INTIMATE PARTNER VIOLENCE IN THE EMERGENCY DEPARTMENT: THE NECESSITY OF SCREENING AND INTERVENTION

A Thesis
Submitted to
the Temple University Graduate Board

In Partial Fulfillment
of the Requirements for the Degree
MASTER OF ARTS

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May 2018

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ABSTRACT

Intimate partner violence (IPV) is a public health emergency and due to the often-hidden nature of IPV, it is not readily apparent who is a victim. However, a large proportion of victims are economically disadvantaged, and the emergency department is the first place where many patients present, whether it be for related or unrelated concerns. IPV is difficult to detect, and unfortunately, physicians are also notoriously poor at predicting who is a victim, especially in the emergency department. Because IPV is lethal, it is imperative to improve detection of victims and to intervene when they come forward. This paper seeks to elucidate future sustainable improvements in IPV detection and intervention in the emergency department. Findings indicate that universal computer screening in the emergency department followed by immediate intervention and contact with an IPV-specific advocate is a necessary step to start combating IPV.

ACKNOWLEDGMENTS

This thesis could not have been accomplished without the generous support of Professor Providenza Rocco, whose feedback and encouragement were instrumental during this process. Thank you very much, Professor Rocco.

I'd like to also thank Dr. Nora Jones for her support and advice through the process of this thesis, and throughout my time with the Center for Bioethics, Urban Health, and Policy.

I also wish to thank my fiancé, Jesse Goldshear, for helping me through every step of the process, from research to editing. And lastly, to my family – my mother, father, and brother – for your extraordinary love, support, and guidance throughout my journey.

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CHAPTER 1: INTRODUCTION

Intimate Partner Violence

Intimate partner violence (IPV), described as a "physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner," has likely been a problem since the dawn of interpersonal relations.[1] It has carried on for millennia with great consequence for its victims, not only causing the obvious consequences of harm to victims, but inferring a significant burden on society directly and indirectly.

IPV is a public health emergency, this is an issue of health and society; it has been estimated that nearly 20 people per minute are physically abused by an intimate partner in the United States. Women who are victims of physical abuse have greatly increased total annual health care costs, even when abuse was in the remote past. Remote abuse increased total annual health care costs by 19%, recent abuse increased costs by 24%, and ongoing abuse increased health costs by 42% when compared to women who hadn't experienced IPV at all.[2]

Separate from the economic costs of IPV, victims of IPV suffer from increased rates of adverse health outcomes. Women who experience IPV have increased prevalence of chronic pain syndromes, mental health disorders, and are at higher risk for HIV, STDs, alcohol and drug abuse, and attempted suicides.[3] Compared to women who were never abused, mental healthcare utilization was significantly higher among women who were victims of both physical and non-physical abuse.[2] This is unsurprising given data that demonstrates victims are three to five times as likely to have depression, PTSD,

substance abuse, and suicidality.[3] When surveying within a population of women diagnosed with major depressive disorder, 60% were found to have a history of IPV, which was two times greater than rates found in the general population.[3] IPV must be treated as a public health emergency, with resources dedicated to understanding its epidemiology and limiting its spread.

The Prevalence of Intimate Partner Violence

In the general population, 1 in 3 women and 1 in 4 men are physically or sexually assaulted by a partner during their lifetime and the rates are even worse among racial groups.[4] Compared to White non-Hispanic women, Asian or Pacific non-Hispanic women, and Hispanic women, rates of IPV are 30-50% higher in non-Hispanic Black women, American Indian or Alaska Native women, and multi-racial non-Hispanic women. In their lifetime, it has been approximated that 41.2% of non-Hispanic Black women, 51.7% of American Indian or Alaska Native women, and 51.3% of multi-racial non-Hispanic women have been reported to be the victims of rape, physical violence, and/or stalking by an intimate partner.[5] While no single factor can explain the higher prevalence of IPV among traditionally disenfranchised ethnic minorities, it is likely related to the interaction of multiple risk factors related to marginalization, including substance abuse, unemployment, education, cohabitation of unmarried partners, pregnancy, and income.[6] This is important to keep in mind because marginalized groups make up a large proportion of patients presenting in the emergency department, and thus they also may be more likely to be victims of abuse.

Due to the often-hidden nature of IPV, it is often not apparent who is a victim. However, because a large proportion of victims are economically disadvantaged, the emergency department is the often the first place where patients may present, whether it be for related or unrelated concerns. With anywhere from 15-54% of women experiencing IPV during their lifetime, a one-year prevalence of IPV that ranges from 14.4% to 30%, and an acute incidence of *physical* abuse as high as 7.2%, it would stand to reason that a high proportion of emergency department patients are victims.[7] In one study of IPV prevalence in the emergency department by Abbott et al., 24% of those with a history of IPV reported abuse by their current partner.[8] It is estimated that anywhere from 5-35% of women who report to the emergency department are actually there because of a complaint related to domestic violence.[9] These numbers are staggering, and IPV has far-reaching consequences that impact everyone.

Consequences of Intimate Partner Violence

Victims of domestic violence are more likely to be socioeconomically disadvantaged and marginalized members of society. IPV itself may further contribute to the downward spiral of socioeconomic disadvantages that affects families for generations. It is important to note that IPV is often first experienced by women and men between the ages of 18-24 (47.9% and 44.1%, respectively).[5] Furthermore, 23.2% of women will first experience IPV at even younger ages, between 11 and 17 years old.[5] That means 71.1% of women who are victims of IPV experience a form of IPV before they turn 25 years old. Entering the dangerous cycle of abuse at the ages when people are

theoretically at their most productive likely creates ramifications throughout the rest of victim's lives and further contributes to the astronomical cost of IPV on our society.

