~ Missouri ACP Annual Fall Meeting ~

Intimate Partner Violence:

Role of the Physician

20 September, 2019

Carol W. Stanford MD, FACP
Professor Of Medicine
University Of Missouri - Kansas City
School of Medicine

Disclosure:

Nothing to disclose.

Objectives:

- Define Intimate Partner Violence (IPV) and its various overlapping forms
- Describe the prevalence of IPV
- Discuss the physical, and psychosocial effects of IPV and IPV during pregnancy
- Discuss use of assessment tools and understand the role of the physician in assisting IPV victims
- Identify local and national resources for victims of IPV

Pre-Test Questions

The USPSTF recommends physicians screen the following patient population for Intimate Partner Violence (IPV):

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B. All females of childbearing age
C. Only females with a past medical history for IPV
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B. Use a body map to document injuries
C. Omit all record of IPV. It has no place in the EMR.
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Outline

- What is Intimate Partner Violence (IPV)?
- Epidemiology of IPV
  - Prevalence
- Consequences
- Profile of the IPV abuser
- What role do physicians/educators play in detecting and responding to IPV and preventing bad outcomes ?

What is IPV ?

- **Four Main types of Intimate Partner Violence (IPV)**
  - Physical Violence
  - Sexual Violence
  - Threats of Physical or Sexual Violence
  - Psychological/Emotional Violence
- IPV occurs on a continuum, ranging in frequency and severity.

(Saltzman et al. 2002)

Intimate Partner Violence

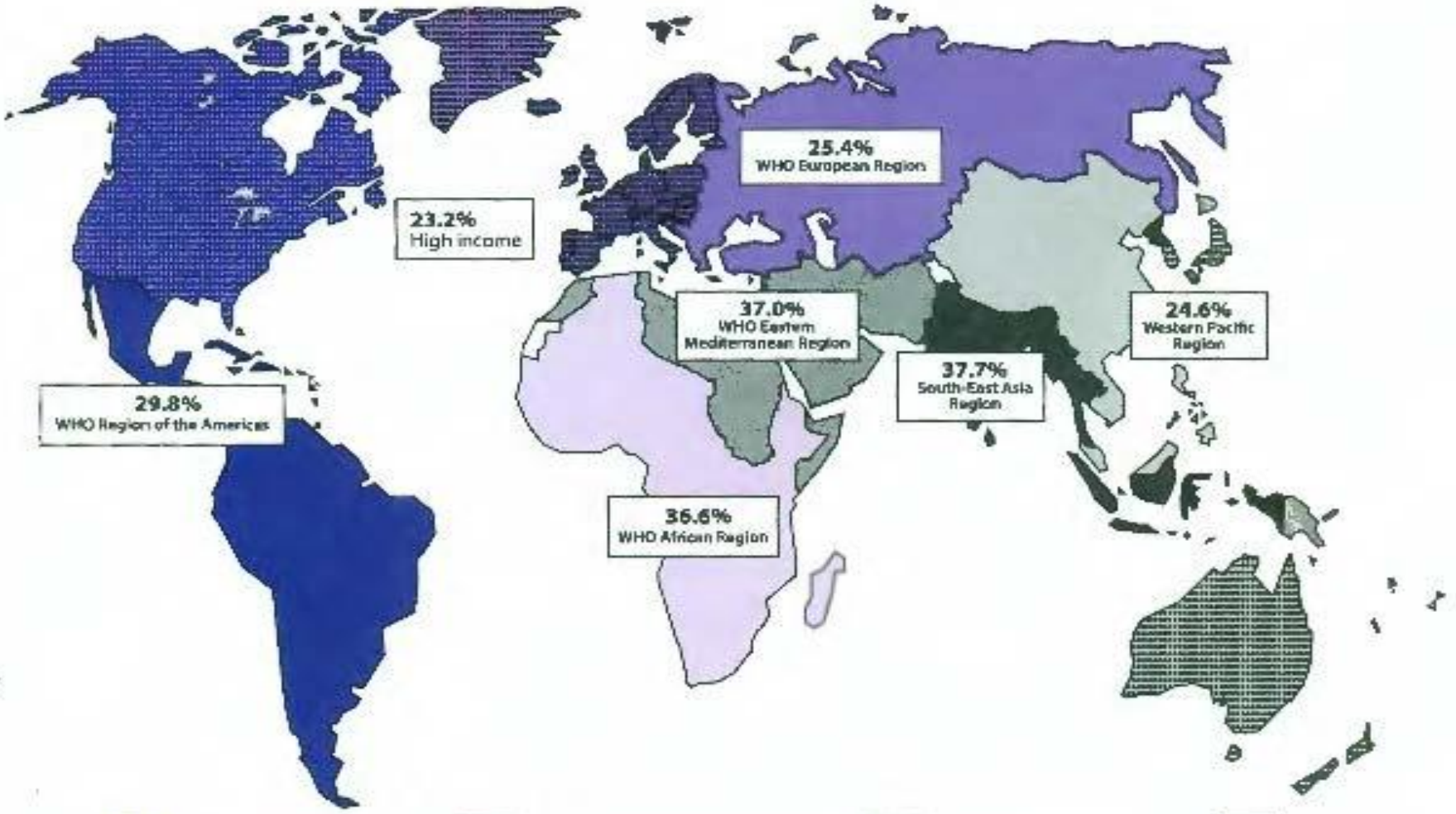
- Term describes physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner
- Includes other family violence
- Victims may be male or female but most are woman

