COURSE 1

Domestic Violence

COURSE BENEFITS

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2 Hrs
$10

- Recognize the signs of an abusive relationship.
- Understand the issues that prevent victims from disclosing abuse.
- Gain clinical awareness for assessing abuse patients in a medical/professional setting.
- Learn to help victims form a safety plan.
- Evaluate the lethality risk to victims.

This course meets the Florida Board of Nursing requirement for mandatory domestic violence education.

Bert Rodgers Schools of Continuing Education is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's (ANCC) Commission on Accreditation.
Provider approved by the Florida Board of Nursing, Provider # 27I2223, for 2 Contact Hours.
Provider approved by the California Board of Registered Nursing, Provider # CEP 12763, for 2 Contact Hours.

Learning Objectives

1. Identify three signs that indicate a patient may be a domestic abuse victim.
2. Name three potential warning signs of an abusive person.
3. Describe a successful procedure for assessing domestic violence victims.
4. Identify intervention techniques to use with victims.
5. Name the primary concerns for safety planning with victims.

THE ROLE OF THE HEALTHCARE PROVIDER

Healthcare professionals are the critical front line crisis workers for thousands of victims of domestic violence. Domestic violence is widely recognized by many clinicians as one of the most common public health concerns facing our culture. The problem is so pervasive that those of us who work in healthcare fields are now mandated to receive annual training on the dynamics of abuse. Each of us needs to be able to accurately recognize a victim of domestic abuse and to be able to offer medical assistance and referral information to the victim.

Medical referrals enable many shelters and abuse centers to operate more effectively. Very often it is the initial, individual medical encounter that will help a victim determine if she will seek further help or mental health guidance. For this reason, the first interaction with medical staff must be as positive as possible. This is a primary consideration when working with victims. If a victim is ever to trust the medical system, this trust must be established during the first contact with a victim, while she is being treated for her injury. The approach that a healthcare worker uses with an abused patient should send the patient a clear message that abuse is wrong, and that the medical system is equipped to

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intervene. This first medical intervention may be a turning point, encouraging a patient to seek further treatment. This intervention might help her to escape a potentially lethal relationship by ending her isolation.

Domestic violence may touch as many as one-fourth of American families. Estimates suggest that at least 2 to 4 million women each year are physically abused. Six out of every ten married couples have experienced violence at some time during their marriage.[1] During the first six months of 1998, the Florida Department of Law Enforcement (FDLE) reported 60,378 arrests for domestic violence.[2] In 1996, a current or former partner killed 75 percent of women murdered.[3] About one in ten women victimized by a violent intimate sought medical treatment at a medical care facility. Women made up about 84 percent of those who sought hospital emergency department treatment for intentional injury caused by an intimate assailant.[4]

THE DYNAMICS OF DOMESTIC VIOLENCE

Battering tends to be overwhelmingly a male problem. While women certainly can be and often are violent, the majority of the cases of battering reflect male perpetrators and female victims. There are several significant reasons that men continue to be the consistent perpetrators of domestic violence. Today's culture continues to reflect the idea that men are the superior and justifiable wielders of power. Men are commonly deferred to in conversation, paid higher salaries, given higher professional, educational, or social positions, and treated with more respect than their female counterparts. Boys learn from an early age that they are expected to have "power" and to be "in control." Due, in part, to these cultural perceptions, many men assume that this power includes dominance over their partners.[5]

For many men, violence was learned at an early age in their own homes. It is known that children who witness violence often grow up to repeat the violence. Studies conclusively demonstrate a significant correlation between witnessing domestic abuse as a child and perpetrating abuse as an adult. By one estimate, 50 percent of children in violent homes are also victims of physical and emotional abuse.[6] A batterer's inability to cope with frustration or problems leads many of them back to the only known remedy, hitting. Nevertheless, it is important to note that many people choose nonviolence, even though they have grown up in a violent home. Battering remains a choice of the offender.

