Domestic Violence

"Cheek the Objectives in the lecture"

Definitions:

Intimate partner violence:

Behavior by an intimating partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors.

Domestic violence :

All behaviors/actions within the family result in mental or physical injury (or death) to another member of the family.

Terminology:

It's better to use the term "**survivor**" than "victim" when speaking about DV cases.

'**Victim'** implies passivity while women are actually active in trying to defend themselves and their children and seeking ways to survive.

Who is reporting DV in KSA? "Numbers are not important"

Parents are the most common, hospitals about 5 %.

Common forms of DV in KSA? "Ranked from most to least common"

1-Psychological/emotional abuse "commonest"

2-Social abuse

3-Financial abuse

4-Physical abuse

5-Sexual abuse

6- Neglect "in children"

Risk factors of DV in KSA? "Ranked from most to least common"

1-Drug & alcohol abuse. "Commonest"

2-Unemployment.

3-Low educational level.

4-Low income.

5-Child living with one parent + step parent.

6-Child living with one parent.

7-Father married to >1 wife.

8-Crowded house.

9-Suspicion on wife's fidelity.

10-Conflicts (financial…etc)

11-Violent & explicit content in the media.

11-Culture (male predominance).

13. History of abuse during childhood. 14-Psychiatric illness.

Which family members are vulnerable the most to DV in KSA?

"Ranked from most to least common"

1-Daughters 2-Sons 3-The Mother 4-Husband's mother

5-Elderly in the family 6-Wife's mother 7-The Father 8-Husband's siblings

9- Wife's siblings.

Who is committing the DV in KSA? "Ranked from most to least common"

1-The father/husband 2-Brothers 3-Father's wife 4-Mother's husband

5-The mother/wife 6-Other relatives 7-Daughters

Prevalence of IPV in PCC in KSA, USA & Globally:

IPV is underreported, the prevalence is different among studies and this is due to **different methodologies, populations, sampling technique and sample size**.

"Numbers are not important"

To whom did victims of DV report in KSA?

To their: families, husband's families and friends.

To the police or the judge.

To a family physician or women protection agency.

Reaction of women after DV in KSA? "Ranked from most to least common"

1-Seeking separation or divorce 2-Doing nothing

3-Visit a doctor 4-Did not visit a doctor while needed

5-Left home 6-Contact human rights

7-Call police 8-Other action..

Consequences of DV:

1-Medical problems "commonest" Ex: Chronic pain، fatigue.

2-Psychiatric problems "2ed commonest"

EX: depression, anxiety disorders, antidepressant use, suicidal behavior.

3-Gynecologic & obstetric problems EX: abortion, per vaginal bleeding.

4-Physical injuries EX: contusions, fractures, scars

Physical and sexual assault are associated with:

Poor self-esteem, alcohol and drug abuse, eating disorders, obesity, depression

teen pregnancy, anxiety, Suicidality , risky sexual behaviors..

In KSA?

Violence exacerbated medical problems "commonest"

Violence needed treatment

Violence needed admission "the least common"

Female victims of DV:

More likely to seek health services.

Have poor overall physical and mental health.

Unfortunately their health needs **are not addressed sufficiently** by current health and social service systems.

Why DV is missed?

Women may not disclose abuse to doctors:

Especially if they are males.

Thinking that is not part of physicians job!.

Physicians may:

Lack knowledge, expertise, training, resources, and time.

Physician feels powerless to offer a solution.

Physician Fear of offending the woman and of opening her wound.

Others: Negative cultural & social attitudes.

Institutional constraints.

Signs and symptoms suggestive of abuse: "see the pictures in the lecture"

Injuries that point to a defensive position over the face "bruises and marks on the inside of the forearms, back".

Injuries to the chest and stomach, reproductive organs, and anus.

The illness or injuries **do not match** the cause given.

Delay in requesting medical care.

Injuries and bruises of **various colors**, indicating injuries occurring regularly over a period of time.

Repeat injuries, someone who is 'accident prone'.

Injuries during pregnancy.

Repeated reproductive health problems: repeat miscarriage, early delivery, sexually transmitted diseases.

Behavioral signs: multiple visits, lack of commitment to appointments, not displaying emotion, crying easily, or poor eye contact.

The hand is the most common 'weapon' of DV.

Injuries that are associated with FALL"non-violence" would include contusions and abrasions to the bony surfaces of the body "see the pictures"

Partner's behavior:

Extreme and irrational jealousy or possessiveness.

Attempts to control time spent with the healthcare providers.

Speaking on behalf of the patient.

Insisting on staying close to the patient, who hesitates to speak before the partner.

Family physician role in DV:

Identify DV.

Assess the patient and her family level of safety.

Provide ongoing medical care & **non-judgmental** support"لاتقول مثلاً: ايه تستاهلين الضرب"

Ensuring privacy and confidentiality.

It is advisable **not** to discuss DV when **children or the partner are present.**

Counseling about the nature and course of DV.

Educating the patient about the range of available support services.

Documenting findings.

Refer for further management or assistance.

Prevent further incidents of abuse.

What should the physician be equipped with?

Proper knowledge.

Communication skills.

Awareness of the resources available in the community.

Screening tools for IPV:

1-HITS (Hurt, Insult, Threaten, Scream): How often QS!

How often does your partner physically **hurt** you?

How often does your partner **insult** or talk down to you?

How often does your partner **threaten** you with physical harm?

How often does your partner **scream** at you?

Scoring: never = 1 point, rarely = 2 points, sometimes = 3 points, fairly often = 4 points, frequently = 5 points. ***A score of greater than 10 points is a positive screen.***

2-WAST (Woman Abuse Screening Tool):

In general, how would you describe your relationship? No tension, some tension, a lot of tension?

