

## Health Care Response To Domestic Violence

### Objectives:

1. Health care providers will learn how to identify domestic violence and recognize the symptoms of battered women.
2. Participants will better understand the dynamics of domestic violence and learn how to effectively assist patients.
3. Participants will learn basic intervention strategies in assisting victims and providing referrals to appropriate services.
4. Participants will learn the importance of documentation in helping victims of domestic violence.

### Activities:

1. Discuss the current policies in your health care facility on domestic violence. Are there any? If not, what is needed and how will you go about instituting them?
2. Do you feel comfortable talking with victims about abuse? Asking women about past or present battering? Is so, what can you do to make this easier?

### Discussion Questions:

1. How can health care providers approach victims with information on services when the partner will not leave the victim alone?
2. How can health care providers work with perpetrators in stopping domestic violence? Is this their role?
3. What is the role of the health care provider when they are aware of children in a violent home and witness violence?

### Training Modules (Power Point Presentations):

[Health Care and Domestic Violence](#)

## HEALTH CARE RESPONSE TO DOMESTIC VIOLENCE

Nurses, physicians and clinicians who accept the challenge and responsibility for caring for abuse victims must recognize domestic violence as a major health care problem, understand the power and control issues which drive partner abuse, accept the victims' choices non-judgmentally, and support the empowerment of battered victims.

The nursing assessment should always include the consideration of domestic violence, regardless of the chief presenting complaint. When taking the initial history, several actions suggest battering and abuse as a possibility. How does the patient interact with his or her partner and the partner is present? What is the partner's behavior? What is the patient's affect, style of communicating, and finally what is the medical history given?

Is the partner reluctant to leave the patient's side? Does the patient "flinch" when partner speaks? Does the partner answer for the patient? Watch facial expressions, vocal inflection and body language for clues to the patient's emotional condition. Are the patient's responses inappropriate (giggling, for instance) or is the patient giving weak clues like stating, "I've had a bad time lately"?

Is the medical history as given inconsistent with injuries or complaints? Are there old injuries in various stages of healing? Are there complaints of insomnia, nightmares, inability to cope, or anxiety? Are any of the injuries consistent with sexual assault?

When the nurse is ready to pursue the source of injuries or problems, the patient must be in a secure, private environment, where no one can overhear her responses. If the partner refuses to leave, follow the protocols in place at the health care setting, including summoning security or others to assist in examining and interviewing the patient alone.

The health care professional must maintain a positive, supportive attitude: caring, objective, and accepting. Teaching may be a prominent part of the interaction, as many victims, particularly those with a long history of abuse, may not recognize the violence as abusive or criminal, as well as undeserved.

Nurses and other health care professionals should:

- Assess all females for current, past or family history of battering.
- Educate patients about the cycle of violence and the impact of violence on children. They are accountable to victims by giving referrals in the community, as well as providing follow up care and advocacy.
- Document, in detail, in the medical record, the physical condition of the patient, as well as the measures taken to treat.
- Validate the magnitude of the problem with research as opportunities arise.
- Interact with other disciplines in the community to provide primary, secondary and tertiary prevention of violence against victims.

The six steps that the healthcare professional should follow when assisting patients who are the victims of domestic violence are:

**ASSIST -**

1. **ASK** about domestic violence
2. **SEND** messages of support
3. **SAFETY** assessment and planning done
4. **INFORM** patients of their options with referrals
5. **SUPPORTIVE** documentation is provided
6. **TELL** other health care providers

**Have you used your RADAR?**

Remember to ask about abuse routinely.

Ask directly, and kindly, as well as non-judgmentally.

Document your findings.

Assess for patient's safety.

Review options and referrals with patient.

**Guiding Principles for Medical Professionals**

The Florida Coalition Against Domestic Violence published the following five principles for health care professionals:

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

Important questions to ask:

1. Is anyone in your family hitting you?
2. Has anyone ever hit you while you were pregnant?
3. Have you ever received medical treatment for any abuse injuries?
4. Can you mark on the body map where he hit you the last time he hurt you?
5. Does your partner ever threaten you?
6. Does your partner prevent you from leaving the house, from getting a job or returning to school?
7. What happens when your partner doesn't get what he wants?
8. What happens when you disagree with your partner?
9. Does your partner destroy things you care about: family photos, your clothes, hurt your pets?
10. Are you forced to have sex when you're not feeling well, or do sexual things you don't want to do?
11. Do you have to have sex after a fight to "make up?"

