

Domestic violence: an approach to identification and intervention

Tara D. Director, MD^a,
Judith A. Linden, MD, FACEP^{a,b,*}

^a*Department of Emergency Medicine, Emory University School of Medicine, 1365
Cliffon Rd, Suite B-6200, Atlanta, GA 30322*

^b*Boston University School of Medicine, Boston, MA 02118, USA*

Breast bruised, brains battered
Skin scarred, soul shattered
Can't scream—neighbors stare,
Cry for help—no one's there
—Nenna Nehru

The term *family violence* describes acts of violence between family members or other intimate relations, including adults, children, elders, and caretakers. This article focuses on domestic violence (DV) or intimate partner violence, terms that can be used interchangeably. DV or intimate partner violence includes a wide variety of behaviors that coerce, control, or demean the victim. Although this article sometimes refers to the “battered woman,” DV also can affect men who are involved in heterosexual or same-sex relationships and women in same-sex relationships. Most DV victims are women, however. The American College of Emergency Physicians defines DV as “part of a pattern of coercive behavior which an individual uses to establish and maintain power and control over another with whom he or she has or had an intimate, romantic, or spousal relationship. Behaviors include: actual or threatened physical or sexual abuse, psychological abuse, social isolation, deprivation, or intimidation” [1]. DV includes nonphysical abuse, such as emotional abuse (ie, threatening, intimidating, and degrading words or actions), social isolation, deprivation, and economic control. Physical abuse ranges in scope from minor injuries due to slapping or pushing to more severe assault, such as punching, kicking, or choking. The most severe outcome of DV is homicide. Legal definitions of DV vary from

* Corresponding author.

E-mail address: jlinden@bu.edu (J.A. Linden).

state to state but generally refer to threats or acts of physical or sexual violence.

DV often has been described as a spiral of violence. Walker [2] first described the cycle of violence as a relationship in which threats, intimidation, control, and battering increase over time. The battered victim experiences a repeating cycle of verbal abuse and increasing tension followed by battering and culminating in a “honeymoon” period or reconciliation. The relationship is unstable, and with time the periods of reconciliation shorten, and the seriousness of the assault increases. Although this cycle does not describe all violent relationships, all abusive interactions are ongoing and debilitating for the victim. Although the more common presentation of DV to the emergency department may seem nonurgent, misdiagnosis of this condition can lead to significant morbidity and mortality, with the most extreme and lethal consequence of DV being homicide of the victim, their children, or innocent bystanders.

Incidence and prevalence

Violence against women is common throughout society. Population-based estimates from national surveys indicate high rates of victimization. The National Crime Victimization Survey (1992–1993), which included robberies and assaults, reported 9 in 1000 women annually experienced violence by an intimate and that women were six times more likely than men to be victims of DV [3]. More recent data from the Commonwealth Fund 1998 Survey of Women’s Health found that 4 in 10 women report at least one type of violence at least once in their lifetime, 38% of which is DV [4]. The National Violence against Women Survey found that nearly 25% of women and 7.6% of men reported rape or physical assault by a current or former intimate partner in their lifetime; 1.5% of women and 0.9% of men reported the same for the previous year. Although these statistics estimate 1.5 million female victims of DV and 834,000 male victims annually, the survey estimates that there are 4.8 million victimizations per year because each victim can have multiple assaults over the year [5].

Research in the field is confusing. Findings on DV vary widely in the scientific studies, partially as a result of differing definitions of DV and methods and differences in the study populations and settings (eg, emergency department, primary care). The literature reports yearly incidence rates ranging from 5% to 11.7%. The lifetime prevalence rate varies from 21% to 54% [6–9]. Based on homicide reports, one third of homicides of women are committed by an intimate partner [10]. Some research indicates that the true number of homicides related to DV is underreported due to nonreporting of multiple victims, such as family members or bystanders [11].

