



**RN/MCPHU Home Study Program  
CE CENTER**

## **Domestic Violence: How To Screen & Intervene**

**This article is approved for 2.0 ANCC/AACN contact hours.  
After reading it you should be able to:**

1. Compare and contrast Walker's theory of the cycles of violence with Prochaska's model of clinically inspired change.
2. Develop a plan of care for victims of intimate partner violence (IPV).
3. Describe how to implement universal screening for IPV using the RADAR technique.

---

Originally posted December 2000

### **Domestic Violence: How To Screen & Intervene**

*Up to 35% of ED patients are victims of domestic violence; 95% of them are women. Many slip through the cracks because traumatic injuries are often not a victim's chief complaint. Find out how to detect abuse and what you can do to make a difference in a victim's life.*

**By MARY GERARD, RN, BSN, CCRN**

The author is a critical care nurse at Jersey Shore Medical Center, Neptune, N.J.

**Subjects covered in this article:**

[Linking the abuse cycle with behavioral change](#)

[Consider the stage of the relationship](#)

[Use RADAR to guide assessment and action](#)

[Screening for batterers would stem abuse, too](#)

[References](#)

[Sidebar: How Violence Cycles](#)

intimate partner violence (IPV), a.k.a. domestic violence, is a pattern of physical, sexual, and psychological attacks that adults or adolescents use to control their intimate relationships. Because IPV is so widespread, a major objective of the Public Health Service's Healthy People 2000 was to encourage universal screening and intervention for IPV in emergency departments nationwide.

But to date, less than 30% of EDs are compliant.<sup>1</sup> Why? Practitioners still question whether or not screening actually makes a significant impact on the victim's health.<sup>2</sup>

Caregivers who are reluctant to screen for IPV say that there's no "scientific" evidence that supports its effectiveness.<sup>2</sup> They also point to the real-life frustration involved in trying to help victims who frequently fail to follow through with recommendations.<sup>2</sup>

The majority of victims who come into the ED are looking for help, though. Many visit for reasons other than battery, hoping to be asked about the abuse.<sup>1</sup> In fact, it is not until we look back that we find that a full 50% of victims murdered by a spouse or lover were seen in an ED—without being screened for domestic violence—before they were killed.<sup>1</sup> Although we cannot accurately measure the effect that screening would have had on the outcome for these patients, there are compelling reasons why we need to step up our efforts to stop the abuse.

Consider these statistics: About one woman in four is subjected to IPV at some point in life, one in six during pregnancy.<sup>3</sup> The effects cut across and through generation after generation: Violent and delinquent behavior in children and adolescents is linked to perinatal trauma caused by spouse abuse.<sup>3</sup> Witnessing violence as a child can lead a man to become an abusive adult, and leave a woman 300 times more likely to become involved in an abusive relationship.<sup>4</sup>

Here, we'll show you how to leverage current knowledge about violence, relationships, and behavioral change into interventions that better serve the victim's needs. Then, we'll help you develop RADAR, the acronym for a screening tool that can help guide your assessment, documentation, and intervention of abuse cases.

Finally, we'll help you recognize the weakest link in violence prevention today: Screening and intervention for the batterer. We know that 70% of victims eventually leave an abusive relationship and some improve their lives,<sup>3</sup> but most batterers just find other victims. Jail is not an effective deterrent for abuse,<sup>5</sup> but research has found that the majority of batterers can be helped. We will show you which treatments hold promise.

### **Linking the abuse cycle with behavioral change**

Current thinking about the best way to help a victim of domestic violence aligns the phases of the violence cycle—tension building, acute battering, and honeymoon phases, as described in the box at right—with Prochaska's model of clinically inspired change.<sup>6</sup> The latter theory emphasizes educating patients based on their readiness to receive information.

According to Prochaska's theory, change begins during the pre-contemplative stage, a point at which it's difficult for a victim to recognize that there's a problem. Moving into stage 2, the victim sees the problem but can't formulate a solution. During stage 3, the preparation stage, she gathers information and starts making plans. In stage 4, the victim takes action, and finally, in stage 5, the maintenance stage, she tries to uphold the change. Progress isn't linear; it spirals.

