Women's Health Care

BRIGHAM AND
WOMEN'S HOSPITAL

Mary Horrigan Connors
Center for Women's Health

# Domestic Violence

*A Guide to Screening and Intervention©*

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# Medical Impact

Domestic violence affects women across the life span. The spectrum of violence is continuous, ranging from adolescent girls to elder abuse. The effects of abuse can be far-reaching, influencing patients' health and well-being, their ability to follow through on treatments, their access to care, and the course of their medical condition. Domestic violence occurs in all communities, regardless of race and ethnicity, social class, religious background or sexual orientation.

## Definition

Domestic violence, or domestic abuse, is a pattern of abusive behaviors used by one person in a relationship in order to gain power and control over his or her intimate partner. It includes any or all of the following types of abuse:

- Isolation tactics (e.g. undermining relationships, withholding access to phone or transportation).
- Instilling fear (threatening physical harm, threatening to kidnap or harm children and/or household pets).
- Verbal and psychological abuse (name calling, belittling, silent treatment, oppression tactics related to race, socioeconomic status, age, disabilities, sexual orientation).
- Economic control (attempting to make partner financially dependent, withholding money, harassing partner at work).
- Inflicting injury (any physical assault, restricting access to medical care and to personal care, withholding or stealing medications).
- Sexual abuse (coercing sexual contact, treating in a sexually derogatory manner, accusations of infidelity).

## Prevalence

The prevalence of domestic violence is difficult to determine because of the social isolation and stigma attached to disclosing and reporting abusive behaviors. Approximately 3.9 million women are physically assaulted and/or raped by an intimate partner annually.

As many as 40 percent of all women who seek care in hospital emergency rooms for violence-related injuries have been injured by a current or former partner. The risk of injury, rape or homicide by a current or former partner is greater than all other combined causes of injury to women. A recent study in Massachusetts found that one in five adolescent girls in Massachusetts reported physical or sexual abuse by a dating partner. The study found that dating violence is associated with substance use, pregnancy, and suicidality. Pregnancy is a particularly high risk time and is often when abuse begins or escalates. The prevalence of domestic violence is seven to 20 percent in pregnant women.

## Economic Impact

The health-related costs of rape, physical assault, stalking, and homicide by intimate partners in the United States exceed $5.8 billion each year. Of this total, nearly $4.1 billion are for direct medical and mental health care services, and productivity losses account for nearly $1.8 billion.

# Mandatory Reporting of Abuse

According to Massachusetts State Law, gunshot wounds and serious burns (>5 percent of body affected) should be reported to the Colonel of the State Police and the town police where the injury occurred. Burns should also be reported to the State Fire Marshall. Stabbings or injuries with sharp objects, if in the physician's opinion a criminal act was involved, also require reporting to the police in the town where the injury was treated.

There is no state mandate to report domestic violence. However, appropriate assessment and intervention by providers, is required. Sexual assault requires a report to the state police without identifying the victim. Abuse of children, elders, and disabled persons requires reporting to state protection agencies.

# Screening for Abuse

Universal screening is the best way to identify abuse. As part of routine care, providers should screen all patients for abuse, whether signs, symptoms or behaviors suggesting the presence of abuse are present or absent. Pregnant women should be screened at the initial visit and again in the third trimester. Simply asking about abuse is an intervention. Even if a patient does not disclose abuse, she will know that the provider is concerned and the hospital or clinic is a safe place to access assistance should she need it in the future. It is a matter of opening – and leaving – the door open.

Screen patients when they are alone, without anyone else present in the room. It is unsafe to screen in the presence of another person. Do not ask the patient for her consent to meet alone. Standard practice is to ask family and friends to wait in the waiting area during history taking or physical examination. If the provider is unable to meet with the patient alone or if a trained medical interpreter is unavailable, screening should be deferred with a note in the medical record stating this. Of note, a patient may be at risk for retaliation by an abusive partner if she discloses abuse to a health care provider.

## Introductory statement

**The following introductory statements can be used to screen patients for abuse:**

- Abuse against women has an impact on health and well-being and is very common. I ask all of my patients if anyone is scaring, threatening or hurting them in any way.
- I'm so concerned about family violence that I ask every patient about this, just as I ask about other health issues.

