

Violence Against Women: Partner Abuse and Sexual Assault

Martin T. Donohoe, MD, FACP

Heise et al¹ have defined *violence against women* as any act of verbal or physical force, coercion, or life-threatening deprivation that causes physical or psychological harm, humiliation, or arbitrary deprivation of liberty, or that perpetuates female subordination. Examples of this include partner abuse, sexual assault (including marital rape), forced prostitution, forced noncompliance with contraception, female genital mutilation, and sexual slavery. This article will primarily focus on partner abuse and sexual assault of US women. Other forms of individual violence against women as well as international violence against women are mentioned briefly in this paper; these and societal/structural forms of violence against women (eg, political and legal marginalization, biased divorce laws, impaired access to education) have been reviewed elsewhere.¹⁻³

Partner abuse and sexual assault occur frequently and are present in all races and social classes, yet remain underrecognized by physicians. Domestic violence and rape lead to myriad harmful physical and psychological sequelae, both short- and long-term. This paper discusses the epidemiology of partner abuse and sexual assault, common characteristics of abusers and their victims, and the reasons clinicians fail to recognize and properly care for those afflicted. Tips on recognizing and managing domestic violence and rape are described. The purpose of this paper is to aid health care providers in assisting victims of domestic violence and rape.

EPIDEMIOLOGY OF PARTNER ABUSE AND SEXUAL ASSAULT

Estimates of lifetime prevalence of assault and sexual abuse in the United States range from 15% to 25%.⁴⁻⁶ An estimated 5.3 million interpersonal violence victimizations occur among US women ages 18 years and older annually, resulting in nearly 2 million injuries, with more than 550,000 of these injuries requiring medical attention.⁷ Annual incidence of 1 or more episodes of intimate partner violence is 17%.⁸ In a recent survey, approximately 1 in 5 female students between grades 9

and 12 reported being physically and/or sexually abused by a dating partner at some point in their lives.⁹ After controlling for potential confounders, dating violence was associated with increased risk of substance use, unhealthy weight control behaviors, high-risk sexual behaviors, pregnancy, and suicidal tendencies. Fifteen percent to 20% of women seen in primary care clinics have been abused within the preceding year,^{5,10} and 22% to 35% of women treated for trauma in emergency departments are there as a direct result of violence.^{10,11} One quarter of women who attempt suicide and one quarter of women treated for psychiatric symptoms are victims of domestic violence; women with depression have a 55% lifetime prevalence of physical abuse. The estimated incidence of abuse in pregnancy ranges from 8% to 20%, with the most common sites of beating being the abdomen, head, and breasts.¹²⁻¹⁴ Abuse in pregnancy increases the risk of low birth-weight, preterm labor, and delayed prenatal care.¹³ Two thirds of teen mothers were raped or abused as children.¹⁴ Fifty percent to 70% of mothers of abused children have been abused themselves.¹⁴

Epidemiology of Partner Abuse

More than 50% of women murdered in the United States are killed by a current or former partner, and 50% to 75% of the 1000 to 1500 murder-suicides per year involve domestic violence.^{4,15} In one study, up to half of women who survived an attempted homicide did not recognize that their lives were in danger.¹⁶ The average prison sentence of men who kill their female partners is 2 to 6 years. Battered women who claim self-defense in criminal trials are acquitted only 25% of the time.¹⁷

Domestic violence against women occurs in all age, race, and socioeconomic brackets.¹⁸ Some investigators have found higher rates in African Americans and Latinos, but confounders include lower socioeconomic

Dr. Donohoe is a medical director, Old Town Clinic, and an adjunct lecturer, Department of Community Health, Portland State University, Portland, OR.

status and fewer resources. Also, these patients may be more likely to be seen in emergency departments or to use public shelters than to visit private physicians, making them more likely to appear in statistics.¹⁹ Women in many cultures are socialized to accept unwanted, forced sex or emotional chastisement as part of the husband's marital prerogative.¹ For instance, Mexican American and African American community attitudes toward rape are significantly less feminist than those of whites, that is, more fault finding of victims and less willing to define situations as rape.²⁰ Furthermore, Mexican American and black rape victims suffer greater psychological distress than white rape victims.²⁰

