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Good Practice Guide

"Medical approach to violence against women and their children"

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The first Quaderns de la Bona Praxi (QBP. Manual on Good Practice) on the "Detection of intra-family abuse of women" was published in 2001 which was addressed solely to hospital emergency services. Today, this has emerged as a morbid condition which is approached from various settings in medical practice, so it was decided to update this QBP

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1 The concept of gender-based violence

Gender-based violence (GBV) refers to male violence against women as a manifestation of discrimination and inequality in the context of an imbalance of power between men and women. It is exerted by physical, economic or psychological force and produces physical, sexual or psychological harm or suffering to women, including threats of such acts as coercion or arbitrary deprivation of liberty, whether occurring in public or private life.

Violence may occur in various spheres, but for the purpose of this QBP we are referring to intimate partner violence and the term adopted throughout is "gender-based violence". Under this term, we implicitly include other terms such as violence against women, sexual violence, family violence and domestic violence.

GBV is not a single isolated act but a process that begins and then becomes chronic over time, hence the importance of early detection to avoid its progression, continuation and inherent sequels.

GBV has serious short and long term health consequences for women; 60% of women who are abused suffer psychosomatic disorders as well as physical injuries. Continued violence generates chronic stress which promotes the appearance of diseases and exacerbates existing conditions.

The exact number of women who suffer this abuse is unknown, as we are only aware of those cases which reach healthcare, judicial or socials services. The last major survey on GBV, conducted in 2011 by the Ministry of Health, Social Services and Equality, estimated that about 10.9% of women in Spain have suffered this violence on one occasion, and 3% identify themselves as being currently maltreated.

Violence affects all ages and all social, economic and educational levels, in women living in rural areas as well as city dwellers.

Various types of violence often exist in the same relationship. It is, however, important to differentiate between GBV and a poor or conflictive relationship. In the latter, there is equality within the couple, but they are in a situation of conflict which does not constitute abuse. In the former, there is no such equality in the relationship.

The abuse begins in many cases with controlling type behavior, and belittling the woman. Later, if the woman is not sufficiently obedient or submissive, the abuse escalates to physical and sexual violence. Most victims of physical abuse are also subject to many other forms of violence for prolonged periods. Identifying this behavior early can prevent progression of GBV to more serious forms, and therein lies the importance of early detection.

2 Behaviors: how the perpetuator behaves, how the victim behaves, and the implications

2.1. Behavior of male abusers

GBV is not an objective in itself but is an instrument of domination and control, used as a mechanism to maintain male dominance and to attain submission of the woman. Thus, it is a type of violent and abusive behavior supported by a system of sexist beliefs which aims to instill fear, control, dominate, isolate and subdue the woman. Violent behavior is expressed in various ways to various degrees, and includes psychological violence, physical violence and sexual violence.

The abuser denies and minimizes his violent actions, arguing that the attacks were warranted, playing down the damage caused with expressions like: "It was only a push, I didn't hurt her." He attributes his actions to external causes (childhood problems, unemployment, alcohol, financial difficulties) and blames the victim for his violent behavior: "She made me lose control, she was annoying me and she made me angry."

2.2. Types of violent behavior

Psychological violence includes a series of hostile verbal and non-verbal acts of emotional abuse, such as threats, humiliation, acts of control, restriction of movement and relationships, and destruction of objects and belongings.

Physical violence is easier to detect, but the woman often tries to conceal her injuries or claims to have had an accident. The purpose of this type of physical aggression is to hurt, to harm and physically annihilate the victim, and includes pushing, hair-pulling, punches, kicks, burns, wounds, bites, strangulation, beating, stabbing, assault with weapons or objects and, in some cases, homicide.

Sexual violence is the least visible violence, and includes all forced non-consensual sexual activity.

Violence is also manifest in:

- social situations or during a consultation, when the perpetrator interrupts the woman or answers for her, belittles her, criticizes her;
- shows her up in public by criticizing how she does things, her work, her friends and her family;
- he never leaves her alone with professionals;
- he displays paternalistic attitudes, deciding what is best for her or what she needs
- he demands to see her medical or therapeutic records, and to have access to them;
- he usually maintains a demanding attitude towards the woman's health.

Table 1 shows the types of GBV behavior and how to explore these.

