

## CHAPTER 2

# **IDENTIFICATION, ASSESSMENT AND INTERVENTION WITH VICTIMS OF DOMESTIC VIOLENCE**

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BY CAROLE WARSHAW, M.D.



# IDENTIFICATION, ASSESSMENT AND INTERVENTION WITH VICTIMS OF DOMESTIC VIOLENCE

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## INTRODUCTION

It has become increasingly evident over the past two decades that domestic violence constitutes one of the most serious public health problems facing women<sup>1</sup> in this country. Ongoing physical violence, psychological abuse and sexual assault from someone a woman has known and trusted carries serious medical, psychological and social consequences. Without intervention this violence usually continues,

involving repeated acts of assault and a pattern of continuing threats, intimidation and control. Although health care providers see the manifestations of domestic violence on a regular basis, they may not connect a woman's symptoms to the abuse she is experiencing, know how to ask if she is being battered, or feel comfortable intervening if the answer is yes.

This chapter provides a step-by-step

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<sup>1</sup> For the purposes of this manual, masculine pronouns are generally used when referring to perpetrators of domestic violence, while feminine pronouns are generally used to reference victims. The term "battered woman" is also used when referring to victims of domestic violence. This is not meant to detract from those cases where the victim is male or the perpetrator is female. This pronoun usage reflects the fact that the majority of domestic violence victims are female. The U.S. Department of Justice estimates that 95% of reported assaults on spouses or ex-spouses are committed by men against women (Douglas, 1991). There are no prevalence figures for domestic violence in gay and lesbian relationships, but experts (Lobel, 1986; Renzetti, 1992; Letellier, 1994) indicate that domestic violence is a significant problem in same-sex relationships as well. Consequently, some of the examples in the manual are specific to gay, lesbian or heterosexual relationships, while others apply to all three.

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description of the identification, assessment and intervention skills that clinicians need to effectively and sensitively respond to domestic violence in their clinical practices. The material presented can easily be adapted to a wide variety of health care practice settings, including emergency departments, private offices, HMO's, community and hospital based clinics and

teaching institutions. The majority of battered women (Goldberg & Tomlanovich, 1984, Stark, Flitcraft & Frazier, 1979; AMA Guidelines, 1992; Randall, 1990) are not seen for acute injuries, but rather for the myriad of medical and psychological problems associated with ongoing abuse and battering.

### I. GUIDING PRINCIPLES

While this chapter focuses specifically on the individual clinician's role in responding to the needs of battered women, Chapter Four addresses strategies for changing institutions and practice settings to improve the capacity of health care providers to meet those needs. As clinicians, there are several issues particular to working with victims of domestic violence that are important to keep in mind, both when inquiring about abuse and when providing interventions. They can be summarized by the following principles which should be used to guide clinical practice:

For all victims of domestic violence, the issue of safety is paramount. This means considering a patient's physical and emotional safety while in the health care setting and helping to assess options for safety when she leaves. For people living in an atmosphere of ongoing threats, intimidation and violence, being treated with respect and feeling free to make their own choices lets them know nonabusive experiences are possible. Being clear that the perpetrator alone is responsible for his (or her) violent behavior and is responsible for stopping it counters the abuser's power to blame the victim.

**FIGURE 2-1**

#### **GUIDING PRINCIPLES**

1. Regarding safety of victims and their children as a priority
2. Respecting the integrity and authority of each battered woman over her own life choices
3. Holding perpetrators responsible for the abuse and for stopping it
4. Advocating on behalf of victims of domestic violence and their children
5. Acknowledging the need to make changes in the health care system to improve the health care response to domestic violence

## IDENTIFICATION, ASSESSMENT AND INTERVENTION

Advocacy adds an additional dimension to traditional clinical interactions. Advocacy involves facilitating, rather than directing, change by helping battered

women become aware of their options and resources and make their own choices about how to best end the violence in their lives.

## II. BARRIERS TO AN EFFECTIVE RESPONSE

Despite the frequency with which battered women present to health practitioners, the abuse itself often goes unrecognized. Early studies indicate that only 6% of battered women were accurately identified in emergency departments (Goldberg & Tomlanovich, 1984; McLeer & Anwar, 1989). There are many reasons that health care providers fail to ask about domestic violence. Some clinicians may simply be unaware of the prevalence of abuse among women seen in health care settings. As of 1988, 53% of Canadian and American medical schools indicated that their students did not receive any instruction about domestic violence (Holtz, Hanes, and Safran, 1989). Additionally, few primary care or specialty training programs specifically educate their residents about domestic violence, and continuing medical education programs rarely address battering in any systematic way.

Some providers say they are afraid to ask about domestic violence because it will take too much time. While the pressures and time constraints of medical practice may pose serious conflicts in providing quality care, early intervention ultimately takes far less time than addressing the repeated and long-term consequences of unrecognized abuse. Other barriers to asking about abuse include providers' own attitudes and misconceptions about domestic violence. Specifically, providers simply may not believe that domestic violence occurs among their patients. This may be particularly true for providers whose patients are of a similar professional, educational, religious or cultural background. Providers may also know the

family and believe that abuse could not be a part of their lives or that the assailant is incapable of violence. When patients' backgrounds differ from the clinicians, the providers' cultural assumptions and biases may prevent inquiry about abuse.

Some providers may be uncomfortable asking about domestic violence because they view partner abuse as a private matter. There are, however, many other "private" matters with important health consequences which are routinely explored with patients, such as sexual practices which may increase an individual's risk of HIV infection. Viewing domestic violence as a private issue may be rooted in the belief that a man has the right to control what happens in his home, or that if a woman does not like what is going on, she can easily leave. These kinds of assumptions can convey to a woman seeking help for domestic violence that the abuse is justified or that she is at fault. Health care providers may also fail to ask about domestic violence for fear of opening potentially troubling issues, such as awareness or memories of abuse in their own lives, feelings of powerlessness, helplessness, and the inability to "fix" the situation, feelings of anger or outrage at the abuser, fear and anxiety about the woman's safety, or feelings of overwhelming sadness and pain in the face of such brutality. All of these issues become barriers to asking about domestic violence and greatly reduce the level of care for its victims (Gremillion & Evins, 1994; Sugg & Inui, 1992; Warshaw, 1993).

Finally, domestic violence may be missed when a woman is reluctant to tell a

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health care provider about the abuse. She may provide an alternate explanation for her injuries or symptoms because she fears retribution if she discusses the abuse. She may be embarrassed to talk about the violence. She may fear that the provider is

too busy to care about her situation. All too frequently when a woman does not talk about the abuse, the provider fails to ask directly, even when he or she believes that abuse may be occurring.

### III. CONSEQUENCES OF NON-INTERVENTION

Despite the fact that information on domestic violence has been available since the late 1970's, health care providers are just beginning to ask about domestic violence (McLeer & Anwar, 1989; Stark, et al., 1979; Helton, Anderson & McFarlane, 1987; Hilberman & Munson, 1977; Jacobsen & Richardson, 1987; Carmen, Rieker & Mills, 1984; Hilberman, 1980; Raskin & Warshaw, 1990). Even in hospitals with established domestic violence protocols, this issue has often been ignored except when recognition of battering becomes inescapable (McLeer, 1989; Warshaw, 1989).

What happens when a woman who is being battered reaches out for help? Stark, Flitcraft and Frazier, in their landmark 1979 study, provide a description of the progression of symptomatology in battered women through encounters with an unresponsive health care system. Through a careful analysis of emergency department records, they began to see a repetitive and disturbing pattern. Initially, a woman seeking medical attention for an isolated injury would be treated only symptomatically. When the underlying problem was not addressed, she would continue to seek help for recurrent injuries and the many medical consequences of ongoing abuse. Over time, however, she herself would be defined as the problem and would be given such labels as "crock" or "hysterical" and, more recently, the pejorative

psychiatric diagnostic labels of "somatization disorder," "self-defeating personality disorder" or — if she happened to express too much anger — "borderline personality disorder." Her credibility would be further diminished if she developed any of the post-traumatic sequelae of abuse, such as anxiety, depression, psychosis, or substance abuse. For some women, this repeated nonrecognition preceded death by serious injury, homicide, or suicide. Having post-traumatic stress-related symptoms (Houskamp & Foy, 1991; Kemp, Rawlings & Green, 1991; Walker, 1991) that are not recognized as such decrease a woman's likelihood of being taken seriously. Alternatively, conceptualizing her symptoms as being caused by overwhelming trauma begins to incorporate context into diagnosis and make her situation more understandable, thus evoking more empathic responses.

What is so significant about the pattern Stark et al. described is that the long-term sequelae (Conway, Hu, Kim, Bullon & Warshaw, 1993; Koss, 1993; Wilson & Daly, 1992) associated with ongoing abuse may be in part a function of thwarted help-seeking and negative responses on the part of the health care system, as well as the hopelessness and despair that ensue from a woman's feeling she is at fault and without viable alternatives to remaining in an abusive relationship.

### IV. PRESENTATION OF DOMESTIC VIOLENCE VICTIMS IN THE HEALTH CARE SETTING

There are a variety of ways in which battered women may present to the health care setting and a variety of reasons for which they may seek care. Clinical manifestations of abuse include acute injuries, medical problems, complications of pregnancy and psychiatric symptoms, as well as chronic problems related to the stress of living with ongoing abuse and danger. Some symptoms are readily identified as being due to domestic violence. Others are less obvious and will only be addressed if clinicians routinely ask all women patients about the presence of domestic violence in their lives.

