. And all of you are adding to it as health providers with the idea that the quality of life of women who experience violence as human beings, their contribution as citizens to the country's future, as well as their dignity as women, is something that you care about and will work together with her to enhance.

## Works Cited

Bradley et al (2002) 'Reported Frequency of Domestic Violence: Cross Sectional Survey of Women Attending General Practice', *British Medical Journal*. 324: 271-274.

Kelleher & O'Connor (1995) *Making the Links- towards an integrated strategy for the elimination of violence against women in intimate relationships*. Dublin: Women's Aid.

# On the Stand: Health Professionals as Expert Witnesses

## DR. JOAN ZORZA

I want to talk about testifying in relation to domestic violence. It is really very simple – get it documented in the medical charts. If it is not in the medical chart it is going to be very hard to recreate after the fact, especially if you work in an Accident and Emergency Unit. Indeed, someone who sees a large number of patients is going to have difficulty remembering a lot of the detail. Remember that battered women are afraid. She is afraid of her batterer and she probably does not think of herself as a battered woman. That is why you are going to ask about the specific behaviours to find out what he is doing to her. She has lots of fears and they are all very, very realistic.

Why are you going to even bother to document the domestic violence? Well, first of all, having it in her chart will help to validate it for her. It is also going to help her realise what it is doing to her and that it is far more serious, certainly, than her abuser is letting her know. If the chart ever gets sent over to either the police or the prosecutors, they are going to have a much better idea of what is going on and they can take her abuse much more seriously.

So how are you going to document it? You obviously need to ask her about the domestic violence. You should also be asking about sexual assault. She will not call it rape, she probably will not call it sexual assault. But if you ask her if he is forcing her to do things sexually that she does not feel comfortable with, or if she is she being forced to do anything at all that she is not comfortable with, you may find out that there are a lot of things he is forcing her to do.

How do you write up the testimony that you have elicited? Avoid abbreviation. Use medical terms but not legal terms. For example, domestic violence is not considered a medical term, it is a legal conclusion that the court has to make. The same is true with words like alleged or suspect which are not medical terms. Alleged is going to imply you do not believe a word she says. Always use quotation marks around what she says.

There are some situations where there really is nothing visible to document. But, nonetheless if she has said that her partner beat her up, document what she says anyway. Bruises, for example, often take a matter of hours or even a couple of days, before they really come up. You may need to encourage her to go and have any bruises she gets photographed, it will show that it was consistent with her story. Taking photographs is good. It is best to use a ruler to show how big it is, what the extent is. If you do not have cameras available use a body chart. Besides the type of injury document her demeanour, how she looked and acted and especially if she was in shock, or if she seemed really upset.

Much more difficult are the denials that she gives when she tells you that she fell, or banged into a door, and you know, or you doubt that that is the case. You may want to put it into the chart that it is inconsistent and why. There are a lot of people who can explain why battered women are too terrified to acknowledge domestic violence. Even though you have pulled her into your examining cubicle and pulled the curtains, it is not very sound proof. You are not aware how far away he is and she certainly does not know, so she may not feel free to speak up and that is always another problem.

I want to talk about strangulation because I know people have not always taken these cases seriously enough. Most women will not come in and say that their partner tried to strangle them. She may use the word choking but she probably will not say strangling, because strangling sounds homicidal. She may act like she is hyperventilating or having an asthma attack or a panic attack. It is very common for people who have been strangled to have trouble talking, and their voice may be obviously raspy or hoarse.

Research in San Diego, California, looked at several hundred cases where women had alleged they had been choked – clear strangulation cases. They found that many of the women had been sent home, even if they had gone to hospital or to the doctor. Even in cases where the women died, many did not die for a day, two days or three days, and a few actually a little longer than that (Gael et al, 2001). He does it for one of two reasons – to kill her or to let her know that he could kill her if he wanted to.

There are three ways of strangling. One is hanging, which leaves very obvious signs. Second is a ligature or garrotting which may well leave a distinctive mark, depending on what was used. The third is manual, which not only involves the hands but could be an arm choking or even a leg around her neck. These cases, at least in the U.S., amount to 10% of all domestic violence homicides. There are virtually no men ever killed by strangulation. It takes very, very little pressure to do and for relatively short amounts of time. It takes only ten seconds before she is likely to pass out and after fifty seconds of being starved of oxygen she will probably die or at least be very badly brain damaged.

The signs of strangulation are subtle and very unusual, but over half at least will have voice changes as I mentioned. She may have a lot of trouble swallowing, or pain, or say that it feels like there is a lump. Some women can only keep the air coming in if they lean over. Look for fingernail scratch marks which could be on his hands, her hands or her neck. He may also have left pattern marks, especially if he was wearing jewellery.

What should you be doing about her fears? Obviously she needs safety. Her fear is that he is going to retaliate. All of these things are realistic. Document her fears, her abuse and especially her strength as a parent. Her fears that he is going to take the children are not unrealistic. Clearly refer her to Women's Aid. I cannot stress that enough. What is not to be recommended is couple counselling or mediation. These are only going to give him further excuses to blame her. Also, what does not help her is failing to take protective orders seriously, sending her to a therapist who has no idea about domestic violence, not assisting her to develop a safety plan, not believing her or supporting her and blaming her.

## **Works Cited**

Gael B. Strack, George E. McClane, Dean Hawley (2001), ‘A review of 300 attempted strangulation cases part i: criminal legal issues’ and ‘A review of 300 attempted strangulation cases part II: clinical evaluation of the surviving victim’, *The Journal of Emergency Medicine*, vol. 21 (3).
303 -- 309