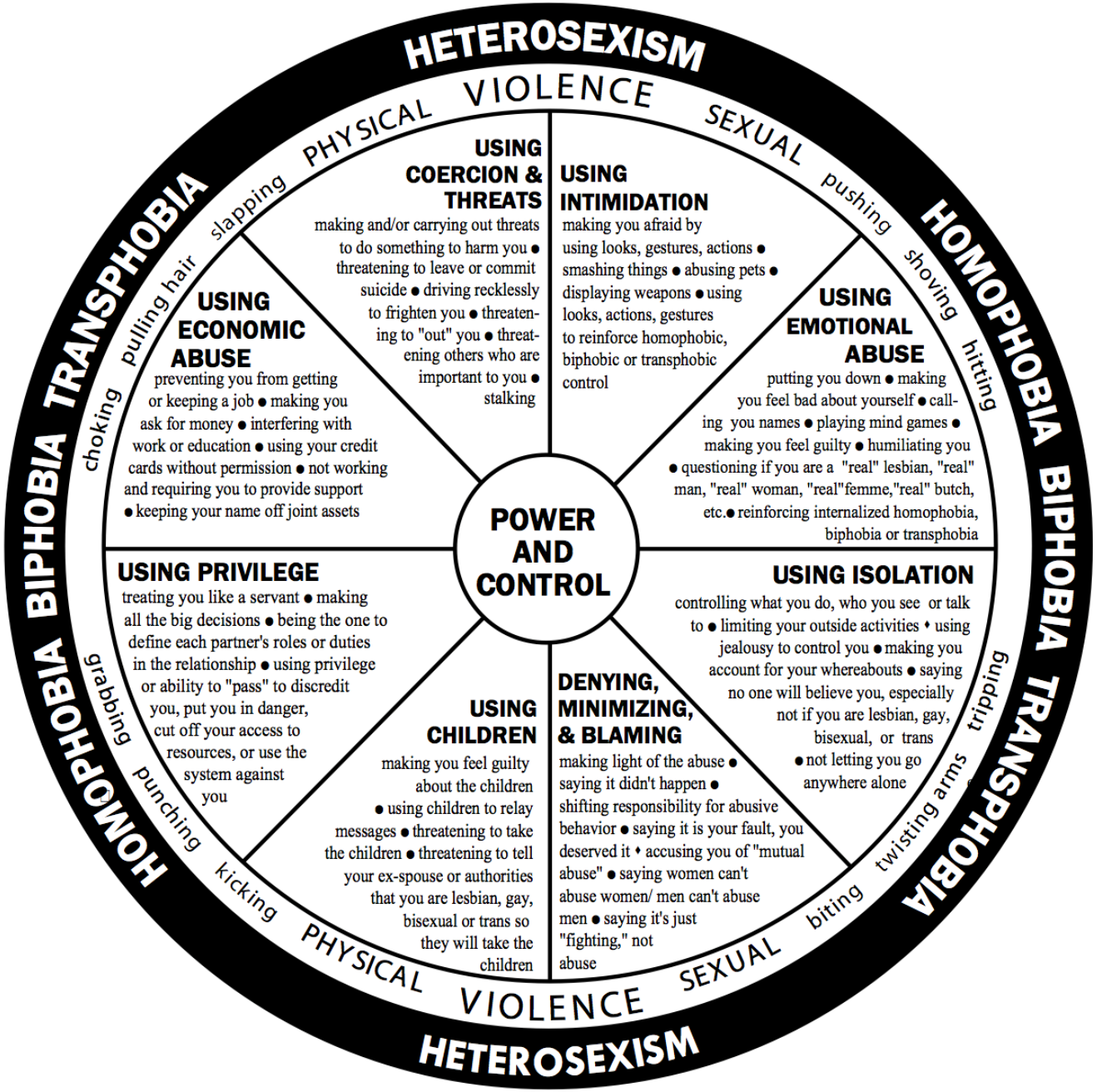
Violence Against Men and Women

- Worldwide problem
- Crosses ALL racial, ethnic, religious, educational and socioeconomic lines
- Tremendous social, economic, and public health implications
- Not new phenomenon and seen throughout world
- United Nations 1993 declared IPV a violation of human rights.

Figure 2. Global map showing regional prevalence rates of intimate partner violenceby WHO region* (2010)

* Regional prevalence rates are presented for each WHO region including low- and middle-income countries, with high income countries analyzed separately. See Appendix 1 for list of countries with data available by region.




HETEROSEXISM
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HOMOPHOBIA BIPHOBIA TRANSPHOBIA
HETEROSEXISM
VIOLENCE
PHYSICAL
SEXUAL
POWER AND CONTROL
USING COERCION & THREATS
making and/or carrying out threats to do something to harm you • threatening to leave or commit suicide • driving recklessly to frighten you • threatening to "out" you • threatening others who are important to you • stalking
USING INTIMIDATION
making you afraid by using looks, gestures, actions • smashing things • abusing pets • displaying weapons • using looks, actions, gestures to reinforce homophobic, biphobic or transphobic control
USING EMOTIONAL ABUSE
putting you down • making you feel bad about yourself • calling you names • playing mind games • making you feel guilty • humiliating you • questioning if you are a "real" lesbian, "real" man, "real" woman, "real"femme,"real" butch, etc.• reinforcing internalized homophobia, biphobia or transphobia
USING ISOLATION
controlling what you do, who you see or talk to • limiting your outside activities • using jealousy to control you • making you account for your whereabouts • saying no one will believe you, especially not if you are lesbian, gay, bisexual, or trans • not letting you go anywhere alone
DENYING, MINIMIZING, & BLAMING
making light of the abuse • saying it didn't happen • shifting responsibility for abusive behavior • saying it is your fault, you deserved it • accusing you of "mutual abuse" • saying women can't abuse women/ men can't abuse men • saying it's just "fighting," not abuse
USING CHILDREN
making you feel guilty about the children • using children to relay messages • threatening to take the children • threatening to tell your ex-spouse or authorities that you are lesbian, gay, bisexual or trans so they will take the children
USING PRIVILEGE
treating you like a servant • making all the big decisions • being the one to define each partner's roles or duties in the relationship • using privilege or ability to "pass" to discredit you, put you in danger, cut off your access to resources, or use the system against you
USING ECONOMIC ABUSE
preventing you from getting or keeping a job • making you ask for money • interfering with work or education • using your credit cards without permission • not working and requiring you to provide support • keeping your name off joint assets
slapping
pushing
shoving
hitting
tripping
twisting arms
biting
kicking
punching
grabbing
choking
pulling hair

Intimate Partner Violence

- 2 million women experience IPV
  - 324,000 pregnant women/year affected
- 1 in 3 homicide due to IPV
- CDC reports IPV accounts for:
  - 33% female homicides
  - 5% male homicides
- 2/3 of rape cases related to IPV
- Peak ages 20-24 years old

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In what year did the state of Missouri make it illegal for a man to force sex upon his wife?

Who is at Risk?

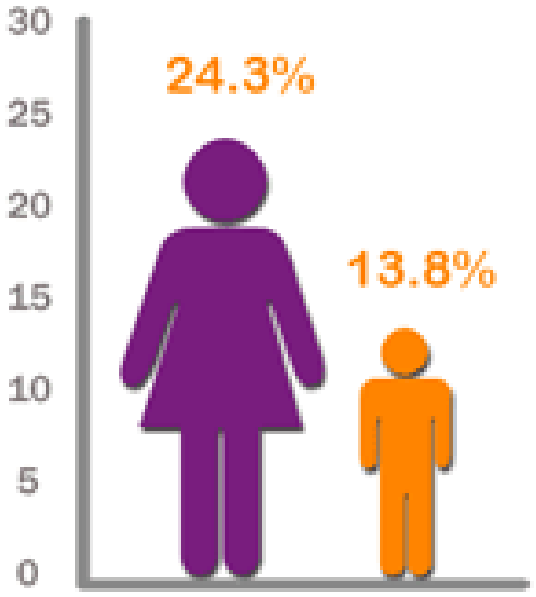
- IPV and DV are frequently unrecognized and unreported
- No single profile fits an abused man or woman OR a perpetrator
- Victims of IPV come from every age, religion, racial/ethnic group, socioeconomic background and sexual orientation

IPV: Power and Control Over the Victim

- May be actual or threatened
  - Physical
  - Sexual
  - Psychological and emotional
  - Financial
- Deliberate, unpredictable and repetitive
- 53% of IPV against women (excluding rape) are perpetrated by spouses
  - 5% former spouses
  - 42% by other intimate partners

Prevalence

- 1 in 4 women (24.3%) and 1 in 7 men (13.8%) aged 18 and older in the United States have been the victim of severe physical violence by an intimate partner in their lifetime (Black et al., 2011).