Simply put, men batter because they can. The sheer strength and size of a man allows him to use physical force to hurt and threats or verbal abuse to intimidate. Society appears to condone men's violence against women when neighbors or family members choose to turn a blind eye to it rather than report the incident to the police and when judges allow perpetrators to walk out of courtrooms despite legislation that calls for stiff penalties.

POWER AND CONTROL WHEEL

The Duluth Model of power and control outlines the belief system of batterers and the tools that batterers use to maintain control in relationships. Most perpetrators have numerous excuses they employ to portray themselves as victims. Batterers are simply men who choose to act violently in order to control situations rather than share power with a partner.

The power and control wheel is a standard that most domestic violence educators use to visually outline these behaviors. There may be variations of the given behaviors; however, the Duluth Model indicates that all behaviors will inevitably fall into one of the eight patterns described. (See Figure 1, Power and Control Wheel.)

THE CYCLE OF VIOLENCE

Violent episodes often follow a pattern in abusive relationships. The commonly referred to "cycle of violence" occurs in approximately 50 percent of violent relationships. This cycle begins with a once charming and sweet abuser becoming increasingly agitated and tense. This phase is known as the *tension-building phase*. Abusers in this phase yell, pick fights, grumble, and gener-

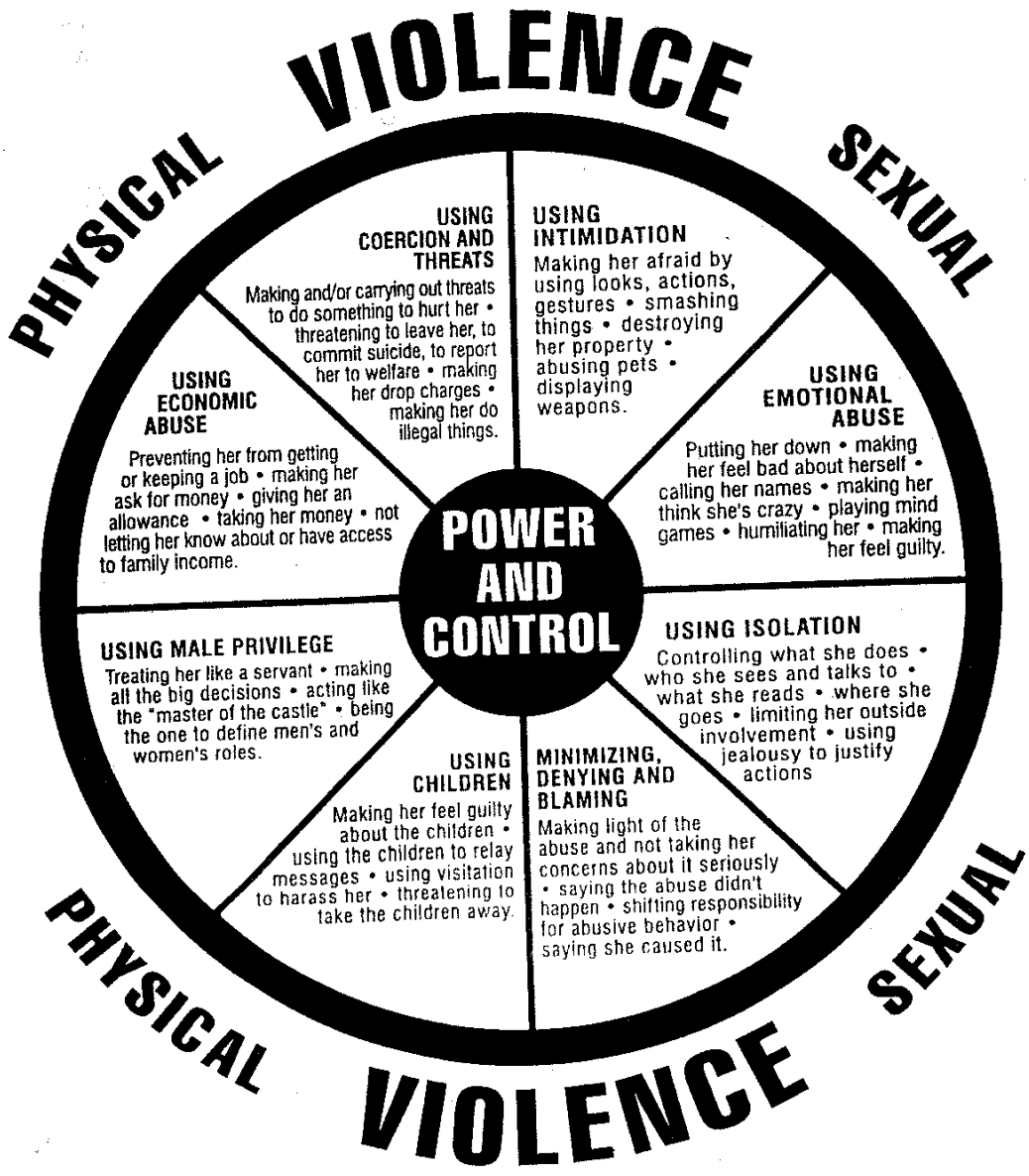

FIGURE 1: POWER AND CONTROL WHEEL

Source: Domestic Abuse Intervention Project, 208 West Fourth Street, Duluth, MN

ally act intimidating. Victims often describe their life with these men as "walking on eggshells." The victim tries desperately to appease her partner and will go to any extreme, from cooking his favorite meal to having sex with him, in order to make him happy. The tension-building phase may last for hours or days. At some point, however, the tension breaks as the abuser ultimately takes out his frustrations on his partner and moves into the second phase of the cycle.

The second phase is the *explosion* or *battering phase*. This phase may include verbal threats of death and physical or sexual abuse ranging from slapping to choking to rape. The severity of the abuse may lead to injuries that prompt the victim to seek help from the medical community.

The final phase is the *calm phase*, previously referred to as the *honeymoon phase*. Here, the abuser repents for his behavior. He often begs for forgiveness, says he didn't

