

# Domestic Violence

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**Synonyms and related keywords:** spousal abuse, wife beating, intimate partner violence, physical violence, psychological abuse, nonconsensual sexual behavior, verbal abuse, psychological abuse, threats, intimidation, coercion, degradation, humiliation, false accusations, ridicule, stalking, cyberstalking, sexual abuse, physical assault, assault, domestic violence, family violence, child abuse, child neglect, child sexual abuse, elder abuse, physical abuse, mental abuse

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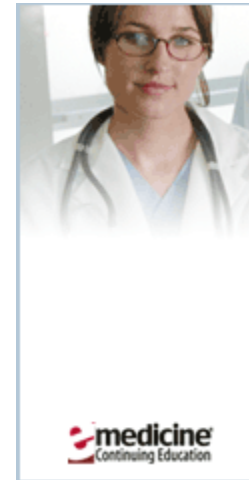
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**Background:** The medical literature defines domestic violence in different ways. In this article, domestic violence refers to the victimization of a person with whom the abuser has or has had an intimate, romantic, or spousal relationship. Domestic violence encompasses violence against both men and women and includes violence in gay and lesbian relationships.

Domestic violence consists of a pattern of coercive behaviors used by a competent adult or adolescent to establish and maintain power and control over another competent adult or adolescent. These behaviors, which can occur alone or in combination, sporadically or continually, include physical violence, psychological abuse, and nonconsensual sexual behavior. Each incident builds upon previous episodes, thus setting the stage for future violence.

- Forms of physical violence include assault with weapons, pushing, shoving, slapping, punching, choking, kicking, holding, and binding. Two forms of physical violence have been posited: occasional outbursts of bidirectional violence (ie, mutual combat) and frank terrorism, of which the "patriarchal" form has been the most researched.
- Psychological abuse includes threats of physical

harm to the patient or others, intimidation, coercion, degradation and humiliation, false accusations, and ridicule. Stalking may occur during a relationship, or during and after a relationship has ended. Of women who are stalked by an intimate partner, 81% are also physically assaulted. A new development is psychological abuse (generally threats) expressed through the Internet, so-called cyberstalking.

- Sexual abuse may include nonconsensual or painful sexual acts (often unprotected against pregnancy or disease).

Domestic violence may be associated with physical or social isolation (eg, denying communication with friends or relatives or making it so difficult that the victim stops attempts) and deprivation (eg, abandonment in dangerous places, refusing help when sick or injured, prohibiting access to money or other basic necessities).

Domestic violence is not a new epidemic—it spans history and cultures. The common law of England permitted a man to beat his wife, provided the diameter of the stick so used was not wider than the diameter of his thumb, hence, the term "Rule of Thumb."

The magnitude of the current problem may be appreciated by examining the burden placed on law enforcement. Police in the US spend approximately a third of their time responding to domestic violence calls. Of women presenting to the ED, research suggests that between 4-15% are there because of problems related to domestic violence. Calls to the police and visits to the ED sometimes are used by victims of domestic violence to strategically manage the episode by de-escalating the violence.

When all victims of domestic violence (male and female) were asked where they would go for assistance, they responded as follows:

- Would seek help from the police - 31.2%
- Did not know - 27.7%
- Would go to a hospital - 14.7%
- Would approach a family member - 10.7%
- Would go to a shelter - 10.7%
- Would forego assistance and simply retaliate - 3.1%

Women who are abused seek medical attention more so than those who are not victimized. A study in the Northwest found that 95% of women with diagnosed domestic violence sought care 5 or more times per year and that 27% sought medical care more than 20 times per year. Often, these women go to the ED.

Victims of acute domestic violence are those patients in the ED whose complaints directly relate to an incident of abuse. Two to 4% of women who present for treatment of injuries, excluding those sustained in motor vehicle collisions (MVCs), are victims of domestic violence.

Of women in violent relationships, 77% who present to the ED do so for reasons other than trauma. The percentage of women with domestic violence-related symptoms who present to an ED with any complaint ranges from 22-35%, including patients requesting nontrauma, prenatal, or psychiatric care.

Abused patients who present for other medical problems resulting from a violent milieu are said to suffer from chronic domestic violence. This term applies to those patients who are victims of violence at the hands of a partner and who seek medical care for symptoms related, directly or indirectly, to the stress of the relationship.

Women report to the police only 20% of all rapes, 25% of all physical assaults, and 50% of all stalkings perpetrated by intimate partners. Even fewer men who are victims of such crimes at the hands of an intimate report them to law enforcement. Thus, the emergency physician is often the first professional from whom an abused person seeks help. In fact, more than 85% of Americans indicated they could tell a physician if they had been a victim or perpetrator of family violence, slightly more than those who would tell their priest, pastor, or rabbi and considerably more than those who would tell a police officer.

Yet, if a request for help is not explicit, the opportunity to intervene in domestic violence often is not addressed. The following elements may deter physicians from interceding in domestic violence:

- Social factors, such as implicit and explicit social norms, societal tolerance of violence, and

- desensitization through exposure
- Personal factors, such as sex bias, personal history of abuse, idealized concepts of family life, concerns over privacy, and perceived powerlessness
  - Professional factors, such as time constraints, inadequate skills, professional detachment, and professional relationships with abusers or victims
  - Institutional and legal factors such as inadequate or unclear policies and fear of legal reprisal
  - Additional barriers including blaming the victim, disapproving of her or his decisions and circumstances, questioning patients in an inappropriate manner, and failing to query middle-class or affluent patients in the mistaken belief that such individuals are not victims of domestic violence

If the emergency physician is to recognize occult domestic violence and correctly interpret its associated behavior, a high index of suspicion is necessary, and battering must be entertained in the differential diagnosis of a wide variety of presenting complaints. In this regard, much improvement is needed. An accurate diagnosis of battering is estimated in less than 1 of 25 women. Data from another study documented that 23% of women presented 6-10 times and another 20% sought medical attention on 11 occasions before a diagnosis of abuse finally was made.

Why would domestic violence consistently be unrecognized by emergency physicians over so many ED visits? The most significant reason for missing the diagnosis of domestic violence simply may be failure on the part of the physician to ask. Limiting inquiry about domestic violence to patients with specific complaints fails to identify many victims of abuse.

The largest ED-based study to date (n = 4501) discovered that 6 diagnoses were more common in women in physically abusive relationships compared with women not in such relationships. The low sensitivity and positive predictive value of these diagnoses made the findings clinically useless in detecting most women in violent relationships—those who do not present with injuries resulting from acute battering.

The US Preventive Services Task Force states that it cannot, at this time, determine the balance between the benefits and the harms of screening for family and intimate

partner violence among children, women, and older adults. However, given the substantial percentage of patients seeking care in the ED who are abused by their partners, considering a context of violence in assessing all types of ED patients would seem prudent. Patients may be males or females from any socioeconomic group, and their injuries may or may not be related to trauma. Moreover, the incidence and prevalence of domestic violence, coupled with its morbidity and potential mortality, strongly militate in favor of routinely screening most adult or adolescent emergent patients.

Recognition of domestic violence and employment of appropriate management strategies may well have even broader implications. Domestic violence fits within a spectrum of family violence that also includes child abuse and neglect, child sexual abuse, and elder abuse.

These forms of violence share many similar root causes, and interventions directed at one may positively influence other forms of violence as well. As the practitioner on the front line of interpersonal violence, the emergency physician is in a unique and vital position to initiate the process that may stop the cycle of violence in all of its familial expressions.

**Pathophysiology:** As with organic pathology, an archetypical abnormal behavioral function characterizes domestic violence. The term *cycle of violence* is descriptive of the pattern of abuse and consists of the following 3 components:

- Tension building
- Explosion, acute battering
- Absence of tension, also called loving respite, reconciliation or the "honeymoon phase"

An appreciation of the cycle of violence is essential to understanding the nature of domestic violence, its clinical presentation, and appropriate intervention.

During the tension-building phase, the battering victim frequently tries to be particularly compliant and kind in an attempt to avoid violence. Irrespective of any special efforts, the abuser still becomes angry with increasing frequency and intensity. Paradoxically, the abused person may be so

frightened during this tension-building phase that she or he attempts to precipitate abuse, just to be done with the episode. When battering does occur, it frequently is followed by a period of indefinite length during which the batterer is contrite and demonstrates loving behavior.

