

When Partner Violence is possible:
remembering to detect this hidden agenda
early in your vulnerable patients.

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Case 1

CD, a 40 y.o. woman c ho migraine ha, APLA complicated by bleeding, CVA, TAH, chronically anticoagulated, PMH rape by BF '85, frequent visits
Married x 20 yrs c 4 children, works as photographer in business c husband
Pt had surgical repair p TAH following early sex, possibly forced by husband.
IPV first detected in ED 1/06, seen by Beacon (UNC Hospital DV Program),
noted again on routine coag visit when pt was suicidal in Gen Med clinic
1/07

Pt says husband delayed medical rx c CVA, accompanied her to appointments, making disclosure difficult

Had been depressed for years but insisted it not be documented in record;
also refused post-op narcotics – feared being labeled and losing kids

Only when suicidal was depression documented

Pt wishing to leave but finding difficulty as partners in business, children

On antidepressant, using Hospital and community DV Programs (Beacon, Interact) for support, doing better, glad to be screened each visit

Pt now separated financially from husband, has not left, q 6 month visits

Provider knows she is doing better, but frustrated she has not left yet



Case I- Questions and Answers

- Is this IPV (Intimate Partner Violence)?
- How common is IPV?
- Which kind of IPV is this (there are kinds of IPV?!)?
- What are the factors that might have alerted me in this case?
- Can we do anything to help people experiencing IPV?



Is this IPV?

- A pattern of psychological, economic and/or sexual coercion of 1 partner in a relationship by the other punctuated by physical assaults or credible threats of bodily harm including social isolation, stalking, deprivation, intimidation
 - Children
 - Dating
 - Partners (85% women by men)
 - Workplace
 - Elders

How Common is IPV?

Stigma confounds reporting

Prevalence

current 5-30%

lifetime 20-63%

Women 29-44% lifetime prevalence (5.2 million incidents/year)

Men 22% lifetime prevalence (3.2 million incidents/year)

- Young, less educated and poor increased risk but
- **Cuts across all socioeconomic, ethnic, religious, educational groups**

1/7 Pts seen in a primary care clinic have experienced IPV in prior year

1/3 of all women murdered were killed by a current or past partner

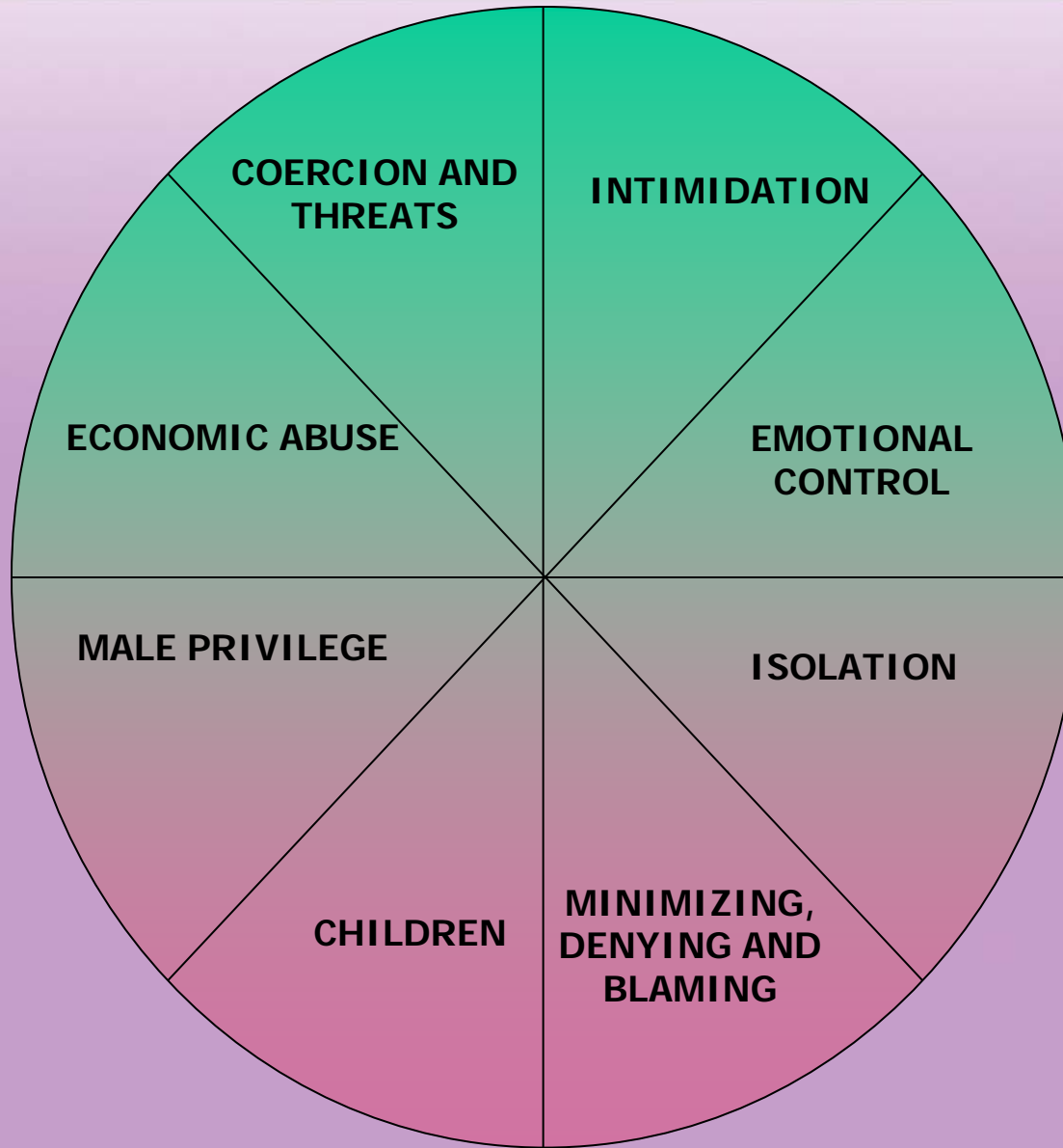
- 1/2 visited ED prior 2 years
- 9/10 sought care for an injury



Which kind of IPV is this (there are **kinds** of IPV?!)?