#### A. Injuries

Victims of domestic violence present to emergency departments, trauma units, urgent care centers, clinics and private practices with injuries. They are seen by physicians, nurses, social workers and other health care personnel in a variety of clinical settings including family practice, internal medicine, psychiatry, obstetrics and gynecology, ophthalmology, general surgery, surgical subspecialties, and dentistry. Almost any type of injury can be a manifestation of abuse. Injuries range from contusions, sprains and minor lacerations

to fractures, abdominal injuries, and gun shot wounds. Injuries may result, for example, from being punched, hit, kicked, burned, or stabbed; from being thrown down stairs, against walls or out of buildings; or from being hit or run over by a car. (See Example 1.)

The most common sites of injuries are the head, face, neck and areas that are usually covered by clothing, such as the chest, breasts, and abdomen. Maxillofacial trauma is common; eye and ear trauma, hearing loss, soft tissue injuries, fractures of the mandible, nasal bones, orbits, and zygomaticomaxillary complex have all been cited in relation to partner abuse (Cascardi, Lanhinrichsen & Vivian, 1992; Zacharides, Koumoura & Konsalaki-Agouridaki, 1990; Fisher & Kraus, 1990). Injury to multiple sites is also a frequent indication of domestic violence. Other manifestations of abuse include injuries which do not fit the provided explanation; injuries in various stages of healing, suggesting infliction over time; injuries with delayed presentations, such as fading bruises or partially healed lacerations; and complaints of injury without physical evidence of trauma (Stark et al., 1979). Although injuries to the extremities, such as fractures, sprains, and lacerations, are more likely to be accidental than those to

#### EXAMPLE 1

**A** 34-year-old woman had been seen by several different physicians for jaw pain. Finally, a primary care physician diagnosed temporomandibular joint syndrome and referred her to a specialist. This specialist, knowledgeable about domestic violence, determined the TMJ syndrome had been caused by repeated episodes of battering during which the woman's husband had grabbed her by the jaw and forcefully yanked it from side to side.

### EXAMPLE 2

**A** 27-year-old woman came to an urgent care clinic for evaluation of a head injury. She said she sustained the injury when she fell off a step ladder. Careful evaluation failed to reveal any evidence of trauma except for a tender hematoma in the scalp on the superior aspect of her head. The nurse practitioner, recognizing that the injury was not compatible with the patient's explanation, asked her directly if someone had hit her on the top of her head.

the head, neck, and torso, those, too, often result from battering. (See Example 2.)

### B. Medical Presentations

A number of studies have described the high prevalence of domestic violence among women seeking care for medical rather than trauma-related problems (Goldberg & Tomlanovich, 1984; Stark et al., 1979; Conway et al., 1993; Koss, 1993). While acute injuries may be the most obvious manifestation of domestic violence, it is often the long-term medical and psychological consequences of battering that are most debilitating over time.

Pain is a common presenting symptom. In one multidisciplinary pain center, 66% of women with headaches had been physically and/or sexually abused as adults. In the majority of these cases, the headaches started after the abuse began (Domino & Haber, 1987). Pain may be a direct result of physical assault even when there are no visible signs of injury. It can also be due to the stress of living in an ongoing abusive relationship. Women with persistent headaches, chest pain, back pain, pelvic or abdominal pain may be victims of domestic violence (Stark et al., 1979; Warshaw, 1989). Other physical symptoms related to stress, anxiety or depression (such as sleep and appetite disturbances, decreased

energy or fatigue, difficulty concentrating, sexual dysfunction, palpitations, dizziness, paresthesia, and dyspnea) may also be signs of domestic abuse. Vague complaints may be manifestations of battering and need to be taken seriously (Koss, 1993). Physicians are more likely to prescribe analgesic and psychoactive medications to battered women than to women not in abusive relationships, even when they do not address the abuse directly (Koss, 1993; Stark et al., 1979; Warshaw, 1989).

Another study in a university-based GI clinic found that 36% of their women patients had histories of physical and/or sexual abuse as adults. Women with functional GI complaints were more likely to have been subjected to forced intercourse and frequent physical abuse (Drossman et al., 1990). (See Example 3.)

Battered women may also present with exacerbation or poor control of chronic medical conditions such as diabetes, hypertension, or heart disease. Battered women may be prevented from obtaining or taking their medications or from seeking medical care. Their medical condition may be worsened as a result of the extreme stress of living with domestic violence, causing for example, more frequent angina.

Abuse may also expose women to serious illnesses. Between 67% and 83% of HIV positive women in one clinic were or had been in abusive relationships with men who refused to use barrier protection

### EXAMPLE 3

**A** 37-year-old woman was seen by a cardiologist after presenting to the ED with chest pain, dyspnea, palpitations, diaphoresis and dizziness. Her EKG revealed sinus tachycardia with no ischemic changes. Further questioning elucidated a history of panic attacks which had begun after her husband threatened to kill her if she ever tried to leave.

(Cohen, Warshaw, Boxer, Damont & Graginski, 1995). (See Example 4.)

### C. Obstetrical or Gynecologic Manifestations

Sexual coercion in any context of an abusive relationship places women at risk for all of the consequences of unprotected sex: HIV infection, other sexually transmitted diseases, and unplanned pregnancy. Battered women, particularly when they are being sexually abused, may also experience dyspareunia, chronic pelvic pain, sexual dysfunction, and frequent vaginal and urinary tract infections. In one random population study, 45% of women with sexual problems and 47% of those with other gynecological complaints were battered women. (Schei & Bakkteig, 1989; Campbell & Alford, 1989). Sexual assault and its attendant consequences are not

limited to male-female relationships. Battered lesbians also report high levels of sexual violence against them by their female partners (Renzetti, 1992), and, though there is little empirical research on sexual assault among gay men, experts estimate that battered gay men are also likely to experience high levels of sexual violence.

Obstetrical manifestations of abuse include miscarriages and spontaneous or multiple abortions (Stark et al., 1979). Any injuries, unexplained pain, depression, anxiety disorders, suicide attempts and substance abuse during pregnancy may all be related to domestic violence. Abused women are twice as likely as non-abused women to delay the start of prenatal care until the third trimester (Macfarlane, Parker, Soeken & Bullock, 1992), after which the care may be sporadic. There is also some evidence that battered women are more likely to give birth to low birth weight infants (Bullock & Macfarlane, 1989).

### EXAMPLE 4

**A** 32-year-old RN presented to her internist with signs and symptoms of HIV infection. Careful questioning revealed her partner was an infected IV drug user who was physically violent, verbally threatening, but intermittently remorseful. He had not only concealed his drug use and HIV status but had also refused to use condoms, accusing her of infidelity whenever she raised the issue.



### EXAMPLE 5

A 23-year-old woman was brought to the ED by her mother. She was acutely psychotic. Her mother told the psychiatrist on call that she thought her daughter's state was related to how her boyfriend was treating her. The patient had no prior psychiatric history and was not using any drugs. She was hospitalized and treated with antipsychotic and anxiolytic medication. As her thinking became more coherent, she described repeated episodes of physical abuse, sexual coercion and controlling and threatening behavior on the part of her boyfriend. After supportive interventions, she was able to access resources for herself and her small children, and was able to call the police and have him evicted when he threatened her again.

Battering during pregnancy is also associated with complications such as placental separation, antepartum hemorrhage, fetal fracture, rupture of the uterus, and preterm labor. In addition, domestic violence has been implicated as a leading cause of maternal death. Twenty-five percent of maternal deaths in one study were due to trauma, and in most instances the perpetrator was either the biological father or a male close to the deceased. (Fildes, Reed, Jones, Martin & Barret, 1992)

#### D. Psychiatric Presentations

Women may present with psychiatric manifestations of abuse in emergency departments, medical clinics or offices, and psychiatric settings. In one study, 25% of all women seen in the Emergency Department with psychiatric symptoms were battered women, as were 10% of the women who presented with acute psychotic episodes. Once a woman becomes psychotic, the fear and terror she may describe is far more likely to be attributed to paranoid delusions than to the real

abuse and violence in her life (Raskin & Warshaw, 1990; Carmen, 1995). In addition, 50% of African American women and 29% of all women seen for suicide attempts were battered, often in close proximity to the attempt (Stark et al., 1979; Stark & Flitcraft, 1995).

The prevalence of abuse among women patients is even higher in psychiatric settings than in other medical settings. Half of the women referred to one rural mental health center by their primary care physicians turned out to be unrecognized battered women (Hilberman & Munson, 1977-78) and 64% of women on an inpatient psychiatric unit had experienced physical abuse as adults (Jacobsen & Richardson, 1987). (See Example 5.)

As primary care providers are increasingly encouraged to screen for the most common psychiatric disorders, it is important to recognize that symptoms of these disorders (depression, anxiety and panic disorders, eating disorders, somatoform disorders and alcoholism) are also frequently found among battered women. Studies of battered women indicate that 37% have symptoms of depression (Gelles & Straus, 1988; Houskamp & Foy, 1991), 46% have symptoms of anxiety disorders (Gelles & Harrop, 1989) and 45% experi-

ence post-traumatic stress disorder (Houskamp & Foy, 1991). While some battered women do not meet the full criteria for post-traumatic stress disorder, many experience acute traumatic stress syndromes or responses (McLeer, 1989; Warshaw, 1989; Campbell & Altard, 1989). (See Example 6.)

