CONTINUING MEDICAL EDUCATION

Responding to the Needs of Low-Income and Homeless Women Who Are Survivors of Family Violence

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Americans have started to recognize interpersonal violence as a major health care issue. Increasingly, clinicians are beginning to recognize both the high rate of victimization among extremely poor women and its health consequences. However, most clinical responses focus on the immediate effects of child abuse, partner abuse, and rape. The long-term medical and mental health consequences and the relationship between early victimization and adult problems are still largely ignored. This article focuses on medical and mental health needs of extremely poor women survivors of interpersonal violence. It begins by documenting the extent and nature of violence against low-income women. Special attention is focused on the long-term sequelae of childhood abuse and on identifying and managing complex trauma responses in these women. The article concludes by discussing obstacles to care and the necessity of advocating for increased resources to respond to women living in extreme poverty.

Violence is a problem of epidemic proportion in our society[1]; many women, especially those living in poverty, suffer from its far-reaching consequences in terms of morbidity and quality of life.[2,3] The medical community—along with the criminal justice system—is most likely to see these survivors and thus constitutes a front line of identification and intervention.[4] With the growing gap between rich and poor and the recent passage of welfare reform legislation, providers—especially those in emergency and primary care settings—will see many more disenfranchised mothers and children with urgent medical, emotional, and psychosocial needs.[3] Their use of medical services is often precipitated either directly by loss, trauma, or victimization or indirectly by medical or mental health disorders related to these experiences.[5] Yet histories of violence still routinely go undetected and physicians routinely fail to ask about violence.[4,6-11]

Americans have started to recognize interpersonal violence as a major health care issue. The American Medical Association,[1,4] the American College of Emergency Physicians,[12] the American College of Obstetricians and Gynecologists,[13] the American Academy of Family Physicians,[14] and other organizations have made violence a major priority.[10,15-17] Screening instruments, curricula, and accreditation guidelines are being developed to improve the delivery of care and to sensitize clinicians,[18] and primary, secondary, and tertiary prevention efforts are more common.[18,19] These activities largely focus on identifying victims of partner abuse, ensuring safety, and making appropriate referrals. While response to the immediate effects of rape and partner violence in settings such as emergency rooms has improved markedly, the long-term medical and mental health consequences are still largely ignored. The connection between early victimization and current problems and the relationship between poverty and violence remain elusive to many practitioners.

This article focuses on the medical and mental health needs of extremely poor women survivors of interpersonal violence (childhood physical/sexual assault and partner violence) and recommends how to respond in clinical settings. Special attention is focused on the long-term sequelae of childhood abuse and on identifying and managing complex trauma responses, especially when multiple barriers to care are present.

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Intimate Violence in the Lives of Homeless and Poor Housed Women

Although violence is distributed across all income categories, poor women are at remarkably high risk of being victimized when compared to women overall.[20-24] Poverty increases stress and can undermine women's ability to alter their environments or live safely.[5,24,25]

A recent epidemiologic study of 436 sheltered homeless and poor housed mothers conducted by The Better Homes Fund (TBHF) found that, although their average age was only 27 years, 84% of these women had been severely assaulted (physically and/or sexually) at some point in their lives.[5] Severe physical assault was defined as the occurrence of at least one of the following: being kicked, bit, or hit with a fist; hit with an object; beaten up; burned or scalded; choked, strangled, or smothered; threatened or assaulted with a knife or gun; or having one's life threatened in some other manner. Although faced with so many crises that violence was often *not* the first stressor they mentioned, nearly two-thirds (63%) had been severely assaulted by parental caretakers while growing up, and more that 40% had been sexually molested at least once before reaching adulthood. As adults, 60% had experienced severe physical attack by an intimate male partner, and nearly one-third had been severely assaulted by their current or most recent partner (prevalence rates corroborated by other recent studies).[5,26,27]

The dramatic increase in the number of families living below the poverty level over the last 15 years makes these findings of urgent concern. More than one-third of all families headed by women

now live in poverty,[28] and among blacks and Hispanics, the number is more than half. Homelessness in America mirrors these patterns: families with children (largely female headed) now constitute more than one-third of the homeless population.[29] Except for the Great Depression, families were not homeless in significant numbers until the last 15 years. However, with the crisis in affordable housing, the growing gap between median rents and income support, cutbacks in assistance to the poor, and increasing numbers of female-headed families, their numbers have swelled. Experts predict that the number of families living in extreme poverty may grow precipitously as states begin to implement new welfare legislation.[3] And as the number of families living in poverty increases, so does the potential for violence.

