MEDICAL PROVIDERS' GUIDE TO MANAGING THE CARE OF DOMESTIC VIOLENCE PATIENTS WITHIN A CULTURAL CONTEXT

Second Edition

Michael R. Bloomberg
Mayor
City of New York

Message from the New York City Mayor's Office to Combat Domestic Violence

Domestic violence is pervasive, with 1 in 4 women experiencing abuse during their lifetimes. In 2002, the World Health Organization identified domestic violence as a serious public health problem with victims experiencing more operative procedures, visits to doctors and hospital stays than non-victims. Domestic violence causes not only acute injuries, but also has been linked to serious health consequences such as chronic pain, abdominal complaints, sexually transmitted infections, unwanted pregnancies, depression, post-traumatic stress disorder, miscarriages and premature labor.

Unfortunately, many victims suffer in silence and are not receiving assistance for their abusive situation. Analysis of family violence-related homicides in New York City reveals that 71% of the cases in 2003 had no prior police contact and 87% had no current order of protection. Healthcare professionals play a crucial role in identifying victims because they have a regular opportunity to ask patients about domestic violence, regardless of the reason for the medical visit. By routinely screening patients for domestic violence, healthcare professionals can assist victims who may not seek assistance elsewhere. By directly asking patients about domestic violence, regardless of symptoms, injuries or reason for the visit, there is an increased likelihood that victims will disclose abuse.

Given medical practitioners' specific roles and time constraints, responding to domestic violence can be challenging. This manual explores methods of overcoming these challenges and intends to assist practitioners to efficiently identify domestic violence victims, intervene effectively, and provide meaningful referrals. It is key that each domestic violence case is approached systemically while having each professional limit his/her role by area of expertise. The manual also focuses on methods of communicating effectively with patients from diverse cultures and practical suggestions are discussed.

This manual is distinctive because it was developed with input from survivors and current victims of domestic violence representing diverse communities as well as healthcare professionals from a variety of clinical settings. Experts from various fields who work with domestic violence victims also contributed significantly to this initiative.

The New York City Mayor's Office to Combat Domestic Violence is pleased to present the second edition of "Medical Providers' Guide to Managing the Care of Domestic Violence Patients Within a Cultural Context," developed in collaboration with the Department of Health and Mental Hygiene and funded by the U.S. Department of Health and Human Services. This second edition contains additional scenarios and an expanded list of domestic violence resources.

Sincerely,

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What You Will Learn

- How to manage the screening process in a time efficient manner
- The relevance of regular screening for all women
- How to optimize the doctor-patient relationship in the context of cultural diversity
- Challenges that prevent women from disclosing abuse
- The danger of using the abuser, family member, friend or another patient as an interpreter
- The importance of documentation for a complete diagnosis
- How to manage the care of a patient who discloses domestic violence
- Available benefits for documented and undocumented immigrants
- How to screen a patient when the abuser accompanies her to the appointment
- How to place theoretical concepts in a practical context
- How to implement guidelines for a domestic violence program in your facility
- The importance of a multi-disciplinary team approach

Special Note

Most domestic violence victims are women, and most abusers are their current or previous male partners. While aspects of this manual are applicable to the prevention, detection and intervention strategies for all domestic violence situations, the focus remains on screening female patients.

In this manual, the victim is often referred to as female and the abuser as male. Please note that domestic abuse also occurs in gay and lesbian relationships, teenage dating relationships, and among elders. In a minority of cases, the female partner abuses the male. No person deserves to be abused and every victim is entitled to effective treatment.

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Section I:

Optimizing Communication and Screening with Patients from Different Cultures

The Relevance of Screening for Domestic Violence

Routine screening is critical for the prevention and detection of domestic violence as well as the effective management of patient care.

The Context of Domestic Violence

Domestic violence refers to abuse between members of a nuclear family or intimate system.[1] It involves the repeated use of coercive and controlling behavior to limit and direct the victim's thoughts, emotions and behavior. The abuser uses physical, psychological, financial and sexual power tactics that escalate in frequency and severity over time. Domestic violence is a complex and multidimensional phenomenon that permeates racial, religious, gender, cultural, social, educational and economic boundaries.[1]

Within the context of domestic violence, partner, child, elder and sibling violence tend to coexist. While occurring in the domestic setting, such abuse has far-reaching ramifications. The World Health Organization has recognized domestic violence as a global public-health concern.[2] Various health and social problems have been identified as consequences of domestic violence such as increased risk of chronic illnesses and lack of housing.[3,4,5] At the macro level, domestic violence may adversely affect future generations and social harmony.

Domestic Violence is Widespread

- Between 21% and 37% of women experience domestic violence during their lifetimes.[6,7,8]
- Research in primary care settings indicates that 3.4-5.5% of patients have experienced domestic violence within the last year.[9]
- Women aged 16 to 24 experience the highest rate of partner violence per capita.[10]
- The reported rate of teen dating violence among adolescents varies from 25-60%.[11,12]
- A national survey of 6,000 American families revealed that 50% of the men who frequently assaulted their wives, also frequently abused their children.[13]
- Approximately 14% of women being treated in emergency departments were victims of domestic violence within the last year.[14]
- Studies estimate that between 3% and 5% of the elderly population have been abused. The Senate Special Committee on Aging estimates that there may be as many as 5 million elders abused every year.[15]
- Each year, between 50,000 and 100,000 lesbian women and as many as 500,000 gay men are battered in the U.S.[16]

Failure to identify domestic violence may have serious consequences

Possible negative health outcomes

- Unnecessary testing and misdiagnoses.[4]
- Complications during pregnancy.[17,18]
- Increased risk of chronic illness such as abdominal pain, migraines, sexually transmitted infections, HIV, depression and other conditions.[5]

Legal implications

- According to New York State law (New York Public Health §2803-(2)), hospitals are required to provide information concerning family violence to pregnant women as well as parents of newborn infants.
- You may be held liable for negligence.[19]

A hospital in Billings, Montana, settled a professional negligence lawsuit brought by a domestic violence victim for failure to evaluate, diagnose and intervene appropriately in order to ensure the patient's safety.[19]

Costly medical care

- A large health plan spent $1,775 more annually on each abused woman than on women who had not been abused.[20]
- A large medical center in Chicago estimated that the national annual cost to provide medical services to abused women, children and older adults was $875 million.[21]

Victims are unlikely to voluntarily disclose their abuse

57% of abused women have never told anyone about their abusive situation.[22]

- Of the women who received domestic violence services in a large healthcare network, 95% had not previously sought treatment from any other organization.[23]
- Immigrant victims may be less likely to seek help due to language barriers, cultural differences, and a fear of deportation if they are not legally documented to live in the U.S.[24]
- In New York City during 2002, 78 family violence victims were killed. 43 of these victims were females aged 18 and older. Only 27 of the total number of homicide cases had a prior police report.[25]

You may be the only person to inquire about the abuse before it results in adverse health consequences.

Opportunity for the healthcare provider to intervene

You may be seeing patients who are victims of abuse, but are seeking medical care for other reasons.

- 96% of pregnant women receive prenatal care, averaging 12-13 prenatal care visits.[3]
- A survey of New York City Medical Examiner records concluded that prenatal and postpartum clinic visits present an ideal situation for the doctor to prevent injury to pregnant women.[26]
- Women who are battered during pregnancy are more likely to seek healthcare for injuries than women battered before pregnancy.[27]

Members of the public take doctors' opinions seriously. When you screen your patients for domestic violence and make referrals to relevant providers, you communicate your concern about this issue, validate the victim's experience and provide an opportunity for her to legitimately seek help.

Relevance of screening for domestic violence

By routinely asking each patient about domestic violence, you may achieve the following positive outcomes:

- Prevent physical and mental health problems caused by domestic abuse;[3]
- Improve the quality of life of the victim's children;[29]
- Protect the victim's friends, family and coworkers from harm by the abuser;[30]
- Prevent the cycle of violence from damaging another generation;[31]
- Affirm the significance of domestic violence as a public health issue;[32] and
- Reduce sick days and lost productivity in the workplace.[33]

Routine screening for domestic violence can save the life of a victim of abuse.[28]

Prevalence of domestic violence during pregnancy

A substantial number of pregnant women are victims of domestic violence.

- Approximately 240,000 pregnant women (6%) in the U.S. are abused by an intimate partner annually.[4]
- Battering during pregnancy is associated with greater severity than battering that occurred before pregnancy.[34]
- Abuse during pregnancy seems to be recurrent, with 60% of abused women reporting two or more episodes of assault.[35]

Estimated intimate partner violence rates for pregnant women range from 3.9 to 8.3%.[36]

Domestic violence risk factors can be identified in pregnant women

Research indicates an association between domestic violence and various risk factors.

- Lack of effective social support is more common among pregnant victims of domestic violence.[3]
- Women with inadequate access to prenatal care are more likely to be battered during pregnancy.[3]
- Women who have fewer places to go for assistance are at greater risk of being assaulted.[19]
- Women battered during pregnancy are more likely to have housing problems.[3]

Possible Warning Signs of Domestic Violence in Pregnant Women[3]

Medical care utilization	Pregnancy	Medical conditions	Mental health
Missed medical appointments	Late entry into prenatal care	Chronic pelvic pain	History of suicide attempts
Repeated visits to the doctor	Young maternal age	Recurrent headaches	Depression and anxiety
Regular medical visits for injuries	History of abuse or assault	Irritable bowel syndrome	Unhappiness about being pregnant
Unscheduled visits to the doctor	Unintended pregnancy	Vaginitis	Substance abuse

However, domestic violence may exist in the absence of any obvious medical and behavioral warning signs, illustrating the relevance of routine screening.[3]

Domestic violence is an obstetric risk factor

Various associations exist between domestic violence and obstetric complications.[37]

- Abused women are more likely to have a poor obstetric history than women who have not been abused.[38]
- Abused adolescents are more likely to experience first or second trimester bleeding than adolescents who are not being abused.[38]
- Physical violence during pregnancy is a significant predictor of premature labor or delivery.[38,39]
- Women who are abused during pregnancy are at greater risk of miscarriage or neonatal death.[38]

Low birth weight is a serious consequence of domestic violence.

- Annually in the U.S., 10.7% of abused women deliver low birth weight babies.[17]
- The average national cost of a low birth weight delivery is $50,300 as compared to $3,355 for a full-term delivery.[40]
- It costs over $1.2 billion annually for domestic violence-related low birth weight deliveries.[4]

Association between maternal illness and abuse

There is a correlation between maternal morbidity and exposure to domestic violence during pregnancy.

- Many women in abusive relationships also experience sexual assault, and are in turn at increased risk of contracting sexually transmitted infections.[37]
- There is a significant association between physical violence and kidney infections in pregnant women.[37]
- 83% of women who were battered during pregnancy reported symptoms of depression.[3]
- 89% of women being abused during pregnancy suffer from symptoms of anxiety.[3]
- Abused women are more likely to smoke, use drugs and use alcohol during their pregnancy than those who are not in abusive relationships. A possible explanation of these behaviors has been postulated as an attempt to manage the heightened stress or trauma associated with being abused.[38]

Domestic abuse and assault are the second most frequent cause of injuries during pregnancy, preceded only by motor vehicle accidents.[41]

Summary

- A substantial percentage of women, including those who are pregnant, are victims of domestic violence.
- Failure to identify domestic violence as early as possible can result in negative health outcomes, costly medical care and legal implications.
- Victims are unlikely to voluntarily disclose their abuse, reinforcing the relevance of routine screening.
- Members of the public generally take a medical practitioner's opinion seriously, providing an opportunity for you to inquire about domestic violence and to recommend interventions.
- Domestic violence is a significant obstetric risk factor.
- The majority of pregnant women receive prenatal care, enabling you to screen for domestic violence during this time.
- While there is a definite association between various risk factors and domestic violence, abuse may exist in the absence of observable medical and behavioral evidence.

The Impact Of Culture On The Doctor-Patient Relationship

(This chapter has been reproduced and adapted from Katz-Levin 2001, Child Law Manual for Prosecutors, Canada-South Africa Justice Linkage Project, with permission from the National Prosecuting Authority and Justice College).[43]

"Men in my culture don't like to have girls. My husband was furious that I gave birth to a girl. He used to come to the hospital and scream at me. He cursed me and accused me of shaming him. My husband hit me with the table. My doctor, who is from my culture, told me that he could not talk about this with me. "

"Because of our cultural background, we are embarrassed to talk about what we go through at home. I'm scared that what I tell to my doctor, he will tell to the community."

(New York City survivors of Domestic Violence, 2002)

It is critical to optimize your interaction with patients from different cultural groups. Culture influences a patient's belief system, emotional expression and behavior.

Please complete the table by writing cultural characteristics of a woman known to you from a different culture from your own.

Race	
Religion	
Socioeconomic status	
Primary language	
Country of origin	
The relevance of extended family	

How do you think these cultural characteristics may impact the following areas?

- Her understanding of her abusive relationship _____

  _____

- Her comfort with communicating her abuse to a healthcare practitioner _____

  _____

- Your cultural characteristics that may encourage or inhibit your response to her disclosure of domestic violence _____

Culture influences how people view abuse; whether they seek help; how they communicate their experience and from whom they are likely to seek assistance.

Relevance of culture

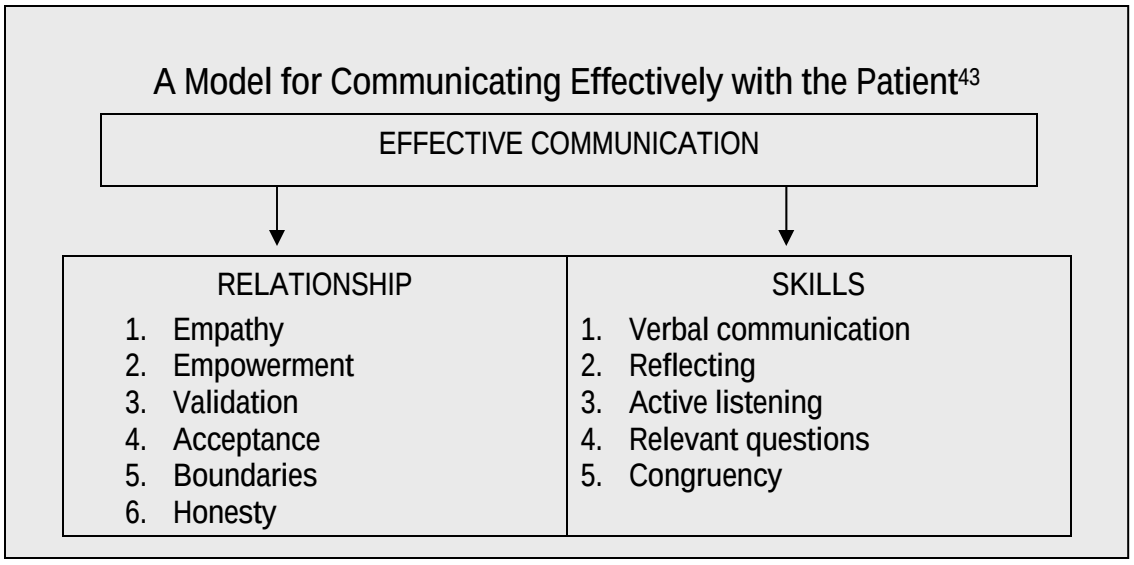
Culture is a complex, multidimensional, deeply rooted system of beliefs. It is a dynamic process which involves shared experiences or commonalities that have developed in relation to changing social and political contexts.[42] Culture is based upon race, ethnicity, gender, religion, sexual orientation, socioeconomic status, country of origin, level of assimilation and acculturation, tradition, disability status, level of privilege in society and language. Culture influences an individual's attitudes, beliefs, emotional expression, choices and consequent behavior.

While culture plays a significant role in shaping personal behavior, it should not be viewed as an automatic predictor of how a person will respond during a domestic violence assessment. Each patient should be assessed as a unique case, with aspects of culture utilized as relevant factors.

