

DOMESTIC VIOLENCE AND DOCTOR'S RESPONSE

The Melissa Institute for
Violence Prevention and
Treatment of Victims of
Violence

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The following dialogue that we have held with doctors on domestic violence provides practical advice on ways to assess and intervene. A forthcoming Conference on "Family Violence in a Diverse Society" to be held in Miami May 7th, 2004 provides a further consideration of these issues. (Please see www.melissainstitute.org for conference details.)

Doctor's Question (DQ): How widespread is domestic violence?

Melissa Institute Answer (MI): It has been estimated that 25% to 30% of American women are beaten at least once in the course of intimate relationships. Each year, nearly 1/8 of husbands in the U.S. commit one or more acts of physical violence against their wives (Straus & Gelles, 1990; Tjaden & Thoennes, 2000). On a yearly basis, approximately 1.6 million women in the U.S. are assaulted by their partners. Out of the 50 million couples in the U.S., some 15 million couples will experience violence during the course of their relationship.

No country or society can claim to be free of domestic violence. Domestic violence cuts across boundaries of culture, class, education, income, ethnicity and age. According to the World Health Organization, violence against women is a major health and human rights issue. Such domestic violence is not limited to heterosexual couples. The same issues of power and control apply to the gay and lesbian population (Burke & Follingstad, 1999; West, 1998).

Once such violence occurs, it tends to be repeated. It will often escalate in frequency, intensity and severity. In fact, prior abuse has proven to be one of the best predictors of future violence.

These statistics become even more troubling when one considers that partner violence co-occurs with child physical abuse and neglect in 40% to 70% of U.S. families. In households where domestic violence occurs, children are physically abused and neglected at a rate 15 times higher than the national average. The more frequent the partner aggression, the greater the escalation of child abuse (Jaffee, Wolfe & Wilson, 1990; Slep & O'Leary, 2001). Locally, this is highlighted by the finding that in the Miami-Dade area, in 60% of homicides of children, newborn to 9 years old, the perpetrator was the parent of the child.

DQ: What is the likelihood that the medical patient whom I see will be a victim of domestic violence?

MI: The likelihood varies according to the setting in which the doctor works. It is estimated that 20% to 35% of all women emergency room visits are the result of battering and that battering occurs in 50% of women who present with physical injuries.

Over a 5-year period, half of all women who were victims of intimate partner homicide had been in the emergency room at least once in the two years before their death (Wathen & MacMillan, 2003). In Miami-Dade County, 15% of 2002 homicides of women were by intimate partners. In addition, intimate partner relationship problems were a precipitant in 20% of female suicide victims in Miami-Dade.

The urgency in identifying victims of domestic violence is not delimited to emergency rooms. The greatest proportion of medical visits by battered women do not involve trauma, but general medical, behavioral and psychiatric presentations. Estimates indicate that 14% of patients in ambulatory internal medicine clinics have abuse-related problems and that 50% of female psychiatric patients have a history of abuse of some form. Eyler and Cohen (1999) observed that battering occurred in 15% of all pregnancies. The per cent escalated when the pregnancy was unintended.

Being a victim of violence can result in the development of a number of other medical conditions such as cardiovascular, respiratory, gastrointestinal and musculoskeletal disorders, chronic fatigue and fibromyalgia, each of which can be exacerbated by the post traumatic stress disorder that many victims experience. As a result, victimized individuals' health care costs are 2.5 times that of nonvictimized patients.

Pediatricians need to be especially vigilant about the impact of family violence. At least 3.3 million children in the U.S. witness physical and verbal spousal abuse each year. This ranges from insults and hitting to fatal attacks. Pynoos and Eth (1995) estimate that children witness approximately 10% to 20% of domestic homicides. In one inner-city 10% of the children under 6 attending the Pediatric Primary Care Clinic had witnessed a shooting or stabbing (Taylor et al., 1994).

Doctors in all fields of medical practice are likely to encounter women who are victims of intimate partner violence (AMA, 1992; Ferris et al., 1999; Pearse, 1994). It is incumbent on every doctor to be hypervigilant to the ever pervasive presence of violence in our society. Doctors must consider the impact of violence as a health issue and not just a social issue.