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A patient may report in lay terms that her partner has displayed certain abnormal personality characteristics. These disclosures may be red flags.

mean to do it, buys gifts, and cries about what he has done to the woman he loves so dearly. This phase is particularly important to the healthcare provider, because many victims seek medical help for minor injuries in this stage. In this phase, when her hope is the greatest, and the belief that he will change is the strongest, medical personnel usually try to educate and intervene in the cycle of violence. This effort often becomes a frustrating and seemingly futile task. What medical staff must remember at this time is that although a victim rarely leaves when others think she should, the domestic violence information presented to her may eventually save her life.

ABUSERS AND ABUSIVE TRAITS

Abusers share many traits that are easily identifiable to the healthcare worker with increased awareness. These traits range from childhood aggression to irresponsibility as adults. Mental health issues can be a factor for some batterers.

Many batterers:

- have an inability to accept responsibility for their actions;
- blame authority figures for their problems;
- use excuses to avoid accountability;
- have a history of antisocial behaviors beginning in adolescence or earlier;
- have substance abuse issues;
- have prior arrest records;
- have poor driving records;
- have a series of failed relationships;
- have made frequent employment changes;
- have financial problems; and
- have emotional problems, from depression and suicidal ideation to mania and homicidal ideation.

They frequently share traits with people who exhibit conduct disorder, antisocial personality disorder, intermittent explosive disorder, and substance-related disorders. Also not to be overlooked are organic disorders (dementia and borderline intellectual functioning). It is important that victims understand that battering may occur in connection with closed head injuries and the like, but that this action is still considered abuse. For further clarification, see the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV).[7]

PERSONALITY CHARACTERISTICS

A patient may report in lay terms that her partner has displayed certain abnormal personality characteristics. These disclosures may be red flags. When these characteristics are coupled with the patient's possibly inexplicable injuries, it may reveal a victim of domestic abuse.

