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# Domestic Violence...Myths and Barriers

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*The past 15 to 20 years have seen the birth of a new national awareness of the impact of family violence on our national health and resources. The Surgeon General of the United States has identified domestic violence as the nation's number one health problem. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has mandated, as of January 1992, that all emergency departments and ambulatory care facilities establish guidelines for the identification, evaluation, management and referral of adult victims of domestic violence. In June 1992, the AMA published guidelines for identification and intervention with domestic violence victims. All states now have provisions in their laws that define marital rape as a crime, and many states have mandatory arrest statutes for men found by the police to be abusing their wives.*

*This review identifies some common societal and professional barriers limiting the emergency response to domestic violence.*

## Myths

A substantial obstacle to intervention is the abundant social and cultural biases which pervade medicine and society as a whole. Left unchecked, they can easily cloud the judgment of physicians evaluating victims of domestic violence. Some common myths are refuted below.

**Myth:** Intimate abuse is isolated and infrequent.

**Fact:** The problem is currently recognized as being of epidemic proportions.

**Myth:** Only poor and minority men beat their wives.

**Fact:** Domestic violence shows no greater affinity for the lower socioeconomic groups or minorities. The difference appears to have more to do with reporting and the accessibility to resources. Women of greater means tend to have more options available to them for dealing with the problem. Women without such resources are more likely to turn to public agencies for help.

**Myth:** Just as many wives batter their husbands as men batter their wives.

**Fact:** In fact, 95 to 99% of domestic violence victims are women. Although not exclusively female, the overwhelming majority of battering victims are women.

**Myth:** Abuse victims exaggerate their injuries.

**Fact:** Most battered women minimize their injuries. They are usually not candid about the source of the injuries due to their shame and embarrassment.

**Myth:** Battered women provoke their abuse.

**Fact:** Abusers often claim they were provoked in order to avoid accepting responsibility for their actions. This enables them to see themselves as victims and continue their behavior. Additionally, some women, aware of their abuser's cycle of violence, may provoke an argument in order to diffuse the building tension and stave off even worse abuse they may feel is yet to come.

**Myth:** Drinking causes battering.

**Fact:** Alcohol is involved with battering about 50% of the time but is not the cause. Studies have shown that a third of abusers are abusive only when they drink, a third are abusive—drunk or not, and a third don't drink. Drinking is not a cause of battering but an excuse that abusers use to deny the abuse is a problem.

**Myth:** Only sick or psychopathic men beat their wives.

**Fact:** About 20% of men who batter are violent with others as well as their family. The other 80% are not. They are often well-liked and appear attentive with their mates publicly. Since they may be seen as the "perfect husband" by others, the women's stress over escaping the relationship is heightened. Victims are afraid no one will believe them. Unfortunately, they're often right!

**Myth:** If a woman wanted to stop her husband from beating her, she would act differently.

**Fact:** Battered women usually find that regardless of their behavior with their partners, the battering continues and usually escalates. This illustrates a major pitfall of "blaming the victim." It is easier to believe that the woman has somehow incited her own abuse. Otherwise, if domestic violence is a random event totally out of the victims' control, what's to keep us or those close to us from becoming victims as well? This myth is difficult to erase. Nevertheless, refuting it is crucial to breaking through the barriers to provide appropriate intervention for these women.

**Myth:** If things were really that bad, the woman wouldn't stay; therefore, she must like it.

**Fact:** Many women do leave abusive situations. Women's shelters are always filled to capacity. Those who stay do so for a variety of reasons. She may think he'll change or that she loves him enough to "make it work." She may be afraid of not being able to support herself and her children without a job or the skills to get one. She may think once he realizes what he's doing, he'll stop. She may be afraid of retribution with her, the children or other family members and friends. She may not want to break up the family. Her attempts to seek help from the police, courts, clergy, family, friends, etc. are often met with denial and/or disbelief. She may be severely isolated from friends and family (contacts who could help her). Most importantly, she believes him when he says he won't do it again.

**Myth:** Domestic violence does not affect children.

**Fact:** It is clear from all reviews of statistics that this is not the case.

**Myth:** If you are pregnant, you are safe from abuse.

**Fact:** It is not uncommon for the first incident of abuse to occur during pregnancy. Women who are abused also frequently notice escalation of abuse during pregnancy.

