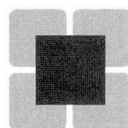

WILLIAM S. WILKE, MD, EDITOR

HIGHLIGHTS FROM MEDICAL GRAND ROUNDS

BATTERED WOMEN: HOW THE PRIMARY CARE PRACTITIONER CAN HELP

BATTERING OF WOMEN by their male partners—an extremely common and serious problem—often goes unrecognized because victims rarely volunteer information about it. Although generally thought of as a social problem, partner abuse has numerous medical consequences, and intervention in the medical setting can be helpful.

A PICTURE OF AN INVISIBLE PROBLEM

The incidence of domestic violence in the general population is difficult to assess because research samples are usually not representative of the general population. We do know, however, that battering is the most common cause of injury in women, accounting for half of all serious injuries in women presenting to emergency departments. It is at least as common as breast cancer, and more common than colon cancer or thyroid disease. During pregnancy, it is more common than gestational diabetes. In up to one half of cases of homicide in women, the murderer is a male partner or ex-partner. However, only 5% of domestic violence victims are identified as such in the emergency department.

Although many victims have a history of abuse in childhood, come from single-parent homes, were married as teenagers, or became pregnant before marriage, it is important to note that there is no "typical" woman victim. *Any* woman presenting for care may be in an abusive relationship.

■ Highlights from Medical Grand Rounds present take-home points from selected Cleveland Clinic Division of Medicine Grand Rounds lectures and other educational presentations at the Cleveland Clinic.

TABLE
HOW TO ASK ABOUT ABUSE

Good questions to ask
Sometimes people feel pain when they remember painful things that happened to them. Did anything like that ever happen to you?
Have you ever been physically or emotionally hurt by...?
Within the last...has anyone hit, slapped, or kicked you? Who?
Has anyone forced you to have sex? Who?
Are you afraid of...?
What have you done to protect yourself?
How do you fight?
Is anyone you care about hurting you?
Are you safe?
Questions *not* to ask
Why don't you leave?
Why do you put up with this?
Why don't you have him arrested?

The cycle of battering

The cycle of battering proceeds from a tension-building phase (name-calling, intimidating remarks), through a violent phase, to a "honeymoon" phase, when the batterer offers apologies and remorse, gifts and promises. Aggression tends to intensify over time in frequency and severity, as the aggressor becomes desensitized to the victim's responses, and the victim acclimates to violence and responds less dramatically. Aggression creates a need to justify the violence by degrading the victim.

During incidents of violence, victims focus on self-protection and survival and display coping mechanisms such as shock, denial, disbelief, with-

Domestic violence: the physician and the law

Although not all states have adopted an aggressive stance to counter domestic violence, Ohio enacted a law in March 1995 that governs how suspected victims of domestic violence should be managed within the hospital. The law also outlines a stronger arrest policy than before. The following guidelines, mandated by the Ohio law, should prove helpful to medical personnel in hospitals, clinics, and private practice.

When you suspect domestic violence, you must:

- Evaluate and treat the patient according to the current medical standard of care.
- Interview the patient in a private setting as soon as possible after her arrival.
- Interview any accompanying family or household members, separate and apart from the patient. Such interviews can help in developing a comprehensive assessment of the patient's safety and support systems. You do not need to tell them your concerns about abuse, but it is helpful to give them the opportunity to voice their concerns. In Ohio, if the alleged perpetrator accompanies the patient to the hospital or office, he or she must be interviewed, though the nature of the interview is unspecified. It is recommended that you not disclose your suspicions, but instead ask how the partner perceives the patient's presenting problem.
- Document any injuries with photographs, taken by a trained photographer (if available), using 35-mm film and with provisions for proper storage. Polaroid film is not advisable and can present difficulties if subpoenaed in court, as the coloring fades quickly. Use of a ruler or some other measurement tool is advised. A written consent should be obtained.
- Notify the police if the incident of domestic violence involved weapons or serious physical harm. All 50 states have similar laws regarding notification.
- Document, but maintain confidentiality. Any physician, nurse, social worker, or other health professional who knows or suspects a patient to be a victim of domestic violence must document that suspicion or knowledge, and the basis for it, in the medical record. However, patient confidentiality is of the utmost importance in these cases, and if there is any chance the patient or batterer could gain access to the chart, such documentation should be kept in a confidential envelope or in a separate file. In large institutions and practices, the medical records department must be aware that there may be separate files regarding abuse incidents, should your records be ordered by the court.

