Domestic Violence Comprehensive, The Secret Epidemic

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Objectives

By the end of this educational encounter, the clinician will be able to:

Identify at risk populations for Domestic Violence
Recognize signs of Domestic Violence
Illustrate interventions to prevent Domestic Violence

Introduction

Laura* walked up the sidewalk toward the door with her keys in her hand. It had been a long day made even longer by the fact that an accident on the freeway had tied up traffic for over an hour. She would be severely behind in getting supper ready and that was sure to put Paul in a bad mood when he got home. He liked their home to run smoothly and he had very exacting standards. When things were not to his suiting, he could become explosive. Lately things were much worse, probably due to stress at work she told herself, but it would get better. His outbursts of temper had escalated to several episodes of pushing her about a month ago, and last week he had hit her in the face during an argument. He had found an unfamiliar name on the caller ID and had accused her of cheating on him. He had been extremely sorry and more loving after each of the events, but the last couple of days had been frequently calling her work to check up on her.

Laura felt the explosion of pain in the back of her head as she fell face forward onto the hardwood floor. Then she felt multiple blows to her ribs, back, and head. Each one took her breath away. Finally, she felt a foot kick her over onto her back as she felt another explosive pain. Her vision started to grow dim. Just as she faded away, she looked up into the rage filled eyes of her husband, Paul!

Prevalence

* * The names in this incident are not real, the events depicted are demonstrative in nature

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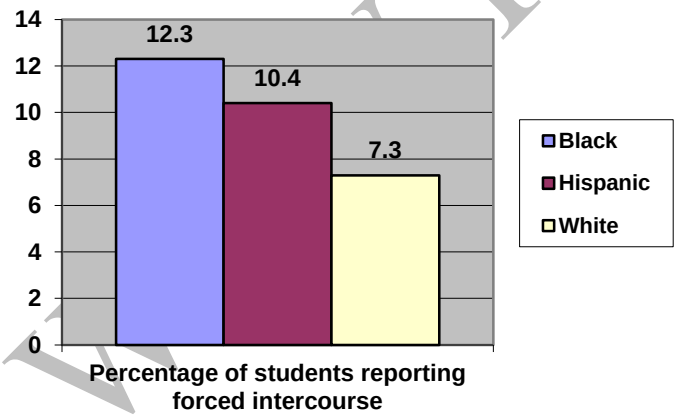
The definition of domestic violence in professional literature is quite variable. The terms used to describe domestic violence can also vary. Intimated partner violence is a term that is usually used to describe violence that occurs between two individuals that have a past or present dating or marital relationship. On the other hand, domestic violence can be extended to include children, and elders that are living or have lived in the same household or had a very close connection to the perpetrator (Burnette & Adeler, 2006).

Every 9 seconds in the United States a woman is beaten. Every year women experience 4.8 million domestic violence physical assaults and rapes. It is estimated that one in four women will experience domestic violence at some point in her lifetime. It is also estimated that 25% of our female patients are current victims of domestic violence. However, women are not alone in the domestic violence issue, each year 2.9 million men experience domestic related assaults. Domestic violence also extends to others as well, with domestic violence affecting and injuring children, elderly adults, and other living within the home of or having a history of a cohabitative relationship with the perpetrator (CDC, 2006).

Why has domestic violence become such a big health issue as opposed to a social issue? In 2004, 1,544 deaths were attributed to domestic violence; of these numbers, 75% of women and 25% of men were victims. In 1995, the cost of domestic violence was 5.8 billion dollars and in 2003, 8.3 billion dollars. These cost include mental and medical health care as well as costs of lost work time (CDC, 2006). The emotional and physical effects of the abusive encounter(s) can last long after the bruises have faded, in many instances for entire lifetimes.

In a study of eighth and ninth graders, 25% indicated that they had been victims of dating violence. One in every eight pregnant adolescents reports being abused by the father of her child (Nelson, 2006). Adolescents and young adult women are 25% more likely to be victims of domestic violence than any other age group.



