Preventing Domestic Violence

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PART 1:
Introduction

The issue of domestic violence has dominated the media for the last six months with the celebrated O.J. Simpson case for the murder of his wife, whom he had battered many times previously. Domestic violence is an issue of great importance for me because of my personal experience with it over a decade ago, which led to my subsequent injury and permanent partial disability. Probably the most horrific aspect of both of these tragic cases, beyond the terror, mental anguish, and physical pain endured, is the fact that this violence could have been prevented.

Overview of the Problem

Interpersonal violence against women has long been considered a private issue, a view which has excused its existence and allowed its escalation. Only now has it begun to be considered a societal problem, requiring interventions targeted to the victims of the violence and also directed at the perpetrators. Mercy, Rosenberg, Powell, Broome, and Roper found that in 1990, homicide accounted for the deaths of 5,328 women, and six out of ten of the victims were murdered by someone they knew--almost 50% by lovers or husbands (1993). Yet over 99% of the assaults women suffer result not in death but in physical injury (sometimes permanent), and severe emotional distress. It was estimated that in 1985, 1.8 million women were physically assaulted by their lovers or husbands (Mercy, et al., 1993). Of the husbands who physically abuse their wives, 47% do so more than three times per year (Loring and Smith, 1994).

Definition

Domestic violence includes not only physical abuse, but also the threat of infliction of bodily injury, verbal abuse and intimidation, stalking, forced sexual activity, destruction of personal property, and the withholding of money, food, transportation, access to children and to the telephone. It is characterized by excessive jealousy and controlling behavior. Domestic violence is not limited to the confines of marital, heterosexual or cohabitational relationships, and the victim is not always female, but the vast majority of cases involve violence against women by men with whom they are romantically involved. This paper will focus on these cases.

Risk factors of domestic violence include, but are not limited to, isolation from a supportive network of family and friends, alcohol use, male unemployment or underemployment, and prior battering episodes (Dannenberg, Baker, and Guohua, 1994). Edelman and Satcher added to this list the experience of discrimination, poverty, and lack of opportunity for education (1993). Clinical problems that frequently are linked to domestic violence include repeated battering, rape, child abuse, substance abuse, attempted suicide, homicide, perinatal morbidity, chronic pain, and somatic complaints (Flitcraft, 1993).

Domestic Violence and its importance to public health

A mainstay of public health is the quantification of mortality related to specific health problems to identify, analyze, determine causation, and draw logical conclusions based on data. **Homicides are the fourth**

leading cause of injury death among females of childbearing age. **Half of all female homicides are battering-related** (Dannenberg, et al., 1994). Only cancer, heart disease and unintentional injuries kill more women each year than do the men they love.

The incidence of domestic violence contrasts the little emphasis that has been placed on it until recently. Berenson, Wiemann,Wilkinson, Jones, and Anderson's recent study of women of reproductive age revealed that 11 %- 25% have been physically assaulted (1994). **An average day in the United States yields 65 deaths and 6,000 physical injuries due to interpersonal violence (Mercy, et. al., 1993).**

If physical abuse were instead a bacterial or viral disease with a prevalence rate this high, research funding would be abundant in an attempt to isolate the infectious agent and to effect a cure. For example, contrasting AIDS to domestic violence, there were 700,000 cases of AIDS in 1992, and billions of dollars were spent on research and development of vaccines, and on education to prevent the disease. One person out of every hundred is HIV-infected in the United States, yet the rate of domestic violence is about 1 in 10. The prevalence of domestic violence directed against women is twice that of AIDS. There is no comparison in the level of funding in prevention of the two afflictions, and it is in no way commensurate with the prevalence. This is due to many reasons, politics chiefly among them, but is primarily due to the orientations with which the two problems have been studied. AIDS is obviously in the domain of the biological, medical and health sciences. Yet, until recently domestic violence was considered the realm of criminology, and therefore was addressed only retrospectively, and consequently, inadequately.

