Intimate Partner Violence

Prevalence, Health Consequences, and Intervention

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KEYWORDS

- Intimate partner • Violence • Health • Intervention • Spouse abuse
- Domestic violence

KEY POINTS

- Intimate partner violence (IPV) affects women and men regardless of race, sexual orientation, or socioeconomic status.
- One in 3 women and 1 in 4 men experience some form of IPV in their lifetimes.
- Patients who experience IPV are more likely to present with health complaints that are not acute injuries, such as headache, gastrointestinal disorders, insomnia, or depression.
- The medical provider's role is to acknowledge the problem of IPV, assess safety, make appropriate referrals, and provide appropriate medical documentation.

DEFINITION

Intimate partner violence (IPV) can be defined in many ways and encompasses many different types of physical and emotional abuse.[1,2] The US Centers for Disease Control and Prevention (CDC) provides a basic definition: "Physical, sexual, or psychological harm by a current or former partner or spouse."[1]

Important caveats are that the violence can occur between couples of any sexual orientation and the relationship does not have to include sexual intimacy.

A variety of behavior can be classed in each of these broad categories. The behaviors may occur in isolation or as an ongoing pattern of abuse.

Physical Violence

Physical violence can range from slapping or shoving to severe physical violence such as a hit with a fist or an object, burning, beating, choking, or the use of a knife or gun.

Sexual Violence

Sexual violence can include noncontact sexual experiences such as coercing or forcing to participate in sexual photographs or videos, unwanted kissing or fondling,

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sexual contact when the victim is unable to consent because of drug or alcohol use, and attempted or completed rape.

Psychological Aggression

Psychological aggression can involve name calling and derogatory statements or use of intense anger as a means of control. Threatening behaviors can range from threats to pets or property to threats of suicide or death threats. Forced or coerced social isolation, restriction of ability to freely come and go, control or coercion of finances, and deprivation or control of food or medical care are all in this category.

Stalking

Stalking includes behaviors or tactics such as unwanted contact by phone, texting, or e-mail; being followed; or entering a home uninvited, which results in fear for safety.

Control of Reproductive and Safe Sex Choices

This category can involve manipulation or control of birth control, refusal to use a condom or failure to disclose a sexually transmitted disease (STD), or attempting to impregnate or attempting to get pregnant without the partner's consent.

Patterns of IPV

The terms "perpetrator" and "victim" are used in this article but are inherently poor terms. The term "victim" diminishes the reality of the strength and resilience of people who are dealing with the effects of IPV in their lives. It also carries the connotation of being helpless and without power, which is not a useful message for patients experiencing IPV.

In addition, the terms "victim" and "perpetrator" do not take into account various patterns of IPV in which the abuse and violence is bidirectional. Johnson and Ferraro[3] categorize IPV into 4 patterns.

Situational couple violence (SCV) is violence that does not arise from a pattern of control but is in response to a specific stress, frustration, or argument. The investigators found that this type of violence was more likely to be mutual, less likely to be severe violence, and less likely to escalate over time and become chronic.

Intimate terrorism is a pattern of violence and abuse that is motivated by the desire to control the partner. As opposed to SCV, intimate terrorism is less likely to be mutual, and more likely to escalate and involve serious injury.

Violent resistance describes violence used by the primary victim to defend against violence or controlling behavior of a partner, and is most often used by women against a partner in response to intimate terrorism.

Mutual violent control (MVC) defines situations in which the violence and abusive behavior are bidirectional and motivated by each partner attempting to control the other.[3–5] There are data to suggest that, among adolescent and young adults in heterosexual relationships, reciprocal violence such as SCV and MVC may be the most dangerous in terms of injury.[6]

PREVALENCE IN THE GENERAL POPULATION

The CDC-sponsored National Intimate Partner and Sexual Violence Survey (NISVS), is one of the largest national surveys examining the prevalence, characteristics, and impact of IPV on women and men in the United States.[7] The study found the following:

- More than 1 in 3 women (35.6%) and 1 in 4 men (28.5%) have experienced rape, physical violence, and/or stalking by an intimate partner in their lifetimes.

- When women experience rape, physical violence, or stalking they are 3 times as likely to be injured compared with men (41.6% vs 13.9% respectively).
- Women are nearly twice as likely to experience severe physical violence (eg, being hit with fist, kicked, choked, beaten, burned, or the use of a knife or gun) compared with men (24.3% vs 13.8% respectively).
- Nearly 1 in 10 women in the United States have been raped by an intimate partner.

