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Survivors' Opinions About Mandatory Reporting of Domestic Violence and Sexual Assault by Medical Professionals

Cris M. Sullivan and Leslie A. Hagen

Sixty-one survivors of domestic or sexual abuse participated in focus groups to discuss their perceptions of mandatory reporting by health care professionals. Only one participant believed that medical providers should notify the police when a woman seeks treatment. This survivor's experience was different from that of most of the other participants in that she was raped by a stranger. The remaining participants were unanimous in their belief that medical reporting should not be mandatory until a number of changes are made in the system to promote victims' safety. The survivors shared numerous examples of having been revictimized by the child protection system, health care system, mass media, and especially the criminal legal system. Practice, policy, and research implications are discussed.

Keywords: *domestic abuse; health care; mandatory reporting; sexual assault*

They love you all the way to the hospital.

—Cindy

Today, everybody can know, but nothing gets done.

—Sheri

Violence by intimate partners against women is pervasive throughout the nation, with millions of women being physically and/or sexually assaulted

Authors' Note: This research was funded by a grant from Michigan State University's Applied Public Policy Research Program, facilitated by the Institute for Public Policy and Social Research, which is made possible through funding allocated by the state of Michigan to develop expertise for Michigan's policy-making community. The authors gratefully acknowledge input from the Michigan Domestic Violence Prevention and Treatment Board and the Michigan Coalition Against Domestic and Sexual Violence. The conclusions and recommendations are the sole responsibility of the authors.

AFFILIA, Vol. 20 No. 3, Summer 2005 1-16

DOI: 10.1177/0886109905277611

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by their partners and expartners each year (U.S. Department of Justice, 2000). Many women seek medical treatment through hospital emergency rooms, clinics, and private physicians' offices for injuries they have received from being physically or sexually assaulted. Others seek no medical attention or are prevented by their abusers from seeking medical help (Raj & Silverman, 2002). In addition, survivors of abuse have contact with medical personnel for reasons other than emergency treatment, including routine physical and health examinations, obstetric or gynecological examinations, and dental checkups.

Individuals who seek health care are generally familiar with the concept of physician-patient privilege and expect that the information they have given to their physicians or diagnoses of their problems will not be shared with persons outside the health care delivery system. However, this concept may not hold true for survivors of domestic or sexual violence. In compliance with a number of state and federal laws and policies, health care professionals now contact the police to report injuries received by survivors of domestic violence. They do so without the women's permission and sometimes without informing the women (Rodriguez, McLoughlin, Bauer, Paredes, & Grumbach, 1999; Rodriguez, McLoughlin, Nah, & Campbell, 2001; Smith, 2000). To date, the debate about mandatory reporting by health care providers has occurred, for the most part, without input from the survivors themselves. This study was conducted to bring survivors' perspectives into the equation.

Many questions have been raised about the utility and propriety of states' medical-reporting requirements in cases involving domestic violence and sexual assault. Proponents of mandatory medical reporting have argued that it helps prevent domestic violence by holding the perpetrators accountable and by providing a means of tracking domestic-violence crimes (Larkin & O'Malley, 1999). Opponents have contended that mandatory reporting violates patients' rights to privacy, can lead to more violence, and deters survivors of domestic violence from seeking needed medical attention (Gielen et al., 2000; Rodriguez et al., 2001). One large study of physicians' views about mandatory reporting found that more than half might not comply if their patients objected (Rodriguez et al., 1999). The physicians were concerned about issues of privacy and confidentiality and feared that such reporting might escalate the violence.

Although few studies have surveyed survivors of domestic violence about their perceptions of mandatory reporting, this is the first study to use focus groups as a setting for survivors to discuss this issue. Survivors of both forms of violence have a unique perspective to bring to this important debate and can knowledgeably speak about the positive and negative ramifications of such policies.

We chose a qualitative methodology for this study because it provides participants with the opportunity to discuss their experiences and perspectives

in their own words (Reinharz, 1992). This methodology is consistent with a feminist approach to research, which strives to bring women's voices into the public and political discourse. Furthermore, we chose focus group methodology in particular because it gave survivors an opportunity to come together to share with and learn from each other. Focus groups provide opportunities for individuals who have shared a particular experience to discuss their varied perspectives and to structure their own experiences in their own words. Unlike quantitative methods, the use of focus groups allows researchers to explore the complexities and nuances of participants' experiences. By design, focus groups are often small and nonrepresentative, seeking to bring together a group of people who are similar demographically, situationally, or ideologically (O'Brien, 1993). Groups generally consist of 6 to 12 participants (Morgan, 1988), a size that is small enough for all members to have time to share their thoughts and perspectives fully.

