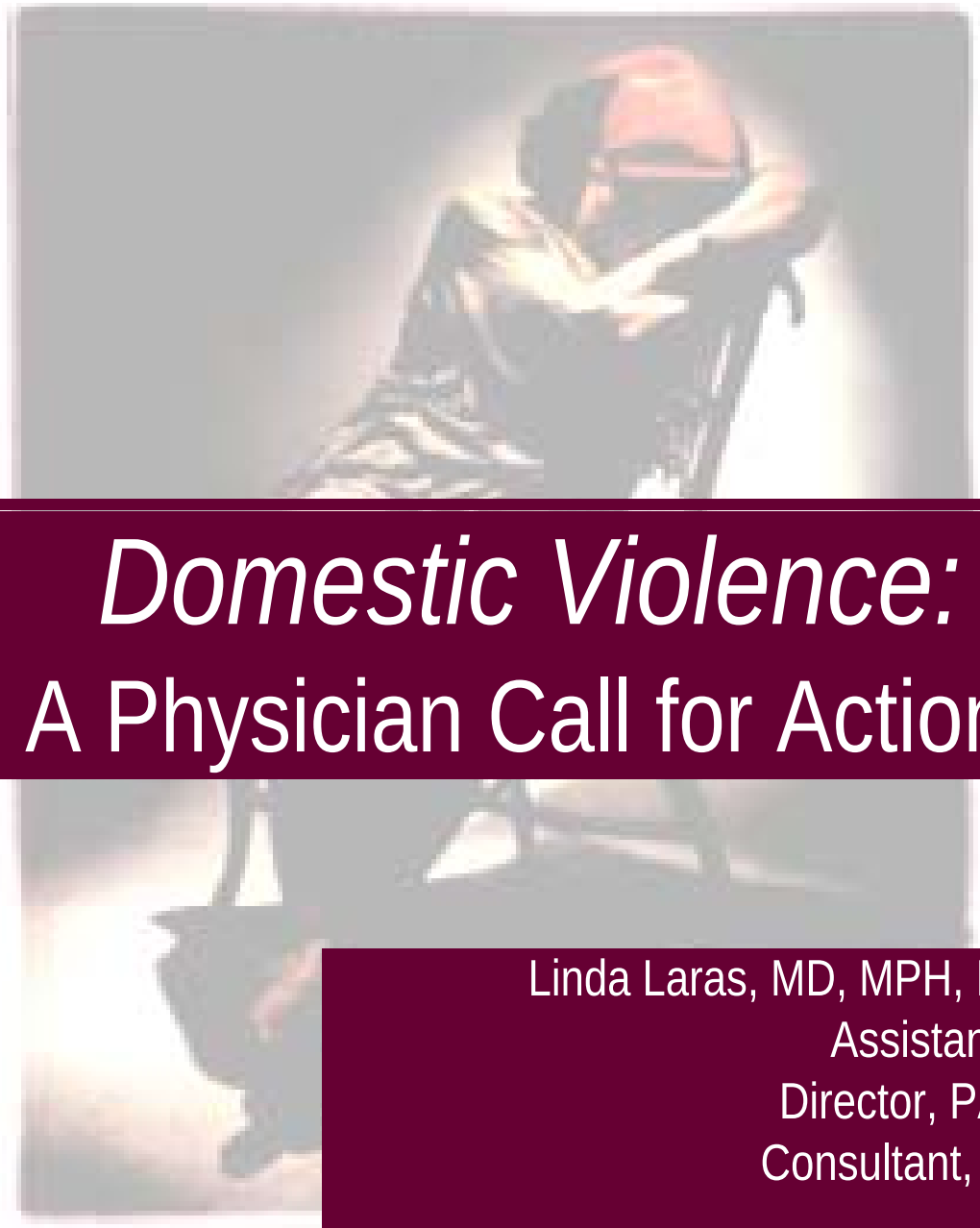


Domestic Violence:
A Physician Call for Action!

Linda Laras, MD, MPH, MScr, FACOG, SAFE
Assistant Professor, OB GYN
Director, PASOS de las Mujeres
Consultant, Forensic Gynecology
787-758-2525, x2814

Degolló a su mujer y se adentró en el monte

Por Miguel Rivera Puig

El Vocero

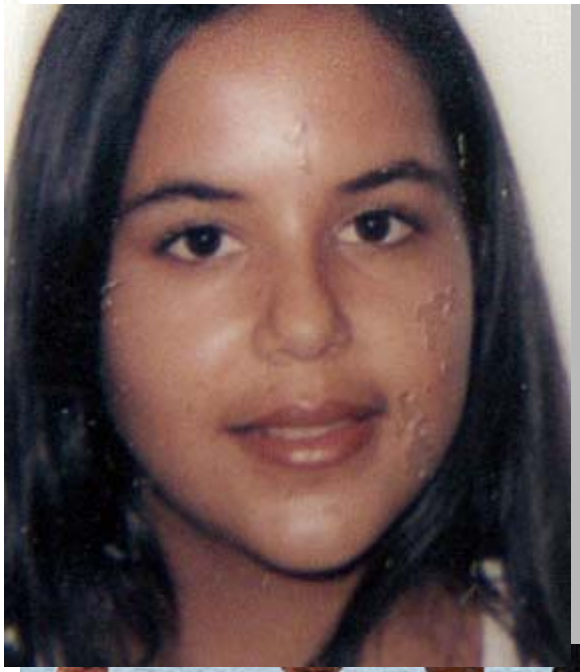
13 de mayo de 2009 11:00 am

Búsque ayuda y denuncie al agresor

Por (AP)

12 de mayo de 2009 04:00 am

Sola, muerta y con su rostro cubierto por cinta adhesiva



Esposo de mujer asesinada ayer en Aguadilla no ha sido arrestado

jueves, 7 de mayo de 2009

Actualizado hace 6 días (11:55 a.m.)

Maelo Vargas Saavedra / Primera Hora

Encuentran cadáver de mujer en Aguadilla

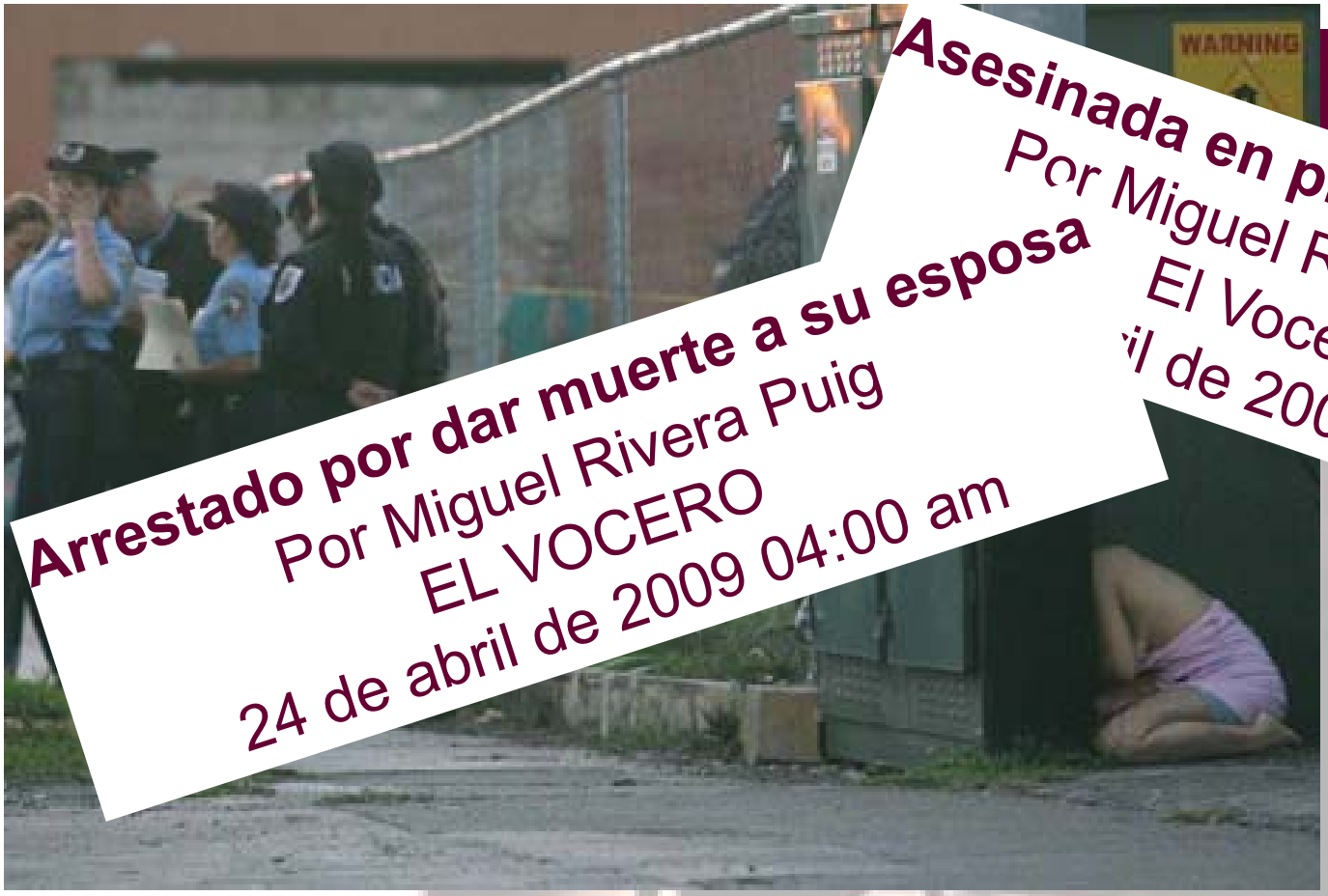
Por (AP)

06 de mayo de 2009 04:00 pm

Mujer apuñalada en hecho de violencia doméstica

Por (AP)

