A Hospital-Based Domestic Violence Group

Ilena M. Norton, M.D.
Joann Schauer, L.C.S.W.

Objective: **This study of a public-hospital-based drop-in group for women who were victims of domestic violence sought to determine whether the group attracted clients from the target population of patients in the medical system, to identify characteristics of the battered women attending the group, and to examine whether the group shared the same characteristics as battered women who were evaluated in other contexts within the medical system.** ***Methods:*** **Fifty-nine clients attending a domestic violence group at an urban public hospital completed questionnaires on referral sources, demographic characteristics, needs, and satisfaction. Included for comparison were clinical data on referral sources and demographic characteristics for 224 battered women evaluated by clinical social workers at the hospital and affiliated clinics.** ***Results:*** **Referral patterns differed for the two groups: the majority of the social work cases were referred from the emergency room, and the majority of the referrals to the domestic violence group were from outside agencies, informal sources, and the hospital's inpatient units. A greater proportion of women attending the group were white, divorced or separated, and no longer living with their partners. Among the social work cases, the women were more likely to be ethnic minorities, single, and still living with their partners.** ***Conclusions:*** **The domestic violence group intervention attracted a different subgroup of battered women than did the social work intervention, which was likely due to differences in readiness to initiate change and to cultural barriers to group participation. (*Psychiatric Services* 48:1186–1190, 1997)**

Recognition of the prevalence of domestic violence among medical patients and the physical and psychological consequences of domestic violence has prompted a growing interest in domestic violence intervention in the medical community (1–9). In 1992 the American Medical Association published diagnostic and treatment guidelines for domestic violence (10), and the Joint Commission on Accreditation of Healthcare Organizations established requirements for hospital domestic violence policies (11). In addition to these efforts, some hospitals have developed specific programs ranging from domestic violence task forces focused on educating hospital staff to clinics providing evaluation and crisis and ongoing intervention to clients (12–15).

In this paper we describe a domestic violence group established at the Denver Health Medical Center, an urban public hospital. The rationale for a hospital-based domestic violence group is to provide patients with increased access to domestic violence intervention. These educational and support groups for women are a type of intervention frequently offered by community domestic violence agencies, but such groups have received little attention in the literature (16). We were interested in learning whether the group attracted clients from the target population of patients in the medical system and whether battered women who attended the group shared characteristics with other group members and with battered women who were evaluated in other contexts within the medical system. To address the last issue, we compared the women attending the group to battered women referred to clinical social workers in the hospital and affiliated clinics.

The domestic violence group

Discussions between representatives of the clinical social work and psychiatry departments and the program director of Safe House for Battered Women, Inc., in Denver resulted in the formation of a drop-in group for battered women at the Denver Health Medical Center. The group was led by a clinical social worker on the hospital's staff and one or two volunteers from Safe House. It followed a protocol developed by Safe House for volunteer-led educational and support groups. The group rotated through specific topics every six weeks, but women dropped in at any time and attended as many or as few sessions as they wished.

The topics included the nature of

Dr. Norton is assistant professor in the departments of psychiatry of the Denver Health Medical Center and of the National Center for American Indian and Alaska Native Mental Health Research at the University of Colorado Health Sciences Center, Box A011-13, 4455 East 12th Avenue, Denver, Colorado 80220. ***Ms. Schauer*** *is a senior clinical social worker in the department of clinical social work at Denver Health Medical Center.* *This paper was presented at the annual meeting of the American Public Health Association held November 17–21, 1996, in New York City.*

Table 1

Demographic characteristics of 59 women in a domestic violence group and 224 victims of domestic violence referred to clinical social workers for evaluation

Characteristic	Domestic violence group		Social work cases		χ^2	df	p
	N	%	N	%			
Marital status					21	3	.001
Married	14	24	62	28			
Single	19	32	124	55			
Divorced	10	17	21	9			
Separated	15	25	17	8			
Missing data	1	2	0	—			
Living with partner					43	1	.001
Yes	11	19	151	67			
No	46	78	73	33			
Missing data	2	3	0	—			
Race					9.46	4	.001
American Indian	1	2	6	3			
African American	3	5	46	21			
Hispanic	17	29	94	42			
White	34	58	73	33			
Other	4	7	5	2			
Employed					.16	1	ns
Full or part time	17	29	73	33			
Unemployed or homemaker	40	68	151	67			
Missing data	2	3	0	—			
Education[1]							
Less than high school	11	19					
High school graduate or general equivalency diploma	23	39					
Some college or two-year college	20	34					
College or graduate school graduate	5	9					
Income[1]							
$0–$9,999	30	51					
$10,000–$19,999	7	12					
$20,000–$29,999	10	17					
$30,000 or more	5	9					
Missing data	7	12					