Post-Trauma Responses to Victimization

Extremely poor families have more and more intense economic, housing, and psychosocial needs than families in higher socioeconomic groups. Mothers in these families, for example, have more acute and chronic medical and mental health problems than women in the general population[5,30,31] In part, these difficulties result from the presence of extreme and unremitting stressors and the pervasiveness of community and family violence.[26,32,33] Abuse, whether current or historical, profoundly compromises a woman's well-being and may lead to adverse medical and psychological outcomes.[4] Although largely unrecognized, many of poor women's medical and mental health problems are directly associated with violence.[5,21,24,34-36] A partial review of the sequelae of victimization follows.

Psychological Sequelae. Women survivors of physical and sexual assault often suffer from anxiety,[37-41] panic disorder,[38] major depression,[41] substance abuse,[42,43] somatization,[44] and eating disorders[41] as well as combinations of these conditions.[41] For example, a recent study reported that women survivors of violence with post-traumatic stress disorder and anxiety are at higher risk for onset of first major depression and alcohol abuse.[45] Also, an extremely high percentage of women in inpatient psychiatric settings has suffered severe violent trauma early in life.[46-48]

Physical and, especially, sexual assault experienced in childhood has the potential for producing severe and long-lasting effects.[42,49-51] Betrayal by caregivers and subordination to coercive control can interfere with normal developmental processes and engender pervasive mistrust, diminished autonomy, and debilitating fear.[52,53] Furthermore, the "sickening anticipation"[54] that victims develop when exposed to repeated trauma may lead to the use of defensive measures such as dissociation, denial, and the tendency to flee intimate relationships, all of which are maladaptive in the long run.

These responses may result in altered functioning, including impaired affect regulation such as sudden outbursts of anger[52] or self-mutilation,[55-57] suicidal behaviors to counter painful states of self-loathing,[57] substance abuse as a form of escape or affective release,[41,58] and an increase in other risk-taking behavior.[41,59] These are symptoms of borderline personality disorder[53,60,61] and dissociative disorders,[56,62-64] labels so frequently applied to women survivors, particularly if the trauma history is not known.

The concept of post-traumatic stress disorder (PTSD) has been used recently to understand the complex responses of survivors of violence.[65,66] Initially applied to war combatants and disaster victims, women who have been violently victimized suffer from PTSD as well.[67-69] The most common traumata suggested for PTSD in the *Diagnostic and Statistical Manual of Mental Disorders*[65] is

> actual or threatened death or serious injury . . . or witnessing an event that involves death, injury or threat to the physical integrity of another person . . . or learning about unexpected violent death, serious harm or threat of death or injury experiencd by a family member (p 424).

Although the TBHF study found that mothers living in extreme poverty were *not* more likely to be psychotic or have anxiety disorders than women in the general population, they did experience significantly higher lifetime rates of major depression, substance abuse, and PTSD.[5] More than one in three suffered from PTSD, a rate three times higher than in the general population.

PTSD includes a debilitating constellation of emotional symptoms characterized by reexperiencing the trauma, avoidance and emotional numbing, and hyperarousal and vigilance.[70] Women with PTSD may relive the traumatic experience through intrusive memories, flashbacks, and nightmares, and by reenacting aspects of the trauma. Overwhelming recollections alternate with efforts to avoid frightening and painful memories, such as avoiding people or places reminiscent of the trauma, anhedonia, emotional and psychic numbing, and self-medicating through substance use. Fear and terror associated with the trauma tend to be mirrored by exaggerated startle responses, altered physiological states, hypervigilance, disrupted sleep patterns, and decreased ability to concentrate. As found in the TBHF study, PTSD is likely to co-occur with depression and substance abuse, as survivors deal with unresolved and intense physical and psychic pain.[41] Unless fully treated, PTSD often persists, with periods of effective functioning alternating with extreme distress.

