Adopted: 09/00
To be revised: 09/02

Domestic Violence: Identifying and Responding to a Battered Woman

Domestic violence is more common than many other health concerns that are routinely screened for in the health care setting. Its prevalence and the subsequent health, social, and economic costs warrant routine attention and effective follow-up by all health care institutions and practitioners.[1] What follows are guidelines for WSCC clinicians on screening and responding to family violence against women. Violence against men from their female partners, violence between same sex partners, and child/elder abuse are important but are not addressed specifically in this protocol.

Examples of ways in which practitioners can ask about abuse are enclosed in boxes.

Protocol Summary

Step 1: *Identifying the battered woman*

Step 2: *Asking about abuse (with sample questions)*

Step 3: *Responding to the disclosure of abuse*

Step 4: *Charting appropriately*

Step 5: *Scheduling follow-up*

Step 1: Identifying the Battered Woman

The most effective way to identify battered women is to screen (face-to-face) all new female patients in a private setting without family (including children) present.[1] In the social history, all female patients over age 18 will be asked about abuse.

In addition to routine screening questions, consider abuse if injuries are present and the explanation does not fit what is observed.

There may be multiple injuries in various stages of repair. There may be delays between injury and requests for care. There may be evidence of untreated previous injuries.[2,3] The patient or her partner may state that she is "accident prone."[4]

Somatic symptoms may include chronic pain, headache, back and pelvic pain, hyperventilation, chest and gastrointestinal symptoms**,** especially if very general or vague.[2]

Psychological sequelae of violence may include depression, addiction, anxiety, insomnia, mental illness, suicide ideation or attempts, and assorted physical symptoms, some of which may be psychosomatic.[2]

Consider the possibility of abuse in established or returning patients or patients who have denied abuse if they appear to have poor self esteem, are socially isolated, exhibit nervous behavior, make poor eye contact, seem dependent, or make references that imply they are accountable to or frightened of their partner.[2] Also consider the possibility of abuse if patients have unusual reactions (hypersensitive or unusually passive) to the physical contact inherent in chiropractic care.

An abused woman may appear shy, frightened, embarrassed, evasive, anxious or tearful. Bear in mind that many battered women will deny abuse and may be noncompliant.[2]

Occasionally batterers will accompany the woman to monitor what is said. In these situations, *the woman should never be questioned about abuse in front of her partner*.[1,3,4]

Interns must report their suspicions to their clinical supervisor. This is not optional.

All discussions with clinicians should be private to protect patient confidentiality.

Step 2: Asking About Abuse

The supervising clinician will decide whether he/she or the intern will approach the woman. In cases of male supervisors, it may be prudent to consider asking a female clinician from another group to intervene.

Create a Safe Environment

Ask about abuse in a *private, safe setting*. If the patient is not alone, questioning should be postponed until it is safe. If the woman's partner is present, try to find a reason to talk with the woman alone, perhaps asking her partner to fill out paperwork, etc. Consider that the right moment may not come during the first visit, but may present itself as the therapeutic relationship evolves.

Show Concern

By asking questions about abuse, chiropractors exhibit concern and with time, patients may gain trust and decide that this is an issue that may be discussed with this doctor. Introduce the topic in an empathic, respectful, relaxed and nonjudgmental manner.

Initially avoid words like *abuse, beaten, rape, battered* because these words may hold charged or different meanings for patients. Appropriate words/phrases may include: *hurt, afraid, forced to do things she doesn't want to do.*

Try to lead into the area of questioning slowly, using direct, nonthreatening questions. Women have the right to deny that abuse has occurred. Always leave the door open for later disclosure of abuse.

Examples of ways in which the opening question about potential abuse can be framed:

"Because violence is so common in many people's lives, we've begun to ask all female patients about it." [1]

"We consider violence a serious health issue." [1]

All female patients over the age of 18 should be asked the following screening question:

"Are you currently or have you ever been in a relationship where you were physically hurt, threatened or made to feel afraid?" [1]

Phrasing the Question

As stated earlier, it may not always be possible to broach the subject of abuse on the first visit. However, by posing the above question to all female patient's over the age of 18, the practitioner demonstrates that domestic violence is a health concern and one that can be addressed in the setting of the WSCC clinics. If abuse is suspected in an established patient, the clinician must inquire about the possibility of abuse using questions that are tailored to the patient. Select questions that will not intimidate the patient or compromise the trust established with this person.

The following are samples of questions that practitioners can use with established patients.