California

California law enforcement logged 176,299 Domestic Violence calls in 2006, 80,946 of which involved some type of weapon. Of these 43,911 people arrested for domestic violence, 80% were men.

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California saw 134 homicides in 2006, 110 women and 24 men. 9,345 forcible rapes were counted in 2005; completed rape accounted for 87% of the cases. In California, one forcible rape occurs every 56 minutes (NCADV, 2007).

Florida

Florida had 115,170 cases of domestic violence in 2006, 54% of these cases ended in an arrest. There were 1,089 forcible rapes, 369 forcible sodomy cases, and 947 cases of forcible fondling reported in 2006. Thirty-five percent of the forcible sex offenses had arrests made in the case. In 2006, 164 domestic violence homicides were counted.

Florida law defines domestic violence as "any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another who is or was residing in the same single dwelling unit" (Allen, 2006).

In 2001, Florida Governor Jeb Bush signed into law the Family Protection Act that requires a mandatory 5-day jail term for any crime of domestic battery in which the abuser deliberately injures a victim. This law also mandates that a second act of battery becomes a felony offense. In 2002, Florida law was amended to include any dating relationship of at least 6 months duration in the definition of domestic violence (Allen, 2006).

New York

In the year 2006, New York reported 50,088 cases of domestic violence. In 2005, 123,649 orders of protection were filed and 3,636 forcible rapes were logged. The impact of these figures resulted in 38,674 adults and 20,119 children receiving aid and assistance by domestic violence programs in 2006. In 2006, 133 adult homicides and 28 child deaths resulted from domestic violence (NCADV, 2007).

Kentucky

According to the Kentucky Cabinet for Health and Family Services, women in Kentucky are more likely to experience domestic violence and abuse than the national average. Approximately 36% of Kentucky women report being victims of abuse. It is estimated that one out of nine Kentucky women will be the victims of a sexual assault in their lifetime (Allen, 2008).

"One study of homicide followed by suicide in Kentucky determined that in 85% of cases, the victim and perpetrator were family members or intimates, and in 70% of cases, the perpetrator was the boyfriend or current or former husband of the victim [16]. This demonstrates that domestic violence, and its associated consequences, is a real threat to the residents of Kentucky" (Allen, 2008).

Guns and Domestic Violence (Violence Policy Center, 2005)

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One study of domestic violence revealed that women are more likely to be murdered with a firearm than all other methods combined stressing the importance of limiting accessibility of firearms to persons with a history of domestic violence.

Gun use in domestic violence may play a bigger role than homicide figures indicate. Guns may be used in subtle or not so subtle ways to intimidate or coerce women or family members and may add to the abuser's feelings of power, domination and leverage in the relationship.

The United States Department of Justice has found that women are far more likely than men to be the victims of intimate partner violence than men, especially when the use of a gun or other weapon is involved. Women are much more likely to be victimized at home than at any other place.

A 2003 study revealed that a woman with a gun present in the home is three times more likely to be murdered than a woman with no gun in the home. Furthermore, women who were murdered were more likely, not less, to have purchased a handgun in the three years immediately prior to their death, negating the myth that the purchase of a handgun by a woman furthers her safety.
A 2005 FBI report of 1,858 female homicides that involved single female victim/single male offender reveals a lot of myth shattering facts:

- In cases where the relationship between the victim and the offender could be identified, 92 percent of the victims were murdered by someone that they knew.
- More than 12 times more females are murdered by a male known to them than by a male stranger.
- For victims who knew their attacker, 62 percent of females were wives or intimate acquaintances of the offenders
- 317 of the female victims were shot by their husband or intimate partner during the course of an argument.
- Nationwide 52 percent of female homicides were committed with firearms. Knives or other cutting instruments accounted for 21 percent of all female homicides. Bodily force accounted for 14 percent of the homicides and blunt objects accounted for seven percent of the weapons used against female victims.
- Of homicides committed with firearms, handguns were used in 72 percent of cases
- Eighty-nine percent of the homicides were not related to the commission of other felonies such as rape or robbery.
- In most homicides, the victim and the offender are of the same race.
- The average age of female victims is 38 years old

