FLEX CEUs

Domestic Violence - Role of the Physical Therapist

Introduction

Domestic violence is a global health problem that affects nearly ten million people per year in the United States alone. One in four women and fourteen percent of men in their lifetime experience severe domestic violence with their partner. Domestic violence can be in the forms of psychological, emotional, physical, and sexual abuse, and stalking. It affects diverse populations including all races and ethnicities, genders, socioeconomic classes, and religions. Healthcare providers have a critical role in the identification and response of cases of domestic violence. Victims of domestic violence seek healthcare for general health and injuries just as the rest of the population, and each interaction is an opportunity for a healthcare provider to screen for domestic violence. Physical therapists and other rehabilitation professionals have a responsibility to detect and assist patients who are victims of domestic violence. This course will overview types and examples of domestic violence, identification strategies, how to assist victims, what policies exist on domestic violence, and what resources are available to both healthcare providers and victims of domestic violence.

Background [1,2]

Domestic violence is also known as intimate partner violence (IPV) and refers to psychological, sexual, and/or physical abuse by one partner on another. Domestic violence occurs at an alarming rate across the USA and the world. Intimate partner violence can affect anyone in a relationship and any children of the partners. It is estimated that domestic violence costs around twelve billion dollars every year and is anticipated to keep rising. Domestic violence cases are likely underreported as well. As crucial healthcare team members, physical therapists and other rehabilitation professionals should understand what groups of people are at a higher risk for domestic violence, how common IPV is, and how serious the consequences are.

What is Domestic Violence? [1]

Domestic violence, or intimate-partner violence, refer to the abuse (physical, emotional, or sexual) from one partner to another in a relationship. This can occur between partners in current or past relationships, and who are married or unmarried. There are four types of intimate partner violence which include physical abuse, psychological abuse, sexual abuse, and stalking.

Physical Abuse

Physical abuse is the purposeful harm to someone that is meant to cause injury. Common forms are choking, pushing, punching, restraining, and forcing the use of drugs.

Psychological Abuse

Psychological domestic abuse is the most common form of domestic violence. Psychological IPV has been difficult to define but is generally accepted as psychological aggression and coercion. Aggression includes degrading someone and typically shouting, and coercion involves threatening and forcing a partner to act a certain way. Psychological violence includes humiliating and intimidating a partner with threats like taking things or people away from the victim that matter to them.

Domestic abusers may shame, blame, criticize, guilt, humiliate, ridicule, dismiss, accuse, neglect, monitor, and verbally berate their victim. Ridiculing involves calling a victim names and using sarcasm to make them feel unimportant. Dismissing refers to making a victim feel unimportant by continually getting told ideas or beliefs are unimportant or valueless. Monitoring means the abuser shadows and monitors messages, calls, and physical whereabouts of their victim.

Sexual Abuse

Sexual abuse is any type of undesired sexual contact. If a victim does not give consent, it is considered sexual abuse. This includes unwanted intercourse, attempted intercourse, kissing, touching, and any accompanying violence.

Stalking

Stalking is the act of following, harassing, or inducing fear in a victim. It involves proximity, unwanted communication, and threats and is repeated at least two times to be considered stalking. Estranged, divorced, or separated former partners may engage in this in an attempt to gain control over their victim.

Financial Abuse

Financial abuse occurs when someone prevents their partner from using financial resources. Signs of financial abuse are having all bills and assets under a partner's name, not allowing a partner to work, having an allowance, or a partner using the other

partner's name on documents without permission. A partner may steal from the other, withhold money and prevent the other from accessing finances.

History of Domestic Violence [3,4]

Domestic violence or intimate partner violence has been commonplace since 753BC when the Roman Empire was founded. Wife beating was made legal under the Laws of Chastisement, which declared that a husband was the head of a household and could punish his wife as long as there was no lasting injury. This is also known as corporal punishment in the home and was commonplace throughout the world. The Roman Catholic religion until past the fourteenth century encouraged beating wives. The belief was that husbands needed to beat wives to enhance spiritual wellness. At this time, husbands were discouraged from using any object with a wider width than the man's thumb. This was called the "Rule of Thumb". In 1824, the Mississippi Supreme Court referencing the Rule of Thumb extended a right for men to beat wives with "moderate" chastisement. This case was called Bradley v. State and it set a precedent for other states to follow for nearly fifty years. The United Kingdom made corporal punishment illegal in 1891 and the United States made it illegal in the 1870s. Bradley v. State was overturned in 1871. These Laws of Chastisement were in place so husbands could keep their wives completing their expected duties within the home.

In the early 1900s, wife beating became a cornerstone topic discussing the women's suffragist movement. Although domestic violence against wives was illegal in the early 1900s, local and state legislature and judicial systems made it difficult to enforce. Instead of arresting men, the judicial systems of states would often advise battered women to file for divorce with allegations of cruelty and sue their husbands for assault. This would rarely get the woman out of their abusive situation and often create a more dangerous situation at home if they spoke up. In addition, the woman would often have to demonstrate that her life is in immediate danger for the court to intervene. As the mindset around the right for men to beat their wives shifted at the turn of the 20th century, divorce and domestic violence judges began distributing punishments but not arrests against male perpetrators. In cases where the abuse was reversed (wives beating husbands), wives rarely got punished at all. In the mid-1900s, many states transferred jurisdiction of court from criminal to family court to handle cases of domestic violence. This made it incredibly difficult for any abusers to face criminal charges. In 1972, an emergency rape crisis line began operating out of Washington D.C. and states began to open organizations to help victims of domestic violence. An example of this is the Abused Women's Aid in Crisis founded in 1975 in New York. This organization still exists

and created a network of shelters for women to seek refuge from their abusers. By 1983, over 700 shelters for victims of domestic violence (typically women and children) were operational in the United States, helping 222 thousand victims per year. Groups for women's rights fought to make marital rape illegal as well, and this happened across every state in 1993. Also, in 1993 the United Nations adopted the Declaration on the Elimination of Violence Against Women. This was the first international agreement to address domestic violence against women by creating a blueprint for action. In 1994 the Violence Against Women Act (VAWA) was enacted which stated that domestic violence and sexual assault were crimes. It also created funding for reducing violence. In 2000, the Sexual Assault Reform Act passed which restricted where people who committed sexual assault could live and stated that a sex offense was an act or an attempt of an act of sexual abuse. Sex offenders were no longer allowed to live or even enter an area that is less than one thousand feet from a school. In 2005 and 2019 VAWA was reauthorized and in 2019 it prevented any former partner who was found guilty of engaging in domestic violence from owning a firearm.

Domestic violence is rooted in religious history and thought patterns around it have shifted only within the last couple hundred years. This is due to the nature of gray areas and indecision about criminally convicting perpetrators of domestic violence. It is now illegal in all 50 states, but this took advocacy from many groups to achieve and hundreds of years of a movement to shift. In many countries across the world, domestic violence is as commonplace or more prevalent than in the United States but legislation or the judicial systems are not in place to punish abusers. Globally, around one billion women live in countries that do not legally punish those who engage in domestic violence.