The controversy of public health as opposed to criminal justice approaches

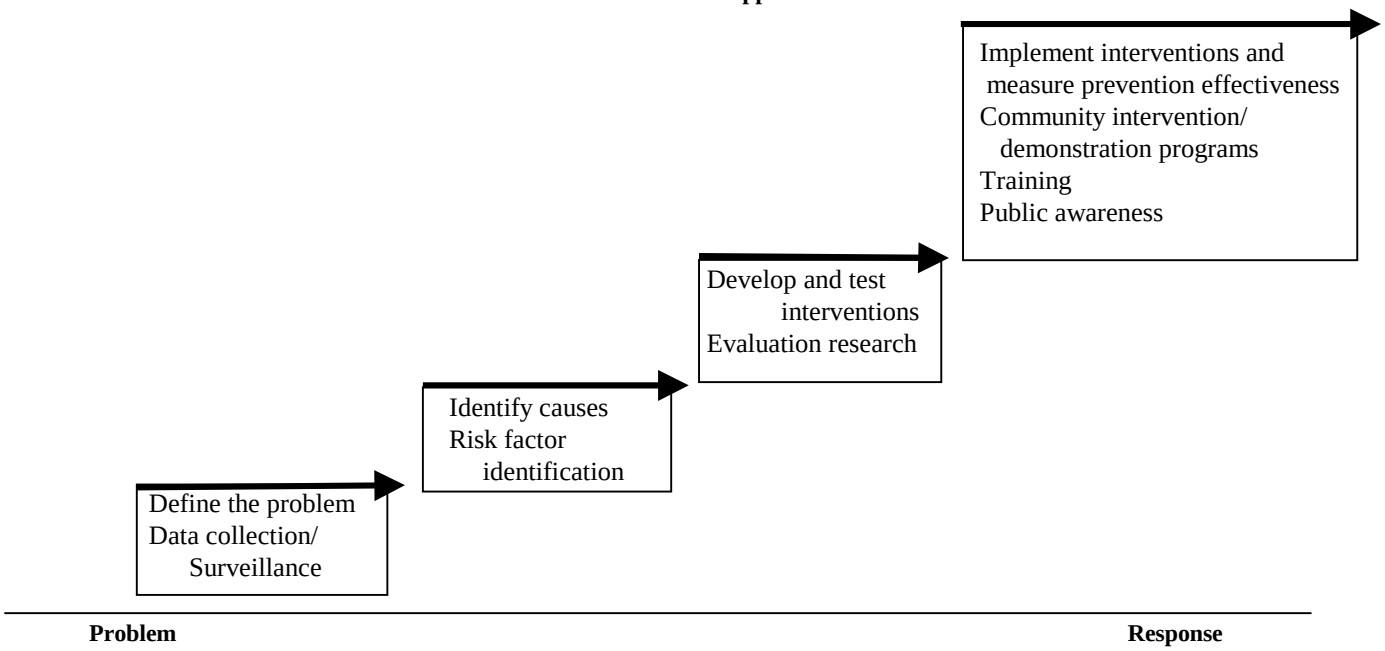
United States Secretary of Health and Human Services, Donna Shalala, recently wrote, "Of all the health and human service challenges we face, perhaps the most devastating, and ironically, most preventable is the epidemic of violence sweeping across this nation." However, violence of all types was dominated by criminal justice advocates, whose approach to the problem has been a reactive stance, imposing penalties (albeit minor ones) on perpetrators of domestic violence. There were virtually no preventative measures, and it was only after injury and death that any action was taken to address the problem. Yet pouring out millions of dollars on apprehending, arresting, adjudicating and incarcerating violent offenders has made virtually no difference whatsoever, as rates of crimes against women continues to soar. (Mercy, et al., 1993).

The traditional stance of public health is to prevent illness, injury, and death. Public health is therefore by definition proactive, while criminal justice is in contrast reactive. Public health approaches violence as a health issue, and uses injuries--physical, psychological, fatal, and nonfatal--to quantify its impact (Berenson, et. al., 1994). Furthermore, the public health approach to the domestic violence field brings with it the strong commitment to evaluation and betterment of existing programs, as opposed to the continuance of ineffective campaigns (as is often seen in the criminal justice approach) simply as a means of upholding the status quo. In addition, public health scientists are able to view the problems of domestic violence more comprehensively, incorporating a multidisciplinary systems perspective.