While domestic violence may aggravate comorbid psychiatric disorders, psychiatric symptoms may also be a realistic response to ongoing danger and entrapment and may disappear once victims are safe from violence. For example, a woman presenting with shortness of breath, palpitations and other features of anxiety may be in realistic terror, rather than suffering from an anxiety disorder. A woman experiencing depression may be reacting to living in a situation where she feels unable to escape the power and control of her abusive partner. These symptoms may stop when the woman achieves relative safety, such as by the batterer's removal from the situation (jail or effective restraint) or her removal from danger (a shelter or other safe place) (Braude, personal communication, January 1995).

### E. Substance Abuse

While a number of studies have found significant correlations between substance abuse and battering for both victims and perpetrators, it is clear that substance abuse does not cause domestic violence. The use of alcohol and drugs by battered women does seem to increase dramatically after physical abuse begins. Up to 50% of alcoholism in women may be precipitated by abuse (Critchlow, 1986; Taylor & Leonard, 1983; Pihl & Smith, 1988; Gandolf & Foster, 1991.). Research indicates that alcohol and drug abuse are likely to be consequences of the abuse or coping mechanisms rather than causative factors.

Substance abusing patients should be screened for domestic violence, and all battered women should be asked about the use of alcohol and other drugs by both themselves and their partners. Treating a battered woman's substance abuse without addressing battering fails to address her most serious concerns, and the situation that may be causing her substance abuse in the first place. (See Example 7.)

### EXAMPLE 6

**A** woman had two visits to her family physician over a two-week period. She complained of left-sided chest pain, tremors, vomiting and headaches. After an unrevealing medical workup, she was referred to a mental health center with the diagnosis of "Adjustment Disorder with Depressed Mood." She returned a week later with symptoms of left arm numbness, difficulty concentrating and a loss of appetite. On this visit she also mentioned there were arguments at home. Direct questioning revealed she was being battered.

### V. OTHER CLINICAL CONSIDERATIONS

#### A. Access and Utilization of Medical Care

An abusive partner may interfere with a woman's access to medical care or medications. Because batterers often control their partner's access to transportation and finances, contact with friends and family, and even use of the phone, battered women may not be able to keep appointments for themselves or their children, and may not be able to leave home in cases of medical emergency. Batterers also may not allow their partners to purchase prescribed medications or may simply take them away and prevent victims from using them. Once in a medical setting, a victim may have to leave before being seen by a provider or before her workup is complete in order to comply with the batterer's demands to be home at a specific time to avoid being beaten. (See Example 8.)

Some women may be homeless as a result of fleeing abusive marriages or partners. Living on the streets or in a homeless shelter can compromise access to

health care and increase a woman's risk of further victimization.

#### B. When the Batterer is Present

Batterers frequently insist on accompanying their partners to health care settings. Abusers often hover around their partners, seemingly concerned, when they are actually trying to prevent their partners from seeing the provider alone. Abusers may answer questions directed to the patient, who may seem too uncomfortable or intimidated to speak or disagree while he is present. When asked to leave, the abuser may try to wait outside the exam door, attempting to hear what is being said. He may also try to intimidate the victim or the provider, demand that she leave before assessment and treatment are complete, or express intense jealousy regarding her relationship with the health care provider. Even if the abuse is obvious, both victim and perpetrator, each for different reasons, may deny, rationalize or minimize the violence.

Some batterers become abusive or threat-

#### EXAMPLE 7

**A** 42-year-old woman was admitted to the hospital for acute detoxification from alcohol. She said she had been a heavy drinker for the last 10 years. She had sought treatment for alcohol abuse in the past but had not returned after the first visit. Detailed questioning revealed that she began drinking shortly after marrying her husband, also an alcoholic. He routinely and severely beat her, especially when he was drunk. He refused to seek treatment for his drinking and forbade her from going to treatment as well. After release from the hospital, she moved to another town under an assumed name. She has stopped drinking and is a regular participant in a group for survivors of domestic abuse.

### EXAMPLE 8

**A** 55-year-old woman came to the emergency department at 2:30 to 3:00 every afternoon for three weeks. She had a variety of vague complaints, but no significant physical findings. Usually she left the emergency department abruptly at 4 p.m. whether the evaluation was complete or not. The emergency department staff considered her to be a “crock.” Finally, a medical resident new to the emergency department obtained her history of domestic violence. The woman’s husband, a prominent executive, had battered her for years. He also kept close surveillance of her activities by calling her at home every 3 hours. She would be beaten severely if she failed to answer the phone.

ening in the medical setting. Others may be charming, making it more difficult to take their abuse seriously. Knowing that many batterers appear thoughtful and concerned

can help clinicians maintain clarity about the batterer’s responsibility for the abuse, regardless of what behavior is displayed in the medical setting. (See Example 9.)

## VI. THE HEALTH CARE PROVIDER’S RESPONSE TO DOMESTIC VIOLENCE

### A. Preparing to Ask About Abuse

There may be specific issues women face that make it more difficult for them to discuss the abuse, access services or ultimately leave their partners. Recognizing and addressing them directly can help alleviate some of the barriers women face in accessing help. For battered gay men and lesbians who have experienced homophobic responses from service providers and denial within the community, revealing abuse may be even more difficult. In addition, their partners may threaten to “out” them if they reveal the abuse or try to leave. A woman who does not speak

English or for whom English is not her first language may find it difficult to discuss her situation, particularly if she does not feel safe speaking through a particular translator. Immigrant women who are undocumented may find it even more difficult to reveal the abuse, in part because they are afraid of bringing attention to their situation and in part because the batterer threatens to have them deported if they tell or threatens to leave them without resources or support. Some batterers control their wives by deliberately failing to file their petitions for permanent residency. Women with mental health or substance abuse problems may fear not being taken seriously, based on previous experiences with helping professionals or because the

### EXAMPLE 9

In one community clinic a physician's assistant saw a young lesbian with asthma who had come in with her partner. When the physician's assistant made it clear that he wanted to see the patient alone, her partner became more and more agitated and controlling. After insisting that her partner wait in the waiting area, he was able to elicit a two-year history of escalating terror and abuse from the patient. She was very frightened, yet concerned about her ability to manage without her partner. Hearing some noises in the hall, the resident opened the door of his office only to find the partner standing outside the door trying to hear what was being said.

batterer has convinced them this is so. For women with serious disabilities or medical problems, some of which have even been caused by the abuse, leaving a partner they depend on for basic care and access to services may be problematic. Cultural or religious constraints may make it more difficult for a woman to discuss the abuse with someone outside her community and she may face social isolation and ostracism if she leaves. For any woman, her attitudes toward revealing personal information to outsiders or feelings of disloyalty toward her partner, family or community will also play a role in how she feels about discussing the abuse and with whom she is comfortable discussing it. Trusting a system that has traditionally not understood or been particularly helpful presents barriers for many women that need to be recognized and addressed.

Appropriate intervention for domestic violence includes the following:

- a. Routinely inquiring about abuse
- b. Assessing safety
- c. Documenting the abuse
- d. Discussing options and resources

- e. Providing advocacy and referral
- f. Treating medical and mental health problems
- g. Providing for follow-up care

### B. Questions to Keep in Mind

The following questions can provide a framework in which to think about domestic violence from the victim's perspective as well as from the provider's. Knowing the scope of issues that should be addressed can help prepare providers in doing an initial assessment. Think about the following questions to be addressed.

- Is this patient currently being abused? Has she been abused in the past? Is she still at risk?
- Who is the perpetrator? What kind of access does the perpetrator have to the patient/victim?
- How has the abuse affected the patient's health?

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- Is it safe for her to go home? How much danger is she in? If she stays? If she leaves? Is she suicidal, homicidal, or otherwise in danger? Is her partner?
- Are there warning signs that allow her to anticipate impending danger? Does she have a safety plan? Can you or someone else help her develop one?
- What does she need? Information, support, shelter, counseling, support group, legal advocacy, mental health services, access to other resources? Can she manage this herself, or does she need more help with the initial steps?
- What resources are available in your community that could help her deal with the abuse: shelter, safe homes, counseling, support groups, legal advocacy? Are they sensitive to cultural issues, to mental health problems, substance abuse, to gay and lesbian issues? Are they accessible and multi-lingual?
- How is she feeling about the fact that you are asking?
- How do your own feelings and responses affect your ability to provide appropriate care?

### C. Initial Concerns for Battered Women

#### 1. SAFETY AND PRIVACY

Before inquiring about abuse, it is essential to create an environment in which it is safe for a woman to talk freely. A battered woman may be afraid to disclose information if she thinks the batterer will learn that she has talked about the abuse. Such disclosure may increase the victim's danger, and may make it difficult or impossible for the victim to access services. It

should therefore be standard policy to interview all patients in private until abuse is ruled out. Registration clerks and triage nurses should not inquire about abuse unless the woman is alone and privacy is assured. Whenever possible, patients should be interviewed outside the presence of their children. Women may be reluctant to discuss the abuse in the presence of the children because of the impact upon them or her fear that they may relay these discussions to the batterer. Additionally, self-report forms should neither be administered in waiting rooms where the batterer, other family members, or friends are present, nor mailed to the home prior to a visit.

Any accompanying individual, including another woman, should be considered a potential abuser. Appearances can be deceptive; some assailants appear solicitous and concerned about the patient's well-being. Others impersonate relatives or persons in authority and insist on being present during the exam. Providers can simply tell accompanying parties that hospital policy dictates that all patients be seen alone and that non-patients must remain in the waiting room. Conversely, anyone accompanying the patient can be told that a medical procedure is to be done that requires privacy, such as taking x-rays, doing a pelvic exam or an EKG, or obtaining a urine sample, and that the patient must be seen alone.

