“We Can Do Better – Addressing Intimate Partner Violence and Health Outcomes”

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“Coaching Boys Into Men” – Family Violence Prevention Fund (www.endabuse.org) campaign

Violence against women is a tragic reality. We must teach our sons early and often what it means to be a real man – that women deserve honor and respect, and that violence never equals strength. A safer world is in their hands. Help them grasp it.

Eat your vegetables.

Don’t play with matches.

It’s cold out, wear a coat.

Don’t talk to strangers.

Respect women.

Family Violence Prevention Fund

Eat your vegetables.

Don’t play with matches.

Finish your homework.

Respect women.

Violence against women is not part of our traditions. Harmony relies on our ability to respect, honor and nurture all our relatives. We must teach the boys in our lives early and often that this is what it means to be a warrior and that violence never equals strength. A safer world is in their hands, help them grasp it.

www.endabuse.org

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Dynamics of Domestic Violence – Definitional Issues

- **CDC**: Physical and/or sexual violence (use of physical force) or threat of such violence; or psychological/emotional abuse and/or coercive tactics when there has been prior physical and/or sexual violence; between persons who are spouses or non marital partners (dating, boyfriend-girlfriend) or former spouses or non marital partners (Saltzman et.al. ‘99)

- **World Health Organization**: Any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship, includes: physical aggression, psychological abuse, forced intercourse & other forms of sexual coercion, various controlling behaviors (Krug et. al. ’03) – including reproductive coercion
Lifetime IPV – 11.5% for men; 23.6% for women
- Significantly higher among multiracial, non-Hispanic & AI/AN women; & lower-income respondents.
- 600,000 injuries to men 1.2 ml injuries to women

Average of 1600-1700 IP homicides per year of women – 500-600 for men (BJS ‘09) – (average 15/yr in Oregon X9 –almost killed) #1 risk factor: prior DV vs. female partner
- 45-47% of women killed seen in health care system before homicide; 83% of cases somewhere in system (Campbell ‘03; Wadman ‘01)

Past year – higher rates documented – esp. low income settings, IPV specific, w/safety protocols &/or anonymous
- Urban, 12 cities pop based - 9.8% past 2 yrs (Walton-Moss et al ‘05)
- Clinic based computerized – 18% - (Campbell ‘10)
Overlap between physical, sexual and emotional abuse (N = 889) (Campbell et. al. ’02 from Ellsberg ’00)
PHYsical Health Effects
(NIH, CDC funded interdisciplinary research)

- Physical Injury (Facial, fractures, dental, neurological - soft tissue, internal, “falls”- Grisso ‘91)
  - TBI & Strangulation: (McClane ’05; Corrigan ‘03; Valera ‘03)
- Neurological Sx - Coker ’00
  - IPV & stroke or Sx consistent w/ stroke (Black ‘08; Lown,’01; Loxton ‘06)
- Chronic Pain (Back, abdominal, chest, head) (Campbell ‘00; Coker ’02; Wuest et al ‘09) - after IPV
  - Fibromyalgia (Alexander ‘99; Walker ‘00)
  - Immune system activation (Gill, Page & Campbell ‘05)
- Chronic Irritable Bowel Syndrome (Drossman ‘98)
- Hypertension (Schollenberger et al ’02; Coker ‘99)
- Smoking (30-34% IPV 13-15% controls) (MMWR ‘08)
TBI in Abused Women – From Repeated Choking &/or Head Injury – ACAAWS study

HI = Head Injury
HI w/LOC = with Loss of Consciousness
Choking = Attempted Strangulation

ACAAWS Study – African American & African American women in the USVI & US – first 832 women – case control design
### Graphical Representation

#### Case vs. Control

- **Headaches**: 87% (Case), 87% (Control), $P = 0.977$
- **Memory Loss**: 40% (Case), 19% (Control), $P = 0.0002$
- **Blacking Out**: 25% (Case), 11% (Control), $P = 0.006$
- **Dizzy Spells**: 57% (Case), 46% (Control), $P = 0.059$
- **Seizures**: 8% (Case), 2% (Control), $P = 0.056$
- **Difficulty Concentrating**: 52% (Case), 30% (Control), $P = 0.0002$
ACAAWS Study – TBI - CNS Sx

Bar charts showing:
- X Sx #: IPV, No IPV
- CNS X Sx: IPV, No IPV
- Choking CNS Sx#: Yes, No
- HI CNS Sx#: Yes, No
New Data from BRFSS (MMWR ’08; Breiding, Black & Ryan ’08a & b)

- Women - lifetime IPV
  - High Cholesterol: AOR 1.3 ([CI] = 1.1--1.4)
  - Disability AOR = 1.7; activity limitations 2.1
  - Arthritis AOR = 1.6
  - Heart Attack; Heart Disease; Stroke: 1.4; 1.7; 1.8
  - Smoking AOR = 2.3
  - Risk factors for HIV/STD’s 3.1 (CI = 2.4--4.0).

