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Intimate Partner Violence (IPV): Both a Social and a Medical Phenomenon: Part II

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Abstract: In this part (II) we present the variety of reasons concerning the appearance of IPV which in no case do they justify this brutal action. There are also several factors of IPV behind this brutal behavior. It is really important to stress that there is no excuse relating to the violent behavior of the abuser. Moreover, since the victims feel ready to share these abusive experiences with the authorities, the clinical doctors and dentists, it is a necessity for the doctor/dentist to be aware of all the indications leading to the conclusion that we have a case of IPV. Having a physical examination combined with the strange behavior of the suspected victim, one can find the truth behind the story of a potential accident and prevent any further brutal behavior connecting with the victim. In concluding it is important to examine cases of domestic violence, the victim's profile, all the dangerous consequences relating to IPV as well as approaches to help dealing with this phenomenon.

Key words: Intimate partner, risk factors, indications, victims profiles, abuser, authorities

INTRODUCTION

Intimate Partner Violence (IPV) refers to the expression of physical aggression, psychological or financial abuse or forced inter-course (Krug *et al*., 2002) that occurs between spouses, former spouses or non-married intimate partners (Thompson *et al*., 2006). Whether it is a physical or a psychological action it aims at controlling the victim. Health care professionals should be aware and alert during examination, for bruises, biting marks and bone fractures are indicators of physical assault and occur most frequently in the head and neck region (Bhandari *et al*., 2006). The victim's explanation for the injuries is significant for the assessment of the real cause as domestic violence victims are reluctant to cooperate for they think of themselves as being it worth to be treated this way by their partners.

IPV is not related to the status of a society for it occurs even in developed ones and is a phenomenon that affects both males and females. Some precipitating factors of IPV are low educational level, financial difficulties, history of familial violence and alcohol abuse. Violence is unfortunately a vicious cycle, for children being victims of violence may become either perpetrators or victims in their adulthood (Welles *et al*., 2010). The consequences of IPV on physical and mental health of the victims are crucial as apart from the injuries and chronic pain syndromes, victims may experience depression, suicidal behaviour and become impaired in their social life. Thus, screening for IPV, albeit difficult is mandatory for providing the adequate social support for protecting the safety and well-being of the victims.

FACTORS ETIOLOGICALLY RELATED TO IPV

The reasons for IPV vary and of course are not adequate to justify this unaccepted and brutal behaviour. Some situations that lead to violent behaviour against the female spouse are (Herschaft *et al*., 2006):

- Stress caused by financial inconvenience like in cases of unemployment
- Jealousy
- Feelings of inferiority when the female has a respectable career and brings a larger income to the household
- Alcohol problems

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- Drug addictions
- Psychological disorders due to childhood traumas

These and other parameters compose the excuses of the abuser. The only certainty is that the blame is never on the victim's side although, most of the times, abused women tend or are forced to believe it's their fault so they are worth to live a life of tolerance, guilds and torture. Because of the above stance that battered women take, any attempt made with intention of helping them and protecting them is unfortunately blocked and eliminated (Le *et al*., 2001). There are some factors which are considered to be the risk factors of intimate partner violence. Some of them include:

- Young age
- Low academic achievement
- Low income
- Involvement in aggressive behaviour as an adolescent
- Certain personality factors such as low self-esteem, depression or antisocial personality disorders
- A history of violence mostly in the male's family (mother beaten by his father) which creates a certain role-model whom the male tries to echo
- Excessive alcohol use which can lead the abuser to act violently without thinking

Nevertheless it is not implied that the violent behaviour is provoked in any way by the victim. The only one guilty and responsible for criminal acts is the abuser (Nixon *et al*., 2004; Ehrensaft *et al*., 2006). An important aspect is that physical or sexual abuse in the childhood is positively related with perpetration as well as victimization in the adulthood (Welles *et al*., 2010).