Risk factors for domestic violence

The DV literature attempts to identify common characteristics and risk factors for victims of DV. Some findings are universal. All of the literature supports that women predominate over men as victims. Additionally, most agree that younger women and women who are on their own (single, separated, or divorced) are at higher risk for victimization [3,7–9,12]. Victims are more likely to report symptoms of depression, decreased self-esteem, and increased daily stressors [4,7,9,12,13]. Findings about race and economic status are more controversial. Some studies find no difference in rates of DV based on race, education level, employment, or insurance status [3,7,8]. Other studies assert that lower economic status and race are risk factors for DV [3,7]. The National Violence against Women Survey found that DV rates vary significantly among women of diverse backgrounds; African-American and Native American women reported higher rates, and Asian/Pacific Islander women reported lower rates. The differences diminished, however, when socioeconomic and cultural variables were controlled [5]. Although research indicates that certain people may be at higher risk for victimization, DV can affect any member of society. Physicians must be aware of the risk to their patients and of the opportunities for intervention.

Characteristics of abusers

Characteristics of individuals who abuse are not global. The literature has identified certain traits, however, that may be common among abusers. One multicenter study indicated women were at greater risk from male partners who abuse substances, are less educated, and are intermittently employed or unemployed [14]. Research by Amaro et al [15] further supported a woman's increased risk of abuse by a partner who abuses alcohol or drugs. Divorce or separation from the partner also increased risk to the woman [3,7–9,12,14]. Other risks for violent behavior include exposure to violence or abuse as a child; personality disorders, such as antisocial personality or borderline personality; and young age [16]. Despite identification of some common batterer characteristics, batterers may come from all socioeconomic strata, and some may be in powerful positions, such as law enforcement, law, medicine, and other fields. Batterers may appear charming and attentive to the observer. Physicians should be alert to common abuser characteristics but realize that a normal-appearing and normal-acting partner may be abusive.

Screening

Research indicates that victims of DV use medical services more frequently [17,18]. One study found that 37% of female patients presenting to the emergency department for violent injury were injured by their partners

[19]. Another study found, however, that emergency physicians identified only 5% of DV victims [8]. Abbott et al [6] found that only 13% of emergency physicians asked about DV. Because of the prevalence of DV in society and the increased use of medical services by victims, the American College of Emergency Physicians advises multidisciplinary policies and protocols for the identification, treatment, and referral of victims of DV. Additionally the Joint Commission on Accreditation of Healthcare Organizations now requires emergency departments to institute protocols for identifying and treating DV victims [20].

The potential severe emotional and health consequences to victims of violence, combined with the frequent contact physicians have with victims, places physicians in a unique position to screen, recognize, and intervene. Often, women who have experienced DV report that a question by a health care worker was an essential first step in disclosure and recognition [21]. Although outcome data regarding the efficacy of screening still are lacking, screening can be the physician's first step in intervention and should be performed routinely. Screening involves simple, targeted questions that ideally identify most persons experiencing abuse. Patients should be questioned alone, in a supportive, confidential, nonjudgmental environment. Opening screening with a simple statement (eg, "Because domestic violence is so common, I routinely ask all my patients if they have been hurt by someone close to them") can ease a potentially difficult interaction.

Many screening protocols exist. The Partner Violence Screen incorporates three simple questions: (1) Have you been hit, kicked, punched, or otherwise hurt by someone within the past year. If so, by whom? (2) Do you feel safe in your current relationship? (3) Is there a partner from a previous relationship who is making you feel unsafe now? The Partner Violence Screen has a sensitivity of 65% to 71% compared with more intensive screens [22]. A more recently developed screening tool, StaT by Liebschutz and Paranjape [23], has a sensitivity of 97%. This screen includes the domains of physical and emotional abuse and is targeted to emergency department patients. It also includes three questions: (1) Have you ever been in a relationship in which your partner has pushed or slapped you? (2) Have you ever been in a relationship in which your partner threatened you with violence? (3) Have you ever been in a relationship in which your partner has thrown, broken, or punched things? Although the StaT questions do not ask directly about sexual abuse, the screen was found to be more sensitive for detecting sexual trauma than direct questions, probably because of the high rate of the coexistence of physical abuse. Other authors suggest simple, open-ended questions (eg, "How does your partner treat you? Are you or have you been in a relationship in which you felt you were treated badly? We all fight at home; what happens when you and your partner fight or disagree? Do you ever feel afraid of your partner? Has your partner ever prevented you from leaving the house/seeing friends/getting a job/continuing your education? Has your partner ever destroyed things you care about?").

