Rape and Domestic Violence

Rape

Rape is both a physical and an emotional trauma. Rape is defined as sexual intercourse without the consent of one party, whether from force, threat of force, or incapacity to consent due to physical or mental condition. Seventy-five percent of rape victims knew the person who assaulted them. Twenty-five percent of females are raped at some time in their lives. One in 7 women will be raped by her husband. Only 16 percent of rape cases are reported.

Medical Assessment

All examinations must be performed in the presence of a female chaperone, even if the healthcare provider is female. This person can also reassure the victim, provide support, and help her gain control of her situation. A history and physical examination with collection of indicated data must be done in a compassionate manner.

The patient should be asked to state in her own words a history of events that occurred. She should be asked to identify her attacker(s) if possible, as well as the date, time, and place, and to describe the specific act(s) performed.

Physician's Responsibilities – Medical

1. Obtain thorough gynecologic and medical history
2. Assess and treat physical injuries
3. Obtain appropriate cultures
4. Provide counseling and prophylaxis for sexually transmitted diseases (STDs)
5. Provide preventive therapy for unwanted conception
6. Assess psychological and emotional status
7. Provide crisis intervention
8. Arrange for follow-up medical care and psychological counseling (examination for STDs should be repeated 2 weeks after the assault; testing for syphilis and HIV should be repeated 6, 12, and 24 weeks after the assault)

Legal

1. Obtain consent for treatment, collection of evidence, the taking of photographs, and the reporting of the incident to the authorities.
2. Provide accurate recording of events
3. Provide accurate description of injuries
4. Collection of appropriate samples as well as clothing
5. Report to authorities, with the victim's consent to do so
6. Label photographs, articles of clothing, and specimens with the patient's name; seal and store safely

Physical Examination

1. General appearance
2. Assessment of psychological and emotional status
3. Assess entire body for signs of trauma such as bruises, bites, lacerations, abrasions
4. Photographs, if appropriate
5. Condition of external genitalia
6. Speculum examination of cervix and vagina
7. Oral and rectal assessment for injury
8. Collection of samples as indicated, that include the following:
    - Oral cavity–secretions and culture for chlamydia and gonorrhea
    - Genitalia–hair combings, hair sample, vaginal secretions, cultures for chlamydia and gonorrhea
    - Fingernail scrapings
    - Rectal cultures for chlamydia and gonorrhea
    - Baseline serology tests for syphilis, hepatitis B antigen, herpes simplex virus (if appropriate), as well as a urine pregnancy test
    - Search for foreign bodies
    - Evaluation of all pertinent areas for sperm and acid phosphatase
    - Collect pertinent clothing
    - Arrange for follow-up of repeat cultures and serology in 2 and 12 weeks
    - Tests for HIV serology repeated in 3 – 6 months

Prophylaxis Against Infection

1. Gonorrhea, chlamydia, and trichomonal infections:
    - Ceftriaxone 125 mg IM plus azithromycin 1 g orally in a single dose or
    - Doxycycline 100 mg orally twice daily for 7 days, plus metronidazole 2 g orally in a single dose
2. If the patient is pregnant:
    - Use erythromycin base to substitute for doxycyline, 500 mg orally four times daily for 7 days
3. Hepatitis B virus vaccination offered
4. Tetanus Diphtheria Toxoid to be administered when indicated

Psychological and Emotional Support

- The victim's emotional status should be of foremost concern. Questioning should proceed in a compassionate manner. Although this statement should be obvious, this does not always occur, especially if the woman is drunk, a prostitute, or claiming spouse/date rape. A nonjudgmental manner must be assumed during the examination.

- It is very important for health professionals to understand psychological and emotional stresses of the "rape-trauma" syndrome, which is also known as the

Rape-Related Post Traumatic Stress Disorder (RR-PTSD). When a woman is sexually assaulted, she has lost control of her life, and may have experienced the threat of losing her life. Fear and anxiety may render her helpless. This acute phase may last for hours or days, with loss of the woman's usual coping mechanisms. Her responses may range from complete loss of control to outwardly well-controlled behavior. The signs and symptoms vary in each individual and may include eating and sleep disorders; physical symptoms such as vaginal itch, pain, discharge, headaches, and gastrointestinal disturbances; generalized body aches and pains, such as chest pain, backaches, and pelvic pain; and mood swings, such as anxiety and depression.

- A reorganization phase that may be characterized by phobias, flashbacks, and nightmares usually follows. Avoidance of reminders, nightmares, intrusive memories, irritability, and social isolation are symptoms of posttraumatic stress. The primary care provider must inquire about these symptoms, whether or not the patient complains of emotional sequelae to the rape. Counseling is advisable.