Of course, not all individuals who have been victimized develop PTSD or other mental health disorders. Women who have been raped or sexually molested, especially during critical formative stages, are at greater risk for developing post-trauma disorders than those who have not experienced sexual assault.[58,71,72] In a review of studies of children who had been sexually abused, factors such as duration and frequency of the abuse, whether or not there was penetration, and nature of the attachment to the perpetrator increased the risk for developing symptoms.[73] A "dose-response" relationship seems to exist, with more severe experiences and multiple episodes increasing adverse outcomes.[71,74]

PTSD can impede a woman's ability to provide safety for herself and her children; engage in and maintain constructive relationships; compete successfully for housing, jobs, and other resources; and seek medical or other services. Awareness of the potential for post-trauma responses to occur in *any* severely victimized individual gives providers a starting point from which to evaluate complex symptoms and recommend treatment.

Medical Sequelae. Identifying the

presence of trauma in the lives of patients is particularly important for providing effective medical care. Survivors tend to use medical and mental health services at higher rates than nonvictims.[75] As Browne cautioned, "Physicians and other health care providers rarely probe for the underlying causes of the [conditions] they treat, but a treatment plan based primarily on the treatment of symptoms is ineffective . . . if assaults are ongoing and thus sequelae continually reoccur," or if the pain of past traumas is maintaining current complaints. Treating only the symptoms carries the risk of "increasingly severe and debilitating sequelae for the patient [and] exhaustion of resources within the system providing care."[4(p 3188)]

Rape victims, battered women, and survivors of childhood sexual molestation are frequent users of medical services. In one study of rape victims, visits to physicians increased 18% during the year of the assault, 56% the following year, and 31% the year after.[76] In a large randomly selected community sample, Golding and colleagues[77] found that 18% of women who had been sexually assaulted used mental health services over a six-month period, compared to 9% who hadn't; the corresponding rates for use of medical services were approximately 60% and 44% respectively. Lack of health insurance did not decrease service use. Similarly, battered women tend to visit medical providers repeatedly, often reflecting the escalating severity of abuse. Stark and colleagues[78] reviewed more than 3,500 randomly selected emergency room patient files and documented that more than half of all injuries and one-fifth of all surgical procedures in women were related to domestic violence. In emergency settings, an estimated 22% to 35% of all women seek services because of problems related to domestic violence.[79] Many of these women are pregnant[80] and are likely to suffer especially severe outcomes.[81]

Victims of ongoing violence seek medical services because of injury or stress related to the abuse. Immediate medical concerns related to rape are well-known and include gynecological trauma, risk of pregnancy, risk of human immunodeficiency virus (HIV) infection and other sexually transmitted diseases, rectal bleeding, and musculoskeletal or other injuries.[82] Injuries from partner violence range from bruises, cuts, concussions, broken bones, and miscarriages to permanent injuries such as joint damage and scars from burns, bites, or knife wounds.[4] Although some victims try to attribute the cause of their injuries to accidents or falls, Flitcraft noted that abuse injury patterns "are relatively specific and generally involve contusions or minor lacerations to the face, head, neck, breast, or abdomen, distinguishable from injuries not deliberately inflicted."[83]

Medical sequelae of partner assaults during pregnancy include placental separation, antepartum hemorrhage, fetal fractures, rupture of the uterus, and preterm labor.[81]

In addition to acute medical problems, victims of all types of violence complain of more health problems and suffer disproportionately from a range of somatic complaints,[84] including chronic pain (especially pelvic),[85-87] other gynecologic difficulties,[88] such gastrointestinal problems as irritable bowel syndrome,[89-91] asthma, heart palpitations,[86] headaches, and musculoskeletal difficulties.[92]

Although studies clearly document increased rates of medical problems among survivors, most have been conducted on community and clinical samples, often without comparison groups, and most do not distinguish between the independent effects of adult and childhood abuse or types of abuse. To overcome these limitations, McCauley et al[92] recently surveyed four community-based primary care practices to determine the prevalence of childhood abuse. Although reporting rates obtained by this study were lower than those of representative community surveys, 22% of the 1,931 respondents disclosed that they had experienced childhood physical and/or sexual abuse. In contrast to women without childhood abuse histories, these women had had more physical symptoms in the previous six months, including back pain, headaches, pelvic pain, fatigue, abdominal pain, vaginal discharge, breast pain, diarrhea and constipation, and more psychological difficulties such as depression, anxiety, substance use, and attempted suicide than women without child abuse histories. Moreover, adult health problems were equally prevalent among women who had experienced abuse in childhood as among those currently in abusive relationships. To date, we know of no published reports that specifically document the prevalence of long-term medical problems in low-income and homeless women who have been victimized.

