Intimate Partner Abuse and Victimization:
Why is this issue relevant for health care professionals?

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Introduction

Traditionally, medicine has primarily focused on human physiology in a narrow sense. But with an increasing number of medical problems being related to human behavior and environments, the division between the psychological and the physical is less obvious. One common link between psychology and physiology is stress. Stress can damage the immune system and is associated with greater risk for cardiovascular disease, diabetes, obesity, substance abuse, chronic non-cancer pain, sleep disorders, and a host of other problems. Health care providers encounter chronic disorders in many specialty practices, but most acutely in the primary care roles, where behavioral health problems are often at the forefront.

Among the many stress-related problems that affect health, a very common one for female patients is partner abuse. This severely stressful condition is commonly overlooked in the examination room. Intimate partner abuse, if unaddressed, may result in poor health outcomes. Victims of partner abuse typically have health problems that bring them to the clinic or emergency room; but they don't come to report their abuse. The abuse, just like many diseases, must be explored and assessed in order to discover it.

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In thinking about the typical patients coming to a clinic or emergency department, one might reflect on the fact that 35.1% of women report having experienced physical violence from an intimate partner and 15.2% have been stalked by an intimate partner during their lifetime. Partner abuse is not a rare condition and the abuse and its consequences are more serious for women than men. Overall, 1 in 4 women and 1 in 20 men who have experienced partner physical assault, stalking, and/or sexual assault also reported feeling serious levels of fear. Partner abuse, and the stress it causes, is associated with many physical and mental health conditions, and women with partner abuse victimization experiences use more health services than non-abused women. Because of the close link between partner abuse victimization experiences and health problems as well as health care services, it is recommended that health care professionals understand and provide appropriate support for patients with partner abuse experiences.

In this short paper, we describe what partner abuse is, how it affects the overall wellbeing of patients and how healthcare professionals can respond more effectively to patient needs. We use the term partner abuse to

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include physical assault, sexual assault, stalking, psychological abuse, and the use of coercive control. Most people are familiar with physical violence between couples, but assault represents only one of many forms the abuse can take. For example, coercive control, even in the absence of physical violence, can have serious and lasting effects on victim health.

Some organizations recommend universal screening (routinely screening all patients) while others recommend targeted screening (screening those with the risk factors for partner abuse). However, health care professionals have several key concerns when thinking about screening for partner abuse including concerns about how the patient will respond, the lack of resources to address the issue, and the lack of knowledge about partner abuse such as concern about knowing where the line is between normal partner conflict and partner abuse.

What is Partner Abuse?

Partner abuse is sometimes referred to as intimate partner violence, domestic violence, or dating abuse/violence. Partners include spouses, cohabitating partners, boyfriends and girlfriends, and partners in dating relationships. There is some debate in the literature regarding the exact definition of partner violence. Some argue that there are actually two distinct forms of partner violence.

One type, called situational violence, is characterized as "fighting that gets out of hand" but neither party feels afraid or controlled once the situation is over. This form of violence is not associated with sustained stress or stress-related disorders. Situational violence is usually an infrequent episode that is not seen as having lasting negative effects on the relationship.

Another type of abuse, called intimate partner terrorism or coercive control, is violence that is embedded in a general pattern of domination and control. In other words, a wide range of tactics, including physical and sexual assault, can be used by one partner to maintain control over the other. This is the kind of violence most often discussed when talking about domestic violence or partner abuse and violence. In coercive control, violent "incidents" or "assaults" are part of a larger systematic pattern of control and domination. It is this second type of abuse that has significant consequences for the more chronic physical and mental health problems and for healthcare

A Case Study

Samantha came to the clinic complaining of stomach pains, headache, and difficulty sleeping. She is overweight (BMI 31) and has a family history of alcohol problems, but she does not drink. She seemed distracted and did not easily volunteer information. At one point during the interview, the physician asked about who lived at home with her and Samantha reluctantly answered her husband, David, and children. Samantha didn't volunteer any information about her husband other than that he worked. The physician could tell something was wrong when she mentioned her family but wasn't sure how to proceed.

What the physician didn't know (because she didn't directly ask) was that David was very controlling with Samantha. The more she complied with her husband, the more he demanded. He isolated her from her friends and family. He told her how to dress and he did not like her to watch religious shows or to read the bible. Samantha believed that if she could be better she could make him happy and that her family was most important. She was also not sure what David would do if she did not comply, he yelled and broke things when he got angry. Although there was no physical abuse in the relationship so far, she never felt she could do anything right which caused significant stress for Samantha.

- Do you think Samantha was being abused by her partner?
- What cues do you think might have suggested there was more to the story than what she initially shared with the doctor?
- What additional questions would you ask Samantha?
- How would you re-assess her presenting health problems if you knew about her situation at home before seeing Samantha?
- What do you think the police would say if she told them her story?

services. Coercive control situations are the ones most associated with health complaints. More women experience this form of victimization than do men.

Coercive control strategies that are typically used by one partner to control the other partner:

> In coercive control, violent "incidents" or "assaults" are part of a larger systematic pattern of control and domination.

