“OPENING PANDORA’S BOX”

Family Violence - A Physician’s Guide To Identify and Treat Victims of Domestic Violence and Elder Abuse

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General Information

This self-instructional activity is specifically designed for primary care physicians, internists, emergency medicine physicians, medical students, residents, interns, and other physicians and allied health care professionals who are involved in patient management. It should also be of use to psychologists, nurses, social workers, marriage & family counselors, teachers, police enforcement officers, and others who are in the position to recognize and provide assistance to victims of domestic violence. This self-instructional course consists of a 50-page handbook with an up-to-date review of the recognition and appropriate intervention to assist victims of domestic violence. The monograph also includes key references as well as a post test that may be completed by participants wishing to receive CME credit for this study. This course fulfills the Domestic Violence CME requirement for Florida licensed physicians.

Target Audience

Physicians

Learning Objectives

Upon completion of this self-study physicians should be able to:

- Understand the incidence and prevalence of domestic violence
- Recognize the cycle of violence and psychological dynamics of abuse and post-traumatic stress disorders
- Identify and assess victims of abuse – battered partners and the elderly
- Apply specific intervention techniques for working with abuse victims
- Identify community resources and learn innovative support methods to meet the needs of victims of family violence
- Be conversant of the interaction between legal systems and health care professionals in working with family violence.
- Recognize victims of human trafficking

This publication is designed to provide general information prepared by professionals in regard to the subject matter therein. It is provided with the understanding that it should not be utilized as a substitute for professional services in specific situations. If legal, medical, or other expert assistance is required, the reader should seek services of a professional.

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Accreditation

The University of Miami Leonard M. Miller School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

This activity was planned and produced in accordance to ACCME Essentials.

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Credit Designation

a) Physicians
The University of Miami Leonard M. Miller School of Medicine designates enduring material activity for a maximum of 2 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This credit is available for the period of August 1, 2016 through July 31, 2019, upon successful completion of the post-test.

Applying for Continuing Medical Education (CME) Credit

To apply for CME credits, click on the links at the end of this monograph. They will take you to Applying for Continuing Education Credit

• (CME) Credit
• Read the monograph
• Complete the post-test* with a score of 70% or greater.
• Complete the online evaluation and registration process*.

* The link to the post-test, evaluation and registration process appears at the conclusion of this monograph.
Fees
UM Physicians........................Complimentary
All others.............................$50

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Participants must obtain a score of 70% or more, in order to qualify for continuing medical education credit. The Division of Continuing Medical Education will issue a certificate of participation indicating the hours earned.
DOMESTIC VIOLENCE

1) Introduction

Interpersonal Violence encompasses Acute Sexual Assault, Intimate Partner Violence, Child and Elder abuse, date violence and human trafficking. Unfortunately, it is too common. It impacts not only the victim, but also children in the home, other family members, friends and neighbors and the community at large. Even the abuser is affected. It is important to recognize the overlapping impact of various types of interpersonal trauma. It can manifest in multiple ways: direct injury, physiologic adaptations to stress and mental health. Although the health effects are wide reaching, the medical community only recently began to recognize interpersonal trauma as a significant “pandemic”. After years in the dark, family violence is now seen as a public health problem. National health care organizations (AMA, ANA, APA, ACP, ACOG, and AAP) and the Institute of Medicine have recommended policies supporting routine screening and interventions and comprehensive education and research. The Joint Commission on the Accreditation of Health Organizations require accredited facilities to have policies in place to identify interpersonal violence and respond.

Physicians and health care providers are in a perfect position to identify abuse or neglect of children and women or older adults. They may be the first and only person abuse victims reach out to for help. All clinicians should be alert to physical and behavioral symptoms and signs associated with interpersonal violence. Opening a discussion with a patient may be like “opening a Pandora’s box”, you don’t know what you’ll find-but it is certain that if unrecognized, it will continue and escalate. Failing to diagnose may further the victim’s sense of entrapment and contribute to their victimization.

The most important skills physicians have are to recognize and acknowledge that abuse exists. What physicians can do for patients is offer effective, timely interventions that can help to heal not only their patients’ wounds but keep them from becoming another statistic.

Clinicians should learn about local hotlines, emergency shelters, support groups, and network with other community support services. In partnership with other community leaders, they can mount a clear response to a serious and destructive health problem within their community.

In this learning program, we will review the magnitude of the problem and its impact on health care. We will learn to identify victims of abuse, clues and signs of family violence, interviewing techniques conducive to eliciting a history of abuse, knowledge of reporting laws and documentation requirements and an understanding of community support services.
study of this program, you may complete the post-test found at the back of the monograph and follow the instructions to obtain CME credit.

2) Defining the Problem –

In this program, the use of domestic violence will be used interchangeable with family violence, and Intimate partner violence (IPV). The CDC definition of domestic violence includes “actual or threatened physical, sexual or psychological harm”. This includes “stalking, sexual violence, psychological aggression (including coercive acts), and economic abuse. A person using violence can be a partner, ex-partner or acquaintance. It can occur among heterosexuals or same-sex couples and does not require sexual intimacy or cohabitation. The Florida Department of Children and Families includes a variety of behaviors used to maintain “fear, intimidation, power and control” over their partner. Florida Law defines domestic violence as “any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another family or household member.” 62 Family/household members, according to Florida definition, must reside in the same single dwelling unit, with the exception of persons who have a child in common”. Men or women can experience or use intimate partner violence. A newer approach is to use a psychosocial rehabilitation framework to guide screening, assessment, and treatment associated with domestic violence and intimate partner violence. 63 This includes the recognition that the use or experience of violence does not define the individual. As such, person-first language using terms such as “persons who use violence” rather than “abuser” or “batterer” and “persons who experience violence” rather than “victim” or “survivor”

3) The Demographics of Domestic Violence

Domestic violence is a serious public health problem in the U.S. Women are more likely to be victimized through assault, battery, rape or homicide, by a current or former partner than by all other assailants combined. Battering is the single most common source of injuries to women, far surpassing that of car accidents and muggings combined. Just over one half of all women murdered in the U.S. are killed by male partners, and 12% of murdered men are killed by female partners. It is estimated that up to 35% of women who visit emergency rooms are there for symptoms secondary to abuse. Studies reveal 15-25% of pregnant women have a history of domestic violence. Traditionally, partner abuse has focused primarily on women; however, men can also be abused in intimate relationships. It is unknown to what extent the findings about battered women can be applied to men who are abused by women or to the often unacknowledged problem of violence within gay and lesbian relationship. Of women in lesbian
relationships, 11% report being raped, physically assaulted and/or stalked by an intimate partner; 23% of men report the same incidence.  

The health impact of violence can be significant. (TABLE 1) They range from severe injuries to chronic health problems, lower preventative health behaviors, aggravation of other medical conditions due to non-compliance and significant mental health disorders. A 1987 study estimated domestic violence annually caused 21,000 hospitalizations, 99,800 hospitalization days, 28,700 E.R. and 39,900 physician visits. Family violence costs the nation billions of dollars. In 2003, CDC estimated that the costs of IPV in US exceeded $5.8 billion per year, $4.1 billion for direct medical and health services, $1.7 billion for loss of productivity.  
Families with domestic violence compared to general population: 
use doctors’ offices 8 x more often; 20-35% of victims seek medical care or are hospitalized for abuse; visit emergency room 6 x more often; and use prescription medications with a 6 x greater frequency. Victims of domestic violence cost one health plan $1775 more per year than non-victims. Researchers can only guess at precisely how many dollars are drained from the economy and from other health care needs.  

Since 240,000 pregnant women are abused annually and 10.7% of abused women deliver low birth weight babies, at an average cost of $50,399 (compared to average cost for term deliveries of $3,355), it has been estimated that there is the potential to save $46,945 per patient (over $1 billion nationally) by identifying victims at higher risk and promoting early interventions.  

The National Institute of Justice estimates that domestic violence accounts for almost 15% of total crime costs-$67 billion per year. Employers pay a large share of these costs, primarily through higher health insurance bills. The toll is even higher when other factors are added in, such as decreased productivity at the workplace. After years in the dark or in the domain of criminal justice, family violence is now seen as a public health problem and every physician has a responsibility to assist in stopping the violence.  

TABLE 1: Impact of Domestic Violence*  

- 1.3 million women and 834,732 men are physically assaulted annually by an intimate partner; 52% sustain significant injuries.  
- 503,485 women and 185,496 men are stalked annually by an intimate partner; 201, 394 women are raped annually by an intimate partner  
- 50% of men who assaulted their female partners also assaulted her/their children; 3.3 million children witness domestic violence each year.  
- 1 in 5 female high school students reports being physically and/or sexually abused by a dating partner. Abused girls are significantly more likely to become involved in other risky behaviors; they are also 4-6 x more likely to become pregnant and 8-9x more likely to have attempted suicide.
3) Diagnosing the Problem: Identifying Symptoms and Signs of Abuse

Health care providers should realize that they are a major point of contact with victims of family violence. There is often a long history of emotional/sexual abuse before an injury is actually seen. Even low severity violence (pushing, shoving, grabbing) is shown to be associated with physical and psychological health problems in women. The number of physical symptoms and psychological distress increases with the severity of violence. Women in current abusive relationships are more likely to have a history of substance abuse and to have a substance-abusing partner. Despite significant health implications of domestic violence, health providers often fail to identify and manage domestic violence when signs and symptoms are present. A variety of common complaints are seen in primary care clinics (TABLE 2). Evidence indicates that a history of abuse is related to later development of chronic pain syndromes, gastrointestinal problems, eating disorders (anorexia/bulimia, obesity) and illicit substance abuse. A study of patients at gastroenterology clinics showed that a significantly greater percentage of women with functional diagnoses compared to women with organic diagnoses reported a history of sexual or frequent physical abuse. Research also suggests an association with delayed physical effects, particularly visual and hearing defects, arthritis, hypertension, and heart disease. Additionally, battered women have a decreased sense of their physical and mental well-being and a higher incidence of injurious health behaviors (smoking, drug and/or alcohol abuse and poor dietary habits). They also have an increased utilization of medical resources. Abuse may exacerbate chronic medical illnesses such as diabetes, cardiac and lung disease, because batterers deliberately interfere with the victim’s ability to take medications or clinic appointments. Repeated failure to comply with treatments may be an indicator of abuse. Mental health providers see battered women for suicide, anxiety and depression. One third to 55% of abused women have suicidal thoughts and 17%-19% attempt it. A variety of other providers also see the psychological sequelae of domestic violence. Like rape victims, long-term reactions in abused women include fear, anxiety, fatigue and intense startle reactions. A recent study in women veterans with IPV revealed that significant other issues commonly co-occur: traumatic brain injury; homelessness and PTSD. These co-occurrences may increase the risk of future IPV because of reduced cognitive/affective capacity to detect and respond to danger. Abuse may also expose women to serious illnesses. Some studies reveal a percentage of HIV positive and women with AIDS may have contracted the virus from coerced sexual activity in the context of a battering relationship.
Unless providers recognize and acknowledge abuse, these complaints will be unrecognized as the result of domestic violence. Physicians often perpetuate victim’s isolation by giving symptomatic treatments (anxiolytics, sleeping pills), making inappropriate referrals or labeling victims as “neurotics”. One study found 20% of battered women presenting to physicians had sought medical attention for injuries from abuse 11 times previously.28 Another study found that physicians’ discharge diagnoses correctly indicated spouse abuse in only 8% of the cases in which explicit information about abuse were recorded in the medical chart.29 The victim may use a medical visit as a way of seeking help without knowledge of the batterer.

