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DETECTING AND REFERRING BATTERED WOMEN: AN EMERGENCY DEPARTMENT CASE STUDY

A thesis Submitted to

The School of Social Work
Faculty of Graduate Studies and Research

In Partial Fulfillment of the Requirements

for

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by

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Abstract

Battery is a major health care issue that, despite increased recognition, fails to be detected in health care institutions. Without adequate detection, referral to social and community services are less likely to occur, rendering women victims vulnerable to continued risk physically, psychologically and medically. This study seeks to describe actual detection and referral practices in an emergency department at a large teaching hospital in Quebec, as well as explore health care professionals' knowledge about and practices regarding the detection and referral of battered women. Its aim is to better understand the pathways and barriers to detection and referral of abused women in order to enhance current practice responses in emergency departments. To examine detection and referral rates and predictors of battery, 200 medical charts from the emergency department were reviewed. Supplementing analyses of the charts were in depth interviews with ten health care professionals working in the emergency department. From these sources of data, it became apparent that neither detection nor referral occur in any systematic fashion. Whereas health care professionals seem to know a great deal about battery, their actual practice appears to be contradictory. Gynecological problems and woman's age were not found to be related to detail in charts but physical injuries were. Whereas a positive relationship was found between detection and referral in the chart reviews, everyday practice showed inadequacy in both areas. Implications for social work contributions to health care practice related to battery are offered.

Résumé

Les agressions demeurent un problème majeur dans le domaine de la santé car malgré qu'ils soient bien identifiés dans les institutions de santé, ils sont difficiles à dépsiter. Sans dépistage adéquat, les consultations au service social et communautaire ne peuvent s'effectuer et ainsi les femmes, victimes de ces agressions, deviennent les personnes vulnérables aux abus physique et psychologique continuels.
Cette étude a tout d'abord pour but de décrire les moyens présents utilisés dans le dépsitage et consultation des agressions à l'urgence d'un grand hôpital d'enseignement du Québec, et également d'analyser les connaissances et pratiques des professionnels de la santé dans l'exercice du dépistage et de la consultation des femmes agressées. Le but est de pouvoir mieux compredre les avenues et obstacles rencontrés lors du dépsitage et de la consultation des femmes battues et ce, afin d'accroître le rendement des pratiques actuelles dans ce domaine dans les urgences.
Afin d'examiner les taux de dépistage, de consultation et de prévisions des agressions, 200 dossiers médicaux de l'urgence ont été analysés. En plus de cette analyse de dossiers approfondie, des entrevues ont eu lieu avec les professionnels de la santé oeuvrant á l'urgence. À partir de ces sources d'information, il apparaît évident que ni le dépistage, ni la consultation ne s'effectuent de maniére systématique. Alors que les professionnels de la santé ont une meilleure connaissance du dépistage des agressions, leur pratique actuelle le contredit. Les problémes gynécologiques ainsi que l'âge des femmes ont été identifiés comme étant des éléments négativement reliés au dépistage, les blessures physiques été identifiés comme étant positivement reliés au dépistage.
Bien qu'on ait pu constater lors de la révision des dossiers un lien entre le dépistage et la consultation, la pratique quotidienne prouve plutôt qu'un manque existe dans les deux cas. L'implication du services social dans les soins des aggressions est également proposée dans cette étude.

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CHAPTER 1

BATTERY: AN OVERVIEW

Battery against women is a serious and widespread problem that health care professionals rarely identify. The term "battery" is often interchanged with such terms as domestic violence, battered women, wife abuse, wife assault, and marital violence. These expressions all refer to the same concept, which Hotch, Grunfeld, Mackay and Cowan (1991, p.4) define as "actual or threatened physical, sexual, financial or emotional abuse of an adult by someone with whom she or he has an intimate, familial or romantic relationship".

Battery against women exists in all cultures and socioeconomic levels of society. In Canada it is estimated that "one in eight women is physically assaulted in a marriage or marital-type relationship" (MacLeod, 1987). The scope of violence in battery cases is dramatic. It may include physical, psychological and emotional injuries, suicide ideation or attempts or even homicide. Battery causes more injury to women than accidents, muggings and rapes combined (Randall, 1990). Assaults are often repeated. Johnson (1996) found that 63% of women were battered more than once and 32% more than ten times. In these cases, the abusers verbally threatened these women, pushed, hit, grabbed, threw, bit and, in 44% of the cases, used a weapon. Furthermore, thirty-four percent of women fear for their lives. In fact, they have one chance in six of being killed if they leave their batterer .

Not surprisingly, one in four women who seeks medical care at an emergency department, is a victim of battery (Loring & Smith, 1994; Wang & McKinney, 1997). Though up to 30% of women who present to a given Emergency Department (referred to as ED) may have injuries or symptoms related to battery by their partners, detection of battered women only occurs between 2% and 10% of the time (Delahunta, 1995; Isaac & Sanchez, 1994; Randall 1990). Health Care Professionals (referred to as HCPs) identify only 5% of victims of battery, even though these women present themselves to emergency departments for multiple reasons related to battery. Thus although many health care professionals see battered women, they fail to detect battery as an underlying reason for the injury or complaint. This is problematic given that emergency departments of hospitals have a crucial role in detecting and referring battered women.

Not only are detection and referral weak, but there is a popular assumption that if HCPs know the risk markers, they will detect battery or will be told about the battery if they inquire (Mullender, 1996). Despite this assumption, current day practice shows the opposite to be true. In 1996, the teaching hospital wherein this study took place saw 48,571 patients; more than half were women. During this same year, only 81 women (0.03%) were referred to emergency social workers for battery (Bronet & Iorio, 1997). Like other hospitals, under detection and lack of referral plague this health care setting. The question remains, simply, "why?"

This study aims to answer this question along two prongs. One, using existing hospital charts, this study describes actual detection and referral practices undertaken in 1996 in an emergency department setting. Two, based on interviews with doctors and nurses from the emergency department, this study explores pathways and barriers to detecting battered women and referring them to social services.

The significance of this study is clear. It is essential that we further understand detection and referral for the cost of ignorance is great for women, their families and the health care system. Without adequate attention to battery, women victims may continue to suffer physically, psychologically and medically. With enhanced understanding of the problem, practices can be advanced for dealing with battered women in medical settings. Detection may also improve referral to social services. Better detection and referral offer an opportunity to link battered women to community and social programs; here, they will be apprised of their rights and possible actions to take.

This thesis is divided into four chapters. In this chapter, I provide an overview of the topic of battery, with specific attention to issues of detection and referral. The second chapter asks the following question "what are the actual detection and referral practices and risk markers identified by health care professionals?" It presents the research design and findings from quantitative analysis of 200 charts of women who presented to a local ED in 1996. Chapter 3 examines the question: "under what circumstances do health care professionals detect and refer battered women who present themselves in the ED of a

major teaching hospital?" It presents a case study of a local ED and major themes that emerged through interviews with ten HCPs. Chapter four concludes the thesis. Here, the impact of detecting and referring battered women is discussed as well as ways in which social work and other HCPs might best deal with battered women are explored.

Effects of Battery

Domestic violence affects the victim, her family, and the delivery of medical care (Council on Ethical and Judicial Affairs, 1992). Physical effects range from minor injuries to more complex and serious damage, even death. Women who are battered have physical and psychological effects that can be as lethal as suicide and homicide.

The psychological effects of battery are reflected in the battered woman's complicated responses toward her assailant. At the beginning of her relationship, the woman may believe that she is in a loving relationship with a strong connection to her mate. As the abuser finds her areas of vulnerability, he asserts his control and reinforces his power over her. He may control where she goes, what she does, and what she thinks and feels. She becomes unable to make a decision, eventually questioning her own thinking and behavior. He thus conquers her mental well-being. As battery is slowly introduced into the relationship, the woman begins to feel confused. Feelings of love are transformed into a sense of terror (Turgeon, 1998). Both love and terror elicit the same responses within a person, according to Turgeon (1998). However, in order to survive and function in her daily life, the woman detaches herself from the feelings of danger.

Battered women suffer feelings of decreased self-worth, helplessness, guilt, low self-esteem, lower self-confidence and depression. They experience many losses as well as anticipatory losses, regardless of whether they stay or leave the batterer. They not only lose their self-esteem, but also their independence.

Turgeon (1998) states that some studies found that 81% of physically battered women have Post Traumatic Stress Disorder, as do 63% of emotionally or psychologically battered women. Post Traumatic Stress Disorder includes symptoms such as reliving the event. This is often diagnosed, in severe presentation, as a psychotic break. Women with Post Traumatic Stress Disorder may present with no affect, detaching themselves from their emotions in order to function. They are often diagnosed with depression, and frequently exhibit stress behaviors such as panic attacks. The trauma has an impact on other aspects of the women's lives. These reactions are normal in any traumatic event. However, with battered women the trauma recurs over a long duration. In a Quebec study with 80 HCPs, 186 battered women were detected in their practices over a six-month period. Of the total, 180 were diagnosed with a psychiatric disorder and 50 % with depression. Only 8% were diagnosed with Post Traumatic Stress Disorder (Turgeon, 1998).

The Battered Woman's Syndrome, a subcategory of the Post Traumatic Stress Disorder, identifies characteristics of some battered women. These include "anxiety, fear, depression, shock, anger, compassion, guilt, humiliation, confused thinking,

intrusive memories, uncontrolled re-experiencing of traumatic events, rigidity, lack of trust, suspiciousness, hypervigilence and increasing startle response" (Sonkin, 1985, p. 161). A process that includes stages of denial, guilt, enlightenment and responsibility is also common. Frequently, women first deny that the abuse exists. They consequently feel guilty that they may actually have caused the battery. They may eventually determine that they are not to be blamed, but they continue to stay for various reasons. In the final stage, the responsibility stage, women leave the relationship (Loraine, 1981).

Battery affects women as mothers. Battered women with children have the added fear that their children may become the recipients of violence. Whether or not children are battered, witnessing battery may have psychological consequences. These children, according to Pahl (1995), have increased anxiety, psychosomatic illnesses and less social competence. Boys who witness battery in their childhood are more likely to be abusive in their intimate relationships as adults (Pahl, 1995). According to Turgeon (1998), these children experience both internal and external problems such as anxiety and nervousness, physical ailments, difficulties concentrating, low self-esteem to antisocial behavior and vandalism. These children are isolated, have poor social skills, and deal aggressively or passively with problems.

Battery is a financial burden on the medical system that could be better controlled. A review of studies by Sabatino (1992) found that medical costs due to battery within families in the United States is about $44 million. In Canada, while no

cost analysis of battered women has been documented, one may conclude that a similarly high cost to the medical system may be attributable to the continued under-detection of battery. For Chambliss (1997, p.630), battery is a "major cause of homelessness, juvenile violent crime, and substance abuse. The cost . . . 5-10 billion dollars annually".

Battery victims have physical and mental health problems after experiencing violence for years, since the abuse often increases in frequency and magnitude (Pahl, 1995). According to Turgeon (1998), battered women are three times more likely to be hospitalized and operated on than women who do not experience battery. The effects of accumulated battery may drive a battered woman to suicidal or homicidal behaviors. Koss, Browns, Fitzgerald, Puryea and Russo (1994, p.73) state that "women are more likely to be killed by their male partners than all other categories of persons combined". Johnson (1996) indicates that homicide between men and women is different. Women are killed three times more often than men; frequently men are killed as a defensive reaction, since the women who kill them do so out of desperation or for fear of being killed themselves or to protect their children. Homicide reactions usually come during a period of intense feelings of danger, in which the woman feels she must protect herself and/or her children.

Given that the consequences of battery are serious and widespread, it is important for health care professionals to recognize the risk markers of battery.

Risk Markers

Abused women tend to be less than forty-five years old (Saunders, 1993; Stark, 1981; Strauss, 1980), with poorer mental health (Ratner, 1995), a history of more hospitalizations (Drossman, 1990; Turgeon, 1998), and overall more use of emergency departments. Some risk markers that are indicative of battery include: headaches; shortness of breath; palpitations; chronic pain; lacerations; fractures, especially to face, skull, and mandibular areas; attempted suicide; depression; internal injuries; nutritional and sleep deprivation; hyperventilation; burns; and abrasions (Alpert, 1995; Brekke, 1987; Ghent, 1985; Hotch et al., 1991; McCoy, 1996; Ratner, 1995). Women who are abused tend to give inconsistent stories about their injury, avoid eye contact, either minimize or over-exaggerate their injury, and delay their search for medical attention (McCoy, 1996). The batterer often accompanies his victim, answers for her, and refuses to leave the patient alone (McCoy, 1996).

Though there may be visible signs of abuse, i.e., bruises, battered women are often injured in areas that are covered by clothing. Injuries to the abdomen, chest, breasts, arms and neck are not in clear view. However, these visual risk markers could be looked for by health care professionals. Unfortunately, Abbott (1995) found that even these obvious indicators were not picked up by physicians. Consequently, women are rarely identified as potential victims of battery.

In a Canadian study, Ratner (1995) analyzed 406 randomly selected married women and looked at 30 potential indicators of battery. Ratner found that battered women were more likely to use ED services, account for more hospitalizations, and/or are followed by a psychologist or psychiatrist. Ratner also found higher use of alcohol and more frequent complaints of headaches, chronic pain or psychiatric disorders among battered women. The researcher suggested that health care professionals pay attention to not only the location of injury, but to the consistency of the woman's explanation.

HCPs need to recognize a broad range of risk markers of battery. For example, battered women tend to have poorer mental health than non-battered women (Ratner 1995). Anxiety, depression, attempted suicide and other psychiatric disorders thus tend to be misdiagnosed: the underlying cause of the ailments remains unexplored and therefore untreated. As a result, medication is often prescribed to battered women rather than determining the cause of such ailments. Frequent visits to the hospital, according to Bergman and Brismar (1991, p.1488), also indicate possible battery. Bergman and Brismar conducted a longitudinal study of 117 patients who were admitted for somatic or psychiatric care and who were offered a treatment program. The results indicated that there was an association between frequent visits to the hospital and battery. The study found that the peak of using medical care was between the ages of twenty-five and thirty-nine, which is the median age of battered women. In fact, there was no decrease in hospital services even after five years of treatment.

Although the effects of battery are far ranging and the risk markers numerous, suicide, pregnancy, and alcohol have been found to be major risk markers.

Attempted Suicide and Abuse

In a study of fifty women who had attempted suicide, Stephens (1985) found that twelve women were in abusive relationships. From interviews with the women, it was revealed that suicide attempts were made in order to escape or avenge the abuse. According to Mullender (1996), one third of suicides are related to battery. This may be a consequence of the depression that Melvin (1995) found in one third of patients who are physically battered. Women who attempt suicide tend to be younger; usually, the suicidal attempt is an unplanned, impulsive reaction to "severe, often chronic, interpersonal conflict" (Stephens, 1985, p. 77). Even when battery is a tolerated or acceptable behavior in various cultures, Counts (1987) found that battered women attempt suicide. In New Guinea, for instance, only women tend to commit suicide and it usually occurs after severe physical battery;. Similarly, with Fijian Indian families, 41% of female suicides are due to battery. Abbott, Johnson, Koziol-McLain and Lowenstein (1995) found that 26% of battered women carried out suicide attempts, whereas only 8% of non battered women attempted suicide. Warshaw (1989, p. 506) estimated that 65 % of women hospitalized in a psychiatry unit had been physically battered. The review of suicide literature by Stark and Flitcraft (1996, p.103) demonstrates a strong link to battery. Some

studies revealed that "up to 80% of those who attempt suicide give marital or boyfriend or girlfriend conflicts as their reason"; however they would not all be cases of battery.

