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Diagnostic and Treatment

Guidelines on

Mental Health Effects of Family Violence

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These guidelines are not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all the facts and circumstances involved in an individual case and are subject to change as scientific knowledge and technology advance and patterns of practice evolve. These guidelines reflect the views of scientific experts and reports in the scientific literature as of October, 1995

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Introduction

We are deluged daily with information from both scientific and media sources that violence in our society appears out of control. Certainly the prevalence and the impact of family violence are far greater than was appreciated even a few years ago. This monograph will provide an overview of the mental health consequences of family violence. Family violence is defined here as inappropriate and damaging interpersonal harm among intimates, regardless of the actual legal or biological relationship of those involved. Such harm includes child physical abuse and neglect, child sexual abuse, domestic (partner) abuse, and elder mistreatment (abuse, neglect, and exploitation). Formerly thought of as primarily a criminal justice, social service, or even simply a purely private matter, family violence is now viewed as a significant public health issue that demands the attention of the medical community.

Physicians, particularly those in primary care specialties, are in especially advantageous positions to address the problem of family violence. Many patients report that they are most willing to discuss their own experiences of family violence with their physicians. Though they may be reluctant to initiate the discussion themselves, they are generally relieved when the topic is raised directly by the physician. Patients will be most likely to discuss issues of family violence when they feel that the physician is listening respectfully and empathically, will preserve their confidentiality, and can be helpful in providing assistance. Even with the best efforts, however, it may take some time before a patient is able to discuss victimization. The physician must be prepared to ask questions about violence on a number of occasions in order to allow the patient to become ready enough to disclose the information.

Several factors have made it difficult for physicians to help patients with the problems associated with family violence. Until recently the scientific knowledge base was fairly limited, and thus little training had been provided in medical schools. Much of the training offered in medical schools and residency programs has focused on the evaluation and care of injuries rather than such aspects as abuse recognition, prevention, or mental health sequelae. It has also been difficult for physicians to address these problems because of limited training about the psychological, behavioral, and social components of medical conditions in general.

Many physicians find it painful to think of the horrors that can be perpetrated by those in supposedly loving relationships. All physicians feel helpless, anxious, and/or frustrated at times dealing with such situations. They may feel a natural tendency to avoid or emotionally distance themselves from these patients or to blame the victim. For some physicians family violence may be an especially difficult issue because they themselves have been or are being victimized.

Previous AMA family violence diagnostic and treatment guidelines have focused on physical health assessment and treatment recommendations. This guidebook will address the psychological and behavioral impact of family violence. This guidebook will:

- increase physician awareness of the relationships between family violence and mental health problems
- review common psychological reactions to trauma, the variety of coping mechanisms that are employed to deal with it, and the common symptom pictures that may emerge
- define the physician's responsibility to consider, recognize, evaluate, and offer appropriate interventions or referrals for mental health problems associated with each type of family violence
- identify barriers to the provision of optimum health care for patients exposed to family violence

References and suggested readings related to the material in this guidebook may be found on page 35.

Scope and Costs of Family Violence

Table 1 shows some recent statistics highlighting the extent of family violence. These figures demonstrate that a sizeable percentage of the general population has been affected by family violence. Such people have a number of problems which frequently bring them into the health care system. They are therefore disproportionately represented in virtually any clinical setting (emergency room, office, hospital, etc.). Recognition rates by physicians in a variety of settings have been as low as 5 percent (i.e., the physician identifies abuse as a problem in only one abuse victim in twenty who presents for care).

Numerous studies have shown the high rates of victimization among those with a variety of psychiatric illnesses, particularly depression, some anxiety disorders, somatization disorder, eating disorders, substance abuse disorders, and certain personality disorders. While many biological and psychosocial factors facilitate the development of any such illnesses, victimization is a strong contributory factor. For example, studies of battered women reveal high rates of depressive and/or posttraumatic stress disorder symptoms as well alcohol and other substance use disorders.

Table 1

Magnitude of Family Violence as a Public Health Problem

2-4 million women battered each year
20-30 percent lifetime risk for a woman to be battered
1,500 women murdered each year by current or past intimate partners
20-30 percent of women seen in medical setting may be abuse victims
5- 6 percent prevalence of elder mistreatment (1.8 million individuals)
1,100 childhood deaths from abuse each year
140,000 childhood injuries from abuse each year
1.7 million reports of child abuse each year
250,000-450,000 cases of child sexual abuse each year
16 percent of adult women report a history of sexual abuse by a family member

Apart from the toll in human suffering, the economic costs of the various forms of family violence and their sequelae are truly staggering. There are a number of cost components:

- acute medical care for injuries or neglect, and their complications
- medical complications from injuries with enduring effects
- mental health and substance abuse care for victims, perpetrators, and families
- inappropriate medical care for unrecognized mental health problems (“distressed high utilizers”)
- criminal justice system expenditures for intervening, arrests, prosecution, incarceration, etc.
- legal system costs for effects on separation, divorce, custody disputes, protection orders, etc.
- social welfare organizations costs for emergency shelters, housing, foster care, etc.
- impediments to work, such as absenteeism or poor productivity

There are other less overt aspects as well, such as the effects on the educational system caused by behavioral problems and impaired school performance, lost taxes and increased welfare needs because of diminished education and employment, years of life lost because of suicide and homicide, and rehabilitation and long-term care costs for those more severely harmed. In short, the effects reach into virtually all aspects of the economy.

Clearly, successful interventions directed at preventing the occurrence or reducing the effects of family violence will reduce the costs of these incidents to society. Individuals with *unrecognized* anxiety, depression, or other problems present themselves more frequently for somatic complaints, undergo multiple, negative organic workups, and receive ineffective, symptomatic treatments. In addition, many medical conditions may be more difficult to control in the presence of co-morbid psychiatric disorders. Because of

concerns about the cost to society of providing mental health and substance-abuse care in general, it is important to appreciate not only the clinical importance of providing such care but the financial implications of failing to provide the care as well. Case 1 highlights some of the direct and indirect costs of family violence.

Case 1

Transmission and Economic Cost of Family Violence

RW was a diminutive, happy fourteen year-old high school freshman whose mother remarried three years after an earlier divorce from RW's father. The stepfather felt threatened by RW's close relationship with his mother, and a pattern of verbal taunting, belittling, and imposing restrictions deteriorated into spankings, slappings, and progressively more harsh physical assaults. RW's mother's attempts to intervene were met by periodic assaults against her, which RW felt powerless to stop. RW became withdrawn and depressed, and a suicide attempt eventually led to a psychiatric hospitalization during which no one in the family mentioned the violence. RW began to smoke cigarettes and use marijuana, and his grades declined as he cut school frequently. He began to hit his eight year-old brother when they fought, leading to frequent visits to the doctor by the younger boy for headaches and stomach pain. When the step-father was away from the home on business, RW acted as if he were in charge of the household, insulting his mother and eventually pushing her a few times, requiring two emergency room trips for lacerations received in these altercations. Shortly after RW got his license to drive, he left the house in the middle of a fight with his step-father, took the family car, and was involved in an accident causing serious injuries to himself and the two occupants of the car he struck.