A Model for Communicating Effectively with the Patient

Maintaining an awareness of different cultural norms can help a medical practitioner establish trust and communicate effectively with patients from diverse backgrounds. Remember, however, that these are guidelines, not determinants of a patient's response.

Establishing a relationship with the patient and developing communication skills are essential for effective communication with the patient.



Relationship factors

Practical suggestions for implementation:

Empathy

Attempt to understand how the patient feels in her current situation.

- Try to distinguish your own thoughts, feelings, judgments and interpretations from those of the patient.
- Be free from external distractions.
- Focus on the patient, enabling her to feel that she has your undivided attention.
- Provide emotional support, while maintaining a level of objectivity.

"You look frightened when you talk about your partner. Do you feel frightened?"

Empowerment

Encourage the victim to take an active role in decision-making.

- Empower the victim by letting her know that she has the potential to make sensible choices about her well-being and safety.
- Empathize with the patient, without showing pity. Pity can increase the victim's sense of powerlessness.
- Try to be solution-oriented, reassuring the patient that help is available.
- Focus on the patient's goal of wanting to be free of violence; encourage her to work towards achieving the safety that she desires.
- Praise the victim's courage to seek help and to communicate with you about the abuse.
- Affirm positive decisions made by the patient regarding her physical and mental well-being.
- Assure the patient that she can survive her abusive relationship by working within a larger support system of caring professionals.

"You have a choice about your safety and whether you remain in your relationship. There are various resources available to assist you in attaining safety."

Validation

Tell the victim that you believe her and that you care enough to want to assist her in resolving her situation.

- Use a warm and professional interviewing style to obtain a detailed history.
- Reassure the victim that her feelings and reactions are understandable.
- Convey that abuse is wrong, unacceptable and against the law.
- Universalize the patient's experience by explaining that many women are subject to abusive relationships and that domestic violence is a worldwide problem.

"Abuse is unacceptable. You deserve to feel free from violence."

Acceptance

Maintain a non-judgmental attitude toward the patient's belief systems, behavior and values.

- Despite age, race, gender or cultural differences, each patient should be treated as an independent and equal person.
- Maintain a caring, supportive and non-threatening atmosphere that encourages dialogue.
- Respect the patient's right to make her own choices about her abusive situation, and accept that your perception of how this situation should be managed, may be different.
- It is normal for people who are traumatized to express emotions, such as crying, when they talk about the abuse. Reflect acceptance of these reactions.
- Accept that in the context of your providing efficient and effective service to the patient, it is the victim who is ultimately responsible for making decisions and managing the consequences thereof.

"It is understandable that you feel sad about your relationship with your partner."

Boundaries

The practitioner should acknowledge his/her personal and professional boundaries and make referrals when necessary.

- Clearly define your role as a healthcare practitioner in managing cases of abuse, including benchmarks for making referrals.
- Avoid playing the role of therapist, because exploring the patient's feelings about the abuse may be detrimental if her reactions cannot be properly addressed.
- Refer the patient to a social worker or psychologist for counseling.
- In some cases, a medical practitioner may also be a victim of abuse or an abuser. Such unresolved issues can compromise the practitioner's objectivity and limit his/her ability to effectively treat a patient who is seeking help. In such circumstances, a practitioner is encouraged to seek assistance. Under no circumstances should the practitioner communicate with the patient about his/her own abuse.
- The practitioner should not share any personal knowledge of friends or family with the patient.
- Avoid showing anger, sadness, shock or distress regarding the alleged abuse, as this may cause the patient to feel that she has to comfort the practitioner.
- Maintain reasonable limitations with respect to providing support, so the patient does not develop false expectations of the practitioner's availability.

Honesty

Being honest with the patient is essential in encouraging her to disclose the abuse or seek help.

- While ensuring the patient's right to confidentiality, limitations in this regard should be made explicit, such as the circumstances in which it is mandatory to report abuse.
- Explain to the patient the relevance of your communicating with other professionals regarding the alleged abuse.
- Do not make false promises to the patient by assuring her of safety following her disclosure.
- In New York State, healthcare professionals are mandatory reporters in cases of child abuse. Under certain circumstances they are also required to report injuries to adults. In cases where it is mandatory to report abuse, the victim should be informed.

"Would you mind if I discuss your situation with the social worker? I feel that we can assist you more effectively by combining our different areas of expertise."

MANDATORY REPORT OF INJURY IN NEW YORK[44]

Health practitioners are required by New York State Law (Penal Law Sections 265.25-26) to report certain injuries that appear to have resulted from a criminal act whether or not a patient elects to file a report. According to the law:

1. Certain wounds must be reported: Every case of a bullet wound, gunshot wound, powder burn, or any other injury arising from or caused by the discharge of a gun or firearm, and every case of a wound which is likely to or may result in death and is actually or apparently inflicted by a knife, ice pick, or other sharp or pointed instrument, shall be reported at once to the police authorities of the city where the person reporting is located by:
    a) the physician attending or treating the patient; or
    b) the manager, superintendent, or other person in charge, whenever such a patient is treated in a hospital, sanitarium or other institution.

    Failure to make such report is a class A misdemeanor.

2. Burn injury and wounds to be reported: Every case of a burn injury or wound, where the patient sustained second or third degree burns to five percent or more of the body and/or any burns to the upper respiratory tract or laryngeal edema due to inhalation of super-heated air, and every case of a burn injury or wound, which is likely to or may result in death shall be reported at once to the office of fire prevention and control. The state fire administrator shall accept the report and notify the proper investigatory agency. A written report shall also be provided to the office of fire prevention and control within 72 hours. The report shall be made by:
    a) the physician attending or treating the patient; or
    b) the manager, superintendent, or other person in charge, whenever such a patient is treated in a hospital, sanitarium or other institution.

Failure to make such report is a class A misdemeanor.

Used with permission:
New York City Health and Hospitals Corporation. 2002. Clinician Guide for Identifying, Treating and Preventing Family Violence, 37-38, summarizing New York State Penal Law Sections 265.25-26.

Skills

Practical suggestions for implementation:

Verbal communication

While it is difficult to customize communication for every patient who is a victim of abuse, the following basic techniques can help to facilitate dialogue.

- If possible, greet the person in her language, using verbal communication as a method of establishing rapport and putting the patient at ease.
- Do not use unnecessary medical jargon, and volunteer explanations for terminology.
- Unless necessary, do not interrupt a victim while she is talking about her abuse and allow her time to think after you have asked a question.
- Communicate with each patient in a vocabulary and sentence structure that is simple and understandable.
- Use only one concept per sentence or question.

" I see the bruising around your eye. Are there any other injuries that you would like to show me?"

Reflecting

Reflecting or summarizing the patient's thoughts and feelings demonstrates that you understand her experience.

- Reflecting is a useful skill when attempting to validate a patient's experience. It assists the practitioner in gaining an accurate perception of the patient's experience as well as assisting the patient to clarify her own thoughts and feelings.
- Paraphrase the main concepts of the patient's verbal communication.
- Emotions are often reflected in facial expression, eye movement and body posture. For example, a person who is ashamed may frown, drop her eye gaze and droop her head.
- The quality of a person's speech may differ depending on her level of comfort. For example, a person's volume may decrease, the tone reflect hesitancy and the speed of speech increase in an environment that is perceived to be threatening.

- In the presence of stress, the sympathetic nervous system is activated. This is evidenced by perspiration, dry mouth and an increase in respiratory rate.
- It is useful to be acquainted with cultural differences in nonverbal communication. For example, some cultures avoid eye contact as a sign of respect, while others perceive this as avoidance.

"It is difficult for you to talk about your relationship with your partner."

Active- listening

Show the patient that you are listening by using appropriate gestures or facial expressions, such as nodding your head in an encouraging manner when she is talking.

- Respond to verbal and non-verbal communication. An example of the latter is saying to the patient, '"You seem to be having a reaction, can you tell me what you are feeling?"
- Focus on the patient's entire statement rather than only on selected words.
- Request explanations for comments that you do not understand.
- Use connecting statements such as "I hear what you are saying.

"Could you please explain to me what you mean by your partner freaking out?"

Relevant Questions

The skill of effectively questioning the patient is critical to screening for domestic violence.

TYPES OF QUESTIONS

Question Type	Description	Example	Use/Avoid
Open-ended	No answer suggested	How did this injury occur?	USE
Closed	Limited number of answers suggested	How many times has your partner hit you?	USE
Leading	Desirable response suggested	Didn't you tell your partner to stop hitting you?	AVOID

- The quality of the patient's response is likely to differ depending on her level of comfort with the practitioner's communication style.
- Open-ended questions enable the patient to relay her experience "through her eyes."
- Open-ended questions may be insufficient to gain the required information about the patient's domestic violence experience. Therefore, closed non-leading questions are useful in clarifying specific issues.

Cultural factors may serve as barriers to treatment, such as an extended family structure in which a family elder supports the abuse. Culture influences a person's perception of abuse. Effective questioning can help to clarify the nature of the abuse within a particular cultural context.

Examples of questions that assist in understanding a person's culture or "world view":

- "What does it mean to you when he does/says that?"
- "What is it like for you to talk about the abuse with people from your community?"
- "Whom can you talk to about your situation at home?"
- "You said that abuse is part of your culture. Can you please explain what you mean by that?"
- "Do you have someone in your life that you can talk to about your situation at home?"

When asking questions, use the patient's words to understand the situation from her perspective.

- "What happens when your boyfriend disrespects you?"
- "What does it mean for your husband to have a bad temper?"
- "What happens when your partner loses it?"

Congruence

The practitioner should communicate with each individual patient, without expecting generalized reactions for respective cultural groups.

- Use each patient's general communication style as his/her own benchmark. Deviation from this benchmark is useful as an indicator of change in the patient's emotions. An example of this is a patient who generally makes good eye contact until she talks about her partner.
- Look for incongruence in verbal and non-verbal communication. For example, a person who may state that she is comfortable in a relationship, but her non-verbal communication reflects discomfort in this regard. Incongruence between the patient's words and body language may reflect her discomfort with the content of the conversation.
- Incongruence between verbal and non-verbal communication should be reflected in a non-threatening manner.

"You seem uncomfortable when I ask you about the cause of your injury. Would it be okay to ask you a few questions?"

Summary

- When applicable, it is useful for the practitioner to acknowledge that he/she does not know much about the patient's culture, and wants to learn from the patient, rather than operating from a false sense of familiarity.
- Culture is a complex and multidimensional concept that is deeply embedded in daily life.
- It is useful to understand norms but not to generalize, as culture is personalized.
- Consider each individual in his/her context, acknowledging that choices are made and based on each person's "world view."
- Establishing a relationship with the patient and developing communication skills are essential for effective intervention.
- It is useful to put yourself "in the shoes" of others in order to gain perspective on your patient's decision process, choices and behavior.
- It is important for the practitioner to interact with patients from different cultures in a non-judgmental manner, so that he/she can facilitate the process of comfortable communication about the abuse.

Techniques to Overcome Barriers that Healthcare Providers May Encounter

It is important to overcome barriers that healthcare providers may encounter with respect to domestic violence screening and intervention.

Please complete this brief exercise:

- Does a woman ever deserve to be physically assaulted by her spouse? _____
- Is domestic violence against the law? _____
- Can domestic violence adversely affect a person's physical and/or mental health? _____
- Does inquiring about domestic violence have the potential to decrease long-term harm to the patient? _____
- Is it appropriate for me to inquire about domestic violence and to be involved in the management process? _____

Answer key: No; Yes; Yes; Yes, Yes

Concerns of Healthcare Practitioners and Techniques to Overcome Them

Is domestic violence screening part of my job?

Despite time constraints and patient overload, domestic violence is an area of increasing concern, and the medical profession plays a central role in ending this problem.

- In many cases, you may be the only person who can provide help to the victim.
- Not asking about abuse can result in adverse health consequences or death for patients.
- Not asking about abuse can lead to costly testing and misdiagnoses.
- In 2002, 51 domestic violence-related homicide cases in New York City had no prior police report.[25]
- Domestic violence is a public health issue.
- Medical organizations such as the American Medical Association and American College of Obstetricians recommend screening for domestic violence.
- The Joint Commission on Accreditation for Healthcare Organizations (JCAHO) requires a domestic violence program prior to accreditation of certain medical facilities.

What is the medical provider's role in the screening and intervention process?

It is the practitioner's role to identify and recognize the presence of abuse, as well as to effectively manage patient care.

- Screen for abuse.
- Assess the medical context of the abuse (e.g. the severity and frequency of injuries; whether food or medication are being withheld from the patient).
- Provide medical treatment for the presenting injuries.
- Assess the safety of the victim.
- Briefly counsel the victim regarding available resources and management options.
- Document your findings and referrals.
- Take photos of the injuries.
- Refer the patient to relevant multidisciplinary colleagues.

What should I do if my patient takes offense when I screen for abuse?

If a patient takes offense, explain that you ask all of your patients these questions and that there is nothing specific about her that is prompting you to screen.

- Include a few basic questions on domestic violence in a general health-status questionnaire, which is routinely completed by all patients prior to entering the practitioner's examination room. Writing an answer may be more comfortable and less intrusive for the patient than responding verbally. Also, the patient is more likely to interpret such questions as routine if they are given to all patients to complete. Ask follow-up questions in a non-threatening way.
- Data indicates that the majority of patients approve of routine inquiry about domestic violence.[45,46,47]

How do I ensure privacy for screening?

Exclude all family members and friends from the screening process since this may bias the victim's response.

- Privacy is essential (see pages 25-27 for issues related to privacy and screening)

How do I find the time for screening and intervention?

Include screening questions as part of the medical assessment and/or a general health-status questionnaire, which should be completed by the patient within the waiting room.

- Ask follow-up questions on domestic violence during the medical examination. Ensure that no partner, child, family member or other patients are present during this time.
- Refer the victim to community-based organizations, City agencies and other resources for counseling, financial assistance, immigration concerns, housing and other issues. At all New York City hospitals, refer patients to the Domestic Violence Coordinator. Give the victim the New York City Domestic Violence Hotline number 1-800-621-HOPE (4673) and 311 for all City services.

How to Approach Screening

I don't know how to ask about domestic violence. It is a personal issue, and I feel uncomfortable intruding on the patient's emotional privacy.

- Explain to the patient the purpose of asking questions about domestic violence. This can be achieved by universalizing the problem in order to provide a context that is less threatening.
- State that questions are asked routinely to all patients because of the prevalence of domestic violence and its potential to harm the victims.
- It may be uncomfortable at first, but with practice it will become easier. It is important for your patients' health and safety that you screen for domestic violence.

How do I manage a patient if she discloses domestic violence?

- Listen supportively and validate your patient's experience. You may be the first or only person that she tells about the abuse.
- Provide necessary medical treatment for the patient.
- Discuss various existing support services with the victim (refer to pages 48-53), give her a general safety plan (refer to page 47), or refer her to the Domestic Violence Coordinator as there is in one in every New York City public hospital (refer to page 53).
- Make appropriate referrals based on the patient's needs:
  - Advocacy services
  - Community based organizations
  - Counseling
  - Legal services
  - Medical services
  - Public benefits for immigrants
  - Social services
  - Interpretation

What if the patient is being abused but either denies the abuse or refuses help?

- You need to respect your patient's choice of whether to disclose abuse and/or to seek help.
  - Attempting to leave an abusive relationship is frequently dangerous for a domestic violence victim.[48,49]
  - There may be financial and housing risks associated with leaving an abusive relationship and emergency shelter may not be immediately available.
- Discuss risk factors of further abuse with the patient. Inform her that women are at greater risk of harm when incidents of domestic violence increase in frequency or intensity.
- It may take several visits to the provider before the victim discloses her abuse.
- Let your patient know that you are available in the future if she chooses to seek assistance for her situation.
- Document your concerns and treatment in the patient's medical chart and make a notation to follow-up at future visits.
- Screen for medical and psychological indicators of abuse during subsequent visits, and offer feedback/suggestions to the patient in this regard.
- Provide information pamphlets in the waiting rooms, examination rooms and bathrooms.