INDICATIONS OF IPV

Since the victims are reluctant to collaborate with the authorities and report the abusive episodes, the clinical doctors and dentists that treat these women, need to be experienced and aware of signs that connect and relate the injuries with intentional and violent background even though the patient insists on the accidental causing (Le *et al*., 2001; Mehra, 2004; Thompson *et al*., 2006). Some of these indications are (Herschaft *et al*., 2006):

- Bruises found in different stages of healing. These imply repeated assaults
- Bilateral injuries in the facial area that can't be the result of an accident of any kind
- Biting marks
- Lip lacerations and nasal injuries that were caused by fist
- Also the neck area is usually injured in cases of abuse
- Mandibular fractures

It is obvious that head, neck and musculoskeletal injuries are the most common types of IPV (Bhandari *et al*., 2006). Physical examination combined with the peculiar and suspicious behaviour of the patient guide the doctor/dentist to suggest the possibility of domestic maltreatment by the intimate partner of the patient. The assumption is conducted due to the following scrappy narrations and explanations of the potential victim:

- In many cases the story of the accident does not agree with the examination findings
- It is possible that the patient avoids straight answering to the medical examiner's questions concerning his/her wounds and gives false and inaccurate information
- Although, it seems childlike for an adult, it is a fact that some of the victims claim strange and rare unknown diseases responsible for the signs and bruising that is found
- When the authorities and the staff in the medical institution notice from the patient's files and previous medical records that this particular person asked for treatment in the past from several different doctors but for very similar situations that connote domestic abuse (Mehra, 2004; Cohen and Johnson, 2006; Herschaft *et al*., 2006)

VICTIMS PROFILES

It is more than a necessity that the doctor and dentist is fully qualified to recognise cases of domestic abuse and IPV and has the promptitude to deal with this according to the procedure regulating similar situations. Firstly it's his/her obligation to isolate the victim for an intimate conversation away from the possible abuser so that he/she feels more comfortable and safe to talk. Of course it is recommended that a female nurse is present during the interview as a witness and as a woman to aid the procedure. It's not paradox that the victim will refuse everything and will insist on the original grotesque story for the incident and this happens for many reasons that will be mentioned later on. The doctor's duties and jurisdictions don't end at the examination, treatment and pointless interview without an outcome; he/she must report the case for further investigation to the proper

authorities, if his suspicions are based on strong evidence or even if it is just a hint for potential abuse. The victims of intimate partner abuse almost never voluntarily respond to the help they are offered and refuse to admit their situation or name the abuser (Le *et al*., 2001; Mehra, 2004; Cohen and Johnson, 2006). Not accepting the situation is self-destructive for the victim and comes from the fear of exposing personal information that will scar her for life as a member of a civilised society. One of the worst cases is when the victim after the repeated assaults is torn and an emotional wreck that doesn't have the strength to fight back, raise any defences and ask for professional assistance. She is terrified of the abuser and his possible threads against her physical integrity. Sometimes the victims feel responsible for their partner's behaviour and violent outbursts. They are in love with their partner and don't want him/her to be imprisoned. They are afraid that their confession will affect her children if there are any and she might even loose them if the authorities get an overlook of the environment the children were growing.

It is possible that the victim is in denial of the severity of the situation, probably because she/he is unaware of his/her rights or of the authorities that specialise on matters of violence and are available to aid them at any time. Prejudice and religious or cultural restrictions conflict with the desire of the victim to report the maltreatment. Generally, disbelief, concerning the credibility of the authorities, prevails over the need for salvation from the torturer/abuser (Herschaft *et al*., 2006).

The dominating feeling the victims of IPV have as an assumption from the above is fear caused from low self-esteem and the psychological and physical damage the intimate partner provoked. So it is of great importance that the people responsible to investigate the case must give a supporting and non-accusatory environment so that she feels safe, protected and secure. It is interesting to note that there are occasions where the victim as time passes becomes the abuser.

When a woman endures long term violence and abuse in her marriage, feels repressed and when the man enters his old age and is unable to take care of himself, she has her opportunity to take revenge for what she suffered throughout the years and becomes the abuser. This is one example of elder abuse that coincides with a case of IPV (Fig. 1).

Another case of IPV that has its roots in past experiences is when a girl during her teen years, a very sensitive and crucial time for character building, tolerates the violent behaviour of her partner thinking it is normal for men to behave this way when she grows and marries her opinion is affected by her past and therefore she is

Fig. 1: Victims turning themselves into plowmen

vulnerable of becoming a victim of IPV. A similar condition is for girls who grew in a family where the mother suffered IPV and no reaction or measures were taken for the improvement of the situation. So the example set for them was a fragile, emotionless, irresponsive mother and wife that endured everything. As a result these girls become women who thing the violent type of behaviour is acceptable and normal (Herschaft *et al*., 2006).