a) Identifying Domestic Violence in Clinical Settings

i) Behavioral Clues

Pay attention to the behavioral clues that may indicate that your patient is a victim of abuse. These include the following: depends on partner (abuser) to answer questions; doesn’t return for follow up appointments for fear of having to address probing questions; depression and panic disorders. When asked, it is not uncommon for the patient to defend or excuse the abuser’s behavior, or he or she may deflect the issue and talk about “a friend’s” problem, rather than admit it’s their own.

In addition to physical injuries, battered women may present histories that are confusing or include anxious and evasive behavior and inadequate explanations for injuries.23 The victim may come in frequently without clear reasons.21 Additionally, the victim may present with varied somatic complaints or stress-related symptoms. (TABLE 2). Because of the general nature of these symptoms, physicians and other health care providers rarely probe for the underlying causes of these symptoms except by running a series of laboratory and radiographic tests. Physicians don’t recognize or correctly interpret the behaviors associated with abuse. When tests are negative and symptoms don’t appear to have an organic basis, patients are judged as “hypochondriacs” or “crocks”. Misdiagnosis and inappropriate referrals and treatment plans can have grave consequences for abused women. Failing to acknowledge abuse fortifies the patient’s victimization and isolates her even further. Treatments with tranquilizers or narcotics may increase her physical danger by blunting protective responses and increase the risk of substance abuse. Victim’s visits to physicians have been estimated to increase by 18% the year post physical assault, 56% the following year and 31% the year after. Patients may not recognize the source of their pain; it is the physician’s role to make a correct diagnosis. Once medicine becomes a system that refuses or can’t help her, the woman’s injury, isolation and illness continues. The cycle of abuse also continues and will escalate with tragic consequences.
ii) Seeing the Unseen
What most physicians identify as domestic violence are the physical injuries which range from bruises, cuts, black eyes, concussions, broken bones, and miscarriages to permanent injuries such as damage to joints, partial loss of hearing or vision, and scars from burns, bites or knife wounds. One project estimated that 21% of all women using emergency surgical services were there for sequelae of domestic violence; one half of all injuries presented by women occurred in the context of partner abuse.32 Another study in the emergency room revealed that only 13% of women who had experienced acute domestic violence had been asked about abuse by emergency room staff. 33 Despite the relationship, in most cases, the victimization history underlying these injuries was never identified. Certain clues should alert clinicians to the diagnosis of physical abuse. Typical pattern for contusions and lacerations is central to the head, face, neck, breast or abdomen in contrast to the peripheral body pattern from accidental injuries.34 Abused women are also more likely to have multiple injuries in combination with evidence of old injuries as compared to accident victims.35 The adult trauma history should be taken and all acute injuries including cutaneous manifestations of violence should be documented in the record. The color of bruises can indicate the timing of trauma. (Figure 1 - see page 29-30). Severe injuries appear late, only 4% result in hospitalization. If health care providers only screen for domestic violence by severe injury, they will miss 96% of the cases.30, 31 Instead, they should be looking for all the clues and treat them as sentinel markers of a very serious health problem.

iii) Documentation of Abuse
The preservation of precise historical and physical exam data in the medical record is important concrete evidence of abuse. (Figure 1 - see page 29-30). This may be the only evidence that remains of an abusive episode after physical injuries heal and may prove crucial to the outcome of any legal case.

Documenting the abuse and reporting, when applicable, to the appropriate authorities is a primary responsibility of physicians. Confidentiality of the medical record and liability of the chart’s content is a particular fear physicians have. Physicians should acknowledge their responsibility by recording precise symptoms and signs of abuse. The record should contain a patient’s “direct quote”, describe in detail physical findings and give a medical opinion such as “suspected” or “probable” abuse or injuries “suggestive of battering”. Let the patient know her medical record is confidential but that she can use it as evidence in court proceedings.2 Photographs can be particularly valuable as evidence. The patient’s consent is required.4 It is recommended that the photographs size the injury (using ruler or coin), precisely
identify the patient (face, name) and are dated. 2, 6, 33, 35

the discharge plan should include safety assessment and plan and information (verbal or written) given to the victim on options for shelter, legal assistance, and counseling. The record should include appropriate follow-up care (or referral) for her medical, psychological, and advocacy needs. Take precautions regarding what’s written on discharge instructions given to the patient, insurance reports, and billing forms, since these may be seen by the batterer and put the patient in danger. A mother’s disclosures (about abuse to herself) during a pediatric visit should not be recorded in the child’s chart since the abuser may have access to that record. 27 Treatment and interventions are strictly confidential unless the injuries are to a child < 18 years, a vulnerable elderly or disabled person, or the result of a gunshot wound (see VI.A Reporting requirements)

v) **Pregnancy-Related Abuse: A Special Problem**

Pregnant women are not immune from abuse; IPV is the leading cause of maternal morbidity and mortality. In fact, violence intensifies during pregnancy. 67
Up to 37% of pregnant women surveyed have been victims of abuse.36 Pregnant women’s risk of abusive violence is 60% greater than non-pregnant women, posing a significant threat to the health of the woman and her developing fetus.67 The 1985 National Family Violence Survey found that 154 out of every 1000 pregnant women were assaulted by their mates during the first 4 months of pregnancy and that 170 out of every 1000 were assaulted during the fifth through ninth months.37 Battering during pregnancy jeopardizes the pregnancy significantly. Abused women are more likely to delay prenatal care to the third trimester. They have higher rates of miscarriage, still births, premature labor, low birth weight babies, and injuries to the fetus, including fractures. 38 This high incidence and severe consequences of abuse during pregnancy compels particular vigilance on the part of providers of prenatal care to identify and reduce the risk of violence. All pregnant women should undergo screening for domestic violence. 39
Additionally, contraceptive coercion is a form of IPV. This has implications for clinical assessment of unintended pregnancy as well. 68

4) **Physician-Patient Clinical Encounter**

a) **Screening Questions**
The hallmark of domestic violence is recurrence. When physicians don’t diagnose abuse and the patient is sent back into an abusive relationship, abuse is most likely to continue and will worsen. If physicians look only for black eyes and broken bones, they are missing many victims. There will be many victims whose lives may be in imminent danger but who
don’t have a mark on them.

One of the biggest problems in identifying victims is that doctors just don’t ask any questions. The 31% lifetime prevalence of domestic violence is greater than that of breast or cervical cancers that are routinely screened for in clinical practice. 40 Still, physician screening rates are generally quite low despite clinical guidelines and recommendations regarding screening that have been promulgated by health care organizations, and professional societies.41 Even after they have received training about domestic violence, the vast majority still felt uncomfortable with their skills in assessing and treating patients, feared offending patients, or forgot. 42 It is critical for health care personnel to routinely assess female patients for abuse.2, 6 The problem is so prevalent and the consequences so severe doctors should ask every woman about abuse and violence in her life.1

It should be asked as part of the social history or review of systems and the evaluation of the chief complaint. Routinely this should be done in private. To assure the privacy of the screening, the patient’s partner, family member or friends should be asked to wait in the waiting area while this portion of the visit is accomplished. It may be at this portion of the encounter that the controlling behavior of the batterer may be unmasked. They may show extreme unwillingness to let the partner speak to anyone alone. Practitioners must be insistent and under no circumstances should a woman be questioned in front of her partner.

Establish rapport with patients by maintaining a non-judgmental attitude and fostering open communication with the suspected victim and/or abuser.

Studies have shown that simple, direct questions, delivered with concern in a safe and confidential encounter are a good beginning. The screening questions should be directed at determining the severity of the abuse, degree of social isolation, and assessment of patient’s safety and emergency plan.43-45 (TABLE 3).

Asking questions in an empathetic and non-judgmental way won’t damage the doctor-patient relationship or offend patients and their families.2, 46 Surveys of patients indicate 80% feel it is appropriate for physicians to ask about family violence.47 Our own study revealed that, although 68% of women could tell their doctors that they were abuse victims, only 12% had been asked about the abuse during the clinical encounter. 15 The majority of the respondents in the study believed that doctors should routinely screen for abuse. Women are not frightened or offended by such discussions. Physicians routinely inquire about the most private details of a patient’s life and the process of physical examination is highly intimate. It is the patient’s trust in their physician that allows this relationship to occur. It is an important responsibility that physicians have to individual patients and to society to prevent family violence. Even if the patient doesn’t respond at the initial encounter the door will have been opened for her to seek help when she’s
ready. If she answers yes to the initial screen then a positive diagnosis is made and the treatment plan can begin.