- Men: increased use of disability equipment, arthritis, asthma, activity limitations, stroke, risk factors for HIV infection or STDs, smoking, and heavy or binge drinking. (AOR’s 1.4 (CI = 1.0--2.0) - stroke to 2.6 (CI = 2.0--3.6) – HIV/STD risk
Well established negative health outcomes of IPV – new findings (C. Mitchell ‘09)

- Mental Health: PTSD, Depression, Substance Abuse
  - MH – Largest proportion of excess cost – Snow-Jones et al ‘06
  - Suicidality (AOR = 10.4 in African American women)
- GI symptoms – chronic irritable bowel, some indication of BMI
- Chronic pain – e.g. fibromyalgia
  - Wuest et al ‘09 – chronic pain after IPV ends
  - From immune system effects – activation with PTSD
    Gil et al ‘05; Woods et al ‘05
- Cutting edge research – intersections with genetics
Average Healthcare Costs by Timing of Abuse

Snow-Jones et al ‘06
Well established negative health outcomes of IPV – new findings

- Forced sex
  - HIV/AIDS intersections
  - Increased STI’s; cervical cancer
  - Forced first sex – Stockman et al ‘09 – up to 21% of US women whose first sexual experience <14
- Other GYN problems
- Unintended pregnancy – Pallitto ‘06
- Reproductive Coercion – Silverman & Raj ‘10
  - Family planning sabotage
Abuse During Pregnancy – Health Correlates

- Patterns of abuse during pregnancy – from PRAMS (‘03)
- Unintended pregnancy (Saltzman ‘03; Pallitto et al, ‘04)
- Maternal health correlates: depression, substance abuse, low social support, spontaneous abortion, smoking, risk of homicide (Gielen et al ‘94; Campbell ‘92)
- Infant outcomes: LBW (Murphy et al. ’01 – meta analysis - CMAJ) especially in MC women (Bullock & McFarlane ’89 & through connections w/ smoking, low weight gain & substance abuse & stress (Curry et al ’99; Altarac & Strobino ‘02)
- Child abuse (most severe - nonbiological father)
- Maternal Mortality (Chang & Horon ‘10; Chang, Saltzman ‘05)
- Post partum depression – PRAMS analysis – MMWR ‘09
MENTAL HEALTH EFFECTS – (Golding ‘99; Stith ‘04)

- Depression 10 - 43 pop; 32 - 70% clinical (9.3% non abused)
- Suicidality 14 - 40% (4.9% non abused)
  - Among African American & African Caribbean women
    – IPV & suicidality AOR = 7.39 (Campbell et al ‘10; Houry ‘09)
- Post Traumatic Stress Disorder 2 - 12% pop; 31 - 84% clinical (weighted X prev 64% vs. 5% non abused)
- Alcohol Abuse 4 - 16% pop; 23 - 44% clinical
- Drug Abuse 5 - 16% pop; 23 - 44% clinical (2% non abused)
Bio-Psycho-Immunologic Response to Trauma (Woods et al, ‘02; Gill et al .04)

- IPV
- Depression
- Comorbid
- PTSD

- HPA axis
  - ↑ cortisol
  - Th2 shift
  - Immune Suppression
  - IgE/ IgA Response

- HPA axis
  - ↓ cortisol
  - Th1 shift
  - Pro-Inflammatory
**Pro Inflammatory Response**

- Associations with chronic pain – Woods et al ’05 (fibromyalgia)
- Other inflammatory conditions – asthma – chronic fatigue syndrome, urinary tract infections
- Implications for BMI, obesity
- Implicated with cardiovascular disease -
  - ACE study
  - Cardiovascular risk factors with BFRSS -
Co-Morbidity of PTSD & Depression in Battered Women

