Physician Intervention For Intimate Partner Violence

Sonia Aneja, MD, Amy S Gottlieb, MD, and Edward Feller, MD

In the United States, as many as one in four women will be physically assaulted or raped by a current or past partner or date during her lifetime.[1] Violence can be any pattern of psychological, economic, verbal, physical, or sexual abuse, including sexual coercion. The vast majority of victims are women.

The impact of **Intimate Partner Violence (IPV)** on women is far-reaching. The most devastating consequences are serious injury and death. Beyond this, women exposed to IPV face a myriad of co-morbidities such as depression, anxiety, and post traumatic stress disorder.[2] IPV has been associated with increased incidence of substance abuse and utilization of substance abuse resources.[3] Victims are more likely to have somatic complaints, such as abdominal pain, headaches, musculoskeletal discomfort and chronic pain syndromes.[3]

IPV places a burden on the health care system. Women in abusive relationships are more likely to utilize medical services and to access out-patient care, mental health and emergency services. It has been estimated that in the United States, IPV results in the expenditure of $5.8 billion annually with $4.1 billion for direct medical and mental health care.[4]

Screening for IPV is a first step in addressing this epidemic. The American College of Obstetrics and Gynecology, the American Medical Association, and the American Academy of Family Physicians, endorse routine screening. Data indicate that patients also support regular IPV screening. Nevertheless, the rate of screening remains around 10%.[5] Although physicians are encouraged and even mandated to screen for IPV, limited office-based resources exist to address the needs of women who screen positive. Lack of time, training, reimbursement or infrastructure are major barriers to physician screening.

Intervention: IPV Desk Reference

We propose a step-by-step protocol for physicians to implement when patients disclose a history of IPV. This protocol was created through a literature review of qualitative studies and primary interviews conducted with non-physician health professionals in the Rhode Island community who work with victims of partner violence. This protocol, including screening questions for IPV, was formatted as a desk reference to be distributed to primary care physicians in RI. (Table 1) We hypothesize that this resource will increase screening and detection rates of IPV by addressing the sense of "powerlessness" that many physicians may feel when faced with possible victims of IPV.[6] Ultimately, the goal is to empower both physicians and patients to optimize resources and improve health outcomes.

Screening

Patient barriers to universal screening include the social stigma surrounding IPV, cultural and language barriers, past failures with the medical and legal systems, shame, denial, fear of losing custody of children, economic hardship and desire to protect the perpetrator.[7]

Physician barriers may include lack of training in screening for IPV, time constraints, lack of compensation, and general discomfort with the issue. Some physicians may feel that they are not responsible for addressing "a social work issue." Data suggest that many physicians feel ill-equipped to react to patients who screen positively, so they simply do not ask the questions.

Women of all racial, ethnic, socioeconomic, and educational backgrounds confront IPV, though this may not be readily apparent to victims or health care providers. Therefore, universal screening is the only effective way to screen for partner abuse. Screening must begin with a commitment to confidentiality. Provider discussions about possible IPV should begin after any accompanying partners, children, or friends are directed to leave the exam room. An initial leading question can be, "Are you in an intimate relationship? If so, do you feel safe in your relationship and at home?" The patient may or may not disclose abuse at this time. Most providers who screen for IPV stop at this point. But many victims will not disclose abuse unless they are questioned further. If the patient denies abuse, the physician should follow up with simple questions. (Table 1, *Screening* section) In summary, every female patient should be briefly screened. This protocol involves a general inquiry about feeling safe at home, followed selectively with specific questions about physical and sexual abuse.

