INTIMATE PARTNER VIOLENCE

A PRACTICAL APPROACH FOR CLINICIANS

A SPECIAL PUBLICATION BY

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SAN FRANCISCO MEDICAL SOCIETY

Adapted primarily from *San Francisco Domestic Violence Health Care Protocol*, developed by the Family Violence Council, 1996; *Diagnostic and Treatment Guidelines on Domestic Violence*, from the American Medical Association, 1992; *Domestic Violence: A Guide to Screening and Intervention*, from Brigham and Women's Hospital, 2004; *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings*, from Futures Without Violence (formerly the Family Violence Prevention Fund), 2004.

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INTRODUCTION

Intimate partner violence is a serious problem in the San Francisco Bay Area. A 1996 review of San Francisco crime statistics found that women here are more likely to be harmed or killed by a partner than via robbery, gangs, drugs, or any other form of crime.

The American Medical Association estimates that nearly one-quarter of American women will be abused by a partner at some time during their lives. Such reports have raised awareness about this issue. Additionally, intimate partner violence occurs in the lives of women and men and among all ethnic, religious, educational, sexual-orientation, and socioeconomic groups. It is now well recognized that clinical assessment and intervention regarding intimate partner violence is an important component of any effort to address the problem. The purpose of this report is to provide physicians with useful guidelines for the screening, treatment, and prevention of intimate partner violence in various clinical settings.

Medical professionals have a unique opportunity to detect and intervene in intimate partner violence. We are often the first and perhaps the only professionals a victim will turn to for help, and many victims would feel most comfortable talking with their physician about this difficult issue. Even if a request for help is not explicit, the opportunity to help may be lost if intimate partner violence is not addressed. In particular, battered women account for substantial percentages of women seeking care in emergency and primary care settings, including those seeking nontrauma, prenatal, or psychiatric care. Chronic health problems may result from domestic abuse, with associated increased use of health care services.

Although few physicians have been formally trained in this area, resulting in many missed opportunities to help our patients, it has been demonstrated that

physicians and other clinicians can make a substantial positive impact with only a little heightened awareness and training. The high prevalence and severity of domestic abuse has led many to demand increased clinical attention to this problem, and in fact the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) requires that hospitals have policies for the identification, treatment, and referral of intimate partner violence victims. California law also requires continuing education for hospital staffs regarding routine screening and clinical aspects of intimate partner violence. The AMA issued diagnostic and treatment guidelines on this topic in 1992. San Francisco's Family Violence Council has developed a detailed Domestic Violence Protocol for use in various clinical settings. The following discussion is a distillation of existing knowledge and guidelines.

RISKS AND FORMS OF INTIMATE PARTNER VIOLENCE

Intimate partner violence is described as a pattern of coercive and abusive behaviors that involve physical abuse or the threat of physical abuse, perpetrated by adults or adolescents against current or former intimate partners.

Such behavior may also include repeated psychological abuse or sexual assault, often progressing in severity and leading to increasing social isolation and risk of death. The majority of assaults on current or former intimates are committed by men against women. Research indicates that the risk of being a victim of intimate partner violence is increased for women who are single, separated, or divorced or who are planning a divorce, who are between the ages of 17 and 28, who abuse alcohol or drugs or whose partners do, or who have a history of exposure to violence during their own upbringing. Intimate partner violence cuts across all ethnic, religious, educational, sexual-orientation, and socioeconomic lines, but different backgrounds may influence a victim's perception of abuse—what one person sees as abuse, another may not.

Physical abuse is often recurrent and escalates in both frequency and severity. Forms of physical abuse may include pushing, slapping, punching, kicking or choking; assault with a weapon; holding or tying down; abandoning in dangerous places; or refusing to help someone who is sick or injured. Sexual abuse is also common, including nonconsensual or painful sexual acts or sex acts unprotected against

pregnancy or diseases. Such physical abuses may be accompanied by psychological abuse as a means of controlling through fear and degradation, including threats of physical harm, isolation both physically and socially, humiliation, false accusations and ridicule, and ignoring or dismissing needs or complaints. These types of psychological abuse may also exist in the absence of actual physical abuse. The most severe result of escalating domestic abuse, as noted above, is murder or suicide.

SCREENING

Given the potentially severe consequences of intimate partner violence as noted above, routine screening is justified for patients in emergency, surgical, prenatal, primary care, pediatric, and mental health settings.

