

# **PARTNER VIOLENCE**

## **How to Recognize and Treat Victims of Abuse**

**A Guide for Arizona Health Care Providers**

by

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**The Arizona Medical Association**

**Arizona law provided by Dianne Post JD**

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*This guidebook was originally prepared in conjunction with the Massachusetts Medical Society's Campaign Against Domestic Violence. The assistance of the Massachusetts Coalition of Battered Women Service Groups and the Office of the Attorney General of the Commonwealth of Massachusetts is appreciated.*

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# TABLE OF CONTENTS

<b>TITLE</b>	<b>PAGE</b>
<b>Introduction .....</b>	<b>5</b>
<b>Definition .....</b>	<b>5</b>
<b>Dynamics of the Abusive Relationship .....</b>	<b>6</b>
<b>Overview of the Problem.....</b>	<b>6</b>
<b>Who is at Greatest Risk?.....</b>	<b>7</b>
<b>Obstacles to Leaving: Why Battered Women Stay .....</b>	<b>7</b>
<b>Clinical Evaluation Strategies.....</b>	<b>8</b>
<b>Interviewing Techniques .....</b>	<b>8</b>
<b>Physical Examination and Documentation in the Medical Record .....</b>	<b>9</b>
<b>Risk Assessment .....</b>	<b>9</b>
<b>Intervention .....</b>	<b>10</b>
<b>Intervention Strategies.....</b>	<b>10</b>
<b>Mandated Reporting.....</b>	<b>10</b>
<b>Developing a Safety Plan .....</b>	<b>10</b>
<b>Using your “RADAR” .....</b>	<b>11</b>
<b>Legal information for health care providers .....</b>	<b>12</b>
<b>Orders of Protection .....</b>	<b>12</b>
<b>Criminal Complaints .....</b>	<b>13</b>
<b>Stalking Law .....</b>	<b>13</b>
<b>Bibliography .....</b>	<b>13</b>
<b>List of Shelters .....</b>	<b>14</b>

# INTRODUCTION

**This guidebook was developed to help physicians improve their ability to respond to the needs of patients who have experienced partner violence, a problem often encountered in medical practice. The purpose of this guidebook is to:**

- Provide physicians in the State of Arizona with basic information about partner violence,
- Help physicians better recognize the varied clinical presentations of partner violence, and
- Provide physicians with a referral guide to effectively identify, counsel and offer informed options to their patients who are at risk.

Because physicians are often the first and sometimes only professionals whom victims of violence may encounter, they can play a crucial role in breaking the cycle of violence.

Individual physicians and other health care professionals may themselves have been victimized as children or as adults, or may currently be in a violent relationship as a victim or a perpetrator.

**Physicians whose lives have been personally touched by violence are urged to seek help from a trusted colleague, therapist, family member or other source of support.**

## DEFINITION

**Partner violence (often referred to as domestic violence, spousal abuse, battering, or wife beating, among other terms) can be defined as intentional violent or controlling behavior by a person who is currently, or was previously, in an intimate relationship with the victim. Partner violence encompasses a syndrome of coercive behaviors that may include, but are not limited to, the following:**

- Actual or threatened physical injury;
- Sexual assault;
- Psychological abuse;
- Economic control; and/or
- Progressive social isolation.

These behaviors can occur in any combination, in sporadic episodes or chronically, over a period of up to several decades.

The overwhelming proportion of violence is perpetrated by men against women, although partner violence also occurs in both male and female homosexual relationships and, in a small proportion of cases, by women against men.

**To reflect the recognized prevalence of this syndrome, this guidebook shall refer to the victim as “she” and the batterer as “he” throughout.**

# DYNAMICS OF THE ABUSIVE RELATIONSHIP

## Overview of the Problem

### Statistical Background

The following statistics highlight the pervasiveness of the problem of violence against women. Conservative estimates indicate a history of partner violence for:

- Between two and four million women per year in the United States<sup>1</sup>
- One in seven women seen for general medical care in office practices<sup>2</sup>
- One in three women seeking care for any reason in hospital emergency rooms<sup>3,4</sup>
- One in four women who attempt suicide<sup>5</sup>
- One in four women who are pregnant<sup>6</sup>
- More than half of the mothers of abused children<sup>7</sup>

The number of battering injuries suffered by women is greater than the total number of injuries sustained from car accidents, muggings and rapes combined, which makes battering the most common cause of traumatic injury to women in the United States.