DQ: What about men who are victims of intimate partner violence?

MI: Men may also be victims of violence, but in most instances when women evidence aggression it is a result of efforts at self-defense. Violence is more likely to be used by males in a heterosexual relationship as a means to assert or maintain power and control and by females as a form of self-defense. In about 50% of distressed couples, physical aggression may be a two-way street. The gender of the patient does not preclude the possibility of being a victim.

Whether male or female initiated, intimate partner violence may take different forms besides physical abuse. These include power and control tactics (threats to children, threats about committing suicide); emotional abuse including psychological put downs, “mind” games and isolation from others; sexual abuse; economic abuse and intimidation by putting the patient in constant fear. Physical violence perpetrated by the partner is usually accompanied by threats, insults, psychological abuse and controlling and coercive tactics. Such an abusive relationship has been characterized as an ongoing “state of siege”.

DQ: How good a job does the medical community do in identifying victims of domestic violence?

MI: Studies consistently show that the medical community identifies only about 2% to 10% of victims of domestic violence. Only 9% of women who experience abuse have ever told a physician and less than 50% have told anyone (Rhodes & Levinson, 2003). Shame, embarrassment and concerns about possible repercussions are factors that contribute to individuals hiding, denying and minimizing abuse events.

The difficulty in assessing and identifying domestic violence is especially challenging when working with women from minority cultures. For example, Ferrer (2002) highlights that immigrant Latino women may fear deportation, mistrust authorities, have language and cultural barriers, be economically dependent and confront community beliefs that such self-disclosure constitutes “betrayal”. For many battered Latinos hiding and minimizing domestic abuse is a means of maintaining family preservation. Similar concerns were raised about the reporting of domestic violence in African American families (Crowell & Burgess, 1996; See Oliver & Williams, 2002).

It is clear that physicians cannot rely on victimized patients to introduce the topic of intimate partner violence on their own. Doctors need to actively seek information about family violence. Such proactive questioning is especially important when patients report chronic pain, have many diverse symptoms, or are overusing healthcare services (Drossman et al., 1990).

DQ: How can I assess for the likelihood of violence in my patients?

MI: There are screening instruments that can identify women who are experiencing violence (see Feindler et al., 2003 for a comprehensive listing and Straus et al., 1996 and Dutton, 1992 for the most widely used measures). However, the busy physician is more likely to depend upon interview procedures. The interview should include direct questions about current partner violence and the risk for future victimization, as suggested by Rhodes and Levinson (2003). The physician should explicitly ask:

“Has your partner ever hit you, or otherwise hurt you?”

“Are you afraid (fearful) of your partner?”

If the answers to these questions are “Yes”, then ask about the nature of injuries and perceived risk. Eyler and Cohen (1999) have suggested that the physician (or other medical team staff members), may instead wish to use a funneling technique of questioning starting with general open-ended questions and moving to more specific direct questions that assess for violence in the patient’s relationships. For example, the doctor can select from the following list of questions:

“Tell me about your relationship with your partner.” “How is your relationship with your partner these days?”

“We all get into disagreements or arguments with our partners at some time. What happens when your partner gets angry, or when you have a fight with your partner?”

“People have different ways of showing disagreements or anger in relationships. How do you and your partner express anger?”

“Do you have calm discussions, argue, yell, engage in name calling or blaming, throwing things, push, shove, hit?” (Address each separately.)

“Has your partner ever physically hurt or threatened you?”

“Are you (or have you been) treated badly in other ways?”

“Has your partner ever forced you to have sex when you didn’t want to, or made you do something sexually that you didn’t like?”

“Is your partner very controlling or jealous?”

“Has your partner ever prevented you from leaving the house, spending time with your friends or controlling you in some other ways?”

“How does your partner act when he (she) has been drinking or using other drugs?”

“Are there guns (or other weapons) in your house?”

“Has your partner (or anyone else) ever threatened to use them?”

“Has your partner ever destroyed things you cared about or stolen your things?”

“Has your partner ever threatened or abused your children?”

“Have you ever been in a relationship where you were hurt or threatened?”

“Do you ever feel afraid of your partner? What do you do then?”

