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Domestic Violence

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Author: Lynn Barkley Burnett, MD, EdD, JD; Chief Editor: Barry E Brenner, MD, PhD, FACEP

Overview

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, stalking, 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 victim or others, intimidation, coercion, degradation and humiliation, false accusations, and ridicule.
- Intimate partner stalking may occur during a relationship or 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 attempting communication) 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."

Domestic violence exacts a multitude of costs. Annual economic costs (in 2003 dollars) was estimated at $8.3 billion, including $6.2 billion for physical assault, $461 million for stalking, $460 million for rape, and $1.2 billion for lives lost. The Centers for Disease Control and Prevention (CDC) reports that victims of severe domestic violence annually miss 8 million days of paid work—the equivalent of 32,000 full-time jobs, and approximately 5.6 million days of household productivity.[1]

The magnitude of the current problem may be further appreciated by examining the burden placed on law enforcement. Police in the United States spend approximately a third of their time responding to domestic violence calls. Of women presenting to the emergency department (ED), research suggests that between 4 and 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 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 moreso 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 partner report them to law enforcement. Thus, the emergency clinician 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 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 clinician 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 over so many ED visits? The most significant reason for missing the diagnosis of domestic violence simply may be failure 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. However, 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 elder abuse, child sexual abuse, and child abuse and neglect.

These forms of violence share many similar root causes, thus interventions directed at one may positively influence other forms of violence as well.

The practitioner in the emergency department is on the front line of interpersonal violence and is thus in a unique and vital position to initiate the process that may stop the cycle of violence in all of its familial expressions.

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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 Proschaska 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.

Inquiry at this stage serves to raise 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 clinician 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.

Epidemiology

Frequency

United States

According to the CDC's National Intimate Partner and Sexual Violence Survey report published in 2017, 1 in 4 women and 1 in 7 men have experienced severe physical violence by an intimate partner during their lifetime. In the US, about 1 in 3 women (36.3%) and nearly 1 in 6 men (17.1%) experienced some form of contact sexual violence (SV) during their lifetime.[2]

Lifetime and one-year estimates for intimate partner violence (IPV), sexual violence (SV), and stalking are alarmingly high for adult Americans, with IPV alone affecting more than 12 million people each year.[2]

Stalking statistics are also quite high; about 1 in 6 women (15.8%) and 1 in 19 (5.3%) men in the US have experienced stalking victimization at some point during their lifetime.[2] The majority of stalking victims are stalked by someone they know. About 6 in 10 (61.5%) female victims and 4 in 10 (42.8%) male victims were stalked by a current or former intimate partner.[2]

Nearly 5.3 million incidents of domestic violence occur annually among US women aged 18 years and older, with 3.2 million occurring among men. Of these incidents, most are relatively minor, such as pushing, grabbing, shoving, slapping, and hitting. Serious consequences certainly do, however, result.

Every year approximately 1.5 million intimate partner rapes and physical assaults are perpetrated against women, and approximately 800,000 are committed against men. About 1 in 5 women (19.1% or an estimated 23 million women) have experienced completed or attempted rape at some point in their lives. Completed or attempted rape was experienced at some point in life by 1.5% of men or an estimated 1,692,000 men in the US.[2]

From 1994 to 2010, according to a 2012 special report from the US Department of Justice, the overall rate of IPV in the United States declined by 64%, from 9.8 victimizations per 1,000 persons age 12 or older to 3.6 per 1,000.[3] Females and males experienced similar overall declines in IPV during the same time period. From 2000 to 2005, the rate of IPV for females continued to decline (down 31%), while male victimization rates remained stable. This pattern differed between younger and older females, however. From 2000 to 2005, rates of IPV continued to decline for females ages 12 to 17 (down 52%), 18 to 24 (down 40%), and 25 to 34 (down 40%), while rates for females ages 35 to 49 and 50 or older remained stable.[3]

Mortality/Morbidity

Almost 2 million injuries occur each year as a result of domestic violence, of which approximately one third of patients will seek care in an ED. Reported injuries include 43,000 patients with gunshot wounds, stab wounds, fractures, internal injuries, and loss of consciousness; 53,000 injured as a result of intimate partner rape or sexual assault; and 390,000 with soft tissue trauma, such as contusions and cuts.

Over the past 20 years, the number of intimate partner homicides has decreased by about 14% overall for men and women.

