

Gender violence and mistreatment (II): approaching the problem from the Emergency Department

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Domestic violence is a significant health problem and the case prevalence rates are high in emergency departments. The staff of these departments are in an excellent position to detect cases of abuse and intervene early in the process. However, few cases are in fact identified because of certain attitudinal barriers affecting both the women who are victimized and the health care staff who treat them. Attention to signs that should raise suspicion of abuse and even systematic screening are therefore recommended. In all cases it is important to carry out a private interview, to guarantee confidentiality, and to offer help. Victims should be cared for in an individualized way that takes into consideration the woman's situation and preferences and the level of threat to her life. The medical problem that occasioned the visit should be treated and the need for psychiatric care assessed. Appropriate social assistance should be offered and legal requirements met, with particular attention to keeping accurate medical records and notifying authorities when necessary. The problem calls for a multidisciplinary approach, especially by creating good channels of communication between the emergency department, primary care, and social services. Staff training and awareness raising are critical in order to improve the emergency care presently given to women who are victims of domestic violence. [Emergencias 2008;20:269-275]

Key words: Domestic violence. Emergency medical services.

Gender violence: impact of the problem on health

Gender violence affects a wide sector of the population but its exact prevalence is difficult to quantify because of its intrafamilial and domestic character. The complexity of the problem increases with the difficulty in its quantification since it is not an isolated phenomenon in time but rather is a process which is becoming increasingly more established and chronic. It usually starts with control of the movements and isolation of the wife on behalf of the aggressor with a limitation in her access to information, assistance, the family and her relatives. This is followed by psychological or emotional mistreatment with devaluation and humiliation of the woman and attitudes of intimidation and disdain. Finally, physical and sexual aggression takes place. This insidious, repetitive and prolonged presentation progressively diminishes the self-esteem of the woman up to the point that

many women in this situation have difficulty identifying themselves as maltreated or are not aware of the mistreatment until many years later¹⁻³. In a macrosurvey carried out by telephone by the Instituto de la Mujer (Institute of the Woman), it was observed that 9.6% of the women surveyed were in a situation of gender violence, although only 3.6% considered themselves to be maltreated. In the same survey, two thirds of the mistreated women had been in this situation for more than 5 years⁴.

Gender violence has negative repercussions on the health of the women involved^{2,5-11}. In addition to the traumatic lesions directly derived from an act of physical maltreatment, the chronic stress generated by psychological abuse and the continued tension caused by numerous psychic symptoms favour the appearance of diseases and worsen those already existing. Table 1 shows the main clinical manifestations which may be found in the women affected. In some cases the decline in health is extreme: death. In

Table 1. Main clinical manifestations associated with gender violence

Psychiatric	Depression
	Anxiety
	Feeling of blame and shame
	Psychosomatic disorders
	Panic crises and phobias
	Unsafe sexual behaviour
	Eating disorders
	Post-traumatic stress disorders
	Psychodrug, alcohol and other drug abuse
	Absence of personal care
Sexual	Suicide attempts
	Reduction in libido
	Anorgasmia
Gynaecological	Lack of sexual autonomy
	Undesired pregnancy
	High risk pregnancy
	Sexually transmitted diseases
	Unsafe abortions
Physical	Recurrent urine infection
	Chronic pelvic pain
	Chronic pains
	Tiredness
	Fibromyalgia
	Gastrointestinal problems
Traumatic	Fractures
	Contusions and bruises
	Burns
	Rupture of the eardrum
Social	Social isolation
	Loss of employment
	Absenteeism from work
	Reduction in the number of healthy days of life

2007, 71 women were killed by their partners. If the secondary deaths are counted (suicides, poisoning and sexually transmitted diseases) the number of deaths due to gender violence is much higher^{1,2}. The closer and more prolonged the mistreatment the greater the effects on the health of mistreated women¹¹. It is therefore necessary to detect this problem early and prevent its development, maintenance and sequelae.

Gender violence does not only affect the health of the persons involved but also represents an important public health problem^{12,13}. Maltreated persons consume many healthcare resources with pharmaceutical products and erratic consultations to the different healthcare departments, mainly traumatology, gynaecology, psychiatry, primary care and the emergency department. Different studies have shown that more than 20% of the women consulting these last departments are mistreated^{2,6,12}.