Child and Elder Abuse [2,5,6]

Children and elders are not immune to domestic violence. Child abuse involves neglect, sexual abuse, emotional abuse, or physical abuse of someone under eighteen years old. Elder abuse is intentional acts from a caregiver that either harms or risks harm to an elder. This can take place in the elder's home or the abuser's home. This almost always happens with a family member or friend.

Child Abuse

Child maltreatment includes abuse and neglect and is an action or failure to act that creates harm for the child. This harm includes physical, psychological, emotional, sexual abuse, or death. Child abuse takes place in around thirty to sixty percent of homes where spouse abuse takes place. Children in homes where spousal abuse takes place

also will witness and face the effects of that abuse. Children may be neglected when parents are more focused on their partner. Children who witness abuse but are not abused themselves will still likely face emotional consequences. Around sixteen million children per year in the United States are exposed to intimate partner violence. Younger children are the most vulnerable to maltreatment, as around thirty percent of victims are under age three. Around eighty percent of child abuse and neglect cases are by a parent(s). Around two-thirds of victims of child abuse or neglect receive child welfare services. Children in situations where they are experiencing or witnessing domestic violence have high rates of engaging in IPV as teenagers and adults. Children who have gone through abuse are nine times more likely to engage in criminal activity and violence. Healthcare providers need to notice and act on child abuse to help children into a safer environment.

Munchausen by Proxy

Caretakers may believe they know the best for children, but situations of neglect and abuse may arise. Munchausen by proxy is a mental illness of a parent or caretaker where they make up symptoms that their child is experiencing. They make up symptoms or actually cause symptoms by creating injury or harm. Munchausen is pretending that oneself has an illness. The psychological understanding of Munchausen or Munchhausen by proxy is to gain attention from others, whether it be from family, friends, or healthcare providers.

Elder Abuse

Elder abuse can take place anywhere an elder lives, whether in their children's home, assisted living, or their own home. Elders may be abused by anyone, including family, friends, and intimate partner violence. Elder abuse is taking advantage of an elder for financial gain, physically, sexually, or psychologically abusing them, or stalking. Elder abuse has elements of intimate partner violence, but it is slightly different. Anyone can commit elder abuse, but only intimate partners can commit IPV. Intimate partner violence in elder adults often is physical, financial, aggression, stalking, and more behaviors. This can occur at any stage in life, and with elder adults can be from a current or former spouse, a boyfriend/girlfriend, and anyone else who attempts to take advantage of them with a personal relationship. Fortunately, there are resources that will be discussed later in the course for providers to help identify and act when they discover intimate partner violence in their elderly patients.

Prevalence of Domestic Violence [2,7,8]

Many groups of people are at risk of domestic violence. It is estimated that ten million people in the USA per year experience domestic or family violence. These numbers, no matter the race, ethnicity, socioeconomic status, or age, are always higher among women. The highest age for risk includes eighteen to twenty-four. Intimate partner violence makes up fifteen percent of violent crime in the United States. Just thirty-four percent of victims of domestic violence seek out medical care. This section will detail by specific groups just how common domestic violence is.

Prevalence of Domestic Violence in Women

Around thirty-six percent of women are physically or sexually abused by a partner in their lifetime in the United States. Twenty five percent of women have experienced severe IPV, and thirty-three percent of women have been the victim of a type of physical violence including hitting, slapping, and pushing.

In the United Kingdom, over twenty-five percent of women endure IPV and nearly forty percent of women who are murdered are killed by their partners.

Many pregnant women are screened for signs of domestic violence at their prenatal visits. Upwards of three hundred thousand pregnant women each year are impacted by domestic violence. Pregnant women face rates of domestic violence at thirty percent emotional abuse, fifteen percent physical abuse, and eight percent sexual abuse. Along with domestic violence in pregnant women, the mother and fetus are at higher risk of addiction, mental health problems, and stress which all affect the baby and mother's health.

Prevalence of Domestic Violence in Men

About eleven percent of men have experienced a severe type of IPV with their partner. Around one fourth of men have been the victim of a type of physical violence by their partner including hitting, slapping, and pushing. Women are more likely than men to engage in psychological abuse towards their male partner. Around sixty percent of women admit they had been psychologically abusive to their male partner, with just fifty percent of males admitting so with their female partner.

Prevalence of IPV in Those who are Gay, Lesbian, Bisexual, and Transgender

Around one fourth of people in gay, lesbian, bisexual, and transgender couples have domestic violence in their relationship. Male same-sex couples have higher rates of IPV

than female same-sex couples. Female same-sex couples also have lower rates of domestic violence than heterosexual couples.

Prevalence of Stalking

Just over nineteen million women and five million men have been stalked in the USA. Sixty-one percent of women and forty-four percent of men that have been stalked were stalked by a current or past partner.

Prevalence of Rape

Twenty percent of women and less than a half a percent of men have been raped overall in their lives. Of these, around half were raped by an acquaintance or an intimate partner.

Prevalence of Psychological Violence

Psychological violence is the most common type of domestic violence. Around thirty-five percent of men and fifty percent of women are the victims of psychological abuse.

Children Exposure

Six percent of children observe or experience domestic violence. The majority of these children are witnesses to their guardians engaging in IPV. Around three million children are referred to child protective services annually due to domestic violence and child abuse situations. Men who are violent with their wives abuse their children at a rate of thirty to sixty percent of the time. In addition to this, around ninety percent of victims of IPV either neglect or abuse their children. Children who are exposed to domestic violence are at a high risk of having dating violence and struggle with intimate relationships.

Groups and Their Risk for IPV

Domestic violence does not discriminate based on age, socioeconomic status, race, or any other factors. However, there are some groups who have a higher statistical likelihood to experience domestic violence more than others.

People who have little education, are of socioeconomic status, same-sex couples, and minorities are the most susceptible to domestic violence.

Age [7]

People of the ages eighteen to twenty-four are the most likely to be abused by intimate partners. This is followed by teenagers who are from the age of eleven to seventeen. These numbers are the highest in young women and teenagers.

Education and Socioeconomic Status [2]

Women who earn under the poverty level and especially under ten thousand dollars annually have domestic violence occurrence of five times higher than women who earn more than thirty thousand per year. Women who are uneducated also tend to engage in riskier behaviors. It is likely that women who are poor and uneducated experienced this from a young age, such as growing up in a violent neighborhood with a lot of crime. Children who are poor often do not have access to good medical care as well, making it unlikely to seek this out as an adult. Generally, women who earn less money have less financial power within a partnership. Partners who engage in domestic abuse may exploit this disadvantage and use it to create a power dynamic with the woman.

Minorities [9]

Nonwhite citizens in the United States are more likely than white citizens to experience domestic violence. Exact numbers are not available for rates of how much higher the risk is, but it is estimated that around forty percent of Black women, American Indian, Alaskan Native, and multi-racial women experience physical or sexual domestic violence in a lifetime. Black citizens are the most likely to experience domestic violence, followed by Hispanic citizens, then white citizens. Asian Americans are the least likely to engage in IPV.

Same-Sex Couples

Domestic violence in same-sex, gay, lesbian, bisexual, and transgender couples have similar rates of domestic violence as women who are heterosexual. This is a rate of around one quarter of couples.