Epidemiology of Sexual Assault

Rape is defined as unwanted, forced oral, vaginal, or anal penetration. Rape is reported by 33% to 46% of women who are physically abused.²¹ Annual incidence is greater than 80 per 100,000 women and lifetime prevalence may reach as high as 25%. Forty percent of college women report forced sexual contact, attempted rape, or completed rape, independent of school demographics. More than 25% of college men actually admit to using sexually coercive behaviors, most commonly ignoring a victim's protests. Interestingly, two thirds of college men report engaging in unwanted sexual intercourse, most citing peer pressure or a desire to be liked.²² Spousal rape occurs in up to 10% to 15% of all marriages and tends to be more violent and less frequently reported than nonspousal rape.²¹ Spousal rape is not illegal in many US states and other countries.^{1,23}

Seven percent of all violent crimes are rape.²¹ Rape is a very underreported crime, and less than 1% of rapists are convicted; average prison time for those found guilty is just 1 year. Some states have instituted chemical castration laws as adjuncts to prison sentences, but the efficacy and ethics of these laws are questionable.²⁴

CHARACTERISTICS OF VICTIMS AND ABUSERS

While abusers and abuse victims fit many profiles and come from all socioeconomic backgrounds, certain characteristics are common among victims. These traits include low self-esteem, feelings of guilt or self-blame, denial, a history of childhood abuse, having few friends, traditional attitudes regarding women's roles, having children; and having poor financial resources, few job skills, and less education than age-matched controls.⁵ Abuse in childhood or adolescence predisposes an increased risk for abuse in adulthood.²⁵ Adolescent victims of dating violence show higher lev-

els of high-risk behaviors (eg, smoking, binge drinking, substance abuse) and higher rates of depression as well as suicidal tendencies later in life.^{26,27}

Women in the military are 5 to 20 times more likely than other government employees to have suffered a completed or attempted sexual assault.²⁸⁻³⁰ The higher rates of chronic pelvic pain, dysmenorrhea, abnormal periods, premenstrual syndrome, and dissatisfaction with sexual relations seen in this group all correlate with a history of sexual trauma while in military service.^{31,32} In a recent Veterans Affairs study, 24% of patients under age 50 years reported domestic violence within the past year.³² Other high-risk groups of individuals include prostitutes, 80% of whom have been physically assaulted and 67% of whom have been raped, and runaway and homeless youths who often use sex in exchange for shelter, food, drugs, or money.³³

Common characteristics of abusers include low self-esteem, dependency, jealousy, and poor communication skills; they are more likely to be unemployed or underemployed, to abuse alcohol and other drugs, to have witnessed or experienced abuse as children, and to abuse their own children.^{5,34} High-risk perpetrators include male college athletes; while they constitute 3.3% of the male student body, they are involved in 19% of on-campus sexual assaults.²² Individual and gang rapes are also reported more commonly in fraternities than in other campus settings.

CHILD ABUSE IN THE SETTING OF PARTNER ABUSE

Child abuse is seen in one third to one half of families where partner abuse occurs.^{5,35} Children witness up to 85% of episodes of partner abuse, which may in itself constitute child abuse.^{5,35} Children of abuse victims may be injured when attempting to intervene to protect an adult victim; they also show decrements in academic and emotional development and are more likely to become abusers themselves.^{5,35,36}

PHYSICAL, PSYCHOLOGICAL, AND SOCIAL CONSEQUENCES OF DOMESTIC VIOLENCE AND RAPE

Physical sequelae of violence against women include trauma (bruises, fractures, and lacerations), chronic pain (headaches, myalgias, and abdominal, pelvic, lower back, and chest pains), hyperventilation syndrome, eating and sleeping disorders, sexually transmitted diseases, recurrent vaginal yeast infections, and urinary dysfunction (including stress and urge incontinence); in addition, there is a delayed risk of hypertension, arthritis, and heart disease.^{5,37-40} Irritable bowel syndrome is common;⁴⁰ symptom severity correlates with the severity and duration of the abuse.⁴¹ Victims of domestic

violence have a fivefold-increased risk of developing a psychiatric disorder; 10% of domestic violence victims attempt suicide.⁵ Victims also may experience a recurrence of both physical and psychological symptoms in later, otherwise healthy relationships.