Look beyond appearances of your patients and their partners

How do I know he is an abuser if he doesn't look like one?

- Is it possible that people with bad tempers are not aggressive all the time? _____
- Note three reasons why an abuser may not want to show his abusive side to people other than the victim.

1. _____
2. _____
3. _____

If the abuse was that bad, wouldn't she disclose the abuse and end the relationship?

- Is it possible that some women do not have overt signs of abuse? _____
- Is it possible that the victim is ashamed of the abuse? _____
- Is it possible that the abuser would threaten to harm the victim if she disclosed the abuse? _____
- Is it possible that the victim fears serious consequences of leaving the abuser, such as retaliation, physical harm, lack of financial assistance or abandonment by members of her community? _____

An abuser has the potential to be a "nice guy" to many people and still abuse his partner. A woman may not display obvious signs of abuse or she may hide the evidence for fear of adverse consequences. This illustrates the importance of routinely screening all patients for domestic violence.

Summary

AVDR[50]

A = Ask patients about abuse
V = Validate, acknowledge abuse is wrong, confirm patient's worth
D = Document presenting symptoms and disclosures
R = Refer victims to specialists

- As a medical provider, it is important to screen all patients for domestic violence; to provide the required medical treatment; as well as to refer the patient to relevant multidisciplinary colleagues.
- Domestic violence screening must be conducted in privacy, in the absence of all friends and family members.
- To minimize the patient's discomfort as well as manage the practitioner's time constraints, include domestic violence screening questions in a general health-status questionnaire, which is routinely administered to all patients. You can then follow-up verbally during the medical examination.
- Domestic violence has potentially adverse physical and psychological effects on the victim, and it is thus important to intervene in order to minimize harm to the patient.
- Validate a patient's experience if she discloses domestic violence.
- Respect a victim's choice of not disclosing domestic violence or remaining within the abusive situation. Ending an abusive relationship may result in serious consequences for the victim, complicating her decision to leave the perpetrator.
- Perpetrators are selective as to whom they show their aggression, and generally have sufficient insight to understand the potential consequences of their actions. Therefore, do not "judge" a potential perpetrator at face value.

Challenges Preventing Immigrant Women from Disclosing Domestic Violence

Overview of Challenges that Prevent Immigrant Women From Disclosing Domestic Violence

An environment that is not conducive to disclosure

- Lack of routine screening
- Lack of privacy from the abuser or family member during screening
- Lack of privacy for screening in the waiting room
- Lack of an objective and professional interpreter
- Lack of assessment beyond physical injuries

Fear for personal safety and pressure from the victim's support system

- Concern about bringing shame to her family and losing their support
- Concern about being ostracized by her community

Fear of legal authorities

- Fear of the police
- Fear of immigration authorities
- Mother's fear of having children removed from her care

Factors complicating the diagnosis of domestic violence

- The victim being unaware that non-physical abuse constitutes domestic violence
- The victim believing that abuse is an acceptable part of her culture or marital life
- The victim being less likely to report forced sex as abuse
- The victim's substance abuse inhibiting disclosure
- The victim's positive HIV status inhibiting disclosure

AN ENVIRONMENT THAT IS NOT CONDUCIVE TO DISCLOSURE

Lack of routine screening

- Although 85.7% of primary care physicians screened patients for domestic violence when they presented with an injury, only 6.2% were screened at the initial examination and only 7.5% at an annual follow-up visit.[52]
- Studies found that physicians providing prenatal care only routinely screened 11% of patients for domestic violence during the first visit.[53]
- Approximately 92% of women who are physically abused do not voluntarily disclose abuse to physicians and 57% do not disclose the abuse to anyone.[21]
- Research indicates that the majority of female patients would disclose domestic violence if asked directly about it.[47,54]
- Immigrant women may not know that they can seek help in the U.S. for their domestic violence situation. By screening, the practitioner can reduce a victim's feeling of isolation and provide meaningful information about her right in this country to be free from abuse.

What you can do

- Medical providers should routinely screen their patients for abuse, during annual visits and at regular periods during pregnancy.
- Screening is crucial because immigrant women may not be fully aware of the laws in the U.S. Use screening as an opportunity to give referral information to victims on the legal representation for battered immigrants. The NYC Hotline Number 1-800-621-HOPE (4673) has language capabilities and can give referrals for legal assistance.
- For suggestions on implementing a screening protocol at your facility, refer to pages 35-. For assessment tools, a safety plan and resource lists, refer to pages 43-53.
- Include screening questions on a general health intake form and follow up on these questions verbally during the examination.

Lack of privacy from the abuser or family member during screening

A member of the victim's family (such as her mother), the abuser or his family member (such as his mother or sister), frequently accompanies the victim to her medical appointments. These family or extended family members may contribute to an environment that tolerates the abuse, complicating the victim's ability to seek help. If these people are present during the screening, it will decrease the likelihood of disclosure. It is crucial to speak to each patient privately in order to effectively screen her for domestic violence.

What you can do

- Be careful not to induce conflict between the victim and the abuser, as this may increase her risk of being harmed.
- Tell the abuser that it is a standard procedure for each patient to be examined alone.
- Have a sign stating "Patients only beyond this point."
- Screen the patient during a time of privacy following a urine test or when she is being weighed.
- Request that the suspected abuser complete some administrative forms while the patient is screened in a separate room.
- The practitioner could speak to the suspected abuser concerning a routine health issue while another member of staff screens the victim.
- Use a key word that will indicate the presence of a potential domestic violence situation to a staff member. The victim would then be called out of the examination room to discuss the possibility of domestic violence, while the practitioner remains with the abuser. The abuser is less likely to be suspicious if the practitioner remains with him.[51]

Lack of privacy for screening in the waiting room

A domestic violence victim is unlikely to disclose her abuse if she feels uncomfortable or unsafe doing so. Privacy for screening is essential.

What you can do

- Do not ask domestic violence screening questions with the abuser, family, friends, or other patients present.
- Reassure your patient that you will respect her rights to confidentiality.
- Include screening questions as part of the medical assessment and/or as part of a general health-status questionnaire, and follow up verbally in the medical examination.
- Ideally, allow patients to complete the general health status questionnaire in privacy.

Lack of an objective and professional interpreter

57% of the participants in a 2002 focus group conducted by the Mayor's Office reported that the abuser, child, family member or person in the waiting room was used to interpret for them. The patient is unlikely to disclose her abuse in the absence of an objective interpreter. Also, lack of a professional interpreter violates the victim's civil rights and entitlement to confidentiality, as well as increasing her risk of negative consequences, such as being harmed by the abuser.

What you can do

- Do not use spouses, friends, family members or other patients as interpreters.
- Do not use the victim's child as an interpreter, as listening to disclosure of the abuse may be distressing, or the child may report the victim's statements to the abusive partner, thereby endangering the victim and child.
- Under Title VI of the Civil Rights Act of 1964, patients with limited English proficiency have the right to receive free interpreter services from any healthcare provider who receives Federal financial assistance.[55]
- Interpretation services should be provided by trained staff at the medical facility's language bank or by contracted telephone interpreters.

Lack of assessment beyond physical injuries

- The majority of your domestic violence patients may be seeking medical care for reasons other than injuries related to abuse, such as an annual visit or prenatal care.
- In addition to physical violence, abuse can be emotional, verbal, financial and sexual in nature.
- 66% of the 2002 focus group participants reported experiencing non-physical abuse.

What you can do

- Be knowledgeable about non-physical types of abuse, including emotional abuse, sexual abuse and financial abuse.
- Routinely screen patients for domestic violence at annual visits.
- Display pamphlets in multiple languages in the waiting areas, examination rooms and bathrooms.

FEAR FOR PERSONAL SAFETY AND PRESSURE FROM THE VICTIM'S SUPPORT SYSTEM

Concern about bringing shame to her family and losing their support

There may be significant pressure from immediate and extended family members, preventing the woman from disclosing abuse.

Some factors to consider when screening a patient for abuse:

- She may not know that her mistreatment is abuse.
- Reporting abuse may imply that the woman has failed as a wife and mother because her role is to keep the family together at all costs.
- The woman may fear shame and abandonment for herself and her family.
- The woman may fear loss of emotional and financial support if she discloses the abuse or leaves the abuser.
- She may believe or be told not to discuss private issues with outsiders.
- She may not have told her family about the abuse.
- Family or extended family members may be present at medical appointments, inhibiting the process of disclosure.
- Some family or extended family members may condone and even participate in the abuse.
- A family's misinterpretation of religious text may sanction abuse.

Concern about being ostracized by her community

Community pressure may play a significant role in the patient's decision not to disclose abuse. Victims may be frightened or ashamed about their community's reaction to their domestic violence situation. Many women go to medical providers who have been recommended by members of their community. Also, certain doctors or facilities predominantly serve certain communities.

Some factors to consider when screening a patient for abuse:

- Community members may deny the prevalence of domestic violence.
- She may fear bringing shame to her community.
- A previous medical provider from the victim's community may have discouraged her from reporting the abuse.
- In certain cultures, family and community reputation is perceived as being more important than an individual's needs.
- She may not disclose the abuse for fear of losing her support system (her family and friends).
- She may fear being abandoned by members of her larger community if she leaves her partner.
- Societal discrimination towards the victim's ethnic group may discourage her from reporting the abuse, for fear of exposure to further prejudice.

WHAT YOU CAN DO

- Screen the patient for domestic violence in private and do not use family members or friends as interpreters.
- Emphasize to the patient that you will respect her right to confidentiality.
- Refer to pages 13-19 for guidelines on communicating effectively with patients from different populations as well as exploring various options of treatment with them.
- Provide the Domestic Violence Hotline number 1-800-621-HOPE (4673) and referral information to the patient, both within and outside of her community, depending on her preference.
- If necessary, allow the patient to call the hotline from the examination room.

FEAR OF LEGAL AUTHORITIES

FEAR OF THE POLICE

Factors to consider

- The victim may believe that her immigration status bars her from seeking police protection and assistance.
- An immigrant woman's negative experience with police in her country of origin may affect her expectations of the police in this country.

Critical information for the patient

- Disclosing abuse to the doctor does not imply that the police will be contacted:
  - In general, the police should only be contacted with the victim's consent, and this requires the signing of a waiver.
  - Healthcare providers are only mandated to report adult domestic violence in cases with injuries such as firearm wounds; knife wounds or on burns over five percent of the body (refer to pages 16-17).
- Orders of Protection are available; the hospital's Domestic Violence Coordinator and various organizations can assist in this process (refer to the Resource List, pages 48-53).
- Police can help to establish a safety plan for the victim as well as provide referrals for her.
- Specially trained officers called Domestic Violence Prevention Officers ("DVPOs") are located in each precinct. At the precinct, the victim can speak to a DVPO privately, in the absence of the abuser. An interpreter will be provided if possible.
- Alternatively, allow the victim to contact the police from your facility and provide her with a safe and private place from which she can talk to the officer.
- It is the policy of the New York City Police Department not to inquire about the immigration status of a crime victim, witness or others who seek assistance from the police.

FEAR OF IMMIGRATION AUTHORITIES

Bureau of Citizenship and Immigration Services
("BCIS," formerly "INS")

Factors to consider

- If a woman is an undocumented immigrant, her abusive partner may threaten to contact immigration authorities to have her deported. She may not know that as a domestic violence victim, she can seek protection from such deportation.
- Many undocumented immigrants fear the risk of discovery by the immigration authorities if they access any social services, including medical institutions.
- Many immigrant victims of domestic violence rely on their abusers for legal immigration status. The victim may fear that if she discloses abuse, the abuser may refuse to serve as her immigration sponsor.

Critical information for the patient

- The victim does not jeopardize her immigration status by seeking medical treatment for her injuries.
- All domestic violence victims who rely on their abusers for immigration status should consult with an immigration attorney who specializes in domestic violence remedies (refer to the Resource List, pages 48-53).
- The abuser does not have the power to have the immigration authorities deport the victim.
- Counseling and other social services may be available in the victim's language and may be offered by individuals who understand her culture.
- The victim may be eligible for certain forms of immigration relief. For instance, if she is an undocumented immigrant and married to a citizen or lawful permanent resident, she may be eligible to self-petition for her Green Card.
- If she has a Green Card that expires (conditional residency), she may be able to receive a permanent Green Card without assistance of her abusive spouse.
- Domestic violence victims who are helpful in the criminal investigation or prosecution of their abusers may be eligible for new forms of immigration relief.

WHAT YOU CAN DO

- Emphasize that you will respect physician-patient confidentiality.
- Inform the patient that there are experts in legal issues who can assist her.
- Refer the victim to domestic violence services, provided by an organization that offers services in her primary language, if possible. Refer to the Resource List on pages 48-53 for additional information.

MOTHER'S FEAR OF HAVING CHILDREN REMOVED FROM HER CARE
PART 1

- Many women fear that disclosure of abuse may result in the removal of their children, if the medical provider notifies the Administration for Children's Services (ACS) of the abuse.
- Depending upon the country, child custody laws may differ. The victim may fear that the abuser or in-laws will obtain custody of the children and/or return them to the country of origin.

WHAT YOU CAN DO

Share information and validate the patient's concerns

- Routinely notify patients of the limits to confidentiality, and the fact that healthcare providers are mandated reporters of child abuse.
- Reassure the patient that your goal is to help her to keep herself and her children safe.
- Validate the patient's experience and concerns.

Understand mandatory reporting laws

- Familiarize yourself with state laws/policies regarding mandatory reporting of suspected child abuse or maltreatment.
- Familiarize yourself with your facility's policies and procedures for reporting suspected child abuse or maltreatment.

Important note regarding mandatory reporting

- Please note that, at the time of this writing, New York State law does not require mandated reporters to make a report of suspected child abuse or maltreatment in <u>every</u> case of childhood exposure to domestic violence.
- Instead, mandated reporters are required to report those cases in which there is a reasonable suspicion that a child has been abused or maltreated, or is at risk of being abused or maltreated.
- The decision to report should be based on the specific circumstances of the case, and may include consideration of such factors as the severity and chronicity of the abuse, whether a child has been physically harmed, the proximity of the child to the abuse, whether the abusive partner has threatened to harm a child, whether a child is demonstrating symptoms of emotional distress, and other information known to the mandated reporter.
- Keep in mind, however, that you do not have to prove child abuse or neglect in order to make a report; your suspicion of abuse or maltreatment is sufficient to require such a report.

MOTHER'S FEAR OF HAVING CHILDREN REMOVED FROM HER CARE PART 2

WHAT YOU CAN DO *(continued)*

Steps to minimize risk to the victim and children

- When making a report of child abuse or maltreatment in a case involving domestic violence, the healthcare provider may consider taking the following steps, in order to minimize the risk to the victim and the children:
  - If appropriate, notify the victim of your decision to file a report of suspected child abuse or neglect. In some instances, you may compile the report together with the victim. Ask the victim how she feels the abusive partner will react to the report, and offer to assist with safety planning or provide a referral to the NYC Domestic Violence Hotline, 1-800-621-HOPE (4673). However, you should not notify the victim in advance if you believe that a child might be hurt as a result, or that the family might flee to avoid the child protective investigation.
  - Reassure the victim that child protective staff will seek to help her and her children be safe together, whenever possible.
  - When making the report, clearly state who you believe is responsible for the risk to the child(ren). For example, if you believe the victim is a responsible parent, and you are making a report because of her partner's dangerous behavior, notify the State Central Register that you believe the batterer is responsible for the abuse or neglect.
  - Provide as much information as possible to assist child protective services in safely investigating the case:
    - History and severity of the abuse
    - How you believe the abuse has placed the child at risk or harmed the child
    - Whether the abusive partner has access to a weapon, or has used weapons in the past
    - Whether the abusive partner has behaved violently to strangers, service providers, or people in authority
    - Whether there are other service providers working with the family
    - How to safely contact the victim
    - The current location of the abusive partner, if known
    - How best to contact you to verify the information in the report
  - If possible, make yourself or your facility's social work staff available to the victim, to assist and support her during the investigation process.
  - Communicate and collaborate with the child protective staff handling the investigation, in order to support the best possible outcome for the family.
  - As a mandated reporter, you can request notification of the outcome of the investigation.

