[Text on Screen] The Network for Continuing Medical Education policy requires that CME faculty disclose any significant relationship they may have with the manufacturer of any commercial product/service discussed in an educational presentation.
Dr. Howard A. Holtz has no such relationships
[Narrator] This is the Network for Continuing Medical Education.
[Text on Screen] NCME
[Images on Screen] Of Bonnie, Joanne and Renee
[Dr. Holtz] Bonnie is 33-years old. She presents with chronic and disabling fatigue, and a history of panic disorder. Joanne is 44. Her chief complaint is worsening headaches. Renee is 19. She is anxious and afraid. A former boyfriend has been stalking her on campus.
Each of these patients is a victim of domestic violence. Psychological or physical abuse that is directed against them in their homes or other places where they should feel safe, but don't. The medical consequences can be enormous, and for the victim the abuse can be life-threatening.
[Emergency siren and image of Saint Barnabas Paramedics vehicle]
[Image on Screen] Of a Saint Barnabas Health Care System in Livingston, NJ]
[Image on Screen] Of Saint Barnabas Health Care System.
[Text on screen] Adult Medical Day Care Center, Ashbrook Nursing Home, Atlantic Artificial Kidney Center, Colts Neck Primary Care Center, Community Connection & Genesis House, Community Health Complex, Community Medical Associates, Community Medical Center, Cornell Hall Nursing & Rehabilitation Center, Country Manor at Dover, Family Health Center, Family Health Care Center, Family Health Connection, Farmingdale Primary Care Center, Greenbrook Manor, Irvington General Hospital, Joslin Center for Diabetes at Saint Barnabas-Livingston
[Text on Screen] Domestic Violence: Recognizing and Treating the Abused Patient]
[Narrator] From the Saint Barnabas Medical Center in Livingston, New Jersey, the flagship institution in the Saint Barnabas Healthcare System which comprises 10 medical centers in New Jersey, this is Domestic Violence: Recognizing and Treating the Abused Patient, presented by Dr. Howard A. Holtz, Associate Chairman of the Department of Medicine at the Saint Barnabas Medical Center, and Associate Clinical Professor of Medicine at the University of Medicine and Dentistry of New Jersey.
[Text on Screen] Howard A. Holtz, M.D., F.A.C.P., Associate Chairman, Department of Medicine, Saint Barnabas Medical Center, Livingston, New Jersey
[Images on Screen] Of doctors assisting patients
This program addresses the prevalence and forms of domestic violence in the United States, and discusses how best to identify and manage patients.
Emphasis is given to prompt and accurate diagnosis and treatment based on the latest assessment and management tools.
[Image on Screen] Of doctor taking pictures with a Polaroid camera
After completing this telecourse, participating physicians should be able to discuss the latest information regarding the prevalence of domestic violence with special attention to the epidemiology of partner abuse; identify key characteristics of the victim of domestic abuse, and determine the level and severity of immediate danger to the patient; document and validate the patient's experience in a nonjudgmental manner, and institute appropriate medical and psycho social treatment; briefly discuss mandatory reporting laws for domestic violence as they apply to physicians, nurses, and other healthcare professionals; identify appropriate community resources for referral, and discuss when to refer the patient.

And now, Dr. Howard A. Holtz.
[Dr. Holtz] Hello. Today we're going to discuss domestic violence within the context of hypothetical patient cases drawn from very real situations. The face of domestic violence in the United States today is varied and complex.
[Image on Screen] People of different ages, races, and genders walking in the street.
The problem affects every socioeconomic group in every community in the nation. As physicians, we don't need to be experts in domestic violence to help these patients; however, there are many steps we can take to assist them.
Physicians are often in a key position to identify patients who are victims of domestic violence.
[Images on Screen] Nurses and doctors attending to patients.
Often they don't go to the police, but we know from the clinical literature that women who experience long-term domestic abuse tend to use the healthcare system frequently. That means that the offices, clinics, and medical centers where we work are an excellent, and often untapped, resource for identifying victims of domestic abuse.
Once these patients are identified, we can provide proper medical treatment, as needed. And we can refer patients to community agencies that are well-equipped to help victims of domestic abuse.
In the past, these patients have not been recognized in part because of a fear by clinicians that a Pandora's Box may be opened. There is no question that a team approach is needed to address these issues. Today there are hundreds of state and community agencies in the United States to help victims of domestic violence.
Physicians are encouraged to work closely with such agencies, and with professional groups like the AMA's Physicians Coalition Against Violence, and the American Medical Association Alliance.
[Text on Screen] Coalition Against Violence American Medical Association Alliance
The Coalition provides information through newsletters and other materials, and the Alliance provides assistance through its nationwide SAVE program, which stands for Stop America=s Violence Everywhere.
[Text on Screen] Stop America’s Violence Everywhere (SAVE)
You can find out more about these programs by contacting the AMA.
In just a moment, we'll talk about some of the major manifestations of domestic abuse, including signs and symptoms that may mask or accompany organic or psychiatric illnesses, but first a few words about the prevalence of domestic violence in the United States today.
[Text on Screen] U.S. Department of Justice: Latest data, August 1997, 17% were injured by a spouse, boyfriend or girlfriend….an estimated 243,000 individuals
We can draw upon various estimates of prevalence; for example, an August 1997 report from the U.S. Department of Justice. It's based on data collected in 1994, and it states that among the estimated 1.4 million patients treated for non-fatal injuries in emergency departments nationwide, roughly 17 percent were injured by a spouse or an ex-spouse, or by a current or former boyfriend or girlfriend. That's an estimated 243,000 thousand individuals a year, probably a low estimate. The great majority of these patients are women.
[Text on Screen] U.S. Department of Justice, Latest data, August 1997, 8% of other non fatal injuries seen in the ER, were caused by a parent or relative. 82,000 people sought treatment for other injuries of vague origin