- **Intimate ‘terrorism’ – ‘classic’ power and control**
- Violent resistance – ‘tough’, fights back
- Situational Violence – low levels of violence without power and control

Power and control wheel



What are the factors that might have alerted us in this case? Clinical Indicators for exposure to IPV

History/Sxs	Physical / Signs	Diagnoses	Encounter
<p><u>Multiple physical & psychological symptoms</u></p> <p>Vague, non-specific symptoms</p> <p>Chronic pain – abdominal, back, pelvic, ha</p> <p>Fatigue/decreased energy</p> <p>Sleep disturbances</p> <p>Decreased concentration</p> <p>Etoh and/or other substance abuse</p> <p><u>Irregular vaginal bleeding</u></p>	<p>Any trauma</p> <p>Multiple injuries at 1 time or injuries at different stages of healing</p> <p>Finger marks or strangulation marks</p> <p>Head, central trunk, or genital trauma</p> <p>Fearful, easily startled</p> <p>Reluctance to have a genital exam/difficulty with genital exam</p>	<p>Recurrent UTI</p> <p>Chronic pain</p> <p>Sexual dysfunction</p> <p>Recurrent sinus/dental problems</p> <p>IBS</p> <p>Fibromyalgia</p> <p>PTSD</p> <p>Attempted suicide</p> <p><u>Depression</u>, anxiety</p> <p>Psychosis/dissociation</p> <p>Late/sporadic prenatal care</p> <p>Hyperemesis/Spont ab, PT delivery, placental separation/ LBW infant</p> <p>Early progression of HIV</p>	<p><u>Partner unwilling to leave patient alone, answers questions for the patient.</u></p> <p>threatening to staff, verbally abusive or indifferent</p> <p><u>Delayed presentation</u></p> <p>Inconsistency between history and physical findings</p> <p><u>Poor control of chronic medical conditions</u></p> <p>Nonadherence</p> <p>“Drug-seeking” behavior</p> <p><u>Repeat visits to ED or clinic</u></p> <p>Social isolation</p> <p>Abuse of child or elder in the household</p>



Can we do anything to help people experiencing IPV?

- Acknowledge that IPV is wrong
- Consider the stage of change
- Perform a safety assessment
- Discuss interventions
- Document in the medical record
- Continue to address at subsequent visits



Acknowledge that IPV is wrong

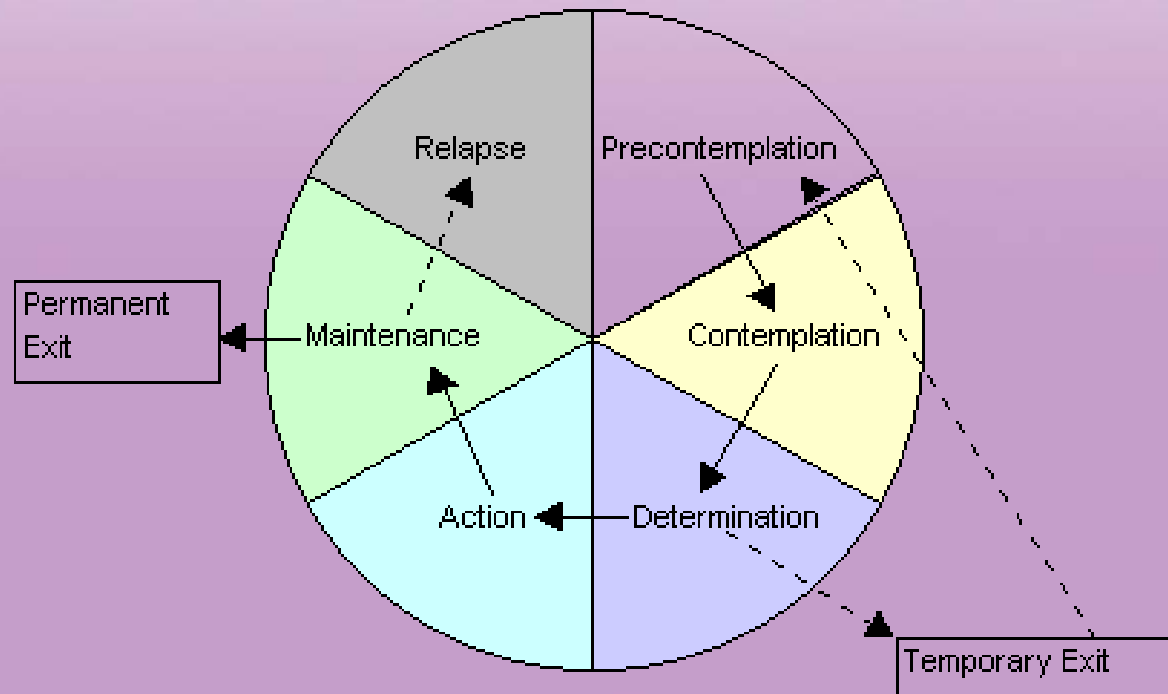
- I am very sorry this is happening to you.
- This is a common problem.
- You do not deserve this and it is not your fault.
- I am glad you were able to tell me.
- I want to help you through this in any way I can.

