

Domestic Violence: Diagnosis, Treatment and Documentation

2.0 Contact Hours

Presented by:

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DOMESTIC VIOLENCE: Diagnosis, Treatment and Documentation

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Objectives

Upon completion of this course the student will be able to:

- I. Identify risk factors for domestic violence.
- II. Recognize the clinical presentations of victims of domestic violence
- III. Assist in the diagnosis and screening process of all patients in any health care setting.
- IV. Understand how documentation can be used for the patient and how to better document abuse.

Introduction

Domestic violence can be difficult to define. A very broad definition is any intentional controlling or violent behavior inflicted on the victim by a person with whom he/she is or was in an intimate relationship. Controlling behaviors can take on many forms including: physical abuse, sexual assault, emotional abuse, economic control, and social isolation. Domestic violence usually follows a pattern. Abusive behavior is episodic and begins with verbal and/or emotional abuse and progresses to physical abuse. The abuser's outbursts are unpredictable, there is usually very little warning that an episode is going to occur, and the victim often lives in fear of the abuser and tries to

“behave” to prevent the outburst from occurring. For various reasons, victims often try to hide the abuse and the signs and symptoms can be very subtle or even absent in the case of verbal and/or emotional abuse which has few concrete, objective signs/symptoms.

Incidence rates for domestic violence and abusive behavior can be difficult to obtain. However, in the early 1990s one study found that about 1 million women and 150,000 men are victims of abuse annually. Likewise, in the mid-1980s 16% of couples reported physical violence within the last year. Abusers do not like victims to seek routine medical care; as a result, many of these patients are identified within Emergency Departments (EDs). A study done in a Colorado ED found that 9% of the females they treated were currently in an abusive relationship and 54% of the females they treated had previously been in an abusive relationship. Similar studies done in the primary care office found that 5% of patients are currently in abusive relationships and 20% have a history of being in an abusive relationship.

In general, women are more often the victims of domestic violence. Pregnant women are often more likely to experience domestic violence, as domestic violence has been shown to begin or escalate during pregnancy and the postpartum period. The vast majority (95%) of the reported case of domestic violence resulted in a criminal investigation. And the rates of domestic violence among homosexual couples equal the rates of domestic violence among heterosexual couples.

Clinical Presentation

Domestic violence affects everyone, its incidence crosses age, socioeconomic, and ethnic barriers. However, there are factors that increase a patient’s risk for

experiencing domestic violence. Risk factors include: over the age of 35, single/divorced/separated, substance abuse, smoking, pregnancy, low socioeconomic status, and recent obtainment of a restraining order.

On the other hand, there is no profile of a “typical abuser”. The abuser will often maintain a public persona that demonstrates behavior far different from their actions within the household. For example, the abuser may be a successful, level-headed, business person by day and restrict violent physical and verbal outburst for home. Abusers often try to deny or minimize their actions. They may apologize profusely for their actions after the episode and/or blame the victim for the outburst.

The relationship between the abuser and victim usually starts out normally and progresses into a typical pattern of abuse. The abuse pattern is episodic, recurrent, chronic, and escalating from emotional abuse to physical abuse. On average, women reported about 6 episodes per year.

Clues to the Presence of Domestic Violence

While victims often do a good job of explaining how they obtained their injuries, the explanation may be inconsistent. If the victim provides a different description of the injury to the RN than the MD or, if the mechanism of injury is inconsistent with the type of injury sustained, then the RN may want to begin to look for other explanations. Delays in seeking treatment are also common in this population. Often the abuser will not allow the victim to leave the house or does not want the victim to seek treatment for fear that he/she will report the abuse. Delays in seeking treatment can be related to a multitude of factors including: the abuser often minimizes his/her actions and does not

think the victim is actually hurt, social isolation of the victim, and/or desire to reconcile with the victim before he/she seeks treatment.

Women who are chronically abused are likely to present to their MD or the ED (more likely) with somatic complaints. Examples of such complaints include: generalized pain (chronic), abdominal pain, headache, GI issues (nausea/vomiting/diarrhea), and/or fatigue. These complaints are usually vague and difficult to prove or disprove.