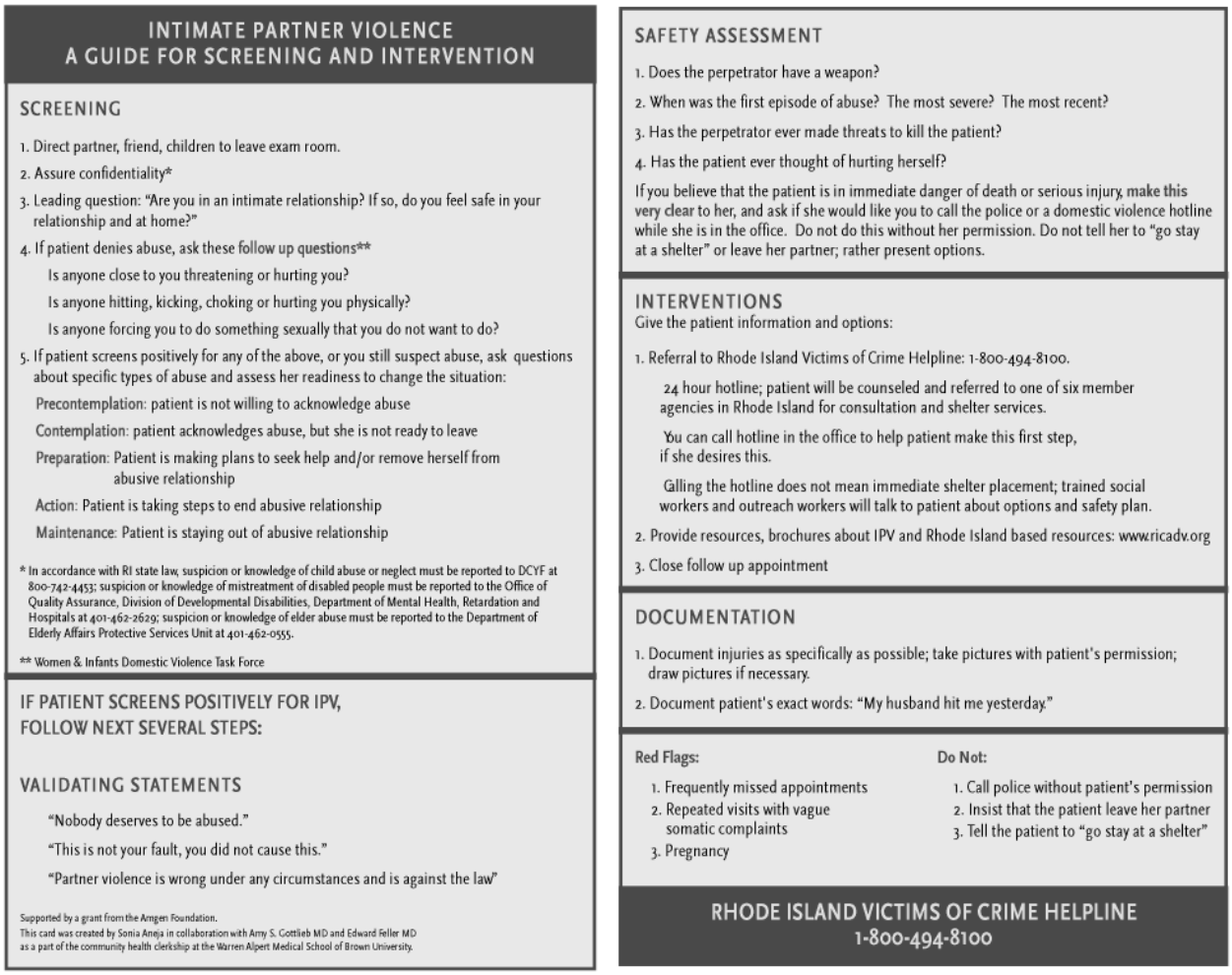
Approach to the Patient

When a patient discloses a history of past or present IPV, a provider must first demonstrate support and empathy. Statements such as "Nobody deserves to be abused," and "This is not your fault, you did not cause this," and "Partner violence is wrong and illegal" are extremely helpful to women who disclose a past or current history of IPV.[8] IPV can have a deleterious impact on self-esteem and be extremely disempowering. Supportive statements attempt to empower the patient and re-build her sense of self-worth.

