



ROBERT KOCH INSTITUTE
Federal Statistical Office



Health Consequences of Violence

*with Special Consideration
of Domestic Violence against Women*



Federal Health Reporting

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of Domestic Violence against Women*

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Published by Robert Koch Institute, Berlin, 2008

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Health consequences of violence

1 Experiences of violence – The problem's relevance for the health service

According to the World Health Organization (WHO), violence, especially domestic violence, is seen as one of the greatest health risks worldwide for women and children [1], a fact that hardly figured in public awareness in Germany until a few years ago. For a long time, data on the incidence and forms of domestic violence were only available occasionally, or indeed not at all, and even the health service largely ignored the problem of violence as a cause of health disorders until the 1990s. A resolution was adopted for the first time during the World Health Assembly in 1996 declaring that the prevention of violence was a priority task of public health services (WHO Resolution 49.25 [2]). It emphasized that violence had serious short-, medium- and long-term health and psychosocial consequences for the victims, representing a special challenge for health services and health professionals. Apart from its individual and social consequences, violence also caused considerable costs to society as a whole (societal costs). The member states were called upon to analyse and document the scale of the problem in their own countries and to support or initiate preventive and intervention measures against violence.

The representative prevalence study conducted by the German Federal Ministry for Family Affairs, Senior Citizens, Women and Youth (BMFSFJ) entitled "Life Situation, Safety and Health of Women in Germany" presents data on the extent and consequences of violence in Germany for the first time [3]. According to the findings of this study, about one in four women nationwide have been exposed to violent assaults by a partner during their adult lives. Between one in two and one in three women living in Germany have furthermore been confronted by sexual and/or physical violence in various (domestic and non-domestic) situations in the course of their lives [3]. According to German estimates, at least one in five women are thought to have experienced gender-related violence with consequences for their health at some time [4, 5]. International studies from the US, the UK and other countries also indicate that the spectrum of

traumatic effects and health problems caused by violence is very broad [1, 6, 7, 8, 9, 10, 11, 12, 13, 14].

Up to now, discussions on the causes of violence, and links between violence and relations between the sexes, have tended to characterize men as the perpetrators, and women and children as the victims of violence. A broadening of the perspective in research and practice observed in recent years shows that violence in the immediate social environment and in close social relationships also involves other victim groups and other perpetrator-victim contexts. These include, for example, children as eye-witnesses of violence between their parents, violence against the elderly and family members in need of care, and violence against the disabled and people with a migration background. Health effects of violence against male adolescents and adult men in various social contexts represent a largely neglected field of research. Yet the findings of the non-representative German pilot study "Violence Against Men" [15] suggest that boys and men as a whole are exposed to a considerable risk of physical, psychological and sexualized violent assault, e.g. in the public sphere and in institutional settings (e.g. in school, the workplace, prisons, etc.), but also in partner relationships. Research on men as victims of violence, particularly in the immediate social environment, is still relatively undeveloped, however. There is a corresponding lack of knowledge about the extent, causes and manifestations of violence, as well as the treatment and support needs of male victims of violence in Germany (cf. [16, 17]). For this reason, the focus of this booklet is on women and children as victim groups.

The violence issue is important for health research and practice because violence has such complex and far-reaching consequences for health.¹ This applies not only to the direct after-

¹ These were recorded, on the one hand, in population-based representative studies on the prevalence of violence and, on the other, by studies in healthcare institutions (for an overview, cf. [1, 11, 18]).

effects of injuries caused by violence, but also in particular to short- and long-term psychosomatic and psychological health impairments. Moreover, exposure to violence can have a negative influence on a person's health-related behaviour: e.g. it can encourage unhealthy modes of behaviour such as consumption of alcohol, tobacco, narcotics or prescription drugs [3, 11, 12, 18, 19, 20, 21, 22, 23, 24, 25].

Because the various forms of violence have such a great quantitative and qualitative influence on the health of women, men and children, detailed knowledge of the links between exposure to violence and potential health consequences is absolutely essential for the professional groups working in the health service. Analyses conducted in this field have shown that there has been a lack of knowledge throughout the medical healthcare system up to now, and that this can lead to victims being provided with too much, too little or the wrong care if, as a result, violence is not recognized as the cause of health problems. Technical knowledge of symptoms and adverse health effects caused by violence, and technical skill in identifying the especially vulnerable groups of the population, are key prerequisites for recognizing, talking about and documenting violence as a cause of health problems and being able to provide the support and assistance that is needed. Since health-service institutions are frequently the first place where victims seek help when they have acute injuries and health disorders (cf. [3]), there is great intervention potential in this field which must be used and expanded – also to prevent further violence. Passing on medical and other important information, providing guidance and disseminating best-practice approaches to dealing with and treating victims of violence is therefore crucial and a task worthy of continued support.

This is currently supported by the activities of the World Health Organization (WHO) in the field of violence, health consequences and prevention, which have been intensified over the last few years (www.who.int/violence_injury_prevention/violence/en/). Moreover, in Germany many practical projects, (networking) initiatives and activities by federal and federal-state ministries, as well as the German Medical Association (*Bundesärztekammer*), have contributed to making violence, the health consequences of violence and violence prevention central priorities in the health system,

as explained later in this booklet and the corresponding links in the Appendix.

2 The extent and health consequences of violence

2.1 Extent to which women, men and children are victims of violence – Findings of national and international studies on the prevalence of violence

2.1.1 State of research and definitions of violence

The issue of sexualized and specifically domestic violence against women and children was first raised by the feminist movement in the 1970s, but it took almost another 20 years before it was recognized in the 1990s as a societal problem at the national and international level (e.g. by the World Health Organization). The question of the extent of domestic violence has since also been examined at the European level by numerous studies on the prevalence of violence (for an overview, cf. [11]). Police statistics – the visible extent of domestic violence – can only depict crimes that are reported, and this does not depict the full extent of domestic violence. By contrast, the potential advantage of basing violence prevalence studies on representative sample surveys of the population is that they are better at determining the true extent of violence within the immediate social environment, i.e. including the "dark figures" that do not appear police records. Despite highly differentiated surveying instruments, more refined methods of field access and interviewing, one particular difficulty remains: how to classify the severity of violent attacks and measure the direct and indirect health consequences of violence. Obtaining a more precise picture of the short- and long-term health consequences of violence requires further surveys. On the one hand these need to be based on representative population samples and include both objective and subjective health data; survey modules on violence in health surveys seem especially relevant in this context. On the other hand, surveys in different healthcare sectors can provide information on existing levels of violence, consequences and needs in specific areas.

In studies on the prevalence of violence, explicit questions are rarely asked on what "violence" a person has experienced; rather, specific questions relating to certain actions are usually put to avoid violence being underreported (e.g. "were you beaten?"). Many acts, especially within intimate social relationships, are not perceived by the victims as "violence" and are therefore not named as such (cf. [11, 23, 26]). Furthermore, sensitive field-access and survey methods are necessary in studies of people's experiences of violence because of the risk of interviewees becoming retraumatized and revictimized [23, 27, 28]. Furthermore, if victims are under pressure from situations of severe violence and control, e.g. in partner and family relationships, they are unlikely to agree to an interview and will be reluctant to talk about violent experiences to third parties. In the light of these facts, therefore, representative population-based studies on victimization and the prevalence of violence, too, only reveal the lower limits of the true statistics and will never be able to reveal all the unreported cases of violence [29, 30].²

The context-dependent, individual perception and assessment of "violence" and the vagueness of the violence concept confront empirical research with the fundamental difficulty of how to define and operationalize "violence" as such, in order to ensure the comparability of the data generated (cf. [11, 23, 26]). Since the questions asked in research on violence vary considerably and examine different violent phenomena, the concept of violence is defined correspondingly broadly or narrowly, depending on the research question on which it is based. It is therefore impossible to arrive at a universal, generally accepted definition of violence; indeed, it would not do justice to the complexity of the concept [31].

As a rule, violence research distinguishes between psychological, physical and sexualized violence. The concept of neglect is also relevant in the case of violence against children and other people needing care. Psychological violence can comprise very different dimensions, depending on the context. In recent years, phenomena such as stalking, mobbing at work and bullying/mobbing at school and during vocational training [32] have gained in importance. Whereas the perception of violence against women concentrated for a long time on sexual harassment, sexualized and

physical violence in the domestic context, the perspective has broadened to include other forms and contexts of violence in the meantime. Increasing attention is being paid to systematic psychological abuse in the form of emotional violence (e.g. humiliation, psychological/verbal threats, intimidation) by intimate partners or acquaintances at work or in vocational-training situations, e.g. in view of the considerable psychological and health consequences [3, 5]. In addition, stalking has been included as a significant form of violence under criminal and civil law since 2002 by the Protection against Violence Act to protect victims from persistent pestering, etc. (cf. [33]).

2.1.2 Extent and forms of violence against women

Many national and international studies have been conducted in the meantime to determine the extent of violence against women (for an overview, cf. [11, 21]). The WHO has compiled the first international study on the prevalence of violence covering mainly non-European countries. The study determined the number of people in individual countries who had been affected by violence (see Figure 1).

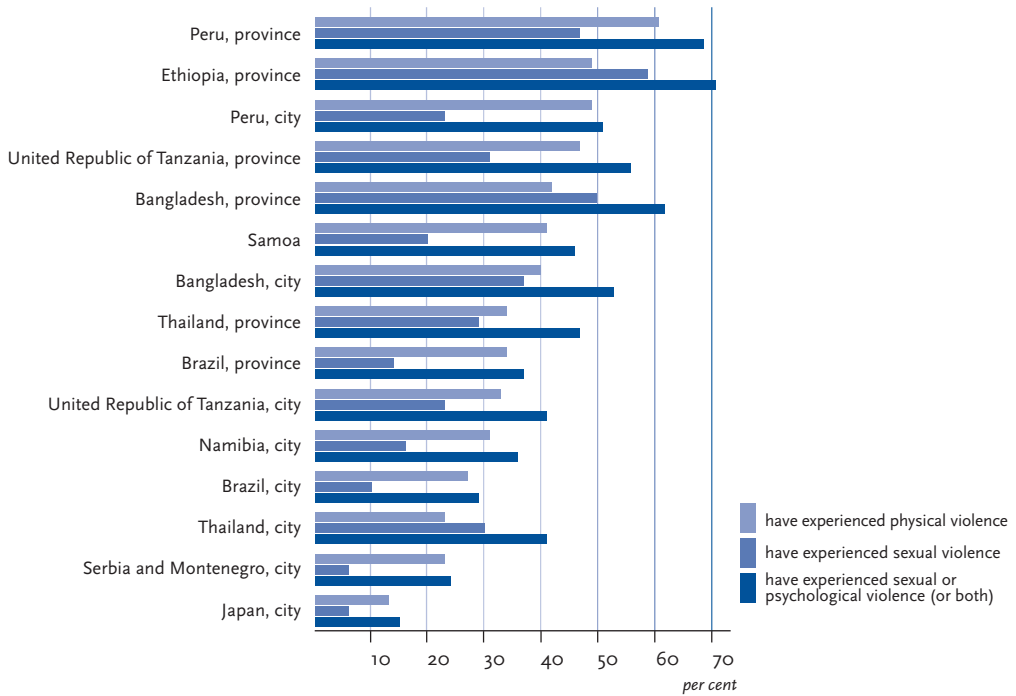
The prevalence of violence in European countries was evaluated in a secondary-analytical, comparative study conducted by the CAHRV research network (cf. [26]). According to the study, between one in three and one in five women in the countries studied – Germany, Sweden, France, Finland and Lithuania – had experienced physical violence from a current and/or former partner during their lifetimes; 6 -12% said they had been victims of sexual violence from current/former partners. 9-23% had experienced physical and 8-19% sexual violence outside partnerships [26].

There are a number of social-science and criminological studies that assess the prevalence of violence against women, men and children in Germany (for an overview, cf. [30, 34, 35, 36, 37]); their findings are briefly summarized below.

On the basis of the first German representative survey to date on violence against women [3], it can

² For an overview of existing European studies on the prevalence of violence, their methodology and the comparability of the data, cf. [11, 26].

Figure 1
Extent of violence against women in various (non-European) countries
according to the findings of the WHO's multi-country study
 Source: [21]



be assumed that about one in four women have experienced physical and/or sexual assaults by an intimate partner at least once in their adult lives. If violent assaults by other perpetrators in the public, semi-public and private spheres are included, as many as 37% of women have experienced physical attacks since their 16th year – ranging from being pushed out of the way to being slapped on the face, kicked, punched and being attacked with a weapon. About two-thirds of the victims spoke of moderate to severe forms of physical violence involving injuries, fear of serious/life-threatening injury, the use of weapons and/or repeated violent situations. 13% of those questioned – i.e. one in seven women living in Germany – had experienced sexual violence in the sense of indictable sexual attacks since age 16, e.g. rape, attempted rape and sexual assault. When other forms of sexualized violence, e.g. severe forms of sexual harassment or unwanted sexual acts, were included, the percentage of female victims of sexual violence rose to 34%. 58% of interviewees mentioned various forms of sexual

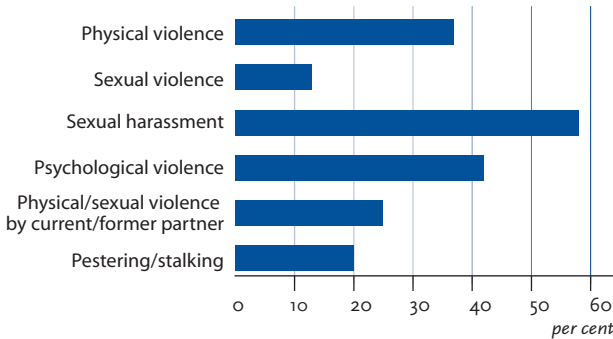
harassment in the public and private sphere and at work. 42% of women had also been exposed to psychological violence during their adult lives, ranging from intimidation to aggressive shouting, slandering, threats, humiliations and psychological terror (cf. Figure 2).

The current state of research suggests a need to qualify the idea that violence against women only happens in precarious social situations. Similarly, in the case of domestic violence there is no simple correlation between education or social class on the one hand and the use of violence, or being the victim of violence, on the other [3]. Experience of violence during childhood and adolescence is one of the main risk factors as regards the development of violence and being prone to violence. In such cases, the incidence of violence is several times higher (cf. [3]).

A secondary analytical evaluation of the data that is currently being conducted on behalf of the BMFSFJ is likely to give further insight into differences in patterns of violence and the severity

Figure 2
Overview of the prevalence of violence against women since age 16

Source: [3]



The figures in the first four categories are based on all the women interviewed (N=10,264); the data on violence in intimate relationships, however, only on women who were currently (or had previously been) in an intimate relationship (N=9,746); the figures on pestering/stalking are based on all the women who completed the written questionnaire (N=9,640). All prevalence data were determined on the basis of a weighted dataset.

of violence in intimate relationships. It will also provide information on the specific risk potential and relevant risk factors in different victim groups, who need specific attention in the context of intervention and prevention.