06 de mayo de 2009 10:00 am



Arrestado por dar muerte a su esposa
Por Miguel Rivera Puig
EL VOCERO
24 de abril de 2009 04:00 am

Asesinada en plena vía pública
Por Miguel Rivera Puig
El Vocero
il de 2009 04:00 am

Asesinada sin piedad a balazos por su compañero

miércoles, 22 de abril de 2009
(11:30 p.m.)
Maribel Hernández / Primera Hora

Hallan mujer degollada en Ponce

Por Tomás de Jesús Mangual

El Vocero

18 de abril de 2009 04:00 am

A la cárcel anciano por agredir a esposa con arma blanca

Por (AP)

24 de marzo de 2009 06:00 pm

Hallan cadáver de mujer en Ceiba

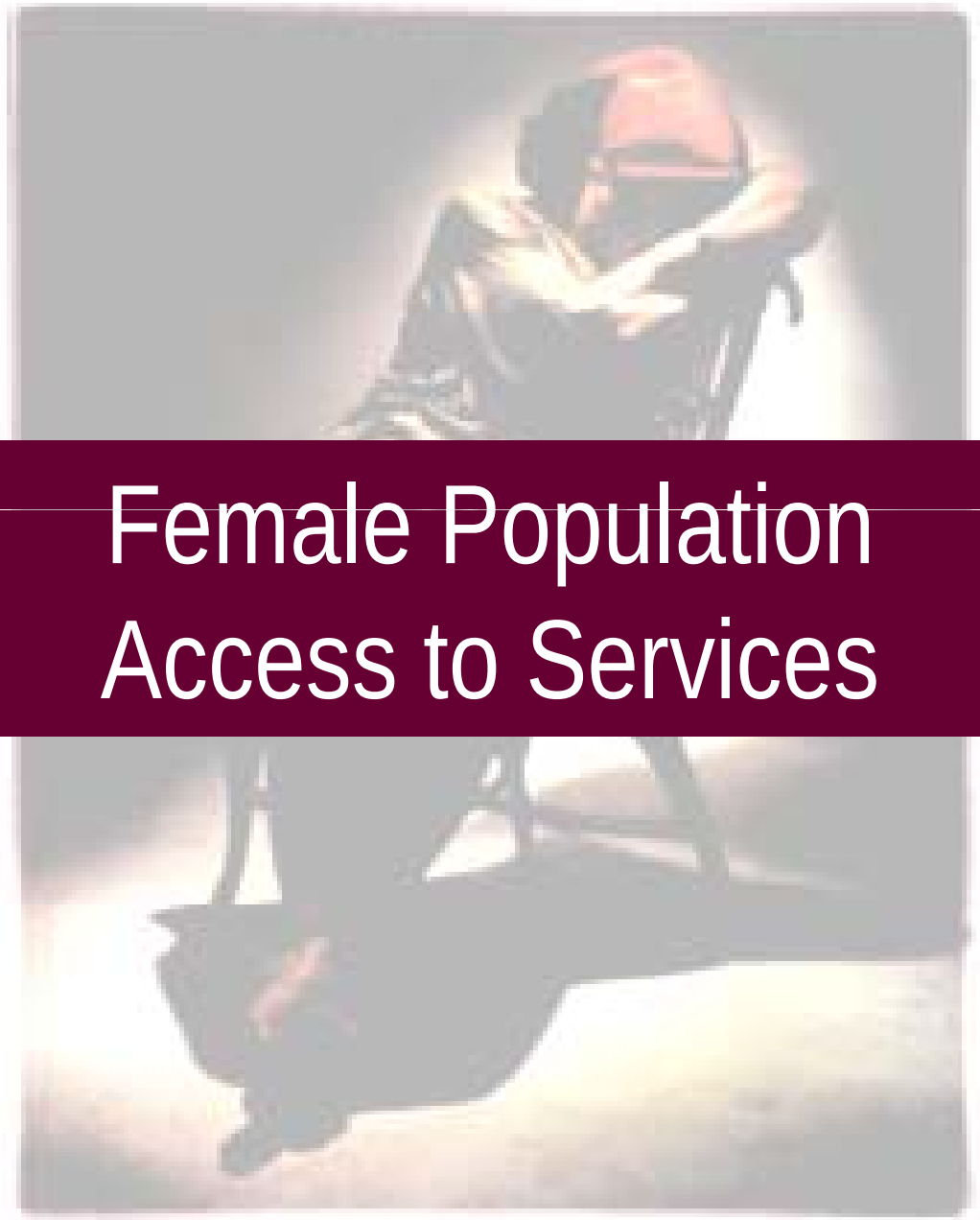
miércoles, 13 de mayo de 2009

Actualizado hace 1 horas (08:11 p.m.)

Prensa Asociada

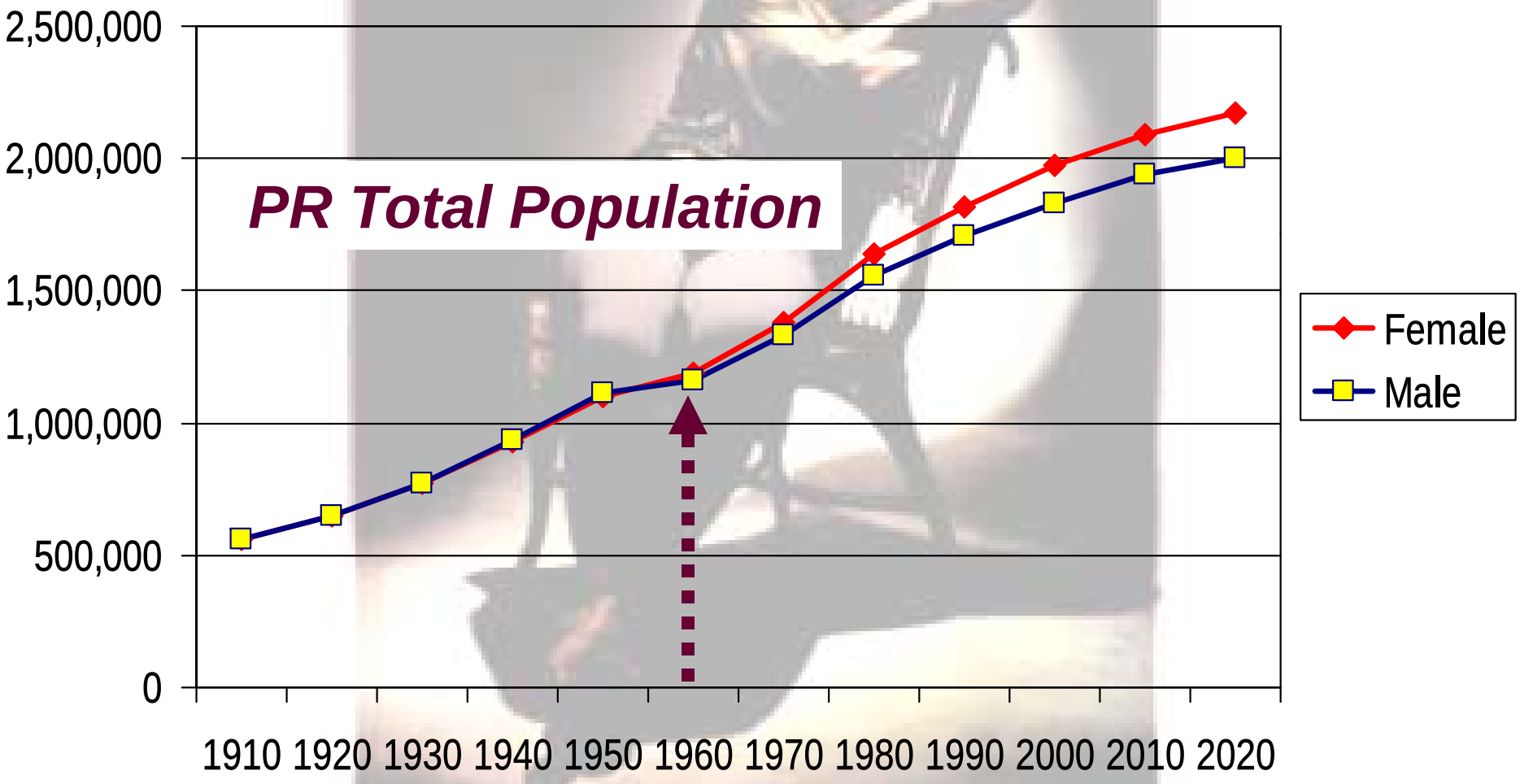
Most Frequent Victims of Domestic Violence