- Knowing about this will enhance our care of your other medical problems.
- We have resources to help with these problems.

- **Do not confront perpetrator!**

Consider the stages of changes

- **Acknowledging a problem**
- Seeking therapy
- **Taking medications**
- **Involving an agency**
- **Separating financially**
- Seeking legal help
- **Adhering to medical advice**
- Changing substance use
- Using a shelter
- Leaving situation





Perform a safety assessment

Victim

- **Has sought outside intervention**
- States afraid for life
- **Suicidal**
- With plan
- Prior attempts
- Means
- **Attempting to leave**
- Homicidal


Perpetrator

- Violent outside home
- Violent to children
- Threatening to kill victim, children, self
- Escalating threats
- Using drugs – esp pcp, crack, amphetamines, etoh
- Abusive during pregnancy
- Obsessed
- Serious prior injury
- Weapons, especially guns
- Threatened friends/family



Discuss interventions

- Hospital Based Program (**Beacon Child and Family Program**)
- Community Resources
 - Family Violence Prevention Center, OCRCC, **Interact**
 - Legal Aid
 - Safe Houses (not in Orange County)
 - Child Protection
 - DSS
 - Police
- Other Medical Professionals



Document in the medical record

- Medical record is legal record.
- State patient's words including their identification of perpetrator.
- Perform a thorough physical and describe and if possible photograph any physical injuries.
- **Don't hesitate to have local resources help with the evaluation if available**
- Order appropriate lab and radiology studies.
- Consider co-morbidities, degree of disability (in I FM clinic women affected by IPV had 2x rate of physical and psychological disability).

Continue to address at subsequent visits

- Acknowledge that IPV is wrong
- Consider the stages of changes
- Perform a safety assessment
- Discuss interventions
- Document in the medical record
- Continue to address at subsequent visits

Case 2

- TB is a 37 yo woman w/PMHx of poorly controlled DM, HTN, headaches, insomnia, irritable bowel syndrome, elective abortion x 2 for fetal anomalies, spontaneous ab x 1,
- Shx: lives w husband, 3 children, & 80 yo mother w early dementia
- Violence Hx: prior beatings, strangulation by husband(their 15 yo pulled knife to stop him), possible sexual abuse, husband has also been violent to children, after brief jail visit, released on bond, he underwent anger management classes. He always comes to appointments with patient
- Pt continues to attempt to conceive w this partner whom she recently married, lives w him intermittently; he is currently jailed x 7 months for credit card fraud
- IM intern uncovered abuse this year after pt in system for 5 years, followed by various residents. Pt with numerous missed appts



Case 2 – Questions and Answers

- What were the signs that this patient might have been experiencing abuse?
- Strangulation – that's not serious, is it?
- What about risks to her children and mother?

What were the signs that this patient might have been experiencing abuse?

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Strangulation – that's not serious, is it?

10% of all violent deaths

- What does strangulation look like?
 - 50 % - No visible injury
 - 18 % - Pain only
 - 22 % - Minor visible injury
 - 16 % - Visible injury



Strangulation – that's not serious, is it?

At a Texas shelter 68% women had been strangled

- Symptoms

- Neck pain
- Sore throat
- Hoarse
- Difficulty swallowing
- Red eye
- Dizzy
- Presyncope / Syncope (11 lbs pressure x 10 seconds)
- Incontinence
- Neuro c/o



- Signs

- Red eyes
- Neck swelling
- Laryngeal fx
- Upper airway edema
- Scratch marks
- Petechiae, red linear marks, ecchymoses
- Rope/cord burns
- B carotid thrombosis
- Miscarriage
- Death





What about Ms. TB's children?

- How are children affected by IPV?
 - Child abuse
 - Witnessing violence
 - Consequences on health
 - Future victims
 - Future perpetrators of violence



Children and Abuse: statistics

- 50% of men who assaulted their wives also abused their children
- Among couples where violence was reported, 60% had children in the house.
 - Extrapolated to 15.5 million U.S. children live in families in which partner violence occurred at least once in the past year,
 - 7 million children live in families in which severe partner violence occurred.

McDonald, Renee, Ernest N. Jouriles, Suhasini Ramisetty-Mikler, et al. 2006. Estimating the Number of American Children Living in Partner-Violent Families. *Journal of Family Psychology* 20(1): 137-142.



Children: Health Effects of witnessing IPV

- Worse health outcomes
- More likely to exhibit behavioral and physical health problems like: depression, anxiety and violence towards peers; attempting suicide, abusing drugs and alcohol; other high risk behavior.
- Greater risk of having serious adult health problems including tobacco use, substance abuse, obesity, cancer, heart disease, depression and a higher risk for unintended pregnancy.
- Graham-Bermann, SA, and Seng, J. 2005. Violence Exposure and Traumatic Stress Symptoms as Additional Predictors of Health Problems in High-Risk Children. *J of Pediatrics* 2005. 146(6) 349-354.
- Anda, Robert. Block, Robert. Felitti, Vincent. 2003. Adverse Childhood Experiences Study. Centers for Disease Control and Prevention, Kaiser Permanente's Health Appraisal Clinic in San Diego.



Children: Effects of witnessing IPV on becoming future victims

- Females who are exposed to their parents' domestic violence as adolescents are significantly more likely to become victims of dating violence than daughters of nonviolent parents

- Noland, VJ, Liller, KD, McDermott, RJ, Coulter, ML, and Seraphine, A E. 2004. Is Adolescent Sibling Violence a Precursor to College Dating Violence? *American Journal of Health and Behavior*. 28: 813-823

Abuse in the family: what about the mother?