These prevalence rates are likely to be an underestimate of the actual rates. The denominator includes participants who responded “do not know” or refused to answer. It is also likely that, because of safety concerns or ongoing emotional stress from current or past violence, some participants were not willing to disclose abuse. The survey also did not capture populations that speak languages other than English or Spanish, those that live in institutions (prisons, nursing homes), or those who are homeless.

Gender

There is no typical battered woman. Certain factors such as young age, female gender, and having a lower income are associated with higher rates of violence, but IPV affects all socioeconomic and demographic groups. As noted earlier, although women are more likely to be injured in violent relationships, men are also victims of violence. The prevalence rate among men is significant and the NISVS study found that nearly two-thirds of men affected by IPV did not receive the services needed.

Age

The NISVS found that among both men and women more than 18 years of age, the highest risk of IPV occurs between the ages of 18 and 24 years. However, 1.4% of men and women more than 55 years of age experienced IPV in the past year, which represents more than 1 million people per year in this older age group. Adolescence (ie, ages 11–18 years) is also a high-risk time for violence. This age group is more likely to experience violence from intimate partners as well as other family members or care givers. The CDC Youth Risk Behavior Surveillance Survey found that 10% of adolescents had experienced physical violence in a dating relationship in the past year, with female adolescents having higher rates than male adolescents (13% and 7.4% respectively).[8] Other studies have found rates of ever experiencing physical or sexual violence to be between 20% and 40% among female adolescents.[9,10] More disturbing is the NISVS finding that, among adults who have experienced rape, physical violence, or stalking by an intimate partner, 22.4% of women and 15% of men had their first experience of IPV between the ages of 11 and 17 years.

Race

Multiracial women experience a significantly higher lifetime prevalence of IPV (53.8%) and Asian-Pacific Islanders experience a significantly lower rate (19.6%) compared with white women (34.6%).[7] Among men experiencing rape, physical violence, or stalking, Native American or Alaska Native men experience significantly higher rates compared with Hispanic men (45.3%vs 26.6%). Across all racial groups the prevalence of IPV is high. The lower prevalence found among Asian-Pacific Islander women still represents 1 in 5 women experiencing IPV during their lifetimes. Place of birth also influences rates of IPV. Breiding and colleagues[7] found that men and women born in the United States are significantly more likely to experience IPV compared with those born outside the United States.

Sexual Orientation

Although much of the medical literature regarding IPV mirrors public perception that IPV is mainly an issue for heterosexual couples, recent studies have shown high rates

among lesbian, gay, bisexual, and transgendered (LGBT) couples. The NISVS found the highest prevalence of lifetime physical violence, rape, and stalking to be among bisexual women (61.1%) compared with lesbian (43.8%) or heterosexual (35%) women.[11] Bisexual women experiencing IPV were significantly more likely to experience severe violence and most (89.5%) report having only male perpetrators. Similarly, bisexual men had the highest prevalence of IPV (37.3%), although this is not statistically different from gay (26%) or heterosexual (29%) men. There was no significant difference in rates of severe physical violence between gay and heterosexual men, with bisexual men having numbers too small to report. Note that most (78.5%) bisexual men reported only having a female perpetrator of violence.

A systematic review of studies involving IPV among men who have sex with men (MSM) found rates of physical violence ranging from 13% to 38% from a variety of socioeconomic groups and study locations (human immunodeficiency virus [HIV] clinics, gay pride events, state and national random digit dialing).[12] The investigators noted that all forms of IPV occur among MSM at rates similar to or higher than those reported for women. Transgendered individuals have similarly high rates of lifetime physical abuse (34.6%) and may have difficulty accessing IPV services and shelters that are mostly oriented toward heterosexual women.[13]

Socioeconomic Status

Income status can also not be used to determine risk for IPV. Although rape, physical violence, and stalking by an intimate partner in the previous 12 months was significantly more likely to be reported among individuals with incomes less than $25,000 per year, 2% to 4% of men and women with incomes more than $75,000 also reported IPV. This percentage translates to more than 2 million men and women in the higher socioeconomic group experiencing IPV every year. Beyond just using income as a marker of socioeconomic status, food and housing insecurity also measures an important social determinant of health. Women and men who lived with food and housing insecurity were significantly more likely to report IPV in the last 12 months.[7]

