# Intimate Partner Violence

by Lauren Auster and Thuy Bui

**Learning objectives**:

- Recognize intimate partner violence (IPV) and how it impacts patient wellbeing
- Learn interviewing and active listening skills that empower survivors of IPV
- Identify creative solutions for medical problems complicated by a patient's IPV situation
- Discuss healthcare and community solutions for those experiencing IPV

**Case synopsis:**

Ms. A is a 41-year-old woman with past medical history of depression and polysubstance use who was recently in a motor vehicle accident and sustained multiple pelvic fractures. Her injuries were managed nonoperatively until she left the hospital a week ago before a successful pain management regimen was implemented. She returns today after a ground level fall with increased hip pain.

For her pain, she was given 30 tabs of 5mg oxycodone on discharge despite being managed on a stronger pain regimen while inpatient. She has also been taking gabapentin, acetaminophen, and ibuprofen. She was set up with home physical therapy and home health but was not seen by either service as she had trouble getting back into her apartment (lost her key and trouble contacting her landlord) and went to stay with a relative. When not living with her husband, she typically stays with her mother and 5 children. She is currently unemployed and does not drive. She has Medicaid, TANF and SNAP benefits.

At home, Ms. A says she is barely getting by. The pain in her low back and left hip are so severe that she has had to crawl to get around at home. She could not use a walker due to severe pain. She thinks she left the hospital too early. Regarding her ground-level fall, she was walking with her walker on thick carpet and her left ankle "gave out" as a combination of pain and weakness. She denies hitting her head or loss of consciousness. She had two drinks that morning before fall. Normally she drinks twice a week, consuming ~50 oz beer each time. Today her UDS is positive for oxycodone, opiates, cocaine, and buprenorphine. She snorts cocaine and previously snorted heroin but hasn't in 1.5 years. She takes no other medications. She was previously on Effexor for depression but self-discontinued the medicine. She wants to try Effexor again.

Of note, Ms. A has a history of sexual assault and rape, both of which were committed by her husband. She currently lives with her husband who has not been helping her around the house and watches her crawl on the floor. Per the patient, it is possible that her husband is hiding or disposing of her medications. Outpatient notes indicate that the patient prefers her medical history be kept from her husband. However, today patient says she feels safe at home and says its okay to discuss medical history pertinent to this hospitalization. She is slightly uncomfortable about discussing her substance use in front of him as "he has used it against her before", but still says it is still okay to discuss.

Ms. A is unaware of positive Hepatitis C titers from a year prior. She was admitted for pyelonephritis at the time, but a viral load was never ordered. She has no IV drug use history but says her mother has known Hep C from a transfusion. Her husband remains in the patient's room during her interaction with the medical team and declines to leave. To speak with Ms. A alone, the medical team has to use creative strategies such as talking with her when she is transported for imaging studies.