TABLE 1. TYPES OF GBV BEHAVIOR AND HOW TO EXPLORE THESE

PSYCHOLOGICALLY VIOLENT BEHAVIOR	HOW TO EXPLORE THIS?
Frequent public humiliations	Does he continually showing you up in front of others? Make fun of your opinions?
Criticizes her cooking, how she dresses, how she educates the children, or how she is or behaves	Does he say you dress badly? That you look awful in that outfit. That the food you prepare is awful. That you are a bad mother. That you are good for nothing. That you get uglier every day.
Blame	Does he blame you for everything that happens? For everything that goes wrong? The daily difficulties?
Humiliations. Verbal abuse	Does he call you crazy, stupid, useless or a whore? Does he often shout at you?
Accusations	Does he often accuse you of cheating on him? Of flirting with everyone?
Threats	Does he threaten to take the children? To kill you? To hurt you? To break your face?
Controlling communication, time and movements	Does he control the calls you make? Read your messages on you cell phone or computer? Open your mail? Call you frequently when you are out? Need to know where you are every minute?
Controls and restricts money and economy	Who controls your money, bank accounts, credit cards? Does he often control your spending?
Restrict movements	Does he control the time when you are out of the house and who you are with and where you go?
Limits relations with her family	Does he prevent you from seeing your parents or brothers/sisters? Boycott family get-togethers?
PHYSICALLY VIOLENT BEHAVIOR	HOW TO EXPLORE THIS
Destructive violent behavior and atmosphere	When angry, does he bang on the door, abuse domestic animals, break or destroy personal objects (photographs, books, letters...)?
Physical aggression. Bites, kicks, strangulation, burns	What does he do when you fight? Has he ever hit you? Has he beaten or tried to strangle you? Has he ever slapped you? Has he ever kicked out of the house?
Child abuse	Has he ever tried to hurt your children?
Assassination attempts	Have he ever thrown an object at you, tried to hurt or kill you?
SEXUALLY VIOLENT BEHAVIOR	HOW TO EXPLORE THIS
Non-consensual sexual relations	Has he forced you to have sex against your will? Has he forced you to do something sexual that you did not want to do?
Use of force during sexual relations	Does he hurt you while having sex? Has he ever tried to strangle you?
Imposing methods and forms of contraception	Can you use condoms or other contraceptives when you want? Does he consider your wishes? Have you had any unwanted pregnancy?

2.3. The cycle of violence

The course of violence is predictable. When one violent episode occurs, it is highly likely that it will be repeated. The violence escalates over the years or in certain circumstances, such as pregnancy, when the couple separates, or when the woman finds another partner.

While living together, the violence increases progressively in three cyclical phases described as the "cycle of violence". The behaviour is different in each phases:

1) The tension building phase is when hostile behavior and acts begin to increase gradually. At this stage, the abuser is hostile towards the woman and humiliates, threatens, insults, criticizes and tries to control her. He blames her for his violence, arguing that it is her character that drives him to do it. The tension increases. The woman tries to adapt, changes her behavior, develops submissive strategies to please him, avoids any conduct or comment that might irritate him and believes that she can change these aggressive attitudes. However, the tension continues to increase until it reaches the next phase.

2) The violence explosion phase is when the abuser unleashes a barrage of violent behavior with acts of physical, sexual and emotional aggression, damaging property (breaking objects, hitting the door) and threatening the lives of the woman and children. This phase can last minutes, hours, days or weeks. It is a life-threatening moment for the woman and children, and the moment when she may decide to seek help, call the police, report him or tell family, friends or professionals. Often when it has already occurred several times, she may contact the health service, and this is the point when the violence to which she is exposed can be identified. The escalation of the violence may produce a crisis, which in turn helps to instigate a process of change.

3) The reconciliation or honeymoon phase when all the tension disappears, the man apologizes and denies his acts of violence. He is friendly and affectionate and promises to change. He declares his love for her, that he needs her and that she must help him keep his promise never to behave like that again. This is the stage when a woman may withdraw the complaint, move back in if she had moved out, forgive him and apologize to the family, friends, professionals and children. She can easily think that she too is guilty. Over the years this phase may gradually disappear, with decreasing cycle times eventually leaving only the tension and aggression phase.

Cohabitation with the perpetrator can last from five years in the general population, to ten or more years in women with health problems.

2.4. Consequences and damage to woman's health

The different types of violence (psychological, physical and sexual) are associated with and produce long and short term effects and damage to various aspects of physical, psychological and sexual health. The woman's health is affected by a morbid condition which presents acute phases, tends to become chronic, and where relapses (withdrawal of complaints, returning to abuser, forgiving him...) may occur. While remaining exposed to the pathogenic factor (abuser), her health recovery is limited. The effects of violence can persist for many years, even after the abuse has ceased. Women who were exposed to intimate partner violence undergo complex and diverse changes in their physical and reproductive health, and particularly in their mental health (**Table 2**).

