LETTING THE LIGHT IN:

UNIVERSAL SCREENING FOR WOMAN ABUSE IN A NORTHERN HEALTH CARE SETTING

by

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ABSTRACT

Given that substantial numbers of abused women seek health care services and given the negative impact abuse has on women, children and communities at large, the health care sector has a vital role to play in addressing violence against women. However, due to a combination of personal, institutional and ideological factors, the needs of abused women are often overlooked in the health care encounter. This is troubling because the hospital emergency room represents a significant point of entry for abused women to receive treatment, support and safety. For those living in northern, rural and remote communities, the hospital may be the only source of assistance available to women experiencing violence. This case study critically explores the implications of adopting a health care policy known as "universal screening" for use in a northern, rural or remote health care setting. It is argued that with appropriate training and education, health care providers can use the screening process to go beyond simply inquiring about abuse and treating the physical symptoms to paving the way to women's empowerment. The main goals of screening from an empowerment perspective are listening with empathy; providing support and validation; offering appropriate treatment, information and referrals; and reassuring women that the violence is not their fault. Most notably, this project asserts that developing a critical consciousness about the complex interplay between the personal, social and political aspects of woman abuse is a necessary component of empowerment practice. With this knowledge, rather than feeling that they need to fix the problem, health care providers will recognize that women are the best judges of their own circumstances.

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CHAPTER ONE

Introduction

The feminist movement of the 1970s was instrumental in raising public awareness about the subject of violence against women in relationships (Bograd, 1988). However, despite years of hard work and public awareness campaigns, violence against women continues to be a pervasive social problem (hooks, 1984). In 1996, the 49th World Health Assembly declared that violence against women is a leading worldwide public health concern and violation of basic human rights. It announced that gender violence is a serious social problem, affecting women of all geographic locations, classes, cultures and age groups (World Bank, 1997). The types of violence that girls and women are subjected to around the world today include sexual assault, female infanticide, forced prostitution, forced marriage, genital mutilation and slavery. However, the most pervasive form of gender violence is the abuse women endure at the hands of an intimate partner (Panos Institute, 1997).

According to a recent worldwide study of domestic violence, up to 50% of women around the globe have been physically assaulted by an intimate male partner (Heise, Ellsberg, & Gottemoeller, 1999). In the United States, for example, a woman is assaulted every 15 seconds, and most often the perpetrator is her husband. In Canada, studies show that 29% of women ever married have been sexually or physically assaulted by a current or former male partner since the age of 16 (Rodgers, 1994). In countries such as Egypt, Bangladesh, Cambodia, Mexico and Zimbabwe, wife-beating is often justified as a husband's right to "correct" his wife (Heise et al., 1999). Each year in the United Kingdom, one woman in ten is severely beaten by an intimate partner (Panos Institute, 1997). In many cases, the abuse is so severe it costs women their lives. Studies conducted in Canada, Brazil, Russia and Israel demonstrate that women are more likely

to be killed by an intimate partner than by a stranger (Panos Institute, 1997). A recent Canadian report revealed that over half (52%) of all female homicide victims in 2001 were killed by an individual with whom they had an intimate relationship at one time, either through marriage or dating (Statistics Canada, 2002). While these figures may be troubling, they do not adequately represent the extent of the problem because many incidents of abuse go unreported. Indeed, many victims do not tell anyone about the violence or ask for help (Heise et al., 1999).

Statement of the Problem

For those who do reach out for help, there are transition houses, crisis lines and other interventions now available to help victims of violence (Duffy & Momirov, 1997). Other services available to abused women today include professional sources of support such as police, lawyers, physicians, counsellors, and other less formal sources of help such as support groups and the clergy (Gordon, 1996). Some studies reveal, however, that not all of these sources of assistance are perceived as very useful or helpful to abused women (Gordon, 1996). The health care system, for example, has come under increasing scrutiny for not adequately addressing issues of violence with patients, despite the fact that abused women use a disproportionate share of health care services (Koss, 1994). This criticism is based largely on studies that reveal that only the most serious cases of physical violence are recognized by physicians, while the social and emotional aspects are virtually ignored (Stark, Flitcraft, & Frazier, 1979; Kurz & Stark, 1988; Warshaw, 1993; Varcoe, 1997). When violence is detected, studies show that women often feel that they have been treated in an insensitive and even hostile manner (Yam, 2000; McCauley, Yurk, Jenckes, & Ford, 1998; Varcoe, 1997). Although some women report feeling validated, respected and supported by their provider (Gerbert, Abercrombie, Caspers, Love, & Bronstone, 1999; Yam, 2000; Varcoe, 1997), some leave the

health care encounter feeling dismissed, judged and blamed for the violence (Yam, 2000; McCauley et al., 1998).

Fortunately, in recent years efforts have been made by the health care sector to respond more effectively to the needs of abused patients. For example, nurses and physicians have been urged by their professional organizations to adopt formal protocols and policies that effectively and routinely inquire about intimate abuse (Hotch, Grunfeld, Mackay, & Cowan, 1996). The American Medical Association (1992) declares: "Due to the prevalence and medical consequences of domestic violence, physicians should routinely inquire about abuse as part of the medical history" (as cited in Grunfeld, 1997, p. 365). The general goals of screening are to ask all women about abuse, regardless of injury; to identify victims; to validate that the violence is not deserved; to document the violence and to refer patients to appropriate sources for help (Hotch, Grunfeld, Mackay, & Cowan, 1995). Similarly, many Canadian organizations, including the Canadian Medical Association of Emergency Physicians, the College of Family Physicians of Canada and the Canadian Association of Social Workers, advocate for screening in all emergency departments (Grunfeld, 1997). In Britain, official recommendations regarding routine screening have yet to be implemented, but there appears to be considerable support for routine screening from both practitioners and patients (Howel, Crilly & Fairhurst, 2002).

Despite this increased awareness about the prevalence of woman abuse and the importance of using screening protocols, many physicians continue neglecting to routinely screen their patients (Morrison, Allan, & Grunfeld, 2000). In fact, few hospitals or primary care facilities in urban or rural Canada have a formal universal screening policy in place (Hotch, Grunfeld, Mackay, & Ritch, 1996). This is troubling, because the costs of not asking are high, particularly for victims who live in isolated communities where access to support is often

severely limited (Greenard-Smith, 2002; Derk & Reece, 1989). When violence against women is not acknowledged, opportunities for women to receive appropriate treatment, support, information and referrals are missed, and the violence will likely continue and escalate. Not only will the emotional, physical and spiritual well-being of a woman living in an abusive relationship deteriorate, her use of health care services will eventually increase (Ingram 1994; Gordon, 1996; Koss, 1994). Besides letting health care providers effectively identify and treat the physical injuries and emotional trauma that women endure, studies suggest that universal screening gives health care providers the opportunity to pave the way to women's empowerment (Hadley, 1992; Archer, 1994; Ingram, 1996). Even if women choose not to discuss the abuse with their health care provider, studies indicate that being treated with respect and being validated can help women look at their situation differently and even plant the seed for moving them toward safety (Gerbert, Abercrombie, et al., 1999).

MSW Case Study: Description and Rationale

> "From my experience here in the emergency department, I know that abuse and violence at home is a problem for many women. Is it a problem for you in any way?" (Hotch et al., 1995, p. 11)

The idea that health care interventions can be empowering for abused women has been discussed in the literature (Campbell, 1998; Warshaw, 1994; Hadley, 1992; Ingram, 1994; Abbott & Williamson, 1999; Archer, 1994; Gerbert, Abercrombie, et al., 1999; Transken, 1995, 2000). However, very little has been written about this topic from a northern health care perspective. This absence of research is not surprising given that the subject of woman abuse in rural locations itself receives very little attention (Websdale, 1998). However, what is known about "domestic violence" is that it is a social phenomenon that is clearly not confined to a

specific geographic region. Despite popular misconceptions about rural areas being immune from these problems, some studies suggest that the prevalence and/or duration of woman abuse is higher in rural communities than it is in urban settings (Johnson & Elliott, 1995; Greenard-Smith, 2002; Rodrigues, 2003). Furthermore, various socio-economic and cultural factors operate in rural communities that make women more vulnerable to the effects of abuse and hinder their ability to access supports (Edelson & Frank, 1991; Websdale, 1998; Greenard-Smith, 2002; Rodrigues, 2003). Given that the hospital may be one of the only outside contacts that abused women can rely on for support and information in a rural community, it is critical that health care providers take a proactive role in addressing violence in the lives of their patients (Abbott, 1997). While the idea that universal screening offers practitioners a way to break the cycle of violence has been raised in the literature, few articles have explored the implications of using this policy in rural or northern settings. It was this gap in the research that inspired me to investigate this topic further and to make it the subject of my Master of Social Work case study.

The purpose of this case study is to provide a critical analysis of a universal screening policy for use by physicians and nurses with abused women residing in northern, rural or remote communities. Furthermore, this paper will discuss the merits of adopting a formal screening policy, based on empowerment principles, for use with abused women in these communities. As such, this paper begins with a discussion about woman abuse from a northern, rural and remote perspective. After this, I address the issues pertaining to abused women's encounters with the health care system. Using a feminist lens of analysis, I argue that unsatisfactory helping by the health care community stems not from a desire to intentionally ignore the needs of women, but from a number of factors including personal attitudes and institutional constraints. However, a

major contributing factor preventing health care providers from being able to provide quality care to abused women appears to be embedded in broader ideological conditions. To be more specific, the negative attitudes and stereotypes that prevail about abused women in a patriarchal society are often mirrored in the institutions that abused women most often turn to in time of need: the criminal justice, legal, social welfare and medical systems (Duffy & Momirov, 1997). As such, through various practices and policies (or, as in this case, lack thereof) social institutions unwittingly tolerate and foster male violence and oppression (Duffy & Momirov, 1997). With regard to the medical system, this means that instead of acting as allies in the fight against violence against women, the medical establishment (and other agencies) unintentionally become passive collaborators in women's victimization (Transken, 1995). While it is true that all women in a patriarchal society are oppressed, it is also clear that oppression of all women is not the same (Lee, 2001). As I will demonstrate, this is the case for women of colour, immigrant women, First Nations women, poor women and rural women, who often face additional obstacles when they encounter the health care system.

Following this discussion, I will explore the merits of adopting a formal screening policy, based on empowerment principles, for use with abused women in a northern setting. "Empowerment" is a term often loosely used, and it may have different meanings for different people. From an anti-oppressive social work point of view, it refers to "a process through which people reduce their alienation and sense of powerlessness and gain greater control over all aspects of their lives and their social environment" (Mullaly, 2002, p. 179). An empowerment framework is an integrative, holistic approach whose aim is to encourage social workers (and I include all "helpers" in this definition) to develop knowledge in order "to help people to empower themselves in the personal, interpersonal and political levels of life" (Lee, 2001, p.

24). This paper will show that empowerment practice represents a shift in ideology: from an individual level of analysis of social problems to one that understands that root causes of social problems such as violence are based on the way society is structured (Mullaly, 1997, 2002). With respect to health care, working from empowerment principles means moving away from a narrowly defined medical paradigm (which tends to pathologize victims and blame them for their circumstances) to an empowerment-based model of helping. I assert that by developing a critical consciousness about the limitations of using a medical model, practitioners are able to recognize that the social arena is an important factor shaping people's experience and lives (Mullaly, 1997, 2002). Because the northern social arena strongly influences the way women experience abuse and seek help, I will argue that it is critical for health care providers to formally screen for abuse and that this process can be more meaningful when a empowerment framework is used to guide practice. Women have reported that after receiving support, validation and information from a caring health care practitioner they were able to take action and gain more control over their lives (Hadley, 1992; Gerbert, Abercrombie, et al., 1999). With this in mind, the final section of this paper will demonstrate how using an empowerment model of intervention to inform practice can enhance the universal screening process. I argue that health care workers who are committed to an empowerment vision measure success in terms of the process of screening, not by the number of women who disclose abuse (Gerbert, Caspers, Bronstone, Moe, & Abercrombie, 1999; Gerbert, Abercrombie, et al., 1999). By viewing women as experts on their own lives, the role of the practitioner is not to cure the problem, but to facilitate empowerment. Biestek (1957) asserts that the job of the practitioner is to open the doors and windows to let the air, light and sunshine in, as nobody can breathe or see for another person. It is hoped that this case study encourages health care practitioners (and other allies in

the fight against woman abuse) working in northern communities to consider implementing a formal universal screening policy based on principles of empowerment. In order to demonstrate how universal screening can be an effective instrument for facilitating women's empowerment in a northern, rural or remote community, the following topics will be presented:

- The challenges facing women who are in abusive relationships in rural, remote or northern locations
- The personal, social, and economic consequences of violence against women
- A literature review pertaining to universal screening of woman abuse and barriers which prevent physicians and patients from discussing the issues
- From a feminist perspective, an analysis regarding the limits of the bio-medical model of health care as it applies to interactions with abused women
- A description of the principles and values of an empowerment model of helping
- The implications of applying the empowerment model to a policy of universal screening with a focus on the northern context
- Implications of screening for woman abuse for social work and health care
- An evaluation of the policy and a discussion regarding future recommendations and research aimed to better serve the needs of abused women seeking support from the health care community in the north.

This case study begins with a description of some of the key concepts being used in this paper. The upcoming section also offers an overview of the method of analysis being used and the theoretical standpoint that guides my analysis.

Key Concepts

Master of Social Work Case Study: A Policy Issue

In accordance with the Master of Social Work project guidelines, I have chosen to conduct a case study about the implications of using a screening policy for abuse in a northern, rural or remote health care setting. Therefore, the focal point of my case is an administrative or agency policy as opposed to a clinical case, which is concerned with the analysis of an individual, group or community (Handbook for the Master of Social Work (MSW), 2000, p. 14). "Policy" can be defined in many ways; however, the policy being used in this case study falls more closely in line with the description provided by Westhues (1999). Offering a broad conception of social policy, Westhues writes that social policy is "a course of action or inaction chosen by public authorities to address a given problem or interrelated set of problems" (p. 239). By "public authorities" Westhues (1999) includes decisions emerging from all levels of government (federal, provincial, municipal) as well as social service organizations and collective agreements which address social problems which "deal with human health, safety or well-being" (p. 239). Clearly, a hospital-based protocol aimed at improving the health, safety and well-being of victims of abuse fits this description.

Universal Screening

The primary premise of universal screening is that it differs from the more commonly used targeted (i.e., discretionary) screening of high-risk patients. Instead of asking only those patients who are suspected of being abused, universal screening entails "routine screening for domestic victimization for all female patients over the age of 14, whether or not symptoms or signs are present and whether or not the provider suspects abuse has occurred" (Johnson, 2000, p. 9). A common way to approach the subject is for a nurse or physician to say something along

the lines of: "from my experience here in the emergency department, I know that abuse and violence at home is a problem for many women. Is it a problem for you in any way?" (Hotchet al., 1995, p. 11). While many hospitals and clinics may have guidelines and policies to help inform their practice with abused women, few have officially or formally adopted a screening protocol (Hotch, Grunfeld, Mackay, & Ritch, 1996). This case study explores the implications of using a *formal* policy of universal screening. Chapter six presents a more comprehensive overview of the screening process.

Health Care Practitioner

The term "health care" is commonly referred to in this paper. Health care is defined as those "activities designed to treat, prevent, and detect physical and mental disorders and to enhance people's psychosocial well-being" (Barker, 1999, p. 211). The health care system consists of physicians, nurses, hospital attendants, medical social workers and so on. For the purposes of discussing the implications of screening in a northern or rural community, the term "health care" mainly applies to emergency departments and/or family practice settings. Therefore, the health care provider refers to the person in these settings who will be directly involved in doing the screening, which is usually the emergency room physician, general practitioner or nurse (often it is the nurse who is the first contact person for patients in an emergency department). Besides emergency room settings, screening protocols have been studied and utilized in a variety of other health care settings, including obstetrics, gynecology, surgery, internal medicine and pediatrics (Johnson & Elliott, 1997).