Diagnoses of diseases of the GU system that are common in victims of domestic violence include: premenstrual disease, sexually transmitted diseases (including HIV), chronic pelvic pain, and unintended pregnancy. Seeking late prenatal care is also common among this population. Other complaints common in chronically abused women include: substance abuse, anxiety, depression, and eating disorders. These diseases are likely the result of years of continued emotional and verbal abuse that have progressed to the point of diminishing the victim's self esteem. Substance abuse is often the victim's way to cope with his/her life. Anxiety and depression result from the chronic abuse in addition to social isolation. The woman no longer has an identity separate from that of the abuser and often becomes anxious for the recurrence of abusive episodes and depressed or hopeless about the future. Eating disorders often occur as a mechanism of control. The victim may feel that food intake is the one thing he/she has not lost control of. Eating disorders may also be the result of the victim's feelings he/she is to blame for the abuse, in this case, the victim may become anorexic or bulimic in an attempt to fix perceived physical imperfections. This often accompanies a severely distorted body image that is the result of years of mental and emotional abuse.

Victims of domestic violence are also likely to have frequent ED visits and not have a primary doctor or access to follow up care. The abuser often sees ED care as fragmented, as in the patient will be seen by different members of the medical team on each visit. To the abuser, the fragmented care makes it less likely that the patient will form a personal relationship with her medical team, as would happen in the primary care setting. It is important to ask the patient if he/she has been seen in other area EDs recently (within the last year) and attempt to obtain medical records from the facility. Remember, when asking the patient for permission to obtain medical records, find a way to get the partner out of the area. Abusers are not likely to allow the transfer of records and/or the patient may not authorize the transfer if he/she feels pressured by the abuser not to do so.

Non-compliance is another common finding within this population. Victims may not keep follow up appointments, take prescribed medications, or have frequent spontaneous and/or planned abortions. In some cases, the victim is not allowed to leave the home or does not leave the home for fear of the abuser. In these cases, missed appointments are common. Not taking medications can be one of the abusers mechanisms of control. The abuser may hide the medications, dispose of the medications, or destroy the prescriptions. It is also possible that the abuser is taking the medication himself/herself. For example, substance abuse is very common among this population and the victim may run out of prescribed narcotics because the abuser is taking them and/or he/she is abusing them.

Common findings on nursing and medical assessment of these patients include: the demeanor of keeping a secret, avoiding eye contact, flat affect, dissociated from

environment, and fearful/evasive/hostile behavior. Physical injuries are often located on the central part of the body (breasts, abdomen, and pubic region). There may be bruising or abrasions on the head and neck if there was attempted strangulation. Bruising along the forearms is consistent with defensive injury and bruises of different ages are often seen when the patient has been abused repeatedly.

The behavior of the patient's partner can also provide clues for domestic violence. A partner who is overly solicitous, answers exam questions for the patient, or refuses to leave patient's side may be simply concerned or may be trying to control the victim and prevent him/her from disclosing the "wrong" information. If the medical team suspects domestic violence, they should find a way to isolate the victim from the partner before screening the patient. Even if the victim can only be isolated for a matter of minutes, screening the victim alone can allow him/her to provide a truthful answer and allow for a more accurate and complete treatment of the patient's medical and social needs.

Diagnosis and Screening

Studies have found that it is effective and appropriate to screen all patients using routine questions. Women are more likely to tell the truth when asked specifically about domestic violence. For example, it is better to ask "In the last year have you been hit, kicked, slapped, punched, shoved, or otherwise hurt by someone?" than "How is your relationship with your intimate partner?". Studies also found that more truthful responses were generated when the patient is asked verbally by a member of the medical team than when given a written questionnaire.

When interviewing the patient, the environment is important. Ensure that the patient feels safe and comfortable and is alone during questioning. If possible, have the patient interviewed by same-sex staff members. Perhaps the most important thing is to ensure confidentiality, making absolutely sure that the patient's abuser is not within hearing distance. Also, reassure the patient that he/she is not in trouble and the answers will be kept between the patient and the medical providers. It is best to have a set of questions that are asked to everyone, and introduce them using a general introduction. For example, "Before we begin, I would like to ask you a few questions about your relationship with your intimate partner. These are questions that we ask all patients but we encourage you to be honest and I guarantee that your answers will stay between you and me."