- **Isolation** by limiting access to outside relationships often through jealousy, embarrassment, or undermining relationships with others. Meaningful relationships are important to our physical and mental well-being but they also play a very important role in stress reduction by helping us figure out what is or is not normal and how to problem solve when various stressors are present in our life.
- **Exploitation** includes intrusive oversight of victims' work, homemaker activities, services, and money. For example, abusers often take the victims' money, require the victim do all the housework and laundry, require the victim to provide food and sex on demand, and require the victim to take all or most of the responsibility for caretaking of children and others (e.g., elderly parents).
- **Deprivation of freedoms** includes control over the conduct of everyday life. Coercive control is not just about punishment, it is also about depriving someone of personal privacy and self-expression such as how to dress, whether and when they can go outside of the home, whether they can work or not, what activities they can or cannot participate in, what to eat, when and how long they can sleep, and access to resources (e.g., money, transportation, medical care, and medication). Deprivation of personal freedoms, like those described above, relates to the freedom and ability to make ones' own decisions rather than being "permitted' to act independently of supervisory control.
- **Regulation** includes strategies and tactics employed to ensure compliance with abusers' demands. Abusers might monitor how victims spend their time, how well certain activities are performed, and/or how finances are handled. Abusers also monitor phone usage, may interrogate or spy on any activity to ensure she is doing what she is 'told to do.' The goal is to achieve control over partner's lives.
- **Degradation** refers to the abuser depriving a partner of privileges, administering punishments, "outing," or publicly disclosing something private, humiliating or embarrassing the partner, undermining the partner's actions, and constant personal attacks and criticisms. Criticisms typically center on the three main areas that women find most shameful: appearance, social roles (e.g., a good partner, a good worker, a good mother), and personal flaws or defects (e.g., intellect, mental health, prior victimization). For example, many victims of coercive control are repeatedly told they are stupid, ugly, unattractive, nobody would want them, and they are worthless.
- **Intimidation** includes threats, property destruction, forced confrontations, threats to or actual harm of self, and threats about harm to others. Direct or even indirect threats to a women's children, other family members, or friends are particularly powerful ways to intimidate women.
- **Physical and Sexual Violence** includes moderate levels such as pushing, shoving, slapping, threatening to hit, and severe levels including kicking, burning, punching, strangling, and beating. Sexual violence includes sexual degradation, implicit threats (victims are often too afraid to say no or sex is demanded after a fight), using substances to manipulate sex, and physically forced sex.

In summary, research tells us that there are some couples with physical assault incidents that are not characterized by control. In other couples there can be control and domination over the other partner – even when there is no physical assault. However, the majority of couples with physical assault incidents are characterized by one partner controlling and dominating the other partner.

Why Isn't Physical Violence a Good Indicator of Partner Abuse?

In the past, and even still today, we have used physical assault as the gold standard to identify partner abuse. There are several reasons for using physical violence to identify partner abuse including the fact that:

- physical violence often (but not always) leaves evidence that is easy to see;
- physical violence is often used in the media and in case studies to define partner abuse; and,
- physical violence is easier to talk about than the other aspects of partner abuse for victims (and perhaps for others).

However, there are several problems with using physical assault to define abuse including: (1) confusion about the gendered nature of partner abuse; (2) emphasis on severe violence; and, (3) focus on incidents rather than context.

Gendered Nature of Partner Abuse. Many people feel that male victims of partner abuse are often overlooked. While it is true that men can be and are victims of partner abuse, they are less likely to be victims of heterosexual partner abuse than women. CDC recently released results of a national household study on intimate partner and sexual violence. Before we look at the results on intimate partner physical abuse prevalence we must think about how it was measured. Respondents were asked "How many of your romantic or sexual partners have ever…"

- Slapped you?
- Pushed or shoved you?
- **Hit you with a fist or something hard?**
- **Kicked you?**
- **Hurt you by pulling your hair?**
- **Slammed you against something?**
- **Tried to hurt you by choking or suffocating you?**
- **Beaten you?**
- **Burned you on purpose?**
- **Used a knife or gun on you?**

Results using all of these questions show that 32.9% of women and 28.2% of men report being physically assaulted by an intimate partner at some point in their life. However, when severe violence (items in blue font) is considered we see a drastic gender difference with 24.3% of women and 14.8% of men indicating they had been severely physically assaulted by a partner.

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The CDC study also measured sexual violence and stalking by intimate partners. Sexual violence included questions about rape, sexual coercion, and non-contact unwanted sexual experiences. Stalking victimization involves a pattern of harassing or threatening tactics that are unwanted and causes fear or concern for safety in the victim.

Overall, 9.4% of women and 0.0% of men reported they had experienced sexual violence and 10.7% of women and 2.1% of men reported they had been stalked by an intimate partner. Women also report more threats of physical harm (45.5%) from partners than men (20.1%) and more threats to harm someone they love (14.5%) than men (4.0%).

Further, when examining the consequences of partner violence, even greater gender differences emerge. Overall, 1 in 4 women and 1 in 20 men who have experienced partner physical and/or sexual assault or stalking also reported being fearful and almost 4 times as many women than men reported being injured from domestic violence and needing medical care. Additionally, more women needed housing, legal services, and report missing work time due to the abuse than men. And, women are more likely to suffer physical and psychological consequences from partner violence than men.

There are also significant gender differences in intimate partner homicides. According to the Bureau of Justice Statistics (2011) of homicide cases between 1980 and 2008 with a known victim-offender relationship,2 16.3% of victims were murdered by an intimate partner. Of those known intimate partner homicides in 2008, 45% of female homicide victims and 4.9% of male homicide victims were murdered by an intimate partner. Control, threats of harm, and assault were all associated with intimate partner-related homicide (Campbell et al., 2003).