### Behavioral Dynamics

Listed below are some of the features that highlight the dynamics of an abusive relationship:

- The aim of the violence is to assert power and maintain control.
- The abuse can be physical, psychological, verbal and/or economic.
- The abuse is generally one-way, although victims may strike back in self-defense.
- Victims of abuse are not constantly being beaten. Batterers may behave in a caring and apologetic manner at times when no overt abuse is taking place. Therefore, there may be no physical evidence of abuse at the time of your encounter with the patient.
- Your patient may be reluctant to disclose information about current or past abuse even when specifically asked because of fear of retaliation by the perpetrator, shame and/or embarrassment. She may also believe that physicians do not know about or understand this problem, may not take her situation seriously, and may not even believe her.
- In general, abusive relationships may not start out being violent but become increasingly so over time, as the perpetrator exerts more and more control over his victim.

## Who is at Greatest Risk?

Any woman, anywhere, can be a victim of abuse. Partner violence cuts across all racial, ethnic, religious, educational and socioeconomic strata. However, the prevalence of partner violence does appear to be greater in certain groups<sup>8</sup>:

- Women who are single, separated or divorced;
- Women who have recently sought a restraining/vacate order;
- Women between the ages of 17 and 28;
- Women who abuse alcohol or other drugs, or whose partners do;
- Women who are pregnant; and
- Women whose partners are excessively jealous or possessive.

## Obstacles to Leaving: Why Battered Women Stay

There are many reasons why it is difficult for battered women to leave their abusers<sup>9</sup>:

### Fear

The batterer may threaten to hurt or even kill his victim, or to take away or hurt the children if his partner attempts to leave. Indeed, more battered women are murdered after obtaining a restraining order while in the process of leaving their abusers than at any other time.

### Economic and Other Constraints

The batterer often controls the financial resources of his victim as well as access to telephones, car keys and even food, making it difficult for the woman to leave because she cannot (or believes she is unable to) independently support herself and her children.

## Social Isolation

The batterer often constrains the ability of his victim to communicate with friends and family. Isolation leaves the victim psychologically dependent on the batterer as her sole social support.

## Feelings of Failure

Many battered women have been made to feel, by the batterer as well as by others, that they are failures and are responsible for having brought on the abuse. They may view themselves as needing to figure out how to adapt or change in order to halt the abuse. The woman may also believe that her children deserve a two-parent family.

## Promises of Change

Many women believe the batterer's promise that he is sorry about becoming violent and that it will never happen again. While some women want the relationship to continue, most are clear about wanting the violence to stop. Many battered women believe it is somehow their mission to change or redeem their batterers.

## Prior Lack of Intervention

All too often, victims of abuse are either blamed for the violence or not taken seriously by family, health care professionals, social service providers and law enforcement authorities, leaving the woman feeling more helpless and vulnerable.

# CLINICAL EVALUATION STRATEGIES

**An abusive act, whether verbal, physical, emotional or other, is rarely an isolated event. Violent behavior usually recurs and tends to increase in frequency and severity over time.**

**Although battered women often sustain life-threatening physical injuries, they may also suffer less obvious sequelae that are just as debilitating. In addition to physical trauma, battered women may present with a variety of other medical problems including chronic pain syndromes, post-traumatic stress disorder, anxiety, depression and alcoholism or other forms of substance abuse.**

## Interviewing Techniques

### Some Do's

All patients should be queried regularly about partner violence. Your patient should be interviewed in private, without her partner or children present. A history of previous trauma, chronic pain complaints, or psychological distress should be sought from direct history or from the medical record.

A single question, asked routinely and non-judgmentally in the course of the social history, can significantly increase the detection rate of partner violence in office practice and can allow your patient to feel safe in disclosing a history of abuse.

This sample question can be adapted as needed to individual practices:

“At any time, has a partner hit, kicked, or otherwise hurt or frightened you?”

Should your patient disclose that she has been battered, or if you suspect battering even in the absence of disclosure, the following specific

questions, asked in the setting of a safe and confidential environment, might help to determine the extent of abuse and the possible risk to your patient:

- How were you hurt?
- Has this happened before?
- When did it first happen?
- How badly have you been hurt in the past?
- Have you needed to go to an emergency room for treatment?
- Have you ever been threatened with a weapon, or has a weapon ever been used on you?
- Have the children ever seen you threatened or hurt?
- Have the children ever been threatened or hurt by your partner?