Women and Children



Female Population Access to Services

Magnitude of the problem



Magnitude of the problem

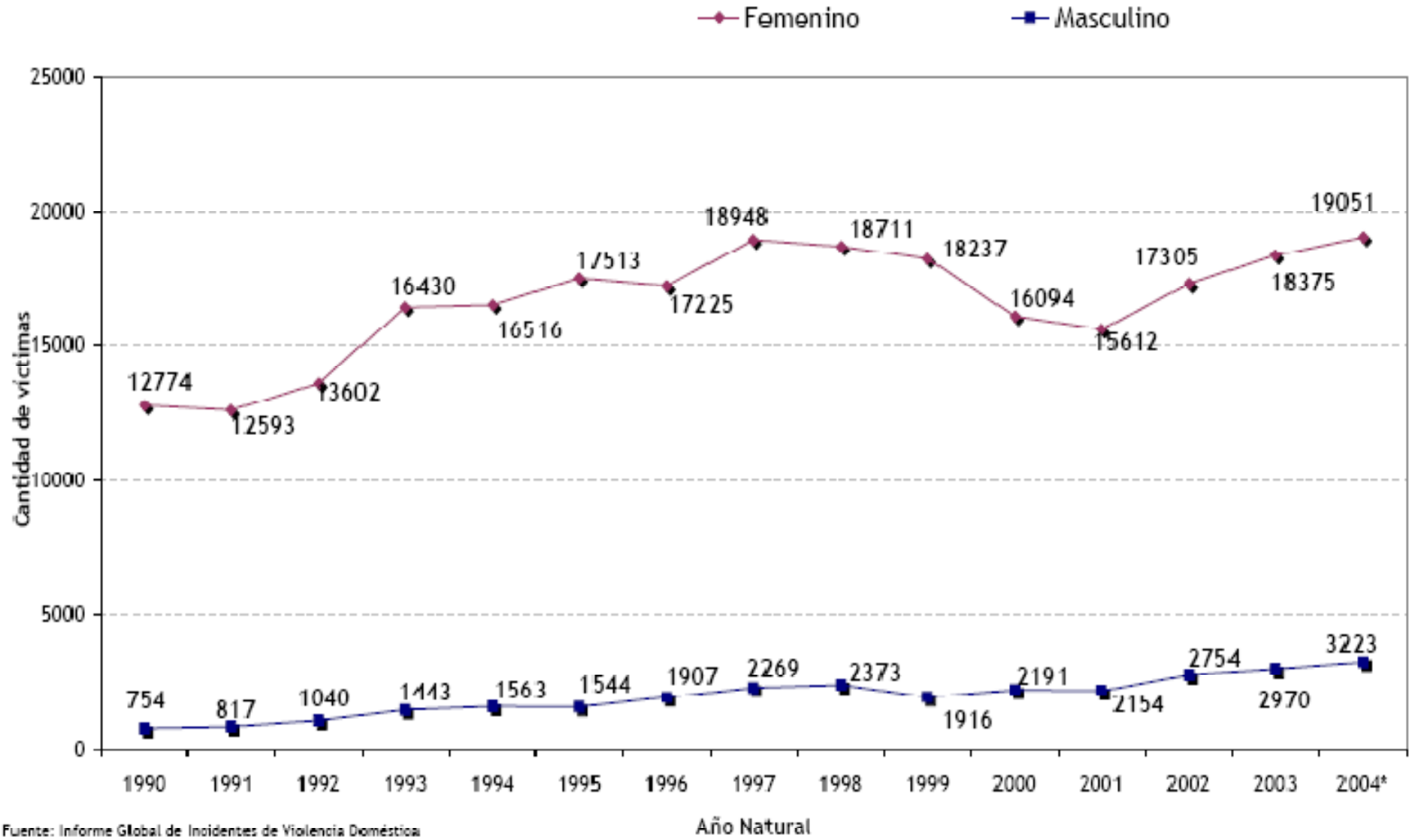
- In Puerto Rico (Census 2000)
  - 52% of the total population: FEMALE
  - 62,968 homes in PR are in charge by women alone
    - 6,841 are in charge by men alone
- Life expectancy at birth:
  - Women: 80 y/o
  - Men: 72 y/o

Domestic Violence Occurence

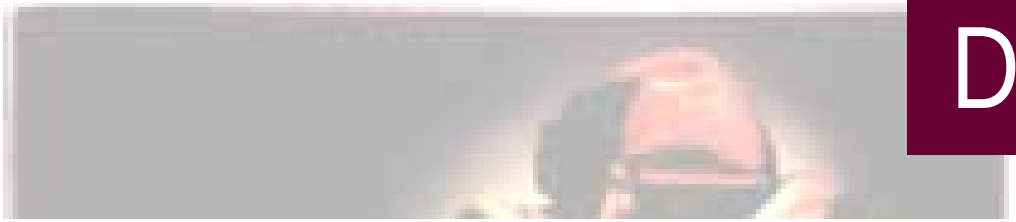
Magnitude of the problem

PR Rate of incidence of domestic violence			
	Rate per every 100,000 inhabitants	Total incidents	Population
2005	588.7	22,718	3,858,806
2000	479.7	18,271	3,808,610
1990	384.1	13,528	3,522,037

Víctimas de Violencia Doméstica, desglosados por sexo: Puerto Rico 1990-2004*

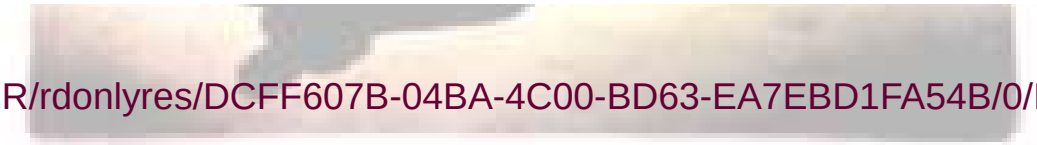


Fuente: Informe Global de Incidentes de Violencia Doméstica
Policía de Puerto Rico, División de Estadísticas
*Informe preliminar



Definition

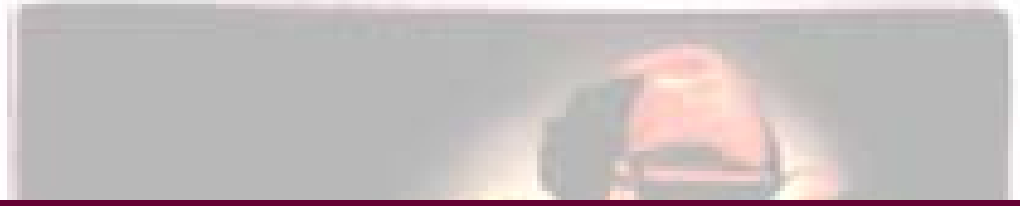
Violencia doméstica – Patrón de conducta constante de empleo de fuerza física o violencia psicológica, intimidación o persecución contra una persona por parte de su cónyuge, ex cónyuge, una persona con quien cohabita o haya cohabitado, una persona con quien sostiene o haya sostenido una relación consensual, o una persona con quien haya procreado una hija o un hijo, para causarle daño físico a su persona, a sus bienes o a la persona de otro, o para causarle grave daño emocional.



http://www.gobierno.pr/NR/rdonlyres/DCFF607B-04BA-4C00-BD63-EA7EBD1FA54B/0/PROTOCOLODEVD.pdf

OPM

http://www.gobierno.pr/mujeres

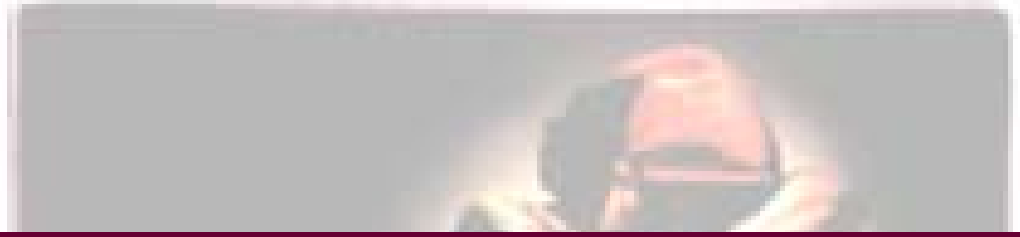


Myths

- Myth 1: Family Violence is Not Very Common
  - Much more common than ever realized.
  - Straus and Gelles in 1986:
    - 28% of American couples experience at least one act of violence during their marriages,
    - 16% experience at least one act of violence per year,
    - 5% experience severe violence in any given year.
- Myth 2: Only Poor People Are Violent
  - “Blue-collar" husbands more violent (13.4%) than "white-collar" husbands (10.4%)
  - Poor people who lack other support or resources are much more likely to turn to police or social agencies more often than families who have money.

Myths

- Myth 3: Battered Women "Ask For It"
  - Blaming the victims for not "just leaving", lead to conclusions such as they must really enjoy being beaten, are nags, or drunks, or are mentally ill, therefore they, and not the batterers are at fault.
  - Attention needs to focus not on why they stay but why "he abuses".
- Myth 4: Alcohol and Drugs Are the Real Cause of Family Violence
  - Alcohol or drug abuse figure in a majority of violent incidents, it cannot be said to be the cause of the abuse.
  - Many abusers batter their partners whether drunk or sober. Many batterers never use alcohol or drugs.
  - Being drunk or stoned often serves as an excuse for the behavior and another way to deny personal responsibility for battering.



Myths

- Myth 5: Violence and Love Cannot Coexist
  - The average battering relationship lasts about 6 years, the same length of time as the average marriage.
  - Physical violence does not preclude the presence of love and intimacy, nor does it spell the end of the relationship.
  - Many victims call police to make the violence stop, not to end the relationship.
  - Children learn very young, that the people who love them, may also hit them.

The Many Faces of Violence Against Women

Physical

Psychological

Sexual

Social / Economical

VAW is about…power and control.

