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GUEST COMMENTARY

E. P. C. M. S.

Interpersonal Violence in Texas: A Physician's Role

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The overall national incidence rates of domestic violence are falling, yet the Texas rates are rising and are now twice the national average. Domestic violence, now termed intimate-partner violence, affects both men and women of all ages, races, and socioeconomic strata. While some risk factors are known, the Texas disparities are not yet fully understood. Studies indicate three contributors to the national decline: the provision of legal services, improvements in economic status, and population aging. Legal action has been shown to decrease repeat incidents by 80%.

A little known Texas law requires doctors to provide safety and shelter information to patients with injuries believed to be caused by family violence and to document in the patient's medical record that the information was made available to the patient. Our best hope to aid in breaking the cycle of violence is to actively screen and distribute safety information to our patients. Every physician can ask every patient, "Do you feel safe in your home?"

Introduction

Her estranged husband, recently released from jail, broke into the house. After forcing her to have intercourse, despite her protests, he took the broken window glass, cut himself, and deliberately bled into her eyes. He told her he wanted her to get his hepatitis C. Despite all this, her initial complaint when she visited my office was "hair loss."

No matter what specialty we practice, we all see patients who have been on the receiving end of domestic violence. While some victims come in with the obvious broken bones and contusions, many others have vague, nonspecific complaints for which domestic violence needs to be considered in the differential diagnosis. Though the nationwide incidence of domestic violence has declined progressively by 61% over 10 years, Texas has seen an 18% increase.^{1,2} Current research indicates that the three contributors to the national decline are legal services, improved economic status, and population aging.³ This research begs this question: why is the Texas record so bad and what can we do to help?

As physicians, we can sharpen our diagnostic skills by learning to identify the previously unrecognized victims and give them access to safety, shelter, and legal information. Texas Law (Section 91.003 of the Family Code) requires physicians to provide safety and shelter information to patients with injuries believed to be caused by violence in the family and to document giving these materials in the patient's medical record.

We can increase public awareness, treat domestic violence as a

disease, and employ preventive and transmission-reduction strategies. In so doing, we stand a better chance of breaking the cycle of abuse, reducing domestic violence, creating improved behavior models for tension and conflict resolution for ourselves and our children, and, as a result, reducing the transmission of domestic violence to the next generation.

Domestic Violence: Incidence and Prevalence

Domestic violence affects our citizens, children, and workplaces. The US economic burden exceeds \$12 billion annually for medical treatment, shelters, police, court time, foster care, sick leave, and nonproductivity.⁴ Domestic violence crosses into the workplace, where 5% of women victimized were attacked by an intimate partner.⁵

Indeed, the incidence of domestic violence in the United States is staggering. In 2001, according to the US Department of Justice, more than 500,000 women were victims of nonfatal violence by an intimate partner.⁶ However, the next year, the *Journal of the American Medical Association* cited that 1.5 million women experience intimate-partner violence (IPV) annually.⁷ Further, the US Centers for Disease Control and Prevention (CDC) reports an additional 800,000 men raped or physically assaulted annually by an intimate partner.⁸ The variability of the numbers has to do with how domestic violence is defined, whether it includes intimate partner and family violence, and whether it is reported.

Domestic violence (DV) is defined as a pattern of violent and coercive behavior where one partner in an intimate relationship controls another through force, intimidation, or threat of violence. The behavior includes degrading remarks, cruel jokes, economic exploitation, false imprisonment, physical or sexual assault, and homicide.⁹ Intimate-partner violence (the new, more inclusive term for DV) acknowledges that domestic violence is not necessarily between married people but exists among those who date, who are former partners, and who are in heterosexual or same-sex relationships. Family violence generally includes DV, situations in which the victim and the perpetrator are both in the same family, child abuse, and elder abuse and neglect.

Depending on how IPV was defined in the studies that considered its prevalence and whether the violence was limited by type of relationship (ie, married, cohabitants, same-sex, opposite-sex, or former partners), the US Department of Justice reports that 1 million incidents of IPV against a current or former spouse or partner occur every year,¹⁰ meaning that roughly 1 in 270 people experience IVP each year.