TABLE 2. PHYSICAL, PSYCHOLOGICAL, SEXUAL AND REPRODUCTIVE HEALTH CONSEQUENCES OF GENDER VIOLENCE FOR WOMEN

Physical health	• Death • Functional disorders (chronic pain, irritable bowel syndrome, somatization) • Lesions and traumas • Hypoxia by strangulation • Brain injuries • Fibromyalgia • More days in hospital
Sexual and reproductive health	• Sexually transmitted diseases • Sexual dysfunction • Pelvic pain • Unwanted pregnancies • Premature baby • Low weight • Miscarriage
Psychological health	• Post-traumatic stress disorder • Depression • Anxiety • Sleep disorders • Eating disorders • Alcohol/drug abuse or dependency • Self-harm • Psychoactive drugs abuse/dependency

About 60% of women present psychiatric disorders. Mental disorders and psychiatric treatment is five times more frequent in abused women than in the general population. The effects may range from emotional to personality changes: loss of cognitive abilities (planning, execution and memory disorders), coping strategies (predominantly avoidance and emotional passivity towards the violence), loss of assertiveness and self-concept (low self-esteem, poor self-confidence, poor self-image), how she relates to others and the world (ambivalence towards the aggressor and mistrust, alienation from others). Post-traumatic stress disorders, depression, alcohol or substance abuse and self-harm are five times higher than in the general population. Between 20 and 40% of suicides in women are related to maltreatment.

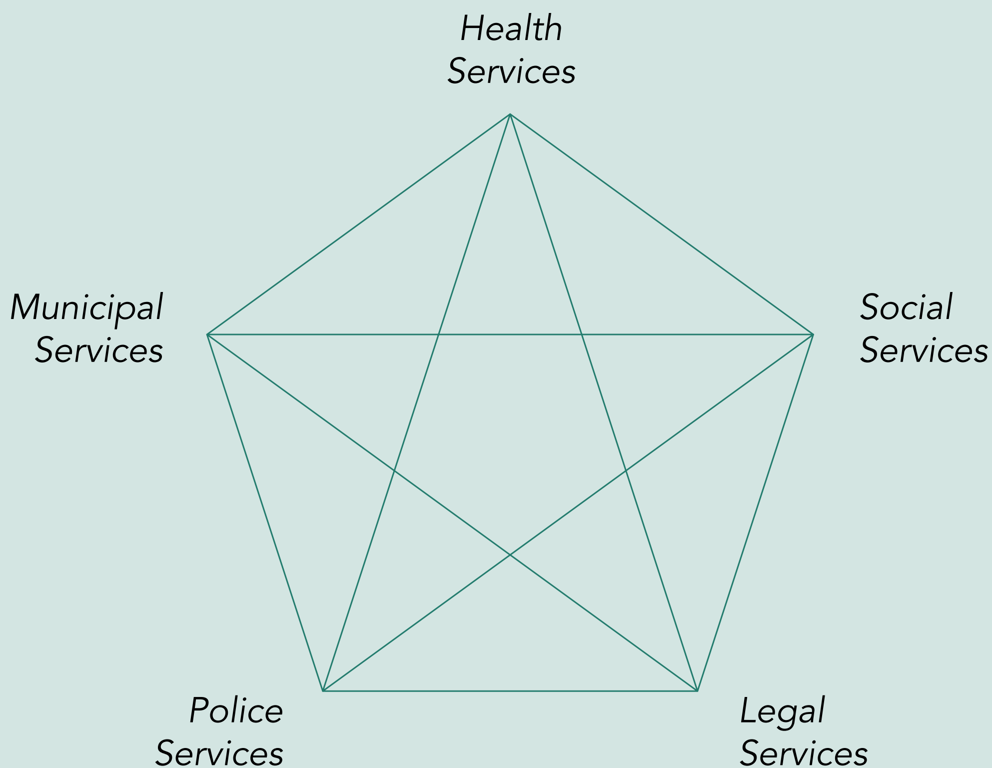
It is usually the woman who takes the initiative to bring about a change. But it is a long process of cognitive changes that enable her to identify the violence and the responsibility, and to recognize her own autonomy to manage her own life and that of her children. Professional, family and institutional support are paramount to her making this change.

3 An integrated care model: a multidisciplinary approach

Given the multifaceted nature of GBV, it must be approached by sharing resources, efforts and objectives. The aim is to work together in a coordinated fashion with clearly defined objectives.

A multidisciplinary approach including all the various institutions implicated is a necessary, efficient and efficacious model **(Figure 1)**:

FIGURE 1. AN INTEGRATED CARE MODEL FOR VICTIMS OF GENDER-BASED VIOLENCE



One example of this is the Barcelona violence against women circuit. This circuit is used in each of the ten districts of the city, and involves the city's services for women, social services, health services, legal services, different police forces and various women's organizations.