CASE REPORTS

Patients (Fig. 2) were referred to the Department of Oral and Maxillofacial Surgery of the General Hospital Papanikolaou for the treatment of lesions that resulted from assaults and batteries of their husbands. The first case is a female patient 37 years old, married and has two children. In this case the victim has periorbital ecchymosis on the right, fractured nasal bone and traumatic lesions on the chin. Reason of the violence: alcohol problems and drugs addictions. The second case is a female 32 years old, married with no children. In this case the victim has traumatic lesions on the cheek and the forehead, scratches and bruises all over her face and periorbital

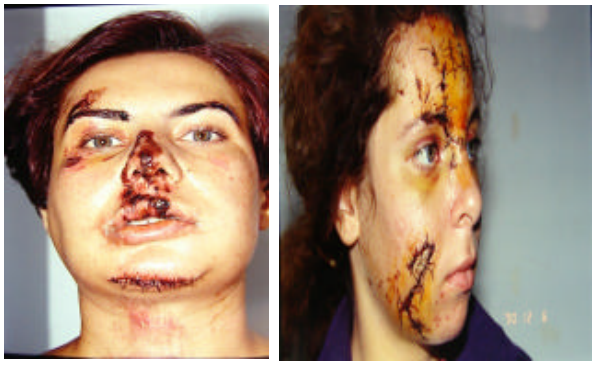

Fig. 2: Left: Periorbital ecchymosis on the right, fractured nasal bone and traumatic lesions on the chin, right: Traumatic lesions on the cheek and the forehead, scratches and bruises all over her face and periorbital ecchymosis

ecchymosis. Reason of the violence: Long term difference of opinion and severe conflict, psychological disorders due to childhood traumas. Unfortunately the above presented cases were photographed without the utilization of metric photography which is quite important in forensic dentistry for the proper record of the dimensions of the injuries.

DISCUSSION

Intimate partner violence is increasingly seen as a public health problem. In 48 population-based surveys from around the world, 10-69% of women reported being physically assaulted by an intimate male partner at some point in their lives (Krug *et al*., 2002). Physical violence in intimate relationships is often accompanied by sexual violence (in a third to over a half of cases). Intimate partner violence also accounts for a significant number of deaths among women.

Studies from a range of countries indicate that 40-70% of female murder victims were killed by their husband or boyfriend. Murder can be the last step in an abusive relationship. Most of the times it is done in such a horrible way and appears in news everywhere, shocking each and everyone of us (Herschaft, 2002; Halpern *et al*., 2005).

Between 6 and 47% of adult women worldwide report being sexually assaulted by intimate partners (Garcia-Moreno and Watts, 2000; Krug *et al*., 2002). Between 7 and 48% of girls and young women aged between 10 and 24 years, report their first sexual encounter as coerced (Garcia-Moreno and Watts, 2000; Krug *et al*., 2002). An investigation of the National Institute of Justice in the U.S clearly outlines the high prevalence of IPV not only on women but also on men. In particular, a population screening of 8,000 men and 8,000 women showed that about 25% of the females and 7.6% of the males in the U.S were physically assaulted (Tjaden and Thoennes, 2000). It is also interesting that males or females in a homosexual relationship report less frequently to be physically assaulted than do men and women in a heterosexual relationship (Tjaden and Thoennes, 2000).

Table 1: Proportion of women ever physically assaulted by an intimate male partner selected national studies (Krug *et al*., 2002)

Country	Years	Sample size	Proportion of women ever physically assaulted by an intimate male partner (%)
Canada	1991-1992	12300	29
Egypt	1995-1996	7121	34
Nicaragua	1998	8507	28
Paraguay	1995-1996	5940	10
Philippines	1993	8481	10
South Africa	1998	10190	13
Switzerland	1994-1996	1500	21
United States of America	1995-1996	8000	22

Although, the percentage of women that experience partner violence ranges when studying different ethnic groups (Table 1) when gathering the statistics that are relevant to the subject, the conclusion make is that the prevalence of IPV is high and women are the weaker sex in matters of IPV. Seeking for help delays the possibility of severe injuries or even lethal traumas as the phenomenon escalates when the woman doesn't react. Statistical data from surveys in hospital environment show that there is a higher prevalence of head, neck and facial injuries compared to limb and other injuries. In particular 94.4% of the victims of IPV have a head and/or neck injury (Arosarena *et al*., 2009). About half of the injuries are in the maxillofacial region (Saddki *et al*., 2010) whereas there are reports of a higher prevalence (81%) (Le *et al*., 2001). Facial injuries due to intimate partner violence are mainly zygomatic complex and orbital blow-out fractures whereas those by unknown abuser are usually mandible fractures (Arosarena *et al*., 2009).

