

COVID-19

CORONAVIRUS DISEASE

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Physicians Caring for Texans

Commentary: Family Violence During COVID-19

TMA Subcommittee on Behavioral Health

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Many families are staying home during COVID-19, but what happens when a patient's home is dangerous? Four physicians address frequently asked questions about how family violence has changed during COVID-19 and how medicine can respond.

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1. What is family violence?

A variety of familiar terms fall under the umbrella of family violence, including domestic violence, intimate partner violence (IPV), and child abuse.

We often think of violence as being an action, but family violence is not limited to physical or sexual acts that harm another person. Family violence can be coercion, neglect, scapegoating, emotional tormenting, or psychological abuse in the family unit. It also includes other forms of nonaction violence such as economic abuse (controlling behavior by limiting access to money) and legal abuse (threats of or filing custody motions).

Children who live in households where family violence occurs are at high risk for a variety of reasons. Children depend on their primary caregivers for basic needs, such as nutrition and shelter, and the adults in their household function as primary decisionmakers. If violence is occurring between adults in the home, children can witness and learn those behaviors, be caught in the middle of violence, or become targets of violence. Equally harmful and even more common is child neglect. Examples include caregivers ignoring a child's basic needs, not providing necessary supervision, or not obtaining needed medical attention.

The U.S. Department of Justice has [defined](#) domestic violence as “a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone.”

The **Centers for Disease Control and Prevention** [defines](#) child abuse and neglect as actions that result in harm, potential for harm, or threat of harm to a child. There are four common types of child abuse and neglect: physical abuse, sexual abuse, emotional abuse, and neglect.

2. What are the risk factors for family violence? Why does it occur?

Often, family violence can be best understood as an ongoing pattern of using abusive behaviors to assert power and control over another person, whether between two adults or between a parent and child. Conflict can be exacerbated by financial, mental health, or interpersonal [stressors](#). As power dynamics in the family widen or change, so too can the patterns of abuse observed.

There is strong evidence for co-occurrence of family violence and [substance use](#). The presence of a firearm in the home also [vastly increases](#) the likelihood of a fatal outcome.

Certain populations are particularly at risk for being victims of family violence. For example, [children](#) and [adults](#) with developmental disabilities experience greater rates of maltreatment than those without.

3. What are some reasons COVID-19 has created an especially dangerous environment for those at risk of family violence?

COVID-19 has been disruptive to families' routines, interrupting typical patterns of work, school, social activities, or family gatherings outside the home. Instead, households are spending more time around each other in the home, perhaps even to the point of feeling “cooped up.” For many families, financial uncertainty due to job loss or transient employment has been layered on top of disruption to normal activities. These have great potential to increase stress in a household.

More stress, more opportunity for family violence because of long stretches of time spent together, and a lack of access to other caring adults (e.g., teachers) can create a dangerous situation for families at risk of violence. Additionally, women often stay in violent or coercive relationships to meet basic needs like food and shelter, or to keep their children safe and sheltered. With COVID-19 further disrupting individuals' economic circumstances and with children not able to attend school, women may feel a powerful incentive to remain in relationships during this time, even if the home is violent.

While no two families will be affected by these stressors in the same way, COVID-19 is likely to create disproportionate risk of violence in households that were already experiencing a great deal of stress before the pandemic began.

4. Do we have reason to believe family violence might be playing out differently in certain populations?

Family violence occurs in all demographic and socioeconomic groups. However, we also have evidence lower-income or less-educated populations tend to be screened for IPV at [higher rates](#) and have fewer resources enabling them to leave violent situations. For child abuse, intact families with higher incomes tend not to be screened as often, and in Texas, Black and Native American families tend to be [overrepresented](#) in the child welfare system.

We do have clear data showing COVID-19 has disproportionately affected populations of color, who comprise a great deal of Texas' "essential" workforce. These individuals' household finances may be more stressed in a struggling economy, and in Texas they are more likely to be uninsured. Uninsured individuals may be more commonly queried for abuse in settings where they typically present for care, such as emergency departments, as opposed to families who have continuous, consistent relationships with a physician in the context of a medical home. These are examples of how COVID-19 may exacerbate societal inequities already playing out in our health care system.

5. In normal circumstances, what are some family violence indicators physicians might typically screen for or be attuned to in the clinical encounter?

In adults, physicians may look for:

- Women with injuries,
- Women with chronic unexplained abdominal pain,
- Women with chronic unexplained headaches,
- Women with sexually transmitted infections,
- Older adults with evidence of neglect, and
- Older adults with injuries.