Elder Abuse

- Neglect
 - Decubitus ulcers, hypernatremia, hygiene, weight loss, frequent hospitalizations, infections, pt not receiving medicines
- **Financial Exploitation Issues**
- Discord among Caregivers
- Overly or unsolicitous caregiver
- Fearful
- Depressed

Physicians' Legal Obligations

- Mandatory reporting laws
 - Child abuse
 - Vulnerable adults
 - Deadly weapons used
 - In some states for documented or suspected Intimate partner violence (IPV)
 - a. National District Attorneys Association also has a list of state laws regarding domestic violence
http://www.ndaa.org/apri/programs/vawa/dv_reporting_requirements.html



Case 3

- 37 y o man with depression and multiple somatic complaints



Initial presentation

- 37 yo well-appearing male with h/o depression, complaining of knee pain
- Attending and resident stay late to inject this polite, quiet man



Next visit

- Returns 2 weeks later to see his primary resident
- Reveals suicidally depressed, h/o childhood sexual abuse from multiple extended family members
- Married, 2 daughters, hard-working (sends \$ to his abusers), says can't 'keep up appearances' anymore
- Felt this way 2 weeks prior, too embarrassed to disclose to 'strangers'

Treatment



- Referred to psychiatry crisis
- They initiated therapy
- Then increased dose of antidepressant
- Not all patients will “buy” psychiatric model
- May have somatoform disorder and not see psychiatric component->high utilizers (knee pain)



Questions & Answers

- He didn't 'look' like a victim or survivor...
What consequences do survivors of childhood abuse exhibit?
- How to ask about a trauma history?
- What are helpful approaches?
- What are his chances of perpetrating intergenerational or intimate partner violence?

What are the factors that might have alerted us in this case? Clinical Indicators for exposure to IPV

History/Sxs	Physical / Signs	Diagnoses	Encounter
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What consequences do survivors of childhood abuse exhibit?

- Risks
 - Childhood psychological, physical, sexual abuse
 - Household dysfunction: Substance misuse, Psychiatric illness, Mother treated violently, Criminal behavior
 - The Adverse Childhood Experiences (ACES) Study – self-report (Felitti et al, Kaiser Permanente, CA. [JAMA. 2001 Dec 26;286\(24\):3126-7](#))

What consequences do survivors of childhood abuse exhibit?

- **Direct linear relationship with adult risk behaviors/diseases**
 - Mechanism hypothesized to be “coping” (tobacco, alcohol, drugs, reckless behavior, overeating) vs depression
 - Ischemic heart disease, Cancer, Chronic Bronchitis/Emphysema, Skeletal Fractures, Hepatitis/Jaundice, Fair or Poor Health
- Increased risk of depression and suicide
 - Lifetime risk 3.8%
 - If 7 or more experiences 31.1%
- PTSD, Dissociative or personality disorders
 - (Hulme, P. Theoretical Perspectives on the Health Problems of Adults Who Experienced Childhood Sexual Abuse [Issues in Mental Health Nursing](#), Volume 25, Issue 4 June 2004 , pages 339 – 361)

What consequences do survivors of childhood abuse exhibit?

- Multiple somatic complaints, especially pain
- High health care utilization
- Little difference in profile by gender
 - (Drossman, Leserman et al)

How to ask about trauma history?



- Follow up on affective “windows of opportunity”
- “We’re being encouraged to ask all patients about past or current violent experiences because, unfortunately, they are common”
- “How were things in your family growing up?” “Was there conflict?”
- Respond empathically, safety planning as appropriate
- Sometimes when patients present w ‘x’ physical complaint they have also experienced....

• Drossman, Leserman et al

What are helpful approaches to somatoform disorders?



- Patient-Provider relationship is foundation of treatment
- Obtain complete biopsychosocial story

Strategies for the Intervention

- Negotiate all treatment on a time contingent basis-reinforces relationship, not symptoms
 - Scheduled, not prn, daily, wkly, monthly
 - Visits, medications, exercise, etc.
- Dissociate complaints from tx and visits
- Supplement visits with 3–5 minute phone calls
- After initial work-up, diagnostic tests or consultations only with new, objective findings



I. Facilitate realistic goals

- Long-term goals
 - Ex: better work/school record, improved relationships, reduction in addicting medications, reduction in pain, improved mood
- Short-term goals (homework)
 - Ex: walk half a block each day, read certain chapters in a book, apply for a job
- Improvement, not cure



2. Educate the patient

- Problem is real-saying “nothing is wrong” repeats childhood experience of denying reality
- Specific name -- e.g., IBS; explain mechanism in lay terms, sensitivity to symptoms, like “foot in the shoe”
- Stress, depression and anxiety are important contributors-not cause

3. Negotiate the Plan

- Antidepressants for depression and anxiety -- full dose
- Non-addicting symptomatic medications
- Avoid excess consultation with specialists by negotiating the following:
 - Individualized physical therapy
 - Individualized physical exercise program
 - Relaxation exercise program
 - Symptom diary



3. Negotiate the Plan (cont'd)

- Establish agreement for no self-referral to ED or specialist and to take only medications prescribed by you -- written contract if necessary
- Rationale is that it's better for pt
- Involve significant support person or family member (if safe to do so)

Consultations

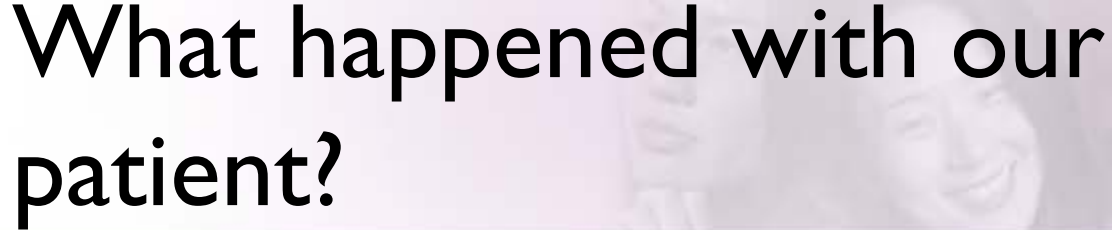


- Psychotherapy to better cope with symptoms
- Subspecialist consultation if needed, advise consultant of prior w/u and risk of iatrogenesis, ie harm due to medical procedures
- Pain treatment program-avoid repeated injections that aren't helping
- Continue primary care relationship

Risks of intergenerational or intimate partner violence?