Friends and family of victims, as well as experts, frequently ask victims of domestic violence why they stay in such apparently horrible situations. A nonexhaustive list of reasons includes love, hope, dependence, fear, and learned helplessness.

- With reference to love, domestic violence often occurs in a relationship in which at least one partner loves the other. This partner wants things to be all right again and does not want to lose the other person's (perceived) love.
- Hope is an operative corollary to love. The abused partner wants to believe the batterer's promises made during the increasingly frequent honeymoon periods of ever-decreasing duration as the cycle of violence deepens.
- Dependence is an additional barrier to seeking help and most commonly is observed in women, who may have a sense of emotional dependency with reluctance to expose batterers to punishment. In fact, few victims cooperate in the prosecution of arrested assailants. After only a few days, many victims even deny that they have been assaulted. Women are also more likely to rely on their partner for financial support. The abused person may feel there are no options but to stay and tolerate the violence, especially if children are involved.
- Fear is a powerful factor. Victims repeatedly emphasize that seeking care or assisting in prosecution of their assailants would escalate the violence, and their fears are based in fact. Batterers often escalate violence when their partners increase help-seeking measures or attempt separation. During prosecution, approximately half of batterers threaten retaliatory violence, and more than 30% actually commit assaults.

The most dangerous time for battered women is during attempts to leave relationships. Women who are separated from their husbands have a risk of violence about 3 times

more than that of divorced women and approximately 25 times more than that of married women. Up to 75% of domestic assaults reported to law enforcement agencies occur after separation of the couple, with women most likely to be murdered when reporting abuse or attempting to leave an abusive relationship.

Another fear experienced by victims of domestic violence is loss of children; batterers often retaliate by abducting offspring, especially during the early period of separation.

Finally, learned helplessness may be a factor. People exposed to unpredictable and inescapable negative stimuli may become passive and unable to protect their lives. A stress response syndrome has been described, which consists of self-blame, chronic anxiety, extreme passivity, denial of anger toward others while directing anger inwardly, and paralyzing terror at the first sign of danger.

Keeping the above factors in mind, attention now turns to the patient's willingness to accept help and take steps to extricate himself or herself from the environment of domestic violence. Recalling the cycle of violence previously addressed, the patient may be amenable to intervention during both the tension-building phase and the battering phase. During the reconciliation phase, the battered person typically is showered with expressions of love and apology and with assurances that the abuse will never happen again. Given the dynamics of this stage, the patient is much less willing to seek or receive help.

Insight into a further consideration of behavioral change is offered by the Transtheoretic Model of Change described by Prochaska and DiClemente. They posit a 5-stage dynamic model characterized by the following: precontemplation, contemplation, preparation, action, and maintenance. Adapting this model to the setting of domestic violence, in precontemplation, the patient may not recognize the abusive state (feeling he or she deserves such treatment or that such treatment is normal) and, therefore, has no thoughts of change; those unwilling or unable to make the requisite behavioral change are also placed in this stage.

Inquiries by the physician at this stage raises awareness of the abnormal state. In the contemplation stage, which can last for years, the victim sees the problems created by the

abuse and begins to think about the advantages and disadvantages of making a change. The contemplation stage may begin with a nondisclosure phase, in which the patient is unwilling or unable to disclose the abusive relationship to others. This may be followed by a disclosure phase, when the patient is ready to discuss abuse with a physician or other person. A study of patients who discussed abuse with a physician identified 4 expectations of significance: affirm the abuse is real, inform the patient about local resources for victims of domestic violence, educate patients about the effects of abuse on them and their children, and document injuries in the medical record.

The preparation stage is marked by active planning for change, as manifested by telling family and friends of the abuse, calling hotlines, and making a plan for leaving. The action stage speaks for itself and is frequently reached when violence is witnessed by or directed at children. This stage is reached when the victim makes the determination that the violence must end, and he or she assesses the presence of adequate support and resources. Maintenance involves solidifying the change and working to prevent relapse. Relapse is commonly seen as the patient moves through the stages of change and is most common in the action stage.

### **Frequency:**

- **In the US:** In 2000, the [National Violence Against Women Survey](#) reported, in a study of 8000 women and 8000 men, that nearly 25% of women and 7.9% of men indicated that a current or former spouse, cohabitating partner, or date victimized them at some time in their life. Rape was reported by 7.7% of women and 0.3% of men. Physical assault affected 22.1% of women and 7.4% of men.

Within the previous 12 months, 0.2% of women reported having been raped, which would equate nationally to 201,394 women. Physical assault was reported by 1.3% of women and 0.9% of men, resulting in national estimates of 1,309,061 women and 834,732 men so victimized.

Victimization often occurs repeatedly. Data from the survey revealed that women averaged 6.9 physical assaults by the same partner, with men averaging 4.4

assaults.

Given the data on multiple attacks per victim, it is estimated that every year approximately 4.8 million intimate partner rapes and physical assaults are perpetrated against women, and approximately 2.9 million are committed against men.

Contrary data has been published by the US Department of Justice. The Justice Department states that, in 2002, women were the victims of an estimated 494,570 rapes, sexual assaults, aggravated assaults, and simple assaults, a decrease since 1993 when the estimate for such crimes was 1.1 million annually. For men, in 2002, an estimated 72,520 violent crimes were committed by an intimate partner, again down from the 1993 estimate of 160,000 such crimes.

Almost 5% of women and 0.6% of men in the Violence Against Women Survey indicated that an intimate partner had stalked them, with an annual rate of 0.5% of surveyed women and 0.2% of surveyed men. Extrapolation from these data indicates that 503,485 women and 185,496 men were stalked by an intimate partner within the previous 12 months.

High-profile news reports may affect willingness to report domestic violence. Following the murders of Nicole Brown Simpson and Ronald Goldman, the Los Angeles County Sheriff's Department noted a significant increase in domestic violence dispatches.

- **Internationally:** Estimates indicate that at least 2 million women are assaulted by their partners each year. The true incidence may be twice that.

#### **Mortality/Morbidity:**

- A home in which anyone has been hit or hurt in a family fight is 4.4 times more likely to be the scene of a homicide than is a violence-free home.
- In the United States, most intimate partner murders are committed with firearms, as is the case for murder in general.
- In 2002, the US Department of Justice reported that 43% of murder victims were related to or acquainted

- with their assailants, while, in another 43% of murders, it was unknown if the victims had a relationship with their attacker.
- According to US Department of Justice data for 1998, women were the victims in 72% of intimate-partner murders and in 85% of nonlethal intimate violence.
  - A study in Maryland found that homicide was the leading cause of death among pregnant women in that state, whereas for nonpregnant women of child-bearing age, murder ranked as the fifth cause of death.
  - Nearly half of the estimated annual 4400 intrafamily murder victims are spouses. Fifty to 75% of the 1500 annual deaths resulting from murder-suicide occur in spousal or consortial relationships. More than 90% of such acts are perpetrated by the male partner, who often has a history of domestic violence. In these incidents, children and other family members may be murdered as well.
  - The literature is contradictory as to the proportion of males and females who sustain injuries as a result of domestic violence. While the conventional wisdom is that women are more likely to be injured than are men, some reports suggest that the frequencies of male and female victims of domestic violence are equal.
  - In 1996, McCoy reported that, in mixed-sex domestic violence, the female is 13 times more likely to be injured than is the male. In 1995, Bachman and Saltzman indicated that, in violent incidents committed by intimates, women sustained injury in 52% of cases, with 41% of those patients requiring medical care.
  - Contrary findings come from a study of 516 patients presenting to an inner-city ED, in which high rates of domestic violence were nearly equal between men and women. Males and females had the following rates of domestic violence, respectively:
    - Past nonphysical violence - 14% versus 22%
    - Past physical violence - 28% versus 33%
    - Present nonphysical violence - 11% versus 15%
    - Present physical violence - 20% versus 19%
  - In an ED study of 1003 patients reported by Sachs et

- al, no significant sex difference was noted in the rate of patients acutely injured by intimate partner violence. No such difference was found in patients reporting abuse within the past year, abuse with a weapon, or abuse with a weapon within the last year.
- With reference to serious injury, in a small study (n = 37) reported by Vasquez and Falcone, victims of domestic violence admitted to one trauma center were just as likely to be male as female.
    - Males were more likely to be seriously injured than were females, with average injury severity scores of 11.4 versus 6.9.
    - While males were less likely than females to be victims of gunshot wounds (6% vs 21%) or to be injured in an assault (22% vs 53%), they were more likely to be stabbed (72% vs 26%).