…Leaving

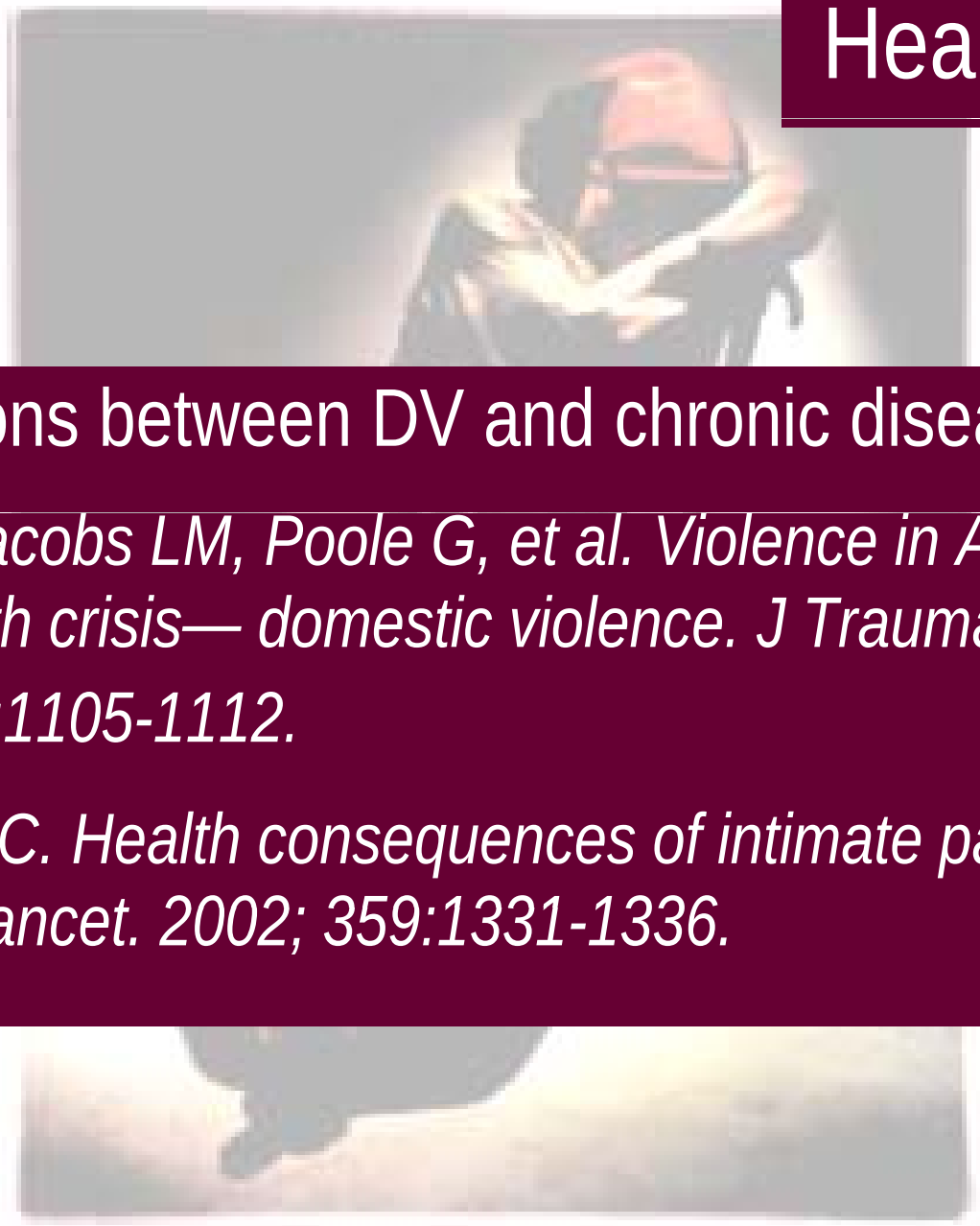
- Leaving increases the risk of being murdered
- Child custody issues
- Economic status drops precipitously
- Family pressures
- Church pressures

Numbers

- 2005 DV as a causal of murder:
  - 30%: women
  - 1%: men
- Most common cause of injury to women aged 15 to 44 years.
  - American College of Emergency Physicians

- Definitions:
  - Domestic Violence
  - Partner Abuse
  - Intimate Partner Violence (IPV): CDC

Health Impact

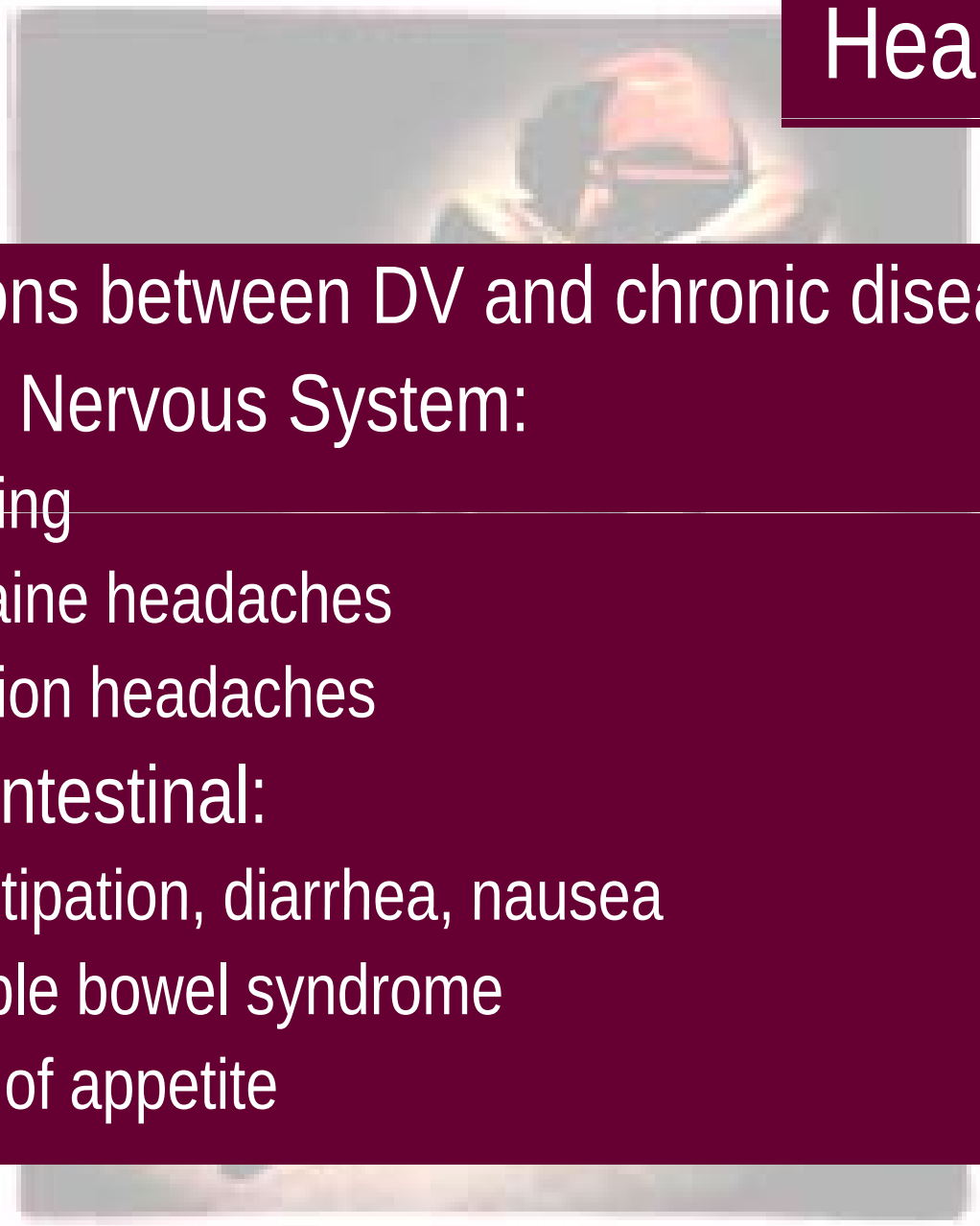


- Associations between DV and chronic diseases:

  Sisley A, Jacobs LM, Poole G, et al. Violence in America: a public health crisis— domestic violence. J Trauma. 1999;46(6):1105-1112.

  Campbell JC. Health consequences of intimate partner violence. Lancet. 2002; 359:1331-1336.

Health Impact

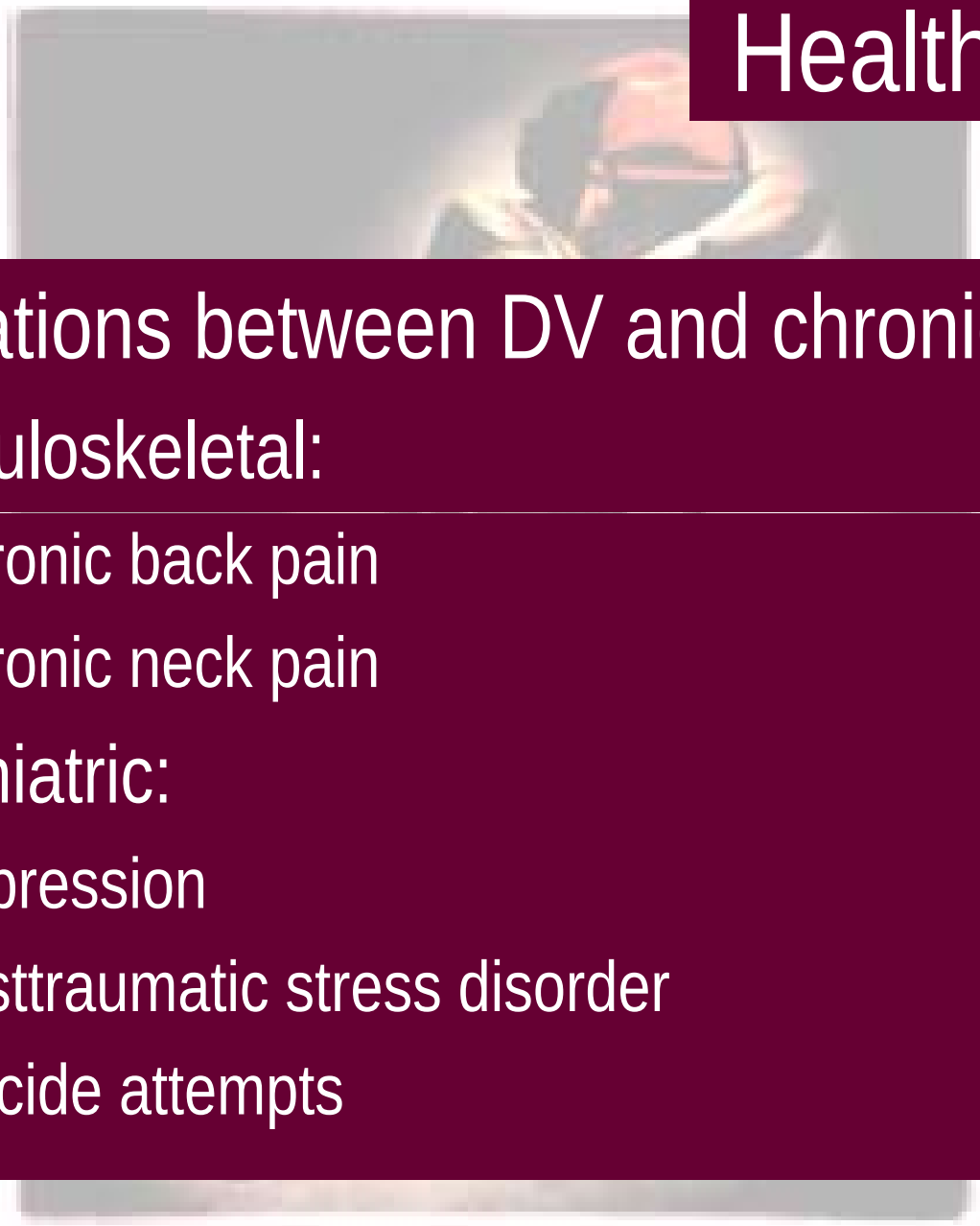


- Associations between DV and chronic diseases:
  - Central Nervous System:
    - Fainting
    - Migraine headaches
    - Tension headaches
  - Gastrointestinal:
    - Constipation, diarrhea, nausea
    - Irritable bowel syndrome
    - Loss of appetite