Examples of questions about abuse [2]

When I see a patient with symptoms like yours, I'm concerned about what stresses there may be in her life. Can you tell me about the stresses in your life? Are there problems involving anyone close to you? Is anyone threatening you or making you feel bad about yourself?

You know, sometimes when women feel the way you do, it's because they're being hurt in some way. Is anyone hurting you at home?

Relationships can be difficult. What happens when you and your partner have a disagreement? How do you resolve it?

Have there been times in your relationship when you've had physical fights or been hurt in any way?

Many women experience or have experienced some form of physical or sexual trauma. Has this happened to you?

When I see injuries like this, I worry that they may have been inflicted by another person. I need to ask if anyone has hurt you?

You mentioned that your partner drinks too much. How does he act when he's been drinking? Has he ever hurt you?

Step 3: Responding to the Disclosure of Abuse

Express concern for the patient's well-being and treat disclosure as a serious issue. Acknowledge the significance of what the patient has disclosed. Assure her that it is not her fault and that she does not deserve to be treated this way.[2]

Assure her of confidentiality. If this exchange occurs with an intern prior to the intern having the opportunity to notify the supervising clinician, the intern must inform the patient that the confidentiality must include a supervising clinician.

Confidentiality may be breached only if the client is under 18, over 64 or is mentally ill or developmentally disabled.*

If there are children under 18 at risk, inform the patient that chiropractors are mandated to report suspicions of child abuse.*

Chiropractors are mandated to report SUSPICIONS of child abuse to the State Office for Services to Children and Families (SCF) or law enforcement.*

Children witnessing domestic violence does not necessarily constitute "child abuse." Consider reporting if you think the child is at imminent risk of injury, tells you he/she is afraid, or when you witness demonstrable effects of domestic violence on the child's behavior (mental injury).[4]

Attempt to assess immediate danger[2] (see "Danger Assessment Questions" on the next page).

Identify the patient's concerns and issues in a non-blaming manner (e.g., barriers to getting safe, self-blame, fears, threats).

Discuss what documentation will be made in the chart, how it will be used, and how it can be accessed.[4]

Include the patient in decisions to use a confidential file and explain clinic obligations if the patient signs a release of records.

Identify the patient's resources[3] and immediate plans—if any (family, friends, financial, etc).

Give information about resources: shelters, help lines, etc. (See Appendix I: Community Resources from Multnomah County Department of Community and Family Services.)

Direct the patient to hotline numbers in the phone book and/or suggest she memorize the number(s) if there are security concerns about her going home with printed material.

If a patient refuses to further discuss the abuse or refuses to create a plan or seek additional help, the practitioner must respect her decision. The issue may be able to be explored in subsequent visits.

Attempt to schedule follow-up visits to maintain contact with the patient.

*Oregon Revised Statutes (ORS) 418.747 to 418.749 and 419B.005 to 419B.050, ORS 124.050 to 124.095, ORS 430.735 to 430.765.

Danger Assessment Questions

Ask as many of the following questions as seem relevant to the individual and the setting. The questions being asked may educate the patient and lead her to reflect on the dangers of her situation.

IMMEDIACY OF DANGER

Are you in immediate danger?
What do you think will happen when you go home?
Are you afraid that your partner will seriously injure you in the near future?

PATTERNS

How frequent and severe are the episodes?
What does he do when he gets angry?
Can you predict when he is likely to become physical?[2]

RISK TO LIFE

Does your partner have a weapon?
Has he threatened to kill you?
Is there a gun in the home?

PREDICTABILITY

Does your partner use drugs or alcohol?

HOMICIDE/SUICIDE RISK

Are you so upset that you've thought about hurting yourself?
*Has your partner been threatening suicide?**
Are you so afraid that you've thought about hurting your partner?

FACTORS AFFECTING JUDGEMENT/ABILITY TO RESPOND

Have you been using drugs or alcohol to help you cope with this situation?

***There is a risk that the perpetrator may kill himself AND the patient/children.*[4]

Step 4: Charting Appropriately

Document disclosure of abuse. Use quotation marks to denote patient's words. Use appropriate modifiers such as "alleged," "suspected" or "suggestive of." Document specific objective findings using "body map" diagrams and measurements. (See Appendix II: Domestic Violence Screening/Documentation Form.)[1]

The decision to use a confidential file is made by the staff clinician. Confidential files are often recommended in these cases. Make sure that photos and related documentation are released if subpoenaed at a later date.