### **Race:**

- The National Violence Against Women Survey found that African American and American Indian and Alaskan Native women and men report higher rates of domestic violence than do other minority groups, whereas Asian and Pacific Islander women and men tend to report lower rates of intimate partner violence than other minority groups. Differences among minority groups diminish, however, when other sociodemographic and relationship variables are controlled.
- In 1998, Salber and Taliaferro reported that the spousal homicide rate among African Americans is 8.4 times more than for whites; however, the US Department of Justice reports that between 1976 and 1998, a 74% reduction occurred in the number of black men murdered by intimates.
- The incidence of spousal homicide is 7.7 times higher in interracial marriages compared to intraracial marriages.

### **Sex:**

- Much of the data concerning domestic violence are based on involvement of the criminal justice system. When interpreting reports from law enforcement

agencies, the following caveat should be noted: In 1997, Ernst and colleagues reported a significant difference in reports of past abuse to the police, with 19% of women having made such reports versus only 6% of men.

- Females are more likely to be repeatedly attacked, injured, or raped by their male partners than by any other perpetrators. The US Department of Justice estimates that females are 6 times more likely than males to experience violence committed by an intimate (ie, spouse or ex-spouse, boyfriend or girlfriend, ex-boyfriend or ex-girlfriend). Of all violence against females that is committed by a lone offender, an intimate is the perpetrator in 29% of cases.
- Half of homeless women and children are fleeing domestic violence.
- Battered lesbians report high levels of sexual violence, in the range of 30-40%. Some experts believe that homosexual men also experience high levels of sexual violence, although little documentation can be found in the literature. The National Coalition of Anti-Violence Programs reported that the rate of domestic violence in same-sex couples increased by 29% in 2000.
  - Approximately 11% of women living with female intimate partners report being raped, physically assaulted, or stalked by their cohabitant. (In comparison, 30.4% of women living with a male partner, reported such victimization by their male cohabitant.)
  - Approximately 15% of men living with male intimate partners report being raped, physically assaulted, or stalked by their cohabitant. (In comparison, 7.7% of men who have lived with a female partner experienced such problems.)

### **Age:**

- Women aged 16-24 years are more likely than other women to be victims of violence at the hands of an intimate. Twenty to 30% of university women report violence during a date.
- The rates of spousal homicide for all groups peak in

the 15- to 24-year-old age category. Rates decline with age in African Americans but not in whites.

- As the age differential between husband and wife increases, so does the risk of spouse homicide.

## CLINICAL

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### History:

- The following is a list of some important points to remember when taking the patient's history
  - The batterer often accompanies the patient to the ED, may hover and refuse to leave the patient alone, and may insist on answering questions for the patient. These factors reinforce the necessity for taking the history in private.
  - Inform the patient of any limits to confidentiality imposed by mandatory reporting requirements for domestic violence and child abuse. If a translator is necessary, he or she should not be a member of the patient's or suspected abuser's family.
  - Simple questions asked in private may elicit previously unrecognized risks and histories of violence. Ask direct questions (eg, "Has your partner ever punched or kicked you?"), as opposed to asking if a person is battered or otherwise a victim of domestic violence. This is critical because the patient may not interpret what occurs as domestic violence.
  - If questioning the family, do so with care, always remembering that the batterer may be among those queried. Phrase questions in an open-ended manner such as "Betty seems upset. Do you have any idea why?"
  - When questioning an abuser who has been injured, use nonjudgmental language, such as

"What happened after you threw your partner on the floor?" as opposed to "What did you do after you beat her?"

- Abusers often blame the victim for their behavior; therefore, take care not to validate such assertions by saying "I can understand why that made you so mad you threw her down." The abuser should instead receive the message that "Hitting does not solve problems; it often destroys families."
- Historical findings associated with domestic violence
  - Presenting complaints relating to illness or stress predominate by a 2:1 ratio over injury.
  - Domestic violence may be causal in a large number of chronic health problems. Women who are battered are more likely to present with vague medical complaints (12% vs 3%), sexual problems (19% vs 3%), depression, or anxiety than are women who are not battered.
  - Presentations common to the ED include acute pain with no visible injuries, chronic pain (especially if evidence of tissue damage cannot be found), repetitive complaints inconsistent with organic disease, pain due to diffuse trauma without visible evidence, and symptoms without evidence of physiologic abnormality.
  - A history of multiple prior visits to the ED (traumatic and nontraumatic) suggests battering.
  - Medical recidivism for vague complaints without evidence of physical abnormality may result from psychosomatic complaints secondary to depression, the ultimate cause of which is domestic violence. Nonspecific complaints of ill or failing health may be voiced in the context of "I can't seem to do what I'm supposed to do."
  - A substantial delay between time of injury and presentation for treatment may stem from ambivalence about discovery of the true cause should the patient seek help. Such a delay also may result from the inability of the patient to leave the house or an absence of independent means of transportation.

- Noncompliance with treatment regimens, missed appointments, and failure to obtain or take medications may be due to a lack of access to money or telephones and ultimately may indicate attempts to exercise control over the patient. The patient and/or partner may deny injury or minimize the incident(s).
  - The patient may feel isolated and may be kept socially isolated. The patient may provide a history of being restrained or locked in or out of shared domiciles. The patient also may feel threatened with violence, institutionalization, abandonment, or guardianship.
  - Reluctance by the patient to speak or disagree with the partner may be noted, as may exaggerated self-blame for the partner's violence. Intense jealousy or possessiveness may be reported by the patient or expressed by the partner.
- Depression and suicide
    - Patients with psychiatric complaints, especially suicide attempts, ideation, or gestures, always should be questioned about current or past domestic violence.
    - Domestic violence may be a factor in up to 25% of suicide attempts in women. Of pregnant women who are battered, 20% attempt suicide. When inquiring about the reason for the suicide attempt, clarify responses such as "fight with my husband" as to presence or absence of physicality.
    - Depression is a correlate of domestic violence. Patients (especially women) presenting with such complaints or with sleep or eating disturbances should be questioned about current or past abuse.
- Stress
    - Symptoms related to stress are common, including anxiety, panic attacks, other anxiety symptoms, and posttraumatic stress disorder (PTSD).
    - Fatigue and chronic headaches also may be noted.

- Abuse of alcohol and other drugs
  - Abuse of alcohol and other drugs is a correlate of domestic violence. Since substance abuse may develop or worsen as a result of domestic violence, it is appropriate to consider domestic violence when evaluating a patient for alcohol intoxication, drug toxicity, or drug overdose.
  - Be aware of frequent use of minor tranquilizers or pain medications.
  - A family history of alcohol and drug abuse or similar history in the patient's partner is also an important risk factor.
  
- Medical complaints
  - Palpitations, dyspnea, atypical chest pain, abdominal or other GI complaints, dizziness, and paresthesias, while common complaints, are noted frequently with domestic violence.
  - Current or past self-mutilation may be noted.
  
- The female patient
  - Gynecologic complaints include frequent vaginal or urinary tract infections, dyspareunia, and pelvic pain.
  - Failure to use condoms or other appropriate means of protection is frequent and is suggested by a history of sexually transmitted diseases, particularly if recurrent.
  - The pregnant patient may be homeless, may report no, sporadic, or late prenatal care, and may present with depression.
  - Other historical findings may include problem pregnancies, preterm bleeding and/or miscarriage, and self-induced abortion.
  
- Trauma
  - Some "accidents" (eg, falls) result from domestic violence. Patients presenting with non-MVC trauma, especially assault-related trauma, should prompt inquiry about the possibility of injury by a known partner.
  - Injuries sustained in a single-vehicle crash, either as driver or passenger, also raise suspicions for domestic violence.
  
- Asking about domestic violence

- Several protocols for inquiring about domestic violence have been recommended and are easily adaptable to the ED.
- The women-validated Partner Violence Screen (PVS) poses the following questions:
  - Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom were you injured? (This question detected almost as many abused patients as the combined 3-question PVS, with better specificity.)
  - Do you feel safe in your current relationship?
  - Is a partner from a previous relationship making you feel unsafe now?
  - In addition, patients were asked, "Are you here today due to injuries from a partner? Are you here today because of illness or stress related to threats, violent behavior, or fears due to a partner?"
- The mnemonic SAFE directs inquiry into domestic violence. Sebastian, in 1996, maintained that simply asking the SAFE questions alleviates the patient's alienation, offers him or her an opportunity to validate his or her worth, and provides a means to assess safety. When SAFE questions are made routine, physicians become more comfortable in discussing domestic violence.
  - Stress/safety: What stress do you experience in your relationships? Do you feel safe in your relationships (marriage)? Should I be concerned for your safety?
  - Afraid/abused: What happens when you and your partner disagree? Do any situations exist in your relationships in which you have felt afraid? Has your partner ever threatened or abused you or your children? Have you been physically hurt by your partner? Has your partner forced you to have



cope with abuse? Who has been contacted and how often? What has been the response?