2.1.3 Extent and forms of violence against children

Most violence against children is perpetrated in the family. Experts use the terms "parental physical violence", "child abuse", "sexual abuse", "child neglect" and "mental or emotional abuse" (cf. [34] on definitions). Another important aspect is psychological and physical violence by and between children and adolescents in the context of school and peer groups (e.g. bullying). In this context, children and adolescents can be both victims and perpetrators of violence [39, 40]. There are no consistent definitions of the different forms of violence against children on either the national or the international level (cf. [11, 34, 41]).

Studies were conducted in Germany in the 1990s to determine the extent of unreported cases ("dark-field studies"); pupils and adults were questioned on physical violence in parental education (cf. e.g. [42, 43]; for an overview, see [34]). In these studies the level of physical violence used by parents and legal guardians against children and adolescents was put at 70 to 80%. Approximately

10-15% of the interviewees had experienced more severe forms which were categorized as physical child abuse (e.g. punching, kicking, choking, beating, scalding, the use of weapons and objects for corporal punishment; cf. [34, 44]). For some time now, there has been an overall decline in the use of physical violence as a tool of parental education. However, this development has not been observed to any comparable extent in the field of child abuse as a severe form of parental violence [43, 45].

It is difficult to determine the extent of child neglect in Germany in view of the large numbers of unreported cases and because it is difficult to operationalize and measure "child neglect". In 2002 the German Society for the Protection of Children (*Deutscher Kinderschutzbund*) estimated the number of cases of serious child neglect at 50,000 at least. Estimates of the number of unreported cases range from 250,000 to 500,000 children and a prevalence of 5-10% [34].

According to a summary of study findings since the 1980s, sexual abuse in Germany is estimated at about 10-18% among girls and 5-7% for boys. When interpreting these data, it is necessary to take into account the heterogeneous definitions of "sexual abuse" and the large numbers of unreported cases (cf. [34, 46, 47]). In the context of sexual abuse it has become clear in the past that violence against children is not restricted to the parent-child relationship or to adult perpetrators, but that acts of violence are frequently committed by child/juve-

nile perpetrators on children and adolescents of the same age.

One aspect that went largely unnoticed for a long time was the role of children who suffered harm because they had witnessed violence between their parents and were also affected by it. According to studies conducted in Germany, between one in seven and one in four of the interviewees had been affected in this indirect way (cf. [3, 29, 47, 48]). Apart from the children's personal physical and psychological risk, the relevance of indirect experience of violence lies in its formative influence on the further development and socialization process (e.g. deteriorating performance at school, anxiety, developmental delay). Studies also point to gender-specific effects which, in the case of girls, increase the risk of their falling victim to partner violence in adulthood themselves [3, 49]. Boys who were forced to witness their father's violence against their mother over a long period have an increased risk of passing on earlier experiences of violence as subsequent perpetrators within their own family or partnership, or some other areas of life [47, 50]; however, an increased risk of victimization in later life is also possible here.

Usually, the described forms of violence against children do not occur in isolation. The majority of the children affected are exposed to different forms and combinations of violence [34].

In the most recent representative National Health Interview and Examination Survey for Children and Adolescents (KiGGS), children and adolescents between the ages of 11 and 17 were questioned on aspects of violence and health for the first time in Germany [39]. About every tenth child said they had experienced "violence"³ over the last 12 months prior to the survey; more than half had been violent themselves [37]. The evaluations of the health consequences of violence were not yet available at the time this booklet was completed.

2.1.4 Extent and forms of violence against men

To date there are no reliable representative data on the prevalence and severity of violence against men in Germany, either in the private sphere or in the immediate social environment, which cover the different forms of violence in detail. Criminological victimization studies, studies on youth vio-

lence, and an initial pilot study by the BMFSFJ on violence against men [38] suggest that victimization by violence is a cross-gender issue which also affects men in different life phases and contexts [51]. Criminological studies conducted in the early 1990s indicate that men in Germany are victims of violence approx. as frequently – and sometimes even more frequently – than women in different life contexts [52, 53]. Younger men and male adolescents in particular are, on the one hand, among the victims most frequently affected by violence in public and during leisure time; on the other they are often perpetrators of violence. Significant contexts of violence are public spheres (e.g. school, on-the-job training, workplace, military service, leisure venues, sports clubs), and a person's circle of friends and acquaintances (youth clique, peer group). According to the findings of the BMFSFJ evaluative pilot study on men's experiences of violence [15], which initially explored the problem area but proved to be non-representative due to the small number of cases covered, 40% of the interviewees stated that they had been exposed to physical violence, 5% to violent sexual attacks, and 58% to psychological violence during their adult lives. The results indicate comparably high levels of exposure to violence among men and women in the case of physical violence; however, men were affected less often by sexual violence and more frequently by psychological violence, largely in the work context. Furthermore, approximately one in four men interviewed in the pilot study stated that they were also exposed to physical attacks in intimate relationships, although these were much less frequent and less severe compared to the greater intensity of violence experienced by women in intimate relationships (cf. [15, 29, 30]).

To sum up, it can be said that both sexes are considerably affected by violence in childhood and adulthood. Whereas in men physical violence plays a special role in childhood, adolescence and

³ The study asks a direct question about the person's experience and practice of "violence", not about specific (objectifiable) actions. As a result, only the subjective component of violence is covered. Actions that are often not subjectively classified as "violence" within the family and the close social environment are not taken into account. Overall, this has probably contributed to an underrepresentation of these violent acts. For information on the methodological standards of research on the prevalence of violence, cf. [23].

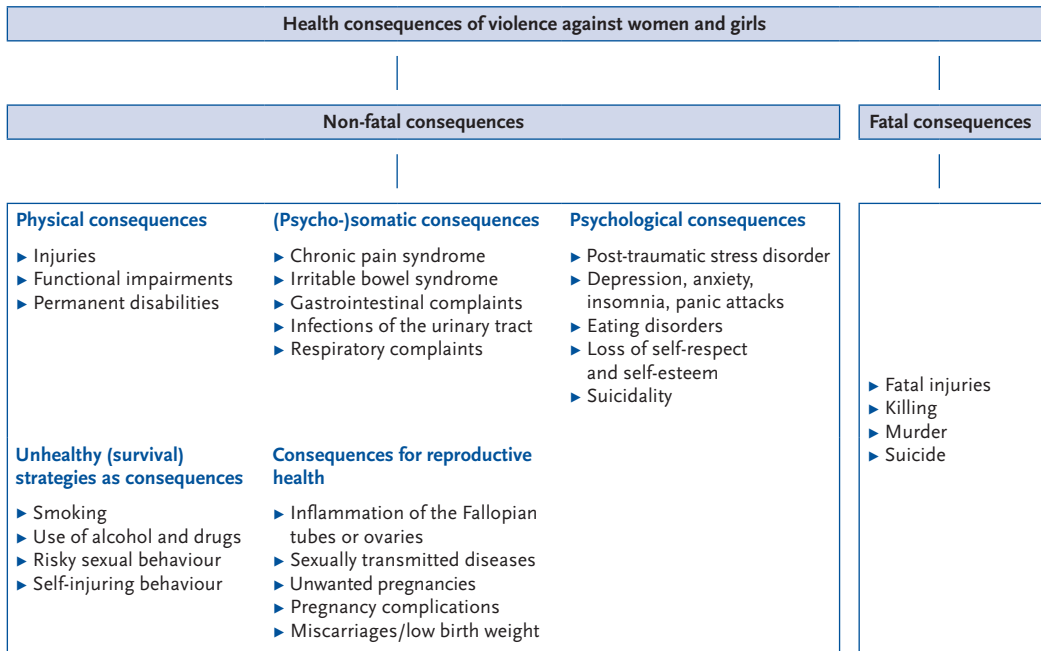
young adulthood, women are, in addition, greatly affected by physical and sexual violence in middle age groups. Significant differences lie in the fact that women experience more severe forms of partner violence and sexual violence more frequently, whereas men and boys are more often exposed to physical violence in the public sphere. Both sexes are exposed to a lot of psychological violence, although a comparison of the sexes will require more profound studies covering different areas of life.

2.2 Health effects of violence – Results of international and German research

Many national and international studies have found a correlation between experiences of violence in childhood and/or during adult life on the one hand, and direct or indirect psychological and health consequences on the other (cf. [6, 18, 19, 54, 55]; cf. also [5, 7, 11, 37, 49, 56]). In particular, early violence in

childhood and cumulative experiences of violence in the course of a person's life can exert a lasting influence on his or her mental and physical health (ibid., also [14, 24, 54, 57, 58, 59, 60]). A distinction is made in the portrayal of the consequences of violence between short-, medium- and long-term impairments. Direct effects initially result from the acute injuries and from the direct psychological and psychosocial problems resulting from violence: e.g. feelings of anxiety and being threatened, mental stress, difficulties with performance and concentration, increased consumption of alcohol and (prescription) drugs. Furthermore, research describes somatic, psychosomatic and psychological symptoms as medium- and long-term health consequences of physical, sexual and psychological violence (cf. [11, 23, 29] on the methodology of recording health consequences in research on violence prevalence and health). The following table shows a compilation of the health consequences of violence against women and girls according to this system (Figure 3).

Figure 3
Systematizing the health consequences of violence
Source: [131]



Since a person's physical and mental health is influenced not only by the violent events themselves, but also by his or her individual assessment and processing of these experiences, the complex multifactorial cause-and-effect relations of health consequences and their interactions with violence are difficult to measure empirically. In addition, the possible interactions between health impairment, increased vulnerability and exposure to violence, as well as social problems following violent experiences (e.g. isolation, poverty) have not yet been scientifically investigated. Available, empirically confirmed findings relate essentially to the health consequences of violence against women and/or girls. Most of these were generated in prevalence studies by means of two methodological approaches:

- ▶ Interviewing victims of violence about their direct injuries, psychological and psychosocial impairments resulting from specific violent incidents or violent situations;
- ▶ Comparing the current state of health of victims and non-victims with regard to their current physical and psychological symptoms, health-related behaviour and aspects of medical healthcare.

Both approaches have provided information on a variety of health consequences of violence in the past (see *inter alia* [3, 5, 6, 11, 18, 23, 54]).

2.2.1 After-effects of injuries

According to the findings of the German study on the prevalence of violence [3], about half (55%) of the victims of physical violence and over two fifths (44%) of the victims of sexual violence stated that they had suffered varying degrees of injuries. Overall, about one in five women living in Germany between the ages of 16 and 85 have suffered physical injuries as a result of violence at least once in their adult lives. The injuries specified included haematomas, sprains, fractures, head and facial injuries, and injuries in the genital area. In about a third of the women who suffered injuries, these were so severe that medical assistance was needed. The women reported injuries more frequently in cases where the partner or ex-partner was named

as the perpetrator (64%) than in the case of other known or unknown perpetrators. These results are consistent with the findings of other European studies, according to which at least 60 to 70% of female victims of physical and/or sexual partner violence were confronted with direct physical injuries and impairments. Moreover, partner violence involved multiple violent assaults more frequently, while one-off acts were rarer (cf. also the secondary analytical comparative evaluations in [26]).

In the German study on the prevalence of violence, the majority of women who had been injured by physical and/or sexual violence perpetrated by an (ex-)partner reported haematomas/contusions (89%), followed by body pain (26%), open wounds (20%), abdominal pain (18%), sprains/pulled muscles or ligaments (18%), head (18%) and/or vaginal injuries (10%), concussion (10%), fractures on the body (5%), miscarriages (4%) and internal injuries (3%) [3]. By contrast, interviews with patients in emergency clinics identified (as expected) an even higher proportion of serious injuries such as head injuries and broken bones [29, 61].

According to the results of national and international studies conducted up to now, the extent and severity of injuries experienced by men as victims of violence in (heterosexual) partner relationships is significantly lower [15, 29, 30, 62, 63]. However, criminological, sociological and youth studies suggest that younger men and male adolescents in particular are often exposed to violent same-sex assaults with severe bodily injuries in the public sphere – but also in school, vocational training, military service and leisure activities – (cf. [15, 52, 64]).

In Germany, no representative quantitative data exist on the extent of physical injuries resulting from child abuse, partially due to the high number of unreported cases [56]. After-effects of injuries caused by parental violence against children, child abuse or sexual abuse become visible in particular in paediatricians' practices, hospital casualty departments, children's and youth welfare services, as well as in educational and child-care institutions (kindergartens/schools). Approx. 40-60% of cases of physical abuse reported to the youth welfare systems of various *Länder* involved injuries; 4-6% of the cases were so serious that medical treatment was given [56]. The most frequently reported injuries were haematomas and

scratches; in addition, more serious injuries such as lacerations, fractures, burns/scalds, shaken baby syndrome and internal bleeding also played a role [56]. Information and advanced training on diagnosing and assessing signs of child abuse are essential, since injuries and deaths among children caused by violence are often not recognized (early enough) in the medical sector or by the children's and youth welfare services [65, 66].

2.2.2 Somatic and psychosomatic after-effects

The specific multifactorial cause-and-effect relationships between the somatic and psychosomatic consequences of violence are difficult to measure empirically. As yet, little systematic knowledge is available on interactions and cumulative processes, e.g. caused by different forms of violence, later problems caused by violence, and other impacting factors. However, available studies do provide evidence of a significant statistical relationship between experiences of violence and physical symptoms. Accordingly, experiences of violence mean a high psychosocial stress factor which is closely associated with the extent of violence suffered, persists after the end of the violent situation, and can furthermore (part-) cause psychosomatic complaints.

International research findings point to associations of experiences of violence in childhood and adulthood with various pain syndromes, gastrointestinal symptoms, cardiovascular complaints, gynaecological and cerebral complaints and skin diseases [3, 7, 9, 12, 13, 14, 21, 24, 54, 55, 60, 67, 68, 69, 70, 71, 72]. According to a large, representative survey conducted in the USA, the likelihood of a gynaecological complaint was considerably higher among abused women than in the control group [72]. Gynaecological problems constituted the most distinct and pronounced difference in somatic health between abused and non-abused women [18].