PREVALENCE IN HEALTH CARE SETTINGS

It is challenging to compare prevalence rates between different health care settings because a variety of different approaches are used in measuring IPV. The type or types of behaviors studied vary (ie, physical violence only versus various combinations of physical, psychological, or sexual aggression). The definitions of each behavior type vary: for sexual aggression, some investigators only study attempted or completed rape, whereas others include all forms of unwanted sexual experiences. Studies have differed in using direct questions or validated tools. Means of data collection vary, including direct face-to-face surveys, written questionnaires, computerized questionnaires, or random digit dialing telephone surveys. The recall times studied include the past 30 days, the past 6 months, the past 12 months, current relationship, most recent relationship, adult life, or lifetime. Eligibility criteria have varied by age, gender, or sexual orientation. Acutely ill or cognitively impaired patients were often not included in studies. Participation was often limited to English or English and Spanish speaking only.

Primary Care

Over the past 2 decades several studies in family and internal medicine clinics have attempted to determine the prevalence of current or lifetime IPV in populations seen

at their clinics. In a systematic review of medical clinics, Sprague and colleagues[14] tabulated the results from a variety of primary care and subspecialty studies in the United States and internationally. In the United States, among patients in family medicine clinics, lifetime IPV rate (physical, sexual, and emotional) ranged from 45% to 66%. The prevalence rate in the current relationship ranged from 13% to 21%.

Specialty Care

Even among patients attending specialty care clinics, high rates of IPV are identified. Orthopedic surgery is considered a specialty likely to have a high rate of patients injured in IPV assaults. A study in 2 Canadian orthopedic fracture clinics confirms this assumption, with an overall (physical, sexual, emotional) IPV rate of 32% in the past 12 months for women attending the clinic, with 2.5% of women reporting their current injury to be IPV related.[15]

Emergency Department

Studies in emergency departments (EDs) find high rates of lifetime IPV, ranging from 30% to 60%, and 1-year prevalence ranging from 12% to 20%.[16–20] Among women seen in the ED, approximately 2% are there for acute trauma related to IPV and 11.7% are there for IPV trauma or other IPV-related medical conditions.[19,20] Among female patients with trauma admitted to a level 1 trauma center, 46.3% experienced severe IPV in their lifetimes and 26% in the past year.[21]

Obstetrics/Reproductive Health

The prevalence of violence against women during pregnancy ranges from 0.9% to 20.1%, with most studies being in the 4% to 8% range.[22] The higher rates were often associated with asking more than once during the pregnancy with face-to-face interviews and with asking during the third trimester and not just as an intake at the beginning of the pregnancy. Higher rates of prenatal violence (16%) have been reported among pregnant adolescents.[23]

Prevalence rates in family planning clinics are also high. In one study of women aged 14 to 26 years who attended a family planning clinic and had a current partner, 43% reported physical abuse.[24] Of those who reported physical abuse, 36% reported more than 1 episode of severe abuse.

HEALTH CONSEQUENCES OF INTIMATE PARTNER VIOLENCE

Medical Consequences

Medical providers often envision lacerations and contusions when they think about IPV. However, women and men who experience IPV are far more likely to present with health complaints that are not acute injuries. Experiencing physical or psychological abuse is associated with significantly higher self-report of poor health.[25,26] The sequelae of IPV often persist long after the violence has ended[27,28] and although it would be logical to assume that most sequelae are directly related to physical violence, Coker and colleagues[25] found that higher scores for psychological IPV were more strongly associated with negative health outcomes than physical IPV scores.

Chronic pain

As expected, chronic pain issues are common among both men and women who experience any form of IPV. Abdominal pain, pelvic pain, headache including migraine, neck pain, and chronic low back pain have all been associated with IPV.[27–29] Wuest and colleagues'[27] study of Canadian women who were survivors of IPV found that

35% experienced high levels of disability chronic pain and that, on average, had 3 separate locations of pain. Along these same lines, Breiding and colleagues[30] found significantly more activity limitations and use of disability equipment among men and women who experience IPV violence.