Role of the Physician

Because so many patients look to their physicians as advisors, educators, and confidantes, and because many physicians have ongoing relationships with patients and families, they are well placed to intervene meaningfully with regard to family violence. A preventive, public health-oriented approach must be taken.

- **Primary prevention** involves efforts to prevent disorders before they occur. In the case of family violence, primary prevention may include such activities as:
 - educating patients about the cycle and progression of domestic violence
 - teaching parents about appropriate measures in disciplining children
 - educating children and adolescents about respect, negotiation, and appropriate assertiveness
 - recognizing and referring patients at-risk for perpetrating future abuse (e.g., persons with known substance abuse, explosive personality, or a past history of abusive behavior)
 - assessing potentially over-stressed caregivers of children or the elderly
 - advising middle-aged parents about the need to plan for future care needs of dependent, impaired adult children

- making routine inquiries about *any* violence in the home, presence of stressors, or the availability of firearms

Secondary prevention involves such efforts as making patients aware of physician interest in hearing about abuse (information in the waiting room, routine inquiry, etc.); screening for all forms of victimization, psychiatric disorders, suicidal ideation, etc.; and making available information about community resources and safety planning related to domestic violence.

Tertiary prevention involves providing medical care for injuries received by victims; identifying and referring for associated mental health disorders; monitoring of an ongoing care plan for abuse; and notifying child welfare, elder, or other reporting entities.

Advocacy involves not only support and encouragement for individual patients, but efforts to achieve broader changes that will reduce the morbidity and mortality from family violence. This may include encouraging changes in health care systems, criminal and civil proceedings, and legislation; offering support for victim advocacy groups; and supporting efforts to reduce social factors which promote violence.

Clinical Aspects

Relationships among family members are expected to be loving and nurturing, yet in violent or abusive families victims experience rejection, devaluation, helplessness, vulnerability, tenor and pain. Thus, what should ideally be experienced as a supportive system becomes instead the source of distress. The disparity between this ideal of the family and the reality of violence within the family contributes to the sense of shame and the secretiveness on the part of so many victims. Family violence occurs in a crucible of relationship or family dysfunction. At times family violence may represent the pathological interactions of two or more family members, while at other times it may represent the domination of a family unit by an individual who uses intimidation and coercion to control others in the family. In the latter case it is the victim(s) who may appear symptomatic, but the symptoms are better thought of as attempts to deal with a horrific situation.

Children develop a sense of trust in the world from the relationship with their early caretakers. The child learns from trusting in others to incorporate feelings of trust and safety inside him/herself. When mistreated by important family members, children's sense of self is badly damaged, the world comes to be viewed as unsafe, and they lack the ability to comfort themselves. Such problems are frequently associated with great difficulties in interpersonal relationships, including gullibility, inadequate self-protectiveness, and greater likelihood of being re-victimized or abused by others. Women who have been victimized in childhood are also more likely to have children who become victimized.

Adaptation to Stress

There are certain characteristic symptoms seen in all people following highly traumatic life events. These symptoms may include hyper-vigilance (e.g., easy startling, guardedness), re-experiencing aspects of the trauma (e.g., unwanted images of the trauma, nightmares), and/or emotional numbing. These sequelae are normal psychological responses to stressful experiences, much as fever, elevated white blood cell count, and activation of the immune system are normal reactions to infection and are the body's attempts to begin a reparative process. When the trauma is especially intense or chronic or the host is pre-morbidly weakened, the normally useful coping mechanisms can be overwhelmed and may be replaced by more drastic survival strategies (e.g., social withdrawal) or by attempts to cope which themselves become harmful (e.g., alcohol or other drug use).

The symptoms of traumatized individuals often represent attempts to master their trauma. Children work toward resolving their trauma through repetition of the struggle with authority figures, the use of play and behavioral reenactment. For adults, work toward resolution occurs in intimate relationships (e.g., when re-experiencing trauma in their adult relationships), in dealings with their own children, or in therapy. Both children and adults may engage in self-injury (cuts, burns, etc.) for similar reasons. Some somatizing patients may also unwittingly be reenacting earlier experiences, and they may present as especially irksome, hostile, or uncooperative.

Most forms of family violence and abuse are chronic in nature. The specific acts and temporal pattern of the abuse, the patient's innate temperament, the patient's psychological make-up (e.g., personality type, defense mechanisms), the patient's developmental stage in the life cycle, family dynamics, and the availability of external support resources are all factors which influence the nature of the clinical picture seen. Table 2 shows some of the more common presentations. Many abuse victims have symptom pictures that do not fit neatly into any one specific diagnostic category. The emphasis for the primary care physician should be less on the exact identification of the syndrome than the recognition of the abuse, the assessment of the danger and urgency of the situation, the development of an appropriate initial treatment plan, and referral to appropriate resources.

While no single syndrome uniformly results from exposure to violence, the presence of at least some mental health sequelae is nearly universal. These sequelae can be found as psychological problems alone or in combination with physical and behavioral symptoms. It is very important to realize that even without the benefit of any therapeutic intervention, some abuse victims are able to maintain the *outward appearances* of psychological adjustment. Such persons are nonetheless suffering, and they may experience long-lasting and devastating consequences from the abuse.

Symptoms seen in the victims of family violence may be understood from a number of perspectives. Some symptoms seem easier to appreciate using a biomedical (e.g., neurophysiological) framework, while others are better grasped from psychological viewpoints (psychodynamic, behavioral-cognitive, etc.).

Physicians at times will also see the abuser in the family as their patient, which presents an ethically and legally complicated situation. While the motivations and treatment of perpetrators of family violence are beyond the scope of this monograph, it is important to appreciate that there is a broad spectrum of clinical pictures. These will range from perpetrators with milder, situational disturbances that lead to the abuse through more severe but still treatable mental illnesses (e.g., bipolar disorder, alcoholism) to individuals who may be recidivistic, brutal, and sociopathic. Certain perpetrator characteristics influence the effects of the abuse on the victim as well as the prognosis for remedying the situation.

