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The Checkup
TUTOR GUIDE

Case Materials:

Instructions For Using Case
Case
Tutor's Guide
Slide Set
References
Handout: Excerpt from the Massachusetts Medical Society Manuel on Domestic Violence
Evaluations Tools
- Tutor's evaluation/prior to presentation
- Tutor's evaluation/post presentation
- Student evaluations

Objectives:

Residents should learn how to:

1. Identify the hidden agenda — violence, and understand barriers to recognizing family violence
2. Take a history in a situation where family violence is suspected
3. Recognize that partner violence affects all cultural, ethnic and socioeconomic groups, although partner violence in women of color and among women of lower socioeconomic status is reported more often.

Supported by a grant from *The Maternal and Child Health Bureau*.

Overview of Violence Against Women/Family Violence Case:

Intimate partner violence has been recognized as a public health problem (Straus and Gelles, 1990; American Medical Association, 1992; National Research Council, 1996; Commonwealth Fund, 1998; American Academy of Pediatrics, 1998). An intimate partner will be defined as a spouse, ex-spouse, boyfriend, girlfriend, former boyfriend or former girlfriend. Women between the ages of 16 and 24 experience the highest per capita rates of intimate violence (Greenfeld, 1998). The 1993 National Survey of Women's Health, sponsored by the Commonwealth Fund found that 4.4 million women (8.4% of the sample) between the ages of 18 and 65 years, living with a man, had been physically abused by their partner in the last year.

Although violence has been reported in all intimate relationships, including gay and lesbian relationships, it is predominantly men perpetrating violence against women. Partner violence against men reflects 5% of all cases (Lewis-O'Connor, 1997).

Violence occurs among women of all socioeconomic groups, races and cultures (Straus and Gelles, 1990; Alpert 1995). There are special groups of women who are at increased risk of partner violence. These groups include young women between ages 17 and 28 years (Sousa, 1996), pregnant women (McFarlane, 1992; Parker et.al., 1994; Guard, 1997), women who are single, separated or divorced, women who have recently sought a restraining order (Alpert, 1995; McKibben and Roberts, 1996) and women who abuse alcohol or other substances (McFarlane, 1992; Alpert et.al., 1995; Guard, 1997). The prevalence of violence among pregnant adolescents at a prenatal clinic was 21.7% versus 15.9% of adult pregnant women (Parker et. al., 1994). Domestic or partner violence can span the life cycle from child abuse to elder abuse and involves all women, including disabled women (Alpert, 1995).

Violence in intimate relationships involves assaultive behaviors, such as physical and sexual abuse. It also includes non-assaultive behaviors such as verbal threats, economic control, and withholding of love, food, clothing and shelter. Isolating the woman from other social supports, such as relatives or friends is a form of partner violence. Often this social isolation is progressive in nature (Alpert et.al., 1995, Alpert, 1995). Intimate partner violence is considered a learned behavior. Inherent in all types of partner violence are the issues of power and control (Alpert et. al. 1995, Alpert, 1995; Guard, 1997).

GUIDING QUESTIONS

1. What is the scope of domestic or intimate partner violence?

2. What is the definition of domestic or intimate partner violence? What types of violence does this include?

3. What are the barriers to disclosure of intimate partner violence?

4. What are the signs and symptoms of domestic or intimate partner violence?

5. How will you screen or assess if there is domestic/intimate partner violence in the history?

6. Physical exam of both mother and child. If the mother is not your patient, she needs to be referred now for an exam.

GUIDING QUESTIONS FOR DISCUSSION:
*Try not to let the discussion veer in a tangent about HPI and other physical complaints.

1. Why do you think Wanda has come in today?

There is no obvious reason for this family to be here. The child does not appear ill in any way, which should lead you to the conclusion that Wanda may have a hidden agenda. Some reasons for this sort of visit include (1) Family Stresses (i.e., job loss, family illness or death, etc), (2) partner violence (3) Relationship problems (i.e., separation and/or divorce) (4) unspoken fears (such as my sister's son died suddenly at this age). These represent just a few possibilities.