Morbid Jealousy/Obsession

Jealousy is a hallmark warning sign of an abuser. This person obsesses about the partner, wondering where she is, whom she is with, and why she is taking so long each time she leaves the house. This person will make accusations and insinuations that the partner is cheating or looking at another person sexually. This person often calls several times a day to check up on her, checks the mileage on the car, has his friends watch her, or stalks her himself. After a breakup, this person will not accept the idea that the relationship is over, even having been told many times or perhaps having been served with a restraining order.

Controlling Behavior

This person controls the majority of decisions in the relationship. The batterer decides how the woman will dress, when or if she will work, how the family should behave, and what is acceptable or unacceptable. There is little or no sharing of power. The partner's friendships and family ties may be deemed unnecessary or inappropriate by the batterer, thus isolating the victim from any contact with people who might help her.

Minimization, Denial, and Blame

Batterers are capable of finding justification for all of their actions: "If she would have just shut up, I wouldn't have choked her." Batterers downplay their part in what happened and their role in making it happen: "She fell and broke her leg," rather than "I pushed her and I broke her leg." Batterers will

deny their violence outright, even if it is obvious to outside parties such as the emergency room staff. There is a great deal of shame in admitting to beating another person, especially a woman. Batterers who felt justified when punching a woman may weep at the memory of their violence. Thus, their need to deny will be strong. For this reason many batterers will attempt to bring the partner into what happened, saying things like, "She was screaming at me: She wouldn't let me leave when I wanted to go," or "She stabbed me, so I hit her." Batterers will also blame another for their behavior. It will rarely be the batterer's fault that the violence occurred, or if they admit that they own any fault, it will be partial. There will inevitably be a "reason" why he became violent, other than that he chose violence to solve a problem.

Quick Attachments

Abusers are very quick to become intensely involved with a partner. It is not uncommon to see relationships progress from dating to living together in a matter of weeks or months. Abusers readily commit to the relationship and may express feelings of love after only several dates. Abusers move from one relationship to another with little time between them.

Diffuse Personal Boundaries

Abusers struggle with an inability to be responsible for their feelings. Often an abuser claims that a partner has hurt him by expressing her own separate emotions. The abuser perceives independence as abandonment. He sees no reason why his partner should want her own space, opinions, or interests apart from him. He may feel responsible for his inability to make her happy. In fact, since the abuser is so entirely dependent on the partner, he is threatened when a woman expresses any thought or choice that differs from his own. He feels shame for being unable to rescue a partner from her feelings of sadness or depression. It is often at this point that his insecurity surfaces with feelings of low self-esteem. These feelings of inadequacy are covered with anger and aggression toward his partner. He batters her to preserve his fragile ego and to reunite the couple, even if the unification is only through pain. He violates her with words and with emotional, psychological, physical, and often sexual abuse.

Batterers' Sense of Entitlement

Batterers often feel they have a right to behave the way they do: "This is my house and I'll do whatever I want in it." Or likewise, "This is my family...wife." If a batterer feels ashamed or threatened, he may revert to the fact that he is in charge or in the position of power and act accordingly. Batterers routinely feel that by being "the man," "the head of the household," or the major financial contributor, they are entitled to call the shots in the relationship or home. They are also entitled to feel however *they* choose, even though the partner or family is not entitled to do the same.

Minimizing the Use of Force during Sex and Rape

Rape is a common aspect of abusive relationships. Sex is closely tied to how the batterer sees himself. If a woman rejects him, meaning she doesn't want to have sex with him, he may feel he is entitled to take sex from her. This is rape regardless of the circumstances surrounding the incident. Batterers will routinely say they have never forced a woman to have sex against her will; however, victims often tell another story. Threats of physical or financial abandonment, emotional abuse, pleading, or violence may preclude a woman from refusing sexual intimacy. Frequently, women who feel they have not been "raped" have indeed been coerced or forced into unwanted sex, often after a beating, to prove forgiveness for the man. For many women, it is a normal pattern in this controlled relationship.