### Some Don'ts

As important as it is to ask the right questions of your patient, it is equally important to recognize and refrain from asking questions in a manner that might increase your patient's perceived level of danger, or increase her sense of humiliation and blame about the violence.

### Here are some pitfalls to avoid:

- Avoid using the words “domestic violence,” “abused,” or “battered” when speaking with the victim. (Most battered women do not identify themselves as battered per se because of the perception of shame and worthlessness associated with such a value-laden term.)

- Do not inquire about the violence in the presence of the partner or other family members.
- Do not break patient confidentiality by disclosing any information or discussing your concerns with the victim's partner.
- Never ask your patient what she did to bring on the violence.
- Do not ask your patient why she has not left her partner.
- Quite commonly, a woman may have left her batterer only to later return. If this is the case with your patient, avoid asking why she keeps returning to her batterer.
- Pregnant women with an injury, particularly to the abdomen or breasts.

Conduct a thorough medical examination and document your findings carefully in the medical record. You may wish to draw a picture free-hand, or include a labeled photograph to supplement your written description. It is important to describe the patient's symptoms and signs accurately and to indicate "domestic violence" or "partner violence" as a diagnosis or problem when appropriate.

**Documentation in the medical record can be a source of invaluable information to your patient should she ever seek legal redress from the batterer.**

## Physical Examination and Documentation in the Medical Record

Be highly suspicious of battering with these physical findings<sup>10</sup>:

- Any evidence of injury, especially to the face, torso, breasts or genitals;
- Bilateral or multiple injuries;
- Delay between onset of injury and arrival to hospital;
- Explanation by patient inconsistent with type of injury;
- Prior use of emergency services for trauma;
- Chronic pain symptoms where no etiology is apparent;
- Psychological distress (i.e. suicidal ideation, depression, anxiety and/or sleep disorders);
- Evidence of rape or sexual assault; and

## Risk Assessment

Once a woman has identified that she is currently in a threatening or violent relationship, it is the role of the physician to help her assess her level of risk, to initiate discussion of her need for a safety plan, and to refer her to appropriate services.

The most important determinants in assessing risk are the woman's level of fear and her appraisal of her immediate and future safety. However, since patients may minimize or deny the danger of their situations, the following indicators of escalating risk should be explored with the patient:

- An increase in the frequency or severity of assaults;
- Increasing or new threats of homicide or suicide by the partner; and
- The presence or availability of a firearm.

# INTERVENTION

## Intervention Strategies

The goal of intervention by the physician should be to communicate concern about the patient's safety and to provide her with a framework by which she can seek support to assure her own safety and that of her children.

Specific interventions by the physician should include:

- Reframing the violent behavior as unacceptable and criminal;
- Communicating concerns for her safety;
- Diagnosing, managing and referring as appropriate for treatment of specific injuries and medical sequelae related to ongoing or past victimization;
- Referring as appropriate for psychological counseling to experts in caring for victims of partner violence. (Local battered women's programs may be sources for referrals.);
- Discussing safer sex practices and protection against sexually transmitted diseases and pregnancy, especially for those women who have been raped or who have experienced coercive sexual activity as part of the violence;
- Avoiding, when possible, prescribing tranquilizers or other sedating psychoactive medications which could impair the victim's ability to respond appropriately should she need to flee; and
- There are no mandatory reporting requirements for incidents of domestic violence. There is a requirement to report suspected injuries caused by a gun, knife or other weapon.

## Mandated Reporting

### Child abuse/weapons

For children under the age of 18, a report must be filed with the local police department or Child Protective Services. Gunshot or knife wounds and other material injuries must be reported to police authorities.

When it is determined that a mandated report must be filed, a physician should make every effort, if appropriate, to explain to the patient the reasons for filing the report. Attempts should also be made to assist the patient in locating resources that will help to ensure her safety if there is a fear of retaliation by the perpetrator.

A physician who fails to make mandated reports may be subject to disciplinary action, fines and/or civil liability.

### Elder Abuse

A physician responsible for the care of an incapacitated or vulnerable adult, who has reasonable basis to believe abuse or neglect has occurred, shall report to a peace officer or protective services worker.

For those patients who are 60 years or older, reports may be filed with the Adult Protective Services at (602) 255-0996.

