Intimate Partner Violence and VHA Medical Care

Megan Gerber, MD, MPH
Medical Director, Women's Health
VA Boston Healthcare System

Acknowledgements

- The women Veterans whom we have the honor to serve.

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Goals/Objectives

- Review the basic epidemiology of Intimate Partner Violence (IPV).
- Understand what is known to date about women Veterans and IPV and understand challenges/opportunities for VA care delivery.
- Learn approaches to responding to IPV in primary care.
- Consider ways in which PACT providers and health services researchers may contribute to improving the care of Veterans impacted by IPV.

Poll #1

- What is your role within the VA?

❑ PCP
❑ Mental Health Provider
❑ Other Medical Provider (Emergency, Specialty etc)
❑ Nurse
❑ Researcher
❑ Women Veterans Program Manager
❑ Administrative/Management Staff
❑ Other

Definition and Background

CDC Definition

- The term “intimate partner violence” describes physical, sexual, or psychological harm by a current or former partner or spouse.
- This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy.

CDC. National Center for Injury Prevention and Control. http://www.cdc.gov/ncipc

Types of IPV

- Physical violence: the intentional use of physical force with the potential for causing death, disability, injury, or harm.
- Sexual violence: unwanted sexual activity (attempted or completed).
- Emotional violence: trauma to the victim caused by acts, threats of acts, or coercive tactics.
- Stalking: repeated behavior that causes victims to feel a high level of fear.

CDC. National Center for Injury Prevention and Control. http://www.cdc.gov/ncipc

Epidemiology

- National Intimate Partner and Sexual Violence Survey (NISVS) is the most recent population based study.
- Lifetime – 35.6%, Annual – 5.9%
- 7 Million women experience IPV annually.
- Same-sex couples understudied; rates may be up to 2x higher.
  - NVAWS 21.5% men and 35.4% women reported lifetime IPV.
  - Advocacy programs: steady increase in reports.

Black 2011, Messinger 2011, NCAVP 2010 report.

SES Risk Factors for IPV

- Younger age (highest 18-24).
- Income (all three major ethnic groups) especially for severe IPV.
- Unemployment.
- Black > Hispanic > White.
- ?gender preference

Capaldi 2012, Caetano 2005, Cunradi 2002, Ellison 2007 Linder 2005

Other risk factors

- Antecedent IPV.
- IPV in family of origin.
- Experience of child abuse.
- Alcohol > drug use.
- Polysubstance use – increased risk.
- Depression.
- PTSD.

Herrenkohl 2007, Kuijpers 2012

Scope of the Problem for Veterans

- We are just starting to understand the true impact of IPV on the Veterans population.
  - Unique set of challenges
  - Early life circumstances
  - Military Life
  - Comorbid PTSD, Substance Abuse, TBI.
- HSR&D has funded two CDA: M. Dichter PhD, MSW and K. Iverson, PhD.
- VA Guidance forthcoming.

IPV is complex

- “Victimization” and “perpetration” infer mutually exclusive states.
- Dynamics of abusive relationships are complex; bidirectional violence is common and IPV may range from low level to severe.
- **Veteran who experiences violence**: A Veteran who is the recipient of violent behavior. Traditionally referred to as victim or survivor of intimate partner violence.
- **Veteran who uses violence**: A Veteran who uses violence toward his/her partner. Traditionally referred to as batterer, abuser, or perpetrator.

Poll #2

- Among clinicians attending today's call, please indicate the % of your patient panel comprised of Women Veterans:

1 0%

2 5-10%

3 10-30%

4 > 30%

Gender Issues

- Women are more likely to sustain physical and psychological consequences from IPV.
  - IPV disproportionately affects women's health.
  - Current research identifies women who experience IPV as the highest risk group.
  - When women use IPV, it tends to be lower severity.
- However, it can be difficult for men to disclose receipt of IPV.
  - NISVS lifetime experience of physical IPV: women (32.9%) and men (28.5%).
  - Older studies have shown lower rates in males.
- Use ("perpetration") of IPV has health consequences of its own.

Bureau of Justice Statistics. National Crime Victimization Survey; Rennison and Planty, 2003., CDC NISVS 2010.

IPV and Military Personnel

- Rates range from 13.5-58%.
- Active duty personnel are at much higher risk of being perpetrators of IPV.
- PTSD incidence correlates with higher risk of IPV perpetration.

Marshall et al, 2005; National Coalition Against Domestic Violence Report 2001.

Women Veterans

- Higher rates of child abuse and pre-military trauma.
- 23-30% report IPV during active duty.
- Mental health: 70% lifetime rate of IPV.
- Primary Care
  - Of 91 patients 24-95, 46% reported current or past IPV.
  - Of 20 OIF/OEF veterans screened, 50% reported current or past IPV.
- BRFSS data: ⅓ veterans experience lifetime IPV compared to < ¼ non-veterans.
- IPV associated with increased odds of heart health risks.