A disproportionate percentage of women with histories of childhood sexual abuse also manifest high-risk behaviors that have adverse medical consequences.[93] For example, researchers found that a sample of adult survivors of childhood rape were more likely to contract HIV infection because of prostitution, frequent changing of sex partners, and substance abuse.[60] Others have found higher rates of smoking[94] and alcohol use[59,95] among those who had been sexually molested during childhood. In a literature review of child sexual abuse, Polusny and Follette[41] reported that approximately one-third of abused women had lifetime alcohol problems, compared to approximately 20% of women in the general population.

Links Between Traumatic Experiences and Medical Complaints

The complex connections between traumatic experiences and physical complaints are numerous and must be identified by the clinician. Victimization may produce actual injuries and presage the development of chronic pain, repetitive inflammation, or skeletal trauma. In addition, stressful and threatening events may disrupt a woman's ability to function. These events are not only terrifying, but also may have devastating consequences involving the need for shelter (a battered woman who must leave her home to escape violence), access to resources (money, health benefits), stability of supports (family structure), and safety (continued threats or retaliation by an estranged intimate, change in residence to an unsafe neighborhood). Thus traumatic experiences can interfere with caregiving obligations, pursuit of goals, and a woman's time or ability to hold a job. Finally, the cumulative effects of trauma increase a survivor's risk of developing stress-related disorders and illness.

Physical distress may also reflect bio-

logically conditioned alterations in the stress response. The hypervigilance commonly seen in traumatized women is associated with a high tonic output of stress-related hormones.[96] Further, individuals with PTSD often have heightened physiological responses to stress when they are reminded of the traumatic events. Thus a traumatized individual may have a full-blown stress response to what are actually benign sources of stress in the environment. Increased autonomic reactivity may escalate into episodes of acute anxiety or even panic.

Somatic complaints may also represent "body memories." Mind-body disconnections and dissociation are a hallmark of trauma; as van der Kolk stated, "the body keeps the score."[51] Due to the high level of emotion during traumatic experiences and the early age at which some trauma occurs, memories may be stored in imagistic and somatosensory modalities. For example, survivors of childhood abuse tend to recover memories of their experiences in the same fragmented and somatic form in which they were initially registered.[97] Positron emission tomography of PTSD patients has shown heightened brain activity in parts of the limbic system connected with the amygdala, suggesting that they "experience emotions as physical states, rather than as verbally encoded experiences."[52(p 233)]

Medical complaints in some trauma victims may be an outgrowth of health perceptions. Individuals with PTSD often have heightened perceptions of autonomic system alterations associated with the disorder. Furthermore, states of anxiety and depression promote attention to somatic activity, which may increase awareness of bodily sensations.[98] Given the negative or fearful state of mind associated with these sensations, they may be magnified or interpreted as ominous or even life threatening.

Strategies for Assessing and Treating Patients

Although women who have been violently victimized are likely to experience more medical and emotional symptoms than those who have not, practitioners infrequently ask about violence unless protocols are in place. Researchers have documented that many victims are identified by asking specific questions.[99] In general, however, questions about childhood abuse are not asked; existing protocols have been developed primarily to identify victims of partner violence in emergency rooms.[10,100]

When asked about this silence, physicians describe women's reluctance to disclose, their own feeling of helplessness, and lack of time. They also express concern about opening a "Pandora's Box" and becoming overwhelmed.[101] In some ways this concern is justified, since the needs of severely victimized women for safety, support, and safe anchoring relationships conflict with the efficiency and cost containment demands of managed care. Providing quality care for extremely poor mothers, who frequently need complex psychosocial interventions and case management, can be especially challenging.