## Screening questions

- Have you ever felt unsafe or been afraid of anyone (for example, your partner, a relative, or anyone else)?
- Is anyone trying to control you (for example, whom you see and talk to, where you go, what you wear, how you spend money)?
- Has anyone ever hurt or threatened to hurt you or someone else that you care about? For example, has anyone ever, hit, kicked, slapped or punched you or forced you to perform sexual acts against your will?
- *For pregnant patients:* Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?

## Additional questions/statements for patients in whom a provider identifies high index of suspicion:

- How does your partner get along with your family and friends?
- Most couples argue from time to time. When you and your partner argue, do you feel afraid?
- When your partner is angry, how does he/she act? Does he/she get physical and push, grab, or hit you? Does your partner force you to have sex or hurt you during sex?
- I'm worried; this doesn't look like you fell.

## Response to screening

**A person is more likely to disclose abuse when she:**

- perceives that the provider is actively listening and concerned.
- understands the provider's reason for screening.
- feels assured that the disclosure will not be reported back to the abuser.

Note: A negative response to screening does not mean that abuse is <u>not</u> present. It may indicate that the person is not comfortable disclosing abuse at this time.

### Domestic Violence Screening Documentation

Document screening in the patients medical record. If the person answers "No" to the screening questions, let her know that support is available related to abuse and patient safety should she ever need them.

**Write:** "Routine screening questions for abuse asked. Patient stated that abuse is not an issue at present time." **Do not write:** "Patient denies abuse."

Many abused persons who are afraid to talk about their situation at one time may return in the future and disclose abuse if they perceive that there is help available. If a provider writes that the patient "denies" abuse and the situation becomes a legal matter, the subjective documentation creates a legal doubt about whether or not the patient is a credible reporter.

# Barriers to Disclosing Domestic Violence

## Interpersonal barriers

- Patient is afraid that provider will judge her.
- Abuser has threatened to harm the patient if she discloses abuse.
- Patient lacks confidence in the system.
- Patient fears no one will believe her, will blame her for staying with the abuser, or will blame her for not taking action sooner.
- Patient has never talked about the abuse and does not know how to bring it up.

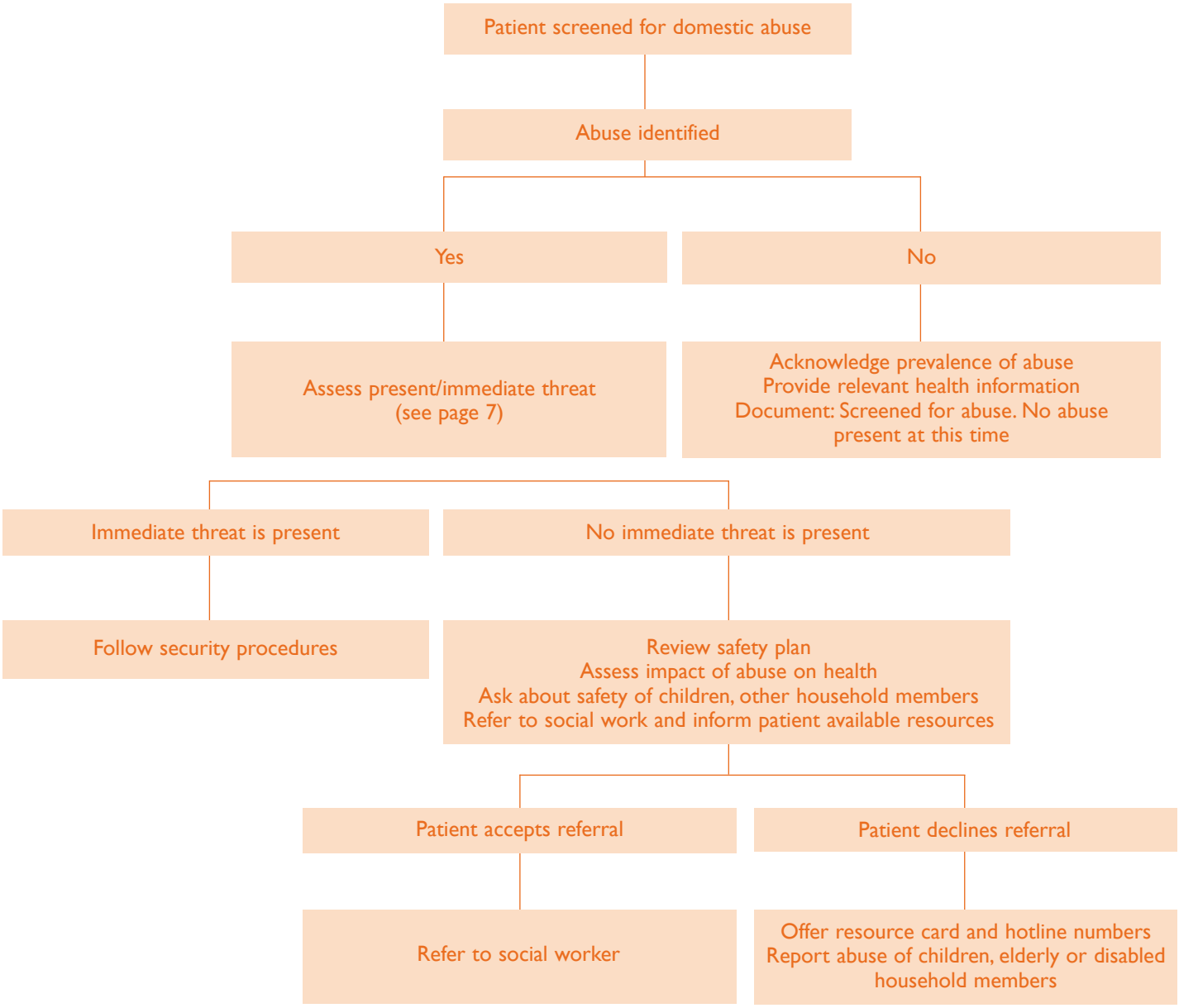
## Lack of access to information and resources

