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Domestic Violence: Not my Job, Not my Problem

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Abstract

The study examines incidences of domestic violence in several communities, police statistics and attitudes of medical professionals. Findings suggest a fundamental ethical dilemma in services for victims of domestic violence: medical professionals view domestic violence as a law enforcement issue, while police view it as a health issue. Victims are confronted by multiple systems each with opposing beliefs and attitudes about their respective roles.

Key words: Domestic violence, attitudes

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Domestic Violence: Not my Job, Not my Problem

According to the Family Violence Prevention Fund (2010), nearly one-third of American women (31%) have been beaten, coerced into sex or otherwise abused in their lifetime. Annual figures range from 960,000 to 3,000,000 incidents of domestic violence in any given year. The major components of domestic violence are battering, sexual assault and stalking, but verbal abuse, control and financial abuse are also common (Family violence prevention fund, 2010).

The institutions that most commonly serve victims cannot seem to decide if domestic violence is a criminal matter (police, courts), a health matter (hospitals, doctors, dentists), a mental health matter (treatment programs for perpetrators), a community matter (women's centers and shelters), or something more appropriately dealt with privately at home. Therefore, it is not surprising that women are not sure where to turn for assistance and frequently opt to silently suffer instead. Thus, domestic violence presents an ethical dilemma on the societal level, left to be solved by the individual.

The current study seeks to shed light on the situation by examining the professionals within three major institutions (domestic violence centers, medical professionals and police) in surrounding communities.

Case Study

Crisis Center North (CCN) provides services to victims of domestic violence in the northern communities of Allegheny County, Pennsylvania. The Center's services are offered to a community of 1,281,666 where 52.6% of the population is female and 25.3% of the total population is represented by female head of households (U.S. Census, 2000). The racial breakdown of the county is 83.4% European-American; 12.4% African-American; 1.7% Asian; .1% Native American; .9% Hispanic/Latina; and 1.1% bi-racial. The Census data also indicates that persons below the poverty level equal 10.9% of the population, with children

below poverty level equaling 17%. It would appear from looking at these statistics that, in many respects, the North Hills is an "ideal" community in which to live. Unfortunately, domestic violence is a problem that does not discriminate on the basis of geographic location or socioeconomic class. Domestic violence is as present in suburban areas as it is in rural or urban environments.

Most of CCN's clients are female (77%), with a majority being 25-34 years of age (29%); 35-44 (26%); and 45-54 (15%). Most are European-American (63%) and 25% are African-American. Many (42%) are at the national poverty level receiving Welfare, Supplemental Security Income (SSI), or have no income. Thirty-one percent of clients became homeless due to the abuse experienced and 69% are involved with drugs and alcohol.

CCN provides a 24-hour hotline, private and group counseling, legal advocacy, medical advocacy, and financial assistance for domestic violence victims.

Domestic Violence Centers

Domestic violence centers come in many shapes and sizes. Centers provide counseling services for adults and children, legal advice and services, medical advocacy, prevention education programs, financial assistance, advocacy services, and shelter facilities. Most centers offer some, but not all of these services. Services are confidential and free to victims, funded through a combination of federal and state funds, foundation and corporate grants, and private donations. Federal and state allocations are generally distributed by individual statewide coalitions. In Pennsylvania, the Pennsylvania Coalition Against Domestic Violence (PCADV) and state agencies such as the Pennsylvania Commission Against Crime and Delinquency (PCCD) distribute state and federal allocations.

Due to the nature of domestic violence, services are confidential and the centers are unmarked. This can be an obstacle to women seeking services. (Most who do seek help from domestic violence centers gain initial access by calling a local hotline.) Such obstacles may

explain why despite the fact that a national network of free, confidential hotlines, legal advocacy, medical advocacy, counseling and shelter services exists, they are not the first resource selected by many women in violent relationships. The results can be fatal. Indeed, a national study of domestic violence murders in the United States found that only 4% of femicide victims actively sought shelter or domestic violence advocate services the year prior to their death; however, nearly half of the women had been treated for medical issues (Campbell, 2004).

Hospitals and Medical Offices

Mandatory domestic violence screening in hospitals is a relatively recent occurrence. Screening methods vary from hospital to hospital. Pennsylvania was among the first states to create formal medical advocacy programs designed to establish effective screening procedures. The difference between a perfunctory questioning and a thorough screening may be the difference between potentially life-saving advocacy services and a victim silently returning to a violent household. Chapin's (2006) study of emergency medical personnel found that self-efficacy was related to successful domestic violence screening; medical professionals who were confident in their abilities to identify and assist victims performed more competent screenings. Not surprisingly, accurate knowledge of domestic violence contributed significantly to confidence levels in screening. Haggblom and Moller (2006) found that nurses in small communities frequently lacked accurate knowledge or specific training in domestic violence, relying more on empathy and familiarity with patients to provide quality services. Thorough initial screenings are vital because victims who are not accurately screened the first time are less likely to report re-victimization (Buzawa, Hotaling & Byrne, 2006).

During the 2006 to 2007 fiscal year (July to July), CCN provided free training to 147 medical professionals (36% nurses, 35% medical students, 20% medical staff, 9% doctors) in

the northern regions of Allegheny County. While participation was voluntary, the sessions satisfied mandatory training requirements for hospital personnel. Participants were 88% female, 96% Euro-American and ranged in age from 19 to 75 (average age = 37).

All the study measures were administered prior to the training to limit skewing responses. The medical personnel were asked to rank primary resources available to victims of domestic violence (police, courts, medical office, hospital emergency room, family/friends, domestic violence center/shelter) in order of importance. Participants completed the measure prior to the training.