Financially, the cost of IPV in 2003 was estimated to exceed $8.3 billion, which included the indirect loss of $1.2 billion in the value of lost lives alone.[10] Furthermore, the economic cost of loss of productivity is also steep; it has been estimated that annually, victims of severe IPV lose nearly 8 million days of paid work equaling 32,000 full-time jobs in addition to the loss of 5.6 million days of household productivity.[10]

Abuse also has health consequences that extend beyond those that directly affect victims. Abuse during pregnancy increased the risk of low birth weight, fetal death by placental abruption, antepartum hemorrhage, fetal fractures, uterine ruptures, and premature labor.[3] These consequences not only immediately affect the pregnancy, but low birth weight and premature labor contribute to further consequences throughout a child's life.

Beyond the direct physical health consequences of IPV on a child's life, exposure to abuse during childhood can have dramatic significance. Even when separating out comorbid child abuse in households reporting IPV, exposure to IPV in early childhood has been theorized to be one of the most psychologically destructive traumas for young children.[11] This may then manifest in infants as symptoms of PTSD that include eating problems, sleep disturbances, and loss of developmental skills.[12] Children who witness IPV may also have problems with emotional regulation, which is then associated with problems in attention, regulation of emotions, the development of a positive and strong sense of self, and future relationships.[13] The chronic stress of exposure to IPV are suspected to also have effects on brain development. Many infants exposed to IPV have

demonstrated chronically hyperaroused neurological states.[14] Glucocorticoids, which are released in response to stress and hyperarousal, are located in high densities in the frontal and limbic systems of the brain. Thus, it is hypothesized that chronic stress can result in neuronal death and reduced cognitive development in areas of memory, learning, thinking, and emotional interpretation.[15] Further down the line, IPV exposure in childhood has been shown to increase the likelihood of risk-taking behaviors during adolescence and adulthood.[16] Because each generation of children becomes the next generation of productive adults in society, adverse childhood experiences from exposure to IPV in childhood contributes to compounding societal ramifications that are still unmeasured. Thus, to determine the best way to combat this worldwide health problem, it is important to understand the mechanisms behind abuse.

The Cycle of Abuse

The Cycle of Abuse theory was first developed by Lenore E. Walker in 1979 after noticing a pattern of patriarchal behavior through a series of interviews with 1,500 women who were victims of IPV. The proposed cycle generally contains four stages: (1) tension building, (2) acute violence, (3) reconciliation/honeymoon, and (4) calm.[17] In many instances, the start of relationships are described as fairytale-esqe, in which the perpetrator lavishes the partner with affection and attention, and expects the same in return.[18] However, over time, the “tension building” stage of the cycle begins, in which the stresses and pressures of daily life build, and the abuser may feel threatened, ignored, or wronged.[19] Victims may respond be becoming overly compliant to try to reduce tension, or on the other side of the spectrum, provocative, in an attempt to get the abuse

over with. Regardless, an outburst of violence occurs, triggering the "acute violence" phase.

Violence, despite public perception, is not limited strictly to physical abuse, but may also include verbal, psychological, and sexual abuse.[18,19] The joining commonality of all types of abuse is the attempt of the abuser to exert power and dominance over their partner in order to release/reduce tension. Abusers may feel remorseful or guilty after their act of violence while the victim may feel humiliated, confused, or, mistakenly, responsible for their own abuse. This is the start of the "reconciliation/honeymoon" phase.[18] During this phase, if the abuse is acknowledged, abusers will often apologize and become exceptionally affectionate, assuring victims that they will change, and the incident will not happen again. Abusers may threaten suicide or engage in self-harm as demonstrations of remorse to gain sympathy or prevent victims from leaving the relationship or reporting the abuse to the authorities. Many victims, especially those entrenched in longstanding abusive relationships in which they have become worn down and have developed low self-worth, are so eager for improvement, they agree to stay.[20] This is the beginning of the "calm" phase, where the relationship remains relatively stable and peaceful. However, as interpersonal difficulties and life stressors begin inevitably to build once again, the cycle continues with the "tension-building" phase once again.

Though not explicit within the cycle of abuse, over time abusers build greater power and dominance over their partners' lives. This results in victims increasing dependence on their abusers. Abusers often work to dismantle a victim's self-worth. For example, through a technique called "gaslighting," an abuser will confidently deny what a survivor is actually perceiving or sensing so that the victim will question their

experiences. This technique makes victims believe that they can't trust their perceptions or their memory of events. In turn, this may make victims doubt their sanity and decision-making ability, allowing abusers to discredit them should they speak out.[21] Furthermore, by reiterating a victim's shortcomings through techniques like "gaslighting," abusers often make victims feel as though no one will ever treat them as well as the abuser will, especially since victims may feel they are not worthy or capable of more. This is accentuated further during "reconciliation/honeymoon" phases, when victims may be showered with gifts and affection, and made to feel as though they are lucky to be in the relationship.[19]

Alongside the psychological attack victims face, abusers may also create physical and economic barriers to further entrap their victims. Abusers may insist that they be the primary breadwinners, limiting financial independence, or insist that they transport their partners everywhere for their "safety," limiting the victims opportunities for escape and isolating the victim.[18] Abusers may insist on starting a family, in order to make victims more reluctant to leave their relationship and further deepening their dependence on the abuser, especially if the victim is not financially independent.[18] By isolating their victims, abusers erode their social support systems and leave them feeling alienated. Without such support initiating help can be difficult or near-impossible.[22]

Thus, medical providers need to be bridge to initiate intervention. Because of the complex nature of IPV, it is important that providers understand abuse. While awareness of IPV has grown in past years, there has been no established standard set to educate future providers. Medical school education on IPV has increased, but much of the education occurs during preclinical years and is not re-emphasized again once students

are finally face-to-face with patients who may be victims.[23,24] During clinical years, student training is largely dependent on their personal clinical experiences and didactics during their specialty-based rotations, making it difficult to implement standardized education. But without understanding the nuances of abuse, it can be difficult to identify when behavior is “healthy” or “unhealthy.”