Wives to Husbands

Although less talked about, domestic violence does happen from wives to husbands. There are not exact numbers available on the prevalence, but providers should know this does exist in many relationships. Due to societal shame and a culture of men expected to show strength, many men do not report their abusive wives. Abusive wives often use emotional and psychological threats and abusive language to control their husbands. In addition to that, physical abuse is also common, but physical injury is typically less severe than male to female abuse.

Risk Factors

There are a few considerations that put people more at risk for domestic violence than their peers. If a child is abused or witnessed domestic abuse as a child, he or she is more likely to view violence as a way to manage conflict with intimate partners. They may also learn violent strategies from culture or observing people in their community. People who become domestic abusers typically have low self-esteem, controlling behavior, dependence on their partner, jealousy, and drinking or drug habits.

Children who experience domestic abuse grow to become adults who become the victims of IPV much more frequently than those who were not victimized as children. In men who were abused as children, they are more likely to develop antisocial personality disorder. Women who were abused as children are more likely to develop antisocial personality disorder, alcohol abuse, and hostility.

In addition, people with mental health problems themselves, attention deficit disorder, aggression, and poor behavioral control are at more risk of abusing intimate partners.

It is known that all ages and genders are equally as likely to engage in domestic violence with their partner. Women are actually slightly more likely to engage in physical and psychological violence towards their partner than men. This is a lesser-known fact because the majority of people injured by known domestic violence are women.

Homicide [10]

Unfortunately, many cases of domestic violence end in murder. There are proportions of those who are victims of murder that depend on several factors such as gender, age, and race. The proportions of those murdered vary slightly from those who are victims of domestic violence of any type.

Gender

The most common group of people who die by homicide are females. Around three-quarters of murder-suicides occur between intimate partners. The majority (ninety-four percent) of the victims of murder suicides are women. Around ninety percent of murderers are male, as around eighty percent of family murderers and ninety-three percent of nonfamily murderers are male.

Age

Age does play a role in domestic violence murder rates. Around thirteen percent of victims of domestic murder are children. About one-quarter of victims are eighteen to twenty-four and another one-quarter of victims are from twenty-five to thirty-four. About thirty percent of victims are from the ages of thirty-five to fifty-four and ten percent of victims are fifty-five or older.

For those under the age of thirteen, two thirds were killed by a family member out of total children killed.

Race

Murders as a result of domestic violence also vary by race. Overall, whites are less likely than blacks to be victims of domestic violent murder. Although blacks make up around thirteen percent of the population, they represent forty percent of murder victims while whites represent eighty percent of the population and make up fifty six percent of those murdered. With respect to children who are married by parents, around sixty percent are white, thirty-five percent are black and about four percent are Asian. In spouse murders around seventy percent are white, twenty-four percent are black, and six percent are Asian. These numbers are skewed because white people make up the majority of the population.

Section 1 Key Words

Bradley v. State – Mississippi ruling in 1824 that supported moderate chastisement of husbands to wives

Laws of Chastisement – Anglo-American law that a husband is able to and encouraged to use corporal punishment to his wife to the point of permanent injuries

Munchausen by Proxy – A mental illness of a caregiver faking or causing real symptoms to a child to cause the child sickness

Section 1 Summary

It is clear that domestic violence and intimate partner violence are prolific in the United States. As noted in this section, IPV happens regardless of race, socioeconomic status, disability, age, and other factors. Domestic violence dates back hundreds to thousands of years based on the ideals of corporal punishment from husbands to wives. Legislation to protect United States citizens has only existed for decades. Many other countries do not have such legislation, leaving domestic violence a global health crisis. It is imperative

for physical therapists to understand the prevalence and history of domestic violence to be aware of the impact and ultimately how to respond when they detect IPV in their patients.

The Impact of Domestic Violence

Domestic violence is widespread affecting somewhere around one fourth to one third of people in the United States. It has many physical and psychological consequences which can affect victims for life. It is important for all healthcare providers to be aware of the impact of domestic violence so they can take steps to detect domestic violence.

The Motive Behind Domestic Abuse [2]

People who abuse their intimate partners or family have typically psychological reasons for doing so. Domestic abusers typically are craving control when they abuse their partner. People who abuse may have experienced domestic abuse themselves, witnessed it as a child, or have a belief that they should be dominant. People who abuse may have problems regulating anger, experienced high levels of jealousy, have low self-esteem, have personality or mental health disorders, or a belief system (typically religious) that gives them permission to control those around them. Abusers may also be under the influence of drugs or alcohol.

Physical Signs of Domestic Violence [11]

Victims of domestic violence will have several signs that reveal they have gone through domestic abuse. The biggest physical signs involve things like fractures, open wounds, bruising in specific places, marks on the neck, sprained wrists, broken lips, and black eyes. Suspicious bruising may be noted on arms or wrists and victims often attempt to hide their bruising. This means they may wear long shirts, scarves, or long pants in the summer. Patients may also try to hide their wounds with heavy makeup or sunglasses.

Caregivers of people who have been abused may refuse to allow a patient to be seen alone. The victim may or may not report being abused. If they don't report it, the victim may have changes in body language such as slouching or cringing while discussing it. Victims may also have too much or too little of certain medications in their system.

Neglect is also a common effect of physical domestic violence. This typically happens with elders or children as victims. Neglect is considered abuse because victims do not have their physical and emotional needs met in a timely fashion. It can have long-lasting psychological and physical consequences. An example of neglect is when a child is not fed for a couple of days because caregivers/parents are busy with other things or not tending to the needs of a vulnerable child.

Physical Impact of Domestic Violence [12]

Domestic violence causes acute and chronic physical health problems. The severity depends on how long the abuse happened and the nature of the abuse. Many victims of physical violence experience sexual and psychological violence as well.

Short-Term Physical Health Impact

Victims may face several injuries that affect patients in the short term and heal with time or medical management. Victims may have injuries like broken bones and torn ligaments. Many of these injuries need examination by imaging and victims may not look outwardly like they are injured. Women who have suffered from sexual violence may experience sexually transmitted infections (STIs), undesired pregnancy, pain with sex, pelvic pain, bleeding, and urinary tract infections. STIs may be life-threatening, including human immunodeficiency virus (HIV) which becomes acquired immunodeficiency syndrome (AIDs). If treated early, HIV and AIDs can be managed, but if not detected, it is fatal. AIDs attacks the body's immune system, meaning victims suffer from an intense illness from infections like the flu and pneumonia.

In addition, it may be difficult to sleep which limits the process of healing. Victims will also experience acute pains from being battered which range from mild to severe. These pains can lead to long-term problems.

Long-Term Physical Health Impact

Acute health problems from domestic violence are very concerning and if not treated properly, can lead to chronic long-term health problems. Acute injuries can lead to chronic pain, especially low back, and neck pain. In addition, victims of physical domestic violence experience higher rates of arthritis than the general population. Many chronic conditions start with stress as a contributing factor. This includes chronic conditions like asthma, digestive problems like irritable bowel syndromes, migraines, and immune suppression. Victims of IPV tend to have weaker immune systems, making it more

difficult to fight infections, viruses, and bacteria. Women may experience chronic problems with sexual health, including reproductive problems, pain with sex, and chronic pelvic pain. Victims may have chronic sleep problems due to nightmares as well.

