“OPENING PANDORA’S BOX”
FAMILY VIOLENCE - A PHYSICIAN’S GUIDE TO IDENTIFY AND TREAT VICTIMS OF DOMESTIC VIOLENCE AND ELDER ABUSE

Sponsored by:
Division of Continuing Medical Education
University of Miami School of Medicine

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**General Information**

This self-instructional activity is specifically designed for primary care physicians, internists, emergency medicine physicians, medical students, residents, interns, and other physicians and allied health care professionals who are involved in patient management. It should also be of use to psychologists, nurses, social workers, marriage & family counselors, teachers, police enforcement officers, and others who are in the position to recognize and provide assistance to victims of domestic violence.

This self-instructional course consists of a 45-page handbook with an up-to-date review of the recognition and appropriate intervention to assist victims of domestic violence. The monograph also includes key references as well as a post test that may be completed by participants wishing to receive CME credit for this study.

This course fulfills the Domestic Violence CME requirement for Florida licensed physicians.

**Learning Objectives**

Upon completion of this self-study physicians should be able to:

♦ Understand the incidence and prevalence of domestic violence

♦ Understand the cycle of violence and psychological dynamics of abuse and post-traumatic stress disorders

♦ Identify and assess victims of abuse – battered partners and the elderly

♦ Learn specific intervention techniques for working with abuse victims Identify community resources and learn innovative support methods to meet the needs of victims of family violence

♦ Understand the interaction between legal systems and health care professionals in working with family violence.

*This publication is designed to provide general information prepared by professionals in regard to the subject matter therein. It is provided with the understanding that it should be not utilized as a substitute for professional services in specific situations. If legal, medical, or other expert assistance is required, the reader should seek services of a professional.*

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**Accreditation:**
The University of Miami School of Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

This activity was planned and produced in accordance to ACCME Essentials.

Date of original release: August 1, 1995
Date of latest review & update: March 31, 2006.

**Credit Hours:**

*Physicians:* The University of Miami School of Medicine designates this continuing medical education activity for a maximum of two (2) credits in category 1 towards the Physicians’ Recognition Award of the American Medical Association.

This credit is available for the period of March 31, 2003 thru March 31, 2009, upon successful completion of the post-test.

This program is eligible for one (2) credit hours in Category 2-A by the American Osteopathic Association.

*Nurse Midwifery:* Category 1 hours are accepted by the American College of Nurse Midwives for continuing education credit.

*Psychologists:* The Division of Psychology, Department of Psychiatry and Behavioral Sciences, University of Miami/Jackson Memorial Medical Center, is an APA approved internship program. This self-instructional activity is approved for two (2) credit hours for Florida Psychologists thru March 31, 2005 upon successful completion of the post-test.

*Nurses:* Credit for Nurses has been applied for. Please contact the Division of Continuing Medical Education for information.

*Social Workers, Marriage & Family Therapists, and Mental Health Counselors:* The Jackson Memorial Hospital Department of Psychiatry Social Work is an approved provider for CEUs for Florida Mental Health Counselors, Marriage and Family Therapists, and Clinical Social Workers (Provider # BAP576, expiring on 03-31-05) This self-instructional program is approved for two (2) CEUs thru March 31, 2005, upon successful completion of the post-test.
Applying for Continuing Medical Education (CME) Credit:

Upon completion of this self-instructional activity, the participant has the option of taking the post-test to qualify for continuing medical education credits.

To apply for CME credits, circle the appropriate response(s) on the answer sheet on page 45, and complete the activity evaluation form on page 44; and send along with your payment in the amount of $50 payable to: UM Division of CME

Division of Continuing Medical Education
University of Miami School of Medicine
PO Box 016960 (D23-3)
Miami, FL 33101-6960

Participants must obtain a score of 70% or more in order to qualify for continuing medical education credit.

The Division of Continuing Medical Education will issue a certificate of participation upon successful completion of the post-test.

For additional information contact:
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While supplies last, an optional video case study is available from The Division of CME at the cost for handling and shipping only ($9.99)
To obtain your copy contact the Division of CME.
I. INTRODUCTION

Domestic violence is common. It impacts not only the victim, but also children in the home, other family members and even the abuser. Although the health effects are wide reaching, the medical community only recently began to recognize domestic violence as a significant “pandemic”. After years in the dark, family violence is now seen as a public health problem. National health care organizations (AMA, ANA, APA, ACP, ACOG, AAP) and the Institute of Medicine have recommended policies supporting routine screening and interventions and comprehensive education and research.1 The Joint Commission on the Accreditation of Health Organizations requires accredited facilities to have policies in place to identify domestic violence and respond.

Every physician has a role to play in stopping the violence.2-4 A physician may be the first and only person abuse victims reach out to for help. Opening a discussion with a patient may be like “opening a Pandora’s box”, you don’t know what you’ll find—but it is certain that if physicians don’t diagnose abuse, it will continue and escalate. Failing to diagnose may further the victim’s sense of entrapment and contribute to their victimization.

The most important skills physicians have are to recognize and acknowledge that abuse exists. What physicians can do for patients is offer effective, timely interventions that can help to heal not only their patients’ wounds but keep them from becoming another statistic. Physicians should learn about local hotlines, emergency shelters, support groups, and network with other community support services. In partnership with other community leaders, physicians can mount a clear response to a serious and destructive health problem within their community.

In this learning program, we will review the magnitude of the problem and its impact on health care. We will learn to identify victims of abuse, clues and signs of family violence, interviewing techniques conducive to eliciting a history of abuse, knowledge of reporting laws and documentation requirements and an understanding of community support services. After your study of this program, you may complete the post-test found at the back of the monograph and follow the instructions to obtain CME credit.

II. DEFINING THE PROBLEM - THE DEMOGRAPHICS OF FAMILY VIOLENCE

Family violence, spouse abuse and battering all refer to the victimization of a person with whom the abuser has had intimate/romantic relationships. Domestic violence may take the form of physical, sexual and psychological abuse, is generally repeated, and often escalates within relationships. It is estimated that 25% of violence is among people who are related.
The health consequences of violence are significant. (Table 1). They range from severe injuries to chronic health problems, lower preventative health behaviors, aggravation of other medical conditions due to non-compliance and significant mental health disorders. Women in the U.S. are more likely to be victimized through assault, battery, rape or homicide, by a current or former partner than by all other assailants combined. Battering is the single most common source of injuries to women, far surpassing that of car accidents and muggings combined. Just over one half of all women murdered in the U.S. are killed by male partners, and 12% of murdered men are killed by female partners. It is estimated that up to 35% of women who visit emergency rooms are there for symptoms secondary to abuse. Studies reveal 15-25% of pregnant women and 64% of hospitalized psychiatric patients have histories of being abused. Most research focuses on women battered by male partners. However partner abuse reflects awareness men can also be abused in intimate relationships. It is unknown to what extent the findings about battered women can be applied to men who are abused by women or to the often unacknowledged problem of violence within gay and lesbian relationship. A 1987 study estimated domestic violence annually caused 21,000 hospitalizations, 99,800 hospitalization days, 28,700 E.R. and 39,900 physician visits. Family violence costs the nation billions of dollars. Victims of domestic violence cost one health plan $1775 more per year than non victims. Researchers can only guess at precisely how many dollars are drained from the economy and from other health care needs. Since

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<td>IMPACT OF DOMESTIC VIOLENCE</td>
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- One woman is battered every 12 seconds.
- Approximately sick children are reported abused and neglected in the U.S. every minute.
- A woman is murdered by her husband or boyfriend every six hours.
- 20% of adult women, 15% college age, 12% of adolescent girls have experienced sexual abuse / assault during their lifetime.
- 2,000 to 4,000 women die every year from abuse.
- Domestic violence is the single most common cause of injury to woman in the U.S.
- In 60,000 incidents of on-the-job violence every year victims know their attackers intimately.
- 25%-66% of battered women report abuse during pregnancy.

Families with domestic violence compared to the general population:
- use doctors offices 8 times more often;
- visit emergency rooms 6 times more often;
- use six times more prescription drugs.

240,000 pregnant women are abused annually and 10.7% of abused women deliver low birth weight babies, at an average cost of $50,399 (compared to average cost for term deliveries of $3,355), it has been estimated that there is the potential to save $46,945 per patient (over $1 billion nationally) by identifying victims at higher risk and promoting early interventions.\textsuperscript{11}

The National Institute of Justice estimates that domestic violence accounts for almost 15\% of total crime costs-$67 billion per year. Employers pay a large share of these costs, primarily through higher health insurance bills.\textsuperscript{12} The toll is even higher when other factors are added in, such as decreased productivity at the workplace.\textsuperscript{13} After years in the dark or in the domain of criminal justice, family violence is now seen as a public health problem and every physician has a responsibility in stopping the violence.\textsuperscript{14}

III. DIAGNOSING THE PROBLEM - IDENTIFYING SIGNS AND SYMPTOMS OF ABUSE

Health care providers should realize that they are a major point of contact with victims of family violence.\textsuperscript{15-17} A physician may be the first and only person they reach out to for help. There is often a long history of emotional/sexual abuse before an injury is actually seen.\textsuperscript{18,19} Even low severity violence (pushing, shoving, grabbing) is shown to be associated with physical and psychological health problems in women.\textsuperscript{20} The number of physical symptoms and psychological distress increases with the severity of violence. Women in current abusive relationships are more likely to have a history of substance abuse and to have a substance-abusing partner. Despite significant health implications of domestic violence, health providers often fail to identify and manage domestic violence when signs and symptoms are present. Primary care complaints include chronic headaches, chest and abdominal pains, muscle aches, pelvic pain and recurrent vaginal infections, sleep and eating disorders. Mental health providers see battered women for suicide, anxiety and depression. A variety of other providers also see the psychological sequelae of domestic violence. Evidence indicates that a history of abuse is related to later development of chronic pain syndromes, gastrointestinal problems, eating disorders (anorexia/bulimia, obesity) and illicit substance abuse.\textsuperscript{21} A study of patients at gastroenterology clinics showed that a significantly greater percentage of women with functional diagnoses compared to women with organic diagnoses reported a history of sexual or frequent physical abuse.\textsuperscript{22} Abuse may also expose women to serious illnesses. Some studies reveal a percentage of HIV positive and women with AIDS may have contracted the virus from coerced sexual activity in the context of a battering relationship.\textsuperscript{23} Research also suggests an association with delayed physical effects, particularly visual and hearing defects, arthritis, hypertension, and heart disease.\textsuperscript{24} Additionally, battered women have a decreased sense of their physical and mental well-being and a higher incidence of injurious health behaviors (smoking, drug and/or alcohol abuse and poor dietary habits).\textsuperscript{25} They also have an increased utilization
of medical resources. Abuse may exacerbate chronic medical illnesses such as diabetes, cardiac and lung disease, because batterers deliberate interfere with the victim’s ability to take medications or clinic appointments. Repeated failure to comply with treatments may thus be an indicator of abuse. Unless providers recognize and acknowledge abuse, these complaints will be unrecognized as the results of violence.