It is the duty of a physician to fight IPV. The Hippocratic oath states: “I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing.”[25] Turning a blind eye to IPV is unethical. When a physician promises to “do no harm,” it could be argued there is no difference between directly doing harm and passively allowing harm. According to utilitarianism, the right action is one that minimizes pain (maximizes happiness) for the greatest number of individuals.[26] In this case, it's clear the “proper” action for the physician is to intervene, because it attempts to minimize harm to people. For a physician to act with beneficence, it is essential to also act against IPV.[27] The problem is determining who, exactly, requires action.

CHAPTER 2: IPV IN THE EMERGENCY DEPARTMENT

Barriers to Physician Screening

Physicians are notoriously poor at predicting who is a victim of IPV. In a general study of primary care physicians, it was found that physicians correctly identified as few as 1 in 20 victims.[28] Another study found that only 6% of physicians always asked about IPV while 10% of physicians never asked about IPV. Only 5% of emergency medicine physicians screened for IPV despite being perhaps the most likely to encounter IPV victims. This is compared to 20% of OBGYN physicians who reported screening for IPV.[29] This is unsurprising given the external pressures on physicians to perform their jobs in a time efficient manner and the lack of emphasize given to IPV in medical education. Not only do physicians admit they routinely forget to ask, physicians often do not feel confident in their ability to recognize when someone is a victim of IPV and are therefore worried about offending patients if they do.[29] Many physicians also admit that they are unsure how to respond to patients who divulge their victimhood, which can be a further barrier to screening.[29]

Common presenting complaints have been recognized in populations of victims of IPV. Common complaints include headaches, insomnia, choking sensations, hyperventilation, GI symptoms, chest pain, back pain, and pelvic pain.[3] If physicians were taught to be better able to recognize the somatic symptoms that are closely coupled with domestic violence, screening rates may also improve. However, regardless of the presenting complaint, it is essential that all patients are *asked* about domestic violence, rather than relying on physician suspicion. In one study, domestic violence identification

rose from 0% (in the control group) to 11.6% with just discretionary inquiry alone, while another demonstrated that screening questions helped physicians identify twice as many victims of abuse.[30,31]

Changing physician behavior to increases rates of screening is especially important in the emergency department. In emergency department populations, the acute incidence of IPV was found to be 11.7%, with a cumulative lifetime prevalence of 54.2%, higher than the prevalence found in the general population.[8] Furthermore, within an emergency department population, only 23% (11 of 47) of the victims who were being abused presented for acute trauma, and even more startling, only 13% (6 of 47) of those who were victims of IPV were *asked* by staff if they were current victims of abuse.[8]

While it is easy to say that everyone needs to be screened, it can be hard to balance this sentiment with the costs it might incur. Screening requires resources – money, time, manpower, etc. – so the question remains, how should screening be done and how can it be improved? *Who* should be doing the screening, and *how*? Past approaches can be separated into various generalized categories: (1) culture change, (2) incorporation into medical record, (3) screening tools/assessments.

Past Approaches to IPV Screening

Creating a culture in the emergency department that encourages screening for IPV has shown moderate success, though its short lifespan has limited its long-term benefits. Changing the culture has been approached in different ways, with varying levels of effectiveness. In one study by Campbell et al., the intervention ED staff was put through a two-day training and planning program to provide didactic instruction on the dynamics

of IPV and appropriate responses in the ED. These included protocol development that incorporated increasing the availability of IPV information. However, while there was a reported significant improvement in ED culture, the increase in documentation of abuse between control hospitals and intervention hospitals was not statistically significant and only 9% of women overall were asked about abuse by the ED staff *after* training.[32] In contrast, when coupling education and policy development with an administrative intervention to enforce mandatory screening, not only was there an increase in screening from 29% pre-intervention to 73% post-intervention, but there was a significant increase in detection of IPV from 5.3% to 8%.[33] This demonstrates that while provider training may be helpful, it still requires reinforcement through other avenues to produce change.

Physicians have reported that common barriers to screening include a lack of confidence in recognizing victims, fear of offending patients, or just routinely forgetting to ask.[29] With that in mind, there has also been a push to increase screening by reminding providers through the medical record. By providing a standardized intervention checklist for the management of IPV, one study found that there was a statistically significant increase in patient odds of receiving an IPV diagnosis.[34] Even the inclusion of just a simple reminder in the medical chart, in the form of a question, "Is the patient a victim of domestic violence? Y/N," increased the proportion of identified cases of IPV by 80%.[9] However, when the reminder in the medical chart was coupled with physician education (a period of time after the implementation of the reminder in the medical chart), there was no difference in proportion of identified cases between the intervention in the medical chart alone and the medical chart intervention with physician education.[9] This suggests

that structural or environmental changes in the approach to IPV identification is more successful than education alone.