[1] Data were not available for the social work cases.

domestic violence, barriers to leaving abusive partners, the reasons batterers batter, the effects of domestic violence on children, anger management, and prevention. Group sessions were scheduled for one hour a week. Depending on the size and interests of the group, the group leaders varied the time devoted to the educational topic and accompanying handouts and to open discussion.

The group was free, open to the public, and advertised by Safe House. Advertising included flyers posted throughout the hospital and clinics, training sessions on domestic violence for medical personnel, and flyers mailed to community agencies. The domestic violence agency advertised the group through its 24-hour crisis line and community program and shelter and in agency brochures. In the hospital and clinics, the clinical social workers routinely referred battered women to the group.

Methods

Data on the source of referrals to the domestic violence group were obtained from a weekly log maintained by the clinical social work group leader from March 1995 to May 1996 (excluding five weeks during which no data were collected). Seventy-six women attended the domestic violence group during this period. All other data on the domestic violence group were obtained from written intake questionnaires completed during the same time period. Sixty-two women completed these questionnaires at the end of their first group session. Three questionnaires were eliminated—one because it was incomplete and two because the women reported that they were observing the group and were not battered women. The most common reason for not completing the questionnaire was early departure from the group session.

The questionnaires included demographic items and questions about whether the group member was a patient within the medical system and was referred to the group from by medical personnel. Questions also were asked about the respondent's level of satisfaction with the group; the reasons for satisfaction or dissatisfaction, followed by a list of possible reasons; and the type of assistance she needed, followed by a list of potential needs.

Included for comparison were data on women who were victims of domestic violence and who were referred for evaluation to clinical social workers at the hospital and affiliated medical clinics. Clinical social workers filled out a standardized form on all cases at the time each case was closed. The form included questions about demographic characteristics and referral source. During the study period, 224 women identified as domestic violence victims constituted the comparison sample. Those who were younger than 17 were excluded from the sample because 17 was the lower age range of participants in the domestic violence group, and children under 17 may have witnessed domestic violence instead of being battered by a partner.

Domestic violence either was the primary reason for referral to the clinical social worker or was identified as a problem during the social work evaluation. The clinical social workers were viewed within the medical system as the primary resource for domestic violence evaluations. The hospital's policy on victims of assault specifically stated that in the emergency room all cases should be referred to a clinical social worker if one was available. The availability of clinical social workers varied by service; for example, a clinical social worker covered 50 percent of the emergency room shifts and 100 percent of the ob-

stetrics-gynecology clinics at the hospital. The sample did not include patients who refused the evaluation, were counseled only by nurses or physicians, or had brief or phone contacts in which a case was not opened.

Statistical analyses used the chi square test for proportions and the t test for comparison of mean differences.

Results

Table 1 shows the demographic profile of the 59 women attending the domestic violence group who completed the questionnaire and the 224 social work cases. The group members were more likely to be divorced or separated and no longer living with a partner, in contrast to the women evaluated by social workers, who were more likely to be single and living with a partner. The percentage of white women was higher in the domestic violence group than among the social work cases, who were more often ethnic minorities. The percentage of African-American women attending the domestic violence group was much lower than among the social work cases. The percentages of American Indian and Hispanic women attending the group were also lower than among the social work cases, but the differences were not as large.

The mean±SD age of the women in the group was 30.6±8.3 years, compared with 32.8±11.4 years for the women who were social work cases. However, the difference did not achieve statistical significance. The upper age range of the social work cases was 79 years, and the oldest participant in the domestic violence group was 51. No difference between the two samples was found in employment.

As shown in Table 2, the largest percentage of referrals to the domestic violence group came from Safe House and other domestic violence agencies. Twenty-one of the referrals to the domestic violence group (28 percent) were from personnel or brochures at the hospital or medical clinics, and the majority of these medical referrals were from the inpatient units. In contrast, the majority of the social work cases were referred from the emergency room.