- Patient is not aware that what she is experiencing is domestic abuse.
- Patient thinks that what she is experiencing is not serious enough to qualify as "domestic violence."
- Patient is unaware that resources are available to help her or she is unable to access resources because of abuser's control.
- Patient lacks financial or social independence.
- Patient is concerned about the safety and welfare of children.

## Provider and institutional barriers

- Provider has not asked screening questions.
- Screening is not conducted in patient's native language.
- Patient is concerned about disclosing information about the abuser because abuser also receives care from the same provider or at the same institution.
- Patient is afraid that disclosure of abuse will result in notification to authorities, which may exacerbate the abuse at home.

## Domestic Violence Screening Algorithm



# Clinical Evaluation

| | |
|---|---|
| **History** | • Chronic unexplained pain, including persistent headache, abdominal, pelvic or chest pain<br>• Chronic medical conditions such as chronic GI complaints, irritable bowel syndrome, chronic back or joint pains, chronic fatigue, various somatic complaints<br>• Sexually transmitted diseases and exposure to HIV through sexual coercion<br>• Multiple therapeutic abortions<br>• Exacerbation of symptoms of a chronic disease such as diabetes or asthma<br>• Intra-oral injuries, facial pain<br>• Non-compliance with medical treatment, frequently missed appointments |
| **Psychological Symptoms** | • Insomnia, sleep disturbances<br>• Depression and suicidal ideation<br>• Anxiety symptoms and panic disorder<br>• Eating disorders<br>• Substance abuse, including tobacco<br>• Post-traumatic stress disorder<br>• Somatiform disorders<br>• Use of psychiatric services by victim or partner |
| **Physical Findings and Common Characteristics of Injuries Caused by Domestic Violence** | • Any injury, especially to face, head, neck, throat, chest, abdomen and genital areas<br>• Poor dental hygiene<br>• Dental or temporomandibular joint (TMJ) trauma<br>• Burns<br>• Signs of sexual assault<br>• Central distribution of injuries, which can be covered up with clothing<br>• Defensive injuries of the forearms<br>• Wrist and ankle lacerations from being bound<br>• Injuries that are not explained adequately or consistently<br>• Injuries to multiple areas<br>• Bruises of different shapes and sizes, reflecting types of weapons used<br>• Bruises in various stages of healing |
| **Behavioral Indicators** | • Delay in seeking treatment<br>• Repeated use of emergency services for trauma or primary care<br>• Evasiveness during history taking or examination<br>• References to partner's temper or anger<br>• Reluctance to speak in partner's presence<br>• Partner answers all questions for patient or insists on being present when asked to leave exam room<br>• Overly attentive or verbally abusive partner<br>• Abuse or neglect of children, disabled person or elderly adult in the home<br>• Abuse of pets |
| **Findings During Pregnancy and Childbirth** | • Frequently missed prenatal appointments, late or no prenatal care<br>• Low maternal weight gain<br>• Any injury including "falls" (1/3 of all trauma in pregnancy)<br>• Complications such as miscarriage, low birth weight infant, premature labor, premature rupture of membranes, and antepartum hemorrhage<br>• Poor self-care or compliance<br>• Substance abuse, including tobacco or alcohol during pregnancy |

