DOMESTIC VIOLENCE

Position Paper

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INTRODUCTION

As chronicled by the news media, America is a violent society. Less well reported is that "the family is the most violent institution, group, or setting that a typical citizen is likely to encounter (except for the armed services and) .... the typical citizen has a high probability of being violently assaulted only in his or her own home" (1).

The medical literature is beginning to document the incidence and frequency of illness and injury caused by domestic violence (2-8), which is increasingly the physician's concern. A survey conducted by the U.S. Department of Justice found that from 1973 through 1976, 33.8% of 580,000 victims of domestic violence (196,000 persons) received medical attention (9). Although emergency care is sought most often, many victims of domestic violence turn instead to primary care physicians, usually for general health problems stemming from systematic abuse but often not recognized as related to assault or violence. Indeed, "the physician is often the first person outside the (victim's) family she* turns to" (10), underscoring the need for physicians to consider domestic violence as a possible etiology for the patient's presenting problems.

Two of the most arresting facts emerging from studies of domestic violence are that violence begets further violence (1-4, 11-13) and that intervention by physicians can break that cycle (3, 10, 14). In addition to treating individual patients, physicians can play a role in establishing crisis intervention programs within hospitals for victims of domestic violence and preventing violence.

SUMMARY OF POSITIONS

1. Medical illness and physical injury can result from domestic violence. Proper medical intervention can prevent further violence and its consequences. The American College of Physicians urges physicians to become more sensitive to the possibility of domestic violence as a causal factor in illness and injury.

2. The American College of Physicians recommends that hospitals and organized medical staffs develop protocols for the identification and treatment of domestic violence victims.

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* The medical literature on adults discusses primarily wives battered by husbands, thus many of the quotations herein refer to women; but the general conclusions about injuries and behavior seem applicable to husbands abused by wives, as well as other victims of domestic violence.

POSITION

1. Medical illness and physical injury can result from domestic violence. Proper medical intervention can prevent further violence and its consequences. The American College of Physicians urges physicians to become more sensitive to the possibility of domestic violence as a causal factor in illness and injury.

RATIONALE

Discussions of domestic violence often begin with a definition of violence. It is commonly agreed that violence consists of the use of physical force, with the intent (6) or perceived intent (11) of causing pain or injury. Some researchers contend that some forms of violence, notably spanking, are acceptable or legitimate (6). Others argue that all violence is unacceptable because severe injury (e.g., whiplash, broken bones, sciatic nerve damage) can result from such commonly accepted forms of violence as spanking and fights between siblings (11, 15) and because severe injury, even death, often is preceded by lesser violent acts. Indeed, it has been reported that "90% of familial homicides are preceded by at least one major domestic disturbance" (13).

Domestic violence dates back to biblical times; researchers cite the story of Cain and Abel as an example of violence between siblings (11, 12). Parental abuse of children, including infanticide and mutilation, was a legal prerogative from ancient Rome to colonial America (11). Husbands were granted rights to chastise their wives in English common law (6, 11) (The classic "rule of thumb" derives from the common law that sanctioned a husband's striking his wife with a switch, provided the stick was no wider than his thumb). It was only in 1971 that a court in Massachusetts declared that a husband's privilege to beat his wife with a stick, pull her hair, spit in her face, kick her about the floor, or "inflict upon her like indignities is not now acknowledged by our law" (6).

Modern statistics amassed by social scientists illustrate that violence within the family (spouse/spouse, parent/child, child/parent, and sibling/sibling) is epidemic (2). In a landmark study of domestic violence in America, Straus, Gelles, and Steinmetz found that in one of every six intact marriages, one spouse commits at least one act of violence against the other every year (11). Of 695 adult patients entering one emergency department in four months in 1981, 22% identified themselves as domestic violence victims (2). In another study of battered women seen in an emergency department over a ten-week period, the "diagnosis of battered wife was seen more frequently than appendicitis, diverticulitis, corneal abrasion, dislocation of major joint, or rape among the same population" (4). Parental abuse of children has been reported as 500 new cases per million population per year (16). Homicide is one of the five leading causes of death for children aged 1 to 18 in the United States, and 29% of child homicides are committed by parents or stepparents (17). Siblings attacking one another with weapons has been reported as 138,000 cases per year (11).

