DOMESTIC VIOLENCE

FLAME LECTURE: 4
TOOHEY / BURNS 4.24.15
Learning Objectives

- Assess risk for domestic violence
- Counsel patients regarding domestic abuse/violence
- Cite prevalence and incidence of violence against women, elder abuse, child abuse
- Demonstrate screening methods for domestic violence
- Communicate the available resources for a victim of domestic violence including short-term safety

Prerequisites:
- NONE

See also – for closely related topics
- FLAME LECTURE 15 – Physician Reporting Requirements
- FLAME LECTURE 234 – Sexual Assault
Introduction

- **Intimate partner violence**: describes actual or threatened psychological, physical, or sexual harm by a current or former partner or spouse. IPV can occur among heterosexual or same-sex couples and does not require sexual intimacy.

- Two patterns of violence between couples have been described:
  - “Battering” – severe, escalating violence with terrorization and increasingly controlling behavior
  - “Common couple violence” moderate form of IPV in which violence occurs occasionally, triggered by frustration and/or anger
    - More common (1 in 6 couples in US) and occurs equally between both partners
Types of Abuse

- **Psychological/emotional:** trauma due to threats of violence and coercion
  - Includes humiliation, control over person’s behaviors, withholding information, isolating the victim from friends and family, or denying access to money or other basic resources
- **Physical:** varies in frequency and severity, ranging from one hit to chronic severe battering
- **Sexual:**
  - Using physical violence to force person to engage in sexual act against their will
  - Performing a sexual act with a person who is unable to consent or consents due to coercion
  - Abusive sexual contact
Incidence, 2008: 4.3/1000 women and .8/1000 men were victims of IPV\(^1\)
IPV accounts for 20% of nonfatal violence against women\(^1\)
Epidemiology & Risk

Battered women represent:

- 25% of female suicide attempts
- 23% of women seeking prenatal care
- 14-35% of women seen in ERs
  - 80% of victims of IPV went to an ER but 72% were never identified as victims of DV
  - When victims were identified:
    - ER response included legally useful documentation 86% of the time
    - Police contacted 50% of the time
    - Social worker 45% of the time
    - Only 33% of the time did providers assess whether the victim had a safe place to go
    - Only 25% referred to domestic violence services.
- 60% of mothers of abused children
- 12-23% of women in family medicine clinics
Consequences and Sequelae

**Reproductive Coercion**

- Male behavior to control contraception and pregnancy outcomes in females
  
  - Pregnancy coercion
    - Threats to physically or psychologically harm a women if she does not get pregnant or get an abortion
    - Injuring her in order to cause miscarriage or stillbirth
  
  - Birth control sabotage
    - Interfering with a woman’s ability to practice birth control or practice safe sex
    - 19% of visits to family planning clinics reported pregnancy coercion

Consequences and Sequelae

- **Pregnancy and IPV** – protective or increased risk? It’s complicated.
  - Homicide is a leading cause of pregnancy-related deaths (17%)\(^5\)
    - However, there is a paucity of population-based data regarding the proportion due to IPV
    - In cases where the relationship could be identified, an intimate partner was responsible for the death in 63.2%
  - Brownridge et. al. 2011 found that 11.3% of patients reporting IPV in current relationship experienced pregnancy violence
    - Like some other studies, this suggest that pregnancy may be protective against violence
    - Women abused during pregnancy were more likely to leave partner and go to shelter but less likely to contact police
  - Pregnant victims receive more injuries to abdomen and breasts
  - Partners who batter during pregnancy are more likely to doubt paternity of child
    - May represent hostility and ambivalence toward unborn child (view child as direct threat)
Assessing for DV: Common Signs

- Isolated
- Can’t make decisions
- Lack of money
- “Cover up”
- Somatic, non-specific symptoms
- Inconsistent explanation of injuries
- Increased dependence on partner
- Accident prone
- Absenteeism
- Noncompliant
- Moves frequently
- Always accompanied by spouse
- Reluctance to undress or have genital or rectal exam
Assessing for DV: Common Presenting Symptoms

- Gynecological complaints:
  - Premenstrual syndrome
  - Sexually transmitted infections
  - Unintended pregnancy or repeated abortions
  - Chronic pelvic pain

- General complaints:
  - Chronic pain
  - IBS
  - Headaches / Musculoskeletal pain

- Injuries:
  - Bilateral bruising on the upper arms
  - Half moon cuts-ring injuries
  - Two parallel bruising lines-baseball bat
  - Oral & facial injuries - loose teeth, petechiae, TMJ, broken jaw