The goal of screening is first to identify the problem. This is most likely to be successfully accomplished if the patient is reassured that she will not be judged or endangered if she discloses the problem to you and seeks your help. Simple, direct, nonjudgmental questions asked as part of a routine history and physical examination have been demonstrated to elicit previously unrecognized risks and histories of violence. It is important that these questions be asked when alone with the patient; in order to see both adult and adolescent patients without others present, it may be necessary to cite confidentiality needs and a standard procedure of interviewing patients alone.

Once alone with the patient, an opening statement may be used, such as:

"Since violence and abuse have become so common, I now ask my patients about it routinely."

Once the subject has been raised, any of the following questions may be useful, with attention to assessing current and lifetime exposure to intimate partner violence.

If the patient has an existing physical injury:

"Many people come in with injuries like yours, and often they are from someone hurting them. Is this what happened to you?"

For patients with no existing injury, the following questions might be used:

"Has your partner ever physically hurt or threatened you in any way?

"Has your partner ever hurt or threatened your children?"

"Has your partner ever forced you into having sex at any time or in way you did not want?"

"We all have conflicts at home from time to time. What happens when your partner and you disagree or fight about something?"

"Do you ever feel afraid of your partner for any reason?"

"If your partner uses alcohol or drugs, how does he act? Does he ever get verbally or physically abusive while drunk or high?"

"Has your partner ever prevented you from leaving the house or seeing your friends or family?"

"Do you have any guns in your home? Has your partner ever threatened to use them?"

Note: If you are unable to converse fluently in the patient's primary language, use of a competent interpreter is recommended—but not a family member. Written forms may be used as well, but some verbal questioning is recommended for each patient. The screening and results should be documented in the patient's chart (a sample screening/documentation form is available from the San Francisco Domestic Violence Protocol). Finally, patients must be routinely informed of confidentiality limits regarding mandatory reporting of both intimate partner violence and child abuse. Also, if a clinician is not able to speak to the patient alone or if a trained interpreter is not available when necessary, then the screening should be postponed and this should be noted in the patient medical record.

DIAGNOSIS AND CLINICAL FINDINGS

Once the history of the patient's present complaint is obtained and a complaint of an intimate partner violence-related physical injury is identified or suspected, a physical examination with the patient disrobed is recommended. Further injuries or scars might be present and possibly related to the present complaint. The following are indications that might heighten suspicion that the patient is at risk for or is a victim of intimate partner violence:

INJURIES

Common types of injuries include contusions, abrasions, and minor lacerations, as well as fractures or sprains. These may be to the head, neck, chest, breasts, abdomen, wrists, or arms, or they may be at multiple sites. Injuries during pregnancy or any repeated or chronic injuries may be indicative. Any implausible explanation for the injury or an unusual delay in seeking medical care should raise additional concerns about possible intimate partner violence.

MEDICAL FINDINGS

The stress of living in an ongoing abusive relationship may result in any of the following: chronic pain, psychogenic pain, or pain due to diffuse trauma without visible evidence. Physical symptoms related to stress, posttraumatic stress, anxiety, or depression may include sleep and appetite disturbances, fatigue, chronic headaches, abdominal or gastrointestinal complaints, palpitations, dizziness, paresthesia, dyspnea, or atypical chest pain. Gynecologic problems might include frequent vaginal and urinary tract infections, dyspareunia, sexually transmitted infections, and pelvic pain. Watch also for frequent use of prescribed minor tranquilizers or pain medications, frequent visits with vague complaints, or symptoms without evidence of physiologic abnormality. Finally, as sexual coercion or assault are common expressions of intimate partner violence, assessment for this should be conducted in the routine taking of a sexual history and in discussions of birth control and safer sexual practices.

PREGNANCY

Presentations during pregnancy include injuries to the breasts, abdomen, and genital area; unexplained pain; substance abuse; poor nutrition; depression; late or sporadic access of prenatal care; and unexplained "spontaneous" abortion, miscarriages, or premature labor.

MENTAL HEALTH/PSYCHIATRIC SYMPTOMS

Symptoms include the following: feelings of isolation, suicide attempts or gestures, depression, panic attacks and other anxiety symptoms, alcohol or drug use, and posttraumatic stress reactions or disorder. Family history of drug and alcohol abuse is also an important risk factor.

RELATIONSHIP CONTROL ISSUES

The presence of the following should increase concern about the risk of abuse: noncompliance with treatment regimens, missed appointments, not being allowed to obtain or take medications, lack of independent transportation or access to finances or telephones, failure to use condoms or other suitable contraception.