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Interpersonal Violence in Texas: A Physician's Role (continued)

In Texas, reported IPV incidents exceed 182,000 annually,¹¹ roughly 1 in 124 Texans.¹²

While national statistics tell us that family violence fell an estimated 61% between 1993 and 2002,¹ Texas statistics, measured during the same years by the Texas Health and Human Services Commission, indicate an 18% increase in IPV incidence in Texas.²

Why is the Texas IPV record so dramatically higher than the rest of the country? Are the reasons socioeconomic? Does the violence vary by ethnicity, occupation, or age? Do patterns of repeated abuse exist in certain populations or communities? The answer is a combination of all of these. The major risk factors for IPV¹³ include:

- ↑ Lower socioeconomic status;
- ↑ Separated or divorced;
- ↑ Couples younger than age 30 years;
- ↑ White upper and lower class;
- ↑ Black middle class;
- ↑ Alcohol use by the perpetrator; and
- ↑ Unemployed or blue-collar perpetrator.

How the Texas mix of the risk factors compares nationally is yet to be fully studied. The single reported study of sexual assault in Texas, published in 2003, estimates that 20% of Texas women and 5% of Texas men have been sexually assaulted. Only 18% of those men and women reported the crime to the police.¹⁴

Types of IPV

I was about to remove a tattoo on the back of her neck. She started quietly sobbing. I stopped, put down the instrument, moved to face her, and asked, "What's going on?" She apologized for getting "so emotional" — she was relieved to finally be getting rid of this tattoo. She quietly told me that 2 years ago she had gone out on a date with a new guy and doesn't remember what happened, except that she woke up the next morning, having been raped and tattooed — essentially branded. She had never revealed the incident before now.

Intimate-partner violence occurs in teen and adult dating situations as well as in married or cohabitating relationships. Domestic violence victims and perpetrators are of every age, race, ethnicity, and socioeconomic background. They are the wives (and sometimes the husbands) or partners of bankers, lawyers, schoolteachers, mechanics, gardeners, utility workers, and even doctors. Domestic violence happens in opposite-sex as well as same-sex relationships. Thinking that IPV is just a female issue is no longer valid.

Male rape by an intimate partner is only beginning to be discussed, and dating-related violence and stalking statistics are just beginning to be recorded. In a 2001 study of adolescent girls, approximately 20% reported being physically or sexually hurt by a dating partner.¹⁵ The CDC reports that 11% of all homicide victims were killed by an intimate partner and, of the women killed, 93% had visited an emergency room within 2 years of the homicide.

Repeating Patterns: Power and Control

This was her second marriage. While relating her medical history, she wondered aloud "Why do I keep meeting guys like this?"

Chances are that this patient as a child witnessed violent and abusive behavior in the household. From the study of adverse childhood events by Felitti and Anda et al, we know that a child's expo-

sure to DV is a significant risk factor for becoming either a victim or a violent abuser later in life; thus, violent behavior is transmitted from one generation to the next.^{16,17}

A study by the US Department of Justice says perpetrators of violence use many tactics to control their victims.¹⁸ These are shown in the "Power and Control Wheel," a term frequently used in domestic violence literature (Fig 1).

The Power and Control Wheel identifies, in no specific order or pattern, tactics that perpetrators of abuse use to control their relationships. These tactics are not always used purposefully but as a learned behavior with respect to relationships and, nonetheless, are part of the abuse. The abuse often is not an attempt to hurt but rather an attempt to control. The abusing partner grips control of the overall emotional tone and behavior of the household. The abuser also controls access to the family financial resources, solely determining the family's economic viability.

People on the receiving end of abuse leave and return to the abusive relationship five to six times before they are ready to leave for good.¹⁹ What is happening in the interim is the cycle of violence.

The Cycle of Violence

At a retreat for a nonprofit agency that provides legal assistance for victims of domestic violence and sexual assault, board members were guided through a mock abuse experience by a skilled national abuse expert:

Take this card: "Your husband just hit you, what do you do?" Take this other card: "He hit you again and is now threatening your children — go to your sister's house." Take another card: "He sends you flowers and tells you that he loves you and this will never happen again — and to please come home. You believe him and return home with the children — they miss their dad. Things are fine for a while. Then, one night he hits you so hard a tooth is loose and you begin to fear for your life. You arrive at your sister's in the middle of the night, children in tow."

The scenario goes on: "The cycle repeats and you return home. You wind up at a local shelter for a month. The shelter has run out of space. You have run out of money (he controls the checkbook). Are you going to live with your children in the car or return home?"

