SIS: CASE STUDIES IN DOMESTIC VIOLENCE AND CHILD ABUSE

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DISCLOSURES

- Katherine Thompson is the CEO/Founder of IPV educators, LLC, a small company founded to help increase healthcare professional education and empowerment surrounding topics of interpersonal violence.
- This presentation is created and maintained through the generous sponsorship by AAPA and is created free of financial or advertising incentive towards IPV Educators, LLC.

OBJECTIVES

- Become familiar with national statistics associated with child sexual abuse and domestic violence.
- Explore and become familiar with evaluating a domestic violence case from initial presentation to conclusion, including interactive checkpoints.
- Explore and become familiar with evaluating a child abuse case from initial presentation to conclusion, including interactive checkpoints.
- Review definitions of child sexual abuse and domestic violence.

TRIGGER WARNING

- Be aware of how you're feeling surrounding these topics because the more self awareness you have, the stronger of a clinician you will become.
- This is a safe place, I encourage you to ask questions, speak honestly about your emotions and thoughts, and support each other.
- If you need to step out or avert your eyes, you may do so. I am available for questions at any point in your career.

A WORD ON LANGUAGE

- Sometimes you may hear gender binary language in my presentation, particularly female pronoun (she/her/hers) for the victim and male pronoun (he/his/him) for the perpetrator.
- This is a nod to the fact that the great majority of IPV and assaults occur along these lines, but not meant to exclude or minimize the disproportionate and understudied assaults that occur outside of these gender binary boundaries.

HOW TO MAKE THIS INTERACTIVE

- This session was originally designed to be a highly interactive small-group session. Since life these days requires a little innovation and flexibility, I've modified it, but I didn't want to lose the essential qualities.

A REMINDER OF STATISTICS AND DEFINITIONS: DOMESTIC VIOLENCE DEFINITIONS

- Domestic violence: a pattern of behaviors used by one partner to maintain power and control over another partner in an intimate relationship.
- Interpersonal violence: an umbrella term
- Intimate partner violence
- Domestic terrorism

A REMINDER OF STATISTICS AND DEFINITIONS: DOMESTIC VIOLENCE DEFINITIONS

- **Physical**
  - Hits, slaps, pushes, punches, pins
  - Threatens to hit or hurt people or things
  - **Prohibits access to medicines / medical care**
  - **Uses public health conditions to control or torture**
- **Sexual**
  - Imposes painful/uncomfortable practices/positions
  - Forced sex
  - Forced pregnancy or abortion
  - Demanding sex in front of other people
- **Psychological**
  - Threatens, berates, ridicules, intimidates, emotionally withdraws
  - Threatens to hurt or take away children, etc.
  - Isolation from friends, family, work, church, etc.
- **Economic**
  - Limits access to work, education
  - Incurs major debt
  - Controls immigration papers or insurance access
  - Accounts only in the perpetrators name

A REMINDER OF STATISTICS AND DEFINITIONS: CHILD SEXUAL ABUSE DEFINITIONS

- CAPTA: the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, and in cases of caretaker or interfamilial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children.

HISTORY OF CHILD SEXUAL ABUSE (CSA)

- CSA is documented from the dawn of culture, including Byzantine Empire, ancient Greeks, Romans, etc.
- Ambroise Tardieu: 900 cases of reported sexual abuse analyzed, drawings made.
- Freud: abandoned original theory about sexual abuse in favor of Oedipal complex
- 1973: physicians were still not being urged to consider child abuse in cases of gonococcal pharyngitis in prepubertal children.

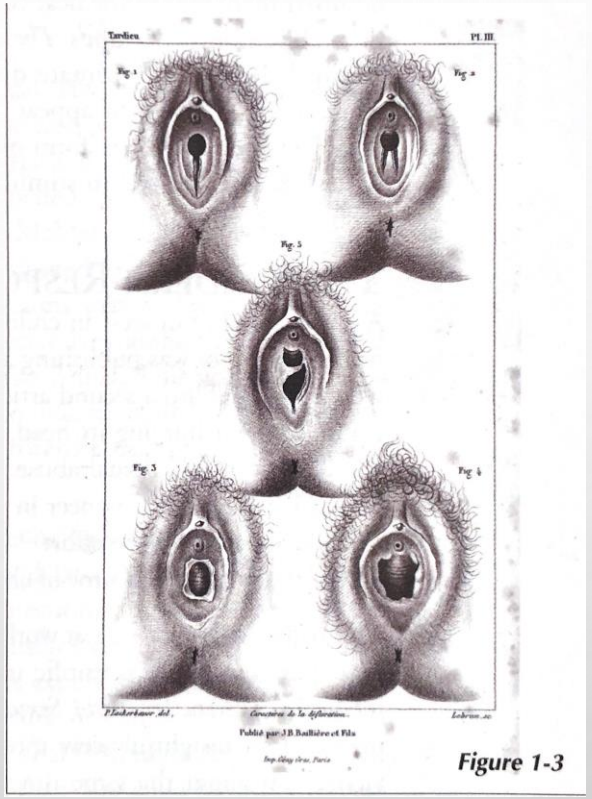


Figure 1-3

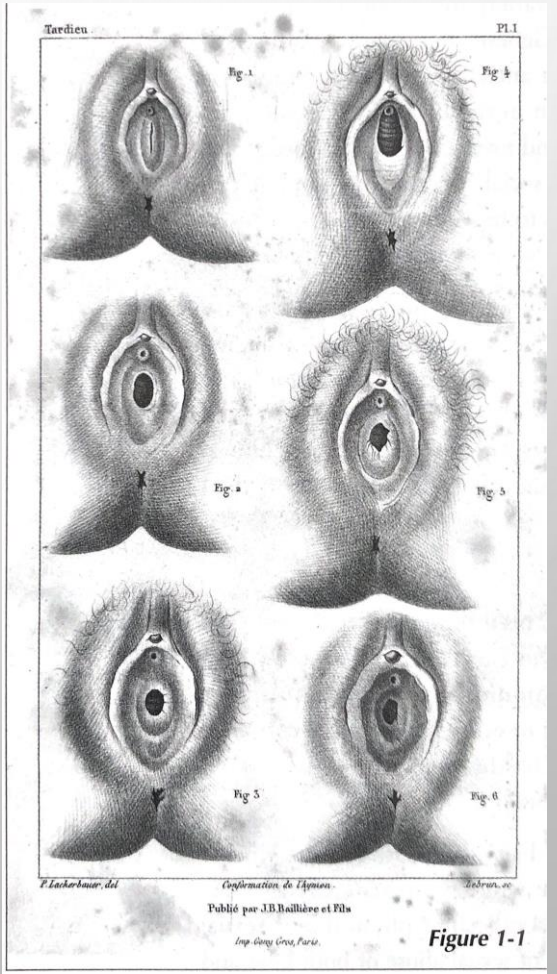


Figure 1-1

A REMINDER OF STATISTICS AND DEFINITIONS: DOMESTIC VIOLENCE STATISTICS

- 1 in 4 women, 1 in 9 men experience severe physical intimate partner violence, intimate partner contact sexual violence, and/or intimate partner stalking.
- 1 in 3 women, 1 in 4 men experience some form of physical violence from an intimate partner.
- IPV accounts for 15% of all violent crime
- 2018: U.S. spent $3.6 trillion on IPV, $2 trillion of that was healthcare related costs.

A REMINDER OF STATISTICS AND DEFINITIONS: CHILD SEXUAL ABUSE STATISTICS

- Every 9 minutes, Child Protective Services substantiates or finds evidence for, a claim for child sexual abuse.
- 1 in 9 girls and 1 in 53 boys experience child sexual abuse
  - 2 out of every 3 of these are aged 12-17.
- 4 times more likely as an adult to develop:
  - PTSD
  - Drug dependence
- 3 times more likely to have a major depressive episode as an adult.

CASE #1

You are a family practice PA moonlighting at the attached urgent care. Your next patient is a young woman who you recognize from your panel. She appears well-dressed and emotionally calm. She speaks quietly, and sometimes it's hard to hear what she's saying.

She says "my sister made me come get checked out. I hope this doesn't take too long, and I'm sorry to waste your time, but my husband and I had a fight and my sister got really upset when I told her."