Photographs. First, you must get the *patient's permission* to take photographs. (See Appendix III: Consent to Photograph.)[3] Use a 35 mm camera or take multiple shots of the same areas with a Poloroid camera. Because multiple copies of each photo may be needed, a 35 mm camera is best until the option of using a digital camera becomes available. (See Appendix IV: Choosing a Camera.)

Note: When close-up photos are taken, also include a wide shot to properly identify the patient.

It is recommended that *four sets* of the photos be made. The first set must stay with the patient's chart. A second set can be given to the patient—if she has a safe place to keep them. Other sets may be needed for patient advocates and/or attorneys and will remain with the chart until requested by these officials. *Photocopies of these photographs are often of insufficient quality to be of value in any legal setting*.

Note: Photos must be kept secured in a sealed envelope to protect the patient's privacy.

Include the following information on the back of each photo. [5]

1. Patient's name
2. Record (chart) number
3. Date of birth
4. Date and time photo taken
5. Clinic site where photo was taken
6. Name of photographer
7. Body location

Step 5: Schedule Follow-up

Schedule follow-up visits to provide care for ongoing health issues and to provide support that may enable the patient, with time, to regain control of her life.

The patient's decisions must be respected. A professional relationship that monitors and supports the patient's process may be key to her taking steps to reclaim control of her life.

Provide ongoing safety assessment. (See Danger Assessment Questions, previous page).

Provide education about domestic violence. Continue to explore resources and options. (See Appendix IV: Community Resources).
Address health concerns and continue to screen for alcohol/drug abuse and suicide risk.

Provide a positive, supportive relationship for the patient. It may be crucial to the patient's survival.

Appendix I: Community Resources: GENERAL SERVICES FOR DOMESTIC VIOLENCE VICTIMS/SURVIVORS

MULTNOMAH COUNTY

Bradley-Angle House (www.bradleyangle.org) – Services for domestic violence victims and their children
503-281-2442* or shelter office 503-281-3540
- Emergency shelter
- Support groups
- Transitional Housing
- Middle and high school education programs

Portland Women's Crisis Line (www.pwcl.org) - Services for domestic violence & sexual assault victims/survivors
503-235-5333 or toll-free **1-888-235-5333**
- 24 hour crisis line; translators available 24 hours a day
- Restraining order & court advocacy
- Middle and high school education programs
- Support services for sexual assault survivors

Raphael House (rahpaelhouse.com) – Services for domestic violence victims and their children
503-222-6222* or office 503-222-6507
- Emergency shelter
- Transitional housing
- Long-term housing

Salvation Army West Women's & Children's Shelter (www1.salvationarmy.org) – Services for single women and women with children
503-224-7718
- Emergency shelter
- Transitional housing
- In-shelter children's program

Volunteers of America Family Center (www.voaor.org) – Emergency shelter for women with children; other services for single women and women with children
503-232-6562 or Outreach 503-771-5503
- Emergency shelter
- Drop-in appointments with advocate
- Support groups, including groups for children

YWCA Yolanda House
Emergency shelter for single women and women with children
503-535-3269
- Counseling

Multnomah County Employee Assistance Program
(http://www.co.multnomah.or.us/dchs/dv/dvman/resdes.html)
503-215-3561 – Free short-term counseling for County employees only

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NEIGHBORING COUNTIES: The following services in neighboring counties are available for Multnomah County residents who are victims/survivors.

CLACKAMAS COUNTY

Clackamas Women's Services (http://www.clackamaswomensservices.org/) – Emergency shelter for single women and women with children; **888/503-654-2288** or Outreach (office) 503-722-2366
- 24-hour crisis line
- Transitional housing
- Drop-in appointments with advocate
- Support groups, including groups for children

WASHINGTON COUNTY

Monika's House (Domestic Violence Resource Center) (www.monikashouse.org)
Emergency shelter for single women and women with children
503-469-8620
24 hour crisis line
Domestic Violence Resource Center (http://www.monikashouse.org/)
503-640-5352
Restraining order advocacy program Counseling for victims and children Support groups

COLUMBIA COUNTY

Columbia County Women's Resource Center (http://www.columbia-center.org/ccwrc/)
Emergency shelter for single women and women with children
503-397-6161

CLARK COUNTY, WASHINGTON

YWCA SafeChoice Shelter (http://www.ywcaclarkcounty.org/safechoice.htm)
Emergency shelter for single women and women with children
1-360-695-0501
Support groups Legal Advocacy Services for sexual assault survivors

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CULTURALLY-SPECIFIC and POPULATION-SPECIFIC SERVICES FOR DOMESTIC VIOLENCE VICTIMS/SURVIVORS