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Most research on women perpetrating violence suggest the vast majority of women's violence is reactive such as using force to try to stop the physical or psychological assault, protecting one's body, and trying to stop abuser from destroying property rather than for the purpose of controlling their partner. Men on the other hand report using violence to get their partner to do what they wanted, because of jealousy, to punish their partner, to feel more powerful, because of anger, or because they felt powerless.

Although this paper focuses more on heterosexual couples, partner abuse is a significant issue in same sex couples as well. Rates of partner abuse in same sex couples are similar or higher than in heterosexual couples. However, experiences of partner abuse may be different because services are more limited or difficult to access, and partner abuse among same sex couples may be even more difficult for professionals, including medical professionals, to identify. Coercive control is relevant for same sex and opposite sex couples; however, in heterosexual couples women are at much greater risk of experiencing abuse by partners than men.

Emphasis on Severe Violence. When partner violence is depicted in media pictures there are extreme images of bruises, cuts, and broken bones which may influence our perception of what a "real" victim of partner abuse looks like. But when we only focus on physical assault we tend to start downgrading more moderate violence. What's a slap, a push, or a shove? In reality, minor violence, stalking, and control tactics are more common and frequent than severe violence. Thus, it is important to remember that severity of assault does not equal the severity of abuse; highly controlling/dominating abusers and/or cases with stalking, even without any violence, can be very dangerous cases.

Severity of assault does not equal the severity of abuse.

[2] Only 63.1% of all murders in the Uniform Crime Report Supplemental Homicide Report Data had known victim-offender relationships.

Focus on Incidents Rather than Context. Incidents are what police and healthcare professionals tend to focus on when thinking about physical assault. Incidents are discreet, unconnected episodes of violence. Incidents, disconnected from context, appear as if they came out of nowhere or that these incidents happened in response to "spilled Kool-Aid," an argument about Facebook, an argument over drugs or money, or because of the way a wife cooked his eggs.3 Context means that we need to look at the larger picture of what is happening. In reality, coercive control tactics are systematic and deliberate—tactics designed by one individual to control, harass, punish, or degrade another individual. This also means that harm and fear accumulate over time.

In summary, research shows that coercive control is prevalent in both same sex and heterosexual couples. In heterosexual relationships women are at a much greater risk of partner abuse than men. Using physical assault, especially severe physical assault to determine whether partner abuse is present or not is misleading. Severe physical assault tends to be very infrequent in abusive relationships while control, threats, and moderate violence are more frequent. Control and domination of one partner by another is a systematic and deliberate course of conduct, and to understand partner abuse one must understand the larger context by looking beyond incidents. Violence is only one tool of many in the course of coercive control, which is about entrapment rather than violence. Those being controlled, threatened, and dominated by one partner must also be very strategic about their safety.

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What Does Living with Coercive Control Look Like?

Please make sure you have watched the Oprah video clip of Susan Still's experience before reading this next section: http://webteach.mc.uky.edu/com/md810/oprah.avi

Susan said the physical abuse started after more than 20 years into the relationship when she forgot an item at the grocery store. However, once it started it escalated. Not only did her husband force the children to witness the abuse he inflicted on their mother, he actually made them participate on some occasions and justified the abuse by telling the children that he was showing his love for them by hitting their mother every time she did something that showed she was a bad mother (like the time her younger son's pants seemed too tight). The children were told that their mother did not care about them and that she was poisoning their food. They were also forced to call her names such as slut and to mock her appearance. Her husband told Susan if she didn't like what was happening she could leave and have no rights to the children or, she could stay and be their slave at the family's every beck and call. She "chose" to stay so that she could continue to have a relationship with her children.

Susan said that her husband constantly accused her of having an affair and of being a bad mother, "Those two things will rip a woman apart inside, and they know it. And they do it just to berate you, just to put you down where they want you."

The filmed incident began on a seemingly normal day. Susan's youngest son asked her for a sandwich. She made the sandwich and brought it to her son who was playing video games with her husband. As she walked to the room where her son and husband were, she froze. She wasn't sure whether she should ask her husband if

[3] All taken from real newspaper headlines

he wanted something for lunch or not. That was what started the day long physical and mental abuse. What makes this day so important in Susan's story is that her husband made his 13-year old son tape 51 minutes of abuse (while the 8-year old son watched). Then, that evening he then made the family sit and re-watch the tape telling the boys what she did wrong, justifying his behavior, and continuing the assaults against her

During the course of this abusive relationship Susan was too afraid to seek help from the police or anywhere else. She did not think anyone would believe her story which kept her silenced. Susan said, "He had literally, physically and mentally beat me down to nothing. I thought I was not as good as a piece of dirt on his shoe."

How is it possible that a grown man would treat his wife this way? How is it possible that a grown woman would stay in a relationship that was so clearly hurtful, harmful, and even dangerous? These are just some of the questions that typically come to mind when hearing about stories of partner abuse.

Coercive control in an intimate partner relationship creates conditions not unlike what we have seen among prisoners of war. On the surface, this sounds unlikely because we believe that adults can choose what relationships they are in. However, living for a sustained period of time under a coercive controlling partner undermines independent thought and independent action. The world narrows to a focus on day to day survival and choices disappear for women much as they disappear for prisoners.

