Do You Routinely Screen For Domestic Violence?

Violence crosses all ages, sexes, races, cultures and socioeconomic groups. There is such a high prevalence rate that family doctors will, on a daily basis, encounter more than one person with a past or present history of abuse.

By Patricia Morris, MD, CCFP

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Denial, minimizing and silencing are harmful and damaging behaviors to use toward any victim of violence. Family physicians have to be open to hearing their patients' criticisms, experiences and pain.[1] Domestic violence is the threatened or actual use of power to control another person in an intimate relationship. It is important to note this control may be of a physical, psychologic, sexual, financial or social nature.

Dr. Morris is assistant professor, department of family medicine, University of Ottawa, and active attending staff member, Ottawa Hospital, Ontario. Her areas of medical interest include domestic violence and obstetrics.

Importance Of Screening

Violence crosses all ages, sexes, races, cultures and socioeconomic groups. There is such a high prevalence that family doctors will, on a daily basis, encounter more than one person with a past or present history of abuse. Patients present with many long-term and short-term sequelae.

Prevalence

Women were assaulted at a one-year rate of 3% and a five-year rate of 8% according to the 1999 General Social Survey (GSS) conducted by Statistics

Canada. The five-year rate of violence decreased between the 1993 and 1999 surveys, but the incidence of reporting violence to police increased.[2] Pregnant women, women aged 18 to 25 and those in relationships of fewer than two years are at higher risk.[3] The rate of emotional abuse was 18%.

As many cultural and racial backgrounds were surveyed, the GSS was able to gather statistics on Aboriginal women from the 10 provinces.[1] Twenty-five per cent of these women were abused during a five-year period. They experienced more severe forms of violence and had a spousal homicide rate eight times higher than non-Aboriginal women.[4] Aboriginal women reported a rate of emotional abuse of 37%.[2]

Men in the GSS reported violence in 1999 at a one-year rate of 1% and a five-year rate of 7%. The rate of emotional abuse was 18%.[2] Aboriginal men had rates of spousal homicides 18 times greater than non-Aboriginal men and a rate of emotional abuse of 30%.[2]

Children in the GSS witnessed 37% of spousal violence in a five-year period. There were approximately 22 investigations of child abuse and neglect per 1,000 children aged one to 15, with almost one-half of these cases substantiated by child welfare workers.

The incidence of unwanted sexual touching is 50% of women and 33% of men in their lifetimes.[1] Elder abuse has been estimated at 4%, with half of that occurring in institutionalized settings and the other half taking place in their own homes (mostly by relatives).[5]

Summary

Domestic Violence

- There is such a high prevalence rate of violence that family doctors will, on a daily basis, encounter more than one person with a past or present history of abuse.
- Pregnant women, women aged 18 to 25 and those in relationships of fewer than two years are at higher risk.
- Men are more likely to deny being abused, blame themselves and will seek treatment less frequently.
- Children who are maltreated are likely to show behavioral problems, have negative peer involvement and suffer from depression or anxiety.
- All unexplained injuries or physical evidence of neglect in an adult or child should alert the family doctor that the person may be a victim of violence.
- It is important to ask about a previous history of violence since, according to the 1999 General Social Survey, 37% of women and men from a former violent marriage or common-law relationship reported the violence continued after the couple separated.
- The physician should perform a detailed examination, gather appropriate evidence, treat the injuries and document the relative positive and negative findings.
- Victims often will need many professionals to help end the violence. They can be referred to women's shelters, police departments, social agencies, lawyers, psychologists and psychiatrists.
- When the family doctor is treating both partners in a relationship, he/she should not disclose knowledge of the violence to the perpetrator unless the victim gives permission.
- The family physician should always be aware of his/her personal safety when confronted with a violent patient, take threats seriously, have a safety plan and get help.

Psychologic Sequelae

In the short term, the domestically abused person may experience post-traumatic stress disorder (PTSD), as outlined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (Table 1). For both men and women, there are often longer-term sequelae of substance abuse, depression, anxiety disorders, borderline personality, dissociative disorders, eating disorders, gender identity, bullying and aggression, low self-esteem and prostitution.