One board member could bear it no more. This highly educated and skilled woman started sobbing — as the mock exercise was too close to home. More than 10 years had passed since she had left her physician-husband. Her abuse had started during medical school with verbal abuse and, over the years, progressed to hitting. Then he began beating her. With no money and needing a safe place, she wound up in a shelter with their daughter, embarrassed and bruised.

The cycle of violence (Fig 2) starts with unresolved tension manifesting into emotional abuse. This increases tension in the home or relationship, leading eventually to a violent outburst. After the apologies, a honeymoon period often ensues. The tension recurs, however, leading to another violent outburst.

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Shelters

In Texas, 11,983 women and 17,619 children in abusive relationships received shelter during 2004.² For 50% to 70% of women who experience abuse, the abuse continues during pregnancy.²⁰

She was a 30-week pregnant mother of four in the obstetrics ward, admitted for contractions and receiving intravenous fluids. She described how living at home was like walking on emotional eggshells and time bombs. She worked every minute of every day to ensure that everything was perfect. Whether ironing her husband's shirts as he demanded, preparing meals exactly to his liking, or arranging the furniture and maintaining the house to his specification, every household action was according to his demands. The children were dressed and expected to behave according to his expectations. The verbal abuse was constant and she never knew when an emotional "land mine" would explode. Her husband beat her nearly every day. She confided that her oldest daughter, now nearly 12, was "getting a little mouthy" and she feared for her daughter's safety. This woman had thought of leaving her husband previously but never did.

We discussed a local safe house. She thought about it overnight; by morning, she was ready to go and medically cleared. Arrangements were made hurriedly with social services, as her husband was due back in town the next day. The next day, I called the shelter to ensure that she and her children had arrived safely. Even though I was the referring physician, the shelter would not confirm her presence. While unsettled with this less-than-complete closure, I came to learn that this is a good thing. The rescued ones disappear -- at least for a while.

Shelters provide immediate safety and, quite literally, a safe place and a separation from the abusive partner, at least temporarily. The first few days in the shelter give the victim valuable time to assess and reassess, but then begins the business of getting ready for life after the shelter. Most shelters are well connected to a network of social services through which the work of rebuilding a life and a family can begin.

Eventually, the victim must find more permanent housing. The hospitality of friends or other family members can endure for only so long. The logical place to go would be their own residence, but if the perpetrator of the violence still lives there, this becomes a dangerous solution, ripe with potential for repeated cycles of abuse or worse.

The Dead

As reported in 2004 by the Texas Council on Family Violence, 116 Texas women were killed by an intimate partner.²¹ This is the tragic result if we miss these patients in our office:

Palestine, age 24 years	Died from a brain injury for refusing him sex
Lufkin, age 21 years	Shot after an argument with her boyfriend
Diboll, age 25 years:	Shot by her estranged husband; witnessed by their son aged 9 years
San Antonio, age 42 years:	Shot by her husband of 27 years, in a murder suicide
Texarkana, age 22 years:	Run over by her husband outside work

Port Lavaca, age 32 years:	Strangled during sexual assault by her ex-boyfriend
Richardson, age 21 years:	Thrown from freeway overpass by her boyfriend
Pasadena, age 40 years:	Blunt trauma
Wichita Falls, age 24 years:	Shot during her son's birthday party by her ex-boyfriend, after recently ending a relationship
Austin, age 42 years:	Died of complications of burns she received after her husband poured gasoline on her

And the list contains 106 more.

The Physician's Role

What can we do about IPV in our daily clinic or hospital routine? Is IPV a social problem? Why is it a health care problem? Why should we get involved? Research shows that IPV victims are twice as likely as nonvictims to come in contact with the health care profession. And while most IPV victims do not seek direct medical attention for their wounds, they are undoubtedly in our offices for other medical reasons. Estimates show that less than 15% of IPV victims seek medical treatment for their injuries, yet they seek medical attention for symptoms directly and indirectly relating to the abuse.²² To help treat and save these silent victims, physicians need to make active screening, identifying abuse patients, and distributing safety information part of their medical routine. In addition, as part of their duty to provide safety information, physicians can offer information on legal resources, such as emergency protection orders, to patients. While the physician's role is not to promote legal intervention, research indicates that legal intervention is one of the three factors contributing to the national decline in IPV, the other two being improved economic status and an aging population.³

The health consequences of victimization are varied and vast (Table 1). The person on the receiving end of IPV is the "frequent flyer" in our offices and accounts for a 1.6- to 2.3-fold increase in health utilization and costs.²³

We can sharpen our diagnostic skills by considering abuse as a contributing or sole cause and, in the process, by identifying this previously unrecognized population so we can treat these patients appropriately.