METHOD

The state in which this study was conducted has a law that requires physicians to report to local police departments by telephone and in writing if they have cared for a person who has a wound or injury that was inflicted by a knife, firearm, other deadly weapon, or other means of violence. The report must contain the name, whereabouts, and residence of the wounded person, if known; the cause of the injury; and the character and extent of the injury. This duty also extends to hospitals and pharmacies. The failure to make the required report is a misdemeanor. This law is similar to many other state laws that mandate the reporting of injuries by health care providers.

Procedure

The research team contacted six domestic violence and sexual assault service programs in one midwestern state to seek their assistance in finding women who were willing to participate in the study. The locales were selected on the basis of their demographic composition (so as to include survivors from rural areas and ethnically diverse survivors) and with the aim of including women who (a) had not received any services from the programs, (b) had received nonresidential services from the program, or (c) had received residential services.

The staffs of the participating agencies used snowball sampling to recruit participants for the study. One recruitment method was to contact current and former clients who might be interested in participating. Through clients, staff members, and community allies, the staffs also identified survivors who had not received any victim services. The survivors were told that

the focus groups would discuss the health care response to domestic and sexual violence, and they were encouraged to participate, regardless of their level of interest in the topic. They were offered refreshments, transportation, child care, and \$25 for participating.

Six focus groups were conducted, with a total of 61 female participants, who ranged in age from 18 to 77. Across the groups, there was representation from the Euro-American, Native American, African American, Hispanic and Latina, and Arab communities. Approximately one fourth of the women were residing in shelters at the time of the focus groups, and about one third had not received services from either domestic violence programs or sexual assault programs. Many of the women were separated from their abusers but were still married. The majority of women had at least one child, and the majority of mothers had two or more children. Each focus group lasted approximately 2 hr.

Two facilitators who were knowledgeable about domestic and sexual assault led the groups. The facilitators were not strongly in favor of or opposed to mandatory reporting laws before they conducted the focus groups and were interested in learning from the survivors' expertise before they formed their own opinions. The discussions were guided by a core group of questions that touched on the mandatory reporting of injuries to the police. These questions pertained to (a) how the law may protect victims of physical and/or sexual violence; (b) how the law may harm victims of physical and/or sexual violence; (c) how the law had helped any women in the group (or women whom the participants knew); (d) how the law had harmed any women in the group (or women whom the participants knew); (e) the level of support for the law; and (f) if the participants did not support the law, specific recommendations that they thought would better protect victims of physical and/or sexual violence. In addition to these six discussion guidelines, the participants were given the opportunity to converse about any other issues that they believed were related to the topic.

The interviews were content analyzed by the second author and verified by the first author and the focus group cofacilitator. The investigators examined patterns and redundancies that arose from the focus group data. Distinct themes emerged from the data (e.g., fear of reprisal from the abuser and concerns about the media), and these themes were used to guide the presentation of the findings. The credibility of the interpretations of the data was enhanced by the use of negative case analysis (searching for exceptions to the inferences of the study), independent interpretations by members of the research team, and external audits (verification by qualified experts that the interpretations appeared to be reasonable and logical).

RESULTS

Survivors' Opinions on Mandatory Reporting

Of the 61 participants, 60 did not support mandatory reporting by health care providers to the police until a number of system-level changes have occurred. Only one participant was adamant that the police should be notified in all cases in which victims seek treatment for injuries that have been inflicted through incidents of domestic violence or sexual assault. That participant's experience was different from the experiences of the majority of participants in that she was raped by a stranger. Her abuser broke into her home and brutally raped her, and when her father tried to stop the assault, the rapist beat him severely with a tire iron. The rapist was later apprehended after he had committed several other similar crimes. The opinions of the other 60 participants were influenced by their previous experiences with health care providers, the police, the criminal legal system, and child protective service agencies. The women also perceived a severe risk to their safety if they were to tell anyone about the violence, and a number of abusers were themselves police officers or providers of social services. The women stressed that victims should be allowed to consider all the potential consequences of reporting before they allow their experience of violence to be reported to the police, because there are consequences for every decision that is made. It was clear that the participants had become adept at engaging in a cost benefit analysis for every decision concerning the violence and abuser. Unfortunately, the costs of reporting the violence often outweighed the benefits.