FACTORS COMPLICATING THE DIAGNOSIS OF DOMESTIC VIOLENCE

The victim being unaware of non-physical abuse

Many domestic violence victims do not realize that they are in abusive relationships, particularly in the absence of serious physical injuries.

What you can do

- Briefly inform the patient about non-physical forms of domestic violence. Please refer to pages 54-55.
- Validate the victim's experience by reassuring her that her feelings and reactions are understandable.
- Refer her to relevant resources. Please refer to the Resource List on pages 48-53.

The victim believing abuse to be an acceptable part of her culture or marital life

Many women believe that being a victim of domestic violence is a normal part of their culture or marital life.

What you can do

- Explain to the victim that domestic abuse is a global problem that affects people from all cultures.
- Emphasize that no one deserves to be abused, irrespective of his/her culture.
- Tell the victim that domestic violence is against the law in the United States.
- For specific techniques on communicating with people from different cultures, refer to pages 13-19 of this manual.

The victim, who is sexually assaulted in her relationship, is unlikely to seek medical attention

Forced sex is an independent risk factor for femicide.[49] Research indicates that many women are raped within the context of their marriage. There is a correlation between domestic violence and forced sexual activity. In general, women who are assaulted by a known perpetrator are less likely to seek assistance than those assaulted by a stranger.[56] Approximately 47% of domestic violence victims who are raped never seek medical attention related to the rape.[57]

What you can do

- Many victims do not disclose sexual assault either because of shame or because they perceive this to be part of the general abusive situation. Some women perceive forced sexual activity to be a requirement of marriage. **Therefore, if domestic violence is identified, assess the patient for sexual assault and vice versa.**
- Inform the patient that being forced to have sex in a marriage is classified as rape, a crime.

The victim's use of substances making it less likely to seek assistance

After the first incident of domestic violence, victims are nine times more likely to abuse drugs than non-battered women.[58] This may be explained as self-medicating; a method of coping with the trauma of being abused.[38] "Many women experiencing both domestic violence and substance abuse feel that they have few places to turn where their co-occurring problems are recognized, understood and dealt with compassionately."[59]

What you can do

- Assess for domestic violence when working with patients who have a substance abuse problem and vice versa.
- Ensure that both domestic violence and substance abuse are addressed in an integrated treatment program for the patient.

The victim's positive HIV status inhibiting her disclosure

A higher proportion of HIV-positive women have histories of abuse than HIV-negative women.[60] Reasons for an association between HIV status and domestic violence include:

- Forced sexual activity.
- Inability to safely negotiate condom use.
- Lack of access to preventive health care.
- Inability to purchase birth control due to financial abuse.
- High prevalence of HIV in the victim's country of origin.
- The association between drug use and battering.

It is estimated that the odds of reporting intimate partner violence were ten times lower among women with a positive HIV status than those who have not been infected with HIV.[61] HIV-positive domestic violence victims may not disclose abuse for the following reasons:

- The abuser threatens to disclose the victim's HIV status.
- The abuser threatens to embarrass the victim in public.
- The abuser limits the victim's access to necessary medication and health services.
- The abuser blames the victim for her HIV-status and makes her feel undeserving of help.
- The abuser accuses the victim of being promiscuous and makes her feel ashamed to report her HIV-status.

What you can do

- According to New York State law (New York Public Health Law §2137), as a practitioner, you must screen for domestic violence when conducting partner identification of HIV.
- Communicate with the patient in a non-judgmental manner.
- Validate the victim's concerns and reassure her of her right to confidentiality.

Summary

- The practitioner should create an environment that is conducive to disclosure.
- Implement routine screening for domestic violence.
- Ensure privacy for screening patients.
- Ensure that neither the abuser nor a family member is with the patient during the screening.
- Pressure from the victim's social system may negatively impact disclosure.
- Concern about bringing shame to her family and losing their support may inhibit the victim's disclosure of domestic violence.
- Some family members may condone and even participate in the abuse.
- Concern about being ostracized by her community may inhibit disclosure.
- Victims may fear legal authorities such as the police and immigration officials.
- Victims may fear having their children removed from their care.
- Ensure access to an objective and professional interpreter.
- Assess your patients for all types of abuse rather than just treating physical injuries.
- If appropriate, inform the patient about non-physical types of abuse.
- Inform the patient that abuse is unacceptable and against the law.
- Women, who are raped by a partner, abuse substances or are HIV positive, are unlikely to voluntarily disclose abuse. It is therefore important to routinely screen all patients for domestic violence.
- Refer the victim to appropriate resources, both within and outside her community, depending on her preference.

Section II:

Implementation of a Domestic Violence Screening and Service Program at Your Facility

Implementation of a Domestic Violence Screening and Service Program at Your Facility

Screening is a critical component of diagnosing and managing the care of domestic violence victims. Screening will be most effective if it is incorporated into a comprehensive domestic violence program.

Elements of Successful Implementation of Domestic Violence Programs[62]

When implementing a domestic violence program at your facility, there are various factors that should be considered:

- *Relative advantage:*
  - The program should assist in accomplishing predetermined goals.
  - The program should surpass current practices.
  - The quality of work in the area of domestic violence should improve.
- *Compatibility:*
  - The program should be consistent with the staff and facility's values.
  - The program should optimize existing expertise and experience.
- *Complexity:*
  - The program should not be perceived as too complex to learn and understand.
- *Trialability:*
  - The program should be sufficiently flexible to explore different approaches.
- *Observability:*
  - Indicators of success should be identified and easily measured.
  - Feedback to staff should be provided as an incentive to continue and improve the program.

Five Stages of Successfully Implementing a Domestic Violence Program[62]

Knowledge

- The person responsible for initiating the program should understand domestic violence as a health issue and the relevance of the program.
- This person should gain exposure to an existing domestic violence program and understand its potential application within his/her facility.

Persuasion

- It is critical to educate key players in the facility about the relevance of the program in order to establish a favorable attitude towards the initiative.
- Collaboration between various disciplines and departments is necessary for effectively managing the many dimensions of domestic violence.
  - Administration
  - Counseling Services
  - Education
  - Geriatrics
  - Medical Services
  - Nursing Services
  - Pediatrics
  - Psychiatric Services
  - Psychological Services
  - Research
  - Social Services
  - Trauma Services

Decision

- Prior to implementing the domestic violence program, it is essential that you have gained commitment from all relevant key players.
- Form an interdisciplinary team that includes people from the respective disciplines involved in a domestic violence program. Involvement of these team members in discussions and decisions regarding interdisciplinary referral and management of victims will assist in long-term commitment to the program.

Implementation

- Develop policies and procedures to ensure the effective implementation of a Domestic Violence Program in your facility. These should include the following:
  - Domestic Violence Coordinator or designated social work staff
  - Mandatory training of all relevant staff
  - Routine screening of all female patients
  - Access to language and interpretation services
  - Documentation and confidentiality of patient information (including photographs)
  - Services, resources and referrals
  - Materials for patients
  - Safety protocol
- Refer to pages 37-39 for detailed guidelines on the implementation of policies and procedures.

Confirmation

- It is essential to evaluate the success of the program and to provide feedback to staff members managing the program and working with victims.
- Set goals, measurement criteria and evaluation techniques regarding implementation of the program.
- Assess the success of the program at routine, predetermined intervals.
- Provide feedback where it is due, as this will motivate staff performance.

IMPLEMENTATION: POLICIES AND PROCEDURES

For a Sample Treatment Flowchart on various aspects of screening and intervention, please refer to page 40 of this manual.

Domestic Violence Coordinator

- Designate a Domestic Violence Coordinator.
- He/she is responsible for proactively facilitating the effective functioning of the program within the facility.

Mandatory training of all relevant staff

- Mandatory training on aspects of domestic violence should be conducted on an initial and ongoing basis for all relevant members of staff within the facility.
- Organize the training schedule in a way that accommodates staff release time.
- All staff members should be trained in domestic violence prior to screening patients.
- Issues to be considered for training members of staff should include:
  - An overview of domestic violence - including the prevalence of domestic violence (refer to pages 9-11), the types of abuse (refer to pages 54-55), risk factors (refer to page 46) and potential indicators of abuse (refer to pages 11-12).
  - The role of the respective professionals in preventing, diagnosing and treating domestic violence victims (refer to pages 9-12, 37).
  - Methods of communicating effectively with patients from different cultures (refer to pages 13-19).
  - Barriers that the practitioner may encounter in screening for domestic violence and methods of overcoming them (refer to pages 20-23).
  - Barriers that the patient may have in disclosing her abuse and methods of facilitating communication in these circumstances (refer to pages 24-32).
  - Services and resources available for different population groups (refer to pages 41, 48-53).
  - Methods of handling documentation (refer to pages 37-38).
  - The method and relevance of taking photographs of violence-related injuries (refer to page 38).
  - Methods of maintaining the patient's right to confidentiality (refer to page 38).

Routine screening of all female patients

- Develop or utilize existing screening assessment tools. (Refer to page 45 for a sample).
- All female patients over the age of 18 should be routinely screened for domestic violence.
- Younger patients as well as males should be screened at the practitioner's discretion.
  - All new patients in this category as well as existing patients should be screened at regular predetermined times (for example, during annual visits).
- Any victim of domestic violence who has children should be questioned about their safety.
- Screening can be conducted more frequently at the practitioner's discretion.
- Patients should always be verbally screened in private.
- The patient's right to confidentiality and safety is of primary importance.
- The screening tool should be part of the medical chart.
- Screening questions should also be included on a general health intake questionnaire.
- Use chart prompts such as colored stickers as a reminder to screen each patient at predetermined times.
- Chart reviews should be introduced to monitor screening, intervention and documentation compliance. This is useful as a method of measuring the effectiveness of the program and can be done on a quarterly basis.

- The screening process includes the following components:
  - Administering a screening questionnaire.
  - Taking a medical history and general assessment of the patient's mental status.
  - Observing the patient's behavior and asking her in a direct but non-threatening way whether she is experiencing abuse in her relationship (refer to page 13-19 for further information on guidelines for communicating effectively with the patient).
  - When possible, observe her partner's behavior for signs of power and control over her (refer to pages 54-56 for types of power and control). For example, the partner answers questions on behalf of the victim during the interview.

Access to language and interpretation services

- Do not use spouses, friends, family members, children or other patients as interpreters.
- Under Title VI of the Civil Rights Act of 1964, patients with limited English proficiency have the right to receive free interpreter services from any healthcare provider who receives Federal financial assistance.[55]
- Ensure that interpreters are professionally trained and are familiar with domestic violence.
- Reinforce the requirement for confidentiality to interpreters that are used for domestic violence cases.
- Interpretation services can also be provided by trained staff at the medical facility's language bank or by contracted telephone interpreters.

Documentation and confidentiality of patient information

- Determine a consistent method of effectively documenting domestic violence screening in medical charts.
- Completed screening assessments should be stored in the patient's file (refer to the Sample Screening Tool and Danger Assessment Instrument on pages 45-46).
- The U.S. Department of Justice recommends that the practitioner quote the patient's response to screening in a factual manner.
- Patients' names or personal details of cases should not be mentioned in public and should only be discussed with relevant professionals.
- Photographs of injuries provide useful forensic evidence of abuse and may be used in subsequent Criminal or Family Court proceedings.
- As of Fall 2003, all New York City hospitals will use digital cameras for the purpose of recording domestic violence injuries. Digital cameras are capable of capturing accurate images of injuries, regardless of skin color.

Services, resources and referrals

- Key domestic violence services should include:
  - Screening of patients.
  - Medical treatment for victims.
  - Crisis intervention (NYC Domestic Violence Hotline and counseling services).
  - Access to legal services and the Police Department.
  - Safety Assessment and Follow-up Plan, which should be collaboratively compiled with the patient.
  - Documentation of the following issues: whether screening took place; whether the patient disclosed abuse; a quote of the patient's description of the abuse; whether a safety plan has been discussed; what referrals have been made and when the patient will have a follow-up session. If possible, use photographs to document injuries.

- The Resource List on pages 48-53 provides names of organizations with relevant resources for the patient groups that attend your facility. Resource lists should be easily accessible to all staff members interacting with victims.

Materials for patients

- Each domestic violence victim should be provided with the following materials:
  - A general Safety Plan (as outlined on page 47).
  - Relevant referrals, including counseling services to assist the patient in managing the emotional trauma of the abuse.
  - Educational and resource materials such as brochures and discrete palm cards with relevant contact information.
- Place general outreach material such as posters, pamphlets and small information cards that are easily accessible to patients in the waiting room, examination rooms and bathrooms.
- According to New York State Law (New York Public Health §2803-p(2)), it is mandatory to provide abused patients with information concerning family violence to pregnant women and parents of newborn infants. Refer to the Resource List (page 49) for the NYS Office for the Prevention of Domestic Violence, for these documents.

Safety protocol

Danger Assessment

- It is useful to administer a Danger Assessment instrument to victims who have disclosed domestic violence. This tool assesses the degree to which a victim is at risk of being harmed again or of harming herself.
- Several risk factors have been associated with homicides of battered women and their batterers in research conducted after the murders occurred. We cannot predict what will happen in each case, but victims of domestic violence need to be aware of the homicide risk in situations of severe battering.
- Refer to page 46 for a copy of the Danger Assessment Instrument.