A secondary analytical evaluation of the German representative study on violence against women [5] provides evidence of a highly significant association between exposure to violence during the interviewees' lives and their health situation. Women who had been exposed to physical attacks and/or sexual or psychological violence since their 16th

year consistently rated their own state of health more negatively than non-victims. They also had considerably more physical and psychological symptoms (e.g. headaches, stomach aches, gastrointestinal problems, trembling, nervousness, dizziness, breathing problems, blood-pressure fluctuations, abdominal pains or other gynaecological complaints). A significant increase in health problems became visible against the background of cumulative experiences of violence in the course of a person's life (e.g. abuse in childhood, partner violence later). Comparable, somatic complaints and pain syndromes causally related to experiences of violence were observed in a survey of female patients conducted by the Berlin S.I.G.N.A.L. monitoring project (chapter 6.1) [29, 61]. Furthermore, patient surveys revealed significant correlations between physical violence and functional heart problems and asthma (cf. [73]).

Table 1, which is based on the data from the German study on the prevalence of violence, shows that all forms of violence are associated with significantly greater health problems and psychological stress for women.

2.2.3 Subsequent psychological problems

Many psychological complaints and symptoms are described in international research which are associated with experiences of violence in childhood and adult life. In the case of violence against women, these mainly include depression, stress symptoms, anxiety disorders, post-traumatic stress disorder (PTSD), eating disorders and suicidality [1, 3, 7, 8, 9, 12, 18, 55, 57, 59, 60, 68, 72, 74, 75, 76, 77, 78]. In addition, impairments in cognitive and emotional development were observed in connection with violence against children [34, 41, 47, 79, 80, 81, 82, 83, 84, 85].

The term rape trauma syndrome [86] was coined as early as the 1970s; it describes reactions such as insomnia, nausea, jumpiness, nightmares and states of insensitivity and numbness as a result of sexualized violence. Here, too, it is important to distinguish between short-term and longer-term, in some cases delayed stress symptoms. The broad spectrum of possible psychological and psychosocial consequences of violence reflect the findings from the German study on the prevalence of vio-

Table 1
Women's experience of violence and their current health as measured by the number of psychological and physical complaints over the last 12 months
 Source: [3]

	More than 11 physical complaints over the last 12 months	More than 7 psychological complaints over the last 12 months
Experienced physical violence since 16th year?		
Yes	46.4%	63.1%
No	24.3%	35.9%
Experienced sexual violence since 16th year?		
Yes	54.7%	71.8%
No	29.4%	42.3%
Physical or sexual violence by (ex-)partner?		
Yes	48.2%	65.2%
No	28.0%	40.2%
Experienced sexual harassment?		
Yes	40.7%	58.0%
No	20.8%	28.7%
Experienced psychological violence?		
Yes	45.8%	64.8%
No	22.9%	32.3%

lence [3] and are in line with other European studies [11, 26]. In connection with the psychological, physical and sexual violence experienced by the women concerned, they mentioned the following direct consequences of different forms of violence: dejection/depression (36-46%), insomnia/nightmares (27-33%), constant brooding (50-69%), reduced self-esteem (36-55%), increased anxiety (18-24%), problems dealing with men or difficulties with social relationships (13-34%), and lack of motivation/concentration (11-26%). 7-9% of the female victims mentioned eating disorders, 6-9% had considered suicide.

Significant correlations were also found between current psychological complaints and various forms of violence in childhood and adult life. Especially striking was a marked increase in the number of women with stress symptoms (nervousness, tension and irritability), memory disturbances and concentration difficulties, weakness, tiredness, insomnia, lack of motivation, depression, anxiety/panic attacks, suicidal thoughts and problems with self-esteem [5]. Adverse effects on health and psychological complaints can be caused not only by acute situations of violence, but also by

earlier experiences of violence. The study revealed high levels of psychological stress among women who had been affected in both childhood and adulthood not only to physical violence but also to sexual and/or psychological violence [5]. These findings underline the relevance of cumulative experiences of violence of varying intensities and confirm associations between the severity or frequency of the violence experienced and the extent of the psychological complaints. In line with other findings of national and international studies on the psychological consequences of child abuse and child neglect, a close association emerges between experiences of violence in childhood (and in adult life) and disturbed social behaviour, depressive disorders, post-traumatic stress disorders and a generally high level of psychiatric disorder (for an overview, cf. [56, 85]). This underlines the importance of timely interventions to counter secondary traumatizations and to enable the victim to individually process the psychological effects in addition to having the physical health complaints treated.

Further studies should be directed towards improving our understanding of the associations

between these different psychological, somatic and psychosomatic (after-) effects and different forms of violence, as well as their interactions with other conditions that can improve or adversely affect health. This could make it possible to deduce further opportunities for prevention, as well as for medical (and psychotherapeutic) diagnosis and treatment.

2.2.4 Unhealthy survival and coping strategies

Unhealthy survival and coping strategies after experiences of violence include the consumption of alcohol, drugs and psychotropic medication [1, 3, 18, 29, 175]. Further modes of behaviour known to be injurious to health include high levels of tobacco consumption, a lack of physical exercise, staying at home, social isolation, auto-aggressive behaviour (e.g. skin cutting) and promiscuity in conjunction with unprotected sexual intercourse (ibid.). According to the analyses of the German study on the prevalence of violence [3], victims of violence consume tobacco and alcohol signifi-

cantly more frequently and in greater amounts; the higher level of tobacco consumption is especially striking (cf. Table 2). Women who had been victims of violence were two to three times more likely than non-victims to smoke at least ten cigarettes a day. The study also stated that many female victims consumed alcohol, drugs and psychotropic medication in an attempt to cope with the psychological stress.

Furthermore, women who had been victims of violence were much less likely to engage in outdoor sports activities than non-victims. Those who had experienced violence in childhood and/or during adult life were more socially isolated and spoke more frequently of deficits and problems in their social relationships [5], whereby the latter problems could be both a cause and a consequence of (continued) violence. Hence, victims of domestic violence were often controlled by violent partners in their external contacts and isolated by them. The study's secondary analytical evaluations showed, furthermore, that social isolation was strongly associated with a poorer state of health on the part of the interviewees.

Table 2
Women's experience of violence and their current daily consumption of alcohol/tobacco
Source: [3]

	Alcohol consumption daily/almost daily	Smoking more than 10 cigarettes a day
Experienced physical violence since 16th year?		
Yes	8.9%	25.0%
No	6.0%	10.8%
Experienced sexual violence since 16th year?		
Yes	9.5%	27.5%
No	6.7%	14.3%
Physical or sexual violence by (ex-)partner?		
Yes	9.2%	29.3%
No	6.7%	11.8%
Experienced sexual harassment?		
Yes	7.8%	19.1%
No	6.0%	11.7%
Experienced psychological violence?		
Yes	8.1%	22.1%
No	6.3%	11.6%

2.2.5 Effects on reproductive health

Pregnancy and motherhood represent a significant turning point in life, and not only for women. They also create new challenges for an intimate relationship and make various adjustments necessary. That this is an especially dangerous and vulnerable life phase and a time of change for women is shown by the fact that violence frequently occurs for the first time in intimate relationships in the context of pregnancy and the birth of a first child [3, 87]. According to a special evaluation of the German study on the prevalence of violence [3], 23% of the women who answered questions on violence in their last violent intimate relationship (N = 784) reported that violence had occurred for the first time in the context of pregnancy and/or the birth of their child(ren). Even though this is not a finding that can be generalized (because of the high default rates and selectivity in answering the question), the results indicate a strong correlation between pregnancy/childbirth and the occurrence of violence in intimate relationships.

Both psychological stress from past and current experiences of violence and the after-effects

of acute violence-related injuries can cause significant complications in pregnancy and childbirth.

In the German study on the prevalence of violence, women who had been victims of violence mentioned abdominal or gynaecological complaints significantly more often than women who had not experienced violence. On average, complications in pregnancy and childbirth were mentioned by victims about 50% more frequently and pelvic operations about 20% more frequently (cf. Table 3).

Surveys of female patients in the health sector show that miscarriages and premature births, abortions and menstrual disorders were mentioned more often by women victims of violence – in some cases as a direct result of the violence [29, 61, 73]. Pregnancy complications caused by violence have also been evidenced by international research findings [1, 88].

Proportionally, female violence victims tend to take part in preventive measures such as pregnancy screening to a lesser extent and later than non-victims. This might correlate with negative effects on the un-/newborn child, premature births and miscarriages, as well as a lower birth weight. In

Table 3
Women's experience of violence and reproductive health as evidenced by pelvic surgery and complications during pregnancy and childbirth
 Source: [3]

	Complications during pregnancy/childbirth	pelvic surgery
Experienced physical violence since 16th year?		
Yes	27.0%	28.5%
No	19.0%	23.8%
Experienced sexual violence since 16th year?		
Yes	31.4%	33.1%
No	20.7%	24.5%
Physical or sexual violence by (ex-)partner?		
Yes	29.8%	30.9%
No	20.9%	25.3%
Experienced sexual harassment?		
Yes	25.1%	26.9%
No	17.5%	23.6%
Experienced psychological violence?		
Yes	26.7%	27.2%
No	18.6%	24.3%

addition, an association has been proven between domestic violence and postnatal depression, pregnancy depression and post-traumatic stress disorders [89].

2.3 Especially vulnerable groups and risky life situations

As regards groups of the population who are exposed to violence more frequently than others, women and children are especially vulnerable to domestic violence, women and children to sexualized violence, and boys and male adolescents to violence among peer groups and in the public sphere. Domestic violence against women occurs in all social strata, and, despite common views to the contrary, the assumption that the perpetrators or families in which violence takes place are likely to be socially conspicuous is rarely confirmed in practice. Even so, there are complex constellations of problems, special life situations and phases of radical change in a person's life which can potentially increase his or her vulnerability to violent experiences and make it more difficult to stop (continued) violence. These include pregnancy and maternity, disability, illness, old age, uncertain residence or minority status, integration in families with traditional, patriarchal structures, situations of socio-economic deprivation related to disadvantaged living and working conditions, and living in institutions involving specific dependencies (e.g. prison, the army/military, nursing and care institutions). Apart from the severity of the attacks, the possible spectrum and extent of the effects of violence on health are essentially influenced by whether:

- ▶ violence is used systematically and/or cumulatively over a longer period;
- ▶ the victims and perpetrators of violence are in a close social and/or emotional relationship, or linked with each other by a dependency relationship (e.g. family and intimate relationships). Such conditions make it considerably more difficult to put an end to the violent situation. Moreover, attempts to resist or escape can be severely limited, for example by psychological and/or physical limitations (if the victim is disabled or needs nursing care) or by situational

circumstances (e.g. financial dependence, loss of residence permit).

It would be beyond the scope of this booklet to examine these vulnerable victim groups (which need to be further differentiated) and their specific life situations in greater depth. The particular vulnerability of women with disabilities and women with a migration background will therefore be taken up here to exemplify the aspects described above.

2.3.1 Violence in the context of migration and refugees

Women and men with a migration background represent a very heterogeneous group. Irrespective of the nationality of both the first and subsequent generations of foreign workers, the group includes immigrants of German origin from Eastern Europe and other naturalized citizens, the children of bi-national relationships, asylum seekers, (war) refugees, and foreign workers with no legal residence status. People with a migration background differ not only in terms of their residence status and, for example, related legal entitlements to healthcare [90, 91], but also in relation to aspects of their life situation and social situation.

Whereas findings on links between migration and health are available from national and international studies (cf. [90, 92, 93, 94]), the association between (domestic) violence, migration and health has so far only been taken up and systematically examined by a few studies. Up to now, studies point to a connection between migration background and health on the one hand (cf. also [5, 90, 92, 94]), and between a migration background and violence on the other [5, 11, 95, 96]. According to the findings of the German study on the prevalence of violence, women with a Turkish migration background were more exposed to severe, partnership-related physical and/or sexual violence leading to injuries than Eastern European immigrants or German women (without a migration background) [3, 5]. Both groups of immigrant women experienced psychological violence and discrimination in the public sphere much more frequently than non-immigrants [5]. Furthermore, a non-representative survey of female asylum

seekers⁴ in the above-mentioned study by Schröttle and Müller [3] came to the conclusion that they were more gravely affected by violence in different areas of life than any other group questioned. In their case, exposure to violence was not concentrated on marriage and partnership, but also included many forms of psychological, physical and sexualized attacks by unknown individuals in the public sphere, by fellow residents of hostels and transitional homes, and by staff and carers in government offices, schools, authorities and aid organizations [3]. Overall, asylum seekers can also be expected to have experienced violence and traumatization in the context of war, persecution and flight more often in their countries of origin, so that the prevalence of post-traumatic stress disorder will be correspondingly high [97, 98]. Since there are few effective support opportunities for protecting asylum-seeking women, men and children in Germany who live in extreme situations of dependence from further or renewed violence and retraumatization, the situation of such victims must be regarded as especially problematic. Another group of people who are particularly at risk from physical and sexual violence are immigrant women who work as prostitutes and have no legal right of residence in Germany [99, 100].

However, domestic violence is not a migration-specific problem, nor is it limited to certain ethnic or religious groups. The greater exposure of immigrant women to violence cannot be satisfactorily explained by the common assumption – and to some extent fact – that violence against women is regarded as legitimate in certain cultural and religious contexts (e.g. among Moslem population groups). Rather, it can be assumed that violence is made more likely by risk factors such as the cumulative strain of minority status, uncertain residence status, lack of integration, financial problems, unemployment, cramped housing conditions, high residential density, loss or inconsistency of men's status, and a lack of social networks [96, 99, 101, 102, 103, 104]. The linkage between immigrant women's residence status and their husbands' right of residence, which is enshrined in the German Residence Act,⁵ tends to foster violent and stressful dependency relationships and the potential abuse of power [105, 106]. In addition, existing financial/material dependencies make it difficult to escape from violent relationships (cf.

[99, 107, 108]). This applies especially to female immigrants who entered the country illegally or were smuggled in, and to women with no independent residence status. In the context of forced prostitution and also forced marriage, they must be regarded as especially vulnerable to violence.

To date, the possible aggravation of violent experiences and health risks both before and during the migration process by additional structural, societal discrimination and violent assaults at home and in public places in the country of immigration has hardly been examined in detail. Special attention should be paid in this context to the group of ageing immigrant women of the so-called first generation of immigrants, who are more exposed than many to health and psychological strain [5]. In certain circumstances, a lack of sensitivity for potential experiences of violence and discrimination in the lives of (elderly) immigrant women – e.g. in the entire field of medical, psychiatric and psychosocial care or nursing homes for the elderly – can contribute to retraumatizations and a wide range of psychological and health after-effects. In order to give the victims support and healthcare that is in line with their needs, more importance will have to be attached to these aspects in research and practice in the future. According to a special evaluation of the German study on the prevalence

4 In der Teilpopulationen-Befragung von Schröttle und Un- like the legal definition, the concept of "asylum seekers" used in the survey of subpopulation groups by Schröttle and Müller ([3]), and also adopted here, comprises all women, "(...) who have applied for asylum, have been recognized as entitled to political asylum, or have a (temporary) residence permit or right of residence." This also includes female refugees "(...) who enjoy the protection of special regulations because they cannot reasonably be expected to return to their country (e.g. after their asylum application has been refused), for example due to civil war, religious persecution or life-threatening discrimination" ([3] subpopulation groups – survey of female refugees, p. 4).