The North

This paper is concerned with universal screening for woman abuse in a health care setting *from a northern perspective*. Defining "north" is not an easy task, but necessary for understanding how geography influences a woman's experiences with violence. The people who make up Canada's north are a diverse group of people. Therefore, this paper refers to women living in a variety of settings such as farming, forestry, mining, fishing, tourism-based and Aboriginal communities. The north is comprised of rural and remote elements as well as urban. For example, cities like Sudbury, Prince George, Edmonton and Thunder Bay are northern cities composed of both urban and rural elements (Delaney, 1995). McKay (1987) defines north by separating it into two main areas: the near north and the far north. The near north, in which the majority of the people are non-native, has an average winter temperature of -15^0C. It includes areas of land found on the southernmost border of the boreal forest and contains a number of larger urban centres accessible by road, train and air (McKay, 1987). Near-north communities have access to educational, health and social services, unlike most communities located in the far north or remote regions (McKay, 1987).

Far or Remote North

The far north (or remote northern regions) consists mainly of remote communities of mostly Aboriginal peoples that are often accessible only by air (Mackay, 1987). Compared to many rural northern regions, remote northern locations experience much colder temperatures and are often separated by vast distances between communities. Isolation is a significant problem which is caused by extreme cold temperatures and transportation challenges due to poor and unpredictable weather (Ingebrigston, 1985). Remote communities have greater challenges sustaining adequate social, health and recreational services and frequently experience

outside government interference in local affairs (Ingebretson, 1985). Arges & Delaney (1996) and Zapf (1991) argue that northern rural and remote communities share a history of exploitation and colonization, and that the north is susceptible to economic and political domination by the south.

Rural

The challenge in clearly defining "rural" is that there are so many different approaches available (Zapf, 1991). Rural can be defined across geographic, population and economic lines. However, some argue that strict geographic or population definitions can leave out important sociological, political and even personal considerations that distinguish rural from urban (Lee, 1991). That is, for some "rural is as much a frame of mind as it is a place" (Coates & Morrison, 1996, p. 3). It is estimated that about one third of Canada's population is rural (Zapf, 1991). From a policy and legislative perspective, Statistics Canada (2001b) defines rural and small towns as communities with a population of 10,000 or less—those that are outside commuting zones of large metropolitan areas and cities. Others (Zapf, 1991) state that rural populations can range anywhere from 2500 to 50,000 people. From an economic perspective, rural communities lack economic diversity as economies are typically based on single industries, such as agriculture, fishing, forestry or tourism (Zapf, 1991). Characterized by an unsteady economy, rural areas often have higher rates of unemployment and low levels of employment due to the seasonal nature of the work (Ingebretson, 1985). Other common elements of rural life are low population density, vast distances from urban centres, strong social connections, an ethic of self-sufficiency and limited health, social and recreational services (Lee, 1991). In addition, rural residents generally adhere to more conservative and traditional values, have a strong church presence, and rely more heavily on informal self-help and natural helping networks

(Ingebretson, 1985). Although "north" and "rural" are not synonymous terms, many of the qualities ascribed to rural areas can also be applied to Canada's north (Ingebretson, 1985).

Woman Abuse

While there are many different definitions of "woman abuse" available, the one used in this paper takes a feminist standpoint as opposed to a family violence perspective.[1] I have chosen the definition provided by DeKeserdy & MacLeod (1997) because it recognizes the complexities that surround woman abuse. They write:

> Woman abuse is the misuse of power by a husband, intimate partner (whether male or female), ex-husband, or ex-partner against a woman, resulting in loss of dignity, control, and safety as well as a feeling of powerlessness and entrapment experienced by the woman who is the direct victim of ongoing or repeated physical, psychological, economic, sexual, verbal, and/or spiritual abuse. Woman abuse also includes persistent threats or forcing women to witness violence against their children, other relatives, friends, pets, and/or cherished possessions by their husbands, partners, ex-husbands, or ex-partners. (DeKeseredy & MacLeod, 1997, p. 5)

It is important to point out that few women endure physical abuse without also being subjected to various forms of psychological abuse such as shaming, intense criticism, verbal harassment, blaming, ridiculing and stalking (Walker, 1980; Loue, 2001). For many women, "the slow emotional torture which produces invisible scars is as abusive as the quick, sharp physical abuse" (Walker, 1980, p. 72). However, acts of physical abuse and psychological cruelty are often accompanied by acts of kindness and promises that the abuse will not happen. Key to understanding the complexities surrounding these dynamics is Lenore Walker's (1980) "cycle of violence" theory. According to Walker (1980), the cycle of violence is characterized

by three phases: the tension-building phase; the explosion or acute battering incident; and the peaceful, loving and often remorseful phase. Phase one, or the tension-building phase, is the time verbal attacks and minor acts of violence take place. Following this is phase two, in which there is typically an acute battering incident, tension reaches its peak and a violent incident occurs. Immediately following this is the third phase, in which the abuser is typically affectionate and loving. This final phase is where many victims find themselves believing that the abuser is going to change his behavior and consequently, they decide to stay and give him another chance (Walker, 1980). It is not difficult to see how living in this environment can, often very slowly, erode a woman's self-esteem and sense of efficacy. About the complexities involved in leaving a violent relationship, one interviewee states:

> I was vulnerable, naïve, blinded. I believed in a man I loved, and I did not believe he would keep hurting me. I stayed with him, and I chose not to see the man I married, the father of my three children, as a batterer who would always be a batterer. I saw each incident as an isolated nightmare, all explained away, all forgiven. I didn't connect them to see the pattern (Loue, 2001, p. 144).

CHAPTER TWO

Method of Analysis: Critical Thinking

"Critical thinking is at the heart of anybody transforming their lives" (bell hooks, 1997).

I have stated that this paper is a critical analysis of the implications regarding a screening policy for use in northern or rural health care environments. In order to assist me in this process, I have used the critical thinking framework offered by Gibbs and Gambrill (1999). According to Gibbs and Gambrill, critical thinking involves the "critical appraisal of beliefs, arguments and claims in order to arrive at well reasoned judgments" (p. xiii). This is a necessary component of social work (and other helping professions), as critical thinking may enable practitioners to identify, change or improve policies in order to put the best interests of clients first (Gibbs & Gambrill, 1999). It is important to note that critical reflection is not theory-free, because it is based on certain fundamental beliefs and assumptions about society (Mullaly, 2002). In *Feminism is For Everybody: Passionate Politics,* bell hooks (2000) points out that every person's actions and thoughts are rooted in theory. Whether people are conscious of it or not, hooks argues that there is an underlying system at work influencing the decisions and behaviors people make (hooks, 2000). With this in mind, it is important to point out that the critical analysis and ideas offered in this paper are informed by a number of different "voices of authority." These voices include academic texts, journal articles, qualitative and quantitative research studies and conversations with health care practitioners. However, the ideas that are brought forward in this paper are also strongly shaped by my own educational, personal and professional experiences. My education in sociology, psychology and social work, and my training as a counsellor, all come together to shape the theoretical lens of this paper. Most significantly, however, this paper is influenced by my previous employment as a feminist-

oriented counsellor, working with victims of abuse of different ages and working in various capacities (as a transition house counsellor and coordinator, Crown counsel victim support worker, Elizabeth Fry counsellor, and a primary school counsellor). Cultural studies researchers refer to this way of weaving together information from many sources as "bricolage" or "collage" research (Transken, 2002). Similarly, feminist scholars advocate for multi-method research because "it creates opportunities to put texts or people into contexts, providing a richer and far more accurate interpretation" (Reinharz, 1992, p. 213). The next section will reveal that while I see the value in considering multiple perspectives (for example, psychological and sociological) for understanding the complexities surrounding violence against women, I believe that an explanation of woman abuse is enhanced when a feminist lens is used.

My Standpoint: A Multi-Focussed Feminist Lens

> Women will not be free from violence until there is equality, and equality cannot be achieved until the violence and the threat of violence is eliminated from women's lives. (Canadian Panel on Violence Against Women, 1993, p. 4)

Many types of feminist scholarship have been developed, including socialist feminism, Marxist feminism, liberal feminism and radical feminism, to name a few (Jaggar, 1983). However, all forms of feminism generally agree that feminism is "a movement to end sexism, sexist exploitation and oppression" (hooks, 2000, p. 1). What distinguishes the different forms of feminism from one another is how they view the origins of women's oppression and how they think the problem should be addressed. The form of feminism I lean closest to is most strongly informed by sociological theories (Gelles, 1983) and socialist feminism (Jaggar, 1983).

A sociological point of view takes into consideration that family violence is largely shaped by the major social structures such as age, sex, socio-economic status, race, religion and

ability. A sociological standpoint also recognizes that social stress is a factor in cases of partner abuse. While there is an understanding that violence cuts across all social and economic groups, the risk of child abuse, wife abuse, elder abuse and so on is greater among those who are poor, unemployed and who possess jobs of low prestige (Gelles, 1993). In addition, sociological theories contend that wider social norms and media images condoning violence contribute to violence being seen as a normal means for resolving conflict. "The frequent portrayal of coerced sexuality in mainstream movies, music videos, television and pornographic materials provides a backdrop for rationalizing gender violence in everyday interaction" (O'Toole & Schiffman, 1997, p. 71). Many feminist sociologists take the position that, while the media is a strong influence in terms of passing on messages that condone violence, it is the structure of the modern patriarchal family as a social institution which most strongly influences family violence (Gelles, 1993; Smith, 1990; Walby, 1990).

From a socialist-feminist standpoint, it is necessary to examine the interrelationship that exists between capitalism and patriarchy in order to understand how society and its institutions promote and perpetuate a violent society (Jaggar, 1983). Some have argued that based on a structure of hierarchy and exploitation of workers, the liberal democratic capitalist Canadian society is in essence abusive in nature (Duffy & Momirov, 1997). Duffy & Momirov (1997) assert that based on competition, self-interest, efficiency and rationality, capitalism results in a situation in which few people enjoy economic prosperity while many are economically deprived and become marginalized members of society. From a socialist-feminist perspective, it is this relationship between patriarchy and capitalism that creates a culture of violence (Jaggar, 1983). That is, a husband's use of violence against a partner is not a random, irrational act; instead it is embedded in a patriarchal society which is "a system of social structures and practices in which

men dominate, oppress and exploit women" (Walby, 1990, p. 20). Being dominant means that generally, men as a group have more privilege and access to resources, while women as a group are devalued and viewed as secondary (Bograd, 1988). Bograd recognizes that while it is true that there are significant social class and race differences among men, all men can potentially use violence as a way to subordinate women (Bograd, 1988). Male violence (both the perception of and actual act itself) is an expression of male power used by men to reproduce and maintain this relative status and authority over women (Alder, 1997). Jaggar (1983) concedes that the use of violence for control in marriage is not only perpetuated through norms about what constitutes appropriate male roles and husbands' rights in marriage, but also through women's continued economic dependence on their partners. Marriage based on a traditional sexual division of labour, in which women are the primary child-care providers and housekeepers, and men are responsible for the economic arena, contribute to women's dependency on husbands (Jaggar, 1983). Women's fear of violence, combined with economic dependence, is further complicated by other structural barriers such as limited child care, housing options and support services which create a situation in which women are often forced to remain in abusive homes (Jaggar, 1983). In addition to the family, patriarchy characterizes all other social institutions such as the church, government and the agencies abused women have the most contact with: the law enforcement agencies, the criminal justice system and the medical establishment (Duffy & Momirov, 1997). This translates into a situation in which violence against women and children is in effect sanctioned and reinforced both by individual partners and by the social institutions women depend on (Duffy & Momirov, 1997).

I agree with the feminist position that violence cannot be understood without an analysis of gender and power, and that attributing violence to interpersonal conflict or psychological

factors is simply not sufficient (Yllo, 1993). In other words, social-psychological theories often point to social learning theory to explain why men are abusive and women are victims. Similarly, psychological explanations for woman abuse tend to focus on the personal pathology of the abuser: looking at childhood experiences, parental relationships and later use of violence (Yllo, 1993). The problem with leaning too heavily on psychological explanations is that there is too much emphasis placed on the psyches of the abusers and less on the role of history, social institutions and dominant ideologies in explaining violent behavior (Duffy & Momirov, 1997). Johnson (1996) cautions against assuming that witnessing violence as a child is a predictor of future abuse. Referring to Canada's national Violence Against Women Survey, she states: "While it is true that the rate of wife beating is much higher for men who have witnessed violence by their own fathers, it is also true that the majority of abusive men were not exposed to violence in childhood. And, over half the men who did have this exposure have not been violent toward their own wives" (p. 177). With this in mind, I believe that psychological and social learning theories both make important contributions to our understanding of violence against women. However, having worked with survivors of abuse reinforces for me the value of using feminist principles to inform practice. The primary benefit of using feminist principles to guide practice with abuse survivors is that the focus of helping is not on changing individual behaviors or getting people "to adapt to their oppressive environments" (Land, 1995, p. 14). Instead, the focus is on helping women see how personal problems are both created by and intensified by societal power imbalances (Burstow, 1992).

The reason I advocate using an empowerment approach for screening for woman abuse is that it is multi-faceted and reflects the principles and goals of feminism, anti-oppressive or structural social work, and cultural studies. It is also the preferred model of practice for many

northern social workers (Delaney, 1995; Zapf, 1991). Empowerment practice is carried out by linking political (structural) reasons to private troubles and communicating this back to those who suffer from its damaging effects (Mullaly, 1997, 2002). Cultural studies is an important element of empowerment practice because it emphasizes the notion of "multiplicity of oppression," asserting that "multiple identities are a major influence on the production, persistence and complexity of oppression" (Mullaly, 2002, p. 147). Cultural studies illustrates how "the ruling hegemony is carried out at the level of everyday cultural practices—practices that support a white, male, bourgeois, Eurocentric domination" (Mullaly, 2002, p. 84). Later in the paper, I explore how empowerment values and practice are particularly concerned with attending to the needs of vulnerable populations (Lee, 2001). The next section shows that one vulnerable group that both health care workers and social workers are likely to encounter in the north is women who are being abused by their partners. By exploring the multidimensional nature of isolation, I will show how the northern landscape can create an untenable situation for women trying to escape violence, particularly for women who are not members of mainstream society.