In addition, 8 percent of other nonfatal injuries seen in the ER were caused by a parent, sibling, or other close relative. Also, 82,000 people sought treatment for injuries of vague origin, injuries that were probably caused by violence.
Various professional medical societies have also gathered data on domestic abuse in the United States.
[Text on Screen] Logo of the American Medical Association Alliance and underneath the text reads: 3 to 4 million are battered each year by husbands or partners.
According to estimates from the AMA Alliance, three to four million women are battered physically or psychologically each year by their partners. By contrast, it is believed that [Text on Screen] Logo of the American Medical Association Alliance and underneath the text reads: about 150,000 men are battered each year.
[Text on Screen] Logo of the American Medical Association Alliance and underneath the text reads: Domestic violence is the leading cause of injury to women aged 15 to 44,
and women are killed by their partners twice as often as women who are killed by strangers.
Medical expenses from domestic violence total more than $5 billion a year.
[Images on Screen] Of women seeking care in hospitals and doctor offices]
A woman is battered every 12 seconds in the United States. An estimated 35 percent of women who visit hospital emergency rooms have a history of domestic violence. An estimated 20 percent of women seen in primary care settings have experienced domestic abuse. That's one out of every five women who come into your office. Even if the abuse is no longer ongoing, the health effects of past abuse are often significant.
[Image on Screen] Of baby crawling, followed by a slide of a woman with her hand over her face in despair.
One-third of women who are victims of abuse in turn abuse their children. It is believed that many men who grew up in violent homes abuse others, usually women or children. Yet, often evidence of domestic abuse is not detected in the ER or the office. The signs may be masked, or the patient is afraid to disclose the problem. But most often it is because we don't ask.
It is possible to screen patients by asking a few questions during routine history taking.
[Dr. Holtz sitting and talking to a female patient.]
The questions I like to use are mostly common sense inquiries. I don't use the words "domestic violence victim," or "battered" when asking screening questions. Many women don't view themselves in that way. I prefer common sense, respectful questions that get to the heart of abusive relationships.
For example, what happens when you and your partner fight or disagree? Do these arguments ever get out of hand? Do you ever feel afraid of your partner? Do you feel you are on an equal footing with your partner in making decisions and resolving conflicts? You mentioned your partner uses alcohol; does he ever become violent when he is drinking or when he is on drugs?
If there is a physical injury I ask directly, "Did someone do this to you?" If a woman answers yes to one or more of those questions, and especially if she expresses concern about her safety, I assume she is experiencing domestic violence, and I ask more specific questions about abusive behaviors and incidents.
[Image of a nurse talking to a female patient.]
[Text on Screen] Detecting Partner Violence in the ER, Source – Feldhaus K et al: Jama 1997
Some clinicians use other screens. For example, the Partner Violence Screen, or PVS, that was developed by Dr. Kim Feldhaus and her colleagues at the University of Colorado. It includes the following questions: Have you been hit, kicked, or punched, or otherwise hurt by someone in the

last year? If so, by whom? Do you feel safe in your current relationship? Is there a partner from a previous relationship who is making you feel unsafe now?
Once sufficient evidence of domestic abuse is available, our primary concern is the immediate safety of the patient.
[Image on Screen] Of a woman sitting in a doctors office.
We deal with the concomitant medical problems, often alcohol or drug abuse, depression, acute or chronic anxiety, and conditions like diabetes, hypertension, or other illnesses, but it's important to keep in mind that the patient could well be at great risk for physical harm. Like the assessment of chest pain, we have to determine if it is safe for this patient to go home, and the patient has to believe we can and will help her.
[Narrator] And now Part 2 of Domestic Violence: Recognizing and Treating Abused Patients.
[Text on Screen] Domestic Violence: Recognizing and Treating abused Patients, Part 2
[Dr. Holtz] Like doctors everywhere, clinicians at our medical center are usually under great pressure to assess a potential case of domestic violence quickly and accurately. For that to occur, the patient must trust that she can speak honestly about the problem.
[Image on Screen] Dr. Holtz talking to a room full of his colleagues.
To ensure that the doctor becomes a source of support and information, and to ensure that trust is established with a patient, I encourage clinicians to keep in mind the ABCDEs of domestic violence.
[Dr. Holtz peaking to students]
So, you have to be very reassuring to the patient that you are going to protect the confidentiality. You never get on the phone and, you know, even if you know the husband or the partner as a patient and say, "Geez, you know, we've got a problem here. You know, your wife just told me that there's been some things going on in the home, and she's afraid." You can never do that because it may put her at a great risk.
[Text on Screen] Alone
"A" stands for alone. These patients are often isolated from friends and family by the abuser. Many times the clinician will be the first person the patient confides in. The secret has been carefully guarded for months or years, but in the safety of the doctor's office an admission is made that can change or save a patient's life.
It's the doctor's job to help break down the barrier of isolation. Statements like, "We see many women here with problems like yours. You are not alone," can be very reassuring to the patient.
[Text on Screen] Belief
"B" stands for belief: the clinician's belief in the worth and well-being of the patient. This is really the most important thing to convey to patients after you express concern for their safety. You are validating the fact that the abuse is a nightmare for the patient. Such nonjudgmental validation is key to gaining the patient's trust, and eventually moving her toward effective care. These patients' self-esteem can be quite low. Often, the batterer has berated them as a wife and mother, or as a sexual partner. It's important to acknowledge your belief that the abuse is not the patient's fault, and while every relationship presents conflicts and problems, domestic violence never helps and it is never justified.
[Image on Screen] Dr. Holtz talking to a female patient.
I advise clinicians to tell patients that domestic violence is a crime, and while you are not going to take the problem out of the patient's hands, you are going to do everything possible as an advocate to help ensure the patient's safety. It's very important to let patients know you are on their side.