"It got a little physical…he shoved me, and I shoved him back, but that almost never happens and it's not like he hit me."

You note a well-dressed, calm young woman in her early 30s. She's wearing a long-sleeve shirt, a stylish scarf around her neck, and jeans. She is well-groomed, her hair is recently styled, and she's not wearing makeup.

She denies pain outside of a mild sore throat "probably from yelling".

Her affect is calm, almost apathetic.

Vital signs: 120/72, HR 82, pulse oximetry 98%, RR 16.

CASE #1

- History: appendectomy five years ago, mild intermittent asthma, mostly exercise induced.
- Allergies: pet dander
- Meds: albuterol inhaler

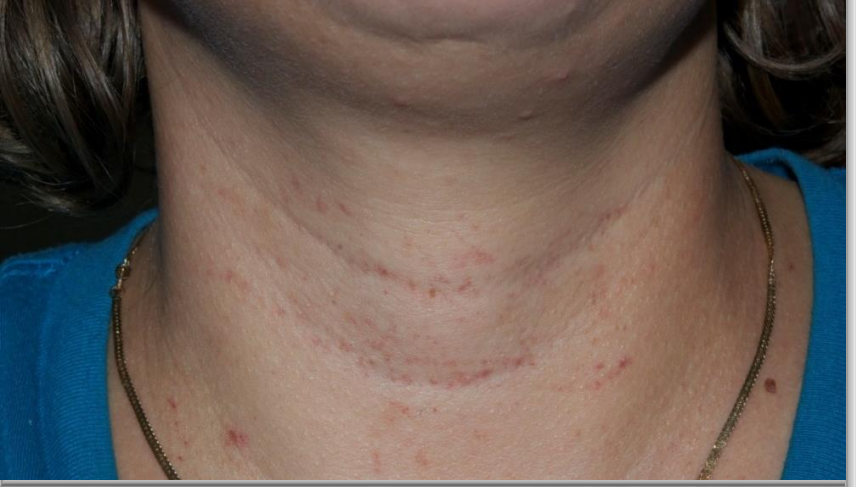
CASE #1

- Checkpoint #1: Please proceed to the following website and answer the question(s).

CASE #1

- HEENT: facial flushing, bilaterally; no scleral icterus, no subconjunctival hemorrhage, pupils PERRL, EOMI. Voice quality slightly raspy (?). throat normal on exam. No lymphadenopathy. No external bruising, perhaps some mild redness.
- Cardiac / Pulmonary: Normal rate and rhythm, no murmurs, gallops or rubs. Heart sounds normal. Lung sounds intact in all fields, no rhonchi, rales, or wheezing.
- Abdominal exam: no tenderness to palpation.
- All other systems not examined on patient request.

CASE #1



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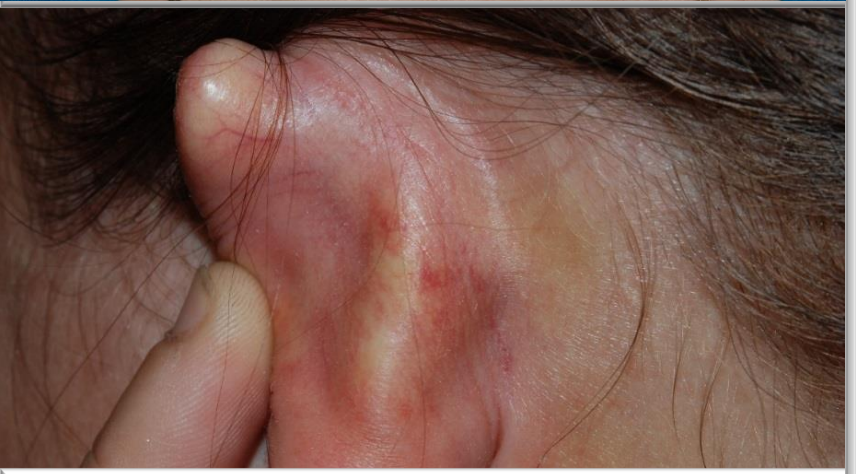

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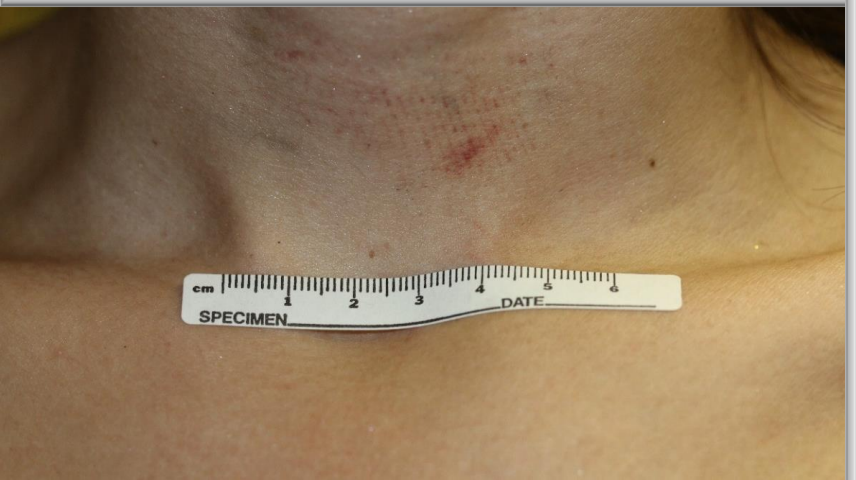


#3

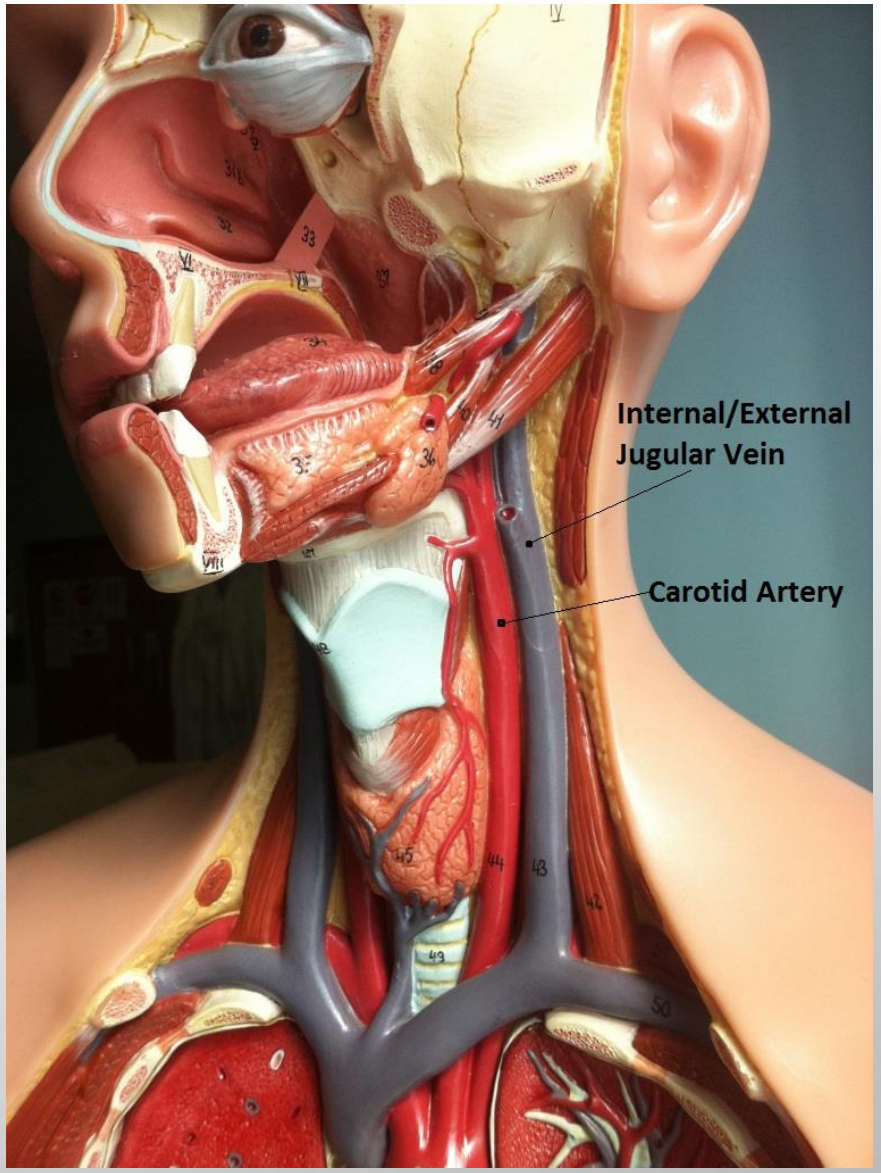
CASE #1

- Checkpoint #2: What do you notice in examining these photographs?