However, beyond the assumption that structural changes in the approach to IPV in the emergency department will improve IPV identification, it is important to consider what an effective structural change is. The use of screening tools and assessments has been a powerful tool in the quick, initial identification of many medical maladies, from alcohol abuse to depression. However, there is no current standard screening tool that has been identified as superior. Given the time constraints in an emergency department, multiple screening tools have been evaluated for both effectiveness (through sensitivity, specificity, NPV, and PPV) and efficiency.

The Index of Spouse Abuse

The Index of Spouse Abuse (ISA), a 30-item self-report score used to measure the severity of aggression (both physical and non-physical) inflicted on women by their partners, is a popular past measure used in medical settings and widely considered a gold standard. The ISA has two scales, one that measures nonphysical abuse and one measuring physical abuse. Each uses a 5-point Likert scale, for a maximum score of 100. A positive result is indicated by a score of >25 on the non-physical abuse scale or a score of >10 on the physical abuse scale.[35] However, given the complicated nature of this tool, which requires a high literary proficiency to read and time to answer the high number of total items, it is unrealistic to use in an emergency room setting.

The Women's Experience With Battering Scale

One potential screening tool, the "Women's Experience With Battering (WEB)" scale, attempts to measure psychological abuse through functionalization of

psychological vulnerability, perception of susceptibility to danger, and the loss of power/control in a relationship into objective criteria. One particular adaptation of this screening tool included 10 items from the WEB scale plus two items that assessed current physical or sexual abuse, and two items that assessed any type of battering within the past five years. In a study conducted in rural care clinics in South Carolina, screening took approximately 15 minutes and was found to have a sensitivity of 79.8%, a specificity of 99.4%, and a positive predictive value of 96.6% if two or more of the 10 statements were answered positively.[36]

However, it is important to note that this assessment was conducted in a rural outpatient clinic, and the reported results may not be applicable in a busy, urban emergency department. While the demographics of the underserved rural population in this study – low socioeconomic status, high rates of infant mortality, poor educational achievement, and ethnicity/race – may be similar to those of an underserved, urban population, the pace of a busy department is still unlikely to be conducive to the proper amount of time required to spend with victims. This is especially true if the end goal is not only the fifteen minutes required to screen a patient, but also the time required to counsel and intervene when a patient is also a victim.

The Hurt, Insult, Threaten, and Scream Tool

The Hurt, Insult, Threaten, and Scream (HITS) tool was initially developed in family practice offices and is a four question tool scored on a Likert scale in men, women, Hispanic, and African-American women.[37-39] It was found to have a sensitivity ranging from 30-100% and a specificity of 86-99%.[40] Unfortunately, the HITS tool fails

to definitively identify and to address ongoing violence, but also may not be sensitive enough to be effective as a screening tool.

The Partner Violence Screen

The Partner Violence Screen (PVS) was developed for use in the emergency department, and is a three-question screen. It has been tested in both males and females with a sensitivity of 35-71% and a specificity of 80-94%.[40] Furthermore, a positive PVS was predictive of future physical abuse; women positive were 11 times more likely to report physical abuse and 7 times more likely to experience verbal aggression at a four-month follow up than those negative at initial screen.[41] However, the PVS only asks about violence in the past year, though any history of past abuse is a risk factor for future abuse, not just recent abuse in the past year.[42,43] Furthermore, the violence implied in questioning may be interpreted to mean violence from anyone, outside of intimate partners.

The Woman Abuse Screen Tool/Short Form

The Woman Abuse Screening Tool/Woman Abuse Screening Tool-Short Form (WAST/WAST-SF) was developed by family physicians and validated for use in the emergency department. The short form version uses only two questions to determine the amount of tension in a relationship and the ability of a couple to work through arguments. The long form, which is an additional six questions asks more explicit questions about physical and emotional abuse. The WAST only had a sensitivity of 47% and a specificity of 96%.[44] Though when the WAST-SF was combined with an known injury, sensitivity jumped to 92% with a specificity of 56%.[45] Unfortunately, IPV may not always present in overt physical injuries, reducing the effectiveness of the WAST.

The Ongoing Violence Assessment Tool

The Ongoing Violence Assessment Tool (OVAT), a four-question screen, was evaluated in an emergency room setting and has been tested in women, men, African-Americans, and Hispanics. The OVAT was found to have a sensitivity of 86% and a specificity of 83% when validated against the gold standard at the time, the ISA.[46] It is a self-administered test that assesses current and ongoing emotional and physical abuse but fails to assess past abuse, which can lead to a failure to identify patients at increased future risk of abuse.

WEB	1. Your partner makes you feel unsafe even in your own house. 2. You feel ashamed of the things your partner does to you. 3. You try not to rock the boat because you are afraid of what your partner might do. 4. You feel like you are programmed to react a certain way to your partner. 5. You feel like your partner keeps you prisoner. 6. Your partner makes you feel like you have no control over your life, no power, no protection. 7. You hide the truth from others because you are afraid not to. 8. You feel owned and controlled by your partner. 9. Your partner can scare you without laying a hand on you. 10. Your partner has a look that goes straight through you and terrifies you.
HITS	How often does your partner: 1. Physically hurt you? 2. Insult you or talk down to you? 3. Threaten you with harm? 4. Scream or curse at you?
PVS	1. Have you been hit, kicked, punched, or otherwise hurt by someone in the past year? If so, by whom? 2. Do you feel safe in your current relationship? 3. Is there a partner from a previous relationship who is making you feel unsafe now?
WAST	1. In general, how would you describe your relationship—a lot of tension, some tension, no tension? 2. Do you and your partner work out arguments with great difficulty, some difficulty, or no difficulty? (#3–#7 response options: often, sometimes, never) 3. Do arguments ever result in you feeling down or bad about yourself? 4. Do arguments ever result in hitting, kicking, or pushing? 5. Do you ever feel frightened by what your partner says or does? 6. Has your partner ever abused you physically? 7. Has your partner ever abused you emotionally? 8. Has your partner ever abused you sexually?
OVAT	1. Within the last month my partner has threatened me with a weapon? *True* *False* 2. Within the last month my partner has beaten me so badly that I had to seek medical care. *True* *False* 3. Within the last month my partner has had no respect for my feelings. *Never* *Rarely* *Occasionally* *Frequently* *Very Frequently* 4. Within the last month my partner has acted like he or she would like to kill me. *True* *False*