However, other studies support the high prevalence of mandible and nasal compared to zygomatic complex fractures (Greene *et al*., 1997). The injury pattern seems also to be gender specific as women show more soft-tissue injuries than do men that is probably related either to the higher frequency of altercations to which men become involved compared to women or to differences in the construction of the bones between the sexes (Greene *et al*., 1997; Arosarena *et al*., 2009).

The case reports of intimate partner violence are in compliance with the above statistical findings. In particular, injuries and traumas to the face are serious indicators of IPV and need further investigation. There is a range of dangerous consequences following the matter of intimate partner violence. Some of them are (Campbell, 2002; Krug *et al*., 2002; Bonomi *et al*., 2006):

- Physical injury
- Gastrointestinal disorders
- Chronic pain syndromes
- Depression
- Psychosomatic disorders
- Problems in social life
- Suicidal behaviour
- Gynaecological disorders
- Sexually transmitted diseases and HIV/AIDS

Recovery from depression and mental health distress is mostly related to psychological abuse than combined physical and psychological abuse of the victims (Blasco-Ros *et al*., 2010). It is interesting that when offering social support, depression is being reported less frequently among abused women. On the other hand depression is frequently present among women with low educational level, a history of migration, a low socioeconomical status and among those being victims of chronic psychological abuse (Wong *et al*., 2011). It is impossible to talk about domestic and sexual violence without talking about HIV/AIDS (Peacock and Levack, 2004). This phrase is unfortunately so true. A form of intimate partner violence is sexual abuse which is any form of non-consensual physical contact. Today, half or more of the 40 million people infected with HIV in the world are women.

Especially in sub-Saharan Africa, young women (15-24 years) account for 75% of HIV infections and are approximately 3 times more likely to be infected than young men of the same age (WHO, 2004). The high rates of HIV infection in women have brought into focus the problem of violence against women. The links between intimate partner violence and HIV/AIDS are explained by biological as well as socio-cultural and economic factors, i.e., direct transmission of through sexual violence, indirect transmission through sexual risk taking, indirect transmission through inability to negotiate condom use, indirect transmission by partnering with riskier/older men. The World Health Organization has published in 2004 a report on intimate partner violence and HIV/AIDS that suggests multi-sect oral approaches on this issue (WHO, 2004):

- Public awareness
- Behaviour change communication strategies
- Responding to violence against women through health services
- Programs targeting gender attitudes and norms
- Strengthening laws and policies related to domestic violence and gender equality
- Micro-credit interventions for economic empowerment of women

There are some factors that may work like bottlenecks in the process of screening for IPV. Those include: lack of health care provider education by means of specific screening questions, lack of time and patient-factors like patient nondisclosure (Waalen *et al*., 2000). Violence against domestic partners and children often co-exist in families with frequency of child abuse doubling in families experiencing intimate partner violence. Sons of abusers demonstrate higher rates of domestic violence when they become adults. The safety and well-being of children who witness domestic violence is closely related to that of their abused parent. Many times the abused parent is not in a position to protect the child, given the fact that he/she is afraid and psychologically vulnerable (Cohen and Johnson, 2006).

CONCLUSION

There is a lot of controversy regarding the description of intimate partner violence. It becomes more and more evident that the term and the related discussion should include not only physical violence but also psychological, economical and sexual abuse of the partner. Each form of IPV whether it is emotional abuse, physical assault or forced inter-course, aims at controlling partner's behavior.

Women are more vulnerable in experiencing intimate partner violence due to their nature thus screenings should focus especially on them. Health authorities should provide education and possibilities for help seeking, in order to prevent from severe injuries. Screening for intimate partner violence remains a challenge for social institutions. The lack of education on specific screening questions, the lack of time as well as patient nondisclosure and other patient-related factors may interfere with the process of IPV identification.

It is of high importance to recognize injury pattern for it is documented that head, neck and facial injuries are the most prominent types of injury in cases of IPV. Nasal bone and zygomatic arch fractures as well as blow-out traumas and periorbital injuries are the most frequent types of injuries after IPV whereas mandible fractures are mostly related to assaults by an unknown.

The management of the problem of IPV is not only based on the repair of injuries and fractures of the face, for the assessment is far more difficult and complex and it should involve physicians, surgeons, emergency care specialists, psychologists and social workers. Social support helps in the identification of victimized persons and it is clearly demonstrated that it helps in minimizing some chronic unwanted consequences of IPV, like depression.

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