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Family Violence: What Is a Health Care Provider To Do?

Domestic violence, spouse abuse, and battering all refer to the victimization of a person with whom the abuser has or has had an intimate relationship.[1] Domestic violence may take the form of physical, sexual, or psychological abuse, is generally repeated, and often escalates within relationships. Batterers and victims alike include parents, spouses, children, and the elderly. Since physicians and other health care providers are usually the only professionals whom victims of domestic violence encounter, they have a unique opportunity to help break the cycle of abuse.

A landmark prevalence study of the general population found that 28% of individuals in the sample population had experienced domestic violence at some point in their lives.[2] Crime data since the early 1980s indicate that at least 1500 women are killed by an intimate partner each year.[3,4] In the United States, women are more likely to be assaulted, injured, raped, or killed by a current or former partner than by all other types of assailants combined.[5] National data collected since the early 1980s reveal that, on average, 1.5 million children annually are seriously abused.[2] Although family violence was previously considered primarily the domain of law enforcement and social work, there is a growing awareness now that this problem is also a major health care concern.

A Case for Screening

Patients are regularly screened for hypertension, diabetes, and cancer. Pregnant women are routinely screened for placenta previa, gestational diabetes, and possible fetal birth defects. Unfortunately, the vast majority of health care providers fail to suspect or routinely screen for abuse. Although research on the health care provider's role in diagnosis and treatment/referral of domestic violence has predominantly focused on physicians, most of the findings also apply to other medical practitioners, such as nurses and physician assistants.

Victims of abuse seek treatment in far greater numbers than health professionals realize because victims characteristically do not disclose their abuse. Battered women typically visit their primary care physicians for complaints such as headaches, abdominal pains, anxiety, and insomnia.[1,6] One study of emergency department visits found that 22% to 35% of women admitted to hospital emergency departments present with injuries or symptoms caused by ongoing abuse.[1,7] In this study, physicians identified 1 in 35 of their female patients as battered, while the medical chart review disclosed that 1 in 4 were likely to have been battered.[7]

Even when practitioners do identify abuse, follow up varies greatly. Another study of emergency department visits showed that in 40% of cases in which physicians were aware of battery as the cause of their patients' injuries, they made no response to the abuse.[8]

Treating only the injuries and symptoms of abuse does not address the root cause of the patient's health problems.[1] Also, when a diagnosis of abuse is missed, treatment can be inappropriate and potentially harmful, and the abuse most likely will continue. Failure to diagnose abuse also can contribute further to the patient's sense of victimization and hopelessness.

Violence towards pregnant women puts the fetus at high-risk for intrauterine bruising, bone fractures, and joint dislocation.[5,9,10] Abuse puts all victims at risk of death. Considering the devastating short- and long-term consequences of family violence to the individual patient and its recognized threat to public health, health care providers should include routine screening for abuse as an integral part of patient care.

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Barriers to Diagnosing and Treating Family Violence

In one study of 38 physicians, predominantly family practitioners, the image of "opening Pandora's box" was used repeatedly to describe physicians' reaction to exploring domestic violence with their patients.[8] A majority of physicians in this study voiced frustration with the seemingly overwhelming effort required, especially regarding time.

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Other studies have mirrored these results and also found that societal misconceptions regarding the causes and magnitude of domestic violence are shared by physicians, contributing to their reluctance to consider abuse in the differential diagnosis and to disbelieve that abuse has occurred even when the signs are evident.[1,5] Most studies also revealed practitioners' frustration with the extreme lack of control over outcomes even when they did take the time and effort to diagnose abuse.[1,2,5,6,8]

Ultimately, outcomes rely heavily on available community support services and on the patients themselves. Appropriate follow-up resources are often inadequate. Also, even with optimal support services, the process of leaving an abusive relationship is not easy. The denial a woman uses to cope with abuse can be very strong. And many women lack financial resources outside the abusive relationship to be able to leave. Thus, a woman may return to an abusive partner time and time again.

Appropriate professional care for abused patients in Texas is available in most communities.

Another concern expressed by a majority of physicians in these studies was that they would offend both the potential victim and the potential batterer by even broaching the subject of abuse.[1,2,5,6,8] They also feared that true victims of abuse might suffer additional trauma when asked to recall and relate incidents of violence/abuse.