**TABLE 3: WHAT PHYSICIANS CAN SAY: SCREENING QUESTIONS**

**IDENTIFYING ABUSE**

<table>
<thead>
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<th>Screening Questions</th>
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<tr>
<td>Have you ever experienced a relationship in which you were hit, punched, kicked threatened or hurt in any way? Are you in such a relationship now?</td>
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<tr>
<td>Within the last year, has anyone forced you to have sexual activities?</td>
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<tr>
<td>What happens when there are fights and disagreements at your home?</td>
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<tr>
<td>Have you ever been hurt or afraid when there are fights at home?</td>
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<tr>
<td>Have you or your children been physically hurt or threatened by your partner?</td>
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<tr>
<td>Are there problems involving anyone close to you?</td>
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<tr>
<td>Sometimes when women feel the way you do it’s because they’re being hurt in some way.</td>
</tr>
<tr>
<td>You are obviously very upset .....is something troubling you? Are you worried or frightened about going home today?</td>
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**EXAMINING AN INJURY**

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<th>Screening Questions</th>
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<tbody>
<tr>
<td>I noticed you have a number of bruises, tell me how they happened?</td>
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<tr>
<td>Did someone hit you?</td>
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<tr>
<td>I’m concerned someone hurt you like this... tell me how it happened?</td>
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**ACKNOWLEDGING ABUSE**

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<thead>
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<th>Acknowledgment of abuse</th>
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<td>You are right to be upset. No one has the right to hurt you like this. This behavior is wrong and illegal.</td>
</tr>
<tr>
<td>What has happened to you is illegal, and you have a right to report it to law enforcement officials.</td>
</tr>
<tr>
<td>I can help you with that.</td>
</tr>
<tr>
<td>We are becoming aware that more women in this community find that violence is a problem in their relationships. It is a problem but you are not alone.</td>
</tr>
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b) **Acknowledging the Abuse: The Victim’s Experience**

Once questions have been asked and the diagnosis of abuse is made, the next step for health professionals is to demonstrate concern and deflect blame from the victim. Acknowledgment of abuse validates the patient’s sense that violence is a threat to her
physical and mental health. This validation begins to break the isolation that accompanies ongoing violence. This message from a health care professional, an accepted authority figure, is the first step in therapeutic interventions to empower the victim. 47, 48 All physicians can acknowledge and validate the experience of victimization and the fact that observed symptomatology are sequelae of abuse. This is a very important step in the treatment process since many battered women have low self-esteem and enormous guilt. They believe they have done something wrong, accepting prime responsibility for creating the violence. Victims come to accept violence as normal behavior in their environment, which further isolates them from social support systems. 49, 50 don’t make minimizing statements and say, “nothing is wrong with you”. These reinforce an “authority figures” message that she is the “sick” one furthering her sense of entrapment and contributing to her health risks. 51 The message from physicians that “violence is not OK” and abuse is not her fault empowers the patient to begin to break her isolation which relates with injury.

Patience and reassurances from the physician can be very important to individuals in abusive relationships. Remind patients that they are not alone and that you are there to help them now, or whenever they are ready.

c) Barriers to Physicians’ Recognition of Family Violence
There are several barriers to detecting and treating family violence. Health care providers share a number of pervasive societal misconceptions about domestic violence: violence doesn’t occur in relationships that appear normal; battered women are responsible for their own abuse; and domestic violence is a private matter that should be resolved without outside intervention. 2, 52, 53 First, abuse does occur in seemingly normal families and abusers often appear indistinguishable from other people and often do not behave violently in other circumstances. They may accompany the patient and appear highly concerned for her injuries and health. Domestic violence cuts across racial and class categories. There is only a 3% difference between the incidence of abuse of lower income women and middle-income women. 54-56 When patients and physicians share similar backgrounds, physicians are more likely to deny their patients could be victims of abuse. Physicians may themselves feel vulnerable to family violence. In one study, 14% of male physicians and 31% of women physicians acknowledged their own abuse. 57

It is particularly frustrating for health care providers to understand why women allow themselves to become victims. Women are often held responsible for their victimization. They may be blamed for provoking the abuse, enjoying the abuse and not leaving the relationship. 2, 34 Blaming the victim may enter into the medical response. Perceiving battered women as non-compliant or problematic may cause physicians to discontinue their care or to fail to intervene in future episodes of abuse. It is important for physicians to understand the dynamics of abuse and the difficulties and dangers victims face in trying
to leave in order to be able to assist their patients effectively. The most dangerous period (highest murder rates) for victims is the window of time when they first leave the batterer. The process of leaving an abusive spouse/partner is not easy and may be slow. Up to a third who leave will continue to be harmed by their partner. Domestic violence is not a private matter to be resolved within the relationship. Battered women can’t simply “work-it-out”. A marriage counselor doesn’t prioritize the safety of the victim. Physicians need to intervene. Evidence suggests battered women expect their physicians to initiate discussions about abuse and they will respond to these inquiries. Even though a woman is not able to leave immediately, when she is ready, the information and assistance provided by the physician will be valuable and even lifesaving.

5) What Can Physicians Do? - Treatment Plans

Physicians often don’t involve themselves with the problem of domestic violence because they believe that an excessive amount of time will be required to listen, to counsel, to make inquiries on behalf of the patient and to document in detail the interaction. Time requirements of depositions and possible court appearances appear as additional barriers. Finally, physicians experience personal fears for their own safety from possible reprisal by the batterer and with emotional pain in identifying with patient’s experiences of abuse or behaviors of an abuser. This may further inhibit physician action.

“Let’s be clear-violence is a public health problem.” The Council on Ethical and Judicial Affairs of the AMA have affirmed that physicians have ethical obligations to patients who are victims of abuse and a responsibility to intervene in cases of domestic violence. Treating only the injuries and symptoms of abuse will not address the ongoing violence which is at the root of its victim’s health problems. While physicians alone cannot prevent abuse from recurring, they can provide a number of important interventions. Physicians can become partners in an integrated community alliance involving the health, legal, and social service systems to treat the problem. Physicians have an obligation to familiarize themselves with:

- protocols for diagnosing and treating family violence,
- their state reporting requirements and protective services,
- community resources for victims of abuse.

The most important contribution a physician can make to ending the abuse and lessen the chances their patient will become another statistic in the epidemic of violence is to identify and acknowledge abuse and make appropriate treatment referrals. (TABLE 4).
TABLE 4: WHAT PHYSICIANS CAN DO TO STOP DOMESTIC VIOLENCE

<table>
<thead>
<tr>
<th>S</th>
<th>SCREEN</th>
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<tbody>
<tr>
<td>Make office a physical and emotional safe space.</td>
<td></td>
</tr>
<tr>
<td>Routine assessment questions to identify abuse victims.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>A</th>
<th>ACKNOWLEDGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms and sequelae of abuse.</td>
<td></td>
</tr>
<tr>
<td>Doctor and patient agree there is a problem.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>V</th>
<th>VALIDATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase patient’s self-esteem and decrease guilt.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E</th>
<th>EMPOWER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Begin to break victim’s isolation and reduce injuries.</td>
<td></td>
</tr>
<tr>
<td>Give victim options and safety planning.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RX</th>
<th>REFERRAL, REPORTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>to community support services when appropriate or required.</td>
<td></td>
</tr>
</tbody>
</table>

a) Plan for the Office
The first step is to make your office a physically and emotionally safe space where privacy is maintained during intake and interviewing. Displays of materials and resource brochures with emergency numbers in private examining rooms, bathrooms and reception areas indicate awareness and the importance you give family violence as a health problem. In addition to the visual messages, you and your staff should provide the verbal clues that it’s “OK” to talk about domestic violence with you. A written protocol on domestic violence will help in detection and management of family violence. Screening questions can accomplish much in a little time. Research indicates that 85% of women when asked open up and feel relieved.

b) Management Strategies - Understanding the Dynamics of Abuse
Health care providers can experience feelings of helplessness and frustration when confronted with the seeming ambivalence and reluctance of the woman to take necessary actions to implement change. To understand their patients, physicians must reframe their assessment and see these as “survival” behaviors rather than as
destructive behavior. \textsuperscript{61} To survive in battering relationships, victims often deny, minimize or “forget” details of control or violence. Understanding the dynamics of power and control in an abusive relationship provides insight into why women don’t and can’t simply “leave the relationship”. (Figure 2 - Power and Control Wheel on page 30) \textsuperscript{62}

\begin{table}[h]
\centering
\begin{tabular}{|l|}
\hline
1 Materials on Domestic Violence - Pamphlets and posters in exam and waiting rooms can increase awareness and signal it’s “OK” to talk about domestic violence. \\
2 Emergency Numbers - Place brochures and posters with emergency phone and hotline referrals in private examining rooms and bathrooms. \\
3. Identify private area - For intake, interviews and where referrals can be made confidentially. \\
4. Familiarize yourself and office staff - with updated Community Referral lists and domestic violence services. \\
5. Develop an office protocol and response plan to assist patients – including resources available at your hospital emergency and social work departments. \\
\hline
\end{tabular}
\end{table}

Both the victim and batterer may be traditionalists in their views of their roles: the male leadership role in the nuclear family and the inferior role of the woman with an absolute duty of obedience. Since the wife is considered the “property” of the husband, he has a right and duty to discipline her. Often the batterer is in deep denial, blames others for his actions and exhibits little self-control. Frequently, batterers are also substance abusers and have witnessed or are victims of abuse themselves. Treatment programs for batterers focus on breaking down their self-denial and helping them recognize appropriate behaviors and their codependency in the relationship. Treatment programs for substance abuse may also be necessary for many batterers. Although substance abuse is associated with domestic violence, it is not the cause and batterers should receive specific treatments to stop the violence. There are currently no good psychological tests to evaluate the prognosis of batterers and the risk of subsequent violence.

Batterers use emotional, economic, in addition to physical abuse to diminish the victim’s self-esteem, maximize her dependency and powerlessness. The victim, emotionally and socially isolated, may not have economic (housing, job skills) and social support systems to make a change.
They may fear the consequences on their children if they leave. It is estimated that 53-70% of batterers who abuse their spouse also injure their children. Since mother is the normal protector, if violence is severe, even if only to the mother, it will predict increased risk to the child. They may fear greater physical danger and risk of retaliation if they disclose abuse or leave the relationship. Women who leave their batterers are at a 75% greater risk of being killed than if they stay, especially in the immediate period. It is very important for physicians to listen to their patients and give them a voice in all discussions. When a patient is subjected to domestic violence, the need for patient trust in the physician is especially important since patients may feel embarrassed, ashamed or afraid to reveal that they’ve been battered. Abuse must be discussed with the patient in privacy and safety. Confidentiality is necessary so that patients feel free to make full disclosure of relevant information about their health. The treatment approach for victims of abuse focuses on expanding their social, legal and economic options and empowering them to make their own decisions.