- Strangulation: A special circumstance
  - Considered a murder attempt
  - Scratches, abrasions from defensive maneuvers or assailsant’s fingernails
  - Bruising – from attacker’s thumbs, may not be visible for hours to days
  - Redness – often short lived
  - Petechiae on eyelids, around eyes and on face - due to capillary rupture
  - Subconjuctival hemorrhages
  - Rope burns
  - Neck swelling; but sometimes they even have normal appearing neck!
  - Involuntary urination or defecation
  - Miscarriage - Hours or days later
  - Fetal demise
Warning signs for DV in Pregnancy

- Substance abuse
- Depression and anxiety
- Sexually transmitted diseases
- Miscarriage and stillbirth
- Decreased fetal movement
- Pain during ultrasound
- Inappropriate use of the ER
- Unusual interactions during counseling
- Preterm contractions
- Preterm delivery
- Vaginal bleeding

ALL WOMEN WITH THE FOLLOWING SHOULD BE SCREENED FOR DV:

- ALL female traumas
- ALL females in the emergency room
- ALL females with chronic abdominal pain
- ALL females with chronic headaches
- ALL females with sexually transmitted diseases
- ALL pregnant women with decreased fetal movement or preterm contractions
Physician Role

- Need to implement routine screening – private, simple and universal
  - Especially during pregnancy because have many prenatal visits and victims more motivated to
  - Removes prejudice and misconceptions
- **RADAR** – developed by Institute for Safe Families
  - **R** - routinely screen women and men
  - **A** - ask direct questions in a non judgmental manner
  - **D** - document—what happened, use patient’s own words, describe all injuries in detail
  - **A** - assess patient safety
  - **R** - respond, review options and refer
- The Massachusetts Medical Society Committee on Violence advises that a single question, asked routinely and without judgment, can increase the detection rate of IPV in office practice (see following slide)
Physician Role – Screening

- **SAFE:**
  - **Stress/Safety** - Do you feel safe in your relationship?
  - **Afraid/Abused** - Have you ever been in a relationship where you were threatened, hurt, or afraid?
  - **Friend/Family** - Are your friends aware you have been hurt?
  - **Emergency Plan** - Do you have a safe place to go and the resources you need in an emergency?

- **Massachusetts Medical Society Committee on Violence:**
  - Has a partner ever hit, kicked, or otherwise hurt or threatened you?
  - Has your partner or a former partner ever hit or hurt you, or threatened to hurt you?
  - Do you ever feel afraid of your partner?
  - Do you feel safe in your relationship?
  - Every couple has conflicts. What happens when you and your partner have a disagreement? Do conflicts ever turn into physical fights or make you afraid for your safety?
  - I see patients in my practice who have been hurt or threatened by someone they love. Is this happening to you?
  - Has anyone ever hurt you emotionally, physically, or sexually?

- **HITS questions - How often does your partner:**
  - Hurt you physically?
  - Insult you or talk down to you?
  - Threaten you with harm?
  - Scream or curse at you?
  - Each HITS question is scored on a five-point scale (never, rarely, sometimes, fairly often, and frequently, with a score >10 indicating likely victimization).
Physician Role

- CA State Law AB 1652 requires that EVERY health practitioner employed in any health care facility who has knowledge of, or observes, a patient whom he/she suspects is suffering from a wound or injury which is the result of abusive conduct to make a report to local law enforcement by:
  - Phone immediately
  - Written report within 2 working days

- Reporting is not enough, need to also determine immediate safety:
  - How serious is the threat or injury?
  - Is there someone else in the house?
  - What about child abuse?
  - What about depression, suicide risk?
  - Is there a gun in the house?
  - Where can she go?
  - Should she be admitted to the hospital?

- History of abuse, even chronic and in current relationship, does NOT have to be reported to police, if injuries are not currently present.
  - Exceptions: children/dependents
  - Allows provider to develop relationship with patient, “escape” plan over time.
Resources

- **Call your local shelter-establish a relationship**
  - Human Options-Irvine-877-854-3594
  - Interval House-Santa Ana-714-891-8121
  - Laura’s House- San Clemente-866-498-1511
  - Women’s Transitional Living Center- Fullerton-714-992-1931
  - Home of Green Pastures-for Korean clients-714-532-2787

- **National Domestic Violence Hotline**
  - 1-800-799-SAFE (7233)  www.ndvh.org
IMPORTANT LINKS / REFERENCES

1. UpToDate
2. Stark, Evan, and Filtcraft, 1996
4. Miller et al, Contraception, 2010
5. Cheng & Horon, Obstet and Gynecol, 2010