In 2002, approximately 11% of homicide victims were killed by an intimate partner, accounting for 1,300 deaths.

In the United States, most intimate partner murders are committed with firearms, as is the case for murder in general.

Women were the victims in 76% of intimate partner murders in 2002. Of women murdered by an intimate partner, 44% had visited an ED within 2 years of the homicide, with 93% having had at least 1 visit for injury.

Four to 8% of women are abused at least once during pregnancy. 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.

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.

According to US Department of Justice data for 1998, women were the victims in 85% of nonlethal intimate violence.

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.[4] 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.[5]

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.[6]

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.[7] 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%).[7]

Race

The National Violence Against Women Survey found that African American and American Indian and Alaskan Native women and men, and Hispanic women, 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. However, differences among minority groups diminish 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 with 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.[8]

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 (eg, 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. Data from the National Coalition of Anti-Violence Programs report 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.

Presentation

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

Training and support programs for clinicians and administrative staff have been shown to improve identification of women experiencing domestic violence and referral to advocacy services.[9] Use of a domestic violence advocate in the ED resulted in a higher incidence of detection of incidents of acute violence than the data reported in the literature.[10] 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.[11] When SAFE questions are made routine, clinicians 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 unwanted sexual relations?
- Friends/ Family (assessing degree of social support): If you have been hurt, are your friends or family aware of it? Do you think you could tell them if it did happen? Would they be able to give you support?
- Emergency plan: Do you have a safe place to go and the resources you (and your children) need in an emergency? If you are in danger now, would you like help in locating a shelter? Do you have a plan for escape? Would you like to talk with a social worker, counselor, or health care professional to develop an emergency plan?

Other appropriate questions: Has you partner ever prevented you from leaving the house or seeing your friends or family? Has your partner ever destroyed things that you cared about?

Computer-assisted screening may be another option to detect risk for intimate partner violence. Ahmad et al assessed whether computer-assisted screening can improve detection of risk for intimate partner violence and control (IPVC).[12] Their randomized study, in 282 women patients at a family practice clinic, used a computer-based multirisk assessment report generated from information provided by participants before the physician visit and attached to the medical chart. Analysis showed that the report increased opportunities to discuss IPVC (adjusted relative risk, 1.4) and increased detection of IPVC (adjusted relative risk, 2.0). The computer screening was acceptable to patients, despite some concerns about privacy and interference with physician interactions.

The patient with known or suspected domestic violence

Concerns include the interval history appropriate to the domestic violence patient who frequents the ED, her or his capacity to cope with the violent situation, and assessment of the patient's legal needs, safety, and risk for serious injury or death.

Heilig and colleagues recommended that a patient with known or suspected domestic violence who regularly seeks help from the ED be asked about the following:[13]

- Violence since the last visit
- Abuse of children since last visit
- Mental health
- Coping strategies (eg, calls to hotlines, discussion with family or friends, attempts to leave)

Assessment of coping skills

See the list below:

- Can the patient function at home and work?
- What efforts has she or he made to 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

See the list below:

- 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 following instruments may be used 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

See the list below:

- 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

See the list below:

- 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

See the list below:

- 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

See the list below:

- 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

See the list below:

- Are you thinking of suicide?
- 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

See the list below:

- 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?

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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 caregivers, 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

See the list below:

- 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 5-6 pounds of pressure per square inch. Either results in strangulation, which accounts for 10% of all violent deaths in the United States 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).[14] 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 manual 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 include a history of family violence, a current relationship involving abuse, and psychiatric history. Of those who report being abused as children, 50.4% also report adult abuse.

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.

Concomitant 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.

HIV

In a study by Reed et al, 11.8 of new cases of HIV infection were directly attributed to recent intimate partner violence when one controls for socioeconomic factors and risky behaviors.[15] In another study by Sareen J et al, patients with a history of abuse were generally diagnosed earlier with HIV because of frequent hospital visits but were then more likely to miss appointments and delay initiating therapy.[16]

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Differential Diagnoses

- Alcohol and Substance Abuse Evaluation
- Child Abuse
- Child Sexual Abuse in Emergency Medicine
- Depression and Suicide
- Elder Abuse
- Panic Disorder

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Treatment & Management

Treatment

Prehospital Care

See the list below:

- 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 department clinicians. 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 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 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:

- Include a description of the abusive event, including present complaints; use the patent'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).
- 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 that should be taken before any medical treatment.