Universal Screening

Only a few studies have been conducted on the value of physician screening for IPV. The research indicates clearly that if you screen for IPV, you will find it. Further, screening and distributing information on safety plans and advocacy services improves the prognosis in terms of quality of life with fewer violence-related injuries.²⁴ Universal screening is recommended by many professional health care organizations, including the American Medical Association, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians.

Initially, a quick, easy way to screen for IPV is to ask during the social history, "Do you feel safe in your home?" Normalize the question by asking it along with "Are you single or married? Work inside or outside of the home? Smoke cigarettes? Drink alcohol? Who lives in the home with you?"

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Another way to bring this up is to talk about conflicts and arguments in the home and how stressful these can be. Ask "What happens when you and your partner disagree or argue?" If the patient responds negatively or even hedges in the answer, a further screening tool may be helpful.

The Hurt-Insult-Threaten-Scream (HITS) questionnaire is one such tool. A patient is asked the following questions and given a score of 1 to 5 for each answer, with 1 meaning "never" and 5 meaning "frequently."

1. Over the past 12 months, has your partner physically Hurt you?
2. Insulted you or talked down to you?
3. Threatened you with physical harm?
4. Screamed or cursed at you?

Scoring ranges from 4 to 20. Scores of 11 or more suggest victims of abuse, regardless of partner gender.²⁵

Significantly, patients (including victims and perpetrators) believe physicians should ask about family conflict and that physicians could be helpful. In a study conducted in private practice offices by the Department of Family and Community Medicine at The University of Texas Health Science Center in San Antonio, patients indicated wanting their physician to ask whether they feel safe at home, listen to their stories, make referrals, provide information, and follow up with them.²⁶

Experts estimate that asking the screening question takes 10 seconds. Responding to a nonurgent positive screen takes 2 minutes, and responding to an urgent, potentially life-threatening situation takes 10 to 12 minutes. In what other urgent life-threatening situation can a physician save a life in such a small amount of time?

Documenting injuries, providing safety information, and documenting the medical record

Once IPV victims are identified and treated, then, under Texas Law (see Appendix), the physician is responsible for doing two more things:

- ↑ Document in the medical record, with careful detail as to the extent of the injuries (a well-documented medical record can help attorneys win court cases against the abuser),²⁷ and
- ↑ Provide shelter information in both English and Spanish and document in the medical record the fact that this information was made available to the patient.

To facilitate meeting the Texas law, the Texas Medical Association has posted on its Web site material for use by physician offices. A handout, posted at www.texmed.org/domesticviolence, can be printed, filled in with local shelter information, copied, and made available in examination rooms and restrooms in physician offices.

Reporting IPV

While some other states (California, Colorado, and Kentucky) mandate the reporting of even suspected IPV to designated authorities, Texas has no such requirement unless the victim is a child, elderly, or disabled. Those cases must be reported to Child Protective Services or Adult Protective Services.

Coding

An IPV office visit can be coded as follows:

CPT Code: 99381-99387 or 99391-99397 Preventive medicine service, with
ICD-9 Code: 995.80-995.85;

Or as part of the overall evaluation and management (E&M) office visit code and documented as time spent with the patient.

Other codes may also be helpful:

V15.41: History of physical abuse, rape
V61.11: Counseling for victim of abuse

Future Medical Focus

The Texas Health and Human Services Commission investigated IPV and published *A Strategic Plan to Prevent Violence Against Women in Texas*.²⁸ While efforts over the last 20 years have focused on how to help the victim once the violence occurs, efforts to prevent sexual assault, domestic violence, and stalking are just beginning. The plan recommends Texas confront IPV with primary prevention through education to break the cycle of violence and, like a disease, with secondary and tertiary prevention through identifying and treating both victims and perpetrators. The primary goal is to get this issue of IPV in the public eye, speak of it openly, send a clear message that IPV in any form is unacceptable behavior, and provide positive behavior-model educational opportunities to communities at large.

Reducing Incidence

Amy Farmer, an associate professor of economics at the University of Arkansas, and her colleague Jill Tiefenthaler, associate professor of economics at Colgate University, compiled a database of the rates of domestic violence in every county in the United States. They applied controls to the data for income, race, education, and age; in predicting the long-term rates of domestic violence, access to legal sources was the only public service variable that contributed to the national decline in IPV incidents.³ The legal system can issue a protective order to physically and legally separate the two parties, thereby, reducing IPV.

