

Domestic Violence: Changing Theory, Changing Practice

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Despite widespread recognition of domestic violence as a public health problem, many clinicians still have difficulty integrating routine intervention into their day-to-day practice. This is in part because domestic violence raises a distinct set of challenges for both providers and the institutions that shape clinical practice. Domestic violence is a complex social problem rather than a biomedical one; addressing it means asking clinicians to step beyond a traditional medical paradigm to confront the personal feelings and social beliefs that shape their responses to patients and to work in partnership with community groups committed to ending domestic violence. In addition, addressing domestic violence raises important challenges to the health care system itself — to its theoretical models, to the nature of medical training, and to the rapidly changing structure of clinical practice. If we truly want to play a role in preventing domestic violence, rather than just treating its consequences, we must work together to transform both the individual and social conditions that create and support this kind of violence in the first place.

It has become increasingly clear over the past 20 years that domestic violence carries not only serious health consequences for women, but many hidden social costs as well. As clinicians we see the profound effects of this violence on a daily basis¹⁻²⁰ and are often deeply affected when we allow ourselves to listen, understand, and grapple with issues that require far more than our medical expertise.

Through the combined efforts of the domestic violence advocacy community, individual practitioners, and a growing

number of professional societies, standards of care have been developed and major initiatives have been launched to increase provider awareness, to establish and distribute clinical guidelines, and to offer strategies for improving institutional responses to domestic violence.²¹⁻²⁵ Innovative hospital-based advocacy programs are increasing in number, and medical schools and residencies are beginning to develop models for incorporating training on family violence into standard curricula.²⁶⁻²⁸

Yet despite widespread recognition of domestic violence as a public health problem, many clinicians still have difficulty integrating routine inquiry about domestic violence into their day-to-day practice.²⁹⁻³¹ Understanding the difficulties faced by health care providers as they attempt to address this issue can help not only to improve clinical practice but also to develop more realistic strategies for prevention and social change.³²⁻³⁵

Domestic violence raises a distinct set of challenges for both providers and the institutions that shape medical practice. Because domestic violence is, in fact, a complex social problem rather than a biomedical one, addressing it requires more than simply adding new diagnostic categories to differential diagnoses or new technical skills to clinical repertoires. It means asking clinicians to step beyond a traditional medical paradigm to confront the personal feelings and social beliefs that shape their responses to patients, and to work in partnership with community groups committed to ending domestic violence. In addition, the health care system itself, through its theoretical framework, the nature of its training process, and the rapidly changing structure of clinical practice, presents another set of barriers that profoundly affect the ability of individual providers to respond to women who have been abused.³⁵

Personal and Social Barriers

As Holtz et al have reported, most health care providers do not learn about domestic violence during their training.³⁶ Con-

sequently, “clinical” responses are often shaped by an interplay of the physician’s own personal experiences and his or her social, cultural, and religious beliefs.³⁷⁻⁴¹

A multitude of factors combines to shape the ways we interpret and respond to life events, including both our individual experiences and the social contexts in which they take place. Koss et al,⁴² Johnson,⁴³ Brown,⁴⁴ Rieker and Carmen,⁴⁵ and Miller⁴⁶⁻⁴⁷ have described the psychological impact of gender socialization, the traumatic effects of social disenfranchisement, and the ways in which the denial of intolerable feelings can distort our perceptions and lead to protectively rationalized ways of viewing ourselves, other people, and the world. For instance, the psychological need to deny or avoid certain feelings or emotional experiences in order to ensure psychic survival often combines with social explanations to solidify into beliefs that may then appear to us as “givens.”⁴⁵⁻⁴⁷ Clinicians absorb a range of societal views regarding gender and power, around which their own identities are constructed. Assumptions about gender, race, and class so permeate our culture that they often provide an unconscious backdrop through which we come to understand our own experiences and interpret those of others.

In addition, listening to women describe the violence in their lives can have a significant psychological impact on providers.^{13,48-50} When physicians are not specifically trained to deal with psychological trauma, they are forced to rely on their own capacities to address painful and potentially overwhelming issues. And, given the prevalence of violence against women in this society, a significant number of physicians will have experienced or witnessed abuse in their own lives.³² These issues touch too close to home for many health care providers, who may be understandably reluctant to have their own painful experiences evoked while trying to function in a professional capacity.^{35,42,44}

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Systemic Barriers

Impact of Medical Training. Once they enter the health care arena, clinicians are faced with a new set of forces that shape their perceptions and responses.³⁵ A number of authors have described the gaps in medical education that influence psychosocial aspects of care.^{51,52} Not only is medical training often lax in equipping physicians to deal with difficult social and personal issues, but more insidiously, the process of professional socialization can actually extinguish the capacities they already have. Pain, anger, frustration, and sadness are common responses to hearing about abuse. Without specific training and support, many clinicians find themselves dealing with these situations through a variety of techniques designed to protect and distance themselves from potentially distressing encounters. In a field where competence and mastery are highly valued, it is difficult to risk venturing into areas that make clinicians feel less competent. They may find it easier to focus on problems where interventions lead to more predictable outcomes or where it is possible to retain a greater sense of control. These difficulties are only magnified by increasingly time-pressured working conditions.^{35,51}

Professional Socialization and the Intergenerational Transmission of Abuse.

