Domestic Violence: What Clinicians Should Know

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Abstract

Domestic violence is a crime of assaultive and / or coercive behavior that can include physical, sexual, and psychological harm of the victim. This crime is a major public health concern as it contributes to poor physical and mental well being of the affected victims, primarily women. Domestic violence also has a large impact on the health care system as many victims are initially identified in a health care setting and often times present with costly injuries. Health care providers are encouraged to screen for domestic violence as a part of the routine history taking process. The screening tools available are simple and do not create constraints of time or impedance of the interview. Screening will aid in not only the identification of those victimized, but to further promote education on the issue and offer available resources to the victim.

INTRODUCTION

For years Sally felt hopeless and thought there was no way out of her relationship. After the physical abuse from her husband, she would try to hide her bruises by staying home while they healed. She would even drive to an out of town grocery store to shop so no one would recognize her. Over the years her self esteem melted. She could not end the relationship due to a fear of what her husband might do and felt that she could not survive as a single parent. The abuse continued. This is a typical reaction to domestic violence. Success stories are not as frequent as we hoped. Many women end up victims of violent crimes.

Despite current trends in the equality and independence of the female gender, violence against women continues to occur. The Family Violence and Prevention fund estimates that one in every three women has been a victim of abuse in her lifetime. It is further estimated that three million women are physically abused by their husband or boyfriend each year.[1] Within the last ten years there has been a major decrease in reported cases of domestic violence, leading one to assume that newly formed educational programs, laws, and health policies have been successful.[2] Even with knowledge of these statistics and the improvement noted, domestic violence continues to be a widespread social dilemma. Health care providers must be aware of the impact domestic violence has on patient's lives, society, and the health care system.

DOMESTIC VIOLENCE DEFINED

Domestic violence is also known as partner-abuse, spouse-abuse, battering, or intimate partner violence3 and is defined as a crime which can present as a pattern of assaultive and coercive behavior that includes physical, sexual, and psychological attacks.[1] These behaviors are perpetrated by someone who is in an intimate relationship with the victim.[1,3]

Physical abuse is often recurrent and may escalate in frequency and severity that may include the following behaviors:

- Pushing, punching, kicking, shoving, slapping, and choking,
- Assault with a weapon,
- Holding, tying down, or restraining against one's will,
- Leaving the victim in a dangerous place, and
- Refusing to assistant in cases of illness or injury.3

Sexual abuse may include any form of forced sex or sexual degradation against one's will, hurting the victim physically during sex with the use of weapons or objects intravaginally, orally, or anally. Psychological abuse may precede or accompany physical violence in a controlling fearful or degradation manner. This may include the following:

- Threats of harm,
- Physical, and social isolation,
- Extreme jealousy, and possessiveness,
- Deprivation,
- Intimidation,
- Degradation, and humiliation,
- Constant criticism, insulting, and belittling,
- False accusations, and blaming,
- Ignoring, dismissing, or ridiculing her needs, and
- Lying, breaking promises, and destroying trust.3

There are no cultural, racial, socioeconomic, religious, or educational barriers to Domestic violence. According to Gerbert, Gansky, Tang, et al., women most usually receive 95% of the serious, violent injuries in comparison to men and children. All family members are potential victims; women and children are the most vulnerable. Women, who are pregnant, in the process of separation, divorce, and financial constraints are also at higher risk.[4]

DOMESTIC VIOLENCE AND THE HEALTH CARE SYSTEM

Domestic violence has an enormous impact on the health care system as over 75 percent of women are first identified in a medical setting and many account for the following:

- 22%-35% of injured women seen in an emergency department,
- 25% of women seeking emergency psychiatric services,
- 23% of women seeking prenatal care,
- 58% of women over 30 years of age who have been raped, and
- 45%-59% of mothers of abused children.3

Thompson, Rivara, Thompson, et al. describe the presentation of domestic violence encountered in a primary care setting as a manifestation of obvious forms of injury to a broad range of findings from gastrointestinal, gynecological, somatic symptoms, sexually transmitted diseases, and psychological presentations.[5]

The Rush Medical Center in Chicago found that the average charge for medical services rendered to abused women, children, and older people is an average of $1,633 per person per year. This would then amount to a national annual cost of $857.3 million.[6] Thus the conclusions that early identification and treatment of victims and potential victims will be a benefit to the health care system in the long run.[7]

SCREENING FOR DOMESTIC VIOLENCE

Numerous screening tools have been developed to assist health care providers increase the identification of victims of domestic violence. Of these proposed strategies for communicating about domestic violence, the most important tools begin with the patient provider relationship and communication process. According to McCauley, Yurk, Jenckes, et al. the elements of trust, compassion, support, and confidentiality must be present within the communication process for the victim to share her most personal feelings.[8] Fogarty, Burge, and McCord report that the patient's ability to answer any screening question candidly is a very complex process; she must perceive these elements as the cycle of abuse often leaves a woman feeling disempowered and lacking credibility.[9]

The Center for Disease Control and Prevention (CDC) has adopted the RADAR system, a training device to encourage providers to incorporate screening into practice. This is an acronym developed to assist in the important issues of screening for domestic violence.

R – Routinely screen every patient, make screening a part of every day practice from prenatal, postnatal, routine gynecological visits, and annual health screenings. A – Ask questions directly, kindly, and nonjudgmental. D – Document findings in the patient's chart using the patients own words, with details and use body maps and photographs as necessary. A – Assess the patient's safety and see if the patient has a safety plan. R – Review options of dealing with domestic violence with the patient and provide referrals.[10]

Screening for domestic violence need not be cumbersome in lists of questions that may impede the process of obtaining patient response. Various programs have created questions or screening tools to use in the patient encounter that are in simple question form, yet powerful in response. In review of the current screening instruments, the following three appear to have concise and reliable properties.