In severe cases of physical domestic violence, traumatic brain injury (TBI) is an unfortunate and serious complication. TBI can range from mild to severe cases. Mild TBIs are concussions and severe TBIs can leave victims in a coma or cause death. The main causes of TBI in domestic violence are striking victims in the head, pushing victims into things or down a flight of stairs, and causing victims to fall and hit their heads. Symptoms of mild TBI are headaches, confusion, dizziness/vertigo, nausea/vomiting, difficulty sleeping, and problems with concentration. In moderate or severe cases, a victim will likely lose consciousness, have slurred speech, have memory loss, or not be responsive. All TBIs should have immediate medical attention. The long-term effects of TBI in mild cases, or concussions, are memory loss, and difficulty with daily procedural tasks like carrying out plans. This perpetuates a cycle of abuse as a person with long-term effects of a concussion may not be able to process a plan for escaping or getting help. When medical providers screen their patients, it is imperative to screen for mild TBI especially if the professional detects memory loss, inconsistent stories, or signs of physical abuse.

Psychological Impact [12]

People who endure emotional and psychological abuse may demonstrate specific signs as well. People may be agitated easily, withdrawn, have low energy, avoid eye contact, or act nervously. Victims of severe psychological abuse may even begin rocking, biting, or sucking as observed in people with dementia as an attempt to self-soothe. People who endure psychological domestic violence will likely have prolonged fear, codependence on their abuser, shame, low self-esteem, social withdrawal from others, and a loss of personal identity. These things will in turn give more power to the abuser as their victim continues to be silenced and isolated.

In addition to these factors, victims may suffer a cycle of seeking risky behaviors. This means that victims have high rates of things like abusing alcohol, abusing drugs, and rates of unsafe sex. Victims of sexual abuse are also more prone to mental health disorders like depression, anxiety, eating disorders, and post-traumatic stress disorder. Being abused can alter one's sense of self, predisposing victims to mental illness.

Section 2 Key Words

Neglect – A form of domestic abuse to either elders or children where physical, psychological, and emotional needs are unmet by the caregiver(s)

Traumatic Brain Injury (TBI) – a brain injury from trauma to the head and brain which ranges from mild to severe

Section 2 Summary

Victims of IPV suffer physical and psychological wounds which may last months to years. Victims may face just about any type of physical injury, ranging from mild injuries to severe ones, such as fractures and traumatic brain injuries. A strong motive behind abusers is being abused themselves as a child or in a past relationship and continuing the cycle with their new partner. Victims may suffer long-term psychological problems such as anxiety and depression, and sexual health problems as well, such as unwanted pregnancies and STIs. Physical therapists and other healthcare providers need to be aware of the impact of domestic abuse, so they know the urgency in which to help their patients out of these situations.

Physical Therapist Identification and Response

Every healthcare professional who provides direct patient care is important in the detection and response of victims of domestic violence. Providers are in a unique position to spend time with potential victims outside of their place of abuse, which may give victims more courage to speak out against their abuser. It is crucial for physical therapists, other rehabilitation professionals, and clinicians to know how to screen for domestic violence in all patients.

Screening for Domestic Violence [13]

It may be unnatural to bring up screening questions for domestic violence to all patients. Healthcare professionals should look at screening for domestic violence as they would screen for other aspects of health, such as asking general questions about family history, alcohol habits, and smoking status. A screen is meant to pick up on one's specific risk factors. If a person does not indicate that anything is wrong with their home life, it is likely unnecessary to dive deeper. However, if bringing up the subject of domestic

violence creates any changes in body language, avoidance of answers, or odd behavior, it may indicate a further screen. Providers should be aware that victims of abuse are likely very good at hiding it. This means a single approach for screening and identification will not work the same for every patient. A provider should have a couple of different strategies in mind for bringing up abuse.

The Necessity of Interpreters

With any patient, it is important to have a professional interpreter who agrees not to summarize but speaks the direct translation whenever a provider is not fluent in a patient's language. If a patient's family or friend offers to translate into their language, they could be misleading the patient by leaving certain parts out of the provider's questions or explanations. Further, this translator could be a person conducting domestic abuse against the patient and would therefore hide any information from both the patient and provider that makes them as the abuser look suspicious. Clinics should have access to a video or telephone interpreter and only provide healthcare services in the patient's language.

Intake Forms and Subjective History

First of all, intake forms and/or subjective history should include a general first question of whether the patient feels safe at home and stable in relationships. When screening for domestic abuse, it is important to approach the subject lightly with compassion, to make sure a patient does not feel anything like intimidation or distrust when discussing their experience. An intake form asking the question "Do you feel safe in your relationship?" will give patients the chance to check "no" without stating anything else. Then, during an examination, the physical therapist should inquire further by gently acknowledging the patient indicating that they do not feel safe and asking if the patient can tell them anything about this. If they can elaborate, the physical therapist may refer to resources and if the patient is uncomfortable explaining, the physical therapist should assure the patient that their appointments are a safe place to discuss anything without judgment, and that help is available. With this in mind, a patient may eventually feel comfortable disclosing this information as they build rapport with their physical therapist.

If the intake forms of the clinic do not contain any screening for domestic abuse, it is fair to ask one of a few general questions about home life and relationships as part of the subjective history. It is ideal to preface these sensitive questions by explaining why a PT may inquire about home life. PTs should state that they ask everyone these questions,

that it is important to understand anything that may cause a patient stress because it can affect the healing process. Doing so can help the practitioner to understand how to help patients heal from injuries. It is important to understand daily activities and how home life and relationships affect life. A PT may ask “How is your home life?” or “How are things at work, home, and in your relationships?”. If a patient indicates on a brief one or two-question screen that they do not feel safe in their home or relationship, further screening is warranted.

Direct Questioning Surrounding Domestic Abuse [13]

It is appropriate to ask further questions after the subjective history brief scan of whether a patient feels safe in their home or relationship. A PT should ask the patient permission if they may ask further questions surrounding the subject and make sure the patient knows that they are in a safe place and that the PT can help. These questions are appropriate only when the patient is alone because asking them in front of the abuser may predispose the patient to further violence at home. Physical therapists and all other rehabilitation professionals should be prepared to ask these questions at the examination, but also on future visits. Patients may not feel comfortable discussing such matters with a provider they just met and may disclose this information when they have more rapport with the PT. Examples of direct questions surrounding abuse include the following list.

- Have you ever been hit or physically harmed by your partner?
- Has anyone you are close to ever threatened or harmed you?
- Are you afraid of your partner?
- Do you feel controlled or manipulated by your partner?
- Has anyone you are close to ever touched you inappropriately?
- Has anyone forced you into a sexual act that you did not want?
- Have you ever been punched, bitten, slapped, kicked, or pushed by your partner?
- Have you experienced violence in your life and what were the circumstances?
- All couples fight but have your fights ever become physical?

This list is not exhaustive by any means, but it gives physical therapists an idea of how to inquire more deeply about domestic abuse, whether it is physical, sexual, or psychological. A yes to any of these questions would be a positive screen and PTs should be ready to refer to resources and report according to their organization protocol.