5 According to the German Residence Act (AufentG section 31 subsection 2), women who have not been living legally with their husbands in Germany for over two years are threatened with deportation if they separate from their husbands. The Residence Act only allows exceptions in cases of particular hardship. Under the existing regulation, physical, sexual or psychological violence within marriage can constitute a special hardship. However, in principle this remains a matter for individual case analysis and is generally not enforced in legal practice, according to women's refuges and counselling centres (situation in autumn/winter 2007).

of violence, the poorer health situation of some Turkish female immigrants is not predominantly due to their being more exposed to violence, but should be seen primarily in the context of societal discrimination, difficult social situations, and poor vocational and social integration. In our context, exposure to violence, which can have a significantly negative influence on women's health irrespective of the interviewees' ethnic background, is only one additional stress factor among many problematic elements of their living conditions [5].

2.3.2 Violence against people with disabilities⁶

Violence in the context of disability was a taboo subject for a long time, and the public has only recently become aware of its individual and overall societal relevance (cf. also the Federal Government's Action Plan II to Combat Violence against Women [109]). People with disabilities do not form a homogeneous group, but live in very different situations; the degree by which they are restricted in their daily lives by disabilities and chronic diseases varies a great deal. Many are especially vulnerable to violence because their lives are determined by others in various areas depending on their impairments and functional limitations. This applies primarily to people who live in institutions or are highly dependent on nursing care. Violence against people with disabilities largely occurs secretly within the close family circle and in care and support institutions for the disabled [10] and the elderly. As a rule they are extremely dependent on potential perpetrators.

There are no national representative studies on the prevalence and health consequences of violence targeting women, men and children with different disabilities, and only a few at the international level. They are hardly comparable because of their different methodologies.⁷ In general the studies point to an increased exposure to violence among people with disabilities, particularly in the fields of psychological discrimination, psychological violence and sexual violence [11, 12, 13, 14, 15, 16]. The everyday lives of women and men with disabilities are often characterized by discriminatory and stigmatizing experiences. A recent British study by the Women's Aid Federation of England said the situation of many women with disabilities was

especially stressful and characterized by extreme dependencies, and that this fostered particularly grave forms and manifestations of psychological, physical and sexual violence in the home and nursing/care context and made it extremely difficult for people to seek help/assistance and put an stop to the situation. The comprehensive study, which surveyed women who had been victims of violence as well as different professional groups working in psychosocial support systems, contains numerous recommendations on preventing violence and improving support for women with disabilities who have been exposed to violence [176]. In a German study on the life situation of women with disabilities [12], two thirds of women with physical and sensory disabilities stated that they had experienced discrimination. This implies a special form of psychological violence whose possible effects on physical and psychological health has not been systematically integrated into research on violence and health up to now. According to the findings of the German study on the prevalence of violence [3], women with chronic illnesses and physical disabilities were significantly more exposed to violence than the able-bodied: 50% had experienced physical attacks, 21% sexual violence, and 56% psychological violence in various areas of their lives since their 16th year (unpublished special evaluations, 2007). Although proof of the differences is not

⁶There are different definitions of disability. According to section 2 of Book IX (1) of the German Social Security Code [SGB] people are defined as disabled, "if their bodily function, intellectual ability or mental health in all probability deviates from the condition that would be typical of their age by more than six months, so that their participation in the life of society is adversely affected" [174]. The World Health Organization's definition of disability distinguishes between three concepts, according to which permanent damage to health can be caused by an illness, congenital impairment or an accident. This damage to health leads to a functional impairment of the abilities and activities of the person concerned. The social impairment (handicap) is a consequence of the damage and manifests itself in personal, family and societal consequences. The causality of disability is today interpreted as being from impairment to disability to handicap (for information on the definition of disability cf. also RKI, GBE glossary, keywords "disability" and "ICIDH").

⁷A comparison of the studies is problematic because of differences between the questions asked, the definitions of violence used, the samples, the examined periods of the violent experience and, not least, the inclusion criteria for people with disabilities.

statistically significant because of the small sample size, and although the methodology and access methods used made it impossible for the study to reach certain relevant groups of women with disabilities, the results nevertheless give an initial indication that – in Germany, too – women with disabilities and chronic illnesses are more exposed to all forms of violence than other groups of the population. In this context it should be borne in mind that physical and psychological disabilities and illnesses can also be a consequence of earlier experiences of violence (e.g. in childhood) [112].

Although there are, as yet, no comprehensive statistics on sexual violence against women, men and children with disabilities, partly because of the high number of unreported cases, it can be assumed on the basis of the state of research that there is a high degree of sexualized violence, especially in institutions [112, 113, 117]. In recent years attention has become increasingly focused on the extent and consequences of sexualized violence against people with intellectual disabilities.⁸ A research project funded by the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth (BMFSFJ) on how sexual self-determination and sexual violence are handled in residential institutions for young people with intellectual disabilities (2001-2004) showed that a lack of self-esteem and a limited ability for self-assertion increased the risk of becoming a victim of sexualized violence. For example, residents' defence against sexualized attacks frequently failed from the outset because they were unable to understand that a borderline was being crossed and they were, in fact, being attacked [177]. According to a nationwide survey [118], 50% of interviewed staff at various care institutions for the disabled had heard of cases of sexualized violence within their own institutions. According to this study, girls and women with intellectual disabilities were sexually abused three to four times more frequently than boys and men with corresponding impairments. Furthermore, there are also indications from other studies that girls and women with intellectual disabilities tended to experience more severe forms of sexualized violence (e.g. rape) than intellectually disabled boys and men [117]. In the case of sexualized violence in particular, potential perpetrators often come from the immediate environment, e.g. family members, assistants and attending medical

staff in care institutions, but can sometime also be other residents [112, 117]. Exposing and ending violent assaults can be much more difficult under such circumstances.

Disabled people seem to react to (sexualized) violence with similar health consequences as non-disabled people [117]: traumatic stress reactions [112], depression, anxiety disorders, mental disorders and behavioural syndromes [120, 121]. Auto-aggression and aggression towards others, eating disorders, and nonspecific behavioural syndromes can be indicators of violent experiences among victims with (learning) disabilities [113]. There is evidence of gender-specific differences between women and men with learning or intellectual disabilities. Whereas auto-aggressive modes of behaviour occur more frequently in women, men tend towards a more extroverted form of aggression [116]. When people have a disability, such symptoms are often (mis-)interpreted by professionals as disability-specific, so that the background of violence remains undiscovered [4]. To compound matters further, women and men with extensive cognitive, social and emotional limitations are often insufficiently informed about the risk of borderline, sexualized attacks, e.g. in the nursing context. Lack of knowledge about sexuality and a lack of conscious experience in dealing with their own bodies and their own sexuality represent key barriers to becoming explicitly aware of – and naming – violent experiences. Moreover, the credibility of the victims is frequently called into question because of their disability [116, 117]. To date, however, few studies have been conducted which systematically examine the health consequences in general, and the psychological consequences in particular, of different forms of violence and discrimination towards women, men and children with disabilities [120]. In the coming years the

⁸ More and more people and organizations have recently stopped using the term "intellectual disabilities"; disabled people's initiatives, as well as some academics and politicians, regard it as (too) vague, (too) focused on deficits and in some case discriminatory (cf. [119]; cf. also [115, 118], People First Network Germany, <http://www.people1.de/>). Since the recommended alternative (or recently used) terms "learning disability" and "learning difficulties" have been defined differently in research up to now, this report continues to use the term "intellectual disability" as used in earlier studies, in order not to distort the contents of the study findings referred to.

BMFSFJ plans a nationwide, differentiated survey on the prevalence and health consequences of violence and the need for intervention and support among disabled women (cf. [109]).

3 Health-economic and long-term societal costs of violence

National and international studies indicate that violence not only has individual and social consequences, but also causes considerable costs to society as a whole (societal costs) [122,123] (for an overview, see 29,106]). Among other areas, these long-term costs affect the social sector (e.g. children's and youth welfare, support services for victims of violence), the judiciary (e.g. law enforcement), the whole area of gainful employment (e.g. inability to work, early retirement [124]), and particularly the healthcare system.⁹ The main costs to the medical sector (e.g. casualty units, general and specialist practices, hospitals) relate to the primary treatment of acute injuries, psychosomatic complaints, sexually transmitted diseases, psychological counselling and therapeutic treatment (psychotherapy/psychiatry). Furthermore, expenditure on drugs, repeated outpatient and inpatient rehabilitation measures and long-term-care needs (e.g. due to pregnancy complications or birth defects) have to be taken into account (for information on the determination and systematization of the costs of violence to the health service, cf. the WHO manual [125] and [29,106]).

Countries like Finland and Switzerland quantify the costs to their national health services caused by violence against women at between €50 million and more than €260 million per annum [106,122,126]. Long-term societal costs are much higher – up to billions of euros at the national level – if further costs are taken into account, e.g. for the police, courts, prisons, income support, victim assistance, refuge accommodation, as well as for loss of labour and underperformance (cf. [29,106]). A cost study on the consequences of domestic violence in England and Wales arrived at an annual sum of €34 billion, almost €2 billion of which was incurred by the health sector alone [123]. When the costs determined in the studies are related to the respective country's population, the annual cost of violence against women is between

€9 and €555 per inhabitant [29,106]. See Table 4 for an overview of international studies on the economic costs of violence.

As yet there are no comparable national data for Germany on the long-term costs of violence. Since the scale of violence in Germany can be assumed to be similar [26], the economic dimensions of violence can be expected to be considerable here, too. If, in line with the Finnish study, it is assumed that a large proportion of total costs affect the health sector, then combating and preventing violence is also an economic factor for the health service that cannot be underestimated. To this extent, supporting victims at an early stage and developing measures to prevent violence is not only a humanitarian and social, but also an economic necessity. In the long term they can help reduce the considerable individual and societal consequences and long-term costs of violence.

4 Healthcare needs and demands on professional groups in the health service

The following sections examine healthcare needs, the role of the professional groups involved in healthcare, intervention measures and examples of good practice. The focus lies on domestic and sexualized violence. The main sources of data here are an expert report on care needs and the demands made on healthcare professionals¹⁰ [4], the scientific work carried out to accompany the S.I.G.N.A.L. intervention programme [131], and international studies compiled and processed by the European CAHRV network.¹¹

⁹ For an overview on this see the Stocktaking Study compiled by Hagemann-White [106] for the Council of Europe, the report by Waters [127] submitted by the WHO, and [29].

¹⁰ The terms "healthcare professionals" and "health professionals" are used here and throughout this report to denote all professional groups in the health sector.

¹¹ The Coordination Action on Human Rights Injuries (CAHRV) is an EU research network set up by over 100 researchers to exchange national and international research findings on interpersonal violence, intervention and prevention; see also www.cahrvi.uni-osnabrueck.de.

Table 4

International studies on the socio-economic costs of violence

Source: [130], quoted in: [29]

Country/study		Sum in € per year*	Cost type/Areas
England/Wales* (Walby 2004 [123])	Domestic violence (physical, sexual, psych.) between current partners, both women and men	€33.1 billion	direct and indirect costs: police, courts, prisons, healthcare, income support, victim assistance and refuge facilities, loss of productivity, wages, human and emotional effects
		incl. €2 billion	direct costs: health sector
USA (NCIPC 2003 [128])		incl. €3.4 billion	direct costs: health sector
		incl. €1.5 billion	indirect costs: loss of productivity, wages, etc.
Andalusia/Spain (Institute for Women of Andalusia 2003 [129])	Violence against women	€2.4 billion	direct and indirect costs: health sector, victim assistance and refuge facilities, police, courts, prisons, loss of productivity, wages, individual emotional burdens
Finland (Piispa, Heiskanen 2001 [122])	Violence against women, especially by the (ex-)partner	€50 million	direct costs: police, courts, prisons, healthcare, income support, victim assistance and refuge facilities
		incl. €6.80 million	direct costs: health sector (total)
		of which €2.57 million	▶ outpatient care
		€0.77 million	▶ inpatient care
	excl. €3.50 million	▶ medication	
		€61–112 million	indirect costs: loss of productivity, wages, etc.
Switzerland (Godenzi, Yodanis 1998 [178])	Violence against women (physical, sexual, psych.) by (ex-)partner	€260 million	direct costs: police, courts, prisons, healthcare, income support, victim assistance and refuge facilities
Netherlands (Korf et al. 1997 [179])	Violence against women (physical (& psych.) violence threatened or used by the (ex-)partner)	€151 million	direct and indirect costs: medical and psychosocial care, police and judicial prosecution, loss of labour productivity, cost of early retirement, etc.

* Amounts are approximate due to the need to allow for currency conversion

4.1 The key position of the health service in violence prevention and intervention

Following the successful establishment of specialized projects to protect and assist girls and women who have been victims of violence, the public discussion in the Federal Republic has primarily concentrated on the question of how to improve the quality of services provided by the social services, child protection agencies, the police and the judiciary, and make them more effective in the context of violence. The Federal Government's first Action Plan to Combat Violence against Women, passed in 1999, adopted a global approach; up to 2004 this involved supporting intervention projects against domestic violence, among others. Models for cooperation between institutions and in local authorities were developed, and ideas on earlier and more effec-

tive intervention were successfully tested with the aim of reducing levels of violence (cf. [132, 133]). There was a considerable delay before health-related issues were integrated and the health service was activated in Germany. Programmes have become established abroad aiming to make physicians and nursing staff more aware of violence as a health risk; they have proved convincingly how well female victims can be reached by the health system and how this also improves the chances of a referring them to specialist counselling and support services. With only a fraction of sexual-assault and domestic-violence cases being reported to the police and thus becoming officially known, the chances of recognizing symptoms as consequences of violence during routine medical examinations is several times greater [3], because:

- ▶ Healthcare institutions are used by all population groups, irrespective of their social position, gender or age;
- ▶ the medical remit includes determining the causes of and factors affecting injuries, complaints and illnesses, and this includes the consideration of social factors as causes of health complaints;
- ▶ healthcare professionals are bound by an obligation to observe confidentiality¹² and enjoy a high level of confidence among the population. They are frequently asked for advice by female patients in various problem situations [3, 134, 173].

