CHAPTER 10

Domestic Violence

Domestic or intimate partner violence is a problem with serious health consequences, and in general, its symptoms are not being recognized by health care providers. This chapter aims to sensitize you to the issue of domestic violence and to help you to understand the dynamics, the barriers to identification, to recognize the physical and behavioral symptoms, to give you guidance on how to inquire about it, and recommendations on how to manage it.

The Silent Epidemic[1]

Domestic violence has been called *silent* because it is both hidden and largely unrecognized in spite of recent media attention and coverage. *Epidemic* because the dimensions of the problem are truly staggering. By some estimates about 4 million American women experience a serious assault by an intimate partner during the average 12 month period.[2] Popular misconception sees domestic violence as a phenomenon only of poor and uneducated women. While it is true that past and current victims of domestic violence are over represented in the welfare population, most are there because of debilitating factors related to the abuse.[3] However, the silent epidemic crosses boundaries of age, gender, ethnicity, socioeconomic status and sexual orientation.[4] Women between 19 and 29 with children under 12 are most likely to be abused.[5] Violence also occurs in dating couples, with 20% of adolescents reporting being physically or sexually abused.[6] It is estimated that 10% of professional and working women are victims of battering mates.[7] Intimate partner violence occurs with similar frequency in lesbian and gay relationships.[8] In addition there is evidence that women or elderly with disabilities are at higher risk for abuse at the hands of intimates or caretakers.[9,10] Approximately 3.3 million children a year are exposed to violence by a family member against their mother.[11] Such children are 1500 times more likely to be abused than those coming from homes without partner violence.[12] The long term consequences on the children living in violent households are:

1. **Witnessing domestic violence is the single best predictor of drug abuse, juvenile delinquency and engaging in multiple health risk behaviors.**[13,14]
2. **Boys learn that males are violent and need not respect women. As adults they are 10 times more likely to use violence on their partners. Girls learn that male violence is normal and tend to accept it in adult relationships.**[15]
3. **Depending on their developmental stage, children witnessing domestic violence may develop serious medical and/or psychological problems.**[16]

The economic costs of treating domestic violence are enormous. Estimates put the annual medical cost attributed to domestic violence at more than $2 billion. Annually there are 243,000, or one fourth of all ER visits, 21,000 hospitalizations, about 40,000 clinic visits, and 175,000 disability days, estimated to be attributable to domestic violence.[17,18] According to the National Coalition Against Domestic Violence, domestic violence accounts for more injury to women than from all other causes combined,

and around 2,000 women a year die as a result of it.[19] Homicide is the number one killer of pregnant and post partum (1 year) women.[20,21] Some of the statistics are mere estimates because typically health care providers correctly identify abuse in fewer than 5% of the cases.[22]

The last statistic of 95% of cases presented in health care settings not being identified as such is most alarming to some. Citing these data, a March 2001 JAMA editorial argued that all health care professionals must do a better job in all settings to recognize and provide appropriate treatment to victims of domestic or intimate partner violence.[23]

CULTURAL FACTORS

In general, domestic violence is overwhelmingly perpetrated by men onto women, so our discussion reflects that fact. As a society, we need to examine norms and values that appear to tolerate (perhaps even encourage) violent and coercive behaviors in intimate relationships. Historically, in most patriarchal societies social, religious, and even legal norms have encouraged male control over women.[24] This included either explicit or tacit understanding that a husband could physically "discipline" his wife. One attempt to limit the amount of violence a husband could visit upon his wife came in the form of old English "rule of thumb." It forbade a husband to use a stick thicker than a thumb to beat his wife.[25] The cultural and religious stigma about homosexuality has made violence in same sex domestic relationships even more hidden. It is rarely considered, diagnosed or treated by health care providers.

PATIENT PROFILE 10.1

I'M SO SICK OF YOUR JEALOUSY!

***SETTING**: Rikki and Maury are two homosexual men in their late 30's, living in a large cosmopolitan city. They have been coming to see Greg, an osteopathic physician for minor health problems for a little over a year. He knows that they have been in a committed relationship for 3 years. Rikki has come into the clinic with a bloody towel around his head accompanied by Maury.*

Greg: What have we here? Let me take a look at that.

As he takes the towel off, Rikki winces. There is a 3 cm gash on his scalp just above his right ear.

Maury: He is so clumsy. He left a kitchen cabinet door open and ran into it.

Rikki groans and rolls his eyes, but does not say anything.

Greg is aware of the tensions in their relationship. He suspects that this explanation given by the partner and Rikki's nonverbal gestures might indicate that this is not what really happened.

Greg: Oh Yeah? Rikki you must have been going pretty fast to get a gash that deep.

Maury: Well, you know how Rikki is, kind of flighty. He moves kind of erratically.

Rikki keeps his eyes down and does not say anything. By now Greg is convinced that he needs to get the two separated if he is to find out what really happened.

Greg: OK, I am going to take Rikki into the surgery room to stitch this up. Maury you wait here.

Maury: Oh, no. I'll come. I want to be with him. .

Greg: Sorry, that's against the rules. It won't take long.

In the surgery room:

Greg: I know you two have had some tensions and fights in the past. Has it become violent? Is that what this is about?

Rikki: He's been so possessive lately. He doesn't want me to see any of my friends any more.

Greg: I understand. So, how did you get that gash on your head?

Rikki: I was on the phone talking to a friend, and we were laughing. Maury got jealous and told me to get off the phone. When I didn't, he got really mad and threw an ash tray at me as hard as he could from across the room.

Greg: I see. Was this the first time that he became violent?

Rikki: Well, he has broken things of mine before when he got mad. A week ago he tried to prevent me from leaving the house. He got pretty rough.

Greg: What do you mean by rough? Did he hit you?

Rikki: Yeah, kind of.

Greg: Where?

Rikki: Right here.

He pulls up his shirt and points to some yellowish green contusions on his ribcage; two along the right side and two in back.

Greg makes a body map outline in the chart and records the injuries.

Greg: Those must have been painful when they were fresh. Anything else?

Rikki pulls up the shirt sleeve on his right arm to reveal some more discolored places along the distal part of his forearm.

Greg: This looks like pretty serious stuff. No one deserves to be hit like this. This is intimate partner abuse.

He then briefly explains about the tendency for such abuse to get progressively worse unless there is early intervention.

Rikki: I can't believe this is happening. We've been together for 3 years. He's always been somewhat bossy, but I just let him. But he has just gotten so controlling over the past few months. He doesn't want me to see or talk to any of my friends any more. He just stays home all the time. It drives me nuts.

Greg: Do you need to leave to be safe?

Rikki: We have this big mortgage on our house. I don't want to walk away from that.

Greg: Do you think he would be open to counseling? There is a fairly good group program for gays and lesbians at the Jackson Center. They have some very experienced counselors there too that specialize in gay-lesbian relationship problems.

Rikki: I didn't know that was available. We have been talking about counseling. Maybe if he hears about this from you, he might go. He thinks I need counseling, too. And that's OK by me. I probably do need it.

Greg: Do you think he'll get mad at you for telling me about the battering?