Campbell et al, 2003; Sadler et al, 2004; O'Campo et al, 2006; Iverson (National Center for PTSD); Latta and Ngo (unpublished, VA Bedford); Dichter et al, 2011.

OEF/OIF Veterans

- Data is limited to date.
- Study of recently returned veterans screened in primary care (recently separated at < 2 years):
  - 75% reported family readjustment issues.
  - 60% reported any IPV; however, the researchers' definition included "shouting" so this may be an overestimate.
  - No difference in rates by branch of service.
  - ¼ reported guns in the home.

Sayers et al, 2009.

Health Impact of IPV

IPV in Medical Practice

Primary Care Prevalence:

- 12-month 5.5-14%
- Lifetime 21-60%

Ob/Gyn Prevalence:

- 12 month 4-15%
- Lifetime 35%
- During pregnancy 6-20%

Emergency Department Prevalence:

- 12 month 11-19%
- Lifetime 11-54%

IPV is a Medical Issue!

- In a multi-city study of femicides, 41% had been in contact with a health care provider prior to death, while only 3% accessed an advocacy or shelter program.
- *You are in routine contact with affected patients!*
- However… while nearly 50% of women who experience physical IPV report being injured by the abuse, only 20% actually seek medical care for their injuries

Sharps et al, 2001; National Coalition Against Domestic Violence Report 2001.

Physical Health Effects

- Linked to increased incidence of:
  - Headaches
  - Pelvic pain
  - Abdominal pain
  - Chest pain/palpitations
  - Gastrointestinal problems/IBS
  - Chronic pain/Fibromyalgia
  - Medically unexplained symptoms
- Your patient with the “list” may be in a relationship impacted by IPV!

Reproductive Health

- Women who report abuse are more likely to have:
  - STI/PID.
  - Repeat vaginal or urinary tract infections.
  - Unwanted pregnancies.
  - Premenstrual symptoms: mood swings, irritability, etc.
  - Adverse pregnancy outcomes
    - Low birth weight.
    - Pre-term labor.
  - Miscarriage in prior 6 mos.

Kovac et al, 2003, Yost 2005.

IPV and Pregnancy

- Women at higher risk of experiencing IPV during pregnancy
- Changes in type of IPV (i.e., from emotional abuse to physical abuse)
- IPV is leading cause of maternal mortality and adverse maternal outcomes in the U.S.
- Increasing recognition of women's use of IPV during pregnancy.

Chambliss LR, 2008, Hellmuth 2012

Mental Health and IPV

- PTSD
- Depression
- Anxiety
- Substance abuse
- Suicidality

IPV and Adverse Health Behaviors

- Women who smoke are 2x as likely to report IPV.
- Women who experience IPV are 5x as likely to engage in problem drinking
  - It has been argued that alcohol and substance misuse increase IPV risk.
  - But alcohol and substance use have been shown to increase from a baseline level when new abuse occurs.
- Predicted probability of IPV is higher with alcohol use and even higher when the patient smokes and drinks.

Hathaway et al 2000; Vest et al 2002; Lemon et al 2002; Kilpatrick et al1997; Gerber et al 2005.

Long-Term Health Effects

- A relationship exists between severity of abuse and degree of physical health problems.
- Even women who have experienced psychological abuse and/or low level abuse report significantly increased physical health symptoms.
- Many chronic diseases more prevalent or more severe.

Abusive Relationship Dynamics

- Women can experience IPV in the absence of physical violence.
- Women experiencing IPV are often isolated.
- Partners can interfere with receipt of healthcare.
- Poorly compliant patients may be suffering abuse.
- A controlling partner may refuse to leave the room.

Patients with a “list” may have abuse histories…

- Greater abuse severity and exposure to multiple forms of abuse is associated with more physical symptoms
- Women experiencing ongoing IPV report more somatic symptoms over time

Nicolaidis et al, 2004; Gerber et al, 2008.

Healthcare Response

Poll #3

- How comfortable do you feel addressing IPV in your VA role?

❑ Very uncomfortable

❑ Uncomfortable

❑ I can do it if I have to

❑ Comfortable

❑ Very comfortable

PACT and IPV

- Complex issue that no single provider can ‘manage’ or fix.
- Patient preferences/needs of family critical.
- Requires knowledge of community and VA resources.
- Patients experiencing IPV…
  - Are often isolated from social networks.
  - Ashamed of the abuse.
  - In poor health.
  - In need of a team approach.

Patient's Voices

I asked my patients the following question:

"What would you like your VA provider to know about intimate partner violence and the abuse you've experienced?"