Screening protocols are effective tools for increasing identification of victims of DV by physicians [19,24,25], but policies, procedures, and physician education must be maintained to retain the benefits of screening programs [19,26,27]. Although the types of questions included in a DV screen are important, performing a DV screen is more important than actual content. In one study, although 78% of DV victims indicated that they would favor routine inquiry, only 7% were asked [28]. Victims often do not volunteer information but may answer if asked directly.

Recognizing victims of violence

Although screening is an important tool for physicians to broach the topic of DV, recognizing patients who are victims is also crucial. Initially, physical injury is less common, and victims may present with vague, nonspecific complaints. Patients may have an increasing pattern of general medical symptoms and use of the health care system [12,17,18]. Other clues, such as evasiveness or fearfulness during the interaction; delay in seeking treatment; an overly protective, hovering, domineering, or verbally abusive partner; injuries inconsistent with the stated history; somatic complaints inconsistent with disease; abuse of a child or other family member; lack of prenatal care; and any injury in pregnancy, indicate possible abuse [29,30]. Victims of DV have increased reporting of fair to poor health compared with nonvictims [4] and report a 60% higher rate of problems such as headache, back pain, vaginal infections, and gastrointestinal problems [31]. General findings, such as chronic abdominal, chest, or pelvic pain; somatic disorders; gastrointestinal complaints; gynecologic disorders; sexually transmitted diseases; headaches; joint pains; and poor compliance, are further indicators of possible abuse [4,7,32,33]. Chronic diseases, such as asthma, diabetes, hypertension, and heart disease, may be exacerbated or poorly controlled in abused persons.

Psychological problems also predominate. Victims may be isolated by their abuser or feel separated because of their feelings of shame or guilt. Additionally, victims are more likely to report symptoms of decreased self-esteem, increased daily stressors, depression, anxiety, substance abuse, eating disorders, and posttraumatic stress disorder [4,7,9,12,13,33–36].

Physical findings often are the most obvious indicators of abuse. Recurrent or frequent injuries, possibly with increasing severity over time, and multiple injuries in varying stages of healing are significant physical examination clues. Frequency, rather than severity, is the strongest indicator of abuse [23]. Victims often present with injuries to the face, head, neck, extremities, and central body areas such as breasts, abdomen, and chest, whereas accidents generally create peripheral injury, rather than injury to core body areas [37,38]. Contusions on normally protected areas, such as the inner thigh or inner arm; rug burns; human bites; burns; and injury outlines suggesting a specific weapon, such as hangers, shoes, or baseball bats, also should prompt consideration of abuse. Additionally, injuries suggesting defensive posturing,

such as bruising or lacerations to the inner forearm, volar surface of the hand, and the back, should warn physicians about the possibility of DV.

Any injury during pregnancy should be a red flag for physicians; lack of prenatal care also can indicate DV. Abuse often escalates during pregnancy and the postpartum period [39,40]; 8% to 17% of pregnant women report abuse during their pregnancy [41,42]. DV during pregnancy affects the mother and fetus. Injuries can include physical injury to the mother, placental abruption, uterine rupture, fetal skeletal injury, preterm rupture of membranes, preterm labor, and maternal or fetal death. Physicians have a unique opportunity during prenatal and postnatal care to screen, identify, and intervene in this high-risk population.

Consequences of abuse

DV can be physically and emotionally devastating for victims. Physical consequences include traumatic injuries and an array of chronic physical problems that may be exacerbated by the constant emotional stress of an abusive relationship. Chronic problems may include chronic pain complaints, such as pelvic, back, head, abdominal, and chest pain; gastrointestinal complaints, such as irritable bowel syndrome or dyspepsia; and gynecologic problems, such as dysmenorrhea and dyspareunia [4,7,16,32,33]. Sexually transmitted disease and unwanted pregnancy are additional consequences. DV also may result in poor compliance or exacerbation of chronic health problems, such as asthma, diabetes, hypertension, and heart disease. The most serious consequence of DV is death.