Does your partner ever abuse you physically? Sexually? Emotionally?

..etc

The physician performs scoring subjectively, using clinical judgment.

How to address DV during the consultation?

Women are ready to talk about abuse when asked.

Use introductory statements: 'violence is so common around here, that we started asking everyone about it'

Then an **A funneling technique**:

1-moving from the **broad less-threatening questions**: **EX 'married couples may disagree, how do you resolve conflicts at home?'**

2-to asking about specific behaviors '**are you being hit'**

Ask in **a non-judgmental** way:

EX avoid asking "what have you done for him to hit you?"

Avoid use of emotionally charged words like '**violence' or 'abuse'.**

Observe the patient's **non-verbal cues**.

Don't pressure her to leave the relationship.

What if she discloses abuse?

The initial response is to show **Empathy**: **'I am sorry this is happening to you'**.

Acknowledge the difficulty to share the information: '**this must be hard on you to talk about it'.**

Express validation while alleviating guilt: **'no one deserves to be hit or treated badly; it is not your fault'.**

Offer help and assurance of continuous assistance in the future: '**you are not alone in this, we can help you take care of your health and support you while going through this problem'.**

Ask **open-ended** questions to assess the safety of the patient.

Violence tends also to escalate during life changes like pregnancy, separation, divorce or unemployment.

If any of the **danger indicators are present**, the physician should discuss a safety plan with the survivor, even when survivors deny danger.

The indicators of Danger/red flags:

History of threats of murder or suicide ideation.

Attempts of suicide or homicide.

Increased severity or frequency of the perpetrator's fits of anger.

Use of weapons or tools in the assault or an attempted strangulation.

Alcohol or substance abuse.

If the survivor acknowledges a fear for life.

Safety Plan:

Calling Police, or (Ministry of Labor & Social Development) MLSD hotline.

Hiding money, a bag with extra clothes, having important documents in a safe place outside the home in the event of an urgent escape.

Agreeing on a safe place to escape to **(relatives, neighbors)**, **ask**: 'If you decided to leave, where you could go?'

A signal to alert neighbors to request their help.

When the perpetrator is around, stay away from rooms with weapons, such as the kitchen, or with hard surfaces, such as a bathroom.

The safety plan is to **be revisited on later visits and modified** according to situation.

Counseling:

Improves the patient's **self-esteem and self-worth** and assists the decision-making process.

Providers are not supposed to encourage survivors to leave the relationship.

Counseling of couples is **to be avoided** when active violence, intimidation, fear, or control is present in the relationship.

Physicians **should resist** the repeated demands from the survivor to confront the perpetrator as this may endanger the patient and the physician.

Why Survivors don't leave the Abuser?

Believe that the abuse will stop one day.

Believe they deserve it.

Fear of losing contact with children.

Financial dependence.

Lack of an alternative place to go to and social pressure.

The physician has to make sure that his feelings and past experiences doesn't interfere with his judgment in DV cases.

Documentation:

The **occurrence, nature, and time** of abuse and the perpetrator identity when possible.

Findings from the **physical examination** with an accurate recording of injuries: nature, shape, and color.

If possible, photographs of any physical injuries may be obtained if the patient permits.

The photographs must include the patient's face or identifying features with the injury to be useful as evidence.

If a camera is not available, the physician should make a sketch of the injuries or use body maps to record injuries.

The **laboratory or radiological** studies ordered, the **medications** prescribed, and the **referral** when done.

Comments on comorbidities; pregnancy, if present; and **degree of disability**.

Follow up: Check for barriers to access and discuss solutions

What if she denied violence?

You should **respect the patient's decision** not to disclose violence **even when there is clinical suspicion** of its presence.

It is better to **acknowledge the relation of the complaints to violence**: '**sometimes patients having symptoms like yours turn out to be abused'.**

Express readiness to discuss DV in future visits whenever the patient wishes

Providing education about the impact of violence

Providing a list of resources and organizations offering support to abused women.

A close follow-up visit is warranted

Multidisciplinary Approach:

Physicians social workers Psychologists/psychiatrists.
Community resources (police, MLSD).

Child Abuse in USA: Is the 3rd leading cause of death in children between 1 and 4 years of age, the risk increased in children with disability.

When a sexually transmitted infection (STI) is detected in a child, evaluation for sexual abuse is **mandatory**.

Child Abuse history:

Physicians must evaluate the consistency of a caregiver's history with other findings from the history or physical examination.

Pregnancy history, including **whether the pregnancy was planned or unplanned**.

What suggest intentional trauma in History?

No explanation or vague explanation for a significant injury.

Significant delay in seeking medical attention.

An important detail of the history changes dramatically over time.

Explanation is inconsistent with the pattern, age, or severity of the injury.

History does not explain the injuries identified.

Explanation is inconsistent with the child's physical or developmental capabilities.

Different witnesses provide markedly different explanations for the injury

Physical Examination for suspected Child Abuse:

Low weight might be suggestive of neglect.

Bruises on the torso, ear, or neck (TEN) in a child **four** years or younger.

Bruises of any region in a child younger than **four** months.

Bruises at **different stages** of resolution.

Burn injuries.

Palpation for tenderness, especially of the **neck, torso, and extremities.**

Sometimes in child abuse cases, you need to admit the child to provide a safe place for the child.

Finally: "phone numbers: 1919 center of communication, 116111 child helpline"

You have to take A CONSET FORM from the patient for reporting

Thank U

Done by:

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