Health Services:

- Mental Health Centers
- Hospitals
- Primary Care Centers
- 061 (medical emergencies number)
- Drug Dependency and Monitoring Centers (CAS)
- Sexual and Reproductive Healthcare Programs (PASSIR)

Police Services:

- Mossos d'Esquadra (Regional)
- Guàrdia Urbana (City)

Municipal Services:

- Information Points/Advice for Women (PIAD)
- Women's Care Team (EAD)

Social Services:

- Emergency and Social Emergencies (CUESB)
- Municipal Social Services

Legal Services:

- Office for Support for Victims of Crime of the Justice Department (OAVD)
- Court-appointed lawyers specialized in Domestic Violence of Barcelona Bar Association.
- Victim Support Services in the Office of the High Court of Justice of Catalonia
- Criminal Technical Advisory Team (EATP)
- Institute of Legal Medicine of Catalonia

The Technical Commission of this circuit undertakes to ensure the correct functioning of the circuit, and proper coordination of the various entities and institutions involved. This Commission includes representatives from various institutions and services of various Public Administrations and guarantees that a holistic approach to violence against women is possible: Barcelona Healthcare Consortium and providers (hospitals, primary care, mental health, drug dependencies services, emergency medical services), Barcelona City Hall (management of women's programs, prevention and social services, municipal education institute, city police), Barcelona Education Consortium, Consortium of Social Services in Barcelona, Mossos d'Esquadra (regional police), the Catalan Institute for Women, Master plan for Mental Health and Addictions of the Department of Health, Department of Justice, Courts, Forensic doctors and the District Attorney.

4 The role of health professionals

GBV intervention guidelines should encompass prevention, detection and care.

Preventive strategies should address matters such as curbing the normalization of violence and prevention and reduction of risk factors. To this end, 1) training professionals on how to approach GBV situations, 2) sensitizing and raising public awareness and 3) education on sexual and emotional health are the three pillars of action for health promotion and prevention.

GBV may be detected during any medical consultation. An occasion may arise during the patient-doctor contact to ask the appropriate questions. It is vital that health professionals are alert and proactive on this matter.

Most women who suffer GBV are reluctant to talk about the situation in which they find themselves. Symptoms resulting from the violence are generally nonspecific and not immediately evident; traumatic injuries, which raise most alarms, are the most infrequent. And even when they exist and there are signs that could raise suspicion, medical personnel rarely pick up on them. As so many cases remain undetected, systematic screening for the detection of violence is recommended.

Suggested questions for detection:

- In the past year, have you been beaten, slapped or kicked by anybody?
- Do you have relations with someone who abuses you physically or threatens you?
- Has your partner or former partner ever hit you or otherwise physically hurt you?
- Has someone close to you ever threatened to harm you?
- Do you feel controlled or isolated by your partner?
- Are things alright at home?
- Have you ever been afraid of your partner? Do you feel afraid? Is it safe for you to go home?
- Has your partner ever forced you to have sex? Has your partner ever refused to practice safe sex?

Questions about the possible violence should be asked in private. They should not be asked if any family member is present, including children. The cultural norms of each patient must be considered, and she should never be made to feel guilty about what is happening to her. Abused persons often feel guilty about the situation, and need to be assured that they are not to blame for the violence.

To facilitate communication, generate empathy with the victim and to break down possible barriers, there are some phrases that can help introduce the topic. The following are some examples:

- "As violence is becoming common in the lives of many people, I have started to ask all my patients about this."
- "I'm worried that your symptoms could be caused by somebody mistreating you."
- "I don't know if this would apply to you, but some women I see here are in abusive relationships. These women are often too scared or embarrassed to discuss it directly, so I have started to ask about it routinely."

It is known that women who are subject to abuse use more health resources than others; they undergo more surgeries, have more prolonged hospital stays and consume more medicines.

In most cases, the health complaint presented by the patient is not identified as

having an etiology in violence, often chronic violence. There are various psychological and cultural barriers that prevent these women from disclosing the abuse. These coexist with other organizational obstacles at health centers and the lack of professional training. This means that it is very difficult to correctly and promptly identify cases of abuse. Factors that should alert us to a possible situation of violence include:

- Repeated visits with various complaints, unexplained injuries or implausible explanations.
- Repeated visits with problems associated with anxiety, including insomnia.
- Seeking attention for headaches, chest, pelvic or back pain.
- History of self-harm, depression or abuse of medicines or drugs.
- Erratic behavior: cancelling appointments, unexpected visits, repeated visits to the Emergency Department.
- History of traumas in breast, genitals, mouth; burns; broken teeth or burst eardrum.
- Musculoskeletal injuries; areas of the scalp without hair, bruises on arms, face, neck; soft tissue injuries, face.
- Excessive conformity, passive and submissive behavior, or resistance and evasive answers.
- A history of unwanted pregnancies and miscarriages, premature births, low weight babies, bleeding during the first or second trimester; inadequate control during pregnancy.

If the violence is disclosed, the next step is intervention and assistance. It is very important to support patients in this situation. Otherwise, the detection will not only have been futile, but could be positively dangerous. For this reason, it is crucial to maintain good communication with different levels of care that may be able to intervene.

The personal situation of each individual must always be considered. Many abused women do not want to break up with their assailant for various reasons (fear, love, economic dependence, cultural and religious norms, family pressures, uncertainties) and, therefore, they should never be forced to take any action, or be judged for not responding to advice or offers from medical or social services. In this regard, we must remember that a woman is most at risk in the six months after leaving the home, if she remains with the aggressor.