## Developing a Safety Plan

To develop a safety plan, your patient needs to assess her level of danger and the resources needed to flee suddenly. The plan should include both a place to go (friends, family or shelter), as well as other resources for daily living such as money, personal papers, car keys and a change of clothing for herself and her

children. Inform the patient that local battered women's programs provide free and confidential services, and that trained advocates from these programs can provide her with information regarding:

- Legal rights;
- Court procedures for protective orders;
- Shelter availability;
- Support groups; and
- Other support resources.

Encourage your patient to call a local hotline for further information. Stress that such a call in no way commits her to a course of action, but can better inform and empower her to make her own decisions. Quite often, the same information needs to be provided more than once. Your patient should be made to feel that she can turn to you, her physician, for assistance when she decides she is ready to take action.

**The Woman's Role**—to decide when it is safe to leave and when she has the economic and emotional resources and support to do so.

**The Physician's Role**—to provide the woman with options, support and information about resources.

Don't get angry or upset with a patient if she denies what is obviously abuse or if she fails to follow-up on your advice. Nationally, 75 percent of battered women first identified in a medical setting will go on to suffer repeated abuse. Just remember to remain supportive and hope that the next time she will take your advice.

**Remember, a woman who does not leave a dangerous or potentially dangerous relationship does not constitute a treatment failure or non-compliant patient, but usually reflects the limited resources available to battered women.**

## USING YOUR "RADAR"

The acronym "RADAR" summarizes action steps physicians should take in recognizing and treating victims of partner violence.

1. **Remember** to ask routinely about partner violence in your own practice. Assume at least a portion of your patients are experiencing spousal abuse and act accordingly.
2. **Ask** directly about violence with such questions as "At any time, has a partner hit, kicked or otherwise hurt, frightened, threatened or demeaned you?" This should be a routine part of taking a medical history.

3. **Document** your findings. Information about "suspected domestic violence" or "partner violence" in the patient's chart can serve a valuable function in court should the woman decide to seek legal redress. A physician's documentation validates the woman's position.

4. **Assess** your patient's safety. Is it safe for her to return home? Find out if any weapons are kept in the house, if the children are in danger, and if the violence is escalating.

5. **Review** options with your patient. Know about the types of referral options (e.g., shelters, support groups, legal advocates).

# LEGAL INFORMATION FOR HEALTH CARE PROVIDERS

**Although physicians are not directly involved in the legal procedures described, it is important to know of their existence and purpose. Your role is to be supportive and to refer the victim to assistance programs or shelters. (See page 14 of this guidebook.)**

**Documenting “domestic violence” or “partner violence” on your patient’s medical chart will strengthen the woman’s claim in a court of law.**

## Orders of Protection

Under ARS 13-3601, an order of protection can be applied for by visiting any court. A short application can be filled out and a judge will determine if there are grounds for an order to be granted. The relationship between the defendant and plaintiff must be one of:

- is married or formerly married
- resided together
- have a child in common
- one party is pregnant by the other party or other relationships
- is related to the defendant or the defendant’s spouse by blood as a parent, grandparent, child, grandchild, brother or sister or by marriage as a parent-in-law, grandparent-in-law, step-child, step-grand-child, brother-in-law or sister-in-law.

After Jan. 1, 1999 it will be valid up to 12 months. Other persons may be able to obtain an injunction against harassment. An emergency order of protection can be obtained after normal business hours, on weekends and holidays, by contacting local law enforcement.

- These orders can be obtained through Superior, Justice or Municipal Court. If the woman has filed for divorce, she must go through the Superior Court.
- The court may order the abuser to refrain from abusing, to have no contact with and/or to vacate the premises occupied by the person suffering from the abuse.
- The order may also cover other people who are at risk and other places frequented by the woman.

The person suffering from abuse can obtain an order of protection in two ways:

### 1. An Emergency Order of Protection

can be obtained if the court is not in session, including nights and weekends. This is obtained with the assistance of the police and the on-call judge. A regular order of protection must be obtained by the close of the next business day.

### 2. An Order of Protection

can be obtained by filing a complaint in the appropriate court and telling the judge about the actual or threatened abuse. The abuser may ask for a hearing, and if so, the woman will have to return to the court for the hearing. She can ask for police protection.

It is best if the woman does not go through the process alone, but rather be accompanied by an advocate from a local battered women’s program, from the court, or by a friend or trusted family member.

If the batterer violates any term of a restraining order, the police **must** arrest him if they have reason to believe he violated the order.