Pregnancy and Abuse

During pregnancy women are more vulnerable, especially if they are already in a violent relationship. Often these women are unable to attain prenatal care as their abusers isolate them from the HCPs who may be in a position to detect the abuse. Abusers may be threatened by the pregnancy, which may account for the increase in violence against battered women. The injuries of pregnant women tend to focus more on the abdominal and genitalia areas, which can result in "placental separation, hemorrhage, bruising, fetal fractures, rupture of the uterus, liver or spleen, pre term labor, miscarriages and stillbirths" (Johnson, 1995, p. 51). Koss et al. (1994, p.50) found 17% of 691 pregnant women reported physical and sexual abuse. Furthermore, findings indicate that battery increases with the number of pregnancies, since "of those becoming pregnant a third time, 55% were assaulted". Various researchers have found that pregnant women are battered between 14 to 37% of the time (Statistics Canada, 1994; Alpert, 1995; Stewart & Cecutti, 1993). Battery thus presents a particular risk to pregnant women and their unborn children. Pregnant women less than three months into their gestation often present themselves to the emergency department with problems which could be caused by battery, thus the emergency department has a critical role to play.

Alcohol and Abuse

Alcohol and drugs are often blamed for battery (Melvin, 1995). It has often been assumed that men who are under the influence of alcohol or drugs batter women. Another related assumption is that women remain in violent relationships or somehow evoke the battery because they are substance abusers. According to Randall (1990), 16% of battered women abuse alcohol. The use of alcohol or drugs represents a method of escaping or avoiding the psychological pain of abuse, since the battered woman may not see a solution to her problem (Melvin).

Disclosure and its Importance

While knowing the risk markers is imperative to the detection of battery, the concealment of abuse by battered women is another important aspect of the problem. Women may endure many years of battery before they realize the severity of their situation. They may take many more years before they disclose this abuse to anyone, including close family or friends. Brown, Lent and Sas (1993) indicate that battered women face certain barriers that stop them from disclosing their situation. These may be economic reasons, societal and cultural attitudes, lack of awareness of community resources, or fear of losing social supports. Despite these barriers, Hayden, Barton and Hayden (1997) and Olson (1996) revealed that women are willing to disclose abuse. Based on anonymous surveys of 243 women at two emergency departments, they found that 9% of women were victims of battery; only 11% were unwilling to disclose the

battery when asked. Similarly, Roberts et al.(1993) conducted a survey of 985 people who attended the ED and found 17.5% disclosed the battery they endured.

According to Roberts, Lawrence, O'Toole and Raphael (1993), women who have been battered consult doctors more often than police, social workers or other helping professionals combined. Similarly, nurses may be helpful. According to Moss (1991), nurses and other health care professionals need to treat the whole person, rather than just the physiological complaint.

When battered women seek medical attention for abuse, this opportunity is ideal for inquiry. Investigating possible abuse is important since the patterns of seeking help change according to the severity of the violence and the reactions the battered women receive when they seek help (Gondolf, 1988). According to Gondolf, very few women remain completely quiet about their situation. Dobash and Dobash (1987) state that battered women search for formal and informal help in the following areas: (a) to stop the battery; (b) to seek a friendly listener; (c) to request that someone speak to their mate; and (d) to search for financial and resource assistance. Though battered women might initially blame themselves, as the battery continues and intensifies, they become aware that they are not responsible for the battery. HCPs should therefore be skilled in detecting and referring battered women. As HCPs are in a unique position for detecting battery, it is essential to understand the link between medicine and battery.

Is Battery a Medical Issue?

Although a call to link battery and medicine has been made for the past 15 years (McLeer, 1989), little progress has been seen. One of the aims of medicine is to diagnose, with the aid of diagnostic tests or tools and information provided by the patient. These diagnoses, however, generally conform to the doctor's repertoire of existing illnesses. When women present themselves to the ED with an injury, medical professionals focus on the injury rather than its cause. By focusing on the medical ailment, women are left with little possibility of disclosure and few alternatives. By ignoring the cause of illnesses or injuries that battered women develop, the problem of battery remains untreated. According to Stark and Flitcraft (1996, p.16), medicine shifts the focus from the "woman's condition to the woman herself". For example, if a woman is diagnosed as an alcoholic, a drug addict, or depressed, she will continue to be labeled as such within the health care system, regardless of the cause of the ailment. It becomes **her** problem. Women are thus further isolated when the medical community fails to detect the problem of battery that may be the basis of their complaints.

Indeed, McLeer and Anwar (1989, p. 651) argue that battery is a medical issue that needs to be addressed, since "to treat a battered women's medical and/or surgical problems without recognizing that she has been chronically battered and without offering essential service is simply bad medical care". "That the injury was caused by a punch is no more significant than it resulted from a fall and, if the cause is recorded, there is no

comment" (Stark et al.,1996, p.17).The authors urge emergency departments to set up simple protocols for dealing with battery situations. Delahunta (1994) suggests that women ought to be screened for battery and a team approach is essential to properly identify battered women.

The members of the Conference of Boston Teaching Hospitals (COBTH) developed a task force on battery, identifying goals which health care professionals need to exercise. Recognizing that the ED is strategically one of the best places to help victims of domestic violence, the goals included educating professionals about violence, its prevention, detection, and intervention, as well as advocating zero tolerance for violence within the hospital work environment. This set of goals fits well with the philosophy expressed by Flitcraft. Flitcraft (1992, p.3190) suggested medicine must not only care for the illness or injury inflicted on someone but also look at an individual's "psychological, social and even spiritual dimensions of this assault". The purpose of medicine, according to Flitcraft (p.3190) is "to heal ...to make whole or sound, to help a person reconvene the powers of the self and return, as far as possible, to his [or her] conception of normal life".

Battery and Health Care Professionals

The emergency department presents a crucial site for identifying battered women (Grendron, 1991). It is open and accessible 24 hours per day (Roberts, 1984). It provides more anonymity than a clinic or family doctor (Olson, Anctil, Fullerton, Brillman,

Arbuckle & Sklar, 1996). Studies as early as 1977-78 (Rousanville & Weissman) indicate that the ED is the best place to detect and help battered women; two decades later, detection continues to be a problem.

Research on battered women in the hospital area has focused on detection rates (Goldberg & Tomlanovich, 1984; Hotch et al., 1991; Warshaw, 1989) and the implementation of screening tools and protocols. It has been shown that if a health care professional detects battery, then the patient may be referred to social or community services (Hotaling et al., 1990; Waller, Hohenhaus, Shah & Stern, 1996). Yet very few hospitals have protocols to follow for battered women who present themselves to their emergency departments. In a study of 90 emergency departments, Isaac and Sanchez (1994) found that 20% of hospitals had protocols which were followed, but that the primary actual detection of battery was rare. The authors concluded that having a protocol is not sufficient, since the barriers to detection are much more complex. The conclusions of Waller et al. (1996) also showed that a protocol will not guarantee referral. Clearly, the people who carry out the protocol have a role to play in the detection and referral processes.

Role of Health Care Professional role of Health Care Professionals

A perusal of literature on HCPs and battery reveals notions of "responsibility," "ethical duty," and "essential role in diagnosing, assessing, preventing and treating battered women" (CAEP, 1994; Clark, 1992; Melvin, 1995; Moss &Taylor, 1991;

Roberts, 1984). For example, Roberts (1984, p.25) insists that the "most significant contribution any member of the health care industry can provide is the initial, accurate and primary diagnoses that domestic violence has occurred". The role of a HCP is to provide the patient with support, options, and resources not just when violence has occurred, but also before violence erupts. Women may not even be aware that they are in an abusive relationship, thus the responsibility of the HCP is to show battered women that their relationships are unhealthy (Melvin). As Moss and Taylor suggest, nurses should know the indicators of battery, the community resources for abuse victims, the patients' legal rights, and the importance of documenting the events of the battery.

Beyond its personnel, the hospital setting itself should invite disclosure and emphasize detection. Chescheir (1996) indicates that battery against women should be addressed verbally and non-verbally with posters, reading material in offices, restrooms, waiting areas and examining rooms. The CAEP news (1994) states that emergency departments have the responsibility to set up policy and procedures to follow when battered women present themselves to the emergency. Other researchers argue that all women who present themselves to emergency departments should be screened for abuse (Campbell et al., 1983; Hotch et al., 1995). It is extremely important that the abusive source of the medical problem be addressed since, as Flitcraft (1992, p.3190) states, if domestic violence is misdiagnosed, "treatment is likely to be inappropriate and potentially harmful".

Various elements have been proposed as contributing factors to the low detection rates of battery by health care professionals: age, gender, personal experience, and professional, societal and institutional barriers (Gremillion & Kanof, 1996; Hotaling et al., 1990; Saunders, Hamberger & Hovey, 1993).Reid and Glasser (1997) found that younger HCPs agreed that battery was a social and medical problem, but few believed that it exists within their practice. Reid and Glasser (1997) also found that older physicians are less likely to agree that battery is a medical problem. Female physicians, on the other hand, are more likely to diagnose battery because battered women may be more comfortable with them, and, female physicians are more likely to identify and empathize with them (Brown et al., 1993; Gremillion and Kanof, 1996; Reid & Glasser, 1997; Saunders et al., 1993). In trying to determine predictors of physicians' responses towards battered women, Saunders et al.(1993) conducted a brief training of the physicians and compared the results. They concluded that women physicians detected abuse earlier and helped with the treatment plan. Reid and Glasser found that 80% of doctors stated that they can best detect battery, yet only 65% believe they could manage the case. They also found that although doctors acknowledge battery as an identifiable problem they chose not to intervene in up to 20% of the cases for various reasons.

Personal Barriers

Attitudes of HCPs about abuse, stereotypes they may have, and their own personal experiences all factor into detection. HCPs may believe that a family should

remain intact, which may thereby communicate to a battered woman that she must stay in an abusive situation. Similarly, certain HCPs may believe that the victim accepts the battery, or that the battery is not that serious, or that it occurs among only the poor (Cohen, 1997; Gremillion et al.,1994; Stark & Flitcraft, 1992). HCPs may also believe that women deserved to be battered or that they can offer no help. They may not involve themselves due to a lack of knowledge or fear of intervening. Whatever the personal issue, it affects the professional relationship with the patient and how the patient will be treated. A study by Hoff (1990) showed that battered women found HCPs to be the least helpful of the professions encountered as a result of their abuse. If HCPs are in the best position to prevent, identify, assess and intervene battered women, then this outcome is most ironic.

It is imperative to identify one's own difficulty with approaching the problem of battery (Brown et al., 1993). Keller (1996) explored how HCPs respond to battered women depending on their individual experiences, defining three main counter transference responses by the HCPs. The first is counter identification which results in blaming the victim. The second is counter transference, where HCPs have anger towards the abuser, which can result in feelings of helplessness, hopelessness and a paralysis in which the HCPs cannot help victims. The third "counter transference [was] helplessness combined with anxiety heightened by the realistic danger of the patient". Both the

second and third type of counter transference result in over-identification of HCPs with victims, which leads to their inability to help.

Denial by HCPs is another barrier. As Gremillion et al. (1994, p.772) state, "denial serves as an emotional shield and is a barrier to truth". By denying that battery occurs in one's practice, it makes it easier for HCPs to distance themselves from battered women. According to Turgeon (1998), denial legitimatizes the lack of detection.

Another personal barrier is the professional's personal experience with violence. Goyette and Foghfoury (1993) found that one in six service providers were victims of battery themselves. Sugg and Inui (1992) found 14% of male doctors and 31% of female doctors have been or are victims of violence. This experience can have dual results. This situation may make the HCPs vulnerable. On the other hand, it can keep the HCPs from helping the victim as they too may not see a solution to the problem. On the other hand, it may also enhance the HCPs empathy towards battered women and serve to direct them to appropriate community resources.

Fear of intruding into personal lives, offending the battered woman, and prying into personal affairs have also been identified as barriers to detection (Alpert, 1995; Loring & Smith, 1994; Stark & Flitercraft, 1992). These attitudes, if conveyed to women, discourage them from seeking help and reinforce the notion that there is no way out of the situation. They may also make women feel responsible for the battery.

Professional Barriers

Lack of training has been identified as a potential reason for lack of detection (Brown et al., 1993; Gremillion et al. 1994; Loring & Smith, 1994; Stark & Flitercraft, 1996). Education in medical schools in the area of battery is scarce, although it has been marginally incorporated more recently in some medical schools (Dickstein, 1997). Although the need for such a curriculum is well documented (Alpert et al.,1997; Cullinane, 1997; Hendricks-Matthews, 1997), medical schools have generally focused on tending to the injury itself rather than on the prevention or diagnosis of battery. According to Hendricks-Matthews (1997, p.47), the role of medical schools is to "support students' honest evaluations of how their own abuse experiences (or lack of such experiences) influence how they respond to patients in general and to those with similar histories in particular". The training focus of battery should not only include treatment of the injury, but also the identification, diagnosis, treatment, and referral. Secondly, and perhaps more importantly, HCPs must become aware of their own personal barriers, attitudes and beliefs which hinder them in their involvement with battered women. Saunders et al.(1993) thus suggested that training is not enough; the attitudes of HCPs are more important, and should be the main focus of training sessions. According to Henderson and Ericksen (1994) nurses should take a vital role in the area of battery however they often fail due to HCPs confusion regarding the nature and role of nurses in cases of battery. These authors recommend the same training focus as medical

schools, being both self awareness of attitudes and beliefs about battery and interventions with battered women.

Time

Time has been identified by most researchers as the main deterrent to identifying battery (Alpert et al, 1997; Brown et al., 1993; Cohen et al., 1997; Gremillion et al., 1994; Loring & Smith, 1994). Sugg and Inui (1997) found lack of time to be the primary barrier since 71% of respondents stated that this factor was the main reason for non-detection.

Time constraints take many forms. For example, length of stay in an emergency department is increasingly short given both financial and institutional pressures. In the ED, turnover of patients is high. These factors inhibit disclosure of battery by victims, given that HCPs do not have time to ask about abuse (Gremillion et al., 1994). Battered women need more time to give the complex account of their injuries as compared to a simple fall or injury. Also, facing such stories of abuse may create feelings of helplessness, frustration and powerlessness since the usual element of problem solving is no longer adequate for HCPs. Since cases of battery are more complex and require more intervention and attention, time becomes paramount. HCPs may have other institutional constraints that limit the time they spend with patients, such as budget constraints, flow of patients and the institutional view of the problem. Indeed, taking the time to be

involved with battered women could have a negative impact on professionalism, since, as Cohen et al. (1997) show, such HCPs may often be marginalized by their peers.

Institutional Barriers

The institution in which HCPs work also creates barriers to the detection of battery. Notably, there is a lack of creation and implementation of protocols, policies, and procedures regarding battered women and interventions in abusive situations. In their study of five communities that identified battery as affecting their client population of children, women, and seniors, Cohen et al. (1997) found that there was no universal policy or procedure to follow. Gremillion et al. (1994) had similar conclusions, finding that neither policy nor procedures existed, but if they did, they were not implemented.

The Women

Battered women themselves may also inadvertently present barriers to the detection of their abuse. They may not speak the same language as the HCPs, which makes them unable to communicate their needs and fears (Loring & Smith, 1994). They may fear losing their financial support or fear an increase of abuse. They might not be aware of available resources and the support that HCPs can provide (Brown et al., 1993; Loring & Smith, 1994). Though battered women may be reluctant to identify themselves as such, Brown et al. (1993) suggest that HCPs keep four key ideas in mind: (1) respond to women's cues, (2) give permission to discuss their concerns, (3) plant seeds of the benefits of disclosure, and (4) be aware of their own personal, cultural and professional

barriers. By attending to these four elements when treating battered women, barriers may be diminished and more battery may be detected and treated.