Gastrointestinal disorders

Gastrointestinal disorders are also common, including peptic ulcer disease, irritable bowel syndrome, gastroesophageal reflux, indigestion, diarrhea, and constipation.[29] It is postulated that both psychological and physiologic mechanisms related to chronic stress are responsible for increases in gastrointestinal symptoms in abused women.[31] These increased gastrointestinal symptoms often lead to increased imaging and invasive diagnostics. Of concern is the finding that patients seen in a gastroenterology clinic with irritable bowl syndrome, dyspepsia, or chronic abdominal pain and a history of childhood or adult abuse were significantly more likely to have lifetime surgeries compared with nonabused patients.[32]

Multiple physical symptoms

Women who experience IPV often have more physical symptoms than nonabused women.[29] A wide range of symptoms, including insomnia, fatigue, fainting, shortness of breath, loss of appetite, vaginal discharge, vaginal bleeding, painful intercourse, and urinary symptoms, have also been associated with current IPV.[26,29,33] Even increased risk of influenza and upper respiratory infections, possibly related to poor immune function caused by stress, have been noted with IPV.[28] However, no discrete set of symptoms has been consistently identified that would inform providers to screen based solely on symptoms.

Chronic disease

Less obvious is the increased association of IPV with chronic diseases. Breiding and colleagues[30] found that both women and men with experience of IPV had increase risk of asthma and stroke. However, only women had a higher risk of high blood pressure, high cholesterol, heart attack, and heart disease associated with IPV.

For many reasons, medical management of all chronic diseases is more challenging for patients experiencing IPV. The chronic stress of violence acutely exacerbates conditions such as hypertension and asthma. Chronic and acute stress are known to activate autonomic, neuroendocrine, immune/inflammatory, and cardiovascular systems, increasing the likelihood of developing and exacerbating cardiovascular disease.[34] Furthermore, men and women who experience IPV are more likely to engage in risky behaviors, such as smoking, that are associated with poorer outcomes for patients with chronic diseases.[30] In addition, perpetrators can use control of medication or access to care as a form of abuse. One study found that nearly 1 in 5 women with a history of IPV in the past year had a partner who prevented them from going to a doctor or interfered with their health care.[35] Conversely, of women who reported interference with their health care, more than half reported IPV in the past year.

Increased Health Risk Behavior

Sexually transmitted diseases/human immunodeficiency virus

Multiple studies have shown a significant association between STD and IPV.[28,33,36] Among women attending an STD clinic, 11% had experienced IPV within the last year and 24% within their lifetime[37], rates similar to those found in other clinical settings. The study also found that abused women were twice as likely to have a history of STD compared with never-abused women. As the study investigators point out, multiple different mechanisms may be responsible, including coercive behavior from

the perpetrator impairing the victim's ability to practice safe sex; or impaired decision making on the part of the victim caused by psychological trauma, posttraumatic stress disorder (PTSD), or substance use. IPV was significantly associated with the victim having used alcohol at the last sexual encounter and with the partner not being monogamous.

HIV shares some of the same risk behaviors as other STDs but also includes behaviors such as intravenous (IV) drug use and sex with partners at high risk for HIV. Among predominantly minority women seeking care at an urban hospital, those who had ever experienced IPV were 3 times as likely to have had multiple sexual partners and 2 to 4 times as likely to intermittently or never use condoms. Of increasing concern is that women who were experiencing IPV in their current relationship were 4 times as likely to have a partner with a known HIV risk factor (IV drug user, recent STD symptoms or diagnosis, recent sex with another man or woman, or known to be HIV positive).[38] The large multistate Behavioral Risk Factor Surveillance System found that men and women with lifetime IPV experience were more than twice as likely to have HIV risk factors including having used IV drugs, history of an STD, ever having given or received money or sex for drugs, or having had anal sex without a condom in the past year. Using data from the National Epidemiologic Survey on Alcohol and Related Conditions, Sareen and colleagues[39] found a significant association between HIV infection and IPV, with an odds ratio of 3.4. Based on these data it is estimated that 12% of the cases of HIV infection among women are attributable to IPV.