Victims of violence may be socially isolated and have feelings of low self-esteem [7,13,33]. The victim may feel helpless, powerless, and guilty. Psychological consequences reflect these feelings and the constant stress inherent in a battering relationship. Victims are more likely to have depression [4,7,13,33,36], posttraumatic stress disorder [34], suicidality, and substance abuse [6,7,36].

Violence in the home also can have devastating consequences on children who witness the violence, including decreased ability to concentrate, disordered attachment behaviors with caretakers, sleep disturbances, increased risk-taking behaviors, and increased aggression [43,44]. Many of the physical and psychological consequences of abuse also are clues to recognition of DV. Any patient who presents with these or similar diagnoses should be screened for DV because early intervention by a physician may prevent further deleterious consequences.

Barriers to care

Despite victims' and physicians' desire to communicate with one another, barriers to care exist from both sides. Patients who are victims of abuse may

be deterred from disclosing the violence to physicians by many factors. Initially the patient may not recognize that he or she is in an abusive relationship. The patient may feel deserving of the abuse or that he or she is not deserving of help. A lack of trust in the physician due to continual betrayal of trust by the abuser also may underlie a patient's failure to disclose DV [16]. One of the largest barriers to care may be the patient's fear of the abuser. The patient often fears physical abuse and retaliation or may have fear stemming from the social and economic isolation created by the abusive relationship [21,45]. Victims also may fear that disclosure mandates reporting to the police or child protective services. Another strong patient deterrent is feelings of shame or humiliation about the abuse and fear that family, society, or the physician may judge the victim as responsible for the abuse or as weak for staying in the relationship [21,45,46]. Additionally, victims may feel a responsibility to fulfill traditional gender roles and to keep the family together despite the personal cost [16,21]. Fear of losing financial support or of being a single parent also may contribute. Lastly, language and cultural barriers play a role.

Barriers between victims of DV and physicians are not one-sided; physicians also have obstructions to caring for victims of violence. One of the largest obstacles is a failure of inquiry by the physician [45,47]. If a patient is not asked, he or she may believe that the provider does not think the victimization is an important issue. Elliot et al [48] found that the overall screening rate by physicians was 10%. Research by McGrath et al [49] indicated that 55% to 68% of physicians never or rarely screen for DV. One of the most common reasons that physicians feel uncomfortable is lack of training about DV. In the McGrath study, 34% of the study population reported no prior DV training [49]. Despite intensive efforts at training, DV recognition and intervention often remain poor [49]. Other deterrents to care include a lack of confidence in the ability to diagnose DV, perceived lack of resources to offer victims, and fear of offending victims [48]. A study by Kurz [50] indicated that physicians identified only 11% of women victims and that 40% of these physicians did not know an appropriate response to the situation. Other studies suggest that lack of time, lack of privacy with the patient, personal discomfort, personal experiences with abuse, and frustration that the victim will return to the abuser are further physician barriers [45,46,49,51]. Fears of offending the patient and prying into traditionally "personal" areas also contribute to lack of screening.

Despite the many barriers to DV recognition and intervention, clinician involvement is vital. Many physicians feel overwhelmed by the scope of the problem combined with a sense of powerlessness because they believe they have nothing to offer the patient [51]. Physicians would have more success if they changed their role from problem solver to listener and advisor. DV victims find it helpful if the physician can create a trusting, confidential, nonjudgmental environment in which he or she takes the time to ask direct questions and offer referrals. Even a brief discussion with a physician can

help change a woman's view of the abusive relationship, even if she chooses not to disclose her victimization [21]. Understanding the ways in which DV survivors are able to make changes may help physicians to feel and to be more effective in aiding victims.

Barriers to leaving: how can a victim become a survivor?