A recent study uses the voices and commentary of domestic violence survivors to provide insights on what physicians can do for at-risk patients by first understanding what patients may need from their physicians. It divides patients into various stages:

1. The patient may not recognize the abuse.
The role of the physician is to help a patient to recognize the abuse, by providing information universally, not just to those who disclose abuse;

2. The patient may not be ready/able to tell a physician about the abuse.
Attention to privacy, displays of empathy, and a discussion of clinical suspicions with the patient may assist the patient to share their history;

3. The patient may be choosing to remain in the abusive relationship.
Commitment to the relationship, belief of excuses, erosion of self-esteem, lack of options, degree of danger on leaving all play a role. Understand, don’t blame, don’t provide resources and referrals and remember the decision is ultimately the patients.

4. The patient may be presenting due to acute physical abuse.
Provide treatments in a supportive manner and document carefully; the patient may have left the relationship, but not fully recovered. Like any significant illness it may take a long time to heal; don’t replicate the controlling, patronizing behavior of the abuser. 63

c) Safety Assessment
The initial and follow-up interventions with a battered woman is to jointly determine immediate danger and future risks. The elements of a safety assessment include:
i **Injury** - The level of injury is not always predictive. How the injury is progressing may be more important: more frequent, more severe, weapons used, threatening to kill her or himself.

ii **Level of fear is escalating** - “You seem more frightened. That’s an important sign we have to pay attention to”. Ask the woman if she believes her life is in danger. Additionally, look for adaptive symptoms whose pattern is similar to post-traumatic stress disorder (PTSD): paralyzing terror; agitation and anxiety bordering on panic; numbing alternating with flooding of emotion; hypersensitivity to any sudden noise/event; hyper vigilance; and nightmares with violent themes.

iii **Degree of Entrapment** - “How have you managed so far/What has worked when he gets angry and hurts you? /What is your next step?”

Help the patient identify her degree of entrapment by specifying elements of control that might prevent her from defending herself, escaping or using helping resources when she is threatened or hurt again. 66 The patient may present with a hostage-like profile, with almost complete material and psychological dependence on the batterer. Like PTSD, this pattern is a normal adaptation to extraordinary stress. The patient will respond to supportive counseling and reestablishing safety for her and her children.

Making this safety assessment and plan with the patient takes very little time. Taking her assessment as the basis for evaluating the situation helps her realize she is not responsible for the violence and her emotional needs cannot be met by maintaining contact with someone who hurts her. Parallel assessments for woman battering and child abuse are essential. Children suffer physical and psychological damage as either witnesses or co-victims in violent homes. The risk to the child is best determined by considering the absolute level of violence and coercion in the relationship. The objective of the assessment is to develop a safety and support plan. 69 If she has to leave, her plan should include:

- need to tell someone
- give an emergency number
- need a copy of important papers: driver’s license, social security card, birth certificates, prescriptions
- access to transportation, money, extra keys
- plans for the kids
- a shelter to go to
- Pack a bag, keep in a secure place
- Code word for others to call police
This plan builds on strategies she is already using to prevent, minimize or avoid violence. The physician should reinforce her autonomy whether she decides to stay or leave the relationship. If she can say, “I can’t leave now but I need to make other plans”, that breaks her isolation and opens up the door for treatment. If any one of the three elements (injury, fear, entrapment) is high, the risk of life-threatening dangers is extremely high and crisis intervention may be required. She may not realize she’s in imminent danger. Threats of homicide or suicide by the partner are indicators of escalating risk. Other studies which have reviewed abuse deaths have reported more factors associated with a higher risk of lethality. (TABLE 6).

**TABLE 6: FACTORS WHICH PREDICT INCREASE DANGER TO IPV VICTIMS**

- Abuser access to weapons
- Abuser uses of substances
- Abuser Decompensation (estrangement/separation, unemployed, suicidal ideation)
- Recent abuse escalation
- History of severe abuse
- History of stalking
- Attempted strangulation
- Obsessive behaviors
- Sadistic acts (pet harm)

The patient should be told of your perspective on her risk and her options should be explored in great detail.

Absence of these factors doesn’t guarantee safety. The patient’s fear of harm establishes the need for urgent interventions. If she feels safe, provide her information listing resources for victims, encourage her to consider legal protection and to participate in women’s support groups or to call Hotlines and speak with local advocates/counselors. If she feels she’s not safe, then it’s critical to initiate crisis intervention. Assist her to call local domestic violence services and/or arrange urgent referral, if available, to your hospital’s crisis intervention services. The physician’s responsibility is to recognize the problem, provide information about domestic violence support services and facilitate the referral with community resources. Let your patients know that you will follow-up. Domestic Violence problems are not solved at one visit. The patients’ safety and plans should be assessed at each visit.
d) Dealing with Batterers

It is important to recognize that there is another “patient” in the context of domestic violence—the batterer. While the priority must remain for the victim’s health and safety, in some instances, a physician may be seeing both victim and perpetrator as patients in their practice. Additionally, it is important for physicians to readily identify batterers when they seek medical attention and intervene to break the cycle of violence. Although batterers are diverse and don’t fit any specific diagnostic category, they share some characteristics as they relate to their partners (TABLE 7).

Domestic violence can only continue in a silent vacuum. Physicians must penetrate this silence by discussing abuse with their patients and listening to their responses. Experts have noted the psychological and behavioral aspects of batterers and counsel physicians to: 1) be direct and don’t force the issue; 2) focus on the abusive conduct and the impact it has on the batterer’s health as well as their partner’s and children; 3) discuss options and make appropriate referrals. Be careful not to blame. Creating a defensive response may result in retaliation against the victim. If the patient becomes angry or attempts to control the encounter, they are not ready for change. While it is difficult to predict when the abuse may reach a critical level of danger, certain patterns indicate higher risk. (TABLE 7).
TABLE 7 - BATTERER’S BEHAVIORS

<table>
<thead>
<tr>
<th>COMMON CHARACTERISTICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>❖ MINIMIZE, DENY ABUSIVE CONDUCT</td>
</tr>
<tr>
<td>❖ VOID TAKING RESPONSIBILITY FOR THEIR CONDUCT</td>
</tr>
<tr>
<td>❖ BLAME THE VICTIMS OR OTHER FACTORS FOR THE VIOLENCE</td>
</tr>
<tr>
<td>❖ USE HEALTH CARE SYSTEM TO CONTROL</td>
</tr>
<tr>
<td>- accompanying victim to all appointments</td>
</tr>
<tr>
<td>- cancel/sabotage appointments</td>
</tr>
<tr>
<td>- withhold medications</td>
</tr>
<tr>
<td>- display emotions: remorse, profound devotion, crying</td>
</tr>
<tr>
<td>- use coercion/psychological threats against victim and health care provider</td>
</tr>
</tbody>
</table>

DANGER SIGNS:

- ESCALATION OF FREQUENCY AND SEVERITY OF ABUSIVE ACTS
- AVAILABILITY AND USE OF WEAPONS
- THREATS OF HOMICIDE AND SUICIDE
- HOSTAGE TAKING BEHAVIOUR
- USE OF VIOLENCE OUTSIDE FAMILY
- STALKING
- ALCOHOL/DRUG ABUSE
- MENTAL ILLNESS

Physicians must be aware that there is an ethical and legal duty to maintain when there is a clear and present danger to a specific victim or victims. Health care personnel should be familiar with local laws and any policies or procedures for the duty to warn in their respective practice settings. Specialized programs for perpetrators of domestic violence are available. A number of states have established standards and required certification for these programs. Most of these programs use group treatment and education, which refocuses the batterer on shared roles in relationships and responsibility for their own behavior. Many programs are combined in a legal component, which prosecutes them for criminal conduct and provides them opportunities to change behaviors. Although outcome data on the effectiveness of these programs is limited, the results are positive with rates of 66-70% of batterers remaining violence free on follow-up.

6) DOMESTIC VIOLENCE LAWS

a) Reporting Requirements

The CDC has reported that 25% of the population is involved in one way or another with domestic violence (DV), (adult and child abuse, sexual assault and elder abuse and neglect). In Florida, in 2014, there were 106,882 DV-related crimes and 64,460 arrests. The domestic violence rates have been steadily decreasing since 1998. However, the death rates related to DV have increased in the past five years to 205 in 2014 which accounts for nearly 20% of the state’s murders.
Despite risk markers for lethality, which indicate prior violence and antisocial behavior on the part of the perpetrators, 30% of murdered victims had never been battered before and the batterer had never been arrested. More significant is the fact that 40% of homicide victims had gone to a physician within the last year of their life.

In most states physicians have a legal obligation to report the treatment of a person suffering from a gunshot wound or other wound caused by a violent act. Since 1992 the Joint Commission on Accreditation of Health Organizations has required emergency department staff to be educated and to write protocols and procedures relative to domestic violence including, mechanisms for identifying, evaluating and referring battered adults and children to appropriate resources. In every state, laws require physicians to report cases of suspected child abuse to child protection authorities and/or law enforcement authorities. All states have reporting laws for elder abuse. Mandatory reporting laws generally exempt physicians from liability from false reports. Physicians should familiarize themselves with the legal reporting requirements and report accordingly. It may be good practice, depending on the community, to call a child or elder protection agency for advice on whether or not to report a particular case. Agencies may inform you when a case will not be acted upon, based on the facts in the report. Hospital-based multidisciplinary teams of persons highly experienced and knowledgeable about specific types of family violence have been found to be an effective resource for physicians.

Mandatory reporting of battered women is highly controversial. Only a handful of states have laws mandating the reporting of adult victims of domestic violence, and practitioners are required to follow statutory guidelines. Reasons for not mandating reporting include:

1. concerns for patient autonomy and confidentiality; and
2. may increase risk and danger.

Informed consent for all non-emergency medical interventions must be obtained from adult victims of abuse, like any other competent adult patients. It is important to encourage victims to consent to specific interventions and assure them of safety and confidentiality, when possible. No intervention should be forced on an unwilling patient. Respecting the patient’s choices is important therapy.