Rikki: Actually my guess is he will be relieved. He has been ashamed and embarrassed every time he loses his temper. Once it is out in the open, he may be glad. At least I hope so. If not, I guess I would have to think about leaving.

Greg: OK then let's dress this suture, and then we'll talk to Maury.

POINTS TO CONSIDER:

- When Maury answers for Rikki, and when the explanation does not match the seriouness of the injury, Greg knows that the patient must be separated from the "helpful" partner.
- Greg educates the patient on domestic violence, and focuses on safety issues.
- Because he knows that intimate partner violence between same sex couples generally does not get a helpful response from the legal system, Greg suggests individual and group counseling for both partners at a community center.
- Greg remembers to probe if there is likely to be retribution from the partner for revealing the abuse.

The legal system has been under pressure to catch up with the problem of domestic violence. It has taken vigorous advocacy as well as some prominent civil judgments by victims of domestic violence to convince state and local lawmakers to enact laws that allow police to arrest perpetrators of domestic violence. However, in many jurisdictions, victims still find barriers to accessing the legal system, getting protection orders, having those orders served on the batterer, and having those orders enforced.[26] Fear of stalking or retribution by the batterer and lack of confidence in the willingness or ability of the legal system to protect them is cited as the principal reason why victims only report one-seventh of domestic assaults to police, and only

55% of serious injuries.[27] The general consensus is that prompt arrest and incarceration deters those abusers who have much to lose from the social consequences.[28] However, unemployed batterers or those with few social ties tend to become more violent after an arrest.[29] When you treat a victim of abuse, and consider possible legal remedies for the woman's safety, this distinction in economic and social status of the batterer is a crucial variable.

BATTERER PROFILE

What kind of man is a batterer? Although batterers come from all racial, religious, and socioeconomic backgrounds, there are a number of characteristics that fit the general profile of a batterer.[30] He objectifies women, and may not even see them as people or as worthy of respect. Rather he tends to see women as sexual objects or even as his property. A batterer may be outwardly successful, and may be seen as a charming, pleasant, "nice" guy. On the other hand, he may come from a chaotic, abusive family, and have feelings of powerlessness. During the pursuit or "courting phase," he may rush into intimacy, convincing his object of love that she is "the one" and that he cannot live without her. However, once he has "captured" her, the process of exercising control over her behavior, freedom of movement and even her thinking will begin almost immediately using the various techniques detailed in the Wheel of Power and Control (Figure 10-1). Victims have described the abrupt change from romantic pursuer to possessive abuser as a Jekyll and Hyde phenomenon.

The Battering Cycle

Relationships involving domestic violence progress through cycles. The first is the **tension building phase.** During this period, the batterer will accuse the significant other of various (often imagined) wrong doings, and in repeated criticisms tell her she can do nothing right. He will start controlling her behaviors by restricting her basic rights, (not letting her drive or leave the house without him), or even ordering her into isolation. The **violent phase** often starts when the batterer uses any real or imagined objectionable act or behavior as a "reason" to launch into explosive violence. In the early phase of a domestic violence situation, this violence may take the form of breaking or throwing objects, or harming or killing pets. As time goes on, the violence of this phase escalates and is directed more and more against their partner. Frequently, the abuser will be under the influence of alcohol or drugs. Once the abuser has released his tension, there follows a calmer phase, also known as the **honeymoon phase.** The batterer becomes remorseful, apologizes, and may make various excuses for his behavior. He may insist that the violence was not intended, that he really loves his partner, and cannot do without her. He will blame it on alcohol, stress at work, or some other external factor.[31] He will promise (often with real tears) that he will *never* do it again. The honeymoon phase, during which the batterer may become a doting husband and loving father, lulls the victim into believing that the perpetrator is truly sorry, that the violence will end, and things will improve. However, without intervention, legal action or counseling, the tension building phase will recommence until it culminates in another violent explosive phase. Over time the abuse tends to escalate in severity and frequency. The honeymoon periods become shorter or may disappear altogether. It has been suggested that this progression is similar to the addictive process, both in the neurochemical reinforcement process in the brain as well as in the tolerance building process which may dictate an increasing violence level to get the same "rush" or release.[32]

RISK FACTORS FOR BECOMING A VICTIM

How do women or any intimate partners get drawn into violent relationships and why do they stay in them? All too often we tend to blame the victim. To understand these questions, we need to look at the typical profile of the woman attracted to batterers, as well as the psychophys-

Figure 10-1. Wheel of Power and Control. From Domestic Abuse Intervention Project, Duluth MN, Used by permission.

iological progression of battering that traps the victim.[33] Many women are drawn to men who call forth their vulnerability and protectiveness. Men who had difficult childhoods were mistreated emotionally, sexually or physically, or who have drinking problems, often seduce women into feeling sorry for them. Women who respond to this kind of man often had a pattern in their childhood or adolescence of having taken injured animals or pets and nursing them back to health. The woman is likely to be even more vulnerable, if in childhood she has been socialized into believing that women are inferior, or that men have the "right" to hit women. This is especially critical if as a child she experienced physical, emotional or sexual abuse, or witnessed domestic violence in her family of origin. Such women as adults are likely to be having feelings of low self worth, and existential guilt. They may be prone to the urge to rescue. They tend to

believe that they can compensate for the man's problems by loving him. The man often evokes this response by saying that *only she* can help him, and that he cannot get along without her.[34]

PATIENT PROFILE 10.2

HE SAYS HE'S REALLY SORRY

***SETTING**: Melody is a 22-year-old college student who has been living with her boyfriend of 1 1/2 years. He is graduating and she is a junior student. Both of them are under a lot of stress because of final exams. They are both Biology majors in a medium-sized mid-Western college. She is a drop in to the student health center and is being seen by Bob, a nurse practitioner.*

Bob: Hello, Melody. My name is Bob Jones. I am a nurse practitioner. How can I help you?

Melody: Hi, it's my boyfriend Henry. He was really sweet and very charming when I first moved in with him. Now he's changed into someone else. I am so shocked and unhappy. I can't sleep. I'm so upset and finals are just around the corner.

Bob: One thing at a time. Slowly now tell me how Henry has changed?

Melody: He slapped me. *(Starts crying.)*

Bob: Hmmm. Here's a Kleenex. Is that what caused that red mark on your left cheek?

Melody: Yes.

Bob: Tell me more about this. Has he ever done this before?

Melody: Yes. It started after the first semester that we lived together. Whenever the push is on for exams or projects, he gets really irritable and everything I do seems to upset him. Now the push is on in his classes for graduating with honors. He keeps saying he'll never do it again. I want to believe him and he got me some flowers. He's being really sweet. Do you think he really means it?

Bob: I don't know but this sounds like domestic violence and let me tell you about how this kind of behavior repeats.

He proceeds to tell her about the Batterers Cycle.

Melody: Oh, he's promised he'll never do it again. And he just slaps me, sort of like what Dad used to do to Mom. Not too bad. I'll just be quiet and nice to him and see what happens. Maybe he'll change. We really care about each other.

Bob: Here's a pamphlet on domestic violence. Will you read it and think about what has happened?