Although the responsibility for the abusive behavior clearly rests on the abuser, there is often little or no incentive for the abuser to change behavior. Most often, victims of DV must choose to change their lives to end the abuse. Many providers ask the question, "Why doesn't she (or he) just leave?" Physicians should recognize, however, that many obstacles might prevent victims in an abusive relationship from providing a simple answer to this question. A victim's feelings of failure, guilt, or shame and low self-esteem and depression may hinder leaving the relationship. Abuser behaviors, such as promising change, minimizing the severity of abuse, blaming the victim, threatening the victim or their children or loved ones, and creating social or financial isolation, often deter the victim. Cultural expectations and traditional gender roles are additional barriers. Some victims may believe they do not have the educational, financial, or social resources to enable freedom from the abuser. Considering these and the many other potential obstacles to leaving an abusive relationship, the physician's question should actually be "How is anyone able to gather the strength to leave?" Despite the multitude of hurdles that exist, many survivors do make changes to end the abuse.

Brown [52] researched the way survivors make changes and applied the Transtheoretic Model of Change first described by Prochaska and DiClemente [53]. Prochaska and DiClemente [53] described behavioral change as a dynamic process comprising five stages: precontemplation, contemplation, preparation, action, and maintenance. People move among the different stages, sometimes forward, sometimes back again; often relapse occurs. This model has been applied to many behaviors, such as smoking and alcohol cessation, weight loss, and exercise [54]. Brown [52] interviewed DV survivors and was able to apply this model to battered women as they struggle to free themselves from violence.

During the *precontemplation* stage, a person may not recognize he or she is a victim and does not contemplate changing the situation. The victim who does not want or is not able to change is also in precontemplation. He or she often denies abuse and is resistant to suggestions of change. Victims often feel a lack of understanding by the physician. During *contemplation*, the victim is thinking of change and gathering information and resources but is not actively seeking change. This stage may last years. Patients in this stage are often open to feedback from physicians, however. During the *preparation stage*, the victim actively plans change. This stage is marked by actions by the victim, such as calling hotlines, creating a plan for leaving, and telling friends

or family about the abuse. Preparation is followed by the *action stage*, which encompasses overt change by the victim. Patients are ready for action when they determine that the abuse must end, and they believe that they have adequate supports and resources to do so. This stage often occurs when the violence is witnessed by or directed against the children. *Action* equals leaving the abuser or ending the violence. The last stage is maintenance. *Maintenance* includes solidifying the change and working to prevent relapse.

Change for victims is a cyclical progression through the five stages marked by regression to previous stages before the victim achieves final forward movement. Relapse is a natural part of the process. Relapse most commonly occurs during the action stage [52]. A physician who understands the stages of change recognizes that screening and intervention can have an effect without the patient actually leaving the abuser. A physician who intervenes enables behavioral change by opening the victim up to the possibility of progressing to the next stage. Catalyzing change depends on using the right approach with each stage. Cognitive changes, such as recognizing behavior as abuse and reassuring patients that DV is not their fault, are more effective for victims in precontemplation and contemplation. Behavioral processes, such as referrals to hotlines, support groups, and advocates, are more appropriate for patients in later stages [52]. Physicians who understand the theory of change are better able to target their interventions and help their patients.

Physicians who combine an understanding of the stages of change with an empowerment approach may have the most success with victims of DV. The empowerment model suggests that the patient is an expert on his or her situation, resources, and ability to make change. In this model, the physician is present to offer options, advice, and resources. The physician “empowers” the patient to make informed decisions. If a physician can tailor his or her empowerment intervention to the correct stage of change, the patient may get the most benefit from the attempt.

Intervention and treatment

The physician’s first step toward intervention for DV is screening. A physician who asks screening questions indicates concern for the patient’s safety and opens an opportunity for initiating internal change in the victim that may lead to disclosure of abuse. McLeer and Anwar [55] outlined a seven-step approach to victims of DV that summarizes the important steps in aiding DV victims: (1) obtain history, (2) diagnose and treat injuries, (3) evaluate the emotional safety of the patient, (4) determine the risk to the victim, (5) determine the need for legal information, (6) develop a follow-up plan, and (7) document findings.