For African American women, the rate of homicide is 3 times that of white females, and African American women are just as likely as white women to know their assailant. Compared to a man, a black woman is far more likely to be killed by a spouse, intimate partner, or a family member than by a male stranger. In 2005, twelve prevent of black homicide victims were less than 18 years old. Four percent of victims were over age 62 years. The average age of a black female homicide victim is 33 years.

In the 1990's, two major laws were enacted to help prevent domestic abusers from obtaining firearms. In 1994, the Wellstone Amednment prohibited individuals who are

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the subject of a protective order from buying or possessing firearms. Twenty states also have state laws to supplement the federal law. In 1996, a provision to the Federal law was made to prohibit persons with misdemeanor domestic violence offenses from purchasing or possessing firearms, further shoring the provision that felony convictions of domestic violence are already precluded from firearms possession due to the nature of felony commission.

The Brady Bill allows for the enforcement of these provisions by requiring a criminal background check through National Instant Criminal Background Check System (NICS) for any person purchasing a firearm through a Federal Firearms License holder. The two domestic violence categories account for 16 % of the rejected firearms transfers. However, not all states make available misdemeanor convictions and protective order information available through NICS.

Number of Females Murdered by Males in Single Victim/Single Offender Homicides and Rates by State in 2005, Ranked by Rate

Ranking	State	Number of Homicides	Homicide Rate per 100,000
1	**Nevada**	**30**	**2.53**
2	**Alaska**	**8**	**2.49**
3	**Louisiana**	**50**	**2.16**
4	**New Mexico**	**21**	**2.15**
5	**Mississippi**	**30**	**2.00**
6	**Arkansas**	**28**	**1.98**
7	**South Carolina**	**43**	**1.97**
8	**Alabama**	**44**	**1.88**
9	**Tennessee**	**57**	**1.87**
10	**Oklahoma**	**33**	**1.84**

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In 2005, Nevada's homicide rate was nearly double the National Average making it the state with the highest homicide ranking. Alaska followed second and Louisiana followed third (Violence Policy Center, 2005).

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State Ranking by Rate	State	Number of Homicide Victims	Homicide Rate per 100,000
12	Alabama	38	1.64
1	Alaska	9	2.87
7	Arizona	60	2.15
18	Arkansas	19	1.37
22	California	232	1.31
23	Colorado	29	1.29
36	Connecticut	16	0.89
42 (tie)	Delaware	2	0.48
N/A	Florida	N/A	N/A
8	Georgia	90	2.05
39	Hawaii	4	0.64
21	Idaho	9	1.32
44	Illinois	30	0.47
31	Indiana	32	1.02
32 (tie)	Iowa	15	1.00
24	Kansas	17	1.24
47	Kentucky	7	0.33
3 (tie)	Louisiana	56	2.42
30	Maine	7	1.05
11	Maryland	52	1.83
42 (tie)	Massachusetts	16	0.48
16 (tie)	Michigan	71	1.38
41	Minnesota	14	0.55
9	Mississippi	29	1.95
25 (tie)	Missouri	34	1.16
46	Montana	2	0.43
45	Nebraska	4	0.45
2	Nevada	29	2.64
49	New Hampshire	1	0.15
20	New Jersey	59	1.33
3 (tie)	New Mexico	23	2.42
35	New York	89	0.90
16 (tie)	North Carolina	59	1.38
40	North Dakota	2	0.63
27	Ohio	66	1.12
14 (tie)	Oklahoma	25	1.40
32 (tie)	Oregon	18	1.00
25 (tie)	Pennsylvania	74	1.16
37	Rhode Island	4	0.72
6	South Carolina	47	2.21
48	South Dakota	1	0.26
5	Tennessee	71	2.38
10	Texas	213	1.92
38	Utah	8	0.68
34	Vermont	3	0.95
19	Virginia	51	1.36