Despite physical evidence and high suspicion, the patient may continue to deny the abuse. Denial often happens when the patient: is not ready to handle the situation, blames himself/herself, feels like a failure for falling victim to domestic violence, feels ashamed, fears rejection or judgment from others, thinks the abuse has ended, fears punishment from the abuser, and/or feel hopeless as though he/she has no alternative but to continue his/her relationship with the abuser. If the patient denies abuse and you strongly suspect it, try asking the questions again after reassuring the patient. If the patient continues to deny abuse, continue to ask the patients the screening questions during subsequent visits.

Treatment

Treating domestic violence should be a team approach involving all members of the medical team as well as social work and any other designated community resources. The medical team is responsible for: diagnosis, providing the necessary medical care, providing emotional support and educating the patient about available resources. Follow up care should be centered on the further provision of support, counseling, and patient education. Assessing the patient's safety could be one of the most important responsibilities of all of the members of the health care team. Ask the patient about their current living and relationship situation, if he/she has any direct or immediate fears, and their perception of their immediate and future safety. It is also important to directly ask about the escalation of abuse. Remember: women tend to minimize their perceptions of danger; get detailed and direct answers whenever possible.

Recommendations for Health Care Providers

Health care providers should be alert to the presence of domestic violence, even if the patient does not seem like the "typical" victim or abuser, screen the patient and pay attention to any clues you find that may suggest domestic violence. If the patient is seen frequently for vague complaints and no objective source can be found consider domestic violence as a cause for illness or injury. In this case, it would be appropriate to do a more thorough screening of the patient, paying specific attention to gaining the patient's trust and providing reassurance. During screening, remember to ask the patient about emotional abuse as well as physical. Early diagnosis of the problem provides a chance for early intervention. The earlier the intervention the better; hopefully intervention will

allow the victim to break away from the abuser before the abuse escalates or does any permanent physical/mental/emotional damage to the patient. Once the presence of domestic violence has been discovered, and the patient's medical needs are met, recommend that the patient seek counseling and suggest area resources in place to help the patient recover.

When referring the patient for follow up care make full use of community resources. Be aware of: which community resources are publically/privately funded, the patient's insurance status, and the patient's access to such resources. Be careful when providing the patient with any written material, this material can be intercepted by the abuser. If the institution has a social worker, utilize him/her. The social worker can better instruct the patient on what to do in a crisis and arrange follow up care. Ensuring discharge planning is a team effort and is critical to the patient's future.

Documentation

Medical documentation of the incident can be crucial if the patient decides to seek legal action. For this reason, documentation should be specific, detailed, legible, and descriptive. Medical documentation can be used by the victim in legal proceedings such as: obtaining a restraining order, supporting allegations of abuse, qualification of exemption or special status for governmental aid, and landlord-tenant disputes. Currently, police reports are the most commonly used documentation in court but because of the variability in documentation styles, medical records can affirm and expand on police data. Medical records are considered unbiased, factual data that was recorded during a period shortly after the abuse occurred making it reliable and valuable.

When documenting health care providers should:

- Take photographs of injuries.
- Ensure legibility of any written documentation.
- Clearly identify any statements made by the patient using quotation marks and/or designating phrases such as “patient states/reports”.
- Not use phrases that imply the provider doubts what the patient is saying such as “patient claims/alleges”. If the health care provider’s observations of injuries differ from the patient’s description of how they were obtained, the provider should clearly document the reason for doubt.
- Use medical terms, not criminal/legal terms.
- Describe the person who hurt the patient using the patient’s own words.
- Use as much detail as possible and avoid summarizing the patient’s statements/complaints.
- Describe the patient’s emotional state and overall affect.
- Clearly document time periods. (Ex. Time that the abuse occurred, time the patient sought treatment, time the patient was seen/examined)

Mandatory reporting is determined on a state-by-state basis. It is mandatory to report any abuse inflicted upon a child, elderly person, and/or the disabled. However, in most states it is not mandatory to report abuse against a competent adult. At all times remember that the patient knows the abuser and what he/she is capable of better than the providers do. While the victim may downplay the harm he/she is in, he/she is often well aware of what the abuser would attempt if he/she tried to escape from the relationship or reported the abuse to the authorities. Encourage the patient to seek legal action or leave

the relationship, but remember that continuous guidance, reassurance, and support are what the patient needs.

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