Addressing Intimate Partner Violence with Primary Care Patients

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I have no relevant financial disclosures
Advocate at DVRC

- Restraining orders
- Youth support groups

Project Director of clinic study

- PI: Christina Nicolaidis, MD, MPH
  Div. of GIM and Geriatrics
- 33 clinics in WA county, two-hour training
- Evaluation found significant increases in providers' knowledge, skills, sense of responsibility, and empathy
Outline

- Screening
- Exploring clinical suspicion
- Responding to Yes
- Safety assessment and planning
- Handing out resources
- Documentation
Intimate Partner Violence (IPV)

Term favored over Domestic Violence

“Threatened, attempted, or completed physical and sexual violence.”

Emotional abuse:

• “Progressive social isolation, stalking, deprivation, intimidation, and threats.”

Committed by current or former dating partner or spouse

POWER and CONTROL

Prevalence of IPV

Women in primary care settings:
- Lifetime: 26-38%
- Past year: 8-14%

Men in primary care settings:
- Lifetime: 8%
- Past year: 1-4%

USPSTF: Screening for IPV

“I” rating in 2004

2013: “B” rating for screening women of child bearing age

• “... high diagnostic accuracy in detecting current or past abuse.”

• “... associated with moderate health improvements through the reduction of exposure . . .”

• Interventions: counseling, home visits, information cards, referrals to community services, and mentoring support.

USPSTF, 2013
More reasons to screen

IPV may:

• Be contributing to symptoms
• Explain why pt is having trouble adhering to your treatment plan
• Put pt at increased risk for other health problems or premature death.

Without knowing, clinicians more likely to
• Waste time and resources addressing the wrong problem or
• Recommending treatments unlikely to work.

Questions serve to educate pt
Barriers

Barriers to patient’s own recognition
  • Stereotypes of abuse
  • Stereotypes of victims
  • Love for abuser
  • Complexities of relationships

Barriers to disclosing to clinician
  • Lack of privacy
  • Fear
  • Embarrassment
  • Feeling docs don’t want to know

Reasons patient often remains in relationship
  • Commitment, belief in excuses, lack of options
Connie-Sue:

“I didn’t associate my situation with domestic violence because I wasn’t all tattered and torn. The images we see of women who are battered are those that end up in the emergency room. And I didn’t look like that.”

Nicolaidis, et al, 2006
Jill:

“As much as he was extreme in his violence he was extreme in his love. Red flags should have been going off – Denial! Denial! These are all things now, I see, but at the time I didn’t, okay? So as much as he beat me or was violent with me, he was also . . . No one had ever loved me like he loved me.”

Nicolaidis, et al, 2006
Patti:

“They basically told me to leave. And it wasn’t as simple as that. You know, I had other children, I was isolated in a trailer. I was pregnant. I felt really kind of trapped. And so I said, ‘Well, then I guess I can’t do anything.’ So I decided to stay, and I just let it go.”
Current practices

• Large study: 7% of women reported being asked by a health care professional

• >90% of survivors seek medical care

• Abused women seek less mental health care and more care for physical complaints than non-abused women

• Most physicians underestimate prevalence of IPV in their patient load

What survivors want from doctors

- To be asked
- Shown empathy
- Offered resources
Screening for IPV

Asymptomatic, based on prevalence

When?
  • Whenever taking a complete history: New visits and annuals
  • Every trimester for pregnant pts

Screening forms?
  • Show the clinic cares, educates pt
  • But should not replace screening in person
    • Abuser may be present
    • “Piece of paper”
Ask only when alone with patient
- Not in presence of children or partner
- Strategies to get patient alone?
- Never confront suspected abuser

Framing the question
- Routine
- Avoid loaded words
- Avoid “Safe at home”
- Avoid bad framing
Recommended questions:

- “Have you ever been kicked, slapped, or hit by a partner, or forced to have sex against your will?”
- “Do you feel controlled or threatened by anyone in your life?”