Documentation

Once HCPs have detected battery, it is imperative that it be documented in the medical chart. Should a charge be laid, the medical chart becomes proof of the extent of her injuries and her physical and emotional state at the time of admission to ED. Battered women may visit an emergency department on many occasions for a variety of complaints from physical injury to psychosomatic complaints. Each visit needs to be documented accordingly even if the authorities are not involved. Unfortunately, all too often battered women's medical charts do not identify their visit as resulting from battery. Chescheir (1996), Covington et al.(1995), and Grunfeld (1994) have found that battered women's charts lack specific information, are incorrectly coded, or do not indicate the battery whatsoever; the underlying reason for the injury thus remains undocumented. Pahl (1995, p.145) emphasizes the importance of documentation, since "careful records made on [the victim's] first visit about the nature and the extent of the injuries, even if not immediately useful, may in the long run save her additional suffering". Some hospitals, according to Gondolf and Fisher (1991), have started to keep special charts for suspected and actual abuse cases. Documentation shows that battered women may visit an emergency department on many occasions for a variety of complaints from physical injury to psychosomatic complaints. Each visit needs to be

documented accordingly even if the woman decides not to proceed with the authorities. One day she may decide to act upon the abuse and it would be beneficial to her to have reports of her hospital visits including details of the injury, what she stated and pictures of the injuries and also video footage if possible.

Summary

Clearly, HCPs are important in the detection of battery. At the same time, detection inadequately occurs in medical settings. There is still, however, little known about the perceptions, barriers and attitudes of the front-line HCPs working in the Emergency Department that would explain the lack of detection.

Although detection has been discussed in the literature, referral has received less attention. It is not clear whether changes in detection will alter rates of referral. No study has shown the link between referral and detection. Nor the link between actual case detection and actual referral of battery cases to social services. Barriers to detection may or may not be the same barriers to referral. Both detection and referral are complex and separate processes and yet interrelated. This study determines the actual number of women detected for abuse and referred to social services by reviewing 200 charts. This result is analyzed with information gathered during interviews with ten health care professionals working at a Montreal Emergency Department teaching hospital.

CHAPTER 2

ACTUAL PRACTICES: Chart Reviews

Method

Design

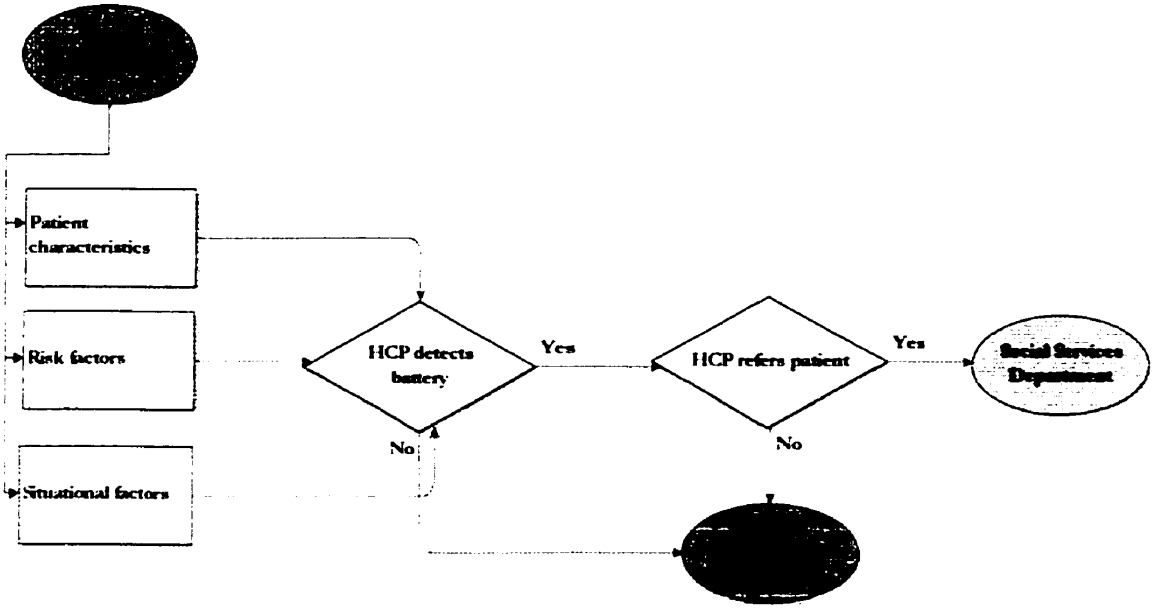
The primary research questions for this aspect of this research are:

(a) to what extent are potential battery cases actually being detected and referred to social services?; and

(b) which risk markers are most easily identified by HCPs?

Charts of two groups of cases were compared: cases already known to social services for battery, and cases randomly selected from the ED database, based on possible indicators of abuse, which were not referred to social services. The hypothesis was that certain risk markers which are easier to identify, such as physical injuries, would result in referral to social services. Figure 1 shows a theoretical model of the factors believed to influence referral to social services.

Figure 1. Referral to Social Services: Theoretical Model



Sample

The total number of ED visits in 1996 was 48,572 patients. From this total, 200 women in the critical age range 14 to 45 years old were selected. To obtain an adequate number of cases referred to social services, the following procedure was used:

***(A) Cases from the Social Service database* (N =23).**

These cases were selected from the total of referrals for battery given to social services in 1996 (Bronet & Iorio, 1997). The sampling frame, that is the number of women who met the age requirement, was 55 (0.11% of total emergency department clients in 1996). Twenty-five cases were randomly selected from this sampling frame. Of these, two cases were already in the ED database sample; a total of 23 cases thus comprised the "social service database sample".

***(B) Cases from the Emergency Department database.*(N=177)**

The literature has indicated attempted suicide, spontaneous abortions, fractures, facial injuries, burns and sexual assault as potential indicators for battery. Using the ED computer database, which registers a diagnosis category number for each patient, nine diagnosis categories were searched, corresponding to the above indicators: abrasions, vagina bleed, suicidal, fracture mandibular, laceration of head, open wound, burns, sexual assault, and social problem. For the category of sexual assault, no case was found in 1996. The total number of patients that met the requirement of age, sex and diagnosis was 1, 117. A total of 177 charts were selected, by a process of stratified random

sampling, to roughly approximate the distribution of categories in the sampling frame, (disproportionate stratified sampling , Rubin & Babbie, 1989). Table 1 presents the sample of 200 charts according to the diagnosis category. Abrasions, lacerations and attempted suicide were somewhat over-represented in the sample, and the large category, vaginal bleed was under-represented. Disproportionate stratified sampling was used to ensure a balance of diagnosis categories.

TABLE 1: Composition of the Total Sample

Diagnosis Category	Sampling frame		Sample	
	N	%	N	%
Suicide	42	3.8	26	13.0
Vaginal bleed	786	70.4	48	24.0
Fractured mandibular	2	0.2	2	1.0
Laceration to head	17	1.5	19	9.5
Laceration	223	20.0	51	25.5
Abrasion	34	3.0	28	14.0
Burns	3	0.3	3	1.5
Social problem	10	0.9	10	5.0
Other			13	6.5*
Total	**1117**	**100**	**200**	**100**

***these 13 cases did not have diagnosis pertaining to the ED but were selected because they were referred to social services**

Instrument

The instrument for reviewing the charts was a checklist developed for this study (Appendix A). It was developed by looking at common indicators of battery cited in the literature. A total of 32 indicators were incorporated into the checklist. Other indicators, such as length of time in seeking medical attention, documentation of patient's report of

how the injury occurred, referral to social services, and the documentation of the ED visit by HCPs, were also included in the checklist. Two additional questions required subjective rating by the researcher. The first, "how much detail does the physician identify of the injury in the chart?" had three possible responses:

> **1. In detail**: includes where the injury took place, how long ago it occurred, who caused harm, relationship between the person and patient, how it occurred and what the patient did.
>
> **2.Vague:** chart states that patient was hurt but no detail of who hurt patient. It may include when the injury occurred and it may include what happened.
>
> **3.No details**: chart does not identify the location of injury, nor who caused harm, nor when it occurred.

The second question involving subjective judgement was a "Likelihood of Violence Rating" based on information in the chart (e.g. age, description of illness and plan and intervention provided) for the present ED visit. Possible responses were:

> **1. Positive for violence**: This is definitely a case of battery; The woman states, either directly or indirectly, that she was battered. The HCPs explored the information provided by the patient. There is an open dialogue between patient and HCP that is documented in chart.
>
> **2. Probable for violence:** There are some suggestions of risks, either by patient or HCPs but not explored. Reason for ED visit may be an injury related to battery, but patient was not questioned in detail. Documentation leads towards battery.
>
> **3. Negative**: There is no indication that this woman has been battered based on this ED visit.

In order to check on the reliability of this instrument, twenty-five charts were randomly picked from the total of 200, and rated independently by a second professional, an MSW Social Worker from the Department of Social Services. Researcher and second rater were not aware of the source of the case (social service or emergency department sample). Twenty-four out of twenty-five charts were rated exactly the same by both raters, showing a good level of inter-rater reliability.

Procedures

The charts were reviewed one by one, and a checklist completed for each one. Each dossier number was recorded on a sheet and checked as it was completed. Each checklist was also numbered to ensure that it could be retrieved should it be necessary. The charts for all 200 cases were reviewed in the Medical Records Department of the hospital over a two-week period.

Analysis

The following statistical procedures were performed, using the SPSS statistical package (version 6.1 1994). The analysis was designed to determine if there was a link between indicators of battery, detection and referral. To simplify the analyses, the 32 indicators of battery were grouped into five major categories by the researcher, using clinical judgement (see table 3). Two comparison groups were used:

(a) The 23 cases from the social service database plus 3 cases in the ED database who had been referred to social services (N =26),

(b) The remaining cases from the ED database sample, who had not been referred to social services(N=174).

A count was done for all presenting injuries or complaints, as each chart could identify more than one indicator. Cross tabulations were performed of all variables by referral to social services, and the number of injuries in each category by likelihood of violence rating, and level of detail provided by doctor in charts. Chi square tests were computed for all cross tabulations.

Correlation coefficients were computed between all possible pairs of the following variables: details provided by doctors, referral to social services, likelihood of violence rating, age of women, and the five injury categories.

Two regression analyzes were performed:

(a) dependent variable, details provided by doctors; independent variables: age, and the five injury categories;

(b) dependent variable, likelihood of violence rating; independent variables: age, five injury categories, and detail provided by doctors.

FINDINGS

Description of sample

Table 2 shows cross tabulations of five variables by referral to social services. For four of these variables there were no statistically significant differences between the distributions for the referred and non-referred samples, However, for the time of arrival at the ED the difference was significant. Cases referred to social services were significantly, $X^2(5, N = 200) = 33.8$, $p<.00001$, more likely to have presented between midnight and 4:00 a.m. than cases not referred, and significantly less likely to have presented in the evening hours, between 4:00 p.m. and 8:00 p.m., and in the morning hours between 8 a.m. and noon. This indicates that HCPs can better determine need for a social service referral when they have more time to investigate the problem. Ironically it is during daytime work hours that social services are available but the rate of referral is lower.

Table 2: Description of Sample by referral to social work

Indicators	Referred (N=26) N	%*	Not referred (n=174) N	%*
Age (years)				
0-19	3	11.5	6	3.5
20-24	7	26.9	44	25.3
25-35	12	46.2	68	39.1
36-45	4	15.4	56	32.2
Admitted to hospital				
Yes	4	16.0	16	9.2
No	21	84.0	157	90.0
missing	1	—	—	—
Accompanied				
yes	6	23.1	34	19.5
No	20	76.9	140	80.5
Lapse time**				
less than 5 hours	7	26.9	76	43.7
5 hours to 10 hours	1	3.9	8	4.6
10 to 24 hours	3	11.5	7	4.0
more than 24 hours	3	11.5	18	10.3
missing	12	46.2	65	37.4
Time of Arrival of ED				
Midnight to 4:00	9	34.6	22	12.6
4:01 to 8:00	1	3.8	7	4.0
8:01 to 12:00	2	7.7	31	17.8
12:01 to 16:00	5	19.2	26	14.9
16:01 to 20:00	3	11.5	48	27.6
20:01 to 23:59	6	23.1	40	23.0

* Column percentages

**Lapse time: time difference between the injury and seeking medical care.

Injuries

The overall number of visits per woman during 1996 ranged from 1 to 127, with a mean of 5.3. This finding speaks to the frequency of ED visits by women, and the likelihood that more battered women are seen than identified. In other words, if battery is

as common as it is believed to be, one would expect a significant number of battered women to be seen in Emergency departments.

Of the 200 cases, 45.5% of the charts indicated that women (n=91) reported that they were hurt (statement written in chart by a HCPs), while the nursing notes only indicated that 29.5% women were hurt (n=59). The women presented to the ED with different medical problems. Table 3 shows the frequencies of injuries recorded in charts, grouped into five major categories. A woman could have more than one of the 32 types of injuries. The most common complaint (26% of the cases) was a bleeding injury followed by pelvic pain (19.5%) and injury to fingers (15%). The total number of injuries or complaints for the 200 women was 444.The most common category was physical injuries with 197 reports (44.37%) followed by psychiatric related complaints, with 112 reported cases (25.2%), (Table 3 and 4).

Table 3: Frequencies of Injuries or Complaints

Symptom	Count(N)	Percentages of symptoms	Percentages of cases*
Physical problems			
injury to arms	2	.5	1.0
injury to face	27	6.1	13.5
injury to fingers	30	6.8	15.0
fracture	3	.7	1.5
injury to hands	15	3.4	7.6
injury to head	18	4.1	9.6
back pain or tenderness	6	1.4	3.0
bleeding injury	52	11.7	26.0
bruises	7	1.6	3.5
burns to body surface	3	.7	1.5
headache	8	1.8	4.0
injury to knee	6	1.4	3.0
injury to leg	12	2.7	6.0

(Table continues)

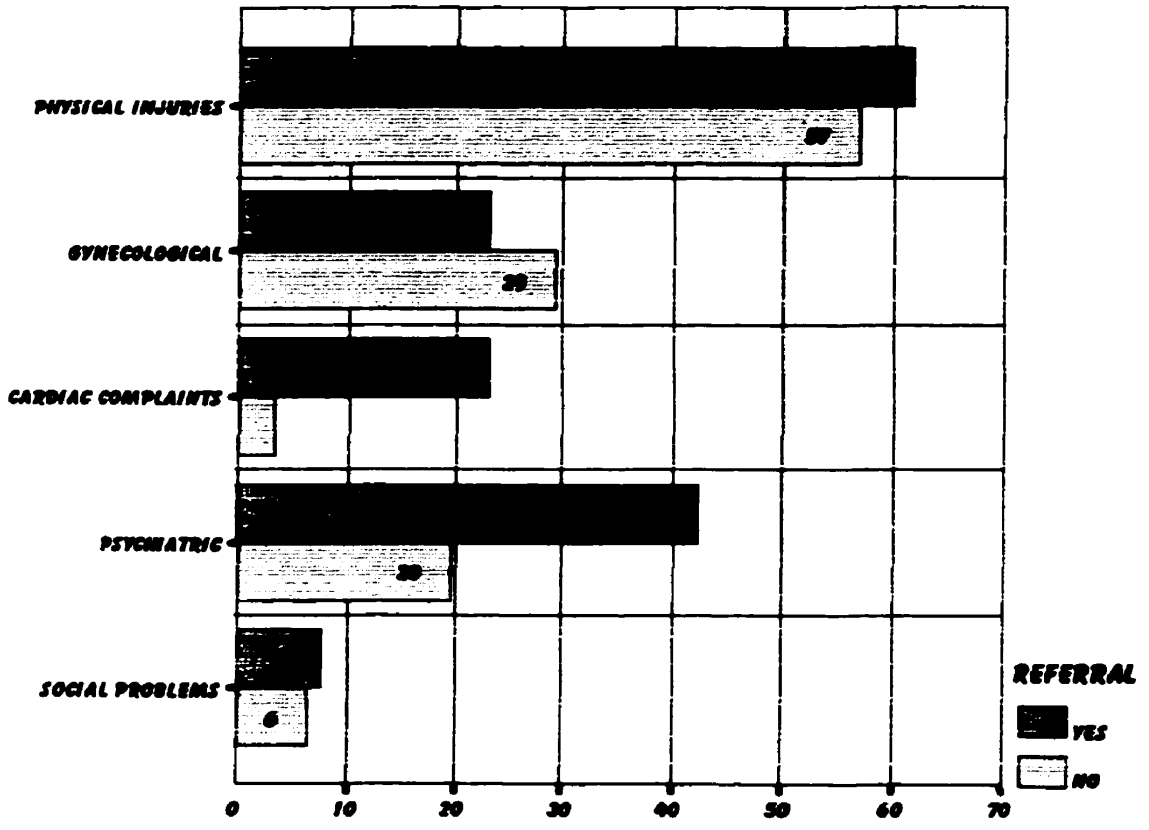
Table 3 continued

Symptom	Count(N)	Percentages of symptoms	Percentages of cases
nasal fracture	1	.2	.5
injury to neck	6	1.4	3.0
muscle pain	1	.2	.5
Total	**197**		
Psychiatric related problems			
crying spells	20	4.5	10.0
depression	28	6.3	14.0
anxiety or agitation	29	6.5	14.5
inability to sleep	9	2.0	4.5
suicide or attempted	26	5.9	13.0
Total	**112**		
Gynecological problems			
pelvic pain	39	8.8	19.5
premature labor	1	.2	.5
miscarriage	26	5.9	13.0
vaginal bleed	22	5.0	11.0
abortion	6	1.4	3.0
abdominal pain	11	2.5	5.5
Total	**105**		
Cardiac Problems			
chest pain	1	.2	.5
complains of dizziness	9	2.0	4.5
palpitation	3	.7	1.5
Total	**13**		
Social problems			
alcoholic	5	1.1	2.0
drug abuse	12	2.7	6.0
Total	**17**		
Total responses	**444**	**100.0**	**222.0**[1]

[1]Women could report more than one symptom therefore sum is greater than 200.