Physicians often perpetuate victim’s isolation by giving symptomatic treatments (anxiolytics, sleeping pills), making inappropriate referrals or labeling victims as “neurotics”. One study found 20% of battered women presenting to physicians had sought medical attention for injuries from abuse 11 times previously. Another study found that physicians’ discharge diagnoses correctly indicated spouse abuse in only 8% of the cases in which explicit information about abuse were recorded in the medical chart. The victim may use a medical visit as a way of seeking help without knowledge of the batterer.

Severe injuries appear late, only 4% result in hospitalization. If health care providers only screen for domestic violence by severe injury, they will miss 96% of the cases. Instead, they should be looking for all the clues and treat them as sentinel markers of a very serious health problem.

A. IDENTIFYING DOMESTIC VIOLENCE IN CLINICAL SETTINGS

1. INJURIES
What most physicians identify as domestic violence are the physical injuries which range from bruises, cuts, black eyes, concussions, broken bones, and miscarriages to permanent injuries such as damage to joints, partial loss of hearing or vision, and scars from burns, bites or knife wounds. One project estimated that 21% of all women using emergency surgical services were there for sequelae of domestic violence; one half of all injuries presented by women occurred in the context of partner abuse.

Another study in the emergency room revealed that only 13% of women who had experienced acute domestic violence had been asked about abuse by emergency room staff. Despite the relationship, in most cases, the victimization history underlying these injuries was never identified. Certain clues should alert clinicians to the diagnosis of physical abuse. Typical pattern for contusions and lacerations is central to the head, face, neck, breast or abdomen in contrast to the peripheral body pattern from accidental injuries. Abused women are also more likely to have multiple injuries in combination with evidence of old injuries as compared to accident victims. The adult trauma history should be taken and all acute injuries including cutaneous manifestations of violence should be documented in the record. The color of bruises can indicate the timing of trauma. (Figure 1 - see page 24).
2. SYMPTOMS OF ABUSE
In addition to physical injuries, battered women may present histories that are confusing or include anxious and evasive behavior and inadequate explanations for injuries.23 The victim may come in frequently without clear reasons.21 Additionally, the victim may present with varied somatic complaints or stress-related symptoms. (Table 2). One third to 55% of abused women have suicidal thoughts and 17%-19% attempt it. Like rape victims, long-term reactions in abused women include fear, anxiety, fatigue and intense startle reactions. Because of the general nature of these symptoms, physicians and other health care providers rarely probe for the underlying causes of these symptoms except by running a series of laboratory and radiographic tests. Physicians don’t recognize or correctly interpret the behaviors associated with abuse. When tests are negative and symptoms don’t appear to have an organic basis, patients are judged as “hypochondriacs” or “crots”. Misdiagnosis and inappropriate referrals and treatment plans can have grave consequences for abused women. Failing to acknowledge abuse fortifies the patient’s victimization and isolates her even further. Treatments with tranquilizers or narcotics may increase her physical danger by blunting protective responses and increase the risk of substance abuse. Victim’s visits to physicians have been estimated to increase by 18% the year post physical assault, 56% the following year and 31% the year after. Patients may not recognize the source of their pain; it is the physician’s role to make a correct diagnosis. Once medicine becomes a system that refuses or can’t help her, the woman’s injury, isolation and illness continues. The cycle of abuse also continues and will escalate with tragic consequences.

3. DOCUMENTATION
The preservation of precise historical and physical exam data in the medical record is important concrete evidence of abuse. (Figure 1 - see page 24). This may be the only evidence that remains of an abusive episode after physical injuries heal and may prove crucial to the outcome of any legal case.

Documenting the abuse and reporting, when applicable, to the appropriate authorities is a primary responsibility physicians have. Confidentiality of the medical record and liability of the chart’s content is a particular fear physician’s have. Physicians should acknowledge their responsibility by recording precise symptoms and signs of abuse. The record should contain a patient’s “direct quote”, describe in detail physical findings and give a medical opinion such as “suspected” or “probable” abuse or injuries “suggestive of battering”. Let the patient know her medical record is confidential but that she can use it as evidence in court proceedings.2 Photographs can be particularly valuable as evidence. The patient’s consent is required.4 It is recommended that the photographs size the injury (using ruler or coin), precisely identify the patient (face, name) and are dated.2,6,33,35

The discharge plan should include safety assessment and plan and information (verbal or written) given to the victim on options for shelter, legal assistance, and counseling. The record should include
appropriate follow-up care (or referral) for her medical, psychological, and advocacy needs. Take precautions regarding what’s written on discharge instructions given to the patient, insurance reports, and billing forms, since these may be seen by the batterer and put the patient in danger. A mother’s disclosures (about abuse to herself) during a pediatric visit should not be recorded in the child’s chart since the abuser may have access to that record. 27

4. PREGNANCY-RELATED ABUSE
Pregnant women are not immune from abuse; in fact violence intensifies during pregnancy. Up to 37% of pregnant women surveyed have been victims of abuse. 36 Pregnant women’s risk of abusive violence is 60% greater than non-pregnant women, posing a significant threat to the health of the woman and her developing fetus. 36 The 1985 National Family Violence Survey found that 154 out of every 1000
pregnant women were assaulted by their mates during the first 4 months of pregnancy and that 170 out of every 1000 were assaulted during the fifth through ninth months. Battering during pregnancy jeopardizes the pregnancy significantly. Abused women are more likely to delay prenatal care to the third trimester. They have higher rates of miscarriage, still births, premature labor, low birth weight babies, and injuries to the fetus, including fractures. This high incidence and severe consequences of abuse during pregnancy compels particular vigilance on the part of providers of prenatal care to identify and reduce the risk of violence. All pregnant women should undergo screening for domestic violence.

IV. PHYSICIAN-PATIENT CLINICAL ENCOUNTER

A. SCREENING QUESTIONS

The hallmark of domestic violence is recurrence. When physicians don’t diagnose abuse and the patient is sent back into an abusive relationship, abuse is most likely to continue and will worsen. If physicians look only for black eyes and broken bones, they are missing many victims. There will be many victims whose lives may be in imminent danger but who don’t have a mark on them.

One of the biggest problems in identifying victims is that doctors just don’t ask any questions. The 31% lifetime prevalence of domestic violence is greater than that of breast or cervical cancers that are routinely screened for in clinical practice. Still, physician screening rates are generally quite low despite clinical guidelines and recommendations regarding screening that have been promulgated by health care organizations, and professional societies. Even after they have received training about domestic violence, the vast majority still felt uncomfortable with their skills in assessing and treating patients, feared offending patients, or forgot. It is critical for health care personnel to routinely assess female patients for abuse. The problem is so prevalent and the consequences so severe doctors should ask every woman about abuse and violence in her life.

It should be asked as part of the social history or review of systems and the evaluation of the chief complaint. Routinely this should be done in private. To assure the privacy of the screening, the patient’s partner, family member or friends should be asked to wait in the waiting area while this portion of the visit is accomplished. It may be at this portion of the encounter that the controlling behavior of the batterer may be unmasked. They may show extreme unwillingness to let the partner speak to anyone alone. Practitioners must be insistent and under no circumstances should a woman be questioned in front of her partner.

Studies have shown that simple, direct questions, delivered with concern in a safe and confidential encounter are a good beginning. The screening questions should be directed at determining the severity
of the abuse, degree of social isolation, and assessment of patient’s safety and emergency plan.\textsuperscript{43-45} (Table 3).

<table>
<thead>
<tr>
<th>TABLE 3</th>
<th>WHAT PHYSICIANS CAN SAY: SCREENING QUESTIONS</th>
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<tbody>
<tr>
<td><strong>IDENTIFYING ABUSE</strong></td>
<td>Have you ever experienced a relationship in which you were hit, punched, kicked threatened or hurt in any way? Are you in such a relationship now?</td>
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<td></td>
<td>Within the last year, has anyone forced you to have sexual activities?</td>
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<td></td>
<td>What happens when there are fights and disagreements at your home?</td>
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<tr>
<td></td>
<td>Have you ever been hurt or afraid when there are fights at home?</td>
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<tr>
<td></td>
<td>Have you or your children been physically hurt or threatened by your partner?</td>
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<tr>
<td></td>
<td>Are there problems involving anyone close to you?</td>
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<tr>
<td></td>
<td>Sometimes when women feel the way you do it’s because they’re being hurt in some way.</td>
</tr>
<tr>
<td></td>
<td>You are obviously very upset ..... is something troubling you? Are you worried or frightened about going home today?</td>
</tr>
<tr>
<td><strong>EXAMINING AN INJURY</strong></td>
<td>I noticed you have a number of bruises, tell me how they happened?</td>
</tr>
<tr>
<td></td>
<td>Did someone hit you?</td>
</tr>
<tr>
<td></td>
<td>I’m concerned someone hurt you like this... tell me how it happened?</td>
</tr>
<tr>
<td><strong>ACKNOWLEDGING ABUSE</strong></td>
<td>You are right to be upset. No one has the right to hurt you like this.</td>
</tr>
<tr>
<td></td>
<td>This behavior is wrong and illegal.</td>
</tr>
<tr>
<td></td>
<td>What has happened to you is illegal, and you have a right to report it to law enforcement officials.</td>
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<tr>
<td></td>
<td>I can help you with that.</td>
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<tr>
<td></td>
<td>We are becoming aware that more women in this community find that violence is a problem in their relationships. It is a problem but you are not alone.</td>
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Asking questions in an empathetic and non-judgmental way won’t damage the doctor-patient relationship or offend patients and their families.\textsuperscript{3-46} Surveys of patients indicate 80% feel it is appropriate for physicians to ask about family violence.\textsuperscript{47} Our own study revealed that, although 68% of women could tell their doctors that they were abuse victims, only 12% had been asked about the abuse during the clinical encounter.\textsuperscript{45} The majority of the respondents in the study believed that doctors should routinely screen for abuse. Women are not frightened or offended by such discussions. Physicians routinely inquire about the most private details of a patient’s life and the process of physical examination is highly intimate. It is the patient’s trust in their physician that allows this relationship to occur. It is an
important responsibility that physicians have to individual patients and to society to prevent family violence. Even if the patient doesn’t respond at the initial encounter the door will have been opened for her to seek help when she’s ready. If she answers yes to the initial screen then a positive diagnosis is made and the treatment plan can begin.