- When possible, and with the patient's consent (attached to the chart), document all injuries with photographs that allow assessment of their adequacy 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.
- 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

See the list below:

- 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 legal obligation to report abuse should be discussed with the patient.
- 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 clinician 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 be 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 clinician
- 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 United States, 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 patient is 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.

Evidence-based recommendations

The World Health Organization published “Responding to intimate partner violence and sexual violence against women” in June of 2013. Although directed to general medical care, and not specifically the emergency department, said publication does provide evidence-based recommendations, although the quality of some is low to moderate.[17]

Consultations

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

Follow-up

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 they 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.

Men presenting with injuries resulting from domestic violence may be true victims, or they may have been injured by a partner's justifiable efforts at self-defense. In one study, 51% of male patients identified by the ICD-9 code of "adult maltreatment syndrome" had prior arrests for domestic violence versus 20% of control patients. Based on the history obtained, consideration should be directed as to the most appropriate referral: domestic violence patient support group or abuser treatment program.

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 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

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Further Inpatient Care

See the list below:

- 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.

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Inpatient & Outpatient Medications

See the list below:

- Do not prescribe tranquilizers or other sedating medications, because such medications may impair victims' ability to flee or to defend themselves.
- Clinicians 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.

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Deterrence/Prevention

See the list below:

- 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.

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Complications

See the list below:

- 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.
- Women with a history of domestic violence have a 60% higher rate of physical health problems than do women in the general population, and these women are 4-6 times more likely to have depression.
- A study of patients in a general practice found PTSD in 35% of patients who had experienced domestic violence; a rate approximately twice as high as in the general population. In this study, PTSD was often comorbid with major depression. While life-threatening traumatic events are not uncommon, PTSD resulting therefrom is usually acute and short-term, whereas in victims experiencing the severe end of the domestic violence spectrum, PTSD may be chronic.
- 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.

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Prognosis

Domestic violence typically recurs and progressively escalates in both 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.[18] 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, see eMedicineHealth's patient education article Domestic Violence.

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Questions & Answers

Overview

How is domestic violence defined?

What is the pattern of coercive behaviors that leads to domestic violence?

What are the societal costs associated with domestic violence?

Where are victims of domestic violence most likely to seek help?

Which factors may deter intervention in domestic violence?

Why is a diagnosis of domestic violence in women frequently overlooked?

What are the US Preventive Services Task Force recommendations for domestic violence screening?

What are components of the cycle of domestic violence?

What are the reasons victims of domestic violence remain in the relationship?

What is the Transtheoretic Model of Change and how is it adapted to the setting of domestic violence?

What is the prevalence of domestic violence in the US?

What is the mortality and morbidity associated with domestic violence?

What is the proportion of domestic violence in males and females?

What are the racial predilections of domestic violence?

What are the sexual predilections of domestic violence?

Which age groups have the highest prevalence of domestic violence?

Presentation

How should a patient's history be taken when domestic violence is suspected?

What are the symptoms of domestic violence caused by trauma?

Which clinical history findings suggest domestic violence?

How are depression and suicide related to domestic violence?

How is stress related to domestic violence?

How is alcohol or substance abuse related to domestic violence?

Which medical complaints are most common with domestic violence?

What are the signs and symptoms of domestic violence in female patients?

What is the role of domestic violence advocates in the emergency department (ED)?

What is the Partner Violence Screen (PVS) for the assessment of domestic violence?

How is the mnemonic SAFE used in the evaluation of suspected domestic violence?

What questions should be asked to in the evaluation for domestic violence?

What is the efficacy of computer-assisted screening for domestic violence?

What is included in the evaluation of patients with known or suspected domestic violence?

How are coping skills assessed in patients with known or suspected domestic violence?

How are legal needs assessed in patients with known or suspected domestic violence?

How are threats of homicide assessed in suspected domestic violence?

How are previous attacks evaluated in cases of suspected domestic violence?

What are the indications of a pattern of isolation in victims of domestic violence?

What is the Physical Abuse Ranking Scale for assessing danger in domestic violence?

Which behaviors and emotions of perpetrators indicated greater danger for victims of domestic violence?

How is physical violence assessed in suspected domestic violence?

How is substance abuse assessed in suspected domestic violence?