2 What questions will you ask now?

Whenever you suspect a 'hidden agenda' you need to give the parent a chance to open up to you with their problems. Questions such as "is there anything else you'd like to talk about" or "you look upset (tired/sad), is everything okay at home?" will give Wanda a chance to bring up other issues. In a situation where you know the family already and/or suspect some issue in particular, you can ask more specific questions, such as "I know money has been tight. Has something happened to make it worse?"

3. What are the barriers to disclosure of partner violence?

A. Specific barriers to the provider?

1. **Opening Pandora's Box**: In the ethnographic study of 38 physicians (Sugg and Inui, 1992), the phrase "opening Pandora's box" was cited by 18% physicians as a barrier to inquiring about partner violence in the medical encounter. Other physicians feared disclosure of many social evils.

2. **Identification:** If the physician identified closely with their patients, this posed a barrier. If the physician identified with the patient in terms of race, socioeconomic status or cultural background, he or she was less likely to ask or recognize partner violence (Sugg and Inui, 1992). If the physician has his/her own personal experience with child abuse or partner violence, close identification with the patient impaired disclosure. In this study (Sugg and Inui, 1992), 14% of the male physicians and 31% of the female physicians sampled had experienced violence.

   Partner violence affects all cultural, ethnic and socioeconomic groups, although partner violence in women of color and among women of lower socioeconomic status is reported more often. Wanda's, Michael's and David's racial and ethnic identities were purposefully left out of the case.

3. **Physician's discomfort about inquiring about "private" or "non-medical" issues** is recognized as another barrier. This barrier often relates to a fear of offending the patient. There are also reports (Sugg and Inui, 1992; Alpert, 1995) by physicians of a sense of powerlessness, both in knowledge and intervention. Sixty-one percent of physicians interviewed (Sugg and Inui, 1992) had no formal training in partner violence. A review of medical schools in the United States and Canada revealed that less than 25% of medical schools required education or training in domestic violence (Holtz and Hanes, 1988).

4. **Time constraints**. Physicians are experiencing increasing constraints on the time spent in the medical encounter. In the primary care setting, where routine office visits may be 20-30 minutes duration, inquiring about partner violence and the subsequent assessment and intervention needed if the response is affirmative, may hinder a physician from inquiring about partner violence at all (Alpert et.al., 1995, Alpert, 1995; Sugg and Inui, 1992).

B. *Specific barriers to the patient?*

1. **Emotional issues**: There is the fear of personal harm or of harm to significant others (e.g. children). Shame, humiliation and low self- esteem have been associated with women who are in violence intimate relationships (Alpert et.al., 1995, Alpert, 1995). The woman may tend to minimize or deny the problem (McKibben and Roberts, 1996).

2. **Economic issues**: There are financial considerations when the woman must depend on the abusive partner for financial support. This may involve financial constraints if the abusive partner is the primary wage earner for the family (Alpert et. al., 1995). It may also involve the partner's control of the woman's paycheck and other finances (Alpert et. al., 1995).

   It is unusual for Wanda (an 18-year-old) to have her name on a lease. What would happen if her name was not on the lease? (i.e. Partner can exert control in this situation.)

3. **Promises of change:** Many women believe their partner will change. Some women believe their partner's apology and promise he will change. Others see their role includes changing their partners' behavior (Alpert et. al., 1995, Alpert, 1995).

4. **Prior history of lack of intervention :** Women who are victims of partner violence may have been in the past, ignored or discounted by other relatives, health care providers, or police when these issues were presented (Alpert et. al., 1995, Alpert 1995).

4. *What are the signs and symptoms of domestic or intimate partner violence?*

These include a myriad of physical and psychological signs. Signs of overt physical trauma include bruises, lacerations, burns, and fractures. The physician also needs to be aware and assess for signs of sexual assault (Alpert, 1995; McCauley, 1995; Guard, 1997). Signs of emotional or psychological distress may include anxiety, depression, post-traumatic stress disorder. Other signs may include chronic pain without an apparent etiology, eating disorders and chronic headaches (Alpert, 1995; Commonwealth Fund, 1998). Alcohol or other substance use must be assessed as both risk factors and as consequences of violence.