When physicians are required to report serious assaults or injuries inflicted by weapons, they should discuss their legal obligations with the patient, explain the reporting, investigation and follow-up procedures that may follow, and address directly the risk of reprisal and possible need for shelter. The physician should document the information conveyed, the materials given to the patient, and the patient’s decisions.
In states that have enacted mandatory reporting statutes, failure to report could give rise to physician liability. However, most reporting laws rarely give victims explicit rights to sue and courts must determine if the right is implicit in the state statute. Contrastingly, child abuse reporting statutes are enacted with the clear purpose of protecting abused children. There are specific penalties for not reporting and some states have allowed abused children to sue physicians who violate a reporting statute.

b) Legal Protections for Victims

In 1994, the first Violence Against Women Act was passed into law. This law dealt predominantly with criminal justice and social services. Since then, numerous additional pieces of legislation have expanded the scope of this law. For example in 2000, amendments to the law added cyber stalking as a Federal violation. Also recently, there have been efforts to establish new and innovative programs to help prevent domestic violence by educating health care providers to intervene earlier. Additionally, funding has gone to the National Institutes of Health for domestic violence research and the National Center for Injury Prevention and Control at the CDC to establish a family and intimate violence prevention program.

Every state has legislation to protect victims of domestic violence. Physicians are not expected to know in-depth the laws regarding domestic violence. However they should communicate the criminal nature of battering to the patient as well as the options that the law affords to restrain the batterer from further contact, initiate formal separation, have the batterer arrested, removed from the home or ordered into counseling. The 2001 Family Protection Act for the state of Florida includes a 5 year mandatory jail sentence for “intentional injury” and a second offense is charged as a felony. Legal remedies available to battered women vary from state to state and the laws are changing rapidly. Women’s Advocacy programs are excellent resources that can explain legal options and assist them to access the legal system. There are many common civil and criminal actions in domestic violence cases. (TABLE 8).

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**TABLE 8: DOMESTIC VIOLENCE LEGAL ACTIONS: CIVIL AND CRIMINAL**

<table>
<thead>
<tr>
<th>CIVIL ACTIONS</th>
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<tbody>
<tr>
<td>Protective Order, Injunction, Restraining Order</td>
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</table>

- Court orders that direct the batterer to stop abusing the victim.
- In some states batterer may be ordered to:
  - leave shared residence
  - grant custody of children to victim
  - make support payments
  - pay medical bills

Violation of protective order in some jurisdictions is grounds for arrest of the abuser.
CRIMINAL ACTION
Prosecution for: assault, battery, aggravated assault/battery, harassment, intimidation, attempted murder.

c) Testimony
A well-documented medical record will often reduce the time required for physicians to testify in court. Although medical evidence is not required in every case (divorce, custody), a physician may be called to testify on the medical record, to give an opinion on whether injury is consistent with the explanation or as an expert witness.

Admissibility of the medical record in court requires that the record be:
1) made at the time of the exam/interview, in the “regular course of business”;
2) in accordance with routine procedures; and
3) stored properly with access limited to professional staff.

d) Community Resources
Initially, community and government efforts to address domestic violence have fallen within the realms of the criminal justice and social service systems with little attention paid to the long-term effects of domestic violence and the role of the health care system in assisting victims. Regardless of the availability of legal remedies, a woman’s safety must be constantly addressed. A working relationship with law enforcement and criminal justice system will facilitate linking the patient with agencies that can provide legal advocacy. Domestic violence victims receive a greater value from interdisciplinary cooperation and problem solving. Since a common barrier to leaving an abuse situation is the victim’s fear that they are not equipped to live both emotionally and financially without a partner, linking victims with community support systems becomes a strategic part of the treatment plan. Today, more emphasis is placed at the federal and state level by policy makers, health care providers and community advocates on the critical role of the health care system in the prevention of domestic violence.

Simply mandating reporting will not ensure the victim’s safety or facilitate access to appropriate resources. It is more important for physicians to put victims in contact with community services. An updated list of local domestic violence service agencies and other community resources should be maintained in every physician’s office. 27

For short-term crisis intervention, shelters meet the need for safe, emergency housing and usually offer counseling around violence, housing, nonviolent parent education, childcare, and advocacy with legal, social service and welfare systems. In addition to shelter and other emergency housing, legal services, and treatment for substance abuse, safety planning includes friends and family and women’s groups. Long-term strategies are geared at enhancing empowerment, which give the woman a sense of control. They include job training, continuing education, links to AA, NA or ALANON counseling for children and working with child and adult Protective Services. Information on services can
be obtained from National organizations on domestic violence and many local and state battered women’s programs. (TABLE 9).

These experts can assist patients and physicians on multiple levels:

1) Availability of support groups which provide opportunities to share survival strategies and trauma recovery for victims and their children;
2) Transitional living, including safe place for patients post discharge;
3) Financial planning, linkages with job training
4) Safety strategies for those who choose not to or cannot leave (free cell phone programs, emergency money) or those who do (assistance with restraining orders, moving out of the area, children’s school, or changing identity if the risk of death is high).

### TABLE 9: DOMESTIC VIOLENCE RESOURCES AND SERVICES

<table>
<thead>
<tr>
<th>Resource Center</th>
<th>Contact Information</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National Resource Center On Domestic Violence</strong></td>
<td>1-800-537-2238</td>
<td>Provides comprehensive information/Directory of DV Programs. The NRC and the following Special Issue. Resource centers work together as the Domestic Violence Resource Network:</td>
</tr>
<tr>
<td><strong>Battered Women’s Justice Project</strong></td>
<td>Minneapolis, MN - 1-800-903-0111</td>
<td>Provides training, resources addressing criminal and civil justice system responses.</td>
</tr>
<tr>
<td><strong>National Health Resource Center on Domestic Violence</strong></td>
<td>San Francisco, CA - (415) 678-5500</td>
<td>Provides specialized information packets designed to strengthen health care responses to DV, including technical assistance and library services support for program development and coalition of physicians against DV.</td>
</tr>
<tr>
<td><strong>Resource Center on Child Protection and Custody Reno</strong></td>
<td>Reno, NV - 1-800-527-3223</td>
<td>Provides resources, consultation, technical assistance and legal research related to child protection and custody in DV to professionals.</td>
</tr>
<tr>
<td><strong>National Domestic Violence Hotline</strong></td>
<td>1-800-799-7233 (SAFE)</td>
<td>Answers 10,000 calls/month from victims, families and friends. Provides crisis intervention, referrals to local programs 24-hrs/7 days/week, multi-lingual.</td>
</tr>
<tr>
<td><strong>National Organization for Victim Assistance</strong></td>
<td>1-800-879-6682</td>
<td>NOVA is a broad-based victim rights group found worldwide. It assists agencies ranging from victim rights services in Federal, state and local levels, allied professionals (police,</td>
</tr>
</tbody>
</table>

Go to TOC
prosecutors, clergy, health and mental health professionals) and direct service to victims thru “crisis response teams”.

NATIONAL FRAUD INFORMATION CENTER HOTLINE - 1-800-876-7060
Takes reports of telemarketing and Internet fraud and refers to law enforcement agencies and maintains a Database of fraud schemes and reported crimes.

WEBSITE INFORMATION FOR HEALTH PROFESSIONALS

www.nap.edu/catalog/10127.html - Confronting chronic Neglect: The education and training of health professionals on Family violence
www.nap.edu/catalog/2117.html- Understanding Child Abuse and Neglect
www.nap.edu/catalog/5285.html Violence in families; Assessing Prevention and Treatment programs

FLORIDA VICTIM ASSISTANCE PROGRAMS

Florida Abuse Hotline –1-800-962-2873
Victim Assistance for Florida - 850-414-3300
Victim Compensation for Florida - 850-414-3300 myfloridalegal.com/victims
Elder Abuse Hot line - 1-800-96 ABUSE or 1-800-962 2873
ELDER Help lines - 1-800-955-8770
Fraud Hotline 1-866-966-7266

Figure 1: Medical Record Patient Assessment Chart

MEDICAL RECORD PATIENT ASSESSMENT

PATIENT NAME: DATE:

CHIEF COMPLAINT:

DESCRIPTION OF INJURIES (APPEARANCE, SIZE, POSSIBLE SOURCE, AND RESOLUTION:

INDICATE ON CHART LOCATION OF PHYSICAL FINDINGS:

A ABRASIONS
B BRUISES
<table>
<thead>
<tr>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>BL BLEEDING</td>
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<tr>
<td>Bt BITES</td>
</tr>
<tr>
<td>B U BURNS</td>
</tr>
<tr>
<td>D DISLOCATIONS</td>
</tr>
<tr>
<td>F X FRACTURES</td>
</tr>
<tr>
<td>L LACERATIONS</td>
</tr>
<tr>
<td>P PUNCTURES</td>
</tr>
<tr>
<td>LOF LOSS OF FUNCTION</td>
</tr>
</tbody>
</table>

**Dating of Bruises**

- 0-2 days, swollen, tender
- 0-5 days, red, blue
- 5-7 days, green
- 7-10 days, yellow
- 10-14 days, brown
- 2-4 weeks, clear

**Assessment (Possible Causes and Opinion on Whether Injuries Were Adequately Explained):**

**Laboratory & Tests Results**

**Treatment Plan (Include All Referrals to Social Services, Police and Actions Taken)**

---

**FIGURE 2 - POWER AND CONTROL WHEEL**

*Domestic Abuse Intervention Project*

206 West Fourth Street  
Duluth, Minnesota 55806  
216-722-4134

*Click on image to view a larger version*

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**7) CONCLUSIONS**

Health Care professionals must demonstrate a firm commitment to ending family violence and helping its victims. Not all patients are alike. Victims of abuse are going to come to different places in the medical system - some to emergency rooms, some to specialists with specific complaints, others to primary care providers. Treatment will be different depending on where the patient is along the disease paradigm. Physicians and other health care professionals must always act as patient advocates. They must play an active role in advocating increased services for victims and to change the behavior of abusers. They must link with other professionals to coordinate the range of community services and provide opportunities not just for tertiary treatment but also for primary prevention of violence. Most importantly, they must become...
leaders in their communities to change the culture of violence and educate the public on a policy of zero-tolerance.

8) Bibliography


62 FL Statutes . 741.046 Definition of Domestic Violence


ELDERLY ABUSE

1) Scope of the Problem

Although much has been examined and written about child abuse and battered adults, it is only recently that the issue of elder abuse has received attention. The demographic shift toward an older age in America is well known. Today 1 in 9 (11%) Americans are over age 65 years, and the fastest growing segment is the group 85 years and older. Like its counterparts of child and intimate partner abuse, while everyone agrees that they should never occur, these problems do occur and do so at an alarming rate. In 1980, the U.S. Senate Special committee on Elder Abuse reported as many as 500,000 to 2,500,000 cases of elder abuse, neglect or maltreatment occur each year in this country, but only 1 in six cases is reported. The first laws requiring reporting for suspected cases of elder abuse began with protective services and guardianship programs to meet the needs of those elders who could not maintain basic living standards without agency assistance. Since then, there has been an expansion of these protections, as more and more health care workers recognized the scope of the problem, and by the beginning of the 1990’s all states had passed elder abuse laws that mandated reporting by physicians and other health care professionals for the protection of the elderly. However, specific requirements and penalties vary considerably among jurisdictions.