12. Does your partner watch you all the time? Call home frequently? Accuse of “coming on” to everyone?
13. Do you know where to go or who could help you if you were abused?
14. Some patients say they had an argument, then later say they were beaten. Has this happened to you?

### **RED FLAGS OF BATTERING**

1. Behavioral: Change in appointment pattern; multiple visits for vague complaints, or multiple missed appointments; frequent walk-ins or emergency room visits; patient can't be contacted at home; doesn't take medication as directed.
2. Past History: States history of child abuse; history of previous emotionally or physically abusive relationships.
3. Illness: Chronic pain (headache, pelvic pain, abdominal pain, irritable bowel); Gynecologic problems such as recurrent STD's, low birth weight deliveries, etc.; Depression, other stress related symptoms.
4. Injury: Delay in seeking care for injuries, minimizing injuries.
5. Pattern of Injury: Primarily central region; face with fractures, hematoma, lacerations around eyes, lips, perforated tympanic membrane; chest, breast injuries, broken ribs; abdomen and genital injuries. Old injuries or bruises in various stages of healing. Bites, burns, injury to a pregnant woman, especially to the abdomen. Recurrent minor trauma.
6. Psycho-social: Suicide attempts, alcoholism, substance abuse, low self-esteem.

### **BATTERER'S LETHALITY**

There is no absolute method of predicting lethal behavior but experience has taught that past assailant behaviors are, when clustered, accurate predictors of danger. These include, but are not limited to, threats and fantasies about homicide and suicide, along with a history of attempts. Also, depression and situational stress, like job loss, are a predictor of lethal behavior, combined with other factors. Possessing and using weapons, being obsessed about the partner, making statements such as “I can't live without her” and isolation with a complete dependency on the victim are all predictors of dangerous behavior. Rage over any hint that the victim may leave, consuming alcohol or other drugs while furious or depressed and having ready access to the victim or stalking her after she has obtained a protective order are other dangerous behaviors.

If a victim discloses any of these behaviors by the partner, extraordinary measures should be taken to protect the victim and her children. These measures might include emergency transportation, and meticulous follow-up. The victim needs to be supported in any attempts she wishes to take to protect herself and health care professionals should contact the local domestic violence center for assistance with immediate safety planning for the victim.

### **DOCUMENTATION**

Well-documented, thorough medical records are essential for preventing further abuse. They can further provide crucial evidence in any legal action as they are generally considered the most credible evidence a victim's advocate can summon to assist her.

Documentation should be detailed, in the patient's own words whenever possible, and should include a complete medical and social history. Description of injuries should be thorough and detailed, and recorded either on a body chart, or drawing, and if possible, amplified with photographs (in color) and/or imaging studies. Names of all medical and law enforcement personnel should be included.

Laboratory tests, x-rays and any other diagnostic procedures should be included, with their relevance to the abuse clearly explained.

For medical documentation to be properly admissible in court, health care professionals need to be prepared to testify that the records were made during the regular course of examination or interview, that they were made in accord with routinely followed procedures, and that they have been properly stored, and access limited to professional staff.

### **BASIC INTERVENTION STRATEGIES**

Interventions will vary from patient to patient depending on the assessment, the nature of the abuse, impact on and condition of the patient, as well as the patient's motivation and resources to deal with the presence of domestic violence in the patient's life. Once the abuse has been identified, there are some basic interventions which can be made in all domestic violence cases. These include: validating and naming the problem of domestic violence, assisting the patient in identifying abuse as a problem, listening to the patient's concerns, educating the patient about abuse and its connection to medical issues, as well as the dynamics such as power and control strategies employed by the batterer and the cycle of violence.

Of vital importance is the need to discuss options with the patient, help with safety planning, make appropriate referrals and establish some method of follow-up with the patient and her children.

Expressing concern about patient's safety, understanding how difficult it is for her to make changes that are necessary, and reassuring her that she is not alone are all appropriate actions to take. Reaffirming that the violence is not her fault is very important since the batterer routinely blames her for all his behaviors. Remind her that only the abuser can stop the battering and that it is a conscious choice he has made.

Finally, state that no one deserves to be beaten and that there is no excuse for violence and that she and her children deserve peace and safety are very strong steps to take with the victim patient. Always remind the victim that there are options and resources available and that health care professionals are there to help her with access to them.

### **CHILD ABUSE AND NEGLECT**

Children are affected by domestic violence at all ages from prenatal to adolescence, physically, developmentally, behaviorally and cognitively as well as emotionally and psychologically. Without intervention and treatment, the injury done to children carries on well into adulthood, often manifesting in a new generation of victims and batterers.