B. ACKNOWLEDGING THE ABUSE AND VALIDATING THE VICTIM’S EXPERIENCE

Once questions have been asked and the diagnoses of abuse is made, the next step for health professionals is to demonstrate concern and deflect blame from the victim. Acknowledgment of abuse validates the patient’s sense that violence is a threat to her physical and mental health. This validation begins to break the isolation that accompanies ongoing violence. This message from a health care professional, an accepted authority figure, is the first step in therapeutic interventions to empower the victim. All physicians can acknowledge and validate the experience of victimization and the fact that observed symptomatology are sequelae of abuse. This is a very important step in the treatment process since many battered women have low self-esteem and enormous guilt. They believe they have done something wrong, accepting prime responsibility for creating the violence. Victims come to accept violence as normal behavior in their environment, which further isolates them from social support systems. Don’t make minimizing statements and say, “nothing is wrong with you”. These reinforce an “authority figures” message that she is the “sick” one furthering her sense of entrapment and contributing to her health risks. The message from physicians that “violence is not OK” and abuse is not her fault empowers the patient to begin to break her isolation which relates with injury. Patience and reassurances from the physician can be very important to individuals in abusive relationships.

C. BARRIERS TO PHYSICIANS’ RECOGNITION OF FAMILY VIOLENCE

There are several barriers to detecting and treating family violence. Health care providers share a number of pervasive societal misconceptions about domestic violence: violence doesn’t occur in relationships that appear normal; battered women are responsible for their own abuse; and domestic violence is a private matter that should be resolved without outside intervention.

First, abuse does occur in seemingly normal families and abusers often appear indistinguishable from other people and often do not behave violently in other circumstances. They may accompany the patient and appear highly concerned for her injuries and health. Domestic violence cuts across racial and class categories. There is only a 3% difference between the incidence of abuse of lower income women and middle-income women. When patients and physicians share similar backgrounds, physicians are more likely to deny their patients could be victims of abuse. Physicians may themselves feel vulnerable to family violence. In one study, 14 of men physicians and 31% of women physicians
acknowledged their own abuse.\textsuperscript{57}

It is particularly frustrating for health care providers to understand why women allow themselves to become victims. Women are often held responsible for their victimization. They may be blamed for provoking the abuse, enjoying the abuse and not leaving the relationship.\textsuperscript{2, 34} Blaming the victim may enter into the medical response. Perceiving battered women as non-compliant or problematic may cause physicians to discontinue their care or to fail to intervene in future episodes of abuse. It is important for physicians to understand the dynamics of abuse and the difficulties and dangers victims face in trying to leave in order to be able to assist their patients effectively. The most dangerous period (highest murder rates) for victims is the window of time when they first leave the batterer. The process of leaving an abusive spouse/partner is not easy and may be slow. Domestic violence is not a private matter to be resolved within the relationship. Battered women can’t simply “work-it-out”. A marriage counselor doesn’t prioritize the safety of the victim. Physicians need to intervene. Evidence suggests battered women expect their physicians to initiate discussions about abuse and they will respond to these inquiries.\textsuperscript{58} Even though a woman is not able to leave immediately, when she is ready, the information and assistance provided by the physician will be valuable and even life saving.

V. WHAT CAN PHYSICIANS DO? - TREATMENT PLANS

Physicians often don’t involve themselves with the problem of domestic violence because they believe that an excessive amount of time will be required to listen, to counsel, to make inquiries on behalf of the patient and to document in detail the interaction. Time requirements of depositions and possible court appearances appear as additional barriers. Finally, physicians experience personal fears for their own safety from possible reprisal by the batterer and with emotional pain in identifying with patient’s experiences of abuse or behaviors of an abuser. This may further inhibit physician action.

“Let’s be clear-violence is a public health problem.”\textsuperscript{3} The Council on Ethical and Judicial Affairs of the AMA have affirmed that physicians have ethical obligations to patients who are victims of abuse and a responsibility to intervene in cases of domestic violence.\textsuperscript{2} Treating only the injuries and symptoms of abuse will not address the ongoing violence which is at the root of its victim’s health problems. While physicians alone cannot prevent abuse from recurring, they can provide a number of important interventions. Physicians can become partners in an integrated community alliance involving the health, legal, and social service systems to treat the problem. Physicians have an obligation to familiarize themselves with: 1) protocols for diagnosing and treating family violence, 2) their state reporting requirements and protective services, 3) community resources for victims of abuse.\textsuperscript{59}
The most important contribution a physician can make to ending the abuse and lessen the chances their patient will become another statistic in the epidemic of violence is to identify and acknowledge abuse and make appropriate treatment referrals. (Table 4).

**TABLE 4**

<table>
<thead>
<tr>
<th>WHAT PHYSICIANS CAN DO TO STOP DOMESTIC VIOLENCE</th>
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<td><strong>SCREEN</strong></td>
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<tr>
<td>Make office a physical and emotional safe space.</td>
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<tr>
<td>Routine assessment questions to identify abuse victims.</td>
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<tr>
<td><strong>ACKNOWLEDGE</strong></td>
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<tr>
<td>Symptoms and sequelae of abuse.</td>
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<tr>
<td>Doctor and patient agree there is a problem.</td>
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<td><strong>VALIDATION</strong></td>
</tr>
<tr>
<td>Increase patients self-esteem and decrease guilt.</td>
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<tr>
<td><strong>EMPOWER</strong></td>
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<tr>
<td>Begin to break victims isolation and reduce injuries.</td>
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<tr>
<td>Give victim options and safety planning.</td>
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<tr>
<td><strong>REFERRAL REPORTING</strong></td>
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<td>to community support services when appropriate or required.</td>
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</table>

A. PLAN FOR THE OFFICE

The first step is to make your office a physically and emotionally safe space where privacy is maintained during intake and interviewing. 48 (Table 5) Displays of materials and resource brochures with emergency numbers in private examining rooms, bathrooms and reception areas indicate awareness and the importance you give family violence as a health problem. In addition to the visual messages, you and your staff should provide the verbal clues that it’s “OK” to talk about domestic violence with you. A written protocol on domestic violence will help in detection and management of family violence. Screening questions can accomplish much in a little time. Research indicates that 85% of women when asked open up and feel relieved.

B. MANAGEMENT STRATEGIES - UNDERSTANDING THE DYNAMICS OF ABUSE

Health care providers can experience feelings of helplessness and frustration when confronted with the seeming ambivalence and reluctance of the woman to take necessary actions to implement change. 60 To understand their patients, physicians must reframe their assessment and see these as “survival” behaviors rather than as destructive behavior. 61 To survive in battering relationships, victims often deny, minimize or “forget” details of control or violence. Understanding the dynamics of power and control in
an abusive relationship provides insight into why women don’t and can’t simply “leave the relationship”. (Figure 2 - Power and Control Wheel on page page 25) 62

Both the victim and batterer may be traditionalists in their views of their roles: the male leadership role in the nuclear family and the inferior role of the woman with an absolute duty of obedience. Since the wife is considered the “property” of the husband, he has a right and duty to discipline her. Often the batterer is in deep denial, blames others for his actions and exhibits little self-control. Frequently, batterers are also substance abusers and have witnessed or are victims of abuse themselves. Treatment programs for batterers focus on breaking down their self-denial and helping them recognize appropriate behaviors and their co-dependency in the relationship. Treatment programs for substance abuse may also be necessary for many batterers. Although substance abuse is associated with domestic violence, it is not the cause and batterers should receive specific treatments to stop the violence. There are currently no good psychological tests to evaluate the prognosis of batterers and the risk of subsequent violence.

Batterers use emotional, economic, in addition to physical abuse to diminish the victim’s self-esteem, maximize her dependency and powerlessness. The victim, emotionally and socially isolated, may not have economic (housing, job skills) and social support systems to make a change.

They may fear the consequences on their children if they leave. It is estimated that 53-70% of batterers who abuse their spouse also injures their children. Since mother is the normal protector, if violence is severe, even if only to the mother, it will predict increased risk to the child. They may fear greater physical danger and risk of retaliation if they disclose abuse or leave the relationship. Women who leave their batterers are at a 75% greater risk of being killed than if they stay, especially in the immediate period.

It is very important for physicians to listen to their patients and give them a voice in all discussions. When

<table>
<thead>
<tr>
<th>TABLE 5</th>
<th>MAKING YOUR OFFICE A SAFE SPACE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Materials on Domestic Violence</strong> - Pamphlets and posters in exam and waiting rooms can increase awareness and signal its “OK” to talk about domestic violence.</td>
</tr>
<tr>
<td>3</td>
<td><strong>Emergency Numbers</strong> - Place brochures and posters with emergency phone and hotline referrals in private examining rooms and bathrooms.</td>
</tr>
<tr>
<td>5</td>
<td><strong>Identify private area</strong> - For intake, interviews and where referrals can be made confidentially.</td>
</tr>
<tr>
<td>7</td>
<td><strong>Familiarize yourself and office staff</strong> - with updated Community Referral lists and domestic violence services.</td>
</tr>
<tr>
<td>9</td>
<td><strong>Develop an office protocol and response plan to assist patients</strong> - including resources available at your hospital emergency and social work departments.</td>
</tr>
</tbody>
</table>
a patient is subject to domestic violence, the need for patient trust in the physician is especially important since patients may feel embarrassed, ashamed or afraid to reveal that they’ve been battered. Abuse must be discussed with the patient in privacy and safety. Confidentiality is necessary so that patients feel free to make full disclosure of relevant information about their health. The treatment approach for victims of abuse focuses on expanding their social, legal and economic options and empowering them to make their own decisions.

A recent study uses the voices and commentary of domestic violence survivors to provide insights on what physicians can do for at-risk patients by first understanding what patients may need from their physicians. It divides patients into various stages:

1. The patient may not recognize the abuse. The role of the physician is to help a patient to recognize the abuse, by providing information universally, not just to those who disclose abuse;
2. The patient may not be ready/able to tell a physician about the abuse. Attention to privacy, displays of empathy, and a discussion of clinical suspicions with the patient may assist the patient to share their history;
3. The patient may be choosing to remain in the abusive relationship. Commitment to the relationship, belief of excuses, erosion of self-esteem, lack of options, degree of danger on leaving all play a role. Understand, don’t blame, don’t provide resources and referrals and remember the decision is ultimately the patients.
4. The patient may be presenting due to acute physical abuse. Provide treatments in a supportive manner and document carefully; the patient may have left the relationship, but not fully recovered. Like any significant illness it may take a long time to heal; don’t replicate the controlling, patronizing behavior of the abuser. 