Safety Plan

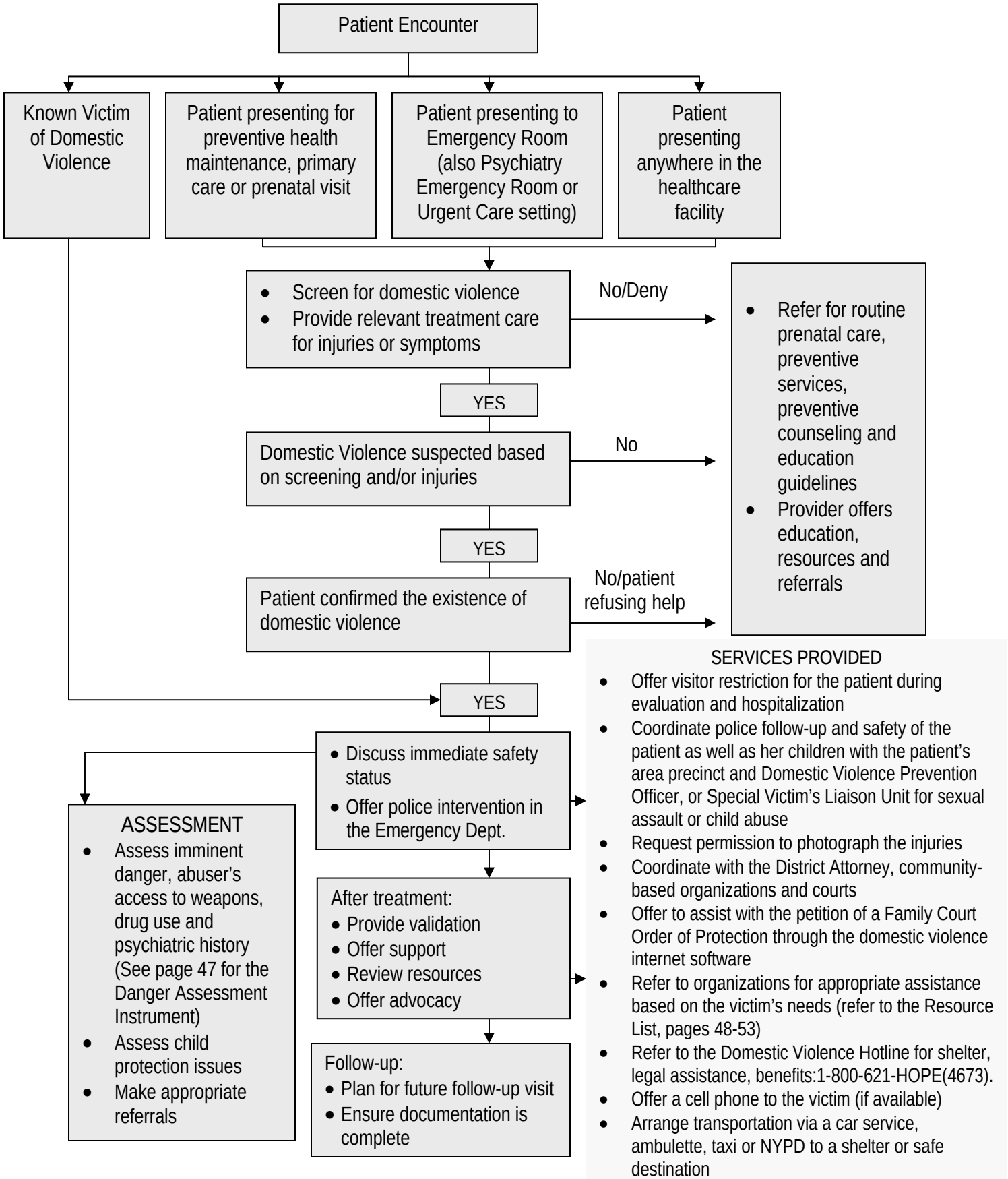
- The relevant personnel involved in managing domestic violence victims should ensure that each patient has a Safety Plan.
- Refer to the sample Safety Plan on page 47.

Additional Security Issues

- The Security Department should be involved in your domestic violence program to ensure safety.
- Educate security personnel on general indicators of domestic violence victims and abusers.
- Ensure that the facility protocol includes in-patient considerations, such as restricting visitation in order to protect the victim.
- If a patient has an Order of Protection against someone, gain permission from the victim to make a copy of this document for security personnel.

SAMPLE TREATMENT FLOWCHART

(Adapted from New York City Health and Hospitals Corporation: Domestic Violence Services) [44]



2004 Resources for All Immigrants

Anyone, regardless of immigration status, can use the following resources:

Emergency	911	All languages
Information on City services (non-emergency)	311	All languages
NYC Domestic Violence Hotline (including domestic violence shelters, legal assistance, benefits)	1-800-621-4673 TDD 1-866-604-5350	All languages
New York State Coalition Against Domestic Violence (outside NYC)	1-800-942-6906 (Spanish) 1-800-942-6908 TTY 1-800-818-0656	English, Spanish, TDD
Prenatal Care Assistance Program, (for women and infants)	1-800-522-5006	All languages
Child Abuse and Maltreatment Hotline (New York State Central Registry)	1-800-342-3720	All languages
Child Abuse Prevention Information and Parent Helpline (24 hours)	1-800-342-7472	All languages
Hunger Hotline (food emergency)	1-866-888-8777	English and Spanish
Women's Healthline 9 a.m. to 5 p.m. Mon.-Fri.	1-800-825-5448	All languages
AIDS Hotline 9 a.m. to 9 p.m. Mon. – Fri.	1-800-825-5448	All languages
General Health Line 9 a.m. to 6 p.m. Mon. – Fri.	1-800-825-5448	All languages
HealthStat (free or low-cost health insurance)	1-888-692-6116	English, Chinese, French-Creole, Spanish and Russian. All children, if otherwise eligible, are entitled to health care. Many adults are also eligible.
Education for children	www.nycenet.edu	All children regardless of immigration status can attend school through grade 12.
Department for the Aging (for the elderly)	212-442-1000 or www.nyc.gov/aging	Information on benefits is available for seniors living in New York City.

Immigrants who have various types of immigration status may be eligible for public assistance such as medical assistance, cash and food stamps. Refer to pages 48-53 for additional resources. Adapted from the Mayor's Office for Immigrant Affairs website: www.nyc.gov/immigrants

Section III:

Assessment Tools, Safety Plan, Resource List, Types of Abuse, Power and Control Over Immigrant Women and Victim Empowerment Wheel

Sample Screening Tool

(This version of the screening tool is to be administered as an interview)

"Because many people experience violence by someone close to them, I have been asking all of my patients the following questions. I believe that no one should suffer from abuse. There are things that healthcare providers can do to help people who are being abused."

	Yes	No
1. Do you feel unsafe with anyone who lives with you or routinely stays in your home?		
2. Within the past year, has someone close to you:		
a) Hit, slapped, kicked, pushed or otherwise physically hurt you?		
b) Controlled your actions such as whom you see, whom you talk to, where you go or what you wear?		
c) Forced you to do something you don't want to do?		
d) Controlled your access to all finances?		
e) Prevented you from having access to your personal and legal documents?		
f) Threatened you?		
g) Intimidated you?		
h) Isolated you from friends and family?		
i) Constantly criticized you, called you names, or put you down?		
j) Used or threatened to use immigration status against you or your children?		
If yes, what is the relationship of that person to you?		
3. Within the past year, has anyone forced you to have unwanted sexual activity?		
If yes, what is the relationship of that person to you?		
4. Are you afraid of your partner, previous partner or anyone who may be living in your home?		
If the person answers "yes" to question 1,2,3 or 4, ask:		
5. Would you like:		
a) To discuss your situation with someone who has expertise in these matters?		
b) Additional information on domestic violence?		

Comments: _____

_____

_____

Referrals made to: (E.g. Social Work Dept., Arab-Am Family Support Center, CAMBA, NY Asian Women's Center)

_____

_____

Follow-up Plan: _____

_____

Completed by: _____ Date: _____

Adapted from the following assessment tools:
Injury Assessment Screen [63]
Abuse Assessment Screen[64]
Mercy Domestic Safety Assessment [65]
2002 Focus Groups

DANGER ASSESSMENT INSTRUMENT

Several risk factors have been associated with homicides (murders) of battered women and their batterers in research conducted after the murders occurred. We cannot predict what will happen in your case, but we would like you to be aware of the homicide risk in situations of severe battering. Please answer the questions below to see how many of the homicide risk factors apply to your situation.

Please mark Yes or No for each of the following. ("He" refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you).

1	Has the violence increased in frequency over the past year?	Yes	No
2	Has he ever used a weapon against you or threatened you with a weapon?	Yes	No
3	Does he ever try to choke you?	Yes	No
4	Does he own a gun?	Yes	No
5	Has he ever forced you to have sex when you did not wish to do so?	Yes	No
6	Does he use drugs? By drugs, I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack", street drugs or mixtures.	Yes	No
7	Does he threaten to kill you and/or do you believe he is capable of killing you?	Yes	No
8	Is he drunk every day or almost every day? (In terms of quantity of alcohol.)	Yes	No
9	Does he control most or all of your daily activities? For instance: does he tell you who you can be friends with, how much money you can take with you shopping, or when you can take the car? (If he tries, but you do not let him, check here: _____)	Yes	No
10	Have you ever been beaten by him when you were pregnant? (If you have never been pregnant by him, check here: _____)	Yes	No
11	Is he violently and consistently jealous of you? (For instance, does he say, "If I can't have you, no one can.")	Yes	No
12	Have you ever threatened or tried to commit suicide?	Yes	No
13	Has he ever threatened or tried to commit suicide?	Yes	No
14	Does he threaten to harm your children?	Yes	No
15	Do you have a child that is not his?	Yes	No
16	Is he unemployed?	Yes	No
17	Have you left him during the past year? (If you never lived with him, check here:_____)	Yes	No
18	Do you currently have another (different) intimate partner?	Yes	No
19	Does he follow or spy on you, leave threatening notes, destroy your property, or call you when you don't want him to?	Yes	No

Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment means in terms of your situation.

SAFETY PLAN

- ☐ Call 911 if you are in danger or have been hurt by your partner.
- ☐ Have a neighbor or friend call 911 on your behalf if they hear suspicious noises coming from your home.
- ☐ Teach your children to use the telephone to call the police.
- ☐ Teach your children to go to a safe place during a violent incident, for example, their bedroom or a neighbor's house.
- ☐ Gather important documents, including:
    - __ Passports (for you and your children)
    - __ Greencards (for you and your children)
    - __ Social Security cards (for you and your children)
    - __ Work permit
    - __ Marriage and birth certificates
    - __ Children's immunization and school records
    - __ Driver's license
    - __ Bank account details
    - __ Order of Protection
    - __ Custody papers
    - __ Medical insurance card
    - __ Welfare identification card
- ☐ Keep these documents in a safe and immediately accessible place.
- ☐ Gather sentimental photographs (including photographs of the abuser) and other personal items.
- ☐ Hide some money, a checkbook, ATM card, spare keys, medications and a bag packed with necessities for you and your children.
- ☐ Identify a place to stay in case of an emergency.
- ☐ Know the location of your local police precinct.
- ☐ Memorize the number of a domestic violence agency. The number for the Domestic Violence Hotline is 1-800-621-HOPE (4673) or call 311 for New York City services.
- ☐ Document your abuse. Take photographs of injuries; get copies of medical and police reports; or write down each incident in a journal. Each City hospital has a Domestic Violence Coordinator who will take and confidentially store photographs of your injuries.
- ☐ Obtain an Order of Protection and give a copy to your local police precinct and children's school or childcare provider.
- ☐ If applicable, speak to an immigration attorney specializing in domestic violence remedies.

NYC RESOURCE LIST FOR VICTIMS OF DOMESTIC VIOLENCE*

NYC Domestic Violence Hotline (all languages)
1-800-621-4673 TDD: 1-866-604-5350

Directory of City Resources	NYC Mayor's Office to Combat Domestic Violence	212-788-3156 www.nyc.gov/domesticviolence
	NYC Alliance Against Sexual Assault	212-523-4344 www.nycagainstrape.org
Hotlines	For emergencies	911
	General information on New York City Services	311
	NYC Domestic Violence Hotline (all languages, 24 hour, shelter, benefits, counseling, legal assistance, teen services, and other necessary referrals)	1-800-621-4673 TDD: 1-866-604-5350
	NYC Incest/Sexual Assault Hotline (24 hour) (English and Spanish)	212-267-7273
	NYC Crime Victims Hotline (all languages, 24 hour)	212-577-7777
	NYPD Sex Crimes Report Hotline (Spanish and English, 24 hour)	212-267-7273
	NY State Coalition Against Domestic Violence (outside of NYC) (all languages, 24 hour)	1-800-942-6906 Spanish: 1-800-942-6908 TDD: 1-800-818-0656
	AIDS Hotline (NYC Department of Health and Mental Hygiene Call Center) (9AM-9PM, closed Sunday, all languages, service referral)	1-800-825-5448
	CAMBA Rape Crisis Hotline	1-800-310-2449
	Child Abuse and Maltreatment Hotline (NYS Central Register for reporting child abuse) (142 languages, 24 hour)	1-800-342-3720
	Child Abuse Prevention Information Resource Center and Parent Helpline (Prevent Child Abuse New York)	1-800-342-7472
	DYCD YOUTHLINE (crisis intervention and youth service referral, all language and Braille printing capabilities, 9AM-9PM M-F, 12PM-8PM Saturday and Sunday)	1-800-246-4646 TDD: 1-800-246-4699
	Elderly Crime Victims Resource Center (English and Spanish)	212-442-3103
	Family Violence Hotline (Jewish Board of Family and Children's Services) (Spanish, English 24 hour)	718-237-1337
	Korean American Family Service Center (English, Korean, 24 hour hotline)	718-460-3800
	Hunger Hotline (food emergency)	1-866-888-8777
	LifeNet (24-hour/7-day counseling and information line for mental health services in your neighborhood--provides services in over 150 languages)	1-800-LIFENET (ask for interpreter for other languages) Spanish 1-877-AYUDESE Chinese, Korean 1-877-990-8585 TDD: 212-982-5284
	PCAP (Prenatal Care Assistance Program) (for women and infants, all languages, 24 hour)	1-800-522-5006
	Shalom Task Force (English, Hebrew, Yiddish and Russian on Wednesday from 12PM-3PM. Service hours: Mon 9AM-5PM, 8PM-10PM, Tue-Th 9AM-10PM, Fri and Sun 9AM-12PM)	1-888-883-2323 or 718-337-3700
	Trafficking and Worker Exploitation Hotline (to report cases to the U.S. Departments of Justice and Labor) (Over 150 languages)	1-888-428-7581
	Violence Intervention Program Hotline (English, Spanish, 8AM-6PM M-F, Saturday, Sunday and M-F after 6PM answering service)	1-800-664-5880

**this is a non-exhaustive list*

	Victim Information Notification Everyday (VINE) Program (for determining a batterer's release date from a correctional facility)	1-888-846-3469
	Women's HealthLine (All languages)	1-800-825-5448
Counseling, advocacy and other services	African Services Committee (English, Arabic, French, Spanish, Bambara, Wolof, Pular, Soninke, Haitian-Creole. Monday and Thursday 9AM-7:30PM. Tuesday, Wednesday, and Friday 9AM-5PM. DV walk-ins Tuesday and Thursday 9AM-5PM)	212-222-3882
	Arab American Family Support Center (English, Arabic, French)	718-643-8000
	Barrier-Free Living (for victims of abuse with disabilities) (English, Spanish, Creole, French, Italian, Sign Language)	212-533-4358
	Bronx AIDS Services, Inc. (Serves residents of the Bronx with HIV. Spanish, English. Tuesday and Thursday 9AM-12PM, 2PM-4PM)	718-295-5598
	CAMBA (English, Arabic, French, Haitian-Creole, Caribbean and other communities in the Brooklyn/Flatbush area)	718-282-5575 Rape Crisis Hotline: 1-800-310-2449 www.camba.org
	Caribbean Women's Health Association (English, Haitian-Creole, Spanish)	718-826-2942 (M-F 9:00-6:00 PM)
	Children's Aid Society (counseling for parents and children who have experienced domestic violence, teen group and individual counseling. English and Spanish)	212-503-6842 / 6829 (Family Wellness Program for Domestic Violence)
	Dwa Fanm (English, French, Haitian-Creole)	1-866-345-FANM (3266) 347-661-6404 (24 hour)
	Elpides (English, Greek)	718-932-2879
	Emerald Isle Immigration Center (English, Spanish, Monday – Thursday 9AM-5PM, Friday 9AM-3PM))	718-478-5502 (Queens Office) 718-324-3039 (Bronx Office) www.eiic.org
	HealthStat (free or low-cost insurance)	1-888-692-6116
	Haitian Centers Council (English, French, Haitian-Creole, M-F, 9-5PM, Saturday by appointment)	718-855-7275
	Harlem Legal Services (English, French, French-Creole, Spanish. Serves clients residing north of 110th Street to the Bronx county line, and west of 5th Avenue until Riverside Drive)	212-348-7449
	Korean American Family Service Center (English, Korean, 24 hour hotline)	718-460-3800
	LifeNet (24-hour/7-day counseling and information line for mental health services in your neighborhood--provides services in over 150 languages)	1-800-LIFENET (ask for interpreter for other languages) Spanish 1-877-AYUDESE Chinese, Korean 877-990-8585 TDD: 212-982-5284
	Metropolitan Council on Jewish Poverty (English, Hebrew, Russian)	212-453-9618
	Mount Sinai Sexual Assault and Violence Intervention (SAVI) Program (English, French, Gujarati, Hebrew, Hindi, Italian, Portuguese, Spanish. Serves clients citywide)	212-423-2140 (Manhattan) 718-736-1288 (Queens) www.mssm.edu/SAVI
	Neighborhood Youth & Family Services (English, Spanish, 8:30AM-5:30PM M-F, serves residents in the Bronx only)	718-299-2340
	New Destiny Housing	www.newdestinyhousing.org