Matching interventions to the stages of change and violence cycle has been shown to improve outcomes for battered women.<sup>6</sup> Here's how it works: A victim who has endured one or two battering episodes that may be far apart in time might enter your system in the pre-contemplative stage. This patient isn't ready to see that she's at risk for more severe injury. According to the theory, you'll want to tailor her teaching around basic information. Instructing her at a level beyond that—how to obtain a protective order, for instance—can actually alienate her.

Likewise, a woman in a long-standing abusive relationship does not need to hear about escalating cycles of violence—she lives it. She may even be ready to take action.

### **Consider the stage of the relationship**

While the romance is still new, a batterer may not have totally isolated his victim yet. There are fewer things, such as children or lack of money, that make her feel trapped. And she's still "in love." She's also at a point in her relationship where she's not only vulnerable to accepting part of the blame, but easily seduced by the abuser's apologies and willing to forgive. In cases like this, you should be very direct about the link between abuse and isolation and how violence cycles.

On the opposite end of the spectrum, a victim who's well beyond the romantic stage of her relationship may feel not only trapped, but afraid for her very survival. While she knows there's a problem, you'll want to assess if she can see a solution, or how close she is to taking action. Then help her develop a plan and take action if she's ready.

Understand that this victim faces the greatest obstacles to leaving. She's often lost touch with friends and may be alienated from family. Usually dependent financially, her greatest concern is how she'll care for her children, if there are children involved. This victim most likely fears for her survival whether she goes or stays.

You can gently reassure her that there are services that can help her, but don't let her dwell on worrying about the future. She needs to focus—one step at a time—on her immediate needs for shelter and safety. You have a chance to truly improve this patient's quality of life. To be most effective, you'll need a plan.

### **Use RADAR to guide assessment and action**

The following acronym was developed as a tool by the Massachusetts Medical Society to guide IPV screening and assessment. Add this to appropriately timed interventions and you just may boost your success with these patients.

routinely screen all female patients over age 14. Don't look only for the obvious signs of abuse such as injuries to the face and trunk, or delay in seeking care. Most victims of domestic violence present with stress-related complaints such as headaches or anxiety. A number of them come in with an upper respiratory tract infection or bronchitis.<sup>1,2</sup>

Using a calm, unhurried, nonjudgmental approach helps victims open up. If you're empathetic, you'll find that most abused women want you to ask them about their experiences. They need to be believed. One of the most important things you can convey to them is that it is not their fault, and no one deserves to be hurt.<sup>5</sup> Your empathy will be appreciated.

Ask direct questions. But first find a safe place away from the abuser. If you don't have a hospital policy that prohibits family members in the exam room, you'll have to get creative. For example, conduct the interview while you have the patient out of the ED proper for tests, such as an X-ray or CT scan. One hospital found that mounting posters with questions on the walls of the ladies' room was helpful for victims.<sup>1</sup>

Then ask simple, specific questions. Researchers found that a single question about physical assault was as effective in detecting abuse as asking more than one.<sup>1</sup> So screening questions need not be elaborate. For example, you could ask, "Have you been hit, kicked, punched, or otherwise hurt by someone within the past year?" Or you may want to develop your own script. Adding a phrase that mentions that screening is your standard protocol for all patients allows you to provide information to patients who are reluctant to disclose anything.<sup>6</sup>

Document your findings. Objectively describe the demeanor and actions of both the patient and the partner. Document who the suspected abuser is and his relationship to the patient.<sup>7</sup>

Always use direct quotes. Paraphrasing diminishes the credibility of your charting as evidence in a court's eyes, and weakens your integrity as well.<sup>7</sup> Likewise, do not use the word "allege" when referring to the perpetrator. It suggests that you don't believe the victim's story.

