

APPENDIX B

PRACTICE TIPS FOR IDENTIFYING AND TREATING THE ABUSED PATIENT

DOMESTIC VIOLENCE

Victim Barriers to Terminating or Disclosing Abusive Relationships

There are many reasons why victims don't report and/or terminate abusive relationships. Such barriers may include the following:

- shame, humiliation, embarrassment;⁴⁸⁻⁵¹
- psychological repression, poor self-esteem/self-image;^{48,50,52}
- fear of reprisal, retribution, repercussions, e.g. threats to kill or harm children, family, friends, etc.;^{48, 49, 51-54}
- fear of abandonment,⁴⁹ poverty/economic concerns^{48,50,52,54} loneliness,⁵² the unknown;⁵²
- fear of not being believed;⁵²
- legal consequences;^{49,50,52}
- religious traditions;^{48,50,52}
- cultural: social, family, marital expectations;^{48,50-52}
- feel protective of partner;⁵¹
- thinks the doctor does not know or care about or can help with domestic violence;⁵¹
- thinks the doctor is too busy;⁵¹
- alcohol or drug problems;⁴⁹
- language barriers;⁵⁰

Physician Barriers To Screening For/Identifying Domestic Violence

Health care providers identify several reasons why they are reluctant to ask patients about domestic violence. Such barriers to screening/identifying domestic violence may include the following:

- lack of knowledge and training,^{48,51,54} unprepared to respond;^{48,51}
- because of the clinical presentation, patients may appear to be neurotic or hypochondriacs;⁴⁸
- discomfort due to own feelings and reactions to a disclosure of abuse;⁴⁸
- misconceptions such as abuse is rare,⁴⁸ private,^{48,51} the battered victim's fault,^{48,51}
- opening up a "can of worms" or "Pandora's box;"^{48,51,54}
- fear of offending the patient;^{49,51,54,57}
- inability to "fix" abusive relationships;^{49,51}
- time constraints/lack of time to deal with the problem;^{49,51,54,57}
- personal bias against women in international community,⁵⁰ racial prejudice;^{50,54}
- sexism;^{50,54}
- frustration with outcome, don't think it will help and "she'll just go back to him;"^{51,57}
- physicians' beliefs or values about abuse;⁵⁴
- loss of control or feelings of powerlessness;⁵⁴
- belief that a victim can leave if he/she just wants to;⁵¹
- knowing the assailant and not believing he is capable of abuse.⁵¹

Patterns of Abuse

There is no single model which can describe all domestic violence patterns.⁴⁸ However, it is useful to consider the following models to conceptualize the abuse process in women.

One model describes a cycle of violence in phases where phase one begins with a minor battering/assault which gradually increases tension in the relationship. The victim may try to decrease the tension but is largely unsuccessful.⁴⁸ Phase two involves a discharge of building tension resulting in an acute battering incident which may be met with disbelief or denial and is dismissed by the victim as an isolated incident. Subsequent episodes are met with shock, rationalization, self blame, denial and repression.⁴⁸ Phase three is often referred to as the "honeymoon phase"⁴⁸ where the abuser expresses remorse, exhibits attentiveness, reaffirms love and promises it will never happen again.^{48,57} This is done mostly out of fear of being caught.⁴⁸ There is not always a honeymoon phase.⁴⁸

Another model highlights the roles of violence and withdrawal where some lesser degree of violence creates emotional withdrawal in the attacked partner. The abuser may be met with withdrawal the next time upset, needy or in want of support. This in turn provokes a more violent attack, which is followed by further withdrawal and/or fear. The escalating cycle of neediness is met with increasing withdrawal until the violence becomes severe.⁵⁸

In addition to the physical violence, emotional abuse always accompanies and typically precedes physical violence.⁴⁸ This cycle of violence is repetitive, escalates in severity and frequency^{48,49,57,58} and is used to gain compliance or control over the victim.⁵¹

Profile of the Abuser

Battering and abuse are learned behaviors that result from being personally abused or witnessing abuse.^{48,51} Abusers may be characterized by any or all of the following:

- extreme jealousy and possessiveness;⁴⁸
- inefficient coping skills;⁴⁸
- thinking they are unique and don't have to follow rules;⁴⁸
- justifying behavior with excuses blaming others for causing their behavior;⁴⁸
- viewing others as holding them back from being successful;⁴⁸
- minimizing abuse as part of avoiding responsibility for violent actions;⁴⁸
- having trouble experiencing close, satisfying relationships with others;⁴⁸
- substituting drama and excitement for closeness;⁴⁸
- being secretive, closed minded, self righteous;⁴⁸
- seeking to gain power and control;^{48,54,57}
- fragmentation (Dr. Jekyll and Mr. Hyde) using a public face that is childlike, dependent, insecure, charming, affectionate, seductive or manipulative;⁴⁸
- alcohol use or abuse involved^{48,49,52,54-57} but not established as causal.^{48,52}

Women at Increased Risk for Domestic Violence

There is no specific highly predictive profile of women at increased risk for domestic violence; however, following are some generalizations about vulnerabilities:

- witness or experience family violence as a child or adolescent;^{48,49,51,57} however, the majority did not grow up in abusive homes;⁴⁸
- under 35 years of age;^{49,54,57}
- refugee, migrant^{50,54} living in rural or remote areas,⁵⁰ homebound;⁵⁰
- conflicting evidence about minorities being more vulnerable;^{50,57}
- lower socioeconomic status^{50,54,57} or education;⁴⁹
- pregnancy;⁵⁷
- mental illness, physical disabilities;⁵⁴
- unmarried;⁴⁹
- unmarried couple living together;⁵⁸
- wives in marriages where their education or occupation level is higher than their spouse;⁵¹
- mixed marriages (religion or race);⁵¹
- history of alcohol abuse by male partner;⁵⁴
- recently separated or divorced.⁵⁷

Presentation

The majority of domestic violence presentations are not "injuries," but are seen for non-traumatic diagnoses.^{48,51,54} Chiropractors should be aware that chronic pain^{51,52,56,57} or back pain itself⁴⁸ may be the result of domestic violence. Other clinical findings that may suggest need for further investigation include the following:

1. Injuries

- explanation for injuries does not fit injuries observed;^{48,49,51,56}
- multiple injuries in various stages of repair;^{48,51,52}
- assaultive trauma, most commonly head, face, neck and areas covered by clothing; mandibular fractures; facial fractures; trunk trauma; blows to abdomen or other areas; other blunt trauma or injuries suggestive of defensive posturing like forearm fractures;^{49,51,52,56,58}
- "accident prone" history.^{51,52}

2. Pain
 - chronic pain; ^{51,52,56,57}
 - back pain; ⁴⁸
 - chest pain; ^{48,51,52,57}
 - pain from diffuse trauma without visible evidence. ⁵²

3. Somatic Complaints
 - headaches; ^{48,51,52,57}
 - choking sensation; ⁴⁸
 - hyperventilation; ^{48,57}
 - gastrointestinal symptoms; ^{48,51,52,57}
 - sexual dysfunction; ⁵²
 - neurologic concerns, syncope, ⁵⁷ paresthesias, ⁵¹ dizziness; ^{51,52}
 - palpitations; ^{51,52,57}
 - chronic non-specific medical complaints often presumed to be psychosomatic; ^{48,51,57}
 - sleep disturbance, e.g. insomnia; ^{48,51,52,57}
 - fatigue, decreased energy, difficulty concentrating; ^{51,52}
 - dyspnea; ^{51,52}
 - upper respiratory tract infections, bronchitis; ^{54,56}
 - poor control of diabetes, hypertension, heart disease. ⁵¹

4. Obstetric, Gynecologic Problems
 - miscarriages; ^{48,49,52,57}
 - injured pregnant woman ^{49,51,52,57} or fetus; ^{51,57}
 - register late ^{49,52,57} or no prenatal care; ⁵¹
 - pre-term labor; ^{49,51,52}
 - low birth weight infants; ^{49,57}
 - spontaneous abortions; ^{51,52}
 - frequent urinary tract infections or vaginitis; ⁵²
 - dyspareunia; ⁵²
 - pelvic pain; ^{48,51,52}
 - injuries to breasts, abdomen or genitals; ⁵²
 - substance abuse, poor nutrition and/or inadequate weight gain during pregnancy. ⁵²