Each case must involve healthcare, social and legal services. Initially and irrespective of the degree of suspicion or risk assessed, the reason for the medical consultation must be attended. This reason may or may not be directly (traumatic injuries, self-harm attempts, rape) or indirectly (somatization, psychiatric symptoms) related to violence. When violence is identified, the pertinent inter-consultations must be made, depending on the problems present, with different specialties and services that can help the patient.

It is important to report any situation of abuse, even if only suspected, to Social Services, which is responsible for informing the patient of the resources available to help her and, if necessary, put her in touch with the most appropriate resource for her situation. The specific action will depend on the willingness of this person to recognize or report the violence, and the level of risk she could suffer when she returns home.

Three situations can occur:

1. A healthcare practitioner may suspect a case of violence, but the patient does not acknowledge it. The patient should never be forced to recognize the situation, or much less to take action to get out of it. She should be given all general support, leaving the door open to further consultations.
2. The patient acknowledges the situation, but does not want to report the aggressor. In this case, all resources are of-

fered depending on the social situation and the risk to the victim.
3. The patient acknowledges the situation and wants to report the case to the police. In this case, all resources are offered depending on the social situation and the risk to the patient. Information is provided on how to file the complaint.
The abuse that a person may suffer can generally be classified into three risk levels:

- **Level I.** Subclinical level. This is when relations within the couple are breaking down. For example, the woman does not believe it possible to talk to her partner, or she is afraid of him. But as there are no clinical manifestations, if questions are not asked, the situation remains undetected. This level is usually detected in primary care, and this is the level where we can intervene in the early stages, and also take more preventive action.
- **Level II.** At this level, the abuse is largely psychological. The woman may abuse medicines, suffer anxiety and feel undermined. Her partner may not allow her to go out alone or does not give her money. She is controlled both economically and socially.
- **Level III.** At this level, the abuse is physical and the woman has self-harm thoughts. Her partner may threaten to beat or kill her. This is a very high risk situation and may reach the stage that the woman cannot go back home.

Life-threatening situations can occur, and each case must be assessed individually, irrespective of where it is detected. These situations usually occur within the third risk level, and include:
- Drug or alcohol abuse by perpetrator
- Increase in number of violent episodes
- The woman suffers a serious injury or injuries
- Abuse of children or other family members
- Changes in employment status of the assailant (e.g. loses his job, unemployment)
- The couple separates
- Death threats after reporting assailant to police
- Psychopathology of the perpetrator (delusional jealousy, paranoia, etc.)
- Possession of firearms by the aggressor, with or without license.

It is very important not to underestimate the risk. If any of these situations or if the patient says that she feels her life is in danger, she must be believed and the appropriate measures taken.

If we believe that there is an immediate life-threatening risk, we must ensure that she is aware of the danger and arrange her departure from the home through Social Services.

Finally, all the pertinent legal documents must be completed in each case. All details should be entered in the patient's medical record, including a description of the injuries, findings, pathologies, chronology and diagnostic and therapeutic procedures.

In cases of physical injury, sexual assault, intoxication or attempted self-harm, a judicial report must always be completed by the physician describing in detail the type of injury, the diagnostic and therapeutic interventions and the severity of the symptoms.

5 Early detection of gender-based violence

Data on the mortality, morbidity and high prevalence in the population justifies proactive measures to ensure early detection of GBV.

Under diseases and health-related conditions considered as emerging, GBV is one of the most important. This social scourge is rejected by governments and the vast majority of people alike. Both Organic Law 1/2004 of 28 December on Integrated Protection Measures against Gender-based Violence in Spain, and Act 5/2008 of 24 April on the Rights of Women to Eradicate Male Violence of the Government of Catalonia serve as examples of this rejection. Both laws oblige health professionals to identify and assist women in situations of violence.

5.1. Must early detection be made from within the healthcare system?

The prevalence of GBV justifies efforts made to detect it, but the health repercussions for women **(Table 2)** justify detection efforts from within the healthcare system.

And we must not forget the negative consequences of violence towards the mother on her children; as well as being witnesses to the violence; they are all too often victims of violence (see chapter 6).

5.2. Why are women reluctant to explain their experience of GBV to professionals?

- Because she does not perceive the violence she experiences as abuse.
- Because she experiences the violent relationship with ambivalence, sometimes feeling ashamed and guilty.
- Fear of being disbelieved: women are often told that these are private matters, or that this man, perhaps a known patient, could not possibly be capable of abusing someone.
- Fear of the aggressor: the perpetrator increases the tension and violent behavior at the time when the woman initiates steps to end the relationship. Disclosing the situation to someone within the health system may be one option.
- Fear of unwelcomed legal consequences.
- Tolerance to GBV situation: the gradual process of submission and victimization means that even very serious cases of GBV are perceived as normal.

Therefore, it is essential that professionals ask about the possibility of violence in the relationship (see questions chapter 4).
Women do not get upset when asked about the possibility of violence in their relationships. To the contrary, qualitative studies reveal that women expect health professionals to ask them questions and appreciate their concern.