How is suicidal ideation assessed in the evaluation of domestic violence?

How is the level controlling behavior in the perpetrator assessed in the evaluation of domestic violence?

How is homicidal ideation assessed in the evaluation of domestic violence?

What are the physical signs of domestic violence in both the perpetrator and victim?

What are the characteristic injuries in victims of domestic violence?

Which fingernail markings are characteristic of victims of domestic violence?

Which pattern injuries are characteristic of domestic violence?

What is the appearance of contusions in victims of domestic violence?

What is the appearance of bite marks in victims of domestic violence?

What are the indications of strangulation in victims of domestic violence?

What are the most common sites of injury in victims of domestic violence?

Which injuries suggest a defensive posture in victims of domestic violence?

Which inconsistencies should raise suspicion of domestic violence?

What are indications of domestic violence during pregnancy?

What are indications of sexual assault in victims of domestic violence?

What causes of domestic violence?

What is the role of alcohol or substance abuse in the etiology of domestic violence?

What is the role of HIV infection in the etiology of domestic violence?

DDX

What are the differential diagnoses for Domestic Violence?

Treatment

What is included in the prehospital care of victims of domestic violence?

What are responsibilities of emergency department personnel when caring for victims of domestic violence?

What are the JCAHO requirements for hospitals treating victims of domestic violence?

What is the emergency department's role in providing a safe environment for victims of domestic violence?

What are primary messages ED personnel should deliver to victims of domestic violence?

What is the initial approach to treatment of a victim of domestic violence?

How is domestic violence treated in the ED?

What should be documented in the medical record of a victim of domestic violence?

What are the legal obligations of personnel treating victims of domestic violence?

How is the risk of further violence assessed in victims of domestic violence?

How is a follow-up plan developed for victims of domestic violence?

What are considerations when planning disposition of a victim of domestic violence?

What are the elements of a safety plan for victims of domestic violence?

What are the referral and shelter options for victims of domestic violence?

Which organization had published evidence-based recommendations for the treatment of victims of domestic violence?

Which specialist consultations may be helpful to a victim of domestic violence?

Follow-up

What is included in further outpatient care of victims of domestic violence?

Which organizations offer help for victims of cyberstalking?

When is inpatient care indicated for victims of domestic violence?

What is the role of medications in the treatment of domestic violence victims?

What is the role of the ED staff in the prevention of domestic violence?

What are the possible complications of domestic violence?

What is the prognosis for victims of domestic violence?

What is included in patient education about domestic violence?

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Contributor Information and Disclosures

Author

Lynn Barkley Burnett, MD, EdD, JD Medical Advisor, Fresno County Sheriff's Office; Attending Consultant-in-Chief and Chairman, Medical Ethics, Community Medical Centers; Instructor in Emergency Medicine, Campbell University School of Osteopathic Medicine; Core Graduate Adjunct Professor of Forensic Pathology, National University Master of Forensic Science

Program; Associate Faculty, University of Arizona College of Medicine-Phoenix

Lynn Barkley Burnett, MD, EdD, JD is a member of the following medical societies: American Academy of Hospice and Palliative Medicine, American Association for the Advancement of Science, American Association of Suicidology, American Cancer Society, American College of Sports Medicine, American Heart Association, American Professional Society on the Abuse of Children, American Public Health Association, American Society for Bioethics and Humanities, American Society of Law, Medicine & Ethics, American Stroke Association, Association of Military Surgeons of the US, Christian Medical and Dental Associations, European Society for Trauma and Emergency Surgery, European Society of Cardiology, European Society of Intensive Care Medicine, European Society of Paediatric and Neonatal Intensive Care, International Homicide Investigators Association, New York Academy of Sciences, Royal College of Surgeons of Edinburgh, Royal Society of Medicine, Society for Academic Emergency Medicine, Society of Critical Care Medicine, World Association for Disaster and Emergency Medicine

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Coauthor(s)

Jonathan Adler, MD, MS Instructor, Department of Emergency Medicine, Harvard Medical School, Massachusetts General Hospital

Jonathan Adler, MD, MS is a member of the following medical societies: American Academy of Emergency Medicine, Society for Academic Emergency Medicine

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Specialty Editor Board

Francisco Talavera, PharmD, PhD Adjunct Assistant Professor, University of Nebraska Medical Center College of Pharmacy; Editor-in-Chief, Medscape Drug Reference

Disclosure: Received salary from Medscape for employment. for: Medscape.