Melody: Sure, after finals.

Bob: If anything else happens, will you come back in to see me?

Melody: Yes, and thanks.

POINTS TO CONSIDER:

- Bob continues to question her because he realizes the importance of clarifying the reasons she has come in to the center.
- Bob's non-judgmental and supportive demeanor is essential to facilitate Melody to share more about the relationship and its dynamics.
- Bob realizes that getting out of an abusive relationship sometimes is a long process and continued education is an essential part of helping Melody.
- Bob has available the appropriate educational materials which when given to Melody at this time can reinforce further proactive behavior on her part.
- Bob makes sure Melody knows she can return to the counseling center for help when she needs it.

Once in an abusive relationship, there are many obstacles facing battered women who want to leave. (See Box 10-1.) One obstacle is the intermittent reinforcement of each honeymoon phase. The victim, experiencing the honeymoon phase, convinces herself that the batterer really does love her and needs her. She may truly believe what many victims have said: "I thought if I loved him enough, he would love himself and not hurt me any more." She may also have well founded fears that the batterer will become more violent or even kill her if she

attempts to leave. Indeed the greatest danger for homicide is at the point she leaves or shortly after she has left.[35]

Progression of Victimization

The Wheel of Power and Control illustrates the wide variety of techniques used by batterers to intimidate, gain power, and achieve almost total control over the victims. Intermittent violence and physical abuse is used by the batterer to intimidate and control his victim. He will combine direct physical assaults with verbal threats, throwing or breaking objects, harming or killing pets, or simply raising his fists to enforce the other techniques. Relentless psychological abuse, designed to undermine the victim's independence and self-esteem, reinforce the feeling of powerlessness. Whether the abuse is primarily physical, or psychological, or both, most victims tend to go through what has been labeled as a **psychophysiological progression of victimization**.[36] One way to understand this progression is in terms of the batterer's increasing need to completely control his victim. There are three stages: the **Injury Stage**, the **Illness Stage** and the **Isolation Stage.** Knowing what goes on in each of these stages can help you identify physical and behavioral symptoms and allow you to plan an effective response.

Box 10-1 Obstacles to Leaving an Abusive Relationship

1. Fear and terror of their abuser
2. Low self esteem
3. Lack of money
4. Lack of shelter and housing
5. Batterer's promises to change
6. Isolation
7. Lack of family and social support
8. Lack of access to legal counsel and advocacy
9. History of prior ineffective legal intervention
10. Denial and minimization by victim and outsiders
11. Shame, embarrassment, self blame, and guilt
12. Religious beliefs
13. Wanting to keep family together
14. Protecting the children (by taking the abuse to shield their children)
15. Lack of employment skills
16. Fear of being considered unbelievable or crazy

Adapted from Buel S (1994) Domestic Violence — A Talk by Sarah Buel. Video Produced by Wyeth Ayerst.

INJURY STAGE

In the Injury Stage, the batterer is likely to combine verbal abuse and threats or displays of violence, with pushing, shoving, restraining, arm twisting, choking and hitting. The victim may still be employed, and be connected to church, family, and other community ties. However, she is likely to be pressured by him to separate from those outside sources of support, and to rely on him completely for emotional and economic support. Injuries at this stage usually consist of bruises and abrasions, possibly broken ribs. She may have difficulty swallowing or speaking from the attempts to choke or strangle her. The physical symptoms generally will be located on the central part of the body, the outside of the arms, the head, face, and peritoneal area. Often they are not severe, and less than 4% require hospitalization. One clue for you is that the location of the injuries usually is *not* consistent with claims of accidental falls or walking into doors (often provided by the solicitous spouse). Shame and fear of retribution will usually prevent a victim from volunteering the true origin of the injuries, especially if the battering partner is present.

ILLNESS STAGE

During the Illness Stage, the violence and/or the psychological tactics are escalating in severity and frequency. The honeymoon phases may become shorter or disappear altogether. Injuries, like black eyes, dislocated jaw, or broken ribs, or pain from such injuries, may force the victim to miss a lot of work. The batterer may repeatedly "check up" on his partner at the work place to the point of annoyance and disruption. Ultimately, embarrassment and shame over the absences, unexplained injuries, and partner interference may get her to withdraw from work

and her social network.[37] Physical trauma from the abuse may lead to various complications. Severe head injuries may lead to sinus, hearing or visual problems, or even brain trauma. Rape or "rough sex" may lead to vaginal infections and pelvic inflammations. Pregnant women are especially at high risk from blows or kicks to the abdomen.[38] As the victim succumbs to the stress of constant psychological pressure of repeated battering or threats of battering, she may somatize the stress. In addition to (or instead of) physical injuries, she is likely to complain of atypical physical and emotional ailments, such as myalgia and chronic fatigue, heartburn, irritable bowel syndrome, and sleeping or eating disturbances. Indirectly reaching out to the health care provider, she may refer to the anxiety she is experiencing, or mention that she feels as if she were "walking on eggshells" at home. Unfortunately if domestic violence is not identified as the underlying problem at this stage, the health care provider may simply respond by treating the symptoms — whether they be physical or emotional. Alternatively, a conscientious provider might order more tests to get to the bottom of some mysterious somatic ailment. When such tests show no evidence of a physical cause, the provider may conclude that the patient is either faking it, or is psychologically disturbed. Such labeling could drive the person into the despair of the next stage.

ISOLATION STAGE

This stage begins when the batterer tries to enforce total isolation through all the means shown in the Wheel of Power and Control (Figure 10-1). Verbal abuse at this stage has been compared to brainwashing, and victims have spoken of feeling like prisoners of war. By denying her gainful employment or education, the victim becomes financially totally dependent on the batterer. The batterer will hammer the victim with assertions that she cannot make it on her own. Without resources of her own and without outside support to contradict the abuser's version of "reality," she comes to believe his assertions that she is worthless and that she deserves the abuse. Calling her crazy is one of the psychological battering techniques used by many abusers. Brainwashing has been successful when the victim identifies herself from the perspective of the batterer. Once this perceptual shift has taken place, she internalizes that she is to blame, that she is worthless, that she is crazy, and that no one would believe her if she spoke up about the abuse. If the victim finds that her health care provider also seems to think she is "crazy," this only confirms the batterer's brainwashing. In the despair of hopelessness, she becomes convinced that she cannot make it on her own, that she will never get away, and that ultimately she may die at the hands of her abuser. At that point she lives in a state of almost constant fear and terror for herself and her children.[39]

When a victim has reached this last part of the Isolation Stage, health care providers may have difficulty interpreting certain behaviors. She may show signs of being anxious, hyper vigilant, and jumpy. Her cognitive functioning may become fragmented. She may also be too depressed to be able to concentrate, to organize her thoughts, or to give coherent answers. When faced with these inconsistent behaviors, and when the frightened patient volunteers no infor-

POW IMAGE

I feel like I've been a Prisoner of War
and there are all those people
who don't even know me that well,
(and some who know me best)
who are celebrating and hugging me
because I've escaped on my own.
But then there are all these people
who refuse to believe
that there was even a war going on
(just a minor skirmish)
or that I could possibly have been a POW.