5.3. What strategy should be used?

- **Universal detection.** Systematic detection as a screening device during routine patient history taking is recommended due to the high prevalence of GBV and the gravity of the health consequences. However, there is no evidence that this strategy has produced any changes in cases of prolonged violence.
- **Selective detection.** Detection linked to situations supporting identification may prove more effective (**Table 3**).
- **Detection via self-reporting.** As well as detection during routine history taking, there are also self-reporting devices, questionnaires and scales designed to identify GBV, some of which have been validated for use in Spain.

TABLE 3. SELECTIVE DETECTION OF GBV: OPPORTUNE MOMENT FOR DETECTION

Women in an "at risk" moment in life cycle	• Pregnancy, especially in adolescents • Separation from partner • Retirement or husband's retirement • Caring for others
Women with mental disorders	• (see **Table 2**)
Gynae/obstetric consultation (see **Table 2**)	• Seeking contraceptives • Repeated gynecological infections • Pregnancy • Sexual dysfunction • Termination of pregnancy • Emergency contraception
Women with a history suggestive of trauma	• Lesions suggestive of abuse • Repeated injuries • Discordance between clinical signs and story • Delayed consultation after trauma
How the woman attend medical consultations	• Frequent consultations • Difficulties communicating with professionals • Poor compliance to treatment regimens • Difficulty conducting interview without partner
Situations of reduced autonomy	• Elderly and frail • Homecare provided • Cognitive impairment • Palliative care • Severe mental disorders • Physical or mental disabilities • Social situations limiting freedom: female prisoners, prostitutes, illegal immigrants, social marginalization • Abuse or dependence on alcohol or substances
Suspected or referral from other professionals	• Children with symptoms of post-traumatic stress or abuse • Cases referred from social services, education or other services.

Source: GBV i Atenció Primària de Salut: una visió des de la consulta. Societat Catalana de Medicina Familiar i Comunitària (CAMFIC) (in print).

5.4. Once detected, what then?

Detection of violence against women is only the beginning in terms of the care that can be provided. If a professional identifies a situation of GBV, he/she may set in motion the intervention designed to facilitate raising awareness of the situation and initiating change **(Table 4)**.

The different care services must have a protocol which outlines the follow-up care.

The presence or indications of GBV (type of violence, health consequences, risk assessment) must be recorded in the patient's medical record, as this improves the medical care for the women and has potential medico-legal implications.

Detecting violence against women and doing nothing about it constitutes malpractice. Following detection, the woman should leave the consultation with the idea that this is an important health factor, that there are people and organizations that can help her and that the health services are committed to her care.

TABLE 4. CLEAR MESSAGES THAT WOMAN MUST RECEIVE AT THE TIME OF DETECTING A CASE OF GBV

This is not an exhaustive list of possibilities, but a proposal as the "minimum package" that a woman should take in at the time of detection:

- Having spoken about her situation is a very important first step **(Invitation to dialogue).**
- Understand what is happening **(Empathy).**
- The relationship with her partner is inappropriate, it is an abusive relationship and this is a crime **(Recognition of abuse).**
- Nobody deserves to be abused. It is not her fault **(Breaking control mechanism).**
- Abuse is a common occurrence affecting thousands of women **(Contextualize and recognize the injustice).**
- This matter is of interest to us because it directly affects her health **(Reinterpret the symptoms).**
- There may be real danger **(Risk assessment and safety strategies).**
- She is not alone; there are people and associations dedicated to helping women in this situation **(Breaking her isolation. Networking).**
- We respect her decisions **(Empowerment. Avoid victimization).**

Source: GBV i Atenció Primària de Salut: una visió des de la consulta. Societat Catalana de Medicina Familiar i Comunitària (CAMFIC) (in print).

6 The impact of gender-based violence in the family on children's health

The word "infant" comes from Latin and means "incapable of speech". Throughout history, the meaning of the word was more along the lines of "he/she who has no voice" because the child was considered a small and vulnerable adult, who worked and occupied adults areas, who could be controlled and whose fate could be determined. So, while these children were abused physically, sexually and emotionally in the workplace and in all social strata, this was not considered abuse since the concept of "childhood" need protection did not arise until after the industrial age (19th century). But it was not until the late 20th century that the scientific community and the general public recognized that children are subjected to abuse of all kinds and their rights must be formulated and hence the signing of the Convention on the Rights of the Child in 1989.

GBV in the family setting is the most important risk factor of abuse or any kind of violence against children. Children are not only silent spectators, but they are victims living with violence. Minors who suffer GBV live within a family in which the father or mother's partner is violent against women. They see the violence, hear the shouting, the insults, the sound of the beatings, they feel the fear and tension in their mothers and live immersed in the cycle of violence.