AFRICAN-AMERICANS

African American Providers Network – Services for African-American victims of domestic violence
503-493-8623
Advocacy Case management

NATIVE AMERICANS

Native American Family Healing Circle (http:**//**www.nayapdx.org)
Services for Native American victims of domestic violence and their families
503-288-8177
Advocacy Case management

RUSSIAN-SPEAKERS

Russian Oregon Social Services (http://www.emoregon.org/ROSSDomVio.htm)
Services for Russian-speaking domestic violence victims
503-777-3437
Advocacy Case management Mental health services

SPANISH-SPEAKERS

El Programa Hispano (http://www.catholiccharitiesoregon.org/503-231-4866/services/hispano.asp)
Services for Spanish-speaking/Latina women
503-669-8350
Counseling Emergency services
Support groups Community health promoter

Programa de Mujeres
Services for Spanish-speaking women
503-232-4448
Help line (not staffed 24 hrs; staff will return calls) Support group for Spanish-speaking children
Case management Support services Advocacy
Desarrollo Integral de la Familia
Bradley-Angle House – Volunteers of America Family Center; **503-771-5503**

OTHER LANGUAGES/CULTURAL GROUPS

IRCO Refugee & Immigrant Family Strengthening Program
Services for immigrants and refugees
503-234-1541
Advocacy Case management
SAWERA (South Asian Women's Empowerment & Resource Alliance)
Services for South Asian women (South Asian countries are India, Pakistan, Nepal, Bhutan, Bangladesh, and Sri Lanka) 503-778-7386
Advocacy Case Management
Counseling Services for children

SURVIVORS OF PROSTITUTION/SEX INDUSTRY

Council for Prostitution Alternatives/LOTUS
Services for survivors of the sex industry
503-282-1082
Support groups
Case management
Lola Greene Baldwin Foundation for Recovery
Support services for survivors of prostitution
503-236-7244
Individual counseling
Emergency services
Drop in center

SEXUAL MINORITIES

Bradley-Angle House Sexual Minorities Outreach Program
The Survivor Project
Support for transgendered victims of domestic violence

IMMIGRATION REPRESENTATION

Catholic Charities Immigration Services
Immigration Counseling Services
SOAR

SPECIALIZED LAW ENFORCEMENT UNITS

Portland Police Bureau Information	
Police Information Line	503-823-4636
Domestic Violence Reduction Unit	503-823-0992
Domestic Violence Intervention Team	503-823-0992
Gresham Domestic Violence Unit	503-618-2581
Multnomah County Adult Community Justice (probation & parole)	503-988-5056

BATTERERS' INTERVENTION PROGRAMS

Men's Resource Center	503-235-3433
Transition Projects' Batterer Intervention Program	503-823-4930
ASAP Treatment Services	503-224-0075
Changepoint	503-253-5954
Women's Counseling Center	503-235-4050

SERVICES FOR CHILDREN WHO HAVE WITNESSED DOMESTIC VIOLENCE

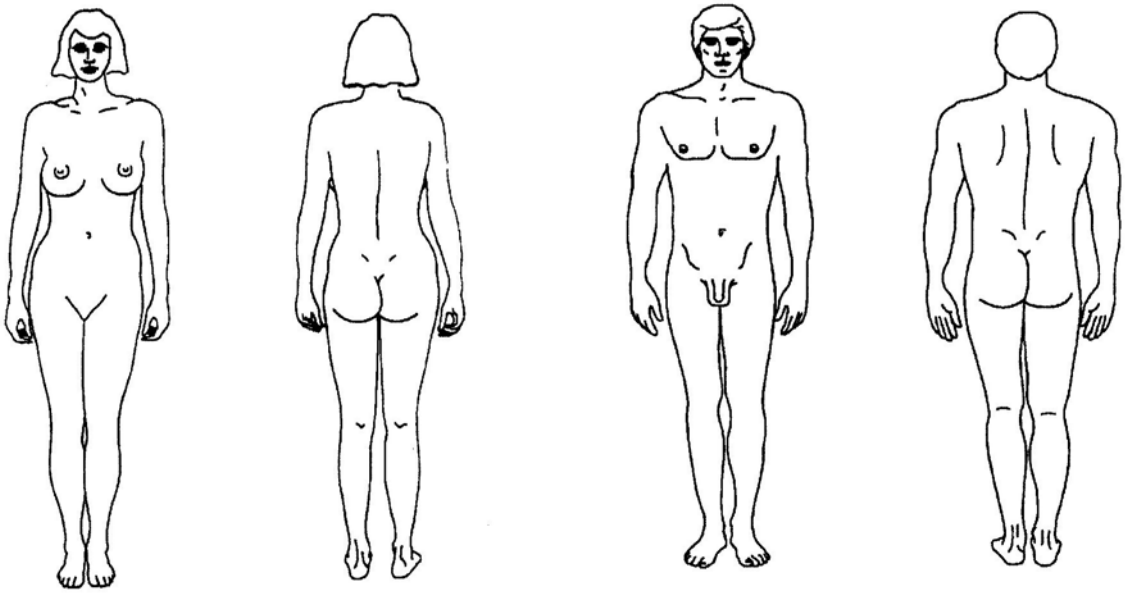
Volunteers of America Family Center *Support groups for children affected by domestic violence*	503-232-6562
Programa de Mujeres *Support groups for Spanish-speaking children affected by domestic violence*	503-232-4448
Child Abuse Reporting Hotline *24-hour line to report suspected child abuse or neglect*	503-731-3100
Community Advocates for Safety & Self-Reliance *School-based domestic violence and child abuse prevention education programs*	503-280-1388