The role of emergency professionals

Detection

Healthcare services may play a very important role in helping the women affected by this

type of violence since most arrive to these services at some time of their life. The emergency departments, in particular, constitute one of the first places of social protection to which the victims arrive since these are always open, they have the freedom to enter and they may solve medical problems related to mistreatment. It should be taken into account that most of these women do not come to the healthcare services for physical injuries directly related to mistreatment¹². The reason for the consultation is usually for a subacute manifestation or covering of the abuse, and on many occasions it is an involuntary via to request help or support. Emergency personnel therefore have a privileged position to detect cases of mistreatment early for the diagnosis of psychological and physical lesions associated with abuse and for early intervention in the cases detected¹⁴.

However, emergency healthcare personnel rarely suspect the existence of a situation of violence in their patients^{15,16}. This lack of detection may be explained by determined barriers which are present in both the women involved and in the healthcare professionals.

With regard to the first, it should be pointed out that most of the victims of gender violence do not openly manifest the situation in which they are found, despite the presence of evident injuries. This occultation makes it enormously difficult to detect these cases. Some of the reasons for explaining this conduct include the feelings of shame and blame for the violence they suffer, the lack of recognition of the acts as mistreatment, low self-esteem, threats by the aggressor or the fear of repercussion that the reporting of the acts may have on the victims themselves or their children. However, there may also be determined barriers such as dissuasive attitudes of the person who asks: manifesting a lack of time or little preoccupation for the patient, overbearing attitudes or blame with respect to the situation or the lack of response to the help offered^{1,12,17-21}.

On the other hand, despite considering gender violence as an important problem, emergency healthcare personnel do not recognise it as a healthcare problem and, thus, the detection of cases of violence is not seen as part of professional responsibility²². Even if it is considered as a healthcare problem, it is often thought that only determined specialties (traumatology, gynaecology, psychiatry) are appropriate for intervention. Lack of time for the consultation and the lack of private space for interrogating the

patient in a confidential setting are also especially relevant barriers in the emergency departments^{16,23,24}. Other barriers which impede the detection of situations of violence are the preoccupation of not knowing how to act in the case of an affirmative response, demotivation with lack of response on behalf of the victims, forgetting to ask or the belief that the victims will voluntarily explain the history of violence, and considering gender violence as a private affair or fear of offending the patients^{1,2,23,24}.

However, many studies have shown that independently of their age or length of abuse, around 80% of the women are grateful for interrogation by the healthcare personnel with respect to this subject and most expect the medical staff to initiate the dialogue related to abuse^{13,25,26}. Indeed, one of the main motivations for revealing their situation is to be asked with empathy, without hurry, directly and confidentially and within a setting of trust and free of judgement^{14,17,21,26}.

There is no common consensus on the indicators of suspicion for identifying a woman who does not spontaneously reveal a situation of mistreatment. Some signs, symptoms and determined attitudes during the consultation may lead healthcare professionals to suspect possible abuse^{1,2}. Table 2 shows the most frequent indicators of mistreatment in the emergency department. It is important to know them and remain alert to their possible appearance in emergency care.

Nonetheless, despite taking the indicators into account, many cases may remain unnoticed. Thus, some authors recommend routine detection or universal screening. Many of the studies relating domestic violence and health have demonstrated the usefulness of specific anamnesis aimed at obtaining information which may be hidden. Emergency departments which have implemented routine detection have observed a considerable increase in the detection of abuse²⁷. This does not mean that routine detection should be immediately initiated in all emergency departments. It is true that not identifying the abuse interferes with the real diagnosis, worsening the prognosis of these patients and raising the costs of healthcare in terms of time and money due to the subsequent consultations and the treatment of the sequelae. However, it should also be considered that if routine detection is carried out by inexperienced personnel, this may inhibit the revealing of the situation by many women or even worsen their situation if

Table 2. Potential indicator of a situation of gender violence in an emergency department

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- Lesions
 - Lesions with a central pattern.
 - Contusions or head, neck or chest injuries.
 - Injuries suggesting a defensive posture.
 - Type or extension of injuries which does not coincide with the explanation of the patient.
 - Delay between the time in which the injury occurred and the consultation.
 - Lesions during pregnancy.
 - Pattern of repeated visits to the emergency department.
 - Evidence of alcohol or other drug abuse.
 - Suicide attempt.
 - Consultation in the emergency department after rape.
 - Behaviour of evasion, shame, lack of preoccupation towards the injuries.
 - Presence of an excessively attentive accompanying person who answers the questions for the patient or who is hostile, defensive or aggressive or who establishes communication barriers.
-

the posterior attitude is not appropriate^{28,20}. For routine detection to be useful, two requisites must be fulfilled: an adequate interview and the immediate offer of help.

