

domestic violence

The responsibilities of physicians, health care providers, and community leaders
by M. Basheer Ahmed, M.D.

Guideline Summary

- Incidences of domestic violence are much higher than reported and every physician must be knowledgeable about the dynamics of domestic violence.
- Physicians must screen all female patients over age 18 for signs of domestic violence. Patients are usually reluctant to share the information, and physicians need to ask direct questions especially to patients who have an unexplained injury or multiple vague symptoms – “Have you experienced violence at the hand of your spouse or partner?”
- Physicians must be aware of community resources to which they can refer their patients. (See Appendix II)
- Women ultimately make the decision as to when they are ready to leave the relationship. Physicians must be compassionate and give appropriate advice to make them aware of the resources in the community.

Reference: Diagnoses and Treatment Guidelines on Domestic Violence, American Medical Association

Our society faces a serious problem of violence, which is symptomatic of deep psychological and social disorders in an individual and the society. Home is supposed to be a safe place where one should see equality and partnership of two spouses and a loving and nurturing environment for children. It is sad to see that millions of individuals face violence at home by the hand of their loved ones. Every few seconds, a wife is battered, a child is abused or an elderly is assaulted; not by a stranger but by someone as close as spouse, a parent

or a child. Family violence and domestic violence appear to be civilized terms but they are characterized by the most uncivilized forms of behavior. Family violence includes all violence occurring within the family unit: child abuse, wife abuse and elder abuse. Domestic violence is defined as a pattern of violent and coercive behavior where one partner in an intimate relationship controls another through force, intimidation, or threat of violence. Arguments occur at some point in all marital partners. Verbally abuse behavior may occur during arguments about childcare, housework and financial matters. Domestic violence is different from routine arguments and expression of anger. The abusive behavior includes emotional abuse, psychological abuse, sexual and physical assaults. Emotional abuse is characterized by cursing, screaming and degradation by constantly criticizing the spouse's thoughts, feelings and opinions. Psychological abuse consists of threats of bodily harm, taking away children and killing spouse or himself. The perpetrator also controls finances, even food and medication and places restrictions on socialization, even with the family members. Physical abuse occurs when perpetrators actually hit, kick, punch, choke or burn causing lacerations and fractures. Forcing unwanted sexual activity is also a form of sexual abuse.

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Four million women are assaulted each year in the U.S.¹ Eight to twelve million women are at risk of being abused by their current or ex-spouse. Every 15 seconds, a woman somewhere in the U.S. is beaten in her home. Violence is

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the number one public health risk to adult women and it is a leading cause of injuries to women ages 15-44. It is more common than accidents or cancer. About 20% of women visit the ER for symptoms of an ongoing abuse.² In Texas, 11,983 women and 17,619 children in abusive relationships received shelter during 2004.³ The U.S. economic burden exceeds \$12 billion annually for medical treatment, shelters, police, court time, foster care, sick leave and nonproductivity.⁴

Domestic violence is a universal problem. All ethnic, religious, racial and age groups are affected. Economic and educational levels do not alter the incidents. There are known cases of abusers who are prominent and successful members of the society. In some ways, women in the higher echelon of society are at greater risk, as they often maintain silence to avoid embarrassment. It may also be less evident among the affluent because they can find and afford private physicians, counselors, attorneys and living arrangements. Individuals with limited financial resources or supporting relatives turn to more public agencies for help.

The Cycle of Violence

The husband hits the wife, she neglects this as a one-time occurrence, he hits her again, and the behavior continues. She temporarily moves to a friend's house. He repeatedly calls, apologizes for the behavior, and asks her to return. She returns home, things are better for a few days. However the pattern of abuse recurs. The threat and the mild abuse turns into a severe blow in the face and bleeding, and she fears for her life. Now she leaves home and goes to her sister's house with the children. She is in a dilemma whether to report or not. If she reports, he will be in jail resulting in shame, guilt, loss of income, and possibly more reprisals. She worries about support for the children and concerned about the limited resources. She gets very little support from her family and/or religious institutions. Many women go through this scenario and face the most serious difficulties in making decisions. Many years ago, I saw an attorney's wife who had to make this difficult decision; giving up a comfortable standard of living and facing serious difficulty in coping with economic hardship, as she gave up her husband whom she had been married to for 15 years, due to persistent physical abuse. She spent several months in a shelter before settling down in the community and getting a modest paying job.