	New York Asian Women's Center (English, Chinese, Hindi, Japanese, Korean, Urdu, Bengali, 24 hour)	1-888-888-7702 www.nyawc.org
	New York Association for New Americans (English, Bengali, Bosnian, Croatian, French, French-Creole, Hebrew, Hindi, Punjabi, Russian, Serbian, Spanish, Urdu, Chinese)	1-888-242-5838
	NYC Anti-Violence Project (Gay, Lesbian, Bisexual, Transgender) (English, Spanish, 24 hour)	212-714-1141 www.avp.org
	Northern Manhattan Improvement Corp. (Serves clients who reside or have ties to Community Board 12 –north of 155th St.) (English, Spanish)	212-822-8300 / 8311 (Manhattan)
	Ohel Children's Home and Family Services (English, Hebrew, Yiddish) (8:30AM-5:30PM M-F. Serves Jewish women in all boroughs)	718-851-6300
	Project Eden (Kings County District Attorney's Office, English, Hebrew, Russian, Yiddish)	718-250-2005
	Queens Legal Services (Romanian, Italian, French, Hindi, Urdu, English, Spanish. Serves residents of Queens only)	718-657-8611
	Queens Women's Network (English, Spanish)	718-657-6200
	Raccoon (English, Albanian, Bosnian, Croatian, Serbian, Slovenian, M-F 10AM-6PM, evenings and weekends by appointment)	718-784-9121
	Sakhi for South Asian Women (English, Bengali, Gujarati, Hindi, Telugu, Urdu, other South Asian languages by request, 10AM-6PM M-F)	212-868-6741
	Sanctuary for Families (English, American Sign Language, Bengali, Dutch, French, French-Creole, German, Greek, Hindi, Korean, Mandarin, Polish, Punjabi, Russian, Spanish, Urdu)	212-349-6009
	St. Luke's Roosevelt Hospital Crime Victims Treatment Center (English and Spanish, specializing in sexual assault counseling and HIV counseling)	212-523-4728
	Violence Intervention Program (English, Spanish, 8AM-6PM M-F, Saturday, Sunday and M-F after 6PM answering service)	1-800-664-5880
Cultural Competence	National Center for Cultural Competence	www.georgetown.edu/research/gucdc/nccc/
	New York State Office for the Prevention of Domestic Violence	www.opdv.state.ny.us/health_humsvc/health/index.html
Children and teen services *Child abuse information and reporting*	ACS Office of Domestic Violence Policy and Planning	212-341-0408
	Child Abuse and Maltreatment Hotline (NYS Central Register for reporting child abuse) (All languages, 24 hour)	1-800-342-3720
	Child Abuse Prevention Information Resource Center and Parent Helpline (Prevent Child Abuse New York)	1-800-342-7472
	NYC Domestic Violence Hotline (all languages, 24 hour, shelter, benefits, counseling, legal assistance, teen services, and other necessary referrals)	1-800-621-4673 TDD: 1-866-604-5350
Information and referrals for teens	DYCD YOUTHLINE (crisis intervention and youth service referral, all language and Braille printing capabilities. 9AM-9PM M-F, 12PM-8PM Saturday and Sunday)	1-800-246-4646 TDD: 1-800-246-4699
	LifeNet (24-hour/7-day counseling and information line for mental health services in your neighborhood--provides services in over 150 languages)	1-800-LIFENET (ask for interpreter for other languages) Spanish 877-AYUDESE Chinese, Korean 877-990-8585 TDD: 212-982-5284

Services for children and teens	ACS (Administration for Children's Services)	www.nyc.gov/acs
	Beth Israel Medical Center (English and Spanish. Ages 12 and up)	212-420-4054
	Children's Aid Society (counseling for parents and children who have experienced domestic violence, teen group and individual counseling. English and Spanish)	212-503-6842 / 6829 (Family Wellness Program for Domestic Violence)
	Domestic & Other Violence Emergencies (DOVE) Columbia Presbyterian Hospital	212-305-4726
	The Door (English, Spanish, and Chinese. Includes services for same sex relationships. Teens only. M-Th 2PM-8:30PM, Saturday 10AM-4PM)	212-941-9090 ext. 3272
	Hetrick Martin Institute (Includes services for same sex relationships)	212-674-2400
	Jacobi Medical Hospital	718-918-3895
	Korean American Family Service Center (English, Korean, 24 hour hotline)	718-460-3800
	Mt. Sinai Adolescent Health Center (provides medical, mental health and reproductive health services, and prevention education)	212-423-2900
	North Central Bronx Hospital	718-519-4798
	Safe Horizon Bronx Community Office	718-933-1000
	Safe Horizon Staten Island Community Office (English, Spanish and Ukranian. Provides services for victims only)	718-720-2591
	Sanctuary for Families (English, American Sign Language, Bengali, Dutch, French, French-Creole, German, Greek, Hindi, Korean, Mandarin, Polish, Punjabi, Russian, Spanish, Urdu)	212-349-6009
	St. Luke's Roosevelt Crime Victim Treatment Center (English and Spanish. Ages12 and up)	212-523-4728
	Staten Island University Hospital Teen Risk Assessment Program (R.A.P.) (Medical, reproductive and mental health care for teens)	718-226-8336
	Steps to End Family Violence Program (counseling for children and teens, teen men's group)	212-410-4200 ext. 125
Immigration Legal Assistance and Information	Emerald Isle Immigration Center (English, Spanish, Mon – Th 9AM-5PM, Friday 9AM-3PM))	718-478-5502 (Queens) 718-324-3039 (Bronx) www.eiic.org
	Greater Upstate Law Project	www.empirejustice.org
	Legal Aid Society, Immigration Unit	212-577-3300
	Mayor's Office of Immigrant Affairs and Language Services	www.nyc.gov/immigrants
	New York Association for New Americans (English, Bengali, Bosnian, Croatian, French, French-Creole, Hebrew, Hindi, Punjabi, Russian, Serbian, Spanish, Urdu, Chinese)	1-888-242-5838
	Sanctuary for Families, Center for Battered Women's Legal Services (English, American Sign Language, Bengali, Dutch, French, French-Creole, German, Greek, Hindi, Korean, Mandarin, Polish, Punjabi, Russian, Spanish, Urdu)	212-349-6009 www.sanctuaryforfamilies.org
	Violence Intervention Program (English, Spanish, 8AM-6PM M-F, Saturday, Sunday and M-F after 6PM answering service)	1-800-664-5880

Legal Services, Advocacy and Referrals	Arab American Family Support Center (English, Arabic, French)	718-643-8000
	Association of the Bar of the City of New York Fund (English, Spanish)	212-626-7373 (referrals) 212-626-7383 (M-F, 9-12:30, referrals, legal info only)
	Brooklyn Bar Association, Battered Women's HelpLine (English, Spanish)	718-624-7700
	Bronx Legal Services, Family Law Unit (English, Spanish)	718-928-3700
	CAMBA (English, Arabic, French, Haitian-Creole, Caribbean and other communities in the Brooklyn/Flatbush area.)	718-282-5575 Rape Crisis Hotline: 1-800-310-2449 www.camba.org
	Center for Court Innovation (legal information for service providers)	212-397-3050 www.courtinnovation.org
	Connect NYC (English, French, Spanish)	212-683-0605
	Haitian Centers Council (English, French-Creole)	718-855-7275 (M-F, 9-5PM)
	Harlem Legal Services (English, French, French-Creole, Spanish. Serves clients residing north of 110th Street to the Bronx county line, and west of 5th Avenue until Riverside Drive)	212-348-7449
	InMotion (English and Spanish)	212-695-3800 9:30AM-5:30PM (Manhattan) 718-562-8181 (Bronx) www.inmotiononline.org
	Emerald Isle Immigration Center (English, Spanish, Monday – Thursday 9AM-5PM, Friday 9AM-3PM))	718-478-5502 (Queens Office) 718-324-3039 (Bronx Office) www.eiic.org
	LawHelp	www.lawhelp.org
	Legal Aid Society, Domestic Violence Project (English and Spanish)	718-991-4600 (Bronx) 718-722-3100 (Brooklyn) 212-577-3300 (Manhattan) 718-286-2450 (Queens) 718-273-6677, M 9-12 (S.I.) 1-800-649-9125 (Homeless Services Division)
	Main Street Legal Services, Inc, Battered Women's Rights Clinic (English, Spanish)	718-340-4300 (Queens)
	MFY Legal Services, Family Law Unit (English, Cantonese, French, French-Creole, Mandarin, Spanish)	212-417-3789 (Manhattan) (Tues 1-3 PM)
	New York Asian Women's Center (English, Chinese, Hindi, Japanese, Korean, Urdu, Bengali, 24 hour)	1-888-888-7702 www.nyawc.org
	New York Association for New Americans (English, Bengali, Bosnian, Croatian, French, French-Creole, Hebrew, Hindi, Punjabi, Russian, Serbian, Spanish, Urdu, Chinese)	1-888-242-5838
	New York Legal Assistance Group (Chinese, English, French, Hebrew, Russian, Spanish, Yiddish)	212-613-5000
	Northern Manhattan Improvement Corp. (Serves clients who reside or have ties to Community Board 12 –north of 155th St. Legal, social, and job placement services for intimate partner violence only) (English, Spanish)	212-822-8300 / 8311 (Manhattan)

	Project Eden (Kings County District Attorney's Office, English, Hebrew, Russian, Yiddish)	718-250-2005
	Queens Legal Services (Romanian, Italian, French, Hindi, Urdu, English, Spanish. Serves residents of Queens only)	718-657-8611
	Safe Horizon Domestic Violence Law Project (English, Hebrew, Spanish)	212-577-3220
	Sanctuary for Families, Center for Battered Women's Legal Services (English, American Sign Language, Bengali, Dutch, French, French-Creole, German, Greek, Hindi, Korean, Mandarin, Polish, Punjabi, Russian, Spanish, Urdu)	212-349-6009 sanctuaryforfamilies.org
	South Brooklyn Legal Services, Family Law Unit (Spanish, English; Serves all of Brooklyn)	718-237-5563 (Hotline) (Tue/Thur 12-1 PM) 718-237-5500 (Front Desk) www.sbls.org
	New York State Office for the Prevention of Domestic Violence	www.opdv.state.ny.us
Workplace Policy Resources	United States Office of Personnel Management	www.opm.gov/ehs/workplac/html/domestic.asp
	Corporate Alliance to End Partner Violence	www.caepv.org
	New York City's Human Rights Commission (Legal services for employment discrimination, English, Spanish, French Creole, Mandarin)	212-306-7450 or 311 www.nyc.gov/cchr
	New York State Office for the Prevention of Domestic Violence	www.opdv.state.ny.us
	Legal Momentum	www.legalmomentum.org/

CITY HOSPITALS WITH DOMESTIC VIOLENCE COORDINATORS

(Health and Hospitals Corporation)

Borough	Hospital	General Information
Bronx	Jacobi Medical Center Lincoln Hospital & Mental Health Center North Central Bronx Hospital	(718) 918-5000 (718) 579-5000 (718) 519-5000
Brooklyn	Coney Island Hospital Kings County Hospital Center Woodhull Medical and Mental Health Center	(718) 616-3000 (718) 245-3131 (718) 963-8000
Manhattan	Bellevue Hospital Center Harlem Hospital Metropolitan Hospital	(212) 562-4141 (212) 939-1000 (212) 423-6262
Queens	Elmhurst Hospital Center Queens Hospital Center	(718) 334-4000 (718) 883-3000

TYPES OF POWER AND CONTROL[67]

Physical violence

- Hitting, punching, kicking
- Withholding medications
- Attempting to force miscarriage

Sexual violence

- Forced sexual activities
- Forced prostitution or exotic dancing
- Threatening to sexually abuse children

Using coercion or threats

- Making and/or carrying out threats to hurt her
- Threatening to leave her, to commit suicide, to report her to welfare or immigration officials
- Making her drop existing charges

Using intimidation

- Making her afraid by using looks, actions or gestures
- Smashing things and destroying her property
- Displaying weapons as a threat to harm her

Using emotional abuse

- Putting her down and making her feel bad about herself
- Making her think that she is "crazy"
- Humiliating her and calling her names including racial slurs

Using isolation

- Controlling what she does, who she sees, who she talks to and where she goes
- Limiting her involvement with others
- Using jealousy to justify his actions

Using economic abuse

- Preventing her from getting or keeping a job
- Forcing the victim to work "under the table"
- Taking the victim's earned income

Using children

- Using children to relay intimidating or threatening messages to her
- Threatening to take children away from her
- Using visitation to harass her

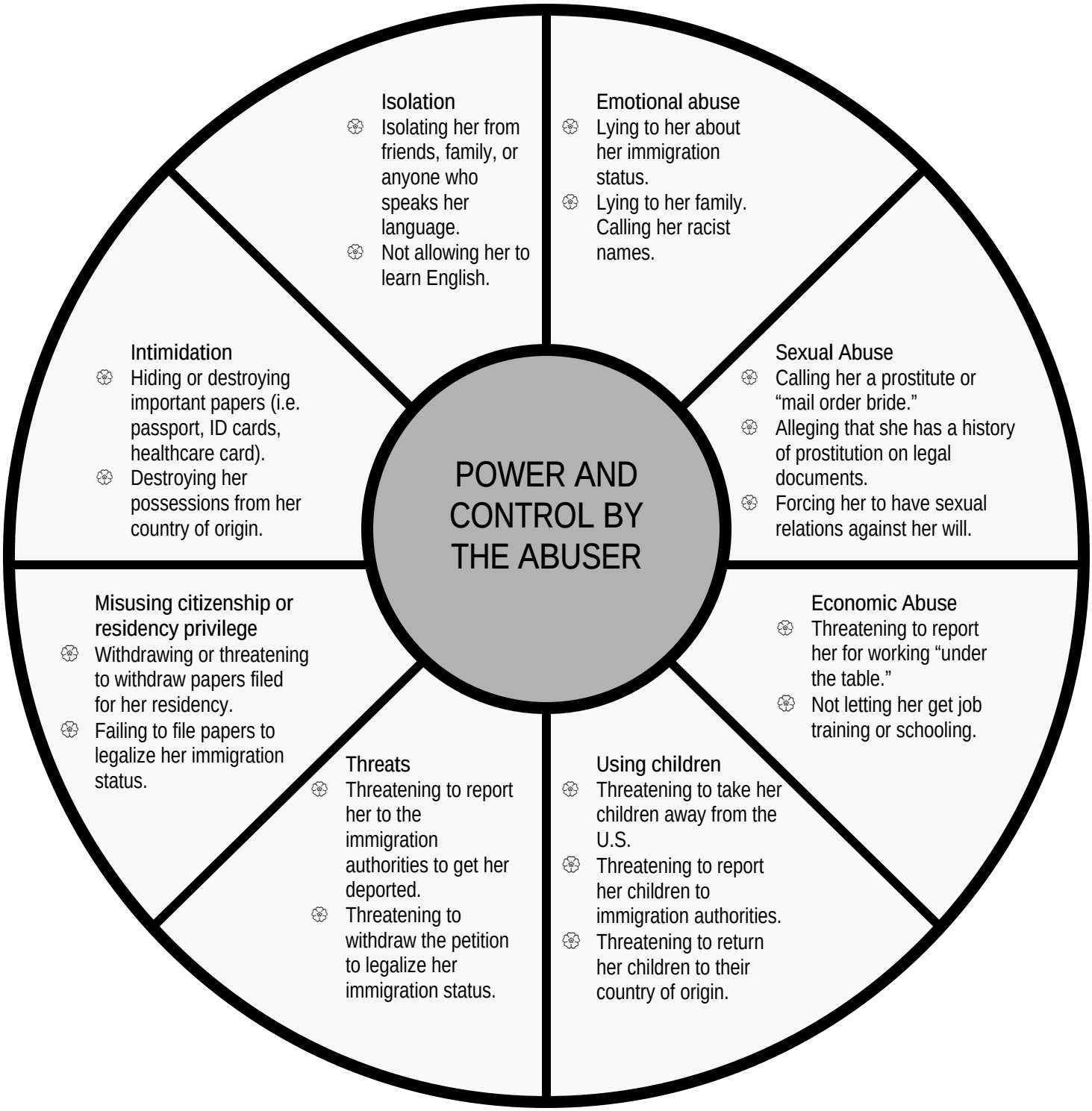
Minimizing, denying and blaming

- Saying the abuse didn't happen
- Saying she caused the abuse
- Making light of the abuse