—Anonymous survivor of domestic violence

mation about her abuse situation, a health care provider may not relate the symptoms of post-traumatic stress disorder to domestic violence, and instead conclude that the patient needs medication for an anxiety disorder, depression, or possibly delusions. Such an assessment would have the unfortunate effect of perhaps closing the last bridge out of the isolation. If her health care provider misses the domestic violence clues, and appears to confirm the batterer's judgment that she is a mental case, she is likely to be driven deeper into despair. She may cease coming for health care altogether. She is also likely to fall into a pattern of self harming behaviors, including abuse of prescription drugs, alcohol, or other dangerous substances, and believing that there is no way out of the abuse even resort to suicide.

It is important to remember that for many victims in the isolation stage, visits to a health care provider or clinic for treatment of injuries or serious somatic complaints, may be the only contact with the "outside" world. The abuser may change health care providers to avoid arousing suspicion about her injuries. He is also likely to accompany her, and may even insist on being in the examining room with her. If you suspect abuse, it is paramount that you arrange a private and confidential examination with only the victim present. Even when alone with you, the victim out of shame and fear may believe she *cannot* tell you what is going on. However, in most instances sensitive and non-judgmental questions are welcomed, and may produce information you need.

Assessment

There are several keys to correctly assessing domestic violence. One is a willingness to overcome various barriers. Another is paying attention to red flags or inconsistencies between the physical evidence or symptoms and the explanations given either by the patient or the partner. A third is to have protocols for handling domestic violence cases in place in your health care setting.

BARRIERS TO ASSESSMENT

The low identification rates of domestic violence in the medical setting are due to specific barriers.[40] Some barriers to identification are related to the difficulty of getting accurate information from either the victim or the batterer. Some are inherent in the delivery of modern health care. Others relate to personal barriers in the health care provider. First, as mentioned above, a victim paralyzed by fear or shame is unlikely to volunteer a truthful explanatory history about the medical complaints related to abuse. Also, abused victims may be prevented by the batterer from coming to a scheduled follow up visit. In fact, you may not see her for another 3–6 months, usually after another violent episode. Rather than identifying the missed appointment as a red flag for domestic violence, you may see it as lack of interest, or as confirming your suspicion of mental problems. A second barrier on the systemic level may be that cost containment concerns may not reward the time and personal attention needed to elicit information about domestic violence. In such a setting, the temptation may be to just bandage the wounds, treat the somatic symptoms pharmacologically, and go on to the next patient.

Third, many health care providers have personal internal resistance to detecting and providing an appropriate response to a patient who may be a victim of domestic violence. You may fear that you might open a Pandora's Box of troubles for which you might be unprepared, or might not have the time for adequate follow up.[41] You may feel that it is the patient's responsibility to raise the issue, and that it is not your place to probe or intervene. Lack of confidence in identification and management skills may make you overly cautious. There may also be language or cultural barriers.[42] You might fear that by asking a question about possible abuse, you might embarrass or insult a patient who does not have a problem. You may not believe the patient, especially if the alleged assailant is present and seems pleasant, solicitous and concerned. Also some health care providers feel it is an issue

between the couple, and that it is not their place to interfere. The fallacy that domestic violence does not happen in higher income families may lead you to ignore even unmistakable symptoms in a patient from a "good" family. This may be a countertransference issue. For example, there is an adage among domestic violence advocates: "The more the batterer looks like you (socially, economically, educationally), the less likely you will be to "see" him as a batterer." This is especially true if you have other social or professional ties to the abuser.

It has also been found that health care providers who have inadequate knowledge about the scope and dynamics of domestic violence may not be aware that domestic violence can occur in same sex or opposite sex relationships, whether married or not. A health care provider may also feel ineffective or helpless when the patient does not take action by seeking counseling or leaving the situation. It is normal to feel frustration when victims seem not to take recommended steps to get out of the violent relationship. When, as frequently happens, the victim goes back to the battering partner, the health care provider might become more judgmental and less supportive the next time. A number of such frustrating experiences might make the provider reluctant to "get involved" when domestic violence is suspected in subsequent patients. Some also fear involvement in legal proceedings. Finally, countertransference may play a part in health care providers who have witnessed or experienced abuse in their own lives. They may feel extremely uncomfortable about investigating something that brings back painful memories or flashbacks. Thus, some former (present) survivors of either childhood or domestic violence abuse might subconsciously not take note of or follow up on even clear evidence of abuse and instead distance themselves from patients in abusive relationships.

CONSTELLATION OF SYMPTOMS

All of these barriers are real, and work against proper identification of symptoms of domestic violence. However, the pervasiveness and tragic consequences of domestic violence place a responsibility on everyone in the health care system to be informed about the constellation of symptoms that point to domestic violence. Here are some red flags for likely abuse situations. One important set of clues is if the patient's intimate partner refuses to leave the examining room, and/or tends to answer all questions for the patient, and when the patient looks at the partner before answering any question. Other clues are if there is an unreasonable delay in seeking treatment, explanations of injury ("ran into door") inconsistent with location of injury, bruises in *various* stages of healing, unexplained stroke in a young woman, and any types of injury related to sexual assault. Indeed, injury to the abdomen and genitals in a pregnant woman should automatically be regarded as a potential abuse symptom. Since most abuse is focused on the abdomen, you will see increased incidence of preterm labor, placental separation, ante partum hemorrhage, uterine rupture, birth defects, and/or fetal fractures.[43]

Box 10-2 presents typical presenting symptoms or characteristics of victims of domestic abuse. These symptoms, presented in the different categories, should be used in combination to see if there is a constellation of signs and symptoms to produce a pattern. For example, the further along in the psychophysiological progression of abuse, the more likely you are to see multiple psychosomatic complaints along with serious injuries and possible signs of psychological disorders, such as anxiety, depression, post traumatic stress disorder, or bizarre behaviors and inconsistent verbal cues. You need to remember that the fear of violence may limit her ability to follow through on a number of health related issues. She may be unable keep medical appointments for herself or her children. She may be constrained from practicing safe sex or using contraceptives. She may not have the money or the transportation to get prescriptions filled. The abuser might prevent her from taking prescribed medicine, and instead take them himself, even samples you might give her. If

Box 10-2 Signs and Symptoms of Domestic Violence

PHYSICAL SYMPTOMS

- Acute traumatic injury
- Headaches or hearing difficulty from head trauma
- Joint pains from twisting injuries
- Abdominal or breast pain following blows to the torso
- Dyspareunia or recurrent urogenital infections from sexual assault
- Recurrent sinus infections or dental problems, dislocated jaw or cervical spine
- Bruises or pain in neck or throat from strangulation, also look for bulging eyes
- Bruises or broken bones at various levels of healing
- Chronic abdominal pain, irritable bowel syndrome
- Recurrent sexually transmitted infections and or frequent gynecological problems.