Family violence varies in frequency and intensity, occurring from once in a lifetime to several times daily and with force to bruise or to break bones, cause permanent brain damage, or kill. In 1965, 31% of all murders in the United States were perpetrated in the home, with over 50% of these committed by one spouse upon the other (6). There are a reported 3,000 marital homicides and 2,000 filicides each year in this country (16). In the mid-1960s, it was reported that more police fatalities (22%) result when police answered family disturbance calls than for any other single type of call (18). Although different studies report different occurrence rates, most agree there is a need for more studies, particularly about the abuse of elderly parents by grown children (an area in which the professional literature is lacking in documentation), and that the "actual occurrence rate probably far exceeds the reported cases" (7).

There also is general agreement that violence in the family crosses all major demographic and socioeconomic factors. Although there are characteristics found to be prevalent in the background of abusers -- such as alcohol abuse (7) and exposure to violence in the home as children (16) -- no demographic factor, including age, education, race, sex, or socioeconomic status, can serve as a predictive index for families at risk.

A patient's presenting complaints and behavior may, however, provide clues that domestic violence is the cause of the injuries or illness. Victims of domestic physical abuse generally present to medical facilities with vague complaints, traumatic injuries, or trouble with children (8). In fact, Goodstein and Page advise that violence is to be considered "in cases of women patients who come in for treatment with strong themes of separation anxiety from the conjugal partner or in women who have the triad of trauma, depression, and problems with children" (7). Victims rarely offer the source of their injury or anxiety (13). In one study of 100 battered women, 70% were taking antidepressants or tranquilizers prescribed by their physicians; none of the physicians had discovered the source of the emotional distress (5). Presenting injuries most commonly include bruises, contusions, and lacerations, especially to the head, neck, chest, abdomen, and upper extremities, and broken bones (3, 7, 10, 13, 19). In one study, all the victims had bruising, 44% associated with lacerations; 24% exhibited fractures of nose, teeth, or ribs; 8% suffered other fractures; 19% were victims of strangulation attempts; and 11% had been burned (5). Another study, of 37 women treated in an emergency department, reported 62% had contusions and soft tissue injuries, 19% had received traumas that resulted in serious injury to the head (e.g., fractured mandible, perforated tympanic membrane), and 5% had lacerations requiring sutures (3). Further, abuse should be suspected if there are repeat or chronic injuries or -- what may be seen most commonly in office practice -- considerable delay between time of injury and presentation for treatment, particularly when familiar excuses (e.g., "I walked into a door") are offered as explanations or if the patient is accompanied by a spouse who appears eager to explain the injury (4, 7, 13, 20). A typical presentation can be a clue to domestic violence: Milligan and Anderson report two cases of stroke

with absence of usual etiologic factors (oral contraceptives, hypertension, blood dyscrasias, diabetes, hyperlipidemia, and heart disease) that occurred one and three days after strangulation attempts by the spouses (21). Finally, Goldberg and Tomlanovich found that "domestic violence victims requested pain medication more often than any service," and they suggest that "medically ill patients' complaints of 'pain' should be explored as a screening device for domestic violence (2)."

When violence is suspected, a skeletal survey by x-ray and a full history of the injury are needed (20). The physician should ask the patient if domestic violence is a possible cause of the injury. Professionals treating abuse victims advise that victims often are relieved that someone else has taken the initiative to raise the subject (22); the relief has been compared to that expressed by some depressed patients when questioned about suicide (19, 23).