“What do you do to protect yourself and your children? How effective are these procedures? What else can you try?”

“How can I help with this situation?”

Flitcraft et al. (1992) and Hamberger and Lahti (1997) and Meichenbaum (2002), as well as the various Websites listed in Table 1 provide additional examples of how to screen for domestic violence. Some of the Websites even have self-report checklists where the patient can answer questions to determine if she is being abused. The doctor can also give the patient the following information:

“If something about your relationship with your partner scares you and you need to talk, please call the National Domestic Violence Hotline at

1-800-799-SAFE (7233)

1-800-787-3224

or email ndvh@ndvh.org

(Other hotline numbers that can be contacted are the Nationwide Crisis Hotline 1-800-999-9999; National Referral for Child Abuse, Domestic Violence and Elder Abuse 1-800-222-2000 and Women Organized to Make Abuse Nonexistent 1-415-864-4722.)

Another suggestion is that the physician can put posters or educational material about domestic violence and local supportive resources in the ladies’ bathroom. **REMEMBER** that unless you explicitly assess for intimate partner violence it is unlikely that patients will disclose such information. The absence of such disclosure can prove deadly!

DQ: Okay, you have convinced me that it is important to systematically assess for intimate partner violence. Should I ask this of all my patients or are there any warning signs I should be on the lookout for?

MI: Victims of domestic violence in a medical setting may have different presentations. Physical injuries such as grab or choke marks, burns, injuries that occur at multiple sites of the body or that reflect sexualized injuries in victims such as bruises to the chest area, gynecological complaints. Each of these injuries may be in various stages of healing. Behavioral indicators may include missed appointments, delay in seeking treatment, inability to communicate by phone, isolation and being accompanied by a hovering spouse. Common symptoms may include a variety of vague physical complaints, fatigue, sexual dysfunction, trouble concentrating, depression and posttraumatic symptoms.

There is an absolute need to consider the impact of exposure to domestic violence on the patient’s children. The effects of this

negative exposure contributes to a wide range of externalizing behavior problems (aggressive behavior, noncompliance, truancy) and internalizing behavioral problems (anxiety, depression, low-self-esteem, and trauma-related symptoms). This developmental pattern is of particular concern since there is evidence for the intergenerational transmission of interpersonal aggression and violence (Feldman, 1997; Holden et al., 1998; Osofsky, 1999; Taylor, 1994).

DQ: Now that I have screened for intimate partner violence, what are the next steps?

MI: There are four key next steps, namely:

1. Document the injury and assess for the degree of risk (level of patient's fear and capacity for self-protection).
2. Provide information and reassurance and make a referral that ensures that the patient and his/her children are safe.
3. Ensure there is active follow-up.
4. Become an active advocate for the reduction of violence.

THE FIRST TASK

Document the abuse and assess for the degree of risk. **REMEMBER** that violence tends to be repeated and it often escalates. Danger assessment has to be an ongoing process, especially if there is a custody process underway. When evidence is found of violence, the physician needs to record the patient's description of what happened using her own words and record the medical details of the injuries (e.g., size, location, age of injuries, possible causes). Photographs or notations on a body map can prove helpful. While the physician may not systematically assess for the specific indicators of risk in the batterer, it is important to keep in mind the factors that have been identified as putting women in danger. These factors include the patient's appraisal of her own and her children's degree of safety; the presence of weapons in the home; the batterer being unemployed; the degree to which high risk behaviors are evident in the batterer such as prior episodes of intimate partner violence, the batterer's overall general level of aggression, violence and antisocial behaviors; prior arrest record; the abuse of substances, the presence of jealousy and stalking behaviors, the level of depression and other forms of psychopathology, and the history of violence in the batterer's family.

In order to address the patient's concerns, the doctor should stress confidentiality and directly ask:

"Will you feel safe when you leave here and return home?"

Are your children safe?"

Has your partner threatened to use a gun

or any other weapon?"

In a supportive fashion, the doctor can reinforce the perceived seriousness of the situation and provide reassurance by saying:

"I'm concerned about your safety and the safety of your children. No one deserves to be beaten or threatened with violence. No matter what happened, it is not okay to be hurt."