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29	**Washington**	**33**	**1.07**
14 (tie)	**West Virginia**	**13**	**1.40**
28	**Wisconsin**	**30**	**1.09**
13	**Wyoming**	**4**	**1.61**
	U.S. Total	**1,817**	**1.31**

Table 1. Number of Females Murdered by Males in Single Victim/Single Offender Homicides and Rates by State, 2003. (Violence Policy Center, 2005)

Identification of abuse

It is estimated in the United States that police offices spent approximately one-third of their time responding to domestic violence calls. When asked where they would seek help when faced with domestic violence thirty-one percent responded that they would attempt to obtain help from the police and 14.7 % responded that they would go to a hospital. However, a study in the Northwest revealed that 95% of women victims of domestic violence sought care 5 or more times in a year. Almost a quarter of those sought care more than 20 times a year. Most go to an emergency room (Burnett, 2006).

With these staggering numbers, it is clear that physicians and nurses are in a prime position to intervene in the domestic violence crisis in America. But, research reveals that screening rates for health care providers remain very low, under a third screen for domestic violence on a routine basis (Nelson, 2006). Multiple interventions exist for decreasing domestic violence and raising awareness of the issues. These range from direct screening, to poster campaigns, to placing the numbers of local domestic violence shelters in female restrooms. Since the abuser frequently is present or nearby during healthcare encounters, female restrooms are prime sites for the healthcare team to target victims of domestic violence.

It is also important to note that domestic violence may exist upon elderly parents of an abusive adult child. An adult child who lives in the home of the parent and is dependent upon the parent for financial support may be in a position to inflict abuse (Allen, 2006). The abuse may not be manifested as violent acts, but may lead to a position where the elder is controlled and isolated. The elder may fear the loss of the adult child's presence as caregiver, and therefore, not be willing to disclose the dominating situation.

Barriers to effective intervention have been identified among health care personnel. If requests for help are not specifically verbalized by the patient, interventions for domestic violence and abuse frequently are not initiated. Some of the barriers to domestic violence intervention are:

- Social Factors: Implied or expected social norms, tolerance of domestic violence within the area, and cognitive immunity to the problem as a result of epidemic exposure.
- Personal Factors: Gender bias, personal abuse history, idealization of the family unit, privacy issues, feeling that one case will not change the big picture.
- Professional Factors: Time and staffing issues, personal comfort with handling domestic violence, inexperience with handling domestic issues, professional detachment or inversely professional involvement with the abuser or the victim.
- Legal Factors: Lack of education or clear facility policies and positions on intervention. Concern over possible legal ramifications.

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- Making judgments about the victim, their choices, or lifestyle. 'Profiling' the typical domestic violence victim.

When assessing a patient, we need to adopt a suspicious wariness to domestic violence and consider it as a differential diagnosis in a vast number of medical complaints. The patient may not even be aware that the true root of the physical problems rests with the experience of domestic violence. Less than 1 in 25 women receive an accurate diagnosis (Barnett, 2006).

Domestic violence is a repetitive pattern of coercion by a competent adolescent or individual in which the aim is to gain and maintain control over another individual. These behaviors can occur alone or in combination, can happen regularly or sporadically and include physical and emotional abuse, and nonconsentual sexual behavior (Burnett, 2006). Domestic violence lasts along a continuum from a single episode to ongoing episodes of physical or emotional abuse (CDC, 2006).

Domestic Violence follows a predictable and repeating pattern. This pattern is termed the cycle of violence and consists of three components:

- Tension building
- Explosion followed by battering
- Absence of tension, also called loving respite, honeymoon phase, reconciliation.