Health Impact

- Associations between DV and chronic diseases:
  - Gynecologic:
    - Chronic pelvic pain
    - Dyspareunia
    - Pregnancy-related violence
    - Sexual dysfunction
    - Urinary tract infections
    - Vaginal bleeding
    - Vaginal infections and sexually transmitted diseases

Health Impact



- Associations between DV and chronic diseases:
  - Musculoskeletal:
    - Chronic back pain
    - Chronic neck pain
  - Psychiatric:
    - Depression
    - Posttraumatic stress disorder
    - Suicide attempts

Health Impact

- Associations between DV and chronic diseases:
  - Risky Health Behavior:
    - Alcohol abuse
    - Cigarette smoking
    - Drug abuse
  - May result in a potential increase in HIV infection rates.

Health Impact

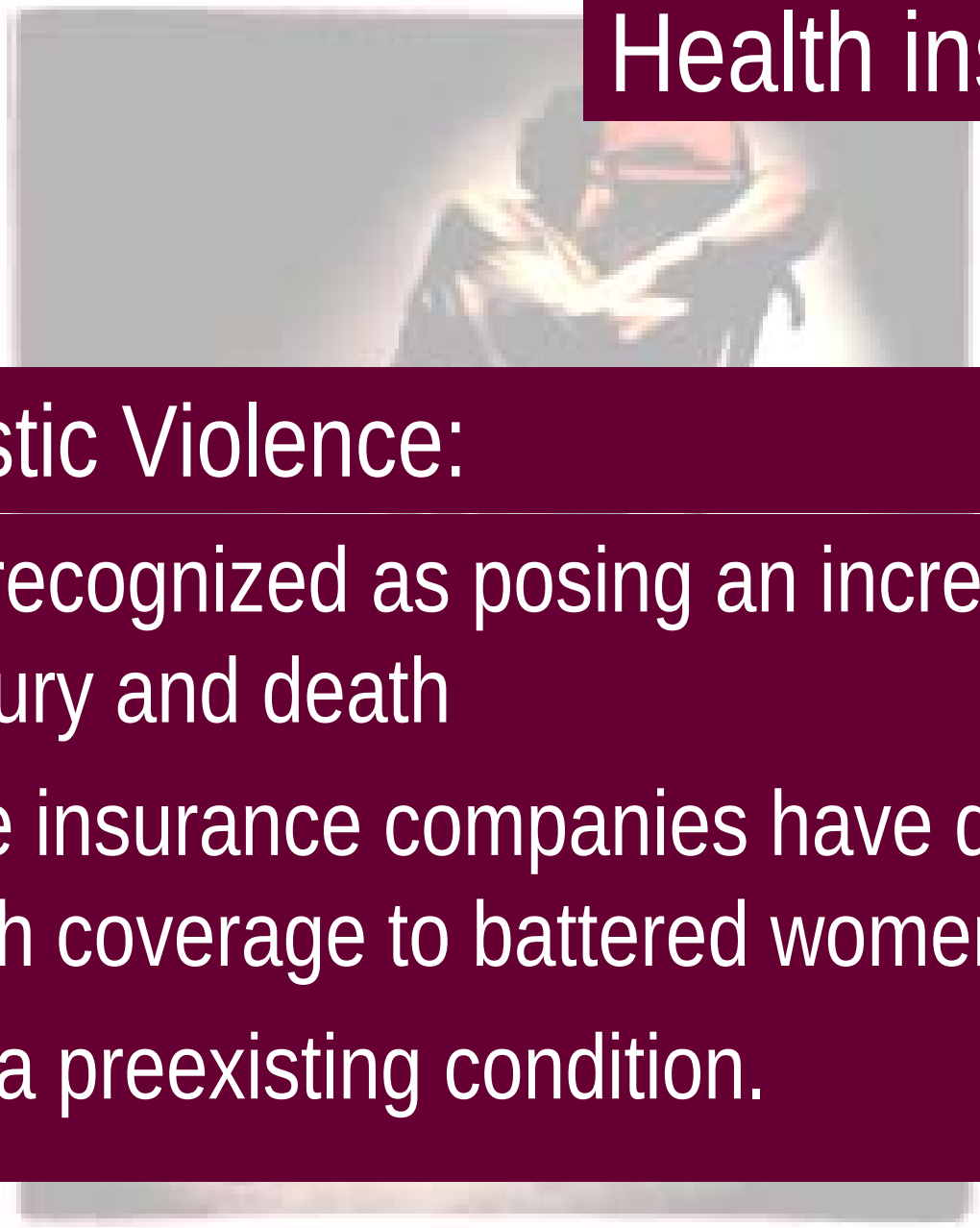
- Research shows that women who are abused:
  - are less likely to engage in important preventive health care behaviors such as regular mammography
  - are more likely to participate in injurious health behaviors including smoking, alcohol abuse, and substance abuse.
- Significantly increases the risk for serious mental health consequences:
  - Depression
  - Traumatic and posttraumatic stress disorder
  - Anxiety
  - Suicidal ideation.
- Health consequences of abuse can continue for years after the abuse has ended.
- IPV can also result in homicide

Health Effects of Intimate Partner Violence

- Results in physical injuries:
  - 23% of cases
    - Abbott, Jean MD, “Injuries and Illnesses of Domestic Violence” Annals of EM,29:6,1997,781-785.

- Injuries , physical and psychological abuse: linked to adverse medical health effects
  - arthritis, chronic neck or back pain, migraine or other types of headache, sexually transmitted infections (including HIV/AIDS), chronic pelvic pain, peptic ulcers, chronic irritable bowel syndrome, and frequent indigestion, diarrhea, or constipation.

Health insurance



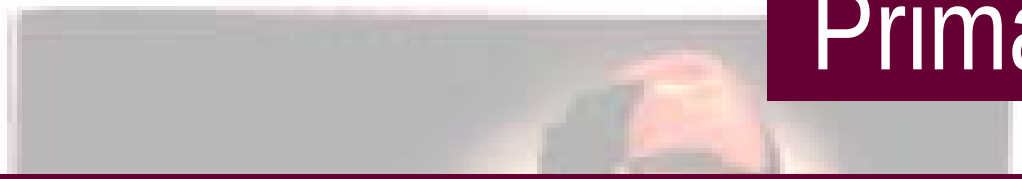
- Domestic Violence:
  - well recognized as posing an increased risk of injury and death
  - some insurance companies have denied health coverage to battered women
  - IPV: a preexisting condition.

Children

- More than 3 million children aged 3 to 17 years witness IPV each year:
  - 40% are also physically abused.
  - At increased risk for:
    - psychological and emotional damage, including anxiety, depression, developmental delays, nightmares, sleep disturbances
    - somatic complaints
    - violent behaviors,
    - drug and alcohol use.
    - twofold higher risk of IPV in their future relationships, beginning with teenage dating.

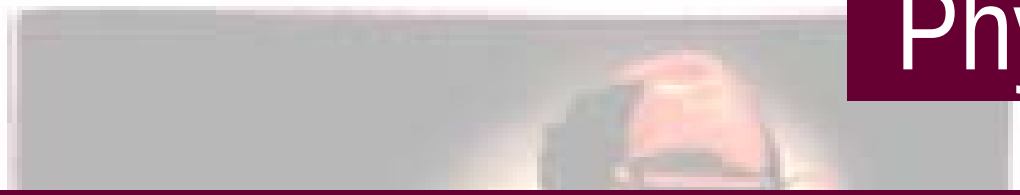
- Hornor G. Domestic violence and children. *J Pediatr Health Care*. 2005;19(4):206-212.

Primary care



- Prevalence studies: at least 1 in 5 female patients in the *primary care setting* have been victims of IPV at some point in adulthood.
  - McCauley J, Kern DE, Kolodner K, et al. The "battering syndrome": prevalence and clinical characteristics of domestic violence in primary care internal medicine practices. *Ann Intern Med*. 1995;123(10):737-746.