[Text on Screen] Confidentiality
"C" stands for confidentiality. These cases require utmost attention to confidentiality. A victim of domestic abuse may fear you will call the police, or she may fear her children's father will be taken away. She may wish to protect her partner. Often he is a source of financial support, and she may describe him as a good father, although the abuse counters this perception.
Frequently she fears that greater violence will be directed toward her by the abuser if the secret has been revealed, and in this she is often right.
[Image on Screen] Of a police officer escourting a man out of his home.
Countless women have been injured or killed when their abusers find out they have taken steps to end the violence either by confiding in a physician, calling the police, or obtaining a restraining order. When we encourage women to take those steps, we have the responsibility to ensure they are accomplished safely.
Advise the patient that the information she has shared will remain in her medical files for her protection as documentation. It will not be shared with a husband or partner without her consent or permission.
[Text on Screen] Most states do not have mandatory reporting laws
Most states do not have mandatory reporting laws for domestic violence. Keep in mind, too, that many authorities believe mandatory reporting by healthcare professionals is a mistake, and may hinder the patient's trust and willingness to come forward.
Clearly, in such instances medical and legal issues can be involved.
[Dr. Holtz] Inspects the bruises on a woman’s arm.
If your state has a mandatory reporting law, you must advise your patient of this, while also encouraging her to report the abuse for her own protection.
[Images on Screen] Of woman shelters and the women who are in these shelters.
Personnel at your nearest domestic violence center or shelter for battered women can be very helpful in advising you how to best counsel patients in light of existing state laws.
Clinicians are encouraged to make use of those local resources, or you could write to the office of your state's Attorney General to inquire about laws that apply to domestic violence in your community.
[Text on Screen] Documentation
"D" is for documentation. Any indication of physical or psychological abuse should be entered in the patient's chart. Also note any previous contact by the patient with the police, or with an emergency department because of domestic violence.
If the patient mentions she is afraid of firearms in the house, write it down. If there is visual evidence of injury, get consent to take a picture before the patient leaves. If you expect bruises will be more visible in several days, schedule the patient for photographs later.
[Text on Screen] Education & Safety
"E" is for education, and "S" is for safety. Counseling patients about domestic violence may be as simple as giving them a card with the phone number and address of the local shelter for battered women, or giving patients the state's hotline number for domestic violence if there is no shelter in your community.
Sometimes you won't have the luxury of time to discuss the situation in detail or to educate patients and discuss safety issues. We can reschedule patients and ask them to return, just as we do when treating other problems that require more time to address.
[Text on Screen] Local Domestic Violence Hot Line Number

Find out if your state or community, or your local Coalition Against Violence has a local domestic violence hotline number that you can keep on file in your office. Nurses, nurse practitioners, and physician assistants often play a key role in educating and counseling domestic violence patients. We work closely with the nursing staff at Saint Barnabas Medical Center. They are an invaluable part of our team.
I have worked with nurse practitioner Kathy Furness for more than 15 years. She has been an advocate for battered women in New Jersey and throughout the United States.
[Ms. Furness] We have found that it's much easier to provide good healthcare for battered women after we learn about the history of abuse. If you don't have that information, you're dealing with a patient who is feeling awful, has a lot of symptoms, but you don't have one of the main keys to diagnosing the problem.
We want victims of domestic violence to leave here feeling safer than before they walked in and confided their problem to us.
[Patient speaking with nurse]
Usually that means counseling the patient as best we can within the time limits of the visit, and referring her to a social worker, or a local shelter for battered women.
Every state has an 800 number that patients can call for information about the nearest shelter. In our state, there are shelters in many major cities and in suburban areas, and in some rural areas. Similar facilities exist in all other states. These shelters are usually in safe neighborhoods, usually in unpublicized locations where the privacy and safety of residents is strictly maintained.
[Image on Screen] Of women of all races, ages, ethnicities walking in the street]
Women and their children have a safe place to live. Child support services are often available and psychological and job counseling is provided. Help is also provided in seeking new housing. Above all, the patient is sheltered from the stress of knowing that she could be badly hurt, or even killed by her partner.
[Dr. Holtz] And that, in turn, can lead to a significant decrease in the patient's anxiety, fatigue, depression, chronic pain, and other symptoms. Abused patients are typically controlled and dominated by the abuser. Those fearful dynamics can and do change, however, when patients receive proper care and counseling.
[Narrator] And now, Part 3 of Domestic Violence: Recognizing and Treating Abused Patients.[Text on Screen] Domestic Violence: Recognizing and Treating Abused Patients, Part 3
[Dr. Holtz] Research has not yet identified a profile of the typical battered woman. The problem is so common that any patient, particularly women, are potential victims. Certain groups of women appear to be at greater risk. They include women who are single, separated, or divorced, and women who are planning to divorce. Also included are women between the ages of 17 and 28, women who are pregnant, and women whose partners are excessively jealous or possessive. Also at greater risk are women whose partners abuse alcohol or other drugs, and women who themselves are substance abusers.
In addition, research in primary care settings by Dr. Jean Abbott at Johns Hopkins University, and by our team at Saint Barnabas, has found an increased risk for domestic violence in women with anxiety, depression, somatization, low self-esteem, or a history of using psychotropic medication. Substance abuse by the victim's partner is a good predictor of domestic violence. According to Dr. Daniel Brookoff and his colleagues at Methodist Hospital in Memphis, Substance abuse by husbands is one of the most powerful variables for discriminating between battered and nonbattered wives.” substance abuse by husbands is one of the most powerful variables for discriminating between battered and non-battered wives.