ANATOMY / PHYSIOLOGY OF STRANGULATION

- Pressure to occlude carotid artery: 11 pounds per square inch (PSI)
- Pressure to occlude jugular vein: 4.4 PSI
- Pressure to fracture the hyoid bone: 6.8 PSI

- Pulling a handgun trigger: 6 PSI
- Opening a can of soda: 20 PSI
- Average female grip strength: 57-65 PSI
- Average male grip strength: 80-100 PSI

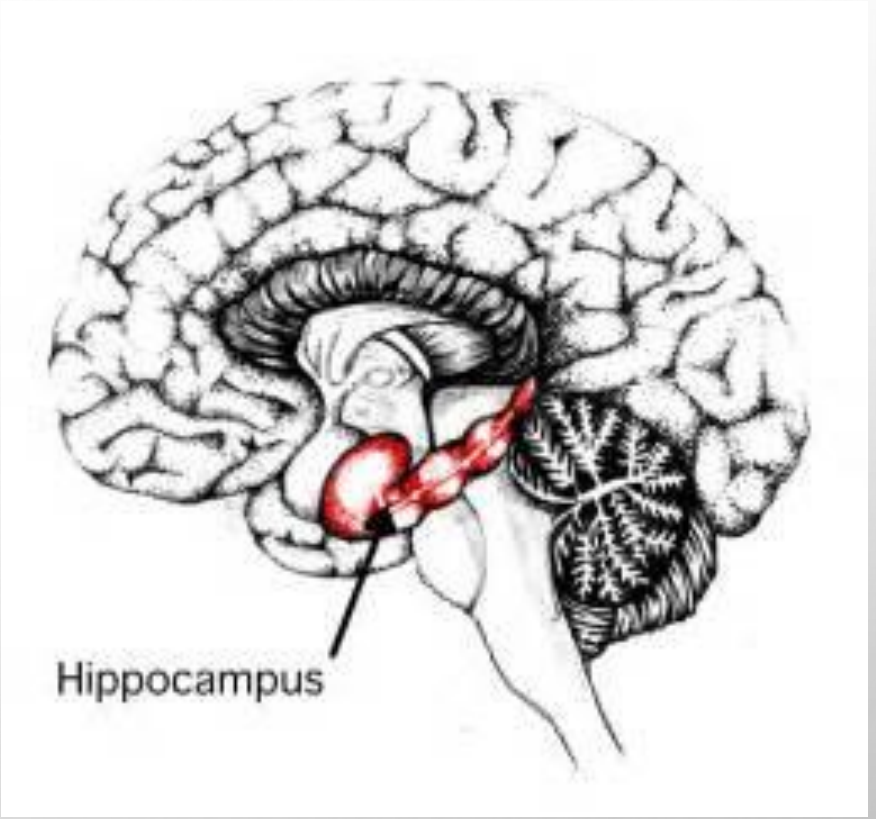


BASIC PHYSIOLOGY OF STRANGULATION

- Loss of consciousness: 6.8 seconds
- Loss of bladder control: 15+ seconds
- Loss of bowel control: 30+ seconds
- 32,000 neurons die with every minute of oxygen deprivation
- Death can occur in as little as two minutes.

STRANGULATION AND THE BRAIN

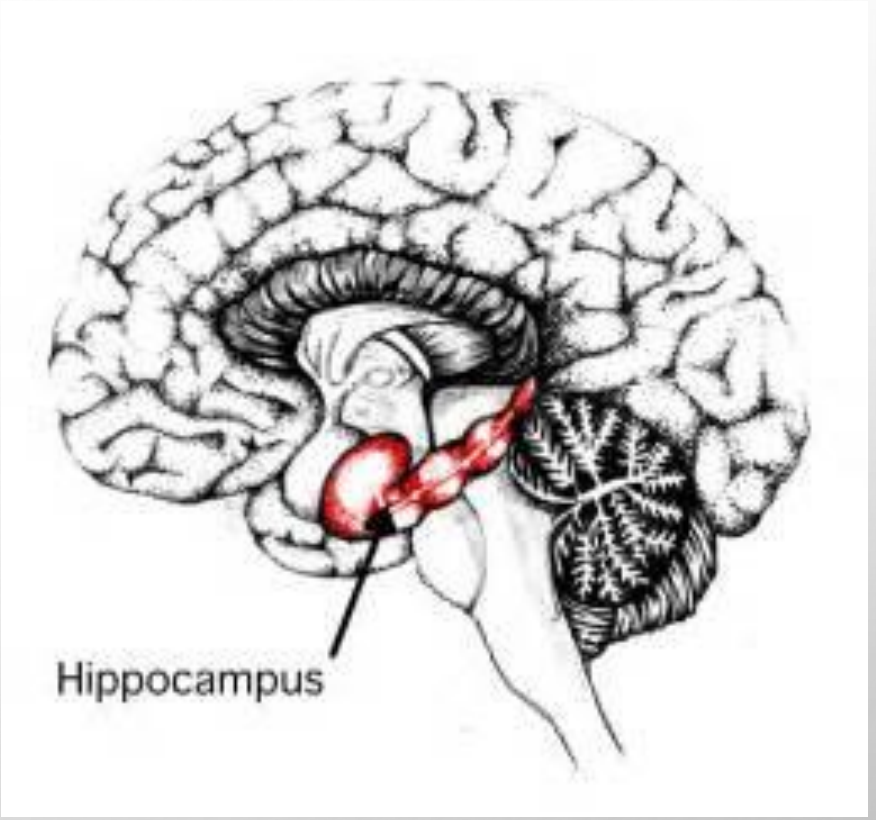
- Different areas of the brain have different metabolic rates; thus, they are differently affected by hypoxia / anoxia
- Areas most sensitive include: hippocampus, basal ganglia, frontal regions, visual cortex



STRANGULATION AND THE BRAIN

- Hippocampus
  - "Place" cells: located in the hippocampus and allow you to recognize your environment as "familiar"
  - Responsible for the formation of new memories

- Other effects of strangulation
  - Apathy, irritability, emotional lability (46%)
  - Amnesia to varying degrees (54%)[7]
  - Spotty or unreliable memories



CASE #1

- Checkpoint #3: What imaging (if any) would you like to order for our strangulation patient?

History of or physical exam with any of the following:

1. LOC
2. Visual changes
3. Petechial hemorrhage
4. Ligature marks / bruising of neck
5. Soft tissue swelling of neck
6. Incontinence
7. Neurological symptoms
8. Dysphonia / aphonia
9. Odynophagia
10. Dyspnea
11. Subcutaneous emphysema

Consider:

1. CT angio (carotid / vertebral arteries)
2. CT neck with contrast (bony/cartilage)
3. MRA of neck (soft tissue)
4. MRI of neck (best study for soft tissue)
5. MRI/MRA of brain (anoxic brain injury, stroke, petechial hemorrhage

If ANY are positive:

- Admission
- ENT consult
- Neurosurgery / Neurology / Trauma

If NEGATIVE:

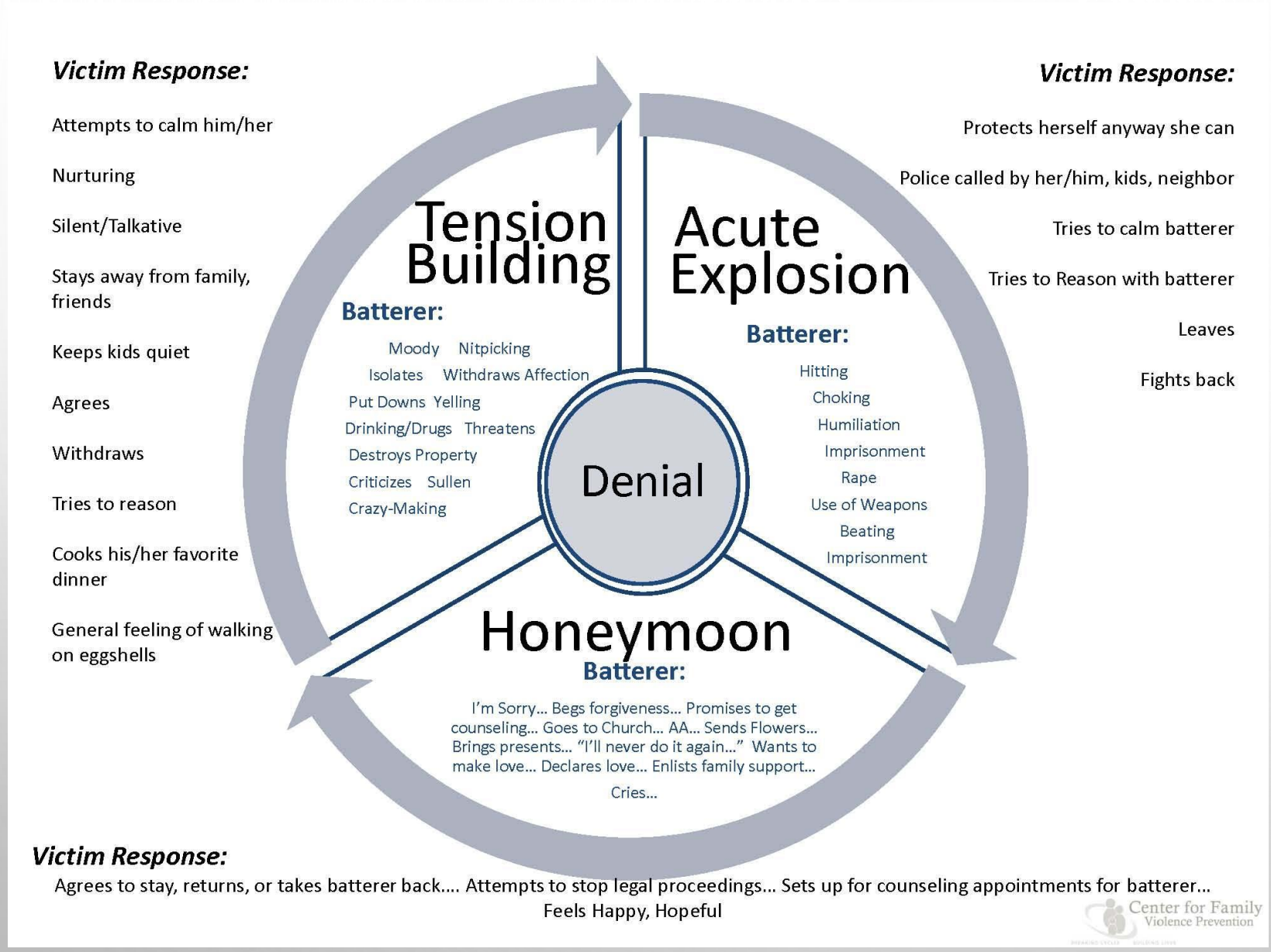
- Continued ED/Hospital Observation
- Discharge with detailed return precautions

CASE #1

- You chose to pursue overnight observation. Your patient wasn't happy about this, but you were able to convince her that this was in her best interest.
- Social worker was able to talk to her during her overnight stay and she was able to safety plan her current relationship and get a counseling referral.

ABUSE AS A PROCESS

- Abuse is not a single incident, a single moment in time, but a process, like erosion. A sand dune doesn't appear overnight, but through the patient relocation of grains of sand for years.
- As demonstrated in one case of chronic abuse:
  - The first time, it was an aberration, so sudden and strange, she assumed it was just a onetime event. He was so remorseful, he cried, bought her makeup to cover the bruises.
  - The abuse slowly escalated over years in a series of isolated incidents. By then, she was so beaten down, "she felt as if there was nothing left, a husk of skin and bone with no spirit, no agency of her own, only a kind of slow, painful slog toward unconsciousness".
  - "The only way that I can really describe what happened to me is like part of me, like, died, and then part of me got ignited in terms of, like, my love with heal us…but I had to stop loving myself and *only* love him."



PSYCHOLOGY OF IPV

A QUICK EXERCISE…BUILD THE PERFECT PERPETRATOR

Take a moment and use the following link to write down a list of qualities that you feel help identify domestic violence perpetrators.

If you imagine someone who is a batterer, what personality or physical qualifications do you feel they're likely to have?

MALE ROLE BELIEF SYSTEM[1]

- Man does not get disrespected
- Man does not get lied to
- Man's sexuality does not get questioned
- Man is the authority
- Man does not get dismissed
- Women should be submissive, obedient, supportive to man
- * Deviations from this belief system create the moment of "fatal peril" where violence becomes a choice to defend this belief system

NARCISSISM

- The following was taken from a series of voicemails left for a victim during a no-contact period (which was broken over 400 times over a 2-week period).
- “You’re blowing it out of proportion. I was just fucking with you. I wasn’t trying to kill you…why you keep fighting me instead of helping me get outta here? Why ain’t you apologizing, too, for staying out all night?”
- “I am in love with you, bitch, and I wish I wasn’t, ‘cause you’re putting me through fucking misery. Why you doing this to me?”
- “I don’t owe you no explanation…you done nothing but put me in jail.”
- *What do you see / hear in all of these? Take a moment to record your thoughts.

CASE #1

- Owning a handgun raises the lethality of a domestic violence relationship by almost 200%
- Non-fatal strangulation raises the lethality by 500%
- Screening for these things routinely can allow us to intervene at an appropriately urgent level.

DANGER ASSESSMENT: CAMPBELL

DANGER ASSESSMENT

Jacquelyn C. Campbell, PhD, RN

Several risk factors have been associated with homicides (murders) of both batterers and battered women in research conducted after the murders have taken place. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of severe battering and for you to see how may of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the past year when you were beaten by your husband or partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or lasting pain
3. "Beating up"; severe contusions, burns, broken bones
4. Threat to use weapon; head injury, internal injury, permanent injury
5. Use of weapon; wounds from weapon

(If **any** of the descriptions for the higher number apply, use the higher number.)

Mark **Yes** or **No** for each of the following. ("He" refers to your husband, partner, ex-husband, ex-husband , or whoever is current physically hurting you.)

__ 1. Has the physical violence increased in severity or frequency over the past year?
__ 2. Has he ever used a weapon against you or threatened you with a weapon?
__ 3. Does he ever try to choke you?
__ 4. Does he own a gun?
__ 5. Has he ever forced you to have sex when you did not wish to do so?
__ 6. Does he use drugs? By drugs, I mean "uppers" pr amphetamines, speed, angel dust, cocaine, "crack", street drugs or mixtures.
__ 7. Does he threaten to kill you and/or do you believe he is capable of killing you?
__ 8. Is he drunk every day or almost every day? (In terms of quantity of alcohol.)
__ 9. Does he control most or all of your daily activities? For instance: does he tell you who you can be friends with, when you can see your family, how much money you can use, or when you can take the car? (If he tries, but you do not let him, check here:____)
__ 10. Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here: ____)
__ 11. Is he violently and constantly jealous of you? (For instance, does he say "If I can't have you, no one can.")
__ 12. Have you ever threatened or tried to commit suicide?
__ 13. Has he ever threatened or tried to commit suicide?
__ 14. Does he threaten to harm your children?
__ 15. Do you have a child that is not his?
__ 16. Is he unemployed?
__ 17. Have you left him during the past year? (If you *never* lived with him, check here: ____)
__ 18. Do you currently have another (different) intimate partner?
__ 19. Does he follow or spy on you, leave threatening notes, destroy your property, or call you when you don't want him to?

___ Total "Yes" Answers

Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment means in terms of your situation.