Screening Tools [14]

There are a few standardized screening tools available for clinicians to use within patient care. These tools are outlined questions that a clinician may have their patients fill out if they detect there may be domestic abuse in the subjective history. The following six questionnaires are evidence-based and have high sensitivity and specificity for domestic violence identification.

HITS (Hurt, Insult, Threaten, Scream)

The HITS tool is just four questions in which a patient answers how frequently certain events happen, rating from never to frequently. Out of twenty total points and a score of ten or more indicates a risk of domestic violence.

How often does your partner?	Never	Rarely	Sometimes	Fairly Often	Frequently
1. Physically hurt you					
2. Insult or talk down to you					
3. Threaten you with harm					
4. Scream or curse at you					
	1	2	3	4	5
Total Score:					

OVAT (Ongoing Violence Assessment Tool)

The OVAT is a questionnaire with four items asking true or false within the last month if the patient had been threatened by a weapon, hurt, had no respect for their feelings, or acted as though they would kill the patient by their partner.

STaT (Slapped, Things and Threaten)

The STaT is a three-question screening for intimate partner violence with the following questions:

1. “Have you ever been in a relationship where your partner has pushed or slapped you?”
2. “Have you ever been in a relationship where your partner threatened you with violence?”
3. “Have you ever been in a relationship where your partner has thrown, broken, or punched things?”

The sensitivity and specificity of the STaT in detecting intimate partner violence are from seventy-five to ninety percent.

HARK (Humiliation, Afraid, Rape, Kick)

The HARK includes the following four questions:

1. “Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?”
2. Within the last year have you been afraid of your partner or ex-partner?
3. “Within the last year have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?”
4. “Within the last year have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner?”

The HARK is a short form questionnaire that detects intimate partner violence with good to excellent specificity and sensitivity.

CTQ–SF (Childhood Trauma Questionnaire–Short Form) [15]

The CTQ-SF is a form used to scale the experience of childhood violence and trauma in the household. The CTQ full form contains seventy items, and the CTQ-SF is shortened to twenty-five items and three validity items. Five subscales detect physical, sexual, and emotional abuse, and physical and emotional neglect. This tool demonstrates adequate reliability and validity in determining childhood trauma.

WAST (Woman Abuse Screen Tool) [16]

The WAST determines intimate partner violence levels in women. It helps to detect whether women could be in an abusive relationship. It is a seven-item questionnaire that asks whether a woman has been abused emotionally, abused physically, or threatened.

There are many more questionnaires and screening tools available for detecting domestic violence. Providers should refer to their organization's protocol when determining which questionnaire to use. Detecting domestic violence starts with the subjective history and should be further examined if and when the patient agrees to answer additional questions. The questionnaires in this section should only be administered if patients indicate they do not feel safe in their home or relationship in subjective history taking.

Physical Therapist Examination and Documentation [2]

Physical therapists should as part of their examination assess all systems to screen for possible physical injury related to a person's subjective answers. This includes screening with questions regarding the general health of the cardiovascular, pulmonary, digestive, reproductive, integumentary, and metabolic systems. The physical therapist should look for any physical signs of domestic abuse that were detailed before this section.

In terms of the musculoskeletal system, physical therapists are among the most qualified professionals to diagnose and treat injuries. Physical therapists need to use skills of differential diagnosis, screening for red flag conditions, and referring to other providers as clinically indicated. When a patient comes in with an injury, it is important to gather a subjective history and base the examination on findings from the history. This means gathering an in-depth account of the mechanism of injury, which is a good time to gather information on any abuse or physical injury from another person.

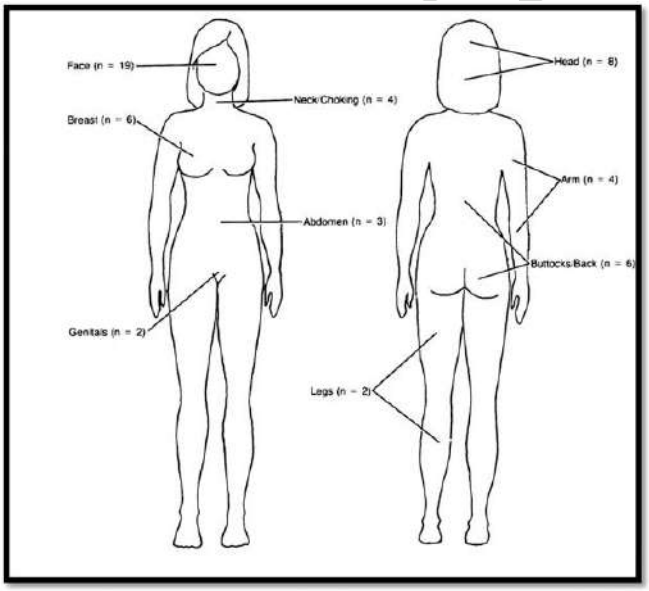
Documentation is crucial with provider encounters with victims of domestic violence. Documentation in the medical record is often used to incriminate an abuser in court. If providers do not capture the nature and severity of abuse in the medical record, an abuser may go unpunished and be able to continue harming victims. Documentation should include a detailed record of the objective findings, subjective history with as many direct quotes from the patient as possible, the behavior of the patient, and any health problems that are related to the abuse. Documentation should always be facts and quotes that were said by the patient. Documentation should never include any judgment or personal opinion. Documentation should also include a detailed description

of any injuries with information on location, color, the size of bruises, and the estimated age of bruises, cuts, and contusions.

Illustrative Domestic Violence Evidence

Providers should be aware of mandatory reporting laws in their state to determine if they are required to report suspected and proven cases of domestic abuse. Clinics and hospitals must have a policy that discloses where health information is sent. All patients need to sign a disclosure of information form to comply with HIPAA laws. The patient may specify on this form in what circumstances they choose to share data. This is especially important with IPV because abusers may be monitoring health records to determine if the victim has reached out for medical care or attempted to leave the relationship. The record should have photos if the patient allows them to be taken and diagrams describing the anatomical location of injuries. A body map allows providers to better illustrate the extent of the injury. They may document objective findings or self-reported data on the body maps, which are then uploaded into a patient's medical record.

Body Map to Illustrate Domestic Violence Injuries



https://www.sciencedirect.com/science/article/abs/pii/S0277953614006601

APTA Stance and Ethics [17]

The American Physical Therapy Association takes a clear stance on the topic of domestic violence. The Code of Ethics and specifically Principle 4 explain the requirements of this. The Code of Ethics is a guide for physical therapists to be knowledgeable about ethical

standards in the profession and how to adhere to them. The principles that take a stance on domestic violence are quoted below and taken directly from the APTA Code of Ethics.

“Principle #4: Physical therapists shall demonstrate integrity in their relationships with patients and clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public.” [17]

> “4F. Physical therapists shall report suspected cases of abuse involving children or vulnerable adults to the appropriate authority, subject to law.” [17]

This principle and sub-principle exist to ensure that physical therapists can detect and report cases of abuse with vulnerable adults and children. To have “integrity” in relationships with patients, physical therapists need to offer patient-centered care and screen for any possible domestic violence in their relationship (treating this is just as important as screening for other causes of injury). Physical therapists and all patient-facing clinicians are mandatory reporters of abuse on vulnerable populations, meaning children, those with disabilities, and the elderly. Protocols vary state by state and by the organization on the reporting of adult cases of domestic violence. There has been considered by some states to require mandatory reporting of domestic violence. Although mandatory reporting is not widespread for adults who are not “at risk”, protocols do exist per organization to refer victims of IPV to housing shelters and appropriate medical care.