Some abusers threaten and intimidate health care personnel, attempting to keep them from seeing the patient alone. Others are verbally or physically assaultive to their partners in the health care setting itself. Clinical staff and hospital security should be prepared and have a plan for separating the woman from the abuser in a way that both increases her safety and makes it clear to the assailant that abusive behavior is not acceptable. This may involve calling hospital security or the police. Such an action conveys to both the woman and her partner that the provider takes this behavior seriously. However, it can also increase the risk of retaliation toward the woman, and this should be kept in mind. (See Example 10.)

### EXAMPLE 10

In a hospital prenatal clinic a Pakistani woman was waiting with her husband to be seen. At one point her husband punched her in the face. The resident was outraged and wanted to rush out and tell him this kind of behavior would not be tolerated. The attending physician, realizing the woman would probably have to return home with her husband, suggested she be seen alone so they could find out how she felt about the abuse, discuss her options and ask her what she thought would be most helpful.

#### 2. WOMEN WITH DISABILITIES

Patients who are disabled are often accompanied by a personal care attendant. The patient has a legal right to have the attendant present if she wishes. However, care must be taken to ask her about this in private in case the attendant is also her abuser.

#### 3. LANGUAGE BARRIERS

When English is not a woman's primary language, a friend or relative who accompanies her may not be an appropriate translator. He or she may be abusing her or may be sympathetic to the abuser. Children are never appropriate as translators, except under life-threatening conditions when no one else is available. The ideal interpreter is someone from your facility (preferably a woman) who is familiar with the woman's cultural background, skilled in medical interpretation, knowledgeable about confidentiality issues, and trained in the dynamics of domestic violence. Providers should also insure that interpreters familiar with American Sign Language are available when needed.

#### 4. CONFIDENTIALITY

Let the woman know that the information she gives you is confidential and, within the confines of the law, will not be revealed to the batterer or anyone else without her permission. If state laws mandate the reporting of domestic violence to the police or to other public agencies (See Appendix N), discuss the implications of reporting with respect to confidentiality and safety at the beginning of your encounter. Also inform her that health care providers are mandated to report child abuse and that steps can be taken to increase both her and the children's safety.

#### 5. RESPECT AND EMPOWERMENT

Physicians and other health care providers have traditionally been trained to extract information from the patient (taking the history) and transform it into something that has meaning for them (formulating the differential diagnosis). They are used to controlling the physician-patient interaction in order to rapidly make a diagnosis and prescribe appropriate treatment. This approach, however, may be detrimental when evaluating a woman who has been battered. The clinician's need to



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be in charge, to feel competent, to diagnose and then “fix” the problem, may interfere with his or her ability to be patient, to listen, and to respect the patient’s ability to make choices she feels are best for her.

Although we cannot really “empower” someone else, providers can stop interacting in ways that are, however well meant, controlling and disempowering. If clinicians interact with victims of domestic violence with both respect and care, and listen and encourage them to make their own choices, they will have conveyed an important message: that all people deserve to be treated with respect, and that victims of domestic violence are entitled to make decisions about their lives and to have those decisions respected. Compassionate, caring interactions need not take a lot of time. Respect and concern can be communicated through eye contact and tone of voice, and by avoiding body language which conveys that one does not have time, does not care, or is not comfortable hearing about domestic abuse. Even if the patient has been isolated in an abusive relationship and is not ready to make major changes, care and compassion from a provider can create a glimmer of hope that another kind of life is possible. Knowing she has a continuing base of support and encouragement can help the battered woman start the process of change.

### D. Concerns of the Provider

#### 1. TIME CONSIDERATIONS

Although it usually takes less than a minute to ask initial questions about abuse, listening to the patient and providing adequate assessment and intervention takes more time. The time spent by a primary provider can be brief when a social worker or domestic violence advocate is available to complete the evaluation. If the primary provider is sufficiently knowledgeable and comfortable, he or she can provide a more thorough assessment, initial intervention,

and referrals in a relatively short period of time.

For the primary provider that has neither time, training, or on-site resources, there are several options for working with battered women. Support can be offered by saying something such as:

- “I’m glad you felt you could tell me about what has been happening to you. I am very concerned about the issues you brought up, especially your safety. Although I don’t have time right now to fully address your concerns, there is someone we can call who has a lot of experience with this issue. I hope you can stay and talk with her today.”
- “I will give you the numbers of some community agencies that provide counseling, shelter and legal help. There are people there who can discuss your situation and possible options with you. You can use my phone to make some calls. Before you leave here, however, let’s discuss how dangerous your situation is right now and make sure that you have a way to be safe.”

#### 2. DEVELOPING PERSPECTIVE

Feelings of anger, blame, fear, and helplessness are natural responses to hearing about terrible situations, particularly when one feels powerless to change them. These reactions may be even more pronounced for health care professionals who believe they are supposed to be able to “treat” the problems they identify, or at least alleviate pain and suffering for their patients.

Understanding the dynamics of abuse and the difficulties women face in trying to leave abusive partners can help providers deal with the frustration and pain they may experience when helping a woman who is in an extremely difficult and dangerous situation. Many battered women are either numb or in a state of terror and confusion due to living in chronically dangerous situations. The process of leaving an



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abusive spouse or partner is often slow. Victims often leave and return many times before leaving for good and creating a life free of violence. Even if a woman is not able

to acknowledge the health care provider's assistance at the time, when she is ready, she will make use of it.

## VII. IDENTIFICATION OF ABUSE

Identification of domestic violence is the first stage of intervention. Asking about abuse helps to break the isolation a battered woman may experience and lets her know resources are available if and when she feels she can use them. There are a number of ways a woman may be identified as being battered. She may tell the provider herself, or the practitioner may find out from others, such as EMTs, the police, children, friends, or family members. There may be specific information or strong indications in her past medical records. A clinician may have heard about the violence outside of the health care setting through interactions in the community, or a provider may observe the perpetrator assaulting the patient in the office, waiting room, or other public setting.

### A. Routine Screening

One of “the most important contribution physicians can make to ending abuse and protecting the health of its victims is to identify and acknowledge the abuse” (Council on Ethical and Judicial Affairs, A.M.A, 1992). Because presentations of domestic violence victims in the health care system are so varied, inquiring only when abuse is suspected or during typical presentations is no longer considered sufficient. Battering is too common and too serious to remain unidentified. Provision of optimal care warrants that health care providers routinely ask all women patients about domestic violence. For many health care providers, the idea of routine screening for conditions affecting a person's health and well-being requires expanding their focus

### EXAMPLE 11

**A** domestic violence advocate was called to the ED to see a patient named Carla who had been battered by her husband. When the advocate came and asked to see her, one of the nurses picked up Carla's chart and pointed her out to the advocate. After speaking with this woman about the violence in her life and discussing her options for safety, the advocate found out that she had been speaking to the wrong Carla. This Carla, also a victim of domestic violence, had come in for a headache. The Carla she'd been called to see had symptoms that had been more obvious to the clinician.

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to prevention as a key to providing quality health care. When dealing with victims of domestic violence, routine inquiry may allow for intervention before injury or illness occur. By routinely asking about abuse, clinicians will also discover patients who are currently being battered and provide the opportunity to reduce further harm. (See Example 11.)

### 1. ROUTINE SCREENING: METHODS

Many women will readily talk about the violence they are experiencing if they feel safe and supported. It is essential to take seriously everything a woman says about abuse and treat her with dignity and respect. Because they may not define themselves as battered, the medical practitioner should always ask direct, specific questions. For example, asking, “Has your partner ever punched or kicked you?” will be more effective than asking, “Are you being battered?”

Clinicians can and should ask about domestic violence during a routine health assessment by asking women direct questions regarding injuries, abusive behavior, threats or fear of harm from their partners. Questions can be integrated into all intake forms and reminders can be printed onto charts as check off boxes or added as stickers or stamps (Domestic Violence:  YES  NO). Screening questions on domestic violence can be easily incorporated into the current and past medical history, the social history, and the review of systems (See Appendix D for samples).

### B. How to Ask

While inquiring about abuse may seem difficult at first, recognizing that it is important, legitimate and potentially lifesaving to ask can help clinicians overcome their initial hesitations and become comfortable addressing domestic violence with their patients. Clinicians can

help decrease a woman’s potential discomfort by framing questions in ways that let her know that she is not alone, that the provider takes this issue seriously, is comfortable hearing about abuse, and that help is available. With practice, each clinician will develop his or her own style of asking questions about abuse.

### 1. FRAMING QUESTIONS

Sometimes it feels awkward to suddenly introduce the subject of abuse, particularly if there are no obvious indications a woman is being abused. The following are examples of ways providers can introduce the issue:

- We now know domestic violence is a very common problem. About 20% of women in this country are abused by their partners. Has that ever happened to you?
- Because violence is common in women’s lives, I now ask every woman in my practice about domestic violence.
- I don’t know if this is a problem for you, but many of the women I see as patients are dealing with abusive relationships. Some are too afraid or uncomfortable to bring it up themselves, so I’ve started asking about it routinely.
- Some women think they deserve abuse because they have not lived up to their partners’ expectations, but no matter what someone has or hasn’t done, no one deserves to be beaten. Have you ever been hit or threatened because of something you did or didn’t do?
- Because so many women I see in my practice are involved with someone who hits them, threatens them, continually puts them down, or tries to control them, I now ask all my patients about abuse.
- Lots of the lesbians and gay men we see here are hurt by their partners. Does your partner ever try to hurt you?