- Low self-esteem, isolated
- Economic stress
- Low academic achievement
- Heavy alcohol and drug use
- **Depression**, Personality disorders
- Anger and hostility
- History of being physically abusive
- Belief in strict gender roles (e.g., male dominance, aggression)
- Desire for power and control
- **Physical/psychological abuse victimization (consistently strong predictor of perpetration)**
- May take the form of trouble protecting children from others in family

What happened with our patient?



- Pt. stopped psych meds-didn't feel like himself, seen with wife and daughters, in marital therapy.
- Wife was controlling, essentially repeating abuse pattern
 - Thought all problems due to sleep apnea, preceptor had to ask her to leave the room
- Restarted low dose of 1 antidepressant
- Pt accepted referral to new CBT program
- Also testing for sleep apnea



Summary

- Consider childhood and/or ongoing abuse, perpetration in pts with depression, anxiety, PTSD or multiple somatic symptoms
- Assess for co-morbid suicidality, substance use disorders and refer as able/needed
- For somatoform disorders negotiate relationship and regular non-contingent visits
- Avoid arguments, over-utilization, iatrogenic harm
- Dx and Tx of child abuse history are a patient and life event driven process
 - Primary care longitudinal model is ideal



References

- ML Paras, et al. Sexual abuse and lifetime diagnosis of somatic disorders: a systematic review and meta-analysis. JAMA. 2009;302(5):550-561.
- DA Drossman, et al. Sexual and physical abuse and gastrointestinal illness: review and recommendations. Ann Int Med. 1995;123:782-94.
- DS Morse, AL Suchman, RM Frankel. The meaning of symptoms in 10 women with somatization disorder and a history of childhood abuse. Arch Fam Med. 1997;6:468-76.

Case 4

- MD 43 y.o. woman migrant from Guinea, W Africa
- 2001: Seen by Ob Gyn (who offered to write note to INS to bring mother to care for her)
- 2002: s/p Caesarian section (preeclampsia)
 - Pt speaks only French
 - Husband translated for her per note
 - Had wound dehiscence,
 - Wound care explained in French, written in English
 - Had chronic headaches



Case 4 (continued)

- 2002: MVA
 - Presented with husband to CHN
 - Rx paroxetine and ambien (for PTSD and insomnia)

Gap of 4 years

- 2006: Seen by French speaking MD (at suggestion of African nurse friend)
- C/o leg pain x 2 years and rash,
- At f/u dx htn,
- Now c/o visual impairment vs trouble reading,
 - optho for glasses,
- Next visit hemorrhoids



Case 4 continued

- 4/2007. Visit # 5
- C/o total body pain, insomnia, depression
- S/p physical abuse 2 months earlier, husband infidelity when abroad, children acting out
- Pt got protective order,
 - His friends harassed her at work,
 - Husband called immigration → pt was fired,
- HIV negative
- 7/07 Pt doing ok off antidepressants, working w FVPC, Legal Aid helping to change legal status



Case 4 – Questions and Answers

- Did the patient exhibit clinical indicators for IPV?
- Are immigrants at special risk for IPV to occur or underdiagnosis of IPV?
- What happens if patients come here on their partner's visa?
- Are there any local organizations to assist immigrants?
- Shouldn't a protective order protect?

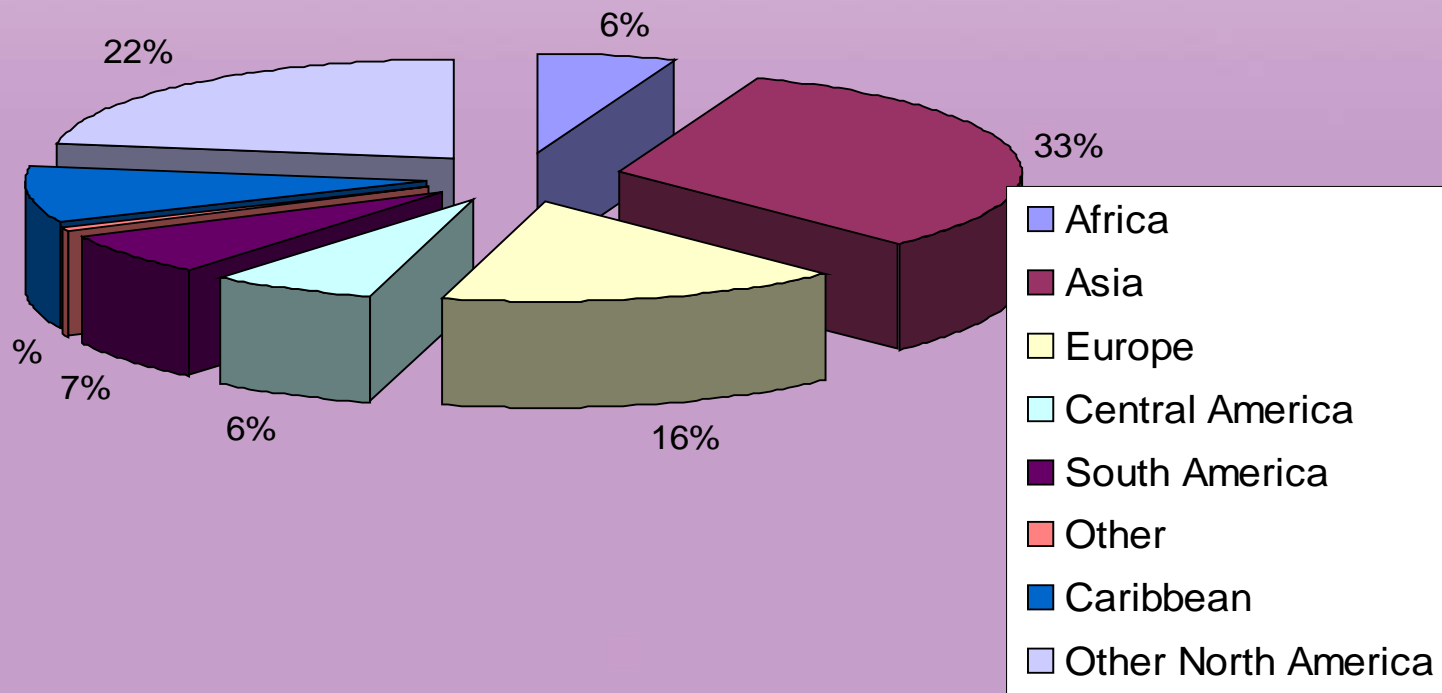
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Other forms of VAW among immigrants