Table 1. Common IPV Screening Tools[36, 37, 40, 41, 46]

Pitfalls of Current Screening Methods and Programs

It is essential to emphasize effective ways to discuss and inquire about IPV due to its sensitive nature. While the vast majority (82% of participants in one example study) of women report that they are open and want physicians to ask about IPV, there are conflicting reports about whether or not just asking is effective at uncovering increased rates of IPV exposure.[47] In one study, when comparing "usual" care to a "treatment" group that received a standardized 3-item IPV screen, there was no statistically significant difference in reported IPV exposure. [47] Given the nature of abusive violence, victims often feel shame and anxiety surrounding their personal circumstances. Thus, it is important to not only ask about IPV, but to determine which style of questioning victims responded to best.

When evaluating provider-patient communication in regards to IPV disclosure, a few troubling patterns of communication were unveiled. 45% of the time, questions were asked in a perfunctory manner, which may imply that IPV is unimportant, and a further 10% were framed in the negative, unconsciously leading patients to a "correct" answer (for example, "He's never hit you?"). Only a third of providers would probe further, defined in this study as at least one follow-up question. [48] There were also some notable pitfalls in communication that contributed to a failure to elicit potential IPV victimization and/or a failure to properly respond to the victim. For example, it was noted that providers occasionally inquired about IPV in the presence of a third party, which limits the victim's ability to safely disclose and may even further endanger a victim. Worse still, even when patients did disclose victimization, some providers failed to acknowledge the disclosure of abuse, did not assess victim safety, and failed to link victims with available

resources.[48] Such failures in communication are dangerous – not only does it deprive the victim of potential life-saving intervention, it also may reinforce the conception the victim is unimportant, insignificant, and powerless, but also that providers do not care. All of the above may discourage victims from disclosing their abuse in the future.

How can these pitfalls be avoided? One method is to provide objective, unprejudiced opportunities for disclosure as well as improvements in compassionate, patient-centered interviewing. Determining what kind of screening questions victims will respond to best could be useful. Most of the clinically used screening questions have been developed by physicians, though some have also been developed by individuals with backgrounds in social work and public health. It may also be worthwhile to have people with more experience and understanding of the dynamics of IPV in a community setting – for example, former victims or community organizers – help create screening questions that make victims feel secure and safe. It is also important to consider the method in which victims are asked about IPV. Is face to face interaction the best method, or are there weaknesses to this approach? Recently, computer-based screening tools are becoming commonly accepted ways to screen patients.

Studies have shown that computer-based support systems can help enhance preventative care, and patients have indicated that they are more likely to be truthful when answering sensitive questions.[49,50] A study on the use of a computer-based IPV risk assessment tool found that both men and women in the "treatment" (computer-based screening) group had more self-disclosures of IPV than those in the "usual-care" group that used traditional face-to-face screening methods. Furthermore, it also resulted in greater chart documentation of IPV cases (19 documented) than those in the usual care

group (1 documented).[51] Computer-based screening can be an effective method to uncover concealed IPV; not only can computer-based screening occur during the long amounts of downtime patients experience while in the emergency department, it can be easier for patients to disclose information to a system perceived as non-judgmental, especially if patients do not wish to appear weak in front of their providers.

Of course, computer-based screening requires resources that are not always available, and further, can not fully replace the individualized needs of victims when responding. Thus, it is essential for providers to feel comfortable empathetically discussing IPV with patients. Patient-centered interviewing, which focuses the conversation on understanding the patient's experience and finding common ground, has been associated with increased patient satisfaction and compliance, reduced concern, reduction of symptoms, and improved physiological status.[52] And despite the common concern of patient-centered interviewing prolonging patient visits, there was not a substantial time difference found when comparing patient-centered interviewing versus physician-driven interviewing.[52]

These concepts can readily be applied to discussion about IPV with patients. It has been observed that patients were more likely to disclose IPV when providers probed for more information, asked open-ended questions with opportunity for further discussion, and were responsive and empathetic to patients who disclosed forms of "stress."[48] While these approaches are difficult to objectively study for statistical significance, past research has shown that demonstration of empathy and open-ended discussion when sharing highly emotional information with patients fosters trust and understanding.[53-56] Due to the sensitive nature of IPV victimization, adjusting physician

practices to provide objective, non-judgmental care coupled with compassionate, empathetic responses will likely result in the most effective method of IPV disclosure.

CHAPTER 3: EMERGENCY DEPARTMENT INTERVENTIONS FOR INTIMATE PARTNER VIOLENCE

The true importance of screening and identification of victims of IPV in the emergency department is the ability to then intervene and prevent future abuse. IPV interventions in general have been found to have a significant and positive impact on the victims who are able to participate.[57] There would be an outcry if providers performed screening without treatment, yet identification without intervention happens routinely. If identification is achieved, but no intervention is attempted, it is unethical. Unfortunately, IPV is deceptively complicated and intervention can often be complex. There is no single method, treatment, or program that is able to suddenly stop abuse. The grip of the cycle of abuse is fierce and insidious. As victims become more and more dependent on their abusers, it becomes harder and harder to leave.