Rape victims show a much higher prevalence of alcoholism and drug abuse than the general population, with the substance abuse beginning after the rape.⁴² Early psychological sequelae of rape include withdrawal, confusion, psychological numbing, a sense of vulnerability/hopelessness/loss/betrayal, shock, denial, and distrust of others. Long-term psychological outcomes include depression, anxiety disorders, phobias, anorexia/bulimia, substance abuse, post-traumatic stress disorder (with nightmares and hypervigilance), and suicide.^{5,12,43} While all women respond differently, in general, rape victims may seem either unnaturally calm and detached or be crying and angry immediately following the crime. Following a denial phase of about 2 months, psychological symptoms gradually increase over several months, followed by slow, gradual psychological healing.⁵

VIOLENCE AGAINST WOMEN IN THE DEVELOPING WORLD

Partner Abuse and Sexual Assault

As in the United States, women in the developed and developing worlds suffer verbal, emotional, physical, and sexual abuse. Worldwide, at least 1 woman in 3 has been beaten, coerced into sex, or otherwise abused in her lifetime.^{2,3,44–50} In several countries, including Bangladesh, Cambodia, Mexico, and Zimbabwe, many people see wife beating as justified. In rural Egypt, up to 81% of women say that wife beating is justified under certain circumstances.⁴⁴ In the developing world, resources for victims are extremely limited. As recently as 1996, Mexico City, one of the most heavily populated cities in the world, had only 1 shelter for battered women.⁵¹

South Africa has recently suffered a “rape epidemic.”⁵² Their official rape rate is 104 per 100,000 people (versus 34 per 100,000 in the United States), the highest rate in the world. An estimated 50,000 rapes occur annually, but only 1 in 35 are reported. Victims are at high risk of acquiring HIV infection, due to rates of infection of up to 40% in young adult males and the poor availability of post-rape antiretroviral drugs in government hospitals.⁵²

Female Genital Mutilation and Other Forms of Individual Violence

Worldwide, 100 million women (most of whom live

in sub-Saharan Africa) have been affected by female genital mutilation.⁵³ Procedures range from simple clitoridectomy to infibulation (removal of the clitoris and labia minora and stitching the labia majora together, leaving a small opening posteriorly for urine and menstrual blood) and are performed on 2 million girls per year. Operations are most commonly carried out on young girls between ages 4 and 10 years, with physicians performing about 12% of procedures.⁵⁴ Cutting is often done under nonsterile conditions and without anesthesia. Complications and sequelae include bleeding, infection, dyspareunia, painful neuromas, keloids, dysmenorrhea, infertility, decreased sexual responsiveness, shame, fear, and depression.⁵⁴ Physicians managing those who have suffered genital mutilation need to be sensitive to cultural identity issues and aware of the availability of deinfibulation procedures.⁵³ Immigrant women who fear that they may face a forced operation upon return to their countries of origin have successfully petitioned for political asylum. The United Nations, World Health Organization, and Federation Internationale Gynecology and Obstetrics have all condemned female genital mutilation.⁵³

Other types of individual violence against women that are noted more frequently in the developing world than in the United States include dowry-related murder; bride-burning; forced abortion and sterilization; divorce restrictions; forced prostitution; child prostitution; selective abortion, malnutrition, or killing of female children; the use of suicide as “vengeance” against an abusive spouse; and post-rape suicide or homicide, often carried out by friends or relatives to “cleanse the family honor” after a rape.^{1,55} Other disturbing international phenomena also include sexual slavery at animist shrines in Ghana, Benin, and Togo;⁵⁶ the widespread belief in sub-Saharan Africa that having sex with a virgin cures HIV infection;⁵⁷ and physicians’ performance of virginity examinations to certify women as pure and “marriageable,” which occurs in Turkey and elsewhere.⁵⁸