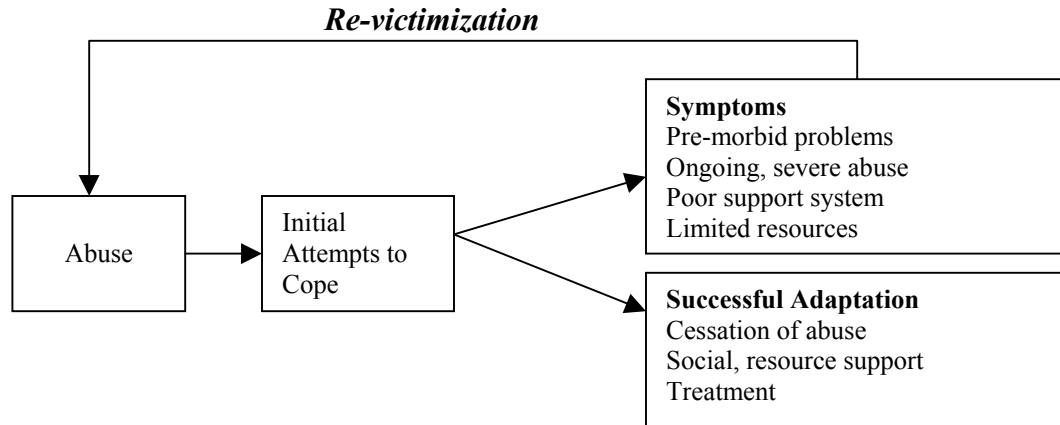
Table 2
Clinical Presentations Associated with Victimization

Self-neglect, malnutrition, dehydration, failure-to-thrive
Depression, anxiety, panic attacks, sleep disorders
Alcohol, drug abuse
Aggression towards self and others
Dissociative states, repeated self-injury
Somatizing disorders, eating disorders, chronic pain
Suicide attempts
Compulsive sexual behaviors, sexual dysfunction
Lying, stealing, truancy, running away (in children)
Poor adherence to medical recommendations

Abusers exert power for a number of reasons. These may include age differences, disparity in physical size or strength, or gender role beliefs, whether the victims are children, elders, or partners. Because of the power imbalances, victims often feel obliged to submit. Children in particular may eventually come to identify with the abuser. When abused children become adults, some will in turn treat others as they were treated, including their own children. Such identification perpetuates a cycle of violence between multiple generations. On the other hand, women in battering relationships often experience cycles of tenor and reprieve, which may result in a feeling of intense dependence on the abuser. Some battered women appear to voluntarily suppress their own beliefs as proof of loyalty and submission, to lend them the feeling of increased safety, or to placate the abuser enough to diminish the frequency of attacks.

Figure 1 shows a schematic illustration of how various psychosocial variables influence initial attempts to cope with trauma and determine whether adaptation is likely to be successful.

Figure 1
Course of Victimization



Multiple exposures to trauma, so common in family violence, cause repeated mobilizations of autonomic and endocrine hyper-arousal (“flight or fight” response). With time there may be alterations of adrenergic, serotonergic, endogenous peptide, and hypothalamic-pituitary-adrenal responsiveness, causing a generalized loss of neuromodulation and affect regulation. This may lead to several important clinical effects:

- emotional “over-reactions” to stimuli, particularly if the current stimulus bears some resemblance to past traumatic events. This is one reason that an apparently slight event (e.g., a physical examination or the confinement in an MRJ scanner) may trigger strong affective or avoidant reactions. The stimulus may be any perceptual or sensory event which evokes the earlier experiences.
- general emotional numbing, occasionally with a need or craving for high-risk, self-injurious, or self-stimulating behaviors in an attempt to palliate the numbness
- difficulty in learning new information, especially in children, bringing about impaired school performance or diminished participation
- difficulty in managing some cardiovascular or endocrine conditions where erratic autonomic or regulatory mechanisms may complicate stabilization

Most emotionally-laden events (such as trauma) are strongly imprinted in memory along with the accompanying affects. The memories may be retained (except for pre-verbal children) in a narrative form and/or with a variety of perceptual impressions from any of the senses. With the passage of time there may be decay in the accuracy of memories as other experiences with similar circumstances, affects, or sensory effects intermingle with the

traumatic experiences. The setting and manner in which they are asked about may also affect recall of memories. Most victims of abuse have vivid, persisting memories of the abuse experiences even if they occurred many years earlier.

Clinicians recognize, however, that some patients may respond to trauma by blocking the events from their conscious memory and may recall aspects of the events only after extended periods of amnesia. There is a great deal of controversy about the actual *historical* accuracy of these repressed memories (which may be very detailed and compelling to the patient). It is for these reasons that physicians should:

- 1) avoid asking overly leading questions,
- 2) not express doubt or disbelief about patient memories,
- 3) not encourage the patient to act on the basis of delayed-recall memories, and
- 4) utilize referrals to those who are experienced in dealing with such complex issues.

Specific Situations/ Populations

Elder mistreatment. Elder mistreatment refers to neglect, abuse, and exploitation. Recognition, assessment, and treatment of adverse mental health effects of elder mistreatment is made more difficult by several factors:

- 1) public lack of awareness of elder abuse and neglect makes it harder for the patient to see him/herself as being victimized,
- 2) patients may have a high degree of shame and guilt over being victimized or dependent and thus may be reluctant to acknowledge the abuse (especially by their own adult children),
- 3) the elderly are generally more reluctant to acknowledge mental health symptoms or emotional distress, or to accept a mental illness diagnosis or referral,
- 4) neglect is the most common form of abuse in this population, so that medical clues (e.g., gross weight loss) are often missing except in extreme cases, and
- 5) there are often fewer community resources available for elderly victims.

In addition, elders impaired by conditions such as stroke or dementia may be unable to report abuse or neglect. Those elders with a recent decline in functioning are at particular risk.

There are a number of common patterns seen in elder abuse:

- 1) expressions of frustration (abuse or neglect) by family members who are overwhelmed with caretaking responsibilities, have unrealistic expectations of the elder, resent dependence on the elder, or are angered by problematic behaviors of an impaired elder (e.g., incontinence, agitation, aggression, lack of appreciation seen in dementia),
- 2) neglect of a frail or impaired elder by family members who are hostile, under-involved (e.g., resenting the caretaking role or being involved with drugs or alcohol), or exploitive (e.g., attempting to hasten death to access assets),
- 3) gross expressions of violence, often as a continuation of previous family violence, and
- 4) over-stressed caregivers with insufficient knowledge of or access to resources.

Of the mental health presentations discussed earlier, mood and anxiety disorders (including more typical post-traumatic states) are the most common problems in this population. Substance abuse and somatoform disorders may be seen as well, but dissociative symptoms, eating disorders, and repeated self-injury seem to be far less common than in adolescents and younger adults. At times allegations of abuse may be erroneously mistaken for paranoia or evidence of dementia.

Child physical abuse and neglect.