Dynamics of an abusive relationship

Although there are rare cases of women who assault their husbands, by and large spouse abuse occurs because men batter women and get away with it. No single theory for why men show such aggressive behavior is confirmed. There are sex-linked differences associating aggression and male gender. Abusive men come from a variety of backgrounds, religions, races and occupations. Rigid sex-role stereotypes are pervasive, as abusive men attempt to place their partners in a submissive role. The abusive behavior is a learned behavior, which is acquired through life experiences in one's

family of origin and through the observation of society at large. The abusers believe that they have the right to control others behaviors. This concept may be reinforced by the religious and cultural beliefs, that the wife should be obedient and subservient. Peer group approval and cultural practices also come to play a role in this behavior reinforcement.

Consequences of violence on victims

Domestic violence does not end until outside intervention takes place. Battered women seldom complain and are hesitant to seek help. As a result of this, they suffer from a variety of physical and emotional symptoms. They experience vague somatic symptoms, backache, headache and gastrointestinal symptoms, sleep disturbance and nightmares. They become anxious and nervous due to their husband's unpredictable behavior. They develop low self-esteem, low self-confidence and become socially isolated. They gradually drift away from family and friends using the excuse that they are busy. They feel powerless, frightened and extremely dependent. They have too much anger and hostility, but they suppress these emotions. They experience difficulty in communicating and developing any trustful relationship. Most victims develop depression and experience suicidal ideas due to persistent hopelessness. Even after separating and divorcing, some of these symptoms continue for a long period of time.

Responsibilities of physicians and other health care providers

On many occasions, physicians fail to recognize an obvious abuse. The major factor is their lack of awareness. All physicians, especially family physicians, internists, psychiatrists, ObGyn specialists, and emergency room physicians come across victims of domestic violence. While some victims come in with obvious broken bones and contusions, many others may present with multiple vague physical complaints. Physician may be treating the patient symptomatically or patient is diagnosed as depressed and anxious and may be treated with antidepressant and anti-anxiety agents. Unless the clinician keeps in mind the possibility of domestic violence, the diagnosis may be missed. Victims of abuse seldom reveal or volunteer the information due to shame, humiliation and denial. They often have difficulty in developing trustful relationship. They are convinced that whatever is happening is their fault, and they need psychological treatment. Unfortunately, the victim will remain in a dangerous situation, while under the care of a physician, if the problem is not recognized early. Similarly, children who are traumatized from living in a home with domestic violence are often treated for behavioral problem and depression without exploring in depth the home environment. Children are very frightened and most often unable to express the reason for their mental anguish.⁵

Diagnostic Guidelines for Clinicians

There are no specific signs and symptoms in a victim of violence. Even after an acute episode of domestic violence, only 23% of the victims visiting the ER have injury related complaints.⁶ They may present with obvious injuries or bruises, lacerations or fractures, injuries to the head, neck, chest and breast. The prevalence of battering during pregnancy is about 6%.⁷ Pregnant women may present with the above-mentioned injuries. Victims of abuse manifest a variety of psychological problems including anxiety, depression and suicidal ideation. Some women may suffer from insomnia, eating disturbance, chronic pain, vague somatic symptoms and sexual dysfunction. Low self-esteem, low self-confidence and minimization of abuse by denial and self-blame are also prevalent. All clinicians must be familiar with this problem and should routinely screen all patients for abuse. Suspect domestic abuse if the patient has unexplained injuries, but denies any abuse. The patient may avoid eye contact and seems more agitated if asked about bruises. Repeated visits to the ER with vague somatic complaints, pregnant women with bleeding or miscarriages, symptoms of high anxiety, depression, and suicidal ideation should also raise suspiciousness of abuse. Be alert if a spouse accompanies the patient and insists on staying close to her.

by the Joint Commission on Accreditation of Health Care Organization (JCAHO) the phenomenon of victim's typical reluctance or inability to initiate discussion of abuse is well documented. Full knowledge of abuse is necessary to provide proper medical care.¹⁰ If a clinician gets negative response to his inquiries but the abuse is suspected, the physician should ask explicit questions. The physician should also give reading material about domestic violence, such as "Family Violence: A Personal Safety Plan." These brochures are available at the Texas Attorney General's Office through the Crime Victim Services Division.¹¹

Documentation

Medical records are the only documents which contain description of the emotional and physical abuse, therefore such documents must be comprehensive. These should include the relevant facts including the use of weapons and any injuries resulted from the use or threatened use. Such records are critical for legal action.¹² Complete medical record may also alleviate the need for health professionals in testifying in court. In documenting injuries, body maps should be used. Emergency room physicians must be overly