Alcohol and substance abuse

Multiple studies have documented the increased risk of alcohol and substance abuse among persons experiencing IPV.[25,29,33] Bonomi and colleagues[33] found that women experiencing current abuse were nearly 6 times as likely to have a substance abuse diagnosis. Conversely, patients who are diagnosed with alcohol or substance abuse issues are at higher risk of IPV.[40–42] Among women who attended a methadone maintenance clinic, nearly half had experienced IPV in the past month and nearly 20% experienced severe physical or sexual violence or severe injury by an intimate partner in the past 6 months.[41] Similarly, Waller and colleagues[42] found that women who drank heavily, infrequently, or frequently (but not occasionally) were 2 to 3 times more likely to experience IPV. One theory is that victims of IPV abuse alcohol or illegal substances as a coping mechanism for the IPV.[28] Another possibility is that women who are alcohol or drug dependent are more likely to be in relationships with men who are alcohol or drug dependent, and the strong association between male substance use and IPV perpetration is well documented.[40,43] Regardless of which came first or the multiple complex causalities, if a provider diagnoses alcohol or substance abuse, it is important to screen for IPV, and vice versa. In addition, it needs to be recognized that IPV and substance abuse are 2 distinct health risks and both need to be addressed separately. Just because a person stops drinking does not mean that the IPV risk will necessarily decrease, and, similarly, ending a violent relationship does not always mean that the alcohol abuse will resolve.

Mental Health Consequences

Depression

The recurrent emotional abuse, threats, and physical violence experienced by victims of IPV result in an increased risk of depression and anxiety.[25,28,29,33] Depressed mood, poor sleep, inability to concentrate, and feelings of hopelessness are often experienced by patients in abusive relationships. A meta-analysis by Devries and colleagues[44] found evidence that women with preexisting depression were more likely

to experience IPV. Not only do depressive symptoms negatively affect quality of life but they also may hinder people's ability to protect themselves.

Posttraumatic stress disorder

PTSD is also frequently diagnosed among women who experience IPV, with rates ranging from 31% to 84.4%.[45] More severe or frequent physical violence, sexual violence, or use of a weapon have been related to the development and increased symptoms of PTSD, but there is also evidence that psychological abuse may be an even stronger predictor of PTSD.[45,46] The intrusive thoughts or nightmares, hyperarousal state, avoidant behavior, and negative and sometimes distorted thoughts and beliefs can occur for years after the abuse has ended. Neuroendocrine and immune function abnormalities associated with PTSD lead to increased insulin resistance and increased central obesity, thereby increasing the risk of obesity, diabetes, and cardiovascular disease.[47] PTSD is often associated with substance abuse and other poor health habits.[45] Furthermore, depression and PTSD are highly likely to co-occur.[46]

Suicide

Suicide attempts are strongly associated with IPV. A study of formerly abused women experiencing chronic pain found that 31% had attempted suicide at some point in their lifetimes[27] and a study of urban women found that abused women were nearly 8 times more likely to attempt suicide than nonabused women.[48] In the latter study, women who were abused and HIV positive were nearly 13 times more likely to attempt suicide compared with nonabused, HIV-negative women.[48] Among male veterans receiving Veterans Health Administration services, nearly 30% of men with a history of IPV had attempted suicide, which was twice the rate of men without a history of IPV.[49] Only 1 of the 53 men who screened positive for IPV reported perpetration without victimization. Data on completed suicides and IPV are scarce but one report from the New Mexico Office of the Medical Investigator found that IPV was documented in 5% of female suicide deaths.[50] The National Violent Death Reporting System found that, in 2010, intimate partner problems were a precipitating factor for 32% of male and 27% of female suicides.[51] The report further found that 1% of female and 0.3% of male suicide victims had experienced interpersonal violence and 4% of male and 1.4% of female suicide victims had perpetrated interpersonal violence in the month before the suicide. However, the terms "intimate partner problems" and "interpersonal violence" may not be synonymous with IPV. However, given the high rates of depression and PTSD, persons experiencing IPV are at higher risk of suicide attempts and completed suicides.

As with substance abuse, the strong association of mental health issues with IPV makes screening for both imperative. If depression or PTSD is diagnosed or a patient has attempted suicide, screening for IPV must be part of the assessment. If a patient is experiencing IPV, then screening for depression, PTSD symptoms, and suicidal ideation must also be part of the evaluation.

Pregnancy

As noted earlier, the prevalence of IPV during pregnancy is significant. For some women, preexisting abuse continues despite the pregnancy. For others the abuse abates during this time. For some, their first experience of abuse occurs with the pregnancy. Identification of IPV during pregnancy is crucial because the consequences of violence affect not only the health of the mother but also the baby.

A strong association exists between IPV and unintended pregnancies.[52] Unintended pregnancies can include mistimed pregnancies that would be wanted if they occurred at a different time, and unwanted pregnancies that would not be wanted at any time.