Alcohol and Drug Use

Alcohol and drugs do not cause violence. While a batterer who beats his partner may be an alcoholic or drug abuser, this is not to say that the addiction causes the abuse. There are many sober abusers. However, the incidences of abuse rise considerably when alcohol or drugs are added to the mixture.

TABLE 1: WHY COURTS SHOULD USE STATE-CERTIFIED BIPS: (SEE F.S. 741.325.(2))

State-certified programs:

- are uniform and systematic within the Florida circuit court system;
- hold domestic violence perpetrators accountable;
- help protect victims of domestic violence;
- have quality assurances for objectives and outcomes;
- fulfill state law requirements that injunction respondents go to certified programs (See F.S. 741.281);
- must accept indigent cases and provide a fee schedule based on a sliding scale ($30 one-time fee to the State can be waived or can be on a sliding scale); and
- must maintain victim contact and assist with safety issues.

Source: Prepared by the Governor's Commission on Minimum Standards for Batterers' Intervention Programs, 1998.

The DSM-IV describes criteria for substance abuse as "continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance, for example, arguments with spouse about the consequences of intoxication or physical fights."[8] Among victims of spousal violence who were able to describe substance use by the offender, 75 percent of the incidents were reported to have involved an offender who had been drinking.[9]

CERTIFIED BATTERERS' INTERVENTION PROGRAMS

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The use of certified batterers' intervention programs is a positive addition to arrest in this country. Abusers are held accountable for their behavior, are taught about power and control issues, and are taught alternatives that can aid them in being nonviolent.

One significant means of disrupting the cycle of violence is to focus on the batterer. The use of certified batterers' intervention programs is a positive addition to arrest in this country. Batterers' programs are recognized as another option when courts hear cases and render sentences regarding violent men. These programs are weekly psycho-educational groups. Men are entered into a program that varies from between 26 and 52 weeks long. These groups are meant to teach men about the negative impact of their violence. Abusers are held accountable for their behavior, are taught about power and control issues, and are taught alternatives that can aid them in being nonviolent. The group is confrontational, and for many men it is the first experience with truly encountering their feelings. (See Table 1: "Why Courts Use a Certified Batterers' Intervention Program.")

State-Certified Batterers' Intervention Programs (BIP) (See F.S. 741.325)

A state-certified batterers intervention program is:

- a psycho-educational group-based intervention—not therapy;
- 26 weekly sessions (not including intake and orientation);
- appropriate only when there is "partner" violence (as in spouses, ex-spouses, current or former cohabitants, but not in cases of sibling violence or child abuse, for example) and where power and control tactics are used in that relationship (See F.S. 741.325(4));
- based on the fundamental concepts that battering is a behavioral choice, is not "uncontrolled anger," and is not caused by substance abuse;
- based on the idea that battering is a learned behavior that can be unlearned through education;
- appropriate for male batterers;
- never a substitute for alcohol and drug treatment as domestic violence is not caused by substance abuse, genetics, stress,

TABLE 2: ASSESSMENT AND INTERVENTION TECHNIQUES FOR VICTIMS OF DOMESTIC VIOLENCE

The following is a quick reference guideline for assessing and intervening with a suspected victim of domestic violence. An extensive outline is presented in the text of this course.

Nursing Assessment

- Screen all female patients for domestic violence.
- Note patient complaints/injuries at the time they present, looking particularly for multiple injuries in various stages of healing.
- Note whether patient gives inconsistent data regarding how injuries were sustained.
- Assess if patient affect appears to be inappropriate.
- Note patient's statements identifying her partner as being a possible abuser.
- Note if patient presents with alcohol or drug intoxication and/or has suicidal ideation.