Children may often be casualties in families experiencing partner violence. Child abuse has been found more often in homes where the mother is being abused, than in homes where the mother is not (Straus and Gelles, 1990). Children who witness violence in the home (Augustyn et.al., 1995; Richters and Martinez, 1993; Martinez and Richters, 1993) display emotional and behavioral disturbances such as withdrawal, numbing, nightmares and aggression against others.

5. *How will you screen or assess if there is domestic/intimate partner violence in the history?*

A. Set the stage:
   1. The physician should maintain an open, non-blaming, non-judgmental manner.
   2. Interview the woman alone, not in the presence of her partner, children or other persons.

B. Include screening for partner violence in routine screening of all patients:

   Open-ending question. An example (Alpert et.al., 1995, p.7) of general screening question: " At any time has a partner hit, kicked or otherwise hurt or frightened you?"

C. Choose your language carefully.
   1. Avoid using the terms "domestic violence", "battered woman", and "abuse" with the woman.
   2. Avoid blaming language.
   3. Do not ask the woman what she did that caused the violent act.
   4. Use gender-neutral language.

D. Risk Assessment
   1. Number and type of violent acts.
   2. Severity of violent acts.
   3. Frequency of violent acts. Is the violence escalating?
   4. Availability and presence of a weapon. Type of weapon (e.g.. gun, knife)
   5. Any criminal history?
   6. Use of alcohol and other substances by woman and/or partner.
   7. Incidence of child abuse.
   8. Batterer's history of psychiatric illness, emotional instability, suicidality.

6. Are there any additional actions that you should take for the family today?

A. Physical exam of both mother and child. (If the mother is not your patient, she needs to be referred now for an exam.)

1. Signs of physical abuse:
   a. Any injury to the face, torso, genitals, breasts.
   b. Bilateral or multiple injuries
2. Physical evidence of sexual assault or rape.
3. Be cognizant of a patient's explanation, which is inconsistent with the type of injury observed.
4. Delay between onset of injury and seeking medical intervention
5. For pregnant patients: Any injury, particularly to the abdomen or breasts.
6. Unwanted pregnancy, especially in adolescent patients.
7. Other symptoms of emotional distress:
   a. Chronic pain, without an apparent etiology
   b. Anxiety, depression, sleep disorders, suicidal ideation, etc.

B. Documentation

Document all physical finding carefully in the medical record. Diagrams, labeled photographs, pictures drawn by hand may be included.

C. Intervention

1. Identify and know the resources for family violence in your institution and/or city.

   After you obtain the woman's permission, consult a social worker and (as appropriate/available) police, battered woman's shelter, crisis hotline, etc.

2. Notify the Department of Social Services or Child Protective Services if warranted. Know the laws of mandated reporting of violence, abuse and neglect for your state.
3. Express your concern for her safety and the safety of her children.
4. Diagnose, manage and treat any illnesses or injuries found on examination.
5. Refer the woman for all appropriate services, such as mental health services, or legal services for a restraining order.

NOTE: After a restraining order is filed, a woman is often at increased risk of violence.

D. Develop a safety plan.

1. Assess the risk of current violence. Is it safe for the woman to go home? The patient also needs to assess her level of danger and risk.
2. Where will she go? (Friend's house, relative's house, shelter, etc.)
3. Other necessities and resources: Money, clothing, car keys, personal documents (i.e.. driving license, passports).
4. Inform the woman of local shelters for battered woman who have advocates with particular expertise, who provide free and confidential services (e.g.. shelters, legal rights, support groups, etc.).

E. Legal Information

Please see excerpt from the Alpert, et.al, Massachusetts Medical Society's guide, Partner Violence: How to Recognize and Treat Victims of Abuse, (1995), pp.16-19. Reproduced with permission.

1. Restraining Orders pp. 16-17.
2. Criminal Complaints pp. 18-19.

NATIONAL RESOURCES:

National Resource Center on Domestic Violence 1-800-537-2238
Family Violence Prevention Fund
383 Rhode Island Street, Suite 304
San Francisco, CA 94103-5133
(800) 313-1310
http://www.fvpf.org

Duluth Domestic Abuse Intervention Project
206 West Fourth Street
Duluth, MN 55086
(218) 722-2781

National Coalition Against Domestic Violence
P.O. Box 34103
Washington, D.C. 20043-4103
(202) 638-6388
or
1202 E. Colfax Avenue
Denver, CO 80214
(303) 839-1852

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The Checkup

Wanda, an 18-year-old adolescent mother, attends a hospital-based clinic where pediatricians provide primary health care to adolescent mothers and their children. Wanda appears unexpectedly wanting a "checkup" for her 13-month-old son, Joey. You are the pediatrician in this clinic and have cared periodically for both Wanda and Joey over the past year.