The findings of various national and international studies highlight the key role of the health system in identifying the consequences of violence and, for example, in referring victims to specialized support institutions. Because it has the institutional facilities to do the job – as well as an interest in avoiding lengthy and cost-intensive treatments – the health service is both predestined and qualified for the task of taking preventive action and intervening to overcome the effects of violence in the context of medical treatment [4]. Physicians, nursing staff and other health professionals are often the first people to be confronted with the consequences of domestic violence; in many cases they remain the only people to whom female victims of violence can turn. Both the German representative study on violence against women and the survey of female patients conducted in the course of the research accompanying the S.I.G.N.A.L. programme showed that women were most likely to turn to a health-service institution in their search for help within the professional system. Physicians were named as the first contacts; women's counselling centres and refuge facilities came second, the police third [3]. The S.I.G.N.A.L. survey of female patients also showed that 67% of the women interviewed would first go to a physician if they were victims of violence [131].

The Federal Government's Second Action Plan to Combat Violence against Women, passed in 2007, was a response to the urgent questions and challenges that arose from both practical experience and the findings of the available scientific studies in Germany. This plan states that the provision of optimum medical care for female victims

and ease of access to the available services of the health system are an important concern of the Federal Government. In particular, the Action Plan takes into account the key role played by the medical profession when it comes to the institutional assistance actually used by victims in and after violent situations. Whereas the first Action Plan promoted scientific monitoring of the intervention programme in the hospital context (S.I.G.N.A.L.), the aim now is to make use of the complex importance of the medical profession in improving the situation of female violence victims in a new project focusing on general practitioners (GPs).

4.2 Fundamental demands on health professionals in the health system when dealing with violence

A fundamental demand on all institutions and professional groups in the health service is to take signs of violence seriously, irrespective of the origin and lifestyle of the people involved, and to offer the kind of support that is in line with the victim's individual reality. The aim should be to break down the kind of barriers that prevent women who have experienced violence – and are often in difficult situations – from seeking and taking advantage of the assistance that is available (see also chapter 4.3 and [4]). Irrespective of the type of assistance involved, the focus must be on violence victim herself, her existential crisis and individual needs. Professional contact should be characterized by a gender-sensitive and culturally sensitive attitude that takes into account not only the stresses that are involved but also the health resources that are available.

One idea that is increasingly asserting itself is that healthcare must be geared to different life phases and life situations, in order not to overlook existing factors (e.g. age, social deprivation) that can involve an increased risk of violence. In this con-

¹² Patient/physician confidentiality lays the foundation of a trusting relationship between the physician and the patient. Physicians' employees are also bound by this confidentiality obligation. However, the patient can release the physician from the obligation. The confidentiality obligation may only be broken in an emergency as defined by section 34 of the German Criminal Code [StGB] (according to a principle called "necessity as justification").

text, particular attention should be paid to women and girls with disabilities and chronic illnesses, and to other vulnerable population groups (e.g. elderly women in need of nursing care, expectant mothers). Physical and psychological impairments mean dependency on support within the family, from outpatient staff or from care institutions, and the degree of dependency varies according to the severity of the impairment. The higher the degree of dependence and need for third-party assistance, the more vulnerable people are to violence and the higher is the threshold before they will seek to support, e.g. from the healthcare system. Experts in counselling centres are gaining the impression that the effects of violence are not being recognized in the majority of cases involving disabled women and girls. Carers and physicians often focus almost exclusively on disability-specific deficits. For example, conspicuous behaviour is frequently interpreted as an expression of the person's disability. Victims are often unable to talk about violent experiences themselves because their skills of linguistic expression and articulation are limited, because of fears, or because of the presence of other persons, e.g. potential perpetrators among care workers or family members. Despite what can be assumed to be a high incidence of sexualized experiences of violence among women with "intellectual disabilities", the level of psychosocial and medical care offered to this population group is absolutely inadequate [113]. Outpatient healthcare services (e.g. gynaecological practices) are usually not geared towards girls and women with physical and/or intellectual disabilities [4]. The practices are often difficult to reach, inaccessible or ill-equipped. In addition, many attending physicians lack experience and expertise in dealing with disabled women. The Federal Government has reacted to this deficit with its second Action Plan to Combat Violence against Women. In order to protect disabled and chronically ill women from violent assaults, projects are being promoted with the aim of strengthening the women concerned, raising the awareness of nursing staff and carers, and supporting a corresponding self-help organization to represent the interests of disabled women. International studies and practical guidelines on dealing with the consequences of violence in the healthcare system also formulate the need to empathize with the different – and particularly

with disadvantaged – life situations of women. Accordingly, the British government Department of Health's "Resource Manual", for example, stresses the special responsibility of healthcare for vulnerable population groups and their increased risk of falling victim to sexual or physical abuse. In Germany this applies not only to women with disabilities but also to certain groups of female immigrants, homeless women and prostitutes, among others. On the one hand, they are more exposed to the risk of experiencing violence; on the other, they receive inadequate medical care in many fields [135]. Women who belong to ethnic minorities or live in relative poverty make use of available healthcare services more rarely and hesitatingly in general; they are also more reluctant to talk about violent experiences [136]. Physicians' contacts with female immigrants are made more difficult by cultural communication difficulties. Many physicians lack intercultural skills [137]. There are also too few qualified interpreters in the German health service who can be called in to support the treatment process.

4.3 Barriers facing attending medical staff and victims

Barriers facing health professionals

According to the professional groups working in the health service, the greatest obstacle is insufficient training in recognizing the consequences of violence and in dealing properly with the problems [4, 131]. The majority of practising physicians and nurses feel inadequately prepared and skilled to diagnose the consequences of physical, sexualized and domestic violence. Furthermore, many physicians, nurses and carers are poorly informed about local and regional support services, such as women's refuges, women's counselling centres, psychosocial counselling centres, intervention agencies, and other bodies catering for specific target groups such as female immigrants or disabled women and girls (cf. [4, 131, 138, 139]). One explanation of the medical staff's fear of being unable to handle certain situations is the strict time limits placed on the amount of time professionals can spend with each female patient; these limits are too tight if a woman needs to talk about experienc-

es of violence ("opening a Pandora's Box" [140]).¹³ Furthermore, stereotyped images of "battered wives" are still widespread and can restrict a person's ability to discern the more subtle symptoms. For their part, professionals criticize in principle the lack of institutional standards and guidelines, since these could give them more self-confidence in dealing with victims of violence [141].

Barriers facing victims

There are various barriers that prevent victims from taking the initiative and speaking themselves about violent experiences with attendant staff in the health service. Women often remain silent out of fear or shame, or because they have the feeling that they are partially responsible for the violence they have suffered. Overall, continuous violence leads to a considerable weakening of the victim's self-esteem and self confidence. In many cases, they are also worried that the police or other institutions might be informed without their consent. Women speak of their fears of renewed violence from their husbands (e.g. in the form of reprisals), if the violence is made "public" or officially reported. Structural conditions within the health system, e.g. long waiting times and very rigid timeframes for treatment [4, 131] are also felt subjectively as potential barriers.

4.4 Provision of too much, too little and/or the wrong care because violence is not recognized as the cause of health consequences

The healthcare situation of female violence victims is often such that the problem is medicalized, pushed aside or suppressed. When health professionals fail to recognize the cause of a complaint, this can lead to an increase in the need for healthcare services at a later date. For example, female victims use healthcare facilities more often, have surgery and stay in hospital more often and have more psychosomatic treatment [1, 135, 142].

Overdiagnosis and oversupply

Gynaecologists often fail to take possible links between abdominal complaints and suffered violence into consideration, so that patients are sometimes given the wrong treatment [42]. This deficit also affects patients who experienced sexual violence in childhood; their physical reactions and symptoms are more rarely seen in the context of traumatizing experiences of violence and are therefore not incorporated into treatment [131, 142, 143]. Health professionals in rehabilitation and psychosomatic clinics believe that a large proportion of female patients who have recurrent pelvic operations (a "career of gynaecological surgery") have in fact experienced violence [135].

Chronification

Failure to recognize violence as the cause of complaints, with the result that the wrong treatment – or no treatment at all – is given, can lead to a chronification of symptoms and permanent disability and impairment (e.g. because of untreated bone fractures and injuries) [131].

Misdiagnosis/mistreatment

Failure to consider exposure to violence as a possible cause in the treatment of physical and psychological injuries can lead in practice to misdiagnoses and, consequently, to the wrong medication being prescribed; in certain circumstances this can have grave detrimental effects on victims' health. This applies especially to the prescription of psychotropic medications (e.g. sedatives and soporifics, psychotropic drugs, stimulants) to patients who complain of anxiety and panic attacks, insomnia, nervousness, depressive states, lack of motivation, etc., without the underlying causes being sufficiently known [145]. It has been observed that a gender-specific practice of prescribing psychotropic drugs can contribute towards women continu-

¹³ This expression describes the fear that questions about experienced violence might set off an "avalanche" for which the attending medical staff are not prepared and which they will not be able to handle [144].

ing to endure destructive living conditions (e.g. in an abusive relationship) [134,143]. Symptoms can be diminished or disguised as a result of the medication, so that the true causes cannot be treated. If psychotropic drugs are prescribed without adequate medical monitoring and supervision, the female victims are at risk of becoming physically and/or psychologically dependent on the respective substance [146].

The French and German representative surveys on violence against women independently found that women who had experienced both physical and sexual violence over the previous twelve months took sedatives or hypnotics significantly more frequently than women without experience of violence [3, 147]. This also indicates an increased vulnerability to addiction.

Nevertheless, psychotropic drugs can be indicated, especially for short-term treatment, if they are prescribed carefully and in a way that is appropriate in view of the cause of the complaints; after all they can give female violence victims relief (e.g. if they are suffering from depression). However, all medication should be prescribed in consultation with the patient, taking her current life situation into account and subject to close monitoring and support [145].

4.5 The role of health professionals in dealing with victims of violence (recognizing violence – "red flags")

In an institution that does not specialize in cases caused by violence, e.g. a hospital or GP's practice, the attending physicians' role is primarily determined by the remit of the corresponding institution and his/her profession. Accordingly, given their lack of expertise it would be not only unrealistic but simply impossible for the health professionals to expect to "solve" the problematic life situation of female victims of violence, or to "clarify" a situation characterized by domestic violence [146]. Even so, being the first place where victims of violence seek help is of key importance. The values and attitudes with which the professionals in the health service respond to women who have experienced violence is not only crucial for their current condition, but a key factor influencing whether further assistance will be

accepted, initiating a process that can contribute to longer-term change and stabilization [146].

The most important tasks of health professionals are:

- ▶ to recognize that domestic violence may have taken place;
- ▶ to offer a protected space in which the woman can feel safe and in good hands, and in which trust can develop;
- ▶ to respond to women with understanding and to contribute to their stabilization by means of suitable interventions;
- ▶ as far as possible, to inform the woman about her rights and the services offered by specialized agencies.

Healthcare institutions such as hospitals, GP practices and health centres can represent an important interface between women who have suffered violence and specific support institutions. The prerequisite is that the physician actively listens and asks the patient questions about her experience(s) of violence within the treatment context; this requires a sensitive approach and knowledge of regional support structures. In addition, documenting acute and past injuries (or traces of injuries) and other complaints in a way that can be used as evidence used in court is an important prerequisite to enable female victims to initiate legal action. Such documentation is not only significant in the event of criminal prosecution, but also for many other legal processes, such as separation or divorce proceedings, arrangements on visitation, access and custody arrangements, court cases on residence rights or protective orders [4].

Recognizing domestic violence: "red flags"

In order to offer female violence victims the proper kind of treatment, it is essential to be able to recognize indicators which point to violence as a possible cause of complaints and symptoms.

As shown by the potential effects of violence described at the beginning of the booklet, the short-, medium- and long-term health consequences and complaints are many and varied. They depend on situational conditions, on the forms of violence used, the intensity of the violence, and

individual processes of evaluation, perception and processing. On the basis of experience in the health field, important indicators, so-called "red flags" have been formulated as warning signs of domestic violence. The simultaneous occurrence of several of these indicators requires increased attention and indicates a high probability that the person has been a victim of violence. The following are regarded as "red flags" (cf. [148]):

- ▶ chronic, vague complaints that have no obvious physical cause;
- ▶ injuries that do not match the explanation of how they occurred;
- ▶ different injuries at various stages of healing;
- ▶ a male partner who is overly attentive, controlling, or unwilling to leave the women's side;
- ▶ physical injuries during pregnancy;
- ▶ late entry into prenatal care;
- ▶ frequent miscarriages;
- ▶ a history of attempted suicide or suicidal thoughts;
- ▶ delays between injuries and seeking treatment;
- ▶ chronic irritable bowel syndrome;
- ▶ chronic pelvic pain.

Moreover, the occurrence of the symptoms described earlier in this booklet can also be an indication of current or past exposure to violence and should be taken into account accordingly in diagnosis and treatment.

5 Preventive and intervention options of the health service

Projects and intervention programmes have been initiated in Germany in recent years to combat and prevent violence and its negative consequences. The Federal Government's first National Action Plan to Combat Violence against Women made a significant contribution to this development. The plan launched an overall concept that focuses on promoting primary prevention and inter-institutional cooperation and provides for a network of measures across all governmental and institutional levels. Action Plan II links up with this development and continues it. There is a growing recognition that action is especially needed in the field of medical care.

Various measures have already been developed in the last few years to optimize the healthcare provided to female victims of violence. However, up to now only some of them have been implemented in practice, and that only selectively (cf. e.g. [4, 131, 149, 150]).¹⁴

5.1 Overcoming communication barriers in anamnesis

Experience reports and studies show that many women do not speak of their own accord about having suffered violence, or else tend to conceal the fact. They often give false explanations for the causes of their injuries or symptoms; fear and shame are key factors in this context. They are afraid that the attending medical staff might doubt their credibility, and they find it difficult to trust anyone. Fears of an escalation of the situation if the violence is exposed, or in the event of a separation, are key obstacles to their talking about the problems themselves. These fears are not unfounded: most homicides are committed in a domestic context during separation processes or shortly thereafter [146]. Another reason why women remain silent is often that they find it difficult to put the violence they have suffered into words. Furthermore, memories are often suppressed because they can lead to retraumatization [145].

Attending medical staff rarely ask female victims direct questions about violence, either because they hope the woman concerned will develop enough trust to talk about the problem herself, or because they fear there is nothing beyond medical treatment that they can do to help. Experience reports and international studies consistently show that such women usually want to be spoken to directly about the violence issue (cf. [131, 134, 151, 152]). They experience it as a relief when the cause of their injuries and complaints – i.e. the violence they have suffered – is named as such, irrespective of whether they have visible injuries (e.g. fractures and haematomas) or hidden symptoms (e.g. anxiety attacks, chronic pain, insomnia). In the research accompanying the S.I.G.N.A.L. intervention project, 80% of the women interviewed were

¹⁴ See also action-oriented manuals and list of links in the Annex.

in favour of routine questioning about violence in the context of medical treatment; the figure was even higher (86%) among women who had experienced violence themselves [131]. In the *Maternité Women's Clinic* at Zurich City Hospital, the introduction of routine questions as part of anamnesis has proved to be an effective way of removing the taboos from the problem of domestic violence and offering female victims the support they need [146]. Opinions among experts differ as to whether it is a good idea to always ask patients about violence on principle, or only if there are certain signs and symptoms. In either case, the precondition is that health professionals are well informed and proceed in a sensitive manner. International studies have found that routine surveys (screenings) require further training courses and training materials to enable the attending physicians to overcome competence barriers and personal resistance (cf. [18, 21, 153, 154, 155]).