5. Emotional and Behavioral or Psychological Sequelae of Violence
 - depression; ^{48,49,51-53,57}
 - suicide attempts; ^{48,49,51,52,56,58}
 - anxiety; ^{48,51,52,57}
 - mental illness; ⁴⁸
 - inability to cope; ⁵²
 - nervous behavior, lack of eye contact, worrying about staying too long in office, frequent comments that she has to check with her partner, comments that partner is jealous, financial dependence, shy, frightened, embarrassed, noncompliant, evasive, passive, cries; ⁴⁸
 - poor self-esteem, social isolation; ^{48,52}
 - hovering (batterer accompanies victim to monitor what is said); ⁴⁸
 - post-traumatic stress reactions/disorder; ^{49,52,57,58}
 - panic disorders; ^{51,52}
 - eating disorders; ^{51,52,57}
 - drugs and alcohol abuse. ^{48,49,51-53,56-58}

6. Other
 - more likely to be prescribed analgesics, minor tranquilizers ^{48,52,57} and antidepressants; ⁴⁸
 - multiple visits ⁵⁶ or frequent visits without physiologic abnormality; ⁵²
 - long term disability from injuries; ⁵⁸
 - homelessness or welfare. ⁵⁸

Screening and Identification

Physicians routinely screen for problems less prevalent than domestic violence, and yet routine screening for domestic violence is rarely practiced.^{48,49,53} This is especially true in the primary care setting where it is estimated that less than 10% of primary care physicians routinely screen for domestic violence during a regular office visit.⁵³ Battery is so prevalent that physicians in an entry-level health care system have an ethical obligation to consider abuse as a possibility in their evaluation of female patients.^{48,52} Screening is simply asking the patient a few direct questions. The goal of screening is not for the physician to “fix” the problem but to identify the abuse and provide appropriate education, support, and referrals, and to acknowledge and validate the situation as real and dangerous.^{48,52} Before initiating any discussions about domestic violence, the physician must put the patient in a position to disclose this information safely and confidentially (without partner and/or children present).^{48,51,54-57} The FAMILY VIOLENCE PREVENTION FUND recommends screening begin as early as age 14.⁵³ It is recommended that all female patients are screened whether signs or symptoms are present or not and whether abuse is suspected or not.

Battered women/victims favor routine questions about domestic violence and expect their physicians to initiate discussions about it.^{48,49} While many find it difficult to volunteer the information, most women are willing to discuss issues about violence if specifically asked. Questions should be direct, sensitive, empathetic, nonjudgmental and asked in a confidential setting.^{48-50,52,57} It is recommended that direct questions about abuse be included in the routine history^{49,52,57} as no one can be excluded from screening.⁵⁶ This is because the prevalence is so high,^{49,54,56} the prevalence of undetected cases is high,^{48,49,57} and there is no, or low, positive predictive presentations for the presence of domestic violence.^{48,52,54,57} In addition, screening for abuse should be considered for each new complaint or when the patient has a new intimate partner.⁵³

Phrasing Questions

An easy way to introduce the topic is a statement such as “Because violence is so common, I’ve begun to ask about it routinely” or “I’ve begun to ask all my patients about it.”^{52,53} This may then be followed by one of the following or similar questions:

- “Are you in a relationship with a person who physically hurts or threatens you?”⁵³
- “Have you been hit, kicked, punched or otherwise hurt by someone in the past year?”^{52,53,58} If so, by whom?”⁵⁴
- “At anytime has your partner or anyone at home hit, hurt or frightened you?”⁵³

Patient Denies Abuse or Does Not Want To Discuss The Topic

When patients’ deny abuse or are reluctant to discuss the topic, they should not be badgered.^{48,54} Providing a list of local programs presents a less threatening resource than face to face confrontation while still providing support for the patient.^{52,54} It is appropriate, however, to make further inquiries with more specific questions when the patient answers “no” or will not discuss the topic if there are signs and/or symptoms strongly indicating abuse.⁵² Some examples of this follow:

- “It looks as though someone may have hurt you. Could you tell me what happened?”⁵²
- “Sometimes when people come for healthcare with physical symptoms like yours, we find that there may be trouble at home. We are concerned that someone is hurting or abusing you. Is this happening?”⁵²
- “Sometimes when people feel the way you do, it’s because they may have been hurt or abused at home. Is this happening to you?”⁵²