Public health seeks to define the problem first by data collection, identifying associated risk factors and determining the causes of violence. Then as a result, the Development and implementation of intervention strategies to address it appropriately are undertaken. A crucial component in the public health approach is evaluation, as previously mentioned. Outcomes are evaluated in a similar epidemiologic fashion in order to test the efficacy of programs, and to continuously monitor their performance. An overview of the public health model for violence prevention (Figure 1) appears on the following page.

Figure 1

Public Health Model Of A Scientific Approach To Prevention



SOURCE: Mercy, et al. **Public Health Policy for Preventing Violence.** *Health Affairs*, Winter 1993.

The public health methodology does not imply that criminal justice is not necessary at all, but rather places more emphasis on the development of a comprehensive system to prevent domestic violence and its related negative outcomes.

PART II:

Domestic violence in historical perspective

The emergence of violence into the realm of health care

The entry of public health into the arena of violence and its prevention was heralded with the October 1985 workshop on Violence and Public Health by then- Surgeon General, C. Everett Koop. In the last decade, the Department of Health and Human Services has become involved in violence prevention research and has culminated in the formation of a National Center for Injury Prevention and Control in 1991 as part of the Centers for Disease Control and Prevention. President Clinton has expressed his commitment to confronting the problems of violence in this country in his September 1992 Congressional address to present his health care reform plan, decrying "the outrageous costs of violence in this country." (Mercy, et. al.)

Views of domestic violence, past & present

Throughout time, men have viewed women not as helpmates and companions, but as property, and the laws of the land upheld this misogynistic assumption. Wife beating was an unfortunate albeit accepted part of marriage throughout much of the nineteenth century. This remained true in America until 1895 when the law made conviction for physical assault sufficient grounds for a woman to legally divorce her abusive husband under the Married Women's Property Act. Though few women could ever obtain such convictions,

due to the burden of proof requirements and the Victorian era's taboos on viewing a woman's body, (and hence the evidence) this law began to change the age-old belief that a woman was her husband's property (Hagion, forthcoming).

Thankfully, things have changed much since the turn of the century, and in the 1970's battered women's shelters began to appear acrcss the country. Federal funding for court-based programs and shelters was supported by the Law Enforcement Assistance Administration (LEAA), as President Jimmy Carter authorized the now-defunct Office of Domestic Violence. Research funded by the National Institute of Mental Health identified domestic violence as a determinant of women's health problems, documenting the failure of health care professionals to identify the problem. The U.S. Commission on Civil Rights conducted hearings on domestic violence in 1978, as did the Attorney General's Task Force. The Domestic Violence Assistance Act of 1984 reestablished the federal commitment to services for domestic violence survivors (Flitcraft, 1993).

Recently, many states law enforcement agencies have changed their policies, to be more supportive to victims of domestic violence and to expand training to social workers, police, prosecutors and judges, court personnel, parole and probation officers, substance abuse counselors, and child protection officers on domestic violence.

Grass-roots organizations (primarily shelters and community-based organizations) have endeavored to educate lawmakers that domestic violence is as important as crimes against other persons, that the top priority must be the safety of domestic violence victims, and that victims' needs require major changes in policy and traditional services. Bills on the federal level are establishing national and regional centers on domestic violence, prodding courts to give presumptive child custody to domestic violence victims, and to increase funding to the National Center for Injury Control and Prevention for research on projects aimed at violence against women (Flitcraft, 1993).

Most recently, the American Medical Association in 1991 developed a campaign to address family violence and formulated the National Coalition of Physicians Against Family Violence. In 1992, the Joint Commission on Accreditation of Health Care Organizations encouraged staff education and the development of protocols on domestic violence, not only for the Emergency Care Departments, but also for ambulatory care services (Flitcraft, 1993).

President Clinton has authorized unprecedented work in seven Cabinet agencies to analyze the problem and propose solutions for not only family violence, but also violence in the streets, hate crimes, and sexual assault (Edelman and Satcher, 1993).

Demographics of violence

Domestic violence occurs in every strata of society, among all races and ethnic groups. However, the severity of the violence differs among races, with more homicides observed in blacks than among whites. For black women, homicide is not only the leading cause of death by injury, but the leading cause of all deaths between the ages of 15-34 years of age (Dannenberg, et al., 1994).