Extrapolating from the work of Richman et al,⁵³ Baldwin et al,⁵⁴ and others,⁵⁵ we can see how abusive training environments may also affect clinicians' abilities to deal with abuse among the women they see as patients. Medical training can be physically punishing, emotionally draining, and socially isolating. Trainees often report feeling humiliated and controlled as well as anxious, exhausted, depressed, overwhelmed, and traumatized.^{35,53} Over time, students and house-staff begin to reorient their identities in terms of medicine's values, to internalize its constructs and judge themselves by its terms. Thus, medical training itself can create some of the same dynamics as abuse. In addition, the structure of medicine is hierarchical and as such, reflects the gendered power arrangements of the larger society. In their review of the sexual harassment literature, Schiffman and Frank found that sexual harassment and gender discrimination were common experiences among women physicians, adding yet another layer of abuse for

women working within that system.⁵³⁻⁵⁸ Clinicians' inability to recognize abuse in their own lives, whether personal, social or professional, or to tolerate acknowledging their own vulnerability, make it more difficult for them to empathize with a woman who is struggling in an abusive relationship. The need to maintain a sense of power and control in order to be recognized as competent within that system and the pressure to avoid feelings that may arise when one cannot, reinforce this dynamic on both individual and systemic levels. While there has been much discussion about how abuse is transmitted intergenerationally in families, the process of professional socialization within the current structure of medicine can also serve as a vehicle for the intergenerational transmission of abuse.^{35,41-44,52,59}

Impact of Theory on Clinical Practice

Medicalization of Social Problems. One aspect of medicalization involves the reduction of complex social problems into distinct clinical diagnoses.⁶⁰ One of the clearest illustrations of the need to shift from a standard problem-oriented framework to a more comprehensive model involves our evolving understanding of the role domestic violence plays in the lives of women with human immunodeficiency virus (HIV). Several studies have reported that many HIV-positive women either are or have been abused by partners.^{61,62} Many "discrete" medical problems are, in fact, intimately connected to domestic violence, but because we think of them as separate issues, their interrelationships are more likely to be missed. For instance, one might easily generate a problem list that includes HIV infection, substance abuse, pregnancy, depression, and domestic violence without necessarily seeing the connections among them. Initial recognition of domestic violence among HIV-positive women led to appropriate concerns about reducing risk for further violence, particularly around partner notification.⁶² It took longer for domestic violence education and intervention to be incorporated into risk reduction counseling for HIV, pregnancy, and substance abuse. There are significant implications for funding, education, and prevention if coerced sex within the context of an abusive relationship also proves to be a

major risk factor for HIV transmission and the other consequences of unprotected sex. And substance abuse among women, the other major risk factor for HIV, also increases in the context of domestic violence.¹ In fact, recognition of these connections has led a number of comprehensive HIV programs to integrate screening and counseling for domestic violence into the preventive as well as treatment services they provide.⁶¹⁻⁶³

Limitations of Mental Health Models.

The process of stripping away context and transforming lived experience into disorders also occurs within the major mental health models and affects the nature of both diagnosis and intervention. For example, clinicians who work within a purely biological or disorder-specific framework run risks similar to medical and surgical colleagues of failing to recognize and respond to the ongoing violence in a patient's life. Or they may see the abuse as being caused by a particular woman's increased vulnerability or as only a secondary problem — a social stressor affecting the course of her primary biological or developmental disorder.

Traditional psychoanalytic theory presents a different set of limitations. The context of ongoing violence and danger that creates and perpetuates a woman's symptoms may not be addressed, or may be regarded as symptomatic rather than etiologic. In addition, a clinician bound by the constraints of remaining true to the neutrality of a psychodynamic framework may find it difficult to play a more active role in advocating for safety and in helping women gain access to community resources. There are, however, newer models — both feminist and psychodynamic — that do recognize the importance of social and intersubjective contexts.^{47,64,65}

A family systems approach can present even greater dangers to battered women. Assuming equal power within and responsibility for relationship dynamics, it inadvertently holds a battered woman responsible for her partner's criminal behavior and keeps her engaged in the countertherapeutic task of trying to change herself in order to get him to change. In addition, sessions often precipitate further threats or violence. Andersen et al⁶⁶ and Walker⁶⁷ have described the dynamics of battering as a form of ongoing domestic terrorism,

akin to hostage situations. In that kind of setting, particularly when her partner continues to engage in violent, controlling behavior or threats, it is not safe for a woman to be honest or to assert herself. Nor is she likely to be free to make her own choices.^{44,68}