What Does an Abuser Get from Controlling His Partner?

Many ask the question "why would someone want to have this kind of control over another human?" The answer to this question is actually very easy. What an abuser gets out of the situation was well said by Susan's husband when he told her that he expected her to be at the family's beck and call—to be the family's slave. A controlling partner gets food on demand, sex on demand, cleaning and laundry services, child care services, someone concerned about their emotional needs constantly, and unquestioning authority and power.

The abuser often does not think what he is doing is wrong or problematic. In fact, the abuser often feels as if he is protecting the family and helping the victim be a better person and that he is entitled to do what he wants because he is smarter, more important, and better than others. He may feel it is the woman's job to take care of him and to serve him. He may also justify his behavior because of how he has been hurt or harmed in the past. Abusers can be very manipulative in controlling, abusing and justifying what they do.

In summary, when you understand both the tactics and the motives to control another person it becomes clear how someone can become entrapped in this kind of a situation and how the controller benefits. It also becomes clear why the situation may become dangerous when the controller is in jeopardy of losing their control such as when his partner tries to leave or when others try to interfere with the situation.

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What are the Consequences of Living in Coercive Control?

Cumulative fear and harm. Coercive control will not look exactly the same in every abusive relationship. Strategies described above will vary in nature, severity, and will change over time. For example, not all coercive controlling relationship include violence. Also, a push can be either minor or more severe and result in a person flying across the room. The overall pattern of conduct is what gives the meaning to the individual events. Thus, the abuse strategies are weaved together such that a hostile and threatening environment is created. This means that victims of partner violence do not feel safe anywhere. They do not feel safe in their home and they do not feel safe away from their home whether or not the abuser is near. In other words, the control and entrapment carry over into every social space for victims.

Entrapment and Dependence. Victims become entrapped in the controlling relationship and dependent on the abuser for several key reasons. First, victims begin to internalize the rules and carry the blame for the abuse. Many victims come to believe that making the relationship "work" is her responsibility which is emphasized by repeated messages from the abuser who blames her for the "failure" of the relationship and of her behavior resulting in "punishment."

Second, because victims are controlled through threats, punishments, and violence, victims often have a hostage-like level of fear. They also have a hostage mentality, which means they do not feel like they can escape either out of fear or because they don't have any viable alternatives or both.

Victims often have a *hostage-like level of fear*. They also have a *hostage mentality, which means they do not feel like they can escape*

Third, victims become dependent on their abuser, in essence "he is the single most rewarding and punishing individual in her life." The deliberate isolation, close monitoring of her every move, and his constantly changing moods and demands monopolize her perceptions keeping her focused on the abuser and the abusers' anger. The dynamic is that if she disobeys or does something he perceives as "wrong" there will be significant consequences. Her life begins to revolve around his rules and his definitions of what is right and what is wrong.

Shame. Victims often feel ashamed and embarrassed for what the abuser has done and how she has become subordinated and dependent on him. The physical abuse is easier for victims to talk about than the other components of coercive control. It is also hard for an individual to leave one situation to reestablish and maintain independence especially when that individual has limited confidence in her ability to maintain a safe and independent life supporting herself and the children. For more information on the power of shame see the Ted Talk by Brene Brown https://www.ted.com/talks/brene_brown_listening_to_shame/transcript?language=en.

Sleep deprivation and physical/mental exhaustion. Victims of partner abuse are often sleep deprived both due to anxiety and stress but also due to direct interference by the abuser. Abusers often dictate when victims can sleep and for how long, and often wake them at all hours of the night. In addition to sleep deprivation, victims are exhausted from working outside the home and/or with taking all of the responsibility of housekeeping, meals, laundry, and other services; especially because, in many situations, the demands for these services or how these services are performed are constantly changing.

Extreme stress, anxiety, and depression. Living within a culture of coercive control, abuse, and violence creates extreme stress, anxiety, and depression. These conditions are qualitatively different from the normal or predictable stress of life and reflect the out-of-ordinary demands on an individual living in these conditions. In these conditions of ongoing chronic stress, stress-response overload can occur. Stress responses protect us under acute conditions, but when the stress response is chronic it causes damage to our psychological and physical systems and accelerates disease which he calls allostatic load. Basically, when the stress response is chronic or is activated too frequently, the stress response continuously floods the physiological system which then leads to health problems. Also, a continuous stress response can itself be damaged such that even when the stressor is removed, the stress response cannot or does not shut off for some reason which exacerbates the problems.

Health and mental health consequences. Victims of partner abuse suffer many health and mental health consequences including anxiety, depression, post-traumatic stress syndrome, and a variety of health conditions created or exacerbated by extreme stress from control and abuse.

How is Safety Strategic?

Victims use a variety of strategies to survive the day-to-day abuse and stress. In order to survive the abuse, some women focus on the fact that they love their partner and believes their partner loves them back. Women may also minimize and deny abuse. Using excuses for her partner's behavior is common such as using his drug or alcohol use or his past victimization (e.g., bad childhood, treatment by ex-wife or girlfriend, poor life circumstances) to excuse and minimize the abuse toward her. Another common way to minimize is to take responsibility for the abuse or to believe he didn't 'mean' to hurt her as much as he did.