Homicide is the fourth leading cause of death among females in the United States, with most of the victims being of childbearing age (Dannenberg, et al., 1994.) As stated previously, domestic violence is implicated in one-half of all of the homicide deaths of women. Firearms are the most common weapon used in homicides, and their presence in the home increases the likelihood of its use in homicide or suicide by 43 times (Dannenberg, et al., 1994).

Many stereotypes abound that domestic violence is found primarily among the poor and minority groups, but this is probably due to bias in the identification by medical personnel and subsequent reporting. Also, cases of domestic violence in the middle and upper-classes are more easily hidden because they have the

financial wherewithal to appropriate services discreetly. Furthermore, domestic violence is less likely to be recognized in those of higher socioeconomic status, due to friends' and acquaintances' denial of the problem.

The group at highest risk is not at all ethnically or racially composed, but is related to a physical condition: pregnancy. Studies conducted recently in prenatal clinics found that **between 4-8% or women are battered at least one time during pregnancy.** Of these victims, more than 20% reported an increase in the level of violence experienced during the pregnancy, and **one-fourth of those beaten during pregnancy were struck in the abdomen** (Berenson, et al., 1994). Women who are assaulted during pregnancy are twice as likely to experience pre-term labor as those who were not victimized. Pre-term labor in abused women is caused by a release of arachidonic acid caused by blunt force to the abdomen, which leads to uterine contractions. Chorioamnionitis was also associated with violence during pregnancy.

PART III:
How domestic violence impacts the health care industry

Costs of medical care (when sought)

Nationally, over 1.5 million women seek medical care each year for injuries related to domestic violence, and account for 20% of the female patient emergency room visits for injury (Flitcraft, 1993). Women are seen at three times as many medical visits for injuries related to battering than for injuries related to motor vehicle crashes (Dannenberg, et al., 1994). Of all female patients seeking emergency room treatment, between 22-35% are battered women; yet, only about 20% of all battered women seek emergency medical care (Loring and Smith, 1994).

Battering may be the major cause of women's injury, beyond muggings, rapes, and vehicle crashes combined (Loring and Smith, 1994). Data gathered from the National Medical Care utilization and Expenditure Survey estimated emergency transport costs for nonfatal injury at $144 for one way transport (Miller, 1993). Direct financial losses associated. with battering include not only the cost of medical care, mental health services and emergency response services, but also insurance administration as well. Blue Cross/Blue Shield of Pennsylvania estimates their spending over $32 million per year to treat injuries related to domestic violence (Flitcraft, 1993). **Domestic violence injuries results in 21,000 hospitalizations, 99,800 inpatient treatment days, 28,700 ER visits, and 39,000 office visits. Total medical costs for injuries related to domestic violence exceed $44,393,700 (Loring and Smith, 1994).**

Health-related spending due to violent crimes (including domestic violence) for emergency transport, medical intervention and mental health services exceeds $10 billion (Miller, 1993). Injury costs are $2.4 million per murder and $22,000 for physical injury due to assault, in 1989 dollars (Miller, 1993).

Impacts on individuals, families and communities

Hidden costs to the individual are losses in productivity: days of work Iost (wages, benefits), and nonmonetary losses (pain, suffering, quality of life), and also, at times, property losses. **Estimates state average long-term productivity losses of $476 per victim for each physical assault. Productivity losses per homicide average $610,000. Lifetime costs paid by society for assault victims is estimated at $96 billion (Miller, 1993).** Beyond the quantitative measurements described above, there are qualitative impacts as well which are not as easily analyzed, and yet are of great importance. The impact of victimization on an individual woman and perhaps her children cannot be overemphasized: a life lived in perpetual terror and fear is not a discrete indicator that can be tested statistically, but is a very costly result of domestic violence, striking the inner core of a person.

Societal impacts

The cost to society of these interpersonal crimes is extremely expensive. For example, the U.S. Department of Justice Office of Victims of Crime supports 1,422 of the 2,000 victims service programs nationwide. Over $35 million in federal funding was authorized through the Victims of Crime Act (VOCA), and the ratio of VOCA monies to nonfederal funding is three to one. Since only 70% of all victim service agencies are funded through VOCA, total expenditures on victim services probably exceed $200 million in 1987 (Miller, 1993). These services can include foster care for children orphaned by domestic violence, and job retraining and public assistance costs as well, to aid in facilitating women's re-entry into the workforce after rehabilitation from injuries sustained.