Physicians who have themselves been abused are likely to have their personal experience with family violence affect their ability to address this issue.[8] The same denial a patient uses for emotional protection can be in effect for a health care provider who has experienced abuse. Just as relating her abuse can be traumatic for the patient, the patient's disclosure also can open wounds for the physician treating her.

Finally, virtually all primary care practitioners surveyed expressed concern over their expertise relative to diagnosing and providing follow up for domestic abuse. Family violence and sexual abuse are among the most difficult issues confronting health care professionals because standard medical training does not necessarily give them adequate skills and resources to comfortably and effectively address this complex, often volatile health concern.[1,2,6,8] A third of the participants in one study reported having received no educational content on family abuse in their professional training programs.[6]

Fortunately, recent research and planning efforts have provided guidelines health practitioners can use to screen for interpersonal abuse and help their patients obtain follow-up care to prevent further abuse. Also, many of the concerns expressed by physicians regarding how to deal with patients identified as victims of abuse can be addressed through referrals to professionals experienced in this kind of care.

Though still inadequate to fully meet the public health needs generated by family violence, resources are continually improving. Appropriate professional care for abused patients is currently available in most Texas communities. Health care providers located in areas of Texas where no direct services are available can at least give their patients the telephone numbers for state and national support hotlines (see Resources section). Once health care staff are trained in assessment and referral of family abuse, and provided with screening tools, most of their reluctance and fears begin to subside.

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Federal and State Action

Family violence has been identified as a major public health problem in the United States. Medical costs alone total $44 million annually.[11] The Healthy People 2000 objectives and two former Surgeons General have called for an organized approach to screen, treat, and prevent further violence.[12,13,14]

In 1993 the Department of Health and Human Services initiated a 5-year, Title X Service Enhancement Project in Region VI (Texas, Arkansas, Oklahoma, Louisiana, and New Mexico).[15] Among the five states, 14 family planning clinics were designated as pilot sites for this project. The Texas Department of Health Family Violence Prevention Project is responsible for implementation of the DHHD Project in the 3 Texas pilot clinics. Region VI goals are to

- Improve quality and increase volume of clinic-based services related to family violence and sexual abuse
- Improve quality and increase volume of community-based public health education to prevent violence and sexual abuse

The specific initial goals of the TDH Family Violence Prevention Project are to

- Determine the prevalence of sexual abuse and family violence in a sample of family planning clients at selected sites
- Expand services to include brief on-site counseling, followed by referral for in-depth services
- Provide community prevention education

The first two years of the Family Violence/Sexual Abuse Prevention Project focused on needs assessment and service delivery. More than 2000 women and teenagers in the 14 pilot sites were screened for family violence/sexual abuse. Thirty-two percent of the women in this study reported having been hit or injured by someone in a close relationship.

Since it began in 1993, the TDH Project has had positive results. The first benefits to be realized at the 3 Texas sites were improvements in identification of and service delivery for family planning clients who had been or were victims of sexual abuse/family violence. A model protocol for staff training was developed and shared with other provider agencies.

A surprising result of this project was that providers who initially were reluctant to participate reported that their relationship with patients who disclosed abuse was actually strengthened and made more comfortable as a result of their demonstrated concern for the patient's safety. Another encouraging finding was that clients genuinely appreciated the opportunity to disclose abuse experiences in a clinic atmosphere characterized by knowledgeable, supportive staff who discussed their needs comfortably and confidentially, and made appropriate referrals.

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The Region VI Family Violence Prevention Project has found that, once equipped with the necessary local network of violence- and abuse-related service providers and with appropriate tools and training, clinic staff fears and resistance have been either alleviated or significantly reduced.

Screening Procedures

The practitioner's most effective role in helping patients alleviate or end violence at home is to openly discuss abuse, offer safety strategies, and link at-risk patients to available resources. Patient histories should include an assessment for family violence/sexual abuse at every health maintenance and most interval visits to their primary care provider.

There is a special need to screen all pregnant patients, a frequently undetected high-risk group. One study found that women battered during pregnancy were battered more frequently and severely throughout the course of the relationship.[16]

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Reference primarily to the female patient by no means implies that only women are abused. At least 5% of reported physical abuse of adults involves male victims,[3] while the incidence of both physical and sexual abuse of male children is reported to be closer to 16%.[17] Even accounting for underreporting, the victim of abuse in any given case is more likely to be female. For the most part, however, recommendations for screening and referring female patients are applicable to male patients as well.