**C. SAFETY ASSESSMENT**

The initial intervention with a battered woman is to jointly determine immediate danger and future risks. The elements of a safety assessment include:

1. **Injury** - The level of injury is not always predictive. How the injury is progressing may be more important: more frequent, more severe, weapons used, threatening to kill her or himself.

2. **Level of fear is escalating** - “You seem more frightened. That’s an important sign we have to pay attention to”. Ask the woman if she believes her life is in danger. Additionally, look for adaptive symptoms whose pattern is similar to post-traumatic stress disorder (PTSD): paralyzing terror; agitation and anxiety bordering on panic; numbing alternating with flooding of emotion; hypersensitivity to any sudden noise/event; hypervigilence; and nightmares with violent themes.
3. **Degree of Entrapment** - “How have you managed so far/What has worked when he gets angry and hurts you? /What is your next step?”

Help the patient identify her degree of entrapment by specifying elements of control that might prevent her from defending herself, escaping or using helping resources when she is threatened or hurt again.\(^6^6\) The patient may present with a hostage-like profile, with almost complete material and psychological dependence on the batterer. Like PTSD, this pattern is a normal adaptation to extraordinary stress. The patient will respond to supportive counseling and reestablishing safety for her and her children.

Making this safety assessment and plan with the patient takes very little time. Taking her assessment as the basis for evaluating the situation helps her realize she is not responsible for the violence and her emotional needs cannot be met by maintaining contact with someone who hurts her. Parallel assessments for woman battering and child abuse are essential. Children suffer physical and psychological damage as either witnesses or co-victims in violent homes. The risk to the child is best determined by considering the absolute level of violence and coercion in the relationship. The objective of the assessment is to develop a safety and support plan:

- need to tell someone
- give an emergency number
- access to transportation, money, extra keys
- plans for the kids

This plan builds on strategies she is already using to prevent, minimize or avoid violence. The physician should reinforce her autonomy whether she decides to stay or leave the relationship. If she can say, “I can’t leave now but I need to make other plans”, that breaks her isolation and opens up the door for treatment. If any one of the three elements (injury, fear, entrapment) is high, the risk of life-threatening dangers is extremely high and crisis intervention may be required. Threats of homicide or suicide by the partner are indicators of escalating risk. Other studies which have reviewed abuse deaths have reported more factors associated with a higher risk of lethality: recent decomposition by the batterer (unemployment, estrangement, divorce); centrality of the victim to the perpetrator, a sense of ownership; prior history of domestic violence; and severity of the violence (sadistic acts, pet harm); and ownership by the batterer of a gun. \(^6^7\) The patient should be told of your perspective on her risk and her options should be explored in great detail.

Absence of these factors doesn’t guarantee safety. The patient’s fear of harm establishes the need for urgent interventions. If she feels safe, provide her information listing resources for victims, encourage her to consider legal protection and to participate in women’s support groups or to call Hotlines and speak with local advocates/counselors. If she feels she’s not safe, then it’s critical to initiate crisis intervention. Assist
her to call local domestic violence services and/or arrange urgent referral, if available, to your hospital’s crisis intervention services. The physician’s job is to recognize the problem, provide information about domestic violence support services and facilitate the referral with community resources. Let your patients know that you will follow-up. Domestic Violence problems are not solved at one visit. The patients’ safety and plans should be assessed at each visit.

VI. DOMESTIC VIOLENCE LAWS

A. REPORTING REQUIREMENTS

The CDC has reported that 25% of the population is involved in way or another with domestic violence, (adult and child abuse, sexual assault and elder abuse and neglect). In 1998, there were reports of 1.4 million cases of abuse in adults. In Florida, that year there were 124,000 domestic violence-related crimes (158 homicides, 1200 rapes, 93,000 assaults) Despite risk markers for lethality, which indicate prior violence and antisocial behavior on the part of the perpetrators, 30% of homicides had never battered before and had never been arrested. More significant is the fact that 40% of homicide victims had gone to a physician within the last year of their life.

In most states physicians have a legal obligation to report the treatment of a person suffering from a gunshot wound or other wound caused by a violent act. Since 1992 the Joint Commission on Accreditation of Health Organizations has required emergency department staff to be educated and to write protocols and procedures relative to domestic violence including, mechanisms for identifying, evaluating and referring battered adults and children to appropriate resources. In every state, laws require physicians to report cases of suspected child abuse to child protection authorities and/or law enforcement authorities. All states have reporting laws for elder abuse. Mandatory reporting laws generally exempt physicians from liability from false reports. Physicians should familiarize themselves with the legal reporting requirements and report accordingly. It may be good practice, depending on the community, to call a child or elder protection agency for advice on whether or not to report a particular case. Agencies may inform you when a case will not be acted upon, based on the facts in the report. Hospital-based multidisciplinary teams of persons highly experienced and knowledgeable about specific types of family violence have been found to be an effective resource for physicians.

Mandatory reporting of battered women is highly controversial. Only a handful of states have laws mandating the reporting of adult victims of domestic violence, and practitioners are required to follow statutory guidelines. Reasons for not mandating reporting include: 1. concerns for patient autonomy and confidentiality; and 2. may increase risk and danger.
Informed consent for all non-emergency medical interventions must be obtained from adult victims of abuse, like any other competent adult patients. It is important to encourage victims to consent to specific interventions and assure them of safety and confidentiality, when possible. No intervention should be forced on an unwilling patient. Respecting the patient’s choices is important therapy.

When physicians are required to report serious assaults or injuries inflicted by weapons, they should discuss their legal obligations with the patient, explain the reporting, investigation and follow-up procedures that may follow, and address directly the risk of reprisal and possible need for shelter. The physician should document the information conveyed, the materials given to the patient, and the patient’s decisions.

In states that have enacted mandatory reporting statutes, failure to report could give rise to physician liability. However, most reporting laws rarely give victims explicit rights to sue and courts must determine if the right is implicit in the state statute. Contrastingly, child abuse reporting statutes are enacted with the clear purpose of protecting abused children. There are specific penalties for not reporting and some states have allowed abused children to sue physicians who violate a reporting statute.

**B. LEGAL PROTECTIONS FOR VICTIMS**

In 1994, the first Violence Against Women Act was passed into law. This law dealt predominantly with criminal justice and social services. Since then, numerous additional pieces of legislation have expanded the scope of this law. For example in 2000, amendments to the law added cyber stalking as a Federal violation. Also recently, there have been efforts to establish new and innovative programs to help prevent domestic violence by educating health care providers to intervene earlier. Additionally, funding has gone to the National Institutes of Health for domestic violence research and the National Center for Injury Prevention and Control at the CDC to establish a family and intimate violence prevention program.

Every state has legislation to protect victims of domestic violence. Physicians are not expected to know in-depth the laws regarding domestic violence. However they should communicate the criminal nature of battering to the patient as well as the options that the law affords to restrain the batterer from further contact, initiate formal separation, have the batterer arrested, removed from the home or ordered into counseling. Legal remedies available to battered women vary from state to state and the laws are changing rapidly. Women’s Advocacy programs are excellent resources that can explain legal options and assist them to access the legal system. There are many common civil and criminal actions in domestic violence cases. (Table 7).
CIVIL ACTIONS

Protection Order, Injunction, Restraining Order

Court order that directs the batterer to stop abusing the victim.

In some states batterer may be ordered to:

- leave shared residence
- grant custody of children to victim
- make support payments
- pay medical bills

Violation of protective order in some jurisdictions is grounds for arrest of the abuser.

CRIMINAL ACTIONS

Prosecution for: assault, battery, aggravated assault/battery, harassment, intimidation, attempted murder.

C. TESTIMONY

A well-documented medical record will often reduce the time required for physicians to testify in court. Although medical evidence is not required in every case (divorce, custody), a physician may be called to testify on the medical record, to give an opinion on whether injury is consistent with the explanation or as an expert witness.

Admissibility of the medical record in court requires that the record be:

1) made at the time of the exam/interview, in the “regular course of business”;
2) in accordance with routine procedures; and
3) stored properly with access limited to professional staff.

D. COMMUNITY RESOURCES

Initially, community and government efforts to address domestic violence have fallen within the realms of the criminal justice and social service systems with little attention paid to the long-term effects of domestic violence and the role of the health care system in assisting victims. Regardless of the availability of legal remedies, a woman’s safety must be constantly addressed. A working relationship with law enforcement and criminal justice system will facilitate linking the patient with agencies that can provide legal advocacy. Domestic violence victims receive a greater value from interdisciplinary cooperation and problem solving. Since a common barrier to leaving an abuse situation is the victim’s fear that they are
not equipped to live both emotionally or financially without a partner, linking victims with community support systems becomes a strategic part of the treatment plan. Today, more emphasis is placed at the federal and state level by policy makers, health care providers and community advocates on the critical role of the health care system in the prevention of domestic violence.

Simply mandating reporting will not ensure the victim’s safety or facilitate access to appropriate resources. It is more important for physicians to put victims in contact with community services. An updated list of local domestic violence service agencies and other community resources should be maintained in every physician’s office. 27

For short-term crisis intervention, shelters meet the need for safe, emergency housing and usually offer counseling around violence, housing, nonviolent parent education, childcare, and advocacy with legal, social service and welfare systems. In addition to shelter and other emergency housing, legal services, and treatment for substance abuse, safety planning includes friends and family and women’s groups. Long-term strategies are geared at enhancing empowerment, which give the woman a sense of control. They include job training, continuing education, links to AA, NA or Alanon, counseling for children and working with child and adult Protective Services. Information on services can be obtained from National organizations on domestic violence and many local and state battered women’s programs. (Table 8).

These experts can assist patients and physicians on multiple levels:

1) Availability of support groups which provide opportunities to share survival strategies and trauma recovery for victims and their children;
2) Transitional living, including safe place for patients post discharge;
3) Financial planning, linkages with job training
4) Safety strategies for those who choose not to or cannot leave (free cell phone programs, emergency money) or those who do (assistance with restraining orders, moving out of the area, children’s school, or changing identity if the risk of death is high).