Patient Acknowledges Abuse or Wants To Discuss the Topic

When the patient acknowledges abuse or wants to discuss the topic, it is important to listen non-judgmentally^{51,52,54} and assure the patient that the disclosure is confidential.^{48,53} In addition, validation^{48,52,54,57} of their position with any of the following statements provides further support:

- “No one deserves to be hurt or threatened with violence.” (The most important and easily provided intervention is this simple message.)^{48,54}
- “You are not to blame for the behavior of the perpetrator.”⁵⁴
- “You are not alone.”⁵²
- “You aren’t crazy.”⁵²
- “What happened to you is wrong.”⁵²
- “Help is available.”⁵²
- “I have treated others with this problem and am comfortable dealing with it.”⁵²

It is important to educate the patient^{48,49,54,57} about the escalating cycle of abuse (nature and course)^{48,49,57} which not only produces serious medical problems^{48,57} but is also a criminal act^{48,54} for which there are protective service agencies and legal assistance, e.g. civil protection orders/restraining orders, criminal prosecution, civil litigation, etc.^{49-52,54,55,57}

Legible, accurate, detailed and complete documentation by the physician is invaluable for legal purposes.^{51,52,54} This may provide the only evidence that abuse has taken place⁵¹ and improves the likelihood of successful prosecution.⁵⁴ Good records also frequently substitute for personal appearance by the physician in a legal setting.⁵⁷ It may be reasonable to establish a “confidential” file set for domestic violence cases in order to further limit access and protect the confidentiality of the patient. Along with the medical information, the file should include the arrival date and time, name, address, phone number of anyone with the victim and the address where the incident occurred.⁵² It is appropriate to begin with an all inclusive medical, trauma and relevant social history,⁵² in addition to a history of the incident using the patient’s own words^{48,51,52,54} with modifiers such as “the patient states...”^{48,51} when possible. A list of complaints and symptoms^{52,55} should be obtained and a complete physical examination including neurological examination, radiographic evaluation, and rape assessment,⁵² should be performed. If any special services aren’t available in the physician’s office, referral to an appropriate facility for documentation is indicated. (See Appendix D) Body diagrams/maps^{48,49,54} may be useful for documenting a detailed description of the injuries including extent,⁴⁸ resolution/acuity,^{48,52} measurements/size,^{48,52} type, number, and location.⁵² Results of laboratory testing, diagnostic imaging or other diagnostic procedures should be included in the chart. The physician should document whether the injuries are consistent with the patient’s explanation.⁵²

If possible, photographs should also be included because they are particularly valuable as evidence.⁵⁴ Prior to taking photographs, written informed consent should be obtained^{48,52,58} in addition to having a female chaperone present.⁴⁸ If available, a digital camera has the greatest versatility for documenting visible injuries. Two views of each injury should be taken, including a measuring device^{51,52} and at least one picture with the patient’s face for identification.^{51,52} The photographs should be marked with the following information: name of patient, photographer, witnesses,^{51,52} time,^{48,52} place,⁴⁸ chart/record number,⁵¹ and date and signature of the photographer.^{48,58} The photographs should be placed in a sealed envelope with the patient’s name and social security number and put in a safe place.⁴⁸ If a standard camera is used, label the films and keep secure until developed⁵¹ at which time 2-3 copies should be made.

If the police are involved, the investigating officer and any action taken should be documented if possible.⁵² The police should only be called with the patient’s documented consent; however, there are some exceptions where reporting is mandatory, which include the following:

- If there is evidence of injury by gunshot, knife or other deadly weapon.^{51,55,57,58}
- Child abuse, elder abuse or neglect.^{62,69}
- Where there is a duty to protect a potential third party victim from danger.^{48,51,52,55} According to the *Tarasoff* case of 1976, if it is determined the patient presents a serious danger of violence to another, the health care provider is obliged to use reasonable care to protect the intended victim against such danger via notification of the intended victim, notification of the police or taking whatever steps reasonably necessary under the circumstances. Sixteen states have adopted *Tarasoff* limiting statutes, which only require reporting when there is an explicit threat made.⁵⁵ “In Oregon, the duty to warn is **not** clear. In the case of possible domestic violence, the physician, **upon advice of legal counsel**, should err on the side of caution and warn the at-risk spouse or partner.”⁵²