Indicators

Observing for indicators of abuse and asking specific screening questions can effectively assess the patient's need for further services. Statistically significant predictors of family violence and sexual abuse were identified in the needs assessment done in the first two years of the Region VI Family Violence/Sexual Abuse Project. Analysis of these statistics suggested the following:

- Younger respondents (age 19 or less) were more likely to report current domestic violence or recent sexual assault.
- Patients who reported any history of control issues (for example, if a patient reported that she has had a partner who would not let her visit friends or use birth control) were more likely to note domestic violence or sexual abuse.
- Reported physical abuse while growing up also appears to be a risk factor for experiencing more recent forms of assault/abuse.
- Individuals who reported substance use at work or school or other drug related issues more often noted domestic violence or sexual abuse.
- Any history of forced intercourse also seems to be a factor in predicting clients who have experienced family violence or sexual abuse.

The following is a list of other common indicators of abuse:

- Lacerations and/or bruises
- Extent or type of injury not consistent with patient's explanation
- Problems during pregnancy; specifically, preterm abortion, bleeding, intrauterine growth retardation, hyperemesis
- Emotional abuse or marital discord observed by staff
- Early age at first intercourse (<15)
- First sex not wanted
- Repeated vaginal infections and STDs
- Severe dysmenorrhea or pelvic pain
- Pregnancy at a young age
- Number of lifetime sex partners >6

These indicators are to be viewed as "red flags" for the health care professional. When observed, there is a higher likelihood of abuse history and further assessment is indicated.

Screening Questions

During the intake process, information regarding experiences with interpersonal violence should be obtained from every patient, especially pregnant women. Procedures should be in place to assure confidentiality of this information and the patient reassured of this fact.

A patient who is asked "*Have you ever been physically or sexually abused?*" is likely to answer no. On the other hand, the patient usually will answer a specific, detailed question accurately, ie, she will answer "yes" if the specific situation described in the question has in fact occurred. The following are examples of questions which could be added to a medical history form.

Initial Screening

1. Have you ever been in a relationship in which you have been hit, kicked, or hurt in any way? Are you in such a relationship now?

2. Has anyone ever touched the sexual parts of your body or made you touch their body in a way that you did not like or without your permission?

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In addition to observing for indicators of abuse, it is important and helpful to ask questions when abuse is suspected. The patient may not respond immediately, but the process of establishing trust will begin if questions are asked in a caring and nonjudgmental manner.

Patients must be asked about abuse in different ways. Not everyone will respond to the same kind of questioning. Studies show that the percentage of people who admit they have a history of abuse will increase with the number of different questions asked. If a patient shows physical signs of abuse or answers yes to the initial screening questions, further screening is recommended. The following list of questions relates specifically to abuse histories and can be asked verbally by a provider.

Follow Up For Suspected Abuse

1. Have you ever been hit, slapped, kicked, or injured by someone in your family or someone you are in a relationship with?

2. Many clients tell me they have been hurt by someone close to them. Could this be happening to you? Are you being beaten?

3. I noticed you have a number of bruises? How did they happen?

4. Many women experience violence in their lives. Has anyone ever hurt you?

5. While pregnant were you ever hit, kicked, or injured by someone?

6. In the past year, have you had sex because you were forced or felt threatened?

7. Do you have intercourse now when you do not want to?

8. Are afraid of anyone you currently live with or have a relationship with ?

9. Has anyone in your family touched you in a sexual way?

With time and practice, providers will become comfortable and familiar with these questions and can use them easily as needed. Some or all of the above questions can be used to create a one-page assessment sheet for the patient to fill out. Once completed, a trained staff member should review the responses and follow through with referrals and any other necessary services.

Develop a "Safety Plan"

If a patient is being abused, ask if she is safe to return home. The patient's own appraisal of her safety is a critical determinant in assessing risk. However, since many women minimize the danger they face, the following indicators of escalating risk should be explored with the patient.

- History of serious injury
- Threats of homicide or suicide by batterer
- Recent increase in physical abuse
- Threats to harm her, her friends or family
- Availability of firearm at home
- Batterer aware of her intention to leave

The circumstances that finally force a woman to leave her abuser can develop slowly. Having a safety plan in place allows her to flee more quickly, since she already has a predetermined safe place to go and has keys, money, identification, and important documents hidden in an accessible place.