SOMATIC STRESS SYMPTOMS

- Chronic headaches
- Chronic abdominal, pelvic, or chest pains
- Chronic joint and back pain
- Myalgia and chronic fatigue
- Sleeping or eating disturbances
- Heartburn, irritable bowel syndrome
- Exacerbation of chronic diseases like diabetes mellitus, asthma, and coronary artery disease
- Signs of post traumatic stress disorder: anxiety, hyper vigilance, jumpiness, disordered thought process, nightmares
- Depression, difficulty concentrating, feeling numb, suicide attempts or gestures
- Conversion disorders: losing feeling in part of body, temporary blindness

BEHAVIORAL CUES

- Nervous or inappropriate laughter or smiling (possibly tinged with fear)
- Crying, sighing, or hyperventilating
- Anxious, jumpy, furtive looks at the examination room door
- Defensiveness, anger
- Eyes averted or downcast, fearful of eye contact
- Partner: overly attentive or defensive; does not want to leave her alone

VERBAL

- Minimizes seriousness of injuries
- Gives explanations of injuries inconsistent with the actual injury
- Talks about "a friend" who has been abused
- Refers to a partner's "anger" or "temper"
- Refers to partner as being very jealous
- Says she will have to check with partner about any treatment suggestions
- If partner is present, patient will defer to him to answer questions, or look at him before answering questions

pregnant, she may be unable to enroll in early prenatal care.

BREAKING THROUGH THE SILENCE

Anne Flitcraft, MD a noted educator on domestic violence, uses the term "bridge out of isolation" to describe the crucial role that health care providers can play for someone trapped in the domestic violence cycle. She writes:

Your response to domestic violence can contribute to

> *the woman's understanding of the seriousness of abuse and her ability to end the violence. Sharing your concerns about abuse validates the woman's concerns that violence threatens her physical and mental well-being. Listening to her concerns about abuse encourages the exploration of options that contribute to her safety.* [44]

The first step is to encourage more information from your patient. Although 90% of identified abused women do not voluntarily confide in their health care provider, they tend to be

relieved and willing to discuss it, *if you inquire*.[45] Each health care setting should have established routines for handling domestic violence patients. All office or clinic staff with direct patient contact need to be knowledgeable about domestic violence and how to recognize its symptoms. One way to signal your readiness to explore domestic violence questions is by having materials or even posters on domestic violence along the path that a woman follows in the clinic. Some posters or material could be placed in the ladies' rest room — the one place the abuser is not likely to follow her. All of the above is part of establishing an atmosphere that gives the woman the impression that you and your staff are aware of domestic violence as a health and safety issue — even before she meets you in a confidential examination room.

Experts recommend that you do routine screening of all your female patients for domestic violence. Routine assessment with new patients and periodic reassessment with all patients during regularly scheduled visits provide the best structure to detect those who are in violent, threatening, or highly controlling relationships. Five simple screening questions known by the acronym **PEACE** can be made part of any Intake Questionnaire. (See Box 10-3.) The questions address **P**hysical violence, anxiety and constant fear (**E**ggshells), rape or sexual **A**buse, **C**ontrolling and isolating tactics, and **E**motional or psychological abuse.[46] They can also logically fit into the psychosocial history and/or the review of all systems. The same screening procedures for partner violence can be applied in same sex relationships. If in the written or oral screening, the patient acknowledges even one incident of abuse, you need to make a note in the record to follow up on each subsequent visit. If the intake information or interview reveals a cluster of symptoms listed in Box 10-2, it is appropriate to focus more directly on the role of domestic violence as you evaluate the chief complaint.

Box10-3 PEACE Questions

1. Have you ever been in a relationship in which you have been **P**hysically hurt by a partner or someone you love?
2. Have you ever felt you are "walking on **E**ggshells" to avoid conflicts with a partner or someone you love?
3. Have you ever been sexually **A**bused, threatened or forced to have sex, or participate in sexual practices when you did not want to?
4. Has your partner or someone you love tried to **C**ontrol where you go, what you do, who you talk to or who your friends are?
5. Have you ever been **E**motionally abused or threatened by a partner or someone you love?

Interviewing for Domestic Violence

Health care providers often feel awkward about broaching the subject of domestic violence with their patients. Here are a few simple guidelines for sizing up the situation. We have already noted that the "overly" solicitous partner who insists on being present during the physical examination, and who tends to answer all questions you pose to the patient, is a red flag. As long as the abusive partner is present, it is unsafe for the victim to give a truthful account about possible abuse. In fact, asking questions about abuse could put the victim in danger as long as the abuser is present. Thus, a first task in such situations is to separate the patient from the presence of the partner. You may tell him that rules of your office or clinic, require that the partner wait outside during the physical examination. Should he become belligerent in response, you may need to tread lightly, and find a way of getting the patient alone, even for a short time such as having her accompanied by you or an alerted nurse for a urine sample or an X-ray, while the partner waits.

In cases where it is difficult to separate the abuser from the patient, you may have only limited time to deal with this issue. Therefore, you need to be as proficient in determining whether there is or has been abuse, and then addressing immediate safety concerns. In cases where the patient appears frightened or fears for her safety,

you may need to assure her of confidentiality, as well as your concern for her safety. Once abuse has been established, there are many questions for follow up. These relate to her medical condition(s), issues of the safety of the woman and her children in the current situation, past history of abuse, and where she is in the psychophysiological progression of violence. The questions in Box 10-4 provide examples for each type of question. They are suggested scripts. Note that all of them are non-judgmental. It is crucial that you not allow your own frustration about her

Box 10-4 Domestic Violence Assessment Questions

Preliminary or Indirect

- All couples have disagreements and conflict. What happens when you and your partner disagree? Do conflicts ever turn into physical fights?
- I treat patients in my practice who are being hurt or threatened by someone they love. Is this happening to you?
- Do you ever feel afraid of your partner?

Direct

- Are you in a relationship in which you are treated badly?
- Has your partner ever destroyed things you cared about?
- Has your partner ever threatened or abused your children?
- At any time has your partner hit, kicked, or otherwise hurt or frightened you?

FOLLOW UP QUESTIONS

Current Episode

- What happened? How were you hurt?
- Were alcohol or drugs involved? By whom? Partner? Both you and he?
- Was a weapon involved? (safety issue, especially if firearm was present)
- Are you living with the person who hurt you?
- Do you know where the person who hurt you is now?
- Do you feel you are in danger now?

Abuse History

- Have you been hurt before?
- Do you recall the first time you were hurt?
- Can you tell me about the worst time?
- Can you tell me about the most recent time?
- Have you ever needed medical treatment because of it?

Control and Isolation Issues

- Does your partner threaten to hurt you or others close to you?
- Do you feel your partner isolates you from family and friends?
- Is your partner jealous? Does he explain his controlling behavior by saying that he loves you so much?
- Has your partner ever prevented you from leaving the house, seeing your family/friends, getting a job or getting an education?
- Does your partner watch your every move? Check up on you? Accuse you of having affairs with others?
- Does your partner belittle, insult, or blame you?
- Has your partner forced you to have sex when you did not want to? Forced you to have "rough sex" with him during which you got hurt?

