

INTIMATE PARTNER VIOLENCE OVERVIEW

Intimate Partner violence is characterized as a pattern of coercive behaviors that may include 'repeated battering and injury, psychological abuse, sexual assault, progressive social isolation, deprivation, and intimidation. Typically, and in 95% of reported cases, the victim is female. However, intimate partner violence occurs in gay and lesbian relationships at the same estimated rate as in heterosexual relationships.

Physical abuse is usually recurrent and escalates in both frequency and severity. It may include the following:

- ◆ Pushing, shoving, slapping, punching, choking
- ◆ Assault with a knife, gun or other weapon
- ◆ Holding, tying down, or restraining the victim
- ◆ Burning with cigarettes, scalding water, an iron, or other means
- ◆ Yanking or dragging victim by the hair
- ◆ Repeated kicking to the abdomen during pregnancy; violence resulting in miscarriage

Sexual abuse in violent relationships is often the most difficult aspect of abuse for the victim to discuss. It may include any form of forced sex or sexual degradation, such as:

- ◆ Rape; trying to make the victim perform sexual acts against her/his will
- ◆ Pursuing sexual activity when the victim is not fully conscious, or is not asked, or is afraid to say no
- ◆ Hurting the victim physically during sex, or assaulting her/his genitals, including use of objects or weapons intra-vaginally, orally, or anally
- ◆ Coercing the victim to have sex without protection against pregnancy or sexually transmissible diseases

Emotional or psychological abuse almost always precedes and accompanies physical or sexual violence as a means of controlling through fear and degradation. It is the type of abuse that victims usually report as the most painful and destructive, and may include the following:

- ◆ Threats of harm to the victim, or to children or other loved ones
- ◆ Physical and social isolation; not allowing free access to friends and family members; sabotaging the victim's efforts to gain or maintain employment, education, or training
- ◆ Extreme jealousy and possessiveness
- ◆ Calling the victim names and constantly criticizing, insulting, and belittling her or him
- ◆ False accusations, blaming the victim for everything
- ◆ Ignoring, dismissing, or ridiculing the victim's needs
- ◆ Lying, breaking promises, destroying trust
- ◆ Driving fast and recklessly to frighten and intimidate the victim
- ◆ Destroying things precious to the victim; injuring or killing family pets

DIAGNOSIC ASSESSMENT

Injury

Episodes of physical assault characterize abusive relationships. Physicians should especially consider the possibility of assault when the patient's explanation of how an injury occurred does not seem plausible or when there has been a delay in seeking medical care. Common types of injury include:

- ◆ Contusions, abrasions, and minor lacerations, as well as fractures or sprains
- ◆ Injuries to the head, neck, chest, breasts, and abdomen
- ◆ Injuries during pregnancy
- ◆ Multiple sites of injury
- ◆ Repeated or chronic injuries

Medical Findings

The stress of living in an ongoing abusive relationship may cause any of the following:

- ◆ Chronic pain, psychogenic pain, or pain due to diffuse trauma without visible evidence
- ◆ Physical symptoms related to stress, chronic post-traumatic stress disorder, other anxiety disorders, or depression. Examples are:
 - Sleep and appetite disturbances
 - Fatigue, decreased concentration, sexual dysfunction
 - Chronic headaches
 - Abdominal and gastrointestinal complaints
 - Palpitations, dizziness, paresthesias, dyspnea
 - Atypical chest pain
- ◆ Gynecologic problems, frequent vaginal and urinary tract infections, dyspareunia, pelvic pain
- ◆ Frequent use of prescribed minor tranquilizers or pain medications
- ◆ Frequent visits with vague complaints or symptoms without evidence of physiologic abnormality

Many practitioners have noted that chronic illnesses such as asthma, seizure disorders, diabetes, arthritis, hypertension, and heart disease may be exacerbated or poorly controlled in patients who are being abused.

Sexual coercion and assault are common expressions of intimate partner violence. Assessment for sexual abuse and rape should be addressed in the sexual or social history taken during routine primary care visits, in discussions of birth control and safer sexual practices and in evaluations during gynecologic and obstetric visits.

Behavioral Signs

Victims of intimate partner violence exhibit a variety of responses to the stress of ongoing abuse; such patients may appear frightened, ashamed, evasive or embarrassed. An abused patient may believe she or he deserves the abuse because the abuser blames the victim.