Nursing Intervention

- Separate the patient from her partner and/or children to allow for privacy.
- Explain that domestic violence is a serious and common problem.
- Express concern for the safety of the patient and her children.
- Make nonjudgmental statements about the things that you see from her assessment.
- Educate the patient on the dynamics of domestic violence and its effects on children.
- Assure the patient that the information she shares with you will be confidential.
- Tell her about options regarding safety and shelters for battered women.
- Offer her written information if it is safe to do so.
- Devise a safety plan for her when she leaves the medical setting.
- Report any instances of child, elder, or disabled abuse.

illness, or problems in the relationship—although these factors are often used as excuses and can exacerbate violent behavior. A batterer who has a substance abuse problem can receive concurrent programming and treatment.

The Florida Department of Corrections certifies programs only for adult males who are not incarcerated. Since these currently certified programs are not appropriate for other important populations, the Department of Corrections is developing guidelines for (1) females who use violence, (2) juveniles, and (3) males who are in jail or prison.

ASSESSMENT

It is important to remember that the medical model assesses, intervenes, educates, and plans discharge of the victim. While our objective is to see that a victim gets the help she needs to leave an abusive situation, she cannot be pushed into this decision. It is essential that we listen to the victim. Only she understands her life and her abuser. We must keep in mind that many women in this country die during attempts to leave their abusers. Table 2 serves as a reference guide for assessing and intervening with a suspected victim of domestic violence.

Triage

Healthcare workers must remember that *any* relationship may involve domestic violence. Evidence suggests that at least one in five women seen in emergency departments has been the victim of abuse.[10] Even so, we rarely screen patients for domestic violence as a routine procedure. Although more than 1 million women seek medical treatment each year for injuries caused by their husbands, ex-husbands, or boyfriends, doctors correctly identify the injuries as resulting from battering only 4 percent of the time.[11] In light of these statistics, all female patients undergoing triage for medical assistance should be screened for domestic violence.

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Preparing to Interview an Abuse Patient

During standard nursing assessment, Craven and Hirnle, authors of *Fundamentals of Nursing*, tell us that "family members and visitors should be asked to leave, unless the patient requests otherwise."[12] An excellent way to interrupt the cycle of violence is to separate the abuser and the victim. Separating patients from their partners and children allows for increased confidentiality. Batterers remain extremely close to their victims in clinical settings, often to feign loyalty, but primarily to maintain control over a medical examination. These men are sometimes so invasive that they even insist on being present during their partner's pelvic examinations. Domestic abuse patients often do not recognize this situation as a gross boundary violation. They sometimes interpret his presence as concern or love. For therapeutic treatment to take place with abuse victims, however, personal boundaries must be modeled for the patient. Do not be surprised if the man is agitated or outright angry when asked to leave the room; distinct boundaries are threatening to these men. In his perception, his control is usurped.

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The nursing assessment is still the most effective tool available to diagnose domestic abuse. The comprehensive head-to-toe examination will reveal a pattern of injuries consistent with domestic abuse.

During the victim's treatment, confidentiality in the medical setting is paramount. A woman's honest disclosure of injuries depends on her ability to develop trust for the medical staff and to feel physically safe in their care. This may begin with allowing the patient to retain her locus of control, which requires that the patient feels that she is participating in the development of her care plan. Her voice is important in deciding what she needs to do next, given her understanding of the batterer. If the batterer is present, whether in the exam room or outside the door, he remains a threat. This being the case, she may wait for another opportunity to seek help concerning her abuse. Likewise, an abuse patient fears that children present during a medical examination could reveal something said or could be questioned by her partner at a later date. These roadblocks to disclosure and treatment must be removed at the onset of medical care.