PART IV:
Analysis

A look at current interventions

There are currently many intervention services employed to help battered women, yet the need far exceeds the capacity. Over 1200 organizations offer services to battered women and their children, including 24-hour hotlines, emergency shelters, legal and social assistance services, community education and peer counseling (Dannenberg, et a I., 1994).

One such program currently being implemented is WomanKind, in Fairview, Minnesota. This program provides advocacy services consisting of support, information, education, community resource referrals for battered women in crisis situations (Loring and Smith, 1994). WomanKind also provides in-service training to medical providers to identify domestic violence victims and to document their injuries. Information on domestic abuse statutes, re straining orders, and community resources is also provided to medical providers to assist in coordination of services for victims, once they have been identified by medical personnel. AWAKE is a similar program based out of Boston, and includes safety planning, since the most dangerous time of all for battered women is during separation. Yet AWAKE has found **a severe lack of space in shelters, where 9 out of 10 women are turned away (Loring and Smith, 1994).**

Public Health-Oriented Recommendations

The framework of public health rests on primary, secondary, and tertiary prevention of illness, injury, and disease. The goal of primary prevention is to reduce the incidence of new cases by changing behavior or environmental factors, a truly proactive stance. The secondary level of prevention goes beyond identification to include appropriate early intervention (Flitcraft, 1993). Tertiary prevention is basically reactive, providing services as appropriate after the incident to lower repeated incidents of battering. Figure 2 on the following page illustrates recommended intervention strategies at each level.

Figure 2

LEVELS OF PREVENTION OF DOMESTIC VIOLENCE

Primary	Secondary	Tertiary
educational outreach to community groups, churches, schools.	routine assessments for domestic violence at standard medical visits (in pregnancy, especially).	increase levels of services required by battered women (shelters, legal protection, emergency hotlines, etc)
change in media representations of violence in romantic portrayals.	change in medical school curriculum to include understanding of and protocols for treatment and identification of domestic violence victims.	increased restrictions of gun ownership, requiring standards which would halt access to weapons for those with a history of violence (domestic or otherwise).
media campaign which stresses that women are not for hitting and that such violence is a crime which will be treated appropriately.	Increase and strengthen batterer's educational interventions after first offense.	Establish Physical Abuse Response Teams to function to not only treat the woman medically, but also to gather evidence to be used for case against the batterer.
Mandated curriculum in schools and colleges to teach girls what are the warning signs of batterers so they can protect themselves.	Mandated reporting laws that suspect domestic violence, similar to suspected child abuse.	Mandated arrests, automatic jail sentences for battering.

Preventative mechanisms

Mercy, et al. suggest three broad-based goals for prevention of all violence, which can be tailored to the specifics of domestic violence, as well. These strategies are 1) to change individual knowledge, skills, and attitudes; 2) change the social environment; and 3) change the physical environment (1993). Examples of the changes to strengthen individual skills and knowledge are obvious: providing training to medical personnel to identify and refer victims of domestic violence. **Currently, emergency room staff identify battening in only about 5-10% of the total cases involving domestic violence (Loring and Smith, 1994).** Therefore, the American College of Obstetricians and Gynecologists has recommended routine screenings for histories of violence in pregnancy (Berenson, et al.). Of great importance is the need to reduce violence on television and in the movies, as it contributes to an acceptance of such violence as a social norm.

Changing the social environment to reduce domestic violence must include expansion of services available, such as battered women's shelters, community education, etc. A recent change in the last decade occurred in some states in response time of police officers called to intervene in domestic violence disturbances. Mandated response is now more the rule than the exception, and some states have instituted mandated arrests for batterers, although the wisdom of such policy has been challenged. Arrests seem to be an effective deterrent to battering in certain groups, and a cause of escalation of violence for others, depending on the batterer's level of social conformity (Loring and Smith, 1994).

Thirdly, changes must be undertaken in the legal and physical environments, such as limiting access to lethal weapons, since assaults involving guns increases lethality twelve times (Loring and Smith, 1994).

Prevention will require change on all levels, but the most drastic change of all will require a restructuring the legal environment to one more sympathetic to the needs of victims, instead of bowing to the offenders, as has traditionally been the case.

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