Responses mostly “No”

- Document if suspicious: “Concern for possible abuse” in DD
- Pts rarely disclose first time asked
Clinical indicators of abuse

General:

- Partner unwilling to leave pt alone
- Multiple concurrent physical symptoms
- Vague and nonspecific symptoms
- Substantial time delay between onset of symptoms/ injury and presentation
- Inconsistency between history and physical findings
- Poor control of medical conditions

Warshaw and Ganley, 1998
Clinical indicators

Injuries that especially raise suspicion:

- Repeated or chronic injuries
- Bruises in various stages of healing
- Improbable mechanism of injury
- Multiple or bilateral injuries
- Human bites, or burns in unusual places
- Bruising in proximal or central body
- Finger marks on inner soft tissue
- Cuts or slashes on hands or wrists
- Fractures to forearm, face, or orbital area
- Black eyes or lacerations on face
- Strangle marks
- Head trauma, spinal injury

Warshaw and Ganley, 1998
Clinical indicators

Mental health

Note: Battering may result in new psychiatric symptoms or aggravate already existing ones

• Acute psychotic episodes
• Substance abuse
• Anxiety disorders
• Attempted suicide
• Decreased concentration
• Depression
• Eating disorders
• PTSD
• Sleep disturbances

Warshaw and Ganley, 1998
Clinical indicators

Gynecologic
- Pain and fear during examination
- Poor contraceptive compliance or STDs
- Recurring UTIs
- Chronic pelvic pain
- Irregular vaginal bleeding
- Sexual dysfunction

Obstetric
- Late or sporadic prenatal care
- Poor nutrition
- Spontaneous abortions
- Preterm delivery, placental separation, or low birth weight infant

Warshaw and Ganley, 1998
Exploring clinical suspicion

Discussed before?

- Lack of direct questions often misinterpreted
- Be open and honest without accusing your pt of lying

Examples:

- “It looks like someone hurt you – tell me what happened again?”
- “Sometimes pts with your symptoms. . . “
- “Sometimes when pts delay treatment . .”
- “Is there anything going on in your life that may be contributing to your stress/depression?”
Responding to Yes

Your first thought may be:
- “Oh no, the rest of my day is shot.”
- Or, “How do I get her out of this?”

First: show empathy and support
1. I’m sorry
2. Not your fault
3. It’s common

Don’t try to “fix” problem

Don’t pressure pt to leave relationship
- Similar to controlling behavior, pt may not return, statistically dangerous - safety first!
Safety assessment

Assess urgency, like any other condition

- Most IPV cases in past, info will help you better manage your pt

Recent violence deserves assessment

- Frequency
- Threats to kill
- Weapons
- Substance abuse
- Separation

Imminent danger

- Rare, but call police
Safety planning

Help pt stay safe
  - What has pt done in past?

Give positive reinforcement
  - Patient knows best
  - A discussion, not prescription

Consider:
  - Emergency bag, neighbors call 911, avoid kitchen/bathrooms
  - Planning can trigger identification
  - Using local resources
Children at risk

Mandatory laws

• Reporting can be done at end of day
• Inform mother is in danger
• Consider calling advocate first, making call with pt in room

Children at risk

• Witnessing violence
• “Sounds like you love your children. . . as you know . . . Let’s think of ways to stay safe.”
Offer resources

- Unlikely to use first time
- Cards and brochures
- Can be displayed in waiting room, bathroom, exam rooms

Make clear you want to see pt back

Show concern, but leave decision to her
Monica:

“Yes, there’s something that you cannot fix. But as long as you’re there, and you can give the help, or let them know that there is help out there, you’ve done your job. Because you’re not completely powerless in the fact that you have given them options. And that’s the most amazing thing, to be given a choice.”

Nicolaidis, et al, 2006
Reasons

• Helpful for contested restraining orders
• May lead to longer sentences
• Protection against malpractice

Subjective:

• Abuser’s full name
• Pt’s report of danger
• Details of assaults
• Presence of children
• Pt’s responses
• Current status of relationship
Objective:

- Pt’s emotional state, affect during interview
- Partner’s demeanor and interactions
- Any physical signs of injury or abuse
- Photographs

Assessment:

- Spell out your concern or suspicion as part of the differential
- Discrepancies between account and findings
- Concern about safety and lethality
- Never proclaim abuse NOT occurring
Plan:

- Counseling
- Referrals
- Follow-up plans
- Report to CPS
- Do NOT include pts whereabouts

General

- Avoid legal language
- Avoid insurance codes that may tip off abuser
Points to remember

- IPV is a slow, chronic process
- IPV is life-threatening, not terminal
- Unlikely to get disclosure first time you ask
- Pt may not want to leave, or may take a long time to access resources
- Address briefly and frequently, rather than act as a counselor
Joan:

“I really think that it’s the compassion, the screening, the referral, which can happen in a matter of minutes, which can be the hinge, the gateway to the way out.”

Nicolaidis, et al, 2006