Unfortunately, legal assistance is many times inaccessible. Even if the victim can afford it, legal help may be unobtainable because the abuser usually controls the family finances. People in smaller, rural Texas counties sometimes apply for legal assistance and are denied. Some counties have never approved funds for legal assistance for domestic violence, citing other local projects as more important for their tax dollars. Some rural attorneys do not know how to file a protective order.²⁹

Texas has a nonprofit corporation providing free legal services to any domestic violence or sexual assault victim. Based in Austin for nearly 25 years, the Women's Advocacy Project, staffed by attorneys, offers hotline assistance in English and Spanish to help file legal documents to physically and legally separate the two parties. The project helps victims navigate their way through the legal system and collaborates with rural attorneys on the specialized legal process of seeking protective orders.³ This action is literally saving lives as the availability of legal services has a significant negative effect on the likelihood that a woman will be battered.³ Permanent protection orders have been associated with an 80% reduction in police-reported IPV.⁷

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Conclusion

The physical and emotional cost that IPV inflicts upon our citizens, especially our children, is incalculable. Physician involvement can make a significant difference in reducing and eliminating IPV through active screening and distribution of information regarding safety and access to legal assistance. We can use our skills as physicians and the rules of society, our laws, to identify and help people affected by IPV. In so doing, the process to create a safe home environment can begin.

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Providing Information to Victims of Family Violence

Under Texas law, a medical professional who treats a person for injuries that he or she believes were caused by family violence

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must provide that person with information regarding the nearest family violence shelter center; document in the person's medical file that the person received the information; and give that person a written "Notice to Adult Victims of Family Violence." Posted on the TMA Web site is the notice, in English and Spanish, which can be printed, filled in with local shelter information, and copied. Also included on the Web site is a list of Texas family violence shelters, by county. Log on to www.texmed.org/domesticviolence.

This article can be downloaded and copied from the TMA Web site (www.texmed.org/domesticviolence) and from the Web site of the Women's Advocacy Project (www.women-law.org). Access to legal assistance has proven to significantly reduce repeated violence and injuries. The Women's Advocacy Project is a statewide nonprofit legal organization that promotes access to justice for any Texan, woman, child, or man, in need. It operates three statewide toll-free legal hotlines: the Family Violence Legal Line, the Sexual Assault Legal Line, and the Family Law Hotline (see "Texas Resources," page xx). The hotlines are staffed by attorneys who provide assistance to Texans on a variety of legal concerns related to domestic violence, sexual assault, and family law.

Texas Resources

Texas Adult Protective Services	(800) 252-5400
Texas Child Protective Services	(800) 252-5400
Texas Sexual Assault Prevention & Crisis Services	(800) 983-9933
National Domestic Violence Hotline	(800) 799-SAFE (7233)
Texas Crime Victim Services	(877) TX4-VINE (794-8463)

The Women's Advocacy Project's Statewide Toll-Free Hotlines for Legal Assistance

Texas Family Violence Legal Hotline	(800) 374-HOPE (4673)
Texas Sexual Assault Legal Hotline	(888) 296-SAFE (7233)
Texas Family Law Hotline	(800) 777-FAIR (3247)

Appendix

Texas State Law, Family Code Section 91.003

A medical professional who treats a person for injuries that the medical professional has reason to believe were caused by family violence shall:

- (1) Immediately provide the person with information regarding the nearest family violence shelter center;
- (2) Document in the person's medical file:
 - (A) The fact that the person received the information provided under Subdivision (1, above), and
 - (B) The reasons for the medical professional's belief that the person's injuries were caused by family violence; and
- (3) Give the person written notice in substantially the following form, complete with the required information, in both English and Spanish:

"It is a crime for any person to cause you physical injury or harm even if that person is a member or former member of your family or household.

"NOTICE TO ADULT VICTIMS OF FAMILY VIOLENCE

"You may report family violence to a law enforcement officer by calling the following telephone numbers:_____.