* 24 hour crisis line

List from: http://www.co.multnomah.or.us/dchs/dv/dvman/resdes.html

Appendix II: Domestic Violence Screening/Documentation Form

Date _____ Pt ID #_____
Patient Name _____
Clinician Name _____
Intern Name _____
Patient Pregnant? Yes ___ No ___



Assess Patient Safety

❑ Yes ❑ No Is abuser here now?
❑ Yes ❑ No Is patient afraid of their partner?
❑ Yes ❑ No Is patient afraid to go home?
❑ Yes ❑ No Has physical violence increased in severity?
❑ Yes ❑ No Has partner physically abused children?
❑ Yes ❑ No Have children witnessed violence in the home?
❑ Yes ❑ No Threats of homicide?
By whom: _____
❑ Yes ❑ No Threats of suicide?
By whom: _____
❑ Yes ❑ No Is there a gun in the home?
❑ Yes ❑ No Alcohol or substance abuse?
❑ Yes ❑ No Was safety plan discussed?

Referrals

❑ Hotline number given
❑ Legal referral made
❑ Shelter number given
❑ In-house referral made
Describe:_____
❑ Other referral made
Describe:_____

Reporting

❑ Law enforcement report made
❑ Child Protective Services report made
❑ Adult Protective Services report made

Photographs

❑ Yes ❑ No Consent to be photographed?
❑ Yes ❑ No Photographs taken?

Developed by the Family Violence Prevention Fund and Educational Programs Associates, Inc.

Appendix III: Consent to Photograph

The undersigned hereby authorizes (name of agency)_____ and the attending physician to photograph or permit other persons in the employ of this facility to photograph (name of patient)_____while under the care of this facility and agrees that the negatives or prints be stored in patient's medical record, sealed in a separate envelope, in the event they may be needed later for evidence. These photographs will be released to the police or prosecutor only when the undersigned gives permission to release the medical records. The undersigned does not authorize any other use to be made of these photographs.

Patient's signature:_____ Date:_____

Witness:_____

Patient's parent/Guardian:_____

Street address:_____

City, State, Zip Code:_____

From the Michigan State Medical Society. Used with permission.

Appendix IV: Choosing a Camera

When establishing a practice, the practitioner will need to have a camera on hand for taking photos for possible cases of abuse and for other cases that may require photographic evidence. Below is a summary of the advantages and disadvantages of the three main types of cameras.

Polaroid camera

- Least recommended
- Will be antique technology in 3 to 5 years
- Polaroid has a "Spectra System Law Enforcement Camera Kit" that may be available at low cost or with discounts
- About $1 per shot
- Disadvantage: no duplicates, so must take multiple shots in order to have copies for file, patient, and/or legal representative or advocate. (Photocopies are not acceptable in legal proceedings.)
- Advantage: immediate feedback to ensure that photographs adequately show injuries.

35 MM

- Use color print film and make 2 or 3 copies
- Has been the forensic gold standard
- Need decent quality (>$250) camera that can focus as close as 2 feet (cheaper models focus > 4 feet)

Digital

- Need accompanying computer software and color photo printer
- Unsurpassed quality
- Electronic transfer option (to legal advocates, etc)

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4. Source: Chiquita Rollins, PhD, Multnomah County Domestic Violence Coordinator.

5. Source: Dan Sheridan, RN, PhD. Abuse Investigator, Forensic Clinical Nurse Specialist, State of Oregon.