Men are more likely to deny being abused, blame themselves and will seek treatment less frequently.[6] Children who are abused are likely to show behavioral problems, negative peer involvement, depression or anxiety, violence toward others, developmental delay, age-inappropriate sexual behavior, irregular school attendance and may run away from home. Children who have witnessed abuse are frequently misdiagnosed as having attention deficit-hyperactivity disorder (ADHD) as the symptoms are similar.[4] Elderly people may present with agitation and aggression, sleep disturbances, denial and the other DSM-IV criteria for PTSD.[5]

Physical Sequelae

All unexplained injuries or physical evidence of neglect in an adult or child should alert the family doctor that the patient may be a victim of violence. In addition, violence also has been associated with migraine headaches, irritable bowel syndrome, fibromyalgia, chronic fatigue, self-mutilation, chronic back, abdominal and pelvic pain, low birth weight and premature labor in pregnant women.

All unexplained injuries or physical evidence of neglect in an adult or child should alert the family doctor that the patient may be a victim of violence.

Screening Tools

There are currently three screening resources being used: Stop Abuse For Everyone (SAFE), Partner Violence Screen (PVS) and the Women Abuse Screening Tool (WAST) (Table 2). These tools mainly screen for current violence. It is important, however, to ask about a previous history of violence since, according to the GSS, 37% of women and men from a former violent marriage or common-law relationship reported the violence continued after the couple separated.[2] Since childhood trauma is so significant, adults should be asked, "Have you ever experienced any physical, sexual or emotional trauma?" or "What was it like for you growing up?" or "How were arguments handled in your home?"

Table 1

DSM-IV Criteria For Post-traumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

- The person experienced, witnessed or was confronted with an event(s) that involved actual or threatened death or serious injury, or a threat to the physical integrity of themselves or others; and
- The person's response involved intense fear, helplessness or horror.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

- Recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions;
- Recurrent distressing dreams of the event;
- Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, such as those that occur upon awakening or when intoxicated);
- Intense psychologic distress inspired by exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event; and
- Physiologic reactivity inspired by exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- Efforts to avoid thoughts, feelings or conversations associated with the trauma;
- Efforts to avoid activities, places or people that arouse recollections of the trauma;
- Inability to recall an important aspect of the trauma;
- Markedly diminished interest or participation in significant activities;
- Feelings of detachment or estrangement from others;
- Restricted range of affect (*e.g.,* unable to have loving feelings); and
- Sense of a foreshortened future (*e.g.,* does not expect to have a career, marriage, children or a normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- Difficulty falling or staying asleep;
- Irritability or outbursts of anger;
- Difficulty concentrating;
- Hypervigilance; and
- Exaggerated startle response.

Table 2

Screening Tools

SAFE

S: How would she describe her ***s***pousal relationship?

A: What happens when she and her partner ***a***rgue?

F: Do ***f***ights result in her being hit, shoved or hurt?

E: Does she have an ***e***mergency plan?

PVS

- Have you been hit, kicked, punched or otherwise hurt by someone within the last year?
- Do you feel safe in your present relationship?
- Is there a partner from a previous relationship who is making you feel unsafe now?

WAST

- In general, how would you describe your relationship?
- Do you and your partner work out arguments?
- Do arguments ever result in you feeling down or bad about yourself?
- Do arguments ever result in hitting, kicking or pushing?
- Do you ever feel frightened by what your partner says or does?
- Has your partner ever abused you physically?
- Has your partner ever abused you emotionally?

SAFE = Stop Abuse For Everyone; PVS = Partner Violence Screen; WAST = Women Abuse Screening Tool

As for children, they should be screened with questions like: "What happens in your family when your parents disagree?" and "How are you disciplined for doing something wrong?"[4]

How to Screen

The family doctor is more likely to uncover abuse if:

- Questions are asked as part of the history taking;
- It is explained that the questions being asked are routine;
- A neutral body appearance is kept;
- Loss of eye contact from the patient is monitored;
- Confidentiality is assured;
- The patient is assured his/her stories are not unique or isolated;
- The abuser is isolated;
- The patient is not interrupted;
- Open-ended questions are asked (*e.g.,* "Can you tell me what happened?");
- "Why" questions are avoided; and
- Pamphlets are visible in the examining room.