In addition, physicians can be attuned to nonphysical indicators of abuse. While not evidence of abuse by themselves, these may occur when a patient is being abused or controlled:

- *Inconsistent explanations of injuries.*
- *Frequent emergency department or urgent visits.* Typically, abusers do not want their victims to form an ongoing allegiance with one clinician. They may feel the victim will be less likely to find an ally in an emergency department where care can be more fragmented.
- *Missed appointments.* The patient may not keep appointments because the abuser will not allow medical attention. In one study, 17% of IPV victims [felt their partner interfered](#) with their access to practitioner visits, compared with 2% of those not experiencing IPV;
- *In pregnancy, late initiation of prenatal care.*

- *Repeated abortions.* Unplanned pregnancy may result from sexual assault and/or not being allowed to use birth control, also known as [reproductive coercion](#).
- *Medication nonadherence.* Victims may not take medicines because the abuser has taken them away or not allowed the partner to fill prescriptions.
- *Inappropriate affect.* Victims may appear jumpy, fearful, or cry readily. They may avoid eye contact and seem evasive or hostile. A flat affect or dissociated appearance may suggest post-traumatic stress.
- *Overly attentive partner.* The clinician should be suspicious if the partner is overly solicitous, answers questions for the patient, or is reluctant to leave the patient alone.
- *Apparent social isolation.*
- *Reluctance to undress or have a genital or rectal examination,* or difficulty with these exams.

Clinical presentations of child abuse can include:

- Unexplained bruising, particularly in babies;
- Fractures or injuries with inconsistent explanation;
- Vague symptoms, such as unexplained headaches or stomach aches; or
- Outcries of abuse during an exam.

Child abuse can be a challenging condition to identify in the office. Even as mandated reporters, physicians are often hesitant to probe, unsure how to obtain information, or unclear how to differentiate if a finding is cause for concern. While injury patterns are clearly a red flag, the more prevalent form of child maltreatment is neglect; in other words, what the child *isn't* receiving can be equally critical and is not easy to establish in the clinical setting.

Even if physicians conduct the recommended [screenings](#) for abuse and violence, patients who do not feel comfortable disclosing their situation are unlikely to screen positive. Threats from a perpetrator or other fears may discourage victims from describing their situation honestly. It is common for patients not to disclose abuse the first time they are asked. Although screening may not “find” these patients every time, it still has value by signaling a patient can feel comfortable disclosing when the time is right.

Physicians must be careful not to over-interpret warning signs, and consider what assumptions surround things that seem “off.” For example, what do we assume about a pattern of missed appointments? Are these assumptions different for lower-income patients? Are explanations more readily accepted from higher-income patients? Physicians may benefit from this type of reflection, perhaps sharpening awareness of implicit biases. These can lead to missed clues that a person needs help.

6. What evidence do we have so far that increases in family violence are occurring during COVID-19?

The data emerging from the first three to four months of COVID-19 paint a mixed picture. Calls to hotlines and shelters for domestic violence have spiked at certain points, and shelters are reported to be at or near capacity. The opposite pattern may be occurring in children, with fewer calls reported to state child abuse hotlines.

While we cannot explain these trends with certainty yet, one plausible explanation is reduced interaction between children and educators. We often refer to educators as “community sentinels” of child maltreatment. Typically, educators account for [around 20%](#) of all reports to Child Protective Services. With educators no longer a routine presence in a child’s day, states including Texas noted corresponding [month-on-month decreases](#) in reports. Declines in reports give cause for concern over unnoticed cases of child maltreatment. Anecdotally, some children’s hospitals in Texas are observing fewer reports, but among those reported the severity of injuries may be worse. More research and evidence will be needed to understand these patterns.

Family violence and COVID-19: What does the data show so far?

- A study conducted by researchers at The University of Texas at Dallas associated a [12.5% increase](#) in domestic violence incidents with stay-at-home orders, with similar trends [across the world](#), including Hubei Province, China, and the United Kingdom.
- An estimated 200,000 allegations of child maltreatment nationwide [went unreported](#) in March and April of 2020.
- In Texas, major cities’ emergency domestic violence shelters have reported [spikes and drops](#) in call volumes during COVID-19.
- Before the pandemic, 42% of requests for emergency domestic violence shelter in Texas were [going unmet](#) because of capacity, with rates as high as 78% in large metro areas. The federal Coronavirus Aid, Relief, and Economic Security (CARES) act provided [\\$3 million](#) to Texas to increase shelter capacity.

COVID-19 has exposed shortcomings in planning for family violence as part of disaster preparedness. Other recent disasters in Texas, such as hurricanes, have also illuminated the absence of support for women and children in abusive situations. These individuals need to be considered and better protected in disruptive disaster events.

7. Beyond screening, what can physicians do about family violence in and out of the clinic?

Right now, physicians may be struggling to reach families at risk for abuse. Practices should consider how to enhance correspondence with families identified to be at risk, such as periodic check-in calls from staff. Physicians can also help enroll eligible pregnant women in [Texas Nurse-Family Partnership](#), available statewide.

In clinic, no matter the reason for the visit, physicians can ask how the family is managing the stress of COVID-19 and whether the household feels safe. It is incumbent upon physicians to know resources in their community, not only family- and child-serving agencies, but also for assistance with stressors that influence risk for family violence, such as employment or housing instability.