Victims subjected to partner abuse alternate between periods of hope and fear. Many victims have hope that their partner may change (and many abusers promise this over and over) or that they may be able to extricate themselves from the abusive relationship. On the other hand, fear arises when they believe they will never escape and must do whatever is necessary to avoid harm to themselves or loved ones. In "living" with abuse, victims repeatedly create "safety zones" or areas of their lives where they can find support, contemplate options, or just find relief from the ongoing chronic stress. Perpetrators, in turn, repeatedly attempt to identify and close these "safe" zones or convince a victim to abandon them, forcing them to move, quit jobs, commanding their presence at home and so on.

In addition to trying to find and keep "safe" zones, women resist abuse using a variety of other strategies. The very fact that women survive these situations suggests that they are doing things to keep themselves and their children as safe as possible within the situational constraints. These strategies include negotiating with the abuser,

escaping the immediate scene when an attack seems imminent, luring the abuser away from danger zones (e.g., guns), calling for help, diffusion strategies (e.g., distraction, try to talk batterer out of abuse), and reactive actions such as protecting one's body, and using other strategies to try to stop the physical or psychological assault and/or to keep the abuser from destroying property. However, often in these situations, victims eventually realize that most of their resistance strategies don't work to change the abuser or that these strategies may work in the short term but not the long term.

Women may feel that leaving is not an acceptable option because of the children, for religious reasons, because of family pressure, because of the lack of resources, because the abuser may harm himself, or because the abuser needs her. Even so, some women, in some situations, may decide to leave their abuser. In fact, research suggests that abuse – particularly early in the relationship may be associated with increased likelihood of separation or divorce. At the same time, research shows that separation from abusive partners actually increases risk of assault and lethal violence. Before separating from an abusive partner, victims must be able to answer two questions: (1) Can I do it? (2) Is it worth the risk(s)? Many victims have been promised they will be killed if they leave, and data does show women are more likely to be murdered by an abusive partner when separated. Risks that must be considered increase when women have children. Violence may be directed at children when the abuser visits without the presence of the mother. Also, there is a risk that Child Protective Services may remove the children from the mother or make the situation worse for the family.

Understanding that safety is strategic suggests that dictating, lecturing, or blaming women in abusive situations undermines victims and denies the true nature of their situational constraints. Thus, it is important to respect women's decisions about whether to stay or leave, whether to seek help from the police or through the courts, or whether to even disclose the abuse, because she is living the situation and fighting very hard every day to survive.

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In summary, partner abuse characterized by coercive control can be understood best as a person living with a chronic stressor. It is important to consider that not only is the victim stressed by the controlling environment and constant threat to her physical and psychological integrity, but she probably has other stressors that we all experience in life. Stress about her children's welfare, financial status, perhaps even work stress. However, even within this context it is important to remember that many women do survive these situations and eventually leave. Safety decisions can only be made by each individual who is living within this context. What they need is respect, validation, and help through information, support, and in other ways depending on victim needs.

What can health professionals do anyway?

It is very clear that partner violence victimization is a chronic stressor that profoundly affects women's physical and mental health. It is also clear that even within the situation of this external stressor women do exercise agency to keep themselves and their children as safe as possible. It is clear that diagnosing partner violence is impossible, writing a prescription to take care of the problem is useless, and that dictating to a woman what she

should or should not do is demeaning. So what can health professionals do then? There are several answers to that question, but there is no definitive solution.

Many organizations and individuals call for universal screening of partner violence, while others suggest that this is preliminary because this "intervention" so to speak has received limited research evaluating. The research that has been done on screening effectiveness has mixed results. Screening could actually be harmful to victims by increasing their risk for more abuse or more psychological trauma depending on how the screening is done and the response to a disclosure. Other organizations and individuals suggest that screening be targeted to women that present with certain risk factors.

Screening. Women in abusive relationships often visit their physicians for a variety of reasons and thus, the health care system is a potentially important place to intersect and reach out to women in these situations, especially for women who have no other way to access education or referrals.