Consequences of IPV

- Short- and long-term
  - Physical
  - Psychological
  - Economic

Physical Consequences

Premature DEATH !

- In 2010, 241 males and 1095 females were murdered by an intimate partner (U.S. Department of Justice, FBI, 2011).

Physical Consequences

Health Conditions Associated with IPV	
Asthma	CNS disorders
Bladder/kidney infections	Gastrointestinal disorders
Cardiovascular disease	Migraines/headaches
Fibromyalgia	Joint Disease
Irritable bowel syndrome	Chronic pain syndromes

Psychological Consequences

Psychological Consequences of Intimate Partner Violence	
Anxiety	Depression
PTSD	Antisocial behavior
Suicidal behavior	Low self-esteem
Fear of intimacy	Emotional detachment
Sleep disturbances	Inability to trust others

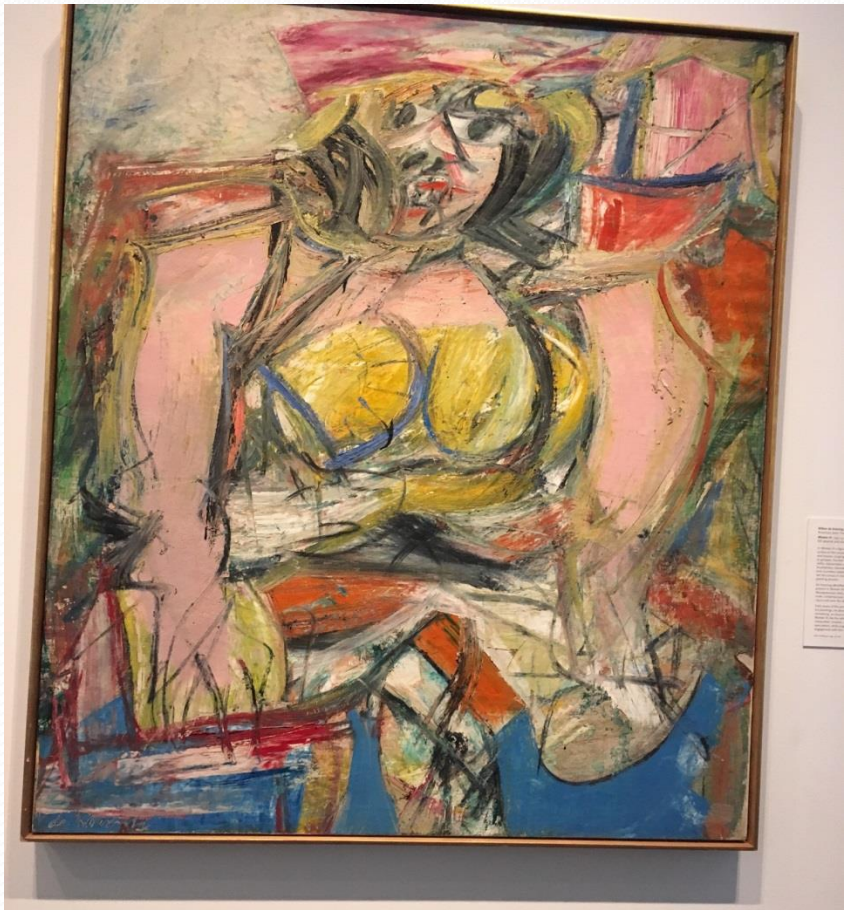
Breast bruised, brains battered

Skin scarred, soul shattered

Can't scream -- neighbors stare,

Cry for help – no one's there

~ Nenna Nehru



Woman IV ..... by
~ Willem de Kooning (1904 – 1997) ~

Economic Consequences

- IPV costs exceeded $8.3 billion, which included $460 million for rape, $6.2 billion for physical assault, $461 million for stalking, and $1.2 billion in the value of lost lives (Max et al. 2004).
- The increased annual health care costs for victims of IPV can persist as much as 15 years after the cessation of abuse (Rivara et al., 2007).

Profile of the Abuser

- Often have a public persona/different from their private selves.
- Violent behavior at home NOT seen in workplace
- Fully aware of consequences of their behavior
- Can be trusted community leaders
- Abusers come from all age groups, religions, ethnic/racial groups, socioeconomic and educational backgrounds

Profile of an Abuser: Goal is to Exert POWER and CONTROL Over the Victim

- Violent behavior is learned behavior
- Blame is placed on victim, situation or substance
- Frequently minimizes seriousness of the act
- Fails to accept responsibility for actions
- Belief of entitlement to use violence
- Were frequently victims or observers of abuse in their family

Role of the Physician

- Most American victims seen at some point by health care provider offering opportunity for identification and prevention

- Responding to IPV:
  - Inquiry
  - Intervention
  - Documentation
  - Follow up

Screening

- The USPSTF recommends that clinicians screen women of childbearing age for IPV, such as domestic violence (B recommendation).
- Numerous validated tools available
  - HITS
  - Partner Violence Screen – 65-71% detection
  - STaT – 97% detection
  - RADAR
- Screen patient for coexisting depression, anxiety, and substance abuse

The HITS Screening Tool for Domestic Violence

How Often Does Your Partner:	Never	Rarely	Sometimes	Fairly Often	Frequently
Physically **H**urt You	1	2	3	4	5
Insult or talk down to you	1	2	3	4	5
Threaten you with harm	1	2	3	4	5
Scream or curse at you	1	2	3	4	5

A total score of more than 10 is suggestive of intimate partner violence.

RADAR Tool	
R=	Routinely screen female patients
A=	Ask direct questions
D=	Document your findings
A=	Assess patient safety
R=	Respond, review options, and refer

Examples of Direct Questions
Is there anyone who has physically hurt or frightened you?
Have you ever been hit, kicked, or punched by your partner?
Does your partner try to control your activities or your money?
I noticed you have a number of bruises; did someone do this to you?
Because violence is so common in many woman's lives, we've begun to ask about it routinely.

Form a Relationship

- Caregivers should present themselves as caring and trustworthy allies
- Thank patients
- Do not force a disclosure
- Universal education even for negative screens

Inquiry-Who Should We Ask?