The Family	The Community	The State
<p>Physical Murder, Battering, Genital Mutilation, Infanticide, <u>Deprivation</u> of food, <u>medical care</u>, Repro coercion/control</p> <p>Sexual Rape, Incest</p> <p>Emotional Confinement, Forced marriage, Threat of Reprisals</p>	<p>Physical Battery, Physical Chastisement, Repro coercion/control, Pernicious traditional practices</p> <p>Sexual assault Rape, Harassment</p> <p>Workplace Sexual aggression <u>Harassment</u>, intimidation</p> <p>Commercialized Trafficking, Prostitution</p>	<p>Political Illegitimate detention, Forced Sterilization, Forced Pregnancies, Tolerating Gender Violence by non state agents</p> <p>Custodial (Military/Police) Child Soldiers Rape, Torture</p>

Are immigrants at special risk for IPV?

Immigrants Admitted by Region, 2002



Are immigrants at special risk for IPV?



Survivor barriers to detection:

- Lack of knowledge (Healthcare, legal rights)
- Social isolation
- Language
- Precedence of intact family over self
- Shame or stigma
- Racial or ethnic discrimination
- Acceptance

For other violence going undetected?

- Possible exposure to war/torture in home country
- Possible trafficking once in country

A Canadian Study found that migrants were more likely to experience IPV after 10 years in new country, rather than on arrival

Community/Social IPV Risk Factors for immigrants



Victimization

- Poverty and associated factors (e.g., overcrowding)
- Lack of institutions, relationships, and norms that shape the quality and quantity of a community's social interactions
- Weak community sanctions against IPV (e.g., police unwilling to intervene)
- Traditional gender norms

Perpetration

- Poverty and associated factors (e.g., overcrowding)
- Lack of institutions, relationships, and norms that shape the quality and quantity of a community's social interactions
- Weak community sanctions against IPV (e.g., unwillingness of neighbors to intervene)
- Traditional gender norms

Prevalence of IPV among South Asian immigrant women, Boston

- IPV prevalence:
 - Physical: 30.6%
 - Sexual: 18.8%
 - Any: 40.8%
 - Resulting in injury/need med.
- Knew about IPV services: 50.6%
- No family in U.S: 28.1%
- No social support: 10.0%

What happens if patients have come here on their partner's visa?

- Many women come on a visa (H1B) with husband who is worker
 - Wife can't work
 - Family pressure to do well in USA
 - Difficulty supporting self independently
 - Financially—no credit card= no credit history
 - Language and cultural barriers
 - Assumption that institutions will do little to protect


Are there any organizations to assist migrants?

- 1-800-799-SAFE: National DV hotline
 - 24 hours a day, 365 days a year, in more than 170 different languages
- Local shelters- large cities should have bilingual services (Spanish)
- South Asian:
 - <http://www.sawnet.org/orgns/violence.php>
- Refugee organizations within your city

Shouldn't a protective order protect?



- Well, pt wasn't physically harmed by perpetrator.
- His friends assisted him w harassment and pt lost job.



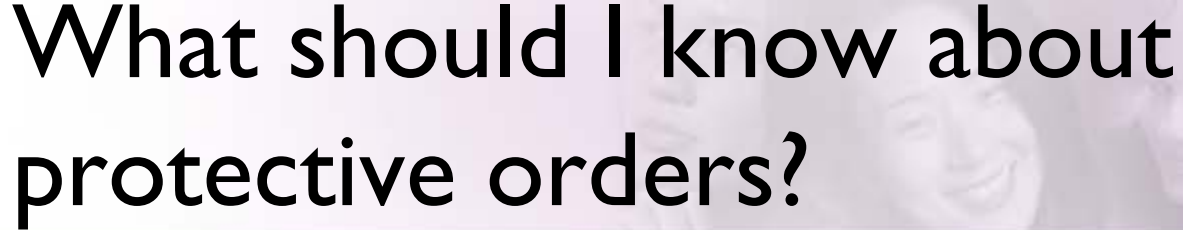
What is a protective order?