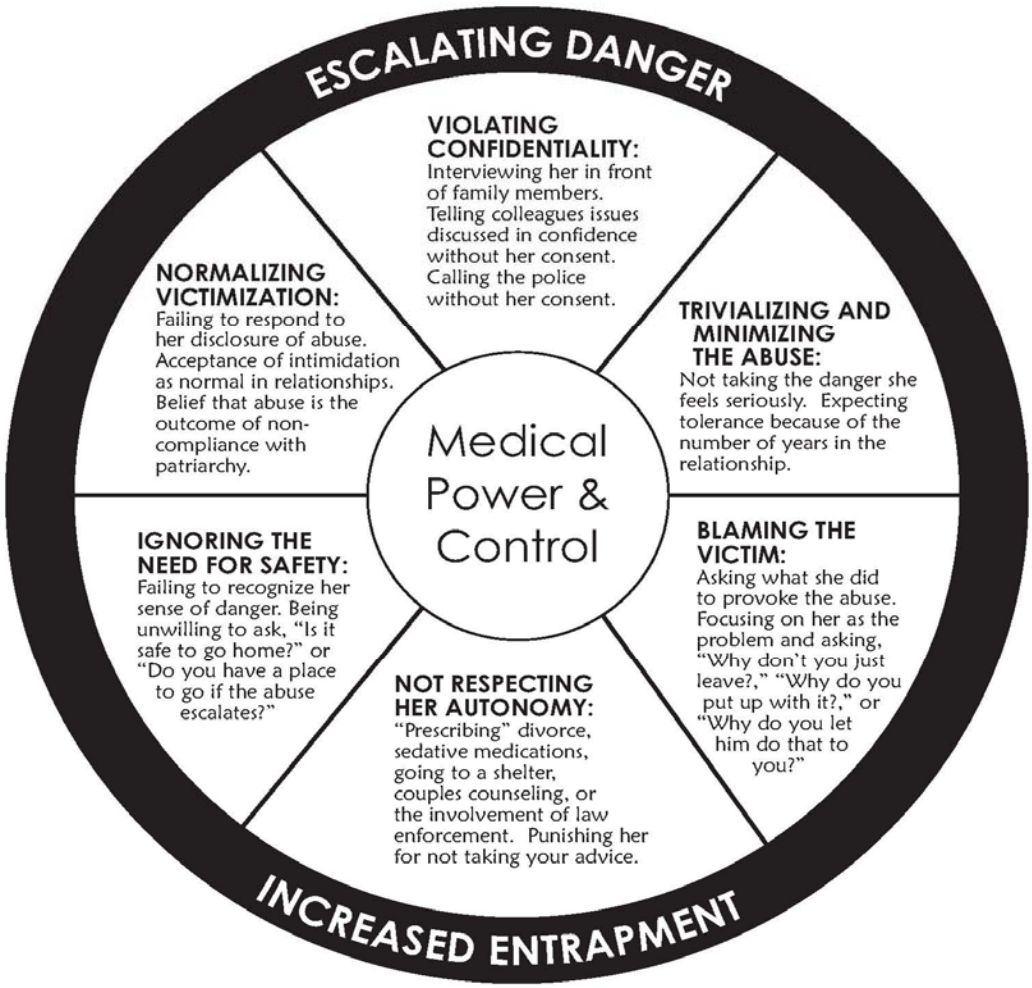
Given the importance of partner violence for health problems, the ability of a physician or nurse to talk privately with women in these situations (which may be rare in their lives), and the ability of physicians or nurses to document the abuse (which may help victims later) some argue for universal screening. Women may see primary care physicians more frequently for preventive care, for small or undiagnosed illnesses, and/or for acute injuries. Universal screening for pregnant women is strongly recommended given the implications not only for her but for the unborn child. Research shows abuse tends to occur during pregnancy as much as before or after pregnancy but that clearly stress and physical assault can be harmful to the fetus. The emergency room is another place victims may be going for acute injuries; however, one study found that only 9% of women went to the ER within one-week of a police-documented assault (Rhodes et al., 2011). Abused women use the health care system more frequently than non-abused women, but are likely to present to the emergency room and primary care physicians with complaints other than immediate assault related.

Several studies have been done showing that women do not mind being screened for partner violence by a health care professional as long as it is done respectfully and where their disclosures are received with kindness and validation rather than judgment, blame, or indifference. Women also report they would rarely self-disclose if they are not asked directly about it. Below is the Medical Power and Control Wheel of how certain responses may be harmful.

Although many groups like the American Medical Association and the American College of Obstetricians and Gynecologists recommend routine screening of their female patients, research suggests that it is rare for this to occur. In fact, one recent study of almost 5,000 women across the nation found that only 7% reported they had ever by asked about domestic violence or family violence by a health care professional (Klap et al., 2007).

What to Think About When Screening. It is important to recognize that there are many reasons health care professionals do not screen women for partner violence including: lack of knowledge about partner violence in general or about prevalence/relevance to their patient population, denial, discomfort with the topic, fear for their own safety, fear of opening "Pandora's box" or because of the complexity of the issue, time constraints, myths or

stereotypes about who is most likely to experience partner abuse, and isolation or a lack of support in working through these issues and addressing partner abuse with patients. You should consider your own feelings and barriers about screening for partner violence and identify what you are most comfortable with doing.



When thinking about routine screening, there are two issues to consider: (1) how do you ask? and, (2) what do you do after you ask? Starting with how you might ask, the CDC advocates using RADAR:

- **R**outinely screen every patient;
- **A**sk directly, kindly, non-judgmentally
- **D**ocument your findings
- **A**ssess the patient's safety
- **R**eview options and provide referrals.

> When thinking about routine screening, there are two issues to consider: (1) how do you ask? and, (2) what do you do after you ask?

Routine screening. Experts suggest that screening for partner abuse should not just be done one time, but rather it should be an ongoing process. Screening can include examining the patent history for previous medical visits for injuries, history of abuse or assault, repeated visits, chronic pelvic pain, headaches, vaginitis, irritable bowel syndrome, history of depression, substance use, suicide attempts, anxiety, and sleep problems. Screening can also include observing patients' affect noting flat affect or whether a patient seems fearful, anxious or

depressed. Also, if possible, observing their partner behavior can be informative. Note if the partner is overly solicitous, answering questions or speaking for the patient, being hostile or demanding, never leaving the patient's side, or monitoring the patient responses to questions. Any of these behaviors, in isolation, might be innocuous, but taken together would clearly signal concern.

Some recommend using some of these "clues" for targeted screening of patients rather than screening all patients for partner abuse. However, it is important to note that abuse can be present even when no overt warning signs are apparent.