Figure 2 and Table 4 show a breakdown of the number of injuries in each category by referral to social services. For two categories, cardiac and psychiatric problems, the percentage of cases were significantly higher for the referred sample than the non-referred sample, respectively: X^2 (4, N =200) = 10.8, $p<.05$; X^2 (2, N =200) = 17.9, $p<.001$; X^2 (5, N =200) = 12.2, $p<.05$. Neither physical injuries nor social problems were significantly related to referral to social services.

Figure 2: Frequency of grouped injuries by referral to social services



Percentage of cases

Table 4: Cross Tabulations of Medical Variables by Referral to Social Services

Variables	Referred (N=26)		Not Referred (N=174)	
	N	%	N	%
Injuries * ‡				
Physical	29	62.0	168	56.8
Psychiatric problems	25	42.3	87	19.4
Gynecological	10	23.0	95	29.3
Cardiac problems	6	23.1	7	3.5
Social problems	3	7.6	14	6.3
Detail reported by doctors in charts**				
In detail	13	37.1	22	62.9
vague	10	13.9	62	86.1
no detail	3	3.2	90	96.8
Likelihood of Violence Rating**				
positive	19	65.5	10	34.5
probable	2	8.0	23	92.0
negative	5	3.4	141	96.6

* Percentages are of cases.
‡ Women could report more than one symptom
** Row percentages

Table 4 also shows a cross tabulation of amount of detail reported by doctors by referral to social services; the percentage of cases referred was much higher for cases where more detail was reported and this difference was highly significant, X^2 (2, $\underline{n}$ = 200) = 25.94, $p < .0001$. Almost half the charts (46.5%) were rated as "no

detail". A cross tabulation of the likelihood of violence rating by referral to social services also showed a highly significant relationship, X^2 (2, n =200) = 83.1, p<.0001. In this sample, 65.5% of the cases rated "positive" for battery had been referred.

However, the most important issue here is the non referral of 33 women in the sample who rated as positive or probable for battery. This relationship is shown graphically in Figure 3.

Figure 3: Referral to social services by Likelihood of Violence Rate

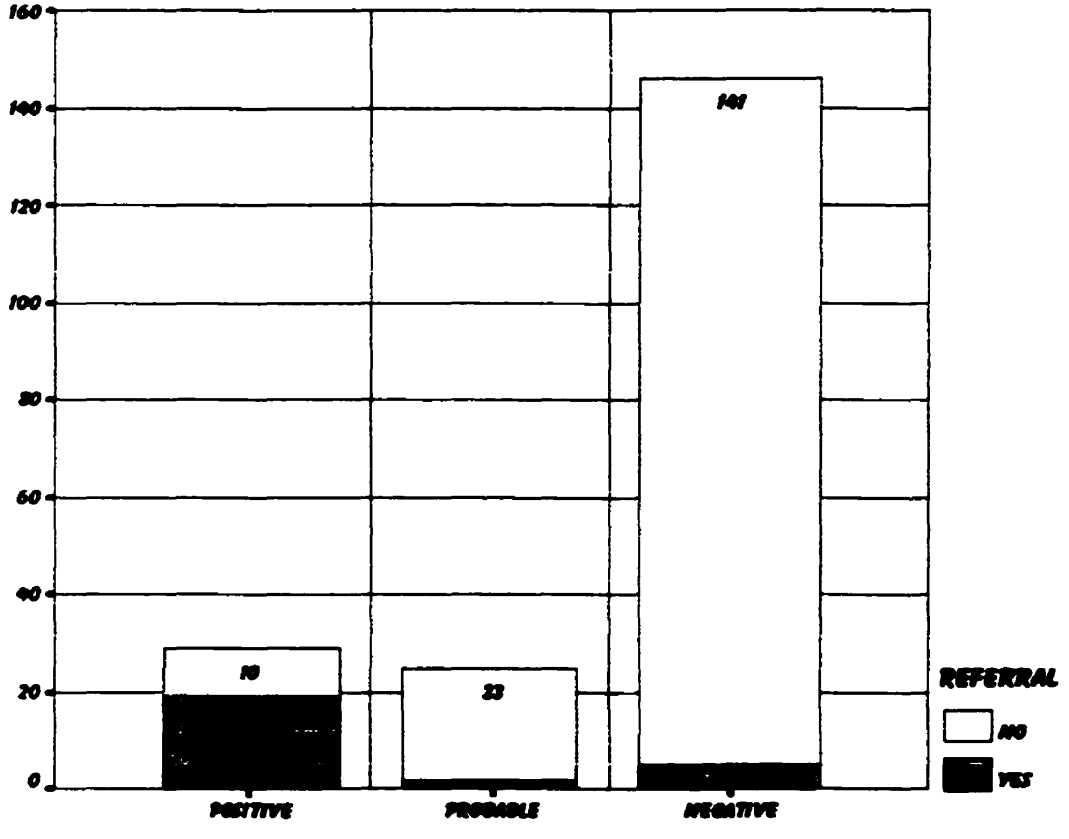


Table 5 shows an inter correlation matrix for selected variables. A significant positive correlation was found between likelihood of violence and social problems. There were a number of significant inter correlations, mainly negative, between the injury categories. If a woman presents with psychiatric problems, social problems were more likely to be also present. The physical injuries were found to be positively correlated with detail in charts meaning that physical injuries were likely to be recorded in the charts. Psychiatric problems were significantly correlated to the likelihood of violence rate but not related to documentation in charts, nor to referral to social services. Referral to social services was more likely to occur if a woman presents with cardiac problems. Also physicians detail was significantly correlated with the likelihood of violence rating, which is not surprising as charts were used to determine the score on the likelihood of violence rating. The charts that rated as "positive" for battery tended to be referred to social services. Again this is not surprising as the social service database was used as a source for some cases.

TABLE 5 : CORRELATION MATRIX

(N=200)	1 Refer	2 Detail	3 Violence	4 age	5 Physical	6 Psych	7 Gyne	8 Cardiac	9 Social
1 Refer to social service	--	.35***	. 60***	-.09	.05	.13	- .06	.24**	.03
2 Detail of chart By doctor	--	--	.47***	-.20**	.36***	.00	-.41***	- .01	.12
3. Violence rate	--	--	--	-.04	.09	.16*	-.16*	.12	.20**
4 Age of woman	--	--	--	--	-.03	.00	.07	.02	.01
5 Physical	--	--	--	--	--	-.35***	-.43***	-.03	-.15*
6 Psychiatry	--	--	--	--	--	--	-.19*	.09	.37***
7 Gynecological	--	--	--	--	--	--	--	.21**	-.14
8 Cardiac	--	--	--	--	--	--	--	--	-.06
9 Social Problems	--	--	--	--	--	--	--	--	--

* p< .05; **p<.01; *** p<.001. Referred, likelihood of violence and detail have been recoded; respectively meaning referred to social services, positive for violence and more detail.

Table 6 and Table 7 show the results of two multiple regression analyzes. Table 6 shows three significant predictors of doctor's degree of detail; more detail was recorded for women reporting physical complaints or injuries; less detail for patients with gynecological complaints.

TABLE 6

Summary of regression analysis for variables predicting degree of detail doctors identify in charts (N=200):

Variable(s)	B	SE B	β
Age	-.02	.01	-.17 *
Physical injuries or complaints	.17	.06	.24**
Psychiatric illness or complaints	-.02	.05	-.03
Gynecological complaints	-.24	.06	-.30**
Cardiac symptoms	.21	.18	.08
Social problems	.28	.15	.13

Note. $R^2 = .27$; adjusted $R^2 = .24$

* $p<.05$
** $p<.005$

Table 7 shows only the detail in doctors charts as a predictor of the likelihood of violence. This is perfectly understandable, as the doctors details in charts are what is used by the researcher to estimate the "likelihood of violence rating". Figure 4 summarizes these relationships graphically.

Table 7

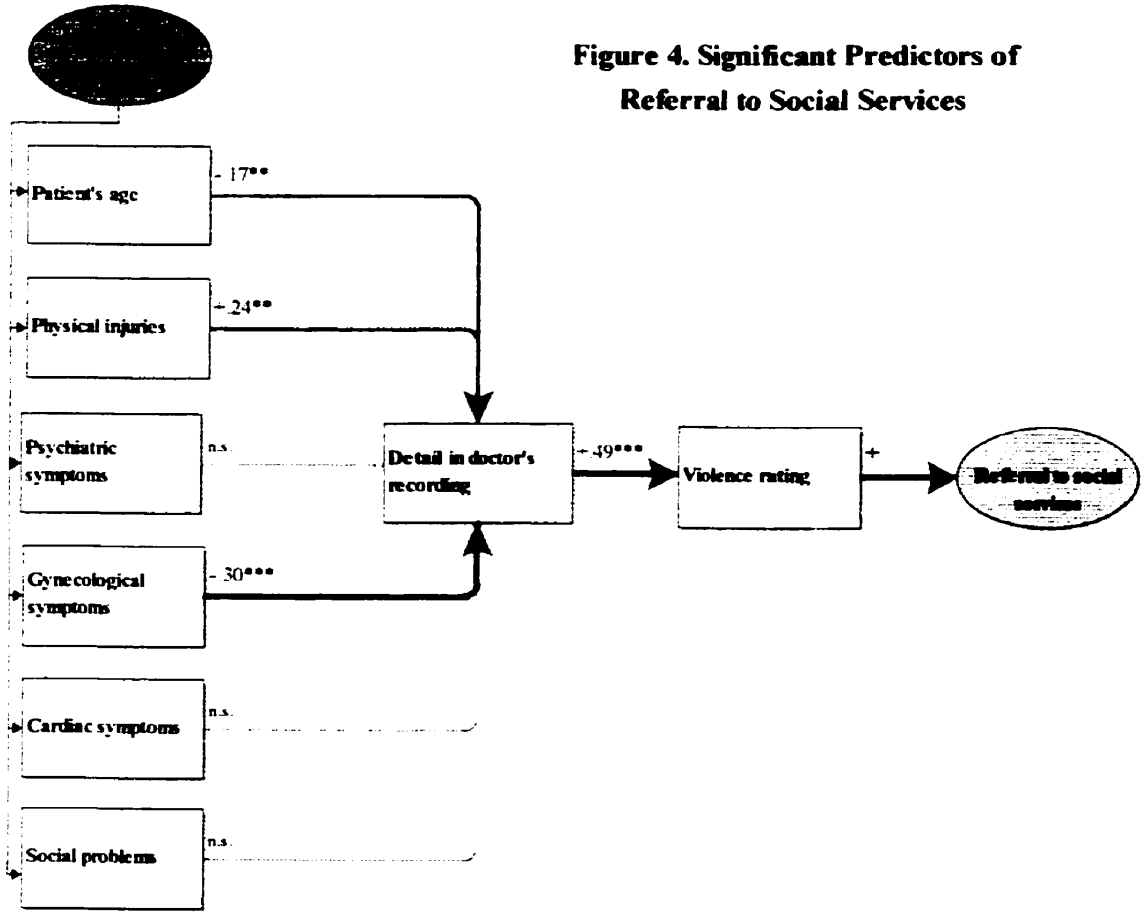
Summary of regression analysis for variables predicting likelihood of violence (N=200)

Variables	B	SE B	β
Age	-.00	.01	.05
Degree of detail in charts	.48	.07	.49***
Physical injuries	- .00	.06	-.01
Psychiatric illness or complaints	- .07	.05	-.13
Gynecological complaints	- .05	.06	-.06
Cardiac complaints	- .29	.18	-.10
Social problems	- .23	.14	-.11

Note. $R^2 = .46$; adjusted $R^2 = .44$

*** $p < .0001$

Figure 4. Significant Predictors of Referral to Social Services



To summarize the findings women present in the ED mostly between 4:00 p.m. and 8:00 p.m. however most referrals to social services were of women who presented in the ED between midnight and 4:00 a.m. Most frequent complaints in this ED were physical complaints followed by psychiatric; however these were not the same cases that tended to be referred to social services. Charts' documentation was more detailed when women with physical injury presented in the ED, whereas gynecological problems received little attention in documentation. Of the 200 charts reviewed for likelihood of violence, 54 were rated as positive or probable; only 21 of these women were referred to social services. What might be the barriers and pathways to detection and referral? Health care professionals offer their insights.

CHAPTER 3
HEALTH CARE PROFESSIONALS DISCUSS BATTERY:
Pathways and Barriers to Detection and Referral

Study design

The research design used in this segment of this inquiry was based on the case study method. Case studies seek to explore a population, an institution or a program. Case studies enable a range of information about a small number of selected cases to be examined to describe a certain situation, in this case, detection and referral of battery. Data were collected with the aid of a semi structured interview guide (Appendix B). In total, ten HCPs were interviewed. Nine participated in two interviews each and one HCP was interviewed only once due to his unavailability because of illness. The questions posed in the first interview explored the barriers and pathways in identifying and referring battered women who present in an emergency department. In the second interview, issues that emerged from the first discussion as well as documentation issues that arose from the chart review were explored.

Setting and Selection of Site

The hospital wherein this study took place is located in the center-west area of the city and serves a large multi-ethnic population with a significant elderly population. This hospital was selected based on personal knowledge. I have been working in Social Services at this institution for the past ten years. Familiar with the hospital and staff, I

was aware of the demands and stresses faced daily. However, I am not a health care professional and thus cannot know what issues they face when they try to detect abuse or refer cases to my department. As a colleague, engaging in qualitative research at this setting, it was relatively easy for me to gain access to the site. According to Seidman (1991), gaining access and developing trust are important features of qualitative research, and a difficult process for researchers.

Briefly, this ED has the following set up. Each patient is seen first by the triage nurse who determines the urgency of the problem and assigns it a code. There are four possible codes. Code I-A refers to critical care patients who are received directly into the "recess room" with four-bed areas, where one nurse is available for every two patients. Code I or II concerns serious injuries or problems. Here patients are sent to the "red unit". This area has twenty-five beds divided into two sections. The first eight beds are for patients who require cardiac monitoring or have a more serious condition. There are a few isolation rooms and a room for psychiatric or violent patients. A wall separates each bed in this area. The remaining nine beds are for patients that require observation without a cardiac monitor. These beds are separated with a curtain and are closer together. Code III deals with minor injuries. These patients wait are assigned to the waiting room. When space is available, the nurse calls patients to be seen.