Knowledge about domestic violence was measured through six true/false items: (1) Domestic violence often begins during pregnancy; (2) It is important to call an advocate, even if the victim does not want one present; (3) Drug and alcohol abuse are reasonable explanations for the prevalence of domestic violence; (4) If a registered translator is unavailable, it is acceptable to use a family member as translator when screening for domestic violence; (5) The incidences and severity of domestic violence are much higher in urban areas than in suburban areas; (6) Gay and lesbian couples experience domestic violence at the same rates as heterosexual couples. The items were completed prior to and following the sessions to gauge any knowledge gain.

Self-efficacy was measured through a single item on a Likert-type scale: How confident are you that you would know how to approach a patient/client who you think might be experiencing domestic violence (1= Not confident at all; 7 = Very confident)? This item was completed prior to and following the session to gauge any change.

Findings

Average ratings of domestic violence resources by medical personnel are listed in Table 1. It was particularly interesting where training participants ranked themselves in terms of responsibility to assist domestic violence victims. Despite the fact that over half femicide

victims sought medical attention for injuries prior to their deaths and that the training sessions were held mostly in hospitals, emergency rooms were ranked next to last by medical personnel. The participating doctors, nurses and medical students continue to believe domestic violence is a matter best suited for the courts and police.

Table 1
Rankings of Resources for Domestic Violence Victims by Medical Personnel

1. Courts
2. Medical office
3. Police
4. Domestic Violence Center
5. Hospital Emergency Room
6. Family/Friends

On the positive end, a paired sample t-test yielded a significant domestic violence knowledge gain resulting from the training. Confidence in one's ability to identify and assist domestic violence victims (self-efficacy) also significantly increased from the pre-test to the post-test. On the negative end, the medical profession views domestic violence more as a crime than a health concern.

Police

Unfortunately, the police often take the opposite position that domestic violence is more of a treatable medical issue than as a criminal concern. Logan, Shannon and Walker (2006) studied 315 police officers during regular shifts during 2000. Participants were 72% male, 52% had some or no college, and 82% had three or more years on the force. Of the four types of crimes under study (domestic violence, drug use, repeated DUI, and drug trafficking), officers ranked domestic violence perpetrators as the best candidates for treatment, versus criminal prosecution and sanctions (incarceration, fines or probation). The outcome is surprising when an array of established in-patient and 12-step programs are available for alcohol and drug abuse and treatment programs for domestic abusers are

preliminary at best. There were no differences in officers' ratings based on gender or education. However, officers with longer service records tended to endorse lesser penalties for domestic violence offenders than newer officers unless drug use or alcohol abuse was involved in the cases.

Discussion

The case study reveals some disturbing trends, which suggest a fragmented approach to a system issue. Hospital personnel rank courts and police as more important resources than emergency rooms, while police recommend treatment versus criminal prosecution. Under these circumstances, domestic violence victims are likely to face personnel who believe they are in the wrong place, regardless of where they choose to seek assistance. Is it any wonder, many choose not to report the abuse?

Using Roberts (2002) typology of domestic violence, the consequences of community attitudes about domestic violence become clearer:

Short-Term Abuse occurs in dating relationships over a period of a few weeks or several months. Violence may include pushing, shoving and hitting. This is frequent among high school and college students. Victims tend to turn to parents or friends. They may contact the police in severe instances.

Intermediate Abuse lasts several months to two years. Victims may be married or co-habituating. The severity of abuse ranges from punching, kicking, and choking to severe beating resulting in bruising or injury.

Long-Term Abuse is characterized by severe and violent episodes without warning, followed by long periods of time without abuse and subsequent episodes without warning. Victims tend to be married with children. The women in these relationships tend to be in the upper and middle classes. They frequently do not seek support resources and stay in the abusive relationships until the children are grown.

Chronic and Predictable Abuse is characterized by frequent severe repetitive incidents. Alcohol or drug abuse often contributes to the family dynamic. The victims endure hundreds of violent acts until the spouse is arrested or dies.

Homicidal Abuse escalates from death threats and life threatening injuries. Most victims do not seek out domestic violence centers or shelters, but are treated for injuries and are seen by the police and courts.

Domestic violence intensifies over time. Victims in early stages may be seen by police or by medical personnel. What each doctor, nurse, or officer may fail to realize is the individual before them may disclose their victimization to one and only one person. Effective screening at this point could link the victims with potentially life-saving free services at a dedicated domestic violence center. Each doctor, nurse, or officer presented with an abuse case must assume individual responsibility, and not assume another system or another person will provide better care. Victim advocates need to identify the standing attitudes among medical personnel, police and the courts and address any misconceptions throughout surrounding communities. The ethics of addressing domestic violence on the individual level can be devastating to victims. Institutions need to coordinate resources to properly address the issue at the community or societal level.

Recognizing that attitudes about domestic violence vary from profession to profession, it becomes necessary to formulate a comprehensive response to domestic violence victims, in which medical professionals, law enforcement, and crisis counselors may operate cohesively. In this regard, the crisis center staff becomes the lynch pin, training professionals in all arenas and specifying the duties of each profession's appropriate response to victims of domestic violence. In this way, a medical professional understands their role and responsibility while seeking the input of law enforcement and counselors regarding those professionals' roles in treatment of the victim. A victim then presenting at a neighborhood

emergency room will have the full advantage of seeking medical care, legal intervention, and crisis counseling assistance from a multitude of professionals applicable to every facet of the circumstance.

In training medical professionals, victim advocates can assist doctors and nurses in recognizing the vital role they play in acting as tools of intervention for families experiencing domestic violence. By showcasing the Campbell study on victims of femicide and their interaction with medical professionals prior to their deaths, staff awaken to the possibility of how their role in the victim's life may serve to de-escalate or even stop a violent relationship and ultimately save a life.

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