COSTS OF INTIMATE PARTNER VIOLENCE

Health care costs associated with domestic violence are substantial.^{59,60} The cost of intimate partner rape, physical assault, and stalking exceed \$5.8 billion each year, \$4.1 billion of which is for direct medical and mental health services. The total costs of intimate partner violence also include nearly \$0.9 billion in lost productivity from paid work and household chores for victims of nonfatal violence and \$0.9 billion in lifetime earnings lost by victims of intimate partner homicide. Despite broad support for public health expenditures for

domestic violence prevention, funding remains woefully inadequate.⁶¹

RECOGNITION AND MANAGEMENT OF DOMESTIC VIOLENCE AND SEXUAL ASSAULT

Management of Domestic Violence

Physicians should make routine, repeated assessments of women for domestic violence in all clinical settings; maintain a supportive, nonjudgmental attitude; avoid victim-blaming; validate the woman's experiences, building on her strengths, and transferring power and control to her; be available, providing frequent follow-up; and involve social services.^{62,63} They should discover the nature and duration of the abuse; assess for child abuse and insure children's safety by following mandated reporting laws; keep detailed records, including photographs; testify in court as needed; and not recommend marriage counseling.^{5,11}

Acutely increased danger is likely when the abuser has a criminal record, an alcohol or substance abuse problem, a gambling addiction, or an active psychiatric disorder; owns a gun; or when there is a situational trigger such as a job loss or death in the family.^{34,64–66} Risk is heightened when the severity and frequency of beatings increases or when threats, stalking, violent or forced sex, or destruction of property escalate.^{64,66} Of men with restraining orders, 75% have a criminal record and 50% have a history of violent crime.⁶⁷ In one study, 15% of reestrained violated their restraining order and 30% were arraigned for a violent crime over a 6-month period.⁶⁷

Physicians should insure the victim's safety, assist her in obtaining a restraining order, provide her with phone numbers of shelters and hotlines, and help her develop a plan for a quick exit, including a safe place to go. Patients should have important items (eg, driver's license, birth certificate, credit cards, and documents related to their children's health) handy in case a rapid exit is required.

Management of Sexual Assault

In caring for victims of sexual assault, physicians should obtain a full medical history, evaluate and treat physical injuries, obtain cultures, treat pre-existing infections, offer postexposure HIV prophylaxis, offer postcoital contraception (versus in utero paternity testing followed by selective abortion for those who might already be pregnant), arrange medical follow-up, and provide counseling.²¹

The risk of pregnancy in rape victims not using contraception has been estimated at 2% to 4%.²¹ In addition, rape victims have a substantial risk of acquiring a sexually

transmitted disease (rates for gonorrhea among rape victims are 6%–12%; chlamydia, 4%–17%; and syphilis, 0.5%–3%).²¹ The odds of acquiring HIV (depending on the nature of the forced sex, infectivity of the perpetrator, and presence of erosions or sores on the victim or rapist) has been estimated at 1 to 2 per thousand.²¹

Physical examination involves collection of clothing; an external evaluation for abrasions, lacerations, ecchymoses, and bite marks; examination of the oral cavity for secretions and injuries, as well as collection of samples for culture; collection of evidence from the genital area through hair combing and sampling; assessment of the vagina and rectum for internal injuries; and collection of vaginal and rectal cultures.²¹

Options for sexually transmitted disease prophylaxis for adult victims of sexual assault are⁶⁸:

- Ceftriaxone 250 mg intramuscularly
- Spectinomycin 2 g intramuscularly plus doxycycline 100 mg orally twice a day for 7 days
- Azithromycin 1 g orally plus metronidazole 2 g orally

Pregnancy prophylaxis options for adult victims of sexual assault are⁶⁹:

- Ingestion of 0.1 mg of ethinyl estradiol and 1.0 mg DL-norgestrel (equivalent to 0.5 mg levonorgestrel) in 2 doses taken 12 hours apart starting within 72 hours of rape (Preven, Gynetics, Somerville, NJ)
- Ingestion of 0.75 mg of levonorgestrel in 2 doses taken 12 hours apart starting within 72 hours of rape (Plan B, Barr Laboratories, Pomona, NY)

Antiemetics taken 1 hour before the first dose may reduce the incidence and severity of nausea and the incidence of vomiting but are ineffective if taken after the onset of these side effects, which occur in 12% to 22% of patients using the combination method and much less frequently with the progestin-only method. HIV prophylaxis can be started up to 72 hours after a rape;^{70,71} tetanus toxoid and hepatitis B vaccination and/or hepatitis B immune globulin should be offered as clinically indicated.^{21,70,71}

Failure to Recognize and Manage Domestic Violence

Screening practices of primary care providers vary, but on the whole, physicians frequently fail to recognize violence against women.⁷² This results from a fear of offending patients, feelings of powerlessness, time constraints, low confidence in their ability to effect change, a

sense of their own vulnerability, and deficits in education and training. Doctors frequently underestimate the prevalence of domestic violence in their patients and communities. Female physicians may be better than male physicians in detecting domestic violence and in taking more thorough histories.⁷³ Compassionate asking and building trust are useful in getting patients to discuss abuse since many victims are reluctant to raise the issue on their own.^{44,74} Buttons, posters, and educational materials prominently displayed in the provider's office help to create an environment conducive to discussion of domestic violence.⁶²

Regrettably, the availability of domestic violence shelters in the United States is poor, with up to 70% to 80% of women and 80% of children turned away on any given night in major cities.³⁵ Shelters are woefully underfunded. The average length of stay at a US shelter is 14 days; most allow a 30-day maximum stay.³⁵ More than 50% of all homeless women and children become homeless as a direct result of fleeing domestic violence.³⁵

Mandatory Reporting of Partner Abuse

Recently, some states have adopted laws mandating that health care providers report actual and/or suspected partner abuse.⁷⁵ These statutes arose from the context of other laws requiring providers to protect often-helpless victims and out of the recognition of domestic violence as assault, a crime.

Laws requiring reporting of child abuse were initially resisted by those who claimed that excessive physical discipline of children was a "family matter." Elder abuse laws were opposed by those who felt that, as adults, elders should be able to speak up for themselves. Nevertheless, we now recognize child welfare as both a parental and societal responsibility, and we acknowledge that the elderly are often unable to confront abusers or escape from unsafe situations for both health and financial reasons. Similarly, laws mandating reporting of domestic violence are thought by some to be unnecessary (laws already require reporting of many types of assault, such as those involving deadly weapons) and to infringe on a victim's rights to assess her own safety and decide when it is wisest to leave her partner. Indeed, the risk of serious violence may increase after a victim leaves, especially if restraining orders are not processed, abusers are not prosecuted, and shelter beds are unavailable.⁷⁵ In a recent study of patients reporting physical or sexual abuse, 56% supported mandatory reporting and 44% opposed it.⁷⁶ Those currently seeing or living with the abusive partner and non-English speakers had higher rates of opposing mandatory reporting. Seventy-one percent of

unabused women supported mandatory reporting. A majority of California physicians recently surveyed reported that they might not comply with that state's law if a patient objected.⁷⁷

CONCLUSION

Partner abuse and sexual assault are common, both in the United States and internationally. The myriad forms of societal and structural violence against women sustain and even promote the milieu in which individual violence against women occurs. The goal of this brief overview is to assist clinicians in recognizing and managing partner abuse and sexual assault in their patients and encourage medical educators to enhance curricular offerings for students, trainees, and practicing clinicians. Curricula should discuss the medical profession's obligations and roles in combating violence against women, with their patients, in their institutions and communities, and in the world. Then, clinicians will be better equipped to discuss abuse routinely with their patients, colleagues, and students as well as to lobby at the local, national, and even global level for more funding for research, treatment, and prevention, and for changes in law and policy to protect victims and to improve the status of women.^{1,2,78,79}

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