CHAPTER THREE

Violence Against Women in Northern, Rural and Remote Communities

Six "gorgeous" children killed in house fire in remote island community. (Canadian Press, March 11, 2002)

Headlines such as this one often evoke strong feelings of dismay and disbelief. The tranquil picture of northern or rural life makes it difficult for people to believe that "domestic violence" could occur in their community. However, as mentioned, all women, regardless of ethnicity, economic background and geography, are vulnerable to violence (World Bank, 1997). It must be pointed out, though, that the impact of violence is magnified for socially marginalized women such as poor women, women with disabilities, older women, immigrant or refugee women, First Nations women and rural women (Morrow, 2000; Canadian Panel on Violence Against Women, 1993). Research indicates that although rural areas have lower crime rates in general, rates of rural domestic violence can be as high or higher than in urban settings (Bogal-Allbritten, 1997; Elliott & Johnson, 1997; Petersen & Weissert, 1982). In some northern Aboriginal communities, the rate of woman abuse is as high as 75 to 90% (Green, 1996).[2]

The aspects of rural life that make it so appealing to many who choose to live there, such as the solitude, simplicity and close-knit nature of the community, also create immense challenges, particularly for abused women (Fishwick, 1998). Studies on rural partner violence consistently cite isolation as a key factor of rural women's experiences with violence (Jiwani, 2001; Goekermann et al., 1994; Fishwick, 1998; Websdale, 1998; Beauregard, 1996; Edelson & Frank, 1992; Greenard-Smith, 2002). Isolation is not unique to rural women. It is not uncommon for abused women to be cut off from everyone they know except the abusive person, regardless of where they live (NiCarthy, 1986). In addition to this kind of physical isolation, the

secrecy surrounding woman abuse often leaves many women feeling tremendously alienated and alone (NiCarthy, 1986). However, as the next section will show, there are additional distinct geographic, social, cultural and economic factors that influence the way northern women experience violence and seek help.[3]

The Key to Control: Isolation

Ensuring silence is key to an abuser's ability to maintain control and intimidation over his partner. A common characteristic of violent men is that they are highly distrustful, possessive and jealous. Abusers will often use extraordinary measures and complex practices to control their partner's whereabouts, carefully monitoring whom she sees and where she goes (Walker, 1980; NiCarthy, 1986). Despite constant surveillance, abusers are often extremely suspicious of their partner's relationships, especially with other men (Walker, 1990). In the written descriptions of ex-partner homicides completed by investigating police officers, fear of infidelity was the central theme for male offenders. The police also note that the most common motive among men for killing an ex-partner was jealousy (41%) (Statistics Canada, 2001a). An abusive spouse will often keep his partner away from her friends and family and prevent her from working outside the home. This isolation ensures that potential sources of help are never contacted, and thus women begin to believe that their situation is one of a kind (NiCarthy, 1986). Without an outside "reality check," women start to believe that they must be to blame for the violence, and they are prevented from learning that there are alternatives to living with violence (NiCarthy, 1986). Those who do find the courage to speak out and flee their abusive surroundings often discover that breaking the silence is only the first hurdle they must overcome.

Barriers to Escaping the Violence

Women stay in abusive relationships for a variety of often complex and interconnected reasons. Some of these include staying for the children; for love; for lack of financial independence; for lack of job opportunities; for lack of life skills; for fear of deportation and, most notably, for fear of partner retaliation (McTimoney, 1993).

The unfortunate reality for many women is that staying in an abusive marriage or relationship is not the worst thing that can happen to them (Bowker, 1993). Studies show that attempting to leave an abusive partner can and does lead to escalated violence and even murder (Wilson & Daly, 1994). Leaving may be especially dangerous for rural women, as some studies suggest that the highest rates of spousal homicide take place in the more rural parts of Canada, such as the western provinces and territories (Gurr, Mailloux, Kinnon, & Doerge, 1996). Some abused women would rather expose themselves to violence and try to protect their children than risk losing custody of their children to a violent man (Bowker, 1993).

Violence and Poverty

A significant barrier for women trying to flee an abusive relationship is related to their socio-economic status. Women in Canada are at higher risk of living in poverty than are men (Status of Women Canada, 1995). Among the women who currently live in poverty, there is an overrepresentation of older women, single mothers, immigrant women, women of colour and disabled women, as well as Aboriginal and rural women (Gurr et al., 1996). Poverty is often a two-way street when it comes to violence against women in relationships. On the one hand it can contribute to violence, and on the other hand it can be the result of leaving a violent relationship. Poverty is associated with higher unemployment, subsistence housing and greater family stress and conflict (violence). Given that an abused woman's economic security is

largely dependent on her husband's income, moving out of an abusive relationship often means moving into poverty (Lochhead & Scott, 2000). With the current cutbacks to British Columbia's social assistance benefits and other programs (i.e., 18% reduction for single mothers, cutbacks to child-care resources, etc.), the welfare option for abused women today is dismal at best. A single mother with two children will need to clothe, house and feed her family on less than $1000 per month (B.C. Ministry of Human Resources, 2002). Single mothers who work outside of the home (usually for minimum wage) instead of collecting social assistance are seldom better off (B.C. Coalition for Women's Centres, 2002). For many women, returning to work often means losing prescription, dental and vision benefits and housing and child-care subsidies. For many women, getting a job essentially means making the shift from the unemployed poor to the working poor (Davies, McMullin, Avison, & Cassidy, 2001).

Institutional & Structural Barriers

While all women in society face similar socio-economic obstacles when it comes to fleeing abuse, there are distinct structural elements that exist in many rural or northern communities that make escaping violence in these settings particularly challenging (Websdale, 1995; Krishnan, Hilbert, & Van Leeuwen, 2001). Northern or rural women typically have less formal education, fewer job opportunities, less job security and benefits, and fewer housing and child-care options than their urban counterparts (Schissel, 1992). A comprehensive discussion about the subject of family violence in Aboriginal communities goes beyond the scope of this paper. However, it is important to point out that these socio-economic conditions are felt even more profoundly by many Aboriginal families (LaRocque, 1994). Many believe that the widespread abuse of Aboriginal women and children is integrally linked to a long history of exploitation and cultural genocide (Green, 1996; Royal Commission on Aboriginal Peoples,

1996). Family violence in Aboriginal communities is attributed to the daily stress of living in poverty, financial hardship, as well as high rates of alcohol and suicide, resulting in chronic despair for many Aboriginal families today (Royal Commission on Aboriginal Peoples, 1996; Canadian Panel on Violence Against Women, 1993).

Combined with numerous socio-economic barriers, rural women's isolation and dependency is further magnified due to inadequate sources of formal support such as transition houses, counsellors, women's support groups, social and health care services and culturally relevant services (Greenard-Smith, 2002; Krishnan et al., 2001; Jiwani, 2001; Websdale, 1998). For women who reside in more remote areas, most of whom are First Nations women, the only way to get to a transition house is by boat or plane (Greenard-Smith, 2002; The Canadian Panel on Violence Against Women, 1993). Further complicating the problem is the challenge northern women face in terms of finding service providers who are knowledgeable about the dynamics of abuse and sensitive to their concerns (Greenard-Smith, 2001). In addition, for women accessing these limited supports, maintaining privacy, anonymity and confidentiality is exceedingly difficult in smaller communities (Fishwick, 1998; Websdale, 1998; Goeckermann, Hamberger, & Barber, 1994). Women are likely to know or be acquainted with those who are in a position to help them, such as social workers, clergy, police officers, court workers and hospital staff. For many women in rural areas, seeking help means risking being blamed for the abuse and ostracized (Jiwani, 1998; Canadian Panel on Violence Against Women, 1993).

Social/Cultural Isolation

> Violence is a secret; [it is] never discussed because it threatens the webs of relationships which hold rural communities together. (Canadian Panel on Violence Against Women, 1993, p. 71)

As mentioned, despite evidence that shows that rural family violence is a major problem, it is still commonly believed that rural areas are immune to these issues (Websdale, 1998; Gurr et al., 1996). Some of the characteristics of rural life that were discussed earlier in this paper play an integral role in contributing to this misconception about woman abuse. Studies have shown that many rural people believe strongly in the "sanctity of marriage" and religious values, and are less tolerant of minority rights (Fishwick, 1998). According to Websdale (1995), "rural patriarchy" characterizes these communities, meaning that traditional sex-role division is more common. In other words, it is the norm for men to assume the breadwinner role and women to assume primary responsibility for child rearing and housework. Added to this is an attitude that domestic violence is a family issue and not a community problem, as well as a strong adherence to values of self-reliance and independence (Fishwick, 1998; Websdale, 1995). Violence may also go unreported because women are hesitant to call the police due to negative attitudes and what Websdale (1995) refers to as a problem of "passive policing" in these regions. Furthermore, in cases where criminal or unsavory activities are taking place (for example, illegal firearms, marijuana growing, welfare fraud, etc.) women may feel that calling the police is not an option. What all this means is that rural women in these complex circumstances are reluctant to seek outside help or to report the abuse, and the conspiracy of silence and violence continues (Websdale, 1995).

For women who are not members of the dominant culture (that is, immigrant women, lesbian women, First Nations women), living in a small community may present different challenges. For example, some immigrant women living in the north may not be able to ask for help because of cultural and social isolation, language barriers, discrimination and fear of deportation. Like many rural women, immigrant women often have strong values around

dedication to family unity (Jiwani, 1998). A woman with strong religious or cultural values may feel that her community will shun her if she leaves her abusive marriage (Bowker, 1993; Status of Women Canada, 1993). New immigrants often report feeling powerless when seeking help in a completely new setting, with little knowledge about law enforcement, legal rights or the availability of shelter services or social services (Bauer, Rodriguez, Szkupinski Quiroga, & Flores-Ortez, 2000.) For women who speak very little English, reaching out for help is not only difficult but dangerous because they are often completely dependent on their abusive partner to drive them to appointments and interpret for them (Jiwani, 2001). For rural women in same-sex relationships, asking for help can be highly anxiety provoking. A woman residing in a northern town in Ontario recalls how the fear of being exposed affected her daily life: "Living closeted in a straight community...I was afraid to be open with anyone...I used alcohol to avoid dealing with my fear" (Beauregard, 1996, p. 236). In Aboriginal communities, some women fear that speaking out about the violence could lead to further victimization by local leaders, most of whom are male (Royal Commission on Aboriginal Peoples, 1996). Aboriginal women's reluctance to speak out also comes from a fear of exposing their communities to contempt or their families to outside intervention (Royal Commission on Aboriginal Peoples, 1996).

Physical Isolation

I have presented some of the broader structural, institutional and social/cultural barriers that contribute to northern women's increased dependency and isolation. Although these factors are being presented individually, it is important to point out that these various forms of isolation intersect with one another and operate in a way that is mutually reinforcing. For example, the physical milieu of the north, which offers privacy and seclusion from others, makes it easier for abusive partners to engage in violent behaviors that would be harder either to carry out or to get

away with in urban areas (Websdale, 1995). In addition, because of the cyclical nature of partner abuse and the extended length of time it takes a rural woman to leave her partner, it is more likely she will be exposed to more serious forms of abuse for a longer period of time (Websdale, 1998). For example, women's dependency is intensified because seasonal jobs are more common in these regions, leading to an abusive partner spending extended periods of time at home. Hence, economic conditions set the stage for increased and enduring opportunities for violence, and at the same time women have access to limited sources of support (Goeckermann et al., 1994).

Websdale (1998) makes an important point, stating that geographic isolation is often the result of a calculated decision on the part of the batterer to reside in the country. Geography means that seeking help from neighbours is hampered by distance (some farms, for example, are kilometres apart, not metres) (Fishwick, 1998). Geography is also a factor in the kinds of tactics used by abusers, such as removing the phone receiver to cut off outside contact; locking the thermostat in the winter; keeping track of the odometer reading to restrict movement (which is particularly effective when there is no alternative mode of transportation); driving recklessly to intimidate the woman; and discharging firearms. Research shows that the presence of dangerous tools and weapons is more common in rural households than in urban (Fishwick, 1998). Other geographical factors, such as poor roads, lack of public transportation and extreme weather, make accessing supports and fleeing an abusive relationship at times virtually impossible (Goeckermann et al., 1994; Greenard-Smith, 2002). A northern BC transition house worker attests to this fact, stating: "At 40 below, you can't even get in the car when you are running." (Greenard-Smith, 2002, p. 62). Moreover, distance, poor roads and dangerous weather conditions often lead to inadequate responses by emergency services such as police and

ambulance, clearly putting women (and drivers) at risk of serious injury and even death (Websdale, 1995; Greenard-Smith, 2002). In addition, rural women may not get the help they need in a crisis because telephone subscription rates tend to be lower and cell phone service is confined to certain geographic areas (Websdale, 1998; Greenard-Smith, 2002).

The aim of this section has been to demonstrate that violence against women in relationships is a serious social problem facing a substantial number of women of all ages, classes, cultures, religions and geographic locations. Isolation is a central feature of most abusive relationships. The primary difference between rural abuse and urban abuse lies in the way the many faces of isolation intersect with one another. More specifically, geography merges with social, cultural and economic conditions in a way that intensifies a northern woman's dependency, increases her risk of enduring victimization and diminishes her ability to escape the abuse. The human and economic costs of women's victimization are far-reaching. As the next section demonstrates, violence against women results in serious emotional and physical consequences at the individual level, but also negatively impacts society at large.

CHAPTER FOUR

Women, Violence & Health

Well she finally got the nerve to file for divorce; She let the law take it from there
But Earl walked right through that restraining order; And put her in intensive care.

(Lyrics to "Goodbye Earl," Dixie Chicks, 1999)

The Many Costs of Woman Abuse

The costs of gender violence are difficult to assess. However, whether the violence takes place in an urban or rural setting, the effects are far-reaching. The costs of violence against women are not restricted to the victim and her children, but also have indirect effects on communities and society at large. Violence not only generates a general climate of fear and insecurity, but it also stands in the way of women's full economic and social development. By draining women's energy and eroding their sense of self-worth, abused women are denied the ability to participate as full members of society (Garcia-Moreno, 1999; Heise, 1994). Being controlled and victimized by a partner reduces a woman's confidence and her ability to work outside the home or to attain an education. The World Health Organization reports that women of reproductive age in industrial countries lose one out of five healthy days of life because of domestic violence and rape (World Bank, 1993). Canada's national Violence Against Women Survey revealed that 30% of battered wives had to cease regular activities due to the abuse, and 50% of women had to take sick leave from work because of the harm sustained (Rodgers, 1994). Moreover, being isolated means that women are denied access to vital information and support, and it makes it difficult for them to care properly for themselves or their children. Canada's national Violence Against Women Survey indicated that approximately 4 in 10 women (39%) reported that their children witnessed the violence (Rodgers, 1994). Witnessing

violence not only instills fear and anxiety in children, but it can be detrimental to their social, emotional and behavioral development (Jaffe, Wolfe, & Wilson, 1990). A serious outcome for children exposed to violence at home is an increased risk of being physically or sexually abused themselves and repeating the cycle of violence (Jaffe et al., 1990).

The economic costs of violence against women not only impact the lives of Canadian women, but violence puts financial pressure on governments, businesses and institutions. In terms of medical or health costs incurred, it is known that victims of violence use a disproportionate amount of health services including emergency room visits, primary care and community mental health centers (Plichta, 1992; Koss, 1994; Day, 1992). The Canadian Violence Against Women Survey demonstrated that four in ten women injured by a partner, or over half a million women, saw a doctor or nurse for medical attention in 1993 (Rodgers, 1994). Day (1995) estimated medical costs associated with treating abused women in Canada in 1992 to be $1.5 billion. Clearly, these numbers do not adequately measure the true cost of partner abuse. Not included in these reports are the non-quantifiable costs of violence such as the emotional and physical suffering, breakdown of quality of life and in many cases loss of life (World Bank, 1997).

Health Consequences of Woman Abuse

Victims of violence often sustain a range of serious physical injuries and psychological problems resulting in broken bones, disfigurement, disability and suicide (Abbott & Willamson, 1999; World Bank, 1997). Physical, sexual and emotional abuse can lead to hypertension, digestive problems, migraines, visual impairments, asthma, chronic pain and other stress-related health concerns such as substance abuse problems, depression, anxiety and insomnia (Heise, 1994; Trypuc, 1994; Plitchta, 1996). Furthermore, the safety of a woman's unborn child is at

risk as it is common for violence to begin and/or escalate during pregnancy (Campbell, 1991). Physical and sexual abuse during pregnancy can lead to low birth weight, miscarriage, maternal mortality and other reproductive problems such as unsafe abortions, chronic pelvic pain and sexually transmitted diseases (United Nations Population Fund, 2000).