If a patient is in immediate danger, ask if she can stay with friends or family. Does she want immediate access to a battered women's shelter? In extreme cases, when an injured patient has nowhere safe to go, temporary, emergency hospitalization under an assumed name may be in order.

Texas state law requires that medical professionals document abuse in the medical record (*Vernons Texas Code*

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Annotated, Family Code Regarding Family Violence, ss73.01-73.05). Careful and thorough documentation of physical injuries, pertinent laboratory tests, and abusive events described by the patient can provide documentation that is admissible in court.

Record the following information in the patient's chart:

- Chief complaint using the patient's own words ("He hit me in the ear with a hammer," rather than "patient was struck")
- Detailed description of injuries including type, number, size, location, possible causes, and explanation given by patient
- Results of pertinent laboratory tests or other diagnostic procedures
- Complete medical and trauma history and relevant social history
- Color photographs and imaging studies, if applicable

If the patient does not admit to abuse but abuse is strongly suspected, document your opinion in the patient's chart and offer phone numbers for counseling, shelter and/or legal advocacy.

Referral

When abuse of an adult patient has been disclosed or is strongly suspected, health care providers are mandated by Texas law to make a referral. Making a good referral requires more than handing the patient an agency name and address. To increase the likelihood that the referral will be followed through, the health care professional must provide as much information as possible about the agency when making the referral, . The most effective referrals resources are ones the health care professional knows personally.

At risk patients should be offered information about local counseling services, shelters, and domestic violence advocacy organizations. Ask if it is safe for her to have resource information in her possession. If it is not safe, provide her with resource phone numbers on small pieces of paper which are easy to hide, or offer to let her call your office staff for the numbers as needed.

Reporting

Minor. A report must be filed with the police department any time a patient who is under the age of 18 years and who has never been married or declared an adult by the court states that she has been abused. Any reasonable suspicion of child abuse must also be reported. A report must be filed no matter how long ago the abuse occurred. **The safest policy is *"When in doubt, report."*** Report your suspicions by telephone immediately or as soon as practically possible. A telephone report must be made within 48 hours of disclosure. (See the referrals list at the end of this article for resources for legal advice.)

Adult. Health professionals are not legally required to report adult abuse to any law enforcement agency. To voluntarily report abuse, providers should have the patient's documented permission.

What to Say

Sometimes professionals not working directly in the field of abuse prevention do not know what to say to provide support to a woman in a violent situation. The following is a list of things a medical health care provider (or anyone else) can say to a woman in an abusive relationship who is reluctant to leave or is returning to a violent situation:

1. I am afraid for your safety.

2. I am afraid for your children's safety.

3. It could get worse. Violence in relationships usually increases over time.

4. I am here for you when you are ready to leave.

5. You deserve better than this.

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Knowing what to say to a patient in a violent situation can make the process of screening less intimidating. Of course, simply developing a routine procedure for screening every patient can increase comfort also.

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In addition to the above references, the following resources provided information, format ideas, and optimal wording for the guidelines sections. The authors would like to give special credit to the New York City Department of Health newsletter, City Health Information, also listed below.

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Domestic Violence: Resources for Services and Information

Legal Information/Services

Each local Department of Protective and Regulatory Services provides information on Texas laws governing abuse or neglect of children, the elderly, and the disabled, and for reporting cases.

Texas Department of Protective and Regulatory Services
Austin Central Office.....(512)835-2350

24-Hour Texas Abuse Hotline.....(800)252-5400

Women's Legal Hotline.....(800)777-3247

Other Resources

National Domestic Violence Hotline.....(800)799-SAFE(7233)
General information on domestic violence topics can be obtained.

Texas Council On Family Violence.....(512)794-1133
Information on Texas shelters and counseling services is available.

American Medical Association Coalition Against Family Violence.....(312)464-5066
Practicing physicians share screening and referral information.

Health Resource Center on Domestic Violence.....(800)537-2238
Specialized information packets are available.

Family Violence Prevention Fund.....(415)252-8900
Copies of Improving the Health Care Response to Domestic Violence; A Resource Manual for Health Care Providers *are available.*