Ask directly, kindly, non-judgmentally. Many women indicate they feel like physicians really don't want to know about the abuse, but when they are directly asked and given time to answer they feel they are more able to respond honestly. Also, asking with an introduction such as "We have started talking to all of our patients about safe and healthy relationships because it can have such a large impact on your health" helps to normalize the questions and to minimize the feeling that you are singling her out. It is also recommended that medical professionals not using stigmatizing terms like rape, abuse, or violence but instead using culturally relevant language when you ask.

Privacy and confidentiality. Women should never be asked about abuse in front of others (including partners, friends or family members).

Also, before asking the questions health professionals need to clearly explain the limits of confidentiality. In Kentucky if you ask about abuse you may be required to report patients to a variety of agencies which could not only increase patients' risk of abuse but also of losing their children4 and taking away even more control over their lives. It is critical that patients be informed of what you will do if they disclose abuse to you. Kentucky has a mandatory spousal abuse reporting law, which requires every citizen (professionals and nonprofessionals) to report spouse abuse to Adult Protective Services. Also, if the victim is in immediate danger the police may need to be notified. If children are present in the household there may be a need to report to Child Protective Services. Adult Protective Services and/or the police may involve Child Protective Services in the case when they are notified of partner abuse.

Once these limits of confidentiality are explained, some women may choose not to tell you because they are concerned about their safety and they may not be ready at that time to be involved in all those systems. In the behavioral health professions, many providers tell patients at the very beginning of assessment about these possible reports and thus, if disclosure is made, it is done under informed consent.

Before you ask specific questions it is important to "set the stage" so to speak or perhaps a better way to phrase this would be to get prepared to open the door. You can do this by finding your own way of introducing the questions and phrasing the questions, being prepared to hear the answer whatever that may be, and talking face-to-face with a caring and empathetic attitude toward your patient.

Screening questions. There are a number of different ways to ask about partner abuse (see Basile et al., 2007 for a review). Several suggested screening questions are listed below:

- How are things at home?

[4] Child protective services can remove children if the children witness partner violence. Patients with children may be even more guarded than one might expect for fear of loss of their children.

- How do you and your partner handle conflicts?
- Who starts and who ends those conflicts?
- Have you ever felt afraid of your partner (or ex-partner)?
- What happens when your partner gets angry?
- Sometimes partners use physical force. Is this happening to you?
- Has your partner ever physically threatened to hurt you?
- Have you felt humiliated or emotionally hurt by your partner?
- In the past year have you been forced to have any kind of sexual activity by your partner?

What not to ask. Now that we have covered what you should ask, here are a few questions you should NOT ask:

- Why don't (can't) you just leave?
- What did you do to make him/her so angry?
- Why do you go back?
- Why don't you try couples counseling (this is contra indicated)?

These types of questions insinuate that the woman is responsible for the violence, or they may imply that it is easy to walk away. For many women **neither of these implications is true**. At the end of this module there is a Medical Power and Control Wheel that highlights some other things that should not be done.

I asked, now what?

Some women may answer "no" to your questions about abuse even though there are strong indicators that they are experiencing violence (which is why ongoing assessment, when possible, is important). There are many reasons women may not want to disclose to you at the time you are asking including embarrassment and shame, fear of retaliation by her partner, fear her children will be removed, lack of trust in others, reasons that she cannot leave her abuser at that time (e.g., economic dependence, desire to keep the family together), lack of knowledge about alternatives, a lack of a support system, and promises of change by the abuser.

What if she says yes? It is important that you accept her response in a supportive way if she does indicate she is currently or has been, in the past, abused. Things you can say to convey support include:

- This is not your fault.
- You are not to blame for any of this. Abuse is wide spread and happens in all kinds of relationships. Once it starts, it tends to continue.
- No one deserves to be hit or hurt.
- No one deserves to be constantly put down, humiliated, or turned into a servant.
- Everyone deserves to feel safe at home.
- Abuse can affect your health and that of your children in many ways.
- I'm sorry you have been hurt.
- Do you want to talk about it?
- I am concerned about your safety and your well-being.
- I will be with you through this, whatever you decide. Help is available.

Document. It is also important to document her response in her medical chart, in her own words, with a body map and photographs (with consent) if there is observable injury, and with specific details. The medical record can be used by the woman to support charges of abuse if she chooses to pursue legal protections or recourse in the future.

Even if she says no, it is important that you document that you asked and how she responded. Also, asking could be thought of as an investment. Although perhaps this time she did not disclose, opening the door to the trust and caring that asking does convey may help her to be able to disclose later on when she is ready to disclose. It is important to remember that it is the woman's choice when and where to disclose what is happening to her, this is the best way to respect her autonomy and safety decisions.

Assess Safety. At this point, most physicians will want to turn to a domestic violence specialist. But in certain situations, you may be the only resource around. Just as you might assess risk of bad consequences from an emerging medical problem, so for the emerging abuse problem. You may want to quickly assess patients' current level of danger. This includes checking to see whether it is safe to return home and whether there are any children or others in the home who might be harmed.