Health Care Response to Abused Women

Stark, Flitcraft and Frazier (1979) were among the first researchers to document the incidence of domestic violence among American women presenting in emergency rooms with medical or psychiatric complaints. They found that 19% of women trauma patients who came to a hospital emergency room were either confirmed as or very likely to have been battered (Stark et al., 1979). Today, estimates of the percentage of women presenting to emergency room departments or other health care settings as a direct or indirect result of partner violence vary. However, a recent review of previous studies led researchers Rodriguez, Bauer, McLoughlin, & Grumbach (1999) to estimate that between 31% and 54% of women who visit an emergency department report a history of domestic violence.

Despite the fact that substantial numbers of abused women regularly seek health care services, the medical community generally has a poor record in terms of detecting abuse and responding appropriately to victims (Baer, 1997). For example, in her review of the literature on woman abuse and health care utilization, Plichta (1992) reports that detection of abuse by emergency room physicians is low, even when the injury is directly due to abuse. It is estimated that only 5% of cases are presently being identified in emergency room departments (Lydon, 1996) and 3% detected in primary care settings (Thompson et al., 1998). Furthermore, in cases where physicians have detected woman abuse, some women have found providers to be unhelpful, unsupportive, disinterested, uncomfortable and blaming (Gerbert, Abercrombie, et

al., 1999; Plitcha, 1992; Varcoe, 1997; Warshaw, 1993; Kurz & Stark, 1988; Yam, 2000; McCauley et al., 1998; Jiwani, 1998; Mehrotra, 1999; Transken, 1995). In a U.S. study, 1000 abused women ranked physicians after clergy, police and social and legal services for their effectiveness in dealing with violence (Brentro & Bowker, 1989). Although the majority of studies on this subject have been carried out in the US, similar studies conducted in Canada, Australia and the United Kingdom suggest that abused women's dissatisfaction with the health care system is not restricted to the United States (Ferris & Tudiver, 1992; Lydon, 1996; Bates & Brown, 1998; Abbott & Williamson, 1999).

A Call for Action

In response to the problem of poor detection rates and ineffective responses to abused women, routine screening tools have been developed for use in various health care environments. Many studies demonstrate that the use of a screening protocol creates an opportunity to increase (sometimes dramatically) the identification and referral rate of intimate partner violence (McLeer & Anwar, 1989; Morrison et al., 2000; Larkin, Hyman, Mathias, D'Amico, & MacLeod, 1999; Olson, Anctil, Fullerton, Brillman, Arbuckle, & Sklar, 1996). Research also suggests that the quality of physician response is better in settings where screening protocols for domestic violence are in place (Kurz, 1990; Jiwani, 2001). In their study at the Medical College of Pennsylvania, McLeer & Anwar (1989) found that after taking a thorough trauma history from every non-motor-vehicle-accident trauma patient using a 15 minute triage interview, the detection rate of domestic violence increased from 5.6% to 30% (McLeer & Anwar, 1989). In addition, Larkin et al. (1999) found that in a Pittsburgh emergency department, the detection rate of abuse in women patients went up from 1% to 18%, even when the universal screening tool was not used consistently among staff. Similarly, a study conducted

by Olson et al. (1996) revealed that the proportion of domestic violence cases identified in a large urban trauma centre almost doubled after putting a one-question stamp on the patients' charts (e.g., "is this visit related to domestic violence?"). Unfortunately, despite support shown by professional associations for screening for woman abuse, health care providers generally fail to routinely screen for violence (Campbell, 2001; Warshaw, 1994; Kurz & Stark, 1988; Morrison et al., 2000). According to Grunfeld et al., (1996) it is not sufficient to informally encourage hospitals to adopt guidelines concerning domestic violence, as this has not been adequate to ensure widespread adoption and implementation. The reasons why physicians are reluctant to screen for abuse are complex. It is evident, however, that the problem of abuse going undetected is connected not only to physicians' reluctance to ask about violence, but also to women's reluctance to discuss the issues (Gerbert, Abercrombie, et al., 1999). The aim of the next section is to shed some light on this dilemma by critically examining some of the most common barriers identified by health care providers and patients respectively.

Barriers to Discussing the Issues

> I don't know why it should be frustrating to us. I think it's because we feel powerless. And physicians don't like to think we're powerless. (Roux & Rittmayer, 1999, p. 174)

Physician/Nurse Barriers

The reasons behind health care providers' reluctance to inquire about family violence issues appear to be varied. Some of the most commonly cited reasons are lack of time, education or training; lack of referral options; fear of offending the patient; identifying too closely with the patient; feelings of inadequacy; inability to control the situation or fix the problem; underestimating the scope of the problem; and frustration with women returning to abusive partners (Yam, 2000; Parsons, Zaccaro, Wells, & Stoval, 1995; Burgh, 1989; Sugg &

Inui, 1992; McGrath, Bettachi, Duffy, Peipert, & Becker, 1997; Rodrigues et al., 1999). It is worth investigating some of these issues more closely.

Lack of time. Time is frequently cited as a barrier for effective intervention with victims of violence. Emergency room physicians and nurses work under severe time restraints, and therefore many feel too pressed for time to engage in a complex and potentially emotional encounter with their patients (Baer, 1997). However, brief screening tools have been developed that take into consideration the busy milieu of the emergency room. These tools, although brief, can still enable nurses and doctors to deal with this issue effectively and in a caring and professional manner (Morrison et al., 2000). Furthermore, given the long-term economic and personal costs of violence against women, the time spent on repeat visits for related consequences of violence over the long run is far greater than the time it would take to address the issue as early as possible (Ingram, 1994; Warshaw, 1994).

Lack of referral options. Some doctors are concerned that they will be opening "Pandora's box" by asking about abuse if they have few referral options to offer their patients (Sugg & Inui, 1992). Some rural physicians (Dr. Leiski, personal communication, April 25, 2002) have identified this as a substantial barrier to screening for abuse. While it is understandable for doctors to be reluctant to ask about abuse when there are few programs and resources in which to refer their patients, *I would argue that screening for abuse is necessary for precisely this reason.* As stated, the number of women who seek health care services for violence-related injuries is significant (Plitcha, 1992). The emergency department is open 24 hours a day, making it an ideal setting for abused women to receive treatment, safety and support. The 1993 Canadian Violence Against Women Survey showed that four in ten women who were in violent relationships saw a medical doctor, whereas only 8% contacted a shelter

and fewer, 6%, stayed in one (Rodgers, 1994). Derk and Reece (1989) argue that it is imperative for health care providers in rural and other underserved areas to pay particular attention to their abused patients. Rural or northern providers may be the only people with whom the woman has contact, who can assist with developing a safety plan, and who can reassure the woman that the violence is not her fault violence. (Derk & Reece, 1989).

Lack of training/education or skill. Many health care providers are reluctant to ask about violence because they feel that they lack the training or skills required to effectively help their patients (Sugg & Inui, 1992). Despite a growing awareness of the medical consequences of violence against women, health care providers today receive little training in working with domestic violence victims (Bates & Brown, 1998). A recent study indicates that despite the fact that more schools now offer curriculum in family violence, students receive an average of only two hours of training (Alpert, Tonkin, Seeherman, & Holtz, 1998). Later in this paper I will argue that training about the dynamics of abuse in relationships is essential to effective intervention and treatment of abused women. Without it, health care providers are likely to react to victims of abuse or rape the same way lay people do, which is to question the patient's credibility and culpability for the offence (Koss, 1994). Furthermore, without education about the prevalence of woman abuse, physicians may underestimate the magnitude of the problem. In one study, physicians estimated the incidence of wife abuse in their practice at less than 2% (Baer, 1997). It is encouraging to note, however, that Canadian family physicians are reporting that they would like to receive more education on the subject of woman abuse (Ferris & Tudiver, 1992). This is a step in the right direction, because some research suggests that physicians who receive training on woman abuse are more likely to detect violent incidents (Parsons et al., 1995).

Fear of offending the patient. Another obstacle to screening for abuse is physicians' fear of offending patients. Studies show, however, that these fears are generally unfounded (Hotch, Grunfeld, Mackay, & Cowan, 1996; Gerbert, Abercrombie, et al., 1999). Researchers find that women are pleased that their physician is open to discussing the problem and women who are not abused are not offended to be asked (Ministry of Women's Equality, 1999; McLeer & Anwar, 1989). An informal, anonymous survey given to emergency room patients revealed that 96% of respondents supported the Vancouver Hospital's screening program (Grunfeld, Ritmiller, Mackay, Cowan, & Hotch, 1994). Some authors point out that screening for violence is not unlike screening for other sensitive issues such as substance abuse, depression, sexually transmitted diseases and breast cancer (King, 1998).

Inability to control the situation or "fix" the problem. A physician's reluctance to intervene may be grounded in beliefs about his or her role and what is considered a successful outcome in the screening process (Cole, 2000; Gerbert, Caspers, et al., 1999). Some doctors believe they are trained to take charge and fix problems, but dealing with woman abuse challenges their perception of themselves as "healers" and demands a new set of skills (Baer, 1997). Some doctors simply feel powerless and frustrated, stating: "...you don't want it to happen to your patients. It's depressing. And it's difficult. It's hard to fix. You may not be able to fix it" (Roux & Rittmayer, 1999, p. 175).

Frustration with women returning to abusive relationships. Some health care practitioners believe that it is not worth bothering to intervene in cases of domestic violence because the woman will not leave the relationship or access the services offered anyway (Roux & Rittmayer, 1999). The position taken here is that the priority in the screening process should not be the number of women who disclose abuse, nor should it be focussed on getting women to

leave their partners or access supports. Given the secrecy and shame surrounding the abuse, it is not unusual for women to be evasive and even uncooperative when asked about the violence (Kurz, 1990; Varcoe, 1997). It is important to note that while a woman may not be ready to talk about the abuse or be open to suggestions about leaving her abuser, knowing that her physician is willing to broach the subject might make a difference the next time she seeks help (Warshaw, 1994). In the upcoming chapter on empowerment practice, I will explain in greater depth why success in screening, as Gerbert, Caspers, et al. (1999) point out, should be about the act of compassionate asking about violence itself, not necessarily full disclosure.

Patient Barriers to Disclosing Abuse

> I think that going to a hospital for domestic violence is like going to the sexually transmitted disease clinic...you feel like the doctors look at you like you're dirty or you weren't protecting yourself. (McCauley et al., 1998, p. 552)

Women seeking health care services are hesitant to discuss the issues for many of the same reasons that prevent them from disclosing abuse to other helping professionals. A few of the most frequently reported barriers for women disclosing abuse are fear of partner retaliation; lack of privacy; shame, embarrassment and denial; cultural barriers; and fear of being misunderstood, discriminated against or blamed for the violence (Jiwani, 2001; McCauley et al., 1998; Yam, 2000; Gerbert, Abercrombie, et al., 1999). After exploring each of these issues at greater length, this section will discuss some additional obstacles facing abused women seeking health care services in northern, rural or remote communities.

Fear of partner retaliation and lack of privacy. Understandably, women are often fearful that their partner (or someone associated with their partner) could find out about their disclosure of abuse and this could lead to retaliation. Clearly, women are prevented from disclosing abuse

if their partner accompanies them to the hospital, which is a common strategy used by abusers to ensure their partner's silence (Lydon, 1996). The lack of privacy, confidentiality and anonymity afforded women in hospital settings reduces the likelihood that women will feel comfortable talking about the violence (Yam, 2000). This lack (or perceived lack) of privacy, confidentiality and anonymity represents one of the most substantive barriers for rural women disclosing abuse (Websdale, 1998; Fishwick, 1998; Canadian Panel on Violence Against Women, 1993). Dual relationships can be a significant problem for both practitioners and patients in rural areas. It is not unusual for health care providers to be related to or acquainted with patients' families. For example, some rural women have told their physicians that their injuries were accidental because they knew someone in the waiting room (Jiwani, 2001). Similarly, a rural American woman states:

> Now I'm not about to tell what's going on at home to anyone at that clinic. Two of his cousins work there. If they find out that I mentioned this, they will just report it back to him [her husband]. And that would make life even worse for me. (Fishwick, 1998, p. 287)

Cultural barriers. The imbalance of power that exists between a patient and physician can make disclosing abuse particularly difficult. Feelings of apprehension around discussing the violence may be further heightened for women from cultures with strong taboos against seeking help (Jiwani, 1998; Bauer et al., 2000; Mehrotra, 1999). For example, talking about the violence with a health care provider may be anxiety provoking for a woman whose first language is not English and who has been told that if she talks about the violence she could be deported (Bauer et al., 2000).

Shame, denial, and embarrassment. The dynamics of violence against women in relationships are such that women often internalize blame and assume responsibility for their partner's abusive behavior (NiCarthy, 1986; Walker, 1990). Given that many abused women have feelings of intense embarrassment and shame, it is not surprising that they may want to keep the violence a secret (Gerbert, Abercrombie, et al., 1999; McCauley et al., 1998). It is not uncommon for women to minimize, deny or lie about the origins of their injuries:

> ...it wasn't like he was beating me, so I didn't quite get it. So if someone would have asked me, I mean, [I would say] "My husband doesn't beat me, no"...I was in a lot of denial. (Gerbert, Abercrombie, et al., 1999, p. 122)

Despite feeling embarrassed and reluctant to disclose abuse, women generally appreciate being asked about the abuse. Many state that they are often relieved and even expect to be asked by their physician (Gerbert, Abercrombie, et al., 1999). One study showed that rather than directly disclosing abuse, some women felt more comfortable dropping hints or offering an "invitational disclosure" in hope that this would lead to more questioning by the physician (McCauley et al., 1998). Similarly, Gerbert, Abercrombie, et al. (1999) found that in terms of addressing domestic violence, the physician and the patient engaged in a "dance of disclosure." Instead of directly talking about the violence, both the physician and patient provided hints and clues about the possibility of abuse (Gerbert, Abercrombie, et al., 1999). However, it is important to point out that some research shows that women will only disclose abuse if asked directly about it (Hayden, Barton, & Hayden, 1997).

Negative attitudes and cultural stereotypes. Studies show that many women are afraid to volunteer information about abuse because they are afraid their concerns will be dismissed or

they will be blamed for the abuse (Yam 2000; McCauley et al., 1998). In some cases, their fears are well founded:

> The doctor asked: What happened? I said, "My boyfriend hit me with a bottle." The doctor asked, "What did you do?" She stated, "What did I do? What could I do? He sent me for x-rays, removed the glass and cleaned my eye." (Yam, 2000, p. 467)

In the medical records reviewed by Kurz & Stark (1988), patients who returned for medical treatment due to violence were often identified and labelled as "repeat patients," "crocks," "hysterics" or "neurotic females." In other cases, women have been diagnosed with "somatization disorder," "self-defeating personality disorder" or "borderline personality disorder" (Warshaw, 1994). For women who developed other post-traumatic symptoms from the abuse such as anxiety, depression or substance abuse, their credibility was further questioned (Warshaw, 1994). Studies show that rather than exploring other options for the injuries women have sustained, they are often prescribed medications to treat their "psychiatric diagnosis" or "adjustment disorders" (Stark, Flitcraft, & Frazier, 1979; Warshaw, 1993).