Routine appointment, new patient visit

When signs and symptoms raise concerns

Bruises in various stages of healing

Injury inconsistent with history

General complaints

Psychological problems: depression/PTSD, anxiety and panic disorder/suicidal ideation

Substance use/abuse

Gynecological Presentations

- Chronic abdominal or pelvic pain
- Recurrent vaginal or urinary tract infections/dysuria
- Sexual dysfunction
- IBS
- Genital trauma
- STIs including HIV

Observe behavior of the patient and partner

- Flat affect, depression, anxiety
- PDST symptoms
- Over compliance
- Excessive distrust

- Partner being overly solicitous or answering questions for the patient
- Being hostile or demanding
- Partner never leaving the patient's side
- Partner monitoring patient's responses

Inquiry: What/How/When Should We Ask?

- Current and lifetime exposure to IPV
- Use direct questions and include physical , emotional and sexual abuse
- Written or computer questionnaire
- In private
  - Inform the patient of confidentiality
- Conduct routinely
  - Any patient encounter/health visit
  - When signs and symptoms suggest possibility

Inquiry: Examples

- Have you ever been emotionally or physically abused by someone important to you?
- Since I last saw you have you been hit, slapped, threatened or physically hurt by someone?
- Are you afraid of your partner or anyone else?
- Are you afraid for the safety of your children or pet?

Inquiry: Special Groups

- Patients with disabilities:
- Has anyone you depended on refused to help you with an important personal need, such as your medicine, getting to the bathroom, getting out of bed, getting food or drink?
- Has anyone prevented you from using a wheelchair, cane, any assistive device?

When NOT to Inquire?

- If you cannot provide a safe, private space
- If there are concerns that the assessment is unsafe for the patient or the provider
- If you cannot provide a secure appropriate interpreter

What to do when the answer is YES…..

ASSESSMENT:

- Create safe supportive environment
- Gather information about health issues associated with the abuse
- Determine health and safety needs and develop and implement a response

Assess Immediate Safety

- Do you have somewhere safe to go?
- Have there been threats or abuse of the children?
- Are you afraid you life may be in danger?
- Has the violence gotten worse, involved weapons, alcohol or drugs?
- Have you/children been held against your will?
- Assess the pattern and history of the abuse

Questions NOT to Ask

- Why don't you just leave?
- What did you do to make him/her so angry?
- Why do you go back?

Patient Barriers:
Reasons for a NO Response

- Shame/Embarrassment
- Fear
- Lack of trust
- Economic/Immigration dependence
- Desire to keep family together / traditional or religious values
- Lack or unaware of alternative
- Lack of support

Referral

- Ask patient if he/she would like to be connected with IPV advocacy services
- Offer the patient the National Domestic Violence Hotline number
- Consider whether child protective services are required

Documentation

- Document the patient's statements
- Avoid judgmental documentation(e.g. write "patient declines services" rather than 'patient refuses services" and "the patient states she was…" rather than "patient alleges"
- Record details and concurrent related medical problems
- Social history to include relationship to abuser
  - If she gives the specific name of the assailant, use it in your record. "She says her boyfriend John Smith struck her…"

Documentation

- Review medical record and ask regarding current and past episode of IPV
- Patients appearance and demeanor: ”tearful, shirt ripped” instead of “distraught”
- Body Map and photographs
- Document an opinion if the injuries were inconsistent with the patient’s explanation.
- *Further information about Coding and Documentation is available from the national organization “Futures without Violence”.*

Documentation: Physical Exam

- Findings related to abuse: neurological, gynecological, mental status
- Document injuries: type, color texture, size and location
- Use a body map/photographs with description
- Obtain consent prior to photo with label and date
- Use the victim actual words
- Document referrals offered and report to authorities
- Appropriate lab, x-rays

If NO Disclosure is made:

- Document assessment was conducted and no disclosure
- If you suspect abuse, document your reasons for concern i.e. “physical exam not congruent with history or “patient presents with indications of abuse”
- Make a follow-up appointment

Follow Up: Continuity of Care

- “I am still concerned for you health and safety?”
- “Have you sought counseling, support groups or other assistance?”
- “Has there been any escalation in the severity or frequency of the abuse?”
- “Have you developed or used a safety plan?”
- Review the resource options
- Continue nonjudgmental, generous listening.

Respond to Safety Issues

- Keep information private and safe from the abuser
- Offer private access to advocate, resources, phone
- Assist with notifying police if desired
- Assess for SI and HI
- Make referrals to advocacy and support services: hospital personnel with special training, law enforcement, shelters, hotlines, child protective services

Additional Important Tips

- Refrain from telling patients experiencing IPV what they *must* do (e.g., "you need to leave.) Recognize that only trained experts in IPV advocacy are qualified to help victims determine their own best course of safety.

- Respect privacy and confidentiality.
  - Employers and insurers could potentially discriminate against patients for their IPV status

What are our Ethical and Legal Responsibilities?

Ethical

- Support and concern for our patients
- Educate that domestic abuse is unacceptable
- Provide resources
- Assess immediate safety
- Report ONLY with consent and plan how to get safety
- KNOW that victims are at highest risk of being killed when they attempt to leave or report the abuse - because they upset the CONTROL

Legal Responsibilities

They are state specific

- In Missouri:
- In Kansas:
- Must always report child or elderly/ vulnerable adult abuse.

What Are The Barriers To Care ?