- Has the behavior or mental status of the victim changed? Is she or he more or less aware of danger or harm? Is she or he reaching out or withdrawing? Does she or he seem in a fog or emotionally dulled?
- Assessment of legal needs
  - Has the patient ever sought help to stop the abuse?
  - Is she or he familiar with protective laws and options they provide? Has she or he used them in the past? Was such use effective in decreasing contact with the batterer? If no, were police called to enforce the court order? Did the police provide adequate protection?
  - Has the patient filed a criminal complaint against the batterer? Has the case been heard? If yes, what was the outcome? If no, why? Did the victim drop the charges?
  - Does the patient want to pursue either criminal or civil legal action at this time? If yes, provide specific written instructions.
  - Give the patient the telephone number of a referral contact person or agency even if she or he does not request additional legal assistance.
- History of previous attacks
  - The frequency and severity of previous attacks indicate the degree of present danger. Threats are as important as any actual injury. The presence of weapons in the home is a risk factor.
  - In addition to threats and physical abuse, relationships with high risk for injury or death commonly feature exaggerated forms of coercion and manipulation to maintain the partner's dependence. This may result in the Stockholm syndrome.

- A pattern may be discerned involving isolation of the victim, as follows:
  - Monopolization of the victim by the assailant (eg, does not allow demonstration of affection for children, family, pets)
  - Use of threats and public degradation
  - Nonviolent induction of disability (ie, assailant does not allow the victim to sleep or seek medical attention)
  - Expressions of omnipotence (eg, following the victim when she or he leaves the house, "I know what you are doing all the time")
  - Triviality (eg, obsessive attention to minor details about housekeeping or dress)
  - Use of indulgences to maintain the relationship (eg, buying gifts after episodes of abuse)
- While the best indicator of danger is the patient's own assessment, the severity of violence and the danger faced by patients often are minimized as a coping strategy.
- The emergency physician may wish to employ the following instruments to assess danger:
  - Physical Abuse Ranking Scale: Incidents ranking higher than 5 indicate a high likelihood of danger.
    - Throwing things, punching the wall
    - Pushing, shoving, grabbing, throwing things at the victim
    - Slapping with an open hand
    - Kicking, biting
    - Hitting with closed fists
    - Attempted strangulation
    - Beating up, pinning to wall or floor, repeated kicks and punches
    - Threatening with a weapon
    - Assault with a weapon
  - Lethality Checklist: The more items checked, the greater the danger. The perpetrator may exhibit the following behaviors and emotions:
    - Objectifies partner (eg, calls the partner

- names, body parts, animals)
  - Blames the victim for injuries
  - Is unwilling to release the victim
  - Is obsessed with victim
  - Is hostile, angry, or furious
  - Appears distraught
  - Is extremely jealous, blaming the victim for all types of promiscuous behavior
  - Has been involved in previous incidents of significant violence
  - Has killed pets
  - Has made threats
  - Has made previous suicide attempts
  - Is threatening suicide
  - Has access to the victim
  - Has access to guns
  - Uses alcohol
  - Uses amphetamines, cocaine, or other drugs
  - Has thoughts or desires of hurting partner
  - Has no desire to stop violence or control behavior
  - Has an extremely tense and volatile relationship with the victim
- In addition to a general history, assessment of immediate safety is critical as discussed by the following points:
  - Physical violence
    - What is the degree of physical violence?
    - Is your partner violent toward you or your children?
    - Has the amount of violence increased in frequency and/or severity over the past year?
    - How often does the batterer attack, hit, or threaten you?
    - Has your partner ever beaten you while you were pregnant?
    - Have you ever been hospitalized as a result of abuse?
    - Is your partner violent outside your home?
  - Threats of homicide

- Has your partner ever threatened or tried to kill you?
- Has your partner threatened to kill you with a weapon?
- Has your partner ever used a weapon?
- Does your partner have access to a gun?
- Has the batterer ever tried to choke you?
- Have you ever been afraid you might die while the batterer was attacking you?
- Substance abuse
  - Are alcohol or other drugs involved?
  - Does your partner get drunk every day or almost every day?
  - Does your partner use uppers such as amphetamines (speed), angel dust (phencyclidine [PCP]), or cocaine (including crack)?
- Control
  - How much control does your partner have over you?
  - Does your partner control your daily activities such as where you can go, who you can be with, or how much money you can have?
  - Is your partner violent and constantly jealous of you?
  - Has your partner ever said that if she or he cannot have you, no one else can?
  - Has your partner ever used threats or tried to commit suicide to get you to do what she or he wants?
- Suicidal ideation
  - Are you thinking of suicide or homicide?
  - Have you ever considered or attempted to commit suicide because of problems in the relationship?
  - If so, do you have a plan?
  - Do you have access to a weapon or other means (eg, medications) chosen for suicide?
- Homicidal ideation
  - Have you ever considered or attempted killing your batterer?

- Are you considering this now?
- Do you have a plan?
- Do you have access to a weapon or other means chosen for homicide?

**Physical:** The partner may exhibit controlling behavior, or coercion may be reflected in the possessiveness and hovering of the intimate (male or female) partner who answers for the patient, seems overly aggressive or agitated, or isolates the patient while visiting. The absence of support in the ED also may indicate the possibility of domestic violence because of social isolation.

The patient may appear depressed. The patient may seem fearful of visitors and care givers, including hospital staff. Eye contact may be poor. The consequences of emotional abuse may be observable (eg, reaction of the patient to a visitor who yells, threatens, or swears inappropriately). The patient may appear withdrawn.

Examine the whole patient, appreciating that the scalp may conceal signs of abuse. Patients may attempt to hide injuries under heavy makeup, turtleneck collars, wigs, or jewelry.

- Characteristic injuries
  - Bilateral injuries, especially to the extremities
  - Injuries at multiple sites
  - Fingernail scratches, cigarette burns, rope burns
  - Abrasions, minor lacerations, welts
  - Subconjunctival hemorrhage suggests a vigorous struggle between victim and assailant.
- Fingernail markings: Three types of fingernail markings may occur, either singly or in combination as follows:
  - Impression marks: These result from fingernails cutting into the skin. They may be shaped like commas or semicircles.
  - Scratch marks: These are superficial and long and may be narrow or as wide as the fingernail. Scratches caused by the longer

fingernails of women are frequently more severe than those from a male assailant.

- Claw marks: These occur when the skin is undermined, thus they appear to be more dramatic and vicious. While claw marks may be grouped parallel markings down the front of the neck, they often are randomly scattered.
- Pattern injuries: Pattern injuries suggest violence. Pattern injuries are marks, designs, or patterns stamped or imprinted on or immediately below the epithelium by weapons. Pattern injuries fall into blunt force, sharp force (incised and stabbed), and thermal categories.
  - Blunt force trauma to the skin includes the most common injury, contusion, as well as abrasions and lacerations. Circular or linear contusions suggest abuse or battering. Parallel contusions with central clearing suggest assault from linear objects. Slap marks with delineation of the digits may be noted. Circular contusions 1-1.5 cm in diameter are consistent with fingertip pressure and may be seen with grabbing. Such marks are often present on the medial aspect of the upper arm, an area commonly overlooked in physical examination. Assaults with belts or cords may cause looped or flat contusions, and shoe soles or heels may cause contusions in patients who have been kicked or stomped on.
  - Contusion caveats: Several factors determine development of a contusion, including the amount of blunt force applied to the skin, tissue density and vascularity, fragility of blood vessels, and amount of blood escaping into surrounding tissues. Bruises of identical age and cause on one person may not have the same color and may not change at the same rate in another person. Some basic guidelines as to the appearance of contusions are as follows:
    - Red, blue, purple, or black colors may occur any time from 1 hour after the causal trauma to resolution of the