Forty-three of the domestic violence group members (57 percent) were self-referred through contacts with domestic violence agency hotlines and victim advocates, flyers, and friends. Less than half of the referrals (N=30, or 40 percent) were made by professionals such as nurses, social workers, counselors, and lawyers. Almost all of the social work cases (N=207, or 92 percent) were referred by physicians, nurses, or other hospital staff; only 5 percent (N=11) were self-referred.

The questionnaire asked whether the woman attending the domestic violence group was a patient in the medical system and whether she had heard about the group at the hospital or its affiliated programs. Forty-four percent of the women (N=26) reported that they were patients, and 23 (39 percent) had heard about the group at one of these sites. Of note, only 14 of the women in the group (24 percent) were both patients and had heard about the group at one of the sites, nine (15 percent) had heard about the group at one of the sites but were not patients, and 11 (19 percent) were patients but had heard about the group from outside agencies or informal sources such as friends.

Almost all of the 59 women who completed the questionnaire (95 percent) reported that they were mostly or very satisfied with the group. The reasons they endorsed most often for being satisfied were that the group leaders were supportive (N=42, or 71 percent), they heard other women tell their stories (N=39, or 66 percent), and they learned about domestic violence (N=37, or 63 percent). Other reasons for being satisfied were that the other women in the group were supportive (N=28, or 48 percent), they got to tell their stories (N=26, or 44 percent), and they received referrals for assistance (N=20, or 34 percent). Some women were dissatisfied because the group didn't solve their problem (N=1, or 2 percent) or they didn't want to talk about their problem (N=2, or 3 percent); some didn't know why they were dissatisfied (N=4, or 7 percent). None of the women indicated that they didn't get to tell their stories or that the group made them feel worse.

Table 2

Referral sources of 76 women in a domestic violence group and 224 victims of domestic violence referred to clinical social workers for evaluation

Group and referral source	N	%
Domestic violence group		
Hospital inpatient unit	9	12
Outpatient medical clinic	2	3
Other medical referral	4	5
Hospital brochure or newsletter	6	8
Domestic violence agency	30	40
Other community agency or professional	12	16
Legal source (court, attorney, or probation officer)	3	4
Friend, phone book, or other source	7	9
Unknown	3	4
Social work cases		
General medicine inpatient unit	10	5
General surgery inpatient unit	13	6
Obstetrics-gynecology inpatient unit	27	12
Other inpatient unit	7	3
Emergency room	139	62
Adult medicine outpatient clinic	11	5
Obstetrics-gynecology clinic	7	3
Other outpatient clinic	10	4

The women in the domestic violence group were also asked about their current needs. They reported needing support from other women (N=26, or 46 percent) and counseling (N=30, or 53 percent) more than any other resources; items endorsed less often were material needs such as clothing, household items, and food (N=6, or 11 percent); housing (N=10, or 18 percent); transportation (N=12, or 21 percent); and financial assistance (N=16, or 28 percent). Also endorsed less frequently than support from other women and counseling were health care (N=6, or 11 percent), employment (N=14, or 25 percent), education (N=19, or 33 percent), and legal assistance (N=15, or 26 percent).

Discussion and conclusions

The first issues we addressed were identifying the referral sources of clients in the domestic violence group and determining whether the group attracted clients from the target population of patients in the medical sys-

tem. Referrals to the domestic violence group were not primarily from medical personnel; instead, the majority of referrals came from outside agencies and informal sources such as brochures and word of mouth. The referrals from medical personnel were primarily from inpatient units, whereas women who were social work cases were most often referred from the emergency room.

The emergency room referral policy explained the predominance of emergency room cases referred to the clinical social workers, but it did not explain why medical referrals to the domestic violence group came primarily from inpatient services. The group's hospital location improved patients' access to the group; many of the women referred to the group attended while they were still inpatients. We also reached many women who were not patients but who had heard about the group through our agency. The hospital and clinics are a fertile site for intervention efforts because of the constant stream not only of patients but of friends and families of patients and large numbers of female health care employees.

We also sought to identify characteristics of the women who attended the group and to determine whether and how they differed from the women evaluated by the social workers. The group members were more likely to be divorced or separated from a partner, and the social work cases were more likely to be unmarried and living with a partner. This difference in relationship status may explain the difference in referral patterns. Many group members were separated from their partners and actively seeking change by contacting domestic violence agencies or seeking help through informal contacts.