It is important to assess a patient's readiness to change her situation or leave an abusive partner. Research has shown that the Transtheoretical Model (stages of change model), which has been widely applied to smoking cessation, alcohol cessation and weight loss, can also be applied to survivors of IPV.[9] The Transtheoretical Model addresses an individual's readiness to change his/her behavior in five stages; precontemplation, contemplation, preparation, action and maintenance. This model recognizes that each patient's situation is unique; to be effective, interventions need to be tailored to the individual. (Table 1, *Screening*, #5)

For most survivors of IPV, the process of leaving an abusive relationship is complex. Health care providers who feel frustrated when women stay in abusive relationships must understand that, in leaving, many women face social isolation, financial instability, cultural barriers, fear of retribution by the abuser and the prospect of being a single parent to their children.[10] Health professionals should assess the victim's stage of change, and attempt to help her reach "preparation" or "action" while recognizing that this journey can be arduous.

Table 1. Intimate Partner Violence: Screening Card



INTIMATE PARTNER VIOLENCE
A GUIDE FOR SCREENING AND INTERVENTION

SCREENING

1. Direct partner, friend, children to leave exam room.
2. Assure confidentiality*
3. Leading question: "Are you in an intimate relationship? If so, do you feel safe in your relationship and at home?"
4. If patient denies abuse, ask these follow up questions**
   - Is anyone close to you threatening or hurting you?
   - Is anyone hitting, kicking, choking or hurting you physically?
   - Is anyone forcing you to do something sexually that you do not want to do?
5. If patient screens positively for any of the above, or you still suspect abuse, ask questions about specific types of abuse and assess her readiness to change the situation:
   - Precontemplation: patient is not willing to acknowledge abuse
   - Contemplation: patient acknowledges abuse, but she is not ready to leave
   - Preparation: Patient is making plans to seek help and/or remove herself from abusive relationship
   - Action: Patient is taking steps to end abusive relationship
   - Maintenance: Patient is staying out of abusive relationship

* In accordance with RI state law, suspicion or knowledge of child abuse or neglect must be reported to DCYF at 800-742-4453; suspicion or knowledge of mistreatment of disabled people must be reported to the Office of Quality Assurance, Division of Developmental Disabilities, Department of Mental Health, Retardation and Hospitals at 401-462-2629; suspicion or knowledge of elder abuse must be reported to the Department of Elderly Affairs Protective Services Unit at 401-462-0555.

** Women & Infants Domestic Violence Task Force

IF PATIENT SCREENS POSITIVELY FOR IPV, FOLLOW NEXT SEVERAL STEPS:

VALIDATING STATEMENTS

- "Nobody deserves to be abused."
- "This is not your fault, you did not cause this."
- "Partner violence is wrong under any circumstances and is against the law"

Supported by a grant from the Amgen Foundation.
This card was created by Sonia Aneja in collaboration with Amy S. Gottlieb MD and Edward Feller MD as a part of the community health clerkship at the Warren Alpert Medical School of Brown University.

SAFETY ASSESSMENT

1. Does the perpetrator have a weapon?
2. When was the first episode of abuse? The most severe? The most recent?
3. Has the perpetrator ever made threats to kill the patient?
4. Has the patient ever thought of hurting herself?

If you believe that the patient is in immediate danger of death or serious injury, make this very clear to her, and ask if she would like you to call the police or a domestic violence hotline while she is in the office. Do not do this without her permission. Do not tell her to "go stay at a shelter" or leave her partner; rather present options.

INTERVENTIONS

Give the patient information and options:

1. Referral to Rhode Island Victims of Crime Helpline: 1-800-494-8100.
   - 24 hour hotline; patient will be counseled and referred to one of six member agencies in Rhode Island for consultation and shelter services.
   - You can call hotline in the office to help patient make this first step, if she desires this.
   - Calling the hotline does not mean immediate shelter placement; trained social workers and outreach workers will talk to patient about options and safety plan.
2. Provide resources, brochures about IPV and Rhode Island based resources: www.ricadv.org
3. Close follow up appointment

DOCUMENTATION

1. Document injuries as specifically as possible; take pictures with patient's permission; draw pictures if necessary.
2. Document patient's exact words: "My husband hit me yesterday."