- contusion. The presence of red coloration, therefore, has no bearing on the age of the bruise.
    - A bruise with any yellow coloration must be older than 18 hours.
    - Although yellow, brown, or green bruises indicate an older injury, further specification of age is difficult.
  - Bite marks: These are another type of pattern injury common in domestic violence. Some bite marks are difficult to recognize as such, appearing as nonspecific semicircular contusions, abrasions, or contused abrasions, while others are rich in identifiable features because of the anatomical location of the bite and the motion of teeth relative to skin.
- Strangulation: Thirty-three pounds of pressure per square inch is required to completely close the trachea, whereas the carotid arteries may be occluded with a third of that pressure. Either results in strangulation, which accounts for 10% of all violent deaths in the US annually. Hanging, ligature, or manual are the 3 forms of strangulation. The latter 2 may be associated with domestic violence.
  - Ligature strangulation (garroting) is strangulation with a cordlike object such as a telephone cord or clothing items. Manual strangulation (throttling) is usually done with the hands; manual strangulation also may be accomplished with the forearms or by standing or kneeling on the patient's throat.
  - Strack and McLane studied 100 women who reported being choked by their partners with bare hands, arms, or objects (eg, electrical cords, belts, ropes, bras, bathing suits). Police officers reported no visible injuries in 62% of women, minor visible injury in 22%, and significant injury including red marks, bruises, or rope burns in the remaining 16%. Up to 50% of victims had symptomatic voice changes ranging from dysphonia to aphonia.
  - Dysphagia, odynophagia, hyperventilation, dyspnea, and apnea may be reported or observed. Notably, reports indicate that some patients with an initial presentation considered

"mild" have died up to 36 hours after strangulation, secondary to respiratory decompensation.

- Petechiae are most pronounced in ligature strangulation. Conjunctival petechia may be observed, as well as petechia anywhere above the area of constriction, including the face and periorbital region.
- The neck may reveal scratches and abrasions from the victim's fingernails or a combination of lesions created by both victim and assailant. Location and extent varies with position of the assailant (front or back) and whether the victim or assailant uses one hand or two. In manual strangulation, the victim often lowers the chin to protect the neck, resulting in abrasions of the victim's chin and the attacker's hands.
  
- A single contusion or erythematous area is most commonly the assailant's thumb. Areas of contusions or erythema frequently run together, with clusters at the sides of the neck, along the mandible, up to the chin, and down to the supraclavicular area.
- Ligature marks may range from subtle to dramatic. They may mimic the natural folds of skin. Marks (eg, wavelike pattern of a telephone cord, braided pattern of a rope or clothesline) may suggest the object with which the person was strangled. The nature and angle of a pattern may assist in differentiation of hanging from ligature strangulation. In ligature strangulation, the impression of the ligature is generally horizontal at the same level of the neck, and the ligature mark is generally below the thyroid cartilage; often, the hyoid bone is fractured. In hanging, the impression tends to be vertical and teardrop-shaped, above the thyroid cartilage, with a knot at the nape of the neck, under the chin, or directly in front of the ear. The hyoid bone usually is intact.
- Other complaints included loss of consciousness, defecation, uncontrollable shaking, nausea, and loss of memory.

- Central distribution of injury
  - Injuries in domestic violence are usually central.
  - Among the most common sites of injury are areas usually covered by clothing (eg, chest, breast, abdomen).
  - The face, neck, throat, and genitals are also frequently the sites of injury.
  - Up to 50% of injuries resulting from abuse are to the head and neck. To avoid obvious injury, male attackers may avoid striking the face, opting instead to hit the back of the head.
  - Facial injuries are reported in 94% of victims of domestic violence.
  - Maxillofacial trauma includes injuries to the eye and ear, soft tissue injuries, hearing loss, and fractures of the mandible, nasal bones, orbits, and zygomaticomaxillary complex.

- Injuries suggesting a defensive posture
  - Fractures, dislocations, sprains, and/or contusions of the wrists or forearms may be sustained as a result of attempts to parry blows to the face or chest.

Defensive injuries commonly are observed. These include injuries to the ulnar aspect of the arm, the palms (which may be used to block blows), and the soles (which may be used to kick away the assailant). Other common injuries include contusions to the back, legs, buttocks, and back of the head (which can result when the victim crouches on the ground for protection).

- Patient explanation inconsistent for extent or type of injuries: Multiple abrasions or contusions to different anatomical sites inconsistent with the history raises suspicions for domestic violence as would, for example, a blow-out fracture of the orbit that, per history, was sustained in falling from a chair. A body map may help document physical findings, especially with multiple injuries in various stages of healing.
- Violence during pregnancy

- Violence often increases during pregnancy.
  - Injuries during pregnancy are commonly, but not exclusively, to the breast or abdomen.
  - The patient also may present with trauma to the genitalia, unexplained pain, poor nutrition, unexplained spontaneous abortion, miscarriage, or premature labor.
- Sexual assault
    - Sexual assault is reported by 33-46% of women who are physically battered.
    - Examine the patient for evidence of sexual assault if indicated by clinical presentation.
    - Any evidence of genital injury, such as labial or vaginal hematomas, small vaginal lacerations, or rectovaginal foreign bodies, should prompt assessment for domestic violence or sexual assault. Dried blood or semen may be noted.
    - Sexually transmitted diseases, particularly if recurrent, raise suspicion of sexual assault.

### **Causes:**

- Both males and females with disabilities are at increased risk of abuse due to reliance on their caregiver.
- Many victims are pregnant.
- Women from families with annual incomes below \$10,000 are at increased risk for intimate violence.
- Conversely, wives whose educational or occupational level is high relative to their husbands are at greater risk for abuse than those in marriages without such differences.
- The abuser is typically an underachiever who has obtained lower occupational status than expected given the abuser's education.
- Other factors associated with domestic violence
  - History of family violence

- Alcohol or drug use by the batterer, victim, or both
  - The use and abuse of alcohol is strongly associated with a higher probability that the drinker will be involved in violence as victim, perpetrator, or both.
  - Illicit use of drugs by household members increases a woman's risk of death at the hands of a spouse, lover, or close relative by a 28-fold factor.
  - Use of alcohol and illicit drugs is associated with a 16-times greater risk for suicide, a risk substantially higher than that observed for the use of either individual substance.
  - In a small study (n = 46) examining the relationship between selected socioeconomic risk factors and injury from domestic violence, alcohol abuse by the male partner, as reported by the female partner, was the strongest predictor for acute injury. Approximately half of the victims stated that their male partners were intoxicated at the time of the assault. Whether male partner intoxication is a direct causal factor, an indirect factor, or a factor that modifies the effect of a causal factor has not been determined.
  - On the day of the assault, 86% of assailants reportedly used alcohol, with 67% using the combination of alcohol and cocaine. The active metabolite of such a drug combination, cocaethylene, is more intoxicating, longer lived, and possibly more potent in its ability to kindle violent behavior than are the parent drugs.
  
- A current relationship involving abuse
  
- Psychiatric history
- Of those who report being abused as children, 50.4% also report adult abuse.

[Alcohol and Substance Abuse Evaluation](#)

[Depression and Suicide](#)

[Elder Abuse](#)

[Panic Disorders](#)

[Pediatrics, Child Abuse](#)

[Pediatrics, Child Sexual Abuse](#)

### **Other Problems to be Considered:**

PTSD

### **Prehospital Care:**

- In addition to attention to ABCs and administration of treatment appropriate to the patient's presenting complaints, emergency medical services (EMS) personnel are in a unique position to identify problems associated with violence.
- EMS personnel are the only health professionals who enter the environment where victimization occurs and are thus more likely to see evidence of domestic and sexual violence than the emergency physician. This is especially true when called into a home for a problem not directly related to abuse. In such cases, EMS personnel may detect abuse and violence that might otherwise go unreported.
- Victims of domestic violence frequently refuse ambulance transport, thereby avoiding medical care in the ED. In such situations, EMS personnel are the only health professionals in a position to recognize domestic violence and make suggestions for appropriate intervention.
- In one study, 140 paramedics who annually respond to 44,000 emergency requests, received training directed at acquisition of assessment skills for violence-related injuries and screening of female patients for history and risk of domestic violence. As with other professionals, however, simply training EMS personnel is not enough. Attitudes must be addressed because follow-up revealed reluctance in collecting specific violence-

related data elements, particularly concerning domestic violence.