D. DEALING WITH BATTERERS

It is important to recognize that there is another “patient” in the context of domestic violence—the batterer. While the priority must remain for the victim’s health and safety, in some instances, a physician may be seeing both victim and perpetrator as patients in their practice. Additionally, it is important for physicians to readily identify batterers when they seek medical attention and intervene to break the cycle of violence. Although batterers are diverse and don’t fit any specific diagnostic category, they share some characteristics as they relate to their partners (Table 9)

Domestic violence can only continue in a silent vacuum. Physicians must penetrate this silence by
discussing abuse with their patients and listening to their responses. Experts have noted the psychological and behavioral aspects of batterers and counsel physicians to: 1) be direct and don’t force the issue; 2) focus on the abusive conduct and the impact it has on the batterer’s health as well as their partner’s and children; 3) discuss options and make appropriate referrals. Be careful not to blame. Creating a defensive response may result in retaliation against the victim. If the patient becomes angry or attempts to control the encounter, they are not ready for change. While it is difficult to predict when the abuse may reach a critical level of danger, certain patterns indicate higher risk. (Table 9).

Physicians must be aware that there is an ethical and legal duty to maintain when there is a clear and present danger to a specific victim or victims. Health care personnel should be familiar with local laws and any policies or procedures for the duty to warn in their respective practice settings. Specialized programs for perpetrators of domestic violence are available. A number of states have established standards and required certification for these programs. Most of these programs use group treatment and education, which refocuses the batterer on shared roles in relationships and responsibility for their own behavior. Many programs are combined in a legal component, which prosecutes them for criminal conduct and provides them opportunities to change behaviors. Although outcome data on the effectiveness of these programs is limited, the results are positive with rates of 66-70% of batterers remaining violence free on follow-up.

VII. CONCLUSIONS

Health Care professionals must demonstrate a firm commitment to ending family violence and helping its victims. Not all patients are alike. Victims of abuse are going to come to different places in the medical system - some to emergency rooms, some to specialists with specific complaints, others to primary care providers. Treatment will be different depending on where the patient is along the disease paradigm. Physicians and other health care professionals must always act as patient advocates. They must play an active role in advocating increased services for victims and to change the behavior of abusers. They must link with other professionals to coordinate the range of community services and provide opportunities not just for tertiary treatment but also for primary prevention of violence. Most importantly they must become leaders in their communities to change the culture of violence and educate they public on a policy of zero-tolerance.
### TABLE 8
DOMESTIC VIOLENCE RESOURCES AND SERVICES

<table>
<thead>
<tr>
<th>Resource Center</th>
<th>Location</th>
<th>Services Description</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>NATIONAL RESOURCE CENTER ON DOMESTIC VIOLENCE</td>
<td>- 1-800-537-2238</td>
<td>Provides comprehensive information/Directory of DV Programs. The NRC and the following Special Issue Resource centers work together as the Domestic Violence Resource Network:</td>
<td></td>
</tr>
<tr>
<td>Battered Women's Justice Project</td>
<td>Minneapolis, MN</td>
<td>Provides training, resources addressing criminal and civil justice system responses</td>
<td>(1-800-903-0111)</td>
</tr>
<tr>
<td>Health Resource Center on Domestic Violence</td>
<td>San Francisco, CA</td>
<td>Provides specialized information packets designed to strengthen health care responses to DV, including technical assistance and library services support for program development and coalition of physicians against DV</td>
<td>(1-800-313-1310)</td>
</tr>
<tr>
<td>Resource Center on Child Protection and Custody</td>
<td>Reno, NV</td>
<td>Provides resources, consultation, technical assistance and legal research related to child protection and custody in DV to professionals</td>
<td>(1-800-527-3223)</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Resource Center</th>
<th>Location</th>
<th>Services Description</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>NATIONAL DOMESTIC VIOLENCE HOTLINE</td>
<td>- 1-800-799-7233</td>
<td>Answers 10,000 calls/month from victims, families and friends. Provides crisis intervention, referrals to local programs 24-hrs/7 days/week, multi lingual.</td>
<td></td>
</tr>
<tr>
<td>NATIONAL ORGANIZATION FOR VICTIM ASSISTANCE</td>
<td>- 1-800-879-6682</td>
<td>NOVA is a broad-based victim rights group found worldwide. It assists agencies ranging from victim rights services in Federal, state and local levels, allied professionals (police, prosecutors, clergy, health and mental health professionals) and direct service to victims thru “crisis response teams”.</td>
<td></td>
</tr>
<tr>
<td>NATIONAL FRAUD INFORMATION CENTER HOTLINE</td>
<td>- 1-800-876-7060</td>
<td>Takes reports of telemarketing and Internet fraud and refers to law enforcement agencies and maintains a database of fraud schemes and reported crimes.</td>
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<table>
<thead>
<tr>
<th>Website Information for Health Professionals</th>
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<tbody>
<tr>
<td><a href="http://www.nap.edu/catalog/10127.html">www.nap.edu/catalog/10127.html</a></td>
<td>Confronting chronic Neglect: The education and training of health professionals on Family violence</td>
</tr>
<tr>
<td><a href="http://www.nap.edu/catalog/2117.html">www.nap.edu/catalog/2117.html</a></td>
<td>Understanding Child Abuse and Neglect</td>
</tr>
<tr>
<td><a href="http://www.nap.edu/catalog/5285.html">www.nap.edu/catalog/5285.html</a></td>
<td>Violence in families; Assessing Prevention and Treatment programs</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>FLORIDA VICTIM ASSISTANCE PROGRAMS</th>
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<tbody>
<tr>
<td>Florida Abuse Hotline</td>
<td>- 1-800-500-1119</td>
</tr>
<tr>
<td>Victim Compensation for Florida</td>
<td>- 850-414-3300</td>
</tr>
<tr>
<td>Elder Abuse Hotline</td>
<td>- 1-800-96 ABUSE</td>
</tr>
<tr>
<td>ELDER Help lines</td>
<td>- 1-800-955-8770</td>
</tr>
</tbody>
</table>
MEDICAL RECORD PATIENT ASSESSMENT

PATIENT NAME: DATE:

CHIEF COMPLAINT:

DESCRIPTION OF INJURIES (APPEARANCE, SIZE, POSSIBLE SOURCE, RESOLUTION):

INDICATE ON CHART LOCATION OF PHYSICAL FINDINGS:

A ABRASIONS
B BRUISES
BL BLEEDING
Bt BITES
Bu BURNS
D DISLOCATIONS
Fx FRACTURES
L LACERATIONS
P PUNCTURES
LoF LOSS OF FUNCTION

DATING OF BRUISES
0-2 DAYS, SWOLLEN, TENDER
0-5 DAYS, RED, BLUE
5-7 DAYS, GREEN
7-10 DAYS, YELLOW
10-14 DAYS, BROWN
2-4 WEEKS, CLEAR

ASSESSMENT (POSSIBLE CAUSES AND OPINION ON WHETHER INJURIES WERE ADEQUATELY EXPLAINED):

LABORATORY & TESTS RESULTS

TREATMENT PLAN (INCLUDE ALL REFERRALS TO SOCIAL SERVICES, POLICE AND ACTIONS TAKEN)
**COMMON CHARACTERISTICS**

- minimize, deny abusive conduct
- avoid taking responsibility for their conduct
- blame the victims or other factors for the violence
- use health care system to control
  - accompanying victim to all appointments
  - cancel/sabotage appointments
  - withhold medications
  - display emotions: remorse, profound devotion, crying
  - use coercion/psychological threats against victim and health care provider

**DANGER SIGNS:**

- ESCALATION OF FREQUENCY AND SEVERITY OF ABUSIVE ACTS
- AVAILABILITY AND USE OF WEAPONS
- THREATS OF HOMICIDE AND SUICIDE
- HOSTAGE TAKING BEHAVIOUR
- USE OF VIOLENCE OUTSIDE FAMILY
- STALKING
- ALCOHOL/DRUG ABUSE
- MENTAL ILLNESS
BIBLIOGRAPHY


Law enforcement and the justice system can do much to enforce the message that domestic violence is a serious crime that will not be tolerated.

A. DEFINITIONS
In Florida domestic violence is defined as “any assault, battery, sexual assault, sexual battery, or any criminal offense resulting in physical injury or death of one family or household member by another who is or was residing in the same single dwelling unit”. The Florida Department of Law Enforcement (FDLE) is required to publish statistics on the occurrences of and arrests of domestic violence as part of its Crime in Florida Annual report. During the first year, 1992, of the reporting program, 109,449 incidents of domestic violence were reported.

B. ROLE OF LAW ENFORCEMENT
Under Florida law, the police called to investigate an alleged incident of domestic violence are required to assist the victim in obtaining medical treatment if required; advise the victim of services available at a local domestic violence center; complete a written police report; and notify the victim of his/her legal rights and remedies. This Notice of Legal Rights and Remedies is in English and Spanish. Since specialized knowledge is required for law enforcement to respond to a victim of domestic violence, some police departments have trained officers and/or specialized units assigned to work with victims as advocates and resource persons. The Governor’s Task Force on Domestic Violence has recommended specialized training for all law enforcement agencies. Within 24 hours of the alleged incident of domestic violence, the police must send a copy of the initial police report to the nearest certified domestic violence center. In the case of child/elder abuse, the police must notify the Florida Department of Health and Rehabilitative Services so that appropriate interventions take place. Under the current law, the police called to the scene of a domestic violence incident can make an arrest upon probable cause and do not need to witness the crime. Florida law enforcement agencies advocate a pro-arrest policy and instruct officers to make warrant-less arrests in domestic violence cases.

C. COURT ORDERS TO PROTECT THE VICTIM
Domestic violence victims may petition the court for protective injunctions, which are served by law enforcement. Two Florida Statutes govern the issuance of domestic violence injunctions. These statutes give the victim of domestic violence an important tool to use in protecting themselves and their children from an abuser. They create a cause of action for a victim of violence or any person who has a reasonable fear that domestic violence may be imminent. They allow any person (regardless of
relationship) who has suffered at least two acts of violence (one of which has occurred within previous six months) to petition for injunctive relief.

**EX PARTE RELIEF** can be granted for up to 30 days. It is available to victims at any time (24 hours, weekends and holidays) and can address the safety of the victims at home, work or school, child custody, removal of the perpetrator from the home and forbids the perpetrator from contact with the victim, and any other relief deemed proper. Florida judges need no evidence and can grant injunctive relief on the sworn petition filed at the clerk’s office. Petitioners don’t need an attorney; the clerks are trained and required by law to assist the petitioners. Additionally, fees for filing, service of process and bonds can be waived for those unable to pay.