[Text on Screen] Characteristic of Participants in Domestic Violence, Source – Daniel Brookoof, MD, Ph. D et al: JAMA 1977
[Text on Screen] Characteristic of Participants in Domestic Violence, Source – Daniel Brookoof, MD, Ph. D et al: JAMA, “In 92 percent of the incidents that Dr. Brookoff and his team studied, the abuser reportedly used alcohol or drugs on the day the violence occurred.”
In 92 percent of the incidents that Dr. Brookoff and his team studied, the abuser reportedly used alcohol or drugs on the day the violence occurred.
[Image on Screen] Of a man and woman outside standing next to a car. The man is screaming at her.
Many experts believe that alcohol or drug abuse by someone predisposed to batter may facilitate and escalate domestic violence, but substance abuse by itself does not cause domestic violence. While domestic violence knows no socioeconomic barriers, women's perception of what constitutes abuse may vary depending on family and cultural background, level of education, economic status, and religious beliefs.
Any of the following can constitute domestic violence: pushing, shoving, slapping, punching, kicking, and choking that is intended to harm a partner. Often such violence escalates and it can include tying down or otherwise restraining a victim, leaving her in a dangerous setting, refusing to assist her when she is injured or ill, and assaulting her with a weapon.
Psychological abuse can be so persistent and longstanding that it can cause patients to be suicidal, and a good number of them are. Such abuse can take many forms and it includes repeatedly threatening to harm a partner; isolating her from family and friends; ignoring or humiliating her in public, falsely accusing her; and other actions that ultimately lead to a break in trust and intimacy.
Any attempt to force the partner to perform sexual acts against her will, or when she is not fully conscious, or any sexual involvement that injures or scares a partner, or places her at risk for a sexually transmitted disease is sexual abuse. Many of these patients are injured during pregnancy.
The evidence of domestic violence may be all too apparent in patients who present with obvious bruises, cuts, sprains, or fractures. In particular, trauma to the head, neck, chest, breast, abdomen, genital area or back: the places where their abusers most often strike.
[Doctor taking photos of a woman’s injuries along with images of the equipment used to take these photographs.]
In our emergency department and outpatient teaching practice we use a high definition Polaroid camera with sonar auto focus to document injuries caused by battering. Saint Barnabas Medical Center is the first hospital in New Jersey to employ this advanced technology. It's called the Injury Documentation Kit. We are currently purchasing these cameras for all the emergency departments in our healthcare system of 10 hospitals.
The Polaroid system produces instant color photographs that record subtle bruises and signs of physical abuse. In addition to providing precise diagnostic information, the photos constitute evidence for potential use by the patient in court.
[Images on Screen] Of a woman’s arm displaying her bruises]
In fact, the pictures are of such high quality that they can sometimes prevent costly litigation because the evidence they represent is so persuasive. When such evidence is present establishing the diagnosis is not difficult.

The greater challenge is to identify domestic abuse in a patient who at first appears to have a medical or psychiatric condition. Let's discuss the diagnosis and management of hidden domestic abuse within the context of three hypothetical cases that are based on very real life situations.
[Image of Bonnie walking down the hall of an office building]
[Narrator] The first vignette involves Bonnie, age 33, a medical assistant. Married for 15 years, she and her husband have two children ages 8 and 12. Bonnie presents with a complaint of extreme fatigue that has waxed and waned for several years, and intensified in the previous week. Her gynecologist referred her to Saint Barnabas Medical Center.
[Dr. Holtz] Has the fatigue interfered with your ability to do your work?
[Bonnie] Generally, it hasn't, but in the last week I've only worked two days because I've been so tired.
[Narrator] In asking about previous medical care, Dr. Holtz learns that Bonnie has experienced panic disorder.
[Dr. Holtz] Can you tell me about the panic disorder?
[Bonnie] It started about 8-years ago. I'd get the sharp attack of chest pains, my fingers would go numb, and I'd get very dizzy.
[Narrator] A full history of the present illness is obtained. It reveals that the fatigue is not related to the history or symptoms of panic disorder. There is no post-viral onset or post-exertional component to the fatigue. There is also no evidence that the fatigue is related to systemic illness, such as hypothyroidism, systemic Lupus infection, or hematologic disorders.
[Text on Screen]Past medical history reveals a laser treatment for a detached retina 8 years ago.
In addition to the panic disorder, the patient's medical history reveals a laser treatment for a detached retina 8-years ago. Dr. Holtz also learns that Bonnie does not have a problem with alcohol, but her husband does. Also, her husband loses his temper during arguments with Bonnie, and they argue often.
[Dr. Holtz] Are you afraid he may hurt you? Bonnie, I've seen many women in my practice who have been hurt by their partners. If that's happened to you, I promise it won't go any further than this room, but I think it's important that you talk to me about it.
[Narrator] Like many women who experience domestic abuse, Bonnie expresses fears. She doesn't want her husband to lose his job or get in trouble. Dr. Holtz patiently assures her that won't happen.
[Dr. Holtz] This isn't like child abuse where we have to report it to an agency. Has he ever hit you?
[Bonnie Shakes her head yes]
[Dr. Holtz] Tell me about the worst time, what happened?
[Bonnie] Well, the worst time was about 8-years ago. He beat me so badly that I didn't go to work for 10 days until the bruises were all gone.
[Dr. Holtz] In this case, the diagnosis of panic disorder and the detached retina were secondary to domestic violence that first occurred 8-years ago, and has continued periodically since then. While the patient does not view herself as a battered women, the history of persistent abuse clearly tells us that she is.
[Dr. Holtz] Converses with Bonnie.
As previously discussed, it is important to reassure the patient that she is not alone, and that you believe she is not the cause of the problem. Also, that confidentiality will be respected, but that it is necessary to document the evidence of abuse for her own protection.