Psychiatric studies have shown that battered women are reluctant to seek help from mental health professionals (3, 7). This may be because they lack the social sophistication to contact the appropriate social service agency (4, 8, 24) or because they are denying the seriousness of their situation (2). In any event, intervention by outsiders, particularly medical personnel, has been found to be a major factor differentiating those victims who seek help -- immediate and practical aid, such as shelter, as well as psychiatric and other professional assistance -- from those who do not (3, 7). In fact, professional intervention may instigate further intervention. Other factors that may be significant in determining whether a victim seeks help after medical intervention include 1) the amount and frequency of violence, 2) the experience with violence in the family of orientation, and 3) the degree to which the victim feels trapped, through fear or economics, in the home (25). Physician identification of a family suffering domestic violence can help stem escalated violence against the known victim and prevent violence against other family members (2). Physicians, once they have confirmed suspicions of domestic violence, must ask about other family members to determine if they are victims also.

In questioning the patient, gentle, tactful probing is required. Most victims of domestic violence feel guilty and unable to judge character; they must, therefore, be reassured. It is never appropriate to imply fault ("I would never let my spouse beat me."), impugn judgment ("Why don't you leave?"), or blame the victim ("You must be getting something out of being beaten.") (26). After treatment of the consequences of the violence and identification of domestic violence, the next medical response is practical advice and referral to shelters and to psychiatric care, if necessary. Physicians should recognize that their advice may not be accepted immediately; the patient may not go directly from the doctor's office to a shelter but may return to the home. Pressure to leave the partner can be threatening (7). This should not discourage the physician from offering support and encouragement, which can be crucial.

Many victims have limited financial resources, fear (justifiably) retaliation by their abusers, are depressed, deny their plight as a defense mechanism, and underestimate their strengths and options. But with continued support, domestic violence victims can gain a truer picture of their situation, learn to plan ahead, and, at the appropriate time, leave their homes to seek shelter and, if necessary, psychiatric and legal aid.

As recognition has grown of the magnitude of domestic violence in the United States and of the benefits of medical identification and intervention, some legislative attempts have been considered to mandate a certain type of physician intervention. This is particularly true for child abuse. Most states have enacted laws that mandate physicians who suspect child abuse to notify the appropriate governmental agency; immunity from liability and confidentiality usually are guaranteed (27). Similar laws have not been enacted for spouse or sibling abuse, although there is some support for mandatory reporting of suspected abuse of the elderly. Proponents contend that mandatory reporting saves lives by immediately breaking a spiraling cycle of violence. Opponents argue that reporting of mere suspicion is not always appropriate, that more personal intervention -- such as that discussed above, offered by a personal physician -- is more helpful when the suspicion is confirmed, and that intervention needs to be more tactful, personalized, and consistent than can be guaranteed by governmental agencies. Reporting known cases of abuse is an option open to physicians and one that should be employed if they believe imminent danger demands it.

POSITION

2. The American College of Physicians recommends that hospitals and organized medical staffs develop protocols for the identification and treatment of domestic violence victims.

RATIONALE

Much of the medical literature on domestic violence is contained in studies conducted in emergency departments, focusing on ways to identify victims and on crisis intervention that can be effected there (2, 3, 4, 7, 8, 10, 20). While there are no data to indicate the percentages of victims treated in emergency departments compared with those who delay emergency treatment and present to primary care physicians, it is logical to believe that many of the most severe injuries are brought to hospital emergency departments. Goldberg and Tomlanovich, after studying 492 patients from a general hospital emergency department, concluded that crisis intervention plans need to be established in emergency departments (2). They suggest that such protocols include identification of victims, thorough history taking of the abuse pattern, assessment of the patient's view of the domestic relationship, exploration of treatment options, and documentation of the process. Rosenberg, Stark, and Evan advise that such protocols be adopted also by all primary care clinics and general medical sites (28). Identification of domestic violence victims is

crucial. Stark et al. report "when health care personnel used only current diagnostic categories and failed to take an explicit 'trauma history,' they accurately identified fewer than 1 abusive episode in 25 and failed to identify any of the psychosocial sequelae of abuse as dimensions of battering" (28).

Domestic violence units within hospitals could serve as valuable resources for the physicians practicing at those hospitals. Their identification of domestic violence victims could be aided by staff from such units, who also could advise on appropriate medical intervention and on referrals to shelters and other forms of aid.

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