Working Amongst the Healthcare Team [2]

Cases of domestic abuse are most commonly caught by the first provider a victim receives care from. This is commonly in emergency departments, primary care, and reproductive care. However, with the fast-paced environment of healthcare and with the volume of patients seen per day and even per hour increase, providers may miss cases of IPV due to time constraints. This highlights the importance of the entire healthcare team, rehabilitation professionals included, to be trained in the identification and response to domestic violence. Physical therapists may discover victims of domestic violence working in the emergency department, in outpatient clinics, in hospitals, skilled nursing facilities, in home health, or even in schools. Providers should never assume that another provider has already screened for IPV because this mindset will result in failing to detect victims. If the entire healthcare team collaborates to identify victims, more than forty percent of victims who do not contact the police can be helped out of their situation.

Referrals

Physical therapists and other healthcare providers should be ready after assessing a patient for domestic violence and finding evidence or strongly suspecting they are a victim, to refer to appropriate resources. Resources vary by state and organization but most often include social work, financial resources, housing resources, and organizations for support. The provider needs to determine from their patient the willingness to accept resources. It may put a patient in danger to leave their situation and providers should always be aware of their mandatory reporting laws per state before reporting to social workers or law enforcement.

Referral to Healthcare Professionals

Physical therapists and other providers need to know their organization's protocol and their state's laws to refer to fellow providers when it is best for the patient. Other providers to refer to include providers that will treat the physical and psychological effects of their experience with domestic violence. It is important to provide these referrals as early as possible so that injuries and psychological disorders do not become chronic.

Primary Care

If a victim of domestic violence does not already have a primary care provider, they need one to help coordinate their care, complete testing, and to screen for other health problems in their body systems. Primary care will help to facilitate any testing for injuries like imaging, will be able to prescribe any medications, and will be able to help facilitate a referral to injury specialists like orthopedists and surgeons for severe injuries.

Reproductive Health

Being a victim of domestic violence can affect long-term reproductive health, especially if the victim is sexually abused. Victims may experience unwanted pregnancies, abortions, miscarriages, sexually transmitted infections, pain, and pelvic floor disorders. As a physical therapist or other rehabilitation professional and screening all body systems, it is important to refer to reproductive health professionals like obstetricians, gynecologists, and women's health physicians for the examination and treatment of reproductive health problems after

Mental Health [18]

Any provider, including physical therapists, should refer any patient in need of mental healthcare to a mental health provider. This of course can be coordinated through primary care but every provider that treats patients should note that a delay in care can exacerbate symptoms of mental health disorders like depression, anxiety, or post-traumatic stress disorder (PTSD). Women who have been abused by a partner have two and a half more likely time to have depressive disorders and over three times more likely to have anxiety disorders. For women with PTSD, it is seven times more likely that they have suffered from domestic violence than have not. It is crucial to prevent the development and manage the symptoms of these and many more mental health disorders that stem from domestic violence for victims to receive adequate mental healthcare. This means a referral to a psychiatrist and a psychologist for the options of medication management, talk therapy, support groups, and many other forms of therapy.

Providers should consult their partnering mental health team if they work on a collaborative hospital campus or a connected clinic. If not, there are resources to help patients discover good mental health providers like Psychology Today where they can check if their insurance covers a mental health provider.

Section 3 Key Words

Screening Forms for Domestic Violence – Questionnaires that objectively screen for the type and nature of domestic abuse that providers use with patients

APTA Code of Ethics – the American Physical Therapy Association's ethical guidelines that state the expected ethical standards of behavior of the physical therapist and physical therapist assistant

Section 3 Summary

Physical therapists should be aware of the screening techniques in this section to provide a safe environment where their patients will feel more comfortable disclosing information about their domestic abuse. Every healthcare provider, no matter how rushed their patient schedule is, should screen for domestic violence by at least inquiring about safety at home and in relationships. If patients indicate they are not safe, there are further screening tools to detect the nature of the abuse, and providers should refer to appropriate resources and report the abuse according to their state law.

Resources and Policies

After detecting and referring patients who are victims of domestic violence to the correct providers, it is also important for physical therapists to know what else to do to manage these cases. Some states require reporting from healthcare providers no matter what and some states require arrests of abusers in domestic violence cases. These policies are essential to understand what the implications of reporting can be on a patient. There are also several national, state, and local resources to help social services, healthcare providers, and victims navigate their way out of domestic violence.

Mandatory Reporting [19]

Laws vary on mandatory reporting requirements for cases of domestic violence. Laws exist to protect vulnerable victims of abuse, as healthcare providers may be the victim of abuse's only outside interaction with their abuser. Most states have statutes where providers must report domestic violence if a patient is directly injured by domestic violence. This is prevalent in California, where healthcare providers are required to report domestic violence cases if they suspect or know that a patient has been injured directly from abuse. They have to either call local police or send a written report within 48 hours of discovering the abuse. Common injuries that are reported include rape, battery, incest, stabbing, gunshot wound, and torture. In other states like Pennsylvania, mandatory requirements for reporting are less stringent. This means that providers do not need to report suspected or known cases if the victim is an adult, is informed of the requirement to report, does not consent to reporting, and is given a referral to a service organization for victims. Physical therapists should know their state's specific stance on whether to report all cases of domestic violence. This will be found in their state practice act and/or their state's Department of Health or legal page.

The report must contain a few elements including the name of the patient, the location of the patient, a summary of injuries, and the identity of the abuser. Federal law states that if a mandatory report is made by a healthcare provider, that provider must alert the patient so they can prepare for interfacing with local police. There is gray area in this law though; if for some reason telling the patient about the report would potentially danger the patient, the provider is not required to tell the patient.

After the report is placed, no matter on a child, elder, or adult, healthcare providers should be aware of what happens next. Local police will shortly arrive at the patient's residence, may inquire family or roommates about abuse, make arrests, distribute

charges, and other actions. This action may put the victim of abuse in further danger. For example, if no arrest is made and the abuser is not forced from the residence, the victim(s) of domestic abuse may face greater anger and severity of abuse. Providers should describe the circumstances of suspected abuse in the police report based on the patient's direct words, alert the patient if it does not him/her in danger, and help the patient as much as possible by involving social work and referral to another short-term residence if possible. Many states consider it a federal offense if healthcare providers do not report domestic violence. This makes it necessary to report but balance keeping patients out of danger.

It is important to note that the above description of how to report domestic violence cases as a healthcare provider is for known cases with direct evidence through injuries. Laws by states for suspected domestic violence or violence reported by a patient are a bit more vague. These are cases where an injury is not directly visible to the healthcare provider, but the patient admits to domestic violence or indicates they may be experiencing it during screening. Six states take it further and require healthcare providers to report known or suspected cases of domestic violence immediately to law enforcement and/or social services. This has been met with the varied opinion because of different laws on arrests. For example, if a provider must report a case of domestic violence to local police but an arrest is not made, the victim of abuse may face a life-threatening situation. The six states that require a report of suspected violence (not evident abuse based on an injury presentation) are California, Colorado, Kentucky, New Hampshire, New Mexico, and Rhode Island. Providers in these states should be aware of this law and be prepared in clinical practice to act when they discover cases of suspected or known domestic violence.