Robert Harwood, MD, MPH, FACEP, FAAEM Senior Physcian, Department of Emergency Medicine, Advocate Christ Medical Center; Assistant Professor, Department of Emergency Medicine, University of Illinois at Chicago College of Medicine

Robert Harwood, MD, MPH, FACEP, FAAEM is a member of the following medical societies: American Academy of Emergency Medicine, American College of Emergency Physicians, American Medical Association, Council of Residency Directors in Emergency Medicine, Phi Beta Kappa, Society for Academic Emergency Medicine

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Chief Editor

Barry E Brenner, MD, PhD, FACEP Program Director, Emergency Medicine, Einstein Medical Center Montgomery

Barry E Brenner, MD, PhD, FACEP is a member of the following medical societies: Alpha Omega Alpha, American Academy of Emergency Medicine, American College of Chest Physicians, American College of Emergency Physicians, American College of Physicians, American Heart Association, American Thoracic Society, New York Academy of Medicine, New York Academy of Sciences, Society for Academic Emergency Medicine

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Additional Contributors

Steven A Conrad, MD, PhD Chief, Department of Emergency Medicine; Chief, Multidisciplinary Critical Care Service, Professor, Department of Emergency and Internal Medicine, Louisiana State University Health Sciences Center

Steven A Conrad, MD, PhD is a member of the following medical societies: American College of Chest Physicians, American College of Critical Care Medicine, American College of Emergency Physicians, American College of Physicians, International Society for Heart and Lung Transplantation, Louisiana State Medical Society, Shock Society, Society for Academic Emergency Medicine, Society of Critical Care Medicine

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References

1. Centers for Disease Control and Prevention (CDC). Costs of Intimate Partner Violence Against Women in the United States. CDC, National Center for Injury Prevention and Control. Available at https://www.cdc.gov/violenceprevention/pdf/IPVBook-a.pdf. March 2003;
2. Smith, S.G., Chen, J., Basile, K.C., et al. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-2012 State Report. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Available at https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf. 2017; Accessed: June 12, 2017.
3. U.S. Department of Justice - Office of Justice Programs. Special Report: Intimate Partner Violence, 1993–2010. November 2012. [Full Text].
4. McCoy M. Domestic violence: clues to victimization. Ann Emerg Med. 1996 Jun. 27(6):764-5. [QxMD MEDLINE Link].
5. Bachman R, Saltzman LE. Violence against women: Estimates from the redesigned survey August 1995. NCJ-154348 Special Report. US Department of Justice:[Full Text].
6. Sachs CJ, Baraff LJ, Peek C. Need for law enforcement in cases of intimate partner violence in a university ED. Am J Emerg Med. 1998 Jan. 16(1):60-3. [QxMD MEDLINE Link].
7. Vasquez D, Falcone RE. Cross-gender violence. Ann Emerg Med. 1997 Mar. 29(3):427-8. [QxMD MEDLINE Link].
8. Ernst AA, Nick TG, Weiss SJ, et al. Domestic violence in an inner-city ED. Ann Emerg Med. 1997 Aug. 30(2):190-7. [QxMD MEDLINE Link].
9. Feder G, Davies RA, Baird K, Dunne D, Eldridge S, Griffiths C, et al. Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial. Lancet. 2011 Nov 19. 378(9805):1788-95. [QxMD MEDLINE Link].
10. Hugl-Wajek JA, Cairo D, Shah S, McCreary B. Detection of domestic violence by a domestic violence advocate in the ED. J Emerg Med. 2012 Nov. 43(5):860-5. [QxMD MEDLINE Link].
11. Sebastian SJ. Domestic violence. Harwood-Nuss AL, ed. The Clinical Practice of Emergency Medicine. 2nd ed. Lippincott-Raven Publishers; 1996.
12. Ahmad F, Hogg-Johnson S, Stewart DE, Skinner HA, Glazier RH, Levinson W. Computer-assisted screening for intimate partner violence and control: a randomized trial. Ann Intern Med. 2009 Jul 21. 151(2):93-102. [QxMD MEDLINE Link].
13. Heilig S, Rodriguez M, Martin S, Louie D, eds. Domestic violence: A practical approach for clinicians. San Francisco Medical Society; 1995. [Full Text].
14. Strack GB, McLane G. How to improve your investigation and prosecution of strangulation cases. Presented at Family Prevention National Health/Domestic Violence Conf. 2000.
15. Siemieniuk RA, Krentz HB, Gish JA, Gill MJ. Domestic violence screening: prevalence and outcomes in a Canadian HIV population. AIDS Patient Care STDS. 2010 Dec. 24(12):763-70. [QxMD MEDLINE Link].
16. Sareen J, Pagura J, Grant B. Is intimate partner violence associated with HIV infection among women in the United States?. Gen Hosp Psychiatry. 2009 May-Jun. 31(3):274-8. [QxMD MEDLINE Link].
17. Feder G, Wathen CN, MacMillan HL. An evidence-based response to intimate partner violence: WHO guidelines. JAMA. 2013 Aug 7. 310(5):479-80. [QxMD MEDLINE Link].
18. Brookoff D, O'Brien KK, Cook CS, et al. Characteristics of participants in domestic violence. Assessment at the scene of domestic assault. JAMA. 1997 May 7. 277(17):1369-73. [QxMD MEDLINE Link].
19. Black MC, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, et al. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. CDC. Available at https://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf. Accessed: October 7, 2014.
20. Ross DS. Adult abuse. Rosen P, ed. Emergency Medicine Concepts and Clinical Practice. 3rd ed. Mosby-Year Book; 1992.
21. Abbott J. Injuries and illnesses of domestic violence. Ann Emerg Med. 1997 Jun. 29(6):781-5. [QxMD MEDLINE Link].
22. Alpert EJ, Sege RD, Bradshaw YS. Interpersonal violence and the education of physicians. Acad Med. 1997 Jan. 72(1 Suppl):S41-50. [QxMD MEDLINE Link].
23. Anderson RJ, Taliaferro EH. Injury prevention and control. J Emerg Med. 1998 May-Jun. 16(3):489-98. [QxMD MEDLINE Link].
24. Barkin RM. Pediatrics. A potpourri of clinical pearls. Emerg Med Clin North Am. 1997 May. 15(2):381-8. [QxMD MEDLINE Link].
25. Boergerhoff LA, Gerberich SG, Anderson A, et al. Out-of-hospital violence injury surveillance: quality of data collection. Ann Emerg Med. 1999 Dec. 34(6):745-50. [QxMD MEDLINE Link].