WT

- Patient came to Boston with children to escape an abusive partner. He doesn't know where she is. She is living in a shelter and hopes to start a new life here. She has diabetes and recently started insulin.
- *"You're looking at me now, your body is turned toward me. I feel safe with you."*

Patients expectations…

- A meta-analysis of studies looking at women's expectations of clinicians also found that women wanted clinicians to:
  - Be non-judgmental and individualized.
  - Not pressure the victim to talk about abuse, or pressure her to leave the situation.
  - Not pressure her to prosecute the abuser.

Women want you to understand the complexity of a violent relationship and to meet them where they are in the continuum of deciding what to do.

Feder et al, 2006.

Can We Help?

- Qualitative studies demonstrate that abused women want their providers to query them about IPV.
- Studies also show that abused women believe medical providers can help.
- **Asking is an intervention.**
- Frame IPV as part of SH, an adverse health exposure.

Common Clinician Barriers

- Fear of opening “Pandora’s box.”
  - Time constraints
- “I don’t know what to do if she says yes.”
- “I can’t fix it.”
  - No quick fix
- Does not follow traditional biomedical model.
  - VA care models ideal for complex issues!

Addressing Barriers

- It’s not your role to “fix it.”
- You can:
  - Provide support and validation
  - Offer education and resources, referrals
  - Address safety
  - Document and treat injuries
- Adopt a patient-centered team approach; use existing VA resources.

Benefits of Routine Inquiry

- Communicates that you believe this is a health issue for patient ("*bringing it into the exam room")*
- Over time, you will become more comfortable talking about IPV.
- Hopefully, as the patient comes to trust you, she may disclose experience of violence.

How To Identify IPV?

- Directly inquire about IPV
  - Many individuals will not spontaneously disclose abuse.
  - When asked directly, many patients are willing to discuss IPV.
- Asking = intervention and begins a process.
- Assessment validates abuse as a legitimate health care issue and enables teams to assist.
- Primary care/PACT ideal for building trust/extending support.

Screening for IPV

- USPSTF
  - Recommends that clinicians screen women of childbearing age for intimate partner violence and provide or refer women who screen positive to intervention services (level B)
- Reasons to screen include:
  - High prevalence
  - Decreases stigma by normalizing discussion of violence
  - Potential to moderately reduce exposure to abuse, physical and emotional injury, and mortality (USPSTF).

*VA guidelines are forthcoming.

Nelson et al, 2012; Tjaden and Thoennes , 2000.

Best practice for asking about IPV?

- Develop your own routine for asking that makes it comfortable for you
- Introduce the questions:
  - “Because violence in relationships is so common, I have begun asking all my patients about it”
- Consider assessing for both current and lifetime IPV.
- Short validated screens exist.

Examples of questions

- Ask behaviorally specific questions, such as:
  - “Have you been physically harmed or threatened by your partner?"
  - “Have you been hit, kicked, punched, choked, or otherwise hurt by an intimate partner?”
  - “Do you (or did you ever) feel controlled or isolated by your partner?”
  - “Do you feel frightened by what your partner says or does?”
  - “Has your partner ever forced you to have sex when you didn’t want to? Has your partner ever refused to practice safe sex?”

Setting and Timing for Inquiry

- Private setting – partner should be asked to leave the room.
- Family, friends, and children over the age of 3 should not be present.
- Get into a routine/combine with social history.
- When signs and symptoms raise concern (‘red flags’).
- During pregnancy.

Potential Clinical Markers for IPV

- Secrecy or obvious discomfort when asked about intimate relationships.
- Unexplained injuries or injuries that are inconsistent with the explanation of the injury.
- Medically unexplained symptoms (MUS).
- Chronic pain without apparent etiology.
- An unusually high number of health care visits.
- Tobacco and alcohol use.

Targeted Inquiry/Case Finding

- When injuries don’t fit the history given by the patient.
- Chronic pain, multiple somatic issues.
- Depression, anxiety, PTSD.
- ETOH or other drug abuse.

Patient Disclosure – Step 1

- Stop what you are doing.
- Turn away from the computer.
- Make eye contact.
- Respond with empathy and compassion.
- Validate what she is saying.

Always be ready for an affirmative response; often it will be a surprise, coming after recurrent denials.

Examples of “First Responses”

- I believe you. That must be a horrible experience.
- I’m sorry that you have to experience that. I would like to help.
- The abuse is not your fault. It is wrong for one person to hurt another person.
- You didn’t do anything to deserve to be treated this way.
- I am worried about your safety.
- I’m glad you told me. Let’s think about ways to get this behavior to stop.
- Unfortunately, you are not alone. Many of my patients have experienced abuse.

Patient Disclosure Step 2

- Your role now:
  - Non-judgmental, supportive, and concerned
  - Provide validation
  - Treat health problems and injuries
- Provide education/palm card.
- Evaluate whether patient is in immediate danger (use your team).
- Make referrals within the VA and for services in the community.