"I want you to know you are not alone. Your sharing this information is an important first step to changing your situation. There are resources and helpers that we can call upon."

In discussing the abuse it is important that the physician convey that it is the behavior of the batterer and not the batterer himself that is being judged as being inappropriate. Do not alienate the patient by demeaning the abuser.

THE SECOND TASK

Provide information, ongoing reassurance and make a referral to an appropriate agency and service that ensures the patients' safety. Agencies have developed specific guidelines and packages for how patients can implement safety plans and even have escape packages, if warranted. You need to discuss how the patients can access a "safe" place and seek social supports, as well as ways to reduce risk.

If the physician believes that legal authorities should be notified, then this should be done with the victim's knowledge and consent. Care must be taken to ensure that the patient is not put at greater risk.

THE THIRD TASK

Ensure that the patient follows through in seeking help and that the doctor actively conducts a follow-up assessment. Remember that women are at most high risk of being victims of violence when they are in the midst of leaving. The physician can call the social agency while the patient is still in the office and allow the patient to talk with the hotline operator in private. The physician can arrange with the patient safe ways that he or she can call and check on the patient. See Eyler and Cohen (1999) for multiple examples of the ways physicians can conduct such follow-up assessments. ***(Their paper can be downloaded from <http://www.aafp.org/aafp/991201ap/2659.html>)***

THE FOURTH TASK

Physicians need to be consciously alert to the possibility of victimization and they need to be proactive in providing help. But such advocacy goes beyond providing assistance to one's patients. It is critical that physicians become advocates among their colleagues in the medical community and advocates to the community at large. A clarion call for

physicians to help reduce family violence has gone out from the medical establishment, as evident in the Websites listed in Table 1.

MI: Let me switch places with you and ask a question. What do you, the physician, consider the main reasons or potential barriers that might get in the way of doctors screening, assessing, educating and referring patients who have been victims of domestic violence?

DQ: I can think of a variety of reasons why physicians rarely identify and refer less than 10% of the victimized patients they encounter. One possible barrier is the lack of awareness of just how widespread is domestic violence and the lack of training and screening tools to systematically assess interpersonal violence. Another barrier is the physician's mistaken belief that it is not his or her role to get involved in personal matters and this is a private matter. Moreover, asking about domestic violence can open Pandora's Box and be very time consuming. Time is a precious commodity! Some doctors may even believe that the patients may have provoked the violence and be prone to blame the victim. In some instances, like their patients, the physician may also be concerned about his or her safety and be fearful of doing anything that could provoke the batterer. Some physicians may have concerns about possible punitive legal responses to medical personnel as a result of putting the woman at greater risk of injury. Other physicians may be more fatalistic and wonder if any form of intervention would prove effective in reducing violence.

MI: That is quite a list of potential barriers. Some reflect beliefs and attitudes that need to be re-examined and discussed and others reflect the absence of information and training. The good news is that research indicates that hospitals have been able to increase the rate of identification of battered women almost six-fold by adopting active policies and procedures (LaTaillade & Jacobson, 1997; Stark & Flitcraft, 1991).

DQ: Yes, I agree. How can I find out more about ways to assess, treat and prevent family violence?

MI: We invite you to attend our forthcoming conference on family violence. See our Website www.melissainstitute.org for registration information. Our Website will also have conference information that you can download. A key focus of the conference will be on ways to tailor interventions depending upon the ethnic background of the patient. There is a need to recognize the unique features of each cultural group and tailor interventions accordingly. Our website has lots of other information about violence prevention and the treatment of victims.

You can also look up other Websites that are directed at physicians. A sample list of these Websites is provided in Table 1 below.

Thank you for the opportunity to discuss this very important topic with you and for your efforts in reducing violence in our community.