Newborn infants born to abused women often suffer poor health due to the abuse she received, the stress she suffered, and lack of proper nutrition and prenatal care. Later, these infants are subject to prolonged crying and irritability, sleep disturbances and digestive problems.

Toddlers and preschool children may be either more aggressive and violent than their peers, or more withdrawn than others. They demonstrate impaired cognitive abilities, delays in verbal development, poor motor abilities, general fearfulness and anxiety, stomach aches, nightmares, lack of bowel and bladder control over three years of age, and an extreme lack of confidence to begin new tasks.

School aged children may have poor grades or be placed in special classes, may fail one or more grade levels, show poor social skills, and general aggressiveness with outbursts of anger. They have low self esteem, may be excessively dependent, or be bullies. They also often have nightmares, and may experience bedwetting. Frequently, they complain of headaches (not related to eyestrain or sinus problems), and may experience digestive problems.

Teenagers may have poor grades, fail or even drop out of school. They often refuse to bring friends home or stay away from home. Some feel responsible for the victim parent's safety and may be injured trying to protect the victim of battering. Runaways are often from a violent home as are delinquents and pregnant teens. They too experience nightmares, anxiety, depression, ulcers and other digestive problems and headaches. Some are immature, withdrawn, have few friends, and cannot communicate their feelings.

Dating teens replicate the behaviors they have seen at home, with males hitting their girlfriends. Non-intimate violence by teens against others is rising at an alarming rate, and many of these young people were abused and saw abuse in their homes, between adults.

Teens from violent homes are at greater risk for suicide and homicide, delinquency, sexual promiscuity and sexually transmitted diseases, and drug and alcohol abuse.

Children of all ages who live in violent homes need not only the safety and stability of a non-violent environment, but support, therapeutic intervention and education just as their victim parents do. Children tend to assume responsibility and feel blame for what is happening in the home. They are often injured attempting to intervene and protect the victim. Some are hit with objects thrown at the victim, and infants and toddlers are injured as they are held by the victim who is being battered.

Children presenting injuries in an emergency department may very well be sending clues to the health care professional that there is domestic violence in the home and need to be assessed as thoroughly and carefully as adult victims.

## HELPING AN ADULT WHO IS A VICTIM OF DOMESTIC VIOLENCE

*Interviewing:* Talk with the person in private (without the partner). Communicate belief, support and confidentiality. Make eye contact when talking with the victim:

- “Our discussion will remain strictly confidential”
- “You have a right to be safe and respected and nobody deserves to be hit or hurt”
- “The abuse is not your fault”
- “How can I help?”

*Help patient assess danger.* Patient’s assessment of safety.

- “Do you feel safe going home?”

*Assessing Violence:* To move from general, open-ended questions to specific, direct questions that help you thoroughly assess violence in a relationship.

- “Tell me about your relationship with your partner.”
- “People have different ways of showing disagreement or anger in relationships. Sometimes people talk loudly, shout, threaten, hit, or use weapons. How does your partner show anger and disagreement?”

Wait for a response, then ask “Anything else?” or “And then what happens?” Repeat until patient offers nothing else.

Probe for specific types of violence, beginning with the least severe.

- “Has your partner ever yelled at you, demeaned or berated you?”
- “Has he ever threatened you, your children or someone else?”
- “Has he ever destroyed your property or other things?”
- “Has he ever tried to control your movements and activities?”
- “Has he ever pushed or hit you?”
- “Has he ever forced unwanted sexual or physical contact?”
- “Has he ever hurt you with a weapon or object?”

*Indices of Lethality:* Severity of injuries.

- Increasing severity; weapon used/available
- Threat to kill
- Forced or threatened sexual acts
- Dangerous life transitions; pregnancy, divorce, leaving home
- Drug and alcohol abuse
- History of violence or suicide attempts by partner or patient

*Children’s safety:*

- “Are your children safe”
- “Do they know who to call in a emergency?”
- “Can they call 911 if they need to?”

- “Is there somewhere they can go to be safe?”
- “Do your children know the safety plan?”

*Plan for Support and Safety:*

- Offer telephone numbers: These include the local Women’s Shelter, legal advocacy, police and 911
- Help make an emergency plan. Some of the topics that you should discuss with the victim include:
  - “If you decided to leave, where could you go?”
  - “Can you keep some clothes, money and important papers in a safe place?”
  - “Where could you go in an emergency? How would you get there?”
  - “Do you have relatives or friends you could stay with who would be supportive?”

*Offer follow-up:* You should consider scheduling another doctor’s appointment or ask the patient to call you.