Using assumed male privilege

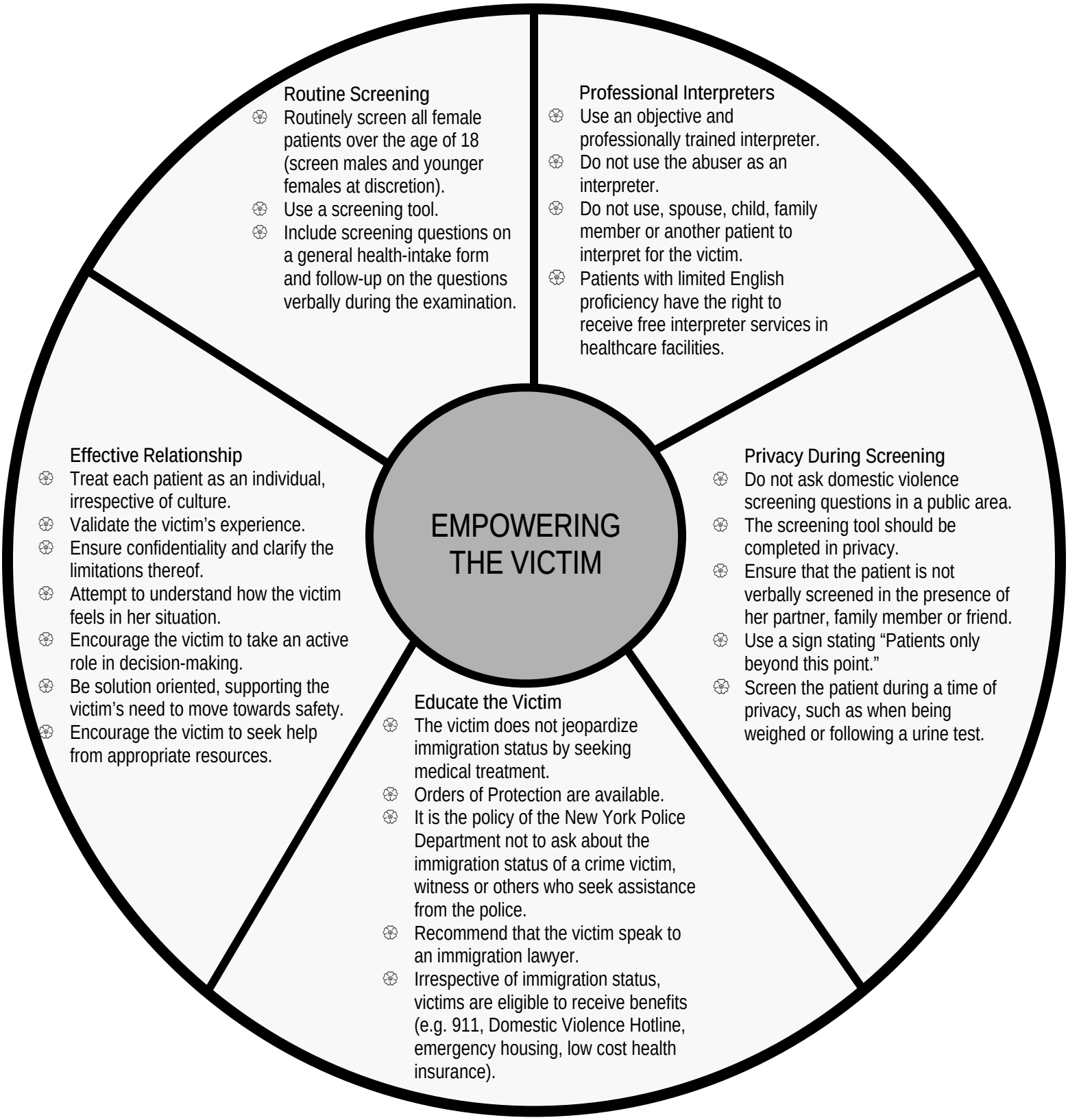
- Expecting subservience based on her perceived status as a woman
- Treating her like a servant
- Making relevant decisions unanimously
- Being the one to define the male and female roles in their relationship

POWER AND CONTROL OVER IMMIGRANT WOMEN[67]



This material was adapted from the publication entitled "Power and Control Tactics Used Against Immigrant Women," produced by the Family Violence Prevention Fund (FVPF): www.endabuse.org. This version of the Power and Control Wheel, adapted with permission from the Domestic Abuse Intervention Project in Duluth, Minnesota, focuses on some of the many ways battered immigrant women can be abused.

VICTIM EMPOWERMENT WHEEL



Section IV:

Learning in Action

PART ONE

Practical Exercises regarding the Care of Victims from Diverse Cultures

SCENARIO NUMBER 1

Kim is 18 years old and in the second trimester of her pregnancy. She has an appointment at a prenatal clinic because she is experiencing some light bleeding. Kim's sister-in-law accompanies her to the doctor and serves as the interpreter during her examination. Kim is very quiet, and the doctor conducts a regular examination.

Questions:

1. What are the potential barriers for Kim to disclose her abusive situation? _____
   _____
   _____
2. Is Kim's sister-in-law an appropriate interpreter? _____
3. Should the doctor screen Kim for domestic violence? _____
4. Who should accompany Kim to the examination room? _____
5. What types of questions should the doctor ask regarding the bleeding? _____
   _____
   _____

Answers:

1. Barriers include: Kim's sister-in-law's presence in the examination room may inhibit disclosure; the provider does not affirmatively screen for abuse or ask follow-up questions in this regard; the victim lacks an objective and professional interpreter.
2. No, Kim's sister-in-law is not an appropriate interpreter because she is a family member. Secure a trained interpreter from hospital staff or use a language line.
3. Yes, Kim should be screened for domestic violence, including follow-up questions during the examination.
4. During domestic violence screening, only the required medical personnel should be present.
5. Abused adolescents are more likely to experience first or second trimester bleeding than adolescents who are not being abused. Examples of questions that the doctor can ask the patient include: When did the bleeding start? Did anything happen to you that might have caused this bleeding?

SCENARIO NUMBER 2

Gloria visits the local HIV clinic. She has contracted HIV from her abusive boyfriend who regularly sexually assaulted her. Gloria's physician is concerned because her partner interferes with her drug regimen by refusing to give her the money to purchase all of the required medication and prevents her from taking it at the required times. Gloria is upset because her boyfriend humiliates her in public by declaring that she contracted HIV through promiscuous behavior.

Questions:

1. What are the potential barriers for Gloria to disclose her abusive situation? _____
   _____
   _____
2. What types of abuse are occurring? _____
3. What questions would you ask Gloria? _____
   _____
4. Is there a specific referral available for Gloria? _____
   _____

Answers:

1. Barriers include: lack of knowledge that forced sex constitutes abuse; shame of forced sexual activity; shame of HIV positive status; the abuser controls her access to medical treatment.
2. Sexual abuse, financial abuse and emotional abuse.
3. What does your boyfriend do to interfere with your drug regimen? How often does his behavior prevent you from buying or taking your medication? Would you like to discuss available options for assistance in resolving this situation?
4. Gloria can be referred to a licensed domestic violence service provider, a hospital social worker, or a community-based HIV service organization such as the Crime Victims Treatment Center at St. Luke's Roosevelt Hospital or Bronx AIDS Services. Her treatment should consider both her abuse as well as her HIV status. Please use the Resource List on pages 48-53. Depending on your facility's protocol, either direct the victim to these resources or refer her to the Domestic Violence Coordinator.

SCENARIO NUMBER 3

Aisha's husband accompanies her to a busy emergency department where she is diagnosed with a broken rib. Her medical record and stored digital photographs indicate that she came to the emergency room with a broken nose three months ago that she claimed was the result of a fall. Her husband is very attentive and does not leave her side. Aisha has recently moved to the United States and does not speak English. She believes that her community will shun her if she discloses the abuse. She fears her family will abandon her and that her husband will force her to return to her country of origin. Her husband interprets for her. The doctor diagnoses her broken rib and prescribes an analgesic.

Questions:

1. What are the potential challenges for Aisha to disclose her abusive situation? _____

_____

_____

2. Should Aisha's husband be allowed to remain in the room during the examination? _____

_____

_____

3. What is the relevance of checking the patient's medical history and stored digital photographs? _____

_____

4. How would you screen the patient in private, while minimizing any risk to the victim? _____

_____

_____

Answers:

1. Barriers include: the provider does not screen; the suspected abuser's presence in the examination room inhibits disclosure by the victim; fear of deportation; lack of a professional interpreter.
2. No, the patient should be screened for domestic violence outside the presence of the batterer and family members.
3. The medical history should be checked in order to determine whether visits to the emergency room establish a pattern of injuries that indicate domestic violence.
4. Be careful not to induce conflict between the victim and the abuser. Tell the abuser that it is a standard procedure for each patient to be examined alone. Use a sign stating "Patients only beyond this point". Screen the patient during a time of privacy following a urine test or when she is being weighed. Request that the suspected abuser complete some administrative forms while the patient is screened in a separate room. The practitioner could speak to the suspected abuser concerning a routine health issue while another member of staff screens the victim. Use a key word that indicates the presence of a potential domestic violence situation to a staff member. The victim would then be called out of the examination room to discuss the possibility of domestic violence, while the practitioner remains with the abuser. Refer to "Lack of privacy from the abuser or family member during screening", page 25.

SCENARIO NUMBER 4

Carla, a woman from Mexico, looks sad and reports insomnia, a lack of appetite and a loss of interest in most areas of her life. A clinical examination reveals significant bruising on her inner thighs. The doctor identifies such injuries as possibly being caused by abuse, and promptly proceeds to screen the patient for domestic violence. Carla refuses to answer the questions. The doctor feels frustrated so he gives Carla the number for the Domestic Violence Hotline. Carla does not want to take the number with her and leaves it behind in the examination room.

Questions:

1. Prior to asking screening questions, how could the doctor have attempted to gain an understanding of the victim's culture and the implications of her disclosing domestic violence? _____

   _____

   _____
2. Are forced sexual relations within the context of marriage a form of abuse? _____

   _____
3. What are some possible reasons why Carla may not have taken the Domestic Violence Hotline number?

   _____

   _____
4. Should the doctor screen Carla for clinical depression? _____

   Why or why not? _____
5. What else can a doctor do in the situation if a patient chooses not to admit that she is a victim of domestic violence? _____

   _____

Answers:

1. Allow the victim to explain the cause of her injuries before asking screening questions. Ask the patient general questions about her life and support system in order to gain a better understanding of her culture; e.g. "What is your life like now that you have moved to New York?"; "Do you have a family member or close friend in New York that you can talk to about difficult situations in your life?"; "What is it like in your community when someone talks about personal issues to an outsider?"
2. Yes.
3. Carla may not realize that the Domestic Violence Hotline provides services in Spanish. She may also fear retaliation from the abuser and abandonment from her family or community. She may justify the requirement to be sexually subservient to her husband based on her religious beliefs or education.
4. Yes. Carla has typical symptoms of depression. She may be at risk for committing suicide. Carla's lack of motivation may prevent her from taking the appropriate action to manage her domestic violence situation.
5. Refer to page 22 for guidelines on managing a victim who denies the abuse or refuses help.

SCENARIO NUMBER 5

Laura makes her annual visit to the gynecologist. The doctor is friendly with Laura's fiancé's father, and uses this as a point of discussion to establish a relationship with the patient. Laura appears to be a shy person who is not comfortable with superficial conversation. The doctor assumes that she does not require screening for domestic violence in light of his connection to Laura's fiancé's family.

Questions:

1. Does a domestic violence victim always have injuries when she visits the doctor? _____
2. Other than physical injuries, note some potential indicators of domestic violence. _____
   _____
3. Is it possible for a family friend who the doctor has known for many years to be an abuser or victim of domestic violence? _____
4. Should a patient with no obvious injuries still be screened for domestic violence? _____
5. How could the doctor have created a trusting professional relationship with Laura as a victim of domestic violence, despite his association with her fiancé's family? _____
   _____
   _____

Answers:

1. No.
2. Sexual, financial, social and emotional symptoms of abuse may also be present. (Refer to the Types of Power and Control, pages 54-55).
3. Yes.
4. Yes. Every woman over the age of 18 years should be routinely screened for domestic violence. Younger patients should be screened at the doctor's discretion.
5. The doctor should affirm his commitment to honoring the patient's right to confidentiality. When necessary, the limits to confidentiality should be explained to the patient.

SCENARIO NUMBER 6

Sue has been in a relationship with Greg for six years. Greg began beating her after she became pregnant with their first child. Greg told Sue that she should have an abortion because she would be a bad mother. Sue told the doctor that Greg ties her down and forces her to have sex with him without any contraception, but then accuses her of being a slut when she becomes pregnant. Sue feels that it is her duty to have sex with Greg and therefore does not resist this violent sexual behavior. Sue tells the doctor that she has thought about leaving the relationship many times, but that she still loves Greg and believes that if she were a better person, he would not hurt her so much. The doctor tells Sue that the abuse cannot be so bad if she has chosen to remain in the relationship for such a long time.

Questions:

1. Is it ever appropriate for the doctor to tell Sue that "the abuse cannot be so bad if she has chosen to remain in the relationship with for such a long time"? _____
2. What could the doctor have said to validate Sue's experience of abuse? _____

   _____

   _____

   _____
3. Is forced abortion considered to be a form of abuse? _____

   _____
4. What are some reasons that Sue may have remained within her abusive relationship? _____

   _____

   _____

   _____

Answers:

1. No.
2. The doctor could validate Sue's experience by acknowledging her courage for disclosing her abuse. He could attempt to understand how Sue feels in her current relationship with Greg, without judging her beliefs or decisions. The doctor could encourage Sue to take an active role in decision-making, be solution-oriented, and encourage her to seek assistance from appropriate resources.
3. Yes.
4. She may be economically dependent on the abuser; fear his retaliation if she attempts to leave; be concerned about her children growing up without the presence of a father; have low self-esteem. Also, the abuse may vary in intensity and is not always unbearable. Refer also to "Challenges Preventing Immigrant Women from Disclosing Domestic Violence", pages 24-32.

SCENARIO NUMBER 7

Sylvia is a senior manager at a multinational pharmaceutical company. She has been in a relationship with Cecilia for two years. Sylvia sees a gynecologist that she has never consulted previously. She does not present with any physical or sexual signs of abuse. Sylvia states that she got divorced five years ago and that she has a child from that marriage. She tells the doctor that one of the reasons for her divorce was that her husband physically abused her on a regular basis. The practitioner fails to screen Sylvia for domestic violence based on her being in a lesbian relationship.