**PERMANENT RELIEF** is determined at a full hearing within 30 days. A permanent injunction allows the court to restrain the respondent from committing any act of domestic violence, to avoid all contact with the petitioner and grant any other relief, such as temporary custody, child support and visitation. Additionally, the court can require the batterer to complete a batterer’s intervention and other treatment (substance abuse, mental health) and counseling programs (including the children). Permanent injunction may be granted for up to one year.

**JOINT CUSTODY AND VISITATION** can create particular tensions and escalate family violence. Court orders are structured to protect the victim and her children from further abuse. Despite Florida laws, which require shared parental responsibility; judges in domestic violence cases can order custody and even structure visitation to occur at locations physically separate from the victim or under the supervision of a third party. Advocates are working actively to establish supervised visitation centers in every county to provide safe and comfortable environment for victims and their children.

**D. VIOLATION OF INJUNCTIONS**
Studies show that violence increases dramatically when the victim leaves an abusive relationship. Violence escalates after separation in an attempt to coerce or retaliate against the victim. National Institute of Justice found that 75% of domestic violence assaults occurred after the victim is divorced or separated.\(^5\) Court ordered protection provides the victim with the security of knowing and sends a message to the abuser that, should the order be violated, the abuser is arrested immediately. Judges structure protective conditions to ensure safety and limit batterer’s power and control before violence escalates to serious injury or death. Follow-up hearings and incremental sanctions for violations help ensure compliance. Studies show that batterer’s behavior can be stopped to the extent that they perceive that penalties for further violence will be certain and severe.\(^6\)
Injunctions are civil actions. When a temporary or permanent injunction is violated it can become a criminal action. The courts use contempt orders to enforce their authority in domestic violence cases. Contempt actions may be civil or criminal in nature. Civil contempt may order specific conduct (paying child support) and if the party fails to comply, the court may incarcerate the party until compliance with the order occurs. This includes failure to attend a batterer’s program. Certain injunction violations (refusing to vacate or returning to a dwelling shared by the parties, committing an act of domestic violence, or committing any other injunction violation, assault) are enforceable through criminal prosecution and are first-degree misdemeanors. The object of criminal contempt is to punish the offending party.

E. VICTIM’S ASSISTANCE THROUGH THE COURT PROCESS
As in the physician’s office, judges can be frustrated by the victim’s reluctance to testify or desire not to proceed with injunctions. They attempt to identify reluctance, which is often based on well-founded fears of the batterer. Experience has revealed that battered women who receive support and accurate information about the court process, and perceive that the laws may hold the offender accountable, will be more likely to appear and testify. Treating domestic violence as a crime was the intent of the legislature in enacting chapter 741. In several jurisdictions across the United States, specialized domestic violence prosecuting units are designed to provide clear evidence of the State’s serious treatment of domestic violence, and can result in improved conviction rates for domestic violence crimes. “Vertical prosecution” (one prosecutor and team, including victim’s advocates handle the case from beginning to end) is a central theme of these units. Such a policy tends to develop a greater level of trust between victim and the judicial system. Additionally, the victim is often relieved of the burden to prosecute, by emphasizing that the decision to prosecute rests with the State. Such “no-drop” policies enhance the likelihood of victims to testify (as witnesses rather than accusers) and reduce the likelihood of future violence, retaliation, harassment, or intimidation by abusers since she can have no effect on “dropping charges” or stopping the prosecution. The Florida legislature mandated that each state attorney develop special units, specialized prosecution and support staff trained in domestic violence. A model of such a system is the Dade County Domestic Violence plan, instituted in 1992 as a joint effort by the Eleventh Judicial Circuit, Metro-Dade government and state agencies. It created a criminal court with a civil component dedicated only to domestic violence. Cases are identified from the moment they enter the system, and are segregated in this court. The domestic violence unit coordinators attend all hearings and serve as liaisons between the court, private social service providers and local and state government agencies, which provide services for victims, counseling for children and treatment or batterers. Access to this system is provided through the county Domestic Hot-line numbers. Across the state access to information and assistance is available to help guide victims through the legal process.
F. HELP FOR BATTERER’S: INTERVENTIONS AND TREATMENT PROGRAMS

Batterer’s intervention and treatment programs are an essential part of breaking the cycle of violence. These programs focus on the safety of the victims and assist batterers to recognize and take responsibility for their abusive behaviors. They teach skills and strategies for developing violence-free communications and shift the power/control paradigm of abusive relationships. Couples counseling, anger and control classes are not effective programs. There is no cause-and-effect relationship between substance abuse and domestic violence. Treatment of substance abuse should be confronted separately and concurrently with treatment of batterers.

Although the effectiveness of batterer’s programs is difficult to assess, data indicate that in and of themselves they are not enough to stop the recidivism rate. But when they are coordinated with a variety of other interventions, including community services, legal and social restraints, they can reinforce the message. Batterers who complete court-mandated treatment following arrest are less likely to re-offend than those who do not. Victims should understand the limitations so that no false hopes or sense of security is developed.

The Governor’s Task force identified 50 Batterer’s Intervention Programs in Florida; 15 administered by domestic violence shelters, 35 affiliated with community mental health centers and a variety of other private and public institutions. Most communities, although not all, have some type of batterer’s program. Urban programs are largest and have easier access, system-wide networking among service providers and carry the additional weight of services for neighboring rural areas. The Governor’s Task Force has recommended the development of minimum standards for batterer’s treatment programs and statewide coalition to enhance program development.

F. DOMESTIC VIOLENCE SERVICES AND REFERRAL RESOURCES

The Florida legislature first allocated funds for domestic violence shelters in 1977. The Florida Coalition Against Domestic Violence is an association of 35 of the 37 domestic violence centers in Florida. The FCADV provides technical assistance and advocacy for these centers that provide a variety of services for victims of domestic violence and their children. Shelter services are confidential and provided without charge. Domestic violence centers across the state provide: information and referral, counseling, temporary emergency shelter, professional training, case management and 24-hour crisis line. Additional services include safe homes, victim advocacy, legal services, transportation, children’s programs, transitional housing, and childcare. Some centers also offer treatment for batterers, employment and vocational counseling, medical and legal advocacy. The Florida Department of Health and Rehabilitative Services, $30 fee on marriage licenses and through federal Family Violence Act monies, fund these services. However, state funds for centers provide less than 25 percent of their
operating revenue. The average shelter houses a woman for four to six weeks. “Transition housing” after victims leave the shelter is often required with an average stay of six to eighteen months. This time provides battered women with opportunities to locate permanent housing, job and other services necessary to rebuild a safe life.

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2. Florida statutes section 741.29
3. Task Force Report
4. Florida Statutes section 781.046
VII ELDER ABUSE

Scope of the problem
Although much has been examined and written about child abuse and battered adults, it is only recently that the issue of elder abuse has received attention. The demographic shift toward an older age in America is well known. Today 1 in 9 (11%) Americans are over age 65 years, and the fastest growing segment is the group 85 years and older. Like its counterparts of child and intimate partner abuse, while everyone agrees that they should never occur, these problems do occur and do so at an alarming rate. In 1980, the U.S. Senate Special committee on Elder Abuse reported as many as 500,000 to 2,500,000 cases of elder abuse, neglect or maltreatment occur each year in this country, but only 1 in six cases is reported. The first laws requiring reporting for suspected cases of elder abuse began with protective services and guardianship programs to meet the needs of those elders who could not maintain basic living standards without agency assistance. Since then, there has been an expansion of these protections, as more and more health care workers recognized the scope of the problem, and by the beginning of the 1990’s all states had passed elder abuse laws that mandated reporting by physicians and other health care professionals for the protection of the elderly. However, specific requirements and penalties vary considerably among jurisdictions.

In the subsequent decade, however, elder abuse remained overshadowed by more dramatic cases of child and intimate partner abuse. While horrific nursing home cases occasionally received public attention, domestic elder abuse remained a silent epidemic. While there was a 150.4% increase in elder abuse reports during the last decade, the magnitude of the number attests to the seriousness of the epidemic. It has been estimated that 4-5% of all elderly Americans are abused yearly (1-2 million/year) and for every 1 reported incidence, approximately 5 are unreported. Applying these figures to Florida, which leads the nation in the percentage of older residents (23% of the population is over 60 years of age - three million), it is estimated that there are over 92,000 victims of abuse or neglect. In 1998-99, a totaling 29,408 complaints of alleged abuse (an increase of 2% over 97-98 and 37% over 6 years ago) were received; 77% of reports were of victims over 60 years of age.

Defining elder abuse
The low reporting rate means that elder abuse is not being adequately dealt with and victims are not receiving services and protection. Part of the problem is the broadness of the definition of elder abuse. This umbrella term encompasses a number of very different types of abuse, which require individual approaches and solutions. Typically, in most state statutes definitions of elder abuse include abuse, neglect and exploitation. Still abuse may be further broken down into physical, sexual, emotional or psychological abuse and may occur in the domestic as well-as institutional settings. Neglect can
Table 1
Definitions of Elder Abuse


<table>
<thead>
<tr>
<th>Type of Abuse</th>
<th>Signs of Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Abuse</td>
<td>Bruises in multiple stages of healing lacerations, Rope marks, signs of being restrained, Bone fractures (skull), Dislocations, Open wounds, untreated injuries, Broken eyeglasses, Sudden changes in behavior, Lab findings of medication overdose or under-utilization of prescribed meds.</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>Bruises around breast, genitalia, Unexplained genital infections, Vaginal/anal bleeding, Torn, stained bloody underclothing</td>
</tr>
<tr>
<td>Emotional or psychological</td>
<td>Agitation, Extreme withdrawal, non-communication, Caregivers refusal to allow visitors to see elder alone.</td>
</tr>
<tr>
<td>Neglect</td>
<td>Dehydration, malnutrition, Untreated, improperly attended medical conditions, Poor personal hygiene, inadequate clothing, Unsafe living conditions.</td>
</tr>
<tr>
<td>Self neglect</td>
<td>Dehydration, malnutrition, Untreated, improperly attended medical conditions, Poor personal hygiene, inadequate clothing, Unsafe living conditions.</td>
</tr>
<tr>
<td>By others</td>
<td>Dehydration, malnutrition, Untreated bedsores, Unattended, untreated medical problems, Poor personal hygiene</td>
</tr>
<tr>
<td>Abandonment</td>
<td>Desertion of elder at a hospital, institution, other public locations.</td>
</tr>
<tr>
<td>Exploitation – financial or material</td>
<td>Sudden changes in bank account, banking practice, Unexplained withdrawal of large sums of money, Provision of unnecessary services, Unexplained sudden transfer of assets</td>
</tr>
</tbody>
</table>

encompass self-neglect and by others, both willful and unintentional. Exploitation can be financial or material in form. (Table 1) Nationally, it is reported that 30% of the cases of elder abuse fit the definition of physical abuse (14.6%), emotional abuse (8.1%), or sexual abuse (0.5%); 55% of the cases represent neglect and 12.3% exploitation. Florida mirrors the national trend; 63% of the cases were neglect, 29% self-neglect and 34% neglect by others. ³ ⁴
Who are the victims? Who are the perpetrators

The NEAIS found that women represented 60-76% victims of all forms of abuse. The oldest elders (80 years plus) were abused and/or neglected the most frequently. In Florida the average age of victims was over 70 years, with the highest rate –30% in those 80-89 years and over 3500 reports involved those over 90 years). Caucasians comprised 80% if victims overall in the reports examined by NEAIS, while African Americans comprised only 8.3% and Latinos only 5.1% of victims. The NEAIS found family members were the most common perpetrators, particularly adult children (43.7% of cases). Spouses compromised the next largest category, at 19% (Table 2) In nearly two thirds of all cases the perpetrator was under 60 years of age. Male perpetrators were more common in physical
and emotional abuse. (62.6% and 60.1%) and financial exploitation cases (59%). Only in cases of neglect were females more likely to be the perpetrator (52.4%). Perpetrators of abuse were more commonly non-Hispanic white (77.4%).