Other communication barriers arise because in some cases victims cannot – or are not allowed to – come for a medical examination alone. They are accompanied, thus putting them under that person's control. In the case of immigrant women with limited or no knowledge of German, family members are often used as translators. This is highly problematic in the case of victims of violence. It is imperative that female patients who do not speak German have an opportunity to express themselves in a protected situation with the help of a professional (female) interpreter [4, 173]. In addition, there is evidence to suggest that, for cultural and religious reasons, speaking about sexual violence is even more taboo among immigrant women than among German women [3].

When women with disabilities experience violence, the perpetrators are frequently people with whom they have a special dependency relationship and who exploit their helplessness and/or restrictions, e.g. preventing self-determination. Here, too, women should not be asked about experiences of violence in the presence of the person accompanying them. Women with physical restrictions (e.g. in their hearing) should be able to communicate in a protected environment through a sign-language interpreter [173]. Lobbyists correctly criticize the fact that deaf women and girls are not informed about their right to the services of sign-language interpreters free of charge, and that healthcare

institutions rarely offer or organize this service on their own initiative.¹⁵ Dealing with female victims of violence with intellectual or learning disabilities in particular makes special demands on health experts, yet as a rule few of them have specific experience or professional skills in treating people with disabilities.

5.2 Provision and distribution of qualified information material

If health professionals are to give female victims the necessary support, they need to know about local and regional services, networks and institutions that have been set up specifically to assist certain target groups. Women who have no social support network and are perhaps socially isolated by a violent partner have little access to relevant information about their rights or where they can find assistance. This also applies, for example, to disabled women who live in assisted apartment-sharing communities. Such factors make it all the more important that healthcare institutions distribute knowledge and provide information on basic rights and available services that can help victims to take steps to escape the cycle of violence. This information can be distributed in the form of "emergency maps" with important addresses, brief information brochures or leaflets left in the waiting rooms of GP practices, hospitals, maternity clinics, and central meeting places such as women's and mothers' groups, etc. (the emergency maps should preferably also be left in washrooms, toilets and changing rooms). This enables victimized women to make contact with specialized counselling bodies at times they choose themselves. Posters, too, can advertise an institution's knowledge and experience in dealing with the problem of violence [4, 131]. These days, many counselling centres and support services provide information in several languages, so that immigrant women can also be reached. But such measures are only worthwhile if the institutions really do offer counselling in the respective languages. Ultimately, only certain groups can be reached by distributing such infor-

¹⁵ For further information on disabled women see, for example, the website of the Weibernetz advocacy group: www.weibernetz.de.

mation material. It is not always suitable for victims with little education or learning disabilities, or for women with sensory impairments (e.g. poor eyesight). It must also be taken into account that immigrant women and women with disabilities often have only limited access to healthcare and must therefore also be targeted in different ways outside the health service.

5.3 Forms of basic and advanced training for all professional groups in the health service

Prevention measures and interventions against violence should be conceived as an interdisciplinary task involving all professional groups in the health service. The importance of healthcare for intervention and prevention on the issue of violence must be taught in basic and advanced training, and steps should be taken to increase awareness of the issue in the various professions. The Working Group of the Federal and State Governments on Domestic Violence has developed standards and recommendations for basic and advanced training formulating important points on content and methodology, recommendations on organization and overall conditions, as well as specific aspects tailored to specific professions [156].

Modules aimed at raising awareness for the situation of immigrant women, disabled women and girls, as well as other minorities and vulnerable population groups should be integrated into all training curricula and include the specific demands on counselling and intervention. It is recommended that advanced training courses should be run by a multidisciplinary team in which one (female) trainer respectively should be recruited from the respective professional group and one from a women's support organization.

At the 110th German Medical Assembly (*Deutscher Ärztetag*) the delegates appealed to physicians in general, and the respective specialist groups in particular (e.g. paediatricians, physicians in general practice and family healthcare, public health services, surgeons and gynaecologists), to keep a lookout for signs of domestic violence in their work with families, children and emergency victims, and to give the people and families concerned the appropriate curative and preventive care. Accordingly, it was recommended, the issue of domestic

violence should be regularly dealt with in initial medical training, included as a further-training module in the 80-hour blocks on basic psychosomatic healthcare, and offered at practice-relevant events (resolutions of the 110th German Medical Assembly in 2007).

The main health-sector participants in the "train-the-trainer" seminars¹⁶ on violence against women and health – which are based on the S.I.G.N.A.L. intervention project – are nurses, therapists, midwives, physiotherapists, staff from health centres and physicians. The "train-the-trainer" seminars aim to train professionals in the health service in prevention and intervention against domestic violence. The seminars qualify the participants to hold training courses for hospital staff and to take part in the introduction of intervention programmes against domestic violence in both outpatient and inpatient care.

Abroad, nurses are increasingly playing a significant role in both intervention and documentation. They are given special basic and advanced training in these skills. In Germany, however, the concept of 'forensic nursing' has not yet asserted itself.

5.4 Guidelines for treating and dealing with victims of violence

Interdisciplinary working groups in various *federal states* have compiled and distributed manuals and recommendations for physicians on how best to deal with women who have suffered violence.¹⁷ They cover the extent of violence, health consequences, recognizing (physical, psychological and psychosomatic) indicators of violence, sensitive interviewing, how to document injuries in a way that can be used as evidence in court, and the role of attending physicians in the referral of patients to specific support institutions. In addition, certain sensitive and respectful treatment steps are recommended in order to avoid aggravating the negative feelings and fears of female victims. They communicate basic knowledge about post-traumatic stress disorders and materials for documenting psychological after-effects.

¹⁶ www.signal-intervention.de/inhalt/trainer.pdf

¹⁷ See action-oriented manuals in the Annex; cf. also [157].

They also offer guidance and form sheets for documenting injuries caused by domestic and sexualized violence and discuss forensic aspects. Furthermore, the overall legal framework is explained, e.g. confidentiality, the obligation to report, the Protection against Violence Act, the Police Act, and the Victim Compensation Act. All the manuals contain the contact addresses of either regional support institutions or the nationwide umbrella organizations of women's support services.

To date, little experience has been gained on how successfully the manuals are being used in practice. Since uncertainty on how to deal with problems of violence is still widespread in the health service, experts differ in their assessments of the need for parallel training to promote the implementation of written guidelines. It can certainly be assumed that guidelines can help improve levels of knowledge and self-confidence.

A unanimous resolution was passed at the 16th Conference of the Federal-State Ministers for Equal Opportunities and Women's Affairs in 2006, calling for a study to be commissioned to compare the different measures and methods used to provide appropriate healthcare for women and children who have been victims of domestic violence.¹⁸ According to the resolution, the evaluation should include materials and methods for raising awareness and training health-service staff in order to improve quality and acceptance among the target groups, as well as the experience that has been gained with strategies aimed at inter-professional and inter-institutional cooperation to improve healthcare in this field.

Further beneficial measures and implementation options are identified and described in detail in the expert's report to the North Rhine-Westphalia state parliament's commission of enquiry into the "Future of a Health Service in North Rhine-Westphalia that is Compatible with Women's Needs" [4]. These include:

- ▶ improving psychotherapeutic services;
- ▶ building up cooperation networks and joint projects;
- ▶ developing and laying down quality standards;
- ▶ adopting the results of good practice and learning from experience with good practice models;
- ▶ strengthening patients' rights.

6 Examples of good practice in prevention and intervention

Initiatives and projects aimed at involving the health service in intervention and prevention in the field of domestic and sexualized violence have been tried out at the regional level in Germany in recent years; "good practice concepts" from abroad have also been adopted. Only a few examples of good practice can be taken up in this booklet.

6.1 The S.I.G.N.A.L. intervention programme

The S.I.G.N.A.L. intervention programme (www.signal-intervention.de/) was the first hospital-based project in Germany to focus on domestic violence against women; it was implemented at Berlin's Benjamin Franklin University Hospital (CBF)¹⁹ in the first aid/casualty unit. The S.I.G.N.A.L. project was conceived as a cooperation model involving internal hospital staff and external experts from women's counselling centres and refuges.²⁰

In terms of content, the project was based on international intervention projects. The key objectives and action steps of the intervention programme are described by the programme's German acronym S.I.G.N.A.L.:

Further-training schemes for nursing staff and physicians were developed and launched in order to implement the programme and integrate it into routine medical and nursing care; patients were provided with information material and staff with forms (for documenting evidence in a way that can be used as evidence in court). Internal cooperation structures were built up aimed at ensuring that victim patients that are admitted to hospital receive the support and care they need; external contacts were developed with support services, and

¹⁸ 16th Conference of the Länder Ministers for Equal Opportunities and Women's Affairs ("Konferenz der Gleichstellungs- und Frauenministerinnen, -minister, -senatorinnen und -senatoren der Länder") – main conference held on 18/19 May 2006 in Hamburg, agenda item 6.5: Evaluation of violence prevention in the health service

¹⁹ Charité Campus Benjamin Franklin

²⁰ The S.I.G.N.A.L. project is described in detail in the manual and the accompanying research [131]. The accompanying scientific research was funded by the BMFSFJ for three years.

S	<i>Sprechen</i> (= speak to) the patient (about violence), signal your willingness. Women open up when they can feel that their situation is understood.
I	<i>Interview</i> (= interview) the patient using specific, simple questions. Listen without judging. Most women find it difficult to talk about violent experiences.
G	<i>Gründlich</i> (= thoroughly) examine old and new injuries. Injuries at various stages of healing can be indications of domestic violence.
N	<i>Notieren</i> (= note down) and document all findings and statements in a way that can be used as evidence in court.
A	<i>Abklären</i> (= clarify) the current need for protection. The basis and purpose of all forms of intervention is to give the patient protection and safety.
L	<i>Leitfaden</i> (= brochure) should be offered to the victim containing emergency phone numbers and offers of support. Women will make use of this information at a time that is right for them.

continuous internal and external public-relations work was carried out. The project was continuously evaluated to review and further develop the concept during the three-year model phase.

The hospital's staff regard S.I.G.N.A.L. as a necessary and useful programme for improving the care provided to female patients who have been victims of violence. Corresponding health-care standards and work skills were developed and communicated in the course of the project. Initial fears expressed by the staff that the S.I.G.N.A.L. project might aggravate the workload in terms of working hours and the treatments given were largely dispelled in the course of the project. A clear-cut set of rules on responsibilities, and a detailed description of work options and limits proved to be important guidelines, especially for the nursing staff [29].

Findings from national and international evaluation research²¹

National and international evaluation findings show that initiatives and projects which aim to change practices in health-sector institutions require the support of management. A clear commitment by the responsible leaders – the hospital management board and professional associations

– gives the necessary changes the credibility they need. Projects and initiatives without support from the management level rely mainly on the commitment of individual professionals. Sustainable implementation is virtually impossible under such circumstances [131, 158, 159].

Within the context of efforts to develop an organizational policy on new intervention practices among violence victims, the establishment of interdisciplinary, interdepartmental steering groups with the participation of external staff from anti-violence support groups has proven an efficient approach for institutional intervention and prevention measures in the hospital treatment of female violence victims. External experts can contribute not only expertise on violence-related issues and the support needs of female victims, but also knowledge of available regional support services. For their part, the clinic's internal professional groups have the necessary nursing and medical expertise as well as internal knowledge of the institutional work processes [131, 158].

6.2 Medical Competence Centre for Victims of Violence in Hamburg

Since 1998, injured victims of violence in Hamburg have been offered a low-threshold clinical-forensic examination at the Hamburg-Eppendorf University Hospital's Institute of Forensic Medicine (www.uke.uni-hamburg.de/institute/rechtsmedizin/). At their own request, any victim of violence can be given an examination free of charge, irrespective of whether an offence is reported to the police or not. As part of this emergency service, injuries are documented, evidence is secured, and forensic expert opinions compiled that can be used as evidence in court. The aspect of psychotraumatization can be treated by psychological crisis interventions offered by the Institute of Forensic Medicine [160]. Furthermore, children who have witnessed and/or are themselves victims of vio-

²¹ International evaluation findings were collected and further recommendations formulated for the health sector in the CAHRV report "Agencies and evaluation of good practice: domestic violence, rape and sexual assault" [158], compiled in the course of the EU project "Coordination Action on Human Rights Injuries". See: www.cahrvi.uniosnabrueck.de.

lence are offered rapid professional assistance. The Hamburg initiative aims to acknowledge violence victims' need for care, optimize the range of legal protection services available to victims, and establish forensic medicine as an integrating and networking element in the existing regional support system.

A similarly differentiated model has existed since 1987 at the Institute for Forensic Medicine of the University of Berne. In the last few years, clinical forensic medicine departments in Germany, as in other European countries, have set up further practical models to look after violence victims; the multi-centric exchange of information on practice and research issues has been intensified. Both the German and Swiss Forensic Medicine Societies have set up working groups on clinical forensic medicine. Their aim is to improve the quality of their own practices, develop systematic cooperation within the health service and with other local organizations, and advance nationwide research into the consequences of violence according to agreed criteria. The development of formally binding guidelines is under consideration.²²

6.3 The "Gesine" network

In order to improve interventions to combat violence against women and children, the "Gesine" network (cf. [161]) has developed practical implementation strategies and secured the involvement of various players in the health and psychosocial-care service in a cooperation model together with experts from specific support institutions (www.gesine-net.info). The aim is to offer practical and effective healthcare systems that are sensitive to the violence issue in the Ennepe-Ruhr region (North Rhine-Westphalia). It targets, for example, physicians working in a range of different fields, hospitals, nursing staff, therapists, counselling centres, midwives and medical assistants. The overriding principle on which the network's central action guidelines are based is that thresholds should be kept consistently low and that clients can rely on the agreed standards being met. Engagement in a sphere that is still a taboo subject requires an additional "win-win situation" for everyone involved. The necessary incentive is that the players benefit from increased self-confidence when dealing with

the violence issue, can generate plausible explanations for symptoms and modes of behaviour that are difficult to interpret, and can rely on an effective practice of referral. The network can inform relevant professional groups such as the judiciary, police and social services about the services it offers via its links with the existing municipal infrastructure and its participation in the "Round Table on Combating Violence against Women" in the Ennepe-Ruhr region. The basic concept provides for the incorporation of further partners into the network, which currently consists of 50 participants; however, this is not currently feasible, given the shortage of personnel needed for coordination and the specific counselling of female victims. Feedback from network partners and female violence victims is taken into account with the aim of optimizing the way the network functions in practice [161].