Other findings include the following:

- ◆ Partner accompanies patient, insists on staying close, and answers all questions directed at the patient
- ◆ Reluctance of a patient to speak or disagree in front of her or his partner
- ◆ Intense irrational jealousy or possessiveness expressed by partner or reported by patient
- ◆ Denial or minimization of violence by partner or by patient
- ◆ Exaggerated sense of personal responsibility for the relationship, including self-blame for the partner's violence

Mental Health and Psychiatric Symptoms

Assessment for intimate partner violence should be included as a routine part of psychiatric intakes and evaluations. The stress of domestic violence may aggravate co-morbid psychiatric disorders. Psychiatric symptoms of abuse include the following:

- ◆ Feelings of isolation and inability to cope
- ◆ Suicide attempts or gestures
- ◆ Depression
- ◆ Panic attacks and other anxiety symptoms
- ◆ Alcohol or drug abuse
- ◆ Post-traumatic stress reactions and/or disorder

Pregnancy

Because of the risk to the mother and fetus, assessment for abuse should be incorporated into routine prenatal and postpartum care. Presentations include:

- ◆ Injuries, particularly to the breasts, abdomen, and genital area, or unexplained pain
- ◆ Substance abuse, poor nutrition, depression, and late or sporadic access to prenatal care
- ◆ Spontaneous abortions, miscarriages, and premature labor

Control in a Relationship

An abusive partner's use of control within a violent relationship may result in the following impact on the patient:

- ◆ Limited access to routine and/or emergency medical care
- ◆ Noncompliance with treatment regimens
- ◆ Not being allowed to obtain or take medication
- ◆ Missed appointments
- ◆ Lack of independent transportation, access to finances, and/or ability to communicate by phone
- ◆ Not being told by a partner that he is infected with HIV or other sexually transmissible diseases

SPECIAL POPULATIONS

Children

Domestic violence involves all family members and children are often trapped within their homes. Children in violent homes face many risks, among them: the risk of observing traumatic events, the risk of being neglected, and the risk of being abused themselves. Many researchers have drawn the conclusion that exposure to domestic violence is a form of child abuse. Recent research has correlated Post Traumatic Stress Disorder symptoms with children of battered women. There is an estimated 30-60% overlap between violence against women and violence against children in the same families. Statistics of abused children indicate that more than 50% have mothers who are being battered. Children exposed to domestic violence often become fearful, withdrawn, depressed, and/or aggressive. They may feel guilt or shame if they blame themselves for the violence, and/or be confused about their feelings regarding their parents. Some children may be injured when they try to protect their mother or get in the way during attacks. In a recent query of sheltered women, although it was painful to disclose, more than 90% of mothers said they knew their children witnessed/overheard the violence in their homes.

In assessing risk to children in a household, some statements/questions might be:

- ◆ *"Sometimes children get hurt too. What concerns do you have for your child's safety?"*
- ◆ *"Is your child afraid to leave you alone?"*
- ◆ *"Does your partner use the kids to monitor you?"*
- ◆ *"Has your child ever been hit/shaken when your partner was after you?"*
- ◆ *"Has your partner threatened to hurt your children?"*
- ◆ *"Has your partner touched your child in a way that made you feel uncomfortable?"*
- ◆ *"Both you and your child's health and safety are important; there may be some safer coping tools you might like to consider."*

To intervene with children, give the message that the non-offending parent is not to blame, that each of us is responsible for our own behavior, and that our feelings do not lead to violence. Safety planning options for children should include: leaving or hiding if there is fighting; telephoning a friend, police, or 911; running to a friend or neighbor to get help; or going to an older sibling for help.

The Elderly

(source: Elder Abuse and Neglect Act– The Illinois Department on Aging)

Many older people who live at home are at risk of abuse, neglect, and financial exploitation by family members and others close to them. It is estimated that over 76,000 persons over the age of sixty in Illinois are elder abuse victims. Yet only 7,000 elderly victims are reported to the Elder Abuse and Neglect Program annually.

Victims of elderly abuse are often isolated, and they may be afraid or unable to seek help for themselves. In many cases, the only person outside the family who sees the victim is a health care provider, home care professional, financial institution, or other helping professional. In accordance with the Elder Abuse and Neglect Act, health care providers should report all known or suspected cases of elderly abuse, when the victim is unable to access help on their own.

Pregnant Women

Experts estimate that one in six pregnant women experience abuse during pregnancy. The number is higher for pregnant teens, with one in five reporting abuse. Pregnant women who are abused have greater risk for complications during their pregnancy, including but not limited to:

- ◆ Poor weight gain
- ◆ Fetal injuries
- ◆ Miscarriage
- ◆ Bleeding
- ◆ Premature contractions

Battered women also tend to enter prenatal care late in pregnancy and are more likely to deliver low-birth weight or pre-mature infants than non-battered women.