When physicians refer to a particular resource, we must acknowledge that it takes planning and organization for patients to act. It is reasonable that a patient may need time to become ready, especially when navigating a violent situation.

Finally, physicians are not only providing a service, but also are valued and trusted members of their communities. Much of the work of preventing violence occurs away from the bedside. Physicians can meaningfully contribute to violence prevention by acting “upstream” of factors that impact their patients’ lives, such as engaging in efforts to improve economic opportunities, schools, and public green space.

8. What tips can physicians offer parents who find themselves stressed and exhausted right now?

The [American Academy of Pediatrics](#) has offered helpful guidance for parents during the pandemic. Keeping consistent routines is important for helping children approach their days and minimizing their sense of disruption. We can also reinforce a child’s sense of control by practicing actions that protect ourselves and those closest to us from the virus – social distancing, mask-wearing, and hand hygiene, to name a few.

Given the potential for prolonged disruption, here are some additional tips for parents that may be helpful, based on [emerging literature](#):

- Social distancing does not mean emotional distancing. Use technology to connect widely.
- Keep consistent routines and schedule, seven days a week.
- Exercise and stay physically active, daily if possible.
- Find enjoyable activities that can be done as a family. Children benefit from intellectual engagement and physical activity – reading books, doing puzzles, active play, and occasional screen time.
- Remember to carve out alone time for yourself.
- Recall things you really enjoy doing that can be done in this situation, and find creative ways to do them.
- Consider limiting exposure to news if it becomes overwhelming. Consume it in small windows and then find ways to disconnect.

9. Many physicians are now incorporating telemedicine into their practice. How do virtual encounters with patients change how physicians detect and respond to family violence?

Some telehealth visits are telephone only and some are video. This makes a difference in what we learn from virtual visits. Video gives us a chance to see the household situation – sometimes we see who else is in the house as they wander by or participate in the visit, or we can see if the home is chaotic. Families may not agree to video visits, either for a technology reason or because there is something they would rather the physician not see. In audio-only cases, we may try to talk to a parent alone as we can, and an older child or adolescent alone as we can.

For anyone in a potentially abusive situation, physicians should do their best to ascertain whether the patient is alone, or the extent to which others can hear the conversation. Patients may be fearful what they say in the appointment may trigger a conflict after the conversation is over.

Some telehealth vendors allow chatting during the video, which may give an opportunity for nonverbal outcries, to send resources, or to talk outside of the audio. Some telehealth platforms can transmit

documents or resources directly to the patient. When transmitting documents, it can help to start with an open-ended framing statement: “*We know COVID-19 is causing a lot of stress for patients and their families. Would you mind if I sent over some resources on dealing with stress?*” This can be an opportunity to introduce the topic of family violence without discussing it directly.

Overall, telemedicine is new to many physicians. As more physicians integrate telemedicine into their practice, more comfort will develop with the cues. TMA has a separate podcast episode (“[Getting Started in Telehealth](#)”) that those interested are encouraged to listen to.

10. If physicians suspect family violence is occurring, what they should do?

All physicians are **mandated reporters** of child abuse, neglect, or exploitation. A report to the [Texas Abuse Hotline](#) must be made within 48 hours of when the physician first has cause to believe these may be occurring. This reporting obligation cannot be delegated. Physicians are subject to criminal penalties for not reporting. For life-threatening situations, call 911. For more information on reporting requirements for physicians and other professionals, you can visit the Texas Department of Family and Protective Services’ [website](#).

Hotlines for Abuse, Neglect, or Exploitation

- To report suspected abuse, neglect, or exploitation, visit the [Texas Abuse Hotline](#) or call (800) 252-5400.
- Call 911 in emergency or life-threatening situations.
- For patients experiencing intimate partner violence, visit the [National Domestic Violence Hotline](#) or call (800) 799-7233.

Major children’s hospitals in Texas have physicians called child abuse pediatricians who are available to help community physicians discern whether a situation ought to be reported or not.

Physicians are required to report suspected abuse, neglect, or exploitation of adults to the Texas Department of Family and Protective Services only if the victim is age 65 or older, has a disability, or there is a suspicion of human trafficking.

Physicians’ first thought when a report is necessary should always be “how can we help?” Involving the child or adult welfare system is a step in the therapeutic process. Although reporting can be adversarial, it can be approached with sensitivity and in conjunction with referrals to other community organizations to help in areas where families may be struggling.

There are other ways to help patients who may be experiencing abuse, especially for adult patients for whom reporting is not required. From the [American College of Obstetricians and Gynecologists](#):

“[E]ven if abuse is not acknowledged, simply discussing IPV in a caring manner and having educational materials readily accessible may be of tremendous help. Providing all patients with educational materials is a useful strategy that normalizes the conversation, making it acceptable for them to take the information without disclosure.”

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