26. Bonds DE, Ellis SD, Weeks E, Palla SL, Lichstein P. A practice-centered intervention to increase screening for domestic violence in primary care practices. BMC Fam Pract. 2006. 7:63. [QxMD MEDLINE Link].

27. Bostock DJ, Brewster AL. Intimate partner sexual violence. Clinics in Family Practice. 2003 Mar. 5 (1):145.

28. Cantu M, Coppola M, Lindner AJ. Evaluation and management of the sexually assaulted woman. Emerg Med Clin North Am. 2003 Aug. 21(3):737-50. [QxMD MEDLINE Link].

29. Condon L. Tracking violence at home (domestic violence involving same-sex couples). The Advocate. 2001 Sept 11.

30. Corrigan JD, Wolfe M, Mysiw WJ, et al. Early identification of mild traumatic brain injury in female victims of domestic violence. Am J Obstet Gynecol. 2003 May. 188(5 Suppl):S71-6. [QxMD MEDLINE Link].

31. Cross M. Why looking for victims of domestic violence makes sense. Manag Care. 2003 May. 12(5):27-30. [QxMD MEDLINE Link].

32. Director TD, Linden JA. Domestic violence: an approach to identification and intervention. Emerg Med Clin North Am. 2004 Nov. 22(4):1117-32. [QxMD MEDLINE Link].

33. Duxbury F. Recognising domestic violence in clinical practice using the diagnoses of posttraumatic stress disorder, depression and low self-esteem. Br J Gen Pract. 2006 Apr. 56(525):294-300. [QxMD MEDLINE Link].

34. Easley M. Domestic violence. Ann Emerg Med. 1996 Jun. 27(6):762-3. [QxMD MEDLINE Link].

35. Feldhaus KM, Koziol-McLain J, Amsbury HL, et al. Accuracy of 3 brief screening questions for detecting partner violence in the emergency department. JAMA. 1997 May 7. 277(17):1357-61. [QxMD MEDLINE Link].