In 30 to 60% of cases, there is also physical, sexual or emotional abuse or child neglect. Children grow up believing that violence against women is normal in adult relationships. In 26 to 73% of the families where there is child abuse, there is also intimate partner violence towards the mother.

World Health Organization (WHO 2002) highlights the negative effects on health, survival, development or dignity in children due to exposure to GBV in the family context. Also, emotional, physical and sexual abuse of women constitutes various forms of abuse of her children: they are witnesses of violence, are direct victims of abuse or may be used by the perpetrator to harm, threaten, control and subdue the women.

6.1. Gender-based violence in the family: Psychopathology in children

Children may show nonspecific signs of stunted or retarded development or emotional or behavioral psychopathology. Children are generally unable to explain the aggression they witness at home, mainly because they are afraid of the perpetrator or they were told not to tell anyone, converting it into a kind of family secret. This is why they generally express their discontent psychopathologically **(Table 5)**.

Children exposed to violence towards their mothers may develop patriarchal beliefs and values: "that the man rules, that women are inferior to men and that they should be controlled. When a man hits a woman, it is because she deserves it. It's normal to beat women. If you want them to respect you, you must be violent".

TABLE 5. GENDER-BASED VIOLENCE IN THE FAMILY CONTEXT: PSYCHOPATHOLOGY IN CHILDREN

Children	Physical and developmental symptoms	• Multiple somatic complaints: insomnia, headaches... • Stunted or delayed development: enuresis, encopresis ...
	Socio-emotional and behavioral symptoms	• Inhibited behavior at play or in social contexts: little spontaneous speech, mistrust of adults. • Post traumatic stress: children exposed to traumatic situations with highly violent visions. • Anxiety with excessive dependence on mother: afraid to leave her and afraid to go to school. • Feeling guilty and responsible for the violent behavior. • School problems: poor performance, few friends.
Adolescence	Behavioral changes	• Behavioral problems, aggression, drinking and drugs, running away from home.
Adults	Risk Factors	• Risk factor for perpetuation of attitudes of acceptance or exercising violence in their own families

6.2. Approach to gender-based violence in the family context

Policies need to be developed to prevent and improve detection and treatment of abuse, including child abuse **(Table 6)**.

6.3. Treating minors

Approach to mental health in children and young people:
- Help them process of traumatic experiences.
- Free the child from feelings of guilt, responsibility, fear or submission to aggressor.
- Improve social habits: self-esteem and conflict resolution to break the circle of violence in boys and avoid victimization in girls.
- Detect possible abuses and treat in a specialized manner.
- In cases of severe aggression with hospitalization or even death of the mother, children may need drug therapy for acute anxiety attacks due to pain or fear for their own lives.

School approach:
- Evaluate curricular needs, consider support tutorials and curricular changes.

Social approach:
- From local social services, including these children in sports or cultural programs, providing economic and social support.

TABLE 6. AN APPROACH TO GENDER-BASED VIOLENCE (GBV) IN THE FAMILY CONTEXT

<table>
<tr><th>PREVENTIVE MEASURES</th><th>DETECTION MEASURES</th><th>INTERVENTION MEASURES</th></tr>
<tr>
<td rowspan="2">Nationwide approach:

Multidisciplinary teams to design policies and protocols for the prevention, detection and treatment of gender-based violence and child abuse.</td>
<td rowspan="3">Training programs for professionals:

Mainly in the education and pediatric setting, on how to detect warning signs of maltreatment of mother or child.
Training on the protocol that must be followed.</td>
<td>In cases of minor aggression, where mother can care for children:

Assistance protocol for abused women.
Evaluation of children to examine impact of exposure to violence, or if they too are victims of abuse.</td>
</tr>
<tr>
<td rowspan="4">In severe cases of violence where mother is hospitalized or dead:

Children's safety is prime concern: safety, foster home, guardianship.
The local emergency child abuse protocol must be activated.
Coordination of child's situation by local child care services: short and long term plan for child regarding family situation.
Children must be immediately separated from the assailant until a specialized assessment can be made.
Evaluation by a team specialized in child mental health for all children to detect signs of abuse, post-traumatic stress or psychopathology.
Immediate economic and social support in the case of foster families.
Legal advice on rights, including economic, mother and children or in foster care or temporary care.
Academic support (via school psychologists or educational inspection), intervene or change schools, if necessary.</td>
</tr>
<tr>
<td rowspan="2">Educational approach:

Development of educational preventive programs for children and young people to promote the development of equal gender relations.</td>
</tr>
<tr>
<td rowspan="2">Coordination of hospital emergency teams or police with the pediatrician who normally sees the child, once abuse is detected in the mother or child.</td>
</tr>
<tr>
<td>Family:

Prevention programs for families at risk of violence by providing educational programs on parenting techniques.</td>
</tr>
</table>

7 Gender-based violence from a legal perspective: the importance of the physician's report

When an act of GBV is committed, a criminal process is necessary to prevent, suppress and punish the violent behavior.