### **Emergency Department Care:**

- The emergency care of a victim of domestic violence is simultaneously straightforward and challenging. Responsibilities when treating such patients, in addition to lifesaving interventions, include the following:
  - Provide a safe environment.
  - Inquire about domestic violence and/or recognize abuse from information obtained during the history and physical.
  - Establish the diagnosis of domestic violence.
  - Acknowledge the abuse and reassure the patient that she or he is not at fault.
  - Evaluate emotional status and treat the emotional injury.
  - Diagnose and treat physical injuries and other medical or surgical problems.
  - Clearly document the history, physical findings, and interventions in the medical record.
  - Determine the risks to the victim and any children and assess safety and available options.
  - Counsel the patient that violence may escalate.
  - Determine the need for legal information or intervention and report abuse when appropriate or mandated.
  - Develop a follow-up plan.
  - Offer referral to shelter, legal services, and counseling, facilitating such referrals with the consent of the patient.
  
- Requirements mandated by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO): Patients who possibly are victims of alleged or suspected abuse or neglect have special needs during the initial screening and assessment process. JCAHO requires hospitals to have policies for the identification, evaluation, management, and referral of adult victims of domestic violence, including the following:
  - The hospital has specific and unique responsibilities for safeguarding information and evidentiary material(s) that could be used in future actions as part of the legal process.
  - Hospitals must have policies and procedures that define their responsibility for collecting these materials. Hospital policy must define these activities and specify who is responsible for their implementation. The following elements are to be documented in the patient's medical record:
    - Consents from the patient, parent, or legal guardian or compliance with other applicable laws
    - Evidentiary material released by the patient
    - Legally required notifications and releases of information to authorities

- Referrals made to private or public community agencies for victims of abuse
- Providing a safe environment
  - The ED should provide a safe haven, albeit temporary, to the victim of domestic violence. An immediate concern is for the safety of the abused patient and any children. Interview the patient alone, a step that also removes him or her from the immediate reach of the batterer.
  - The patient needs to know that the situation is taken seriously by compassionate health professionals. One way of communicating the concern of the staff toward domestic violence is by placement of posters that give information about domestic violence in waiting rooms, treatment rooms, and restrooms.
  - Among the resources from which posters may be obtained are the American Medical Association (AMA) at 1-800-AMA-3211 for physicians who join the National Coalition of Physicians Against Family Violence and from the Family Violence Prevention Fund at (415) 252-8900 or 1-800-313-1310.
- Evaluation of emotional status and treatment of emotional injury: Clinicians should ensure the patient feels respected, cared for, listened to, and encouraged to make her or his own choices to the extent allowable under the law. The following are primary messages to victims:
  - There is no excuse for domestic violence. Violence is not your fault—nobody deserves to be abused.
  - It must be very difficult for you to face your situation. You are not alone; there are people you can talk to for support, shelter, and legal advice.
- Management of the immediate aftermath of violence: This can be a major determinant of the victim's response to psychologic trauma, the effects of which have the potential to be severe. Appropriate intervention lessens the likelihood of long-term conditions such as PTSD, depression, anxiety disorders, substance abuse, and counterphobic behavior.
  - Respect the patient's modesty and, when possible, touch the patient only with permission. Use plain language to honestly explain procedures and their importance.
  - Carefully explaining the physiologic and psychologic reactions to be expected in the posttrauma period provides an organizing framework and may assist in reestablishing some sense of control. The following responses may result from violent victimization:
    - Dissociation - Person feels separated from his or her body, from reality, or both
    - Eidetic memory - Flashbacks characterized by vividness, intensity, and experiencing the memory as currently happening each time it is recalled

- Recall - Repetition of the full experience (ie, sights, sounds, smells, tactile perceptions, emotions), including the horror of the moment
  - Hyperarousal of the autonomic nervous system
  - Hypervigilance - Paranoid level of fear or mistrust, or intense awareness of every word and act of the ED staff, and a distorted sense of time
- Treatment of physical injuries and other medical or surgical problems
  - In addition to injuries or other conditions identified during the workup, protection against sexually transmitted infections and pregnancy may be discussed.
  - These measures also are indicated if the victim has been sexually assaulted or subjected to coercive sexual acts.
- History, physical findings, and other interventions
  - The chart: The medical record could mean the difference between convicting an abuser or allowing him or her to go free and potentially assault again. Document the details of all findings, interventions, and actions in a legible medical record, which should contain as much of the following information as possible:
  - History
    - Include a description of the abusive event including present complaints; use the patient's words verbatim (in quotation marks whenever appropriate). Include the patient's domestic violence history.
    - When indicated (eg, patient presents an inconsistent history suggesting the true problem is being concealed), it is appropriate to include an objective description of the patient's behavior in the medical record.
    - Include other health problems, physical or mental, that may be related to the abuse.
    - Include the alleged perpetrator's name, address, and relationship to the patient (and any children).
  - Injuries
    - Detailed descriptions of the patient's injuries, including type, location, size, color, and apparent age.
    - Thoroughly document injuries via completion of anatomical diagrams and, when possible, color photographs taken before any medical treatment.
  - Photographic documentation of abuse
    - When possible, and with the patient's consent (attached to the chart), document all injuries with Polaroid "instant" photographs. Use of a Polaroid camera allows assessment of the adequacy of photographs before the patient leaves the ED.

- At least 1 of the photographs should be a full body shot that includes the patient's face (to link injuries to patient). Others include a mid range photograph to show torso injuries and close-ups of all wounds and contusions. Take photographs from different angles with at least 2 views of each injury, and include an object (eg, a ruler) that indicates the size of the injuries.
    - Write the name of the patient, medical record number, date and time of the photograph, name of the photographer, location, and names and titles of any witnesses on the back of each photograph before they are attached to the medical record. The photographer should sign the photograph.
    - Consider indicating on the back of the photograph the part of the body represented and the victim's stated cause of the injuries.
    - Torn and damaged clothing also may be photographed.
    - Document any injuries not shown clearly by photographs on a hand-drawn or preprinted body map.
  - Preservation of physical evidence
    - Preserve any physical evidence (eg, damaged clothing, jewelry, weapons) that may be used for prosecution. Preserve the chain of evidence.
    - With rape or sexual assault, follow appropriate protocols for physical examination and for evidence collection and preservation during forensic examination.
- Legal information and intervention and reporting abuse
  - Inform the patient that battering is a crime and that help is available. Ascertain if the patient wants intervention from law enforcement or other legal referral. The provider should ensure priority assistance if the patient wants immediate help.
  - In those jurisdictions in which reporting of domestic violence is mandated, the physician should discuss with the patient the legal obligation to report abuse.
  - Explain how local authorities respond to such reports and outline follow-up procedures that may be necessary. Also, address the risk of reprisal and the possible need for shelter or an emergency protective order (available to battered women in every state and the District of Columbia).
  - If the patient believes that police intervention will jeopardize safety, the physician should work with the patient and recipient of the report to best meet the patient's safety needs. The role of the clinician in the care of the abused patient thus goes beyond simply obeying the laws that mandate reporting. An attempt must be made to mitigate the potential harms resulting from those laws, to maximize the role of the patient's choices regarding future actions,

- and to provide appropriate ongoing care to the patient.
- Ensure that the patient will be safe pending arrival of the police. If the patient desires, a health professional should remain with the patient during the police interview.
  - The medical record should reflect that the incident was reported to law enforcement, any subsequent police report, including the date and time the report was taken and the name and badge number of the officer(s) who responded to the ED call. Reporting domestic violence to law enforcement does not substitute for thorough documentation of the abuse in the medical record.
- Determination of risk to victim and children
    - Ask the patient, "If you return home now, will you be in danger?" Risk also includes the potential for suicide. Accordingly, it is appropriate to ask, "Have you had thoughts of harming or killing yourself?"
    - Take threats by the perpetrator to kill the victim, children, or himself or herself very seriously. Any need to restrain an assailant is especially troublesome.
  - Development of a follow-up plan
    - Inquire as to the patient's state of mind.
      - What type of help would you like?
      - Are there any changes you would like to make in your situation?
      - What steps might help you make those changes?
      - How might we help?
    - Considerations when planning disposition
      - Does the patient need immediate medical or psychiatric intervention? Does she or he require admission or urgent follow-up for medical conditions? Is she or he suicidal or homicidal? Does she or he need urgent crisis counseling to deal with the stress of abuse? If so, arrange appropriate appointments or referrals.
      - Who is waiting outside for the patient? Leaving via a less visible exit might be best for a patient. Does the patient think that it is safe to go home? Where is the batterer now? Was she or he arrested? Was she or he released? Does the batterer have access to a firearm or other weapon? Has she or he been threatening to kill the victim? Does she or he believe the threats? Has she or he been harassing or stalking the victim? Are abusive behaviors escalating?
      - Does the patient have friends or family with whom she or he can stay? Does she or he feel safe at their home or afraid the batterer will come there? Is the patient confident that family and friends will not inadvertently collude with the

batterer in the mistaken belief that they are helping the couple?