For some minority women, entering the health care system can be anything but empowering. Studies in both Canada and the US reveal that immigrant women and women of colour are reluctant to discuss issues of abuse for fear of being discriminated against by health care providers (Jiwani, 2001; Bauer et al., 2000). These studies reveal that health care providers have a tendency to dismiss immigrant women's health care issues. In a U.S. study conducted by Bauer et al. (2000), many immigrant women found their encounters with health care providers to be characterized by racial and ethnic prejudice, leaving them feeling disempowered, mistreated and disconnected. Regarding her experience with the health care system, one woman states:

> Doctors are not capable of asking if you have a problem in the house. No, they don't ask you. And I think they should at least try to be more human, because they use a lot of discrimination because you're Latino and you notice the difference when an American arrives, they behave very kindly, "No, go ahead, sit down," and you're so aware of the difference, the brusque change of how they treat you and how they treat the others. (Bauer et al., 2000, p. 5)

Similarly, in a study conducted in northern British Columbia, some First Nations women reported feeling disconnected or viewed as "other" or outside of the mainstream health care system (Browne, Fiske & Thomas, 2000). In their research studies on abused women's encounters with the health care system in British Columbia, both Jiwani (2001) and Varcoe (2001) contend that immigrant women and women of colour are "racialized" by the health care system. In Jiwani's (2001) opinion, nurses and doctors have an emotional white-out when it comes to offering help to immigrant women of colour. In her qualitative study, Jiwani (2001) found that nurses assigned women "deserving" status if the women were willing to leave the abusive relationship. When staff felt that they were contributing to something "valuable" by rescuing the woman, her status was elevated to that of a preferred patient (Jiwani, 2001). Similarly, Varcoe (1997) found that non-white women, poor women, women who were substance abusers and those who did not leave their abusive partners (so-called "frequent flyers"), were labelled undeserving by nursing staff, while those who did not fit into that category were deemed deserving. Some believe that this labelling process is the effect of women being seen as evasive or uncooperative in the health care encounter, and as a result the staff view them as "deliberate deviants" (Warshaw, 1994; Kurz, 1990; Varcoe, 1997). In other words, women who refuse to change their situation are seen as causing their own problems and

therefore they should not be making claims on already scant medical resources (Kurz & Stark, 1988; Varcoe, 1997).

Additional barriers for rural women seeking health care. In order to understand abused women's experiences with the health care system in northern, rural or remote communities, it is important to be aware of some of the broader health care issues facing those who live there. Generally speaking, residents living in northern or rural settings have a more difficult time accessing adequate health care services than do urban residents. Health care workers in these areas are under more stress due to a number of problems including staff shortages, difficulties recruiting and retaining physicians, hospital closures, lack of specialty services and difficulty accessing timely emergency care (Johnson, 2000; BC Centre of Excellence for Women's Health, 2000). These problems affect everyone who lives there, but they are particularly problematic for abused women seeking health care services. First of all, while it is true that both urban and rural women may encounter insensitive health care providers, women in isolated communities are at a further disadvantage because they have fewer medical alternatives (BC Centre of Excellence for Women's Health, 2000). Often there is only one medical setting available to serve the whole community in smaller northern towns. Women who have had negative interactions are more likely to avoid health care services altogether, accessing them only in life-threatening or critically ill circumstances (BC Centre of Excellence for Women's Health, 2000). This was the case for some First Nations women in northern BC who described their interactions with mainstream health as being so negative and invalidating that it discouraged them from seeking help altogether (Browne, Thomas, & Fiske, 2000). Secondly, women who have felt helped by health care practitioners report that it is the quality of the patient-doctor relationship that facilitates disclosure of abuse (Gerbert, Abercrombie, et al.,

1999). However, establishing trusting, quality relationships may be much harder to accomplish in a rural community where physician and nurse turnover is high. A final barrier for women seeking health care in northern, rural or remote areas is that it may be more of a challenge to rally support for programs and services that deal with violence against women issues because these communities tend to be more conservative and traditional in political values. Similarly, health care providers may be reluctant to raise concerns about domestic violence in order to avoid being seen as an "outsider" or "homewrecker" (Fishwick, 1998). However, as the next chapter points out, for victims of abuse, especially those who have access to very few resources, the cost of overlooking this issue is very high.

CHAPTER FIVE

Case Study Analysis and Assessment: From Oppression to Empowerment

> In a culture of domination everyone is socialized to see violence as an acceptable means of social control. (hooks, 2000, p. 64)

Failure on the part of the medical system to identify or intervene appropriately in cases of woman abuse has many personal, social and economic ramifications, but the most serious outcome is women's continued victimization and oppression. Women's oppression occurs in a number of interconnecting ways. Women (and the children who live with them) are unintentionally victimized by the health care system because undetected abuse can lead to women not exploring options other than staying with an abusive partner. Because of the cyclical nature of partner abuse, which usually escalates in both frequency and severity over time, women could be subjected to continued and more severe forms of physical and emotional violence (Warshaw, 1994). When the violence is not made known, perpetrators are not held accountable and victims do not receive the support or treatment they need to heal and move toward safety (Transken, 2002). Undetected abuse often results in repeated health care visits with vague medical complaints, serious injury or even death (Furniss, 1998). For example, Stark et al., (1979) found that one in five women attending the emergency department had sought medical attention for abuse injuries at least 11 times previously. Failure to routinely inquire about abuse means that health complaints can be misdiagnosed, which can translate into unnecessary surgery, hospitalization and medicalization (Ingram, 1994). In some cases, women have reported feeling that their safety was jeopardized because the medication they were prescribed actually weakened their resistance to the abuse:

> I'm still living with my husband, and I'm afraid that if I take any kind of medication, that this man is definitely going to have control all over again. So I'm scared, I refused to take anything...I know if I take any kind of medication, I won't be as strong as I am now....(McCauley et al., 1998, p. 553)

Women can also be harmed as a result of receiving poor advice from well-intentioned practitioners. For example, lack of understanding about the social context of woman abuse leads some physicians to attribute woman abuse to individual factors, such as substance abuse, lack of self-esteem on part of the woman and pathology on part of the abuser (Roux & Rittmayer, 1999; Dr. Paul Herselman, personal communication, November 20, 2002). Insufficient understanding about how power and control dynamics operate in abusive relationships has resulted in some practitioners referring their abused patients to couples' therapy (Roux & Rittmayer, 1999). Studies show that this helping context is actually harmful for victims of abuse because it can provide a forum for abusers to further victimize their partners (Loue, 2001).

Secondary Oppression: The Isolation Continues

Ann Bishop explains that oppression (such as violence against women) is held in place by violence in many different forms: "visible, such as injury and death, or less visible, like exclusion, denial of access and denial of needs" (Bishop, 1997, p. 38). This less visible, but nonetheless damaging, consequence of an unresponsive health care system is referred to as secondary victimization. Secondary victimization is a form of oppression that occurs because women are actually re-traumatized by the negative attitudes of health care workers (Hattendorf & Tollerund, 1997; Transken, 1995, 2000). Some contend that these negative encounters are, in essence, a re-enactment of the abusive experience (Warshaw, 1994; Transken, 1995, 2000). In fact, many women say that the secondary trauma of coming face to face with an unresponsive

and blaming "helper" can be more painful and traumatic than the actual violent incident that preceded it (Hattendorf & Tollerund, 1997; Transken, 1995, 2000). Not surprisingly, a helping professional who communicates in an unkind, racist or judgmental manner will only cause the woman to feel a sense of failure, shame and powerlessness. As a result, women who find the courage to seek help from those who they expect to protect, support and understand them (i.e., law enforcement, social services, and health care) often end up feeling betrayed and more isolated by the encounter (Hattendorf & Tollerund, 1997).

How a problem is framed by major institutions determines the kind of attention it will receive and the solutions proposed to address it (Kurz, 1997; Mullaly, 1997, 2002). When woman abuse is seen as an individual, private, family matter rather than a pervasive social problem affecting millions of women of all backgrounds, it clearly impacts how victims are perceived and the kind of support they will receive (Warshaw, 1994). Of course, failure by the medical community to respond adequately to abused women is not a conscious act on the part of the health care profession. Clearly, most health care workers are genuinely concerned about their patients and want to help them. As shown, the problem of unresponsive helping is highly complex. However, what makes it difficult to confront is that it is largely a systemic problem, stemming from broader ideological ideas about violence against women and reinforced by institutional constraints that exist within the health care system (Varcoe, 1997; Warshaw, 1994). According to Varcoe (1997), "Violence and abuse are neglected because the power of dominant interests is exercised through ideologies which are congruent with neglect" (p. ii).

Mullaly (1997, 2002) points out that many people who work in various social institutions (police, education, social services, health care) unintentionally contribute to and maintain oppression in simple day-to-day activities, but do not consider themselves to be

oppressors (Mullally, 1997, 2002). Mullaly explains how social structures (including the medical establishment) operate as a major source of oppression, primarily due to unquestioned norms and underlying assumptions:

> The dominant relations of men over women, white people over persons of colour, affluent people over poor people, heterosexual over homosexual and bisexual persons, physically able persons over physically and mentally challenged persons have been so internalized into the structures of society that they have also become intrinsic to the roles, rules, policies and practices of [social] institutions (Mullaly, 2002, p. 19).

Peggy McIntosh (1989) agrees, saying that people are socialized not to see how class, gender and race inequities (among others injustices) are systemic problems, not just individual acts of "meanness." For example, McIntosh says that white privilege is simply taken for granted, and refers to it as "an invisible weightless knapsack of special provisions, maps, passports, codebooks, visas, clothes, tools and blank checks" (p. 10).

Without an understanding about the systemic nature of woman abuse and other social problems, health care providers will adhere to the same cultural stereotypes and negative attitudes about victims that are held in society at large and reinforced in the media. Thus health care providers may hold the view that women abuse is an individual (as opposed to a social or legitimate medical) problem, leading to victims being held responsible for their victimization. Others may believe that some women deserve to be abused (i.e., sex-trade workers) or that a wife's obligation is to be sexually available to her husband at all times (Heise et al., 1999). Similarly, discriminatory practices may be linked to misconceptions such as the belief that only poor women or women of certain ethnic or religious backgrounds are victims of domestic violence and sexual assault (Heise et al., 1999). Another common misconception about intimate

partner violence is that educated, older and disabled women are not victims of abuse, and educated, professional men do not abuse their spouses. This physician admits to dismissing the possibility of abuse in her practice based on these kinds of stereotypes:

> I have what I think is a very nice, mostly White, middle- to upper-class practice. Most of my women are educated…I would say that 90% have a college degree. And so, I just figured it was something I'd never see in my practice. (Roux & Rittmayer, 1999, p. 175)

These attitudes, which play an important role in the labelling and discrimination of victims of violence along the lines of gender, class and ethnic origin in the health care system, are the same attitudes that exist within dominant society: a patriarchal, capitalistic and racist society (Mullaly, 1997, 2002).

Medicine & Patriarchy

From a feminist perspective, patriarchy is central to understanding why women are mistreated or neglected in the health care system. Many health care practitioners (Muszinski, 1994; Hamilton, 1994) contend that the medical establishment has become highly professionalized and organized over the years, and this has resulted in a male monopoly over the practice of medicine. For example, areas in which women held expertise, such as midwifery, became increasingly under the control of male physicians. Similarly, women were brought into medicine as subordinate to male physicians through a traditional division of labour. Carol Baines (1991) argues that this "sharp division of labour allocated the curing role to men with women relegated to the maternal tradition of caring" (p. 50). From a feminist lens, this dynamic is seen as essentially mirroring the sex role division found in the nuclear, patriarchal family. In other words, the manner in which women are treated in the health care sector does not differ dramatically from the way they are treated in their home or place of employment. Hamilton

(1994) points out that in both the home and work situations, women are relegated to the role of caregiver, caring for young children, the elderly and the disabled, a role for which they are seldom financially compensated. As a result, Hamilton asserts (1994), "women have too often felt devalued and disbelieved, with our concerns either trivialized or overly pathologized" (p. 60). Others point out that a male-dominated health care system has led to male physiology and behavior being taken as the norm, resulting in sex bias in research and treatment areas and women's health concerns not being taken seriously (McBride & McBride, 1994; Jiwani, 1999). For example, gender differences are shown to exist in terms of the kinds of medical treatment offered to women, compared to men, such as a tendency to prescribe mood-altering drugs to women for the same symptoms (Harding, 1994).

Bolaria & Bolaria (1994) add to this by stating that, similar to the power structure found in a patriarchal society, women and racial minorities generally occupy the lowest rungs of the medical hierarchy. As well as having little input in terms of program, policy and knowledge creation, they are also often the lowest paid and most highly exploited groups of the health sector workforce (Hamilton, 1994; Jiwani, 1999). In contrast, physicians, most of whom are white males, enjoy a higher status and income than all other groups of health care professionals (Hamilton, 1994). Also, despite increased enrollments of women in medical school, studies suggest that gender discrimination is still a problem for many women (Kirk, 1994). As this next section shows, these gender dynamics are also complicated by the biomedical model that is deeply engrained in the Canadian health care system and reinforced in medical training and practice (Wuest, 1994).

The Medical Model

"A healthy being is more than the sum of its blood/bones/flesh" (Transken, 1995, p. i).

A significant feature of the medical system, and a contributing factor in practitioners' inability to effectively intervene with victims of abuse, is the medical model. Critics say this model is problematic because it tends to rely primarily on clinical, mechanistic and individualistic interventions with patients (Bolaria & Bolaria, 1994; Warshaw, 1993; Varcoe, 1997; Abott & Willimason, 1999; Transken, 2000). Hamilton (1994) argues that instead of viewing women's health holistically, the prevailing medical system is based on a reductionist model of health or model of "biological primacy," in which complex issues are reduced to or explained as stemming from simple biochemical or genetic factors. Critics of the medical model point out that this paradigm neglects the importance of social context on health and illness by separating the mind from the body (i.e., mind/body split) and viewing the body as a machine (Hamilton, 1994; Transken, 1995, 2000). By focussing more on disease and illness than on health and prevention, psychological and emotional aspects of healing and psychosocial contributors to health and illness are neglected. A disease model of health care is problematic, because it serves to obscure the social nature of disease and fails to recognize the interconnections between social, economic and political conditions in society, health and illness (Bolaria & Bolaria, 1994). This means that critical relationships that exist between a person's health and factors such as gender, class, ethnicity, income levels and geography are often not considered (Jones & Rothney, 2001; Bolaria & Bolaria, 1994; Hamilton, 1994).

The Medical Model and Interventions with Victims of Violence

The medical model, which is based on biological primacy, strongly impacts how practitioners relate to victims of abuse. Adhering to the medical model means that often only the immediate physical injuries of physical and sexual abuse are seen, and these are what are addressed in the health care visit (Kurz & Stark, 1999; Yam, 2000; Transken, 2000). Studies show that, in keeping with the medical paradigm's values of neutrality, science and objectivity, physicians are compelled to document incidents of violence using language that focusses primarily on the physical injury (i.e., hit by fist, blunt trauma) without identifying how the injury happened. For example, the medical language commonly used in the documentation of patient records essentially makes the problem of violence invisible (Warshaw, 1993):

> Physicians frequently used disembodied language to describe a traumatic event such as "was beaten to face and head with fist," "blow to head by stick with nail in it," "hit on left wrist by a jackhammer." What they recorded was the mechanism of injury, how the blow impacted on the body, not on the person. The entire battering event was reduced to an interaction between a fist and an eye. (Warshaw, 1993, p. 140)

When attention is given solely to the physical and mechanistic aspects of the violence, it obscures and discounts the real experience of the person who is receiving help (Warshaw, 1993). The medical model does not see the whole life of the woman before the moment she attends the emergency department or where she may be going after she leaves (Transken, 2000). Victims of abuse who are not informed of any other alternatives than living with the violence will often leave the hospital and go right back into the abusive environment:

> They asked me nothing. I told the nurse and I told the doctor. Nothing. Nothing was said, and I didn't go to a shelter. I went back home after the hospital, limping around,

and his father called and asked me, "Just don't leave, please don't leave him." (Yam, 2000, p. 467)

The problem with adopting a strictly clinical or reductionist stance with patients is that in this view illness or social problems are associated with individual lifestyles and behaviors, which suggests that improvements in health can be restored by changing individual behaviors (Bolaria & Bolaria, 1994). When violence against women is a seen as a problem stemming from personality or situational factors, it leads workers to conclude that these are the reasons why women are abused and why they will not leave the abusive relationship (Plichta, 1992). By adhering to a medical model framework for dealing with woman abuse, the effects of the violence often become confused with the cause. For example, the woman who uses alcohol as a way to cope with the trauma of being abused is labelled and treated as an alcoholic. Therefore, in the words of Kurz and Stark (1988), she is viewed by hospital staff as "the problem patient," not the "patient with the problem" (p. 265). When woman abuse is seen as an individual problem caused by something the woman has done (and therefore can change), it perpetuates feelings of guilt, shame and isolation and increases a woman's dependency on the medical system. Rather than addressing the root of the problem, which could prevent future injury and increased use of health care services, the woman becomes dependent on the medical system to treat (often by way of medicating) her "disorder" (Stark et al., 1979). Ironically, the "frequent flyer" patient, who is often a product of a medical establishment that does not get to the root of the problem, is frequently blamed for making excessive demands on the health care system (Varcoe, 1997; Stark et al., 1979). The labelling process also shapes the way people are perceived and treated in subsequent health care visits. More than likely, these patients will not be taken seriously. Smith makes a good point, stating that "once someone is diagnosed or

labelled with a mental disorder, the helper no longer expects them to make sense, so people tend not to listen to or respond to them as if they do" (as cited in Dickinson, 1994, p. 91).