Risk Assessment

- Has your partner become more controlling lately? Increasingly jealous?
- Has the violence become worse?
- Is there a firearm in the house? Does he brandish it or threaten you with it?
- Do you believe your partner is capable of killing you?
- Has your partner threatened to kill you or others close to you?
- Have you ever considered, threatened or attempted suicide? How do you feel about suicide now?
- Have you ever tried to leave? What happened?
- Are you planning on leaving your partner?
- Do you know how to get help if you are hurt or afraid of being hurt?

Questions *not* to ask:

- What keeps you staying with someone like that?
- How long are you going to put up with this?
- What did you do that made him hit you?

staying in such a relationship to come out in your questions.

In many instances, you will not have the time to conduct such an in depth interview yourself. However, if you have a protocol for dealing with domestic violence for your office or clinic, it should specify a follow up procedure. Ideally it should include summoning a domestic violence advocate immediately. Some clinics, ER facilities, or offices now have trained domestic violence advocates on their staff (usually a social worker or nurse). This person can then complete the more time consuming tasks, such as a complete psychosocial history, risk assessment and safety planning. If there is time pressure, i.e., the abuser is waiting outside, such a history may need to be taken while you are conducting the physical examination. If you do not have someone on staff trained as a domestic violence advocate, it is recommended that you establish a good working relationship with the nearest domestic violence program or shelter. Many will agree to dispatch an advocate immediately to work with the patient while she is still in the clinic or office.

Treat, Document, Educate — Don't Rescue!

What do you do after you have established that domestic violence is present in your patient's life? The first task is to treat the patient's medical condition(s) and document your findings. You need to conduct a thorough physical examination to determine the extent of injuries or bruises to parts of the torso normally covered by clothes. You also need to conduct a urogenital examination, looking for evidence of forcible rape, or violent insertion of foreign objects into the vagina or anus. If the patient is pregnant, you need to look for abdominal trauma and rule out possible injury to fetus or uterus. Due to the common practice of the abuser taking the victim to different providers to avoid detection of abuse patterns, you also need to inquire about other medical professionals who have treated her. This means obtaining names of all clinics and health care providers she has visited, or from whom she received medications.

When the extent of abuse becomes apparent, your emotions of outrage, sympathy and caring may be aroused. You may be tempted to rescue the victim. While understandable, this would be a mistake that could leave you frustrated, angry, and possibly disgusted with your patient. *It is* ***not*** *your function to get her to leave the batterer. She needs to reach that decision herself.* Your pushing her before she is ready will sabotage the critical work she herself needs to do before she can decide to leave. Remember, due to the barriers listed in Box 10-1, usually it takes multiple attempts at leaving the domestic violence situation before a survivor succeeds in resisting the batterer's pressure to return.

PATIENT PROFILE 10.3

...BECAUSE I LOVE HIM

SETTING: *Rhonda is a 27-year-old married woman with two children, 5 and 3. She is currently being followed because she is pregnant. She has been treated on and off for 3 years for minor bruises and abrasions in a large urban medical office. She is often seen by Sue, a physician assistant, who is aware of the domestic violence and has been talking with her about it for 2 years now. Alerted by the staff that Rhonda had come in with a black eye, Sue tried to summon a domestic violence advocate from the nearby shelter, but was told that both were unavailable.*

Sue: Hi Rhonda, let's take a closer look at that black eye. Did he hit you again?

Rhonda: Yes. Day before yesterday.

Sue: That must have really hurt. Did you get hurt anyplace else?

Rhonda mutely raises her arms to show some bruises on the distal sides of her forearms. Sue marks the locations on the body map she has pulled out.

Sue: Did he choke you?

Rhonda shakes her head.

Sue: Did he kick you or punch you in the abdomen?

Rhonda again shakes her head.

Rhonda: I fell when he hit me, but I don't think I hurt the baby. At least the children didn't see him do it. They were all in bed. He came in late, drunk as usual.

Sue: We are doing an ultrasound anyway, so we'll take a closer look to make sure the baby is OK.

Rhonda: OK.

Sue: I know its hard to think about leaving while you are pregnant, because your whole body wants to make a family. But I am worried about you and the baby. Should we think of taking out a protection order and get him out of the house? Would that be safe?

Rhonda's eyes widen with fear.

Rhonda: Oh no. That would just make him madder. No telling what he would do.

Sue: Do you need a break? Do you want to go to the shelter?

Rhonda: No, I don't think I want to do that right now. He's been really nice since he hit me, and promised he won't do it again. He is under a lot of stress right now. I need to stand by him.

Sue: OK, I understand. I am really concerned for your safety and that of the baby and also your kids. You know, after this little honeymoon, it is probably going to get worse. Let's talk about safety. Could you call the police if he starts his threatening behaviors?

Rhonda: Naw, if he heard me talking to the police, he would really get mad. He might kill me.

Sue: Do you have close neighbors who know?

Rhonda: Yes, the people next door. I think Linda knows. She has asked me several times if she can help — like keep the kids, when he is really drunk.

Sue: If she is willing, maybe you could work out a signal with her, so she could call the police, when he comes in drunk and looks like he is going to get violent. What kind of code word could you use so she would know to call for the law?

Rhonda: Well, as soon as he walks in and starts to threaten me, I could say I had to call Linda because she was expecting me. Then if I can make the call, I could tell her that I could not come, and the signal would be that I left little Stevie's shoes at her house. That would be the signal for her to call the cops.

Sue: Good. Now let's think of some other safety issues. Can you safely pack and store a bag with a change of clothes for you and the kids in case you need to leave quickly? Where will you keep it?

Rhonda: I have to think about that. Maybe Linda can keep it.

Sue: You know you can call the domestic violence program or go to the shelter any time you need to. I am going to write their number down on the back of the card for your next appointment. Remember to not get cornered either in the kitchen, the bathroom, or any room where he keeps guns. In general, when you think he is going to get violent, try to stay in rooms that have another exit so you don't get trapped. Rhonda, nobody deserves to be hit. That includes you and this baby.

Rhonda's eyes fill with tears.

Rhonda: You must think I am crazy. I don't know why I stay with him. I guess it's because I love him, and I keep hoping that if I love him enough, he is going to start loving himself, and wouldn't want to hurt me or the kids any more. I wish he wouldn't drink.

Sue squeezes her hand.

Sue: No, you are not crazy. I know how hard this must be for you. I am just worried about you and the unborn baby. I just want to be sure that you will take steps to keep yourself, the baby and the children safe.

Sue completes her physical examination. The eye exam and the ultrasound reveal no abnormalities.

Sue sends Rhonda on her way with: You know that any time you are ready, I am here for you.

Rhonda: *(again with tears in her eyes)* Thanks. You have no idea how much that means to me. I feel so alone most of the time.

POINTS TO CONSIDER:

- Sue cognizant of the abusive situation, tries to make it a team effort.
- With pregnancy as a risk factor for increased abuse, Sue focuses on safety concerns for the mother and the fetus.
- Sue is not trying to rescue Rhonda but offers her safety alternatives and lets Rhonda make the decision about how to keep herself safe.
- Understanding the tenuous hold on sanity of someone in Rhonda's position, she offers Rhonda the assurances that symbolize the bridge out of isolation.