A battered woman knows that one slip may cost her life. Therefore, a victim may be hesitant to disclose information to the staff under certain circumstances. Only 8 percent of women discussed their abuse with their physicians, while another 38 percent discussed the incidents with someone other than their physician, leaving more than 50 percent of the women who have been physically abused discussing it with no one.[13] Victims legitimately fear the batterer's ability to manipulate medical staff into disclosing their account of the incident. Batterers are excellent charmers. If the victim tells the truth about how she received her injuries and he finds out, she incriminates him as a batterer and risks his retribution. If she doesn't tell the truth, she loses all credibility with the medical staff. In her mind, she loses either way. The difference is that if she refuses to talk to medical staff, she may live to get help at another time.

Taking a History

The nursing assessment is still the most effective tool available to diagnose domestic abuse. The comprehensive head-to-toe examination will reveal a pattern of injuries consistent with domestic abuse. This assessment should be conducted routinely; exceptional procedures may alarm the patient and impede the diagnostic process.

When taking a medical history, therapeutic communication is an essential means of empowering the patient to give accurate facts. All findings should be charted objectively, beginning with subjective data presented through the patient report. Both written and verbal complaints from the patient should be noted and assessed. Following this, the head-to-toe assessment may take place, including past history, vital signs, affect, incongruent communication, old wounds or fractures in various stages of healing, and physical and/or verbal guarding, that is, tactics intended to deceive, hide, cover up evidence to keep the truth from being discovered. If a patient becomes defensive, necessary information may be concealed from the medical examiner. Inconsistencies are often telltale signs that a

patient is covering up or leaving out important facts. Intrusive questioning, a condescending attitude, or taking a parental stance with the patient may, in turn, elicit skewed data. Craven and Hirnle remind us that "nonverbal behavior, particularly the nurse's body language, can convey a strong message during an interview."[14] The patient must be free to express herself without judgment. A healthcare provider's judgmental tone will inhibit a patient from answering medical questions accurately and openly.

There are many clinical warning signs to help alert a medical care worker to abuse. The Florida Coalition Against Domestic Violence offers healthcare providers a substantial list of these signs.[15]

SIGNS OF ABUSE

Clinical Warning Signs

General appearance. Increased anxiety, fatigue, flinching on touch, overweight, underweight, hypertension, flat affect, depression, anxiety, fear, suicidal ideation, low self-esteem (anxiety, depression, insomnia, and vague complaints without physical findings are often abuse-related).

Any injury or multiple injuries. Face, neck, chest, breasts, abdomen, and genitalia are frequent sites of injury from abuse. If a patient seeks care for a medically insignificant trauma, it may be a sign that abuse is pending or that fear and anxiety related to abuse are affecting health.

Skin. Burns, bruises, old healed scars.

Head. Decreased hearing from multiple blows, subdural hematomas, headaches.

Eyes. Swelling, subconjunctival hemorrhage, detached retina.

Gastrointestinal. Non-ulcer dyspepsia, irritable bowel syndrome, globus.

Genital/urinary. Bruises, tenderness, dyspareunia, recurrent vaginitis, vague pelvic pain, miscarriage, preterm labor, low birthweight delivery, symptoms of rape or sexual assault (more than half of all rape victims over 30 have been raped by their partner).

Rectal. Bleeding, edema, irritation.

Musculoskeletal. Fractures, especially of the face, radius, ulna, ribs; shoulder dislocation; limited motion; old fractures; chronic pain; primary fibromyalgia.