6.4 Cooperation between midwives and gynaecological specialists

Since the health service is not a uniform, hierarchically structured system, but is made up of many independent players, it makes sense to develop forms of cooperation that are based on a specific activity or a specific area of healthcare.

An excellent example of such an approach is cooperation between gynaecologists and midwives, which is currently being tried out at more and more locations. Midwives contribute to this collaboration the advantages of working in a confidence-building setting and the fact that they can promote the personal responsibility of women and provide intensive support for families by means of regular home visits. The overall context and opportunities of midwives' work put them in an especially good position to notice and talk about a pregnant woman's acute experiences involving violence and/or any risks she may face [163]. Midwives can give sexually traumatized women comprehensive support during pregnancy and childbirth and help prevent or mitigate the development of fear-induced, pathological disorders [164]. Experience with cooperation between

²² Interim results of a pan-European appraisal of clinical forensic practice (cf. [162]).

gynaecologists and midwives in jointly attending to and supervising pregnant women shows that, by distributing their medical roles in a way that mirrors their respective expertise, they can give traumatized women a great deal of security and stability. Professional expertise and the psychosocial support they provide enables them to recognize and talk about connections between sexual violence and any health problems that might occur at an early stage (e.g. complications during pregnancy) and suggest medical treatment. In certain circumstances this can make medication or hospitalization unnecessary [4].

This approach of integrated medical and psychosocial healthcare for pregnant women is new for Germany. It is based on concepts from abroad and backed up medically by research findings in the field of evidence-based medicine (EBM) [165].

An interdisciplinary working group called Sexualized Violence against Women and its Effects on Pregnancy, Childbirth and Puerperium TARA,²³ which was formed in 2001, is made up of female specialists from different professional groups, e.g. midwives, gynaecologists, psychologists and social education workers. They also have contact with paediatric nurses, paediatricians and lactation consultants. The working group has been working since 2006 on recommendations for supporting female violence victims during pregnancy, childbirth, the puerperium and the lactation period. They suggest introducing the issue of violence against women into the curricula of midwifery training.

7 Conclusion – areas for research and action in healthcare provision for victims of violence

The violence perpetrated primarily against women, but also against men and children, documented in this booklet underlines the relevance of the health sector as a low-threshold area of prevention and intervention. Over the last few years, awareness of the issue of violence in general, and domestic violence in particular, has been growing among the general public and healthcare professionals, especially in psychosocial advice centres, law enforcement and the judiciary. Now the healthcare sector is becoming increasingly aware of – and sensitive to – this issue. The medical profession – in collabo-

ration with other professional groups – has a key role to play in this context. At a joint symposium of the German Medical Association and the Federal Ministry of Health entitled "Health Consequences of Domestic Violence against Women" (2007), ongoing activities were discussed and new ideas developed with the aim of helping people working in the health service to deal with the issue. Complex problem situations like domestic violence require complex interventions and demand integrated support services, and healthcare provision plays a key role in this context. Ideas developed in positive approaches – e.g. from trials of new preventive and intervention models in individual federal states – should increasingly be taken up in order, on the one hand, to overcome existing deficits in the systematic implementation of health-related support services and, on the other, to fill gaps (and rectify mistakes) in the provision of violence-related healthcare services at different levels of the health system.

Need for research

Given the relevance of the problem of violence, the gaps that exist in research and available data in Germany can only be described as extensive. Up to now, only selected correlations between violence and health have been examined. Very little work has been done so far on health consequences and comorbidities (e.g. post-traumatic stress disorder and dementia) in specific target groups (e.g. older women with experience of sexualized violence) or on the forms of care such disorders require. Areas in which comparatively little research has been done include the possibility that the health consequences of violence mutually aggravate each other; the influence of biography-related risk factors on a person's experience of violence and subsequent health complaints; and the issue of gender-specific differences in the context of sexual and/or domestic violence. Moreover, studies of the health consequences of violence, which are based on the

²³TARA is part of the Women's Health Working Group (Arbeitskreis Frauengesundheit, AKF e.V.) and the Association of German Midwives (Bund deutscher Hebammen, BDH e.V.). For more information see the following website: www.geburtskanal.de/TARA/.

tradition of research into women's health, have mainly focused on women and girls as violence victims up to now. Only in recent years have boys and men been perceived as a relevant victim group at all – e.g. as victims of sexual abuse and domestic or nondomestic violence – and defined as a target group of gender-sensitive health research and healthcare [36]. In order to (further) develop healthcare concepts that take the different needs of men and women into consideration, more light needs to be shed on this "black box" by initiating both sex-specific and gender-sensitive research projects. Uniform data-collection systems providing consistent information are needed as a central basis for such research.

Furthermore, the health consequences of violence among especially vulnerable population groups (e.g. migrants, refugees, the homeless, disabled people, prostitutes) remain largely unexplored. Not only physical and sexualized violence, but also psychological violence in the form of discrimination and restrictions experienced both in society in general and in the immediate social environment play a special role here. Healthcare concepts that also provide culturally sensitive and competent support for these target groups in the field of healthcare are still poorly developed in Germany.

Finally there is still a lack of instruments that provide a continuous analysis of the effectiveness of interventions and prevention measures in practice that would make it possible to determine whether the measures really can be effectively and successfully implemented, and where any modifications or improvements are meaningful.

(Domestic) violence in the context of Federal Health Reporting

The data situation is currently inadequate and needs to be further developed and optimized. This is a direct prerequisite for the provision of information on the healthcare needs of violence victims and for the development, implementation and evaluation of health-related interventions. Available routine data (e.g. hospital dismissal reports, mortality and crime statistics) only provide information on selected partial aspects, and it is usually difficult to generate data on the overall contexts

and circumstances surrounding violent assaults (e.g. detailed information on violent incidents, types of injuries, etc.) [166]. Representative, valid and continuously collected data that complement official statistics, process data, observation practices (sentinels) and clinical studies are needed in order to set up a qualified health reporting system. This could then form the basis of both nationwide statements on the prevalence of domestic violence and differentiated statements on the health consequences of violence. It could also uncover associations with the relevant social environment and living conditions.

Work is currently in progress at the European level on an "injury surveillance system" based on the ideas of the WHO and the International Classification of External Causes of Injuries (ICECI). Furthermore, a standardized module for reporting (domestic) violence against women is being developed and discussed as part of European and international research on the prevalence of violence. Such a module, supplementing a "Minimum Data Set for Injury Surveillance" (MDS-IS, see www.rivm.nl/whofic/ICECIeng.htm), could also represent a key instrument in German reporting for collecting systematic and long-term data on levels, contexts and health consequences of violence; it would need to be coordinated with current international standardization and module developments for reporting violence and its consequences in the context of research on health and the prevalence of violence [21, 23, 167, 168].

A consistent database is a key precondition for being able to recognize and treat potential risk groups and the health consequences of violence in the health service. Possible ways of improving the data situation include incorporating violence victimization into Federal Health Surveys, carrying out long-term studies, implementing sentinels, setting up surveillance and documentation systems for injuries caused by violence, and establishing routine questioning by professionals as an integral part of healthcare [166].

Prevention potential in healthcare provision for victims of violence

The World Report on Violence and Health [1] and the Multi-Country Study on Women's Health and

Domestic Violence against Women, conducted by the WHO in 2005 [21], show that the health sector offers many areas in which preventive interventions can be firmly established in healthcare provision for violence victims (cf. [166]). As already mentioned, numerous pilot projects with institution-specific approaches are also being tried out in various *federal states* in Germany in the meantime. The first pilot projects looked at the situation in hospitals (see the S.I.G.N.A.L. programme). Now, another scientifically monitored project aimed at integrating general practitioners into intervention (MIGG – Medical Intervention against Violence) was launched in 2008 funded by the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth (BMFSFJ) under the auspices of the Federal Government's second Action Plan to Combat Violence against Women. Part of the project is managed by Forensic Medicine department in Düsseldorf and stresses the importance of forensic medicine; the second sub-project is a cooperation project between Gesine and S.I.G.N.A.L.

Another project is called SELBST which [in German] is an acronym standing for "self-confidence for disabled girls and women" (section 44 of the Book IX of the German Social Security Code [SGB IX]). It is mentioned in the Federal Government's Action Plan II and also looks at what needs to change in rehabilitation in order to implement the "exercise to strengthen self-confidence in rehabilitation sport" (supplementary service to medical rehabilitation). The idea behind the exercises to strengthen self-confidence is to provide protection in a preventive sense by enabling the girls and women to exercise and practise their right to (sexual) self-determination.

From the prevention perspective, up to now there has been a clear dominance of measures and services focusing on women who have already experienced violence. In other words they are mainly limited to secondary prevention in the sense of providing support services and reducing the long-term health effects of violence. A WHO expert group [169] now believes it would be useful to expand perspectives pursued up to now and also examine the possibilities and opportunities for the prophylactic prevention of domestic and sexual violence against women and girls; this has been greatly neglected in the past. In 2007 this situation led the WHO to form a group of experts to examine issues of primary prevention

in the coming years. The focus will be on the causes of violence against women and girls (an issue that is often only discussed superficially), the question as to possible (e.g. behaviour-related) stress factors on the side of the perpetrators which exacerbate the risk of domestic and sexual violence, and on identifying potential protective factors [169]. The aim is to identify potential stress factors at a very early stage, to prevent violence against women and girls in this way in advance, and to reduce the overall number of casualties. The expert group proposes, for example, that efforts at perpetrator prevention should be stepped up, i.e. to prevent men from becoming perpetrators, and that structural measures be taken to make life safer for women and girls in the public sphere [169, cf. also 21]. The term "primordial prevention" [170] has become established in the health sciences to describe this type of primary preventive measures outside the medical sector; they can either be directed rather unspecifically at the general population or at defined target groups. Building on the WHO's overall concept on the primary prevention of domestic and sexual violence [169], primordial measures aim to prevent potential risk factors which can aggravate violent behaviour (e.g. alcohol and drug abuse), and to modify structural conditions in a person's environment (e.g. social isolation, exclusion) which can favour violence. Particular priority should already be given in this context to strengthening emotional and social skills (e.g. conflict resolution strategies) in children and adolescents, thus improving their health resources and boosting health-promotion (coping) factors as an important element of prevention, e.g. in kindergartens, schools, leisure facilities and sports clubs. However, there is also a need for primordial prevention measures in adulthood. Information and educational material that has been prepared for specific target groups – e.g. in municipal institutions and as part of the publicity work of scientific and professional organizations and the like – has an important role to play in making the public aware of not only the violence issue in general, but also of violence as a key health risk for women and girls in particular [143].

Following the differentiation according to primary, secondary and tertiary prevention which has become established in Germany, the focus of intervention at the primary prevention level is on uncovering existing violent situations, supporting

victims of violence in their search for suitable further assistance, and initiating protective measures to prevent further violence (or to end violence) by documenting injuries. Moreover, children and adolescents who are directly or indirectly affected must be incorporated into primary preventive interventions as a separate target group for prevention in the context of domestic violence. Uncovering domestic violence, therefore, plays a key role in providing preventive health protection for children and young people.

The field of secondary prevention comprises the treatment of injuries and complaints caused by violence in order to stabilize the victim's overall state of health and, as far as possible, to prevent long-term traumatization effects. Tertiary preventive measures that can help the victim process and cope with trauma are for the most part the responsibility of psychotherapists working either in hospitals or in an outpatient capacity. Protection from further violence – e.g. during outpatient/inpatient therapy or on mixed-sex wards in old people's and nursing homes – is also part of tertiary prevention. Self-determination and choice when it comes to the sex of the attending physician/carer and the method of treatment used are elements in tertiary prevention that need to be considerably strengthened in view of the risk of retraumatization or trauma reactivation and situations that could potentially make violence more likely, especially in inpatient institutions [4].

The diversity of target groups who are potentially victims of – or prone to – violence can only be touched on and described in an exemplary way in this Federal Health Reporting booklet. To sum up, it can be said that preventive interventions – irrespective of the level and objective of intervention – need to be sensitive to the specifics of the target groups (e.g. as regards age, sex, social background, educational level, life situation, sexual orientation, cultural background) and to vulnerable life situations (cf. also [171]). Only in this way can preventive service structures explicitly serving certain target groups in specific contexts be assured, and mistakes and gaps in healthcare provision for women, men and children who have been victims of violence be further reduced in the health service in the long term. The *sine qua non* for this is cross-sector cooperation, a pooling of resources and activities, and the provision of corresponding

knowledge and information for all professionals working in the healthcare occupations.

Integrating the violence issue into basic and advanced training

The issue of violence needs to be firmly established in the awareness of staff in the health service because there are so many and varied work-related contexts in which specialized health professionals are confronted with victims of violence, as this booklet has shown. In order to enable medical, non-medical, nursing and care professionals to do justice to their key roles in preventing violent assaults and treating the consequences of violence, it is necessary to structurally integrate the issue into the relevant vocational training and university curricula and in the licensing regulations for physicians. This applies not only to physicians of different disciplines (e.g. GPs, psychiatrists, gynaecologists) and psychological psychotherapists, but also to receptionists, who usually have the first informal contacts with victims in GP and specialist practices. Further professional groups involved include paramedics who have to deal with acutely affected victims of violence in emergency situations (e.g. in ambulances), nurses who look after patients in very intimate nursing situations – e.g. in mobile nursing services, inpatient old people's homes, acute care and rehabilitation institutions – and midwives in their task of accompanying families/women over an extended period of time (cf. [172]).

Extensive specialist expertise based on uniform standards and guidelines is required in order to diagnose violence, recognize gender-specific care needs, document forensically important injuries in a way that can be used as evidence in court, and provide information on available assistance and support services. Specialized medical and nursing knowledge on symptoms of violence, health consequences, treatment and counselling approaches is not sufficient on its own, and this applies to all professional groups. Furthermore, staff working in different treatment settings and care facilities must acquire personal, self-reflective and communication skills in dealing with problems caused by violence [146]. These skills must also be included when the curricula for the basic and advanced training of professional groups in the health sector are devel-

oped or supplemented [29]. The aim should be to secure uniform, quality-assured training standards on dealing with violence victims for the different professional groups working in the health service; these standards must also emphasize the need for interdisciplinary cooperation and networks, and ensure that knowledge of scientific findings is passed on to people working in the field.