In the subsequent decade, however, elder abuse remained overshadowed by more dramatic cases of child and intimate partner abuse. While horrific nursing home cases occasionally received public attention, domestic elder abuse remained a silent epidemic. While there was a 150.4% increase in elder abuse reports during the last decade, the magnitude of the number attests to the seriousness of the epidemic. It has been estimated that 4-5% of all elderly Americans are abused yearly (1-2 million/year) and for every 1 reported incidence, approximately 5 are unreported. In recent studies, the incidence of elder abuse problem accounted for 6-7% of the adult population studied and the incidence rises to 47% of elderly patients diagnosed with dementia. The prevalence rates of abuse in long term care facilities range from 24 to 44% depending on the reporting (nurses and aide staff and elderly residents, complaints to LTC Ombudsmen).

2) Definitions of Elder Abuse
The low reporting rate means that elder abuse is not being adequately dealt with and victims are not receiving services and protection. Part of the problem is the breadthness of the definition of elder abuse. This umbrella term encompasses a number of very different types of abuse, which require individual approaches and solutions. Typically, in most state statutes definitions of elder abuse include abuse, neglect and exploitation. Still abuse may be further broken down into physical, sexual, emotional or psychological abuse and may occur in the domestic as well-as institutional settings. Neglect can encompass self-neglect and/or neglect by others, both willful and unintentional. Exploitation can be financial or material in form. Nationally, it is reported that 30% of the cases of elder abuse fit the definition of physical abuse, emotional abuse or sexual abuse; 57% of the cases represent neglect and 15% exploitation. Florida mirrors the national trend; 63% of the cases were neglect, 29% self-neglect and 34% neglect by others.

3) Who are the victims? Who are the perpetrators?

The NEAIS found that women represented 60-76% victims of all forms of abuse. (TABLE 10) The oldest elders (80 years plus) were abused and/or neglected the most frequently. In Florida the average age of victims was over 70 years, with the highest rate –30% in those 80-89 years and over 3500 reports involved those over 90 years). Caucasians compromised 80% if victims overall in the reports examined by NEAIS, while African Americans comprised only 8.3% and Latinos only 5.1% of victims. The NEAIS found family members were the most common perpetrators, particularly adult children (43.7% of cases). Spouses comprised the next largest category, at 19% (Table 10); in nearly two thirds of all cases the perpetrator was under 60 years of age. Male perpetrators were more common in physical and emotional abuse. (62.6% and 60.1%) and financial exploitation cases (59%). Only in cases of neglect were females more likely to be the perpetrator (52.4%). Perpetrators of abuse were more commonly non-Hispanic white (77.4%).

Table 10: Characteristics of Victims and Perpetrators of Abuse

<table>
<thead>
<tr>
<th>ELDER ABUSE</th>
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<tbody>
<tr>
<td><strong>Age of victim</strong></td>
</tr>
<tr>
<td>80 + years while 19% of elder population they were:</td>
</tr>
<tr>
<td>52% neglect victims</td>
</tr>
<tr>
<td>44% physical abuse</td>
</tr>
<tr>
<td>41% Emotional</td>
</tr>
<tr>
<td>48% Financial</td>
</tr>
<tr>
<td><strong>Gender</strong> – female</td>
</tr>
<tr>
<td>60-72%</td>
</tr>
<tr>
<td><strong>Race</strong></td>
</tr>
<tr>
<td>%</td>
</tr>
</tbody>
</table>
### Perpetrators

<table>
<thead>
<tr>
<th>Role</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family member</td>
<td></td>
</tr>
<tr>
<td>Adult child</td>
<td>43</td>
</tr>
<tr>
<td>Spouse</td>
<td>19</td>
</tr>
<tr>
<td>Grandchild</td>
<td>9</td>
</tr>
<tr>
<td>Other Relative</td>
<td>9</td>
</tr>
<tr>
<td>Friend/Neighbor</td>
<td>6</td>
</tr>
<tr>
<td>In-home service</td>
<td>3</td>
</tr>
<tr>
<td>Provider</td>
<td>1</td>
</tr>
<tr>
<td>Out-of home</td>
<td></td>
</tr>
<tr>
<td>Service provider</td>
<td></td>
</tr>
</tbody>
</table>

4) **Reasons for abuse—barriers to reporting**

There are several theories of causation for elder abuse proposed in the literature: impairment of the victim, pathology of the abuser, internal family dynamics and stressors (internal-care-giver burden and external-financial pressures). A theme which threads through domestic abuse cases is that the elder victim is usually dependent, living with family where there is a crisis of economic, overcrowded living setting, unresolved relationship problems, life-event such as divorce, retirement. There may be mental illness, developmental disability or substance abuse among the family perpetrators. Finally, there is often a family history of violence, which leads to a cyclic familial pattern of abuse. A clearer understanding of causal relationships is important to the assessment and management of elder abuse. Not all caregivers are alike. In dealing with care-givers, red flag warning signs include the following:

- Care-givers acknowledge that they view care—giving as a burden
- Care-giver experiences emotional/mental burnout, anxiety or severe depression

They feel “caught” in the middle, so to speak, providing multigenerational care and not feeling adequately prepared to do so and/or feel lack of support from others.

Additionally important, is the recognition that unlike in cases of adult abuse where the victims usually come forward to seek help outside, there is barriers that keep elderly victims from doing so. The elderly lack economic, legal family support and fear alienating their family member, or worse, losing their care-giver. In elder abuse, “divorce is not a viable option” Since
they fear abandonment, alternative housing may not be available or worse yet it may lead to institutionalization, which for many elders is a “fate worse than death”. The elderly fear that coming forward may be used against them or that no one will believe them because of age bias. They also have cultural issues and prejudices in which “family shame” is not to be shared. Finally, navigating the legal system may be intimidating and too difficult.

5) Signs and Symptoms of Abuse in the Elderly

Given the circumstances in which abuse is likely to occur and the barriers to reporting, elder mistreatment (abuse and neglect) is often undetected, and goes unreported more than any other form of domestic violence. Health care providers' awareness of signs and symptoms (Table 11) and risk factors (Table 12) is critically important to the detection and eradication of the problem. Unlike adult abuse, the signs of elder abuse can be confusing because they may present like many other common geriatric syndromes, such as depression, falls, fractures and decubitus ulcers. However, there are clues to the diagnosis of elder abuse and healthcare providers should be alert to the clear signs of abuse and include mistreatment in their differential diagnosis. Clearly elderly patients have complex constellation of symptoms and concerns. The nature of the doctor-patient relationship provides a unique opportunity to detect elder abuse. It is important however, to remember that, unlike other adult victims of abuse, the elderly are less likely to self-report, more likely to deny because of fear, shame or not even realize they are being mistreated. Up to one third of elderly victims deny abuse, even when specifically asked. Also, cultural factors should be considered when evaluating elder abuse cases: lack of knowledge of what constitutes abuse in this culture; family roles and degree of acceptance of family roles; verbal and non-verbal communication in the culture. One caveat when interviewing patients is to never use younger family members to translate, since they may filter important information. A trained professional should be used for medical translation whenever possible, since subtle verbal and non-verbal clues of that culture will be picked-up even though the patient denies abuse.

Table 11: Presentations of Elder Abuse
The following presentations of elder abuse were developed from the National Abuse Incidence Study. Final Report 1998 Administration on Aging Report (+http://www.aoa.dhhs.gov/abusereport/default.htm)

**Signs & Symptoms**

**Physical Abuse**  Bruises in multiple stages of healing lacerations,  
Rope marks, signs of being restrained  
Bone fractures (skull), Dislocations  
Open wounds, untreated injuries  
Broken eyeglasses  
Sudden changes in behavior  
Lab findings of medication overdose or under-utilization of Prescribed meds.

**Sexual Abuse**  Bruises around breast, genitalia  
Unexplained genital infections  
Vaginal/anal bleeding  
Torn, stained bloody underclothing

**Emotional or Psychological Agitation**  
Extreme withdrawal, non-communication  
Caregiver’s refusal to allow visitors to see elder alone.

**Neglect (Self)**  Dehydration, malnutrition  
Untreated, improperly attended medical conditions  
Poor personal hygiene, inadequate clothing  
Unsafe living conditions.

**Neglect (By Others)**  Dehydration, malnutrition  
Untreated bedsores  
Unattended, untreated medical problems  
Poor personal hygiene  
Abandonment  Desertion of elder at a hospital, institution, other public locations.

**Exploitation – financial or material**  
Sudden changes in bank account, banking practice  
Unexplained withdrawal of large sums of money  
Provision of unnecessary services.
Unexplained sudden transfer of assets

### Table 12: Red flags for possible elder abuse

<table>
<thead>
<tr>
<th>Risk indicators</th>
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<tbody>
<tr>
<td>Prior abuse</td>
</tr>
<tr>
<td>High degree of dependence on caregiver</td>
</tr>
<tr>
<td>Financial dependency of caregiver on the patient</td>
</tr>
<tr>
<td>Emotional/mental health of victim/family member</td>
</tr>
<tr>
<td>Dementia and behavior issues</td>
</tr>
<tr>
<td>Alcohol/substance abuse</td>
</tr>
<tr>
<td>Shared living arrangements</td>
</tr>
<tr>
<td>Social isolation</td>
</tr>
<tr>
<td>Incontinence</td>
</tr>
<tr>
<td>Caregiver stress) (Divorce, bankruptcy, legal problems)</td>
</tr>
</tbody>
</table>

**Patient history/behaviors**

- Explanation for findings not reasonable
- Unresolved/recurrent medial problems despite RX plan
- Injuries not properly cared for
- Delay in seeking medical care—untreated medical problems
- Frequent ER visits
- Fear of caregiver
- Caregiver refuses to leave patient alone; abusive tone; hostile
- Overly medicated
- Sudden changes in elder behavior (including, anxiety, withdrawal confusion, disorientation)

**Physical findings**

- Clothing soiled, inappropriate for season
- Unexplained multiple bruises/abrasions
  - Variable healing stages
  - Patterns of objects
  - Bruises on face, throat, trunk, buttocks, scalp,
  - Inner arm stocking-glove
- Bilateral, parallel injuries
- Signs of self-mutilation—seeping wounds in clusters
- Poor personal hygiene (nails, teeth, hair, skin)
- Decubitus ulcer
- Dehydration, malnutrition, weight loss
- Bruised, bleeding in genitalia, anal areas
6) Special considerations for dealing with elder abuse

Since the prevalence of abuse is so high and any elderly patient is a potential victim, all elderly patients should be screened. The most important step besides treating the actual effects of the abuse is to determine if the patient is in imminent danger of harm (whether it is active, e.g., physical abuse or passive, e.g., serious medical consequences from inattention). Elder abuse victims are at increased risk for death, greater than the chronic illnesses they may have. 17 Health care providers must recognize that traditional safety planning may not work for the elderly (installing new door locks, key lock for the bedroom, security system, passwords for friends, preprogrammed phones to call 911, injunction for protection). Even safe-space shelters may not be equipped to meet the medical or physical needs of an elderly victim (handicapped rooms, treatment facilities).