Effects in younger children may include social withdrawal, oppositionality, aggressive behavior, depression, lying, stealing, thumb-sucking, or any age-inappropriate behavior. Older children and adolescents are more likely to demonstrate substance abuse, engage in risky sexual behaviors, or exhibit school performance problems (truancy, lowered grades), running away, and dangerous (speeding, frequenting more dangerous places) or suicidal behavior.

Situations which might suggest children at-risk include:

- parental depression or other mental illness
- parental substance abuse
- parental chronic physical illness
- physical abuse of a parent by the parent's partner
- poor adherence to medical recommendations for children or erratic office visits
- marked aggression among siblings
- extreme over-protectiveness by one parent
- parental over-investment in proving child physically ill (e.g., Munchausen's by proxy)

Child Sexual Abuse. The traumatic impact of child sexual abuse includes the effects of betrayal, stigmatization, powerlessness, and traumatic sexualization on the victims. In addition to post-traumatic symptoms, younger children may exhibit precocious

sexualization, pseudo-maturity, or extreme over-compliance or obedience. In older children and adolescents, dissociative symptoms, eating disorders, substance abuse, prostitution, runaway behavior and school performance problems have been reported more frequently. Children may be fiercely protective of the abuser or work strenuously to try to keep the family unit intact. Abused children may demonstrate resentment of the parent who failed to intervene to prevent or stop the abuse. Problematic family dynamics, especially in the relationship between the parents, are often part of the picture.

Factors that influence the effects of childhood sexual abuse are known. Increased symptomatology results from molestation at an especially early age, extended and/or frequent abuse, incest by a parent, the presence of force, severe injury, and a greater number of perpetrators. More extreme psychological problems are also predicted by the lack of a protector or advocate, the presence of other concomitant forms of child maltreatment, including physical and psychological abuse or neglect, and/or subsequent re-victimization in adulthood. Supportive responses from other people -- especially individuals who are important to the victim -- may mitigate the impact of the (traumatic) events, while a hostile or negative response may compound the damage and aggravate the trauma syndrome.

Partner abuse/neglect. Most abused women are still in danger at the time they seek help, and if they decide to leave, the danger may increase significantly. Financial exigencies and concerns about dependent children may also be important practical deterrants to leaving. In the presence of ongoing abuse, many battered women will initially attempt to remedy the situation themselves: by talking, by seeking help, by fighting back, or by trying to change the conditions either they perceive or the perpetrator tells them cause the abuse. When those attempts fail, the woman may retreat into a mode that appears more passive and “compliant” but which she has learned may reduce her immediate danger. When those tactics also fail, she may still manage to cope by withdrawing emotionally. For others who become increasingly isolated from outside resources, suicide or homicide may seem like the only options for ending the abuse.

Domestic violence may also aggravate co-morbid psychiatric disorders, and women with psychiatric histories may find their complaints of abuse mistakenly regarded as delusions or other evidence of psychopathology. Women who are immigrants, developmentally or physically disabled, from cultural backgrounds different from the physician, or who do not speak the dominant language are also at higher risk for not having their complaints taken seriously. Case 2 illustrates some of the preceding points.

Although partner abuse most commonly refers to women as victims and men as perpetrators, all gender permutations are seen in clinical practice. There has been less empirical research on abuse by women against men or in same-sex couples. It appears that the prevalence for gay men is probably similar to that in opposite-sex couples, and perhaps it is somewhat lower among lesbians.

Fears of prejudice, feelings of community solidarity, or concerns about having the homosexuality disclosed may make some gay or lesbian victims reluctant to disclose the abuse. Shame typically serves as a barrier to men reporting abuse by female partners.

Case 2

Brief Reactive Psychosis

A 23-year-old woman was brought to the emergency room by her mother. The younger woman was acutely psychotic and panicky. She had been psychiatrically hospitalized twice previously for depression, but each time her complaints about her boyfriend were thought to be due to paranoia. The patient was hospitalized and treated with antipsychotic and anti-anxiety medication. As the patient's thinking became more coherent, she clearly described repeated episodes of physical abuse, sexual coercion and controlling and threatening behavior on the part of her boyfriend. It was for the first time during this hospitalization that the patient's mother became involved in her care and corroborated the history about the abuse. After supportive interventions, the patient was able to access resources for herself and her small children, and was able to call the police and have the boyfriend evicted when he threatened her again.

Adult Survivors of Childhood Sexual and Physical Abuse.

While there are many presentations seen among survivors of childhood abuse, one group of survivors has particular relevance to physicians. Medical providers may recognize that some patients routinely and repeatedly present with somatic complaints which are difficult to treat and which are non-responsive to routine treatment protocols. The physician may fail to “put all the pieces together” and identify sequelae of an abuse syndrome. Ineffective or inappropriate treatment can perpetuate the secrecy and shame often associated with childhood abuse and may subject the survivor to unnecessary — and costly procedures. Some of the more common medical problems are shown in Table 3.

Table 3

Common Medical Problems in Adult Survivors of Childhood Physical and Sexual Abuse

Chronic head, face, back or pelvic pain
Gastrointestinal distress
Musculoskeletal complaints
Asthma/respiratory ailments
Obesity, eating disorders
Insomnia
Pseudocyesis
Sexual dysfunction
Pseudo-neurologic symptoms (dizziness, paresthesias, etc.)

Disturbances in sexual interest and sexual functioning have been identified in studies of incest survivors. Due to the association between sexual stimuli and invasion or pain, many adults abused as children or who have been in battering relationships report difficulties during sexual contact, including dysfunctions of desire, arousal, or orgasm. On the other hand, seductive behaviors, compulsive sexual activity and prostitution may also be present as the result of learning “all you’re good for is sex.” Child sexual abuse survivors frequently confuse sexuality with nurturing behavior and may exhibit precocious sexual behavior. Sexually transmitted diseases, teen pregnancy, or poor adherence to family planning efforts may result. Some victims of childhood sexual abuse also describe attempts to gain (or less commonly lose) excessive amounts of weight in an attempt to make themselves as sexually unattractive as possible.

Certain life events may trigger symptoms for survivors of childhood abuse. These are shown in Table 4.

Table 4
Common Life Event Symptom Triggers for Survivors of Childhood abuse

Pregnancy or birth of a child
Illness or death of a parent/perpetrator
Divorce of parents
Age of patient’s child recalls onset of abuse
Key “anniversary” dates or holidays
Family get-togethers, reunions
Illness or injury of child
Hospitalization or medical workup
Workplace situations that mirror a relationship with abuser
Home re-location, especially to area where abuse occurred
Viewing movies or television shows with abuse content

Effects on Children of Parental Battering. Effects of witnessing domestic violence during childhood vary with the age and gender of the child. All ages may exhibit somatic concerns, including headaches, school avoidance, and abdominal complaints. Preschool children most often develop stuttering, enuresis, insomnia, and separation anxiety. School age children frequently develop impaired concentration and difficulty staying focused on school work. Older children often manifest aggressive behavior, with boys being more likely to have such aggressive behavioral problems, while girls are more likely to have somatic concerns. Both sexes often express guilt at not being able to stop domestic violence.