In addition we recommend the following:

- Enlist a social worker (if available) for support, counseling, and referrals to the appropriate community resources. If no social worker is available, help the patient develop a safety plan.
- Give the patient the phone number of the local domestic violence hotline. Even if the patient does not wish to talk about the problem or make any plans now, she may change her mind later.

drawal, confusion, or fear. Afterwards, they may display extreme suggestibility and dependency and often minimize the problem. Long-term reactions are fear, confusion, acute sensations of powerlessness, depression, withdrawal, passivity, listlessness, chronic fatigue, intense startle reactions, perpetual vigilance, disturbances in sleep and eating, and social isolation. Seventeen percent attempt suicide. Victims are often misdiagnosed as being schizophrenic or having borderline personality disorder.

WHAT THE PHYSICIAN CAN DO

The first step is to obtain an adequate history. Asking is, in itself, therapeutic and communicates that the problem is not too shameful, deviant, insignificant, or irrelevant to discuss. Asking twice increases the rate of response. The *Table* lists questions to use and others to avoid.

Bringing the problem into the open helps the patient see that her reactions are understandable and rational, she is not alone, and the situation is not hopeless. Above all, the physician should not blame the victim. This will further erode the patient's self-esteem if she accepts the blame, and will make her resistant to treatment if she does not. The physician should reassure the patient that the abuse is not her fault, that no one deserves to be beaten, that she has a right to safety, and that abuse is not tolerable. Keep in mind that the physician may be one of the few contacts the patient may have outside of the abusive relationship.

Recognizing the signs

Physicians should be alert for chronic physical complaints (insomnia, headache, globus sensation, gastrointestinal symptoms, chronic pain, sexual dysfunction, or hyperventilation), a history of substance abuse, repeated emergency department visits, or non-

compliance or frequently missed appointments. Some affective clues are shyness (victims of abuse do not usually express anger well), fright, embarrassment, evasiveness, anxiousness, passivity, and crying. Common psychiatric disorders are anxiety, depression, panic disorder, and posttraumatic stress disorder. There may also be factitious or self-induced disorders. Of note, spousal violence is the strongest predictor of alcoholism in women, but the converse is not true.

Physical examination may reveal bruises on the head, neck, chest, abdomen (especially during pregnancy), breasts, and upper extremities. The patient may also have bruises in various stages of healing. Injuries may not be consistent with the patient's explanation. However, there may be no visible signs of injury.

Forming a plan

Victims often request analgesics, but habituating substances should be avoided if possible: these help maintain the cycle of violence and provide an opportunity for chemical dependency or suicidal gestures. The patient's emotional status needs to be evaluated, as does the risk to the patient (and her children). The patient should be referred to appropriate community agencies and given information on local shelters and hotlines. She needs to develop a follow-up plan ("safe plan" or "exit plan"); however, do not expect her to make all of her plans while in the office.

The patient herself must establish the goals of intervention. Most women do not necessarily want the relationship to end; they want the abuse to stop. Beware of establishing separation as your goal: separation may increase violence. Marriage counseling, however, is usually not appropriate in the acute setting, as such counseling generally assumes both partners have equal power in the relationship, and may perpetuate the false belief that the abuse will stop if the woman works harder on the relationship.

WHAT ABOUT THE ABUSER?

Abusers typically have strong, controlling personalities and cannot tolerate autonomy in their partners. They are rigid and have low tolerance for stress; they also have low self-esteem, feelings of inadequacy, and a sense of helplessness. In general, abusers refuse to take responsibility for their behavior. They may be charming and manipulative outside the marriage. They often make unrealistic demands on their partners and often exhibit contempt for women in daily activities. Two thirds abuse alcohol, but many episodes of violent behavior occur when the abuser is sober, even if he has an alcohol problem.

Treatment of the abuser is directed at helping him understand that violence and controlling behavior is an inappropriate way to express himself and solve problems. Legal action is often necessary to get batterers into therapy. Therapy usually takes at least 6 months in specialized programs. The abuser must be violence-free for 2 to 3 years before marriage counseling is safe or appropriate. It is important not to bolster a woman's hope that her abuser will change: even the most successful programs take a long time and have only a 40% to 60% success rate for those who complete them.

CONCLUSIONS

Partner abuse is a common, serious, and potentially treatable problem that is frequently overlooked in medical practice. Greater awareness, nonjudgmental questioning, and support on the part of primary care physicians can go a long way toward helping battered women change their lives and improve their physical and emotional health.

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SUGGESTED READING

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EXERCISE AND HYPERTENSION: COMMON QUESTIONS

IN PERSONS with hypertension, the benefits of regular aerobic exercise far outweigh the risks. As more people with hypertension take up exercise, they will have questions about it for their physicians. Surprisingly little information exists