Medical training teaches student physicians skills of denial and avoidance in order to help them effectively cope with the extreme trauma they will be exposed to in the emergency room (Hamilton, 1994). Students who are trained using the biomedical paradigm learn that the role of communication and empathy is not as important as maintaining an ethic of short-term efficiency and swift history taking (Hamilton, 1994). This ethic of short-term efficiency is especially problematic for nurses and physicians treating victims of abuse in the emergency department. Varcoe (1997) argues that nurses' ability to provide quality care to victims of violence is seriously compromised because the emergency room setting operates under an ideology of scarcity, which is complicated by limited resources such as staff shortages and high turnover. All of these factors contribute to a situation in which providers have less time to spend with patients and a "controlling...dismissive and demeaning interview style" (Hamilton, 1994, p. 62). The process of objectifying also serves to maintain a professional distance between the patient and the health care provider, making it difficult for the provider to empathize with the patient.

To summarize, it appears that unresponsive helping on the part of the medical community is a complicated and multi-faceted issue. However, the way victims are perceived and treated in the health care system appears to be firmly grounded in an adherence to a medical model of health care, and is reinforced by institutional constraints (Varcoe, 1997; Warshaw, 1994; Transken, 2000). Bishop (1997) asserts that ideological power, or the "power of belief" makes one group or individual decide what is deemed valuable and possible in our society. Thus, it becomes easy for institutions to justify maintaining the status quo and not correct

discriminatory policies or practices if people buy into the notion that injustice and inequality are a natural or normal part of life (Bishop, 1997). Feminists (and structural, anti-oppressive, cultural-studies-oriented social workers) believe that in order to reform institutions and social practices that encourage, tolerate or enable violence against members of specific groups, changes need to be made at many levels (Van den Bergh, 1995; DeKeseredy & MacLeod, 1997; Mullaly, 2002; Reinharz, 1992; Varcoe, 1997). Most agree that these reforms must begin with changing dominant cultural images and stereotypes about violence against women and the day-to-day reproduction of dominance through oppressive policies and practices (Varcoe, 1997; Mullally, 1997, 2002).

Although anti-oppressive or empowerment practice is more commonly associated with social work practice (Van den Bergh, 1995; Lee, 2000; Mullaly, 1997, 2002) it is increasingly being applied to a number of other helping contexts, including the health care system (Hotch, Grunfeld, Mackay, & Cowan, 1996; Hadley, 1992; Rodrigues, 2003). For example, the BC Centre of Excellence for Women's Health is promoting a model of women-centred care that is participatory, empowering, respectful of diversity, holistic and has a social justice focus (Rodrigues, 2003). In addition, the health care sector has been increasingly calling for the development and implementation of anti-oppressive (or empowerment-focussed) research approaches, practice models and policies in the area of violence against women (Varcoe, 1995, 1997; Hadley, 1992; Archer, 1994; Campbell, 1998; Warshaw, 1994; Hotch, Grunfeld, Mackay, & Cowan, 1996). Across Canada and the United States, more conferences are being held and more resources and training materials[7] are being developed in order to help practitioners respond more effectively to victims of violence (Johnson, 2000; Morrow, 2000). For example, Atlanta, Georgia hosted the 2002 National Conference on Health Care and Domestic Violence entitled

"Prevention and Response Strategies: Pushing the Envelope." This conference brought together over 600 physicians, mental health professionals, dentists, nurses, nurse practitioners, social workers and advocates interested in exploring ways to prevent and respond to domestic violence in a health care setting. And of course, another important example of the health care system's desire to become more proactive in responding to victims of domestic violence is its adoption of formal screening protocols to be used in a variety of health care settings, including the hospital emergency department.

Universal Screening: Setting the Stage for Empowerment

> One thing I really remember is that she put her hand on my shoulder...She had all this compassion in her face, and I almost like broke down and cried right then because I was thinking to myself as she was talking to me "She thinks I'm a human being. She thinks I'm worth something." (Gerbert, Abercrombie, et al., 1999, p. 128)

Due to the disproportionate amount of health care services used by abused women and because of its accessibility, many believe that the emergency department is an integral source of safety and support for victims of partner violence (Grunfeld et al., 1994; Koss, 1994; Abbott, 1997). Advocates of formal protocols argue that without universal screening it is impossible to identify those patients who are either past or present victims of violence. Although some injuries clearly indicate partner abuse, many other injuries and health problems (bruises, migraines, depression, substance abuse, sleep loss) are less recognizable (Dutton, Mitchell, & Haywood, 1996). By going beyond viewing abuse as a constellation of symptoms, this screening policy is congruent with the ethics, values and principles of self-determination and human rights that is the foundation of both social work and health care (Pelligrino & Thomasma, 1988). It is also consistent with the World Health Organization's definition of health, which is "a state of

complete physical, mental, and social well-being and not merely the absence of disease or infirmity (World Health Organization, 1997).

Earlier it was stated that although all women can benefit from universal screening, this policy is particularly meaningful for those who have access to few sources of help. For abused women living with violence in a rural or northern community, the emergency room may represent a woman's only outside contact (Abbott, 1997). A woman living in these regions may never have the benefit of meeting with other women in a support group, or going to a transition house to find out that she is not the only person going through this ordeal. In some cases, the small community hospital is the only public institution that is likely to interact with all women at some point in their lives (Derk & Reece, 1989). *For this reason, and because of the complex nature of rural woman abuse, screening for woman abuse in the emergency department could make a real difference in the lives of women.*

However, simply because physicians (or nurses) routinely screen for violence or detect more cases of violence, the experience will not necessarily be empowering for women. As the next chapter points out, successful screening is about the process and the quality of the interaction between the patient and provider, not simply the goal of disclosure. It is only when patients feel heard, believed, validated and informed that providers can pave the way for empowerment to begin (Warshaw, 1994). In order to explain how a policy of universal screening has the potential to empower women, a definition of empowerment will be provided. Following this definition, I will demonstrate how the principles of empowerment can be used to enhance the screening process.

CHAPTER SIX

Empowerment Approach to Helping Abused Women in the Health Care Encounter

> Since all forms of oppression are linked in our society because they are supported by similar institutional and social structures, one system cannot be eradicated while the others remain intact. (hooks, 1984, p. 35)

Empowerment Defined

The *Social Work Dictionary* defines empowerment as "the process of helping individuals, families, groups, and communities increase their personal, socio-economic, and political strength and develop influence toward improving their circumstances" (Barker, 1999, p. 153). As an integrative framework for practice rather than a particular theory, the empowerment standpoint is multi-focussed (Lee, 2001). This approach addresses both clinical and community-oriented holistic work with individuals, families, small groups, communities and political systems. As such, it is an ally to many social work practices and frameworks including feminism, structural and anti-oppressive social work, interactionism, constructivism, cultural studies and liberation theory (Lee, 2001). This perspective is strongly influenced by Germain & Gitterman's (1980) "life model" of social work or ecological approach. Ecology is a metaphor used to describe the continuous reciprocal exchanges (or transactions) in which people (organisms) and environments influence, shape and, at times, change each other (Germain, 1991). This is a strengths-based and action-oriented approach as it recognizes that human beings strive to achieve the best "person-in-environment" fit possible between their needs, rights and capacities (Germain, 1991). By extending the ecological model, an empowerment orientation recognizes that stigmatized people (northerners, immigrant women, Aboriginal women, gay people, poor people, the disabled, and so on) seldom achieve a "good fit" in their environments

because they are faced with social, political and economic discrimination which "stifles human potential" (Lee, p. 24). What makes an empowerment approach meaningful is its ability to see that marginalized people are often overlooked in mainstream social work practice because change is typically directed at the personal or family level, and because traditional practice tends to be colour blind (Mullaly, 1997, 2002). In short, empowerment social work is committed to understanding the nature and dynamics of oppression, how social and political functions are carried out in the best interest of the dominant groups, the effect it has on the oppressed and how people cope or resist their oppression (Mullaly, 2002).

According to Burstow (1992), oppression, lies and isolation all work together to alienate, confuse and disempower people. For empowerment to occur, therefore, people will need to develop an awareness in order to cut through the lies and confusion, and rid themselves of their internalized oppression. According to Paulo Freire's liberation theory, "critical consciousness and knowledge of structural inequalities and oppression are power" (Freire, 1970, p. 12). However, action, both individually and collectively, is as important to the process of empowerment as is critical reflection. This means that while individual helpers can facilitate empowerment, the process is most meaningful when people have an opportunity to connect with other members of their oppressed group. The benefit of connecting with other people in similar circumstances is that it not only breaks down the alienation they experience, but it also fosters mutual support and stimulates common analysis and further action (Burstow, 1992).

As mentioned, it is often a lack of awareness and education around the subject of woman abuse that sets the stage for inappropriate or unresponsive interventions with abused women (Ingram, 1994). However, before health care workers or other helpers are in a position to empower abused women, they need to first develop their own critical consciousness about the

issues facing abused women. For the intervention to be empowering, education and training need to be aimed at physicians gaining a better understanding of the broader social implications of violence against women, as well as the physical and emotional consequences of woman abuse. This section will explore these areas in more depth.

Developing a Critical Consciousness: Seeing the Bigger Picture

At a broader level of analysis, for empowerment to take place in the health care encounter, there must be an attitude shift in which violence against women is seen not simply as a series of isolated cases of violence, but a pervasive social phenomenon (Warshaw, 1994). Being critically conscious means that workers are especially sensitive to the broader social issues that operate to disempower vulnerable groups of people (Lee, 2001). Whether a person works in an urban or rural setting, an integral part of an empowerment-based helping approach is being aware of all aspects of a person's environment or having a multi-focal vision. Practitioners committed to a multi-focal vision will need to put the history of a group's oppression under a microscope (Lee, 2001). The goal is to make sure that people's personal, private struggles are linked to the structural source of their troubles (Land, 1995; Mullaly, 1997). As such, all social problems are not viewed solely as individual, family problems but are viewed with a historical/social/cultural lens. When workers use this lens, they are able to see that high incidences of woman abuse or other issues such as suicide, depression and substance abuse are not characteristics of a particular group (i.e., northern residents, poor people, immigrant women, First Nations women, and so on). Rather, workers know that these are outcomes of oppression—a condition that comes with patriarchy, capitalism and racism (Burstow, 1992; Arges & Delaney, 1996; Mullaly, 1997). Furthermore, a multi-focal perspective brings a greater appreciation for how the effects of violence are more profoundly

felt by those who are socially marginalized (the disabled, elderly, immigrant and refugee women and First Nations women, for example) (Morrow, 2000). More specifically, workers providing support to abused women in the north need to possess knowledge of abuse in general, but they also need to be sensitive to the unique elements that make life challenging for women experiencing violence in this context. These include the elements of northern life that shape women's experiences with violence, such as the sociological, psychological, cultural and economic factors of isolation, patriarchal family structure, the implications of religious and cultural beliefs and inadequate social and health services. Being sensitive to the issues which shape the north also requires understanding how the north is historically characterized by colonization, exploitation and social and economic inequities (Arges & Delaney, 1996).

Once practitioners develop a critical consciousness, they are then in an ideal position to share this information with their patients, allowing patients to gain new insight into their situation. Most notably, these new insights help to break down the stigma, shame and internalized guilt that comes with being a member of an oppressed group. Paulo Freire (1970), a well-known Brazilian educator, believed that as people begin to visualize themselves as creators of their own culture, they may realize that they were not destined to hold an inferior class status but that their status is determined by broader economic-political-ideological conditions. According to Varcoe (1997), critical reflection is the key to changing neglectful practices with victims of abuse:

> When individuals practice in resistance to dominant ideologies, collective practices that challenge unequal power relations are promoted. With regard to violence and abuse, such resistance can create collective practices that can contribute to ending violence and abuse. (p. 353)

As individuals become more critically conscious about partner violence, the collective practices of other physicians and nurses in the hospital setting could be impacted (Varcoe, 1997). This could then have a positive influence on other helping institutions and the community at large. For example, by regarding woman abuse as a legitimate medical and public health concern, the medical community could use its authority to draw more public attention and sympathy and attract public funding (Findlay & Millar, 1994). Publicly declaring that violence is unacceptable may have a significant impact in smaller communities where the conspiracy of silence can be even more pervasive. Given that physicians are usually held in high esteem in smaller communities, their influence in community programs regarding health care issues may be viewed highly (Fishwick, 1998).

In addition to developing a critical awareness about the broader issues affecting people seeking help, physicians and nurses need to possess a thorough knowledge of the complex dynamics of violence against women, as well as the health-related consequences that stem from violence.

Education About the Dynamics of Woman Abuse and Health Consequences

> She'd rather have him beat her up once in a while but still provide food and shelter. (Roux & Rittmayer, 1999, p. 177)

Health care professionals can only begin to help women become empowered once they have a thorough understanding of the physical, sexual, psychological and spiritual forms of abuse women experience.[5] Providers should be aware that most victims of violence first seek medical help for secondary causes of violence rather than for the initial abuse-related incident (Koss, 1994). This requires doctors to be cognizant of the common violence-related health concerns raised earlier in this paper, such as anxiety, hypertension, depression, migraine

headaches, addiction issues, gynecological problems and sleep disorders (Heise, 1994). Physicians should also be aware that abused women are particularly vulnerable during and after pregnancy (Abbott & Williamson, 1999). Finding out which stage the abusive relationship is at is essential, as treatment will vary according to whether it is a case of chronic, lifelong abuse versus a recent violent episode in which the woman may be suffering from post-traumatic stress disorder (PTSD) (Dutton et al., 1996). Furthermore, it is essential that physicians know that it is common for partner violence to get more severe over time.

Gaining critical insights into the complexities surrounding the issue of woman abuse benefits individuals, health care professionals and communities at large. After consciousness-raising, dialogue aimed at helping victims find their own voices is the next most important feature of empowerment practice (Lee, 2001). As this upcoming section will demonstrate, universal screening is a forum in which this dialogue can take place.