- In addition, there may be gynecologic complaints. This phase may be delayed, occurring months or even years later. It is imperative that the victim receive appropriate psychological and emotional support and counseling, regardless of the extent of her injuries or her apparent emotional control at the time. The victim's defense mechanisms should not be misinterpreted as indicating that she is able to cope with the particular circumstance. It should always be anticipated that she will demonstrate one or more aspects of the rape-trauma syndrome. Forty-six percent of rape victims have considered or attempted suicide.

- The patient should not be discharged from the healthcare facility without proper psychological and emotional counseling from health personnel specifically trained to help victims of sexual assault.

Domestic Violence: The Lost Right of Sanctuary

Prevalence of Partner Abuse

- Twenty-five to 35 percent of women presenting to emergency rooms have a history of domestic violence. Approximately 1 in 4 women on university campuses have experienced physical abuse.

Characteristics of Domestic Violence

- Episodes are not random events, but instead recur and are chronic in nature. The pattern is usually one of increasing frequency and severity. Tactics of the abuser are selected from physical, psychological, and/or sexual behaviors. The impact of these tactics on the survivor and children involved are injury,

pain, fear, isolation loss of self-esteem, and ultimately, being totally controlled.

- Sexual abuse occurs in about two-thirds of relationships involving physical abuse. Sexual abuse may consist of any activity that is generally thought of as being part of a sexual act or sexual behavior but is not desired by the victim. Control of reproductive behavior, including contraception, sterilization, and pregnancy termination or continuation, can be forms of sexual abuse.

- Psychological or emotional abuse may be more subtle and include ridiculing or humiliating the partner in public, as well as name calling, yelling, and criticizing.

- Survivors of domestic violence can be found in all age, racial, educational, occupational, religious, and sexual-orientation groups. In relationships where violence is present, direct injury of children from abuse occurs in about 50 percent.

Relationship

- The pattern of behavior in the relationship is often characterized as a "cycle of violence." The first phase of the cycle is one of increasing tension. At this point, the woman feels that if she is cautious about her behavior, she will be able to prevent or control the violence. Increasing verbal assault in this phase, as well as emotional abuse, may occur. The cycle ultimately leads to the acute battering phase, when physical, sexual, and emotional abuse may occur. This phase is the most dangerous and attempts to leave may lead to homicide of either partner. The last phase is that of reconciliation. Women may seek to leave a relationship at this time, but the persuasiveness of the partner regarding the partner's remorse and promises of no more violence may lead her to stay. The controlling nature of the relationship is the greatest deterrent to a woman's departure. She may also believe this behavior is normal. Other reasons for staying or returning to the partner include dependence resulting from psychological trauma; physical illness; continued contact because of the perpetrator's access to children; cultural/family/religious beliefs or values; hope that the relationship will improve; lack of social support; and continued love and her identity as partner/wife/mother.

- Just as there is no specific profile for a survivor, there is similarly no one profile of an abuser. The abuser will have one face for the public and one for private. He or she may appear to be a most protective, supportive, and available partner. This behavior makes questioning of individuals difficult. Health providers should be alert for behavior used by a perpetrator to control the victim through manipulation of the health care system. Control of medications; canceling appointments; preventing the obtaining of health care; use of multiple doctors; victim-blaming in front of health care providers;

arguing with or threatening the health care team; or refusal to leave the patient's side to allow private conversations may indicate a woman in an abusive relationship.

Recognition

- Women may present to an emergency facility or primary care office with injuries related to abuse. Injuries are most commonly to the head, eyes, neck, torso, breasts, abdomen, and genitals. They often have bilateral or multiple injuries. Commonly, a delay exists between the onset of the injury and the woman seeking treatment. Her explanation for the etiology of the injury may be inconsistent with your findings. A history of repeated trauma may be seen in the record. The primary care provider should be alerted to the possibility of domestic violence when women call or visit frequently for general somatic complaints. Choking sensation, hyperventilation, chest pain, gastrointestinal symptoms, headache, back pain, abdominal pain, or other pain have been associate with past or present partner violence. Women often present with difficulty sleeping, anxiety or panic disorders, depression, attempted suicide, substance and alcohol abuse, or eating disorders (either overeating or anorexia). Survivors may appear hostile or uncooperative and noncompliant with therapy.

- An increase in gynecologic complaints has been demonstrated in abused women.

- The adolescent who has experienced family violence either by observation or as the direct recipient of abuse may exhibit chronic anxiety, difficulty in controlling anger or aggression, dissociation, or a fantasy life. Depression and hopelessness occur and indeed family violence is an important cause of teenage suicide.

Universal Screening: Creating Opportunities for Assistance

- Women do not volunteer their history of abuse, nor do they recognize medical problems related to that history which leads to the logical conclusion regarding abuse screening: everyone must be screened, just as with any medical problem. This information should be clearly designated as confidential. Direct questions regarding abuse have been more successful than non-direct questioning.