- A civil remedy – lower burden of proof, lower cost, violators more speedily noted, can be specific to situation, can empower women
- Why get them?
 - Increase safety, protect others, deter others from similar crimes, validate that it happened, retribution

What else should I know about protective orders?

- 16-40% of women experiencing IPV get an order
 - 2 types - vs contact, vs violent contact
 - 75% have tried other assistance (police, friends, medical, clergy, advocates, shelter, call in line)
- Seekers are more often married, educated, employed, depressed, sought mental health assist, physically assaulted, children, cohabiting, increasing severity of threats
- *Immigrants without resources may not avail themselves of a TPO*

What should I know about protective orders?



- Does violence continue?
 - 23-70% experience a violation of the order including stalking, physical, sexual assault
- Only 20-30% violators arrested after violation, 1 study claimed 70% arrest rate with high risk



Do protective orders work?

- I study full protective order less abuse during 9-12 months but this was 6.9% of sample
- Limited sample felt life improved
- Women w children twice as likely to experience violations, 1.5x threat and property damage, prior criminal hx
- Lethality and stalking – more severe prior violence, protesting in court, protection orders cannot prevent femicide in these cases

Disadvantages



- **Accessibility** –
 - Proof of relationship, bureaucratic barriers (7.5hr process), should be free,
 - 18-90% not served! ? Difficult to enforce
- **Acceptability** –
 - fear of retaliation,
 - embarrassment,
 - lack of efficacy, lack of resources,
 - perceived inefficacy of justice system

Case 5

- DH 33 yo former cheerleading coach transferred from OSH co severe ruq pain, noted w lle bka 7 months prior but pt could not recall circumstances and didn't have prosthesis.
- Hemangioma in ruq thought unlikely to be causing pain.
- Further hx pt had multisystem failure, hypotension in context of cocaine use, prior ho multiple abusive relationships, husband age 17-22 abusive, brother 'choked' pt, threatening her and multiple family members with whom he was living, also sexual assault by stranger 6 weeks prior to hospital
- Beacon (Hospital program) was involved, as was psych, pt started on antidepressant, lost to fu.
- Pt had attempted protective order vs brother, but it was never served.



Case 5 – Questions and Answers

- What elements in the history caused us to probe more?
- Are pain complaints more common in IPV survivors?
- How should we handle requests for pain medicine?
- How can we ensure patient's safety?

What elements in the history caused us to probe more?


History/Sxs	Physical / Signs	Diagnoses	Encounter
<p><u>Multiple physical & psychological symptoms</u></p> <p><u>Vague, non-specific symptoms</u></p> <p><u>Chronic pain – abdominal</u>, back, pelvic, ha</p> <p>Fatigue/decreased energy</p> <p><u>Sleep disturbances</u></p> <p>Decreased concentration</p> <p>Etoh and/or <u>other substance abuse</u></p> <p>Irregular vaginal bleeding</p>	<p><u>Any trauma</u></p> <p>Multiple injuries at 1 time or injuries at different stages of healing</p> <p>Finger marks or strangulation marks</p> <p>Head, central trunk, or genital trauma</p> <p>Fearful, easily startled</p> <p><u>Reluctance to have a genital exam/difficulty with genital exam</u></p>	<p>Recurrent UTI</p> <p>Chronic pain</p> <p>Sexual dysfunction</p> <p>Recurrent sinus/ dental problems</p> <p>IBS</p> <p>Fibromyalgia</p> <p>PTSD</p> <p>Attempted suicide</p> <p><u>Depression</u>, anxiety</p> <p>Psychosis/dissociation</p> <p>Late/sporadic prenatal care</p> <p>Hyperemesis/Spont ab, PT delivery, placental separation/ LBW infant</p> <p>Early progression of HIV</p>	<p>Partner unwilling to leave patient alone, answers questions for the patient, threatening staff, verbally abusive, indifferent</p> <p>Delayed presentation</p> <p><u>Inconsistency between history and physical findings</u></p> <p><u>Poor control of chronic medical conditions</u></p> <p>Nonadherence</p> <p><u>“Drug-seeking” behavior</u></p> <p><u>Repeat visits to ED or clinic</u></p> <p><u>Social isolation</u></p> <p>Abuse of child or elder in the household</p>

Are pain complaints more common in IPV survivors?

- Higher rates of chronic pain in women who have experienced IPV (Campbell 2002, Coker 2000, Plitchta 2004, Wuest 2008).
- Higher disability chronic pain associated with more severe IPV as well as history of child abuse/adult sexual assault.
- PTSD associated with chronic pain leads to more intense pain, distress and disability (Otis 2003). Often not assessed!
- Co-morbid substance abuse potential high.

How should we handle requests for pain medicine?

- Definitely with usual safety limits and boundaries
- Attend to power dynamic in pt/provider interaction so as not to replicate prior abuse (Norvold study)
 - My aim is to keep you safe; we can work together on this...
- Try to find hidden agendas in request for pain meds (self medication, meds for perpetrators, meds for sale)



How can we ensure patient's safety?

- Perform a safety assessment.
- Make a safety plan with patient.
- Involve law enforcement if appropriate.
- Give patients information about protective orders.
- Give patients information re local agencies.
- Offer to assist with alternative housing.
- Give patient information about crisis services.
- Schedule follow up.