There are several reasons why healthcare providers may support mandatory reporting laws. Mandatory reporting is an opportunity for providers to detect and act on domestic violence cases earlier. A visit with a healthcare professional is often the first opportunity for a domestic violence victim to be discovered. Common settings for this are at a women's health, primary care visit, emergency room visit, or outpatient appointments (physical therapy, occupational health, etc.). In addition to this, reporting battery can create an investigation and build a report against a potential abuser. This fact, along with documentation in the victim's medical file, will help to convict abusers of their crimes. Mandatory reporting laws are always changing and vary on stringency per state. It is the responsibility of physical therapists as licensed patient care providers to determine their state's law on their Department of Health or licensing website.

Domestic Violence Laws

https://www.findlaw.com/family/domestic-violence/domestic-violence-laws.html

Several laws exist governing how domestic violence cases are handled, and by which authorities. State and federal laws protect victims of domestic violence. A typical process after a domestic violence case is discovered is helping local law enforcement to build a case against the abuser with evidence followed by civil and/or criminal court.

The Violence Against Women Act (VAWA) [19]

This act was passed in 1994 to establish and provide funds for victims of domestic violence. The national domestic violence hotline was also established through the VAWA. The act also allowed battered spouses who immigrated to the United States to apply for permanent residency separate from their abusive partner. The VAWA prevented abusers from simply moving states to avoid penalties as the act made it illegal to travel via interstate when committing acts of domestic violence. It also created policies for the mandatory arrest of perpetrators of domestic violence.

Federal Child Abuse Prevention and Treatment Act (CAPTA) [2,20]

The CAPTA was established in 1974 to create a National Center on Child Abuse and Neglect to organize child abuse programs, to create training materials for healthcare and welfare professionals, and to fund research on bettering national programs to end child abuse. This act created grants to support training programs for professionals to treat child abuse and neglect. Following passing of the act, it was amended or reauthorized in 2010, 2015, 2016, 2018, and 2019. It is currently expanded to provide state funding and assistance in preventing, assessing, investigating, prosecuting, and treating cases of child abuse and neglect. This is also expanded to victims of child sex trafficking due to the federal definitions of child abuse and neglect and sexual abuse to include victims of trafficking.

Elder Justice Act [21]

Elders are defined as people over the age of sixty-five, the early elderly are from sixty-five to seventy-four and the late elderly are those over seventy-five years old. The Elder Justice Act was passed in 2010 and was the first federal legislation to focus on the abuse, neglect, and exploitation of the elderly. The act put several efforts in place to research and promote justice among elder abuse cases, to support Adult Protective Services, and to protect elders in long-term care. The Elder Justice Act also created the Elder Justice

Coordinating Committee to organize activities on the issues of elder abuse, neglect, and exploitation in the federal government.

Patient Safety and Abuse Act [22]

The Patient Safety and Abuse Prevention Act was introduced in 2009 to protect residents of long-term care facilities. It required the Secretary of Health and Human Services to create a program for making procedures to background check prospective workers in long-term care facilities. The searches include checking whether an employee is on a neglect registry, is a federal criminal, fails a fingerprint background check, or has engaged in an attempt to duplicate fingerprinting. This law exists to prevent abuse in nursing homes whether it be physical, emotional, or financial. It has prevented thousands of workers from being near vulnerable elders annually. It was signed into law in 2010.

https://www.ncbi.nlm.nih.gov/books/NBK499891/

State Domestic Violence Laws

Each state has different laws on how to manage cases of domestic violence. A large point of variance is whether states recognize only physical or if they include emotional, psychological, and financial domestic abuse in the definition. States may vary on reporting requirements based on what forms of abuse they include in the definition of domestic abuse. States vary in their policies and conditions when they make arrests with cases of domestic violence. Most states in modern times have a “preferred arrest” policy where they have to arrest at the scene or document why they did not make an arrest. Other states have a “mandatory arrest” policy where the officer must make an arrest if the domestic violence meets criterion. Officers in states with mandatory arrest rarely leave the scene without arresting because of how dangerous the abuse could become after leaving. They must arrest the person whom they believe is the primary aggressor. States have different laws and conditions on the mandatory arrest policy. States are trending towards helping victims of domestic violence and it appears that more states will implement more rather than less stringent arrest policies. Healthcare professionals should monitor their state’s statutes on the arrest policy of their state.

Implications for Policy and Practice

Domestic violence has consequences on every aspect of a patient’s life, but also on the care, they may receive. If a patient is going through domestic violence and a physical therapist detects it, how the therapist responds may affect rapport and the patient’s

willingness to come back for follow-up physical therapy appointments. If a patient's abuser is arrested, that patient will have to rebuild their life which is normally intertwined with their abuser. This is a painful and difficult process that leaves many patients with little energy to continue participating in physical and mental healthcare.

Policies are ever changing in domestic violence law. More states are evolving to mandatory arrest and mandatory reporting policies. As advocacy groups and resources discussed in the next session continue to shed light on the issue of domestic violence, most states are trending towards stronger protection for victims of IPV.

Resources

As awareness and policy supporting victims of domestic violence have risen in the past couple of decades, many resources exist for domestic violence/intimate partner violence. These resources are on the national level which then typically connect victims to local and statewide resources.

The National Domestic Violence Hotline [23]

The hotline number is **1-800-799-7233**. It is available at all times and in over 200 languages. Anyone can call this number, chat live at https://www.thehotline.org/, or text "START" to 88788. The call center staff can get callers in touch with local resources for handling any situation. The website itself has a network of resources, information that defines domestic violence, and safety plans. The website has a local resources tab where site visitors can search directly for resources in their city and state. Resources include domestic violence shelters, food assistance, counseling, health, transportation, youth services, elder services, sexual assault services, and many more categories to help victims navigate their survival of domestic abuse.

Rape, Abuse, and Incest National Network [24]

The hotline number is **1-800-656-4573 (HOPE)**. The Rape, Abuse, and Incest National Network (RAINN) is also available 24/7 and the system recognizes the area code of the caller to be connected to a local RAINN center. The call is anonymous unless the caller shares information to obtain help. RAINN is available to help victims of rape, abuse, and incest navigate the next steps in getting help through healthcare and other services such as shelter. More information is available at www.rainn.org.

The National Resource Center on Domestic Violence (NRCDV) [25]

The NRCDV was established in 1993 by a grant through the US Department of Health and Human Services. Its purpose is to provide training and assist in developing resources to work against domestic violence. The NRCDV has the vision to help end domestic violence. It is stated here:

“WE PROMISE to lead boldly in centering and amplifying voices of survivors and traditionally marginalized communities.

WE PROMISE to make you feel Valued, Inspired, Equipped, and Informed, in every interaction you have with NRCDV.

WE PROMISE to provide opportunities to make you feel Invested and Connected in the movement to end domestic violence.”