Reasons for abuse—barriers to reporting
There are several theories of causation for elder abuse proposed in the literature: impairment of the victim, pathology of the abuser, internal family dynamics and stressors (internal-care-giver burden and external-financial pressures). A theme which threads through domestic abuse cases is that the elder victim is usually dependent, living with family where there is a crisis of economic, overcrowded living setting, unresolved relationship problems, life-event such as divorce, retirement. There may be mental illness, developmental disability or substance abuse among the family perpetrators. Finally, there is often a family history of violence, which leads to a cyclic familial pattern of abuse. A clearer understanding of causal relationships is important to the assessment and management of elder abuse. Additionally important, is the recognition that unlike in cases of adult abuse where the victims usually come forward to seek help outside, there are barriers that keep elderly victims from doing so. The elderly lack economic, legal family support and fear alienating their family member, or worse, losing their care-giver. In elder abuse, “divorce is not a viable option” Since they fear abandonment, alternative housing may not be available or worse yet it may lead to institutionalization, which for many elders is a “fate worse than death”. The elderly fear that coming forward may be used against them or that no one will believe them because of age bias. They also have cultural issues and prejudices in which “family shame” is not to be shared. Finally, navigating the legal system may be intimidating and too difficult.

Signs and symptoms of abuse in the elderly
Given the circumstances in which abuse is likely to occur and the barriers to reporting, elder mistreatment (abuse and neglect) is often undetected, and goes unreported more than any other form of domestic violence. Health care providers’ awareness of signs and symptoms and risk factors is critically important to the detection and eradication of the problem. Unlike adult abuse, the signs of elder abuse can be confusing because they may present like many other common geriatric syndromes, such as depression, falls, fractures and decubitus ulcers. However, there are clues to the diagnosis of elder abuse and healthcare providers should be alert to the clear signs of abuse and include mistreatment in their differential diagnosis. (Table 3) Clearly elderly patients have complex constellation of symptoms and concerns. The nature of the doctor-patient relationship provides a unique opportunity to detect elder abuse. It is important however, to remember that, unlike other adult victims of abuse, the elderly are less likely to self-report, more likely to deny because of fear, shame or not even realize they are being mistreated. Up to one third of elderly victims deny abuse, even when specifically asked. Also, cultural factors should be considered when evaluating elder abuse cases: lack of knowledge of
Table 3
Signs and Symptoms of elder abuse

<table>
<thead>
<tr>
<th>Risk indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior abuse</td>
</tr>
<tr>
<td>High degree of dependence on caregiver</td>
</tr>
<tr>
<td>Financial dependency of caregiver on the patient</td>
</tr>
<tr>
<td>Emotional/mental health of victim/family member</td>
</tr>
<tr>
<td>Dementia and behavior issues</td>
</tr>
<tr>
<td>Alcohol/substance abuse</td>
</tr>
<tr>
<td>Shared living arrangements</td>
</tr>
<tr>
<td>Social isolation</td>
</tr>
<tr>
<td>Incontinence</td>
</tr>
<tr>
<td>(caregiver stress) (Divorce, bankruptcy legal Problems)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient history/behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explanation for findings not reasonable</td>
</tr>
<tr>
<td>Unresolved/recurrent medial problems despite RX plan</td>
</tr>
<tr>
<td>Injuries not properly cared for</td>
</tr>
<tr>
<td>Delay in seeking medical care–untreated medical problems</td>
</tr>
<tr>
<td>Frequent ER visits</td>
</tr>
<tr>
<td>Fear of caregiver</td>
</tr>
<tr>
<td>Caregiver refuses to leave patient alone; abusive tone; hostile</td>
</tr>
<tr>
<td>Overly medicated</td>
</tr>
<tr>
<td>Sudden changes in elder behavior (including, anxiety, withdrawal, confusion, disorientation)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clothing soiled, inappropriate for season</td>
</tr>
<tr>
<td>Unexplained multiple bruises/abrasions</td>
</tr>
<tr>
<td>Variable healing stages</td>
</tr>
<tr>
<td>Patterns of objects</td>
</tr>
<tr>
<td>Bruises on face, throat, trunk, buttocks, scalp, Inner arm stocking-glove</td>
</tr>
<tr>
<td>Bilateral, parallel injuries</td>
</tr>
<tr>
<td>Signs of self mutilation-seeping wounds in clusters</td>
</tr>
<tr>
<td>Poor personal hygiene (nails, teeth, hair, skin)</td>
</tr>
<tr>
<td>Decubitus ulcer</td>
</tr>
<tr>
<td>Dehydration, malnutrition, weight loss</td>
</tr>
<tr>
<td>Bruised/bleeding genitalia/anal area, blood under</td>
</tr>
</tbody>
</table>

what constitutes abuse in this culture; family roles and degree of acceptance of family roles; verbal and non-verbal communication in the culture. One caveat when interviewing patients is to never use younger family members to translate, since they may filter important information. A trained professional should be used for medical translation whenever possible, since subtle verbal and non-verbal clues of that culture will be picked-up even though the patient denies abuse.
Special considerations for dealing with elder abuse

Similar to other adults, since the prevalence of abuse is so high and any elderly patient is a potential victim, all elderly patients should be screened. The most important step besides treating the actual effects of the abuse is to determine if the patient is in imminent danger of harm (whether it is active, e.g., physical abuse or passive, e.g., serious medical consequences from inattention). Health care providers must recognize that traditional safety planning may not work for the elderly (installing new door locks, key lock for the bedroom, security system, passwords for friends, preprogrammed phones to call 911, injunction for protection). Even safe-space shelters may not be equipped to meet the medical or physical needs of an elderly victim (handicapped rooms, treatment facilities).

Every state has mandatory reporting laws. Statutes require health care professionals, social service workers, law enforcement officials, and others to report suspected cases of child, elder and disable
abuse to some state authority. Most states are similar to what happens in Florida. All incoming calls are screened by counselors for acceptance as reports of abuse of elders according to specific criteria (meets the definition of adult victim and alleged perpetrator and abuse under Section 415.102 of the Florida Statute and means to locate). (Table 4). Only accepted reports are referred for further investigation. On referral the required actions vary widely according to jurisdiction, and range from following a physicians management plan to conduct a full-scale investigation. They can even obtain court order to remove the elderly person from the living environment. In Florida, if the call requires “immediate investigation because the alleged victim is in imminent danger of serious harm” the hotline counselor has one hour to contact the appropriate district office by phone, otherwise non-immediate situations are entered into the computer system where they are checked for routinely by district offices, usually during business hours only. There are controversies regarding mandatory reporting laws. Critics
point to them as an example of extreme ageism—“treating the elderly as children and incompetents”. It may place them in grave danger or expose them to services, which are inadequate to meet their needs and lead to inappropriate institutionalization of elder abuse victims. 13,14

As an adjunct to mandatory reporting, many states provide other support systems and services that can be given to the elderly victim, and even the abuser to assist in stopping the cycle of violence in the home. Health Care providers must be creative and open to new ideas in the management of elderly abuse victims. They should determine that the potential danger is significant and arrange for alternative care for the victim until the issue is addressed. This may include hospitalization, if appropriate or shelters qualified to care for the elderly. They should be facile with resources available to assist elder victims and make appropriate referrals. It is equally important to partner with other professionals and facilities to provide a comprehensive and coordinated management plan for victims and their families. Finally, like in any chronic disease, ongoing care is needed. Management should target specific risk factors, which have contributed to the situation (victim behavior, care-giver stress). The living environment should be monitored regularly to ensure patient safety.

Health care providers must be advocates for their patients and try to develop long-term programs to reduce the abuse. Studies have shown that direct services to victims and their families coupled with strong case management by specialized elder abuse workers have great potential to reduce elder abuse. 15 Development of support groups, shelters and “safe houses” that are geared to the elderly abuse victim would also be of benefit, reducing the need to nursing home placements. These living facilities need to provide for special needs of the elderly: the physical needs, (including assistance with ADLS), counseling for grief issues, maintenance of independence, economic resources, and greater family involvement). Equally important are services to connect abuse victims and their families with community resources to resolve abuse environment (e.g psychological counseling, stress-reduction for caregivers.)

SUMMARY
Although the problem of elder abuse and neglect is not new, only recently has this form of societal violence elicited the attention given to child abuse and battered abuse. Unlike the latter instances of domestic violence, 90% of cases of elder abuse are not being reported and the rest may be rescinded because the elder is totally dependent on the caregiver and removal will mean going to a long term care facility. Unlike its counterparts in domestic violence, the signs of elder abuse may be less obvious or confusing because of the multiplicity of other illnesses in the elderly. Additionally, because of age biasm, it is often easy to write off the symptoms, or disbelieve the victim’s complaints as by-products of aging. Even when acknowledged, treatments are hampered because there are no shelters or safe-spaces
geared to the elderly victim’s needs. It takes an especially trained team and a concerted effort to recognize the abuse, work with the elderly person to meet their desires and needs and assist caregivers when it is appropriate for families to stay together. To avoid further discrimination and victimization, elder abuse treatments must meet the dual needs of sensitivity and safety for the elderly patient.

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8. SE Fla center on Aging Report.


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SELF ASSESSMENT TEST

Note: Please complete all 15 questions.