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### 2. DIRECT QUESTIONS

However one initially raises the issue of domestic violence, it is important to include direct and specific questions:

- Did someone hit you? Who was it? Was it your partner/husband?
- Has your partner or ex-partner ever hit you or physically hurt you? Has he ever threatened to hurt you or someone close to you?
- I'm concerned that your symptoms may have been caused by someone hurting you. Has someone been hurting you?
- Does your partner ever try to control you by threatening to hurt you or your family?
- Has your partner ever forced you to have sex when you didn't want to? Has he ever refused to practice safe sex?
- Has he/she ever tried to restrict your freedom or keep you from doing things that were important to you? (like going to school, working, seeing your friends or family)
- Does your partner frequently belittle you, insult you, and blame you?
- Do you feel controlled or isolated by your partner?
- Do you ever feel afraid of your partner? Do you feel you are in danger? Is it safe for you to go home?
- Is your partner jealous? Does he frequently accuse you of infidelity?

### 3. INDIRECT QUESTIONS

In some clinical settings, it may be appropriate to start the inquiry with an indirect question before proceeding to more direct questions. The following are examples of this approach:

- Have you been under any stress lately? Are you having any problems with your partner? Do you ever argue or fight? Do the fights ever become physical? Are you ever afraid? Have you ever gotten hurt?
- You seem to be concerned about your partner. Can you tell me more about that? Does he ever act in ways that frighten you?
- You mentioned that your partner loses his temper with the children. Can you tell me more about that? Has he ever hit or threatened to physically harm you or the children?
- How are things going in your relationship/marriage? All couples argue sometimes. Are you having fights? Do you fight physically?
- You mentioned that your partner uses alcohol. How does he act when he is intoxicated? Does his behavior ever frighten you? Does he ever become violent?
- Like all other couples, gay couples have various ways of resolving their conflicts. How do you and your partner deal with conflicts? What happens when you disagree? What happens when your partner doesn't get his way?

(See Appendix B for training handout on how to ask.)

### C. If a Woman Does Not Acknowledge Abuse

If a patient says that abuse is not occurring, but the clinician is still concerned about abuse, there remains a variety of issues which may be discussed. Let her know your concerns. Sometimes a patient may listen silently, without overtly

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acknowledging what is being said. In this case it is still helpful to offer some information about abuse. Make sure to provide the woman with a referral sheet or phone numbers. Encourage her to return if she has

any problems in the future and/or to contact any of the resources that have been provided. Document your concerns in the medical record.

### VIII. ASSESSMENT

Once a woman acknowledges she is being abused, there are several issues to address before proceeding to a more detailed history and physical examination. They involve creating a supportive atmosphere in which she can discuss the abuse and her feelings about it, assessing her immediate safety in the clinical setting, and informing her if and when reports to other agencies such as the police or child protective services must be filed. Express concern and acknowledge the injustice and danger of her situation. Let her know the violence perpetrated against her is not her fault and that you are glad that she has confided in you.

#### A. Addressing Immediate Safety Needs

It is important to insure that a person who has been battered is safe in the clinical setting. If there appears to be an immediate threat from the abuser, notify security outlining the potential risk (e.g., the husband is in the waiting room and has a gun). Other questions to be considered include:

- Is the victim's partner here now or likely to return?
- What would she like you to do if her partner tries to get her to leave the health care setting?
- Does she want you to call security or

the police?

- Does she want to leave with her partner?
- Does she want to keep hidden and then find a shelter?
- Does she need to call someone to pick up her children?
- Does she have an order of protection? If so, does she want the abuser arrested if he shows up?
- Does she think it would be better to go home with him at this time?
- Does she need to be home by a certain time in order to avoid further abuse? If so, try to expedite the evaluation, but at a minimum make sure she receives referral numbers for domestic violence advocacy resources.

#### B. Chief Complaint/ History of Present Illness

If a patient is being seen for an injury or other symptoms related to an acute battering event, ask in detail about what happened. Ask specifically when this abusive episode started, who inflicted the injuries, and whether there have been prior incidents. Ask the patient to describe both current and prior patterns of abuse. Ask if

### EXAMPLE 12

**IF MARITAL RAPE IS SUSPECTED, THE FOLLOWING ROUND OF QUESTIONS MAY BE PURSUED:** “Often when a woman’s partner is physically abusive, he is sexually abusive as well. Sexual assaults are often the most difficult to discuss. I’m wondering if your partner ever forces or coerces you to have sex when you don’t want to? Does he refuse to wear condoms? Can you tell me when this began? Can you describe what happens when he does this? First he does.... and then? Has this caused you to have any medical problems, like injuries, pain, or infections? Do you know if he has any other partners? Does he use drugs? When was the last time he did this? When was the most severe episode? Can you tell me what happened? Can you remember all the times you’ve had infections, and what treatment you received? Were they always soon after one of these assaults? This seems to be very painful for you to talk about, but I’m very glad you could tell me. Have you been feeling this way for a while?”

**DOCUMENTATION MAY CONSIST OF:** “Patient states that her husband on repeated occasions has forced her to have sex (vaginal and anal intercourse) by throwing her on the floor ..., by choking her until ..., by threatening her with. ... He does not use condoms. She says that she has had multiple urinary tract and vaginal infections after these episodes, the first one being ..., the most recent being ... She has been treated with ... She also states that she has recently found out that her husband uses IV cocaine. She was in tears as she described these events and describes recent feelings of sadness, fatigue, decrease in her appetite and in her ability to concentrate and she reports early morning awakening. She denies having any suicidal thoughts. She feels ... about this, is concerned about. ... and would like ...”

the abuse is increasing in frequency or severity, if there is a history of alcohol or drug use, and if weapons are involved. Elicit the relationship between physical and/or psychological symptoms and the abuse.

Record the chief complaint and detail the specific descriptions of the abuse, including the identity of the perpetrator, his or her relationship and access to the patient and the time, date, and location of abusive episodes. Use the victim’s own words in quotes whenever possible. For example, “My husband hit me with a bat” is better than “Patient has been battered.” Also, use neutral language, such as “Mrs. Smith says....” rather than “the patient alleges.”

Do not include information that is extraneous to the medical facts. Examples include statements such as “It was my fault he hit me because....” or “I deserved to be hit because I was.....” (See Example 12.)

### C. Physical Examination and Preservation of Evidence

Before performing the physical examination, the woman should be asked to disrobe

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completely and put on a hospital gown so hidden injuries can be seen. The process of examination and evidence collection should be explained in detail. She should be informed of each step you are about to take so that the exam itself does not become another traumatic experience. Again, the way that the provider interacts with a battered woman is very important. Expressing compassion, maintaining eye contact and conveying respect are all necessary.

Perform a thorough physical exam including neurologic exam and mental status exam if indicated. Be sure to palpate for areas of tenderness which may be manifestations of injuries not yet visible, such as scalp hematomas and deep bruises.

Carefully evaluate and describe injuries. Include in your description the type of injuries, the number, size, location using a body map. (See Appendix F for samples of body maps.), degrees of resolution, possible causes, and explanations given. Be specific (e.g., contusions and lacerations to the throat will support allegations of attempted strangling). Include other details such as broken fingernails, smeared makeup and disheveled or torn hair.

If a patient indicates there has been a recent sexual assault, assess for evidence of forced sexual activity, including injuries to the genitalia and restraint marks on the skin. Also assess for other adverse effects of forced sexual activity, such as emotional trauma and lack of barrier protection (e.g., STDs, contraception/pregnancy status, exposure to HIV). Sexual assault procedures as designated by the facility should be followed.

Record non-bodily evidence of torn clothing and broken jewelry. Preserve as evidence bloodied clothing, foreign objects, or objects used as weapons. Obtain permission from the patient to preserve these items after explaining that evidence may be necessary for legal documentation now or in the future. Have her sign a release of information form and explain the conditions under which the evidence can be released. Place the evidence in a sealed paper bag. Each wet or bloodstained item should be placed in a separate bag. The patient's name, medical record number, date and time of evidence collection, as well as a listing of the contents, should be attached to the individual bags.

In cases where you are concerned abuse may be occurring, but the woman does not acknowledge that battering is happening, be sure to note in the chart whether the injuries are compatible with her explanation. This may help clarify the situation at a future visit as well as provide documentation in the event that she decides to pursue legal action. Also, document the names of all personnel who examined or talked with the patient about abuse. (See Example 13.)

### D. Expanded Primary Care Assessment

In a primary care setting, a more detailed history of abuse is warranted. A complete social history should also be obtained, including any history of prior

### EXAMPLE 13

**A** 25-year-old gay man presented to the ED with a black eye. There was no other evidence of injury. He stated he had fallen off a bar stool, landing on the floor. The provider noted in the chart that an injury such as an isolated black eye was unlikely to be the result of a fall and more likely to be the result of a direct blow, such as with a fist.

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abuse with the patient's current partner or history of past abuse as a child. Questions to ask her include: How has the abuse affected her? Her children? What does she do to cope with the abuse? How does she protect herself and her children? How does she see herself and her situation? What would she like to happen? What has she tried? Where is she in the process of trying to change her life?