Cooperation and networking as a resource and quality feature that promotes synergies

Numerous collaborations and networks have emerged in recent years in areas outside of health service, e.g. between the police and the judiciary, counselling centres, children's and youth welfare offices, etc. [132,133]. However, there is often a lack of systematic participation by the health sector in regional cooperation schemes and of interdisciplinary collaborations within the healthcare sector. Healthcare provision for violence victims could be made much more effective and efficient, and much better use could be made of prevention potential, if healthcare institutions (e.g. hospitals) coordinated their activities with the various support services for victims of sexual and domestic violence (e.g. women's counselling centres, women's refuges, emergency hotlines, social services, etc.). In the past, locally organized networks with the inter-professional participation of as many professional groups and institutions as possible (e.g. physicians, midwives, public health and youth welfare departments) have proved especially productive, e.g. in taking preventive action to reduce stress factors that aggravate violence in families. Politicians have recently been paying more attention to the issue of child abuse and/or neglect, and family- and child-centred "early warning systems" (e.g. involving family midwives, screening) have subsequently become established. Such developments represent key areas in which networking activities might begin.

If healthcare services that take account of gender needs and are sensitive to the problem of violence are to be successful in the long term, sufficient financial and human resources must be provided and guaranteed. This will ensure that model projects and prevention approaches can be implemented and structurally integrated into the regular

medical, nursing, therapeutic and obstetric healthcare system [29]. In view of economic constraints in many municipalities and the need to cut costs in social and health services, it can be assumed that the necessary and ethically justified further development and optimization of healthcare for violence victims can only succeed if it is part of an interdisciplinary and collaborative approach to action. Internal and cross-institutional networking with other professional groups, support services and responsible authorities can make a significant contribution to overcoming the familiar interface problems in the health sector. It makes it possible not only to pool expertise, but also to make use of existing instruments and materials in an inter-professional, resource-efficient way (cf. [132]).

Evaluation and quality assurance of measures and projects

Up to now, hardly any evaluation studies have been conducted to assess implementation processes and examine the effectiveness of institution-specific schemes for improving healthcare provision for violence victims [29]. Only the research accompanying the S.I.G.N.A.L. project has produced well-founded results confirming the effectiveness of the project measures. Given the lack of evaluation of intervention programmes, many questions remain unanswered. What effects can be expected from routine violence screening as part of anamnesis? What potential for improving healthcare lies in the implementation of existing guidelines and the systematic use of action manuals? [166] Similarly, little is known about the usefulness and the methods used to distribute the available materials on dealing with patients who have suffered (domestic) violence. For example, a study should be made on whether these materials are used in practice without accompanying training measures, or whether (and to what extent) the materials have already been incorporated into the training curricula of health professions [29].

The many open questions and the identified healthcare and prevention needs underline the relevance of further quantitative and qualitative scientific analyses of the problem of sexual, psychological and physical violence against women and girls, men and boys.

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9 Glossary

Acculturation	Process during which immigrants adapt to the culture of the immigration country
Anamnesis	A patient's medical history determined in conversation between the physician and the patient and relating to the current symptoms and complaints
Best-practice approaches	Innovative solutions or procedures that have been successfully tested in practice and scientifically evaluated; best-practice approaches meet defined evaluation criteria which qualify them as exemplary, worth emulating and suitable for universal distribution or transfer to other institutions and places
Bullying	(as opposed to mobbing) – Physical violence and/or the threat of violence among children and adolescents
"Comorbid disorders"	In this case concomitant psychological and/or physical disorders resulting from experiences of violence which can arise in addition to another primary disorder (e.g. abuse of/addiction to medications, alcohol or narcotics in connection with a post-traumatic stress disorder)
Coping factors	Ways of dealing with a difficult life situation; in this case a person's physical, psychological and social skills in dealing with illness or impaired health (e.g. in the case of physical complaints or after traumatic experiences)
"Dark-field" studies (Grey-area studies)	Studies on criminal acts that go unreported; dark figure studies on violence analyse acts of violence that are not covered by official statistics such as police crime statistics. In most cases, representative population surveys are conducted for dark figure studies; they use special methods to optimize the collection of evidence on victims' exposure to violence, especially in sensitive areas such as sexual violence and/or violence in family and/or intimate relationships
Domestic violence	Violent assaults within a partnership relationship or between adults who are members of a family and/or live together in one household (e.g. violence against spouses or relatives who require nursing care, etc.), irrespective of where the violence occurs
Evidence-based medicine (EBM)	Method for improving treatment and care by balancing benefits and risks on the basis of statistically proven efficacy; the key task of EBM is to develop guidelines for the proper assessment and treatment of health disorders
Forensic sciences	Sciences serving the administration of justice. Their main tasks are the identification and analysis of criminal acts (example: forensic medicine)
Gender sensitivity	Systematic awareness and consideration of differences in life situations and conditions between women and men (in healthcare: e.g. an awareness of differences in disease patterns and healthcare needs between the genders)
Good practice	Local measures and interventions (e.g. in the field of prevention) which meet certain quality criteria and whose effectiveness has been proven; successful models for transferring suitable measures to similar contexts and issues
Injury surveillance system	A system for improving the information and data available on violence against women and men in Europe (e.g. in terms of age, gender, place, type of injury) using systematic and continuous data collection
Migrants	Individuals or population groups who themselves (or whose parents/grandparents) leave a geographically defined region (or country) in which they used to be resident, either permanently or for a long period of time, and move their main place of residence to another country/region. They are made up of very heterogeneous groups, e.g. foreign students, labour migrants, seasonal workers, refugees and emigrants of German origin from Eastern Europe. Whatever their nationality, migrants are people with a migration background, i.e. including e.g. people of the 2nd and 3rd generation who were born in Germany and have German nationality, but whose parent(s) or grandparents were born and grew up in a different country.
Migration background	People or groups who themselves or whose parents/grandparents leave a geographically defined region (or country) in which they were previously resident, either permanently or for a long period, and move their main place of residence to a other country/region (e.g. foreign students, seasonal workers, refugees, emigrants of German origin from Eastern Europe)
Minority status	Societal status of people from population groups which are in a numerical minority compared to the majority of a country's population and who stand out from the majority of the population on the basis of ethnic origin, social and cultural differences

Mobbing	Subtly used form of psychological violence: systematic verbal comments and/or modes of behaviour which can range from continuous harassment in everyday life to targeted psychological terror and are specifically directed against a particular person
Peer group	Group of people of the same age or of equal status; in this case a peer group of children and adolescents in the context of the socialization process outside the parental home
Post-traumatic stress disorder	Also known as psycho-traumatic stress syndrome (PTSS): psychological and/or psychosomatic symptoms (e.g. nightmares, depression, addictive behaviour, jumpiness, insomnia) resulting from a traumatic experience
Prevalence	Frequency; number of people suffering from an illness in the population at a particular time or within a specified period; in this case the prevalence of violence as the percentage of people who have been victims of violence in a given reference period (1 year, 5 years, during adulthood, childhood, life)
Primordial prevention	Health promotion by reducing health risk factors
Protection against Violence Act	(<i>Gewaltschutzgesetz</i>) – "Act on Civil-Law Protection against Acts of Violence and Stalking, Facilitating the Use of the Family Home in the Event of Separation" (GewSchG); this law has been in force since 1 January 2002
Psychotropic drugs	Drugs that affect the psyche
"Rape trauma syndrome"	A term coined in the 1970s to describe the traumatic effects of rape; since the 1980s the term post-traumatic stress syndrome has also been used to describe the consequences of sexual violence
Representativeness	Quality criterion in the assessment of statistical research findings; a study is deemed to be representative if the findings can be generalized and are based on a study group whose structure and composition reflect that of the population or the group to be described
Retraumatization	Remembering a previously experienced trauma or the renewed confrontation with a traumatic experience (e.g. in the context of surveys, court proceedings, police questioning)
Sentinel	Population-based survey in which monitoring doctors' practices or monitoring health offices regularly report cases of certain illnesses or other relevant data (on a voluntary basis) to an evaluation unit; in the context of health and violence, an information tool for determining relevant data on the healthcare of violence victims either continuously or according to a particular time rota
Setting	An area of life within which people spend most of their time (e.g. workplace, school, place of residence, etc.)
Stalking	The intentional and persistent following, harassment and terrorizing of a person over a relatively long period
Studies on the prevalence of violence	Studies on the frequency of interpersonal violence; basis for the formulation of standards on intervention, support and prevention
Surveillance	In this case the continuous recording of illnesses and deaths by means of systematic and controlled data collection and data evaluation
Trauma	Injury; a one-off or long-lasting unusual and extremely stressful event which for victims is associated with feelings of threat, fear and helplessness and can cause both physical and psychological injuries
Trauma reactivation	Recurrence of psychological or psychosomatic symptoms caused by a previous traumatic experience (e.g. rape at an adolescent age) after a prolonged period without symptoms; victims are often elderly, war-traumatized women or refugees and immigrants from war zones
Treatment setting	The external framework of treatment (e.g. outpatient, inpatient treatment, partial hospitalization) and the methods and techniques used in the treatment
Validity	Quality criterion; statistically collected data are valid if they meet the criteria of reliability and accuracy
Victimization	Process by which people find themselves in the role of the victim in experiences of violence
Violence screening	Active search to identify victims of violence; in this case routine questioning of patients about physical and/or violent sexual attacks in outpatient and inpatient healthcare
Vulnerable groups of people	Because of their physical and/or psychological constitution (e.g. disabilities, psychological disorders, pregnancy, old age) and/or their special social situation (e.g. homeless women)

10 Links and further information

Working aids and practical guidelines for dealing with domestic violence in the health service

Federal pilot project on medical intervention against violence (MIGG) with further links www.MIGG-Frauen.de

GESINE Intervention Against Domestic Violence. Information and safety advice for female patients, information and working aids for medical professionals (materials, research findings, documentation from training seminars) www.gesine-net.info

S.I.G.N.A.L. Intervention Project. Practical handbook. www.bmfsfj.de/bmfsfj/generator/RedaktionBMFSFJ/Abteilung4/Pdf-Anlagen/signal-handbuch,property=pdf,bereich=,sprache=de,werb=true.pdf

Information for physicians. "When patients are affected by violence" www.big-interventionszentrale.de/veroeffentlichungen/broschueren/pdfs/patientinnen.pdf

Documentation sheet on domestic violence – physical abuse. Background information and handout for medical practices. www.frauennotrufe-hessen.de/formulare/index.htm

"Domestic Violence" manual. Information on diagnostics, documentation and case management.

Published by the Hamburg Medical Association in cooperation with HIGAG, UKE, Techniker Krankenkasse (health insurance company), Association of Statutory Health Insurance Physicians, Hamburg www.aerztekammer-hamburg.de/diekammer/ausschuesse/leitfaden_haesuslichegewalto6.pdf

Information and working aids on domestic violence for physicians. Published by the Working Group on Domestic Violence. Reference: Lower Saxony Ministry for Social Affairs, Women, Family and Health. http://www.aekn.de/web_aekn/home.nsf/ContentView/information_materialien_haesusliche_gewalt

Diagnosis, collecting and evidence, healthcare in cases of suspected sexualized violence www.frauennotruf-frankfurt.de/AErztlicheDokumentation.40.0.html

Assistance WITH working and planning on "Domestic Violence and Health". Published by Landesinstitut für den öffentlichen Gesundheitsdienst NRW (Nord Rhein-Westfalia (NRW) Institute of Public Health) (lögD) 2005 www.loegd.nrw.de/1pdf_dokumente/2_gesundheitspolitik_gesundheitsmanagement/gendergesundheit/planungshilfe-c11-haesusliche-gewalt-12-8.pdf

Practical working materials and guidelines, documentation sheets for health-service professionals (among others "Diagnosis: Violence" – guidelines for dealing with patients affected by domestic violence) with med-doc cards (cards that fit into a white-coat pocket, containing essential points for documentation in compact form) Frauengesundheit NRW (Women's Health NRW) www.frauengesundheit-nrw.de/ges_them/gewalt.htm

More than a broken heart – poster for doctors' practices and medical institutions as a "door opener" for conversations with patients and for patient information on the health consequences of violence. www.gesine-net.info/images/pdf/gesine-plakatera.pdf www.gesine-net.info/images/pdf/mehr-alsdas-herzera.pdf

Violence makes women ill! – a multi-lingual emergency card for female patients www.gesine-net.info/images/pdf/mini-folder-1era.pdf

"Violence by men makes women ill" with brief guidelines, January 2008. RIGG – Rheinland-Pfälzisches Interventionsprojekt gegen Gewalt in engen sozialen Beziehungen (Rhineland-Palatinate Intervention Project Against Violence in Close Social Relationships)
www.rigg-rlp.de/downloads.html

Anti-Violence Awareness. A site with comprehensive information in several languages on violence against women for victims and multipliers.
www.gewaltschutz.info/

Women's Health in NRW. Website with detailed information and material on violence against women and children (research findings, political documents and theory, pilot projects in the health service; information material for physicians and health-service professionals, action-oriented practical guidelines, further training, networking, activities and projects)
www.frauengesundheit-nrw.de/ges_them/material_gew.htm

Further information on forensic aspects, dealing with child abuse/neglect, support institutions in the field of violence against women and violence against children, action plans of the Federal Government, and national/international publications/resolutions (e.g. from the WHO and the EU) in the internet under:
www.rki.de/DE/Content/GBE/Gesundheitsberichterstattung/Themenhefte/gewalt_links.html

Bibliographic information from Deutsche Bibliothek
Deutsche Bibliothek records this publication in the
Deutsche Nationalbibliografie.

Published by

Robert Koch Institute
Nordufer 20
13353 Berlin

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Robert Koch Institute
Federal Health Reporting
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Translation

Bob Culverhouse, Berlin

Typesetting

Kerstin Möllerke
Robert Koch Institute

Printed by

Mercedes-Druck, Berlin

ISBN

978-3-89606-201-7

The political and financial responsibility for Federal Health Reporting lies with the Federal Ministry of Health.

*Gesundheitsberichterstattung des Bundes
(Federal Health Reporting)*

Robert Koch Institute in collaboration
with the Federal Statistical Office

October 2008

Health Consequences of Violence

Berlin: Robert Koch Institute
ISBN 978-3-89606-201-7

The high incidence of domestic and public violence affecting women and children, but also men causes considerable health consequences, and more attention should be paid to this issue in medical diagnostics and preventive medicine. Recognizing violence as the cause of physical and psychological problems can help overcome the provision of too much, too little and/or the wrong care for victims. Public health institutions are often the first and only places where people go to seek help for acute injuries and health problems resulting from violence; they therefore play a key role in intervention and the prevention of further violence. This booklet presents the results of national and international research on the health consequences of violence, paying particular attention to domestic violence against women. It also suggests guidelines and best-practice approaches to assisting the victims of violence.



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ISBN 978-3-89606-201-7

The Robert Koch Institute is a Federal Institute
within the portfolio of the Federal Ministry of Health