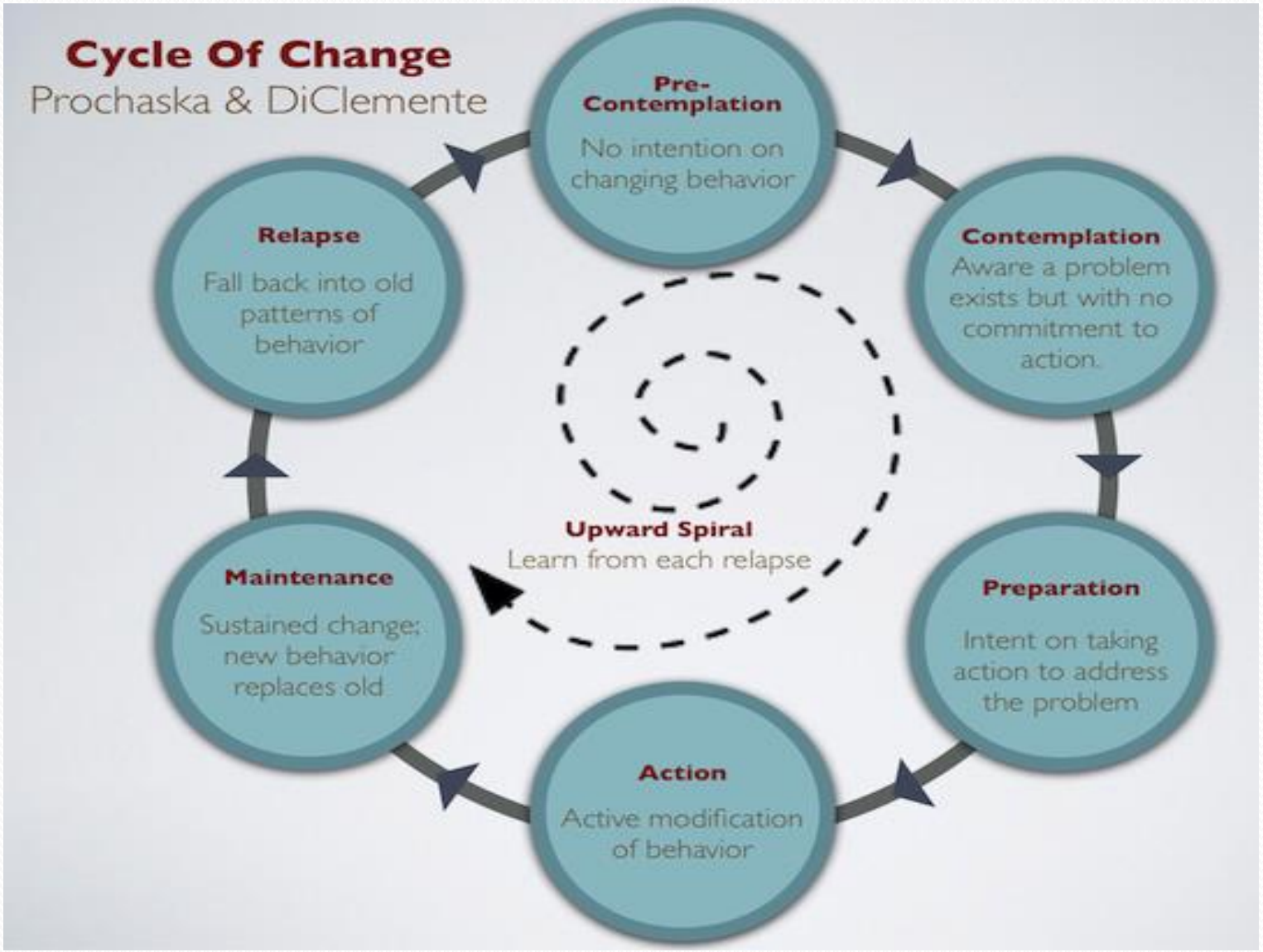
Patient Barriers

Physician Barriers

Physician Barriers

- 55 – 68% of physicians never / rarely inquire
- 34% uncomfortable due to lack of training
  - Lack confidence in ability to diagnose IPV
- Fear of offending
- 40% unsure of appropriate response
- Lack of time, privacy
- Personal experience with abuse
- Frustrations re inadequate resources, system barriers, victims returning to abuser, etc

How Can A Victim Become A Survivor ?



Stages of Change: Intervention Matching Guide

1. Pre-contemplation

- Offer **factual** information
- Explore the **meaning of events** that brought the person to treatment
- Explore **results of previous efforts**
- Explore **pros and cons** of targeted behaviors

2. Contemplation

- Explore the person's **sense of self-efficacy**
- Explore **expectations** regarding what the change will entail
- **Summarize** self-motivational statements
- Continue exploration of **pros and cons**

3. Determination

- Offer a **menu of options** for change
- Help identify **pros and cons** of various change options
- Identify and **lower barriers** to change
- Help person **enlist social support**
- Encourage person to **publicly announce plans** to change

4. Action

- Support a **realistic view** of change through **small steps**
- Help **identify high-risk situations** and develop **coping strategies**
- Assist in **finding new reinforcers** of positive change
- Help access family and social **support**