36. Flitcraft A. Learning from the paradoxes of domestic violence. JAMA. 1997 May 7. 277(17):1400-1. [QxMD MEDLINE Link].

37. Furbee PM, Sikora R, Williams JM, et al. Comparison of domestic violence screening methods: a pilot study. Ann Emerg Med. 1998 Apr. 31(4):495-501. [QxMD MEDLINE Link].

38. Gazmararian JA, Lazorick S, Spitz AM, et al. Prevalence of violence against pregnant women. JAMA. 1996 Jun 26. 275(24):1915-20. [QxMD MEDLINE Link].

39. Greenfeld LA, Henneberg MA. Victim and offender self-reports of alcohol involvement in crime. Alcohol Res Health. 2001. 25(1):20-31. [QxMD MEDLINE Link].

40. Gremillion DH, Kanof EP. Overcoming barriers to physician involvement in identifying and referring victims of domestic violence. Ann Emerg Med. 1996 Jun. 27(6):769-73. [QxMD MEDLINE Link].

41. Gribbin A. Murder biggest cause of death in pregnancy. The Washington Times. March 21, 2001.

42. Horon IL, Cheng D. Enhanced surveillance for pregnancy-associated mortality--Maryland, 1993-1998. JAMA. 2001 Mar 21. 285(11):1455-9. [QxMD MEDLINE Link].

43. Houry D, Feldhaus K, Thorson AC, et al. Mandatory reporting laws do not deter patients from seeking medical care. Ann Emerg Med. 1999 Sep. 34(3):336-41. [QxMD MEDLINE Link].

44. Houry D, Feldhaus KM, Nyquist SR, et al. Emergency department documentation in cases of intentional assault. Ann Emerg Med. 1999 Dec. 34(6):715-9. [QxMD MEDLINE Link].

45. Hyman A, Schillinger D, Lo B. Laws mandating reporting of domestic violence. Do they promote patient well-being?. JAMA. 1995 Jun 14. 273(22):1781-7. [QxMD MEDLINE Link].

46. Iavicoli LG. Mandatory reporting of domestic violence: the law, friend or foe?. Mt Sinai J Med. 2005 Jul. 72(4):228-31. [QxMD MEDLINE Link].

47. Kaufmann MC. Decreasing the burden of trauma for victims of violence. Ann Emerg Med. 1997 Aug. 30(2):199-203. [QxMD MEDLINE Link].

48. Kernsmith P. Exerting power or striking back: a gendered comparison of motivations for domestic violence perpetration. Violence Vict. 2005 Apr. 20(2):173-85. [QxMD MEDLINE Link].

49. Kyriacou DN, McCabe F, Anglin D, et al. Emergency department-based study of risk factors for acute injury from domestic violence against women. Ann Emerg Med. 1998 Apr. 31(4):502-6. [QxMD MEDLINE Link].

50. Landis JM, Sorenson SB. Victims of violence: the role and training of EMS personnel. Ann Emerg Med. 1997 Aug. 30(2):204-6. [QxMD MEDLINE Link].

51. Marwick C. Domestic violence recognized as world problem. JAMA. 1998 May 20. 279(19):1510. [QxMD MEDLINE Link].

52. McAfee RE. Physicians and domestic violence. Can we make a difference?. JAMA. 1995 Jun 14. 273(22):1790-1. [QxMD MEDLINE Link].

53. McCauley J, Kern DE, Kolodner K, et al. Clinical characteristics of women with a history of childhood abuse: unhealed wounds. JAMA. 1997 May 7. 277(17):1362-8. [QxMD MEDLINE Link].

54. McLeer SV, Anwar RAH. The abused, assaulted adult. Schwartz GR, ed. Principles and Practice of Emergency Medicine. 2nd ed. Lea & Febiger; 1992.

55. Muelleman RL, Burgess P. Male victims of domestic violence and their history of perpetrating violence. Acad Emerg Med. 1998 Sep. 5(9):866-70. [QxMD MEDLINE Link].

56. Muelleman RL, Lenaghan PA, Pakieser RA. Battered women: injury locations and types. Ann Emerg Med. 1996 Nov. 28(5):486-92. [QxMD MEDLINE Link].

57. Muelleman RL, Lenaghan PA, Pakieser RA. Nonbattering presentations to the ED of women in physically abusive relationships. Am J Emerg Med. 1998 Mar. 16(2):128-31. [QxMD MEDLINE Link].