In contrast, most women referred for clinical social work evaluation were still living with their partners and either visited the emergency room seeking medical treatment or were hospitalized, often for obstetrical care. The women who saw the social workers may not have been as motivated to seek assistance as the women attending the group. Some women who visit the emergency room do not seek care on their own accord but are brought in by ambulance or sent by the police. In some cases, the emergency room staff suspect that domestic violence is the cause of the injury, but the women deny it.

There are many reasons why some of these women may remain in an abusive relationship and not be ready to accept help. They may be concerned with keeping the family together and may feel committed to the relationship. They may be financially dependent on their abusive partner or fear retribution by the batterer. If they have been acutely battered, they may be experiencing emotions such as denial or shock that interfere with taking action (17–22).

The women attending the domestic violence group may have had different needs than the social work cases. The women in the group reported needing counseling and support from other women more often than needing material help or financial assistance. In a study of 141 women leaving a battered women's shelter, the percentages who needed assistance with material goods (84 percent), finances (63 percent), and employment (62 percent) were much higher than among the women attending our group (23). Although questions about needs were not posed to the women evaluated by the clinical social workers, they may also have been in greater need of shelter and financial assistance than the women attending the group, particularly the women who were acutely battered and who required treatment in the emergency room.

The domestic violence group appears to attract battered women who have begun the process of separating from their relationship and have more material resources. Different subgroups of battered women may exist with different intervention needs based on individual characteristics or resources. Alternatively, the women seen in the emergency room may be in an earlier stage in their reaction to the battering, while the women attending the domestic violence group are at a later stage, when they are more ready to initiate change and seek help.

Another notable demographic difference is that the women who were social work cases were more likely to be from minority ethnic groups, while those in the domestic violence group were more likely to be white. Despite the location of the group in an urban public hospital setting, this particular type of intervention appears to attract a smaller percentage of minority participants, compared with those referred for social work intervention. Location of such groups in a facility that serves ethnic minority populations, such as a public hospital, may improve access for some minority women, but other cultural barriers may still limit the use of services.

For example, one factor contributing to the lack of participation by African-American women is the importance of confidentiality in African-American communities. In a focus group we conducted to explore these issues with African-American women at the domestic violence shelter, the women explained that "you don't tell your business at your table" and "some business you should always keep to yourself." Family and community may exert subtle or overt pressure not to share these problems with outsiders because of the history of abuses by institutions such as the police. Instead, family problems are kept private and addressed within the family and community.

Furthermore, help-seeking behavior may also be influenced by concerns that the revelation of violence in African-American families will reinforce the negative stereotypes and racism experienced by African-American communities (24). Another example of this phenomenon is found in Wyatt's research (25) on sexual assault, which found that more African-American women than white women did not disclose sexual assaults to anyone until years after the assault.

Another factor that may have lessened the appeal of this intervention to minority women is that the group leaders did not have specific ties to the minority communities, either through being members of or working directly within these communities. In addition, the group members did not meet the group leaders before attending because of the drop-in nature of the intervention. Therefore, those at-

tending the group for the first time had no prior knowledge of or relationship with the group leaders. For minority women the establishment of a relationship before attending the group may be particularly important because of the barriers to intervention described above (26).

Although we do not know if the drop-in group resulted in decreasing either the women's exposure to physical abuse or their psychological distress, we did learn that almost all the women who completed the questionnaires were satisfied with the group. The women reported being most satisfied with the support they obtained from the group leaders. Listening to other women tell their stories and receiving education about the nature of domestic violence also were important aspects of the group process. Support from the group leaders and listening to other women may decrease the isolation and stigma of domestic violence, while knowledge of batterer behavior and the nature and consequences of domestic violence may result in feelings of increased control and improved self-esteem.

A pre- and posttest evaluation of ten- to 12-week support groups for battered women found improvements in locus of control and self-esteem and decreased exposure to physical abuse (27); these groups differed in design from our group because they were closed instead of drop-in groups and each session lasted two to three hours. Because the study of those support groups did not use a control group, it is possible that the improvements were related to the characteristics of women who are motivated to participate in a program.

The domestic violence intervention described here is one type of intervention that can be applied in a medical setting, although many other interventions can be incorporated into medical care. They include staff education through training sessions, patient education through distribution of brochures, and the use of protocols for domestic violence screening and assessment. Community domestic violence agencies are a source of information about domestic violence intervention, and opportunities for collaboration need further exploration. Medical professionals should be challenged to use their knowledge and resources to develop innovative ideas and expand on current efforts to intervene among battered women. ♦

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