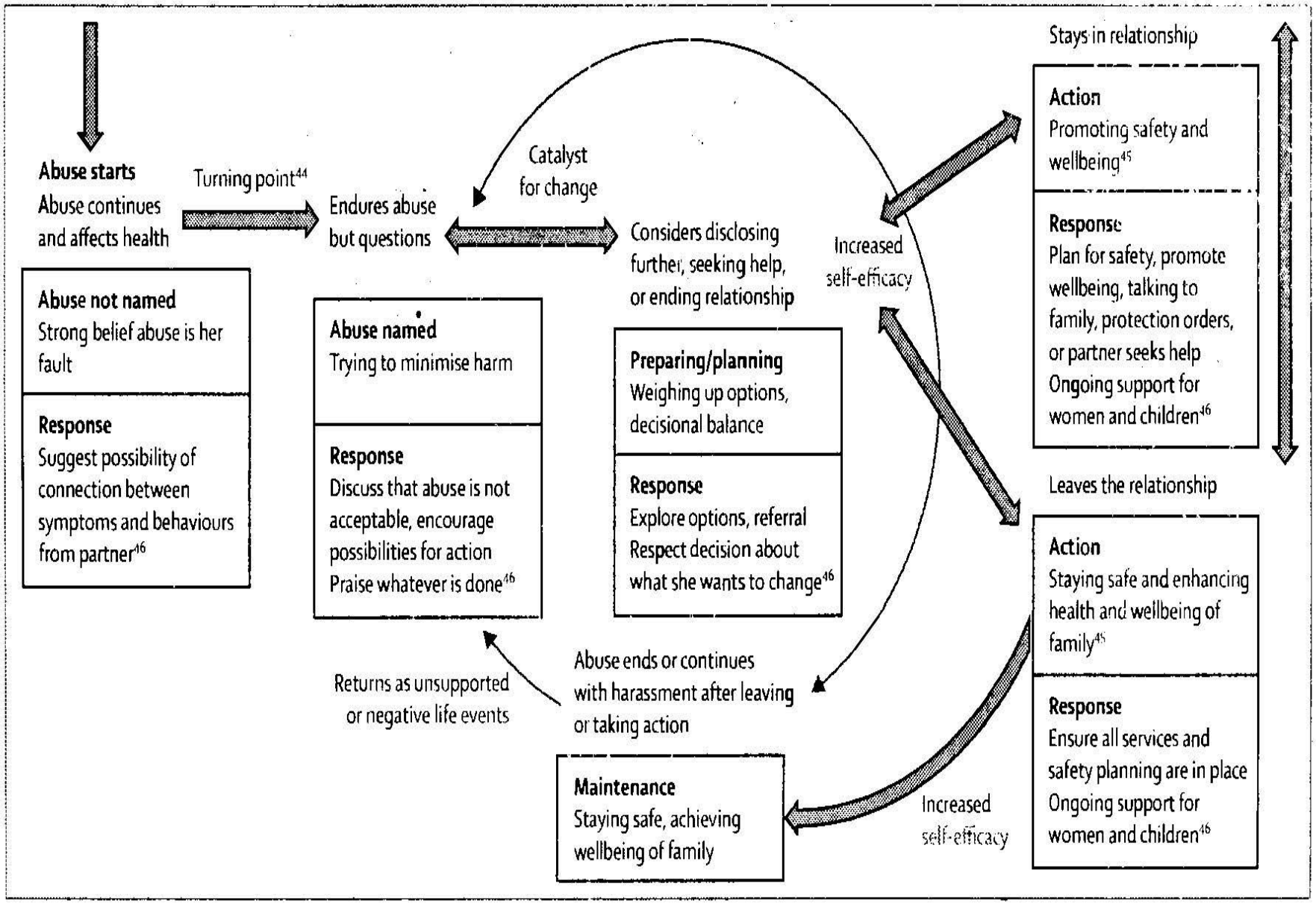
5. Maintenance

- Help identify and try **alternative behaviors** (drug-free sources of pleasure)
- Maintain **supportive contact**
- Help **develop escape plan**
- Work to **set new** short and long term **goals**

6. Recurrence

- Frame recurrence as a **learning opportunity**
- Explore possible behavioral, psychological, and social **antecedents**
- Help to develop **alternative** coping strategies
- Explain Stages of Change & encourage person to **stay in the process**
- Maintain **supportive** contact