Wanda is in the 12th grade at a local high school. She is financially supported by welfare and other forms of public assistance. Her parents also assist her financially.

Wanda has kept all scheduled appointments. There have been rare urgent care visits for episodic illnesses. Medicaid covers Wanda and Joey's health care.

Joey had a routine well-child care visit three weeks earlier. He was up to date on all immunizations and his growth and development were appropriate. Joey's next visit was scheduled to occur in two months.

When asked about any present illness, Wanda says that Joey has no recent symptoms of an illness. You examine the boy. He is playful and the physical exam is unremarkable.

Supported by a grant from *The Maternal and Child Health Bureau.*

Wanda currently lives with Michael, Joey's father, who is 26 years old and has never come to the clinic for any reason. Michael's most recent job has been at a construction company, painting new buildings and houses. Two years ago, when she was 16 years old and living with her parents, Wanda met Michael at a neighborhood party. Wanda often characterized Michael as "jealous", which initially she found flattering. Having an adult for a boyfriend produced envy among her high school girlfriends.

Wanda had volunteered in earlier clinic visits that their relationship was tumultuous. In fact that they had ended the relationship on several occasions, often after verbal arguments, but they had always gotten back together.

Wanda also described how Michael had a history of "problems," which involved cocaine use, the alleged sale of drugs, and slapping Wanda when Michael was inebriated. To date, Michael had not harmed their son. She mentioned also that Michael owns an unlicensed gun, which he keeps at home.

In several recent clinic visits, Wanda presented with reports of suffering physical trauma, but no overt signs of trauma were found during the examinations. Wanda also reported on Michael's verbal abuse, tied to episodes where "he kept thinking I was sleeping with another guy." Wanda met with the clinic's social worker at each visit to discuss her issues. She refused services (i.e., emergency shelter or a restraining order) each time.

Recently, Michael was laid off from the construction company and had become increasingly despondent as he tried to secure employment.

Wanda now reports that Michael and she have again ended their relationship and that he will be moving out, at her request. Wanda is proud and relieved that only her name is on the apartment lease. "He's so angry now. We fight all the time. He sort of hit me last night," she said.

EPILOGUE

Michael appeared outside the clinic and verbally threatened Wanda. Michael stated he intends to sue for custody of their son. He referred to his gun and said he would use it against Wanda, though at no time did Michael display the weapon on the hospital grounds. These verbal threats were witnessed by a hospital security guard who summoned the City Police when Michael refused to leave the hospital.

Wanda again refused temporary emergency shelter for herself and her son, but obtained a restraining order. Michael violated the restraining order later that night when he appeared outside her apartment. The City Police issued a warrant for Michael's arrest.

The Checkup - REFERENCES

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Straus, MA and Gelles RJ. (eds.) Physical violence in American families. New Brunswick, NJ.: Transaction Publishers, 1990

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LEGAL INFORMATION FOR HEALTH-CARE PROVIDERS

Although physicians and other health-care professionals may not be directly involved in the legal procedures described, it is important to know of their existence and purpose. Your role is to refer the victim to an advocate who will then advise an appropriate legal course of action (see pages 23-27 of this guidebook). Documenting "domestic violence" or "partner violence" on your patient's medical chart will strengthen the woman's claim in a court of law.

Restraining order

Under the Massachusetts Abuse Prevention Act (Massachusetts General Laws, chapter 209A), any person in a familial or dating relationship may obtain an emergency, temporary, and/or permanent restraining order against the abuser. A permanent restraining order is good for up to one year.

- These orders may be obtained through the Superior, Probate and Family, District, or Boston Municipal Court.
- The court may order the abuser to refrain from abusing, to have no contact with, and/or to vacate the premises occupied by the person suffering from the abuse.