Rodriguez and colleagues[102] asked victims of family violence, convened in focus groups, to describe obstacles to disclosing and to care. Women described fearing the perpetrator, but wanting to preserve the relationship and their families; feelings of shame, humiliation, and low self-esteem; concerns about police involvement; and mistrust of providers. Despite these concerns, they strongly encouraged clinicians to ask about victimization directly and to deal with patients respectfully, compassionately, and without blame. When asked about institutional barriers, they described long waiting periods, brief appointments, and high costs. Sensitive to time constraints, many of the women suggested that treatment referrals be made to community agencies.

Given these issues, what should clinicians do? The literature describes various multidisciplinary strategies for assessing women for traumatic victimization.[4,13,19,40,100] A crucial beginning in the helping process is to establish a safe patient-provider relationship, which can help facilitate disclosure and implementation of a treatment plan. But for extremely poor women, these steps must be combined with knowledge of institutional barriers to care. Based on the literature and our own experiences, we recommend the following strategies for responding to the needs of extremely poor women who have been victims of family violence.

Screen Routinely and Assess Basic Needs. In 1992, the American Medical Association established that domestic violence is sufficiently prevalent to justify screening all women in medical and mental health settings.[12] Based on recent findings on post-trauma sequelae, screening should include questions about childhood physical and sexual abuse as well. Physicians should have a particularly high "index of suspicion" when treating women with the functional somatic complaints described above.

Initially, simple and direct questions should be asked to assess for current and past histories of physical, sexual, or emotional violence. Clinicians can begin by destigmatizing the topic: "Because violence is so common in many people's lives, I've begun to ask all my patients about it routinely. In the last 12 months, has anyone physically hurt you or threatened you, even if you think they didn't mean to hurt you?" The physician might then ask some combination of the following questions. "Has anyone used a knife or gun to hurt you or to scare you? Has anyone choked, kicked, bitten, or punched you? Slapped, pushed, grabbed, or shoved you? Forced or coerced you to have sex? Have you been afraid that a current or former intimate partner might hurt you physically?" The physician should also determine whether these experiences are ongoing or have happened in the past. If a woman indicates she is currently involved in an abusive situation or is worried about danger from a former partner, assess her current level of safety. "Are you afraid to go home? Are there weapons in the house? Are you being followed or threatened? What are your fears? What do you *think* might happen?"

Always respect a patient's resistance to discussing these issues. Answering questions may depend on whether the patient experiences the relationship with you as safe and on the nature of her fears about the outcomes of disclosure. For poor women, these fears may include threat to public housing status, unwanted social service contact, loss of employment of a financially supportive partner/other perpetrating adult, or the loss of social support or child care services provided by the assailant's family. The timing and

sequence of questions should be determined by how you read the patient. Keep in mind that, although a trauma survivor may be mistrustful, she is also likely to be greatly distressed and to desire help in some form.

Patients who seem to have trauma-related injuries, yet do not admit to abuse, may be asked more indirect questions. Also remember that a substantial minority of women are thought to have long-standing amnesia of their experiences[103] and that shame and terror as well as a desire to not think about painful incidents may prompt women to disassociate, deny, or be circumspect in disclosing their experiences to others. If clinicians have serious concerns about the patient, additional appointments might be scheduled to allow more time for the relationship to develop. Ideally, violence assessment is an ongoing process, as is a woman's emerging acknowledgment of abuse and her capability for leaving an unsafe situation.

For extremely poor women, routine screening must include questions about whether their basic needs are being met. This includes questions about safe housing, income support, ongoing coordinated medical care, food, child care, and transportation. Before developing an adequate treatment plan, physicians must understand the reality of a patient's life, including practical barriers to following through on treatment recommendations.

Validate the Experience. If a patient discusses an abusive situation—or even intimates its existence—the clinician can explain that many people experience aggression over the life span, that they often have not shared these experiences and live with them in secret, and that such experiences can be painful and interfere with their well-being.[4] Flitcraft has noted that simply acknowledging domestic violence and agreeing that it is a serious problem "is a very powerful and therapeutic first step."[83] The physician's simple assertion that these acts are illegal and unsuitable can be an effective intervention, one that may reinforce a woman's instincts for self-protection and care. Believing a survivor and not shaming her for either the violence or her symptoms may catalyze a woman's recovery. Physicians should also acknowledge the circumstances associated with poverty, such as unsafe housing and some clinicians' biases against poor women, which may reinforce her unwillingness to seek help.