The interview should be undertaken in a private place using direct questions without prejudice, and taking the cultural peculiarities of each patient into account. It should not be made in the presence of another member of the family, not even the children. As previously mentioned, this is an especially difficult condition to achieve in an emergency department. Therefore, in suspected cases this space should be actively sought (for example, accompany the patient to carry out a radiography) because if not it may be impossible to find an adequate setting for the interview. Questions should be asked with empathy, showing respect and interest in the patient. Explain the reason for the question and offer trust and safety with regard to confidentiality and the future of the woman and the children. And, lastly, it is important to leave the door open for them to reveal their situation or search for help later^{1,30,32}.

Although the victims of gender violence rarely recognise their condition, they do admit to determined aggressions. Thus, the questions should be specific. In addition, the type of question should be adapted to the language and culture of the woman to whom it is directed. Some validated tests are available for the detection of gender violence¹, although most are in English and only refer to physical violence. One of these tests, the "Partner Violence Screen"³³, is very useful in the emergency setting because of its brevity and its capacity of detection of both physical and psychological violence and it has recently been validated in Spanish (Table 3)³⁴.

To facilitate communication and empathy with the women affected and to break the possible barriers on the part of the healthcare professional, several formulas can be used to introduce the subject such as those depicted in Table 4.

Lastly, in cases of suspicion of mistreatment but lack of knowledge as to how to approach the situation, it is important to note that only listening with respect is a therapeutic action and doing both this and delegating this to someone better prepared are preferable to ignoring the situation.

Intervention

Help should always be offered to patients in this situation, despite their lack of confession, since this may prevent chronification of the situation or the appearance of medical problems or sequelae. If the patient recognises the situation the response should be immediate since this is what she needs and expects and is the reason why she has revealed the situation.

Privacy is essential in the care provided to these patients. The situation should not be reported to any member of the family and least of all to the aggressor, despite being in an attempt to solve the problem and the patients should be guaranteed this confidentiality. They should even be informed that the case will be reported to the authorities and will not be done if the woman denies the abuse except in cases in which not doing so may be dangerous for the woman or the persons depending on her^{31,32}.

Another mainstay in the attention to the women receiving domestic violence is taking the personal situation of each woman into account. Many women do not want to break up the relationship with their aggressor for many reasons (fear, love, economic dependence, cultural and religious norms, family pressure, uncertainty) and they should therefore not be blamed, obligated or punished for the lack of response to advice or the offer of help on behalf of healthcare or social services personnel^{1,31,32,35}. Criteria or decisions should not be imposed upon her. It is convenient to respect the evolution of each woman. The situation of maltreatment is usually very complex for the women affected, and changes with time and in the conception which these women have towards it and getting out of this situation is not easy. It should be taken into account that a woman is in more danger six months after having left than at any other time.

In addition to the capacity of detection of cases of gender violence, emergency professionals have the capacity to intervene, and they

Table 3. Spanish version of the Partner Violence Screen

1. In the last year have you been hit, kicked or punched or received another type of physical abuse?	YES	NO
If yes, who did it?.....		
2. Do you feel safe in your relationship with your current partner?	YES	NO I do not have a partner
3. Do you feel threatened by any of your previous partners?	YES	NO
Correction: Add up the pointed obtained. Questions 1 and 3: Yes = 1 and No = 0; Question 2: Yes (and I do not have a partner) = 0 and No = 1.		
Cut off points:		
– Mistreatment (physical/psychological): Cut off point 1 (sensitivity 93 and specificity 88%).		
– Physical abuse: cut off point 2 (sensitivity 83% and specificity 88%).		

Table 4. Formulas for initiating the questions

- Since violence is so common in the life of many persons I have started to ask all my patients about this.
- I am worried that your symptoms may be caused by someone who is mistreating you.
- I don't know if this is a problem for you but many women who I see have abusive relationships. Some women are too frightened or ashamed to talk about this directly and so I have started routinely asking about it.

have access to specific information and the means to act¹⁴. However, for every adequate assistance to the women affected, good coordination is also necessary with other levels of care, especially primary care and social services, which the person affected will attend^{31,32}.