Mark your answers on the post-test form provided and return the post-test/evaluation form to the Division of CME. A 70% pass rate is required to obtain credit. Individuals may retake the test up to two times. The post-test must be an original (xerox copies will not be accepted).

1. Which one of the following statements is true about domestic violence in the United States:

A  Impact on health is limited: the rate of injury to women by male partners is less than that of other accidents and to men by female partners is nonexistent.

B  Battered women are primarily from very low socioeconomic groups and their abusers are easily identifiable as excessively violent.

C  Domestic violence escalates during pregnancy and it is considered one of the leading causes of miscarriage.

D  Physicians have a legal duty to report all forms of domestic violence; spousal, child and elder abuse.

2. Which one of the following statements is true concerning the impact of domestic violence:

A  Sexual abuse / assault is only seen in adult women and is rarely experienced by college age or adolescent girls.

B  Domestic violence is the single most common cause of injury to U.S. women far surpassing that of car accidents and muggings combined.

C  Families with domestic violence don’t visit doctors’ offices more often as compared to the general population.

D  Less than 2% of married couples experience violence.

3. The impact of domestic violence on the health care system is significant. All of the following statements are true except:

A  Estimates indicate 22 to 35% of women visiting emergency rooms are there for symptoms secondary to abuse.

B  Studies reveal that up to 64% of hospitalized psychiatric patients have histories of being abused.

C  In one year alone, domestic violence caused 21,000 hospitalizations, requiring 99,800 hospitalization days.

D  Health care providers should only screen for domestic violence by severe injuries, since these appear early and 96% result in hospitalizations.
4. Physicians have an ethical duty to diagnose and treat family violence. Which one of the following statements is true about physicians’ actions:

A  Battered women seldom provide information that they have been abused by their partners when asked by health care providers.

B Physicians’ prescriptions of medicines, usually pain medications or mild tranquilizers, are contraindicated for abuse victims, due to an increased risk for battered women of suicide and substance abuse.

C Probably the most important contribution physicians can make to ending abuse and protecting the health of battered women, is to report it to the law enforcement authorities.

D Treating only the injuries and symptoms of abuse will address the ongoing family violence which is at the root of its victim’s health problems.

5. Certain clues should alert clinicians to the diagnosis of physical abuse. Which one of the following statements is true concerning injuries received from battering:

A The typical pattern for contusions and lacerations is peripheral in contrast to the central body pattern (head, neck, breast or abdomen) from accidental injuries.

B Abused women are more likely to have multiple injuries in combination with evidence of old injuries as compared to accident victims.

C miscarriages don’t often occur as a result of battering during pregnancy, since blows to the abdomen are avoided by batterers.

D Noting coloration of bruises in order to indicate the timing of trauma, is not useful for the medical record.

6. Battered women may present with varied somatic complaints. All of the following are symptoms of abuse except:

A Over one third of abused women have suicidal thoughts and nearly a fifth attempt it.

B Chronic pain syndromes (headache, atypical chest pain, abdominal and pelvic) are common presenting symptoms.

C When symptoms don’t appear to have an organic basis, patients are often labeled by physicians as “hypochondriacs” or neurotics”.

D Since stress-related symptoms in abused women include fear and anxiety, treatment with tranquilizers or narcotics are appropriate and will not increase their physical danger.

7. In order to diagnose family violence, all of the following statements are true regarding the screening process except:

A Health care personnel should routinely assess women patients for abuse as part of the social history, review of systems and evaluation of the chief complaint.

B Simple direct questions, delivered with concern in a safe and confidential encounter, is the most useful method for identifying abuse victims.

C Surveys of patients indicate that the majority of victims are uncomfortable and feel that it is inappropriate for physicians to ask about family violence.

D Screening questions should be directed at determining the severity of the abuse, the degree of social isolation, and assessment of patient’s safety plans.
8. All of the following statements are true regarding appropriate therapeutic responses physicians can make during the clinical encounter except:

A  Acknowledgement of abuse validates the patient’s sense that violence is a threat to her health.
B  A physician, as an accepted authority figure, delivering the message that abuse is wrong, begins to break the isolation that accompanies ongoing violence.
C  Because battered women have low self-esteem and enormous guilt, accepting prime responsibility for creating the violence, telling her that it is not her fault, empowers her to break her isolation.
D  Abused women are often responsible for their own victimization so when the patient doesn’t respond at the initial encounter, she should be considered non compliant and physicians should discontinue their care.

9. There are several barriers to detecting and treating family violence. All of the following statements are true regarding physicians’ recognition of abuse except:

A  Violence does occur in seemingly normal families: 6 out of every 10 married couples experience violence.
B  Abusers often appear indistinguishable from other people and often do not behave violently in other circumstances.
C  In one study, 14% of men physicians and 31% of women physicians acknowledged their own abuse.
D  Domestic violence is a private matter to be resolved within the relation and a marriage counselor can assist the couple to work out their problems.

10. While physicians alone can’t prevent abuse, all of the following are important interventions they can do except:

A  Make the office a physically and emotionally safe space by displaying informational materials and providing resources with emergency number in waiting and exam areas.
B  Develop an office protocol and a updated resource list that they and their office staff can access for referrals to community domestic violence services.
C  Bring the batterer into the clinical encounter and discuss the allegations of abuse with the victim present.
D  Preserve precise historical and physical exam data in the medical record as important concrete evidence of abuse.

11. Which one of the following statements is true regarding the dynamics of abusive relationships:

A  A woman’s reluctance to leave an abusive relationship relates to her need to be a victim and is a result of her own destructive behavior.
B  Batterers’ main problems are impulse and anger control; they can be easily identified using aggressivity scales and psychological testing.
C  Batterers use emotional and economic, as well as physical abuse, to control victim’s lives, contributing to fear and inability to leave the relationship.
D  Substance abuse is the main cause of family violence.
12. When assessing safety and emergency planning, all of the following statements are true except:
A. The progression of injury pattern (more frequent, more severe, weapons used) is important to determining life-threatening danger and crisis intervention.
B. The more isolated the victim has become in order to contain the violence the fewer options she has available to insure her safety.
C. The risk to children in the home is best determined by considering the absolute level of violence and coercion in the relationship.
D. Threats of homicide or suicide by the partner are not indicators of escalating risk that should be explored with the patient.

13. In making a safety assessment with a battered woman, the physician should:
A. Respect the assessment of the victim when she determines it’s safe to go home.
B. Realize that the degree of injury (broken bone versus black eye) predicts the ultimate safety of the patient.
C. Tell the victim that physicians are legally required to report women battering, in order to relieve her of the burden of decision-making.
D. Insist that she initiate format separation and get a court restraining order against the batterer as her best safety option.

14. Which one of the following statements is true regarding reporting requirements:
A. Concerns for patient autonomy, confidentiality and increased danger have made mandatory reporting of battered women a requirement in all states.
B. When physicians are required to report serious assaults of injuries inflicted by weapons, they do not need to inform the patient or address directly safety planning.
C. Informed consent for all non-emergency medical interventions is not required from competent adult victims of abuse.
D. In states that have enacted mandatory reporting family violence statutes, failure to report could give rise to physician liability.

15. Every state has legislation to protect and assist victims of domestic violence. All of the following statements are true regarding these programs except:
A. Legal remedies available to battered women vary from state to state.
B. Medical evidence and physician testimony is a requirement in every judicial proceeding, including divorce and custody hearings.
C. Civil and Criminal penalties are often aimed at restraining batterers from further contact and providing for the security of the victim and children.
D. Community services, such as shelters and counselling, can provide both short-term safety and long-term assistance for victims and their families to gain control over their lives.
Opening Pandora’s Box: Family Violence - A Physician’s Guide to Identify and Treat Victims of Domestic Violence and Elder Abuse

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Content Level:  
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2 = Intermediate  
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The program met the following objectives:  
4 = Strongly Agree ..........1 = Strongly Disagree

Upon completion of this study, I’m able to:

1. Understand the cycle of violence and psychological dynamics of abuse and post-traumatic stress disorders

   4  3  2  1

2. Identify and assess victims of abuse – battered partners and the elderly

   4  3  2  1

3. Learn specific intervention techniques for working with abuse victims Identify community resources and learn innovative support methods to meet the needs of victims of family violence

   4  3  2  1

4. Understand the interaction between legal systems and health care professionals in working with family violence.

   4  3  2  1

Additional comments and/or suggestions:

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Will you make any changes in your professional practice as a result of this CME Study?  [ ] Yes  [ ] No

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**Post-Test Answer Sheet / Credit Recording Form**

*Opening Pandora’s Box: Family Violence - A Physician’s Guide to Identify and Treat Victims of Domestic Violence and Elder Abuse*

Name: ___________________________________________ Degree: ________________

Address: ____________________________________________________________________________

City, State, Zip: _______________________________________________________________________

Tel: _________________________________ Fax: ______________________________

Email: _______________________________________________________________________________

Specialty: ___________________________ Last 4 digits of Social Security #: ________________

(for recordkeeping purposes)

Circle the correct answer, and Mail this form to the address indicated on the evaluation page to request credit. A score of 70% or higher must be obtained on the Post-Test, in order to receive credit.

<table>
<thead>
<tr>
<th>1.</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>9.</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
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</thead>
<tbody>
<tr>
<td>2.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>10.</td>
<td>A</td>
<td>B</td>
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<td>3.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>11.</td>
<td>A</td>
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<td>5.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>13.</td>
<td>A</td>
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</tr>
<tr>
<td>7.</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>15.</td>
<td>A</td>
<td>B</td>
<td>C</td>
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</tbody>
</table>

8. A B C D

Initial here: ______ to verify you have completed the program and post-test and wish to receive credit.

Total hours spent in this CME activity: ________________

*Please note that only the original Test/Credit Recording Form will be processed

**TYPE OF CREDIT REQUESTED**

(Please indicate by placing a check mark in the appropriate box)

**Physicians:**

- ☐ category 1 AMA/PRA  ☐ AOA

**Allied Health Professionals:**

- ☐ Nurse Midwifery (category 1 AMA/PRA)
- ☐ Nurse Practitioner (category 1 AMA/PRA)
- ☐ Physician Assistant (category 1 AMA/PRA)
- ☐ Psychology (FL License # required) ____________________
- ☐ Marriage & Family Therapist (FL license # required) ________________
- ☐ Clinical Social Workers (FL license # required) __________________

☐ Enclosed is check in the amount of $50(USD) made payable to: UM Division of CME

☐ Charge my recording fee in the amount of $50 to the following credit card:

( ) Mastercard ( ) Visa ( ) Discover

Number: ________________________________ Exp Date: ________________

Authorized Signature: ________________________________