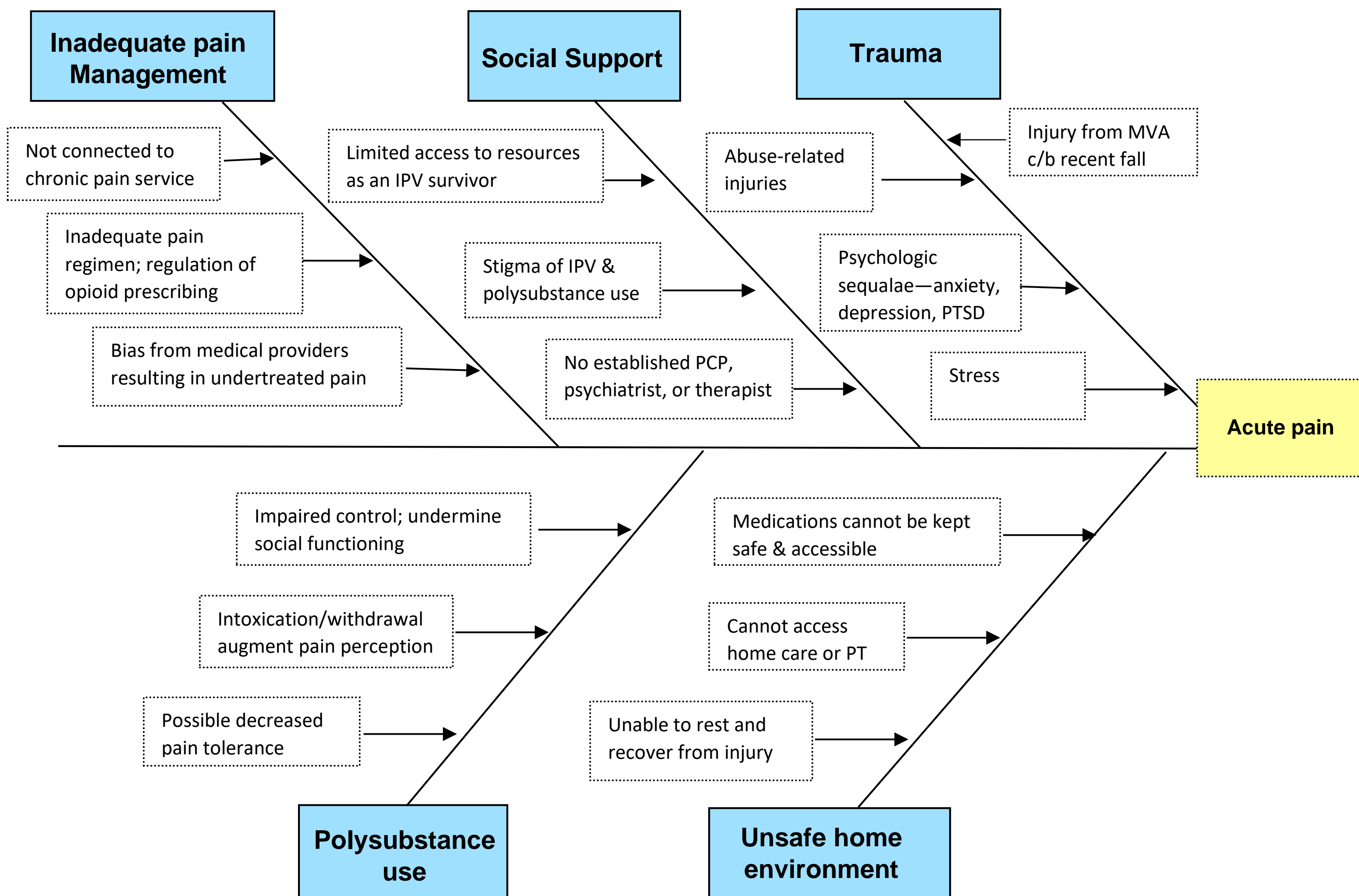
1. **Construct a problem list for this patient**
2. **Conduct a root-cause analysis for at least one problem**
3. **Describe positive/protective social determinants of health for this patient**
4. **Describe negative social determinants of health factors**
5. **Propose patient-level solution with attention to facilitators and barriers**
6. **Imagine possible health system or institutional solutions**
7. **Discuss potential community/societal-level solutions**

# Facilitator's Guide

**1. Construct a clinical problem list for this patient**

- Acute pain secondary to fall and recent MVA
- Polysubstance use
- Depression
- Hepatitis C
- High suspicion for IPV

2. **Conduct root-cause analysis for at least one problem**



**3. Describe positive/protective social determinants of health for this patient**

Protective social determinants of health for this patient include:

- Has health insurance coverage through Medicaid
- Motivated to seek treatment for her depression
- Family support and access to alternative housing
- Fluent in English with no overt language or cultural barriers

**4. Describe negative SDH factors**

Negative SDH factors include:

- Unsafe home environment and high suspicion for IPV
- No established PCP, physiatrist, or therapist
- Mobility difficulties from injury/pain and lack of reliable transportation
- Currently unemployed
- Subject to bias as a woman with polysubstance use

The inpatient team was not able to learn more about Ms. A's socioeconomic situation.
**If you were her provider, what else would you like to know regarding her social determinants of health?**

- Economic stability: other sources of income or financial support, expenses, debt
- Physical Environment: quality of housing, access to transportation, neighborhood safety, walkability
- Education: literacy, level of education
- Food: hunger, food dessert, access to healthy options
- Community: social integration, other systems of support, community engagement, sources of discrimination
- Healthcare: quality of care received, provider availability
- Legal: encounters with law enforcement and history of incarceration

**5. Propose patient-level solution with attention to facilitators and barriers**

When caring for patients with a history of IPV or those in a current IPV situation, it is crucial that the medical team make the patient feel safe and heard. This includes respecting the patient's autonomy, allowing them to control the discourse about their IPV experience and medical care, and ensuring their medical information is kept confidential. Barriers to caring for patient in IPV situations include recognizing when IPV is happening and knowing how to approach and help patients who have experienced current and past trauma. Complicating factors, as exemplified by Ms. A's case, may be a current abusive partner who continues to exert control over the relationship. These barriers can be overcome through early recognition of IPV, shared decision making and using trauma informed care (TIC).