GIVING ASSURANCES

But there are certain things you, or an expert in domestic violence with whom you consult, can do to assure her physical and emotional needs while she is in your office or clinic. You can create a supportive environment. Assure her of confidentiality and privacy. Let her tell her story. After listening to her, tell her clearly that she is not crazy. This is a crucial reassurance that will help her to counteract the batterer's brainwashing efforts. Point out to her that she is a **survivor.** Commend her for taking the first step toward improving her life and that of her children. Affirm that she did the right thing by telling someone about the crime that is occurring to her. Emphasize that no one has the right to hurt others, and that no one deserves to be beaten or threatened with violence no matter what responsibility she feels she has for the "problems" in the home.

By being supportive, pointing out the danger to herself and her children, and setting in motion other procedures for helping her, you communicate to her that she is not alone. The recognition that you, your staff, and/or a domestic violence advocate understand how difficult her situation is, and that you stand ready to assist her in planning for her safety, offers her hope that she will survive when she leaves the situation. This is the **bridge out of isolation** that will help the survivor counteract the feeling of being trapped in a sea of helplessness and hopelessness. If she feels understood and cared for, she may be able to take the first steps in the sometimes lengthy process of empowerment for her to reach freedom from abuse and move towards regaining control over her life.

You or a domestic violence advocate can also provide her with information about the community resources available for battered women and their children. You might review with her a brochure from the nearest shelter or Coalition on Domestic Violence. However, giving her a brochure to take home might endanger her safety if the batterer later finds it. You might simply write the number of the nearest domestic violence shelter or of the advocate on one of your business or appointment cards. If you have an advocate present, she can identify options, and devise a safety plan. In many locales, the legal advocate will help the abused person make a report to the police, and/or walk her through the legal system to obtain a court order of protection. The advocate can also explain her medical and legal rights to the woman. For example, the batterer can be made legally liable for the cost of treating the injuries and even for counseling she may need. Free legal assistance is usually also available through the nearest office of the state Legal Aid Society. Because the batterer has restricted her education and employment, she may need to

Assurances to Give to a Victim Who Says She Cannot Leave Now

- "You are not crazy."
- "You deserve better than this."
- "I am afraid for your safety (and the safety of your children)."
- "It will only get worse."
- "I am here for you when you are ready to leave."

apply for welfare and work training programs after she leaves him.

DOCUMENTATION

It is imperative that you clearly document your findings from the physical examination and the history. Using a simple front and back body map, clearly indicate locations of injuries or wounds, and label them. Always reference any injuries drawn on the body map in the medical record and link them to the "suspected violence." If a woman comes in with somatic symptoms only, and you have indications from her that they are connected to the stress of being in a domestic violence relationship, your documentation should use the phrase "related to suspected domestic violence." If a distraught victim spontaneously narrates the circumstances of the abuse, it is recommended that you quote the victim's own words and relate them to the injuries or somatic complaints. Such direct quotes are called **excited utterances** in legal terminology, and they carry weight in court proceedings. Report all laboratory findings and note that they were ordered in connection with injuries or somatic complaints "attributed to domestic violence" as illustrated in Box 10-5. If possible, incorporate the notes from the interview by a domestic violence advocate directly into the record, or at least reference that such an interview was conducted. It is critical to have as many details as possible, because such a record can become evidence against the batterer in subsequent legal proceedings.

Before she leaves your office or clinic, schedule a follow up visit in the near future. Given the rate of no-shows, you might flag your office staff to call the home before the next appointment — and without saying anything about domestic abuse— remind the patient to come for her follow up appointment. If the batterer is present in the clinic, you should also impress upon him the importance of her receiving follow up treatment for the presenting symptoms.

Box 10-5 Sample Documentation

Pt states she was "punched" in the left shoulder two times, beaten on her arms while covering her head and face, and stabbed with a screwdriver in her back.

Pt states husband screamed at her "I am going to kill you" at least three times, while trying to strangle her.

Physical examination of the skin reveals a 3 cm swollen ecchymotic area on left anterior shoulder consistent with a wound from a direct hit. There are three linear ecchymotic areas on each side of the neck consistent with strangulation marks from fingers. There is a closed puncture wound medially near vertebrae of left scapula consistent with stab wound from a blunt instrument. The lateral surfaces of both arms are discolored with blue and red contusions consistent with the blunt trauma as described by patient. See locations marked on body map. X-rays of right and left humerus were without evidence of fractures.

SAFETY PLANNING

Before the end of the first visit, you need to review her situation with her. Your primary aim here is *not* to get her to take action, but simply to focus on safety for herself and her children. First and foremost is her immediate safety if she returns to the home. You, or the domestic violence advocate could discuss a plan on how to get out of the house during a violent incident. Box 10-6 contains the major elements of a safety plan. She may need important documents if she and the children are forced to flee the house with only their clothes on their back. She will need such documents if she later has to apply for welfare assistance or a medical card for herself and her children. Your office can help by having the person who takes the information on her insurance and means of paying, also ask for the driver's license and social security card and make a copy for the medical file.

You and she need to know, that the immediate period after she leaves, or after the batterer has been forced out of the home by police or a

Box 10-6 Safety Plan

SAFETY DURING A VIOLENT INCIDENT:

- Stay out of rooms with no exit.
- Avoid rooms that may have weapons.
- Select a code word that alerts children, friends or neighbors to call the police if in immediate danger.
- Practice how to get out of your home safely.
- Keep purse and car keys readily available.
- Have access to clothes.
- Teach children how to use the telephone to contact the police and the fire department.
- Have the police file a report. Write down the officers' names. This way you can get in touch with them again later if you have questions about what happened.
- Get medical attention if needed.

SAFETY WHEN PREPARING TO LEAVE:

- Leave suitcase and copies of essential documents with neighbor or friend.
- Open a savings account to increase independence.
- Rehearse an escape plan.
- Practice it with your children.

SAFETY WITH AN ORDER OF PROTECTION:

- File an Order of Protection with the court to prevent stalking.
- Keep your protection order on or near you at all times.
- Give your protection order to police departments in communities where you visit family or friends.
- Inform your employer, minister, closest friends and relatives that you have a protection order in effect. Show them pictures of the abuser.
- Ask for help screening telephone calls at work.
- Call police immediately if order is violated.
- Change locks on doors and windows. Have outside lighting with movement sensors installed.
- Have smoke alarms and fire extinguishers installed. Plan an escape route from second floor or apartment in case of fire.
- Change phone numbers, screen calls, have caller ID blocked.
- Carry a noise maker or personal alarm. Vary your route to and from home.
- Inform landlord, neighbors of situation and ask that police be called if abuser shows up.
- Let those who care for children know who is allowed to have contact with them. Take copy of the protective order to the school, and inform teachers, counselors, and principal of the order.
- Keep copies of protection order in case original is lost or destroyed.