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Given the high prevalence of domestic violence in the acute care setting, the reluctance of women to volunteer information about abuse and the difficulty in identifying abused patients, it is recommended that suspected patients should be screened for domestic violence by explicit questions. This questioning must take place without the presence of victim's partner.⁸

The following are some examples of questions one must ask: Did someone hurt you? Are you in a relationship in which you felt you are badly treated? Are you ever afraid at home? Does your spouse threaten you? Does your spouse destroy property? Does your spouse force you to have sex with him? Does your spouse prevent you from leaving the house? Seeing friends? Getting a job or continuing your education? Does your spouse control your behavior? What happens when you have a fight? Has your spouse ever hit, pushed, shoved, slapped or choked you? Have you ever been hit while pregnant? Sometimes people feel depressed and suicidal when one in their life tries to control them. Do you feel safe going home?

Breaking a relationship is not easy and therefore clinicians must reassure that help is available. Clinicians must also show support and understanding to gain the confidence and trust of victims of abuse.⁹ In standards issued

cautious when evaluating female patients with injuries. They should note inconsistencies between possible causes and explanation of injury if the patient will not confirm the abuse.

A physician is negligent if the standard of care is not employed based on what he/she knew or should have known about the patient. Clinicians cannot avoid liability by failing to conduct universal screening or respond in accordance with the standard of care. Effective risk management should include an understanding of legal and ethical standards, clear documentation and competent treatment and referral practices.¹³ Many physicians do not like to get involved; they feel it is not in their area of expertise and they are hesitant to accept responsibility for referral to the appropriate agency.¹⁴ The lack of knowledge and sometimes the lack of available resources are also a major hindrance. Many physicians have difficulty in dealing with the victim's feelings and they have very little time or patience to listen and explore the victim's feelings. Another area of concern is the medico-legal aspect.

Texas Law (Section 91.003 of the Family Code) requires physicians to provide safety and shelter information to patients with injuries believed to be caused by violence in the family and to document giving these materials in the

patient's medical record. Some states mandate the reporting of suspected family violence cases. However, Texas has no such requirement unless the victim is a child, elderly or disabled. These cases must be reported to Child or Adult Protective Services.¹⁵

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Appendix I

Texas State Law, Family Code Section 91.003

A medical professional who treats a person for injuries that the medical professional has reason to believe were caused by family violence shall:

(1) Immediately provide the person with information regarding the nearest family violence shelter center.

(2) Document in the person's medical file:

(A) The fact that the person received the information provided under Subdivision 1 (above)

(B) The reasons for the medical professional's belief that the person's injuries were caused by family violence.

(3) Give the person written notice in substantially the following form, complete with the required information, in both English and Spanish: "It is a crime for any person to cause you physical injury or harm even if that person is a member or former member of your family or household."

APPENDIX II

Community Resources:

- Police Emergency: 911
- Safe Haven of Tarrant County (Women's Shelter): 817-536-5496
- District Attorney's Office Tarrant County: 817-701-7233
- Mental Health, Mental Retardation Services: 817-335-3022
- West Texas Legal Aid: 817-336-3943
- The Women Center of Tarrant County: 817-927-4040
- Muslim Community Center for Human Service: 817-589-9165

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M. Basheer Ahmed, M.D., was born in Hyderabad (DN), India. He obtained his medical degree from Dow Medical College, Karachi, and completed his postgraduate studies at Glasgow University, Scotland. He is a board certified psychiatrist and a distinguished life fellow of the American Psychiatric Association. He was assistant professor at Albert Einstein College of Medicine, NY, and Prof. of Psychiatry at Southwestern Medical School, Dallas, TX, and UNT Health Science Center Fort Worth. He recently retired from private practice in Fort Worth.

Dr. Ahmed is the past president of the Islamic Medical Association, North America and is the Vice President of the Institute of Medieval and Post Medieval Studies. He edited the book, "Muslim Contribution to World Civilization," which was published in 2005 and he recently edited another book on "The Islamic Intellectual Heritage and Its Impact on the West." (2008)

Dr. Ahmed is the founder and chairman of the Muslim Community Center for Human Services, which is a medical and social service organization, helping the underserved residing in the Dallas/Fort Worth area. He is program chairman for the Second Regional Conference on "Domestic Violence—Cross Cultural Perspective," jointly sponsored by MCC for Human Services and School of Social Work, University of Texas, Arlington. He can be reached at mbahmed03@hotmail.com.