Recognizing IPV:

**What is intimate partner violence (IPV)?**

- Abuse or aggression that occurs in a close relationship
- Can occur with current or former partners
- Includes four types of behavior
    - Physical violence: when a person hurts or attempts to hurt a partner
    - Sexual violence: when a person forces or attempts a partner to take part in unwanted sexual acts
    - Stalking: repeated, unwanted contact or attention by a partner that causes concern for one's safety

    - Psychological aggression: verbal or nonverbal communication or acts used to exert control over a partner and harm them emotionally or mentally. Examples include restricting a partner's phone use or taking their medications, using digital tools to control a partner's thermostats, locks, and lights, or restricting a partner's access to necessities like birth certificates, bank account info, and transportation.
- Affects 1 in 4 women and 1 in 10 men
- IPV often starts early, when IPV start in adolescence it's called teen dating violence (TDV)

**Discuss why Ms. A's case is highly suspicious for IPV & categorize the behaviors you identify based on the IPV definition above.**

- History of sexual assault and rape by her husband, with whom she lives (sexual violence)
- Ms. A is uncomfortable discussing her substance use in front of her husband as he has "used this information against her before" (psychological aggression)
- Ms. A is suspicious of her husband for hiding and taking her medications (psychological aggression)
- Her husband refuses to leave the patient's room (psychological aggression)
- Her husband showed minimal compassion towards Ms. A after her MVA injury, leaving her to crawl around the house (psychological aggression)
- Acute pain secondary to recent fall after MVA injury, difficult to discern if the totality of her injuries are from these 2 incidents or if physical violence was involved (physical violence)

**But Ms. A says she felt safe at home. Why might she have said this?**

- Pressure or direct threats from her husband
- A belief that sharing her IPV experience will not help the situation
- Fear of judgement
- Feelings of hopelessness or helplessness

Providing Trauma Informed Care (TIC):

**What is TIC and how can we best provide care to Ms. A?**

The following framework is from *Trauma-Informed Care in Behavioral Health Services* published by SAMHSA

- Create a safe environment: Anticipate that the physical environment of your practice may be triggering, establish consistent interactions and treatment practices so that patients know what to expect
- Recognize that language choice is powerful: Use strength-based language that does not place blame on the survivor. Examples from the APA Guide to IPV Among Women include:
    - Using the term "survivor" over "victim"
    - Asking "What gave you the courage to leave" or "What were the reasons you felt you couldn't leave?" instead of "Why didn't you just leave?"
    - Believing survivors and don't ask "Did that really happen?"
- Support control, choice, and autonomy: IPV is often about control and takes this away from survivors. Empowering your patients may be critical to their recovery. Create opportunities for choice and control by offering patients options and asking how they would like to proceed. Examples include:
    - How would you like to be addressed?
    - Where/when would you like us to call you?
    - What information would be helpful for us to know about what happened to you?
    - Of the services I've described, which seem to match your present concerns and needs?
- View trauma through a sociocultural lens: Understand that some populations and cultures are more likely to experience IPV. Know that culture can influence how a traumatic event is perceived. Culture can also affect what qualifies has a legitimate health concern or what qualifies as abuse.

- Provide hope and promote resilience: Use strength-oriented questions that redefine how an IPV survivor views themselves. Examples include:
    - The history that you provided suggests that you've accomplished a great deal since the trauma. What are some of the accomplishments that give you the most pride?
    - How do you manage your stress today?
    - What behaviors have helped you survive your traumatic experience?
    - What are some of the creative ways that you deal with painful feelings?
    - How do you gain support today?
    - What does recovery look like for you?
- Foster trauma-resistant skills: Help patients identify and practice coping mechanisms that help them adapt and combat the effects of trauma.