Selected References

- Campbell, A. Jones, J. Dienemann, J. Kub, J. Schollenberger, P. O'Campo, A. Gielen and C. Wynne, Intimate partner violence and physical health consequences, *Arch Intern Med* **162** (2002), pp. 1157–1163.
- A. Coker, P. Smith, L. Bethea, M. King and R. McKeown, Physical health consequences of physical and psychological intimate partner violence, *Arch Fam Med* **9** (2000), pp. 451–457.
- S. Plichta, Intimate partner violence and physical health consequences: Policy and practice implications, *J Interpers Violence* **19** (2004), pp. 1296–1323.
- J. Otis, T. Keane and R. Kerns, An examination of the relationship between chronic pain and post-traumatic stress disorder, *J Rehabil Res Dev* **40** (2003), pp. 397–406.
- Wuest J, Merritt-Gray M, Ford-Gilboe M, Lent, B, Varcoe C, Campbell JC. Chronic pain in women survivors of intimate partner violence. *The Journal of Pain* **9** (2008) pp 1049-1057.



Case 6

- LW 56 yo woman passed from resident clinic “drug seeker who needed an attending”
- H/o alcoholism, pancreatitis, chronic abdominal pain, escalating pain complaints (abdomen and back), tobacco use, poor adherence, depression.
- H/o abuse by partner whom pt shot and killed per pt in self defense, served jail time. Subsequent gang rape.
- Managed in conjunction w anesthesia pain clinic (stable med dose), local mental health agency, antidepressant, recent dx of dm, TAH for menorrhagia, menopausal symptoms
- Pt returned to school, got GED, CNA and opened thrift shop to benefit victims of violence!



Case 6 continued

- Recently, w closing of local mental health agency took first drink in 8 years and told me, referred to UNC psych
- Weathered this, then built house on cesspool
- Last December had intractable dental pain just after anesthesia pain clinic stopped seeing pt due to staffing shortage. Pt unable to afford extractions
- I had to decide whether to prescribe additional narcotics until pt could have extractions performed.
- With frequent visits, trust and love did give additional narcotics and pt had extractions, now back on stable dose of narcotics.
- I still remain worried and cautious when she requests cough medicine...

What are the factors that might have alerted us in this case? Clinical Indicators for exposure to IPV

History/Sxs	Physical / Signs	Diagnoses	Encounter
<p><u>Multiple physical & psychological symptoms</u></p> <p>Vague, non-specific symptoms</p> <p><u>Chronic pain – abdominal</u>, back, pelvic, ha</p> <p>Fatigue/decreased energy</p> <p><u>Sleep disturbances</u></p> <p>Decreased concentration</p> <p><u>Etoh and/or other substance abuse</u></p> <p>Irregular vaginal bleeding</p>	<p>Any trauma</p> <p>Multiple injuries at 1 time or injuries at different stages of healing</p> <p>Finger marks or strangulation marks</p> <p>Head, central trunk, or genital trauma</p> <p>Fearful, easily startled</p> <p>Reluctance to have a genital exam/difficulty with genital exam</p>	<p>Recurrent UTI</p> <p><u>Chronic pain</u></p> <p>Sexual dysfunction</p> <p>Recurrent sinus/<u>dental problems</u></p> <p>IBS</p> <p>Fibromyalgia</p> <p><u>PTSD</u></p> <p>Attempted suicide</p> <p><u>Depression</u>, anxiety</p> <p>Psychosis/dissociation</p> <p>Late/sporadic prenatal care</p> <p>Hyperemesis/Spont ab, PT delivery, placental separation/ LBW infant</p> <p>Early progression of HIV</p>	<p>Partner unwilling to leave patient alone, answers questions for the patient, threatening to staff, verbally abusive or indifferent</p> <p>Delayed presentation</p> <p>Inconsistency between history and physical findings</p> <p><u>Poor control of chronic medical conditions</u></p> <p><u>Nonadherence</u></p> <p><u>“Drug-seeking” behavior</u></p> <p><u>Repeat visits to ED or clinic</u></p> <p><u>Social isolation</u></p> <p>Abuse of child or elder in the household</p>

What should I remember about IPV?

It's not a

- As common as breast cancer
- More common than colon cancer
- More common than gestational diabetes in pregnant women
- **Most common cause of injury in women**
- **25% lifetime prevalence**



What should I remember about IPV?



- It causes significant morbidity and mortality through direct means such as emotional, physical and sexual trauma.
- It causes indirect morbidity and mortality by interfering with therapy for other disease processes, putting patients at risk for more health complaints and poor outcomes, PTSD and depression.
- Patients miss work and family opportunities to contribute and cost society money through lost work (\$8.3 billion in 2003 excluding legal costs).
- It causes unnecessary human suffering.

What can I do to help?



- Remember to **consider IPV in your differential diagnoses**, especially with multiple somatic complaints, unexplained symptoms, chronic pain, nonadherence to medical regimens, depression, anxiety, substance use, unexplained trauma, partner always in room.
 - Frame around the issue of concern when querying, normalizing inquiry but being specific
 - Avoid the words ‘domestic violence’, ‘abuse’, try ‘trauma’

‘Often when it is hard to pin down the cause of abdominal pain I have found that patients I’ve cared for have experienced a traumatic event in their past. Has this ever happened to you where you were hurt emotionally, physically or sexually?’

What can I do to help?



- **Inquire** about a history of present or past emotional, physical or sexual violence **in all your new patients.**
 - It's important for you to know
 - Your patient will appreciate that this issue is important to you for detection and prevention.
 - Try for one emotional and one physical/sexual ?
 - “Do you feel threatened or controlled by your partner, or anyone else in your life?”
 - “Has your partner or anyone else ever hurt you physically, for example by pushing, shoving, hitting, slapping or kicking you, or by forcing you to have sex?”

What else can I do to help?

- Let's continue to study the problem to find the most effective modes of inquiry and treatments.
- Step up and say to yourself, peers, patients and society that the patterns that perpetuate violence are wrong and can be changed.



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Bibliography

- Available upon request
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