Bonnie's chief complaint is fatigue, a disorder with an enormous differential diagnosis, but several minutes into a state-of-the-art social history, one which includes screening questions about domestic violence, the precise cause of Bonnie's fatigue is discovered. It is part of Bonnie's severe anxiety and depression related to her husband's escalating psychological abuse.
[Bonnie] Nothing I do is ever right. This is just how it was 8-year ago before he got very violent.
[Dr. Holtz] Expensive and unproductive diagnostic testing is avoided. Asking about domestic violence isn't opening a Pandora's Box, it is a quick, efficient way to make accurate, cost-effective diagnoses in many patients. And while many physicians may conclude that Bonnie's fatigue is related to stress or depression, they might not determine the underlying social etiology of domestic violence.
[Bonnie Sits down to talk with a specialist.]
A treatment plan of anxiety-reducing exercises or psychotropic medications alone would fail, and an opportunity to alleviate Bonnie's suffering, and perhaps save her life would be lost. After making the diagnosis, patient education and safety assessment are essential.
[Dr. Holtz] Do you think it's safe to go home?
[Bonnie] Yes. He's not at the boiling point yet.
[Dr. Holtz] The best assessment of safety comes from the patient who knows the abuser best. Other indicators of short-term risk to the patient include the following.
[Text on Screen] A List of Short Term Risks to the Patient
Does her partner own or have access to a firearm? Has he ever assaulted or threatened her with a weapon? Does he abuse alcohol or take drugs? Has he assaulted or threatened children or other members of the family, or pets? Is the abuser violent outside the home? Has the batterer threatened to commit suicide? Has there been abuse during pregnancy?
Although Bonnie does not appear to be at acute risk, she was severely assaulted in the past. Education and safety should include giving her the local domestic violence hotline number, reminding her she can call 911 if her safety is threatened, and reviewing a safety plan for getting away from the abuser.
[Dr. Holtz talks with Bonnie.]
An escape or safety plan anticipates the extra dangers women face when they try to leave an abusive relationships. A safety plan reviews how to be ready to leave at a moment's notice with car keys, money, and important documents. Educating a patient to plan for such a contingency is critical.
[Dr. Holtz] Do you have a relative to a friend that you could go to at any hour, if you felt in danger?
[Bonnie shakes her head no].
[Dr. Holtz] I like to refer the patient to a counselor at a domestic violence center directly from my office. A private room and a telephone is all that is needed to fulfill one of the most important responsibilities a physician has in caring for domestic violence victims, that is, serving as a link to community services. The counselor can also provide patient education, if the physician is short on time.[Bonnie Speaks with a counselor.]
[Text on Screen] List of what Domestic Violence Centers Provide
Domestic violence centers can also provide many other services to our patients. For example, legal assistance, including helping to obtain a restraining order; programs for batterers to learn nonviolent conflict resolution; programs for children who have witnessed domestic violence, information regarding emergency shelter or assistance in finding affordable housing; community education programs for healthcare professionals, hospital staff, schools and police; counseling

services; and 24-hour hotline numbers with information and referral to mental health services and substance abuse programs.
[Narrator] And now, Part 4 of Domestic Violence: Recognizing and Treating Abused Patients.
[Text on Screen] Domestic Violence: Recognizing and Treating Abused Patients, Part 4
[Dr. Holtz] Even routine medical problems can worsen in the context of domestic violence. Previously stable conditions such as hypertension, arthritis or diabetes may become uncontrolled as the next patient vignette illustrates.
[Joanne Walks into the building of her Dr's office.]
[Narrator] Joanne is 44. She presents with headaches that have worsened in intensity and frequency during the last six months. She's had similar headaches since she was a teenager usually around the time of her menstrual period. The headaches often respond to over-the-counter ibuprofen but recently they've become refractory to medication. The pain is described as throbbing or pulsating in nature.
[Dr. Holtz] Where do you experience the pain?
[Joanne] Here over my eyes and sometimes on the side of my head. I feel like vomiting when the headache gets this bad, but I usually don't.
[Narrator] She also reports that noise and bright lights make the headache worse. Also, just walking down a flight of steps. This headache has persisted for three days. Her periods are still the worst time for her headaches, but now she gets them between cycles, about two a week, and they don't completely resolve for a day and a half.
[Dr. Holtz] Is there anything in your diet like chocolate, or cheese, or alcoholic beverages that might be triggering your headaches?
[Joanne] I don't think so.
[Dr. Holtz] Do changes in the weather seem to bring on a headache?
[Joanne] No, I haven't noticed that.
[Dr. Holtz] Tell me about your sleep schedule. Has it been less regular in the last six months?
[Joanne] Oh, I would say yes. I've had a problem sleeping. I have trouble falling asleep at night, and I wake up sometimes at 4 a.m., and I can't get back to sleep. I have tried antihistamines. They usually make me drowsy. I started having a scotch before bed, but nothing really seems to help.
[Narrator] The patient has no aura or neurologic symptoms. Caffeine withdrawal does not appear to trigger the headaches. When asked if there's been an increase in stress in her life, she replies, "The usual." The patient meets the criterion for major depression.
In the social history, Dr. Holtz learns that Joanne has been divorced for two years, and she has custody of an 11-year old daughter. Her ex-husband lives in the same town and takes care of the child every third weekend. Joanne is not currently in a relationship, is not dating, and has been sexually inactive for two and a half years.
[Dr. Holtz] Does your ex-husband or any partner from a previous relationship make you feel unsafe?
[Joanne] Yeah, sometimes my ex.
[Dr. Holtz Examines Joanne's arm and looks at her bruises.]
[Narrator] The question brings tears and an admission of recurrent battering both before and after the divorce. The physical examination reveals fingerprint bruises on the arms.
[Dr. Holtz] This case shows us that we cannot think of domestic violence only in married couples or those in relationships. Remember being single, separated, or divorced increases the risk of domestic violence.