Obtaining Medical Treatment

The majority of the participants indicated that they had sought medical attention for at least one injury that was related to the violence. Injuries that prompted a trip to a physician spanned a wide range of severity, with some being life threatening. Even with this level of risk to their lives, many of the participants carefully weighed their options and the attendant risks of seeking medical care. The women described being beaten with fists and objects; being run over by a car; and being strangled, stabbed, or sodomized. If they sought medical attention, they often lied to the treating physician and/or nurses about how they became injured. Some women said that they felt too humiliated to admit to how they received their injuries, but most lied because they feared that the police would be called and that their abusers would retaliate. Some common response by the participants (who provided the names for use in this study, which may or may not be their actual first names) included the following:

Most of us are in a situation where we seek medical attention, and 98% of us lied and didn't tell the doctor how we really got hurt. If it was known that hospital will tell the police, that 98% would move to 100%. (Laura)

We are in a no-win situation. We believe in doctor-patient confidentiality, and I trust him to keep my secret. I had a female doctor once. I was so humiliated that I couldn't tell. It's too embarrassing to tell. (Elle)

It's a life-and-death situation if going to the hospital. If asked how injured, I lied. Because of consequences if you tell the truth. (Diane)

Even when the women desperately needed medical attention, their abusers sometimes prevented them from going to the hospital for fear that the hospital would contact the authorities, as the following comments illustrate:

He wouldn't let me go to the hospital. He put a steak on my eye. (Mandy)

He took the keys away from me so that I couldn't get medical treatment because [he was] afraid the police would be called. (Laura)

In other cases, the abuser allowed the victim to go to the hospital, but remained in the treatment room and would not let her speak for herself. The participants reported that their abusers supervised them during medical visits when the treatment was for injuries that were inflicted during assaults and even during routine prenatal visits. None of the participants who experienced this monitoring reported that the physicians or their staffs requested that the abusers leave the room. Some of the women described a desire to report the violence to their physicians but were unable to do so because their abusers were present, as in these comments:

My throat was cut by [my husband]. . . . The medical staff person asked my husband how I was injured because I was not able to speak. The doctors believed my husband's word on how the injury happened. He said I fell down. Once he jabbed me with a fork, imbedding it in my hand. The doctors had to remove it for me. They never asked me what happened and believed my husband's reason that the injury was another accident. Doctors should learn how to identify abuse of women. For 7 years, the abuse was hidden. No one gave a shit or provided me with any assistance. (Nicky)

On [specific date], I was spending time with a friend and left and returned home to my angry husband who pushed my arm behind my back, and I heard it snap. I went to the hospital, and my husband came with me. He told the doctor that I injured my arm when I was picking up weights. . . . My husband told me that he would kill me if I told anyone he hit me. (Mary)

Experiences With Dentists

The majority of participants reported receiving injuries as a result of abuse that required treatment by a dentist, and several had a large number of missing teeth because of violent assaults. Given that many survivors of

domestic and sexual violence suffer slaps or punches to the head, dental injuries are to be expected. Just as abusers prevent women from obtaining medical help, some participants reported that their abusers kept them from seeing dentists. Also, some survivors stated that even if they were allowed to see a dentist, their abusers insisted on being present in the treatment room. Their abusers' presence obviously prevented the victims from telling the dentists how their teeth had actually been broken or knocked out. Many of the women reported that the dentist simply did not ask them about the cause of their injuries. Those few who were asked chose to lie about how they received their injuries for fear that the police would be notified and their abusers would retaliate. These women believed that reporting injuries to the police that were inflicted through violence should be a woman's choice. The women, as a whole, thought that the issue of self-determination was critical. The following comments illustrate the women's experiences:

My first husband was an abuser who decided I didn't need to see the dentist. I got infected teeth, so my husband pulled four teeth out with pliers. He chipped my jawbone, and I got an infection. I then got to go to a dentist. [The dentist] asked what happened, but I didn't answer. (Diane)

I went to a dentist for an abscess. He said I needed a root canal and sent me to a specialist. The first thing the second dentist said to me after taking X-rays was, "Are you still in a domestic violence situation?" He asked a second time. I asked [him] how he knew. He said he knew from the X-ray because of how my jaw was set and three teeth where the roots were twisted. It made me feel good that he asked but upset that my own dentist hadn't asked. (Mia)