These models are limited precisely because they are clinical models. They do not provide a framework for recognizing that it is the combination of the abuser's use of violence, threats, and intimidation *with* the social conditions that support gender inequality and limit options for safety that keeps women trapped in abusive situations and restricts their possibilities for change.⁶⁹⁻⁷⁰

Inadvertent Retraumatization. Inadvertent retraumatization of patients through disempowering interactions with the health and mental health system is another crucial issue. The pressure under current practice arrangements, particularly in managed care environments, to make rapid assessments, diagnoses, and treatment recommendations can push clinicians into taking a more controlling stance in their clinical encounters. For someone whose life is already controlled by another person, the subtly disempowering quality of many clinical interactions can serve to reinforce the idea that adapting to another's controlling behavior is both expected and necessary for survival.

Changing Theory and Incorporating Context. Clearly, a purely clinical framework limits our ability to respond to abuse. In fact, maintaining such a stance would require that we "diagnose" and find ways to "treat" a pervasive, long-standing form of normative social pathology characterized by a gender socialization process that (in its most polarized form) has taught women to focus their identities on meeting men's needs and on maintaining relationships at all costs, while teaching men that it is both necessary and legitimate to sustain their sense of self at the expense of those with less power, often women and children.⁴⁶ It is produced within the context of a socioeconomic system that frequently leaves women, particularly those with small children, increasingly fewer options for living independent lives⁷¹ and a criminal justice system that often fails to protect. While the health care system is finally beginning to face the consequences of a problem rooted in centuries of social

and legal tradition, it is also important for us to address the more difficult task of transforming gender socialization patterns and to recognize that gender equality is an essential component of primary prevention.

We also stretch the boundaries of the health care system when we work with the domestic violence advocacy and criminal justice systems. For example, many women are in danger at the time they seek health care, yet the danger itself is not something amenable to "medical" intervention. By becoming informed of options available in their communities for increasing women's safety, clinicians can help women get the services they need and begin to understand the complexity of their situations. Will a woman risk losing her children in a custody battle? Will she risk losing her means of providing for them? Will she risk losing someone she loves and who may act loving to her much of the time? Will she risk being killed if she leaves? A more comprehensive model provides a framework for understanding responses not only to trauma, but more significantly, to ongoing danger, and for mobilizing the social and legal resources that can increase safety, expand options, and ultimately prevent further violence.^{69,70}

Structural Constraints

Health care providers also face a number of structural constraints that affect their ability to provide appropriate care to women dealing with ongoing abuse. In the current health care climate, cost containment is often achieved at the expense of care, and clinicians' needs are placed in conflict with patient's for access to diminishing resources.^{72,73} This is a problem for primary care providers, who are often penalized for spending too much time with patients and for making too many referrals. This is even more problematic for patients, however, at a time when reimbursement for social and mental health services is rapidly diminishing.

Micromanagement strategies devised by insurance companies to reduce "unnecessary" mental health care utilization, (eg, continuous intrusive demands to justify treatment) can be disruptive and traumatic in themselves. They create an environment in which short-term medication management or potentially retraumatizing directive treatments

focused on symptom reduction rather than healing, are rapidly becoming the standard of care, making the consistency and safety required for long-term trauma recovery nonreimbursable. It is unfortunate that, just when an expanding body of research is clearly delineating the impact of trauma on the human psyche and the need for more intensive treatment for many survivors,^{74,75} market forces are decreasing the likelihood that these kinds of services will be available. This becomes increasingly true as managed care further erodes the possibility of choosing one's provider and type of treatment, removing even the consumer-based economic power from individuals seeking care. For low-income women whose only access to services has been through the public mental health system, this lack of choice has been the norm.⁷⁶

While providing short-term reductions in cost, these policies do not address the long-term personal, financial, and, ultimately, social costs of failing to provide appropriate intervention.⁷⁷ In this rapidly proliferating type of system, cost containment is seen only in terms of direct individual costs to a given health care corporation whereas the exponential but indirect personal and social costs that could be prevented by early intervention are not considered part of the relevant financial equation.

A diagnosis driven reimbursement system poses yet another set of problems for battered women. In order for a woman to use mental health services, she has to be given a diagnosis. But for battered women, the very diagnosis itself may create new dangers.³⁵ Batterers often use their victims' psychiatric diagnoses to "prove" that they are right, that the problems are her fault, that she is crazy, or that she is an unfit mother. In seeking treatment, a battered woman potentially risks losing her children in custody battles and losing her credibility in court. For some women, "psychiatric" symptoms disappear once they are out of danger, but many women continue to be threatened and stalked long after they have left the relationship.^{67,69,70} For others, symptoms of post-traumatic stress disorder may not begin until they are relatively safe.^{35,37}

Women have been refused health insurance for having the pre-existing condition of being battered and disabili-

ty or life insurance because they are considered at higher risk for injury and death.^{78,79} In addition, if a woman is insured on her husband's policy and the bills are sent to him, she is likely to be placed in further jeopardy when he discovers she is seeking outside help.