Emotional and Psychological Signs

There are a number of emotional and psychological signs of abuse:[16]

- feelings of isolation and inability to cope
- suicide attempts or gestures
- depression
- panic attacks or other anxiety symptoms
- alcohol or drug abuse
- post-traumatic stress reactions and disorder (PTSD)
- limited access to routine and/or emergency medical care
- noncompliance with treatment regimens
- not being allowed to obtain or take medication
- missed appointments
- lack of independent transportation, access to finances, ability to communicate by phone
- failure to use condoms or other contraceptive methods
- not being told by a partner that he is infected with HIV or other sexually transmissible diseases

Source: Florida Coalition Against Domestic Violence. *Domestic Violence Health Care Training: A Training Manual for Trainers.* (Tallahassee, FL: FCADV, 1995): 117.[17]

INTERVIEWING PATIENTS

Many victims blame themselves and even accept responsibility for the injuries sustained at the hands of the batterer. By the time medical help is sought, the cycle of violence is revolving, and the batterer, often in the calm phase by this time, is expressing remorse. The batterer manipulates his victim into believing that seeking medical help, even if she desperately needs it, is betrayal. By seeking help, she may reveal his private acts of violence. He makes her believe that her

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need for treatment is the problem, rather than his violence. His manipulation serves two purposes: First, it permits the victim to believe the violence is an acute episode, not a chronic cycle. Second, it keeps her from placing the blame wholly where it belongs, on the batterer. He convinces her that her honesty with medical personnel victimizes him.

It is essential then that medical staff approach abuse survivors with nonjudgmental statements. While many suggest that direct, specific questions are best with victims, it may be easier to have a victim talk honestly if she does not feel attacked.

Questioning a Victim is Intrusive

Victims generally feel shame about being battered. Questioning implies the patient has a deficiency rather than stating that the medical examiner needs information to aid the examination. Someone who asks questions can be perceived as blaming, shaming, and assuming a superior position. Nonjudgmental, declarative statements are less threatening. A victim may feel revictimized by medical staff if she has the impression there is disdain for her predicament. It is essential that healthcare personnel never present personal feelings regarding her situation or her decision to stay in or to leave a relationship.

Additionally, it is important that medical staff use nonblaming language when speaking to victims. Words or phrases that minimize the violence to her, that trivialize her injuries or pain, or that serve to implicate her as a contributing factor in the attack are to be avoided. Use of phrases such as, "It was only ...," "He only...you," "He just ...," "What did you ...?" or the like, appear to place blame on the victim and to collude with the batterer. Showing any form of agreement with the batterer's use of violence is unacceptable. Asking a victim what she did to him, how she "pushed his buttons," or "why he got so mad at her" places blame on her, and ignores the abuse. (See Table 3 and Table 4, "Statements to Use with Domestic Violence Victims" and "Blaming and Colluding Statements to Avoid Using with Domestic Violence Victims.")

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Accurate and specific documentation is essential in the treatment of a woman who has been battered.

TREATMENT

Treatment begins with the patient and the patient's complaints. Healthcare professionals must keep the patient's needs in perspective. As medical staff, we frequently make decisions and assumptions about patient care. Effective healthcare providers present alternatives and trust patients to make the right choices. Our role is to educate and to empower the patient so that she may choose the most appropriate treatment. Abuse is paternalistic; paternalistic care can be abusive. In the case of a domestic violence patient, she truly may need to make an immediate decision that keeps her alive, even though it may not be medically astute. A domestic violence victim works incessantly to keep her needs balanced. Thus, treatment for a broken finger may not be as important as getting home to have supper prepared on time for an abusive husband. It is a choice that the victim must make for herself. Our role is to offer choices and to support her decision.

DOCUMENTATION

Accurate and specific documentation is essential in the treatment of a woman who has been battered. The use of medical records and photographs in court is commonplace for establishing a past history of abuse. The more detailed the records, the clearer the case. While a victim may not choose to use these records immediately, they may be subpoenaed, and all information contained in the records can be used in court. These records must be carefully documented to protect the victim. The records should not reflect historical data about the patient that could put her in further danger.[17] Accurate records also protect the healthcare worker by documenting that abuse was suspected or confirmed, noted, and that appropriate actions were taken to ensure patient care and safety. There is mandatory reporting by medical personnel of injuries from life-threatening wounds, the abuse of the elderly, and child abuse.

Many medical centers have now dedicated significant areas on the medical chart to describe these injuries. The chart needs