There are three shifts for doctors in the emergency department: 8:00 a.m. to 4:00 p.m.; 4:00 p.m. to 12:00 a.m.; and 12:00 a.m. to 8:00 a.m. Three doctors cover the emergency on weekdays. Residents are under the supervision of the doctors. The nurses

also have three shifts but start a half-hour earlier than the doctors. Each nurse has four patients in the area of the eight monitoring beds and six patients per nurse in the non-monitoring area. Nurses in recess have two patients each. Two flow nurses take over whenever there is an overflow and cover during breaks. Social Services has two offices located in the emergency department. Two social workers are available weekdays from 8:00 a.m. to 6 p.m., each having a seven hour shift. The same social workers are also responsible for short term units in the hospital, which are patients that come from the emergency department.

Each morning and afternoon there are multi disciplinary rounds attended by the following personnel: the out going doctor(s), a nurse-in-charge, a social worker, a unit agent, a discharge coordinator and incoming doctor(s) and residents. During rounds, discussions center on patients' diagnoses, tests performed and to be performed, possible disposition of patients, and any outstanding concerns.

Sample

The participants were selected using convenience and purposeful non random sampling techniques. Both purposeful and convenience sampling are appropriate for qualitative research studies (Neuman, 1994; Maykut & Morehouse, 1996). According to Maykut & Morehouse (1996) purposeful sampling is based on the notion that each participant is able to offer variability. According to Neuman (1994), purposeful sampling is suitable to gain a " deeper understanding" of the population being studied. A convenience sample is one wherein the sample is selected because of availability; it

offers a "quick and cheap" sample from which to study a particular case or situation (Neuman, 1994).

In this study, purposeful and convenience sampling were reflected in the following ways. For one, all participants were selected from an emergency department with which I was very familiar as I was working in this setting at the time of the study. In this ED, there are a total of 17 doctors and 70 nurses. I approached 13 HCPs and ultimately interviewed ten. The others were not willing to participate due to time constraints. HCPs were five nurses and five doctors assigned to the emergency department in 1996 and were working in the ED when the research was conducted. Both nurses and doctors were included in order to have representation of both sexes (as the physicians in this case are all males) and to have the views of different professionals working in the ED. As well certain HCPs were purposefully approached, according to their role in the ED. For example, one nurse who was an educator was asked to participate because she was involved with all nurses. I also approached one nurse who works mainly in the triage as this is the entry point into the emergency department. They both agreed to participate.

The doctors comprised a fairly homogeneous group. They were all from the same cultural background, educated in Montreal, and had all worked only in this institution. Of the doctors, four were married and one was divorced. Of the married doctors, all have children. The nurses range more broadly in culture, race, education, language and marital status. Table 8 presents demographic information on the participants.

Table 8: Participants demographic information

Participant	Age	Education	Years of Experience	Marital Status	Children
N1	36	McGill	11	married	2
N2	48	College	13	divorced	1
N3	29	College	7	single	0
N4	38	college	12	separated	2
N5	24	college	6	Single	0
D1	34	McGill	7	divorced	0
D2	32	McGill	4	Married	3
D3	35	McGill	6	Married	2
D4	39	McGill	14	Married	3
D5	43	U of M	12	married	2

Procedures

An interview guide was developed with an understanding of the possible reasons that HCPs do not detect battered women as derived from the literature. As little was found in the area of detection and referral, questions were posed to more fully understand, based on the experiences of HCPs, their perceptions regarding the processes of detection and referral of battered women.

Prior to starting the interviews, consent was obtained. Participants were provided with a letter describing the study and their participation (Appendix C). As Glesne and Peshkin (1992 p.111) state, informed consent participants are made aware "that participation is voluntary" and that "they may freely choose to stop participation at any time". Interviews were conducted in the office of either the participant or the researcher. Interviews were conducted between July 1997 and May 1998. Interviews lasted an

average of 62 minutes with the shortest being 40 minutes and the longest 90 minutes. The second interview aimed to clarify any issues that arose from the first transcription, and to include new questions developed from the accumulated responses and from reviewing the charts. This resulted in 259 single spaced pages of transcriptions from a total of 19 interviews.

Data Analysis

As qualitative research is flexible and open-ended, this study used emerging findings to raise and address other issues. As data were collected, the interview guide was refined to address new issues. From the first interview onwards, the data were transcribed and analyzed to identify themes. Additional notes that described each interview were also immediately completed. Each transcript was photocopied, excerpts cut, and grouped together based on themes as suggested by Bogdan and Biklen (1992). All similar themes were piled together and given a temporary name. Also, main ideas were posted on a newsprint board to see if any links could be made. The board allowed for visual linkages. Upon completion of the groups of common material, a name was given which would describe the theme of that group of ideas. Finally, larger connections were made and linked together. The procedure that was followed for this study thus follows Strauss (1990), for whom the first step is to conceptualize the data. Cutting it down into parts is the beginning of the process of analyzing. Naming or labeling is necessary for describing the phenomena as we see it. Strauss (1990) calls this procedure open coding. The next step is to put the information together again in a systematic way

which would connect all the categories and describe the phenomena being studied, which Strauss (1990) refers to as axial coding.

FINDINGS

Intellectual Understanding

Defining the problem

Interviews with HCPs[2] revealed that the problem of 'battery' was familiar to them. When asked to propose their definitions of battery, it became apparent that physical forms of abuse were much easier to present than other configurations (i.e. emotional, sexual or financial). D3 described battery as "physical". Similarly, N2 equated battery with "physical abuse". She added, "I think emotional abuse is really high up there like physical. But for physical abuse I tend to use the word battery". A comprehensive definition was provided by D4:

> Any type of spousal, I will use spousal instead of significant other, is abuse. This could be physical or emotional abuse. Emotional entails degrading, demeaning, abusive behavior that can cause the other person psychological injury, it is not necessarily physical.

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[2] Each quote from a HCP is identified by "D" for doctor and "N" for nurse. The letter is followed by a number 1 to 5 indicating which nurse or doctor happened to be speaking in the particular excerpt.

Causes of Battery and Its Impact

HCPs are aware of the wide range of theoretical explanations for battery. They mentioned male pathology, learned behavior, cultural acceptance, and issues of control. Women provoking abuse was also mentioned in two contexts: if she had a pervious experience of abuse or witnessed abuse as a child or if she instigated a fight with the abuser, she was somehow seen to provoke abuse. The following excerpts illustrate their understanding:

> Well I think it is mostly male pathology. Men may have psychological insecurities or personality problems. They become domineering and have uncontrolled aggression towards the closest person in their life- which is their child(ren) or wife (D2);
>
> Women have very low esteem, poor self worth and probably have been abused as a children (N4);
>
> A lot of cases where there is abuse, they can be traced back to their childhood (N5);
>
> Husbands abuse their wives because of their past [his], their problems and the way they grew up and how he learned to deal with confrontation (N2);
>
> Women where their cultures do not allow them to express their ideas or are considered second class citizens are at risk of being abused (D1);
>
> Some people just do it [batter] because it is their way of feeling secure or to maintain their control over the situation. Perhaps they have no control in other areas of their lives (N5);
>
> People from other countries where they are pulled between what was acceptable in their country and what is acceptable now vis a vis battery is an important thing to remember (N3).

According to D1 anyone can become a batterer if the conditions are right, i.e., "anyone can crack once under the right circumstance with the right degree of stress".

Similarly, D4 stated, "I think it has to be recognized and it can happen under any circumstance that has enough stress".

HCPs viewed battery as affecting women, their health and their children. Depression, learned helplessness and substance abuse were identified as potential outcomes.

> Fairly rare for physical abuse to result in permanent disability. I'm sure all women who are in abusive relationships have psychological sequella and most murders occur from someone they know (D2);
>
> She was a very bright little girl, she was about seven years old. She could tell us that daddy smashed mom (N1);
>
> It could come out as depression (D3);
>
> They sometimes get into a pattern of learned helplessness and they just do not respond to the battery because they feel that it will not make a difference. They become blase or sometimes it becomes a routine (N3);
>
> It [battery] seems to make them [battered women] feel even sadder because their self esteem is stepped on and going back to the same thing. It must be hard for them (N1).
>
> It is [battery] a conflict for women; between he's a great guy to disbelief of this behavior. It could come out as depression, physical complaints or worse; she could get killed (D3);
>
> It's a vicious cycle unfortunately they turn to drugs or alcohol. It affects the children. It affects the woman's physical or psychological self (D1).

HCPs acknowledged that battery occurs but questioned its prevalence amongst patients seen at this institution. They explained this position by relying on the hospital's heavy elderly population. D2 stated "battery is a big issue, but the extent of it is being

overplayed". HCPs feared that the increased focus on battery may create a "paranoia" (D2). The following passages clearly show the HCPs expressing their beliefs that battery is not a problem for their institution, yet admitting that they are perhaps missing the detection of battered women:

> I don't think we are missing as much as literature states. Maybe we are more sensitive to it here, probably not (D2);
>
> In our ED, I would probably say [we see] not that many [battered women] (D3);
>
> Honestly, I don't know how many come [for abuse]. I don't think it happens often (N5);
>
> I am sure we miss a lot. I can't deny it. I could tell you the ones we tend to catch, so the number is an underestimate but mostly we do not know (D4);
>
> I can't say we have a big problem with it [battery]. When I teach the triage course I always address that [abuse] but I don't have much experience (N1).

HCPs have a good understanding of battery. However, when questioned about how they acquired such knowledge, it was evident that their training was minimal to nil. HCPs who were interviewed mostly graduated in the early to mid 1980s. Battery was probably not included in the curriculum, especially in Medicine. D4 explained that "medicine has become more psycho social thus more emphasis on battery exists today". Most of their informal training comes from cases seen in the ED and "reading, discussions like this [referring to interview] and social service orientations"(N1).

Not only do HCPs claim to be sensitive to the issue of battery and know the indicators, they are also aware of what needs to be done to help a battered women.

However, nurses and doctors provided different types of help. Nurses tended to provide more concrete help whereas doctors delegate who would help them.

I give them the S.O.S. number (N3);

I told the patient if it doesn't get better [battery] the ED is always open (N2);

I called the police. They accompanied her to go to a shelter (N4);

I make sure that someone arranges for a shelter (D4);

My job is to identify it [battery] but I can't do the next step (D2).

Detecting Battery: Theory vs. Practice

Despite the theoretical understanding, HCPs were able to recall few cases. "I've worked four years in this ED and I have probably seen about four or five" stated N3. "I have been ignorant on picking it up. Over seven years that I have been here, I probably could count them [battered women] on all my fingers and toes", said D1.

How could it be that HCPs consistently missed battered women? Conversely, what does it take to detect? It seems that only the most explicit cases were identified by the HCPs. As such, the case had to almost hit them on the forehead! The following examples illustrate the point:

> A lady came in with multiple injuries like arm bruising and leg bruising. She said she fell down the stairs but she had a real aggressive, overbearing husband. He was always talking for her. So I was convinced she was abused (D2);
> She came with bruises all over her body; her back, ribs, breasts. She expressed she wanted to die. She gradually told us she had been physically abused by her husband (N5);

> A lady who was five months pregnant, with kick marks on her belly. She went to the caseroom (D3);
>
> This lady was brought in by the police who stated she was beaten up by her husband. The police left and said to call them when she was ready to go to the shelter, as it was already arranged by them (D1);
>
> Her boyfriend beat her over the head with a piece of wood. She told us. (D4);
>
> I remember one that was obvious when she came in she said her husband bit her and took a big chunk out of her forehead. She asked for a divorce (N1).

When asked to describe a case from the recent past where they suspected battery HCPs generally could not recall a case. The response from N1 was typical: " I can't remember. I've been here for 11 years and I can't think of such a case". D1, on the other hand, described case of a woman who came in with a black eye and bruises on her arms. This case had been flagged by the triage nurse. "She said she fell down the stairs. You could see that she was trying to make up a story". D1, suspicious of the story, asked a second time if someone had hurt her and she denied it. As a result, no battery was detected. Unless the abuse is obvious, as will be discussed further in this chapter, it is neither recalled nor detected.

Ingredients needed for detection

When asked what barriers exist in the ED to detect battery, time was indicated as a major deterrent. "Time" emerged in different forms:

> The biggest barrier is that the length of stay in the ED is so short that it does not allow a relationship to be established between HCP and the patient (D5);

> We deal with the objective part in the ED. We lack the time to do a psycho social (N4);
>
> Time is a big issue. How much time we take to triage the patient. Amount of time they spend in the waiting room. Acceptable time they should be in the whole emergency as a whole and it's a matter of statistics, a matter of time (N3);
>
> It would be difficult in terms of time [to detect]. I want to make it clear that I do recognize the importance of it but the time factor is important. Time constraints. Time being able to spend with the patient. Time and not keeping on top of your list of all possibilities related to the injury (D4);
>
> It is basically you have no time or if she starts crying you have to take the time to get the wheels turning for some help but everything else backs up (N5);
>
> I don't want to blame time but they [doctors] don't have time. If they take each and every story personally they will never get out of here (N3).

When probed further, the issue of time seemed less pertinent to detection. Rather, there had to be certain conditions in place in order for detection to occur.

Most striking, it seemed that HCPs relied on the battered woman to a large extent. In order to detect battery, she must present with obvious injuries and in an emotional state. D4, for example, looks for "ugly" injuries. Furthermore, the victim must inform the HCP of the situation, "if they don't tell you, it [battery] goes undiagnosed". D3 stated that the "woman has to be willing to bring it up, admit to it and be ready to deal with it".

HCPs seemed reluctant to probe without certainty of abuse. N5 stated, in a case that "wasn't clear like the other one who came in with all those bruises", "I would prefer to wait and see if she would bring it up".

Another important ingredient is the HCPs own willingness to open up discussion on the issue of battery. It was best expressed by D3: "As a physician I have to be ready to listen and accept what someone is telling me. If I'm stressed I may, not intentionally, not ask or probe". It is not due to lack of knowledge or know how that HCPs do not detect but rather it is because they "do not ask". As D4 put it, that, "I think we find it [battery] more if we are looking for it. Realistically, I do not probe".

HCPs mentioned that "gut feeling" is another element in detecting battery. It was defined as an inner reaction to a visible or invisible evidence that battery may be occurring. The following excerpts show how "gut feelings" help to detect battery.

> To detect abused women you go with your gut feeling, often they present in a fashion that indirectly suggests abuse (N5);
>
> The orthopedic doctors put themselves on the line. They expressed their gut feeling that the injury could not be due to a fall (N2);
>
> I trust my guts in everything I do whether it is taking care of patients, even with very sick, complicated patients. I trust my instincts. My gut feelings are usually right (D1).

Hustling in the ED

The ED is described as a chaotic, exceedingly hectic , high pressure, scary, overcrowded place where HCPs have to be confident and attentive at all times. One needs to work in an organized fashion in order obtain all pertinent information, not to mention survive. The following passages characterize a typical day in the ED.

> It is a battle. Lots of people to see, lots of sick people to see, lot of people who want to be seen right away and lot of people you want to see right away but you can't (D3);
>
> A typical day would be making sure that you have done your job to the best of your ability and make sure you have done things safely(N4);
>
> Lots of coffee. A typical day is running around, seeing lots of patients, and being harassed by different people (D4);
>
> It [ED] is stressful but it's a positive stress for me. I get a buzz, a psychological lift. It's great (D2).

Times are tough

All HCPs expressed some frustration with the health care system. Doctors focused on the hospital and its the links to the community as sites of frustration. They revealed that the number of patients seen in the ED has increased over the past few years. Furthermore, not only are more patients presenting to the ED but they seem to present more complicated medical problems. The virage ambulatoire[3], which was to expedite discharges home more quickly and effectively, is failing according to the experience of HCPs in this ED. Patients are discharged sooner and with limited community resources. As a result, patients return to hospital because the community is unable to maintain them at home.

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[3]Virage ambulatoire: introduced in 1997 this program is designated to have patients leave early from hospital and the community to continue the care plan at home. For example, a patient who has undergone surgery can be discharged earlier and the community [CLSC] will provide daily nursing care such as I.V. antibiotics and dressing changes at home. This decreases length of stay in hospital and cost to the hospital.