Goodwin and colleagues[53] found that women with unintended pregnancies that resulted in a live birth were 2.5 times as likely to experience physical abuse around the time of pregnancy as women with intended pregnancies, and this increased risk remained strongest for older, more educated women of higher socioeconomic status when controlling for maternal characteristics. Conversely, Pallitto and colleagues[52] found that women who had been physically or sexually abused had a 41% higher risk of an unintended pregnancy in the past 5 years. Multiple factors may account for the increase in mistimed and unwanted pregnancies. Miller and colleagues[54] found that, among young adult women seeking care in a family planning clinic, 35% reporting IPV also reported reproductive control by their partner. Reproductive control included pregnancy coercion and birth control sabotage. Pregnancy coercion included behavior such as attempts to force or pressure the victim into becoming pregnant and threats to leave the relationship or threats to harm the victim if they did not agree to become pregnant. Birth control sabotage included sabotaging or refusing to use condoms or preventing access to birth control pills. Other factors have also been cited to account for the overlap of IPV and unintended pregnancies, including the role that stress around an unintended pregnancy might play in increasing violence between partners. In addition, women who experience sexual violence and rape are at increased risk of unintended pregnancies. In addition to unintended pregnancies, Hathaway and colleagues[55] found that women described pressured or forced abortions or forced sterilizations as an additional means of reproductive control by an abusive partner.

Determining adverse pregnancy outcomes related specifically to IPV is challenging. Patient characteristics such as young age and low income are risk factors for both IPV and poor pregnancy outcomes. Known risk behaviors for poor pregnancy outcomes such as smoking and substance abuse are also risk behaviors found in pregnant women who experience IPV.[56] Women who experience IPV are nearly twice as likely to delay entry into prenatal care (entering care in the second or third trimester) but after controlling for maternal characteristics this association only remains for older, more affluent women.[57]

The overlap of risk factors between IPV and pregnancy outcomes and the heterogeneity of study methods used in various studies makes teasing out the specific role of IPV difficult. Low birth weight, premature and very premature births, antepartum hemorrhage, and perinatal deaths are some of the adverse pregnancy outcomes documented in the literature as being associated with IPV during pregnancy.[58–61] However, other studies have failed to show an association of abuse with low birth weight or the association was no longer significant after adjusting for confounding factors such as smoking, alcohol, maternal weight gain, or maternal health.[52] A meta-analysis of 8 studies did find abused women who experienced physical, sexual, or emotional abuse to be at increased risk of giving birth to a low birth weight baby by an odds ratio of 1.4%.[62]

The mechanisms by which adverse pregnancy outcomes can occur include direct trauma resulting in antepartum hemorrhage or perinatal death; stress leading to poor weight gain by the mother; or risk behaviors including alcohol, smoking, and substance abuse, for which abused women are known to be at higher risk. Prematurity and low birth rates often result in long-term sequelae for the children, including cognitive impairment, motor and language delays, as well as behavioral and psychological problems.[56] Thus the physical and psychological consequences of IPV can extend directly to the children.

Adolescent Health

Given the high rate of IPV among adolescents and very young adults, their health risks and health consequences require specific attention. Silverman and

colleagues[10] found that among female students in grades 9 to 12, those experiencing physical and/or sexual violence or both were significantly more likely to use alcohol, tobacco, and cocaine; to use laxatives, diet pills, or to intentionally vomit; to have early sexual intercourse and multiple partners; and to have suicidal ideation and suicide attempts. Female students who experience both physical and sexual violence were 4 times as likely to ever have been pregnant and 8 times as likely to attempt suicide. A study of adolescent and young women attending a family planning clinic found that those with very recent IPV were nearly twice as likely to have unprotected vaginal sex and more than twice as likely to have unprotected anal sex.[63] The study found that physically or sexually abused young women were 4 times as likely to fear asking to use a condom and 11 times more likely to fear refusing sex. Furthermore, female adolescents experiencing recent teen dating violence were more than 3 times as likely to use IV drugs or have a partner who used IV drugs compared with those not currently experiencing teen dating violence.[63] Teens experiencing dating violence are at high risk of STD (including HIV), teen pregnancy, and substance abuse.

Teen girls who report poor health are more likely to have experience dating violence.[9] The adverse effects of teen dating violence extend into early adulthood. A study of men and women who reported psychological or physical violence by a dating partner in their adolescence found that, in follow-up 5 years later, women reported increased heavy episodic drinking and depression, whereas men reported increased antisocial behavior and marijuana use.[64] Both men and women reported increased suicidal ideation and adult IPV victimization.