Non-linear Trajectory To Safety



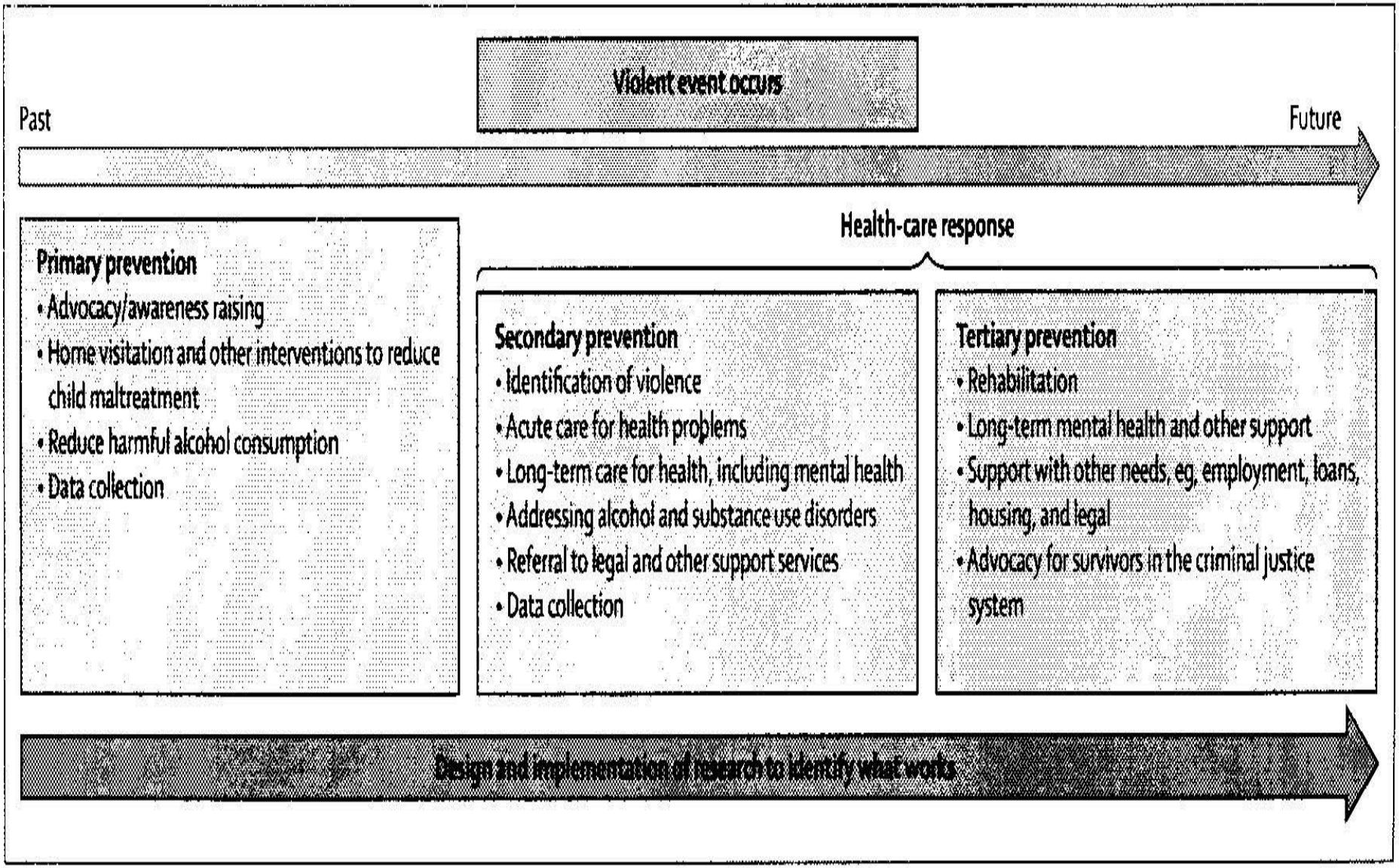


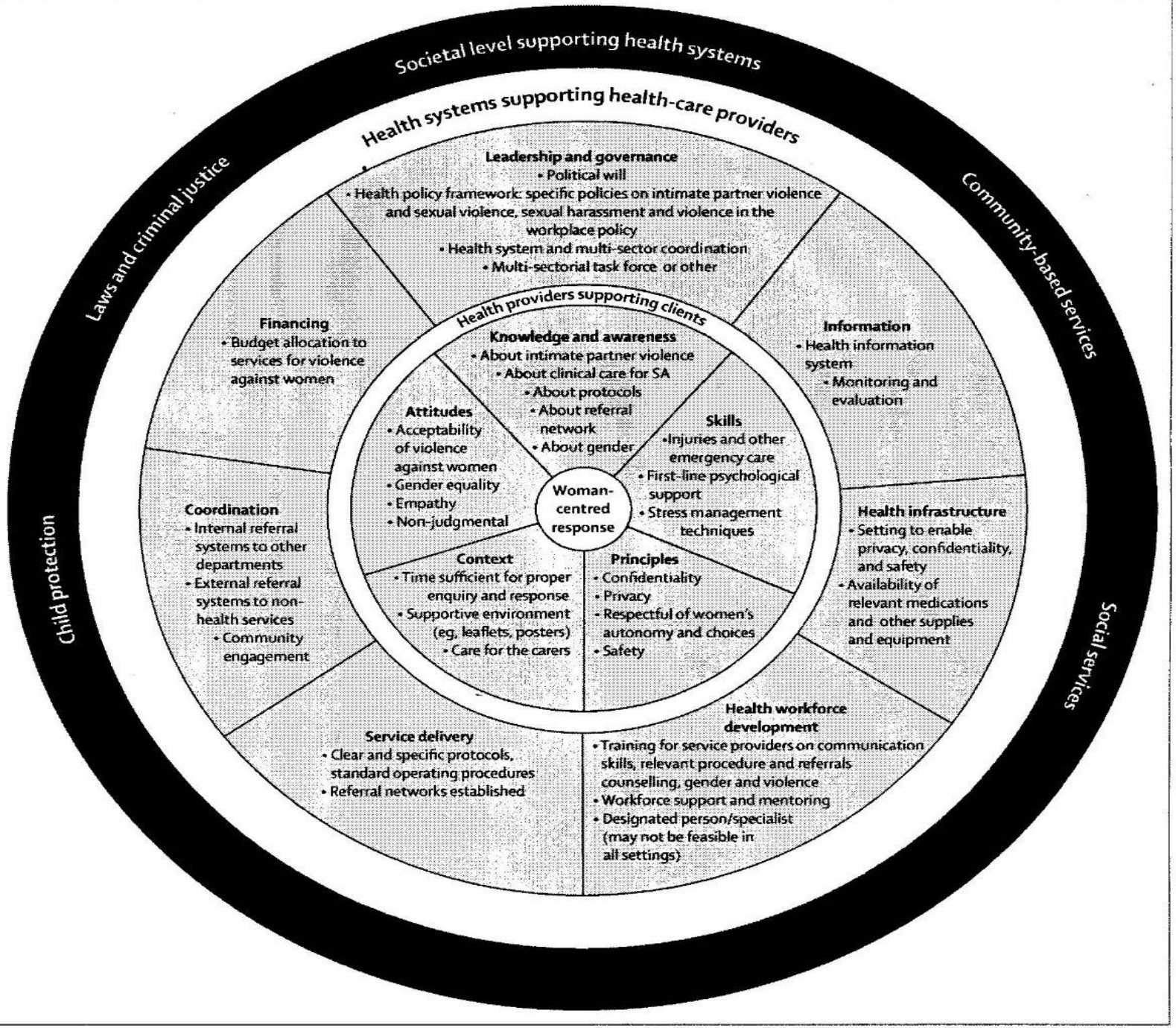
Figure 1: The role of the health system to address violence against women

What About The Children ?

The Silent Victims

So Where Do We Go From Here ?

- Promote Gender Equality
- Improve (Multi - / Inter-Disciplinary) Education
- Utilize the *"Empowerment Model"*
  - Understand and use Stages of Change
  - The patient as the expert on his/her situation, resources, and readiness for change
  - Physician Empowers The Patient


Societal level supporting health systems
Health systems supporting health-care providers
Laws and criminal justice
Community-based services
Child protection
Social services
Leadership and governance
• Political will
• Health policy framework: specific policies on intimate partner violence and sexual violence, sexual harassment and violence in the workplace policy
• Health system and multi-sector coordination
• Multi-sectorial task force or other
Financing
• Budget allocation to services for violence against women
Information
• Health information system
• Monitoring and evaluation
Coordination
• Internal referral systems to other departments
• External referral systems to non-health services
• Community engagement
Health infrastructure
• Setting to enable privacy, confidentiality, and safety
• Availability of relevant medications and other supplies and equipment
Service delivery
• Clear and specific protocols, standard operating procedures
• Referral networks established
Health workforce development
• Training for service providers on communication skills, relevant procedure and referrals counselling, gender and violence
• Workforce support and mentoring
• Designated person/specialist (may not be feasible in all settings)
Health providers supporting clients
Knowledge and awareness
• About intimate partner violence
• About clinical care for SA
• About protocols
• About referral network
• About gender
Attitudes
• Acceptability of violence against women
• Gender equality
• Empathy
• Non-judgmental
Skills
• Injuries and other emergency care
• First-line psychological support
• Stress management techniques
Woman-centred response
Context
• Time sufficient for proper enquiry and response
• Supportive environment (eg, leaflets, posters)
• Care for the carers
Principles
• Confidentiality
• Privacy
• Respectful of women's autonomy and choices
• Safety

~ IPV: Concluding Thoughts ~

- Violence by intimate partners is linked to both immediate and long-term health, social, and economic consequences
- Factors at all levels – individual, relationship, community, societal – contribute to IPV
- Preventing IPV requires:
  - Reaching a *clear understanding* of all factors
  - *Coordinating* resources
  - Fostering and initiating *change* in individuals, families, society
- Physicians embracing role – education / training / resources/ time

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Resources

- **Moskovic C, Wyatt L, Chirra A, et al. Intimate Partner Violence in the Medical School Curriculum: Approaches and Lessons Learned.** *AMA Journal of Ethics*. 2009; 11 (2): 130-136.
- **World Health Orginization. Intimate partner violence and sexual violence against women-clinical and policy guidelines 2013.** http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf. Accessed May 15, 2017.
- **National Domestic Violence Hotline (1-800-799-SAFE)**

Resources

- **Family Violence Prevention Fund**
  www.endabuse.org
- **National Coalition Against Domestic Violence**
  www.ncadv.org
- **National Network to End Domestic Violence**
  www.nnedv.org
- **Local Domestic Violence Hotlines**
  www.ojp.usdoj.gov/vawo/state.htm

Improving Medical Student IPV Education

- Existing IPV curricular approaches at the university level fail to adequately increase knowledge about IPV
- Comprehensive approaches to teaching IPV should be integrated fully into medical school curricula
- Didactics vs. serving as educators in a community-based adolescent IPV prevention program