The Primary Goals of Universal Screening

Many universal screening tools are available for use in a variety of health care settings. However, the screening policy presented in this paper comes from the Domestic Violence Intervention Program developed by the Vancouver General Hospital (Hotch et al., 1995). Based on the guidelines offered by the American Medical Association's *Report on Violence Against Women: Relevance for Medical Practitioners*, the Vancouver General Hospital implemented its own domestic violence screening program in 1992. Four recommendations put forward in that report were incorporated into the Vancouver General Hospital screening policy. The following have been developed specifically to assist physicians in providing quality, compassionate care to abused women:

1. Routinely incorporate screening to identify female patients who are or have been victims of violence
2. Validate the woman's experience of victimization and recognize symptoms as possible causes of violence
3. Record patient victimization histories
4. Refer patients to appropriate medical or health care professionals or community-based resources as soon as possible (Hotch et al., 1995)

I have chosen to use this screening tool in this paper for a number of reasons. First of all, it is the policy being used (albeit informally) in many BC hospitals. Second, the benefits of this screening policy have been documented. The staff estimate that the number of documented cases of domestic abuse has doubled since its inception, and the feedback from the staff has been positive (Ministry of Women's Equality, 1999). Finally, and most importantly, the principles of this screening program reflect feminist/empowerment principles. For example, the training guidelines highlight the significance of changing dominant ideology (i.e., myths regarding abuse victims), screening *every* woman, respecting choices, validating women's experiences, empowering women by raising their consciousness about the violence, and offering valuable information and resources (Jiwani, 1999). The purpose of this next section is to look more closely at how the four steps of universal screening are put to practice with an emphasis on how they have the potential to empower patients. Particular attention is given to how this process may impact patients and practitioners in rural, northern and remote communities.

Step 1: Routine Screening and Identification

As discussed above, the fact that the health care community has not been responsive to the needs of abused women is largely due to the education and socialization process within the

medical establishment and not because helping professionals consciously choose to ignore the needs of certain populations. The purpose of an empowerment approach is to fill that gap by ensuring that the needs of all oppressed populations are addressed (Lee, 2001, p. 48). Being asked about abuse does not have a negative impact on those who are not abused, but it could make a difference for a woman who is. Therefore, the first objective of universal screening is to ensure that all women are asked about violence regardless of their history with violence or presenting injury. To be clear, it is not enough to informally adopt a screening policy. Universal screening has to be a formal protocol that ensures all women patients are questioned upon entering the emergency department. While most physicians are good at detecting cases of obvious physical violence, many do not recognize that other symptoms or stress-related problems could be violence related (Rodriguez et al., 1999). Therefore, screening helps alleviate the risk of missing someone whose injuries are not visible and identify those who may be reluctant to disclose without direct questioning (Dutton et al., 1996).

An important aspect of routine screening is that by telling patients that *all* women are being asked about woman abuse, health care providers demonstrate the magnitude of the problem to the patient. When women believe that they are a very tiny minority of women being affected by this issue, they believe they must be doing something to deserve the violence (Mullaly, 1997). As such, screening all women regardless of age, cultural or socio-economic background, ability or sexual orientation reduces the chance that only certain populations are singled out and challenges myths about certain groups being more prone to violence than others. Knowing that all women are being asked about abuse might also help women feel less alone in their situation. In other words, the screening process allows the health care provider to normalize the experience for patients, which in turn helps to reduce the internalized blame, guilt

and stigma. By asking all women, screening also gives providers an opportunity to intervene at different stages of relationship violence: current, past and possible future abuse. Physicians who uncover abuse are able to intervene at the secondary and tertiary levels (i.e., tend to the immediate effects of abuse and long-term effects of abuse), but screening also has a preventive element to it. This means that screening provides staff with an opportunity to intervene before the cycle of violence even begins, which is particularly salient for teens who may be involved in a violent relationship (Dekeserdy & MacLeod, 1997). Another potential benefit of screening is that women who are asked about abuse in a health care visit could then share this experience and knowledge with other women, some of whom may be victims of abuse themselves (King, 1998).

Why language is important. Although screening in a busy emergency room requires the physician to be brief and direct, it can still be conducted in a respectful and caring manner. Concern can be demonstrated through words as well as through attentive body language and reflective listening (Gerbert, Abercrombie, et al., 1999). By believing the woman and being open to discussing the issues, the health care provider may set the stage for the woman to feel safe enough to break the silence and reach out for help. It is important to note that this could be the first time the woman ever told anyone about the abuse (particularly in a smaller community). For the woman in this interview, speaking out about the violence was the first step in her decision to leave her abusive spouse:

> It was a relief to be able to tell someone, and I actually think [laugh] that was the beginning of the end of our marriage…and I think what started the wheels turning in my head, that I could get out of this and I should get out of this…if I tell someone that my

husband's breaking my bones, it's time to leave. (Gerbert, Abercrombie, et al., 1999, p. 127)

As the next section shows, screening questions can be framed in a way that reflects concern for the patient's well-being and a willingness to talk about the violence.

The questions. The following is a list of questions that I have adapted from the Vancouver General Hospital Domestic Violence Guide (Hotch et al., 1995). These are simply guidelines; the exact wording is not as important as making sure that every woman is asked and it is done in a non-judgmental and sensitive manner. However, it is important to pay attention to language, as some questions could unintentionally re-victimize the woman by suggesting that she is to blame for the violence.

When there are no obvious injuries a provider may say

- From my experience here in the emergency department, I know that abuse and violence at home is a problem for many women. Is it a problem for you in any way?

When there are obvious injuries, a provider might ask

- The injuries you have suggest to me that someone hit you, is that possible?

It is important not to neglect the possibility of emotional abuse and sexual abuse. Establishing good rapport with a patient is necessary before asking about sexual abuse:

- Does anyone call you names, criticize you or insult you?
- Does anyone monitor what you are doing, prevent you from seeing people or going to work, or withhold money from you?
- Have you ever been forced to have sex with your partner when you did not want to?

If the screening process reveals abuse of any kind (physical, sexual or emotional), a more complete assessment is then carried out. It should address the following areas: the nature and

details of the abuse (i.e., the date, time, and circumstances of the incident), previous assaults and resulting injuries (Loue, 2001). The following are important questions as they reflect the seriousness of the abuse and the risk of danger:

- When was the last time you were abused. What happened? What did he do/say?
- How often does the abuse occur?
- What events preceded the violence?
- Is the abuse getting worse? More frequent?
- Has your partner ever threatened you? Has he ever used a weapon?
- Are you afraid of your partner? Are you afraid for your life or for the lives of your children?

Key message: The violence is not her fault. One of the most important functions of universal screening is that it provides practitioners with an opportunity to reassure women that the physical, sexual and emotional abuse they have endured is not their fault. Physicians and nurses who are cognizant of this will be less likely to attribute the woman's symptoms to something she has brought on herself (Warshaw, 1994). Additionally, a woman's sense of self-blame can be lessened when she understands that the depression and other stress-related problems she may be experiencing are normal reactions to living with violence (Land, 1997). On the other hand, practitioners can unwittingly re-traumatize a women by asking her questions along these lines: "why did you go there with him?" or "why don't you just leave him" (Archer, 1994). Similarly, screening questions should avoid stereotypical or stigmatizing language (Dutton et al., 1996). Some abused women report that the words used by their health care providers impacted how they viewed their situation and what steps they took to change it (McCauley et al., 1998; Warshaw, 1993). Asking a woman if she is a "battered woman" or a "wife-abuse victim" is not going to facilitate disclosure, as these terms do not accurately

describe the experiences of many women who are in violent relationships. For example, many women will not see themselves as battered because they may not have sustained physical injuries. As well, it is important to realize that denial and minimization of the violence are common coping strategies for many abused women; thus, asking a patient is she is an abused woman will not likely facilitate disclosure. An empowerment model reflects a move away from a disease model of intervention, which sees abused women as sick, deficient or passive, to a view of women as survivors. Stated another way, empowerment practice sees abused women seeking help "as victors not victims" (Lee, 2001, p. 60). Workers need to realize that many abused women, despite living in a climate of fear, often make frequent attempts to flee their abusers and protect their children. Studies attest to this fact, showing that women are not passive but actively work to make their environments safer. Bowker's (1986) study of 1000 abused women suggests that the reason it takes women so long to leave is not from passivity but is a testament to the abuser's persistence to maintain control and domination and to a lack of support from social institutions.

Understandably, as physicians and nurses become more critically conscious about the issues surrounding violence, they are going to develop more concern and empathy for their patients (Warshaw, 1994). Where there is empathy, there is genuine concern and compassion, and these are the main ingredients of an empowerment perspective of helping (Lee, 2001). Studies reveal that some survivors of violence feel that being asked about the violence in a *compassionate manner* provided validation and even helped them move toward safety (Gerbert, Abercrombie, et al., 1999). Validation plays an integral role in the empowerment process and is an important element of a universal screening protocol.

Step 2: Recognizing Symptoms and Validating Women's Experiences

Recognizing symptoms. Understandably, there are serious physical injuries (broken bones, lacerations, burns and so on) that accompany violence that require immediate medical attention. As mentioned, the benefit of screening is that it may uncover those aspects of abuse that may otherwise go undetected because the symptoms are not always visible. Domestic violence guidelines encourage physicians to be suspicious of abuse in cases in which the woman has headaches, non-specific pain, sleep disorders, anxiety, dysphasia or hyperventilation. As stated earlier, these health concerns, as well as substance abuse problems and various gynecological and reproductive problems, are all indicators of possible abuse (Loue, 2001).

Validation. For some women, simply being asked about abuse and being reassured that the violence is not their fault can bring about a sense of relief, comfort, validation and in some cases facilitates the leaving process (Gerbert, Abercrombie, et al., 1999). The woman in this interview reveals how information and validation from a health care provider "planted the seed" for leaving her abusive partner:

> And after they sat down and said no, I was not the one that was causing it, nobody deserves to get hit…The doctor told me that, and the deputy told me that. That I don't deserve to be hit…I don't have to stay there, and that there's other ways of dealing with it. And I'm sitting there listening to these people saying these things to me, and I say, "oh, okay!"…it's like a seed was planted. (Gerbert, Abercrombie, et al., 1999, p. 128)

Accepting that planting a seed is all that the screening process might accomplish may be difficult for health care professionals to accept, given that they are used to diagnosing, treating and curing medical problems. Practitioners who want to empower victims of abuse will need to make every effort to diminish the power dynamic that typically characterizes the physician-

patient relationship. By seeing women as experts on their own lives and circumstances, practitioners who are committed to empowering women will respect all of their choices. Even though they may be treated in a sensitive manner, some women will choose not to discuss the issues, access supports or leave their abusive partner. As stated, the primary goal of screening is not to get more women to disclose abuse, but to give them the option to do so (King, 1998).

One of the most important objectives of screening, regardless of a woman's choice, is that she hears that the violence is not her fault. While the woman may not be in an emotional or financial position to leave her partner at the time of screening, she may be at a subsequent visit. By helping her let go of the blame and shame surrounding the abuse, her self-esteem may improve; this could then give her the inner resources she needs to re-evaluate her situation and deal with it in a more effective way (Mullaly, 1997). It is important to realize that individual empowerment is rarely "a linear, forward moving, and uninterrupted journey" (Mullaly, 2002, p. 215). Some women report that their ability to successfully leave an abusive relationship is attributed to learning about themselves, the truth of their victimization and the batterer's responsibility for the violence (Ulrich, 1991). Knowing that this is a long-term process for many women raises some serious safety issues, particularly for northern women.

Paying attention to safety, privacy, and confidentiality. Ensuring the woman's safety is essential in the screening process. It is imperative that screening not increase risk to the patient. Privacy is necessary in order to ensure confidentiality, but most importantly, to protect women from repercussions from an abusive partner (Dutton et al., 1997). As mentioned, ensuring privacy and confidentiality is even more of a challenge in a smaller hospital setting. However, every effort should be made to ensure that screening protocols are conducted privately and away from those who may have accompanied the woman. Disclosure is unlikely if the woman can be

heard or believes she can be heard. During the screening process, physicians and nurses must carefully assess a woman's immediate safety, particularly if her abusive partner brings her in. Clearly, breaking confidentiality could put a woman's (and her children's) safety in serious jeopardy (Ingram, 1993). Furthermore, breaching confidentiality by taking action without her consent (i.e., calling a transition house, counsellor, etc.) is also disempowerng for women. Making choices without a woman's consent takes away her control over the situation and fosters feelings of dependency and powerlessness (Dutton et al., 1996).

Step 3: Recording Patient Victimization Histories

Documentation is an important consideration so that future physicians and nurses can help patients who return after another incident and also for legal purposes and custody issues. Recording the abuse also shows women that their concerns are being taken seriously. Documentation may include recording a detailed description of present and past abuse including photographs and/or a body map of any injuries (Plitcha, 1992). From an empowerment perspective, use of language is important. Documentation should clearly state how the injuries were sustained. Recording comments such as "hit by fist" neglects the broader context of who was hit by whom. Also, practitioners who are committed to empowerment principles believe a woman's story. This can be reflected in the language used in medical files. Brockmeyer & Sheridan (1998) caution against using phrases such as "*allegedly* beaten by boyfriend" or "refuses to go to transition house" (p. 222). These comments are not only disempowering to the woman, but they also question her credibility, which can be harmful to her if the file is later used in court.

Step 4: Referring Patients

Women can be empowered simply by increasing their knowledge of and access to resources such as the legal system, shelters and support groups (Dutton et al., 1996). Given the busy nature of an emergency department, it is not possible for physicians and nurses to engage in long counselling sessions with patients. Clearly, hospital-based social workers have an important role to play after a patient has disclosed abuse. Whoever is working with the patient, whether it is a health care provider or social worker, needs to be familiar with several community resources and referrals so that abused women can access them immediately or at a later time. To adequately serve the needs of abused women, partnerships need to be made among all helping agencies in the community: the hospital, social services, the police, crown counsel as well as community groups (transition houses, women's centres, multicultural services and so on). Health care providers can supply a woman with a package of educational materials or a card with important contact numbers, such as crisis lines, shelters, legal services, women's centres and so on. For example, a women's support group can be a particularly powerful forum for women to connect with other women who are going through similar circumstances and to validate each other, while at the same time working toward alleviating the isolation, stigma and shame (Burstow, 1992).

While urban-based physicians may be able to refer patients to a hospital social worker, transition house or women's support group, rural- or northern-based physicians often do not have these services at their disposal. Because physicians working in isolated regions typically have limited referral options, they may have to be more active in terms of providing supportive counselling, problem solving, safety planning and follow up (Goeckermann et al., 1994). In rural areas, the physician may be an abused woman's primary source of help for an extended

period until she can get in touch with other resources, which may be many miles away. If there is no transition house available and the woman has no other safe place to go, sometimes an extended hospital stay may be necessary. In the United States, some hospitals have established safe-rooms for women whose physical safety is at risk (Loue, 2001).

Clearly, this health care policy has a more direct impact on health care workers than social workers. The goal of the next section is to describe how this policy is relevant to social work. It will show that whether or not social workers provide direct services to abused women, the subject of universal screening for violence in a health care setting is still a matter of considerable interest for the profession of social work. Given the personal, social and economic costs of violence against women (Koss, 1994; Day, 1995), implementing a screening policy that contributes to the intervention and prevention of woman abuse impacts all members of society: individuals, families, governments and all sectors of the helping community.

CHAPTER SEVEN

Implications for Social Work

> Affirming that violence against women constitutes a violation of the rights and fundamental freedoms of women and impairs or nullifies their enjoyment of those rights and freedoms, and concerned about the long-standing failure to protect and promote those rights and freedoms in the case of violence against women. (*Declaration on the Elimination of Violence Against Women*, United Nations, 1994)

The first and most significant reason that screening for abuse is relevant to social work is that violence against women in relationships is a global social problem that represents a violation of basic human rights and a barrier to social justice (World Bank, 1997). All social workers have a responsibility, according to the Canadian Association of Social Work (CASW) Code of Ethics, "to advocate change in the best interest of their clients and for the overall benefit of society, the environment and the global community" (Westhues, 1999, p. 237). Social work as a profession is also committed to "the elimination of discrimination; equal distribution of resources; advocacy for a clean and healthy environment; and the promotion of social justice" (Westhues, 1999, p. 237). Clearly, understanding the implications of social policies and advocating for policies that promote social justice is a central feature of social work practice. Whether the focus of a policy is on the international, federal, provincial, local or agency level, social workers' understanding of an involvement in policy development benefits clients, their families and communities (Westhues, 1999). Graham, Swift, & Delaney (2000) agree, stating that participating in social policy development allows social workers to tune in to the realities of the people they serve. They state: "knowing the circumstances under which many of our clients

live, we can become proponents for policies that will enhance their well-being and advocates against policies that negatively affect them" (p. 15).