- The choice of words during screening is important. Be cautious in interpreting the response to any question containing the word "abuse." The questioner's interpretation of abusive behavior may be quite different from that of the battered woman.

- Emotional abuse may be more difficult to identify. Questions may be more lengthy because the pattern of behaviors can be varied.

Reasons to Screen for and Assist Survivor of Domestic Violence

1. Prevalence of abuse: injuries, deaths
2. History is not volunteered
3. Women do not recognize that their medical problems may be related to abuse
4. Inability to treat somatic problems unless history is recognized
5. Child abuse occurs in 50 percent of relationships, while 100 percent of children are affected by observation of abuse
6. Cost of health care for injuries, somatic problems
7. Mental health costs, including depression and suicide
8. Improper use of medications (pain, anxiety, depression, sleep)

Abuse Assessment Screen

1. Have you ever been emotionally or physically abused by your partner or someone important to you?
2. Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
3. Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
4. Within the last year, has anyone forced you to have sexual activities? Has anyone in the past forced you to have sexual activities?
5. Are you afraid of your partner or anyone you listed above?

Screening for Emotional Abuse

1. Does your partner:
    - Belittle or humiliate you?
    - Blame you for problems?
    - Insult or swear at you?
    - Make you cry?
    - Threaten to hit or throw something at you?
    - Threaten to use weapons on you?
2. Is your partner overly jealous or possessive?
3. Does your partner break things that are important to you?
4. Does your partner threaten your children, parents, friends, or pets?
5. Does your partner control you by keeping you from working, going to school, or seeing friends or family?
6. Does your partner control all of the money by not giving you enough money, taking your money, or drinking or gambling away your money?
7. Does your partner lock you in or out of the house/room/car or prevent you from leaving?

8. Does your partner only want you to do things with him/her? (Adolescent)
9. Does your partner want to know where you are all the time? (Adolescent)
10. Does your partner tell you where you can go and who you can be with? (Adolescent)
11. Does your partner criticize what you wear, your weight, how you look? (Adolescent)

If because of injury, medical history, or patient or partner behavior, you suspect abuse but are unable to elicit a history, other questions may be utilized; for example, "With this particular injury (or medical problem), I find that it has often occurred because a woman has been hit by her partner or another person. I am available to discuss this with you at any time."

Physician's Response to Women Who Are Screened Positive for Abuse

- While listening in a nonjudgmental fashion, inform her that the violence is not her fault and that she does not deserve to be abused (validation). Clearly state that the abuser is responsible for his or her own behavior, and that the pattern of abuse is usually one of worsening behavior. Instead of using the word "victim" when referring to her use the word "survivor."

- For women in a currently abusive relationship, safety must first be assessed. A safety plan or exit plan should be discussed.

- During your medical evaluation, do not prescribe drugs for pain, sleep, anxiety, or depression except under very close supervision. Narcotics should be used in a limited fashion for acute injuries only. Drugs may impair the ability of the woman to respond in a dangerous situation, lead to addiction, or be used for suicide or suicide attempt. Mental health services should be offered and information about domestic violence should be provided. Make her aware of your continued availability even if she is not ready to leave the abuser.

Documentation

Precise factual documentation in the medical record is essential in domestic violence. The records can be used in a legal case to establish abuse, thus becoming critical for prevention of further abuse.

Documentation in the Medical Record

S=

- Chief complaint
- Abuse history in patient's own words
- Past medical history and review of systems
- Substance abuse
- Sexual history

- Medication use

O=

- Injuries (use description, body map, photographs, x-ray)
- Sexual assault kit if indicated
- Physical examination
- Indicated labs, cultures (STDs)

A=

- Safety/danger assessment (children, suicide, homicide)
- Medical assessment

P=

- Provision of violence information
- Community resources, counseling offered
- Follow-up information
- Appropriate notifications depending on state (child abuse, mandatory reporting of domestic violence, weapons use)
- Indicated medical treatment

- Whenever possible, the patient's own words should be used as in, "The patient states…."

- Objective evidence of abuse should be carefully documented.

- The safety assessment should be recorded, including that the individual has been informed of her increased risk of homicide. Assess her degree of readiness for change.

- Document the options which where discussed with the patient and the referrals that were offered.

Overcoming Barriers

- The two most common barriers are lack of time and insufficient training in dealing with psychosocial issues such as domestic violence. Other common barriers include the belief that domestic violence could not occur among their patients, concern that questioning will offend patients, a belief that domestic violence is a "private" issue, and a feeling of helplessness or frustration in not being able to improve the patient's situation.

- Screening questions should be incorporated into all history forms and asked routinely. Questions may be asked by trained office personnel and not necessarily by the physician.

Physician Power and Opposition to Domestic Violence

- A statement can be made in every office by placing educational materials in the waiting room and exam rooms.