Intimate Partner Violence: Role of the Physician

20 September, 2019

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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):

A. Only those females, of childbearing age, who have significant risk factors (such as bruises on physical exam etc.)
B. All females of childbearing age
C. Only females with a past medical history for IPV
D. Never screen for IPV, it can increase patients risk of being physically harmed
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When documenting in the Electronic Medical Record (EMR) about Intimate Partner Violence, physicians should do all of the following EXCEPT:

A. Use names of specific assailant, if pt provides the information
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 women.
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
Figure 2. Global map showing regional prevalence rates of intimate partner violence by 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.
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
In what year did the state of Missouri make it illegal for a man to force sex upon his wife?

- 1960
- 1991
- 1943
- 1972
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

<table>
<thead>
<tr>
<th>Health Conditions Associated with IPV</th>
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<tbody>
<tr>
<td><strong>Asthma</strong></td>
</tr>
<tr>
<td><strong>Bladder/kidney infections</strong></td>
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<tr>
<td><strong>Cardiovascular disease</strong></td>
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<tr>
<td><strong>Fibromyalgia</strong></td>
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<tr>
<td><strong>Irritable bowel syndrome</strong></td>
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### Psychological Consequences of Intimate Partner Violence

<table>
<thead>
<tr>
<th>Psychological Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
</tr>
<tr>
<td>PTSD</td>
</tr>
<tr>
<td>Suicidal behavior</td>
</tr>
<tr>
<td>Fear of intimacy</td>
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<tr>
<td>Sleep disturbances</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>How Often Does Your Partner:</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Fairly Often</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physically Hurt You</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Insult or talk down to you</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Threaten you with harm</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Scream or curse at you</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

A total score of more than 10 is suggestive of intimate partner violence.
<table>
<thead>
<tr>
<th>RADAR Tool</th>
<th></th>
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<tbody>
<tr>
<td><strong>R=</strong></td>
<td>Routinely screen female patients</td>
</tr>
<tr>
<td><strong>A=</strong></td>
<td>Ask direct questions</td>
</tr>
<tr>
<td><strong>D=</strong></td>
<td>Document your findings</td>
</tr>
<tr>
<td><strong>A=</strong></td>
<td>Assess patient safety</td>
</tr>
<tr>
<td><strong>R=</strong></td>
<td>Respond, review options, and refer</td>
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### Examples of Direct Questions

<table>
<thead>
<tr>
<th>Question</th>
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<tbody>
<tr>
<td>Is there anyone who has physically hurt or frightened you?</td>
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<tr>
<td>Have you ever been hit, kicked, or punched by your partner?</td>
</tr>
<tr>
<td>Does your partner try to control your activities or your money?</td>
</tr>
<tr>
<td>I noticed you have a number of bruises; did someone do this to you?</td>
</tr>
<tr>
<td>Because violence is so common in many woman’s lives, we’ve begun to ask about it routinely.</td>
</tr>
</tbody>
</table>
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 your 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’s 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?

Cycle Of Change
Prochaska & DiClemente

- **Pre-Contemplation**: No intention on changing behavior.
- **Contemplation**: Aware a problem exists but with no commitment to action.
- **Preparation**: Intent on taking action to address the problem.
- **Action**: Active modification of behavior.
- **Maintenance**: Sustained change; new behavior replaces old.
- **Relapse**: Fall back into old patterns of behavior.

**Upward Spiral**
Learn from each relapse.
<table>
<thead>
<tr>
<th>Stages of Change: Intervention Matching Guide</th>
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<tbody>
<tr>
<td><strong>1. Pre-contemplation</strong></td>
</tr>
<tr>
<td>- Offer <strong>factual</strong> information</td>
</tr>
<tr>
<td>- Explore the <strong>meaning of events</strong> that brought the person to treatment</td>
</tr>
<tr>
<td>- Explore <strong>results of previous efforts</strong></td>
</tr>
<tr>
<td>- Explore <strong>pros and cons</strong> of targeted behaviors</td>
</tr>
<tr>
<td><strong>2. Contemplation</strong></td>
</tr>
<tr>
<td>- Explore the person’s <strong>sense of self-efficacy</strong></td>
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<tr>
<td>- Explore <strong>expectations</strong> regarding what the change will entail</td>
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<tr>
<td>- <strong>Summarize</strong> self-motivational statements</td>
</tr>
<tr>
<td>- Continue exploration of <strong>pros and cons</strong></td>
</tr>
<tr>
<td><strong>3. Determination</strong></td>
</tr>
<tr>
<td>- Offer a <strong>menu of options</strong> for change</td>
</tr>
<tr>
<td>- Help identify <strong>pros and cons</strong> of various change options</td>
</tr>
<tr>
<td>- Identify and <strong>lower barriers</strong> to change</td>
</tr>
<tr>
<td>- Help person <strong>enlist social support</strong></td>
</tr>
<tr>
<td>- Encourage person to <strong>publicly announce plans</strong> to change</td>
</tr>
<tr>
<td><strong>4. Action</strong></td>
</tr>
<tr>
<td>- Support a <strong>realistic view</strong> of change through <strong>small steps</strong></td>
</tr>
<tr>
<td>- Help <strong>identify high-risk situations</strong> and develop <strong>coping strategies</strong></td>
</tr>
<tr>
<td>- Assist in <strong>finding new reinforcers</strong> of positive change</td>
</tr>
<tr>
<td>- Help access family and social <strong>support</strong></td>
</tr>
<tr>
<td><strong>5. Maintenance</strong></td>
</tr>
<tr>
<td>- Help identify and try <strong>alternative behaviors</strong> (drug-free sources of pleasure)</td>
</tr>
<tr>
<td>- Maintain <strong>supportive contact</strong></td>
</tr>
<tr>
<td>- Help <strong>develop escape plan</strong></td>
</tr>
<tr>
<td>- Work to <strong>set new</strong> short and long term <strong>goals</strong></td>
</tr>
<tr>
<td><strong>6. Recurrence</strong></td>
</tr>
<tr>
<td>- Frame recurrence as a <strong>learning opportunity</strong></td>
</tr>
<tr>
<td>- Explore possible behavioral, psychological, and social <strong>antecedents</strong></td>
</tr>
<tr>
<td>- Help to develop <strong>alternative</strong> coping strategies</td>
</tr>
<tr>
<td>- Explain Stages of Change &amp; encourage person to <strong>stay in the process</strong></td>
</tr>
<tr>
<td>- Maintain <strong>supportive</strong> contact</td>
</tr>
</tbody>
</table>
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
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


Works Cited

- Prochaska J, DiClemente C. The transtheoretical approach: crossing traditional boundaries of therapy. Homewood (IL): Dow Jones/Irwin; 1984
Resources


• 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
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. A 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

- Yes
- No 17 (62.96%)
- N/A
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%)
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

- Yes: 25 (92.59%)
- No: 0
- N/A: 0