Some research has indicated that homicide is the leading cause of death in pregnant women. Pregnant teenagers are more at risk of homicide than adult women. Victims are more likely to have been killed in the early months of pregnancy, making it difficult to link the pregnancy with the homicide. According to Deanne Williams, Executive Director of American College of Nurse-Midwives: "What pregnant women do not know, is that instead of facing joyful celebration at the announcement of pregnancy, too many face violence and death. We have got to do a better job of identifying this problem and helping the women and their partners avoid such a horrific outcome (Flapan, 2001)."

Gay, Lesbian, Bisexual, and Transgender Issues

A fundamental fear of many gay, lesbian, bisexual, and transgendered (GLBT) individuals is that, if they disclose their sexuality, they will receive poorer treatment than if they stay "in the closet", i.e. if they pretend to be heterosexual. They fear that they will be denied care. Or they may anticipate being made to feel judged or unwelcome in the consultation at a time when they are especially vulnerable.

In reality, most health care providers are committed to fair treatment for all. However, it is important for the health care team to remember that no matter how free of prejudice you may be, it may still be rational for members of the GLBT community to have expectations of inequitable treatment because of a history of such treatment. Firstly, inequitable treatment is what homosexuals have grown to expect from many public services and, indeed, from society in general. Secondly, homosexuals are aware that hostile or discriminatory attitudes persist among some health care staff.

GLBT concerns can be addressed by a few simple, low-key signals that the practice is committed to equality of treatment irrespective of sexual orientation. Many have grown up keenly attuned to such signals and will respond well to them. Heterosexual patients will hardly notice these signals of goodwill, let alone object to them. Simple reassurances allay GLBT concerns without offending other patients. When taking a sexual history, or in a first sexual consultation, ask the patient about his or her partner or partners, rather than husband/wife or boyfriend/girlfriend. Using sensitive, neutral language like this is something that will be noticed and welcome, but which heterosexual patients won't object to.

Handicapping Conditions

As with Elder Abuse, many handicapped individuals are cared for by family members or home care workers who may be perpetrators of abuse. Handicapped persons are also at a greater disadvantage when it comes to seeking help, as they may be limited in their ability to be mobile or in their ability to communicate. If a caretaker is abusive, he or she may restrict visitors. It is important to screen the patient alone, thereby creating a more comfortable environment for the patient to disclose any existing abuse.

Heterosexual Men

It is a widely held assumption that women are always the victims of battering and men are always the perpetrators. Though women are indeed the victims in 95% of reported cases of domestic abuse, they are not the only victims. In addition to the 5% of reported incidents in which a male is identified as the victim (including heterosexual and homosexual partnerships), there may be a significant number of existing cases that go unreported for a myriad of reasons. Often the idea that men could be victims of domestic abuse and violence is so unthinkable that many men will not even attempt to report the situation. Even when men do report domestic abuse and violence, most people are so astonished that men usually end up feeling like nobody believes them.

Domestic violence against men goes unrecognized for the following reasons:

- ◆ It has taken years of advocacy and support to encourage women to report domestic violence. Virtually nothing has been done to encourage men to report abuse.
- ◆ In most cases, the actual physical damage inflicted by men is so much greater than the actual physical harm inflicted by women. The impact of domestic violence is less apparent and less likely to come to the attention of others when perpetrated by women.
- ◆ Help for men who are victims of domestic abuse and violence is not as prevalent as it is for women. There are virtually no shelters, programs or advocacy groups for men.

Teens

Health care providers are ideally situated to provide primary prevention and intervention of adolescent partner violence because of their regular contact via well-child examinations and sports physicals. Because many adolescents, both girls and boys, accept physical and sexual aggression as normal in dating and partner relationships, it is rarely reported. Health care providers can provide an important alternative view by talking with them about types of behavior they expect in intimate relationships.

It is important to take an active approach to identification of teen dating violence. Effective identification is best accomplished by implementing a clinical protocol, which includes routine screening of adolescent patients for dating violence. One effective screening approach is to begin with an open-ended question about relationships with peers. The focus of the questions then narrows by asking how they resolve conflicts with peers, followed by direct questions about specific behaviors such as pushing, hitting, being afraid, being hurt, or being forced to have sexual contact. Physicians should avoid using emotionally loaded terms such as *abuse*, *rape*, or *violence*. Active patient education should be well received because both adolescents and parents view physicians as a good source of information and want physicians to address common health and psychological issues.