The things you can ask include finding out if there are weapons in the home, if other persons or children might be harmed, and if patients have a safety plan. *The CDC strongly suggests that if guns are present, threats to kill have been made, or violence has escalated, these are risk factors that suggest an emergency that requires the formulation of a safety plan before the patient is discharged.* A team approach to care is helpful to both patients and you. For example, you may consider having a specially trained social worker or nurse take over in formulating a safety plan with patients and then you can be informed of any decisions or plans that are made.

In the event it is not safe to return home, there are crisis services that may be available to assist her with the police, legal options, and alternative housing. Leaving can actually increase danger so survivors may need to take additional steps to ensure safety for themselves and their children if they plan to leave.

Each safety plan must be tailored to the individual needs of the woman. Generic handouts often don't help.

> Each safety plan must be tailored to the individual needs of the woman.

You may wish to visit ACOG's Web site www.acog.org/About-ACOG/ACOG-Departments/Violence-Against-Women or contact local domestic violence advocates for more information. Finally, each practice setting should establish a plan for following up on patients who decide to take action.

Review Options. Once a victim has disclosed abuse, she has three main options: (1) to stay with the abuser and formulate a safety plan; (2) to try to seek protection by talking to the police or through protective orders (talking to police or using the court system cannot and does not guarantee an arrest or stopping the violence); and, (3) leave the abuser and formulate a safety plan (because leaving does not always stop the violence and may even increase the risk of more frequent or severe violence).

Finally, it is critical that you have a set of referral resources that list both national and local options. This should be community specific for the local resources and kept up to date. Appendix A provides some national and local resources for partner abuse victims. Shelters also often have a wealth of information about resources and a

variety of brochures that you can keep in your office to hand to women who may need them herself or who may know someone who could use the information.

Summary

This paper describes many of the features of partner abuse characterized by coercive control. Partner abuse is one of the major contributors to many physical health problems – particularly chronic conditions that are difficult to treat. The effectiveness of healthcare professionals may lie with closer exploration of things other than 'just the body' and just the lab results. There are no quick tests for partner abuse victimization; instead, screening and referral takes some time. The expenditure of professional time may mean the difference between life and death; it certainly will be the difference between meaningful and merely mechanical healthcare.

Being prepared to address partner abuse may take some time to get up to speed with screening and referral. It may also require learning about community service providers who can be important adjuncts to your treatment efforts.

For more information, resources, and related topics, see:

Futures without violence
http://www.futureswithoutviolence.org/

Academy on Violence and Abuse
http://www.avahealth.org/

National Health Resource Center on Domestic Violence (lists of resources)
http://www.nrcdv.org/dvrn

OutrageUs
www.OutrageUs.org

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Appendix A: National and Local Resources for Victims of Partner Abuse

NATIONAL DOMESTIC VIOLENCE RESOURCES FOR VICTIMS

National Domestic Violence Hotline
1-800-799-7233
Can discuss your situation with you, help you problem-solve, talk with family and/or friends involved, and help you create an exit plan. They can provide you with referrals to resources in your area including shelters. There is also a chat line for those that do not feel comfortable calling.

Rape, Abuse, & Incest National Hotline
1-800-656-4673
If you call this number, you will be transferred to your local rape crisis center. Pres #1 to reach a counselor.

National Suicide Prevention Hotline
1-800-221-0446 OR 1-800-262-7491
Can call here for any type of crisis, not just suicide. Can discuss your specific situation with you and refer you to resources that may be able to help you depending on your situation.

LOCAL DOMESTIC VIOLENCE RESOURCES FOR VICTIMS

Bluegrass Domestic Violence Program
1-800-544-2022 OR 255-9808
Provide emergency shelter. Can also provide counseling, support groups, case work and legal advocacy.

Bluegrass Rape Crisis Center
859-253-2511
Offer 24-hour crisis line, medical advocacy, legal advocacy, therapy, education and professional consultation.

Fayette Co. Court Clerk
859-246-2248
Contact for EPO information.

Fayette Co. Sheriff's Dept.
859-252-1771
This department assists women with EPOs and filing; they also take photos, change locks, refer you to God's pantry for food, supply you with 9-1-1 cell phones, advocate for you and attend civil court, and also monitor the perpetrators for treatment.

Kentucky State Police
1-800-222-5555 (emergency) OR 502-227-2221

KY Cabinet/Abuse Reporting (Child or Adult Abuse)
1-800-752-6200 OR 859-245-5258

Intervention for women in domestic violence situations. Can refer to family support for counseling or help you get a job.

Mental Health Crisis Line/Comprehensive Care Center
859-233-0444 OR
1-800-928-8000
Offer individual mental health counseling based on income. This service covers 17 Kentucky counties including Fayette, Jessamine, Nicholas, Franklin, Scott, Harrison, Bourbon, Clark, Estill, Madison, Garrard, Lincoln, Boyle, Mercer, Anderson, Powell and Woodford. Counseling is available for the victim and perpetrator counseling is offered in Fayette, Nicholas and Lincoln counties.

Center for Women, Children, and Families
859-254-9319 OR 859-259-1974
Offer free individual and group counseling including "The Circle of Healing," a group offered to domestic violence victims and/or victims of crime. Parenting classes are also offered.

United Way of the Bluegrass
859-313-5465
Offer support groups of all types including domestic violence. Call the above number for dates and times.

Family Counseling Services
859-233-0033
Treat victims in domestic violence situations. They offer counseling for grief and loss, depression, anxiety, abuse, severe mental disorder, relationship adjustment, and parenting.