Physicians

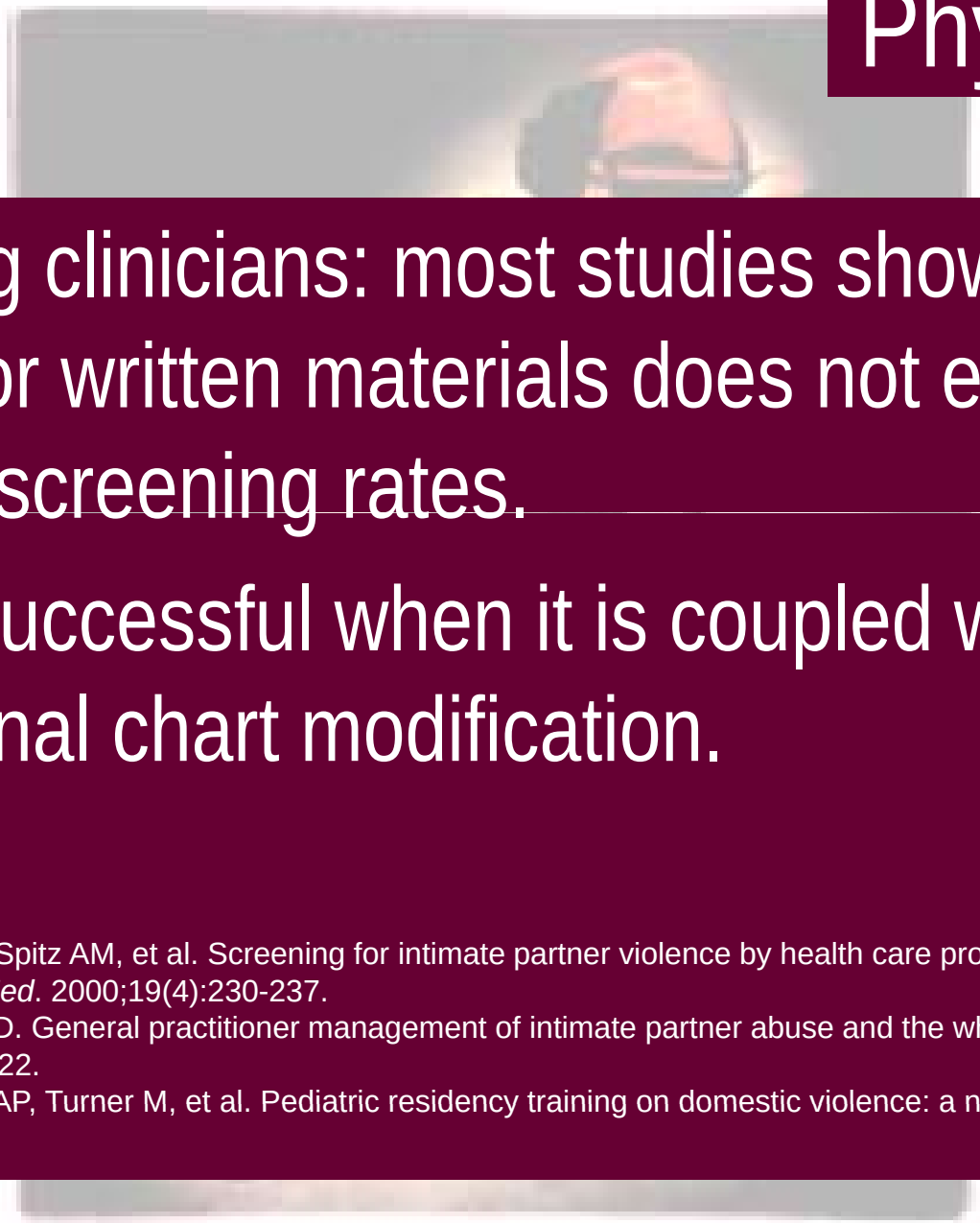


- In the presence of obvious injuries, only 79% of physicians stated that they would question the patient regarding partner violence.
  - Rodriguez MA, Bauer HM, McLoughlin E, Grumbach K. Screening and intervention for intimate partner abuse: practices and attitudes of primary care physicians. *JAMA*. 1999;282(5):468-474.

Physicians

- Emergency department (ED) screening rates for IPV: very low.
  - 13% of patients presenting with injuries due to IPV were screened.
    - Garcia-Moreno C. Dilemmas and opportunities for an appropriate health-service response to violence against women. *Lancet*. 2002;359:1509-1514.
- Low ED screening rates: great concern; Crandall ML, Nathens AB, Kernic MA. Predicting future injury among women in abusive relationships. *J Trauma*. 2004;56(4):906-912.
  - 44% of women murdered by an intimate partner had a previous ED visit within 2 years before the homicide
  - 93% had at least one prior contact with emergency personnel for an injury.

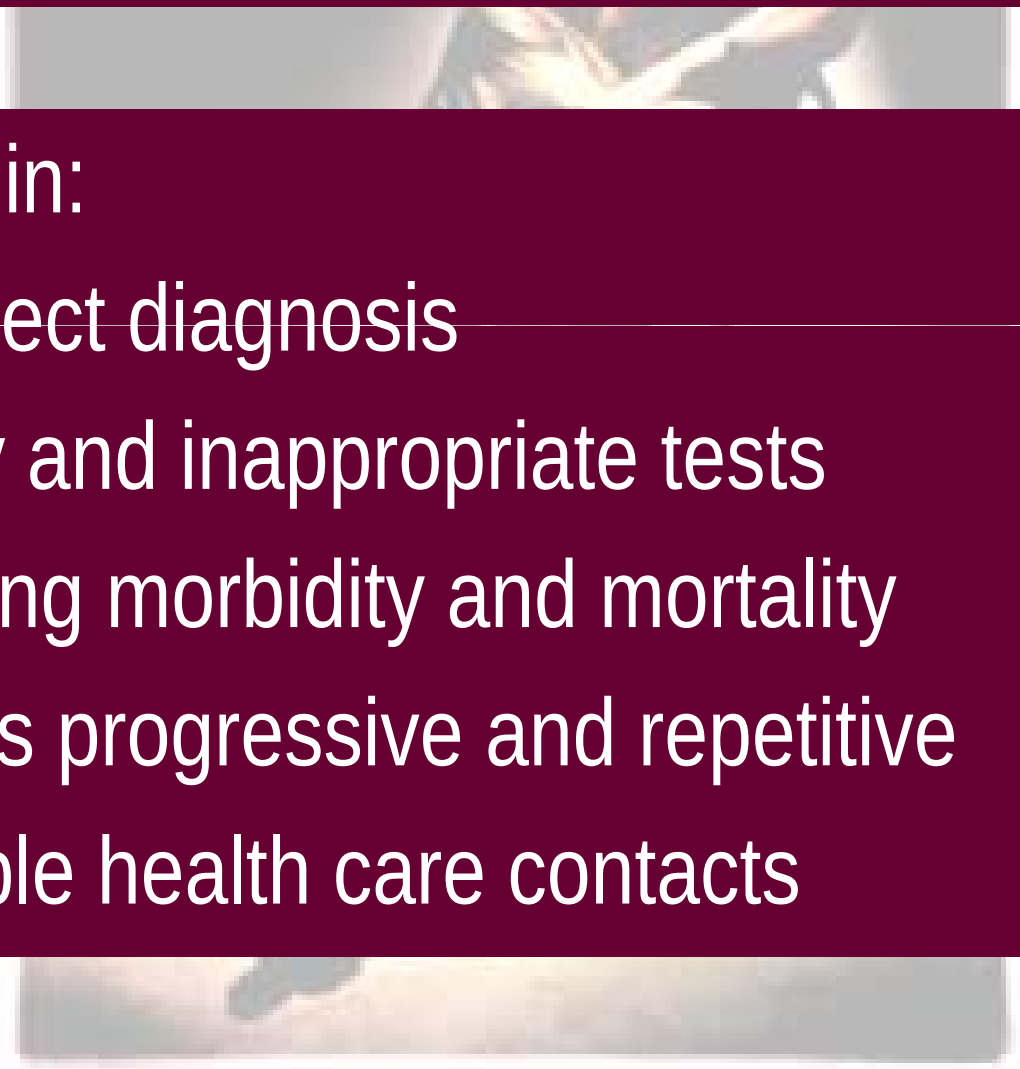
Physicians



- Educating clinicians: most studies show that lectures or written materials does not effectively increase screening rates.
  - more successful when it is coupled with additional chart modification.

- Waalen J, Goodwin MM, Spitz AM, et al. Screening for intimate partner violence by health care providers: barriers and interventions. *Am J Prev Med*. 2000;19(4):230-237.
-Taft A, Broom DH, Legge D. General practitioner management of intimate partner abuse and the whole family: qualitative study. *BMJ*. 2004;32:618-622.
-Bair-Merritt MH, Giardino AP, Turner M, et al. Pediatric residency training on domestic violence: a national survey. *Ambul Pediatr*. 2004;4(1):24-27.

Failure To Identify DV



- Results in:
  - incorrect diagnosis
  - costly and inappropriate tests
  - ongoing morbidity and mortality
- Impact is progressive and repetitive
  - multiple health care contacts

Reflection

- 1 in 5 female patients

  – in the *primary care setting*

    - have been victims of IPV at some point in their adulthood.

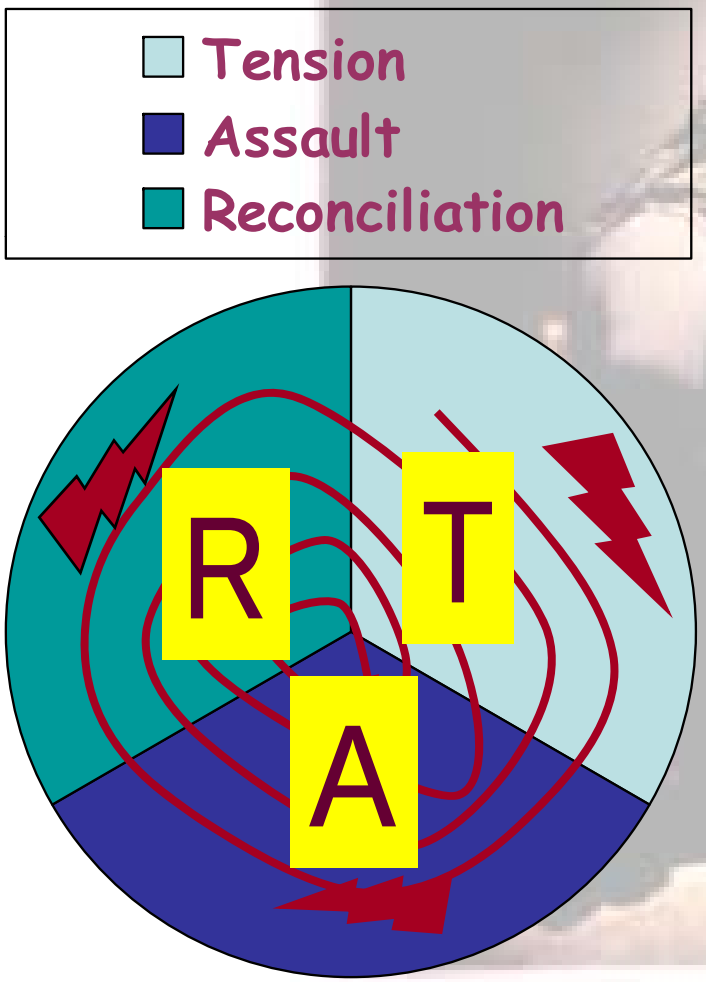
Cycle of Violence

Reconciliation

Tension

Assault

Cycle of Violence



IMPORTANCE

- It Repeats
  - *Increasing in frequency*
  - *Increasing in severity*

Barriers to Screening

Suggs and Inui (JAMA 1992), Suggs et al (Arch Fam Med 1999)

- Time constraints
- Opening Pandora's Box
- "It's a Private Matter"
- Physician Bias
- Fear of offending the patient
- Powerlessness
- Lack of Training
- Safety Concerns

Barriers to Screening

- Barriers to screening:
  - lack of effective interventions once victims are identified,
  - fear of offending the patient by asking,
  - lack of provider education about IPV,
  - some provider bias,
  - and limited time to conduct the screening.