BEHAVIORAL SIGNS

During patient encounters, the following are causes for concern: The partner accompanies the patient and insists on staying close and answering questions for her; the patient is reluctant to speak or disagree with the partner; intense jealousy or possessiveness is expressed by the partner or reported by the patient; denial or minimization of violence by the partner and/or patient is expressed; the patient exaggerates self-blame for partner's violence.

FURTHER ASSESSMENT

For clinicians without the expertise, time, or confidence to conduct a full assessment of intimate partner violence, referral to other clinicians with such expertise is recommended. This may be done immediately or over multiple visits.

INTERVENTIONS

If domestic abuse is revealed or suspected, the following three issues might be addressed prior to the patient's leaving:

IMMEDIATE RISK

"If you return home now, will you be in danger?"

STATE OF MIND

"What type of help with this would you like? Are there any changes you would like to make in your situation? What steps might help you make those changes? What actions are you ready to take, and how might we help?"

SUICIDE

"Have you had any thoughts of harming or killing yourself?"

Develop a plan to ensure the patient's safety. Answers to these questions will help guide further intervention and follow-up.

There are a number of important factors to consider with each patient when intimate partner violence is identified. First is that medical professionals take the situation seriously and compassionately. Second is that you or others in the office have a working knowledge of community resources that can provide treatment, safety, advocacy, and support, including those targeted to specific populations. Referral to these resources is crucial to address whatever physical, substance abuse, and psychiatric problems are present. One caveat is that couples' counseling or other forms of family therapy, which otherwise might appear to be a reasonable option, are generally contraindicated in the presence of intimate partner violence. The immediate concern is for the safety of the victim and any children that may be involved.

The following are some of the issues that need to be addressed when violence has been identified:

PRIMARY MESSAGES

"There is no excuse for intimate partner violence. Nobody deserves to be abused. Violence is not your fault. It must be very difficult for you to face leaving your situation. But you are not alone—there are people you can talk to for support, shelter, and legal advice."

PATIENT EDUCATION

Basic knowledge about intimate partner violence can be helpful for patients. Let the victim know that such violence occurs often, that it continues over time and increases in frequency and severity, that it has long-term damaging effects on children who are hurt or who witness violence, that violence is a crime, and that there are resources available.

PATIENT SAFETY

Note that many victims tend to minimize the severity of violence and danger they face. Again, assessment and plans for the victim's safety need to take place before the patient leaves the clinical setting.

CONSIDER VARIOUS OPTIONS

- Does the patient have friends or family with whom she could stay?
- Does the patient want immediate access to a shelter? If none is available, could she be admitted to a hospital or other clinical setting? If the patient does not want immediate access, offer information about shelters and other resources, keeping in mind that written information may pose a danger to the patient at home.
- Does the patient need immediate medical or psychiatric intervention?
- Does the patient want immediate access to counseling to help deal with the abuse?
- Does the patient need referral to local intimate partner violence support organizations?
- If the patient is returning home or to the previous living arrangement, suggest that she gather important papers (e.g., birth certificates and other documents of identification) and some money and clothing for herself (or himself) and children (if any). Tell patient to keep these items in an accessible, hidden place or at a friend's home in case she has to leave home in a hurry.

POLICE INVOLVEMENT

Given potential personal and legal ramifications, the decision whether to involve legal authorities is a serious one. Does the patient want police intervention? If so, assist her/him in asking the local police department to make an official police report.

If the perpetrator is posing immediate danger, call 911.

If the perpetrator is not posing immediate danger and the patient wants police assistance, call police dispatch at (415) 553-0123. Health care personnel should remain with the patient during the police interview, if the patient so desires.

Ensure that the patient is in safe place while awaiting police. Suggest that the patient call the District Attorney's Office Family Violence Project at (415) 553-9044 to help him/her navigate the criminal justice system.

Document in the medical record that a police report was made (include date, time, and officer name and badge number).

See the "Mandatory Report of Injury in San Francisco" section in this booklet regarding whether or not you are mandated to report to the police, and, if so, the appropriate procedures.

It is important to develop an implementation strategy in the given health care setting to ensure that patient education materials are available, staff receive training, protocols are followed, and staff are supported in their efforts to integrate intimate partner violence screening into their duties and to intervene when necessary. Additionally, efforts to intervene should involve individuals in multiple professions such that intimate partner violence intervention occurs within a multidisciplinary, interorganizational framework for action.

REFERRALS

• **Refer the patient to available community resources.** Offer a written list of resources at each visit. (See www.sfms.org for a resources list.)