Injury

Physical injury from IPV can include scratches, bruises, contusions, lacerations, fractured teeth, bone fractures, joint dislocations, strains, sprains, abdominal and pelvic injuries, head injuries, and strangulation-related injuries. A meta-analysis of ED studies found that head, neck, or facial injuries were significantly associated with IPV in women who presented to the ED, whereas extremity injuries were less likely to involve IPV.[65] In an earlier study by Muelleman and colleagues,[66] in addition to head, neck, and facial injuries, thorax and abdominal injuries were also significantly more common among abused women. Although the study was able to identify 12 specific injury types that occurred more frequently in abused women, the positive predictive value was low. Other studies have also noted that women injured by IPV were more likely to have multiple injuries compared with women who experienced accidental injuries.[65] Among injured women, excluding motor vehicle accidents, multiple injuries mainly involving the head, neck, and trunk should increase the suspicion for IPV.

The good news regarding injury is that over the past 2 decades the US Department of Justice has found that the rate of serious IPV has declined by 72% for women and 64% for men.[67] However, among those who have injuries, 13% of women and 5% of men have severe injury such as internal injury, unconsciousness, or broken bones. In addition, only 18% of women and 11% of men sought medical treatment of their injuries.

Kothari and Rhodes[68] found that, among female victims of IPV identified in a police database, 64% received care in an ED in the year before the assault. The median number of ED visits over the course of 3 years was 4 for this same group. For most visits (71%), the victims were being seen for non–injury-related complaints. This finding again emphasizes that by only screening patients who present with injuries a large number of people who are at risk for IPV-related health consequences are missed.

Homicide

Homicide is the ultimate injury inflicted on a victim by an intimate partner. Based on information reported to the US Federal Bureau of Investigation, 14% of all homicides in the United States are committed by an intimate partner.[69] Women account for 70% of victims killed by an intimate partner. Put another way, when women are murdered, 45% of the time they are killed by a spouse, ex-spouse, boyfriend, or girlfriend. In comparison, 5% of male homicide victims are killed by an intimate partner. However, there is positive progress even in these grim statistics. Although 14% of all homicides are committed by an intimate partner, this represents a 29% reduction between 1993 and 2007. During this time period, female intimate partner homicides decreased by 35% and male intimate partner homicides decreased by 46%.

Of special note are the homicide-suicide incidents that occur, in which the perpetrator of the homicide then commits suicide. In one study of homicide-suicide incidents, most of the homicide victims were female (75%) and in nearly 60% of all homicide-suicide incidents, the victim is a current or former intimate partner of the perpetrator.[70] Furthermore, the study found that 31% of men who killed their intimate partner went on to commit suicide within 24 hours compared with 6% of women.[70] Another study of medical examiner records found that in cases of intimate partner homicide-suicide, 95% were female homicides followed by male suicides. Of the women who were murdered, 11% were pregnant or within 1 year postpartum.[71]

The homicide rates presented earlier do not fully take into account all the lives lost because of IPV because most homicide rates only focus on the intimate partner couple. The rates do not reflect the deaths of others at the hands of the perpetrator. A study using data from the National Violent Death Reporting System found that in IPV-related homicide incidents, 80% of the homicide victims are the intimate partner, but 20% are corollary homicide victims.[72] These victims included family members, new intimate partners, friends, neighbors, acquaintances, police officers, and sometimes strangers, and 38% of the family member homicide victims were aged 11 years or younger.

SCREENING

Many professional organizations, including the American Medical Association, the American College of Obstetrics and Gynecology, the American Nurses Association, the Joint Commission on the Accreditation of Hospitals and Health Care Organizations, and the Institute of Medicine (IOM) have all recommended routine screening for IPV. The IOM recommendations were adopted by the Department of Health and Human Services and are now incorporated into their Women's Preventive Service Guidelines to be covered under the Affordable Care Act.[73] Although screening is supported by many medical organizations, there is little consensus on best methods, tools, or intervals for screening. There is also lack of consensus regarding routine (universal) screening of all patients versus selective screening (case finding) of patients who have higher-risk symptoms (somatization or chronic pain), belong to a high-risk group (adolescent girls, unintended pregnancies), or have known risk factors (mental illness, substance abuse).