- Physical violence increased over the last year?
- Ever used a weapon or threatened you with a weapon?
- Does he ever try to choke you?
- Ever forced you to have sex when you didn't want to?
- Does he own a gun?
- Use drugs? Drink?
- What percentage of your daily activities does he control?
- Has he ever beaten you while you've been pregnant?
- Is he unemployed?
- Have you left him during the past year?
- Do you have a child that isn't his?
- Do you currently have another intimate partner?
- Does he follow you, spy on you, "stalk" you?
- Does he ever threaten your children?

BASICS OF NON-FATAL STRANGULATION: QUESTIONS TO ASK

One hand, both hands, forearm, knee/foot, ligature?	In the victim's estimate, how long was she/he strangled for?	1 to 10, how hard was the grip of the perpetrator?	1 to 10, how painful was it?
Suspect right or left handed?	What did the suspect say before, during, after?	Was she shaken? Straddled? Pushed against a wall?	Was her head pounded against a wall / bed / floor?
What did the victim think was going to happen to her?	How or why did the suspect stop?	What was the suspect's demeanor? His facial expressions?	Prior incidents?

CASE #2

- You are a pediatrics PA. Your next case is a 7-year-old girl. The mother has brought her in because the child has been complaining of dysuria and showing reluctance around bathing times because she says it “hurts down there”. This has been happening for a few days.

CASE #2

- History: no medical history
- Allergies: no allergies
- Meds: no medications
- Family history / social history
  - Divorced parents, mother has sole custody
  - Child attends public school, does well, teachers say she is normally very attentive in class.
  - Child is normally calm at home, but lately has been picking fights and being defiant.
  - No siblings

POSITIONING FOR THE PHYSICAL EXAM

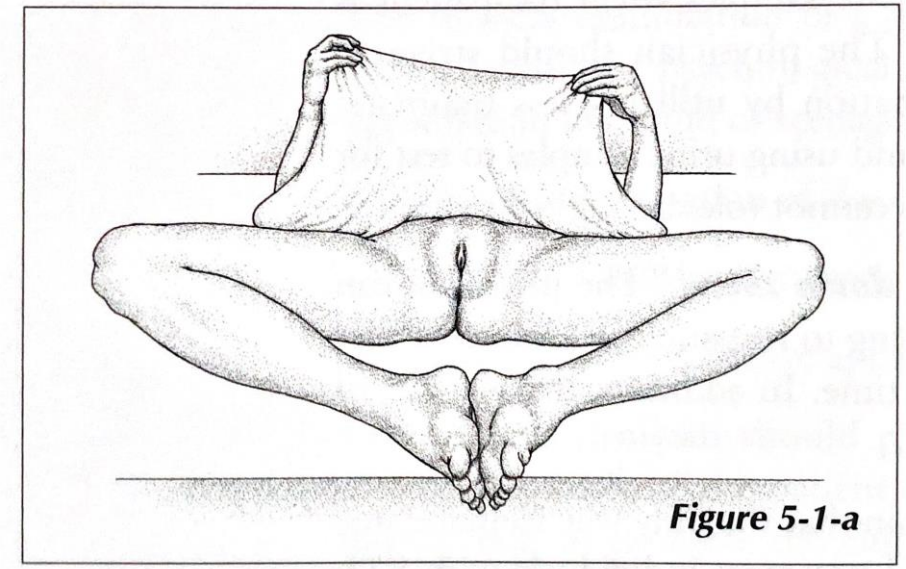


Figure 5-1-a

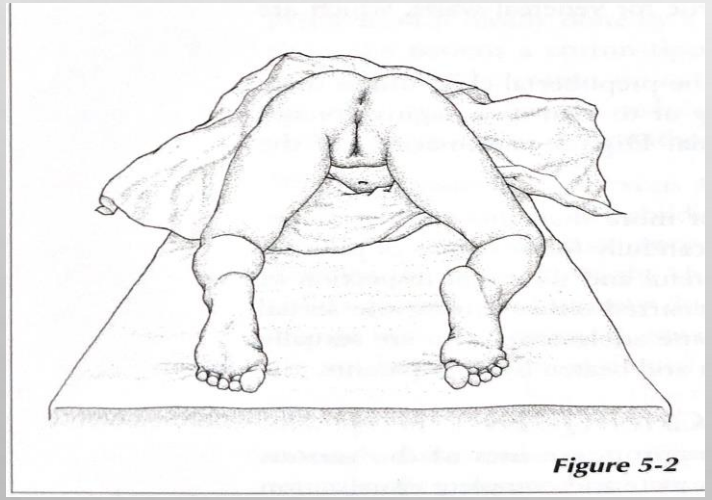


Figure 5-2

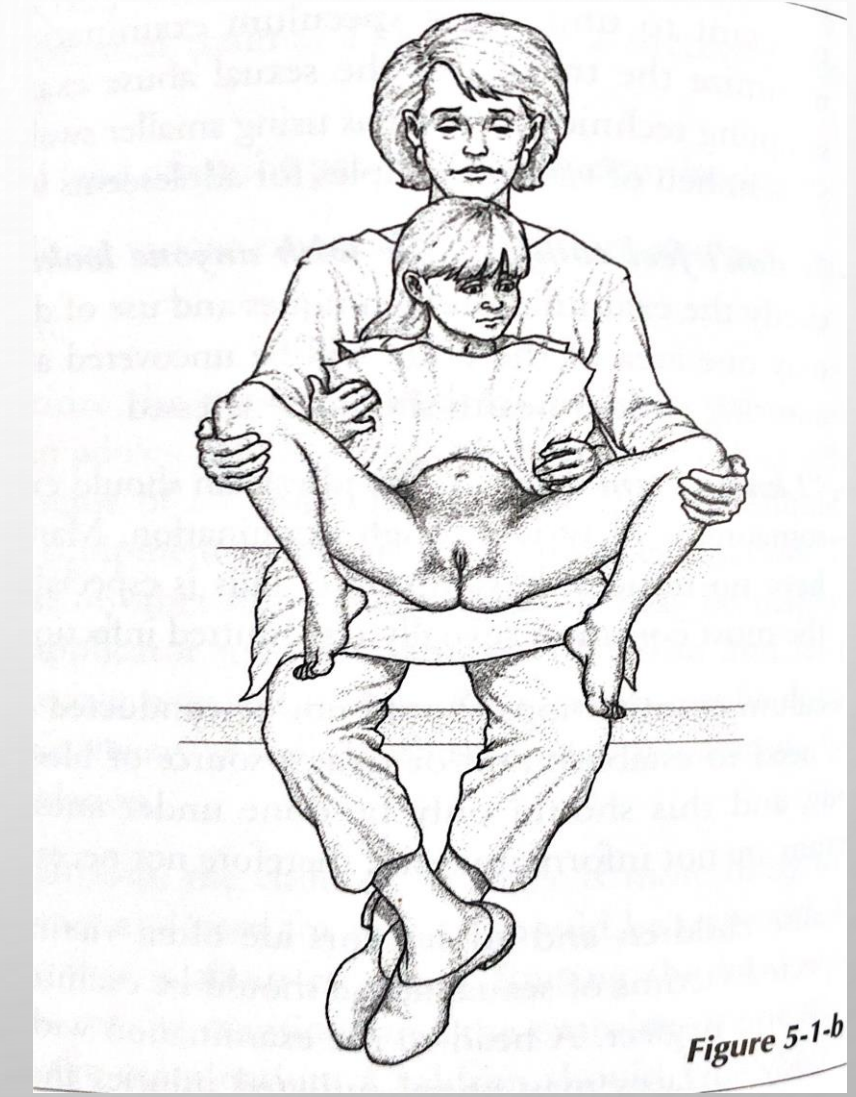
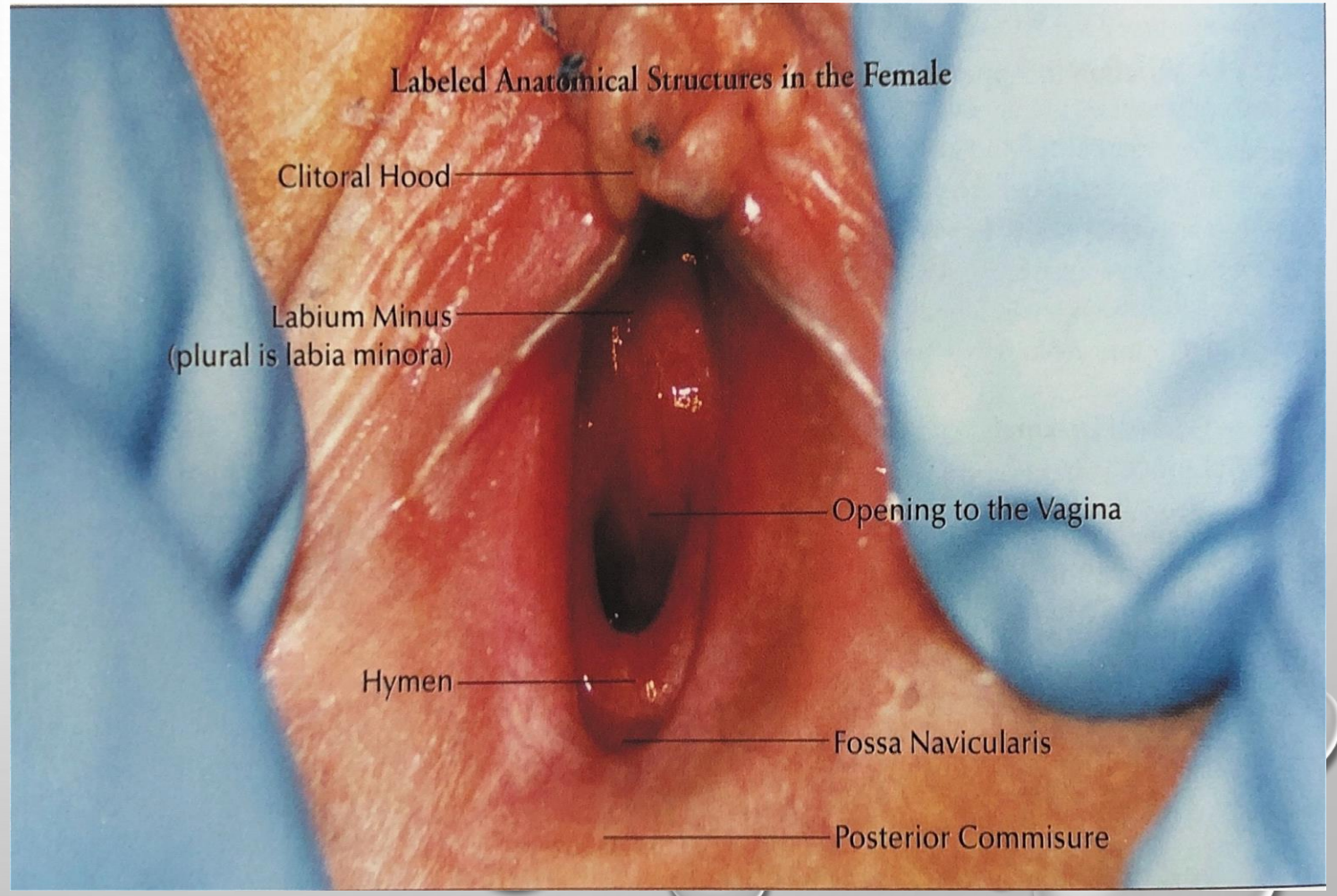