A physician’s actions after screening should be to ensure the emotional and physical safety of the victim. Victims should be interviewed and

examined alone to ensure a safe, open environment. The physician should strive to make the patient feel supported and safe. At the same time, the physician must treat any physical injuries and provide the victim with support, guidance, referrals, and options. Intervention after screening is a multifaceted process that includes history taking, physical examination, injury treatment, and documentation. It also includes referral, resourcing, advocacy, and safety planning.

After an acute episode of violence or disclosure of abuse, the physician first should evaluate the patient for severe injuries that require immediate attention. The next step is the medical interview. During this process, the physician should use a direct, empathetic, nonjudgmental approach with open-ended questions. The goal is to make the patient feel safe, supported, and comfortable with questions and treatment. The clinician should acknowledge, but attempt to alleviate the patient's possible feelings of shame, blame, and guilt by stating that it is not his or her fault, no matter what he or she may or may not have done. When the patient discloses DV, the physician should try to obtain a chronologic history of the violence; assess for risk factors for serious injury, such as increasing frequency or severity of violence or weapons in the home; and evaluate the victim for signs of depression, anxiety, posttraumatic stress disorder, or suicidality. The physician also should elicit details about the current episode.

Physical examination follows the interview. Recognizing common presenting complaints and patterns of injury as discussed earlier may help the physician. During the physical examination, the health care provider should empower the victim by requesting permission to perform the examination, explaining each step of the examination, and stating that the patient can stop the examination at any time. The patient should be fully undressed to enable evaluation and treatment of unreported or unseen injury and to assess signs of previous injury. Examination should include vital signs and general appearance. The skin should be examined for scars, burns, abrasions, and bruises. Examination of central body areas is key because many injuries are located on parts that are easily covered. Facial trauma also is common, so the examination should include careful evaluation for bone; ophthalmologic; and ear, nose, and throat injury. Extremities should be evaluated for ecchymoses, sprains, and fractures. Victims who report sexual assault should be evaluated for perineal injury, sexually transmitted diseases, and pregnancy. Injury treatment follows standard trauma management.

Documentation is essential. The medical record can provide corroboration for a victim often years after the injuries have healed. The record may be helpful in criminal complaints, when obtaining restraining orders, in custody and visitation disputes, and to facilitate specialized housing and entitlements. The record should contain a complete description of the assault, including the batterer's name, preferably in the patient's own words, and should indicate clearly that the victim states the injuries were due to DV. The physician should document direct quotations or phrases such as "the patient

states” when documenting. The victim’s description of what, when, where, who, and how should be recorded. If a patient does not disclose abuse, the physician can document the nature and location of injuries that are inconsistent with the patient’s explanation. Injury description, such as type, number, size, location, and nature, is important; a body map or photos are helpful visual documentation techniques. Photographs require written patient consent and should include full body images and close-ups of injuries. A scaling object should be included in each photograph to enable accurate assessment of injury size. Photographs should be labeled accurately with the patient’s name, location of injury, and name of the photographer.

Reporting of DV to state authorities may be mandatory. Houry et al [56] found that seven states have mandatory reporting laws for injuries resulting from DV (some anonymous and some requiring identification). Additionally, only five states have no mandated requirements for reporting assault-related injuries, such as injury from weapons, crime, or domestic causes. The efficacy of mandatory reporting laws is controversial. Supporters of mandatory reporting believe that required reporting would facilitate prosecution of batterers, encourage physician identification of DV, improve DV data collection for investigation, and relay the message that DV is an unacceptable crime [57]. Opponents and some victims believe that mandatory reporting would increase the risk of retaliation, necessitate separation of the family, undermine patient autonomy, destroy patient confidentiality creating a barrier between patients and physicians, and decrease help seeking by patients [57,58]. Abused women have a higher opposition rate to mandatory reporting [59,60]. Although emergency physicians are more likely to report DV-related injuries than primary care physicians [61], 59% of primary care and emergency physicians admitted that they might not comply with mandatory reporting if a patient objected [62]. The California mandatory reporting law failed to increase the number of DV reports during its first 2 years [63]. Although the debate continues regarding whether mandatory reporting would be an effective means of decreasing further abuse and injury, physicians should be aware of their individual state’s reporting laws.