• **When the patient is willing, assist her/him in calling an intimate partner violence hotline during the health care visit.**

• **Tell the patient she/he can always call back for support or more information.**

Tell the patient about the National Domestic Violence Hotline: 1-800-799-SAFE (799-7233).

CONTINUITY OF CARE

As a history of intimate partner violence is linked with increase risk of recurring violence, it is recommended that at each visit, for patients with known or suspected intimate partner violence:

• Ask about history of violence since last visit.
• Ask about mental health.
• Ask about coping strategies. Has the patient sought counseling services? Called a hotline? Told any family or friends? Attempted to leave?
• Ask about any abuse of children since last visit.
• Give messages of support and concern.
• Reiterate options to patient (emergency protective order, civil restraining order, friend's home, shelter, hotline, support groups).

For patients without suspected intimate partner violence when screened at your site in the past: There are no studies that address appropriate rescreening intervals. You might consider rescreening the patient at the following times (whichever comes first): patient starts intimate relationship with new partner, presents with symptoms or signs of intimate partner violence, or at periodic intervals (at provider's discretion).

DOCUMENTATION

It is highly advisable to complete a legible medical record for each known or suspected victim of intimate partner violence.

Medical records can be used as evidence in court. As much of the following as possible should be included in the medical record:

- The patient's intimate partner violence history, including present complaints or injuries. Include date, time, and location of intimate partner violence incidents. Whenever appropriate, use the patient's own words in quotation marks.
- A description of patient's injuries, including type, location, size, color, and age.
- Alleged perpetrator's name, address, and relationship to patient (and children, if any).
- A description of other health problems, physical or mental, that may be related to the abuse.

Whenever possible—and with patient's consent—take photographs of patient's injuries. Take photographs of all injuries, including:

- One full body shot (to link injuries with patient)
- One mid-range to show torso injuries
- Close-ups of all wounds and bruises

Preserve any physical evidence (e.g., damaged clothing, jewelry, weapons, etc.) that can be used for prosecution.

In the case of rape or sexual assault, follow protocols on physical and forensic examinations and evidence collection, with the patient's consent.

Document details of intervention made and all actions taken.

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, colors, and sizes of bruises. A body map is most useful.

• **Do not attempt to "date" bruises subjectively**, as this can lead to contradiction and doubt in court.

Source: Brigham and Women's Hospital. Domestic violence: A guide to screening and intervention. Boston (MA): Brigham and Women's Hospital, 2004.

MANDATORY REPORT OF INJURY IN SAN FRANCISCO

Health practitioners are required by California State Law (Penal Code Section 11160 et. seq.) to report certain cases of intimate partner violence to law enforcement.

This is different from a patient's voluntary request for an official police report and/or request for police assistance.

• Report to the local law enforcement agency when providing medical services for a physical condition to a patient you know or reasonably suspect is suffering from a physical injury that is a result of a firearm or assaultive or abusive conduct.

• Discuss with the patient your reporting requirements and what may occur as a result of reporting. Be aware of potential consequences for the patient and work to address patient needs. Patient consent, however, is not required.

• Telephone report of intimate partner violence as soon as possible to the San Francisco Police Department by calling (415) 553-9220 to leave a voicemail message. The police will record your message. Document in the Medical Record that the call was made.

• Complete the "Report of Injuries by a Firearm or Assaultive or Abusive Conduct" form. Mail this form within two working days to the San Francisco Police Department, Domestic Violence Unit, 850 Bryant Street, San Francisco, CA 94103.

• Keep a copy of the report in a confidential location; it cannot be accessed by friends, family, or other third parties without the patient's consent.

•When two or more health care providers have knowledge of a known or suspected instance of violence required to be reported, the providers can agree to report as a team and only one person is required to submit the report. All health care providers involved are equally responsible to see that the report is made according to state requirements.

If you or the patient wants police intervention or follow-up, you must call 911 for emergencies or (415) 553-0123 for nonemergencies to ask that an official police report be made. Your mandatory report is not an official police report.

Child and elder and dependent adult abuse laws require different reporting procedures:

• For patients under the age of 18, report in accordance with the Child Abuse and Neglect Reporting Act (Article 2.5 of Penal Code, commencing with Section 11164).

• For patients age 65 and older and for dependent adults, report in accordance with Elder Abuse and Dependant Adult Civil Protection Act (Chapter 11 of Part 3, Division 9 of Welfare and Institutions Code, commencing with Section 15600).

Child and elder mandatory reports may result in investigation by Child Protective Services or Adult Protective Services.

Note: Reporting is not a substitute for thorough documentation of the abuse in the medical records.

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