Often children in domestic violence families are also themselves victims of abuse, frequently when they try to intervene to protect one parent from another. This dual violence exposure has been found to be associated with increased severity of behavioral and emotional problems for children over either witnessing or being a victim alone.

Evaluation and Management

Appropriate medical intervention in response to family violence includes routinely inquiring about abuse, assessing each family member's safety, thoroughly documenting the abuse, discussing options and resources, providing advocacy and referral, and arranging for treatment of medical and mental health problems. It may also include providing for follow-up care and monitoring the treatment plan.

Most physicians are not trained to deal with severe psychological trauma, particularly in developing the capacity to remain both emotionally and intellectually present and thus to provide an empathic response. Personal experiences and attitudes about victimization may limit the physician's ability to care for people who have been abused. Attempts to "deal" with situations may serve to distance the physician from painful encounters- through avoidance, blaming or pathologizing the patient, and by attempting to over-control the clinical interaction. All of these can mimic the dynamics of abuse and inadvertently re-traumatize patients.

Clinicians working with victims of abuse (i.e., all physicians) may find some of what they hear overwhelming, disturbing, and draining at times. Collegial support may be extremely helpful not only for assistance with patient care but to help the physician cope with his or her own distress as well. Physicians who have had personal experiences with victimization may be able to use such experiences to demonstrate empathy for patients.

On the other hand, such physicians may also find dealing with victims too painful (and thus avoid it) or over-identify too readily (and try to take over too much of the patient's autonomy).

Assessment

How to Ask. Many victims will readily talk about the abuse if they feel safe and supported and are asked about it directly by the clinician. If asking about abuse does increase the patient's distress, let him or her know that you understand how hard it is to discuss, that you are glad s/he felt s/he could tell you, that you want to make sure s/he feels safe before leaving, and that you can refer to a mental health provider and/or advocacy program. Just asking about abuse and listening to the response is already a significant intervention, one which creates an opportunity for prevention as well. Letting victims know that they are not alone, that they don't deserve to be abused, that they are not responsible for the violence, that resources are available, that you are concerned about their safety, and that this is a place they can come to for help, can give them hope. Even briefly discussing the dynamics of abuse gives them the tools to recognize a pattern of escalating violence before it becomes more deadly.

Before inquiring about abuse, it is essential to create an environment in which it is safe for a patient to talk freely. A battered woman may be afraid to disclose information if she thinks the batterer will learn that she has talked about the abuse or that she will lose her children. A child may be afraid of retaliation or loss of a parent. All patients should be seen alone at least until abuse has been ruled out--this includes family members, friends, personal assistants, and non-official translators. Let patients know that the information they give you will be confidential within the confines of the law. Mandatory reporting requirements for elder abuse, child abuse or partner abuse should be explained at the outset so that the patient can decide whether or not s/he feels it is safe to disclose.

Avoiding Retraumatization. Because many medical procedures involve touch, are invasive, or are performed by authority figures in positions of control or power, physicians must be sensitive to the risk of re-traumatizing vulnerable patients during examinations and testing. All procedures (even "routine" ones) need to be explained carefully and patiently in advance, and the patient should be invited to offer ideas about how to make the procedure less problematic. This may include changing the rate or duration of the procedure or having other staff, friends, or family members present.

Pelvic, rectal, oropharyngeal, and breast examinations may be especially difficult when sexual abuse has been part of the victimization. Talking patients through the steps, allowing the patient additional control (eg, stopping or re-starting the exam as needed), maintaining eye contact, allowing the patient to see more (eg, use of a mirror in pelvic exams), or having the patient assist (ie, putting his/her hand over the physicians to guide the exam) may be useful techniques in increasing the patient's comfort.

Table 5

Medical Situations Which May Cause Re-experiencing of Trauma

Genital, breast, rectal, oral examination
General anesthesia, muscle paralysis
Insertion of catheters, needles
Confinement (e.g. MRI, restraints)
Seclusion, immobilization
Endoscopic procedures
Labor
Inadequate privacy arrangements
Loud procedures (e.g., breaking bones)
Open discord between care staff members
Practitioner resembles the patient's abuser in some way

Hospital care may be particularly intimidating to many abuse victims, and the involvement of so many caregivers can be daunting. Keeping the treatment team to a minimum (e.g., judicious use of trainees and consultants, consistent nursing and other staff, etc.), introductions of all new team members, and careful explanations in advance of all anticipated events (even transport, starting intravenous lines, blood draws, etc) can be most helpful. Some medical situations which may simulate earlier traumatic events are shown in Table 5.

When to Ask. Questions about current and past abuse should be asked of *all* new patients as part of the initial health screen. The questions about victimization and mental health effects may be part of a general review of systems, the social or sexual history, and/or part of psychiatric screening. For ongoing patients, such questions should be asked when:

- the presenting complaint suggests that abuse should be part of the differential diagnosis (e.g., suggestive injuries, STDs, mental health presentations described earlier, etc.)
- a woman is contemplating pregnancy or is seen for first and subsequent pre-natal visits of each pregnancy
- the patient reports a change in family relationships or intimate partnership (e.g., a patient starting a new romantic relationship, a child acquiring a step-parent, a child with a newly ill parent, etc.)
- there are frequent unexplained appointment changes or cancellations, especially when made by someone other than the (adult) patient
- an elderly patient reports a change in living or caretaking arrangements or when there has been a recent decrement in functional abilities
- physical symptoms do not make sense, do not suggest a clear etiology, or fail to respond to treatment

Even if the preceding situations are not present, physicians should periodically ask ongoing patients about victimization.

What to Ask. The outline of history-taking for family violence is similar to that for exploring any patient complaint: current history of problem (including effects and complications), past relevant history of the problem, pertinent review of systems, and related psychosocial information. The history should be supplemented by a focused physical examination and an assessment of any mental status abnormalities. There are a number of standard protocols for the assessment and documentation of child sexual abuse. Table 6 shows some of the key areas to cover in taking the history as well as some specific questions. Additional questions may be found in the AMA guidelines for specific forms of abuse (see references).

Assessing Safety. Before the patient is allowed to leave it is imperative that the physician evaluate and take steps to insure the patient's safety. This includes physical safety (from further assault, suicide) and the ability to care for him/herself. It is also vital to assess for homicidal risk against the perpetrator of the abuse.