Discipline-Jumping

While this case study examines a policy that directly impacts health care practice, social workers and other helping professionals have an important role to play, particularly in northern communities. For hospital-based social workers, involvement may take place in a number of capacities. This might involve providing training and education on the dynamics of abuse to staff, assisting in both the development and delivery of the policy and offering counselling support to victims (i.e., patients may be referred to the social worker) (Shields et al., 1998). Small, northern or rural hospitals do not always have the benefit of having social workers to call on. Despite this, many opportunities still exist for social workers to partner and share the burden of care with health care practitioners by contributing to the development and implementation of a screening tool and offering support to women in the community (Johnson, 2000; Shields, Baer, Leininger, Marlow, & DeKeyser, 1998). In fact, working collaboratively and making partnerships with all members of the professional helping community (justice system, social services, mental health, health care, etc.) is the most effective way to address social issues in northern communities (Arges & Delaney, 1996). In order to promote local control and empowerment, multi-disciplinary practice must involve building bridges with both formal and informal (natural helping) sources of support from the community (Delaney, 1995). Being responsive to northern communities means that social workers and other practitioners work *with* their communities, as opposed to working *in* their communities (Delaney, 1995). According to Arges and Delaney (1996), the best way to accomplish this is to adopt a polycentric or cultural studies perspective. As mentioned, a cultural studies perspective is one which uses a multi-focus

and anti-discipline approach, which makes its primary focus understanding and changing the "structures of dominance everywhere" (Sardar & Van Loon, 1998).[6] The point here is that understanding and changing structures of dominance (i.e., oppressive practices, policies or ideas) is not confined to the domain or territory of one particular discipline (medicine, law, education, psychology) or agency such as social work or health care (Transken, 2002). To the contrary, intervening in issues such as woman abuse, criminal harassment and other social injustices benefits from a discipline-jumping approach (Transken, 2002). This is particularly relevant in northern communities where both health care and social work operate as generalists and both operate from similar professional principles. More specifically, violence against women is a matter of interest to any profession that is concerned about the well-being of vulnerable populations and is committed to values of social justice, autonomy and beneficence (Warshaw, 1994).

CHAPTER EIGHT

Evaluation of the Policy and Future Research Recommendations

> Equality for all women will come about only as these attitudes, imbedded in the workplace, educational institutions and the family, are challenged and begin to change. To achieve true equality, actions must be taken that adjust for the differences in experiences and situations between women and men, and among women, and that correct the systemic nature of inequality. (Status of Women Canada, 1995, p. 14)

The previous chapter highlighted some of the practice implications for screening for woman abuse in a health care setting using an empowerment framework. The purpose of this chapter is to present an evaluation of this policy and to offer some suggestions for future research regarding woman abuse and screening in northern, rural or remote health care settings.

Potential Challenges of Universal Screening

I have already explored some of the obstacles found in the literature regarding health care workers' abilities to effectively intervene in cases of domestic violence. I have indicated that implementing a formal screening policy in rural areas will have its own set of distinct challenges. Although I believe that the benefits of screening certainly outweigh any shortcomings it may have, there are some additional side effects that are worthy of mention.

First of all, because this idea is relatively new, there are no studies available that address the feasibility of universal screening. However, it is likely, particularly in the short term, that screening could have an impact on the hospital staff (i.e., social workers, physicians, nurses and specialists) with regard to increased time and resources needed for training, screening and intervening. In addition, as more violence is detected, screening could lead to more women seeking secondary sources of support from various helping institutions, such as the police,

transition houses, support groups, mental health services, legal services, social services and so on. However, I agree with proponents of screening who point out that the long-term costs (personal, financial, social and economic) of not intervening in cases of domestic violence are much higher than the costs of developing and implementing a tool that could potentially interrupt the cycle of violence (Warshaw, 1994).

Along the same lines, some critics argue that routine screening should not be done because there is little evidence that screening is helpful to clients or that it actually prevents violence (Cole, 2000). A comparison of screening tools goes beyond the scope of this paper, but researchers have explored the efficacy of some protocols.[8] The position taken in this paper is that success in screening for violence in intimate relationships cannot be measured the same way other screening practices can (e.g., for cancer or diabetes) (Gerbert, Abercrombie, et al., 1999). The preventive qualities of screening are difficult to assess. Screening may be the catalyst for a woman who leaves an abusive partner, or it be one of many factors contributing to her decision-making process. It takes most women a long time and several attempts before they feel they can safely leave an abusive relationship (Bowker, 1993; Warshaw, 1994). However, though the benefits of screening are not always visible to the health care practitioner, it does not mean the intervention is not worthwhile.

Another limitation of this screening tool is that achieving true universal screening is difficult, even where hospital staff supports the idea and recognizes the seriousness of the problem (Grunfeld et al., 1994). The nature of a busy emergency room department means that even when there is a formal screening protocol in place, it is still not always possible to screen every patient who comes through the door. Screening policy evaluations indicate that those who fall through the cracks are patients who come in to the emergency department by ambulance, or

those individuals who are intoxicated, hostile or seriously ill. Screening is also not easily carried out with women for whom English is their second language, such as immigrant women or refugee women (Grunfeld et al., 1994). Screening patients who do not speak English is problematic in urban settings, and this would undoubtedly present a greater challenge in a smaller community where access to interpreters is even more limited. However, one of the primary tenets of empowerment practice is ensuring that vulnerable people (e.g., women who have limited English language skills) do not fall through the cracks in the screening process. This means that every effort should be made to ensure that all women have a voice in the screening process (and in all health care visits), either through face-to-face or phone translation services.

There are also problems that come with asking about violence at a triage desk, in both urban and rural settings. Triage desks offer limited privacy and confidentiality, and given how brief the screening process is, fostering rapport could be difficult, particularly in smaller communities. To be sure, practicing in northern, isolated regions, whether it is social work or health care, often requires innovative and creative strategies to overcome these kinds of obstacles. What is clear is that working collaboratively and creating networks of support with other agency workers from the social service, mental health, justice and health care sectors, seems to offer the most promise for effectively addressing social problems such as woman abuse (Morrow, 2000; Shields et al., 1998). Urban-based social policies are generally a poor fit for rural settings (Delaney, 1995). In order for a screening tool to be truly effective in a northern, rural or remote health care setting, it will have to be tailored in a way that reflects the unique qualities of the particular community. Furthermore, practitioners who want to implement a screening policy in a northern health care setting will be required to seek out allies in the

community (including survivors of abuse) who are also committed to addressing the issue. One effective way of doing this is to build on the strengths of self-help and informal helping resources that are already present in the community (Fuchs, 1997). Building bridges with community members and agencies is imperative in order to share the burden of care (Johnson, 2000) that comes with the training, education and development needed to implement a screening protocol. An example of this kind of partnership approach to addressing woman abuse can be found in Fort St. John, BC, where collaboration took place between the Fort St. John Hospital Emergency Department, the Specialized Victim Assistance Program and the Sexual Assault Centre. Working together, this team developed innovative fundraising techniques which led to the creation of a hospital-based sexual assault service (Morrow, 2000).

Finally, I recognize that universal screening is a micro-level policy that may limit its ability to affect the broader structural changes that are needed to truly eliminate a pervasive social and political problem such as violence against women. Women's continued victimization is linked to national and provincial social policy issues such as poverty, unemployment, education and housing as well as broader structural issues of racism, patriarchy and capitalism. Clearly, universal screening is not a panacea. However, this policy represents only one component of a number of micro- and macro-level initiatives needed to address a problem of this magnitude. Addressing this problem adequately requires the coordinated efforts of individuals, communities, agencies and governments to prevent it from becoming another Band-Aid or ad hoc approach to addressing social problems. However, because universal screening has the potential to break the cycle of violence, I agree with Mullaly (1997, 2002), who points out that policy and practice strategies that are directed at both the personal and the political level have an equally meaningful role to play in creating a socially just society.

Future Research

While preparing this case study, a number of potential topics of research were brought to my attention. For example, some health care practitioners recommend that longitudinal studies be carried out in order to determine whether screening tools have the potential to prevent future episodes of violence and injury (Cole, 2000). Similarly, while many argue that screening should be done, it is not clear what is the best way to do this. Some call for more evaluations to be carried out on screening tools in order to make them more precise and promote better uniformity (Larkin et al., 1999). In addition, there appears to be a gap in research with respect to cost-effectiveness of screening for woman abuse. This knowledge is important because it could help guide policy makers, providers of funds and activists in demonstrating feasible interventions for most effectively addressing violence against women (Garcia-Moreno, 1999).

Although there is a great deal of discussion about efforts to improve health care response to abused women, most of this literature pertains to urban populations. It appears that no models of universal screening have been developed for rural areas, and few articles have been written that address the unique challenges facing practitioners in these areas (Johnson, 2000). Jiwani (1998) and Websdale (1998) recommend using qualitative methods as opposed to quantitative approaches in northern or rural communities. They argue that research development (as well as practice and policy development) is most beneficial to northern communities because it can draw on the expertise of local residents and practitioners. I would add to this that feminist-oriented, qualitative studies (participatory action, ethnographic or phenomenological) are also ideal ways to explore sensitive topics such as violence against women. More specifically, few studies have explored the factors that contribute to abused women's *helpful* encounters with health care workers (Gerbert, Abercrombie, et al., 1999). Therefore, using a qualitative

approach that allows women (including "differently situated" women) to share what they perceive as helpful encounters with health care providers could benefit those who are trying to develop screening protocols in these areas. However, because few data exist on the prevalence of woman abuse in rural areas, quantitative studies (i.e., surveys) have an important contribution to make toward enhancing our understanding of the scope of this problem in northern communities. With evidence showing that partner violence is a significant problem for women residing outside urban centres, there may be a greater willingness and cooperation on the part of the health care sector and the broader community to implement programs and services to address this issue.

CHAPTER NINE

Summary and Concluding Comments

> Never doubt that a small group of committed citizens can change the world. Indeed, it's the only thing that ever has. (Mead, 1928)

Violence against women in relationships represents a significant public health concern and human rights violation. All individuals, communities and agency workers have a role to play in eliminating this problem. One of the major reasons that woman abuse continues to be pervasive today stems from the fact that society collectively permits it to occur, through its silence and failure to respond adequately to victims in need of support (Loue, 2001). In recent years, many have argued that the health care sector is ideally positioned to help in the intervention and prevention of woman abuse (Transken, 2000; Warshaw, 1994; Varcoe, 1997; Ingram, 1994). By implementing formal screening policies which ensure that all women (regardless of background) are asked about abuse, health care workers can use their front-line status in the community to prevent women from further victimization, serious injury or even death. I have demonstrated that universal screening entails properly identifying and treating the consequences of abuse, as well as validating women's experiences, documenting injuries and referring women to sources of support. The main goal of this case study, however, was to show how universal screening could also be a forum for fostering women's empowerment. I have argued that one of the most important qualities of empowerment practice is that the focus is placed on the *process* of screening, as opposed to the goal of disclosure. This means resisting the need to fix the problem and realizing that women know what they need better than anyone else in their circumstances (Roux & Rittmayer, 1999; Ingram, 1994). I have argued that because women residing in northern communities usually have fewer avenues of support, screening is

especially critical. The current climate of cutbacks to funding for BC social services and other programs (legal aid, victims' services, women's centres, social assistance benefits, etc.) will surely have a negative impact on the most vulnerable members of society, particularly those trying to escape violence. This means that now, more than ever, victims of violence need to be able to count on the support and advocacy of all committed members of the social service and health care sector, particularly in underserviced areas. On a final note, in keeping with the tenets of feminist scholarship, it is hoped that this case study will give a voice to a subject that is seldom heard, and that this paper will be understood to be not simply "about women" but "for women" (Reinharz, 1992). With this said, it is hoped that health care workers in the north will be motivated to examine current practices and policies regarding woman abuse and consider implementing a universal screening protocol that could have a positive impact on women, families and society at large.

ENDNOTES

[1]Consistent with a feminist perspective on woman abuse, this paper utilizes a "violence against women in relationships" perspective. The reason for this is that terms such as "family violence," "domestic violence," or "wife abuse" tend to obscure the severity and gender nature of the violence and limit the scope of the problem (Kurz, 1997). A violence against women perspective is one that acknowledges that it is most often women, not men, who are victims of violence. Although some men are victims of violence in relationships, numerous studies show that the overwhelming majority of victims of partner violence are women and that women sustain more serious injuries in violent disputes (Koss, 1994; Johnson, 1996; Statistics Canada, 1999; U.S. Dept. of Justice, 2000). In addition, when women use physical force toward their male partner, it is often in self-defense and rarely part of a continuing pattern of control and coercion (Warshaw as cited in Cole, 2000).

[2]Due to limited space I will not be able to offer a comprehensive discussion about the subject of domestic violence in Aboriginal communities. While every person's experience with abuse is unique, it must be pointed out that there are distinct social, historical and economic factors that contribute to the high incidence of domestic violence found in many Canadian Aboriginal communities. For more information about this subject, see Frank, 1992; LaRocque, 1994; Green, 1996; Maracle, 1996; and McTimoney, 1993.

[3]This paper is written with the understanding that every woman's experience with violence is unique, regardless of geographic location or background. The aim of this discussion is not to generalize, but to show how the northern landscape can play a significant role in shaping women's victimization and help-seeking abilities.

[4]Due to the limited scope of this paper, I will not be exploring the issue of screening for child abuse in the health care setting. However, it is worth noting that the American Academy of Pediatrics, American Medical Association (AMA), American Academy of Family Physicians and the Bright Futures guidelines all recommend that physicians be on the alert for signs and symptoms of child physical abuse and child sexual abuse in routine examinations. The AMA's Guidelines for Adolescent Preventive Services recommend that teens should be asked annually about a history of emotional, physical and sexual abuse. The use of screening devices to identify families at risk for child maltreatment is not recommended by the Canadian Task Force on the Periodic Health Examination. Legislation in the US and Canada requires health care professionals to report suspected cases of child abuse (U.S. Task Force on Preventive Health, 1996).

[5]A useful resource recommended for health care practitioners to become more aware of the dynamics of woman abuse is the "power and control wheel," a model developed by the Domestic Abuse Intervention Project in Duluth, Minnesota (Yllo, 1993). This model is based on a feminist perspective of woman abuse and is often used in transition houses, support groups and educational settings. It clearly demonstrates the interconnections between violence and other forms of coercive control. For example, this framework shows how a wheel connects physical and sexual violence to the hub of power and control, connecting to spokes which represent the various forms of control: minimization and denial, intimidation, isolation,

emotional abuse, economic abuse, use of children, threats and asserting male privilege (Yllo, 1993).

[6]For a more comprehensive discussion on cultural studies see Agger, 1992; Grossberg, Neslon, & Treichler, 1992; Storey, 1996; and Sardar & Van Loon, 1999.

[7]Johnson (2000) and Morrow (2000) offer a comprehensive list of health professional resources and initiatives pertaining to violence against women.

[8]The goal of this paper is to encourage health care workers and other helping professionals to recognize the benefits of screening for abuse, not to advocate for one particular tool over another. However, in addition to the Vancouver General Hospital screening guidelines, there are numerous screening protocols available for use in a wide range of health care settings. For more information about the efficacy of screening tools see Feldhaus et al., 1997.

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