- Far more comorbidity in battered women than rape victims or Vietnam Vets – recent research suggests that only depression IF PTSD (Woods ’05; Resick ‘07)
- Predictors: childhood victimization, – importance of child abuse on physical health – ACE
- Importance of severity of physical abuse
- Lifetime trauma response?
- Issues of ongoing trauma
We know routine assessment or inquiry (versus screening language) does no harm – MacMillan et al (JAMA ‘09)

Creating an opportunity

We know women – abused & not – support routine inquiry – in many samples & contexts – ED’s, military, US national population based (Gielen et al ‘06)

We know what to “assess” with – Abuse Assessment Screen (Helton & McFarlane – ’86; Rabin et al, 2009 AJPM, 36,439–445)

Need to do a sensitivity/specificity analysis
And if we do not **routinely assess & appropriately refer**

- Indicator based assessment – so many indicators – will we remember?
  - We will often mis or incompletely Dx & inadequately treat if we fail to identify current or past IPV (e.g. CNS Sx w/o identifying TBI from IPV HI or choking)

- **RADAR (MASS Medical Assoc) - National Consensus Guidelines at [www.endabuse.org](http://www.endabuse.org)**
  - **R** = Routine Inquiry
  - **A** = Assessment – types of IPV, associated px, forced sex, HIV risk, mental health
  - **D** = Document – for now & for later
  - **A** = Assess immediate safety – homicide & suicide risk
  - **R** = Review Options; appropriate referral
PURPOSES OF ROUTINE ASSESSMENT

- OPPORTUNITY CREATION - FOR DISCLOSURE, SEEKING HELP EARLY, A PLACE OF SANCTUARY FOR THOSE NOT READY FOR SHELTER, COUNSELING, CRIMINAL JUSTICE
- PRIMARY PREVENTION - EDUCATION ABOUT ISSUE RATHER THAN DETECTION

More women would disclose if didn’t think would be reported to CPS (Renker ’06)
- 97% not embarrassed, offended or angry – abused & not
- But almost ½ of abused did not disclose but would have if known would not be reported to CPS

Part of new Women’s Health Initiative in VA – make part of other such initiatives!
1. Have you ever been emotionally or physically abused by your partner or someone important to you?

2. Within the last year, have you been hit, slapped, kicked, pushed or shoved, or otherwise physically hurt by your partner or ex-partner?

   If YES, by whom

   Number of times

3. Does your partner ever force you into sex?

4. Are you afraid of your partner or ex-partner?

Helton & McFarlane, 1986

Mark the area of any injury on body map.
Routine Assessment Protocol: All women aged 14 & over (National Consensus Guidelines FVPF- www.endabuse.org)

- **Primary Care** - Every: 1st visit for new cc, new pt. encounter, new intimate relationship & periodics
- **ED & urgent care** - All visits
- **OB/GYN** - Each prenatal & pp visit; new intimate relationship; routine gyn visit, family planning, STD clinic, abortion clinic
- **MH** - Every initial assessment; each new intimate relationship & annually if ongoing or periodic tx.
- **Inpatient** - as part of admission & discharge
- **Pediatrics** – protocols being tested
- **Women with Disabilities** – Curry, Hassouneh-Phillips, ’01 – also Humphreys & Campbell ’04)
Single Question – Gender Neutral

- Are you safe at home? (JHH) – does NOT work well
- Are you afraid (or concerned) that someone at home or someone you love has (or may) hurt you or tried to hurt you?
- If yes, need to ask specifically about forced sex – or have a separate forced sex question
We know

- How to “assess” – computer based approaches well supported - 3 studies – women prefer computerized inquiry – build into HIT – computer tablets?
  - Trautman et al –’07 - ED – increased disclosure through computerized assessment
  - O’Connor et al – pediatric primary care setting – well child and acute illness – handheld
  - McMillan et al . – ED’s & primary care in Canada

- Current study in Baltimore, MD – X3- X4 prevalence using ACASI system than question on history form or over phone assessment in same population
- Takes away issues of asking badly!! – (Rhodes ’09)
ED provider (46 attendings, 47 residents, 4 NP’s) communication behaviors associated with women disclosing IPV:

- Included probing (asking 1 additional topically related question),

- Providing open-ended opportunities to talk

- Being generally responsive to patient clues (any mention of a psychosocial issue)

Rhodes et al ‘09
How you introduce the screen
- Because domestic violence happens to so many women, we are asking ALL women
- Because domestic violence results in so many health problems for women…..