Nurses, on the other hand, focused more on direct patient care. They described patient care as discouraging. N2 says "we do patchwork". N4 stated " we write, do this and that but what about quality? What about care?". N1 commented, "you skim the surface. There are budget cuts. We don't have enough qualified nurses to work in high demand areas like the triage and recuss in the ED. Regardless of the profession, HCPs described a system that is limited and fragmented in providing care to the population.

Constraints within the ED

There is great frustration working in a fast-paced environment where contact is limited and split among an overload of patients, families, and co-workers. These features of the workplace, coupled with time constraints, deter identification of battered women. Also problematic is the physical set up of the ED. The triage area, where patients are first seen for their problems, is open and not very private. HCPs are not able to communicate freely in such an environment. In most other areas in the ED, patients are separated by a curtain. According to N3,

> It's the whole setting. I though we would have a closed triage area where you can get their story and you can ask them questions alone. There is no privacy. A battered woman coming to the ED is difficult enough...you don't want ten other people listening.

Most patients with minor injuries or complaints are seen in the Blue unit where old charts are not available due to the high turnover of patients. In this unit, there are no multi-disciplinary rounds that might identify potential victims of battery. Most battered women are seen in the blue unit. The surroundings are crowded, limited time is spent

with the patients, often little history is taken by the nurse. All these barriers make detection less likely. "Unless a patient is very verbal, it [battery] will not get detected. If a HCP has to probe, forget it" (N1). This statement was thematic.

The ED is a stressful environment, not always conducive to the disclosure and detection of battery. The HCPs knowledge and know-how do not guarantee detection due to multiple restrictions. HCPs take an indirect and modest role in detection.

Personal/ Professional Dilemmas

Despite an intellectual awareness of the issues surrounding battery, HCPs working in the ED struggle between their professional duty and their personal feelings and reactions to battery. For instance, D2 indicated that although he would like to take the time with a battered woman, he believes he cannot do much for her. Thus when confronted with two patients, he will devote more time with the patient for whom he believes his medical knowledge will have the most benefit. "I mean it would be wrong not to ask a woman with a bruise what happened, but spending several minutes trying to get something out of her, that is not a worthwhile investment when you could be seeing other patients." He expressed feelings of helplessness with cases of battery. Nevertheless, this doctor conveyed concern with not fulfilling his medical oath to prevent injuries from occurring as well as caring for those in need of medical interventions. Hence the battle within.

Battery may elicit overwhelming feelings which affect helping the victim. For example N1 stated "I think a lot of us can identify [with a battered woman]. We are

from the same age group. [Yet] we are afraid of getting involved. What am I going to say?" " I really feel badly for her and you are almost afraid to tell her because it may not be professional". "I think people feel uncomfortable [with battery]."

Although doctors are diagnosticians and trained to treat, they are afraid to think that they cannot help an individual. When presented with a situation, such as battery, where there is not a clear problem/solution combination, they set limits on themselves regarding how much they will devote to the issue. D3 states "I can only deal with someone else's emotional problems if I'm emotionally okay and open to it. I have a life too and I have problems like everyone else. I have to shut my problems out when I am dealing with such problems. I try my best."

Battery is not a typical medical injury as it encompasses many aspects of the individual's life. HCPs have an easier time intellectually and emotionally focusing on the "injury" rather than the "whole" person.

> Everyone wants a straight forward case but if you don't get the straight forward one, you want to get one that you diagnose but unfortunately medicine is not like that and every day is a physical and mental challenge because you are supposed to keep your cool (D3).

Battery: Whose Job is it to Detect and Refer?

As illustrated earlier, HCPs focus on the physical injuries. The notion that battery may or may not be a medical problem was a complex theme that emerged through the interviews with HCPs. It became apparent that battery was a medical problem by definition but the focus of medical intervention was geared towards the injury.

> It [battery] is 100% a medical problem (D5);
>
> Abuse covers all aspects of a biopyschosocial problem. It [battery] is a medical problem by definition (D1);
>
> Although battery is a medical problem, we are so used to looking at the physical, organic problem. We look at nothing more (N3);
>
> Battery is a police issue, nothing more (N4);
>
> I'm sure we could detect more battered women if we looked at the chief complaint but we don't. We look at the injury (N5).

Battery is a medical problem according most HCPs. Doctors define their role as "protecting the health of the patients" and that they have a responsibility to "do what I can do to identify and enable women to deal with their situation and not to get worse and end up in the newspaper [dead]" (D3). However, on the hierarchy of medical problems, battery is on the low end of the continuum, receiving little attention or direct intervention:

> It would be wrong not to ask a woman with a bruise what happened; but spending several minutes trying to get something out of her, that is not a worthwhile investment when you could be seeing other patients (D3);
>
> Serious psychosocial problems like youth protection or battery, doctors want to know but don't tell them [doctors] to do something about it (N3);
>
> We take care of the booboo and move on to the next patient (N3);
>
> Pain can be a cry for help. You have to go underneath to determine the cause, which we do not do, especially in the ED (N2).

Emergency medicine can be very instrumental in helping patients with a medical problem but with cases of battery, emergency medicine is limited. D3 stated, "you will

not send anyone home that has something bad or present in atypical fashion," but with cases of battery, "there is only so much I can do".

Once battery has been detected, doctors and nurses indicated an obligation to intervene. Ironically, the "medical" treatment plan may not change; the only change in treatment is a referral to social or psychiatric services.

> Once you find out [about battery] you are obligated to find out what extent the woman is in danger and what risk is posed with this woman returning home, whether they need shelter or something else (D2);
>
> The impact on me would be that the patients would stay longer in the emergency or in the waiting room waiting for social services or until the nurse can deal with it (D4);
>
> I always refer to social services, even if she does not want help (N1);
>
> Psychiatry can check it [battery] out for us if the patient is depressed and nothing else seems wrong (N5).

Although battery is declared a medical problem, HCPs seem to focus on the injury and refer the case out. Dealing with the actual cause of the injury, in this case battery, is certainly not clear cut. HCPs within the ED spoke about the professional best suited to screen for battery. Doctors debated the advantages of nurses doing the screening and detecting. "I think they [nurses] could do a better job in identifying the underlying cause of the injury. They take a history and spend more time with the patients"(D4). There are only two doctors during an eight hour shift while there are thirteen nurses. HCPs, in particular the doctors, indicated that as long as they "recognize the problem, that's the

important part; but I'm not the one who will deal with it". They seemed to assume that dealing with it was the nurses' job.

Nurses believed that patients would disclose more to the doctor because "people see nurses as nurse, and doctors as doctors. And doctors know everything. So they give more details to doctors. They tell nurses the bare minimum"(N5). Each HCP believed that the other professional would be better suited to detect and deal with abuse. Thus HCPs may elicit few disclosures because it is believed that someone else will detect. HCPs indicated that someone who could deal with the answer, should ask the question. D5 expressed that battered women will not be detected until someone knowledgeable in the area of battery takes the full responsibility of creating a proven screening tool and administrating it themselves because leaving it up to doctors and nurses in the ED is probably not realistic.

Documenting Battery

Documentation is a discretionary matter . HCPs suggest that documentation is performed according to an individual's style. As D2 states, "It's on an individual basis. Physician X will document one way; physician Y another way". Nurses and doctors presented different issues related to documentation but they all agreed that documentation is, "very, very, very poor and you cannot depend on what is in it [the charts]".

Although there are no clear guidelines for documentation in either nursing or medicine, nurses indicated that their minimum requirement is the completion of a flow

sheet for each patient. The flow sheet was introduced in the latter part of 1996; it records different information about the patient in a checklist fashion. If the patient presents with a problem that is psycho-social in nature, such as battery, a separate sheet is required to document the incident. Nurses generally only include facts in the charts. Few suspicions of abuse or battery will be documented because of fear that legal action might be taken. N2 indicated that "there is very little for psycho-social or interaction documented in the charts. I think that nobody really wants to say [a woman is battered] and be held to what they write." Nurses reported that patients may be asked many questions, but the responses may not be recorded. Nurses often alleged that much more is said during verbal report than what is written in the charts. Nurses replied that doctors do not read their assessment because "the nurse has her charting separately from the main chart. Doctors only ask for the nursing part if they want to know something medical"(N1).

Doctors focused on legal implications regarding documentation. According to D3, HCPs must focus on items such as chief complaint, past medical history, allergies, medications, findings from physical exam, impression and plan. This minimal information is imperative, "anything less is unacceptable". Doctors had no problem writing in the charts their suspicions and gave examples of how they would write it.

> If the injury pattern is so suspicious for abuse then I'll document it, even if she does not admit to it (D2);
>
> I'll write R/O [rule out] domestic Violence and this is acceptable and legal (D3).

In contrast to this rhetoric, the chart reviews (chapter 2) showed documentation in charts is overall poor, detail is provided on certain complaints or injuries. Women with gynecological problems were less likely to have documentation in their medical chart. Women with physical injuries were more likely to have more documentation in their charts.

To Refer or Not to Refer: That Is The Question

The referral process is complex and a far cry from being systematic. There was some discussion around who battered women should be referred to for support and help. The determining factors seemed to center on how the woman presented herself. If the woman appeared depressed, then she would be referred to psychiatry. Psychiatry also received referrals for women whose husbands admitted to battery in the ED. These couples were then referred to psychiatry for "couple therapy". HCPs indicated that referral to social services was secondary. One HCP stated that battery is not a social service issue but rather a police issue. "I think abuse in the ED is predominantly a business with 911, rather than social services... I usually get my way, I involve the police myself" (N4). As D2 said, "If there is a psychiatric component you go to psychiatry. If social services are around and I don't think it is psychiatric issue then I would call you [social worker].

HCPs used words such as "probably," "maybe," "most," or "it depends" when discussing referral of battered women to social services. Clearly, battered women are not all referred. There seems to be no clear indication of when battered women are referred

to social services even though the protocol in the ED recommends that **all** battered or potentially battered women be referred to the social worker. Even though N5 said, "Usually if I suspect abuse, I refer them to social services," the chart reviews (Chapter 2) showed that actual referrals for suspected battery were very few indeed. To be specific, only three from the emergency department database were referred to social services.

There is a tendency to refer battered women to social services when the HCPs are 100% sure that the woman has been battered. According to D2, "90% of referrals made to social services are cases where it [battery] was obvious and she says I've been beaten up".

Some reasons that HCPs gave for not referring battered women pertain to their beliefs and experiences. These included the belief that a battered woman will just return home, therefore it would do no good to refer the woman to anyone, or the view of battery as an overwhelming issue with which to involve oneself or others. HCPs also communicated fear of involving social services for fear of being wrong in their suspicions. D1 said "I can call social services but its a big thing. If I was totally wrong, there is a defamation of character for the husband or boyfriend".

As with detection, HCPs have their own way of deciding which and when battered women are referred. The roles of social services and psychiatry vis-a-vis battered women are confused, giving the impression that these disciplines are not well understood by HCPs working in the ED.

CHAPTER 4: DISCUSSION

Key findings

In this study, it was found that women were between 25 and 35 years old, arriving to the emergency department between 4:00 p.m. and 8:00 p.m., predominately. The most common category of injury was physical, followed by psychiatric related symptoms. The majority of women presented to the ED with physical injuries (44%), which is a predictor of degree of documentation but not significant in relation to referral to social services. Literature indicates that visits to the ED for physical injuries are often visits related to battery, as are the strong indicators of attempted suicide, pregnancy related problems and drug addictions. In this study, physical injuries did offer a clue to battery, whereas psychiatric or gynecological problems did not.

A number of women with a positive or probable rate for likelihood of violence were referred to social services (10.5% of the total number of cases). A significant number of women who were rated as positive or probable for violence were not referred (N=33, 16.5%). The actual number of women referred to social services for battery from the random sample of the ED database were few (n=3). There is no way to empirically check on the rate of detection, except for the doctor's detail in charts, a proxy variable. The likelihood of violence rating was a significant predictor of referral to social services. This makes perfect sense given that these charts were derived from the social service database.

Doctors provided very little detail in charts. From the sources for the sample in this study, the social service database had more injury detail. This finding makes sense given the particular selection of the chart sample. Of the non-referred emergency database charts most had little detail concerning the presenting problem. The risk markers that predict how much detail doctors include in charts are women with physical injury or complaints. Women with gynecological problems received less documentation by doctors; cardiac, social and psychiatric problems had no relation to detail in charts.

Intervention requires detection, referral and action. In this study, HCPs were seen to have an intellectual knowledge about issues surrounding battered women, however they had difficulty providing case examples. In this study, the interviews revealed that HCPs did not probe nor detect; they either relied on women to tell or assumed that someone else would ask about abuse. As a result, referrals were few. Thus, the ED has potential as an "ideal" setting, but the ideal is far from reality.

The possible reasons for non-detection and non-referral identified by HCPs in the ED were environmental barriers, personal attitudes and beliefs and a curious reliance on the woman to disclose the battery. Thus for detection to occur, the injuries must be explicit and severe and the women must disclose. According to the literature, battered women have little self worth, often feel responsible for the battery and feel trapped in their endless cycle of violence. By imposing the responsibility of disclosure on the battered woman, she is further isolated, her fear of never being able to address her abuse is reinforced and she is further entrapped in her complicated and devastating life.

In this study, doctors were more likely to document cases involving women with physical problems. This finding was not surprising since, from the interviews, HCPs stated that their intervention stopped at the injury, i.e. fractured wrist. What was documented in the chart was a fractured wrist, not battery as the possible cause of injury. Medical practice, which supposedly entails a biopsychosocial assessment, in fact offers only the "biological" component. Nursing practice, even more so than medicine is supposed to include attention to a broad range of variables. This must be detrimental to the health and well being of battered women.

In the rare instance that detection did occur, there was no indication that all cases were referred to social services for intervention and planning. HCPs in the interviews were not always in agreement that battered or potentially battered women should be referred to social services. One would surmise that a doctor who provides enough detail in the charts is asking more questions and in doing so s/he is in the position to detect battery and subsequently refer. Having said this, the charts displayed few well documented accounts of battery.

Methodological Limitations

This sample was constructed in a fashion that included a number of women who were referred to social services for violence in order to make comparisons with the random emergency department sample. As such, it is impossible to assess how much the HCPs actually knew about battery from the chart documentation, given that during the interviews, 7 out of 10 HCPs indicated that information was often passed verbally but not

documented. Documentation is thus only a partially satisfactory source for answering the question of whether HCPs detect battery. The grid completed for each chart only included information from the chart that was documented. As charts were poorly maintained, the results from the chart review were limited to the information available in the charts. The extent and type of intervention that occurred could not be inferred. Finally, the selection of the cases reviewed was based on a specific set of diagnoses from the literature. Cases referred to social services could have been missed as women may have presented with other possible risk markers.

As well, the insights garnered from these 10 health care professionals should not be generalized to all HCPs. Rather, these insights could be subjected to broader study, possibly with the aid of a survey design.

Suggestion for Research and Practice

This study gives rise to a number of unanswered questions. For one, known indicators of battery failed to alert HCPs to this problem, i.e. gynecological problems such as difficult pregnancies or psychiatric problems such as suicide. Is this an issue of inadequate knowledge and training or inadequate documentation? Two, even in cases where battery was positive or probable, referrals were not made in almost 2/3 of cases, including 1/3 of cases with positive identification of battery. What roles do lack of familiarity with social services, and multiple barriers to detection and referral, i.e. fear of involvement and fear of erroneous judgement, play in this process?

Clearly, better training is needed for health care professionals which confronts the barriers to detection seen here. Also, since HCPs seem to have diverse ideas about the role of social work, it would be of interest to further explore the conceptions and misconceptions that they have about social work as well as the issue of battery. Training could include case examples where HCPs are asked what they would do in such situations as well as developing a instrument that can measure their reactions to videos or role plays.