What To Do Upon Disclosure

Detailed history

The physician always should take a detailed history of the abuse, inquiring about the following issues:

- Ask about times and dates of abuse, alcohol use, and use or access to weapons.

If there is evidence of children being hurt, the physician has a duty to inform the child protection agency.

- Was there emotional, financial or social maltreatment? When?
- What has the perpetrator threatened to do if the patient leaves the situation?
- Who has the patient told about the abuse and how can those people support the patient?
- Who, including children, has witnessed the abuse?
- What has the patient tried to do in the past to stop the violence?
- Is the violence increasing?
- What would the patient need to do to overcome the violent relationship?

Detailed examination

The physician should perform a detailed examination, gather appropriate evidence, treat the injuries and document the relative positive and negative findings. Good documentation is essential if the doctor is called in a civil or criminal case.[4]

Educate the victim

The victim should be told the following:

- Violence is the responsibility of the perpetrator.
- Violence is a crime and nobody deserves to be violated.
- Violence often follows a pattern. There is a phase where tension builds and the violence happens, followed by a honeymoon period or time of remorse when the perpetrator tries to make amends for the violence.
- Violence is unlikely to stop unless you take action.
- Threats and witnessing violence has profound effects on you and your children. Couples or family therapy is inappropriate until the perpetrator admits and gets help for the violence.
- The information you disclose is confidential and can only be released on your written consent.
- If there is evidence of children being hurt, the physician has a duty to inform the child protection agency.
- Only you can call the police and/or leave the situation.
- Violence can escalate after separation.
- You will need support through the criminal and family justice system, securing housing and financial aid.
- The more help you receive, the greater the chance of overcoming the violence.
- Whether you leave or decide to stay in the relationship, I will continue to help you.

Establish a safety plan

If the patient decides to leave the situation, he/she should be given a safety plan with information on what to bring with him/her and phone numbers of shelters and relevant social agencies. The plan also should explain to always take children along whenever possible and to keep the safety plan a secret from the perpetrator.

Give resources to the patient

There are many excellent pamphlets and books written for the victims of violence (see Suggested Readings): National Clearing House on Family Violence pamphlets; YWCA Fresh Start; *Courage to Heal Workbook; Secret Survivors; The Emotionally Abused Woman;* and *Codependent No More.*

Referrals

Victims will often need many professionals to help end the violence. They can be referred to women's shelters, police departments, social agencies, lawyers, psychologists and psychiatrists. The family doctor will need to co-ordinate and facilitate these referrals, and give permission for the patient to return for further appointments at his/her office. The physician should make office staff aware of the issues surrounding violence and direct them on how to best handle the situation. Child victims of violence must be reported to the child protection agency.

In some provinces, physicians have a duty to warn the authorities if they have evidence that a violent crime is likely to occur. If the patient is an elderly victim of violence and cannot advocate for him/herself, an alternate decision-maker may need to be appointed.

Treatment Of Long-term Sequelae Of Abuse

1. Male and female victims must be able to appreciate the relationship between a past history of abuse and their physical and psychologic sequelae.
2. The victim must be able to form a therapeutic alliance with the therapist.
3. The victim must be able to keep him/herself safe.
4. The therapist must be able to listen to, show empathy, empower and have a great deal of patience toward the victim.
5. Addictions should be treated before trauma therapy.
6. The victim may choose a safe group therapy.
7. Children should be assessed by and treated by professionals experienced in recognition and treatment of childhood victims.

The physician should make his/her office staff aware of the issues around violence and direct them on how to best handle the situation.