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## **Barriers to Physician Intervention**

### **Lack of knowledge and Education**

Physicians aren't trained to recognize the subtleties inherent in the history and physical examination of victims of domestic violence. This difficulty is partly due to the limitations of the "medical model." It teaches us to break every problem down into the most basic and definable physical entity. Thus, the diagnosis becomes: periorbital contusion, colles fracture, multiple contusions, nonspecific abdominal pain, closed head injury or laceration etc., rather than addressing the larger issue of assault—whether domestic or otherwise. The history becomes ahistorical and decontextualized. Therefore, the chart may state "blunt trauma to head, indoors" rather than "head slammed against wall by husband at home."

Victims may have multiple visits to the Emergency Department (ED), often for nonspecific complaints with the occasional smattering of "real" illness/injury. Rather than recognizing this pattern as symptomatic of domestic violence, physicians may label these patients as "neurotic", "hypochondriacal", "hysterical" or "crocks". In this way, the victim's feelings of powerlessness and low self-esteem are reinforced. Proper training regarding these patterns of presentation can help to overcome this barrier.

### **Limited resources**

Although improving, the availability of medical and community, resources remains inadequate. Those community and hospital resources which do exist are frequently operating at maximum capacity. More shelters, safe houses, social services, drug and alcohol treatment centers and rehabilitation facilities, legal assistance and support groups are needed. The relative lack of those resources is a major source of frustration for those emergency physicians engaged in attempting to impact on this issue.

### **Societal Misconceptions and Cultural/Personal Biases**

Individual experiences and upbringing necessarily affect a physician's management of domestic violence. The nature of the issue makes it difficult to remain impartial and objective. With little training regarding proper management, we fall back on personal experience for direction. A number of commonly held myths and misconceptions have already been discussed. Additionally, there is the temptation to view domestic violence as a private matter that is best resolved privately—especially in the context of little or no physical injury. In fact, without intervention the vast majority of domestic violence escalates to pose a much greater threat to victims.

Another source of frustration for physicians is the frequency with which violence is repeated. Patients are advised to leave the violent situation and are provided with phone numbers of community outreach organizations. Yet they continue to return to the same environment. This may be incorrectly interpreted as the patient's lack of concern for her own welfare. In fact, returning to the environment may have a great deal to do with concern for her welfare and that of others with whom she is close. Physicians can provide resources and offer support. We cannot force others to accept our solutions to their problems. Intervention may be undertaken at a later date when further action is more feasible for the patient. Although victims may be unable or unwilling to accept help on one visit, it does not necessarily follow that the response will be the same on the next.

### **Too close for comfort**

Depending upon the age, sex and circumstances of the victim, physicians may identify with them. Those physicians who have not experienced violence in their own lives may have difficulty acknowledging that others who seem so much like themselves could

have such problems. They may also identify with their abused patients on the basis of their own history of abuse. As an example: One study showed that 14% of all male MDs and 31% of all female MDs have experienced significant familial violence. This may make intervention with victims of violence "too close for comfort" causing some emergency physicians to avoid the issue altogether.

### **Fear of Offending**

Fear of offending the victim is common but rarely occurs. Most victims will welcome the opportunity to discuss the problem. Regardless of whether they disclose their situation, a message of concern was still provided. This identifies the physician and his/her institution as a potential future resource.

Physicians concerned with offending abusers may view the revelation of violence as an accusation needing to be either proven or refuted—neither of which is the role of either physician or patient. It is possible to provide support, information and referral to patients reporting abuse without ever needing to "prove" their credibility.

### **Powerlessness**

All physicians like quick fixes. Unfortunately, intervening with domestic violence will not be one. Lack of training fuels feelings of inadequacy to manage the problem ourselves, and it may appear easier to avoid the issue altogether. Nevertheless, although we can't "fix" the problem, we are often the first contact for victims. We have the ability to acknowledge the problem and make appropriate referrals. It is important to begin to accept and acknowledge that simple goal as an important beginning for many patients. Physicians must be able to tolerate the repeated events of violence and not give up on their patients.

