Case Studies In Domestic Violence

Practical techniques for increasing effectiveness among physicians

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Barriers to assessment

- Knowledge base regarding domestic violence (95%)
- Confidence in ability to identify domestic violence (93%)
- Knowing what to do when DV appears present (89%)
- Feeling comfortable with the issue (83%)

(Shetf et al. '07)

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Additional research on barriers to assessment

- Lack of confidence w/assessment (73%), inadequate resources to help ID'd victims (45%); forget to ask routinely (41%) (Elliott et al. '02)
- Time and privacy: not enough training on DV, risk of offending patient; personal discomfort; presence of partner (Baig et al. '04)
- Lack of education: lack of time; no office protocols; note: those with more education were less likely to cite lack of time as a barrier (Erickson et al. '01)

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Assessing out of duty or assessing out of mission?

- Do you assess because you’re being told it’s a good idea to assess and you take your job seriously?
- Do you assess because you believe it’s part of your mission as a physician, to prevent violence against women?
- My goal today is to make it your mission.

Domestic Violence 301

- Same term is used for a variety of situations, not all of which involve control and coercion
- Intimate terrorism/coercive controlling violence = domestic violence
- Situational/common couples violence = domestic violence
- Violent resistance = domestic violence
- Only intimate terrorism involves control and coercion

Why differentiate?

- Some research suggests that men and women are equally abusive in relationships. (Dutton ’05)
- Misunderstanding this finding can lead to minimizing what you may be seeing:
  - We were fighting
  - We each hit each other, it wasn’t his fault
  - I hit him too
- The above stories hit on our desire to not have to deal with “intimate terrorism.”
How to differentiate

- Intimate terrorism is about a variety of behaviors used to organize or control their partner.
- Monitoring via phone/visits to workplace
- Discouraging contact with friends/family
- Threats of harm to partner/children/self
- Victim stance (why do you do this to me?) from him
- Verbal/psychological abuse
- Subtle organizing...and much, much more...
- May have only been one incident of physical abuse, may have only been the threat of physical abuse.

Power Over

- Intimate terrorism is marked by a cognitive stance of Power Over:
  - One right way/belief/truth
  - You're with me or against me
  - Others seen as hostile/competitors
  - Scarcity of resources (even time, love, etc)

- This stance results in the victim feeling powerless to influence her partner.

Invalidation

- The experience of invalidation is inherent to victims of intimate terrorism.
  - Family rules, directions from partner, partner's desires change without warning/notice.
  - You become tuned to the environment, not yourself.
  - Often the perpetrator is only controlling/abusive inside the home – outside the home he may be seen as a great colleague or neighbor.
  - This leads to fear that she will not be believed AND the fear that disclosure will get back to him.
Invalidation cont.

- As a physician you play a unique role:
  - You are seen as someone with status/expertise.
  - You’re willingness to believe and listen plays a crucial role in a victim's process.
  - Disbelief or questioning of her experience can reinforce the invalidation she experiences at home.
  - Belief and validation can provide some sense of empowerment.

The research says...

- Intimate terrorism:
  - Results in more frequent and more severe violence.
  - Is less likely to stop.
  - Is 2.5x more likely to result in injury.
  - Victims are more likely to use pain killers.

- If you suspect DV, it probably is DV and not situational/common couples violence.

(Johnson & Leone ’05)

Why assess if there is no threat to physical safety?

- The research is very clear: not all intimate terrorists are physically violent.
- So why assess for DV if it’s a case of a single incident of physical violence where she doesn’t fear for her safety?
- Psychological abuse is experienced by victims as longer lasting and more damaging than physical abuse “the wounds healed, my sense of self didn’t.”
Why assess if there is no threat to physical safety?

- Remember the consequences:
  - Risk to stroke/heart attack, depression, PTSD, alcohol/drug abuse, smoking, arthritis
  - Not all of these consequences are related to physical injury or physical violence

- There appears to be a connection between a relationship predicated on control/lack of influence/invalidation and these consequences.

How often should we assess?

- Bottom line is: as often as is reasonable
  - Guidelines are in handout provided
- In ED/Urgent Care: every visit
- Do routine assessment as opposed to “red flag” based assessment
  - Even if you get a denial, you send a message that you are open to knowing and increase chance of disclosure on next visit
  - Some patients will need to be asked over a period of months or years before disclosing

(Nelson '04; National Consensus Guidelines FVPF '04)

How physicians with expertise assess for DV

- 45 physicians participated
- Had to see patients 20 hrs week
- Research conducted in focus group setting
- Six physicians average per focus group – each group represented a different medical specialty
- Average of 28 patients per year assessed positively
- Five major themes cut across medical specialties

(Gerbert et. al. ‘99)
The Five Themes

- Questions were framed so as to minimize patient discomfort and fear.
- Physicians felt attuned to signs/symptoms that suggested DV was an issue.
- They engaged direct and indirect approaches to identification.
- They didn’t get direct patient disclosure very often.
- They redefined “successful assessment.”

Framing

- Talk about assessment as a routine part of a physician’s job.
  - “Well, we ask everybody about their relationships, but I can understand it probably feels a bit intrusive.”
- Educate your patients about the prevalence of domestic violence.
  - “Domestic violence is a big problem in our society. Doctors have been asked to find out how many folks are hurt by it and we’d like to help those who are.”

Being attuned to DV

- Have an awareness of what we talked about today: that not all DV is physical abuse, your patient may be seeing you for pain killers or depression or a condition that you may not be the direct result of an assault.
- With patients you see more than once/regularly, use your relationship to foster disclosure if you suspect DV even during a regular visit when you might not assess.
Be comfortable being both direct and indirect

- In cases of an acute presenting injury be direct.
- In less obvious cases, for example seeing a patient over several visits and despite denial you strongly suspect DV, use more indirect questioning and normalizing:
  - “Anything at work or at home that you think might be aggravating this?”
  - “I’ve seen this in the past and sometimes it can be due to partners being hit or threatened, is there any chance that might be happening to you?”

More on being indirect...

- Ask your questions early in the interaction to give yourself time to listen.
  - “The first thing is do (after asking) is I stop moving… I stop writing, I sit up, and I look at the person.”

- Physicians reported that building a trusting relationship increased disclosure and decreased patient drop out.

Rarity of direct disclosure

- Physicians reported that unless there was an acute injury or an emergent situation, direct disclosure was rare.
- Specific assessment questions rarely produced disclosure.
- Reactions to assessment ranged from angry denial to subtle acknowledgement and direct disclosure.
Reframing successful assessment

- Rather than gaining disclosure, success was seen as a compassionate asking.
- "I think domestic violence might be the only thing in medicine that I’ve let go of trying to fix or cure or even know if it’s really happening. The minimum I have to do is make sure I said that I know they don’t deserve it and that there’s resources available if they want them."
- As a person in a position of power in our society, your voice matters. If you care to, make it a mission.

Three subtle signs

- Signs of verbal/psychological abuse
  - Disclosures about name calling, yelling, fighting (not always physical), put downs, isolation, etc.
- Signs of fear of partner
  - He’s not going to know you asked, will he?
  - Outright disclosure upon being asked “are you ever afraid of your partner/husband/boyfriend?”
- Signs of control
  - Checking up on her, restricting her movement, expressions of jealousy from him, inability to influence him, etc.

Questions? Comments?

- Please feel free to contact me with questions or comments after today:

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