With regard to physical safety from the perpetrator the physician should ask: is it safe for the patient to go home? How much danger is s/he in? Immediately? Have there been recent death threats (homicide or suicide or an escalating pattern of violence? Is there a gun or other highly lethal weapon in the household? Have there been assaults with weapons or threats to use weapons? Does s/he have an escape or other safety plan? What will happen to others in the home (e.g., children, elders) if the patient leaves?

Table 6

Taking the Abuse History

Current history of abuse:

Is the patient currently being hurt or harmed? In the past? Is s/he still at risk? Who is the perpetrator? What kind of access does the perpetrator have to the patient/victim?

Impact of Abuse:

How has the abuse affected his/her physical and psychological health? What is the relationship of abuse to her present symptoms? How does s/he feel about the abuse? How has the abuse affected his/her life—children, work, school, personal relationships?

Options/resources:

What has s/he tried already? What has worked? What has not? How has this affected hopes for change? What other options are seen as available? What does s/he want immediately? In the long run? Where is s/he at in the process of being able to change his/her situation? Who else knows? Who else can help? Who else actually will?

Needs Assessment:

What does s/he need—information, support, shelter, counseling, support group, legal advocacy, mental health/substance abuse services, access to other resources? Can s/he manage this herself, or does s/he need more help with the initial steps? What resources are available in the community: shelter, safe homes, counseling, support groups, legal advocacy? Are there special service needs—cultural, religious, sexual orientation, language, disability, communication? If not, what alternatives exist or could be developed? Are there needs for children or others requiring attention too?

Maintaining a Supportive Relationship:

How is s/he feeling about the fact that you are asking?

With regard to suicide the physician should ask: does the situation seem hopeless? Do you think you would be better off dead? Do you see any alternatives? Have you had any thoughts about hurting yourself? Do you feel you might act on those feelings now? Do you have a plan? What is it? Can you carry that out? Have you ever contemplated or attempted suicide before? What might prevent you from killing yourself?

Questioning about homicide runs in a parallel vein: does the situation seem hopeless? Do you think you would be better off if s/he were dead? Do you feel that is necessary to protect yourself (your children, mother, etc)? Do you see any alternatives? Have you had any thoughts about hurting him/her? Do you feel you might act on those feelings now? Do you have a plan? What is it? Can you carry that out? Have you ever contemplated or attempted killing someone before? What might prevent you from killing him/her?

Treatment

Completion of the assessment outlined above will allow the physician to triage the care required. Patients of any age felt to be suicidal or homicidal (or if there is any doubt) need immediate psychiatric evaluation for risk and possible hospitalization. If this is not available, hospitalization on a medical or pediatric floor with appropriate surveillance may be provided short-term until more definitive arrangements can be made. Patients at immediate risk of harm from their perpetrators need immediate referral to shelters or child or elderly welfare services. Some localities have hotel vouchers, which can be used. Again, hospitalization (with appropriate security arrangements) may be utilized if suitable resources are not immediately available. Patients unable to care for themselves, depending on circumstances, may need urgent psychiatric evaluation, a protected living environment, or hospitalization.

Patients not in immediate danger will need an integrated care plan, generally involving outpatient psychiatric care and/or supportive community resources. The specific mental health care required, if any, will depend on the patient's age, type of victimization, clinical syndrome, and role of the family. Some patients with milder psychiatric sequelae may only need victim advocacy services initially, though follow-up over time allows monitoring to assess for additional needs. Given the complexity of most cases needing mental health care, the physician will do best by referring to a practitioner who can perform a complete psychiatric evaluation and develop a comprehensive treatment plan in collaboration with the physician and community resources. Making referrals for specific forms of therapy is generally ill-advised (see below).

Domestic Violence. Mental health care for the victim of battering requires ongoing assessment of the victim's safety regardless of treatment modality. Support groups, individual or group psychotherapy, and at times, pharmacotherapy may be required.

Medications which may impair the victim's ability to assess his or her safety and respond accordingly (such as sedatives) should be prescribed especially cautiously by the physician.

Couples therapy, court mediation, or referral for the batterer without help for the victim are all *contra-indicated* because they may actually increase the risk of violence to the victim. Couples therapy and mediation assume partnership equity and mutual responsibility of the partners for the battering, neither of which is the case in almost all such relationships.

The results of anger management and similar treatment approaches for batterers are currently being evaluated--some centers are reporting encouraging short-term outcomes, but it is not yet known if these results are generalizable or can be sustained over time. Only when abuse has ceased for many months or years *and* both partners are amenable can couples therapy to re-build the relationship be considered. Coordination should be made with local victim services.

Child Abuse. Once safety issues are adequately addressed, a broader array of mental health interventions may be valuable for children who are physically abused, sexually abused, or who witness parental violence. These include group or individual psychotherapy for the child, play therapy for younger children, family therapy (parent-child dyad or other combinations), couples therapy for the parents, parental training in childrearing, pharmacotherapy, or behavioral therapy for specific symptoms (e.g., precocious sexuality, phobias, etc.). Treatment of recidivistic physical abusers and pedophiles requires long-term, specialized care, so the child's safety must be assured by other means (incarceration, strictly supervised visits, etc.) in the meantime. It is critical to coordinate mental health treatments with the network of local child welfare services.

Adult Survivors of Childhood Abuse. Unless these patients are being re-victimized in current relationships, safety issues *vis-a-vis* perpetrators are less pressing than with other forms of abuse, although suicidal ideation, substance abuse, self-injury, and other behaviors may require that safety concerns be kept in the foreground. Individual and/or group psychotherapy, often over extended periods of time (one to two years or longer), are often required to undo the extensive psychic harm that was done to these patients. Pharmacotherapy may be quite valuable for symptoms of depression, anxiety, and eating disorders, among others. Substance use disorders may require specific treatments as well.

The Elderly. Safety concerns for this population must be addressed whether the patient is a victim of abuse, neglect, or exploitation. Competency (guardianship) and/or capacity assessments of the elder may be necessary to help plan treatment. Environmental changes, such as changes in caretakers, nursing home placement, or a move to an assisted living setting may both increase safety and greatly ameliorate the sequelae of the abuse. Such changes themselves, however, may be stressful for the patient because of the losses incurred. Treatment of psychiatric syndromes generally follows traditional psychotherapeutic and psychopharmacologic lines. At times additional support for the caretaker or treatment of his/her substance abuse or mental illness may improve the situation.

Although most states have reporting requirements for elderly abuse, resources tend to be quite limited. It is especially important that physicians familiarize themselves with state reporting laws for the elderly. States vary in the cutoff age for reporting, the sequence of mandated post-reporting steps (if any), and whether there is a penalty for failing to report.