Joanne has a severe exacerbation of a chronic stable medical problem, migraine headaches. The trigger wasn't one of the conventional explanations such as dietary factors, oral contraceptives, or poor sleep habits. It was a specific common stressor called domestic violence, which has been the missing etiology of all of Joanne's medical problems.
Joanne's medical documentation reads: "Number one, exacerbation of common migraine" and, two, major depression with prominent sleep disturbance. Both problems are secondary to domestic violence perpetrated by her ex-husband."
[Image on Screen] Of bruises on Joanne's arm
A picture of the patient's bruises adds graphically to the medical record. Joanne's story also reveals another feature of domestic violence, the use of alcohol or other drugs to self-medicate. The need to numb, the need to sleep, the need to treat the depression or fear caused by violence is real. While Joanne is not yet alcohol-dependent, she is using alcohol to treat the sleep disturbance of depression. And if things continue as they are, Joanne is at high risk of becoming an alcoholic.
And what about Joanne's 11-year old daughter? Here is a vulnerable adolescent who has unsupervised visitation with a man who has been physically and sexually abusive to her mother. As an internist who treats adults, I have an obligation to explore potential abuse of my patient's children. It is also necessary for pediatricians and family practitioners who are typically very attuned to possible child abuse and neglect, to look for signs of adult domestic violence in parents.
[Joanne] My daughter is somewhat quiet when she comes back from a weekend with Stan, and her grades have really dropped this year.
[Narrator] These symptoms certainly don't mean that Joanne's daughter is being abused. They might be seen in any child who's lived through the trauma of parental violence and divorce, but Dr. Holtz and Joanne agree that the daughter will see a pediatrician who has specialized training in childhood sexual abuse.
Within the context of the ABCDEs discussed earlier, Joanne worked with a domestic counselor for six months. She was encouraged by the progress she was making with the counselor during her monthly visits, and symptomatic medications gradually were withdrawn as the headaches, sleep disturbance, and depression resolved.
[Joanne Sits down with an attorney.]
[Dr. Holtz] Joanne met with an attorney referred by the Domestic Violence Center. The attorney was given the medical records to review including the Polaroid photograph and careful documentation of the abuse history. The lawyer met with the ex-husband's attorney and informed him that this evidence would be turned over to the Domestic Violence Unit of the prosecutor's office if psychological and physical abuse did not end immediately.
[Joanne Walks out of Doctor's office building.]
One year later, Joanne feels safer and has occasional menstrual migraines that respond to over-the-counter ibuprofen. The pediatrician determined that Joanne's daughter was not physically or sexually abused, and she is doing better at school.
[Text on Screen] List of what patients living in an abusive relationship are at higher risk of
In patients like Joanne, the stress of living in an abusive relationship for years can lead to psychogenic pain, including signs of post-traumatic stress disorder. For example, dysfunctions in sleep and appetite, an inability to concentrate, sexual dysfunction, gastrointestinal disorders, dyspnea and paresthesia, atypical chest pain, dizziness and palpitations. These patients often rely