ITEMS TO CONSIDER TAKING WHEN LEAVING:

- Identification, birth certificates, social security cards, school and vaccination records, money, checkbook, ATM card, credit cards, bank books, house and car keys, driver's license and registration, medication, welfare identification, work permits, green card, passport(s), divorce papers, medical records, lease or rental agreements, house deed, mortgage payment book and insurance papers.

Adapted from Domestic Violence: There's No Excuse (2001) Brochure produced by Women's Aid in Crisis, Inc. PO. Box 2062, Elkins, WV.

court order, is the most dangerous time. Most murder/suicides in abusive relationships happen at this juncture. Hence safety planning is critical.

Conclusion

Treating patients who are in domestic violence situations is a necessary part of health care. Given the high number of medical incidents related to domestic violence that go unrecognized in the health care system, it is imperative that health care providers become part of the solution rather than part of the problem.[47] The first part of a solution is to create increased awareness not only among health care providers, but all support personnel. Your office or clinic staff will need periodic training. Your receptionist/telephone opera-

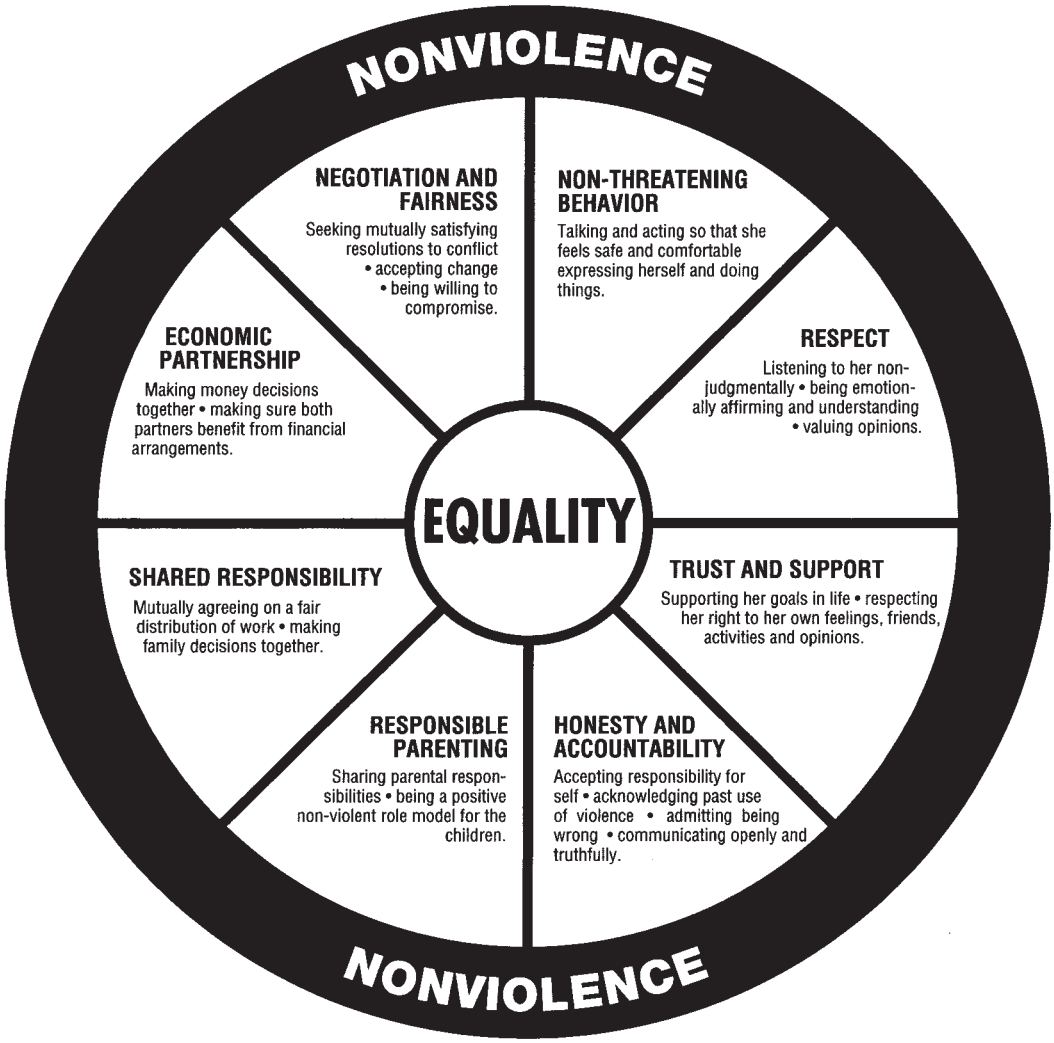

Figure 10-2. Wheel of Non Violence and Equity. From Domestic Abuse Intervention Project, Duluth MN, Used by permission.

tor needs to be alert to the verbal cues of distress of someone who "can't come in," but wants to know what to do for some of the physical or somatic conditions of abuse listed in Box 10-2. Generally, the local shelter or state Coalition on Domestic Violence will be glad to provide training on how to recognize and respond to patients who are potential or actual victims of domestic violence. They will train your staff to be sensitive to the need for non-judgmental support of the victim. Their trainers will help you set up a protocol for alerting everyone in the office or clinic, especially if the batterer is present. They will give you emergency phone numbers for summoning a domestic violence advocate to the office or clinic as quickly as possible.

Managing patients who have been abused can be quite frustrating and stressful. You and staff

members may have strong visceral and emotional reactions to the injuries you see, the descriptions of severe abuse you hear, or the look of terror or hopelessness you see in the patient's face. In fact, such experiences can create **secondary post traumatic stress** symptoms, i.e., sleep disturbances, even flashbacks and anxiety attacks, for staff members who are themselves survivors of violent abuse. Such feelings may be complicated by a sense of failure, if the abuse victim is not ready to leave the batterer.

The stress on you and those in your office or clinic will lessen if you have effective protocols in place which specify what part of the team effort each staff person will play. After any encounter with a particularly horrendous example of domestic violence, it is essential that you pay attention to the emotional stress of yourself and those who worked with you. We suggest that after any such incident you take time at lunch or after office hours to debrief yourself and those members of the staff who came into contact with the abuse survivor and/or the batterer. Unless you do this promptly, you and other staff members are likely to build up resistance and internal barriers to acknowledging symptoms of domestic violence in your patients the next time you encounter them.

No matter how well you perform these tasks, encounters with victims (and perpetrators) of domestic violence are neither easy nor rewarding in the short run. Remember the goal of the office visit, or clinic encounter is ***not*** to get the woman to leave the abuser. Rather it is to treat and document the injuries, and educate the survivor on the options and community resources available to her. A second task is to do a risk assessment and safety planning. A third major goal is to provide the emotional assurances and support to help her break the stranglehold of isolation, and increase her self confidence so ***she*** can make choices to move towards gaining control over her life. The survivors of intimate partner violence coming into your office or clinic need your active participation in lifting the veil of shame and secrecy, and in giving them hope that they can gain control, and create lives free from violence. (See Figure 10-2.) This is a team effort in which you, trained advocates, and your staff work with the victims as you treat their injuries, supportively listen to their stories, and educate them on the options available to them. This is how you can collectively build that bridge out of their isolation.

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