Referrals

Choosing a Clinician. As mentioned earlier, the complexities of many of these cases mandate referrals to clinicians capable of comprehensive evaluation, experienced in treating trauma, and knowledgeable about local resources. Unfortunately, due to media attention to violence and victimization, some therapists and programs falsely present themselves as abuse or trauma experts. Physicians may begin compiling a list of true experts in a number of different ways. Many victim advocacy groups (veterans centers, battered women's shelters, rape crisis centers, hotlines, etc.) are quite knowledgeable about such experts in the community. In addition, some of these groups may offer low-cost group counseling or other therapeutic services themselves.

Often, contacting state medical or psychiatric societies or psychological or social work professional groups can be beneficial in locating therapists who are skilled in treating victims of trauma. Due to the relationship between trauma histories and alcohol and drug abuse, therapists should be comfortable working with individuals who have dual-diagnoses.

Discussing the Referral with the Patient. To avoid a sense of abandonment or rejection when making a mental health referral, it is important to emphasize your ongoing involvement in the patient's care (if this is realistic and appropriate). Patients accept such referrals most willingly if the therapist or agency is known personally by the physician and if they feel there will be ongoing review by the referring physician. Even if the physician will not remain involved, prejudices and misinformation about mental health diagnoses and services must be addressed ("no, "I don't think you are crazy," "anyone would be overwhelmed by what you've been through," etc.).

It is also important to keep in mind cost considerations when making referrals. Many patients are uninsured or have marked restrictions on mental health benefits covered by third-party payers, so utilization of publicly funded services, agencies with low or no cost, or clinicians who provide a flexible (sliding-scale) fee schedule may be required. This is especially relevant with abuse victims since they may need extended periods of psychotherapy.

Legal and Reporting Issues

Many physicians have limited experience in reporting different types of victimization in their communities. The resource list (p.28) may be a useful starting point. Those physicians interested in learning would also do well to contact local victim advocate or shelter services for up-to-date practical information. Physicians should acquaint themselves with the specifics of the laws in their jurisdictions.

Documentation. It is extremely important that information obtained from the patient as well as any pertinent observations made by the physician or any laboratory results be carefully and fully entered into the medical record. Any future legal proceedings may well draw on information contained in the record: the failure to document the abuse may be used by the perpetrator to deny its existence, or the physician may be held liable for failing to recognize the abuse and respond to the patient's complaints. Patient statements are best recorded using direct quotations wherever possible. Injuries should be photographed if equipment is available, or careful schematic drawings made if not. The fact of the abuse and any sequelae noted should become part of the master problem list. Extra precautions should be made in handling these records to make sure that information is not inadvertently conveyed to the perpetrator of the abuse.

Duty to Report. All states mandate the reporting by physicians of suspected cases of child abuse or neglect. The reporting requirement may include emotional abuse, battery, sexual contact, and willful neglect by adult caretakers. The physician need not be certain that abuse or neglect has occurred, but must report if a reasonable suspicion exists. Immunity from civil action is provided for acting in good faith. Failure to report leaves the physician liable to criminal misdemeanor prosecution or civil action for harm subsequently suffered by the child. Most states have somewhat similar reporting laws for abuse or neglect of the elderly, and a few require reports of domestic violence as well. Most states have laws requiring physicians to report injuries arising from criminal acts or from deadly weapons, so some cases of elder or domestic abuse will need to be reported under these statutes even if there is no specific abuse reporting law. Physicians should avoid contacting police unless domestic violence victims are ready to proceed with doing so.

Duty to Warn. If a physician is aware of a patient's intent to harm a third party, such as the patient's spouse or partner, the clinician may have a legal duty to take steps to protect the intended victim (the so-called *Tarasoff* duty). States vary in the breadth and specificity of this duty. The limits of confidentiality should be explained to the patient. Satisfying this duty may take a number of forms:

- having the patient turn in weapons involved in the threat
- relocating the patient, including hospitalization
- bringing in other friends or family to protect the intended victim or monitor the patient
- using medication which diminishes the homicidal ideation
- notifying the police or notifying the intended victim

Notifications of others of course breaches the patient's confidence. Utilization of the methods other than notification which serve to protect the third party may obviate the need to warn the intended victim. *Tarasoff* is a duty to take reasonable steps to protect a potential victim — it is *not* necessarily a duty to warn (as it is often misrepresented).

Other Issues. Physicians may at times need to advise patients about the availability of protective orders, involuntary psychiatric commitment, or guardianship. They may be called as a material witness (ie, as the treating physician) or as an expert in criminal or family court proceedings. Consultation is usually necessary before engaging in these specialized activities.

Summary

The chronic and traumatic nature of all forms of family violence may lead to serious mental health consequences. These consequences may include emotional distress, interpersonal problems, and behavioral disorders. In addition, physicians may see these consequences in the form of somatization, difficulty complying with medical recommendations, and increased difficulty of managing existing medical conditions. All physicians, regardless of specialty or setting, are encouraged to learn about family violence, make appropriate inquiries of patients about victimization, assure patient safety, make appropriate referrals, and follow their local reporting requirements.

Resources

National Information Centers

Domestic Violence:

National Resource Center on Domestic Violence
800 537-2238

Family Violence Prevention Fund's Health Resource on Domestic Violence
800 313-1310

National Coalition Against Domestic Violence
202 638-6388 or 303 839-1852

Duluth Domestic Abuse Intervention Project
(some batterers' treatment information too)
218 722-2781

Battered Women Fighting Back!, Inc.
617 482-9497

National Center on Women and Family Law, Inc.
212 674-8200

National Clearinghouse for the Defense of Battered Women
215 351-0010

National Clearinghouse on Marital and Date Rape
510 524-1582

Fenway Community Health Center's Victim Recovery Program
617 267-0900

National Coalition Against Sexual Assault
202 483-7165

Child Abuse:

National Child Abuse Hot Line (Child Help USA)
800 422-4453

State Programs

(DVC = Domestic Violence Coalition)

State	Domestic Violence	Elder Maltreatment	Child Abuse
Alabama	DVC: 334 793-5214	Hotline In-State (Report to Ombudsman) 800 243-5463	Dept. of Human Resources 334 242-9500
Alaska	DVC: 907 586-3650	Division of Senior Services 907 563-5654	24-hr hotline: 800 478-4444
Arizona	DVC: 602 279-2900 800 782-6400	Adult Protective Service 602 542-4446	Phoenix hotline: 800 541-5781
Arkansas	DVC: 501 663-4668	Hotline In-State 800 482-8049	Dept. of Human Services 800 482-5964
California	DVC: Central: 209 524-1888 Southern: 310 655-6098	Ombudsman 916 323-6681	Dept. of Social Services Office of Child Protective Services 916 445-2771
Colorado	DVC: 303 573-9018	Elder Abuse Hotline: 800 773-1366	Denver County: 24hr hotline 303 727-3000
Connecticut	DVC: 203 524-5890	State Ombudsman: 203 424-5200	Reporting 24 hrs. 800 842-2599
Delaware	DVC: 800 701-0456	Hotline: 800 223-9074	Reporting 24 hrs in-state: 800 292-9582
District of Columbia	DVC: 202 783-5332	Adult Protective Services 202 727-2345	Report child abuse 202 576-6762 Report child neglect 202 727-0995
Florida	DVC: 904 668-6862	Hotline In-State 800 96-ABUSE	Abuse Registry 800 962-2873