Understanding the dynamics of the domestic violence cycle is important in intervening in abuse. During the tension-building phase, the victim attempts to be exceedingly compliant to the abuser in the hopes of preventing another episode of battering. Regardless of the effort upon the part of the victim, the abuser continues to become increasingly angry. Sometimes the victim will dread the battering episodes so horribly, that they either will consciously or unconsciously precipitate the event in order to get the battering episode over with. After the battering episode concludes, the abuser becomes very remorseful and loving for a period of time. As the cycle of violence deepens the time between episodes grows shorter and the battering episodes more intense.

Characteristics of abusers have been studied far less frequently than those of the abused, however, the consumption of alcohol or drugs has been frequently found within abusive relationships. Abuse victims frequently report that the abuser is very controlling of the victim or family activities, even to the point of paranoia. Abusers also tend to be very jealous or possessive. The domination tends to be all-compassive, to the point of compulsion. One victim recanted how her husband insisted that the furniture be placed back in the indentations in the carpeting and that the vacuum marks on the carpeting run parallel to each other (Allen, 2007).

Another characteristic of abusive relationships is an extreme dependence one upon the other. Each partner in the relationship has a tendency to believe that they will perish without the other. This thinking is a form of denial about the escalating violence and an attempt to solidify and validate their relationship (Allen, 2007).

Domestic violence victims use a variety of coping mechanisms to help them deal with the abuse until they can find a way out of the abusive situation. However, these coping mechanisms can sometimes be barriers to the victim receiving the help that they so desperately need. Identified coping mechanisms in domestic violence victims and their characteristics are:

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Denial

The abused person denies that the abuse is actually happening or tries to deny the degree of abuse and its impact on her. This is manifested by excusing the bruises, “I ran into the door.” “It was an accident, he didn’t mean to do it.” Denial helps the victim cope by avoiding feelings of terror and humiliation.

Minimization

Minimization is closely linked to denial. With minimization, the victim attempts to rationalize that the abuse is less serious than it is. May make statements such as: “this isn’t abuse, abuse is much more serious,” or, “he only hit me once with his fist.”

Nightmares

Nightmares help the victim by allowing the playing out in the mind of thoughts and feelings that are too horrible to be experienced during waking moments. These feelings may involve fear, anger, panic, and shame.

Shock and Disassociation

These feelings help to numb the mind of the victim so that the true impact of the abuse does not occur until the victim is in a safer environment with which to confront the emotions.

These coping mechanisms may continue even after the victim reaches safety, until they are no longer needed or they are no longer helpful. At this point, the victim may be in a position to receive support services.

There are four main reasons that the victim often stays within reach of the abuser: love, hope, dependence, and fear. The victim is afraid of losing the perceived love of the batterer and hopes that things will change. The victim wants nothing more than for every thing to be all right again. The victim may not to expose the abuser to punishment, or may not have the financial means to support herself, especially if children are involved. Victims may fear that the violence would escalate if they attempt to leave, and often it does. The most dangerous time for a victim is during times of separation. Often the abuser will kidnap children in retaliation for the separation (Burnett, 2006).

Persons who are repeatedly exposed to a negative and unpredictable environment may begin to exhibit signs of stress response with self-blame, chronic anxiety, inward turning of anger, denial of anger toward the batter, passivity, and paralyzing terror at the first signs of danger. This results in a form of learned helplessness on the part of the victim.

Knowing the cycle of violence and being able to assess which stage of violence that the victim is in gives the health care provider increased leverage in helping the victim. During the tension building and battering phases, the patient is going to be the most willing to receive help. During the reconciliation phase, the abuser has convinced the victim that the abuse will never happen again and therefore the patient is in a state of unwillingness to receive help in the face of being showered by the love of the abuser.

Relating the victim to the Prochaska Model of Change gives further insight into the stages in which a victim might be most willing to receive help. These stages of change are hallmarked by certain behaviors and thought processes within the victim.