Conflicts Of The Family Doctor

When family doctors treat both partners in a relationship, they should not disclose knowledge of the violence to the perpetrator unless the victim gives permission.[7] The exception to this rule is if a child is at risk of self-harm — the parents may need to be informed if this is the case. The family doctor should never condone violence by a partner, parent or caregiver. The family doctor can refer the perpetrator to a psychiatrist, psychologist or social agency specializing in anger management and violent offenders. Some physicians may find it necessary to terminate the therapeutic alliance with the perpetrator.

Support For Family Doctors

Family doctors need to learn strategies for coping as they treat victims of violence. They need

to continue to get support from peers, specialists and social agencies. They should reach out to a network or coalition of other practitioners involved in treating abuse, such as Doctors Opposing Violence Everywhere (DOVE). The family physician should always be aware of his/her personal safety when confronted with a violent patient, take threats seriously, have a safety plan and get help.

Conclusion

The family doctor can play a pivotal role in stopping violence by routinely screening all patients as often as he/she can. Family doctors may be the first and, possibly, the only people to whom the victim discloses a history of violence. By having pamphlets and prepared safety plans, the patient can be given a great deal of information in a short time in the office.

Family doctors should maintain a high level of vigilance for all patients regardless of age, sex, culture or socioeconomic status. There are both physical and psychologic sequelae of abuse that present to our offices. By recognizing the violence, relating to the patient and referring him/her to appropriate resources in his/her community, family doctors can start the process of stopping the violence and healing long-term sequelae. CME

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References

1. Mathews F: *The Invisible Boy: Revisioning the Victimization of Male Children and Teens.* Health Canada, The National Clearinghouse on Family Violence, Ottawa, 1996, pp. 9-11.
2. Statistics Canada: Family violence in Canada: A statistical profile, 2001. *www.statcan.ca/english/IPS/Data/85-224-XIE.htm*
3. Jamieson W, Beals E, Lalonde R: *A Handbook for Health and Social Service Professional Responding to Abuse During Pregnancy.* Health Canada, The National Clearinghouse on Family Violence, Ottawa, 1999, p. 2.
4. Jaffe P, Sudermann M: *A Handbook for Health and Social Service Providers and Educators on Children Exposed to Woman Abuse/Family Violence.* Health Canada, The National Clearinghouse on Family Violence, Ottawa, 1998, pp. 1-13.
5. Collins A, McDonald L: *Abuse and Neglect of Older Adults: A Discussion Paper.* Health Canada, The National Clearinghouse on Family Violence, Ottawa, 1998, p. 20.
6. Crowder A: *Opening the Door: A Treatment Model for Therapy with Male Survivors of Sexual Abuse.* Health Canada, The National Clearinghouse on Family Violence, Ottawa, 1993, p. 33.
7. Ferris LE, Norton PG, Dunn EV, et al: Guidelines for managing domestic violence when male and female partners are patients of the same physician. JAMA 1997; 278(10):851-7.

Suggested Reading

1. National Clearinghouse on Family Violence. Family Violence Prevention Unit, 7th Floor, Jeanne Mance Bldg., Tunney's Pasture, Ottawa, ON, K1A 1B4. Tel: 1-800-267-1291; Fax: (613)941-893
www.hc-sc.gc.ca/hppb/familyviolence
2. Lefeuvre J and YWCA, Fresh Start. 590 Jarvis St., 5th Floor, Toronto, ON, M4Y 2J4. Tel: 416-962-8881; Fax: 416-962-8084; e-mail: national@ywcacanada.ca
www.ywcacanada.ca
3. Blume ES: *Secret Survivors.* Ballantine Books, New York, 1993.
4. Engel B: *The Emotionally Abused Woman.* Ballantine Books, New York,1992.
5. Beattie M: *Codependent No More.* Hazelden, Minnesota, 1992.
6. Davis L: *Courage to Heal Workbook.* Harper and Row, New York, 1990.
7. Radomsky N: *Lost Voices: Women, Chronic Pain and Abuse.* Haworth Press Inc., New York, 1995.
8. Herman J: *Trauma and Recovery.* Basic Books, New York, 1992.