Leaving an abusive relationship requires prolonged support of victims, something that is not within the typical purview of emergency medicine, which often acts as a throughput and gateway to either the hospital or the home. Even admission into the hospital, while feasible, is still only a short-term solution to a chronic problem, because a hospital necessarily only functions as a sub-acute health facility. The solution therefore must lie at home, and the function of the emergency department in this respect is paramount. As a gateway to the home, initial identification in the emergency department can set a patient up for continued support and resources they would otherwise not have access to.

IPV interventions in the emergency department have included attempts to connect patients to social services, motivational interviewing, and in-house advocacy before discharge. Obviously the ideal solution would be to intervene so that abusers will stop their violent behavior. However, the roots of abuse lie in deeply entrenched societal structures that can take generations to dismantle. Alerting the abuser that his/her abuse is known to the medical community and empowering victims is more realistic in the emergency department. Thus, most current efforts to address IPV in the emergency department aim to provide victims with information and materials to later connect with supportive services outside of the hospital. However, such tactics place the onus on the patient to take charge. Not only does that require further effort on the part of the victim, but it may also further endanger them. As most victims are often closely tracked and monitored by their significant others, it can be impossible for victims to initiate access to help without fear of retribution. Furthermore, victims are often not unaware of resources, but may be unsure of where to begin a confusing process.

Current Intervention Methods

Motivational interviewing is a technique that is often employed in counseling for substance abuse. The provider acts as the helper in the process of change, helping patients move through the stages of change: pre-contemplation, contemplation, preparation, action, and maintenance. [58] Working with victims to discover intrinsic motivations and values that align with their goal (i.e. quitting a substance or leaving an abusive relationship) empowers the victim to change their behavior.[59] There has been evidence that disclosing abuse and receiving validation from providers in return, caused victims to

change the way they perceived their situations. This validation of a victim's self-worth was even powerful enough to occasionally serve as a turning point for victims to start the process of leaving the abusive relationship.[60,61] However, when attempted in the emergency department in patients who were victims of IPV and also heavy drinkers, brief intervention via motivational interviewing demonstrated no difference in incidents of IPV or reduction in days of heavy drinking.[62] Brief motivational interviewing as an IPV intervention may be ineffective because of the persistent nature of IPV, as well as the fact that the pattern of abusive behavior does not stem from the victim, but rather the abuser.

Advocacy programs in the emergency department have exhibited some quantity of success. Community-based advocacy programs have demonstrated that women who participated experienced less physical abuse and improved quality of live up to two years after initial intervention.[63] Further, after advocacy intervention, 25% of those women experienced no violence in the two year follow-up compared to only 10% of women in the control group that experienced no violence in the two year follow-up period.[63] However, community-based advocacy programs often occur over longer periods of time than what can occur in the emergency department. Plus, women who seek community advocacy programs are more likely to be more ready for change than those who are passively discovered by screening.

Regardless, advocacy interventions in health clinics and emergency departments have proven moderately effective. In a health clinic setting, on-site counseling and follow-up telephone counseling sessions resulted in a significant increase in safety-promoting behaviors. Meeting with advocates in the emergency department to discuss options for dealing with victims' situations, discuss their incidents, address safety,

receive education on IPV and community resources, significantly increased the number of women who sought counseling or shelters.[64,65] While not as direct as a reduction in violence, these increases are indicative of a change of behavior. By bridging the gap between community resources and the patient in the emergency department, barriers to access are lowered and victims have better and more direct access to trusted resources.

While women do benefit from advocacy interventions, not all women use these services. For example, when victims were referred to outside community services, one study found that only 38% of women had any contact with a community agency.[22] This inaction may be due to several reasons. Many women who chose not to seek help revealed that they believed that the situation "wasn't serious" or that medical care, counselors, or law enforcement were not useful and that they felt shame in a situation they wished to keep private.[66] Others cited the barriers to getting help – the hassle of money and time, the lack of knowledge of resources – or were fearful that their partner would get into trouble.[66] Combating these beliefs requires empathetic education. If victims feel isolated from help from the beginning, change will be more difficult. Even if victims intend to contact outside services, the time from when victims leave the emergency department until they come into contact with community intervention is a time of potential danger. Visiting an emergency department can be a risk factor for further IPV – short-term violence recurred in 13% of cases after a visit to the emergency department versus the general prevalence of 7% in New Zealand.[47] This suggests that leaving victims without a plan when they leave the emergency department heightens their risk. It is therefore crucial to immediately provide some sort of support to victims.

Advocate intervention while in the emergency department may be effective. In studies performed in outpatient clinic settings and in the emergency department, women who met with an in-house IPV advocate to provide needs assessment, safety planning, education, and support with further linkage to community allies were more likely to use outside services after the initial visit (compared to usual care of a business card and hotline number).[67,68] 96% of women indicated that they felt their living situation was safer after the ED-based intervention largely because of the individualized safety-plan.[67] Furthermore, women who immediately met with an advocate were also more likely to involve legal services and had significantly lower depressive symptoms and suicidal ideation over time.[68] However, it is important to consider that IPV victims are more likely to visit the ED overnight than during daytime hours, and it may be difficult to staff an emergency department 24/7 with the necessary dedicated personnel and advocates to immediately provide services.[9] Thus, while not ideal, it is pragmatic to consider other options.