*Adapted from Eisenstat, S & Bancroft, L, Primary care: Domestic Violence, New England Journal of Medicine, 1999; 341: 886-92 and Lewis-O'Connor, A., Neighborhood Health Plan, 1997 and Passageway at BWH – Training Materials.

# Intervention

## Step 1. Acknowledge and validate the patient's disclosure

An abused person experiences isolation and shame. The provider's first step in responding to a disclosure of abuse should be to validate the person's experience and concerns.

| Validating and supportive statements | Harmful statements |
|---|---|
| • You are not alone.<br>• You deserve to be safe.<br>• I'm so sorry that this is happening to you.<br>• I'm glad you told me–I'd like to help.<br>• I'm concerned for your safety.<br>• There are resources available here for you.<br>• The abuse is not your fault.<br>• You don't have to deal with this alone. I can offer you some helpful information and contacts. | • Are you a victim of domestic violence?<br>• What was your part in the argument or fight?<br>• Why did you get involved with him if you were aware of his violence?<br>• Why didn't you tell me sooner?<br>• Why didn't you just leave him the first time he hit you?<br>• Why didn't you call the police?<br>• Why didn't you get a restraining order?<br>• Why do you stay? |

**Contraindicated interventions:**

- Couples, marital or family therapy.
- Anger management groups (or any non-certified batterer group) that do not provide safety planning for the victim.
- Mediation for legal issues, divorce, and custody.
- Confronting the abuser or suggesting that the victim confront the abuser.
- Any intervention without a safety plan or without the victim's consent.

It is important for providers to examine their own assumptions and biases with regard to gender, race, culture, age, and sexual orientation when speaking with abused patients. Providers' personal biases may affect their ability to initiate interventions.

## Step 2. Respond to the medical consequences of the abuse

- Assess effects of abuse on patient physically and mentally.
- Examine current and past injuries.
- Treat injuries and other medical complaints as indicated.

## Step 3. Assess immediate or present threat

- Ask if the patient is afraid that the abuser will harm her today.
- Determine if the abuser is present in the hospital or medical office, and whether the abuser is aware that the patient is seeking medical care or support services.
- Obtain information about the abuser: name of the abuser, prior incidents of abuse, drug use, types of weapons used, and types of weapons in the home.
- Ask about the abuser's threats. Has the abuser threatened to harm or kill the patient?
- Does she feel safe in the office today? Does she feel safe enough to go home?
- Is the patient concerned that her children or loved ones are in immediate danger?

**If there is an immediate or present threat, follow security procedures.**

## Step 4. Develop a safety plan

- Ask if the patient has a plan if the violence or abuse escalates. Review the safety plan.
- Ask about patient's ability to access supports and services.
- Always refer the patient to a social worker and/or domestic violence program to assist the patient in developing a safety plan.

## Step 5. Utilize hospital and community resources

- Contact a social worker for questions about intervention or documentation, and for consultation.
- Many health care institutions have domestic violence programs and/or advocates. Be aware of the contact information for these programs in your area.

## Step 6. Document findings in medical record

- For detailed recommendations on documentation of domestic abuse, see page 8.