It is very important to include an assessment of the patient’s danger and fear.^{48,51,52,54,57,58} To evaluate the patient’s level and immediacy of danger, it may be helpful to ask some further questions,⁴⁸ as the most critical components of assessment are the patient’s level of fear and appraisal of immediate and future safety.⁵² Following are some questions that may provide further insight to the patient’s position:

- “Are you in immediate danger?” “What do you think will happen when you go home?”^{48,54} (This is one of the most important questions: “Is it safe to go home?”⁵¹)
- “Is another violent attack imminent?”⁴⁸
- “How frequent and severe are the attacks?”^{48,51} “Are they escalating?”^{51,52}
- “Do they have a firearm or deadly weapon?”^{48,51,52,54}
- “Is there a history of violent behavior outside the home⁵¹ or history of violent acts or threats using a weapon?”^{51,58}
- “Have they threatened to kill you^{48,51,52} or you them?”^{48,51}
- “Is there drug or alcohol use?”^{48,51,58} as this makes behavior less predictable.⁴⁸

- “Have there been threats to children?”^{48,52,54,58}
- “Are you, or a partner, threatening suicide and if so, is there a suicide plan?” If so, the situation is urgent.^{48,51,52}
- “Are there forced unwanted types of sex or refusing to use birth control?”⁵³
- “Is there humiliation, swearing, name calling, mental instability, obsession with victim,^{51,58} drug/alcohol use or abuse?”⁵⁸
- “Are there threats to injure self or patient,⁵² reporting to immigration or stalking?”⁵⁸
- “Is there isolation which includes controlling access to friends and family and limiting outside involvement?”^{51,53,58}
- “Has there been destructive behavior such as destroying patient’s property, injuring pets of patient or child?”⁵⁸
- “Does the abusive partner control all the money?”^{51,58}

Appropriate treatment for the patient’s injuries should be provided⁵² as well as appropriate referrals for support. (See Appendix D) In addition, it is important to discuss alternatives in a safe place,^{51,56,57} giving the patient an opportunity to decrease the sense of isolation and lack of power.⁵⁷ The patient may or may not be in immediate danger and may or may not want access to a shelter. Based on these criteria, additional decision-making and appropriate action may proceed.

If the patient is in immediate danger, it should be determined if there are family or friends to stay with⁵⁰⁻⁵² or if immediate access to a shelter^{51,52,57} or police contact is wanted.^{52,54} An opportunity should also be given to use a private phone to assist with any/all of the above.⁵²

If there is no immediate danger or the patient doesn’t want immediate access to a shelter, the chiropractor may offer written information about shelters and other community resources^{48-52,54,55,57} or instructions how to find this information in the phone book.⁴⁸ Shelters and affiliated agency referrals should be made carefully and only to those dedicated to assisting battered women.⁴⁸ Affiliated agencies and community resources may include the following: children’s services, counseling, legal and employment services⁵⁴ and law enforcement.^{50,51} With respect to legal needs, possibilities are criminal prosecution, civil litigation,^{52,57} civil protection/restraining orders,^{51,52, 57} temporary custody, and mandatory payment of rent or mortgage.⁵⁴ It is important to remember that written information may be dangerous for the patient to possess.^{48,52} The patient should not be forced to take written information. The number of a local hotline or other information may be most safely given on a prescription blank or appointment card.⁵²

The victim should be assisted in developing a safety plan^{48,50-52,54,57,58} with which they can prepare for future situations as well as make judgments about the safety of their current situation. This should be an ongoing process where questions such as “Is it safe to go home?”^{48,51,54} can help the victim to regularly assess their safety status. Identification of potentially dangerous situations and appropriate responses increase the preparation and safety when or if the risk of violence increases.^{48,50} Options should include planning for immediate relocation to a shelter⁵⁷ and/or seeking shelter and financial help from family and friends.⁵⁰⁻⁵² If possible, three options should be included for emergencies where shelters may be full, family and friends are out of town, etc. Victims should be given information directly and/or made aware of how to access available resource numbers for assistance.^{48-52,54,55,57} A packed overnight bag⁵⁷ or “flight kit” which may be an unused suitcase placed in a well-hidden area⁵² should include as many of the following items as possible: enough money to get started, clothing, medicine, address book, car/house keys, valuables, books, children’s toys, papers (social security card, health insurance information, birth certificates, driver’s license, restraining order, etc.).⁵⁸