State	Domestic Violence	Elder Maltreatment	Child Abuse
Georgia	DVC: 800 643-1212	Director of Family and Childrens' Services 404 657-3409	Dept. of Human Resources Child Protective & Placement Services Unit: 404 657-3408
Hawaii	DVC: 808 486-5072	Adult Protective Services 808 832-5115	Dept. of Human Services 24hr hotline: 808 832-5300
Idaho	DVC: 208 384-0419	Bureau of Adult Services Dept. of Health and Welfare 208 334-2200	For information and referral to regional office: 208 334-0808
Illinois	DVC: 800 241-8456	Hotline In-State 800 252-8966 After 5pm: 800 279-0400	Parents under stress & Reporting 24 hrs: 800 252-2873
Indiana	DVC: 800 332-7385	Hotline In-State 800 992-6978	Reporting: 800 562-2407
Iowa	DVC: 800 942-0333	Hotline In-State 800 362-2179	In-state hotline: 800 362-2178
Kansas	DVC: 913 232-9784	Hotline In-State 800 432-3535	Reporting 24 hr hotline: 800 922-5330
Kentucky	DVC: 502 875-4132	Adult Services 502 564-7043	Local Dept. for Social Services or statewide hotline 800 752-6200
Louisiana	DVC: 800 837-5400	Elderly Protective Services: 800 256-4277	24 hr hotline: 504 925-4571
Maine	DVC: 207 941-1194	Hotline In-State 800 452-1999	Reporting 24 hrs: 800 452-1999

State	Domestic Violence	Elder Maltreatment	Child Abuse
Maryland	DVC: 800 634-3577	Adult Protective Services Dept. of Human Resources 410 333-0161 In Nursing Homes: 410 764-4960	County office of Dept. of Social Services Each office has 24hr hotline.
Massachusetts	DVC: 617 248-0922	Hotline In-State 800 922-2275	24 hr hotline: 800 792-5200
Michigan	DVC: 517 484-2924	In-State Hotline: 800 996-6228	800 942-4357
Minnesota	DVC: 800 646-0994	Adult Protection Consultant Aging and Adult Services 612 296-4019 (Oct.1,1995 subject to change)	County office of Dept. of Human Services; each office has 24 hr hotline.
Mississippi	DVC: 601 981-9196	Hotline In-State 800 354-6347	24 hr hotline: 800 222-8000
Missouri	DVC: 314 634-4161	Hotline In-State 800 392-0210	Reporting: 800 392-3738
Montana	DVC: 406 256-6334	Office on Aging 406 444-7780	24 hr: 800 332-6100
Nebraska	DVC: 800 876-6238	Hotline In-State 800 358-8802	Reporting 24 hrs: 800 471-5128
Nevada	DVC: 800 500-1556	Adult Protective Services Dept. of Human Resources 702 687-4588	800 992-5757
New York	DVC: English: 800 942-6906 Spanish: 800 942-6908	Ombudsman: 800 342-9871	Reporting 24 hrs: 800 342-3720 Mandated reporters: 800 635-1255

State	Domestic Violence	Elder Maltreatment	Child Abuse
New Mexico	DVC: 800 773-3645	Hotline In-State 800 610-7610	24 hrs: 800 432-2075
New Jersey	DVC: 800 572-7233	Hotline In-State	800 792-8820
New Hampshire	DVC: 800 852-3388	Hotline In-State 800 852-3345	In-State Hotline 800 894-5533
North Dakota	DVC: 800 472-2911	Aging Services Division Dept. of Human Services 701 328-2577	Reporting: County Social Services or 701 328-4806
North Carolina	DVC: 919 956-9124	Hotline In-State 800 662-7030	Reporting: 800 662-7030
Ohio	DVC: 800 934-9840	Dept. of Human Services 614 466-0995	Dept. of Human Services Child Protective Services Unit 614 466-9824
Oklahoma	DVC: 800 522-9054	Hotline In-State 800 522-3511	Reporting 24hrs: 800 522-3511
Oregon	DVC: 503 223-7411	Hotline In-State 800 232-3020	Dept. of Human Resources Childrens' Services Division 503 945-5651
Pennsylvania	DVC: 800 932-4632	Dept. of Aging 717 783-1550	Reporting 24 hrs in-state: 800 932-0313
Puerto Rico	809 722-2907		Reporting 24 hrs: 800 981-8333
Rhode Island	DVC: 800 494-8100	Hotline In-State 800 322-2880	Reporting 24 hrs: 800 742-4453

State	Domestic Violence	Elder Maltreatment	Child Abuse
South Carolina	DVC: 800 260-92393	Division of Adult Services Dept. of Social Services 803 734-5670	Dept. of Social Services Division of Child Protective and Preventive Services 803 734-5670
South Dakota	DVC: 605 225-5122	Office of Adult Services and Aging 605 773-3656	Child Protective Services 605 773-3227
Tennessee	800 356-6767	Adult Protective Dept. of Human Services 615 532-4041	Dept. of Human Services Child Protective Services 615 313-4746
Texas	800 252-5400	Hotline In-State 800 252-5400	Reporting 24 hrs: 800 252-5400
Utah	DVC: 801 538-4100	Division of Aging and Adult Services Dept. of Social Services 801 538-3910	Reporting 24 hrs: 800 678-9399
Vermont	DVC: 802 223-1302	Hotline In-State 800 564-1612	Dept. of Social & Rehabilitation Services 802 241-2131
Virginia	DVC: 800 838-8238	Adult Protective Services Dept. of Social Services 804 692-1260	Reporting 24 hrs w/in VA: 800 552-7096
Washington	DVC: 800 562-6025	Adult Protective Services 800 562-6078	Reporting 24 hrs: 800 562-5624
West Virginia	DVC: 304 765-2250	Hotline In-State 800 352-6513	Reporting 24 hrs: 800 352-6513

State	Domestic Violence	Elder Maltreatment	Child Abuse
Wisconsin	DVC: 608 255-0539	608 266-2536	Dept. of Health and Social Services 608 266-3036
Wyoming	DVC: 800 990-3877	Hotline In-State 800 528-3396	Reporting: 307 777-7922