With regard to specific care given to the patient, medical, social and legal aspects should also be approached^{31,32}.

Medical intervention. Initially, independently of the degree of suspicion or risk, the medical reason for which the patient is consulting should be attended. This reason may be directly related to mistreatment (traumatic lesions, attempted suicide, rapes) or indirectly related (somatization, psychiatric symptoms) or not related. It is always necessary to evaluate the indication of psychiatric care.

Social intervention. The resources provided may be different according to the situation of the woman.

On the other hand, the willingness of the women to recognise and/or report the mistreatment, her personal and family situation, the willingness to break or not with the aggressor, and the risk involved if she returns home should be taken into account as should vital risk^{1,31}.

Some indicators of vital risk may help to assess the possibility of a patient or the persons depending on her, especially children, of receiving new abuse with the possibility of death:

- Consumption of drugs or alcohol abuse on behalf of the aggressor.
- Increase in the frequency of the episodes of violence.
- Severe lesions.
- Mistreatment of children or other members of the family.
- Changes in the work situation of the aggressor.
- Phase of legal separation.
- Threats of death after the reporting of the abuse by the woman.
- Psychopathology of the aggressor (zealousness, paranoia...).
- Possession of firearms on behalf of the aggressor.
- Aggressor belongs to a security force.
- Opinion of the patient related to her risk or to dependent persons.

It is very important not to underestimate the risk and to keep it in mind whenever any of these indicators is detected.

With respect to the resources available, in addition to emergency telephones, police and information telephone numbers for the Institute of the Woman, each autonomous community has its own resources of care, information, presentation of charges and shelter.

In all cases, the woman should be informed of the situation in which she is in. If mistreatment is suspected but the woman does not recognise the situation, the patient should never be forced to recognise the mistreatment or initiate action to leave it. Support should be provided as should information on the resources available and the door should remain open for new consultations. Useful examples of the way to inform in these cases are pocket guidelines, posters in the bathrooms or general oral information in the consultation.

If the patient recognises the situation of mistreatment but there is no immediate vital risk, the resources necessary should be offered according to the risk, the social situation and the desire of the woman with respect to abandoning the aggressor or reporting the abuse. It is in these cases when the relationship with the primary healthcare and social services is most necessary since without their support the work load of emergency healthcare personnel would be even greater or they might incorrectly approach the situation. In case of willingness to report the abuse, information on the steps necessary to do so should be provided.

If the vital risk is immediate, removal of the patients from home must be arranged. In these cases it is convenient to make the report to social services immediately. If the centre in which the case has been detected does not have 24-hour services of this type the patient may be sent to the services of continued attention to women which are available throughout all the autonomous communities and, if necessary, police custody.

Legal intervention. Finally, the adequate legal documents should be correctly completed in each case. The most important thing is the clinical history since it always exists regardless of the will of the woman, and this facilitates a more precise evaluation of the clinical situation of the woman. The situation of mistreatment must be reported as should even suspicion of the same, but the woman should not be provided with a copy if it may be found by the aggressor. The use of an anatomical map is useful to depict the injuries found on physical examination.

In the case of physical lesions, poisoning or suicide attempts, a legal report should always be made explaining the type of lesions, the diagnostic and therapeutic interventions and the severity of the clinical picture. The woman should be informed as to the making of the legal report prior to its submission.

It is important to correctly redact all these documents with a complete clinical history describing the lesions, findings, pathologies, chronology and diagnostic and therapeutic procedures performed.

Conclusion

Gender violence is a very frequent phenomenon which affects the health of the persons involved. Emergency departments attend many women in this situation and, therefore, have a key role in the detection of these cases and in their medical and social management. In order to do this these professionals must be sensitised to this subject, with adequate formation and good coordination with primary care and social services.

References

- 1 S. Scout Polsky, J Markowitz. Color Atlas of Domestic Violence. St. Louis, Missouri: Mosby. 2004.
- 2 Blanco P, Ruiz-Jarabo C, García de Vinuesa L, Martín-García M. La violencia de pareja y la salud de las mujeres. Gac Sanit 2004;18:182-8.