upon pain relievers and anti-anxiety medications, but get little or no long-term relief unless the domestic abuse is addressed.
[Text on Screen] List of what abused patients show a higher incidence of
An abused patient may first go to a gynecologist with a vaginal or urinary tract infection, dyspareunia, or pelvic pain.
[Text on Screen] List of what battered women have a higher incidence of poorly controlled
As we have discussed, battered women also are more likely to have poorly controlled chronic medical conditions, such as asthma, seizure disorders, diabetes, arthritis, hypertension, and heart disease.
The patient may feel ashamed and humiliated at the revelation of abuse, or she may think she somehow deserves what is happening to her. Often, she is unaware that her physical symptoms are caused by the stress of an abusive relationship.
Each of these perceptions must be addressed in counseling either by the physician or by the physician or by the counselors at a domestic violence center.
[Image on Screen] Domestic violence pamphlets.
Another effective intervention is to keep domestic violence literature in the office. Patient education pamphlets not only provide information, they let patients know this is a valid medical concern, and the staff is willing to help.
[Image on Screen] A women is in the bathroom and she takes a small palm card
We keep small palm cards with the state hotline number in the bathroom. Women can put these in their purse.
[Narrator] And now, Part 5 of Domestic Violence: Recognizing and Treating Abused Patients.
[Text on Screen] Domestic Violence: Recognizing and Treating Abused Patients, Part 5
[Dr. Holtz] Our final vignette takes a look at abuse directed toward teenage women. In this instance, a woman who is being stalked on campus. Here to discuss the case is registered nurse practitioner, Kathy Furness.
[Ms. Furness] Stalking is a very real form of domestic violence. It can be an extreme manifestation of the power and control an abuser attempts to exercise on his partner. Stalking behaviors can affect every aspect of a woman's life. It's an especially pernicious form of psychological abuse.
[Renee enters the elevator of the university medical center to see her doctor]
[Narrator] Renee is 19 and a junior in college. She visits the university medical center because she's lost more than 15 pounds in the past three months, and her mother has urged her to get a checkup. Careful history taking reveals no indication of alcohol or other drug abuse, no eating disorders, and an unproblematic sexual history. She's a B+ student.
Overall, her previous medical history is unremarkable. The history and physical do not suggest a medical diagnosis for the weight loss.
[Ms. Furness] Are you currently in a relationship or dating anyone?
[Renee] No, I can't see anyone now.
[Ms. Furness] You can't see anyone right now. Can you tell me about that?
[Renee] It's a bit complicated. I was in a relationship and he's very jealous, but I don't want my mom to know about this because her health is really poor, and she really didn't like Jim to begin with.
[Ms. Furness] Hm, well, we can talk about your mother in a little bit, but tell me more about Jim, first.
[Image on Screen] Renee is walking outside and Jim is following close behind her.

[Narrator] Renee went out with Jim for four months. They met at a party and started dating. At first, she was very happy. He would drive her to class, and send flowers every Friday, and he was very charming.
She took him to her mother's, but Renee's mom didn't like Jim and described him as too clingy. Renee's mother was right. Jim started talking about marriage and the family they would raise together. This made Renee feel very uncomfortable and pressured. She suggested that they date other people. Jim became very angry.
[Renee] He said, "I can't believe you would do this to me. I don't want to date anyone else, and I don't want you to, either."
[Image on screen] Jim followed Renee to her destination and they are sitting down talking. Jim is visibly angry.
[Narrator] At first, Renee felt guilty and agreed to an exclusive relationship. By their third month anniversary, Renee was feeling smothered. Finally, she broke it off, but Jim didn't. He continues to follow her to class, and is waiting after class to see where she goes. The phone calls are nonstop. He has not physically abused her, but she feels he's controlling her life, and she feels scared when she's alone.
[Renee sits down with the nurse practitioner, Ms. Furness]
The nurse practitioner patiently counsels Renee that first of all, she is not alone. Many women encounter situations like this at some point, and she is not causing the problem.
After validating that the patient is undergoing great stress, the nurse completes her documentation of the evidence of psychological abuse. Immediate counseling is provided. The nurse practitioner discusses disclosing the problem to Renee's mother.
[Ms. Furness] Sometimes in situations like this, mothers can be very helpful rather than I told you so kind of people. I think maybe we need to think about how we could use her help and support through this.
[Narrator] Renee decides to inform her mother. The nurse practitioner reviews a safety plan with Renee, which includes having friends accompany her to classes and work. A team meeting is arranged with a domestic violence counselor, a representative from the Dean of Students office, campus police, and Renee's Residence Hall Advisor.
[Ms. Furness and and the domestic violence counselor are talking]
The nurse and the domestic violence counselor have worked closely to educate university officials about the seriousness of situations like these. They are all acutely aware of a domestic violence stalking crisis at a nearby college the previous year, a young woman was murdered, and the young man who was stalking her committed suicide.
Renee obtains a restraining order under the stalking provision of the New Jersey Prevention of Domestic Violence Act, but strict security precautions are followed since it's uncertain how Jim will react to the restraining order.
[Ms. Furness] Renee moves from the dorm to a relative's home off campus, a place that Jim doesn't know about. Renee also does her course work at home, not in the library. Two days after the restraining order is issued, Jim looks for Renee at her mother's house, but is arrested for violating the provisions of the restraining order. Jail does seem to have a sobering effect on Jim's obsession, and as part of his plea bargain he agrees to mandatory counseling.
[Renee is leaving the doctor’s office, she is on the elevator]
This case illustrates the destructive nature of psychological abuse even when no physical injuries have occurred. The real possibility that physical harm could be inflicted on the patient can create unmanageable stress.