The Abuse Assessment Screen (AAS) is a four question screening tool designed by the CDC to encourage use and to improve the capacity to identify, prevent, and reduce intimate partner violence. This was initially created for use in pregnant women, but can be modified with omitting the question in direct reference to pregnancy. The questions are as follows:

1. Within the last year have you been hit, slapped, kicked, or otherwise physically hurt by someone? (If yes, by whom? Number of times? Nature of Injury?).
2. Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone? (If yes, by whom? Number of times? Nature of Injury?)
3. Within the last year, has anyone made you do something sexual that you didn't want to do? (If yes, who?).
4. Are you afraid of your partner or anyone else?10

HITS is a screening tool that is designed for outpatient clinical settings and consists of four questions based on the acronym for Hurt, Insult, Threaten, and Scream. The questions are as follows:

How often does your partner:

1. Physically Hurt you?
2. Insult you?
3. Threaten you with harm?
4. Scream or curse at you?11

PVS which is the acronym for the Partner Violence Screen was developed for use in emergency room situations. This is a short list of questions that allows for an opening to the evaluation of domestic violence. The questions are as follows:

1. Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?
2. Do you feel safe in your current relationship?
3. Is there a partner from a previous relationship who is making you feel unsafe now?12

These screening tools are recommended for use on a routine basis and an affirmative response to any of the questions should be considered a positive result. Unlike other types of patient screening tools the effectiveness of the tool also relies on the basis of the patient – provider relationship. Providers must establish an empathetic and trusting relationship with the patient for screening to be effective. The interpersonal nature of the questioning has as more to do with the disclosure and the comfort of the patient than the actual questions themselves.[9]

BARRIERS IN SCREENING FOR DOMESTIC VIOLENCE

Research estimates that one in ten physicians actually screen for domestic violence.[13] Sugg and Inui suggest that physicians may avoid addressing issues of abuse and violence more commonly because of lack of time, training, recognition of the associated social and psychological factors, personal feelings of helplessness or inability to “fix” the situation, disbelief in the situation, and the overwhelming prospect of “opening up Pandora's box” and the controversy that is associated with it.[14]

Patients may be reluctant to disclose their domestic situations out of fear or intimidation and the concern for safety of herself, her children, and out of love and affection the abusive partner. There may be financial concerns that may create concerns of support for her and her children. The victim may also experience shame and humiliation that may confound the situation and create a continued cycle of degradation where she is reluctant to discuss the events. Victims may also feel deserving of the abuse and may often negate the situation. In situations where the partner may not always be abusive, the victim may experience hope that he will change.[3]

Understanding the potential barriers that may exist for both the patient and the provider is the first step in the creation and reparation of more effective screening for domestic violence.

THE PROVIDER'S RESPONSE TO DOMESTIC VIOLENCE

Victims of domestic violence should be counseled on their options to respond to the abuse. Providers must be aware of local resources to refer victims to, keeping a list of local resources such as safe houses or shelters, counseling, victim

advocates, law enforcement advocates, legal services, local hotlines, and the national hotline 1-800-799-SAFE will best ensure the safety of the victim.[10] National resources on violence are readily available and for a listing of references see Table 1.

Figure 1

Table 1: Domestic Violence Resources*

Resources	Comments
National Domestic Violence Hotline 1-800-799-SAFE (7233) TTY: 1-800-787-3224 www.ndvh.org	National Hotline providing assistance to victims of domestic violence. Associated web site for information for victims, abusers, children, advocates, and community leaders.
National Coalition Against Domestic PO Box 18749 Denver, CO 80218	Contact information for state coalitions and direction for local and regional resources.
Family Violence Prevention Fund Health Resource Center on Domestic Violence 383 Rhode Island Street San Francisco, CA 94103 1-800-313-1310 www.fvpf.org	Free resources on domestic violence topics.
Center for Disease Control and Prevention. Intimate partner violence during pregnancy: a guide for clinicians. Available at: http://www.cdc.gov/nccdphp/drh/violence/ipvdp.htm	Educational slide series for health care providers.

*Adapted from Paluzzi.[2]

Health care providers have a duty to the victim of domestic violence to be aware of legal obligations in diagnosing and reporting domestic abuse. The provider must do what is in the best interest of the patient from a risk management situation. Failure to inquire about abuse and take steps to prevent subsequent harm can result in legal actions. Providers must know their state laws on mandatory reporting statutes. Laws vary from state to state in reference to domestic violence reporting, being an informed provider makes for better practice.[3]

CONCLUSION

Domestic violence can potentially cross into the lives of everyone, there have been great strides to address and educate the public on the issues. Health care providers are encouraged to continue with this effort by screening patients for domestic violence on a routine basis. The more diligent the health care community is with screening the more likely the abused are to be found and assisted. Screening need not be cumbersome or uncomfortable for either the patient or the provider. The screening tools that have been discussed in this article demonstrate the few simple questions that are needed to begin the assessment.

Domestic violence is an enormous financial burden on society as well as on the health care system. Early intervention with screening measures can only aid in the process of addressing the burden created by the violence.

Screening is the first step in addressing domestic violence the second step is being prepared for the needs of the victim. There are numerous resources available for providers and victims on a local and national level. Health care providers should be aware of their local offerings of counseling, shelter, legal services, law enforcement, and victim advocates to offer the appropriate references to the victim.

The routine screening of all patients also promotes patient education on violent free relationships. Health care providers have routinely addressed risk behaviors with patients that in the past have been considered private, such as alcohol use, smoking, and sexual behaviors. Asking questions of domestic violence in the patient interview are also not that obtrusive. By screening for domestic violence as a routine part of history taking, providers can make an enormous impact on the health and well being of those exposed to domestic violence.

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