- 3 Ruiz-Pérez I, Plazaola-Castaño J, Blanco-Prieto P, González-Barranco JM, Ayuso-Martín P, Montero-Piñar MI, y el Grupo de Estudio para la Violencia de Género. La violencia contra la mujer en la pareja. Un estudio en el ámbito de la atención primaria. *Gac Sanit* 2006;20:202-8.
- 4 III Macroencuesta sobre violencia contra las mujeres. Informe de resultados. Instituto de la Mujer. Ministerio de Trabajo y Asuntos Sociales. Abril 2006.
- 5 Plazaola-Castaño J, Ruiz I. Violencia contra la mujer en la pareja y consecuencias en la salud física y psíquica. *Med Clin* 2004;122:461-7.
- 6 Roche M, Moracco KE, Dixon KS, Stern EA, Bowling JM. Correlates of intimate partner violence among female patients at a North Carolina Emergency Department. *NC Med J* 2007;68:89-94.
- 7 Campbell J, Snow Jones A, Dienemann J, Kub J, Schollenberger J, Campo P, et al. Intimate partner violence and physical health consequences. *Arch Intern Med* 2002;162:1157-63.
- 8 Ruiz-Pérez I, Plazaola-Castaño J, del Río-Lozano M. Physical health consequences of intimate partner violence in Spanish women. *Eur J Public Health* 2007;17:437-43.
- 9 Coker AL, Smith PH, Bethea L, King MR, McKeown E. Physical Health consequences of physical and psychological intimate partner violence. *Arch Fam Med* 2000;9:451-7.
- 10 Pico-Alfonso MA, García-Linares MI, Celda-Navarro N, Blasco-Ros C, Echeburúa E, Martínez M. The impact of physical, psychological, and sexual intimate male partner violence on women's mental health: depressive symptoms, posttraumatic stress disorder, state anxiety, and suicide. *J Women health* 2006;15:599-611.
- 11 Bonomi AE, Thompson RS, Anderson M, Reid RJ, Carrell D, Dimer JA, et al. Intimate partner violence and women's physical, mental and social functioning. *Am J Prev Med* 2006;30:458-66.
- 12 Kramer A, Lorenzon D, Mueller G. Prevalence of intimate partner violence and health implications for women using emergency departments and primary care clinics. *Women's Health Issues* 2004;14:19-29.
- 13 Snow Jones A, Dienemann J, Schollenberger J, Kub J, O'Campo P, Carlson Gielen A, et al. Long-term costs of intimate partner violence in a sample of female HMO enrollees. *Women's Health Issues* 2006;16:252-61.
- 14 McCloskey L, Lichter E, Williams CM, Gerber M, Wittenberg E, Ganz ML. Assessing intimate partner violence in health care settings leads to women's receipt of interventions and improved health. *Public Health Rep* 2006;121:435-44.
- 15 Richardson J, Feder G. Domestic violence: a hidden problem for general practice *Br J Gen Pract* 1996;239-42.
- 16 Siendones Castillo R, Perea-Milla E, Arjona JL, Agüera C, Rubio A, Molina M. Violencia de género y profesionales sanitarios: conocimientos, opiniones y barreras para la infradetección. *Emergencias* 2002;14:224-32.
- 17 Petersen R, Moracco KE, Goldstein KM, Andersen K. Moving beyond disclosure: Women's perspectives on barriers and motivators to seeking assistance for intimate partner violence. *Women & Health* 2004;40:63-76.
- 18 Yonaka L, Yoder MK, Darrow JB, Sherck JP. Barriers to screening for domestic violence in the emergency department. *J Contin Educ Nurs* 2007;38:37-45.
- 19 Kelly U. "What will happen if I tell you?" Battered Latina women's experiences of health care. *Can J Nurs Res* 2006;38:78-95.
- 20 Duxbury F. Recognising domestic violence in clinical practice using the diagnosis of posttraumatic stress disorder, depression and low self-esteem. *British Journal of General Practice* 2006;56:294-300.
- 21 Chang JC, Cluss PA, Ranieri LA, Hawker L, Buranosky R, Dado D, et al. Health care interventions for intimate partner violence: What women want. *Women's health issues* 2005;15:21-30.
- 22 Coll-Vinent B, Echeverría T, Farràs U, Rodríguez D, Millá J, Santiña M. El personal sanitario no percibe la violencia doméstica como un problema de salud. *Gaceta Sanitaria* 2008; en prensa.
- 23 Yonaka L, Poder MK, Darrow JB, Sherck JP. Barriers to screening for domestic violence in the emergency department. *J Contin Educ Nurs* 2007;38:37-45.
- 24 Waalen J, Goodwin MM, Spitz AM, Petersen R, Saltzman LE. Screening for intimate partner violence by health care providers. Barriers and interventions. *Am J Prev Med* 2000;19:230-7.
- 25 Glass N, Dearwater S, Campbell J. Intimate partner violence screening and intervention: data from eleven Pennsylvania and California Community hospital emergency departments. *J Emerg Nurs* 2001;27:141-9.
- 26 Chang JC, Decker MR, Moracco KE, Martin SL, Petersen R, Frasier PY. Asking about intimate partner violence: advice from female survivors to health care providers. *Patient Educ Couns* 2005;59:141-7.
- 27 Thurston WE, Tutty LM, Eisener AE, Lalonde L, Belenky C, Osborne B. Domestic violence screening rates in a community health center urgent care clinic. *Res Nurs Health* 2007;30:611-9.
- 28 Nelson HD, Nygren P, McInerney Y, Klein J. Screening women and elderly adults for family and intimate partner violence: A review of the evidence for the U.S. Preventive Services Task Force. *Ann Intern Med* 2004;140:387-96.
- 29 Vives-Cases C, Gil-González D, Carrasco-Portiño M, Álvarez-Dardet C. Detección temprana de la violencia del compañero íntimo en el sector sanitario. ¿Una intervención basada en la evidencia? *Med Clin (Barc)* 2006;126:101-4.
- 30 Dienemann J, Glass N, Hyman R. Survivor preferences for responses to IPV disclosure. *Clin Nurs Res* 2005;14:215-33.
- 31 Comissió de Violència Intrafamiliar i de Gènere. Guia d'Atenció a la Violència Intrafamiliar i de Gènere. Ed. Hospital Clínic de Barcelona. Barcelona 2007.
- 32 Protocolo común para la actuación sanitaria ante la violencia de género. Comisión contra la violencia de género del Consejo Interterritorial del Sistema Nacional de Salud. Ministerio de Sanidad y Consumo. 2007.
- 33 Feldhaus KM, Koziol-McLain J, Amsbury HL, Norton IM, Lowenstein SR, Abbott JT. Accuracy of 3 brief screening questions for detecting partner violence in the emergency department. *JAMA* 1997;277:1357-61.
- 34 Torres A, Navarro P, Tarragona MJ, Martín-Santos R, Gelabert E, García-Esteve L. Algoritmo para la detección de la violencia doméstica en el ámbito sanitario. XXIII Reunión de la Societat Catalana de Recerca i Teràpia del Comportament, 23 Maig, 2008 (SCRIT).
- 35 Zink T, Elder N, Jacobso J, Klosterman B. Medical management of intimate partner violence considering the stages of change: pre-contemplation and contemplation. *Ann Fam Med* 2004;2:231-9.