Experiences With the Police and the Criminal Legal System

All but one participant had been extremely disappointed by the responses they had received from the police, prosecution, and the courts. They reported that the police did not take their cases seriously and failed to investigate the crimes fully, pursue charges against the abusers, or apprehend the abusers if charges were authorized. They also reported that the prosecutors either did not consult with them before plea bargains were offered to the defendants or failed to prosecute the cases vigorously through to trial. They described a long history of judges failing to give meaningful sentences to convicted defendants; failing to enforce personal protection orders, conditions of bonds, or probation orders; and awarding abusers custody and parenting time with children.

The survivors who had been involved with the men who had abused them clearly stated that they wanted the violence to end. In fact, they would like to have medical providers be involved in stopping the violence. However, they said that involving the police and criminal legal system was too big a risk, given that abusers often quickly return to their homes or neighborhoods, which creates a severe safety risk for the survivors. Many of the women talked about the retaliatory violence they experienced at the hands

of their abusers and said that the retaliation assault was often more violent than the original beatings. These participants believe that it should be a victim's choice to have the hospital contact the police, as these comments show:

If [the injury] is reported, the police will step in, and the defendant will be taken in overnight. When he is released, what about the retaliation? (Ann)
I paid the fines for him [the abuser]. If he goes to anger management, he comes out pissed off at [me] because he wasted three hours, and then I have to pay for it. (Laura)

When I finally called the police on my husband, it had been 5 years of abuse. I had researched all of the laws first. But my husband is a cop. The shelter can help you emotionally, but they can't get justice for you. (Michelle)

Experiences With Child Protective Services

Another powerful deterrent for injured women who seek medical treatment is the threat that child protective services (CPS) will be notified and will remove their children. A number of the women who participated in the study had previously or currently had children removed from their homes. For instance, in one focus group, 6 out of 19 women currently had their children placed outside of their care by the child welfare system. The women's experiences with CPS were typically reported to be prejudiced against the mothers. Their experiences led them to believe that no matter what happens or who is violent and abusive, they will be the ones who are punished by losing their children. Some of these women had failure-to-protect charges filed against them primarily because of the domestic violence in their homes. Although the children, as well as their mothers, were sometimes injured during the domestic violence incidents, the persons who inflicted the injuries were often not apprehended by the police and did not receive sanctions through the child welfare system. Some of these survivors had been involved in the child welfare system for years, trying to have their children returned to their care and custody.

If CPS removed the children from their homes and child welfare cases were opened in family court, the mothers believed that they received inadequate legal representation by their court-appointed attorneys. Some reported little to no contact with their attorneys between court hearings and their attorneys' failure to return their telephone calls. The women also reported that court-appointed attorneys in child welfare matters and criminal cases always tell the women to plead guilty no matter what the charge and no matter the guilt or innocence of their clients. None of the participants who had been represented in child welfare or criminal cases said that her attorney actually litigated her cause at a trial.

Given these women's experiences, it is understandable that they were concerned that if the police became involved in their assault cases, they might eventually lose their children. Some counties, for example, have

policies that require the police to notify CPS whenever they investigate a domestic violence call in which children are present in the home. Clearly, the presence of CPS in these families is not an idle threat but a stark reality. This reality keeps abused women from seeking medical treatment and reporting the violence to the police. The fear of CPS involvement was one of the major reasons why the majority of the participants did not support the requirement that health care providers report cases of domestic violence to the police, as the following comments illustrate:

Kids are a huge factor in what you are willing to tell. (Laura)

I was afraid that if I told, my children would be taken away. (Ann)

I went through a CPS investigation. After he shot up the house, the police spent 11 hours digging bullets out of the walls. The house was torn up. Then my mother-in-law called CPS and said, "She always lives like this." It took 3 years to get my kids back. (Nicky)

Other Concerns

In addition to their concerns about the criminal legal system and child protective services making the situation worse for them, the participants mentioned a number of other issues that influenced their desire not to have their victimization reported to the police. The most prevalent concerns were related to the cost of medical treatment associated with their victimization, their fear that their mental health histories would become public and be used against them, and unwanted attention from the mass media.