As individual social workers, we too must become aware of our own barriers and beliefs about battery. We must keep informed on effective intervention plans as well as resources available within the community. Social Work as a discipline might take an active role within the hospital on the issue of battery: a joint effort from the institution and the department of social work could demonstrate to hospital employees that battery is not acceptable; social work could offer support, counseling and resources to workers; and, devise training programs to be implemented with the HCPs regarding detection and referral. Some final suggestions on improving detection and referral are:

- The department of social work should provide training to HCPs about battery issues, both formal and informal;
- To improve detection, Social workers should provide on-going training to all ED staff, not only new residents and student nurses. The staff need to be refreshed on indicators, as well as methods of intervening quickly and effectively. Training should also include information about the role of social work. The significance of related issues to battery should be included in the training. These are youth protection, alcoholism, suicide and pregnancy. In doing so, the rate of detection may increase;

- Social work can assist in developing a way to screen all women as potential victims of battery. A simple question could alert the HCPs to involve social services for an assessment. HCPs need to question in more detail how injuries occur and explore the circumstances around the injury. A screening tool for all patients should be considered. The injury or complaint needs to be properly documented. In case of battery, pictures or body maps may be easier and faster to complete. The development and implementation of such protocol for treating battered women would be followed with every case of potential and actual battery;

- For this emergency department, certain structural barriers need to be addressed. First, the triage area which offers no privacy should be redesigned so that the triage nurse can speak to the patient privately. Second, the Blue unit needs to have better ways of ensuring that all women have their charts documented and that they can be seen and assessed without other family or patients nearby. Thirdly, the ED computer system must include a diagnosis category for violence and the primary reason for ED visit is the battery; not the injury;

- Nurses' charts should not be separate from the medical chart as information is lost between HCPs. The patient medical chart should include all information- nursing and medical as well as other disciplines that may be involved;

- Screening for battery is a responsibility of all HCPs working in the ED. Due to the circumstances in the ED, an open dialogue is needed between nurses and doctors to discuss which discipline is better suited for initial screening of battery.

- Patients could be provided with pamphlets on battery with telephone number of community and hospital social work departments;

- Training should include issues not only regarding the abuse of the patient, but also regarding the personal beliefs of HCPs that may affect their interaction with these patients;

- Realistically with the pressures and demands on HCPs working in the ED and added limited hospital resources and institutional demands, social workers are essential as team players in the planning and intervention of battered women. A presence versus on-call basis is more beneficial since women need to be seen at the time of crisis to make an impact.

> Furthermore, follow-up post-discharge is difficult and, at times, impossible, which means that patients will not be re-evaluated and they will be left without resources unless social workers deal with them at the time of their hospital visit. Recommendation would be to have a social worker should work the evening and night shifts to provide services to battered women and support to staff.

As social workers, we not only work with the battered women but we are connected to all the systems with which battered women come into contact. Without taking responsibility to educate, train and inform, we are not providing the optimal care to battered women who present in a hospital. We too, like other HCPs, will be providing band-aid treatment to battered women, and it may cost the woman, her life.

APPENDICES

A. Check list: Grid of indicators and likelihood of violence rate

B. Interview Guide

C. Letter to HCPs and Consent form

APPENDIX A
CHECKLIST OF RISK MARKERS

U#_____

Name of physician:
Date of ED visit:
Time of ED visit:
Diagnosis code:
Name of nurse:

CIRCLE APPROPRIATE RESPONSE 1=YES 2=NO

1 Age_____

2	Admit	1	2
3	Patient accompanied to ED?	1	2
4	With whom **spouse**	1	2
5	**boyfriend**	1	2
6	**friend**	1	2
7	**parent**	1	2
8	**child**	1	2
9	**neighbor**	1	2
10	**other** _____		

WHICH OF THE FOLLOWING INJURIES ARE IDENTIFIED IN THE CHART?

11	Injury to arms	1	2
12	Injury to fingers	1	2
13	Injury/pain to hands	1	2
14	Injury/pain to head	1	2
15	Injury/pain to neck	1	2

cont' which of the following injuries are identified in the chart?

CIRCLE APPROPRIATE RESPONSE 1=YES 2=NO

16	Injury to face	1	2	
17	nasal fracture	1	2	
18	bruises	1	2	
19	pelvis pain	1	2	
20	back pain or tenderness	1	2	
21	chest pain	1	2	
22	chronic pain	1	2	specify_____
23	muscle pain	1	2	
24	Palpitations	1	2	
25	dizziness	1	2	
26	headache	1	2	
27	inability to sleep	1	2	
28	injury to genitals	1	2	
29	injury to breasts	1	2	
30	burns to body surface	1	2	
31	strangulation marks	1	2	
32	bleeding injury	1	2	
33	fracture specify	1	2	
34	suicide attempt	1	2	
35	drug abuse	1	2	
36	alcoholic	1	2	
37	anxiety	1	2	
38	depression	1	2	
39	crying spells	1	2	

40	abortion	1	2
41	miscarriage	1	2
42	premature labor	1	2

PART II

43	Is it stated in dossier if patient stated she was hurt?		1	2
44	Does patient state who hurt her?		1	2
45	specify	spouse	1	2
46		boyfriend	1	2
47		friend	1	2
48		other	1	2

49 Do nursing notes indicate that patient was hurt? 1 2

50 Do nursing notes identify the abuser? 1 2

51 Does physician identify details of injury? (CIRCLE ONE NUMBER)

(1) **in detail**, including where injury took place
how long ago it occurred
who caused harm, what relationship is the person to to the patient, how did it happen
what did the patient do

(2) **vague** chart states that patient was hurt
no details of who harmed the patient
may include when injury occurred
may include what happened

(3) **no details** chart does not identify the location of injury, who caused harm, nor when it occurred

LAPSE TIME BETWEEN INJURY OR PAIN AND ED VISIT(CIRCLE ONE)

52	less than 5 hours	1	56.	not indicated	0
53	5 hours to 10 hours	2			
54	10 to 24 hours	3			
55	more than 24 hours	4			

57 **was case referred to social services**? 1 2

58 **BASED ON THE WHOLE MEDICAL DOSSIER**

HOW MANY ED VISITS ARE RECORDED? _____

59.

LIKELIHOOD OF VIOLENCE RATE

OVERALL HOW WOULD THIS LAST ED VISIT BE RATED? (CIRCLE ONE)

(1). _____**POSITIVE**: This is definitely an abused woman who stated she was abused either directly or indirectly. The health care professionals did continue to explore the information provided by patient. There is an open dialogue between patient and health care professionals.

(2). _____**PROBABLE:** There are some inferences to risks, either by patient or Health care provider but it is not explored. Reason for ED visit may be related to an injury related to battered women but patient was not questioned in detail. Documentation lends towards abuse.

(3). _____**NEGATIVE**: There is no indication that this woman has been abused upon this last ED visit.

comments:_____

_____

_____

APPENDIX B

INTERVIEW GUIDE

UNDERSTANDING OF BATTERED WOMEN

1. **General**

What do you believe are its causes of [insert concept]?

What forms does it take?

Who is at risk of being battered

What are the effects of this abuse?

2.Personal observation

In your lifetime, have you seen this problem?

Did this experience have impact on how you think about battery against women?

3.Professional experiences

Describe a typical day in the ED.

Thinking about your professional experience in the recent past, describe one case of battery that you could easily identify.

Thinking about your experience in the recent past, describe one case where you suspected battery but were not sure.

Thinking about your experience in the recent past, describe a case that was not identified as battery but might have been on hindsight.

Considering these three cases how do you identify battery?

Considering these three cases how do you distinguish a battered woman from one who is likely not battered?

Upon review of two actual dossiers (present Health care professional with summary) describe those factors that gave rise to a referral for battery and those factors that appeared to discourage referral.

PROFESSIONAL FORMATION

Medical or nursing education

Your graduation

TRAINING re violence against women during your formal education.

Length of professional practice.

Length of professional practice at this ED

DEMOGRAPHIC PROFILE

AGE PLACE OF BIRTH CULTURAL IDENTITY

language RELIGION MARITAL STATUS

FAMILY COMPOSITION

APPENDIX C
July 1997
I am studying pathways and barriers encountered by health care professionals in identifying and referring battered women in the Emergency department. Though battered women come to the Emergency Department for medical treatment, often they do not reveal their abuse and under detection remains a problem. I would appreciate your participation in this study designed to better understand ways of detection and responding to the needs of battered women in the ED.

As a participant in this research, I request that you participate in two 60 minutes interviews, which will be scheduled at your convenience. In the first interview, I will ask you to examine the pathways and barriers in identifying battered women. During the second session, I will focus on your professional experience in general and your understanding of wife abuse in particular as well as discuss any outstanding issue that emerged from our first meeting. You may decline to answer questions with which you are not comfortable.

Each interview will be audio taped and transcribed for analytic purposes. All identifying information will be removed from the transcripts in order to ensure confidentiality. Audiotapes will only be heard by the interviewer. You can withdraw from the study at any time.

Please be advised that this study is undertaken as part of the requirement for a MSW degree at McGill School of Social Work. The study will be published in thesis format and its findings may be submitted to scholarly journals.

Attached, please find a consent form to be signed by you. This form demonstrates my commitment to your anonymity and confidentiality.

Thank you for taking time from your very busy schedule. I value your cooperation, and your insights into this problem. If you should have any questions please do not hesitate to contact me.

Sincerely,

Cristina Iorio, BSW, PSW
Department of Social Services
(514)340-8240
(514)366-0913

CONSENT FORM

I agree to participate in a study designed to examine pathways and barriers to identification, detection and referral of battered women presenting in the Emergency Department, as articulated by health care professionals.

I agree to participate in two 60 minute interviews. I understand that these interviews are being conducted for research purposes. I am aware that these interviews are being audio taped and transcribed. I am assured that all identifying information about me will be removed from the transcripts. I understand that the researcher, Cristina Iorio, will produce written documentation resulting from these interviews.

I understand that my participation is voluntary, and that I may withdraw my consent at any time.

Signature:_____ Date:_____

Witness:_____ Date:_____

REFERENCES

Abbott, J.; Johnson, R.; Koziol-McLain, J.; Lowenstein, S.R. (1995). Domestic violence Against Women Incidence and Prevalence in an Emergency Department Population. *JAMA* 273(22), 1763-1767.

Alpert, E.J.(1995). Violence in Intimate Relationship and the Practicing Internist: New "Disease" or new agenda? *Annals of Internal Medicine*, 123(10), 774-781.

Alpert, E.J.; Cohen, S.; Sege, R.D.(1997). Family Violence: An Overview *Academic Medicine* 72(1), Suppl. Jan, S3-S5.

Alpert, E.J.; Sege, R.D.; Bradshaw, Y.S.(1997). Interpersonal Violence and the Education of physicians. *Academic Medicine* 72(1), suppl Jan, S41-S49

American Medical Association, Council on Ethical and Judicial Affairs(1992) Physicians and domestic violence: Ethical considerations. *JAMA* 267(23), 3190-3193.

Ashur, M. L.C.(1993). Asking about Domestic Violence SAFE questions. *JAMA* 269(18),2367.

Baker, N.J. (1995). Strategic Footholds for Medical Education about Domestic Violence. *Academic Medicine* 70(11), 982-985.

Bergman, B.; Brismar, B. (1991). A 5 year Follow-up Study of 117 Battered women. *American Journal of Public Health* 81(11), 1486-1488.

Bersani, C.A.; Chen, H.. (1988). Sociological Perspectives in Family violence. In VanHasselt, Vincent B.; Morrison, Randell L.; Bellack Alan S & Hersen Michel (editors) Handbook of Family Violence.

Bogdan,B; Biklen,B.(1982). Qualitative research for education: An introduction to theory and methods. Boston: Allyn & Bacon inc.

Bograd, M. (1984). Family Systems Approach to Wife Battering A Feminist Critique. *American Journal of orthopsychiatry* 54(4), 558-568.

Bokunewicz, B.; Carman, L. (1992). Attitudes of Emergency nurses before and after a 60 Minutes Educational Presentation on Partner Abuse. *Journal of Emergency Nursing* 18(1), 24-27.

Bowlby, J. (1988). A Secure Base. N.Y.: Basic Books.

Breines, W; Gordenn,L. (1983). The new scholarship of family violence. *Signs* 8(3), 490-531.

Brekke, J.S. (1987). Detecting wife and Child abuse in clinical settings. *Social Casework* 68(6), 332-338.

Bronet, M; Iorio, C. (1997). A descriptive study of Social Service referrals in a Hospital Emergency Department. Submitted to Syndey Duder for Quantitative Research Methods Course. Unpublished manuscript, McGill University School of Social Work.

Brown, J.B.; Lent, B.; Sas, G.(1993). Identifying and treating wife abuse. *The journal of family practice*, Vol 36(2), 185-191.

Campbell, J.; Harris, M.J.; Lee, R.K.(1995). Violence research: An overview. Special Issue: nursing's response to our culture of violence. *Scholarly Inquiry for Nursing Practice* 9(2), 105-126.

Campbell, J.C.; Sheridan, D. (1989). Clinical Articles: Emergency Nursing interventions with battered women. *Journal of emergency Nursing* 15(1), 12-17.

Chambliss, L.R(1997). Domestic Violence: A public health crisis. *Clinical obstetrics and gynecology* 40(3) 630-638 sept.

Chescheir, N.(1996). Violence Against women: response from clinicians. *Annals Emergency Medicine* 27, 766-768.

Chez, R.A.; Jones, R.F. (1995). The battered women. *American journal of obstetrics and Gynecology* 173(3), part 1, 677-679.

Cohen, S; DeVos E.; Newberger, E.. Barriers to physician identification and treatment of family violence: Lessons from five communities. *Academic medicine* 72(1) S19- S25, Jan 1997.

Counts, D.A.(1987). Female suicide and wife abuse: A cross cultural perspective. *Suicide and Life Threatening Behavior*. 17(3), 194-204.

Covington, D.L.; Maxwell, J.G.; Clancy, T.V.; Churchill, M.P.; Abrens, W.L.(1995). Poor hospital documentation of violence against women. *Journal of trauma*, 38(3), 412-416.

Cullinane, P.M.; Alpert, E.J.; Freund, K.M.(1997). First year medical students' knowledge of, attitudes towards, and personal histories of family violence. *Academic Medicine* 72(1) 48-50 Jan.

DeKeseredy, W. (1991). Women abuse: sociological perspectives. Toronto: Thompson Educational publishing.

Delahunta, E.A.(1995). Hidden Trauma: The Mostly Missed Diagnosis of Domestic Violence. *American Journal of Emergency Medicine* 13(1), 74-76.

Dickstein, L.J.(1997). Practical recommendations for supporting medical students and faculty in learning about family violence. *Academic Medicine* 72(1) S105- S109, Suppl. Jan.

Dobash, E.R.; Dobash, R.P.(1987). Violence Towards Wives in Treating the Disorder Treating the Family. Jim Orford (ed.) Baltimore: John Hopkins University Press.

Domestic Violence Task Force, Conference of Boston Teaching Hospitals (1997). Responding to Domestic violence: A coordinated response by a consortium of teaching hospitals. *Academic medicine* 72(1) Supp, S59- S65.

Drossman, D.A.; Leserman, J.; Nachman, G.; Li, Z.; Gluck, H.; Toomey, T.C.(1990).Sexual and physical abuse in women with functional or organic gastrointestinal disorders. *Annals of internal medicine* 113, 828-833.

Dunber, D.; Jeannechild, N. (1996) The stones and strengths of women who leave battering relationships in Brothers, B.J. (Ed) Couples and Change. NewYork: The Haworth Press Inc.

Dutton D. (1988). The domestic Assault of women: Psychological and criminal justice perspectives. Boston: Allyn and Bacon.

Easley, M.(1996). Domestic violence. *Annuals of emergency medicine*. 27, 762-763.

Eisner, Elliot (1991). The enlightened eye: Qualitative inquiry and the enhancement of educational practice. NY: Macmillan Publishing Co.

Family Violence Education on Medical school based residency programs (1995). *MMWR* 45(31), 669-671.