**How can we help patients like Ms. A stay safe at home?**

- Safety planning: Ensure patients have a safe place to go when violence ensues. This can be an alternative housing options such as living with family or friends. This can also be identifying rooms in a home that are safer than others (limited items that can be used to facilitate violence) or can be locked from the inside. Develop a plan for collecting necessary items like clothing, government identification, and money. Create a safe word that can be shared with children or family members and used in the case of emergency.
- Offer resources: Connect patients with the local women's or IPV shelter. Inform them of the National Domestic Violence Hotline. Save emergency phone numbers under innocuous titles or names if the abusive partner has access to a patient's phone.
- Document injuries and abuse: Accurate, thorough, and descriptive information about a patient's physical and mental abuse can be helpful if an IPV case is brought to court. However, if an abusive partner has access to the patient's medical record, it may be necessary to covertly record this information.

## 6. Imagine possible health system or institutional solutions

Immediate evaluation for services once IPV is identified: There is little evidence that universal screening alone improves health outcomes for IPV survivors. However, the USPSTF recommends that clinicians screen for IPV in women of reproductive age, deeming this a grade B recommendation. Despite the uncertainty of how beneficial screening is to patients, it is crucial that for those who screen positive, interventions are implemented immediately to prevent recurrence of abuse. Using a "warm referral", a provider can contact resources on a patient's behalf and ensure they are connected to the appropriate services.

Teach trauma informed care (TIC) to all clinicians: As described previously, TIC ensures that patients feel safe and empowered, that there is optimal communication between patients and their providers, and that providers assume that every patient they see may have experienced some form of trauma.

Integrated care solutions: IPV survivors often have comorbid health conditions, especially psychiatric comorbidities such as depression, anxiety, PTSD, and substance use disorder. These comorbidities can be addressed in an integrated care model where patients can easily access a myriad of providers and treatment. Oftentimes survivors lack access to their own health insurance, the appropriate clothes to go on a job interview, or legal aid. These resources can also be provided in an integrated care setting, especially one that works closely with community organizations. Successful integrated care examples include clinics at women's shelters, where medical and psychiatric care is often provided alongside safe housing, employment resources, childcare, and more. However, the number of shelters and funding available is limited, increasing the need for integrated care within the healthcare system.

7. **Discuss potential community/societal-level solutions**

Structural or systemic violence contributes to interpersonal violence against women. The following societal-level solutions have been suggested by the CDC:

- Teach safe and healthy relationship skills at young age
- Engage men and boys as allies in prevention and empower bystanders
- Disrupt pathways towards violence through early childhood home visits, family enrichment, and relationship programs
- Create protective environments in the community, at schools, and in the workplace
- Strengthen household financial security such as cash transfers to families, paid leave, and childcare subsidies
- Support survivors by providing housing programs, legal aid, no cost treatment for IPV survivors

A solution developed here in Pittsburgh:
*Coaching Boys into Men* is an athletic coach-delivered gender violence prevention program for middle school male athletes that increased positive bystander behaviors and was determined to be an effective strategy for reducing relationship abuse among younger adolescents. This program was developed by Dr. Elizabeth Miller, Chief of the Diversity of Adolescent and Young Adult Medicine at UPMC and Professor of Pediatrics, Public Health, and Clinical and Translational Science at the University of Pittsburgh. Her results were published in JAMA Pediatrics in January 2020.

**Case outcome:**

During Ms. A's inpatient stay, her medical team ensured that she felt safe and comfortable by limiting the number of team members in her room. The resident overseeing her care asked questions about her safety and IPV experience where appropriate and when her husband was out of the room. Although her husband was there most of her stay, the team took advantage of moments when he was not present to share important and confidential medical information with Ms. A. The team explored local IPV resources to assist her going forward. To ensure Ms. A could contact her medical providers after discharge, the resident overseeing her care also hid their phone number and contact information for hepatology in the discharge paperwork. Unfortunately, immediately after arriving home, Ms. A's husband assaulted her and took her medications and wheelchair. She was trapped inside their house and could not get away. The resident tried to call Ms. A to check in, but her husband kept answering the phone. Eventually Ms. A was able to call for help. She was readmitted to the hospital and her husband was arrested. Ms. A is now set up with a PCP, the resident who cared for her during this inpatient stay, and a chronic pain provider. Her medical team is overjoyed that she is now safe and has improved access to care.

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