You should steer clear of subjective language, too. Words such as "refused," "uncooperative," and "appears agitated" reflect your judgment. Document only what you see: For example, "Patient is crying and trembling. She states that 'he put his hands around my throat until I could no longer breathe or speak.'"<sup>7</sup>

Use a body map to document injuries. Photograph injuries and be sure that your written documentation is consistent with the pictures. Keep the chart safe from inquiring eyes to protect patient confidentiality.

Assess patient safety and that of her children. Ask the victim if she's afraid to go home. If she says No and plans on returning home, assess what has worked to keep her safe in a past emergency and try to determine if it will work again. Find out if there's anyone who can stay in the home with her for a while, which will lessen the chance of another battering. Also, find out if she'll call for police if the need arises, or make sure she has some plan for getting help when she needs it. Respect her decision to go home.

One of the biggest reasons many women choose to return home is because they feel it's their safest option. Often the fear is warranted. About 70% of IPV victims who are murdered die either as they're trying to leave or after they've moved out.<sup>6</sup> So ask about threats of homicide or suicide. Weapons in the house and drug and alcohol use increase the victim's risk of a fatal outcome, as does being pregnant.<sup>3,8</sup>

Pregnancy increases the stress and anger level in the relationship, automatically making it a more lethal situation. But some men are also jealous of, or angry toward, the fetus, or battering occurs because it's just business as usual.<sup>3</sup>

In any case, you can further determine how dangerous the batterer is by asking if he is violent toward others. Studies show that men who are violent outside the relationship as well as within it are more dangerous than men who are not.<sup>9</sup> Ask about violence toward children, pets, family, and friends—and ask about a past head injury. It's well documented that head injuries are associated with pathological jealousy and violence.<sup>6</sup>

Then determine the patient's need for a shelter and willingness to go. Ask her if she wants police protection.

Review options and referrals. If you don't have volunteer advocates on-site who can help discuss the patient's options, prepare a list of referral information ahead of time. Include crisis hotlines, police phone numbers, and lists of shelters and advocacy agencies. Involve a social worker if one is available—unfortunately, many victims present during off hours.

Help the victim outline or develop a plan before she leaves the ED. If appropriate, you can also schedule an appointment for her with police, and follow up on the appointment.<sup>1</sup> In any case, education can facilitate change.

### **Screening for batterers would stem abuse, too**

Once you find that your efforts have paid off, and someone's life has been changed for the better, you'll always screen. Hopefully in the future we'll view the batterer as our patient, too, and screen accordingly. This would not release them from responsibility for their actions, but it may actually stop abuse at its origin.

Many batterers suffer from depression, chemical dependency, and post-traumatic stress disorder. As the severity of violence in a person's family history increases, so do psychological difficulties and abusive behavior.<sup>5</sup> Although most batterers with an antisocial personality disorder may not be amenable to treatment, the majority of abusive spouses can be helped.<sup>10</sup> Treatment that uses an empathetic rather than a confrontational approach has been found to work best.<sup>5</sup>

Hopefully, the future will show that our efforts to screen, intervene, and treat violence pay off in a kinder, gentler nation.

### **REFERENCES**

1. Do you selectively screen for victims of domestic violence? (2000). *ED Nursing*, 3(10), 124.
  2. Cole, T. (2000). Is domestic violence screening helpful? *JAMA*, 284(5), 551.
  3. Datner, E., & Ferroggiaro, A. (1999). Violence during pregnancy. *Emerg. Med. Clin. North Am.*, 17(3), 645.
  4. Lamberg, L. (2000). Domestic violence: What to ask, what to do. *JAMA*, 284(5), 554.
  5. Frank, J., & Rodowski, M. (1999). Review of psychological issues in victims of domestic violence seen in emergency settings. *Emerg. Med. Clin. North Am.*, 17(3), 657.
  6. Haywood, Y., & Haile-Mariam, T. (1999). Violence against women. *Emerg. Med. Clin. North Am.*, 17(3), 603.
  7. Fulton, D. (2000). Recognition and documentation of domestic violence in the clinical setting. *Crit. Care Nurs. Q.*, 23(2), 26.
  8. Kellerman, A., & Heron, S. (1999). Firearms and family violence. *Emerg. Med. Clin. North Am.*, 17(3), 699.
  9. Waltz, J., Babcock, J., et al. (2000). Testing a typology of batterers. *J. Consult. Clin. Psychol.*, 68(4), 658.
  10. Wexler, D. (1999). The broken mirror. A self psychological treatment perspective for relationship violence. *J. Psychother. Pract. Res.*, 8(2), 129.
- 