[Image of Jim walking outside]
Stalking is a destructive form of harassment. Encourage patients to get the counseling help they need, and help from law enforcement officials, if necessary.
[Text on Screen] Domestic Violence: Recognizing and Treating Abused Patients, Conclusion
[Narrator] And now here again is Dr. Howard Holtz, with the conclusion of Domestic Violence: Recognizing and Treating Abused Patients.
[Dr. Holtz] Today we have discussed some of the major epidemiologic and clinical facts about domestic violence in the United States. We have looked at common sense medical and community approaches to dealing with the problem. It's clear that as physicians we must plan now to meet patient needs in this area.
[Image of a woman crying while her abuser is being escorted out of the house by a police officer]
Domestic violence is a human rights issue in this nation, and a problem of epidemic proportions. Dr. Ann Flitcraft states that in the United States, domestic violence is a major cause of injury, disability, homicide, homelessness, addiction, attempted suicide, and child abuse. And she points out that the problem requires interdisciplinary solutions from professionals in health care, law, and law enforcement, and the social sciences.
[Image on Screen] A woman crying while her abuser is being escorted out of the house by a police officer]
Most often, abused patients are women, but men are also battered, and they may need medical help and counseling, too.
[Image on Screen] A man and woman standing outside next to a vehicle. The man is screaming at the woman]
Abuse occurs in heterosexual and homosexual relationships. Wherever it occurs, physicians may be the only link to helping resources in the community. [Text on Screen] ABCDE’s of Domestic Violence (Alone, Belief, Confidentiality, Documentation, Education and Safety
By keeping in mind the ABCDEs of domestic violence, we can identify and assist many patients who might otherwise not receive help. If we are not identifying these patients regularly, we are missing the problem. When we identify and assist these patients, we are helping to reduce a growing threat to the welfare of families and communities across the nation.
[Text on Screen] Information about how physicians can help to reduce domestic violence in the U.S. contact info.
[Narrator] For more information about how physicians can help to reduce domestic violence in the United States, contact SAVE, Stop America's Violence Everywhere, at the American Medical Association Alliance, Inc., 515 North State Street, Chicago, Illinois 60610, or phone the AMA Alliance at (312)464-4470. Ask for the AMA's Diagnostic and Treatment Guidelines on domestic violence.
Other good sources of information about domestic violence include the American College of Obstetricians, 409 12th Street, N.W., Washington, D.C. 20024-2188. Phone ACOG at (202)863-2518 and ask for their Technical Bulletin and Patient Education Pamphlet on Domestic Violence.
Physicians are also advised to contact the Family Violence Prevention Fund. You can reach them at (415)821-4553. And the National Woman Abuse Prevention Center, they can be reached at (202)857-0216.
[Dr. Holtz] In summary, the great majority of domestic violence in the United States is directed at women. A woman is battered every 12 seconds in this country.
[Images on Screen] Of doctors and nurses caring for battered women in the hospital]

An estimated 35 percent of women who visit hospital emergency rooms have experienced domestic violence at some point in their lives. The same is true for an estimated 20 percent of women seen in primary care settings. One out of 20 women seen in primary care practice have been victims of domestic violence within the previous 12 months.
We physicians represent a vast and largely untapped resource when it comes to addressing this problem. By remembering to ask about domestic violence and by using the skills you've learned today, you can diagnose domestic violence and its myriad medical presentations.
[Narrator] Now the post-telecourse quiz. Please mark your answers in the NCME Physician Participation Record. A key to the correct answers will follow the CME credit information at the end of the program.
According to an August 1997 report from the U.S. Department of Justice, Bureau of Justice Statistics, of the estimated 1.4 million patients treated for non-fatal injuries in emergency departments nationwide in 1994, roughly 17 percent were injured by a spouse or ex-spouse. True or false?
According to the American Medical Association Alliance, in the United States domestic violence is the leading cause of injury to women aged 15 to 44 and women are killed by their partners twice as often as women who are killed by strangers. True or false?
As discussed in the program, an estimated 10 to 15 percent of women seen in primary care settings have experienced domestic violence at some point in their lives. True or false?
The following represent the ABCDEs of domestic violence. Patients are often alone and isolated from the help of friends and family. Key elements in aiding these patients include the clinician's belief in the patient's worth. Confidentiality and documentation of any signs of domestic violence. Education for patient safety is vital to the care of domestic violence patients. True or false?
Each of the following groups of women are thought to be at higher risk for domestic violence. Women who (a) are married; (b) have a history of depression or anxiety; (c) have an income near or below the official poverty level; (d) are between the ages of 35 and 45. True or false?
Recent research confirms that substance abuse by a victim's partner is one of the most important predictors and facilitators of domestic violence. True or false?
Each of the following groups of women are thought to be at higher risk for domestic violence. Women who (a) are single, separated, or divorced; (b) are between the ages of 17 and 28; (c) are pregnant; (d) have a history of anxiety disorder or depression; and (e) live with someone who abuses drugs or alcohol. True or false?
Alcohol and drug abuse are thought to be a main cause of domestic violence. Is that true or false?
Women's perceptions of what constitutes domestic violence usually do not vary due to differences in women's economic status. True or false?
In an at-risk patient or in any woman, the following may constitute physical evidence of unreported domestic violence; trauma to the head, neck, chest, breasts, abdomen, genital area, or back. True or false?
[Text on Screen] Domestic Violence: Recognizing and Treating Abused Patients
This has been Domestic Violence: Recognizing and Treating Abused Patients.
[Text on Screen] Picture of Dr. Howard Holtz MD, F.A.C.P. and a list of his credentials
Our presenting physician is Dr. Howard A. Holtz, Associate Chairman of the Department of Medicine at the Saint Barnabas Medical Center in Livingston, New Jersey, and Associate Clinical Professor of Medicine at the University of Medicine and Dentistry of New Jersey in Newark.

[Text on Screen] NCME Accreditation Council for Continuing Medical Education
The Network for Continuing Medical Education is accredited by the Accreditation Council for Continuing Medical Education. The Network for Continuing Medical Education designates this educational activity for up to two hours in Category 1 credit toward the AMA's Physician Recognition Award. Each physician should claim only those hours of credit that he or she actually spent in the educational activity.
NCME Up to 2 Credit Hours AMA Category 1
NCME See Physician's Guide for Credit Information Learning Objectives Instructions
Please consult the accompanying NCME printed material for credit information and instructions for completing this telecourse.
[Text on Screen] Quiz Answer Key Sheet

This is the Network for Continuing Medical Education