In some states, laws that require mandatory reporting of domestic violence may again place the clinician's legal obligations in conflict with the wishes and the safety of his or her patients. Not only do these policies potentially destroy the ability of clinicians to provide a safe place for women to discuss their most pressing concerns, they violate women's rights to choose what they feel will be safest and most helpful to themselves and their children. Under these conditions, both clinicians and patients may avoid raising concerns about abuse, thus losing important opportunities to intervene.⁸⁰

Listening to patients, learning about the repercussions of our interventions, and working to prevent systemic revictimization become important components of our roles as physicians practicing preventive medicine. Without a clear institutional commitment to address these issues, however, the pressures to continue practice as usual may be greater than the ability to change.

Implications for Training and Practice

Experience has led many clinician-educators to realize that new training strategies must be developed in order to change attitudes and behavior on the scale that is required to address domestic violence.^{22,26,28,81} Standard didactic formats, for example, do not provide sufficient opportunity to address the attitudes and feelings that may interfere with a clinician's ability to provide appropriate care, nor do they offer room to acquire the interviewing skills necessary for an optimal response. Training environments that offer the emotional safety to explore personal and cultural responses to abuse and the opportunities to discuss individual, professional, and institutional obstacles may also provide a vehicle for generating change within the health care community. While one-time trainings may raise awareness, ongoing feedback and support are necessary to sustain provider response.^{22,81}

Providing quality health care involves integrating routine inquiry about domes-

tic violence into ongoing clinical practice. This means asking all women patients, including women in lesbian relationships, about abuse and violence in their lives. Whether or not a woman chooses to use services or leave her partner, our intervention is very important. Women often return to violent partners many times before they feel safe enough to leave, that they can survive on their own, or can accept that the person they love will not change. When we fail to ask about abuse, we inadvertently isolate women who are living in danger.⁶⁹ Just by inquiring and expressing concern, we begin to build bridges, decrease isolation, and create hope. For a person who lives in an atmosphere of ongoing threats, intimidation, and violence, being treated with respect and taken seriously and feeling free to make her own choices lets her know supportive experiences are possible. By asking women to describe the pattern of their abuse and level of danger and to discuss their options for safety, we provide a place for women to reflect on their situations and consider their choices. By providing access to resources and by facilitating a woman's own decision-making process rather than attempting to direct her to change, we help her shift the balance of power in her life. When we work collaboratively with other members of our communities we not only help individual women rebuild their lives, but also help change the conditions that allow domestic violence to exist.

In order for clinicians to develop and sustain appropriate responses to domestic violence, however, they must also have the support of the institutions in which they practice. Thus, addressing this issue requires some fundamental changes in the nature of most medical training and in the culture of medical institutions. Creating practice environments and policies that model nonabusive ways of interacting, that support clinicians' efforts to address complex issues with skill and compassion, and that reimburse the more labor-intensive tasks of listening and advocating for change, are important components of institutionalizing effective responses to domestic violence.²² Refocusing our priorities is particularly important in the rapidly changing health care climate where administrators, insurers, and those who influence health care policy must begin to recognize that the

long-term consequences of nonintervention far exceed the costs of investing in appropriate intervention and prevention.⁷⁷

In addition, providers acting alone, no matter how motivated, cannot meet all the needs of battered women and their children. An optimal response requires the efforts of all members of the community. Developing interdisciplinary teams within the health care setting and creating collaborative partnerships between the domestic violence advocacy community, the health care system, the child protective system, and the legal system serves a number of functions. It not only provides referral networks for patients, but also creates support networks for providers. More important, it is only by working together that we can begin to develop the kinds of intervention strategies that will be appropriate for and respectful to all victims of domestic violence, while laying the groundwork to develop effective prevention strategies as well.

Conclusion

When we ask what battered women need from individual providers, we must also ask what providers need from their training institutions and practice environments in order to respond to those needs. When we do not address the denial of intolerable feelings at a personal level, we are in danger of recreating them not only in individual relationships, but also on social and political levels as well. Further, when socially sanctioned abuses of power are not acknowledged, they are often internalized and reproduced through individual interactions. If we truly want to play a role in preventing domestic violence, rather than just treating its consequences, we must work together to address the social conditions that create and support this kind of violence in the first place. A social structure sustained through abuse of power cannot end domestic violence. We know that. We need to use that knowledge. ■

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