Risk Assessment

- Women may not realize they are in imminent danger
  - Over half of the victims of a completed or attempted homicide did not think that they were in danger.
- Danger increases if:
  - Abuser has access to weapons.
  - Abuser uses alcohol or other drugs.
  - There is past history of severe abuse (with serious injuries).
  - History of stalking.
  - Recent escalation of the abuse.
  - Unemployment.
  - Partner controls daily activities.

Campbell et al, 2002.

Documentation

- Document your assessment.
- Document in specific detail what the patient has told you – be specific; include name of perpetrator, specific instances, and timing.
- Document injuries and physical findings.
- Comply with state mandated reporting laws.

Your Patient Might Not Leave…

- It's hard to leave a relationship.
- Info or kind words may help down the line.
- You haven't failed if your patient doesn't leave the relationship.
- Remember that survivors of IPV have lost their sense of agency and autonomy – support patient's choices even if you don't agree with them.
- *Never tell a patient impacted by IPV what to do.*

Be supportive

- Understand the barriers to each woman's decision to leave or not and respect her decision. (Be patient-centered).
- Respect the victim's timetable.
- Help the victim gain self-esteem by validating her actions, while at the same time being honest about your concern for her safety.

Next Steps

- If no immediate danger…
- If affected patient is not ready to leave the situation…
- Provide local resources:
  - Hotlines all states have these – may be used from your facility 1-800-799-SAFE.
  - VA Social work and mental health referrals.
  - Women Veterans Program Manager.

Children and Reporting

- Some states have mandatory reporting for IPV. The majority do not.
- Many women fear that their children will be placed in protective custody.
- What if there are children in the home?
  - You may need to report.
  - Social work consult is advisable.

Safety Planning

- Process similar to “harm reduction” strategy.
- Provides a back-up plan for any escalation of violence.
- Pack a bag and keep it in a safe place, copy important documents (DD214).
- Code word that friends, neighbors, or family will recognize to prompt them to call the police. Protection order information.
- Safety plan available from National Coalition Against Domestic Violence
  - http://www.ncadv.org/protectyourself/SafetyPlan_130.html
  - YOUR TEAM CAN HELP.

What if My Patient Endorses Past IPV?

- Provide validation and education.
- Discuss the impact of past IPV on mental and physical health.
- Inquire about current mental health symptoms.
- Offer appropriate mental health referrals.

Helping Veterans Who Use Violence

- Screening issues
  - No good evidence for screening for use of IPV.
  - Targeted inquiry is warranted when patient shows signs of chronic pain, mental health issues, substance abuse.
  - Study of screening for perpetration showed low rates of disclosure with direct inquiry by PCP

- Interventions for use of violence/perpetration alone lack evidence of efficacy.
  - Treat co-morbid PTSD, substance abuse
  - Veterans with PTSD 2-3x more likely to perpetrate and interventions for this group show reductions in IPV.

- Self-identified perpetrators
  - Respond in non-judgmental manner that supports disclosure, and does not cut off further discussion, but also does not condone the behaviors
  - Refer to an expert in dealing with perpetrators.

Ferris 1997, Gerlock, Jaeger 2008; Smedslund 2007, Taft.

Efficacy of Advocacy and Referrals

- Advocacy is very helpful to victims of IPV
- Research shows that patients who talk to their health care provider about IPV had higher likelihood of using an intervention (e.g. shelter, restraining order, IPV hotline)
  - Qualitative and RCT data.
- Our conversations and referrals do help!

National Hotlines and Helplines

- National IPV Hotline
  - 1-800-799-SAFE
  - English and Spanish (24 hr)
- National IPV website
  - ndvh.org
  - Resource list: www.ndvh.org/resources/
- National Center for PTSD: http://www.ptsd.va.gov/public/pages/domestic-violence.asp

Summary

- IPV is prevalent in medical populations and is a significant issue for Veterans.
- Some of your most vexing patients could be abused or have a history of abuse.
- You are in regular contact with patients who have experienced (used) IPV.
- Your patient care skills, PACT team and existing VA resources can help.
- With practice, addressing this issue becomes more routine.

What questions do you have?

Military/DoD Resources

- Military Home Front
  - http://www.militaryhomefront.dod.mil/tf/domesticabuse
- Family Advocacy Program (FAP) service providers
  - Search by military installation and program type online at http://www.militaryinstallations.dod.mil/
  - Every installation has a FAP or access to one.
- Battered Women's Justice Project - Military Advocacy Resource Network
  - http://www.bwjp.org/military_advocate.aspx
- Military OneSource
  - 1-800-342-9647, 24 hours a day, 7 days a week

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