If a potential pitfall of the usual care provided in emergency departments is that it places the onus to receive help on the victim, it may be prudent to consider outreach by a community advocate. In implementation of interventions, it is essential to be cognizant of how IPV intervention may endanger the patient. Given the foundation of IPV in domination and control, not only is there a definitive danger to an abuser finding out that a victim is reaching out for help, but there is also a higher likelihood that a victim may not have the requisite privacy to answer a phone call from a community organization. This may be circumvented through an agreed upon verbal protocol between the advocacy organization and a victim, but that requires extra organization and manpower to achieve.

Nonetheless, when an outreach protocol was studied in comparison to a referral protocol, victims in the outreach protocol reported less fear and greater decreases in PTSD and depressive symptom severity than those who only received a referral.[22] Not only does outreach reduce loss to follow-up after initial emergency department visits, it may also be tailored to a victim's needs, so that victims are more quickly connected to relevant services. It is important to be cognizant of the fact that women who opt for outreach services may be more ready for change or ready to leave than those who refuse outreach. Regardless, if done in a safe manner, considering follow-up outreach after set-up in the emergency department may be another option to increase rates of victim intervention.

Besides the importance of IPV intervention in terms of beneficence for the individual victim, IPV intervention is beneficial for society at large. In terms of pure economics, health costs have been estimated to be 1.2 - 1.4 times higher for women who have been exposed to IPV compared to women who have not.[69,70] This is unsurprising – physically abused woman are more likely to utilize the emergency department, outpatient services, pharmacy services, and specialty services, especially for those with ongoing abuse. Similarly, in woman who are victim to both non-physical and physical abuse mental health utilization is significantly higher.[2] Such use of services, which would otherwise be unnecessary, likely contributes to an estimated increase of $585 per victim added to annual health care costs during periods of abuse.[70] Multiplied over the large number of estimated IPV victims, this is an incredible sum. IPV adversely affects eight of the ten leading health indicators listed by the Department of Health and Human Services. In 2003 it was estimated that conservatively, the cost of IPV equals $5.8 billion a year (given inflation, this is likely a higher sum now). This goes beyond just direct health care

costs; while $4.1 billion was estimated to be directly for medical and mental health care, $900 million was from lost productivity, and another $900 million was from lost earnings from women lost to IPV.[71]

IPV intervention not only improves the health and safety of the individual victims, but it is also of the interest of the greater society to intervene. While health care costs are elevated during periods of abuse, there is evidence that IPV-attributable costs will wane over time as victims are further removed from the period of abuse. By five years post-IPV exposure, health care costs among women exposed and not exposed to IPV were similar, with a continuation of this trend for the rest of the follow-up period (totaling ten years).[70] IPV is a complex and cyclical pattern of behavior that isn't suited to a one-size-fits-all approach. Yet, however difficult it may be to address the issue, there is clear hope that there is a way forward toward a future where IPV can be addressed and treated more readily by physicians.

CHAPTER 4: IPV CASE STUDIES

Stories from the Emergency Department

Encounters with victims of IPV are not always clear cut. In a packed emergency department, it is easy to focus in one the issue the patient initially complains about or what is written on the triage note. However, when taking time to focus on the bigger picture, some victims may give emotional or physical cues that hint at IPV or give a history with medical inconsistencies. These personal examples below demonstrate the varied ways that potential IPV victims present to the emergency department.

Case 1

A 33-year-old well-nourished female with no significant past medical history presents to the emergency department with rib pain. She reports that she slipped and fell on a patch of ice outside a few days ago. She reports pain with inhalation and when she coughs, but denies any other symptoms. Physical exam demonstrates bruising and tenderness over the ribs but no other abrasions over her chest or extremities. Chest x-ray demonstrates rib fractures. When the patient is asked about her home life and relationships, she reveals that her relationship with her partner is stressful and sometimes turns physical. She admits that she would like help with her relationship and is given some pamphlets. However, after discharge, while she has taken her discharge paperwork, the pamphlets she was given are found left behind.

Case 2

A 22-year-old female, gravida 3, para 1, at 12 weeks gestation presents to the emergency department with her partner for vaginal bleeding. Her partner wishes to remain with her during the entire encounter and refuses to leave her side when asked. While examining the patient, with her partner by her side, it is discovered that there is bruising over her abdomen. The patient looks to her partner before her partner answers for her and reports that she accidentally fell down the stairs. Her partner then interrupts and asks how long the visit will take because they have to get home to take care of their child. The patient is discharged after ectopic pregnancy and miscarriage are ruled out.

Case 3

A 40-year-old female without significant past medical history presents to the emergency department with abdominal pain. She reports non-specific symptoms of abdominal pain that do not clinically correlate to a specific cause of abdominal disease. She reveals that she has been to various emergency departments over the years for the same problem, and no one has been able to give her a definitive answer. She reports trying medications for GERD in the past but stopping them when it did not help her symptoms. When asked more about her home life, she reports she is a stay at home mom with three children. She reports that her relationship with her husband is often tumultuous and they often get into arguments. He has threatened her recently and thrown objects in their house, but he has only ever hit her once and was sorry at that time. She reports she sometimes feels unsafe, but believes this is normal behavior, as she witnessed similar behavior from her parents growing up as well. However, she agrees to talk to a social

worker in the emergency department. While she does not take any paper information with him upon discharge, she reports that she knows what to do if she feels unsafe again.