Questions:

1. Does domestic violence occur within lesbian relationships? _____
2. Should the practitioner abstain from screening any person based on her/him being in a relationship with a person of the same sex? _____
3. Are people in senior positions within the work environment exempt from becoming victims of abuse? _____

   _____
4. If Sylvia was in an abusive relationship previously, is it possible that she was susceptible to entering into the cycle of domestic violence again? _____

   _____

   _____

Answers:

1. Yes.
2. No, abuse occurs within both heterosexual and same-sex relationships.
3. No, all people are potential victims of domestic violence.
4. Yes, victims are susceptible to further partner violence if they do not resolve the issues from the initial abuse, and thereby break the destructive cycle.

SCENARIO NUMBER 8

Safoora is 16 years old and has been married for about six months. Her family arranged this marriage for her to a man in his 30's. Safoora is three months pregnant but seems to be unhappy about the prospect of being a mother. She tells the doctor that her husband screams at her and embarrasses her in front of the family. The doctor screens for physical abuse, and Safoora acknowledges that her husband has hit her on two occasions. She tells the doctor that they live in the same house as her in-laws, and that her mother-in-law accuses her of being a poor wife and a bad daughter-in-law. Her mother-in-law told Safoora that she deserves to be hit. Safoora has not discussed her domestic violence situation with anyone from her community because she does not want to bring shame to her family. The doctor tells Safoora that she should leave the relationship before it is too late.

Questions:

1. Would you refer Safoora to a counseling agency within her community?_____
   _____
   _____
2. How could the doctor encourage Safoora to manage her abusive situation without telling her to leave the abuser? _____
   _____
3. How could the doctor validate Safoora's experience and courage for disclosing her abuse? _____
   _____
   _____
4. Should the doctor educate Safoora on the risks of abuse during pregnancy? _____
   _____
   _____

Answers:

1. Yes. Provide the victim with contact details for both an agency that serves her cultural group as well as one outside her community. Allow the patient to make a choice about where she would prefer to seek assistance.
2. Provide the patient with a safety plan, counseling resources and the Domestic Violence Hotline telephone number.
3. Reassure Safoora that her feelings and reactions are understandable. Convey that abuse is wrong. Tell her that it must have taken a lot of courage to tell you about the abuse and thank her for sharing this challenging situation with you. Reinforce your concern for Safoora by referring her to relevant resources, such as a social worker. Refer to the section on methods of communicating effectively with the patient, pages 13-19.
4. Yes, both the risks to the mother and unborn child should be discussed.

SCENARIO NUMBER 9

Yasmin takes her 6-year old son to the pediatrician because he has the flu. At this appointment, Yasmin tells the doctor that her husband has been abusing her for many years and that she is currently feeling "depressed" because of the regular battering. Yasmin tells the pediatrician that she is concerned about her son's behavior because he frequently hits other children at school. Yasmin says that being hit by her husband is a normal part of her culture. She fears that her son will be taken away if she tells someone about the abuse, and that she will have to leave her home and go to a shelter because she is reliant upon her husband's income to pay the rent.

Questions:

1. What are the potential barriers for Yasmin to disclose her abusive situation? _____
   _____
   _____
2. Should the pediatrician ask Yasmin whether her husband is abusing their child? _____
   _____
3. Is it mandatory to report child abuse? _____
   _____
4. What recommendations could the doctor make regarding the behavior of Yasmin's child? _____
   _____
   _____
5. How would you respond to Yasmin's comment of abuse being accepted as part of her culture? _____
   _____
   _____
6. Is there a specific referral based on cultural background and the concerns regarding child abuse? _____
   _____
   _____

Answers:

1. Barriers include: fear of having her children taken away; her belief that the abuse is part of her culture; concern that she will be unable to financially support herself and her child.
2. Yes. Any domestic violence victim who has children should be questioned about their children's safety.
3. Yes. Refer to the section on mandatory reporting, pages 16-17 and "Mother's Fear of Having Children Removed from her Care", pages 29-30.
4. The doctor should tell Yasmin that her child's behavior might be caused by his emotional distress. He should give Yasmin a referral for children's counseling services, such as the Children's Aid Society, or refer her to a social worker or your facility's Domestic Violence Coordinator.
5. Reinforce that abuse is unacceptable. Please refer to pages 13-19 on guidelines for communicating effectively with patients from different cultures.
6. Familiarize yourself with the resources available for domestic violence victims. Please use the Resource List on pages 48-53 of this manual. Depending on your facility's protocol, either direct the victim to these resources or refer her to the Domestic Violence Coordinator.

SCENARIO NUMBER 10

Luisa is having her annual OB/GYN exam. Her gynecologist notices bruises on her back and chest that are in different stages of healing, and asks how the injuries occurred. After a few moments, Luisa begins to cry. Her doctor says that she does not deserve to be hit and that there is help available. Luisa begs her doctor not to tell anyone because she is an undocumented immigrant and fears legal authorities. She is also afraid that her community will find out about the abuse and view her as a bad wife. The doctor asks Luisa if she has spoken to her family about the abuse. Luisa explains that her family believes that she must be doing something wrong and therefore she deserves to be hit.

Questions:

1. What are the potential barriers for Luisa to disclose her abusive situation? _____
   _____
   _____
2. How should the doctor respond to Luisa's concerns regarding legal authorities? _____
   _____
   _____
3. What can the doctor do to address Luisa's concern about her family and community? _____
   _____
   _____

Answers:

1. Barriers include: blame from her family; fear of being ostracized by her community; fear of deportation and the legal implications of being an undocumented immigrant.
2. Inform Luisa that 1) it is the policy of the New York Police Department not to inquire about the immigration status of a crime victim, witness or others who seek assistance from the police; and 2) she should speak with an immigration lawyer who specializes in immigration remedies for domestic violence victims as soon as possible, because she may be eligible for relief. Refer to the Resource Guide on pages 48-53. Please refer to Fear of Legal Authorities on page 28.
3. Please refer to Pressure from the Victim's Support System, page 27.

SCENARIO NUMBER 11

Brigitte is brought to the hospital emergency room with burns in the shape of an iron on her legs and buttocks. Brigitte's English proficiency is limited but with the help of an interpreter she is able to explain to the treating doctor that her partner assaulted her. The doctor diagnoses Brigitte with third degree burns on her legs and buttocks. She also notes significant bruising in different stages of healing on her arms, and marks in the shape of a belt on her back. The doctor is sympathetic and, after treating her burns, informs her that due to the severity of her wounds, she recommends that Brigitte report the incident to the police. When Brigitte hears this she immediately changes her story and denies that her partner had any involvement in her injuries.

Questions:

1. What are some of the possible reasons Brigitte changed her story? _____
   _____
2. How should the doctor proceed now that Brigitte has expressed fear regarding reporting the abuse to the police? _____
   _____
   _____
3. Is the doctor required to report the burns and belt marks to the police? _____
   _____
4. How should the doctor provide effective multidisciplinary intervention to Brigitte? _____
   _____
   _____

Answers:

1. Brigitte may fear retaliation from the abuser. Also, some immigrants living in the United States fear having any interaction with the police. One contributing factor is that in some countries, the police are viewed as oppressors. Brigitte may not be a documented immigrant and therefore fears being deported or arrested.
2. The doctor should acknowledge Brigitte's fear/concern regarding the reporting of her injuries and ask whether she is comfortable talking about this. If Brigitte is frightened because of the abuser's threats, the doctor or social worker should affirm her experience and discuss a safety plan. The doctor or social worker should also explore various options and resources with Brigitte to ensure effective multidisciplinary intervention. Refer to the Resource List on pages 48-53. The doctor should try to alleviate Brigitte's fears by explaining her rights as a domestic violence victim and as an immigrant woman in New York City. It is the policy of the New York City Police Department not to inquire about the immigration status of a victim or witness to a crime. Refer to "Fear of Legal Authorities," page 28.
3. If the patient has second or third degree burns over 5% of his/her body, then a report must be filed with the State Fire Administrator and Office of Fire Prevention and Control. Please refer to the section on mandatory reporting, pages 16-17.
4. The doctor should affirm Brigitte's experience, be non-judgmental and provide emotional support. Refer to the section on methods of communicating effectively with the patient, pages 13-19. In addition to medical treatment, the doctor should refer Brigitte to the Domestic Violence Coordinator at the hospital or a social worker (depending on the facility's policy). She should be assisted in developing a safety plan. Available resources should be discussed with Brigitte and referrals for legal, social and counseling intervention should be made.

SCENARIO NUMBER 12

Bintou is a nurse in the Emergency Department at a local hospital. Bintou and her husband, Omar, moved to the U.S. four years ago. Omar was a respected businessman in their country of origin, but is currently unemployed. He cannot find a job because his degree is not accredited as being equivalent to a qualification from a U.S. institution. One of Bintou's colleagues is concerned because recently Bintou has become withdrawn and has taken a high number of sick days. During a break, Bintou's co-worker asks her if everything is okay. Bintou is silent at first, but then explains that Omar has been yelling at her quite frequently, calling her names and, earlier that week, even hit her. She says that he is under a lot of stress because it is difficult for a him to be unemployed. Bintou does not have the same support network that she had in her home country and doesn't know what to do.

Questions:

1. If you were Bintou's co-worker, what would you do? _____
   _____
   _____

2. What resources are there for Bintou at your facility?_____
   _____
   _____

Answers:

1. In light of the fact that Bintou is working with patients who have been abused (by virtue of her responsibilities in the Emergency Department), it should be brought to her attention that not receiving effective treatment for her own abuse may be detrimental to the abused patients with whom she is working. Reassure Bintou that her feelings and reactions are understandable. Convey that abuse is wrong. Tell her that it must have taken a lot of courage to tell you about the abuse and thank her for sharing this challenging situation with you. Reinforce your concern for Bintou by referring her to relevant resources. Refer to the section on methods of communicating effectively with the patient, pages 13-19. Show empathy by attempting to understand how Bintou feels in her current situation. Encourage Bintou to take an active role in managing her domestic violence situation. Assure Bintou that you believe her and care enough to assist her in her challenging situation. Maintain a nonjudgmental attitude toward Bintou, irrespective of her belief systems and the choices that she makes regarding the treatment of her abuse. Work with Bintou to develop a safety plan and by assisting her to brainstorm options optimizing her safety. Provide Bintou with the Domestic Violence Hotline, 1-800-621-HOPE (4673), and relevant resources. Refer to the Resource List on pages 48-53. While it is critical to communicate effectively with Bintou (refer to pages 13-19 on methods of communicating effectively), avoid playing the role of therapist/counselor, unless this is your profession and you are qualified to do so. Rather, suggest that Bintou speak to the Domestic Violence Coordinator, a social worker or psychologist for counseling. Many facilities have an Employee Assistance Program. Refer to the section on Boundaries, page 16.

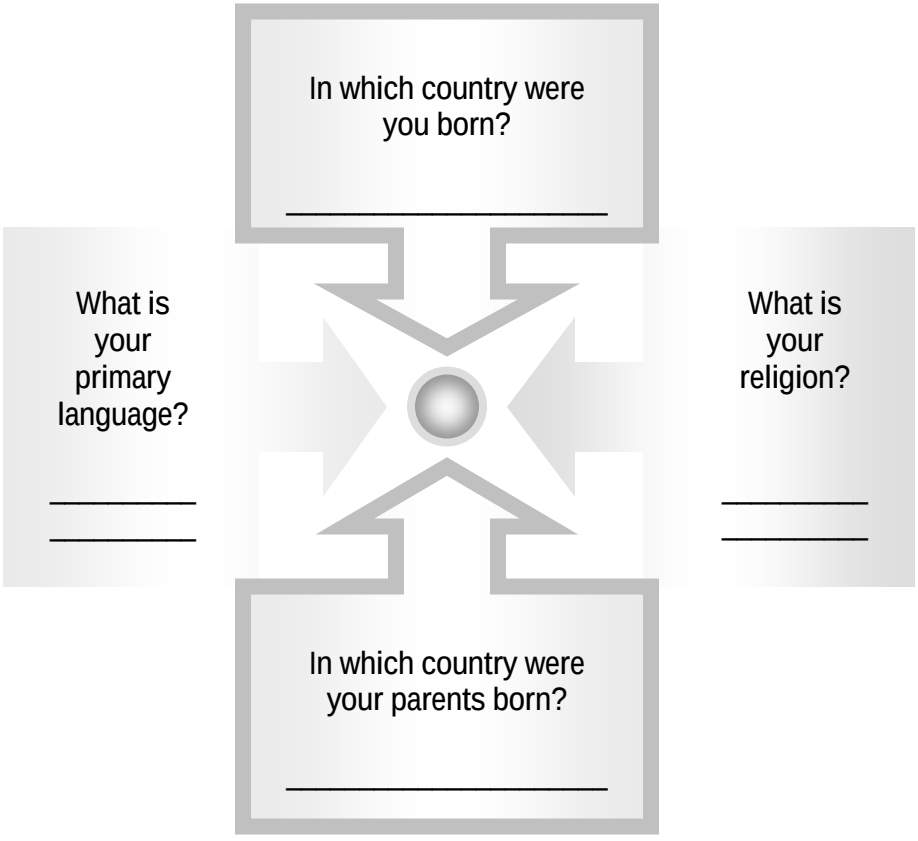
2. Many facilities have Employee Assistance Programs. The Domestic Violence Hotline, 1-800-621-HOPE (4673), is anonymous and can recommend organizations which offer culturally appropriate and language-sensitive services. Refer to pages 35-41 for ideas on implementing a domestic violence screening program at your facility. Ensure that your facility has structures in place so that staff who are domestic violence victims can receive appropriate support. Refer to the Resource List on pages 48-53.

PART TWO

Exploration of Culture

Convergence of Cultural Concepts

Please answer the following questions:



How have these factors allowed you to integrate into the communities in which you have interacted and lived?

_____

_____

If any of these factors were different, what impact might this have had on your experiences and view of the world?

_____

_____

Food for Thought

How important is your extended family?

_____

What traditions do you have?

_____
_____
_____

What events does your family observe?

_____
_____
_____

What food does your family generally prepare?

_____
_____
_____

How have these factors enabled you to be accepted by your community?

_____
_____
_____

Is it possible that patients from different cultural backgrounds may differ in their comfort levels with you?

_____

Note one practical step that you could take in order to increase your <u>patients' comfort level</u> with you.

_____
_____

(Suggestions: Learn to greet patients in their language; acknowledge that you are not familiar with her culture and ask her to explain relevant aspects to you; put fabric or an artifact from a patient's culture in your examination room).

How important is extended family to some other cultures?

_____

Note some traditions of other cultures:

_____
_____
_____

What events do families in some other cultures observe?

_____
_____
_____

How does the diet in other cultures differ from your own?

_____
_____
_____

How may some of these factors inhibit you from being incorporated into another culture?

_____
_____
_____

How does your life experience influence your <u>expectations</u> of patients from different cultural groups?

_____

How does your own perspective impact the way that you <u>relate</u> to patients from different cultural groups?

_____

Note one practical step that you could take in order to increase <u>your comfort level</u> with different patient population groups.

_____

Choices to Contemplate…

Do <u>others</u> think that domestic abuse is part of <u>their</u> culture?

_____
_____
_____

Do <u>others</u> think that domestic abuse is part of <u>your</u> culture?

_____
_____
_____

How would you feel if a patient from <u>your</u> "culture" disclosed domestic abuse?

_____

Do <u>you</u> think that domestic abuse is part of <u>your</u> culture?

_____
_____
_____

How would you feel if a patient from a <u>different</u> "culture" disclosed domestic abuse?

_____
_____

Putting Yourself into Another's Shoes

Note one situation when you have "put another person into your shoes" by assuming that they should react differently in a particular situation.

_____

Now, put yourself into that person's shoes. Why do you think he/she made that choice?

_____

If the person understood your perspective as you understand it, is it possible that their choice would have been different?

_____

If you understood the other person's situation as they do, might your initial choice have been different?

_____

What questions could you have asked in order to better understand his/her perspective?

_____

_____

What could you have said or done to convey your perspective more effectively?

_____

_____

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New York City Mayor's Office to Combat Domestic Violence
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