### **Time Constraints**

This is a powerful concern. How do we deal with involved psychosocial issues with a busy office or an entire department of sick and injured people waiting? Although adept in identifying and managing child abuse victims, we have not, as yet, sufficiently applied those skills to the identification and management of abused women. Although time and resources are often limited, child abuse is not ignored. Rather, available resources are accessed and used to the patient's best advantage. Fortunately, systems exist for victims of child abuse. It is time to extrapolate that concept to include all victims of domestic violence. Asking direct questions while being knowledgeable of available support systems can ultimately reduce the time required to effectively intervene.

### **Pandora's Box**

By inquiring about potential violence, physicians fear getting "more than we bargained for". The problem of limited resources factors heavily here. However, once the problem has been identified, the other physical concerns and unusual complaints attain sudden clarity. The problem can now be addressed rather than puzzling over the question. Domestic abuse victims are three times more likely to suffer repeated violence than victims of other violent crimes. Identifying victims may, in fact, decrease the number of subsequent visits because the core issue is being addressed.

### **Conclusion**

Domestic violence is not just a medical or social issue. It is not only a police, trauma of women's issue, nor a children's issue or an issue of the elderly. Domestic violence is a pervasive and insidious problem that affects every level of our society.

Our actions may have enormous impact upon the direction this










society takes in the future. We live in the most violent peacetime society in the industrialized world. The sad truth is beginning to unfold that the overwhelming majority of this violent and destructive behavior is learned in our homes. What can be learned can be un-learned. There has been a profound change in the public response to domestic violence over the last fifteen years. However, personal biases, gender stereotypes and societal misconceptions still legitimize control of one partner over the other and therefore rationalize abuse. Let's seize the opportunity to improve the outcome for these patients while optimizing the proper and efficient use of our limited medical resources. The task may appear daunting. However, considering the potential for improved patient care and outcome, it's well worth the effort.