Intervention

- How to screen:
  - Setting: ensure privacy.
    - Every patient should have time alone with the medical provider.
      - Ask anyone who has accompanied the patient into the examination room to leave before the physical examination.
    - Ask about possible partner violence in a nonjudgmental, matter-of-fact manner.

Screening Examples

- Direct question: “Many people have had problems with violence in the home. Is anyone hurting you?”
- PVS: “Have you been hit, kicked, punched, or otherwise physically hurt by someone in the past year? If so, by whom?”
- WAST short questions 1. In general, how would you describe your relationship? (a lot of tension, some tension, no tension), 2. Do you and your partner work out arguments with…(great difficulty, some difficulty, no difficulty)?

Screening Examples

- Mnemonics:
  - HITS: "How often does your partner… Hurt?…Insult?…Threaten?…Scream?
  - SAFE:
    - Stress/safety: Do you feel safe in your relationship?
    - Afraid/abused: Have you ever been threatened/hurt/afraid?
    - Friends/family: Are friends/family aware/supportive?
    - Emergency plan: Do you have a safe place/resources?

Screening Examples

- Mnemonics:
  - RADAR (what to do)
  - Routine screening
  - Ask direct questions
  - Document your findings
  - Assess patient safety
  - Review patient options and referrals
- Reminders like **Screen Chart Stamp**:
  - Domestic violence ____Yes ____No, on each encounter page

Screening Examples

ASK - It's Simple...

- Ask everyone about domestic violence
- Suggest a safety plan
- Keep a medical record

Where should identification and response to DV victims occur?

- Adult Primary Care
- Pediatric Primary Care
- Family Practice
- Geriatrics
- Urgent and Emergency Care
- Ob/Gyn & Women's Health
- Mental Health
- Family Planning
- Pre-Natal Care

- Public health settings
- Dental care settings
- Orthopedic Surgery
- Inpatient
- Substance abuse treatment
- School health settings
- STI clinics
- Rehabilitation/occupational settings

Who should be routinely asked about current and past IPV victimization?

- All adolescent and adult patients
- Parents or caregivers of children in pediatric care

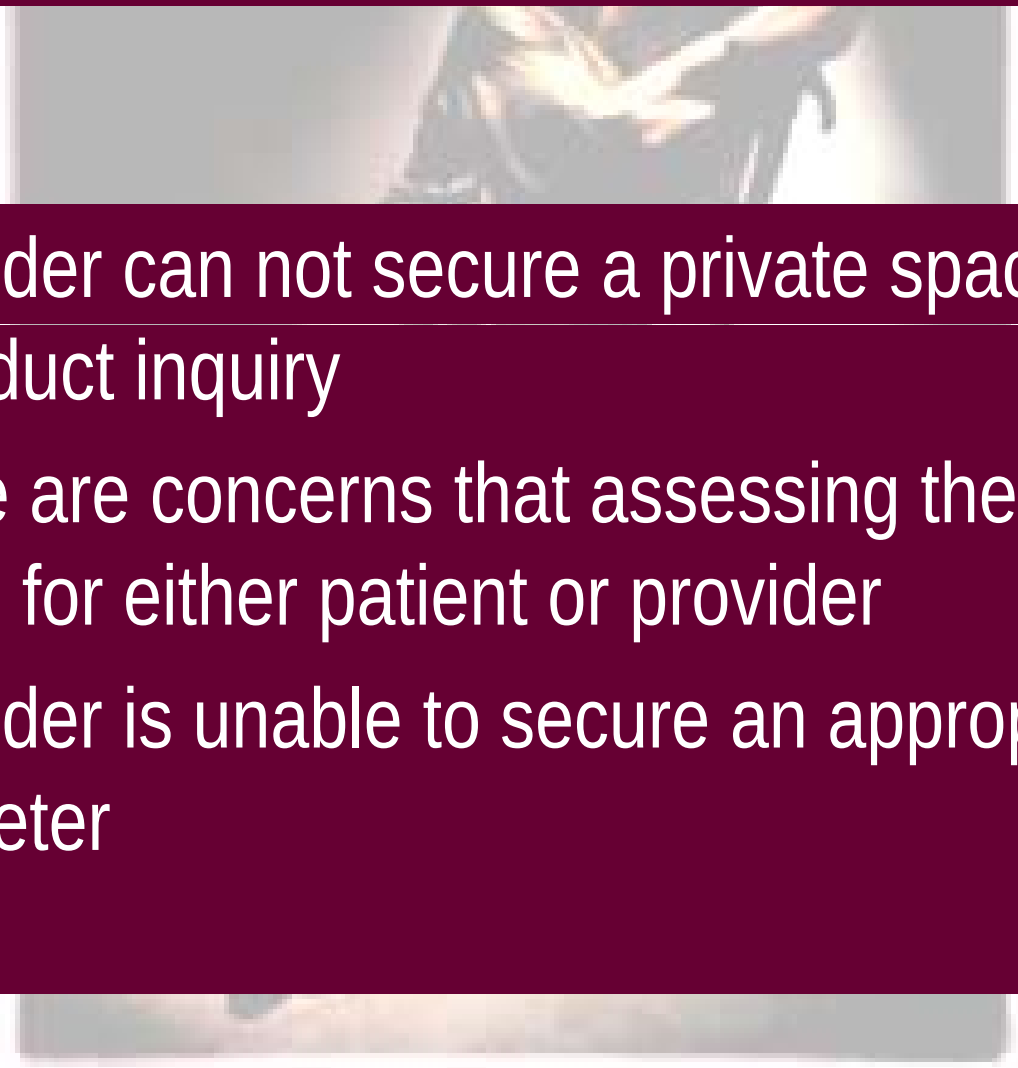
When should inquiry for past and present IPV victimization occur?

1. As part of the routine health history (social history/review of systems)
2. As part of the standard health assessment (at every encounter in urgent care)
3. During every new patient encounter
4. During periodic comprehensive health visits (assess for current victimization only)

When should inquiry for past and present IPV victimization occur?

5. During a visit for a new chief complaint (assess for current victimization only)
6. At every new intimate relationship (assess for current victimization only)
7. When signs and symptoms raise concerns or at other times at the provider's discretion

When should inquiry not occur?



1. If provider can not secure a private space in which to conduct inquiry
2. If there are concerns that assessing the patient is unsafe for either patient or provider
3. If provider is unable to secure an appropriate interpreter

If inquiry does not occur:

- Note in chart that inquiry was not completed and schedule a follow-up appointment (or if in an urgent care setting, refer patient to a primary care provider)

- Have posters, safety cards and patient education materials about IPV available in exam or waiting rooms, bathrooms or on discharge instructions

Red Flags of Battering

- Illness:
  - Chronic pain (headache, pelvic pain, abdominal pain, irritable bowel)
  - Gynecologic problems such as recurrent STD's, low birth weight deliveries, etc
  - Depression, other stress-related symptoms.
- Pattern of Injury:
  - Primarily central region: face with fractures, hematoma, lacerations around eyes, lips, perforated tympanic membrane; chest: breast injuries, broken ribs; abdomen and genital injuries.
  - Old injuries or bruises in various stages of healing.
  - Bites, burns, injury to a pregnant woman, especially to the abdomen.
  - Recurrent minor trauma.

Red Flags of Battering

- Injury:
  - Delay seeking care for injuries, minimizing injuries.
- Psycho-social:
  - Suicide attempts, alcoholism, substance abuse, low self-esteem.
- Head: decreased hearing from multiple blows, subdural hematomas, headaches.
- Musculoskeletal: fractures, (especially facial, radius, ulna, ribs, shoulder dislocation), limited motion, old fractures, chronic pain, primary fibromyalgia.

Red Flags of Battering

- Behavioral:
  - Change in appointment pattern
  - Multiple visits for vague complaints, or multiple missed appointments
  - Frequent walk-ins or emergency room visits
  - Patient can't be contacted at home
  - Doesn't take medication as directed.
- Past History:
  - States history of child abuse
  - History of previous emotionally or physically abusive relationships.

Intervention Strategy

- If a patient discloses abuse:
  - Provide emotional support
  - Emphasize that abuse is never acceptable and that no one deserves to be abused.
- Never criticize a patient for remaining in the relationship,
  - Do not advise a patient to “just leave.”
- Most dangerous moment in an abusive relationship: when the victim leaves.