Every state has mandatory reporting laws. Statutes require health care professionals, social service workers, law enforcement officials, and others to report suspected cases of child, elder and disabled abuse to some state authority. Most states are similar to what happens in Florida. All incoming calls are screened by counselors for acceptance as reports of abuse of elders according to specific criteria (meets the definition of adult victim and alleged perpetrator and abuse under Section 415.102 of the Florida Statute and means to locate). (TABLE 13). Only accepted reports are referred for further investigation. On referral the required actions vary widely according to jurisdiction, and range from following a physician’s management plan to conduct a full-scale investigation. They can even obtain court order to remove the elderly person from the living environment. In Florida, if the call requires “immediate investigation because the alleged victim is in imminent danger of serious harm” the hotline counselor has one hour to contact the appropriate district office by phone, otherwise non-immediate situations are entered into the computer system where they are checked for routinely by district offices, usually during business hours only. There are controversies regarding mandatory reporting laws. Critics point to them as an example of extreme ageism—“treating the elderly as children and incompetents”. It may place them in grave danger or expose them to services, which are inadequate to meet their needs and lead to inappropriate institutionalization of elder abuse victims. 13, 14

<table>
<thead>
<tr>
<th>TABLE 13: Adult Protective Services Act in Florida Statutes 415.102</th>
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</table>
Definitions

1. **ABUSE**-“non-accidental infliction of physical or psychological injury or sexual abuse upon a disabled adult or an elderly person by a relative, care giver or household member... or any action by any of those persons which could reasonably be expected to result in physical, psychological injury or sexual abuse of a disabled adult or any elderly person by any person,,, the active encouragement of any person by relative, or care giver, or household member to commit an act that inflicts or could reasonably be expected to result in physical or psychological injury...”

2. **ELDERLY PERSON**-“ A person 60 years of age or older who is suffering from the infirmities of aging as manifested by organic brain damage, advance age, or other physical mental or emotional dysfunction to the extent that the person is impaired in his/her ability to adequately provide for the person’s own care or protection is impaired...”

*DCF policy dictates anyone 75 years or older meets the definition of elderly automatically.

3. **MANDATORY REPORTING**- “Any person, including, but not limited to any physician...nurse... who knows, or has reasonable cause to suspect that an aged / disabled person is abused, neglected, or exploited shall immediately report such knowledge or suspicion to the central abuse registry and tracking system of the Department or the single state wide toll free telephone number.”

As an adjunct to mandatory reporting, many states provide other support systems and services (TABLE 14) that can be given to the elderly victim and even the abuser to assist in stopping the cycle of violence in the home. Health Care providers must be creative and open to new ideas in the management of elderly abuse victims. They should determine that the potential danger is significant and arrange for alternative care for the victim until the issue is addressed. This may include hospitalization, if appropriate or shelters qualified to care for the elderly. They should be facile with resources available to assist elder victims and make appropriate referrals. It is equally important to partner with other professionals and facilities to provide a comprehensive and coordinated management plan for victims and their families. Finally, like in any chronic disease, ongoing care is needed. Management should target specific risk factors, which have contributed to the situation (victim behavior, care-giver stress). The living environment should be monitored regularly to ensure patient safety.
Table 14 - Elder Abuse and Neglect—Information for Physicians and Patients (5)

1. **Florida Elder Help-line** 1-800-955-8771
   Access to information regarding elder services and activities and referral to specific area agencies. ☐ equipped with telecommunication devices for the deaf.

2. [http://www.state.fl.us/cf-web/districts/11](http://www.state.fl.us/cf-web/districts/11)
   Relevant information of resources in the state to assist victims.

3. **Shelter for abused women 24 hour crisis line** 941-775-1101

4. **Florida Abuse Hotline** 1-800-96-ABUSE 1-800-500-1119
   Available 24 hours/7 days a week.

5. **National Domestic Violence Hotline** 1-800-799-SAFE

6. **National Center on Elder Abuse c/o Institute on Aging**
   810 First Street NE, Suite 500
   Washington, DC 20002, Tel: 202-898-2586

7. **National Committee for the Prevention of Elder Abuse**
   Medical Center of Central Massachusetts
   119 Belmont St.
   Worcester, Ma 01605 Tele. (508) 793-6166

**Publications For Health Workers**

Diagnostic and Treatment Guidelines on Elder Abuse and Neglect (1992) AMA 515 N. State Street
Chicago IL 60601

Elder Mistreatment Guidelines for Health Care Professionals: Detection, Assessment and Intervention
(1988) Available from Victim Services, N.Y. 212-517-7700

**Publications For Patients**

AARP fulfillment, 601 NW Washington DC 20049 Tele. 1-800-424-3410
Request publication #D 15218 Abused Elders or Older Battered Women,

Health care providers must be advocates for their patients and try to develop long-term programs to reduce the abuse. Studies have shown that direct services to victims and their families coupled with strong case management by specialized elder abuse workers have great potential to reduce elder abuse. 15 Development of support groups, shelters and “safe houses”
that are geared to the elderly abuse victim would also be of benefit, reducing the need to nursing home placements. These living facilities need to provide for special needs of the elderly: the physical needs, (including assistance with ADLS), counseling for grief issues, maintenance of independence, economic resources, and greater family involvement. Equally important are services to connect abuse victims and their families with community resources to resolve abuse environment (e.g. psychological counseling, stress-reduction for caregivers.)

7) Summary

Although the problem of elder abuse and neglect is not new, only recently has this form of societal violence elicited the attention given to child abuse and battered abuse. Unlike the latter instances of domestic violence, 90% of cases of elder abuse are not being reported and the rest may be rescinded because the elder is totally dependent on the caregiver and removal will mean going to a long term care facility. Unlike its counterparts in domestic violence, the signs of elder abuse may be less obvious or confusing because of the multiplicity of other illnesses in the elderly. Additionally, because of age bias, it is often easy to write off the symptoms, or disbelieve the victim’s complaints as by-products of aging. Even when acknowledged, treatments are hampered because there are no shelters or safe-spaces geared to the elderly victim’s needs. It takes an especially trained team and a concerted effort to recognize the abuse, work with the elderly person to meet their desires and needs and assist caregivers when it is appropriate for families to stay together. To avoid further discrimination and victimization, elder abuse treatments must meet the dual needs of sensitivity and safety for the elderly patient.

8) Elderly Abuse - Bibliography


8. Florida Statutes 825.102 Abuse, Neglect and Exploitation of elderly persons and disabled adults.


HUMAN TRAFFICKING

Human trafficking is the third largest international crime industry (behind illegal drugs and arms trafficking). It reportedly generates a profit of $150 billion every year. People are reported to be trafficked from 127 countries and exploited in 137 countries, affecting every continent and every type of economy. Worldwide it is estimated that over 600,000 to 800,000 adults and children being trafficked in a human “slave” trade. More than 70 percent are female and half are children. These people are kidnapped or duped and smuggled illegally for sex trade (80%) or labor trade (19%) in either debt bondage, forced labor, or indentured servitude. Pregnant women are increasingly being trafficked for their newborns. Additionally, in some third world countries, children are forced to become soldiers. UNICEF estimates that 300,000 children younger than 18 are currently trafficked to serve in armed conflicts worldwide.

This is a growing issue which has impact in our country as well. It is estimated there are 100,000-300,000 people trafficked into the U.S. each year. Most human trafficking in the United States occurs in, California, Texas and Florida. Florida as an international hub, with a large hotel and tourist and agriculture and sex industry is a perfect site.

The average age a teen enters the sex trade in the U.S. is 12 to 14-year-old. Many victims are runaway girls who were sexually abused as children. California harbors 3 of the FBI’s 13 highest child sex trafficking areas in the nation: Los Angeles, San Francisco, and San Diego. The International Labor Organization estimates that women and girls represent the largest share of forced labor victims with 11.4 million trafficked victims (55 percent). These patients come for physical exams, and as in victims of domestic violence, the only moment to intercede in their lives may be in the doctor-patient encounter.

1) Recognizing Victims

Consensus is building on the warning signs to look for to recognize victims of human sex trafficking (TABLE 15) Providers may be able to identify these individuals because someone else usually, not family, accompanies them and does the speaking for them. The answers related to their job, and housing often are inconsistent. Patients don’t have their own identification papers or passport; someone “holds” it for them as a means of control to keep them from escaping. Signs of being a victim may include the traditional signs of domestic violence, including neglect of health and coming late in a disease process.
TABLE 15 Warning signs of Sex trafficking to look for.

- **Inconsistent** history
- **Injuries** or other signs of physical abuse, sexual abuse, confinement, malnourishment, or torture
- **Lack of control** over personal schedule, money or identification documents
- **Branding tattoos** that reference $money, “daddy” or a man’s name in prominent places
- **Controlling “boyfriend”** or intimate relationship with an older person who is not age-appropriate
- **Unexplained new items** such as cell phones, jewelry and clothing
- **Hiding** computer, phone communications or details of whereabouts
- **Chronic runaway**
- **Sexually explicit** online profile
- **Referencing sexual situations** that are not age-appropriate
- **Refers to trafficker/pimp and associates** by familial titles such as daddy or family

2) **Interventions**

Attaining privacy in an interview is key to the intervention for these victims. Separating them from their companions should be done routinely. Always use interpretation services/translator banks so you can learn information from the patient and not through the companion.

