Taking an Intimate Look at Domestic Violence

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Outline

AS A NURSE who survived more than a decade of domestic or “intimate partner” violence, I believe that nurses can help improve—and sometimes save—the lives of victims of violence. Unfortunately, many nurses are unsure how to identify a possible victim or what to do.

In this article, I'll explain how to assess for violence between intimate partners and how to help the victims. Keep in mind that violence can occur in heterosexual or same-sex relationships and that both men and women can be victims or perpetrators. Because at least 85% of victims are women, however, I'll refer to victims as women and abusers as men.

The brunt of the problem

The most recent statistics from the Centers for Disease Control and Prevention show that approximately 1.5 million women and 834,700 men are raped or physically assaulted by an intimate partner each year. More than 500,000 women victims require medical treatment for their injuries each year, and as many as 324,000 victims are pregnant at the time of the assault.

An abuser's belief that he's entitled to control another person is the basis for domestic violence. He may use fear, intimidation, sexual assault, threats to and about children, control of the victim's money or earning ability, isolation, and other controlling

behaviors. He believes violence is acceptable if it's necessary to get the desired outcome.

Domestic violence occurs in all socioeconomic groups, although low income is a risk factor, along with young age, mental health problems, alcohol or substance abuse by either partner, divorce or separation, and a history of childhood abuse. Pregnancy increases a woman's risk.

Once started, violence between intimate partners tends to progress and escalate. It often includes the threat or use of physical force and occurs in cycles of three repeating phases. Yelling, name-calling, punching a wall, or kicking a pet may progress to pushing, slapping, punching, restraining, and choking the victim.

Understanding the cycle of violence

In the *tension-building* phase, the abuser may be moody, then become harshly critical and yell. He may become angry about minor aggravations or imperfections, such as unfolded laundry or crying children. Typically, the victim tries hard to keep the abuser calm.

The *event* phase is when the abuser physically or verbally acts out his aggressions on the victim. The victim may fight back or call for help.

In the *calm* phase, the abuser often apologizes profusely and promises never to attack the victim again. This phase commonly keeps her in denial and in the relationship.

Why not get involved?

Nurses who feel that they don't know enough about domestic violence may hesitate to reach out to victims. Believe me, you don't have to be an expert to help. As I'll discuss shortly, you need to follow only a few practical guidelines to assess for abuse,

intervene (if necessary), and document your patient encounter. You may be surprised to learn that nurses who regularly ask screening questions and uncover domestic abuse report that the typical encounter with a victim takes only 5 to 10 minutes. If you think that this issue is none of your business, think again. In some states, failing to report this type of violence is a crime.

More than broken bones

Victims of domestic violence are "beaten down" long before they're "beaten up." Emotional abuse is often just as damaging as broken bones and other physical injuries. Many victims describing their worst abuse don't even mention physical injury. Although I suffered broken bones, bruising over my whole body, and a kick to the head that caused permanent deafness in one ear, my most haunting memory is of my ex-husband severely humiliating me in public.

One of the most frustrating aspects of working with a victim of domestic violence is that fear keeps her in the relationship; she knows that leaving can be more dangerous than staying. Of victims killed by their abusers, 70% are killed trying to leave. Severe depression that frequently accompanies abuse is another obstacle to leaving. Depression saps the victim's energy to act so she withdraws and loses self-esteem, which isolates her further. Religious, cultural, and societal pressures may also encourage her to stay put.

A woman may stay for the children's sake, even if she recognizes the risks of keeping them in an abusive home. Perhaps her partner has threatened to hurt the children or kill her if she leaves. She may feel that she can't support herself and the children alone. Even if the children aren't physically abused, staying in an abusive relationship can lead them to long-term problems such as drug use, truancy, behavior problems, unwanted pregnancy, illness, depression, and even suicide.

On average, victims of domestic violence leave their abuser seven times before staying away for good. A victim who prepares a safety plan for herself and her children increases their safety whether she chooses to stay or leave. *First Step*, a booklet from the Florida Department of Health, details facts about abuse and includes a safety plan.

Asking the right questions

The best way to identify domestic violence is to screen all female patients age 14 and older in *total privacy*. If a victim doesn't feel safe and supported, she'll be afraid to reveal the truth.

Anyone accompanying your patient should stay in the waiting area while you conduct your interview. This is easier to enforce if a facility policy is posted in waiting areas guaranteeing all patients a private health screening. If a patient has children along, ask another staff member to stay with them. Don't make any exceptions to the privacy rule, no matter how doting and compassionate the partner appears. And keep in mind

that same-sex friends or partners can be abusers too.

When a patient's companion is reluctant to leave her alone with you, use an authoritative tone of voice to encourage cooperation. If he still won't leave her side, ask another staff member to make an excuse to speak with him, such as discussing billing options. If he balks, don't press the issue—it could increase your patient's risk of danger.

If you can't manage a private interview with a patient, phone her later at work or at home when her partner isn't likely to be there. Ask if it's a good time to talk before you discuss possible abuse. Advise her to tell her partner that your call was for routine follow-up if he discovers you called.

If you encounter a language barrier, try to find an interpreter who's the same sex as the patient, familiar with her cultural background, and respectful of the need for confidentiality. Never ask the patient's companion or child to serve as an interpreter. He or she could be an abuser or may want to protect the abuser.