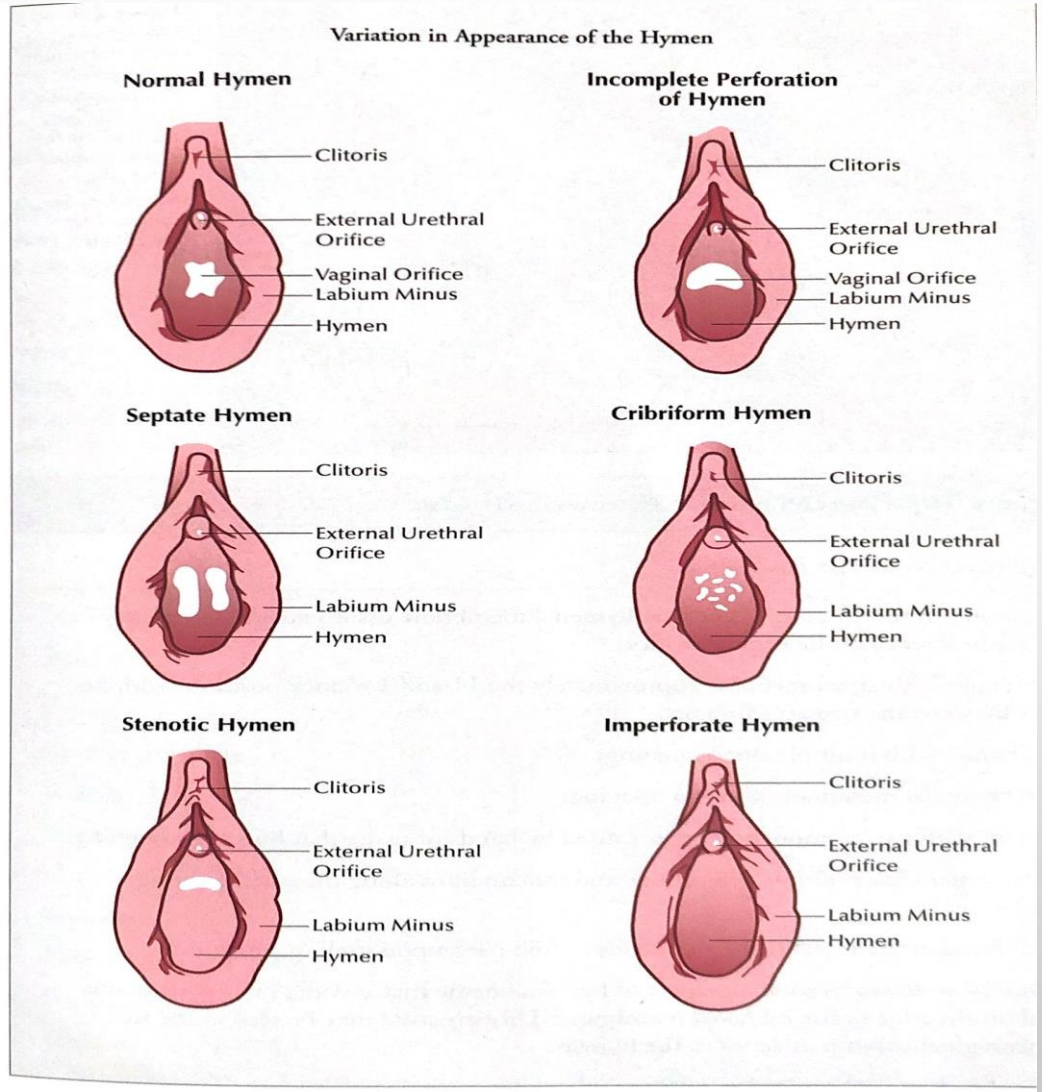
Figure 5-1-b

CASE #2

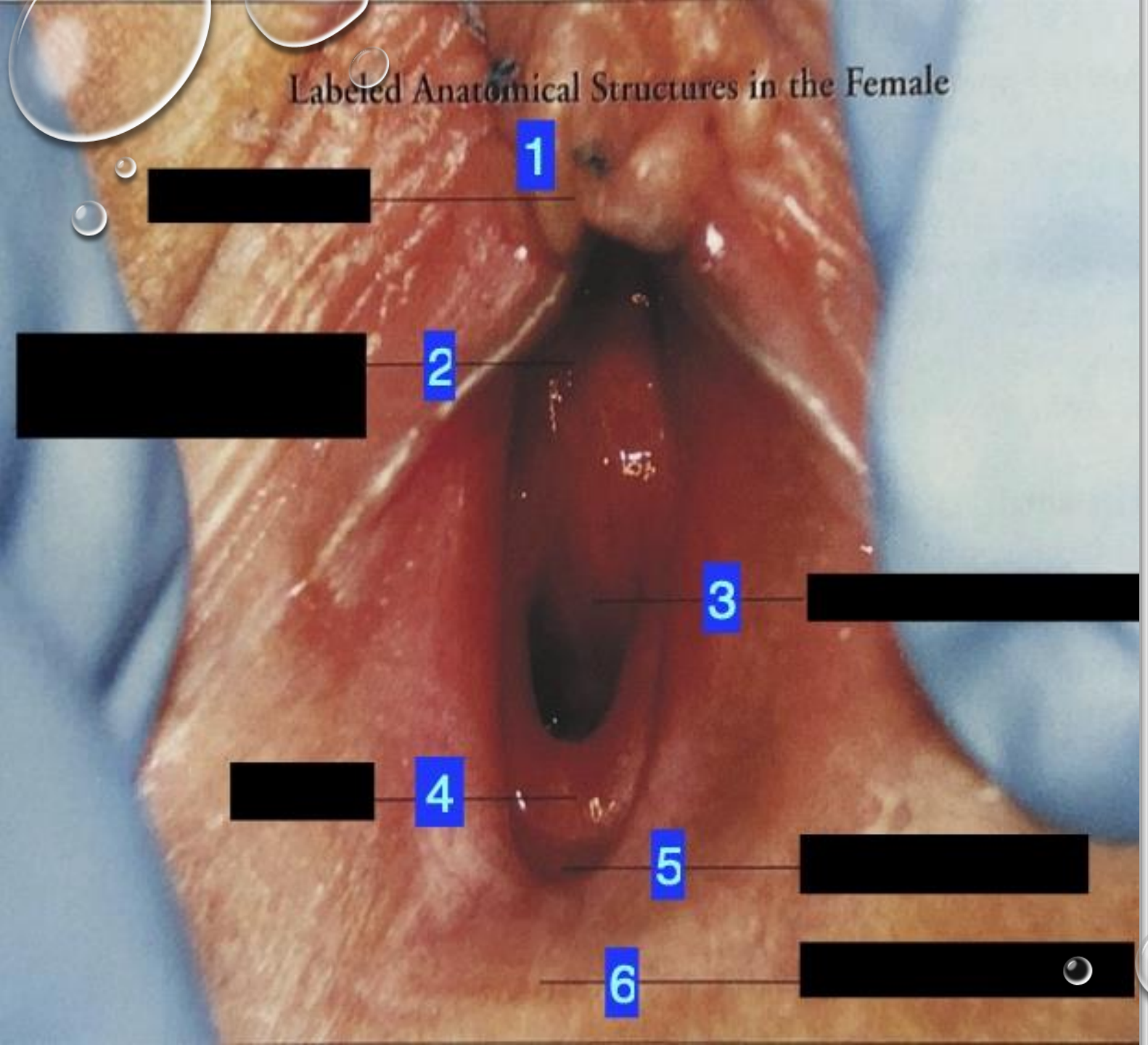
- Clitoris: commonly small, covered by clitoral hood in prepubescent children.
- Labium minus / labia minora: folds extend from clitoral hood to midpoint of lateral walls on vestibule (in adults, they enclose vestibular structures)
- Hymen (see next slides)
- Fossa navicularis: concavity on lower part of vestibule, extends to posterior commissure
- Posterior commissure: union of labia majora inferiorly



NORMAL HYMENAL VARIATIONS



- 6 main types of "normal" hymenal variation
  - Annular: hymenal tissue extends circumferentially around orifice