### E. Safety and Lethality Assessment

Anyone who is battered should be assessed for risk of serious injury or homicide at the hands of a partner before being discharged from the health care setting. No matter what the outcome, the process of inquiry itself can help make it clearer to the victim that he or she is in danger. Although not necessarily predictive in individual cases, the following are considered risk factors for serious injury or homicide:

- Violence outside of the home
- Violent against the children
- Threats to kill the victim, the children, and/or threats of suicide (e.g., "If I can't have you, no one else will," "If you leave me I'll kill myself")
- Escalation of threats
- Batterer abuses drugs, especially those known to increase violence (amphetamines, PCP, crack cocaine)
- Batterer physically abused victim while she was pregnant
- She has attempted to or is planning to leave or divorce him in the near future. Or, she has sought outside intervention to end the abuse. (Abusive men are most likely to kill their female partners

when the woman tries to leave or seek outside help to end the violence.)

- Batterer sexually assaults victim
- Batterer is obsessed with victim, says he cannot live without victim, is stalking or harassing victim
- Batterer has seriously injured victim in the past
- Weapons, especially firearms, are present in the home or readily accessible
- Batterer has threatened friends or family members
- Victim states she is afraid for her life

After reviewing all of the risk factors, ask the victim if she feels she is in danger of being seriously injured or killed. If she says yes, take this very seriously. If she says no but you believe she is at risk, discuss this with her frankly. Let her know that she has specific risk factors for increased violence and homicide. Discuss your concerns about these risks. If she is already at high risk and is planning to leave the relationship, let her know that she should seriously consider leaving without telling him. Make sure she has a safe place for herself and the children to go.

### F. Suicide and Homicide Assessment

Assessing a woman's safety before a discharge from the health care setting also includes assessing for potential suicide or homicide on her part. Battering appears to be risk factor for suicide attempts (Stark & Flitcraft, 1995). All battered women should be asked about suicidal ideation. A woman should be asked directly if she is thinking of harming herself. Assessing for suicide entails asking direct questions to elucidate a patient's thoughts, possible



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suicide plans, and means of carrying out these plans:

- Have you ever felt so bad that you didn't want to go on living?
- Have you ever thought about killing yourself?
- Have you thought about how you would do it?
- Do you have a gun, pills, poison, a car (whatever patient mentioned in the above question)?
- Have you ever attempted suicide in the past?

If there is a significant risk of suicide, the patient should be kept safe at least until an emergency psychiatric evaluation can be obtained.

Homicidal ideation and acute psychosis also warrant emergency psychiatric evaluation. In the majority of cases, women who kill their partners have been severely abused for long periods of time and see no other way out. They kill their partners in self-defense or to prevent the murder or serious injury of themselves or their children. Assess her current situation by asking her to describe how she perceives her options for safety. If homicide is a possible scenario, ask directly if she has plans to kill or harm her partner. Ask if she has a weapon or plan for how to carry out that action. If she has a plan, the practitioner may have a legal duty to breach the patient's confidence and to warn the third party of the impending danger (see Page 79, Duty to Warn). It is also important to know that some women will say things such as "I wish he would die" or "I'd really like to kill him," expressing anger rather than genuine intent to kill. Asking if she feels that she would ever act on those feelings can help clarify both the immediate risk and the severity of her entrapment.

- Explain that you cannot let her go while she is at risk of committing

homicide; inform her about the need for a psychiatric evaluation and keeping her safe. Let her know about the duty to warn and discuss ways to keep her safe.

- Tell her that sometimes women feel homicidal when they feel they have no other options but that resources are available and you will help her to access them.
- See if she is willing to see a psychiatrist voluntarily. Utilize available security if she won't. If she does have the explicit intent to kill, you are obligated to warn the intended victim.

### G. Mental Health Assessment

Psychiatric problems, including severe depression, panic disorder, psychosis, suicidality or substance abuse, may hinder a battered woman's ability to assess her situation or take appropriate action. When serious psychiatric conditions are present, an appropriate plan includes psychiatric evaluation and treatment. On the other hand, emotional, behavioral and cognitive responses to abuse can be misinterpreted as psychiatric in origin. When working with victims of domestic violence, ask yourself the following questions:

- Are psychiatric symptoms and substance abuse secondary to battering? Will they be resolved once she's safe?
- Does she need specific mental health and/or substance abuse treatment in the meantime to help her cope, make decisions, or leave?
- Does she have a psychiatric disorder/substance abuse problem in addition to being abused? Does this increase her vulnerability and limit available services?



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Does she need additional assistance in order to access community services and to be safe?

Whenever possible, try to refer to a mental health provider knowledgeable and sensitive to abuse-related issues. Remember to be very careful about assigning a psychi-

atric diagnosis as your records can be subpoenaed and be used against the victim in court. Discuss these issues with her. If a psychiatric diagnosis is made, also clearly document the abuse, its relationship to her psychiatric symptoms and the efforts she has made to protect herself and her children .

## IX. INTERVENTION

### A. Validating

Intervention begins by letting a battered woman know that you are concerned, that she is not alone, that she doesn't deserve the abuse and that help is available. These things can begin to bridge her isolation and open other possibilities. When women talk about the violence in their lives, they are often blamed or told to make the best of it, or the seriousness of their situation is minimized. Often a victim of abuse has never been told that domestic violence is wrong or

considered a crime or that no matter what the abuser tells her, she is not responsible for his behavior. Many women report that what is most helpful to them is being listened to, believed and taken seriously, rather than being judged or given advice they cannot use. Health care providers can express support by communicating the validating points outlined in Figure 2-2.

In the context of ongoing care, a primary provider, advocate or counselor should continue to inquire about the abuse and its impact, and help patients reassess

**FIGURE 2-2**

### **VALIDATING**

1. You are concerned about her safety and well-being
2. You understand how difficult it is for her to make the necessary changes
3. She is not alone
4. The violence is not her fault, and only her abuser can stop his or her abusive behavior
5. No one deserves to be abused, there is no excuse for violence and she deserves better
6. There are options and resources available

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their situation and safety needs, gain perspective, weigh options, make use of resources, and reconsider choices about their lives.

### B. Providing Information About Domestic Violence

It is important to discuss the patterns of abuse in violent relationships. It may be helpful to describe the typical controlling behaviors used by perpetrators (as described in the “Power and Control” wheel in Appendix B). The most important message to be conveyed is that most violence continues over time and that the isolation, fear, entrapment, and the risk of lethality tend to increase.

If a woman is seeking help for her abusive partner, discuss what is known about perpetrators, such as: he alone is responsible for his violence and only he can stop his continued abuse; he needs to make a long-term commitment to counseling to change his behavior; he is likely to continue his controlling behavior even if he stops his physical violence; treatment programs are often not successful in stopping abusive behavior. When a woman's abusive partner is in counseling, she may stay with him longer in the hopes that he will stop the abuse. Many batterers enter counseling solely to keep their partners from leaving. Often women have a primary concern that their children grow up in an intact home. Discuss the fact that violence in the home can have long-term damaging effects. Even if the children are not being physically abused themselves, witnessing the abuse of their mother seriously affects their development.

Finally, let each woman know that while it may be difficult to acquire both the internal and external resources needed to leave, there is assistance so that many women are able to find safety and rebuild their lives. It often helps to give women written information about abuse, about their legal options, and about resources

available in their community. Discuss what written material will be safe for her to take home. Discharge instructions or insurance information sent home may also put her in danger. Ask her if precautions should be taken to avoid writing information about the abuse on materials he may see. She may need to write important phone numbers on scraps of paper or memorize them, or she may be able to leave the information at work or with a friend. Providing information about abuse can help a woman gain perspective and access resources, but it is the quality of the interaction that can help change her experience (see Appendix G for sample patient information).

### C. Safety Planning

Safety planning with a battered woman will depend on her situation, her priorities and the options she decides will work best for her. Her safety and the safety of her children must be top priorities. Explore with her the following possibilities:

#### 1. LEAVING OR STAYING SOMEWHERE ELSE TEMPORARILY

Finding temporary shelter when there is immediate danger or when a woman is ready to leave the relationship permanently is facilitated by having a working knowledge and relationship with domestic violence programs in the community. While battered women's shelters are the first place most clinicians think of, they are not the only resource available. Some women do not feel comfortable utilizing shelters, some live too far from shelters to find them accessible, some do not meet criteria for admission, and many times there are simply not enough beds. Given the insufficient resources for temporary housing, most advocates have developed a range of strategies for helping women come up with other options. If there are no other options,

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temporary emergency hospitalization under an assumed name is a way to provide immediate safety. The following are some questions to consider if the woman wants to leave her current residence to escape more violence:

- Can she stay with family or friends?
- Does she want to go to a battered women's shelter, homeless shelter, or utilize other housing assistance, such as obtaining hotel vouchers from social services or advocacy programs?
- Does she want to move secretly to another community or state? Are there means to help her get bus or airplane tickets? Access out-of-state shelters or find another type of safe place to stay?

(An in-depth Safety Planning Form is enclosed in Appendix D.)

### 2. ADDRESSING RECURRING VIOLENCE IF SHE RETURNS TO THE ABUSER

Many battered women choose to return home. Sometimes they feel it is their safest option, given the nature of the abuser's threats and the realities of the legal protection available to them. Others don't feel they can survive on their own and still other women have not yet given up hope that the abuser will change. Part of the safety assessment for women returning to their homes involves discussing what she has already done to minimize her and her children's danger.

- Discuss what has worked to keep her safe or minimize injury during emergencies in the past and whether she thinks such strategies could work again.
- Discuss whether having a friend or relative stay in the home will serve as a deterrent to her partner's violence.