Additionally, state laws for protecting victims of violence vary. Civil actions, such as a protective order, injunction, or restraining order, exist to prevent further abuse by the perpetrator. Some states may have the authority to order an abuser to leave the residence, make support payments, or receive counseling. When an abuser violates an order of protection, it becomes a criminal violation, and police have the ability to arrest the abuser. Physicians can become familiar with their state’s laws or refer the patient to advocacy programs that can explain the victim’s legal options and help him or her access the legal system.

During the encounter with a victim of DV, the physician should work closely with other staff members, such as social workers, DV advocates, local shelter resources, and police to aid the patient in multiple areas. The foremost concern should be ensuring the patient’s safety before he or she leaves the

medical setting. Patients should be asked the following questions [64]: “Will you be safe if you leave the premises? Where is your partner? If he or she is not here, do you expect him or her to be here soon? Does your partner have access to weapons? Are your children in danger?” Steps to decrease immediate and future risk should be implemented. Safety planning can be complex and is accomplished best with the help of a social worker, advocate, or local hotline.

The extent of further intervention depends on the victim’s readiness to change. Patients in precontemplation or contemplation may be ready only for referrals to DV hotlines. Victims who are not ready or able to leave their abuser can be counseled on how to increase safety by taking steps such as making a safety plan, hiding potential weapons, securing important documents or records, and ensuring phone and monetary access. Victims who are ready to act to leave their abuser can be aided by finding a safe place to go and providing resources for advocacy, education, and protection. DV advocates are experts in helping victims of DV plan a safer escape, understand their options and legal rights, connect with support groups, and link with financial and educational opportunities. No matter the patient’s stage, physicians should be ready and able to provide patients with a range of resources, including educational materials; national resources such as the National Domestic Violence Hotline (1-800-799-SAFE) and the Family Violence Prevention Fund; and community-based resources such as local DV hotlines, shelters, and support groups and advocacy, mental health, and protection services. The Internet is another resource, but survivors should realize that websites they access may become known and available to the abuser. Some helpful websites include the National Domestic Violence Hotline (www.ndvh.org), the Family Violence Prevention Fund (www.endabuse.org), the National Coalition against Domestic Violence (www.ncadv.org), the National Network to End Domestic Violence (www.nnedv.org/who.html), and local domestic violence hotlines (www.ojp.usdoj.gov/vawo/state.htm). This list is not comprehensive; many additional website resources exist. Overall, DV intervention is multidisciplinary and includes health care providers, social workers, advocates, and protection services such as the police. Patients who are recognized or disclose themselves as victims of violence also should be provided with a follow-up plan for the next step after the acute intervention.

Summary

DV encompasses a wide variety of actions that coerce, control, or demean the victim. Victims of DV suffer many physical and mental health consequences that cause emergency physicians to encounter them knowingly or unknowingly in the medical setting. Physicians who are aware of the prevalent problem of DV are able to help victims the most. A physician

should be educated to recognize the physical and emotional presentations of victims, but, more importantly, the physician should be knowledgeable about the need for screening of all patients to reach the greatest number of victims. Victims often are not ready or able to disclose DV because of patient and physician barriers. Clinicians should work to overcome these barriers by initiating screening, ensuring patient comfort and safety, and understanding the many stages involved in behavioral change that a victim must traverse. The emergency physician would experience less frustration and more success if he or she would change their role from problem solver to listener and empowerer. This approach allows the survivor to make informed choices. Patients who are ready to make changes must be provided with protection, treatment, resources, and support. Informed, active physicians have great potential for improving DV victims' lives, reducing the effects of violence, and facilitating the patient's progression from victim to survivor.

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