  - Crescentic: two attachments at 11 and 1 o'clock and no tissue present between attachments
  - Cribiform: multiple small openings
  - Imperforate: no opening
  - Septate: two or more openings with tissue between the openings
  - Fimbriated: hymen with multiple projections and indentations ("ruffled")



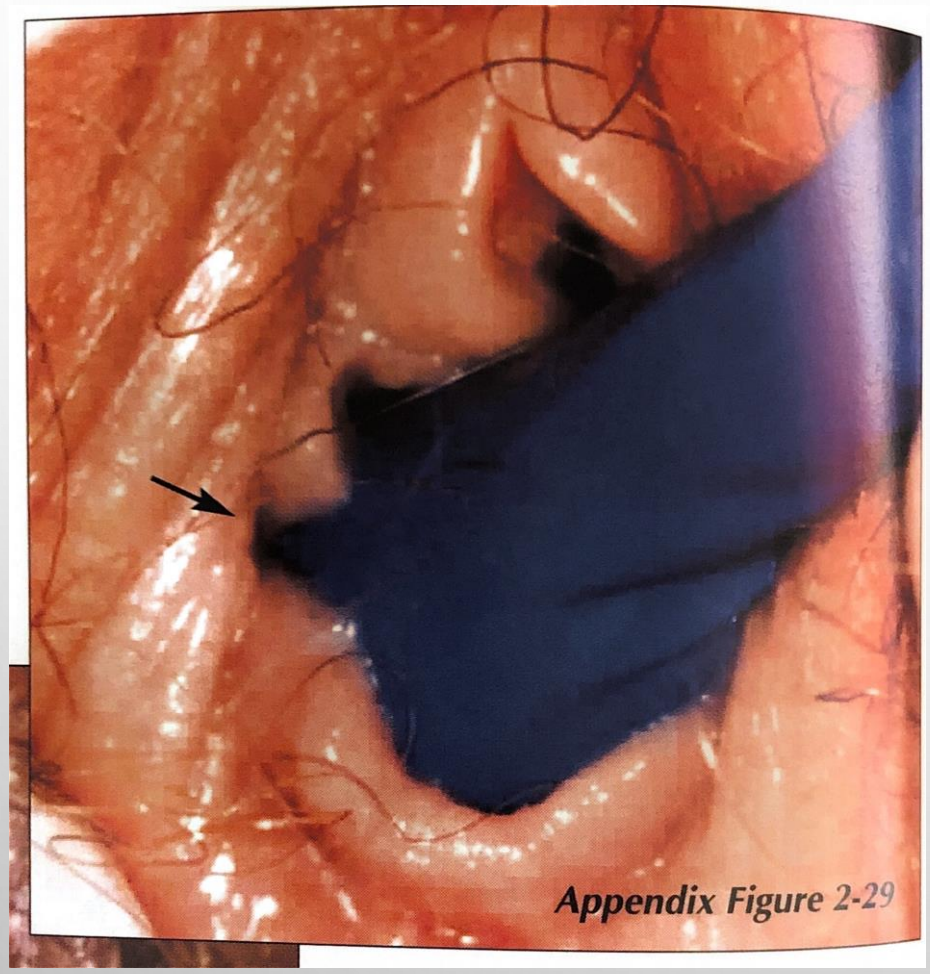
CASE #2

- Quiz time – normal anatomy interactive quiz
- Using the following link, please label the drawing to the left with the correct anatomical terms.

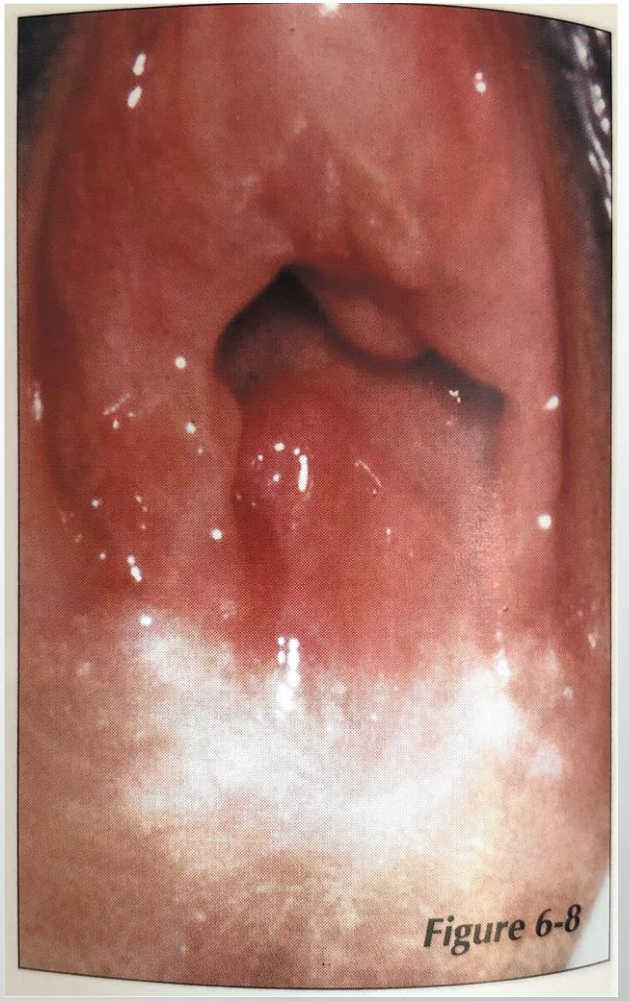
PHYSICAL EXAM AND CSA (ADAMS)
SEE HANDOUT