## Criminal Complaints

Most criminal complaints are initiated by the arrest of the batterer by the police. However, a woman can seek a criminal complaint on her own through the local police department. Advantages and disadvantages of criminal complaints and types of criminal charges follow:

### Advantages of a Criminal Complaint

Upon conviction, the batterer receives a criminal record. In addition, a criminal complaint sends a clear message to the batterer that battering is considered a serious crime for which criminal penalties, including fines and a jail sentence, may be imposed.

### Disadvantages of a Criminal Complaint

The woman does not control the processing of a criminal case. That is the job of the local prosecutorial agency. In addition, a criminal case can take a long time before it is resolved.

### Types of criminal charges:

- Violation of an Order of Protection
- Assault
- Assault with a deadly weapon

- Breaking and entering
- Disturbing the peace
- Criminal damage
- Trespassing
- Endangerment
- Threats or intimidation
- Sexual assaults
- Stalking
- Kidnapping
- Unlawful imprisonment
- Disorderly conduct

## Stalking Law

The stalking law states that any person who repeatedly seriously threatens, alarms or harasses another person and causes emotional distress is guilty of the crime of stalking (A.R.S. 13-29.21).

The purpose of the stalking law is to target for prosecution those persons who are “obsessed with their victims and who continue to harass them.”

The stalking law will not apply in every case when a restraining order has been violated, but will apply in those cases where the stalking or harassment is repeated and accompanied by a threat.

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# Arizona Shelters From Domestic Violence

Arizona Coalition Against Domestic Violence (ACADV)  
 (800) 782-6400 – (602) 279-2900 – (602) 279-2980-fax

Information/Referral Services/Phoenix/northern Arizona  
 (800) 352-3792 – (602) 263-8856

Information/Referral Services/Tucson/southern Arizona  
 (800) 362-3474 – (520) 881-1794

Arizona Attorney General's Office Victim/Witness Program  
 (800) 458-4911 – (602) 542-6454 (Maricopa County)

COUNTY	CITY	PROGRAM	PHONE
Apache	Chinle	ADABI	(520) 674-8314
Cochise	Douglas	House of Hope	(520) 364-2465
	Sierra Vista	Forgach House	(520) 458-9096
Coconino	Cottonwood	Verde Valley Sanctuary	(520) 634-2511
	Flagstaff	Northland Family Help Center	(520) 774-7353
	Page	Another Way	(520) 645-5300
Gila	Payson	Time Out, Inc.	(520) 472-8007
Graham	Safford	Mt. Graham Safe House	(520) 348-9104
Greenlee	* Morenci	Mt. Graham Safe House	(800) 786-7380
La Paz	Parker	Colorado River Reg. Crisis Shelter	(520) 669-0107
Maricopa	Chandler	My Sister's Place	(602) 821-1024
	Glendale	Faith House	(602) 939-6798
	Litchfield Park	New Life Shelter	(602) 935-9161
	Mesa	Prehab's Autumn House	(602) 835-5555
	Phoenix	Cassie's House	(602) 936-7446
	Phoenix	Chrysalis-Phoenix	(602) 944-4999
	+ Phoenix	DeColores	(602) 269-1515
	Phoenix	Dignity House	(602) 997-6105
	Phoenix	Sojourner	(602) 244-0089
Scottsdale	Chrysalis-Scottsdale	(602) 481-0402	
Mohave	Bullhead City	SafeHouse of BHC	(520) 763-7233
	Kingman	Kingman Aid for Abused People	(520) 753-4242
	Lake Havasu	Interagency Council	(520) 855-8877
Navajo	Kayenta	Tohdenasshai Shelter House	(520) 697-8591
	Pinetop	White Mountain Safe House	(800) 224-1315
	Winslow	Safe Haven	(520) 289-5500
Pima	Tucson	Brewster Center	(520) 746-1501
	Tucson	Tucson Center for Women & Children	(520) 795-4266 or (520) 795-4880
Pinal	Casa Grande	Against Abuse	(520) 836-0858
	Casa Grande	Behav. Health Agency of Central AZ	(520) 836-1688
Santa Cruz	Nogales	New Life Center @ Nogales Mission	(520) 287-5828
Yavapai	Prescott	Faith House	(520) 445-4673
Yuma	Yuma	Safe House Shelter	(520) 782-0077

\* Denotes Non-Residential Services

+ Denotes Bilingual Programs

## **END NOTES**

**Material in this guidebook has been adapted from existing reference sources including the American Medical Association's Diagnostic and Treatment Guidelines on Domestic Violence. Additional copies of this publication can be obtained by contacting:**

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