In Her Shoes: Interdisciplinary/AMWA

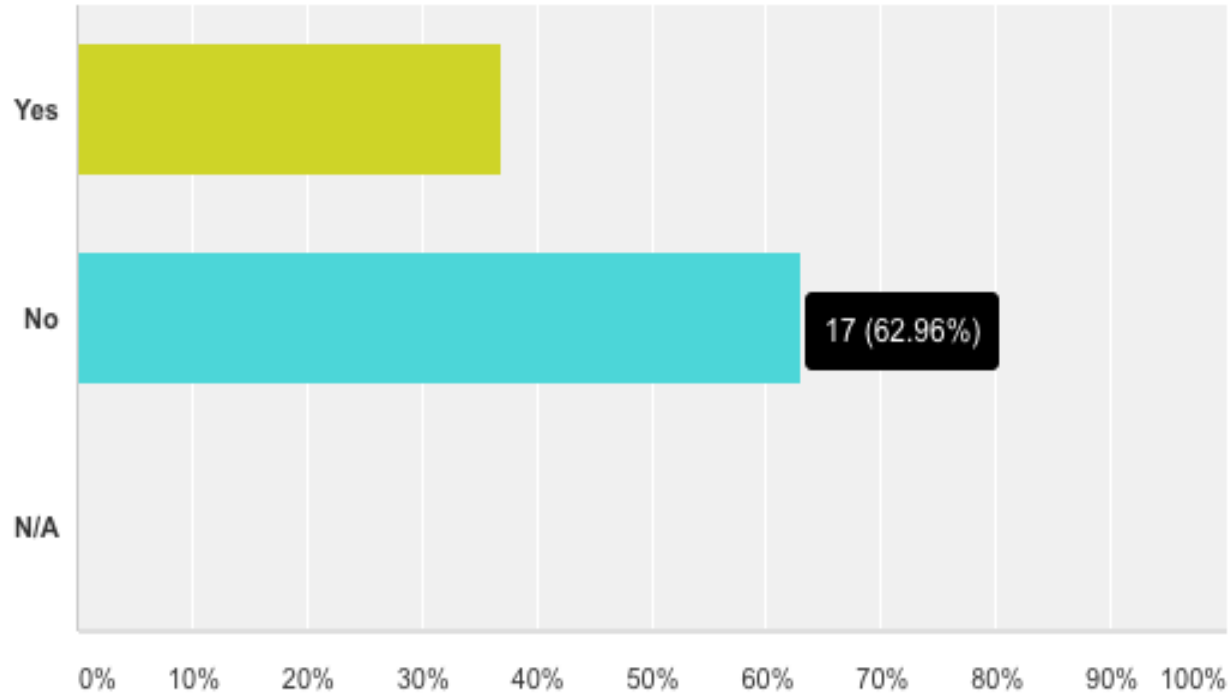
- Interactive learning experience
- Law, nursing and medical students
- Medical students with special groups for men and women
- AMWA program with
- Women from Midwest region

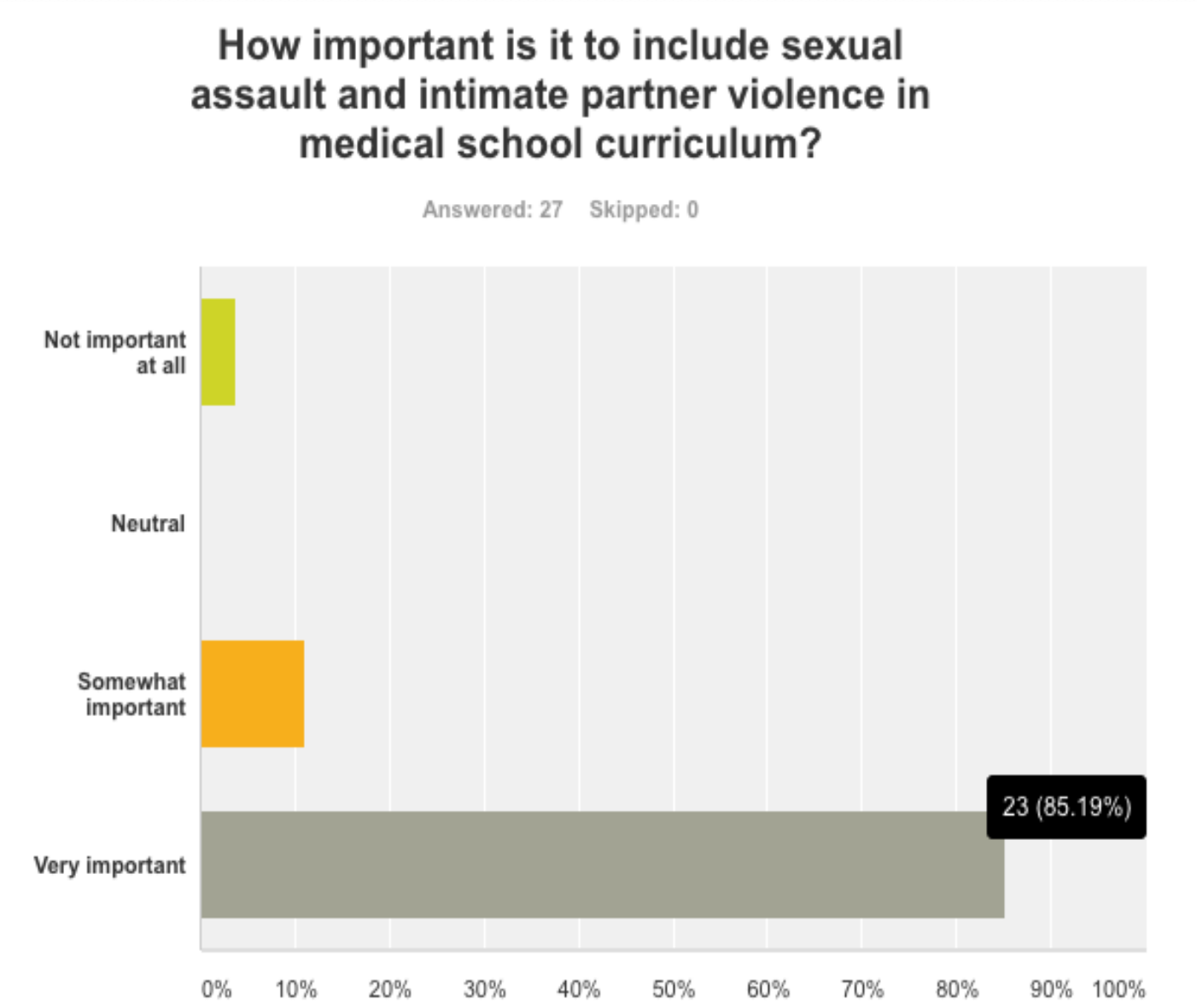
UMKC Student Assessment

- Medical students are amongst the first providers to engage patients
- A routine history and physical exam can very quickly trigger panic or anxiety in a victim of assault
- Survey administered to UMKC School of Medicine students (n=27) years 3-6 to assess importance and interest in sexual assault training
  - **63% had received no formal IPV education**
  - **85% and 12% of students responded that it was very important and somewhat important, respectively, for formal IPV education to be included in the SOM curriculum**
  - **92.6% of students would like for there to be IPV learning and training experiences in the clinical setting**

Have you received any formal education (lecture, modules, active learning activity) during your time at UMKC SOM on how to approach a patient who may have experienced sexual assault?

Answered: 27 Skipped: 0




How important is it to include sexual assault and intimate partner violence in medical school curriculum?
Answered: 27 Skipped: 0
Not important at all
Neutral
Somewhat important
Very important
23 (85.19%)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

Would you like UMKC SOM to provide learning and training opportunities for medical students regarding sexual assault in the clinical setting?

Answered: 27 Skipped: 0