Intervention Strategy

- Validate and name the problem as domestic violence
- Assist the patient in identifying abuse as a problem
- Listen to the patient's concerns
- Educate the patient about abuse and its connection to medical issues
- Orientate on the dynamics such as power and control strategies employed by the batterer and the cycle of violence.
- Discuss options with the patient

Intervention Strategy

- Help with safety planning.
- Make appropriate referrals and establish some method of follow-up with the patient and her children.
- Express concern about patient's safety, understanding how difficult it is for her to make changes that are necessary, and reassure her that she is not alone.
- Reaffirm that the violence is not her fault.

Intervention Strategy

- Remind her that only the abuser can stop the battering and that it is a conscious choice he has made.
- State that no one deserves to be beaten and that there is no excuse for violence and that she and her children deserve peace and safety
- Remind the victim that there are options and resources available and that health care professionals are there to help her access to them.

Intervention Strategy

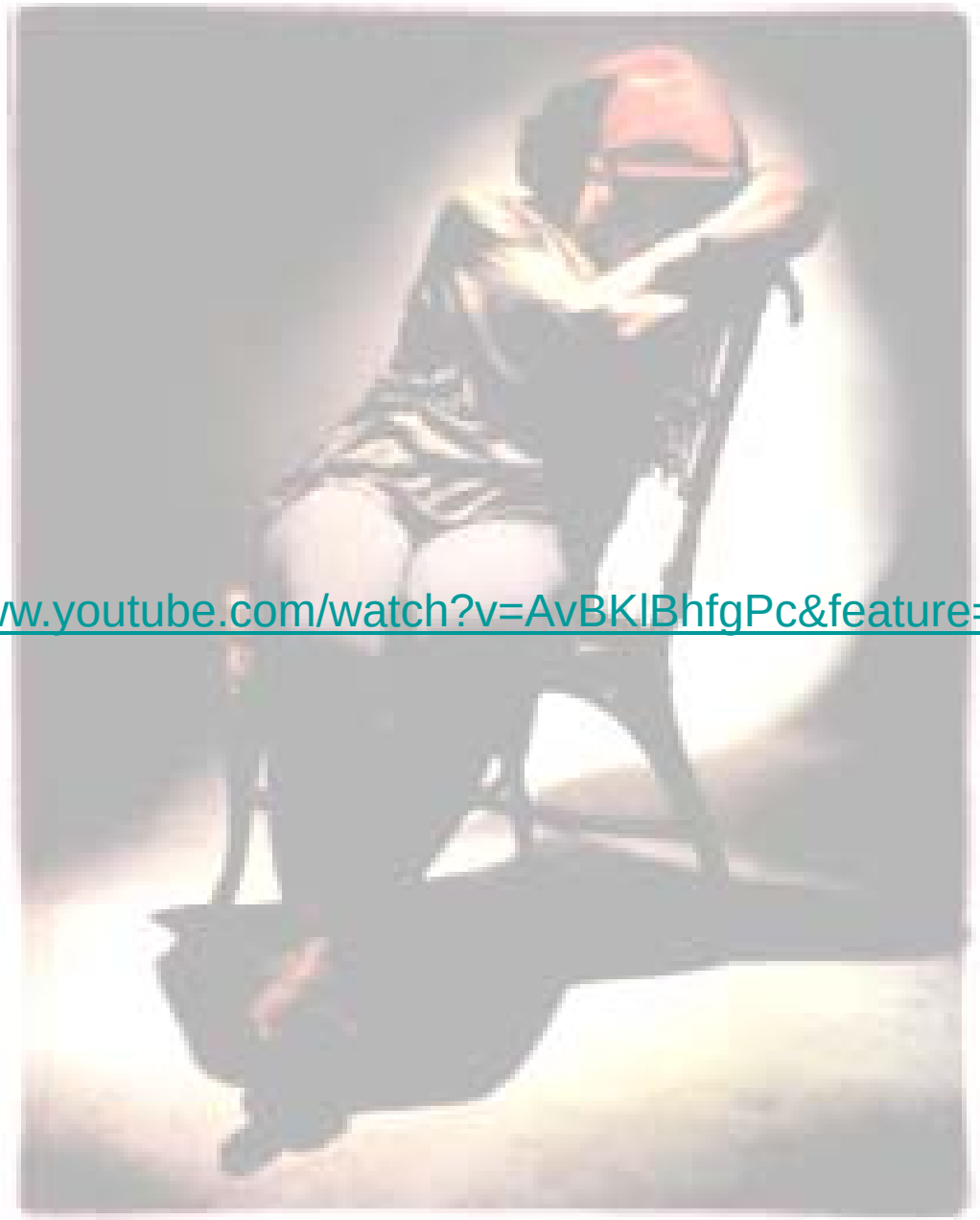
- Never confront or try to counsel the abuser.
  - Most likely, this will escalate the violence.
- Do urge the victim to call the National Hotline while still in your office.
  - CAVV: (787) 765 - 2285 (504- 2646)
  - OPM: 722-2977
  - PES: 749-1333
- Remember to document the abuse and any injuries in the chart in case of future need for legal substantiation.

Batterer's Lethality

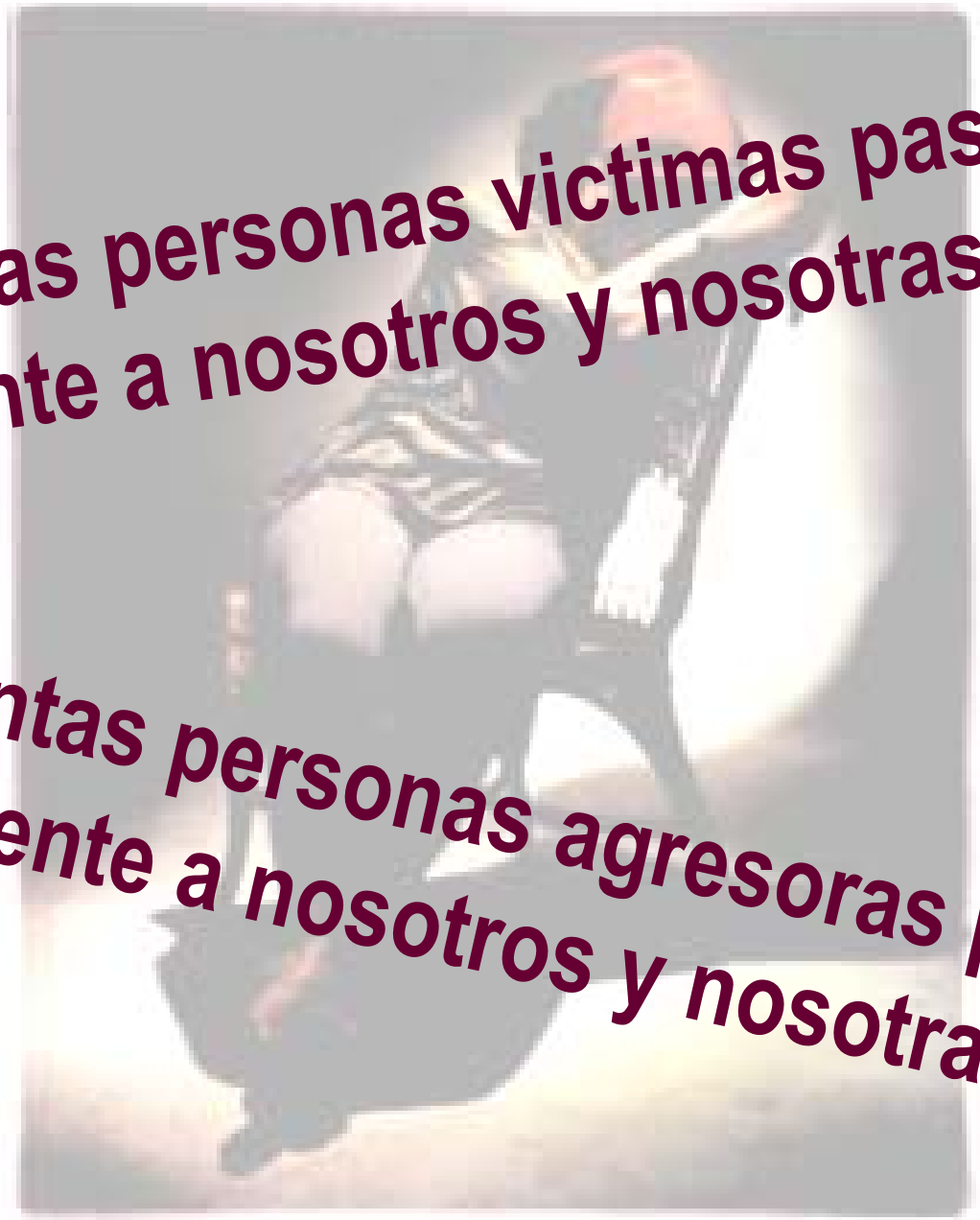
- If a victim discloses any of these behaviors by the partner, extraordinary measures should be taken to protect the victim and her children.
  - These measures include: emergency transportation, and follow-up.
- The victim needs to be supported in any attempt she wishes to take to protect herself and health care professionals should contact the local domestic violence center for assistance with immediate safety planning for the victim.

Batterer's Lethality

- There is no absolute method of predicting lethal behavior
- When clustered, accurate predictors of danger:
  - threats and fantasies about homicide and suicide
  - depression and situational stress, like job loss
  - possessing and using weapons
  - being obsessed about the partner
  - making statements such as "I can't live without her“
  - isolation with a complete dependency on the victim
- Rage over any hint that the victim may leave.
- Consuming alcohol or other drugs while furious or depressed
- Having ready access to the victim or stalking her after she has obtained a protective order



http://www.youtube.com/watch?v=AvBKlBhfgPc&feature=related



¿Cuantas personas victimas pasaron frente a nosotros y nosotras?

¿Cuantas personas agresoras pasaron frente a nosotros y nosotras?

"La seguridad que tiene un agresor de seguir libre,
no depende tanto de la víctima,
como de los profesionales de ayuda."
Sandra Bloom, MD


Familia
BIENESTAR
Justicia
Policía
Salud
Salud
PASOS de las Mujeres
Thank You