FAMILY/DOMESTIC VIOLENCE: HOW TO INTERVENE? HOW TO PREVENT?

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(*Ethn Dis.* 2003;13[suppl3]:S3-104–S3-105)

INTRODUCTION

The Society for Academic Emergency Medicine defines domestic (partner) violence as "the exercise of emotional intimidation, non-consensual sexual behavior, or physical injury by a competent adult or adolescent which is utilized to maintain coercive behavior in an intimate relationship with another competent adult or adolescent."

"Partner violence is about power and control," Dr. Haile-Mariam said. "It involves rape and sexual assault, physical violence, threats and psychological abuse, and stalking."

The data are astounding:

• Four million American women experience a serious assault by an intimate partner during an average 12-month period.

• Nearly one in 3 adult women experience at least one physical assault by a partner during adulthood.

"The Bureau of Justice Statistics says that half of female victims sustain a physical injury, only half of female victims report violence to law enforcement officials, and fewer than half of injured victims seek medical treatment," said Dr. Haile-Mariam. "We know that patient self-reporting is low, we know that these patients are coming to us, and we know that partner violence is repetitive and escalating," she said.

ROUTINE EVALUATIONS AND SCREENINGS

"This is a good indication that we need routine evaluations or screening methods to detect women who are at risk," she advised. Screening increases the diagnostic rates and raises patients' awareness of the dangers. Accreditation bodies, professional groups such as the American Medical Association, and non-governmental organizations all advocate screening for domestic violence.

"We aren't doing that badly with routine screening," she said. "Medical personnel are catching about 80% of women who have evidence of injury."

She also believes that other health professionals should be trained to identify and treat victims of domestic violence. "Dentists see a lot of victims," she noted.

Dr. Haile-Mariam thinks screening should be brief, simple, and non-judgmental. She offers 10 steps for domestic violence screening from the Family Violence Prevention Fund (Table).

FRAME QUESTIONS CORRECTLY

Dr. Haile-Mariam believes it is very important to "frame" questions correctly—to make them seem like routine questions to elicit the most realistic responses. "You want to make the woman feel more comfortable" talking about the problem, she said. Dr. Haile-Mariam gave examples of "framing" questions from the Family Violence Prevention Fund:

"Because violence is so common in women's lives, I've begun to ask about it routinely . . ."

"I don't know if this is happening to you, but because so many women have experienced abuse in their lives . . ."

"I'm wondering if some of your medical problems might not be related to how you are being treated by your partner . . ."

10 steps for domestic violence screening

- Ensure privacy and safety.
- Establish rapport.
- Use professional translators. Too often, the only translator available is a family member or a community member whose translation is ineffective in finding the truth.
- Discuss the limits of confidentiality.
- Frame your questions as common and routine. The patient should not feel as if she is being singled out.
- Ask respectful and nonjudgmental questions.
- Gather behavioral descriptions of what happened.
- Use open-ended and direct questions.
- Acknowledge and accommodate various language and cultural perspectives.
- Listen to the patient's perspective.

Then there are the screening questions that are designed to yield more definitive information, Dr. Haile-Mariam said: "Do you feel safe in your current relationship?" "Is a partner from a previous relationship making you feel unsafe now?" "Have you been hit, kicked, punched, or otherwise hurt by someone in the past year? By whom?"

WARNING SIGNALS

Signs that a patient is being abused may include: history inconsistent with injury, delay in seeking care, an "accident"-prone history, suicide attempts or depression, and/or recurring physical complaints not suggestive of organic disease, such as chest pains, headaches, palpitations, pelvic pain, and numbness or tingling. Other clues are the patient's demeanor, a companion's behavior, noncompliance with medical regimen, and chronic pain syndromes. A physical exam may produce evidence of injuries that indicate the patient has been in a "defensive" position, bruises on the inner arms and legs, and injuries to the side or the top of the head.

What if a patient denies that she has been abused? Dr. Haile-Mariam recommends: "Accept her response—don't challenge her answer. Reassure her that the inquiry is routine. Let her know that you are a resource and that there are other resources available in the community and in the law."

Dr. Haile-Mariam warns against statements that "victimize the victim." Examples are: "You should be more assertive . . ." "Maybe you should be a little more understanding . . ." And worst of all, "Next time, duck . . ."

The key elements of intervention are:

- Listen, validate, and communicate concern.
- Respond to safety issues and discuss the patient's options.
- Provide information about domestic violence.
- Make referrals to local resources.
- Initiate follow-up.

SAFETY PLAN

"Healthcare providers can help abused women develop a safety plan," Dr. Haile-Mariam advised. The first step is to create a "lethality" checklist: Does the perpetrator blame the victim for injuries? Is he obsessed with the victim? Have there been previous incidents of significant violence? Has the perpetrator killed a pet? Is he threatening suicide? Does he use drugs or alcohol? Does he have access to guns? Is there a gun in the house?

"A safety plan includes a realistic appraisal of risk, cues that indicate violence, and assistance in developing the plan," Dr. Haile-Mariam said. The plan might include avoiding "dangerous rooms," identifying a safe place to go, and remembering that leaving is the most dangerous time in a violent relationship. "All of these actions will be recommended during counseling," she added.

Dr. Haile-Mariam recommends keeping a complete chart to document the patient's visit(s). The documentation should include specific information about the incident; the date, time, place, and perpetrator; the patient's own words; history, pattern, and impact; clinical findings and medical opinion; safety of the patient and any children; and referrals and follow-up. The documentation format can include written notes, body maps or drawings, and photos.

The good news is that partner violence rates are decreasing, Dr. Haile-Mariam said. "The reasons include physician screening and intervention, public awareness, and improved law enforcement." She pointed out that October 2002 was National Domestic Violence Awareness Month.

One major problem remains, Dr. Haile-Mariam said. "There is a serious mismatch between when people seek help and when services are available. Most patients need assistance in the off-hours instead of from 9 to 5. We need to make sure that a hot line or a counselor is available in the peak times for domestic violence."

(Data for this presentation were derived largely from studies by the Centers for Disease Control and Prevention [CDC] and the US Department of Justice. The sources include the National Violence Against Women Survey, the National Crime Victimization Survey, the Uniform Crime Reporting Program [National Incident-Based Reporting Program and supplementary homicide reports], the Study of Injured Victims of Violence from the National Electronic Injury Surveillance System, and surveys of jail and prison inmates.)