Ferris,L.E. (1994). Canadian Family physicians' and general practitioners' perceptions on their effectiveness in identifying and treating wife abuse. *Medical Care* 32(12), 1163-1172.

Finn, M.A.; Stanlans, L.J. (1995).Police referrals to shelters and mental health treatment: examining their decisions in domestic assault cases. *Crime and Delinquency* 41(4), 467-480.

Flitcraft, A. Council on Ethical and Judicial Affairs American Medical Association (1992). Physicians and domestic violence Ethical considerations. *JAMA* 267(23), 3190-3193.

Gelles, R.; Cornell, C.P.(eds), (1983). *International Perspective on Family Violence.* Toronto: D.C. Health & Company.

Gendron, Colette.(1991). Developpment d'un instrument d'identification des femmes violentees en melieu conjugal .Ecole sciences infirmieres de L'Universite Laval.

Ghent, W.R.; DaSylva, N.P.; Farren, M.E.(1985). Family Violence: Guidelines for recognition and Management. *Canadian Medical Association Journal.* 132(1), 541-548.

Goldberg, W.G.; Tomlanovich, M.C.(1984). Domestic Violence Victims in the Emergency Department: New Findings. *Journal of the American Medical Association* 51, 3259-3264.

Gondolf, E.W.; Fisher, E.R.(1991). Wife battering in Ammerman, R.T.; Hensen, M. (eds) Case Studies in Family Violence. plenum Press, N.Y..

Gondolf, E.W.; Fisher, E.R.(1988). Battered Women As Survivors: An Alternative to Treating Learned Helplessness. Lexington Books: D.C. Health Company.

Goyette, C.; Faghfoury, N.(1993). A Window on Family Violence in Canada Results of Vis- a Vis National Survey. *Vis- a - Vis* Nov. 18, 8-9.

Gremillion, D.H.; Kanof, E.P.(1996). Overcoming barriers to physician involvement in identifying and referring victims of domestic violence. *Annals of emergency medicine* 27(6), 769-773.

Grunfeld, A. CAEP News.(1994). Detection and care for women in abusive relationships: Consensus opinion for emergency physicians. *The journal of emergency medicine.* 12(4), 567-568

Hadley, S.M. (1992). Clinical articles working with battered women in the emergency department: A Model program. *Journal of Emergency Nursing* 18(1), 18-23.

Hartman, C.R.(1995). The nurse-patient relationship and victims of violence. *Scholarly Inquiry for nursing Practice: An international journal.* 9(2), 175-192.

Hamby, S.L.(1996). The dominance scale: Preliminary Psychometric Properties. *Violence and victims* 11(3), 199-212.

Hampton,R.L.; Gullotta, T.P.; Adams, G.R.; PotterIII, E.H.; Weissberg, R.P.; Murphy, C.M.; Lascardi, M.(1993). Family violence prevention and treatment. CA: Sage publications.

Hayden, S.R.; Barton, E.D.; Hayden M. (1997). Domestic violence in the emergency department: How do women prefer to disclose and discuss the issues? *Journal of Emergency medicine* 15(4), 447-451.

Henderson, A.D.; Erickson, J.R.(1994). Enhancing Nurses' Effectiveness with abused women. Awareness, reframing, support, education. *Journal of psycho social nursing* 32(6) 11-15,

Hendricks-Matthews, M.K(1997).. A survey of family violence curricula in Virginia medical schools and residences at university medical centers. *Academic Medicine* 72(1), 54-56, Jan.

Hendricks-Matthews, M.K.(1997). Ensuring students' well being as they learn to support victims of violence. *Academic Medicine* 72(1), 46-47, Jan.

Hoag-Apel, C.M.(1994). Protocol for domestic violence intervention. *Nursing Management sept., 81-82.*

Hotaling, G.; Sugerman, D.; Lowell, M.A.(1990). A risk marker analysis of assaulted wives. *Journal of Family violence*. 5(1), 1-13.

Hotch, D.; Grunfeld, A.; Mackay, K.; Cowan, L.(1991). Domestic violence Intervention by emergency department staff. Vancouver Hospital & Health Sciences Center.

Hudson, W.W.; McIntosh, S.R.(1981). The assessment of spouse abuse: two quantifiable dimensions. *Journal marriage family*. Nov, 873-885.

Isaac, N.E.; Sanchez, R.L..(1994). Emergency department response to battered women in Massachusetts. *Annuals of emergency medicine* 23(4), 855-858, April.

Jaffe, P.; Wolfe, D.A.; Wilson, S.; Zak, L.(1986). Emotional and physical health problems of battered women. *Canadian journal of psychiatry* Vol 31, Oct., 625-629.

Johnson, Holly.(1996). Dangerous Domains Violence against Women in Canada. Toronto: Nelson Canada.

Johnson, Holly (1990). In C.McKie and K. Thompson (eds) Canadian Social Trends. Toronto: Thompson Educational Pub.

Johnson, Norman in Kingston, P; Penhale, B. (Eds) (1995). Family violence and the caring professions. Macmillan London.

Keller, E. (1996). Invisible victims: battered women in psychiatric and medical emergency rooms. *Bulletin of the menninger clinic* 60(1), 1-21.

Klingbeil, K.S.; Boyd, V.D. Emergency room intervention. Detection, assessment and treatment. In Roberts, A.R. (Ed) (1984) Battered women and their families. Intervention strategies and treatment programs Springer Publ. Co. N.Y.

Kornblit, A.(1994) Domestic violence an emerging health issue. *Social science Medicine* 39(9), 1181-1188.

Koss, M.; Goodman, L.; Browns, A.; Fitzgerald, L.; Puryea, K.G.; Russo, N (1994). No safe Haven: Male violence against women at home, at work and in the community American psychological association.

Krane, J. E. (1996). Violence against women in intimate relations: Insights from cross-cultural analyses. *Transcultural Psychiatric Research Review* 33, 435-465.

Kurz, D. (1989) Social science perspective on wife abuse: current debates and future directions. Special Issue Violence against women. *Gender and society* 3(4) 489-505.

Lacroix, S. Double Isolation; The case of the abused immigrant woman. *Focus* 4(2), 1-5.

Lazzaro, M.; McFarlane, J. (1991). Establishing a screening program for abused women. *JONA* 21(10), 24-29.

Lloyd, S.. Social work and domestic violence. In Kingston, P.; Penhale, B (eds) (1995) Family violence and the caring professions. Basingstoke: Macmillan.

Loraine, K. (1981). Battered women: The ways you can help. *RN*, 102, 23-28.

Loring, M.T.; Smith, R.W.(1994). Health Care Barriers and interventions for battered women. *Public Health reports* 109(3), 328-338.

Loseke,D. "Violence" is " violence"...or is it? The social construction of "wife abuse" and public policy. In Best, J (ed) (1989) Images of Issues: typifying contemporary social problems. N.Y.: Aldene de Gruyter.

Lupri, E. Male violence in the Home in McKie, C; Thompson, K. (Eds) (1990) Canadian Social Trends. Toronto: Thompson Educational Publishing.

Mackenzie, D. (1985) Wife abuse: An overview of salient Issues. *Canadian journal of community mental health* 4(1), 65-79.

Mancoske, R.J.; Standifer, D.; Cauley, C.(1994) The effectiveness of brief counseling services for battered women. *Research on social work practices* 4(1), 53-63.

Margolin, G.; Burman, B. (1993). Wife abuse versus marital violence: Different terminologies, explanations and solutions. *Clinical psychology review* 13(1) 59-73.

Maxwell, J.A. (1996). Qualitative Research Design: An interactive approach. Thousand Oaks, CA: Sage.

Maykut, P; Morehouse, R.(1994). Beginning Qualitative research: A philosophic and practical guide. London: The Falmer Press.

Mc Coy M.(1996). Domestic Violence: Clues to Victimization. *Ann. Emergency Medicine*. 27, 764-765.

McFarlane, J.; Greenberg, L.; Weltge, A.; Watson, M.(1995) Identification of abuse in emergency departments: effectiveness of a two question screening tool. *Journal of emergency nursing* 21(5) 391-394.

McLeer, S.V. (1989). Education is not enough: A systems failure in protecting battered women. *Annals of emergency medicine* 18, 651-653.

McLeer, S.V.; Anwar, R.(1989). A Study of Battered Women Presenting in an Emergency Department. *American Journal of Public Health.* 79(1), 65-66.

Melvin, S.Y.; Brunton, S.A.(1995). Domestic violence: The physician's role. *Hospital Practice* October 15, 45-53.

Moros, D.A. (1996). Violence and the physician's duty: A panal discussion. *Mount Sinai Journal of Medicine* 63(2), 107-110.

Moss, V.A.; Taylor, W.K. (1991). Domestic Violence Identification, assessment and intervention. *AORN journal* 53(3), 1158-1164.

Muellaman, R.L.; Lenaghan, P.A.; Pakieser, R.A. (1996). Battered women: injury locations and types. *Annals of emergency medicine,* 28(5), 486-492.

Mullender, A.(1996). Rethinking Domestic Violence; The social work and probation response. London: Routledge.

National Clearinghouse on Family Violence (1990) Woman Abuse: The relationship between wife assault and elder abuse. Ottawa: Government of Canada.

Neufeld, B.(1996). SAFE questions: overcoming barriers to the detection of domestic violence. *American family physician* 53(8), 2575-2582.

Neuman, W.L. (1994). Social Research Methods: Qualitative and Quantitative Approaches. Toronto: Allyn and Bacon.

Norušis, M. J. (1994). SPSS 6.1. Chicago: SPSS inc..

Olson, L.; Anctil, C.; Fullerton, L.; Brillman, J.; Arbuckle, J.; Sklar, D.(1996). Increasing Emergency physician recognition of domestic violence *Annals of Emergency Medicine* 27(6) 741-746.

Pahl, J.(1995). Health Professionals and Violence against women. In Kingstonm P (ed.) Family Violence and the Caring Professionals. London: Mcmillan.

Physical violence and injuries in intimate relationships.*(1996)*. *MMWR* 45(35), Sept.6, 765-767.

Randall, T.(1990). Domestic Violence Intervention Calls for more than Treating Injuries. *JAMA* 264(8) 939-940.

Ratner, P.A.(1995). Indicators of exposure to wife abuse. *Canadian journal of nursing research.* 27(1), spring, 31-46.

Reid, S.; Glasser, M. (1997). Primary care physicians' recognition of and attitudes toward domestic violence. *Academic medicine* 72(1), 51-53.

Roberts, A.R. (ed), (1984). Battered Women and their Families: Intervention strategies and Treatment Programs. New York: Springer Publishing Co.

Roberts, G.L.; Lawrence, J.M.; O'Toole, B.J.; Raphael, B. (1997). Domestic violence in the emergency department: 2 Detection by doctors and nurses. *General hospital Psychiatry,* 19, 12-15.

Roberts, G.L.; Lawrence, J.M.; O'Toole, B.J.; Raphael, B.(1993). Domestic violence victims in a hospital emergency. *Medical journal of Australia*, 159(5), 307-310.

Roberts, M.T. The relationship between locus of control and level of violence in married couples. In Viano, E.C. (Ed) (1992) Interdisciplinary perspectives Hemisphere publishing corp.

Rodgers, K. (1994). Wife assault: the findings of a national survey. *Juristat service bulletin* 14(9). Canadian center for justice statistics.

Rose, K.; Saunders, D.G. (1986). Nurses' and physicians' attitudes about women abuse: the effects of gender and professional role. *Health care for women International,* 7, 427-438.

Rounsaville, B.; Weissman, M.M.(1977-78). Battered Women: A Medical Problem requiring Detection. *International Journal of Psychiatry Medicine* 8, 191- 202.

Rubin, A.; Babbie, E. (1989). Research Methods for Social Work. California: Wadsworth Publishing Co.

Sabatino, F. (1992). Hospital cope with American's new 'family value'. *Hospitals*, Nov 5, 24-30.

Saunders, D.G. Wife abuse husband abuse or mutual combat? A feminist perspective on the empirical findings. In Yllo, K.; Bograd, M. (Eds) (1988) Feminist perspectives on wife abuse. Newbury park: Sage.

Saunders, D.G.; Hamberger, K.L.; Hovey,M(1993). Indicators of women abuse based on a chart review at a family practice center. *ARCH Family Medicine*, 2, 537-543.

Saunders, D.G.; Kindy, P. (1993). Predictors of physicians' responses to women abuse: the role of gender, background and brief training. *Journal of general internal medicine* 8 (Nov), 606-609.

Seidman, I.E.(1991). Interviewing as qualitative research: A Guide for researchers in education and the social sciences. New York: Teachers College Press.

Seremitis, S.V. (1996). Violence and women: case presentation and discussion. *The mount Sinai journal of medicine*, 63(2), 103-104.

Sheridan, D.J.; Taylor, W.K. (1993). Developing hospital-based domestic violence programs. Protocols, policies and procedures. *AWHONN*, 4(3), 471-482.

Stark, E.; Flitcraft, A. (1996). Women at risk: domestic violence and women's health. Thousand oaks: Sage publications.

Steiner, R.P.; Vansickle, K.; Lippmann, S.B. (1996) Domestic violence. Do you know when and how to intervene? *Postgraduate medicine* 100(1),103-116.

Stephens, B.J.(1985). Suicidal women and their relationships with husbands, boyfriends and lovers. *Suicide & life threatening behavior*. 15, 77-90.

Strauss, Anselm; Corbin, Juliet. (1990). Basics of qualitative research: grounded theory, procedures and techniques. Newbury Park: CA: Sage Publications.

Sugg, N.K.; Inui, T. (1992) Primary care physicians' response to domestic violence: opening pandora's box. *JAMA* 267, 3157-3160.

Sussman, M.B.; Steinmetz, S.K. (1987). Handbook of marriage and the family.

Taylor, I. "For better or for worse" Caring and the abused wife in Baines, P.E.; Neysmith, S. (1991). Women's caring: feminist perspective on social welfare. Toronto: McClelland and Steward, Inc.

Thorne-Finch, Ron(1992). Ending the silence: The origins and treatment of male violence against Women. University of Toronto Press.

Tilden, V.P.; Shepherd, P. (1987) Increasing the rate of identification of battered women in an emergency department: Use of a nursing protocol. *Research in nursing and Health* 10(4), 209-215.

Tintinalli, J.E. (1996). Domestic Violence: Issues for Health care Providers. *Annals of emergency medicine*, 27, 761.

Titus, K. (1996). When physicians ask, women tell about domestic abuse and violence. *JAMA* 275(24), 1863-1865.

Trute, B; Sarfield, P.; Mackenzie, D. (1988) Medical response to wife abuse: A survey of physicians attitudes and practices. *Canadian journal of community mental health* 7(2), 61-71.

VanHasselt, V.B. (1988). Handbook on Family violence. New York: Plenum Press.

Viano, E.C. (1992). Intimate violence: Interdisciplinary perspectives. Washington: Hemisphere publishing Co.

Walker, Lenore E.A. Psychological causes of family violence in Lystad, M (1986) Violence in the home: Interdisciplinary perspectives. N.Y.: Brunner/Mazel inc.

Wallace, H. (1996). Family violence legal, medical and social perspectives. Boston: Allyn and Bacon.

Waller, A.E.; Hohenhaus, S.M.; Shah, P.J.; Stern, E.A.(1996). Development & Validation of an Emergency Department Screening and Referral protocol for victims of Domestic Violence. *Annals of Emergency Medicine* 27(6) 754-760.

Wang, J.F.; McKinney, J.(1997). Battered Women's Perceptions of Loss & Health. *Holistic Nursing Practice* 11(2): 50-59.

Warshaw, C. (1997) Intimate partner abuse: developing a framework for change in medical education. *Academic medicine* 72(1), Supp, S26- S35.

Warshaw, C.(1989). Limitations of the medical model in the case of battered women. *Gender and society*. 3(4), 506-517.

Yllo,K.; Bograd, M. (ed) (1988). Feminist perspectives on Wife abuse. Newsbury Park: Sage.