- The court may also make orders regarding temporary custody and support of the children, as well as other orders appropriate to a particular case.

The person suffering from abuse can obtain a restraining order in three ways:

1 An Emergency Restraining Order

Can be obtained if the court is not in session, including nights and weekends. This is obtained with the assistance of the police and the on-call judge.

2 A Temporary Restraining Order (TRO)

Can be obtained by filing a complaint in the appropriate court and telling the judge about the actual or threatened abuse.

3 A Permanent Restraining Order

Can be obtained by returning to court for a hearing before the judge, after a TRO has been served on the abuser. The batterer has a right to appear at this hearing to tell his version of what happened.

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

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

Excerpt from "Partner Violence: How to Recognize and Treat Victims of Abuse" by Alpert et.al.

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Criminal complaints

Most criminal complaints are initiated by the arrest of the batterer by the police. However, a woman can seek a criminal complaint on her own through the clerk's office of the local district court. Advantages and disadvantages of criminal complaints along with types of criminal charges follow:

Advantages of a Criminal Complaint

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

Disadvantages of a Criminal Complaint

The woman does not control the processing of a criminal case, rather, that is the job of the District Attorney's office. In addition, a criminal case can take a long period of time before it is completed, particularly if the batterer is convicted and he appeals.

Types of Criminal Charges

- violation of a restraining order
- assault and battery
- assault or assault and battery with a deadly weapon
- breaking and entering

- trespassing
- annoying telephone calls
- threats
- sexual assaults
- stalking

Stalking law

The stalking law was enacted in Massachusetts in May, 1992. It states that any person who willfully, maliciously *and* repeatedly follows *or* harasses another person and who threatens that other person with death or serious bodily injury is guilty of the crime of "stalking" (Massachusetts General Laws, chapter 265, section 43.)

The purpose of the stalking law is to target for prosecution those batterers who are "obsessed" with their victims and who continue to harass them even after the victim has broken off the relationship.

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

Excerpt from "Partner Violence: How to Recognize and Treat Victims of Abuse" by Alpert et.al.

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Module Evaluation

For presenters to fill out before the teaching session

A. I consider myself

1.A nationally known expert on this topic	**2**. A locally known expert on this topic	**3**. Very knowledgeable on this topic	**4**. to have learned about this topic to teach it	**5**. **Not sure**

B. I spent approximately _____ minutes preparing for teaching this topic.

C. Of the time I spent preparing to teach this topic, I used material provided to me as part of the Serving the Underserved Curriculum

1. 100% of the time
2. 75-99%of the time
3. 50-74% of the time
4. 25-49% of the time
5. <25% of the time

D. How appropriate were the educational objectives?

1. **Excellent** **2**. **Good** **3**. **Average** **4**. **Poor** **5**. **Not sure**

E. How appropriate were the tutor notes?

1. **Excellent** **2**. **Good** **3**. **Average** **4**. **Poor** **5**. **Not sure**

F. How appropriate were the references?

1. **Excellent** **2**. **Good** **3**. **Average** **4**. **Poor** **5**. **Not sure**

G. If your answer to any of the above questions (except A) was 3, 4 or 5, please comment.

Please feel free to write further comments on the back of this sheet.

Thank you for taking the time to fill out this evaluation.

*This material was adapted from that created by Janet Hafler, Ed.D.

Module Evaluation

(For Presenters to use after the teaching session)

Presenter:_____

Your responses will help us refine and develop this case.

A. Please rate the overall quality of this material as a stimulus for learning.

1. Excellent **2. Good** **3. Average** **4. Poor** **5. Not sure**

B. Please rate the classes participation in the learning

1. Excellent **2. Good** **3. Average** **4. Poor** **5. Not sure**

C. How comfortable were you with case based teaching

		Not at All				Very Much
1.	**Prior to this teaching session**	**1**	**2**	**3**	**4**	**5**
2.	**During the teaching session**	**1**	**2**	**3**	**4**	**5**
3.	**After the teaching session**	**1**	**2**	**3**	**4**	**5**