This vision is directed at real change at different levels including systemic, societal, and individual levels. The organization directs its efforts at training organizations in recognition and response to domestic violence. It offers several courses that organization leaders and employees in healthcare can take.

In 2016 the NRCDV began a racial justice initiative where it incorporated elements of racial inclusivity into its efforts on helping manage domestic violence. This addition allowed an internal focus on racial and equality training to ensure equal treatment of diverse populations when it comes to helping stop domestic violence.

VAWnet [26]

VAWnet is an online library that is a large source of information for professionals working on ending domestic violence. These groups are professionals in human services, educators, and leaders in faith organizations. It is directed at gender-based violence and has resources, training tools, and events on advocacy and the prevention and end of intimate partner violence.

PreventIPV [27]

Prevent IPV, or prevent intimate partner violence, is a national resource that connects national resources with expanding state and local resources to help support intimate violence prevention in all parts of the United States. It was formed in 2011 as a unified approach to prevention acts against IPV. Their strategies are to continually promote and develop their organization, to achieve continued funding, to present nationally and locally for healthcare and other organizations, to share all ideals at federal, state, and

local levels, and to release data reports on prevention activities at the federal, state, and local level.

Safe Housing Partnerships [26]

Safe Housing Partnerships is a nationwide resource to help find housing for minorities who are facing problems such as human trafficking and domestic violence. Domestic violence is one of the main causes of homelessness for women and children in the United States. There are several barriers that victims of domestic violence go through that impact their ability to find stable housing and living. The nature of domestic abuse involves the control and power of the abuser, which lessens the victim's ability to seek out help. Further, factors of discrimination against people of color, people who have been incarcerated, people in poverty, and people with disabilities face homelessness at a much higher rate than others. Safe housing partnerships fight to establish shelters and affordable housing across the United States for victims of domestic abuse, poverty, disabilities, and many other factors.

Eldercare Locator [29]

The Eldercare Locator is a nationwide resource to connect anyone to services for elder adults. The hotline number is 1-800-677-1116, and there is an online chat feature at https://eldercare.acl.gov/Public/index.aspx. This resource can help families and elders navigate finding different methods of in-home, assisted living, or long-term care options to live if their situation is abusive. Visiting the eldercare.acl.gov site allows a search of what organizations are available in a city and state for housing, food, and care of elders.

ChildHelp.org [30]

ChildHelp.org is a site dedicated to helping abused and neglected children meet their emotional, physical, and educational needs. The national ChildHelp Child Abuse Hotline which is open 24/7 is **1-800-422-4453 (1-800-4-A-Child)**. The site has resources on finding schools, short-term programs, foster services, adoption resources, and advocacy groups. The hotline number can help callers make a report and contact the appropriate authorities for helping the child(ren) out of their abusive situation.

Section 4 Key Words

Mandatory Reporting – the requirement to report within 48 hours of domestic abuse, child abuse, and elder abuse by healthcare providers

Mandatory Arrest – Refers to officers being required to arrest at the scene whom they believe is the primary aggressor in cases of domestic dispute

Preferred Arrest – Policy in some states where officers can use discretion on whether or not to arrest a perpetrator of domestic violence at the scene and if they do not, they are required to document the reasoning

National Resource Center on Domestic Violence – the largest resource center on domestic violence in the United States with a purpose to change response to domestic violence cases at systemic and organizational levels

Section 4 Summary

Several policies have been developed which protect and help victims of domestic violence achieve long-term health after escaping their situation. Healthcare providers should know all of their state's policies on mandatory reporting and mandatory arrest in cases of domestic violence. All healthcare providers are mandatory reporters of abuse of children and elders, but states vary on the circumstances of adult domestic violence reporting. Providers should be able to explain what may happen to their patients who admitted they are being abused by their partner. Resources exist nationally and locally to help providers who discover victims and victims of domestic violence navigate their way to a safe life.

Case Study

Sandra is a physical therapist working in an outpatient clinic in a small town in Texas. She is evaluating her next patient, Laura who is 33 years old for low back pain who was referred to physical therapy from her primary care office. Sandra asks her standard subjective history questions and seems to be building a good rapport with Laura until she asks about Laura's home situation. Laura immediately breaks eye contact with Sandra and hesitates to answer "yes" when asked if she feels safe at home. Sandra asks further about details of why she does not feel safe. Laura refuses to answer and states that this has nothing to do with her back pain. Sandra continues with her questions to review the remaining systems. When asked about the nature of her low back pain injury, Laura states it just happened over time.

Reflection Questions

1. What approach may have improved Laura's willingness to answer questions regarding her home safety?
2. What challenges may Sandra and other clinicians in her rural clinic face in identifying and responding to domestic violence cases?
3. What might explain Laura's change in demeanor when asked about her home life and what might the result of this be?
4. What should Sandra do if she detects that Laura is interested in seeking help for domestic violence?

Responses

1. Sandra should review Laura's intake forms to see if she indicated a "no" response to feeling safe in her relationship or at home. This may be a better way to bring up the potential for domestic abuse by stating something like "I noticed you indicated that you do not feel safe at home. I wanted to let you know that this is a safe space, and I can help with this through resources and referrals I can make. Is that something we could discuss in more detail?" This response is less abrupt because when Sandra asked about home safety, it was likely she was just screening and didn't expect Laura's reaction.
2. Sandra's physical therapy clinic may not have a protocol on how to screen for and respond to suspected cases of domestic violence. Sandra may suggest to her managers that they include screening questions on intake forms, have evidence-based domestic violence screening questionnaires if patients indicate they are experiencing domestic violence on their intake forms, and know how to respond by referring patients to appropriate practitioners and resources.
3. It is highly suspicious that Laura does not feel safe at home given her response to Sandra's question. This may be why Laura was vague about the nature of her low back pain as well. Abruptly asking may have invaded Laura's personal situation and triggered her to check out of the physical therapy session. Doing so may negatively impact any trust that Laura has in Sandra.
4. Sandra should refer Laura to national and local resources on domestic violence and a mental health professional. Practitioners must familiarize themselves with

state mandates and policies to which they practice. Policies are ever changing in domestic violence law. More states are evolving to mandatory arrest and mandatory reporting policies. In this scenario, if Laura discloses more details about her abuse and if Laura's life is in danger, Sandra should contact local police but is not required to in the state of Texas. Texas also does not have a mandatory arrest policy, so a report that is unwanted by Laura may put her in more danger by her abuser.

Conclusion

Domestic violence is a nationwide health crisis that healthcare providers need to be prepared to intervene on. Federally, domestic violence is illegal, and states have various policies on mandatory reporting and mandatory arrest. Domestic violence can happen to anyone regardless of diverse characteristics and can impact everyone around the victim including their family, friends, and children. Physical therapists and other rehabilitation professionals should be educated on how to screen for domestic violence in their subjective histories and how to help patients get help without putting them at increased danger from their abuser. It is crucial to know state policy, local, state, and federal resources, and to refer to the best providers to help victims of domestic violence. Physical therapists and other rehabilitation professionals can play a large role in saving the lives of patients who are suffering from intimate partner and domestic violence if they follow the identification and response tasks in this course.

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