Proceed with great care when a personal care attendant (PCA) or other support person accompanies a patient with a disability. Legally, this patient can have a PCA with her in the treatment area. But if you suspect this person may be abusive, ask the patient privately if she wants her PCA in the treatment area.

Interviewing tips

Begin your interview by sitting next to your patient to show you want to spend time with her. Keep in mind that your nonverbal behavior, including your facial expression, reflects your sincerity. Reassure her that what she tells you is confidential and keep an open mind. Ease into conversation by saying, “Abuse in the home is so common that we now ask all patients: ‘Are you in a relationship where you're being threatened or hurt?’” You might also ask, “Do you feel safe at home?”

If your patient indicates that she's in a risky relationship, ask her open-ended questions in an empathetic, nonjudgmental manner. Be a good listener when she replies. Offer written materials and review them if you suspect she's a victim of abuse. Include information on the phases and progression of abuse, characteristics of victims and abusers, reasons victims stay, effects on children, and—most important—how to devise a safety plan. Accept that she may not take these materials if she believes that her abuser might find them.

If indeed you learn that she's a victim, your job isn't to rescue her or convince her to prosecute her partner. Follow your facility's protocol for addressing abuse. Tell her you believe and care about her, that the frequency and severity of abuse will escalate, that she deserves to be treated with respect, and that abuse isn't her fault; it's a crime. Assure her that she's not alone and that help is available.

Encourage her to talk with an on-call trained victim advocate or ask her permission to

call the local domestic violence shelter; let her use a private room with a phone for the conversation. If she chooses not to call, write the 800 number of the local abuse hotline or abuse shelter on a prescription pad or discharge form, but *don't* write what it's for. She's an expert at survival, so praise her repeatedly for her strength and courage. Help her recognize personal resources she can use to help with her safety.

She denies abuse, but you suspect otherwise

When to suspect domestic violence
Suspect abuse in any patient who:

* has unexplained bruises, lacerations, burns, fractures, or multiple injuries in various stages of healing (particularly in areas normally covered by clothing)
* delays seeking treatment for an injury
* appears embarrassed, evasive, anxious, or depressed
* has a partner who's reluctant to leave, uncooperative, domineering, or who insists on answering all questions for the patient. Keep in mind that some abusers are excessively solicitous of the victim.
* says her partner has a psychiatric history or problems with alcohol or drugs
* has injuries that don't reflect the nature of her "accident"
* expresses fear about returning home or fear for her children's safety
* talks about harming herself.

Even when a patient doesn't have these characteristics, trust your instincts if you think she's suffering abuse.

What if you strongly suspect a patient is being abused, but she denies it or won't talk? Like a prisoner of war, she may be brainwashed into believing she can't escape and isn't ready to accept help.

Don't give up. You can still present your concerns and gain her trust with positive statements like these:

* "I want you to know that I see many women with injuries like yours, and they seldom happen accidentally. Usually they come from someone hurting them on purpose."
* "Anyone with injuries like yours who delays getting medical treatment is typically living in fear."

Offer your patient basic information on domestic violence, resources, and a safety plan. This offers help without requiring her to disclose her situation. When counseling her, avoid words and phrases that minimize the seriousness of abuse and tend to make the victim feel at fault. These include *why, just, only, you should, Is that all?* and *Why don't you just leave him?*

Finally, don't think you've failed if an abuse victim refuses help.

She's probably listening carefully and will retain the information for future reference.

Even if your patient is willing to discuss domestic violence with you, she may choose to stay with her abuser for now. Remain supportive and nonjudgmental, but express your concerns for her safety and that of her children. Review the safety plan with her and encourage her to talk with a victim advocate when she's ready. You may be the only person who's ever offered her help and support. Though she may not be able to act now, she may follow through later because of your encouragement.

Documenting abuse

I can't say enough about the value of accurate and complete charting. It can help an abuse victim successfully prosecute the abuser, resolve child custody issues, or get a protective order. Document the following:

* details of old and new injuries. Use a body map if appropriate or take photographs with the victim's permission.
* the abuser's name and how he injured her. Use direct quotes whenever possible.
* your conversation with the patient
* your patient teaching
* resources you gave her, including referrals to social services.

To protect your patient's confidentiality, never place her chart on a counter or anywhere else that's visible to others. If you chart on a computer, turn off the monitor. Tell her that her medical records are available if she needs them for legal purposes.

Measuring success

You can't gauge your success by whether a victim of domestic violence leaves or chooses to prosecute her abuser. Measure instead how well you assessed her situation, provided counsel, explained safety options, and respected her right to self-determination without judging. Even if you don't see immediate results, you may have given her the lifeline she needs at this low point in her life to pull herself up to a safe, hopeful future.

SELECTED WEB SITES

Family Violence Prevention Fund http://www.fvpf.org

U.S. Department of Justice—Office on Violence against Women
http://www.ojp.usdoj.gov/vawo

National Coalition against Domestic Violence http://www.ncadv.org

National Domestic Violence Hotline http://www.ndvh.org

Hotline: 1-800-799-SAFE

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This article has been updated from "Domestic Violence: How You Can Make a Difference" in the August issue of *Nursing2001* .

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