Link Trauma with Current Medical and Psychological Distress. Clinicians have only recently come to understand the association between past trauma and current distress, and many patients are still unaware of the link. Recognizing this association can be very helpful: "Difficult experiences of violence in your past may be contributing to your pelvic pain." This is especially true for women who do not have ways of organizing their experience and feel "crazy." A cognitive framework may explain seemingly disparate symptoms by identifying a coherent theme that can be named and thus associated with hope for recovery. Further, this explanation may counter the stigma associated with trauma and bolster motivation to follow through with referrals.

Discussing the links between past and present is key, but requires caution with regard to timing and potential reactions. Disclosures to physicians and acknowledgment of the seriousness of their distress may represent a novel experience for women who have deflected their own feelings out of a sense of self-preservation. Providers should be mindful of the possibility that this new understanding may trigger strong feelings, memories, or further emotional processing of these difficult experiences. Thus, when validating a woman's experiences, it is important to assess her coping style as well as the availability of support.

Physicians should document all injuries in the chart, noting the perpetrator and the mechanisms of injury (if known). If past violent incidents have involved injuries, medical professionals may be in a position to describe the pattern of events in a way that suggests their likely origins.

Make Appropriate Referrals. Patients should be referred to appropriate health professionals and/or community-based resources.[4] The clinician must consider the optimal sequence for different types of referrals for each patient. Engaging a homeless woman in treatment, for example, may begin with identifying such basic needs as housing. The interaction, with its potential to yield tangible, positive results, can form the basis of a trusting relationship the provider can use to make other referrals for specialized services. Many homeless and extremely poor clients will accept help with basic amenities before they are willing to participate in specialized services.

When the timing is right, extremely poor women survivors should also be referred to mental health providers with expertise in trauma and/or to support groups.[4] Treatment options vary greatly according to the woman's symptoms and available resources. Current research suggests that the type of trauma may dictate preferred treatment options. Cognitive-behavioral and exposure treatments, for example, have been successfully used with victims of single-incident rape and with substance-abusing trauma survivors.[82] In contrast, treatment for survivors of childhood violence with longstanding difficulties generally involves a more prolonged combination of individual and group therapies that provide a staged process of recovery.[104]

Although subsidized insurance may provide poor women access to these services, these treatments have generally been used with and evaluated on middle-class women. Literacy, consistent attendance, and other systems barriers must be identified in treating poor women. Services allowing for drop-in attendance and/or located in neighborhood health clinics may be preferred for poor women whose lives are unstable and who face transportation constraints.

Providers must understand that women currently facing violence in intimate relationships may be reliant on an abusive family member or partner for such essentials as insurance, transportation, housing, and financial support. Finding reliable instrumental support may not be a simple task given the social isolation of many poor and homeless women.[5] Welfare reform has made financial and logistical support increasingly tenuous. Further, efforts to leave the abusive partner may escalate into additional threats or actual violence, and thus must be prudently undertaken and carefully planned.

Safety planning is a major priority. Support groups at battered women's shelters are often recommended in combination with individual therapy and

logistical support.[105] Thorough care also includes providing survivors with the popularly known "palm cards," which list emergency phone numbers and free resources. In sum, treatment decisions must be based on a comprehensive assessment of a woman's social ecology and economic predicament.

Depending on the extent and nature of mental health difficulties, some women may require additional services such as supervised/shared housing or residential drug treatment programs. Finally, pharmacotherapy is increasingly recommended as part of an overall treatment plan for help with hyperarousal and reexperiencing symptoms.[106] As always, efforts to integrate medical care among providers and to find affordable medication are of primary importance.

Address Systems Barriers. Institutional barriers limit low-income women's access to health care and must be dealt with realistically by referring clinicians. Obstacles to obtaining care may be financial (lack of insurance and restrictive public assistance benefits), bureaucratic (restricted clinic hours, inflexible scheduling, long waits and waiting lists, complicated registration procedures), programmatic (scarcity of appropriate services, fragmented care, inadequate transportation, negative attitudes of some providers to disenfranchised patients), or individual (mistrust of providers, making health care a low priority because of the pressures of daily survival). How can a busy physician respond to these discouraging realities? Although not a panacea, referring low-income patients with complex needs to case managers can help with assessing evolving needs, locating entitlements and services, and coordinating care with the client's medical providers. The case manager may be the only person in a position to integrate the practical and treatment parts of the service plan and then to ensure its implementation through support and monitoring. It is essential that the case manager and physician establish open channels for communication.