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Precontemplation- In this stage the victim of abuse has no thoughts of change. The victim may even feel that they are deserving of the abusive treatment that they have received. Persons who are unwilling or unable to change are classified at this stage. In Precontemplation, the victim will be unwilling to receive help. However, inquiry on the part of health care providers will alert the victim that they are in an abnormal state and move the victim toward contemplation.

Contemplation- This can be a prolonged stage on the road to change, perhaps lasting for years. The victim realizes that a problem exists and begins to weigh the pro and cons of removing themselves from the abuser. However, in this stage the victim is still not ready to expose the abuser. This may be closely followed by a disclosure phase in which the victim finally discusses the abuse with the healthcare provider.

The role of the healthcare provider at the stage of disclosure has four elements that need to be met.

1. Validate and affirm that the victim is being abused
2. Inform the victim about local domestic violence resources
3. Educate the victim about effects of abuse on themselves and others
4. Document the abuse in the medical record.

Preparation- In this stage the victim begins to arm themselves with the information and resources necessary for change. This is the stage in which the victim actually plans to leave the abuser.

Action – This is the stage in which the victim actually leaves the abuser. This stage is frequently reached when the violence extends to or is witnessed by children

Maintenance- In this stage of change, the change is solidified and progress is made toward preventing relapse. Sadly, many women leave an abuser and return to them, often many times, before this stage is solidified (Burnett, 2006).
There are four types of Domestic Violence:

- **Physical Abuse** This is the use of physical force against a partner or other household member. Includes hitting, striking, biting, and shoving the victim. Other less violent forms include pinching, or scratching. Physical harm to the victim does not have to occur
- **Sexual Abuse** This is a forced non-consentual act or attempted act of sexual intercourse with the victim. The force may be physical or emotional in nature.
- **Threats** Threats may be of a sexual or physical nature. The threats may involve actual or perceived harm to the victim or family members of the victim such as children, elders, or even pets.
- **Emotional Abuse** Involves threats to the victim or family. Destruction of the victim's self esteem, name calling or other attacks on character or social standing. May also involve preventing the victim from interaction with friends, family, or other social encounters. This also includes stalking (CDC, 2006).

Risk Factors for Domestic Violence

- Any person with a disability is at risk for domestic violence
- Pregnancy
- Family income below $10,000
- Females with higher educational or occupational levels have a higher risk of abuse

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- History of family violence
- Alcohol or drug abuse by either the victim or batterer
- Current abusive relationship
- History of psychiatric disorders
- History of abuse as a child

Signs of Domestic Violence

The patient who is a victim of domestic violence may have a history of multiple care providers, but only a few visits made to each one, or the patient may have repeated visits with vague symptoms and multiple complaints (Nelson, 2006).

Physical symptoms include multiple bruises with different healing stages, bruises or marks that resemble the hands or fingers. The bruises are usually in areas that can be easily covered up. The patient may have a history of multiple fractures or fractures present for which treatment was never sought. The abuse victim may exhibit a withdrawn personality, be vague in answering questions, and frequently misses or cancels appointments. Appointments that are cancelled by someone other than the patient, especially a domestic partner should be a red flag signal

A patient who is pregnant may have bruises to the abdomen, and may have late entry into prenatal care. An overbearing partner may accompany the patient when medical care is sought and answer all questions for the patient (Nelson, 2006).

Assisting the Victim to Make an Exit Plan

If the patient is not willing to take immediate action to leave the attacker, assist the patient in making an exit plan for use should the need arise. Make sure the patient knows where he or she will go if they need to leave. The victim should have 24-hour access to this location whether it is a shelter, friend's home, or other place of safety. Gather the following items together in a place where they can be accessed quickly, maker sure, they will not be located by the abuser.

Identification for yourself and any children. Driver's license, birth certificates, passports, green cards ect.