# Documenting Domestic Violence

Medical records are often the best and only documentation of abuse that can be used in court. Providers who document detailed, objective, and legible accounts of patient presentations are less likely to be subpoenaed to appear in court than are those who write vague, subjective, and illegible notes about abuse. Words and phrases that are commonly used in medical records may have a very different meaning in court. In some cases, such phrases may be misinterpreted as disbelief on the part of the provider.

Documentation should provide detailed and objective information and include the following:

- Date and time of incident or abusive situation.
- Patient's account of what happened, including the first and last name of the person who abused her. Include specific details about the incident, including type and nature of threats, injuries sustained, and weapons used.
- History of previous incidents of abuse with the abuser (physical, sexual, emotional, verbal, economic, etc).
- Description of physical findings.
- Provider's assessment, recommendations, information provided, safety planning, resources and referrals provided to patient.
- Documentation of mandatory reporting of child, disabled, or elder abuse.

If clinicians make an assessment that is in conflict with the patient's report of the situation, note the difference. For example: "Although the patient, who is six months pregnant, reports that she accidentally fell down the two flights of stairs, provider questions if injury was inflicted. Patient previously has reported multiple incidents of physical abuse by boyfriend. She said that he often hit her and shoved her during her past pregnancy in 1998. When speaking today about the fall, patient did not make eye contact, declined to answer and began to cry when I asked if her boyfriend pushed her down the steps."

| Documentation Tips | |
|---|---|
| • Write "screening for abuse is negative at the present time." | • Avoid writing "patient denies abuse." |
| • Record the patient's spontaneous statements in quotation marks. Such statements, legally termed "excited utterances" are admissible in court. | • Do not tell the patient that the statements she is about to make may be used in court. The statements then no longer qualify as spontaneous, excited utterances and will be disqualified. |
| • Write "patient stated" or "patient reports" (e.g., " patient reports that her boyfriend, Joe Smith, twisted her arm behind her back"). | • Avoid writing "patient alleges" or "patient claims." |
| • Record what you saw and heard and write "Patient was shaking and crying while describing the incident where her husband threatened to kill her." | • Avoid phrases that leave room for misinterpretation. For instance, avoid writing "Patient was hysterical." |
| • Describe what you see on exam, including various locations, shapes, and sizes of bruises, as well as colors. A body map is most useful. | • Do not attempt to "date" bruises subjectively, as this can lead to contradiction and doubt in court. |

## Photographing Injuries

Photographic documentation is intended to complement written documentation and provides additional evidence of abuse that can be used in court proceedings. Take photographs only if a patient consents verbally and signs a written consent form specifically authorizing photography. Place photographs in a sealed envelope within a medical record and label as "Confidential – to be used only for litigation purposes."

All patients should be offered the opportunity to have photographs taken. If a patient agrees, complete the written consent form. The photographer must follow the following guidelines for photographs to be useful:

(1) Take an initial photo of the person, including the person's face and any visible injuries. It is helpful to include an identifying document (e.g., person's license or ID) in the set of photos.

(2) Take a medium range photo showing the location of the injury on the person's body.

(3) Take close-up photos of the injury or injuries. Be sure to include a photo that enables the viewer to identify the body part where the injury was sustained.

(4) Label each photo with the date (including year) and time the photo is taken, the name of the hospital, the name of the patient, the signature of the patient, the photographer and a witness.

# Guideline Summary

Domestic violence is highly prevalent, occurs in all age groups, and has an impact on the health and well-being of the abused.

**All providers should be able to:**

- Identify and screen for abuse
- Respond to abuse disclosures
- Address safety issues
- Address clinical effects of abuse
- Refer to appropriate services
- Document in the medical record

## Screen

All patients should be screened for abuse, in a private setting, apart from family members or friends.

## Respond

*If a patient discloses abuse,*

- Provide emotional support
- Assess current safety risks
- Address the impact of the abuse on patient's health

## Refer

*Refer to appropriate services.*

- Social Work Program
- Domestic Violence Program
- Employee Assistance Program

## Document

*Document disclosure of abuse in the medical record. Documentation should include:*

- Date and time of abuse if known
- First and last name of person patient states has committed abuse
- Clinical findings (with photographs of injuries if appropriate)
- Patient's account of what happened
- Provider's response, including safety plan and referral

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