## HOW VIOLENCE CYCLES

According to Walker's cycle of violence theory, abuse occurs in a predictable way. The beginning of the relationship is intense. Couples are rarely apart. The abuser is often jealous and possessive of the victim and begins to isolate her from family and friends.

Criticism heralds the onset of phase 1. Called the tension-building phase, it's characterized by belittling and condemnation. The batterer may become withdrawn. He'll make unrealistic demands that the victim works hard to satisfy. Although her efforts pay off for a while, leading her to believe that she can control the abuse, his frustration escalates anyway.

Denigrating comments, ridicule, and criticism are punctuated with slapping, pinching, or shoving. If the abuse is not confronted, the cycle continues escalating in severity.<sup>1,2</sup>

The victim often ends up blaming herself when placating the abuser no longer works. Feeling powerless and alone, shame prevents her from seeking help.

*Phase 1* can last for years before serious violence erupts. The rate at which the cycle progresses depends on a number of factors such as a

prior abusive relationship, and now rearrange the abuser is that she will leave. A victim who threatens to leave can intensify the batterer's rage and need to control her.

*Phase 2*—the acute battering stage—is often triggered by something minor and results in violence that can last from two to 24 hours.<sup>1</sup> Whether or not the victim fights back, tries to escape, or calls for help, she's rarely able to stop the abuse.

Fighting back, however, can fuel the batterer's rage, increasing the severity of the battering. Once it's over, the victim is in a state of shock. She may not realize the seriousness of her injuries, and may not get treatment. Her abuser will often play down the damage, and may even prevent her from seeking care. He does not want to be found out and may feel genuine remorse.

*Phase 3* is often called the honeymoon phase and is a period of reconciliation. It begins a few hours to several days after a battery incident. The victim senses that the beating is over. The man is apologetic, loving, and full of promises not to do it again. He'll usually work hard to win back the victim's affection, buying presents and stepping up attentiveness. He may even take her to the hospital.

From her point of view, this is the person she fell in love with. She's hopeful that the violence is over and the loving phase will last. It's during this phase that the victim is vulnerable to accepting blame for the incident and may drop any legal charges. The batterer often successfully makes her feel guilty for any action considered or taken against him. She may also deny that it could happen again.

Over time, phase 3 wears off and the woman is left with a cycle of tension-building and battering. The result is a syndrome of increasing medical and emotional problems, such as depression, anxiety, substance abuse, and other signs of post-traumatic stress.

Battered women who appear passive and overly accepting have learned this way to adapt to violent circumstances. Other women cope by developing somatic complaints. By directing toward themselves the anger that would normally be aimed at the abusers, they engender his sympathy rather than provoke his rage. Still others resort to trance states—known as dissociation—to cope with an unbearable situation.

To uncover dissociation, ask the patient if she ever loses time, if she sometimes feels like she's in a dream, or if time speeds up or slows down for her. You'll need to take extra time to fully engage this patient's attention. In addition, get her to repeat or even write down the information you've given her or it may not register. Many of these symptoms improve when the woman is no longer threatened with abuse.

## REFERENCES

1. Thobaben, M. (1998). Survivors of violence or abuse. In N. Frisch, & L. Frisch, (Eds.), *Psychiatric mental health nursing* (pp. 559-605). New York: Delmar.
2. Frank, J., & Rodowski, M. (1999). Review of psychological issues in victims of domestic violence seen in emergency settings. *Emerg. Med.*