58. Muelleman RL, Reuwer J, Sanson TG, et al. An emergency medicine approach to violence throughout the life cycle. SAEM Public Health and Education Committee. Acad Emerg Med. 1996 Jul. 3(7):708-15. [QxMD MEDLINE Link].

59. Neufeld B. SAFE questions: overcoming barriers to the detection of domestic violence. Am Fam Physician. 1996 Jun. 53(8):2575-80, 2582. [QxMD MEDLINE Link].

60. Phelan MB, Hamberger LK, Guse CE, et al. Domestic violence among male and female patients seeking emergency medical services. Violence Vict. 2005 Apr. 20(2):187-206. [QxMD MEDLINE Link].

61. Ponsell MR. Assessing facial fractures in the emergency department. JAAPA. 2003 May. 16(5):43-4, 47-50, 69. [QxMD MEDLINE Link].

62. Rivara FP, Mueller BA, Somes G, et al. Alcohol and illicit drug abuse and the risk of violent death in the home. JAMA. 1997 Aug 20. 278(7):569-75. [QxMD MEDLINE Link].

63. Sachs CJ, Peek C, Baraff LJ, et al. Failure of the mandatory domestic violence reporting law to increase medical facility referral to police. Ann Emerg Med. 1998 Apr. 31(4):488-94. [QxMD MEDLINE Link].

64. Salber PR, Taliaferro E. Domestic violence. Rosen P, ed. Emergency Medicine Concepts and Clinical Practice. 4th ed. Mosby-Year Book; 1998.

65. Salber PR, Taliaferro E. Domestic violence. Tintinalli JE, ed. Emergency Medicine: A Comprehensive Study Guide. 4th ed. McGraw-Hill; 1996.

66. Salber PR, Taliaferro E. Intimate partner violence and abuse. Rosen, ed. Emergency Medicine: Concepts and Clinical Practice. 5th ed. St Louis, MO: Mosby; 2002.

67. Salber PR, Taliaferro E. Men and domestic violence. Acad Emerg Med. 1998 Sep. 5(9):849-50. [QxMD MEDLINE Link].

68. Science News. Childhood trauma raises risk of heart disease. Science News. 2004 Nov 30.

69. Shkrum MJ, Ramsay DA. Forensic Pathology of Trauma. Totowa NJ: Humana Press; 2007.

70. Smock WS. Forensic emergency medicine. Rosen P, ed. Emergency Medicine Concepts and Clinical Practice. 5th ed. St Louis, MO: Mosby; 2002.

71. Spitz WU, ed. Medicolegal Investigation of Death. 4th ed. Springfield, IL: Charles C. Fisher Publisher; 2006.

72. Tjaden P, Thoennes N. Extent, nature, and consequences of intimate partner violence. Findings from the National Violence Against Women Survey. July 2000. NJC 181867:

73. U.S. Preventive Services Task Force. Screening for family and intimate partner violence: recommendation statement. Ann Fam Med. 2004 Mar-Apr. 2(2):156-60. [QxMD MEDLINE Link].

74. Wahl RA, Sisk DJ, Ball TM. Clinic-based screening for domestic violence: use of a child safety questionnaire. BMC Med. 2004 Jun 30. 2:25. [QxMD MEDLINE Link].

75. Waller AE, Hohenhaus SM, Shah PJ, et al. Development and validation of an emergency department screening and referral protocol for victims of domestic violence. Ann Emerg Med. 1996 Jun. 27(6):754-60. [QxMD MEDLINE Link].

76. Wattendorf G. Expert testimony and risk assessment in stalking cases: the FBI's NCAVC as a resource. The FBI Law Enforcement Bulletin. Federal Bureau of Investigation, National Center for the Analysis of Violent Crime. Nov 1, 2004.

77. Ziegler MF, Greenwald MH, DeGuzman MA, et al. Posttraumatic stress responses in children: awareness and practice among a sample of pediatric emergency care providers. Pediatrics. 2005 May. 115(5):1261-7. [QxMD MEDLINE Link].

78. Zink T, Elder N, Jacobson J, et al. Medical management of intimate partner violence considering the stages of change: precontemplation and contemplation. Ann Fam Med. 2004 May-Jun. 2(3):231-9. [QxMD MEDLINE Link].