Case 4

A 26-year-old male without significant past medical history presents to the emergency department with a head injury. He reports that he slipped and fell in the shower and hit his head on the tile. He denies loss of consciousness and any nausea or vomiting. On physical exam, he is neurologically intact with a laceration over his scalp but no other visible signs of trauma from a fall. Upon further questioning, he eventually admits that he had been arguing with his partner and his partner threw a lamp that shattered near his head. He reports that such behavior has been happening with increased frequency and makes him feel unsafe. He agrees to speak with the social worker in the emergency department. He takes the information for a domestic violence hotline with him, and reports he feels as though he has a plan in place should he feel threatened again.

Wrap-Up

IPV may be subtle and variable in its presentation. Common emergency department presentations, such as abdominal pain, occur with such frequency that it may be easy to dismiss if no medical red flags are raised. However, it is important to consider IPV in a differential for common complaints, as IPV can have physical manifestations. Further, it is important to consider men as victims of IPV as well. Once suspicions of IPV are aroused, it is essential to act but also take into consideration the best way to address the individual's circumstances. Experience in the emergency department has demonstrated that simply giving patients information and placing the onus of their

therapy on them is ineffective. Health care providers, patients, social workers, and advocates collectively working together is the best way to address each victim's individual issues.

CHAPTER 5: CONCLUSION

Future Directions

It is imperative to continue to work towards identifying the most efficacious ways to uncover IPV and then, to determine how best to work with IPV victims to prevent harmful outcomes. First then, it is most important *to ask*. Physicians often cite a fear of offending women by asking about IPV as a reason why they do not ask. However, 82% of women strongly agreed that a "health care provider should ask about difficulties in home life and relationships."[47] However, it is still important to ask in a sensitive and empathetic manner and in a manner that is safe for the patient. The controlling nature of abusers means that it is essential that victims are given the opportunity to disclose IPV in a safe and private setting without the partner present and without arousing suspicion of their abuser. This can be established by first providing a private area which all patients must enter alone. While providers should still inquire about IPV at the bedside without any other visitors, it can be difficult to separate patients from insistent friends and family without arousing suspicion that will turn questioning around back to the patient later. Furthermore, many emergency department bays offer little privacy with only curtains surrounding a patient, which not conducive to honest conversation.

This should be separate from general triage. Triage is a wonderful function for improving workflow in the emergency department, but is often an overwhelming, fast-paced environment for both patients and the providers who work there. It may not be completely private and the goal of triage is not establishing diagnoses, but to figure out where to send a patient. Patients are often asked about IPV in a perfunctory manner,

which sends a negative message about what a patient's answer should be. Furthermore, if a patient does disclose while in triage, there is little time to establish a therapeutic relationship and address potential solutions. While trying to incorporate IPV questions into triage has been done with the best intentions, triage is far from a safe space to do so. Instead, assigning space for a private room, with four walls, for each patient who visits the emergency department to enter alone in with the specific purpose of screening for IPV would be more effective.

Determining which questions should be asked and how to ask them is also crucial. High sensitivity is crucial to an effective screening tool. Unfortunately, with such a highly charged topic and the potential for retribution, victims may be hesitant to come forward. It is important to ask the right questions and in the right way in order to elicit honest responses. While empathetic patient-centered interviewing is important, it may be more appropriate as a follow-up tactic after IPV is discovered. Given the manpower, time, and resources that would be required to spend appropriate amounts of time with patients, it may be best to start with a computer-assisted screening tool. It would be inappropriate for a provider to elicit a history of IPV only to dismiss it to be dealt with later. By first screening with a computer, which patients have indicated they view favorably, they can immediately be provided with printed information that is relevant to the questions they answered affirmatively, and providers can be notified of the results before they see the patient.[51] It is important to be sure that these patients have the option to not print out information because it may be dangerous for them to have that information on their person. The computer-assisted screening tool should utilize question

items that have high sensitivity, such as the OVAT, and also take relatively little time to complete.

Once a patient screens positive, it is imperative that the patient is put in immediate contact with an advocate specifically hired for the emergency department to maximize patient's future safety. Collaboration between different disciplines will be essential in treating IPV. Physicians and medical providers can provide the medical knowledge and expertise to help identify patients with suspicious medical issues and provide medical treatment. However, physicians and medical providers are not properly trained to provide the requisite counseling services that victims need. IPV education is not standardized across medical education, nor is it yet considered an essential topic to cover. However, social workers, counselors, and bioethicists do receive specific training in understanding the cycle of IPV and how to help victims break the cycle. Furthermore, different disciplines are able to approach the issues of IPV from different angles that may not be considered by just one profession. IPV is not one size fits all. By working together, screening and intervention plans can be formulated that will be effective in the social context in which they are developed. While the potential infrastructure and personnel changes necessary to adequately address IPV are costly, these costs would quickly be recouped through saved long-term medical and economic expenses. Physician have a duty of beneficence – to take action that serves the best interests of patients.

While it is discouraging to see the cruelty that can occur at the hands of others, it is even more discouraging to feel helpless to stop it. In a discipline where expectations are so high and patients often believe that there is a magic pill for everything, the low rates of successful intervention in IPV can seem like a failure. But for the victims who

are able to escape the cycle of abuse because of intervention, the intervention is life-changing. Solving the root causes of IPV is not easy and is beyond the scope of a hospital-based intervention; eventually, it will require a change in the mindset and the values of society. But for now, emergency departments must have patience and support to help victims overcome their abuse as a form of tertiary prevention. Current practice is not working. Future studies must be done that will combine effective screening practices in the emergency department with an intervention that is follows patients over time. By trialing different best practices together, more effective ways to combat IPV will emerge, and IPV can be overcome.

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