

DOMESTIC VIOLENCE

Responsibilities of Physicians, Health Care Providers, and Community Leaders

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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 someone as close as spouse, parents or children. 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 spouse's thoughts, feelings and opinions. Psychological abuse consists of threats of badly harm, taking away children and killing spouse or himself. Perpetrator also controls finances, even food and medication and place restriction on socialization even with the family members. Physical abuse occurs when perpetrators actually hit, kick, punch, choke or burn causing laceration and fractures. Forcing unwanted sexual activity is also a form of sexual abuse.

Four million women are assaulted each year in the U.S.A.¹ 8-12 million women are at risk of being abused by their current or ex-spouse. Every 15 seconds, a women somewhere in the U.S. is beaten in her home. Violence is 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 and 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 US 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 abuser who are prominent and successful members of the society. In some ways, women of high 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 repetitively 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 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 a 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 have seen an attorney's wife, who had to make this difficult decision as she has to give up a comfortable standard of life and had to face 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 had to spend several months in a shelter before settling down in the community after getting a modest paying job.

Dynamics of Abusive Relationship - Although there are rare cases of women who assault their husbands, by & large spouse abuse occurs because men batter women and get away with it. No single theory for why men show such an aggressive behavior is confirmed. There are sex-linked differences associating aggression & male gender. Abusive men come from a variety of backgrounds, religions, races and occupations. Rigid sex role stereotype 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 and 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 Physician 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 frequently the victims of Domestic Violence. While some victims come in with obvious broken bones and contusions, many others may be presented 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 what ever is happening, it is their fault and they need psychological treatment. Unfortunately the victim remains 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 victim of violence. Even after 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 be presented 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 complains, 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.

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 victims' partner.⁸

The following are some of the 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 by the joint commission on Accreditation of Health Care Organization, JCAHO, the phenomenon of victims' 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, physician should ask explicit questions and give the reading material about Domestic Violence and "Safety Plan brochures" available from Attorney General's Office of crime victim's compensation.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 actions.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 over cautious when evaluating female patients with injuries. They should note inconsistencies between possible causes and explanation of injury if 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 feelings and they have very little time or patience to listen and explore the 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

Safety Plan: In suspected cases physician must advise about the safety plan. The victim of Domestic Violence should share the information with a trusted friend or relative, must save money for emergency and keep all the documents such as driving license, passport, birth certificate, school record and insurance paper. She must have all the emergency numbers easily available.

Domestic violence is a crime. It is not a private family matter. If community leaders, health care professionals and community at large are not aware and involved, women will remain in the victims' role for many years.

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

(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.

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Dr. Ahmed is the founder and chairman of Muslim Community Center for Human Services, which is a medical and social service organization, helping indigent 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.

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