Important Records- Mortgage documents, titles, health records, insurance cards and records, address book, marriage license

Copies of court records- Divorce papers, custody decrees, restraining orders.

Money, checkbook, bankbook, and credit cards.

A small supply of medications or a list of the drug and the dosage, along with the name and address of the prescriber.

Clothing, toys, and comfort items for yourself and any children.
Sentimental items
Small, sellable objects
Extra set of keys to car, home, office, and safety deposit box (Burnett, 2006).

The Cycle of Separation

When the victim decides to leave the abuser, the abuser goes through a set of very predictable behaviors:

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Indifference

Initially the abuser will say things like, “go ahead and leave, I don’t care” or “I don’t need you.”

Manipulative Anger

Anger is a tool that abusers use to gain and maintain control. He may claim outrage at not being able to see his children. Abusers, in truth, are no angrier than anyone else. They choose to be angry, because anger is a tool.

Manipulative Courting

The abuser attempts to win the victim back by courting her again. This tool sometimes is very successful. The abuser may make promises to change, such as to quit drinking, gambling, ect. He may remind her of good times that they might have shared. He will not discuss the abuse; he emphasizes past and future good times and says he wants her back.

Defaming the Survivor

In this stage of the separation process, the abuser tells lies about the victim to her family and friends. His goal is to isolate her socially and to diminish her support structure. Often the victim does not know about the lies. The most frequent lie is that the victim was having an affair. This is his attempt to justify his abuse, and maintain his perceived esteem.

Renewal of Manipulative Anger

This is the point of danger in the separation process. The abuser realizes that the victim is not coming back and may attempt to act upon prior threats toward the victim.

Documenting the Abuse in the Medical Record

The medical record is a tool that may result in the conviction of an assailant if the case ever goes to court. Clearly, document all finding, interventions, and actions in a legible manner.

Record what the patient says verbatim enclosing in quotation marks as needed. Record a description of the incident as the patient relates it, and history or incidents of abuse.

If the patient is reluctant to speak frankly or it seems they are not telling all the truth document the patient behavior using objective language.

Include other areas of physical or mental concern that may relate to the abuse.

Include the name and as much demographic information as possible about the abuser and their relationship to the victim.

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Document injuries as completely and thoroughly as possible noting location, size, shape, color, and apparent age. Also, include anatomical charts and color photographs of the injuries before treatment.

If photographs are taken, attach a consent form to the chart and use a Polaroid or digital camera to take the images. One photograph should be a full body shot that includes the victim's face. This clearly links the injuries to the victim. Include a torso image and close-ups of all bruises and wounds. Include two shots of each injury taken from two different angles with a reference device such as a ruler in the picture to indicate size of the wounds.

On the back of the photograph write the patient name, medical record number, date and time of the photograph, name of the photographer, location, and names and titles of witnesses. The photographer should sign the photograph.

One the back of the photograph indicate the location of the injury and the subjects stated cause of injury. Torn and damaged clothing also may be photographed. Document injuries not clearly indicated by photographs on a body chart. Preserve any damaged clothing, jewelry, or weapons using the chain of evidence protocol.

If the patient has been sexually assaulted, take care to preserve any evidence and follow protocols for examination and collection of specimens (Burnett, 2006).

Assess the victim's safety for returning home. Are they suicidal or homicidal? Is the victim going to be in danger if they return home? Offer the victim immediate referral to a domestic violence shelter. Are children involved? In some states domestic violence falls under mandated reporting and if a child is injured or in danger mandated reporting is in force in most states. Follow you state's mandated reporting guidelines.

Conclusion

Health care providers are in a unique position to intervene in domestic violence. Domestic violence is not limited to being a social issue; it is a medical issue as well. As nurses, we can open the door of help to abuse victims by initiating screening at every healthcare encounter. It is time that we accept responsibility for educating the public in general about domestic violence issues and helping victims to locate resources. Eventually the cycle of domestic violence can be broken and more victims moved toward the process of change.

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