Concerns about medical costs. Some participants who obtained medical treatment reported being left not only with the physical and emotional scars of the assault, but also with the bills for the treatment. Several women had unpaid bills with hospitals that used rape kits on them. One reported many outstanding bills for complications that resulted after an abortion that she had following a rape; she also has had to obtain medication for a sexually transmitted disease (STD) that she contracted during the rape. What was particularly troubling for these women was that they were saddled with bills that were incurred because of criminal offenses that were committed against them. A number of women experienced damaged credit because their cases were referred to collection agencies. These women also reported that the hospitals where they sought treatment did not inform them that it would be their responsibility to pay for the forensic examinations or the medical treatment. Again, the women felt revictimized by the system. This experience was particularly painful for those whose abusers received little or no jail time.

The participants also reported incurring significant expenses owing to depression or suicide attempts. Many of these women had struggled with mental health issues because of the violence they had experienced. Some

had been hospitalized in psychiatric facilities or had taken antidepressants for years—expenses that occurred some time after their assaults but were the direct results of the crimes. The women were also responsible for the costs of visits to mental health providers and prescription drugs, as these comments indicate:

I have a battle with the insurance company. They said a rape kit is not a medical emergency and could have waited. I still haven't paid the bill. The hospital told me they would sue. (Shari)

I got pregnant because of rape and chose to have an abortion. Could the crime victim unit pay for the abortion? I got an infection because part of the fetus wasn't removed during the abortion, so an infection set in. I had to have a D & C [dilatation and curettage]. I also contracted an STD because of the assault, and I had to pay for treatment. (Kathryn)

The hospital staff didn't say when they told me about an option to report—that is, if I didn't report, I could be saddled with the costs. (Erin)

Concerns about mental health issues. Many of the women described the emotional and mental issues they struggled with because of the violence they had endured. Some had been hospitalized in psychiatric facilities one or more times, some had attempted suicide, and many had sought mental health counseling and had taken prescription drugs for either depression or anxiety. All these women feared that their mental health histories would become known to their abusers or to criminal legal or social service professionals because this information could be detrimental in criminal or family court cases.

These types of fears made it difficult for some women to seek the help they believed would benefit them. The women were concerned that if they sought help from any type of service provider, the police might be contacted, and they would eventually suffer from retaliatory violence. The costs of counseling and medication also kept some women from seeking this type of treatment, as the comments of three women show:

Having the strength to get help is viewed as a weakness by the justice system. I hit the stress unit, yeah, but my husband had raped me the night before. (Shari)

The law should contain a component for mental abuse. If a person is mentally worn down and so depressed that she wants to die, this is just as cruel as any cut or gash. Men try to take your mental health. They make you do things. I have been to ER psych so many times. (Brenda)

I have had to endure so much abuse. . . . I did attempt suicide once; that was when my husband pointed a gun at me and told me he would give me a 20-min head start and then he was coming after me to kill me. (Sue)

Concerns about media attention. The women shared a concern that if they disclosed an assault to medical providers, this information could find its

way to the mass media. Some of the participants had their cases reported in a local newspaper or on television by a local news station. They thought that media exposure was detrimental to their safety and negatively affected their emotional healing after the assault. Most expressed feeling ashamed, embarrassed, and guilty about the criminal offense perpetrated against them. Having an account of the assault reported in the media only intensified their negative perceptions of themselves. The women, particularly those whose abusers were never apprehended, also feared that media exposure might result in an act of retaliation against them or their families, as Maggie and Erin stated in the following:

My concern was the newspaper. I was abducted by more than one person [and] beaten and raped for several hours. I didn't even realize I was raped I was so traumatized. I had an incest history, too, so I ended up hospitalized in a psych ward. All this ended up in the newspaper. These guys had my ID. I felt so vulnerable, and they never caught them. I was never given a choice if I wanted to report. I worried about my kids at home and them still out there. (Maggie)

When I told my therapist about the rape, I was terrified because I knew she is a mandated reporter. I went through the paper every day for the next [few] weeks. (Erin)

Even if a newspaper or television station does not specifically identify the victim, what is reported is often enough to allow the general public and, what is more important, the abuser, to determine the victim's identity. Given the problematic criminal legal response to the majority of the participants, this identification may be a severe safety risk. Many of these women did not tell their families about the assaults, so they were also afraid that media reports would alert the family members, friends, and coworkers to the abuse, which, they felt, could compromise their relationships and employment and result in further isolation, blame, or shame. The fear of identification was noted by two women:

Crime reports need to be protected from the media. They give the age of the victim and the address of the crime. (Erin)

I was raped and had a 13-inch knife blade held to my throat. His [the abuser's] attorney gave him my address. (Pamela)

Mandatory Reporting of a Sexual Assault

Although the participants were told that they did not have to share their individual experiences, many were forthcoming about specific instances of domestic violence. However, when asked if their opinions on mandatory reporting would be different if the cause of the injury was a sexual assault, the generally talkative women became quiet. It became evident that sexual assault was even more difficult for these survivors to discuss than were

physical beatings. Some participants identified primarily as survivors of sexual assault, but the majority identified as survivors of domestic violence. However, most of those who identified primarily as survivors of domestic violence also had been sexually assaulted by their abusers. The participants believed strongly that it should be a woman's choice whether the police are contacted following her arrival at a medical facility for treatment. The only time these women wavered in this opinion was if the victim was a child. The issue of children was raised by the group, not by the facilitators, and was raised because some of the participants had been sexually abused as children and had wished that a physician had done something to stop the abuse.

The issue of sexual assault also generated significant conversation among the participants about the need for health care providers to receive better training. Those who had sought medical help for rape generally reported that the treatment they received by physicians and nurses made them feel worse about themselves and about what had happened to them. They described a variety of victim-blaming questions and comments uttered by health care professionals. Some of them regretted seeking treatment and said that if they were confronted with the issue again, they would not seek treatment. A few participants reported that they had received good medical treatment following their sexual assaults. Here are some of the women's experiences with and opinions about sexual assault:

Especially in African American culture, I can't imagine reporting marital rape because it's your duty [to have sex with your husband]. (Brenda)

I woke up, and my husband was inside me. I was afraid if I went to sleep, someone else could do the same thing. (Lola)

I was in a hospital residential program for women, and my husband came to visit and raped me in my room. I tried to tell someone, but they thought I was crazy. (Kate)

It's more mortifying if it is a sexual assault. It is more emotionally damaging. It is an assault on womanhood; it goes deeper than the physical assault. (Laura)

Survivors' Suggestions for Improving the System

Most of the participants noted that they would not support mandatory reporting by health care providers until a number of changes are made in the system to promote victims' safety. The women had a number of ideas for improving the system's response, and most of their recommendations were related to enhancing the training of both health care providers and police officers, improving the criminal legal response to hold perpetrators accountable for their actions, and coordinating and enhancing services for survivors, as these comments illustrate:

Instead of the doctors calling the police, make them call the rape crisis center for protection for the victims. (Shawn)

Before I would tell, I would have to know for certain that (a) he would not just be jailed overnight, (b) he'd be sent to some kind of treatment, (c) he'd be told by a judge that there would be serious consequences if he did it again, and (d) he's receive at least six months of treatment. (Ann) @EX = Advocates need to be better trained. The advocates' primary purpose seems to be to get the victim to report the rape. This is just an added burden on the victim. (Maggie)

We need more awareness [by the] police. There was child abuse on the reservation when I was growing up. There would be things done to me until I needed hospital attention. The tribal police blamed me. (Shannon)

We need more women police officers. The first responder in my case was a man who made me feel stupid for reporting. A woman officer came in, and I felt completely different. She could empathize with me. (Pat)

We need special victim units like they have in Colorado. A counselor and a nurse come in and talk to the woman about her options. (Mia)

DISCUSSION

The results of this study have implications for practice, policy, and research. At the practice level, the women endorsed having physicians, nurses, and dentists ask their patients directly if they have been or are being abused. This finding corroborates the findings of other studies (Dobash, Dobash, & Cavanagh, 1985; Hathaway, Willis, & Zimmer, 2002; McFarlane & Parker, 1994) and speaks to the importance of health professionals asking these questions in private, without the potentially abusive partner in the room (J. C. Campbell, Moracco, & Saltzman, 2000; Thompson et al., 1998). It is equally, if not more, important for such professionals to have the skills and knowledge to follow up affirmative responses with understanding, support, and appropriate referrals (Loughlin, Spinola, Stewart, Fanslow, & Norton, 2000; Thompson et al., 1998). Social workers in medical settings are well positioned to assist survivors of domestic and sexual abuse if they have the proper training to understand the wide variety of needs that such survivors may present.