Red Flags:

1. Frequently missed appointments
2. Repeated visits with vague somatic complaints
3. Pregnancy

Do Not:

1. Call police without patient's permission
2. Insist that the patient leave her partner
3. Tell the patient to "go stay at a shelter"

RHODE ISLAND VICTIMS OF CRIME HELPLINE
1-800-494-8100

Safety Assessment

Partner abuse can be a medical emergency. Health care providers must act decisively when a patient discloses that she is a victim. From 1996 to 2005 the US Department of Justice estimates that homicides against women were committed by intimate partners in 30.1% of cases compared to 5.3% of homicides against men.[11]

Consequently, safety or risk assessment is an important part of interventions. Risk factors for serious injury and lethality include the perpetrator's access to a firearm, previous threat with a weapon, previous threats to kill the patient, and use of illicit drugs. One study indicated that having a child living in the home who is not the perpetrator's biologic child more than doubles the risk of femicide.[12]

A safety or risk assessment has two purposes: to help determine the risk of lethal injury and to facilitate the patient's awareness of her situation and its potential for danger. The Danger Assessment, a validated tool, can be accessed at www.dangerassessment.org. While providers may not have enough time to implement this tool in its entirety, they can utilize portions of it in their clinical practice. (See *Table 1*) If a provider believes that a patient is at immediate risk of serious injury or death, he/she should make this very clear to the patient. While the police should never be called without a patient's permission, this option can be discussed with the patient.

Referral and Follow-up

Clinicians are often the bridge between the patient and domestic violence advocacy organizations. Offering information about local agencies is one of the most powerful things that a provider can do. Raising awareness about IPV potentially helps a patient move from a place of denial and self-blame to a point where she may be ready to make a change.

In our state, the Rhode Island Coalition Against Domestic Violence oversees the six local domestic violence agencies. (Table 2) Also in Rhode Island is a 24-hour hotline called the Victims of Crime Helpline (1-800-494-8100) which patients or their providers can access. With the patient's permission, a physician may call this hotline to help her take this first step. Health care providers and patients should understand that referral to a local agency does not result in immediate shelter placement. These organizations advise clients in court advocacy and affordable housing. They will assist with shelter placement if requested by the victim. They may also provide support groups and psychological services.

Table 2. Rhode Island Coalition Against Domestic Violence Member Agencies in Rhode Island

- Blackstone Valley Advocacy Center 723-3057
- Domestic Violence Resource Center of South County 782-3990
- Elizabeth Buffum Chace Center 738-1700 (Kent County/Cranston, Johnston/North Providence/Situate/Foster)
- Sojourner House 658-4334 (Providence/North Providence)
- Victims of Crime Helpline (statewide resource): 1-800-494-8100
- Women's Center of Rhode Island 861-2760 (Providence/East Providence)
- Women's Resource Center of Newport and Bristol Counties 846-5263

RI Coalition Administrative office: 467-9940

After patients identified as abuse victims are informed about resources, physicians should schedule a close follow-up appointment. This gives the patient time to think about her options. In recommending follow-up, the provider is sending a clear message of support and concern. Lastly, the provider should document a disclosure of abuse or suspected abuse in the patient's chart. The provider should state, in the patient's own words, a description of abuse and the name of the perpetrator. If the patient has injuries as a result of IPV, these should be documented and photographed if possible. Such documentation can be extremely important if legal action is taken for protection, prosecution or child custody.

Conclusion

Intimate partner violence is a major public health problem that can have devastating consequences for women and their families. Every physician has a responsibility to screen female patients for IPV and take appropriate steps if a patient screens positively. Our project aims to guide physicians in a plan to assist their patients who are victims. Our hope is that this desk reference will empower physicians to screen for IPV and ultimately improve health outcomes for victims of partner violence.

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Sonia Aneja, MD ('09 Brown), is a resident in Obstetrics and Gynecology at Duke University Hospital.

Amy Gottlieb, MD is Assistant Professor of Medicine and Obstetrics and Gynecology (Clinical) , The Warren Alpert Medical School of Brown University.

Edward Feller, MD is Clinical Professor of Medicine and Adjunct Clinical Professor of Community Health and Co-director of the Community Health clerkship at Brown.

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Correspondence

Edward Feller, MD
Box G- S121-2
Brown University
Providence, RI 02912
Phone: (401) 863-6149
e-mail: Edward_ Feller@brown.edu