Violencia y maltrato de género (II): una aproximación desde urgencias

Coll-Vinent Puig B

La violencia doméstica constituye un importante problema de salud, con una alta prevalencia en los servicios de urgencias. Los profesionales de estos servicios ocupan un lugar privilegiado para la detección de casos de maltrato e intervención precoz en los mismos. Sin embargo, se detectan pocos casos debido a la existencia de determinadas barreras presentes tanto en las mujeres afectadas como en los profesionales sanitarios que las atienden. Por ello se recomienda estar atento a determinados signos de sospecha e incluso un cribaje sistematizado. En todos los casos es muy importante realizar la entrevista en un ámbito privado, asegurar la confidencialidad y ofrecer ayuda. La atención que se debe ofrecer a estas mujeres debe ser individualizada, teniendo en cuenta la situación y el deseo de cada mujer y el riesgo vital en el que se halla. Se debe atender el problema médico por el cuál consulta, valorar la necesidad de atención psiquiátrica, ofrecer la ayuda social adecuada a las necesidades de cada mujer, y cumplir los requisitos legales, poniendo especial cuidado en la correcta cumplimentación de la historia clínica y del comunicado judicial en los casos en que sea necesario. El abordaje del problema requiere un enfoque multidisciplinar y una buena comunicación con la atención primaria y con los servicios sociales. La sensibilización y formación del personal sanitario de las urgencias es crucial para conseguir mejorar la atención que actualmente se ofrece a las mujeres afectadas. [Emergencias 2008;20:269-275]

Palabras clave: Violencia doméstica. Servicios de urgencias.