- Have her describe her support network and how she can use it in an emergency.
- Ask if she will call the police if he becomes violent. If she couldn't get to the phone, could she work out a signal with a neighbor for help? Can she teach the children to call the police if necessary?
- Discuss basic legal options, like orders of protection and arrest.
- Ask whether she is able to anticipate an escalation of violence. Can she take precautions? Is there likely to be time to leave once she knows the violence is inevitable?
- Discuss where she can go if she needs to flee. Help her put together a list with phone numbers and addresses.
- Ask whether there are weapons in the house. Can she have them removed or can she remove the ammunition?
- Suggest that she might want to discuss what is happening with her children so that they do not believe they are to blame.
- Encourage her to begin to imagine an independent life. Where might she live? What would she need to live on her own? An apartment, more education, the help of friends or relatives? What would she be doing if she were free?
- In isolated rural communities, safety planning takes on a different perspective. Many women have no phones to access the police, who, even if they called, may not arrive until the next day. Help her realistically assess other resources for safety.
- Encourage her to tell friends or family members about what is happening so as to reduce her isolation.

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- Encourage her to find out as much as possible about domestic violence by reading about it.

Suggest that she have the following items hidden in a place that she can access if she needs to make a quick escape:

- a. Birth certificates;
- b. Identification for herself and her children (social security cards, driver's licenses, passports, green cards);
- c. Important papers (marriage licenses, car titles, lease/rental agreements, house deed, mortgage papers, insurance information and forms, school and health records, immigration papers, etc.);
- d. Protective orders, divorce or custody papers or other court documents;
- e. Medications and prescriptions;
- f. Phone numbers and addresses for family, friends, and community agencies;
- g. Clothing and comfort items for her and for the children;
- h. Extra set of keys;
- i. Check book, bank books, credit cards.

### 3. ADDRESSING RECURRING VIOLENCE IF THE ABUSER IS REMOVED

If the abuser is removed from the household by a court order or some other legal means, the woman may or may not be safe from repeated abuse. Some men will be deterred from further violence, others may escalate the abuse.

- Discuss safety measures such as changing locks on doors and windows and installing smoke detectors, fire extin-

guishers, and outdoor lighting sensitive to movement.

- Discuss teaching children how to use the phone and make collect calls if he kidnaps them, and telling people who care for the children who has permission to pick them up.
- Talk about safety going to and from work and on the job. Discuss the possibility of informing sympathetic co-workers of her need for protection, and involving her boss and company security.

## D. Contacting the Police

Patients identified as victims of domestic violence should be told that battering is a crime and that help from the legal system is available. Ask her if she wants you to call the police. If she does, offer to call them or assist her in doing so. Do not pressure her. If she chooses not to make a police report at this time, respect her judgment.

If you practice in a state with mandatory police reporting laws (see Appendix N, Part II) it is important to inform the patient of this requirement in the beginning of the evaluation, preferably before she or he has discussed the abuse. If the woman does not want her abuser reported or arrested, she may choose not to discuss the abuse further at this time. Ask the woman if she wants to be present during the telephone report to the police. She needs to know what to expect when the police are called. Providers can call the local shelter to learn about police response in their communities. Explain the consequences that may follow from reporting. Will they take a report over the phone or will they come to the health care setting to interview her? Will they try to contact her at home? Will they arrest the abuser even if she does not want to press charges?

If she is ambivalent about calling the police, the provider can discuss the possible advantages and disadvantages of filing a

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police report. For example, a call to the police can help establish temporary safety for her and her children and will document the abuse. This can be helpful if the victim later seeks redress in the criminal or civil justice system. In some states, a victim of domestic violence can file a police report without charges being filed. If this is the case in your state, inform the patient of this right.

A woman may not want to call the police because she does not want her partner arrested, or because she fears retribution for having reported the violence. Calling the police does not mean there will necessarily be an arrest. Even if arrested, the abuser may be released at the station or detained only a few hours. Arrest and temporary detention, while serving as a deterrent to some abusers, may increase the risk of retaliation by others. When discussing arrest, ask her, “What do you think your partner would do if you called the police? What about if you got a restraining order?” The standards for arrest vary between states and the response of law enforcement will differ between jurisdictions. (See Appendix J on Legal Protection for Battered Women.)

Calling the police is also an option for patients who are not being seen for acute injuries. For example, if a woman is afraid to go home and needs a police escort, if she is being stalked and threatened, or if her partner has violated a restraining order, calling the police may be a desirable action. Knowledge of state laws and local police response can help to facilitate discussions of these options with battered women.

If she agrees to have the police called, every effort should be made for a domestic violence advocate or health care provider to remain with the patient during the police interview to serve as an advocate. It is important to document the name of the investigating officer and any action that was taken in the patient’s record.

## E. Child Abuse Reports

It is essential to inform patients about reporting obligations before inquiring about child abuse. While you must be frank about the potential consequences of involving child protective services (CPS coming to the home, risking retaliation if the batterer finds out she told, losing children to foster care), it is important to discuss the hazards of having children continue to live in an abusive home. Let her know there is help available for both her and her children. If she feels that reporting will provoke immediate retaliation from her partner, help arrange a safe place for her and her children to go.

## F. Referrals

It is very important for providers to have an updated list of local domestic violence service agencies and other community resources to give to battered patients. Many domestic violence programs have brochures or resource lists that may be helpful to victims of domestic violence who seek help from the health care system. Examples of brochures and resource cards can be found in Appendix G.

Many community service organizations serving special populations (e.g., immigrant and minority communities, prostitutes, lesbians and gay men) have developed expertise in domestic violence and have specialized programs for victims within their communities. Find out what programs are available in your area. In making referrals, particularly for Native American women and other indigenous people, it is important to acknowledge a woman’s preference for traditional treatment or ceremonies led by native healers, medicine men or women, or other traditional practitioners.

For many women trapped in battering relationships, just giving referral information may not be sufficient. Remember that

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“an abused woman is in a process. She will move through that process when she has sufficient strength and safety to take that next step. It is important to accept where she is in that process, even though you may not agree with her decisions and may fear for her safety” (Hadley, 1992). This has been the most difficult concept for both health care providers and advocates to learn and incorporate.

### 1. DOMESTIC VIOLENCE PROGRAMS

Domestic violence advocacy programs and shelters provide a variety of services for victims of domestic violence and their children, as well as public education and training for service providers. Clinicians should find out about the nearest domestic violence programs in their communities.

**FIGURE 2-3**

### DOMESTIC VIOLENCE ADVOCACY SERVICES AND SHELTERS

#### Services May Include:

- 24-hour hotline and crisis intervention counseling
- Assistance in evaluating options, resources, safety planning and referrals
- Information about legal remedies and legal and court advocacy (e.g., assistance with protective orders.)
- Emergency shelter, hotel vouchers, safe homes
- Counseling, support groups, and referrals for therapy
- Bilingual services
- Immigrant rights information
- Advocacy with child protective services
- Special programs and counseling for children in the shelters
- Literacy programs, job training, and transitional housing
- Referrals to mental health and substance abuse programs
- Appropriate referrals for perpetrators/abusers in some communities
- Linkages with advocacy programs for women and children with disabilities in some communities
- Referral to a range of services for gay men and lesbians in some communities
- Bilingual and multilingual and culturally specific services are available in some areas, particularly in urban centers

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(See Appendix M for a list of the state domestic violence coalitions.) When encouraging women to call these programs, let them know which services are confidential and either free or available for a nominal fee. Domestic violence programs generally have a wealth of experience in dealing with the legal system, the child protective service system, and immigration laws. They know of resources for education, housing, welfare, job training, and child care. They have often been involved not only in community education but also in legislative efforts at local and national levels. (See Figure 2-3 on page 77.)

## 2. COUPLES COUNSELING

Couples counseling is inappropriate in cases of domestic violence for several reasons. It can put victims in greater danger: many victims report serious assaults during or after sessions of couples counseling when abuse was discussed. Given the imbalance of power in relationships in which abuse occurs, it is impossible for victims to participate safely in couples therapy. Providers should explain that it is the perpetrator's responsibility to stop the violence, and that victims who want counseling should seek it separately from the abuser.

## X. LEGAL OBLIGATIONS

### A. Duty to Report

If an injured victim of domestic violence is treated by a physician or nurse who does not inquire about abuse or who accepts an unlikely explanation of the injuries, and the patient then returns to the abusive situation and sustains further injuries, the physician or nurse could conceivably be held liable for those subsequent injuries. Providers must ask all women patients about abuse and should know how to identify it.

Because health care providers in your state may be required by law to report injuries they suspect resulted from a battering incident, it is important to become familiar with your state's reporting laws. Statutory reporting mandates vary greatly from state to state based on who is required to report, what kind of injuries need to be reported, penalties for failure to report and/or immunity from liability.

Health care providers should inform patients of their legal obligation to report if domestic violence assaults are included within their state's reporting law. This

safeguard enables the patients to terminate an examination if their safety considerations are compelling enough to prompt them to do so.

Before making a report, health care providers should explain what consequences may result from reporting (e.g., the likeliness the police will follow up on the case). The provider should also ask patients if they want to be present during the telephone report to the police. The following are important issues the health care provider should know regarding making a report to law enforcement:

- Patients may be reticent to seek future care because they fear possible police involvement.
- Some patients may fear reporting for other reasons (i.e., their immigration status).
- The patient's safety must be the primary focus: if the batterer finds out your patient revealed the true source of her abuse, she might be in greater danger. Therefore, directly address the risk of retaliation by the batterer and



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discuss with the patient how she might protect herself from further abuse. Indicate on the reporting form any special concerns regarding how the report should be handled to maximize patient safety.