- In what type of situation are children and other dependents? Does the patient think they are safe? Is the patient afraid they will be harmed if she or he does not go home?
  - Does the patient want immediate access to a shelter or other temporary living situation? Ask where the patient will go if she or he leaves the ED. If the patient wants to go to a shelter now, where should she or he go? If no beds are available, what other options exist (eg, motel vouchers, overnight stay in the ED, admission to the hospital)?
  - If the patient does not want to go to a shelter, give the victim telephone numbers for domestic violence or crisis hotlines in the community in case she or he wants or needs them at a later time. Be mindful that written materials may pose a danger once the patient returns home.
  - If the patient wants to go home, a referral should be made to a primary care provider or other appropriate resource.
  - Advise the patient to have a safety plan.
- Elements of a safety plan: This plan is adapted from the San Diego city attorney's Personalized Safety Plan of April, 1990. Copies of a fill-in-the-blank, personalized safety plan may be obtained from the Family Violence Prevention Fund, 383 Rhode Island St, Suite 304, San Francisco CA 94103-5133, telephone (415) 252-8900 or 1-800-313-1310, fax (415) 252-8991.
    - Safety during a violent incident that occurs in the home
      - Try to avoid arguments in small rooms, rooms with access to weapons (eg, kitchen), or rooms without access to an outside door. Be aware that alcohol and other drugs can decrease your ability to act quickly to protect yourself and your children.
      - Know which doors, windows, or fire escapes you and your children would use if you must quickly escape to safety. Know where you will go once you leave the house. If possible, practice taking this route.
      - If you can, tell a friend or neighbor to call the police if they hear suspicious noises coming from your home or over the telephone.
      - Arrange use of a code word with children or friends so they know when they should call for help.
      - Teach children how to use the telephone to contact police or fire agencies (911, if available, is preferable to dialing "0").
    - Hide the following items where they may quickly accessed in an emergency:
      - Identification for self and children (eg, driver's license, social security cards, birth certificates, green cards, passports)

- Important documents (eg, school and health records, welfare identification, insurance records, automobile titles, lease or rental agreements, mortgage papers, marriage license, address book)
  - Copies of any protective or restraining orders, divorce or custody papers, or court documents
  - Money, checkbook, bankbook, and credit card (in your own name if possible)
  - A small supply of any prescription medicines or a list of the drugs and dosages and the name, address, and telephone number of the prescribing physician
  - Clothing, toys, and other comfort items for self and children
  - Items of special sentimental value
  - Small, sellable objects
  - Extra set of keys to the car, house, office, and safe-deposit box
- Safety if you no longer live with the batterer
  - Change the locks on doors and windows as soon as possible.
  - Try to live where doors are secure (eg, steel or metal instead of wood).
  - When possible, install safety devices, such as extra locks, window bars, motion-detecting outdoor lights, and electronic security systems.
  - Install smoke detectors, purchase fire extinguishers, and have rope ladders for upper floor windows (kept inaccessible from the outside until needed).
- Safety on the job
  - Is there someone at work (eg, coworker, supervisor, employee assistance counselor) who can be informed of the situation?
  - Can calls be screened by voice mail? Can a receptionist or coworker screen calls or visitors?
  - Have a plan for safely arriving at and leaving work and other public places. Vary the time of arrival and departure and the routes used to and from work and children's school.
- Referral and shelter
  - A primary aim of ED intervention is to bring the victim of domestic violence into contact with helping resources such as the 1500 domestic violence shelters in the US, social services, legal assistance, and support groups. The social worker is a valuable asset for making appropriate referrals.
  - If the patient has no safe place to go, consider overnight hospitalization, emphasizing that such action is only for the patient's protection and not because the physician believes the patient to be

- mentally ill.
- Reiterate the options available to the patient, including obtaining an emergency protective order or restraining order, going to a friend's home or shelter, and accepting services offered through hotlines and support groups.
- The patient may choose to return to the battering relationship after the ED visit; nevertheless, important therapeutic interventions may have begun that can help extricate the person from violence.

**Consultations:** Obtain a consultation with a psychiatrist if the patient is suicidal or homicidal.

## FOLLOW-UP

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### Further Inpatient Care:

- Consider admission if the patient has no safe place to go.
- If the patient is suicidal or homicidal, discuss the need for hospitalization and consultation with a psychiatrist.

### Further Outpatient Care:

- If screening is to be effective, established protocols for making appropriate referrals must be in place. ED staff should have working knowledge of community resources that provide safety, treatment, advocacy, and support and should make appropriate referrals for physical, psychological, and substance abuse problems.
- Family therapy generally is contraindicated in the presence of domestic violence.
- Patients who are victims of chronic domestic violence are at high risk even after ending the abusive relationship and are most likely to be in need of immediate and intensive intervention services.
- Inform the patient that local programs for abused women provide free confidential services and that representatives from these agencies frequently can provide information concerning legal rights, police and court proceedings for protective orders, and referral to shelters, support groups, and other services.
- If the patient is willing, assist her or him in calling a domestic violence

hotline or local crisis intervention center during the ED visit.

- The patient should receive a list of emergency numbers, including the name and telephone number of the local crisis intervention center.
  - General referral cards that have several emergency telephone numbers not limited to agencies dealing with abuse may be kept more safely by the patient.
  - Offer a written list of resources each visit.
  - Place informational brochures in the women's bathroom, out of sight of an abusive (male) partner.
  - The toll-free number of the [National Coalition Against Domestic Violence](#) is 1-800-799-7233.
  - The toll-free number of the National Domestic Violence Hotline is 1-800-799-7233.
  - Refer victims of cyberstalking to the local police or sheriff's department, the district or state attorney, and/or the FBI. The following organizations also offer help for victims of cyberstalking:
    - [WHOA \(Working to Halt Online Abuse\)](#)
    - [Cyber Angels](#)

#### **In/Out Patient Meds:**

- Do not prescribe tranquilizers or other sedating medications because such medications may impair victims' ability to flee or to defend themselves.
- Physicians may contribute to the overuse or abuse of psychoactive or sedating medications by prescribing them for anxiety, panic symptoms, or chronic pain syndromes that are actually psychiatric or somatic manifestations of abuse.
- The use or abuse of alcohol and other drugs appears to increase after physical abuse begins; in most people probably as a consequence of abuse rather than a cause.

#### **Deterrence/Prevention:**

- Reportedly, at least 40% of domestic violence victims never contact the police. Of female victims of domestic violence homicide, 44% had visited an ED within 2 years of their murder.
- The ED staff may represent the only opportunity for victims of domestic violence to obtain professional help for their life situation, reinforcing the need for a high index of suspicion and routine screening for domestic

violence.

### **Complications:**

- Undiagnosed abuse may compound the patient's sense of entrapment, thereby continuing the victimization.
- Missing a diagnosis of domestic violence may result in inappropriate and potentially harmful treatment.
- Different backgrounds may influence how an abuse victim responds to the abuse.
- Intentional violence results in many short- and long-term effects, including acute injury, injury-related long-term disability, chronic pain syndromes, abuse of alcohol and other drugs, depression, suicidal behavior, panic disorder, and other mental health conditions to include PTSD.
- Abused women have a 16-times higher risk of abusing alcohol and a 9-times higher risk of drug abuse when compared with nonabused women.
- One study of women presenting to the ED with psychiatric symptoms revealed that 25% were battered.
- Misdiagnosing the sequelae of domestic violence as mental illness may lead to inappropriate use of psychoactive medications and hospitalization for nonexistent psychiatric illness.
- Murder or suicide ultimately may result from escalating domestic violence.
- Factors that increase the risk of homicide in domestic violence include the presence of a firearm in the home, use of alcohol or other drugs by the abuser, increasing frequency of battering, increasing severity of injuries, sexual abuse, and threats of homicide or suicide.