Effective case managers advocate for their clients, helping to negotiate complicated and fragmented bureaucracies that are often intimidating and incomprehensible. Expert and aggressive guidance can make a tremendous difference for a low-income woman seeking access to services. While initially helping to meet basic needs, case managers can also become sources of consistent support in the fragmented, single-category world of social service agencies. They will not only save the physician time, but can provide outreach and facilitate successful referral and follow-through to trauma-specific services. Furthermore, for many low-income women, especially those who are homeless, practical help can become a "hook" to engage the patient. Addressing basic needs will help the patient link the treatment experience with the likelihood that a tangible aspect of her life may be improved. As the relationship evolves, it may shift from being primarily focused on practical issues to becoming increasingly therapeutic.[107]

Case managers can also support patients through acute crises by helping them navigate the associated network of public contacts, such as crisis intervention services at hospitals, district attorneys offices where restraining orders are administered, police offices with domestic violence units, and battered women's shelters. Use of case managers also helps to ensure continuous contact by withstanding potential breaks in care caused by housing evictions and telephone cessations.

While case managers help patients negotiate our fragmented system of care, they do not address the underlying systems problems. Physicians are in a position to advocate for critical systems changes that may improve their ability to deliver high-quality care in the long term. For example, they can advocate for spending more time with patients or persuade health maintenance organizations that delivering services earlier will save costs later. Consistent with the studies reviewed in this article, they can also argue that early identification and treatment of trauma-related problems may reduce unnecessary medical care and inappropriate and excessive service use. Most important, reducing institutional barriers is critical for effectively delivering high-quality medical care to low-income women.

Develop a Safe, Caring, Anchoring Relationship. Because most victims have experienced betrayal in primary relationships, treatment for trauma survivors emphasizes establishing a safe therapeutic attachment as a prerequisite for recovery.[54] Effective treatments are based on fostering trust and safety regarding honest disclosure of physical and emotional complaints and medical recommendations. By adopting a nonjudgmental attitude, clinicians can capitalize on the concern inherent in doctor-patient interactions and provide an example of a safe relationship. A consistently nonjudgmental stance can be especially powerful for poor women who face judgment in many of their contacts with public agencies.

Listening to women's stories often evokes intense feelings of helplessness and hopelessness in providers. Clinicians may identify with and experience the fear, grief, shame, and rage that the patient has experienced (known as secondary traumatization).[108] Part of the physician's task in treating traumatized individuals includes recognizing and managing his or her own emotional reactions and identifying those that may subtly interfere with treatment. If clinicians are able to acknowledge and feel comfortable with their own feelings, they will be more able to accept and respond to the patient's emotions. Physicians can ease their feelings of helplessness by realizing that their role is not to single-handedly resolve a woman's predicament, but to provide referrals, find a professional to coordinate services, advocate for the woman, and offer encouragement. Physicians must be aware of their own need for self-care.

Conclusion

Knowledge of victimization provides a starting point from which to evaluate confusing symptoms or conditions. Failure to screen routinely for interpersonal violence can undercut the effectiveness of medical care and drain resources, since unacknowledged trauma may exacerbate medical and mental health symptoms. For low-income women, routine screening for trauma must always be accompanied by an evolving assessment of basic needs.[105,107] A doctor's knowledge of patients' medical and psychological needs must be combined with an appreciation of the social context of their lives.

Physicians must also be aware of the obstacles to care. Because the availability

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of resources varies greatly across communities, especially for poor women, physicians must find ways to ensure that care is coordinated, continuous, and comprehensive. Institutional barriers are numerous and exacerbate trauma survivors entrapment in their symptoms and distress. Physician's efforts to educate themselves about existing services and to advocate for greater depth and breadth of resources are critical steps for ensuring high-quality care and appropriate service use. Unless physicians are willing to embrace this issue, many victims of violence will continue to suffer and receive compromised care.

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