- Reporting is **never** a substitute for complete documentation in the medical record describing the nature and cause of the injuries sustained.

To find out more about your own state's reporting laws, call the legal department of your state medical society. (Refer to Appendix N for a more lengthy discussion of the potential consequences of mandatory reporting and a state-by-state summary of existing reporting statutes.)

### B. Duty to Warn

If a medical care provider is aware of a patient's intent to harm a third party, such as the patient's spouse or partner, the provider may have a legal duty to breach the patient's confidence and to warn the third party of the impending danger. In cases of domestic violence, one must intervene in a way that protects both the victim and batterer. The victim must be told of your intention and offered protective services. If commitment to a psychiatric facility is planned, the third party is thus protected and does not have to be warned.

## XI. DOCUMENTATION

### A. Medical Record

Thorough, well-documented medical records can be essential for the prevention of further abuse. They provide concrete evidence of abuse and violence that can be crucial in any legal case. For example, if at trial the medical record and the abuser's

testimony are in conflict, the record is often considered more credible. Old records may also be helpful in uncovering and documenting past abuse. (See example 14.)

Figure 2-4 on the following page outlines the essential elements of documenting domestic violence cases.

### EXAMPLE 14

**A** 32-year-old woman was initially reluctant to tell the emergency physician that her partner has caused her injury. After reviewing her chart, the physician found that she had been seen in clinic four weeks before for a similar injury. She had stated at that time that her partner had hit her. With gentle probing, pointing out the similarity of the circumstances, the emergency physician was able to discuss the abuse with her. A safety assessment revealed escalating violence and a significant risk of more serious injury.



**FIGURE 2-4**

### **ESSENTIAL ELEMENTS OF DOCUMENTATION**

#### HISTORY

- *Chief Complaint/History of Present Illness:* Elicit and record precise details of the abuse and their relationship to the presenting problem. Include relevant trauma history and relationship of abuse to any concurrent medical symptoms.
- *Past Medical History/Review of Systems:* Ask about and record any medical, trauma, obstetrical/gynecologic, psychiatric, or substance abuse histories that are related to domestic violence. Document conditions which will affect the patient's safety or ability to deal with the abuse.
- *Sexual History:* Document any sexual assault, lack of barrier protection, STD's, unplanned pregnancy, abortions, miscarriages and ability to use birth control.
- *Medication History:* Document any relationship between the abuse and the use of psychoactive, analgesic or other medications.
- *Relevant Social History:* Document relationship to abuser, living arrangement, abuser's access to victim.

Whenever possible, use patient's own words: "*Jimmy, my husband, hit me in the eye.*"

#### PHYSICAL EXAMINATION

- Record precise details of findings related to abuse, including a neurologic and mental status exam. Use body map (see Appendix F) and photographs to supplement written descriptions. Use standard evidence collection techniques for acute injury or sexual assault.

#### LABORATORY AND OTHER DIAGNOSTIC PROCEDURES

- Record the results of any lab tests, x-ray, or diagnostic procedures and their relationship to the abuse.

#### SAFETY ASSESSMENT

- Assess and record information pertaining to the patient's risk for suicide or homicide, and potential for serious harm or injury. Determine if it is physically/psychologically safe for her to go home. Are the children or other dependents safe? Assess her degree of entrapment and level of fear.

#### POLICE REPORT

- Note whether one was filed, and record the name of investigating officer and actions taken.

#### OPTIONS DISCUSSED AND REFERRALS OFFERED

#### ARRANGEMENTS FOR FOLLOW-UP/DISCHARGE INFORMATION

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Specific information on photographs, body maps, labs, x-rays and imaging follows.

### B. Photographs

Photographs are particularly valuable as evidence, and should be offered to all patients with visible injuries. The health care provider should ask the patient for permission and obtain written consent to take photographs. (See Appendix E and F for model films.) Explain that the photos will become part of her medical record and can only be released to the police or prosecutor with her written permission or by court order. Let her know that should a case be filed against the assailant at some point in the future, photographs will be very useful evidence. It is also advisable to take pictures a few days after the incident, when bruises and swelling may be more apparent. She can have these pictures taken herself; however, photos taken by hospital staff or the police are sometimes more admissible in court.

The following are useful guidelines when taking photographs:

- If possible, take photographs before medical treatment is given.
- Use color film along with a color standard (if available) and a ruler, other devices or film with grids to help assess the size of the injury.
- Polaroid photos are preferred as they can be attached to the medical record at the time of the patient's visit, thus decreasing the chance that they will be misplaced. Polaroid film also allows the photographer to assess the adequacy of the photos before the patient is discharged.
- If standard film is used, the film must be placed in a sealed envelope and placed in a safe place until it can be

developed. The envelope should be clearly labeled with the patient's name, date, medical record number, location of the injury, and names of the photographer and any witnesses to the photography. (In some jurisdictions, 35 mm may not be admissible in court because it can be tampered with. Providers should check with local law enforcement about what film is preferred.)

- When the developed photographs are obtained, the patient's name, date, medical record number, location of the injury and names of photographer and witnesses to the photography should be written on each photo. The photos should then be attached to the patient's medical record together with the written consent form. In settings with a hospital-based advocacy program, a set of photos can be kept in a locked file with the patient's advocacy information.
- Take the photographs from different angles and include full body as well as close-up views, where appropriate. Include the patient's face in at least one picture.
- Take at least two pictures of every major trauma area.

(See Appendix F for tips on Polaroid Techniques.)

### C. Body Maps

A preprinted or hand-drawn body map, such as the one shown in Appendix F, can be very useful to document injuries which may not show up well in photographs, like scalp hematoma or deep bruises not yet ecchymotic. Bruises may not be well demarcated in cases where the contrast is not strong between skin tone and the color of the bruise. Be sure to label each site on the body map with the description of the patient's complaint; e.g., mark the area of the scalp and draw a line to a

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statement such as, “My scalp hurts when you touch me because last night my husband kept slamming my head against the floor.”

### D. Labs, X-rays, and Imaging

X-rays showing old injuries can support a past history of abuse. Otherwise, laboratory studies are usually not helpful in assessing victims of domestic violence. Reports of CT scans and other imaging procedures should also be documented. These can provide additional concrete evidence of abuse-related trauma.

## XII. DISCHARGE

Upon discharging patients, providers should discuss what written material will be safe for her to take home. (See Appendix G

for model discharge instructions.) Many batterers go through their partner’s drawers, pockets, purses, briefcases, etc.,

**FIGURE 2-5**

### DISCHARGE REVIEW

HAS THE FOLLOWING BEEN PROVIDED?

1. Screening for possible abuse
2. Treatment for acute medical problems
3. Assessment and addressing of acute psychiatric risk, and evaluation and referral for mental health needs
4. Assessment of pattern and impact of abuse. Assessment may be basic or more comprehensive depending on the setting.
5. Appropriate documentation and evidence collection
6. Validating
7. Safety assessment and plan
8. Information about domestic violence in verbal and written form
9. Options for shelter, legal assistance, and counseling
10. Appropriate follow-up care (or referral) for her medical, psychological and advocacy needs
11. Assurance of confidentiality

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and even discharge instructions or information sent to insurance companies if the statement goes to him may put her in danger. Try to avoid writing information about the abuse on her discharge instructions if this will increase the likelihood of retaliation, and make sure she knows what is written on any material he may see so that she can take precautions. She may need to write important phone numbers on scraps of paper, memorize them or have them embedded in other less threatening materials. The important thing is that this is discussed so that she can make the necessary choices.

Make sure that she has follow-up for her medical problems and appropriate referrals for mental health and substance abuse problems when indicated.

Let her know that she can return any time and that you, someone in your practice setting, or someone in your community will continue to support her through the process of (dealing with) addressing the abuse in her life.

Before discharge, be sure that the primary provider, social worker or domestic advocate has offered and/or provided the interventions outlined in the Discharge Review: Figure 2-5.

## CONCLUSION

Providing quality health care involves integrating routine inquiry about domestic violence into ongoing clinical practice. This means asking all women patients, as well as others who may be at risk, about abuse in their lives. Whether or not a woman chooses to use services or leave her partner, our intervention is very important. Some women return to violent partners several times before they feel safe enough to leave, feel they can survive on their own, or can accept that the person they love will not change. When we fail to ask about abuse, we may further isolate

women who are living in great danger. Asking questions can build bridges, decrease isolation, and create hope. By providing a safe place for women to talk about abuse and consider their options, we support and foster their ability to end the violence in their lives. We can help prevent further assaults and their resulting injuries and trauma, whereas to remain silent is to allow domestic violence to continue, unabated. Through our interventions we play a tremendously significant role in reducing and preventing domestic violence.

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**AUTHOR'S NOTE:** In addition to the works cited, there were a number of other documents utilized as background reading in the preparation of this chapter. They include the domestic violence guidelines and protocols for health care providers from the Massachusetts Medical Society, from the New York State Commission on Domestic Violence, from Dartmouth Medical Center, from Project Safe of the DVTP in New Haven, CT and a wealth of materials from the Family Violence Prevention Fund and the Pennsylvania Coalition Against Domestic Violence. Additional editorial assistance was provided by Lee McLain.

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