### **Prognosis:**

- Domestic violence typically recurs and progressively escalates both in frequency and severity.
  - Of persons first injured by domestic violence, 75% continue to experience abuse.
  - Half of battered women who attempt suicide try again.
  - Brookoff reported a study of 62 episodes of domestic assault, in

which 68% involved the use or display of weapons (5 handguns, 1 shotgun, 17 knives, and 19 blunt instruments such as hammers or baseball bats), and 15% resulted in serious injury. Eighty-nine percent of victims reported previous assaults by their current assailants, with 35% experiencing violence on a daily basis.

- The ultimate result of domestic violence may be death from suicide or homicide.

### **Patient Education:**

- Basic knowledge about domestic violence may help promote the willingness of the victim to seek help.
- The patient should know the following:
  - Domestic violence occurs often in our society.
  - It continues over time and increases in frequency and severity.
  - It may well have damaging long-term effects on children who are hurt or who witness violence.
  - Domestic violence is a crime.
  - Resources are available to help.
- For excellent patient education resources, visit eMedicine's [Public Health Center](#) and [Abuse Center](#). Also, see eMedicine's patient education article [Domestic Violence](#).

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### **Medical/Legal Pitfalls:**

- Evidence
  - The emergency physician untrained in forensic medicine may inadvertently overlook or destroy gross and/or trace evidence.
  - Recent bite marks may well contain the assailant's saliva. This is important since 80% of the population secretes an ABO blood group protein antigen in saliva. Do not wash away that potential evidence; instead, swab the skin surface with a sterile cotton-tipped

applicator moistened with sterile saline. Such evidence rapidly degrades; therefore, obtain and send the swab to the crime laboratory as quickly as possible.

- Documentation
  - Careful documentation in the chart may assist in subsequent legal proceedings such as grants of temporary protective orders, permanent restraining orders, and child custody requests. Conversely, misinterpretation of physical injuries or other objective evidence may lead to an inaccurate opinion, which, if documented on the chart, may pose considerable problems when used in future court proceedings.
  - Legibility and clarity of the medical record are vital. When the chart is illegible or unclear, the physician frequently is subpoenaed to read and interpret the medical record. The chart should be dictated, typed, or neatly written. Adequate documentation in the chart should include narrative, diagrammatic, and photographic documentation.
  - Reports suggest that more than half of the information for all assaults that is potentially obtainable at the time of the patient visit is not recorded on the medical record.
  - Identity of the assailant, use of a weapon, and place of the assault should be routinely recorded. Yet, a study of 288 ED charts of intentional assault victims treated in a Level 1 trauma center revealed absence of assailant identification in 67% of cases, no documentation of force or object used in 13%, and no documentation of place of assault in 79%.
  - In a review of 100 patients (not limited to domestic violence) who presented to a Level 1 trauma center in California, improper or inadequate documentation was found in 70% of the charts.
  - In 38% of those cases, potential evidence was improperly secured, incorrectly documented, or inadvertently discarded.
- Mandatory reporting
  - Another potential pitfall in the medicolegal arena is that of reporting requirements. The physician must report to law enforcement homicidal threats that appear serious. The physician also has a duty to attempt to warn potential victims of such threats. Review state law to determine what legal obligations, if any, EMS and ED personnel may have to report certain types of interpersonal violence. Other possible reporting requirements include those for the abuse or neglect of a child, elderly persons, or certain persons with disabilities.

- Most states have laws that may require health practitioners to report cases of domestic violence. The criteria for reporting and the authorities designated to receive such reports vary widely from state to state. Reporting facilitates timely steps to increase the victim's safety. Steps include immediate arrest of the perpetrator or obtaining an emergency protective order directing the suspect to stay away from the victim, thereby providing law enforcement a mechanism for making an arrest if the order is violated.
- Fears that mandatory reporting does more harm than good spring from concerns that the involvement of law enforcement against the will of the victim further strips power from someone who already feels powerless. Additionally, it may be possible that victims refuse to seek medical attention if they know that their partner will be reported and possibly arrested. Victims may fear that such reporting will anger the perpetrator and increase the level of violence.
- Mandatory reporting may raise conflicts between legal mandates and stated wishes of the patient, thereby creating an ethical dilemma. While the physician certainly must obey the law, The Center for Healthcare Ethics (St Joseph Health System, Orange, CA) recommends a tripartite approach to the analysis of dilemmas with such multiple conflicts, examining in turn the medical, legal, and ethical issues in the case.
- The ethical principles operative in such case conflicts include patient autonomy, beneficence, and nonmaleficence, as well as the ethical obligation of the physician to respect confidentiality. (See [Ethics in Emergency Medicine](#) for further elaboration of these principles of ethical analysis and decision making.)
- Laws vary from state to state; therefore, emergency physicians should obtain a copy of their state reporting statute and remain abreast of changes. Evaluate these statutes with the following questions in mind:
  - What is the purpose of the statute?
  - What is to be reported?
  - Who makes the report?
  - What level of knowledge or suspicion is required of the reporter?
  - Who receives the report and what is their response?
  - Are there penalties for failing to report?
  - Is immunity from liability provided?
  - Are there provisions for confidentiality of reports?
  - Are provider-patient privileges explicitly revoked?
  - Is there case law interpreting provider liability?
- Failure to report domestic violence as required has the potential for

liability exposure. Physicians also may have obligations under common law and other statutes to report domestic violence.

- Conversely, reporting suspected but unsubstantiated domestic violence has potential for liability exposure. When reporting is required, however, state laws generally have statutory protections from liability similar to the reporting of suspected child abuse. When not required to do so, physicians could be held liable for breaching confidentiality or privacy by reporting domestic violence.
- Routine inquiry about, diagnosis of, and prompt treatment and referral for victims of interpersonal violence is becoming recognized as the accepted standard of care. Failure to diagnose and treat can leave the physician vulnerable to liability. A civil suit could be filed, under a theory of negligence, as a result of failing to diagnose and treat domestic violence.
- A group of 577 men and women were questioned in a 3-part study involving 2 EDs and a primary care clinic, an inner-city ED, and community outreach centers for battered women. Most people interviewed (85%) felt domestic violence screening was appropriate, although a minority (15% of men and 8% of women) said they would be dissuaded from seeking care because of mandatory reporting laws.

### **Special Concerns:**

- Pregnant patients
  - Injury during pregnancy indicates direct questioning about domestic violence and requires thorough physical examination.
  - Violence may be a more common problem for pregnant women than preeclampsia, gestational diabetes, and placenta previa.
  - Most studies report the prevalence of violence during pregnancy in the range of 3.9-8.3%, although others indicate a much higher prevalence.
  - In one study, approximately 23% of sexually exploited teens became pregnant by their perpetrator. The prevalence of battering during teen pregnancy reportedly ranges up to 22%.
  - Two patterns of violence appear to occur as follows:
    - Women who were not previously abused may become victims of acute violence.
    - For women who experience abuse periodically or regularly, the pattern of violence may increase or decrease in severity or frequency during pregnancy.
  - In fact, violence during the postpartum period may be more

prevalent than during pregnancy.

- In 1992, Ross reported that 13% of women first experience abuse during pregnancy, although Salber and Taliaferro indicated that 40% of battering begins during the first pregnancy. Twenty-one to 29% of women report increasing abuse during pregnancy, while some pregnant women report a decrease in abuse.
  - Domestic violence during pregnancy, as with domestic violence in general, crosses all lines of class, race, and education.
  - Pregnant women who are abused are 4 times more likely to have children with low birth weight.
- Pediatric patients
    - Children are frequently silent victims of domestic violence, directly witnessing 85% of assaults.
    - Children not only witness battering, they also comprise 15% of victims injured in domestic assaults.
    - In a home in which a husband has hit his wife, there is a greater chance of child abuse. In 30-70% of domestic violence relationships, children are themselves being beaten.
  
    - Among children of battered women, 34% of boys and 20% of girls demonstrate clinically significant behavioral problems.
    - Men and women who have witnessed abuse are more likely to be in an abusive relationship, as is true of those who were abused as children. Children who are exposed to family violence may perceive such behavior as usual or acceptable, thus increasing the likelihood that they will imitate the roles of aggressors or victims and ensuring continuation of violence from generation to generation. Of children from violent households, 30% become abusive parents, a rate 10 times higher than for the general population.
  
    - Children who experience multiple forms of psychological hardship, including an abusive home, demonstrate an increased risk for development of heart disease as adults, even when controlling for other factors such as obesity, smoking, and depression.
  
  - Geriatric patients: Of female victims of elder abuse, approximately a third to half of women older than 65 years are being beaten by their partners.

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**NOTE:**

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