## References

- American Medical Association: Diagnostic and treatment guidelines on child sexual abuse. Berkowitz, et al. 1992 Jun.
- American Medical Association: Diagnostic and treatment guidelines on child physical abuse and neglect. Berkowitz, et al. 1992 Jun.
- American Medical Association: Diagnostic and treatment guidelines on domestic violence. Flitcraft A, et al. 1992 Jun.
- Berliner L, Wheeler RJ. Treating the effects of sexual abuse on children.
- Berrios DC. Domestic violence—risk factors and outcomes. *West J Med* 1991 Aug; 155:133-135.
- Council Reports: Violence against women: relevance for medical practitioners (Council on Scientific Affairs, AMA) *JAMA* 1992; 267:3184-3189.
- Domestic violence: A guide for health care professionals. State of NJ, Dept of Community Affairs; Division on women; Domestic violence prevention programs. 1990 Mar.
- Feldman, DM: Recognizing the Barriers to Intervention. Interpersonal Violence: A Primer; *PaACEP Newsletter Supplement*; November, 1993.
- Feldman, DM: Breaking the Barriers to Intervention. Interpersonal Violence: A Primer; *PaACEP Newsletter Supplement*; December, 1993.
- Feldman, DM: Creating a Model Emergency Department Protocol to Manage Domestic Violence. Interpersonal Violence: A Primer. *PaACEP Newsletter Supplement*; February, 1994.
- Foley, Hoag, Eliot: Empowering Battered Women: Suggestions for Health Care Providers, 1991.
- Finklehor D. Sexual abuse as a social problem. *Child Sexual Abuse: New Theory and Research*, Chap. 1, NY Press 1984.
- Flitcraft A. Battered women in your practice? *Patient Care* 1990 Oct; 107-118.
- Grayson M. Family violence: Breaking the cycle. *Hospitals*; Nov 1992.
- Goldberg W, Tomlanovich MC. Domestic violence victims in the Emergency Department. *JAMA* 1984; 251:3259-3264.
- Haack D. Suggested Protocol for Victims of Domestic Violence. Colorado Department of Health; July 1992.
- Heise L, Koblinsky M, et al. Violence against women: The missing agenda Women's Health: A Global Perspective, Westview Press, 1992.
- Identifying and Treating Battered Adult and Adolescent Women and Their Children: A Guide for Health Care Providers. Massachusetts Department of Health 1992.
- Jones J. Emergency Department protocol for the diagnosis and evaluation of geriatric abuse. *Ann Emerg Med* 1988 Oct; 17:1006-1015.
- Klingberl KS. Interpersonal violence: Hospital based model from policy to program. *Response* 1986; 9:6-9.
- Kobemick M E, et al. Emergency department management of the sexual assault victim. *Journal of Emergency Medicine* 1985; 2:205-214.
- Larkin M. Curbing domestic violence: Emergency medicine's critical role. *American Med News*; Jan 6, 1992.
- Lazzaro MV, McFarlane J. Establishing a screening program for abused women. *JONA* 1991 21:24-29.
- Ludwig S. A multidisciplinary approach to child abuse. *Nursing Clinics of North America* 1981; 16:161-165.
- Marzuk P., et al. The epidemiology of murder suicide. *JAMA* 1992; 267:3179-3183.
- McFarlane J, et al. Assessing for abuse during pregnancy: Severity and frequency of injuries and associated entry into prenatal care. *JAMA* 1992; 267:3176-3178.
- McLeer S, Anwar R. The role of the emergency physician in the prevention of domestic violence. *Ann Emerg Med*. 1987;16:1155-1161.
- McLeer S, et al. Education is not enough: a system failure in protecting battered women. *Ann Emerg Med* 1989 Jun; 18:651-653.
- Morrison L.J. The Battering syndrome: A poor record of detection in the emergency department. *Current Practice in Emergency Medicine* 1988; 521-526.
- Novello A. A medical response to domestic violence. *JAMA* 1992; 267:3132.
- Parker B, Ulrich Y, A protocol of safety: research on abuse of women. *Nursing Research* 1990; 39(4): 248-250.
- Parker B, McFarlane J, et al. Physical and emotional abuse in pregnancy: a comparison of adult and teenage women. *Nursing Research* 1993; 42(3): 173-178.
- Physicians & Domestic Violence: Ethical Considerations (Council on Ethical & Judicial Affairs, AMA) *JAMA* 1992; 267:3190-3193.
- Prothrow-Stith D: Deadly Consequences. Harper Perennial, NY 1991.
- Randal T. ACOG Reviews domestic violence campaign, calls for changes in medical school curricula. *JAMA* 1992; 267:3131.
- Randal T. Adolescents may experience home, school abuse: Their future draws researcher's concern. *JAMA* 1992; 267:3127-3131.
- Rintz M, Briere J. Adolescent "acting out" and childhood history of sexual abuse. *Journal of Interpersonal Violence* 1986; 1:326-334.
- Sabatino F, et al. Violence: Hospitals cope with America's new 'Family Value'. *Hospitals* 1992. Nov; 24-30.
- Star B, Clark C G, Goetz K M, O'Malia L. Psycho-social aspects of wife battering. *Social Casework: The Journal of Contemporary Social Work* 1979 Oct; 479-487.
- Stark E. Domestic violence: the changing criminal justice response. Training and Retraining Battered Women, Chap. 14, Auburn House Press.
- Stark E, Flitcraft A. Emergency department protocol: Identification and treatment of adult domestic violence victims; Domestic Violence Training Project.
- Sugg NK, Invi T. Primary care physician's response to domestic violence—opening Pandora's Box. *JAMA* 1992; 267:3157-3160.
- Taylor W K, Campbell J C. Treatment protocols for battered women. *Response* 1992; 81(14), #4, 16-20.
- Taylor WK, Moss N A. Domestic violence: Identification, assessment, intervention. *AORN. Journal* 1991; 53:1158-1164.
- The Battered Woman. ACOG Technical Bulletin No. 124, 1989 Jan.
- Treatment of family violence victims: Connecticut Medical Facilities 1989 Annual Report 1990 Apr.
- Vavaro F, Colman P G. Domestic violence: A focus on emergency room care of abused women.
- Violence, values & gender. (Editorial) Flitcraft, A. *JAMA* 1992; 267:3194-3195.
- Warshaw C. Poirier S. Case and commentary: Hidden stories of women. *Second Opinion* 1991. Oct: 48-61.
- Walker L E. Post-traumatic stress disorder in women: Diagnosis and treatment of battered women syndrome. 28:1.
- Walker L E. The Battered Woman. Harper & Row, NY 1979.
- Yeo HM, Yeo WW. Repeat deliberate self harm: a link with childhood sexual abuse? *Archives of Emergency Medicine*, 1993, 10, 161-166.

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