Findings Caused by Trauma and/or Sexual Contact
Acute trauma to external genital / anal tissues, which could be accidental or inflicted: 1. Acute lacerations or bruising of labia, penis, scrotum, perianal tissues, or perineum. 2. Acute laceration of the posterior fourchette or vestibule, not involving the hymen.
Residual (healing) injuries to external genital/anal tissues (rare findings, difficult to diagnose): 1. Perianal scar 2. Scar of posterior fourchette or fossa.
Injuries indicative of acute or healed trauma to the genital/anal tissues: 1. Bruising, petechiae, or abrasions on the hymen 2. Vaginal laceration 3. Perianal laceration with exposure of tissues below the dermis 4. Healed hymenal transection / complete hymenal cleft 5. Defect in posterior (inferior) half of the hymen wider than a transection with an absence of hymenal tissues
Infections transmitted by sexual contact, unless evidence of perinatal transmission or clearly, reasonably, and independently documented by rare nonsexual transmission: 1. Genital, rectal, or pharyngeal *Neisseria gonorrheae* infection 2. Syphilis 3. Genital or rectal *Chlamydia trachomatis* infection 4. *Trichomonas vaginalis* infection 5. HIV, if transmission by blood transfusion has been ruled out
Absolutely diagnostic of sexual contact: 1. Pregnancy 2. Semen identified in forensic specimens taken directly from a child's body.

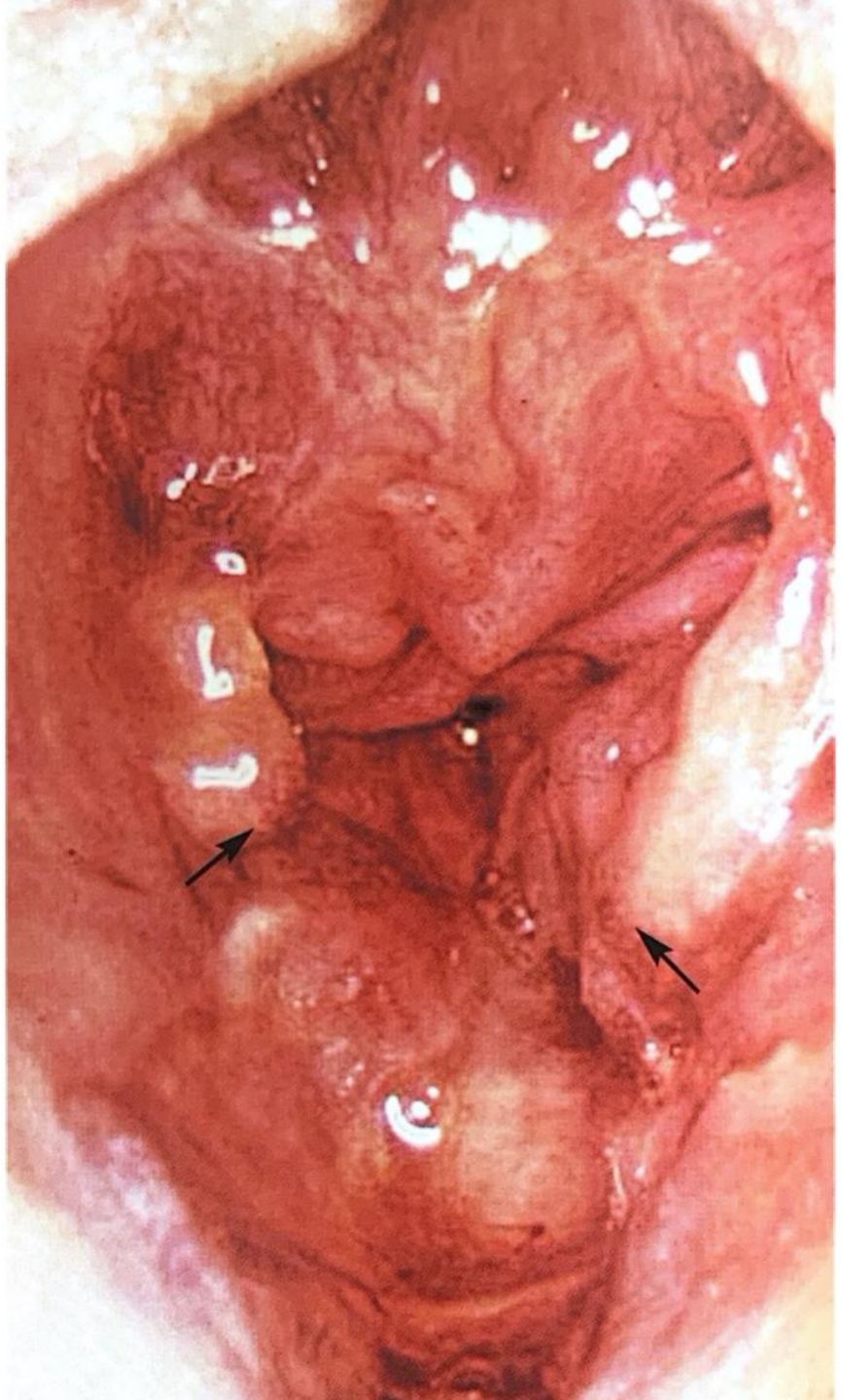
PHYSICAL EXAM AND CSA



Complete transection of the hymen found in an 18-year-old who disclosed consensual intercourse (note the estrogenized hymen).



Complete lack of posterior hymenal tissue + perineal scarring (history of abuse)



CASE #2

- Take a moment independently and see if you can identify what you're looking at.
- The voiceover will tell you the answers.

CASE #2

- Checkpoint: where do we go from here?

INTERACTING WITH PARENTS: TIPS

- Setting expectations
  - Start every encounter with an overview of what to expect
  - Include the fact that you will be talking to the child alone at some point
  - Explain early that you will not be sharing what is said during the interview
- Honesty
  - About the process
  - About the results (within reason)
  - About your limitations
- Reassurance
  - In the safety of the child in your care
  - In your thoroughness and your ability to refer accurately and completely
- A clear path
  - A complete overview of the encounter from start to finish.

INTERACTING WITH PARENTS: SUPPORTING PARENTS AND CHILDREN

- Pre-exam
  - Set clear expectations and boundaries
  - Allow time for questions
  - HONESTY: remind parents of mandated reporting status
- Post-interview
  - Reaffirm that you will not be discussing the interview with the parents
- Post-exam
  - It's normal to be normal, but normal doesn't mean that nothing happened
- Overall
  - Counsel parents on not independently questioning the child (spontaneous discussion is different)
- What IF questions
- Consider: child safety, DCFS reporting, mental health, need for physical / forensic exam

CASE #2

- What tests do we order? How do we collect evidence in children?

- In pre-sexual children, we routinely order gonorrhea / chlamydia tests. In sexually active or "presumed" sexual activity teenagers, this is much more complicated (like adults) and we tend to treat prophylactically / blindly.

- There are a few principles of evidence collection in children, most notably that we do not routinely perform speculum exams on pre-estrogenized children (i.e., before puberty). Thus, we do not routinely collect evidence from the vaginal vault unless deemed necessary.

CASE #2

- Lab test results
- Negative GC/CT.

- You referred to CPS. They did a complete investigation, including a forensic interview, and found that the child disclosed that mother had a new boyfriend who was abusing her. The child was able to stay in the home since mom was not aware of the abuse and the boyfriend was arrested. The child is doing well in therapy and the family is also attending therapy.

CLINICAL CITATIONS

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STAY SAFE AND HEALTHY!

THANK YOU!

- Please contact me with any questions, concerns, or thoughts – I welcome your feedback, stories, successes!
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