Providing information on the legal proceedings to all women who suffer physical, mental or sexual abuse by their partners is one of the most effective ways to combat GBV.

The judiciary must collaborate with other sectors, including the health sector, so that optimal results can be attained in the fight against GBV.

Organic Law 1/2004 of 28 December on Integrated Protection Measures against Gender-based Violence established this joint action, as reflected in Article 15: "The Health Administrations, under Interregional Ministry of the National Health System, shall promote and boost action by health professionals for the early detection of gender-based violence and shall propose the measures they deem necessary to optimize the contribution of the health sector in the fight against this type of violence [...] In particular, it will develop awareness programs and continuing education for health personnel in order to improve and promote early diagnosis, care and rehabilitation of women in situations of gender-based violence as referred to herein".

The coordination of the various agents has a dual purpose:

- When a complaint is filed: to prevent further consequences of the abuse by means of an immediate and powerful response, as repeated violence has been found to cause psychological break down as well as the physical injuries.
- Following lodging of complaint: both the aggressor and the victim need to perceive the response action as firm and decisive, with adequate protective measures for the victim, should this be necessary.

Most crimes in the context of GBV cause bodily harm which requires medical attention. The same applies to psychological violence, which requires the intervention of a professional.

The importance of health professionals in the criminal proceedings is invaluable because:

- They are the first point of contact for the victim.
- They report what was manifested.
- They provide impartial information on the victim's injuries or condition.
- They provide the Judiciary with an impartial witness, totally removed from the facts, who is a qualified professional.

Thus, as a fundamental element in the medical attention for the victim, early detection of such situations in the healthcare setting is of particular relevance at two different points:

- Following the complaint, in evaluating the injuries inflicted.
- When the violence is not reported, in treating the injuries inflicted.

Irrespective of whether or not the case is reported to the police, any intervention by a health professional must be fully docu-

mented including the victim's story and a complete physical examination of the injuries described by the patient as well as those she tries to conceal in a report.

The intervention shall differ depending on the stage of the judicial process:

1. In the INSTRUCTION (investigation) phase, specific information is required regarding what happened, who the aggressor is, what injuries were caused, what was the victim's condition, what was said.
2. In the ORAL TRIAL (to prove facts) phase, an impartial witness who observed the facts is required and a professional opinion about how the injuries were caused.

The physician's report, in the first instance, informing the court of alleged actions that could constitute abuse is the basis for further investigation for two reasons:

- Sometimes the victim does not report the violence.
- In the majority of cases, there are no witnesses to the events, which normally occur in private. Thus, the medical report is the only objective data in the investigation.

Reports issued by medical practitioners must be extremely concise about the injuries the victim presents. These reports are sent to judges so that an investigation can be opened. From this preeminent position, as the physician who first attended the victim, all possible information must be provided. The data must be as accurate as possible.

All reports of assistance are sent to the courts where it is decided if the injuries are accidental, caused during a fight, occupational accidents, intoxications. All possible data must be provided that would indicate if this involved a case of abuse in the context of GBV. Close attention to detail is more important in this case than in other crimes because sometimes the report is all there is, at times there is not even the testimony of the victim.

Remember that with other types of crime, the affected party provides all the information available, voluntarily goes to the forensic doctor, submits his/her version of the events, and is interested in ensuring that the complaint is followed through.

In criminal proceedings, even in cases of serious injury, victims of GBV can avail of their right not to testify or may even claim that the injury was caused by accident. In these cases, the physician's report is the only objective data there is as the victim may even refuse to be seen by the forensic doctor. The forensic doctor would then have to write up his/her expert report based solely on the report written by the physician who attended the victim.

The role of the forensic doctor is to assess the GBV from a medico-legal perspective.

Experience has taught us that the doctor who first treated the victim is critical, because if she trusts and feels she is being heard by this doctor, she will be more willing to answer questions and provide details.

We must remember that under our law, assault is a crime prosecuted ex officio. A court must only be made aware that an act of aggression has been committed in order to open an investigation and to follow it through.

8 Conclusions

- The GBV leads to long and short term effects and damage to various aspects of the physical, psychological and sexual health of the women and her children.
- Hostile and violent behavior of the aggressor can be observed and identified, and includes emotional, physical and sexual abuse.
- Early detection of GBV is key to preventing the situation from continuing and producing further harm to the health of the woman and her children.
- Doctors must adopt a proactive approach in detecting GBV, by asking questions orientated to this aim in the medical visit.
- Any situation of abuse even if only suspected must be reported to Social Services, who will inform the woman of the resources that are available to help her.
- The care protocol for women suffering GBV must include a health and care assessment for her children.
- Filing a complaint to the Authorities by a victim of GBV raises the possibility that the aggressor may be prevented, reprimanded and punished for his violent behavior.
- The physician's report must include the full story and a complete physical and psychological examination of the injuries sustained by the victim.

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