In the case where no apparent emergent situation exists and the patient is returning home, a follow up appointment should be scheduled.⁴⁸

Despite the limited and imperfect options for detecting and intervening in domestic violence situations, the benefits are substantial for families in which the cycle of abuse is interrupted.⁴⁹ Patients should not leave the health care facility without knowing that battering is a crime and there is help in the judicial system.⁵⁴ It would be useful for the physician to be familiar with, or help develop, a network with physicians, and community referral resources (shelters, legal services, law enforcement, district attorney’s office, etc.) as this can be extremely effective in developing a coordinated response to meet the complex needs of battered women.⁵¹

Educational Materials for the Health Care Providers

Chiropractors can increase public awareness about domestic violence,^{48,57} show willingness to discuss the topic,⁴⁸ and help women understand the problem⁵⁰ by having pamphlets, posters, etc. in the office. This is an important form of intervention and prevention.⁵⁷ There should be materials from community resources relating to domestic violence in the waiting room, examination room, female restrooms and other strategic locations.^{49,51,57} It is also

important to support culturally sensitive publications in different languages for women in the international community as it is more difficult for them due to cultural, religious, social, family, legal and immigration reasons.⁵⁰

Child Abuse

The various forms of abuse have potential physical and behavioral indicators.⁶²

(A) Physical abuse, possible physical indicators;

- bruises and welts on the body;
- bruises and welts reflecting the shape of an object used (electrical chord, belt buckle);
- various types of burns (cigarette, rope, etc.);
- laceration;
- fractures.

Physical abuse, possible behavioral indicators:

- wary of adult contacts;
- apprehensive when other children cry;
- behavioral extremes;
- frightened of parents;
- afraid to go home.

(B) Neglect, possible physical indicators:

- consistent hunger, poor hygiene, inappropriate dress;
- consistent lack of supervision;
- unattended physical and/or emotional problems or medical needs.

Neglect, possible behavioral indicators:

- begging, stealing food;
- extended stays at school;
- poor school performance;
- fatigue;
- alcohol or drug abuse;
- delinquency.

(C) Mental injury or emotional maltreatment, possible physical indicators:

- failure to grow;
- speech or sleep disorders;
- forced to dress in "opposite sex" clothing.

Mental injury or emotional maltreatment, possible behavioral indicators:

- behavior extremes: aggression or withdrawal;
- habit disorders (sucking, biting, rocking);
- attempted suicide;
- conduct disorders (antisocial, runaway, destructive behavior);
- emotionally needy.

(D) Sexual abuse, possible physical indicators:

- difficulty in walking or sitting;
- pain or itching in the genital area;
- bruises, bleeding or infection in external genital area;
- venereal disease;
- pregnancy.

Sexual abuse, possible behavioral indicators:

- withdrawal, fantasy or infantile behavior;
- poor peer relationships;
- delinquent or runaway;
- reports sexual assault (children seldom lie about sexual abuse);
- refer also to behavioral indicators of mental injury or emotional maltreatment.

Elder Abuse

Observations suggestive of elder maltreatment include:⁶⁸

(A) General

- absence of caregiver or abandonment;
- poor supervision;
- recent conflicts or crises;
- medication problems (duplications or unusual dosages);
- recurrent healthcare admissions or visits;
- delay in seeking care;
- unexplained injuries;
- inconsistent histories between patient and caregiver.

(B) Patient

- fearful of caregiver.

(C) Patient or caregiver

- depressed;
- reluctant to answer questions.

Physical indicators of elder abuse:⁶⁸

(A) Physical abuse

- unexplained bruises, wounds, burns, or other injuries;
- rope or restraint marks on wrists and/or ankles.

(B) Psychological abuse

- habit disorder (sucking, rocking);
- neurotic disorders (antisocial, borderline).

(C) Neglect

- dehydration or malnutrition;
- poor hygiene;
- inappropriate dress;
- unattended physical or medical needs.