Many women did note, however, that even if their doctors had asked them about abuse, they would have lied if they had known that this information would not be kept confidential. This perspective must be drawn into the state and national debates about mandatory reporting by health care professionals. Although those who support mandatory reporting have survivors' best interest in mind, they may not consider the unintended, dangerous consequences of mandatory-reporting laws. Whether such consequences would occur for many or a few women, the implications must be fully weighed and considered by policy makers (Smith, 2000).

It is also critical to consider that the overwhelming majority of the participants had experienced profound failures by the criminal legal system.

Although the intent of mandatory reporting is to lead to an effective criminal legal response to assist survivors, this was not the perception or experience of most of the participants. Some women believed that they did not receive a helpful police response because their abusers were police officers. Others found that the incident was reported but the abuser either was not arrested or was released in a short time. The abusers' early release often led the women to fear that the abuse would only worsen as a result of police involvement. Because most charges of domestic violence are prosecuted as misdemeanors, when they are prosecuted at all, the severest penalty that most survivors can expect for their abusers is 90 days in jail, and the usual penalty is probation (Ames & Dunham, 2002; Coulter, Kuehnle, Byers, & Alfonso, 1999). Such a penalty does not offer many women lasting protection from their abusers. Furthermore, charges of rape are seldom brought against perpetrators, especially when there is a relationship between the victim and the abuser (R. Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Frazier & Haney, 1996). So again, survivors are faced with incidents being reported but no protective action being taken.

Many women had also been let down by CPS. A number of the women had already lost their children to the state, and others were anxious that it would happen to them. As many women noted, reporting the violence to authorities leads to the involvement of numerous systems in women's lives, regardless of whether such involvement is desired or helpful. Survivors consider these ramifications when deciding who to tell about the abuse they are experiencing, and many did not want to lose the ability to make this determination for themselves on the basis of their own needs and experiences.

Only one participant was unwavering in her belief that health care providers should notify the police when a woman seeks treatment. However, as we explained earlier, her experience was different from that of most survivors of domestic and sexual violence in that she was the victim of a brutal rape by a stranger. She had no prior relationship with the man who assaulted her and thus had a different experience with the various systems than did most of the other women. The remaining 60 participants, including another woman who had been raped by strangers, were unanimous in their opinion that reporting by health care providers should not be mandatory until the criminal legal system consistently protects victims and punishes perpetrators. The medical system's response cannot be separated from the criminal legal system's response when discussing mandatory reporting. A change in the policy or law of one system dramatically affects other connected systems. As many of the participants stated, no system adequately protects survivors of domestic and sexual violence.

The findings of this study should be considered in light of the study's methodological strengths and limitations. The focus group methodology not only allowed us to hear individual survivors' experiences and perspectives,

but also facilitated the valuable sharing of ideas and opinions by the participants. The in-depth conversations often led the women to clarify their perspectives and recommendations, and after the groups concluded, a number of the women were interested in becoming more active in this policy debate.

There were limitations to the methodology as well. Almost all the women had been victimized by men with whom they had had a relationship, and their perspective differed from that of one of the women who had been raped by a stranger. Thus, future research is needed on the perspectives of a diverse group of women who have been assaulted by strangers, because their perspectives about mandatory reporting may differ from the findings presented here. In addition, all the participants had self-selected into the focus groups, and the extent to which their views represent other survivors of domestic or sexual assault is unknown. More and larger-scale studies are needed to answer this question adequately.

In spite of these limitations, a great deal of important and enlightening information was obtained through the focus groups. For instance, although the original question structure for the groups did not include a discussion of dental care, this issue was raised by multiple women in every group. The women also raised a number of other concerns that are not always considered to be related to the issue of mandatory reporting, such as how it can lead to unwanted or dangerous attention from the mass media. The participants provided thoughtful and thorough insights into the many issues that must be considered in debates on mandatory reporting by health care professionals.

In short, the experiences of survivors themselves must be heard by those who create or modify any federal, state, or local policies because they are the ones whom the laws and policies are enacted to protect. What the survivors in this study stressed is that without a better response from medical professionals; other system responders; and, most important, the criminal legal system, mandatory reporting will lead to greater harm for many victims of domestic and sexual violence. On the basis of these findings, we would concur with the National Resource Council (Chalk & King, 1998) that there should be a moratorium on mandatory reporting until more is known about its consequences for survivors of domestic and sexual violence. As Laura stated, "It's always the beginning when a woman reports, not the end."

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