D. Please list how long you spent on this topic, and how the time was devided

Total Time **_____ minutes**

Time spent on case discussion **_____ minutes**

Please describe how you spent the rest of the time

E. Please Rate each of the following

		Poor				Excellent
1.	**The Educational Objectives**	**1**	**2**	**3**	**4**	**5**
2.	**The Case Vignette**	**1**	**2**	**3**	**4**	**5**
3.	**The Tutor Guide, including guiding questions**	**1**	**2**	**3**	**4**	**5**
4.	**Reference List**	**1**	**2**	**3**	**4**	**5**
5.	**Handouts**	**1**	**2**	**3**	**4**	**5**
6.	**Audiovisual Materials**	**1**	**2**	**3**	**4**	**5**

If you answered 1-3 on any of the above, please comment further

F What were the cases strengths

1.
2.
3.

G What were the cases weaknesses

1.
2.
3.

H What is the single most important thing that you learned from the case discussion?

I Case Evaluations

1. Do you think facts or data should be added? **1. Yes** **2. No**
If **yes**, what should be added?

2 Do you think facts or data should be deleted? **1. Yes** **2. No**
If **yes**, what should be deleted?

J. Tutor notes evaluation

1. Did you use the **tutor notes**? **1. Yes** **2. No**
If **no**, why not?

2. What were the **tutor notes** strengths?
1.
2.
3.

3. What were the **tutor notes** weaknesses?
1.
2.
3.

4. How would you suggest improving the t**utor notes**?

5. Do you think facts or data should be added to the **tutor notes**? **1. Yes** **2. No**
If **yes**, what should be added?

6. Do you think facts or data should be deleted from the tutor notes? **1. Yes** **2. No**
If **yes**, what should be deleted?

K Slide Evaluation

1. Did you use any of the **slides**? **1. Yes** **2. No**
If yes, which ones

2. How would you suggest improving the **slides**?

3. Do you think more slides would be useful? **1. Yes** **2. No**
If **yes**, what should be added?

4. Do you think there are slides that will never be useful? **1. Yes** **2. No**
If **yes**, what should be deleted?

L Did you use any other materials **1. Yes** **2. No**
If **yes**, what other materials?

If supplied by the Serving the Underserved Project, how would you improve the material

M. What did you as a teacher learn about this topic?
#1
#2
#3

Please feel free to write any further comments on the back of this form

Thank you for taking the time to fill out this evaluation.

*This material was adapted from that created by Janet Hafler, Ed.D.

The Checkup

Module Evaluation

Presenter:_____

Your responses will help us refine and develop this educational material. The person completing this form is:

PGY1 PGY2 PGY3 Fellow Faculty Other_____

A. What is the single most important thing you learned from the case discussion today.

B. Please rate the overall quality of this case as a stimulus for learning.
1. Excellent **2. Good** **3. Average** **4. Fair** **5. Poor**

C. The facilitator

		Not at All				Very Much
1.	**Encourages student direction of teaching**	**1**	**2**	**3**	**4**	**5**
2.	**Stimulated interest in the subject matter**	**1**	**2**	**3**	**4**	**5**
3.	**Encouraged Group Participation**	**1**	**2**	**3**	**4**	**5**

D. I consider the facilitator

1.A nationally known expert on this topic	**2**. A locally known expert on this topic	**3**. Very knowledgeable on this topic	**4**. a teacher who learned about this topic to teach it	**5**. **Not sure**

E. Please rate each of the following components of the teaching session (N/A for not applicable)

		Poor		Good		Excellent	
1.	**Case Vignette**	**1**	**2**	**3**	**4**	**5**	**N/A**
2.	**Case Based/Learner Centered Format**	**1**	**2**	**3**	**4**	**5**	**N/A**
3.	**Handouts/Supplemental Materials**	**1**	**2**	**3**	**4**	**5**	**N/A**
4.	**Teacher/Facilitator**	**1**	**2**	**3**	**4**	**5**	**N/A**

F. Do you think information should be added? **1. Yes** **2. No** **3. Not Sure**
If **yes**, what should be added?

G. Do you think information should be deleted? **1. Yes** **2. No** **3. Not Sure**
If **yes**, what should be deleted?

H. Comments

Please feel free to write any comments on the back of this sheet.

Thank you for taking the time to fill out this evaluation.
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