"If you, your child, or any household resident has been injured or if you feel you are going to be in danger after a law enforcement officer investigating family violence leaves your residence or at a later time, you have the right to:

"Ask the local prosecutor to file a criminal complaint against the person committing family violence; and

"Apply to the court for an order to protect you. You may want to consult with a legal aid office, a prosecuting attorney, or a private attorney. A court can enter an order that:

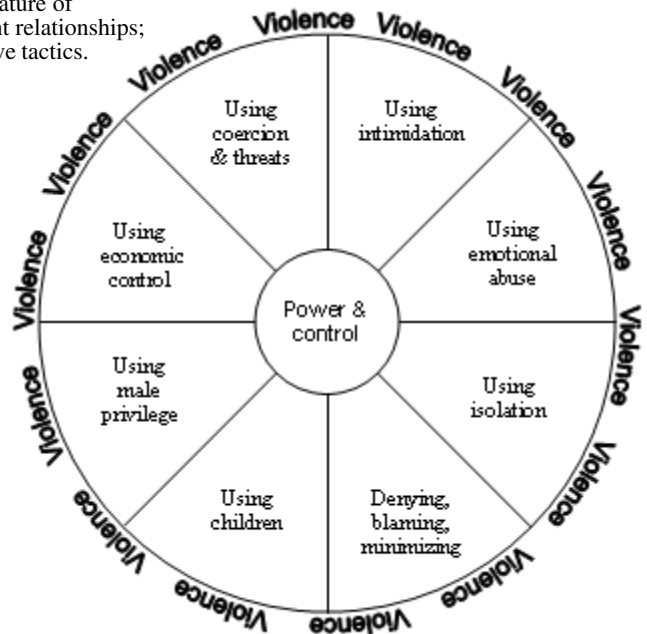
- (1) Prohibits the abuser from committing further acts of violence;
- (2) Prohibits the abuser from threatening, harassing, or contacting you at home;
- (3) Directs the abuser to leave your household; and
- (4) Establishes temporary custody of the children or any property.

"A VIOLATION OF CERTAIN PROVISIONS OF COURT-ORDERED PROTECTION MAY BE A FELONY.

"CALL THE FOLLOWING VIOLENCE SHELTER OR SOCIAL ORGANIZATIONS IF YOU NEED PROTECTION _____"

Figure 1
The Power and Control Wheel.

The nature of violent relationships; abusive tactics.

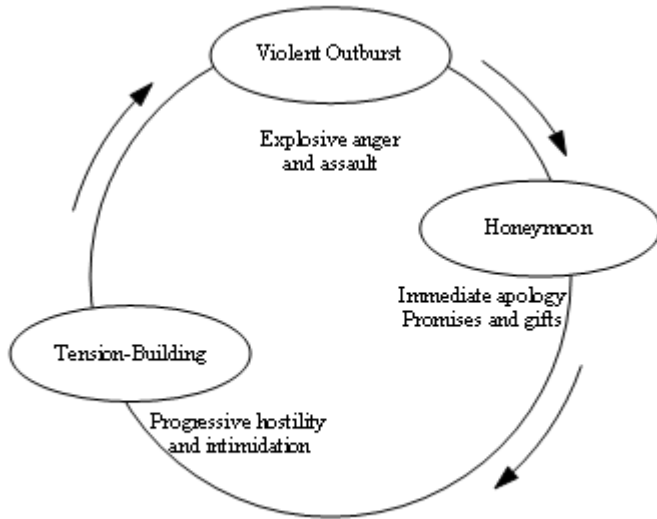


From Pence E. Paymar M: *Education Groups for Men Who Batter: The Duluth Model*, New York: Springer Publishing Co; 1993.

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Figure 2
The Cycle of Violence.



From Walker LE: *The Battered Woman*, New York, Harper & Row; 1979.

Table 1. Health effects of victimization.

- Injuries
- Chronic pain
 - Headaches
 - Pelvic pain
 - Somatization
 - Fibromyalgia
- Recurrent vaginitis
- Urinary symptoms
- Infections and impaired immunity
- Sexually transmitted diseases
- Chronic diseases
 - Heart disease
 - Hypertension
 - Diabetes
 - Stroke
 - Cancer
 - Lung disease
 - Liver disease
- Fractures
- Tobacco use
- Substance abuse
- Anxiety
- Stress
 - Reflux
 - Ulcers
 - Irritable bowel syndrome
 - Eating disorders
- Posttraumatic stress disorder
- Sexual dysfunction and infertility
- Unintended pregnancy and abortion
- High health care utilization
- Depression
 - Suicide
- Homicide

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