The environment – posters – signals we care
- Notices in rest rooms
- Forms changing
- Incentives for staff
- Privacy - policy of separating family from patient at some point during the encounter – always – every time
What matters - culture

- Hispanic women in LA – afraid of deportation –
  - self, do not know can self petition for citizenship –
    VAWA (citizenship classes, English language classes –
    content on DV)
  - perpetrator, want him to stop, not be deported
  - family members – he has threatened her with
    deportation of family if she discloses

- M. Rodriguez ‘07; ‘09
G. Feder systematic review – ‘09 Tiwari (& Humphreys) adaptation of the 10 minute intervention (McFarlane & Parker) in Hong Kong – clinical trial supporting health care system intervention IPV
- For pregnant women/prenatal care
- Sharps, Bullock – DOVE adaptation

New trial showing significantly less repeat IPV and fewer very LBW babies & very preterm deliveries w/brief computerized intervention (Kiely - OB/GYN 2/10)
- Most effective for safety – shelter and arrest IF serious – offer to call police for her
Legal & Ethical Obligations

- Report felony assault – with a weapon – to police
- Report to CPS if direct harm to child or if child present at time of assault
- Serious suicidality
- Ethical obligations in terms of duty to warn – homicide risk?
Ten Minute or Empowerment IPV Intervention (McFarlane, Parker JOGNN ‘98)

• “Brochure Driven” or computerized (e.g. Kiely ’10)
  • Brochure is for provider – not for woman to take home
  • Can be modified for various audiences/settings
    • Cover is Walker “cycle of violence” – or use Power & Control Wheel – purpose is to start dialogue with her
    • Inside – modification of Danger Assessment
    • Menu of intervention and safety strategies to choose from – including those for staying with partner – can add hers
    • Offer to make calls WITH her (e.g. police Campbell, Gielen ‘02)
    • Resource #’s made local
  • Intervention on March of Dimes website – also brochure
    microsoft publisher – www.nnvawi.org
DOMESTIC VIOLENCE PROGRAMS

- Make sure she knows entire range of services through DV Advocacy Organizations
- Shelter
- Batterer’s Counseling
- Non-Residential Counseling
- Children’s Counseling
- Victim Advocacy
- Court Companion Services
- Attorney Services

- Use a general referral sheet – if suspect and she denies – “if you or a friend or family member ever needs”
Safety Strategies

- Engage her best parenting skills & desires - listen to the kids (Henderson & Erikson ‘92; Sullivan et. al. ‘99)
- The gun(s) - safety pamphlets; search warrants
- If she plans to leave, cannot do face to face
- If she leaves to get him into intervention - stay gone until he completes
- Engage employers, relatives, neighbors - help her break out of the isolation
- Put $$ aside - employment opportunities
- Ensure follow-up
DOCUMENTATION

❖ Charting Should Include:
❖ Date and time care provided
❖ Patient’s own words-”My husband, John Jones, struck me in my face on X date at X time”
❖ Patient demeanor
❖ Complete medical & social history and physical exam
❖ Patient’s explanation response to direct questioning about abuse
DOCUMENTATION

- Charting Should Include:
  - Results of pertinent lab and diagnostic procedures
  - Injury map and/or photographs
  - Discussion of safety assessment and referral plan
  - Any police involvement (including badge number)
  - Lethality assessment

Note: this documentation should be a collaborative effort between all appropriate health care team members per policy/protocol
EXCITED UTTERANCE

- Exception to hearsay rule
- Made for purpose of medical diagnosis or treatment or and describing medical history
- Statements made to MD, SW, or RN
- Upheld 1995 in STATE V. SIMS, Washington (Domestic Violence Case)
- Recent Supreme Court decision makes more difficult but many prosecutors still admitting such evidence WITH provider testimony
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<tr>
<th>PHOTOGRAPHS</th>
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<tbody>
<tr>
<td>❖ Camera accessible 24 hours a day?</td>
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<tr>
<td>❖ Patient permission</td>
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<tr>
<td>❖ Digital - some controversy regarding possible alterations</td>
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<tr>
<td>❖ Photograph before treatment</td>
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<tr>
<td>❖ Photographs from all angles - so that patient identifiable</td>
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NATIONAL DOMESTIC VIOLENCE HOTLINE: 1 800 799-SAFE (7233)

DATING VIOLENCE HOTLINE
1-866-SAFEYOUTH
1-866-723-3968