Understand special issues facing children who are most vulnerable to the full range of “prisoner of war” emotions, including transference/dependence on the captor. Indirect questions may be the best approach. *(TABLE 16)* Answers that are vague should raise suspicion. Responses to explain oddities in their living and working conditions may expose the fact that they are not here under their own free will.

**TABLE 16 – Interventions to Identify Trafficking**

<table>
<thead>
<tr>
<th>HOW and WHY in the US?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where do they live and with whom? Are you locked up?</td>
</tr>
<tr>
<td>What is your understanding of what would happen if you left your job?</td>
</tr>
<tr>
<td>Type of work, How are you paid?</td>
</tr>
<tr>
<td>Permission needed to eat, sleep, use bathroom, and talk with others?</td>
</tr>
<tr>
<td>Have you been physically harmed? Has anyone threatened your family?</td>
</tr>
<tr>
<td>What happens if you make a mistake at work?</td>
</tr>
</tbody>
</table>
Have you been threatened with deportation or being reported to immigration if you try to leave?
How much are you in debt? How are you expected to pay it back?

2) Certification and Resources

Once a victim is identified and upon referral to the Department of Health and Human Services, Office of Refugee Resettlement, the victim can be “certified” indicating that they are a victim of “severe form of trafficking” and this opens the door to a wide range of benefits and help. (TABLE 17) The victim must be willing to assist the investigation/prosecution of the traffickers, apply for a T visa. This process usually requires an immigration legal services and/or advocates and victim specialists with the federal offices. Victims are eligible for the Florida Crime Victim compensation, food stamps, cash assistance, medical care and other services under Florida Refugee social services. Other remedies include asylum, special immigrant juvenile status, S Visa and VAWA which once obtained, may grant the victim work authorization.

TABLE 17 Resources for Victims of Human Trafficking

National Human trafficking Resource center 1-888-373-7888
Provides information and access to supportive services through the Trafficking Victims Protection Act of 2000 including housing, health care, immigration assistance, food, employment and legal assistance.

ICE Victim Assistance Program helps coordinate services to help such as crisis intervention, counseling and emotional support 1-866-872-4973

POLARIS Project information and assistance on resources www.polarisproject.org and www.traffickingresourcecenter.org

4) References

5) Resources
• Coalition to Abolish Slavery & Trafficking - 213-365-1906. www.castla.org
• Family Violence Prevention Fund - 415-252-8900. www.endabuse.org
• National Immigration Project – 617-227-9727. www.nationalimmigrationproject.org

FLORIDA DOMESTIC VIOLENCE LAWS AND SERVICES: INFORMATION FOR HEALTH CARE PROVIDERS

Law enforcement and the justice system can do much to enforce the message that domestic violence is a serious crime that will not be tolerated.

1) Definitions
In Florida domestic violence is defined as “any assault, battery, sexual assault, sexual battery, or any criminal offense resulting in physical injury or death of one family or household member by another who is or was residing in the same single dwelling unit”. The Florida Department of Law Enforcement (FDLE) is required to publish statistics on the occurrences of and arrests of domestic violence as part of its Crime in Florida Annual report. 

Role of Law Enforcement
Under Florida law, the police called to investigate an alleged incident of domestic violence are required to assist the victim in obtaining medical treatment if required; advise the victim of services available at a local domestic violence center; complete a written police report; and notify the victim of his/her legal rights and remedies. This Notice of Legal Rights and Remedies is in English and Spanish. Since specialized knowledge is required for law enforcement to
respond to a victim of domestic violence, some police departments have trained officers and/or specialized units assigned to work with victims as advocates and resource persons. The Governor’s Task Force on Domestic Violence has recommended specialized training for all law enforcement agencies. Within 24 hours of the alleged incident of domestic violence, the police must send a copy of the initial police report to the nearest certified domestic violence center. In the case of child/elder abuse, the police must notify the Florida Department of Health and Rehabilitative Services so that appropriate interventions take place. Under the current law, the police called to the scene of a domestic violence incident can make an arrest upon probable cause and do not need to witness the crime. Florida law enforcement agencies advocate a pro-arrest policy and instruct officers to make warrant-less arrests in domestic violence cases.

2) Court Orders to Protect the Victim

Domestic violence victims may petition the court for protective injunctions. Any victim of domestic abuse who believes that he or she is in imminent danger can file a protective injunction which prohibits the restrained party from coming within 500 feet of the victim.

a) Restraining Orders (Ex Parte Relief) can be granted for up to 30 days. It is available to victims at any time (24 hours, weekends and holidays) and can address the safety of the victims at home, work or school, child custody, removal of the perpetrator from the home and forbids the perpetrator from contact with the victim, and any other relief deemed proper. Florida judges need no evidence and can grant injunctive relief on the sworn petition filed at the clerk’s office. Petitioners don’t need an attorney; the clerks are trained and required by law to assist the petitioners. Additionally, fees for filing, service of process and bonds can be waived for those unable to pay.

b) Permanent Relief is determined at a full hearing within 30 days. A permanent injunction allows the court to restrain the respondent from committing any act of domestic violence, to avoid all contact with the petitioner and grant any other relief, such as temporary custody, child support and visitation. Additionally, the court can require the batterer to complete a batterer’s intervention and other treatment (substance abuse, mental health) and counseling programs (including the children). Permanent injunction may be granted for up to one year.

c) Joint Custody and Visitation can create particular tensions and escalate family violence. Court orders are structured to protect the victim and her children from further abuse. Despite Florida laws, which require shared parental responsibility; judges in domestic violence cases can order custody and even structure visitation to occur at locations physically separate from the victim or under the supervision of a third party. Advocates are working actively to establish supervised visitation centers in every county to provide safe and comfortable environment for victims and their children.
3) Violation of Injunctions

Studies show that violence increases dramatically when the victim leaves an abusive relationship. Violence escalates after separation in an attempt to coerce or retaliate against the victim. National Institute of Justice found that 75% of domestic violence assaults occurred after the victim is divorced or separated. Court ordered protection provides the victim with the security of knowing and sends a message to the abuser that, should the order be violated, the abuser is arrested immediately. Judges structure protective conditions to ensure safety and limit batterer’s power and control before violence escalates to serious injury or death. Follow-up hearings and incremental sanctions for violations help ensure compliance. Studies show that batterer’s behavior can be stopped to the extent that they perceive that penalties for further violence will be certain and severe.

Injunctions are civil actions. When a temporary or permanent injunction is violated it can become a criminal action. The courts use contempt orders to enforce their authority in domestic violence cases. Contempt actions may be civil or criminal in nature. Civil contempt may order specific conduct (paying child support) and if the party fails to comply, the court may incarcerate the party until compliance with the order occurs. This includes failure to attend a batterer’s program. Certain injunction violations (refusing to vacate or returning to a dwelling shared by the parties, committing an act of domestic violence, or committing any other injunction violation, assault) are enforceable through criminal prosecution. The object of criminal contempt is to punish the offending party.

4) Victim’s Assistance through the Court Process

As in the physician’s office, judges can be frustrated by the victim’s reluctance to testify or desire not to proceed with injunctions. They attempt to identify reluctance, which is often based on well-founded fears of the batterer. Experience has revealed that battered women who receive support and accurate information about the court process, and perceive that the laws may hold the offender accountable, will be more likely to appear and testify. Treating domestic violence as a crime was the intent of the legislature in enacting chapter 741. In several jurisdictions across the United States, specialized domestic violence prosecuting units are designed to provide clear evidence of the State’s serious treatment of domestic violence, and can result in improved conviction rates for domestic violence crimes. “Vertical prosecution” (one prosecutor and team, including victim’s advocates handle the case from beginning to end) is a central theme of these Units. Such a policy tends to develop a greater level of trust between victim and the judicial system. Additionally, the victim is often relieved of the burden to prosecute, by emphasizing that the decision to prosecute rests with the State. Such “no-drop” policies enhance the likelihood of victims to testify (as witnesses rather than accusers) and reduce the likelihood of future violence, retaliation, harassment, or intimidation by abusers since she can have no effect.
on “dropping charges” or stopping the prosecution.

5) Help for Batterer’s: Interventions and Treatment Programs
Batterer’s intervention and treatment programs are an essential part of breaking the cycle of violence. These programs focus on the safety of the victims and assist batterers to recognize and take responsibility for their abusive behaviors. They are usually 29 weeks in length and include 24 weekly sessions based on a psycho-education model. They teach skills and strategies for developing violence-free communications and shift the power/control paradigm of abusive relationships. Couples counseling, anger and control classes are not effective programs. There is no cause-and-effect relationship between substance abuse and domestic violence. Treatment of substance abuse should be confronted separately and concurrently with treatment of batterers.

Although the effectiveness of batterer’s programs is difficult to assess, data indicate that in and of themselves they are not enough to stop the recidivism rate. But when they are coordinated with a variety of other interventions, including community services, legal and social restraints, they can reinforce the message. Batterers who complete court-mandated treatment following arrest are less likely to commit re-offenses than those who do not. Victims should understand the limitations so that no false hopes or sense of security is developed.

6) Domestic Violence Services and Referral Resources
The Florida legislature first allocated funds for domestic violence shelters in 1977. The Florida Coalition Against Domestic Violence is an association of domestic violence centers in Florida. The FCADV provides technical assistance and advocacy for the 42 certified Florida centers that provide a variety of services for victims of domestic violence and their children. Shelter services are confidential and provided without charge. Domestic violence centers across the state provide: information and referral, counseling, temporary emergency shelter, professional training, case management and 24-hour crisis line. Additional services include safe homes, victim advocacy, legal services, transportation, children’s programs, transitional housing, and childcare. Some centers also offer treatment for batterers, employment and vocational counseling, medical and legal advocacy. Not all Florida cities are served by domestic violence centers. Information regarding safe spaces can be accessed by calling 1-800-500-1119. Victims spend four to six weeks in DV shelters. “Transition housing” after victims leave the shelter is often required with an average stay of six to eighteen months. This time provides battered women with opportunities to locate permanent housing, job and other services necessary to rebuild a safe life.
7) **Bibliography - Florida Laws**

1. Florida Statutes section 741.30 (1992)
2. Florida statutes section 741.29
3. Task Force Report
4. Florida Statutes section 781.046