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TABLE 1 INTERNET RESOURCES ON

DOMESTIC VIOLENCE

Local Resources

(CASA) Community Action Stops Abuse (St. Petersburg, FL)
<http://www.casa-stpete.org/>

Dade County Preventing Abuse in Intimate Relationships (PAIRS)
<http://www.pairs.org/>

Florida Certified Domestic Violence Centers
<http://www.fcadv.org/centers.html>

Miami Dependency Court Intervention Program for Family Violence (DCIPFV)
<http://www.ncsc.dni.us/KMO/Topics/FamVio/States/FVmodelprograms.htm>

Miami-Dade County Clerk - Domestic Violence
<http://www.miami-dadeclerk.com/dadecoc/>

Miami-Dade County's Department of Human Services: Domestic Violence Services
http://www.co.miami-dade.fl.us/dhs/domestic_violence_svcs.asp

State of Florida - Domestic Violence Contact Information
http://www5.myflorida.com/cf_web/myflorida2/healthhuman/domesticviolence/contacts/index.html

State of Florida-Domestic Violence "What to do if someone you know is being abused."
http://www5.myflorida.com/cf_web/myflorida2/healthhuman/domesticviolence/help.html

Resources for Physicians

American Academy of Family Physicians
<http://www.aafp.org/>

American Academy of Pediatrics
<http://www.aap.org>

American College of Emergency Physicians
<http://www.acep.org/>

American College of Obstetricians and Gynecologists
<http://www.acog.org/>

American Psychological Association: Issues and Dilemmas in Family Violence
<http://www.apa.org/pi/pii/familyvio/homepage.html>

Centers for Disease Control and Prevention (domestic violence information)
<http://www.cdc.gov/ncip/dvp/fivpt/spotlite/home>

Pediatrician's Domestic Violence Screening Measure

<http://pediatrics.aappublications.org/>

San Francisco Medical Society
<http://www.sfms.org/>

State Reporting Requirements
<http://endabuse.org/statereport/list.php3>

World Health Organization (1997) Violence against women: A priority health issues
http://www.who.int/frh-whd/VAW/infopack/English/VAW_infopack.htm

World Health Organization (2000). Prevalence of violence against women by an intimate male partner.
http://www.who.int/violence_injury_prevention/vaw/prevalence.htm

Same-Sex Violence

American Psychiatric Association: Domestic Violence Overlooked in Same-Sex Couples
<http://pn.psychiatryonline.org/cgi/content/full/37/12/>

Same-Sex Domestic Violence

<http://www.cuav.org/>

The New Network of Lesbian and Gay Survivors of Abuse

<http://www.nwnetwork.org/>

Additional Resources

Centre for Children and Families in the Justice System of the London Family Court Clinic: Children Exposed to Domestic Violence: A Teacher's Handbook to Increase Understanding and Improve Community Response
www.lfcc.on.ca/teacher-us.PDF

Domestic Violence and Women's Employment

<http://www.northwestern.edu/ipr/publications/nupr/nuprv03n1/lloyd.html>

Domestic Violence Prevention Fund

<http://endabuse.org/>

Domestic Violence Project of Silicon Valley California

<http://www.growing.com/nonviolent/>

Family Violence Prevention Fund: Working to End Violence

<http://endabuse.org/programs>

Health Canada: Guidebook on Vicarious Trauma for Helpers Who Work on Family Violence

http://www.hc-sc.gc.ca/hppb/familyviolence/pdfs/trauma_e.pdf

Interrupting the Cycle of Violence (Minnesota Center Against Violence and Abuse)

<http://www.mincava.umn.edu/vaw.asp>

Minnesota Center Against Violence and Abuse

<http://www.mincava.umn.edu/>

National Domestic Violence Hotline: Texas Council on Family Violence (ndvh@ndvh.org)

<http://www.ndvh.org/>

National Institute of Justice: Prevalence, incidence and consequences of violence against women

<http://www.ncjrs.org/pdffiles/172837.pdf>

National Latino Alliance for the Elimination of Domestic Violence

<http://www.dvalianza.org/>

National Organization of Women (NOW)

<http://www.now.org/>

New York State Office for the Prevention of Domestic Violence

<http://www.opdv.state.ny.us/>

Stop Abuse for Everyone (SAFE)

<http://www.safe4all.org/>

U.S. Department of Justice

<http://www.ojp.usdoj.gov/vawo/>

Women's World Forum Against Violence

http://www.gva.es/violencia/activid/mujeres/foro_e.htm

World Health Organization: Violence Against Women

http://www.who.int/violence_injury_prevention/violence/en/

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