Despite the acceptance of the importance of screening by many large medical organizations there is still controversy regarding the efficacy of screening. In 2010 the US Preventive Services Task Force (USPSTF) recommended routine screening of all women of childbearing age[74]; however, a Cochrane Review determined that there was insufficient evidence for routine screening in health care settings.[75] The Cochrane Review found that routine screening did increase identification of abused women in antenatal settings but not other health care settings, and found no evidence

that screening significantly improved health outcomes such as recurrence of violence, quality of life, PTSD, or substance abuse. The USPSTF recommendations for routine screening of women in childbearing years were based on research showing several screening tools having high diagnostic accuracy and on intervention trials that showed lower rates of recurrent abuse experiences.

Whether screening is done routinely or for case finding, it is important to create an environment in which patients are comfortable in discussing IPV. Placing posters in the waiting room and brochures in the bathroom gives the message that IPV is an important health issue and indicates a willingness on the part of providers to discuss it. If an intake health questionnaire is used, having a question about IPV communicates to patients that this is a standard question asked of all patients, provides permission for patients to discuss the issue, and reminds providers to ask as part of a general history. It is also of paramount importance to interview the patient alone. Finding nonthreatening ways to have the partner or older children (age >2 years) leave the room can be challenging but is the only safe and effective way to have a discussion about IPV and other highly confidential health issues.

Screening can occur by many different methods: self-report either in writing or via computer or face-to-face verbal questioning. The method used to screen varies by the patient populations; younger patients may opt for computers, non–English-speaking or low-literacy patients may require face-to-face questioning, and older patients may find written questions to be a less threatening means of screening. Ideally all 3 methods of screening would be available to patients to maximize the case finding and increase patients' comfort levels. However, financial resources and the clinic flow may dictate choosing only 1.

When asking face to face about IPV, it often helps to open with a generalized statement such as:

> *Many people experience problems at home or in their relationships that can affect their health, so I have started to ask all my patients about any issues at home.*

Assure the patient of confidentiality unless it becomes clear that a child is in danger or abused. Use nonjudgmental language, avoiding words that can be misinterpreted (like "abused" or "battered woman"), and then ask directly about behavior:

> *Have you ever had problems with anyone hitting you or hurting you or threatening you?*

There are also a variety of screening tools that have been developed. Again, these can be adapted to self-report via computer or writing or used in a face-to-face screening. An excellent review and critique of the most common tools was done by Rabin and colleagues,[76] who described the complexity of developing a tool when no gold standard exists and the tool must be both comprehensive (covering physical, emotional, and sexual abuse) and concise to make it acceptable to busy medical practices (**Table 1**).

INTERVENTION

Whether by universal screening, symptom-based, or risk factor–based screening, or spontaneous self-report by a patient, medical providers will be faced with patients who are experiencing IPV. When a patient reveals IPV, nonresponse by a medical professional can be devastating. Medical providers must be prepared to engage patients around the issue of IPV and provide assessment and referral.

Much of what is known about effective intervention comes from studies involving women seeking family planning, obstetric, perinatal, or primary care who received

Table 1
Screening tools

Name	Description	Sensitivity (%)/Specificity (%)
HITS[77]	Developed for use in primary care. Four-item tool captures emotional and physical abuse in current relationship but not past sexual abuse	Women: sensitivity, 86; specificity, 99[74] Men: sensitivity, 88; specificity, 97[78]
OVAT[79]	Developed for EDs. Four-item tool measures severe physical violence, emotional abuse, and threats with weapons over past month	Sensitivity: 86 Specificity: 83
PVS[80]	Developed for EDs. Three-item tool measuring past physical violence with any perpetrator and safety with current or former partners	Sensitivity: 35–71[76] Specificity: 80–94[76]
AAS[81]	Developed for prenatal clinics. Five-item tool	Sensitivity: 93–94[76] Specificity: 55–99[76]
WAST[82]	Tested in primary and emergency care settings. Eight-item tool covering physical, emotional, and sexual abuse	Sensitivity: 47[76] Specificity: 96[76]

Abbreviations: AAS, Abuse Assessment Screen; HITS, Hurt, Insulted, Threatened, or Screamed; OVAT, Ongoing Violence Assessment Tool; PVS, Partner Violence Screen; WAST, Woman Abuse Screening Tool.

counseling by social workers, nurses, or community mentors.[83] Many of these studies showed a reduction in IPV and improved birth outcomes but some studies failed to show a significant difference.

However, there are currently no randomized controlled trials to help inform medical providers regarding their role in intervention in the context of a clinical visit. Unique methodological, safety, and ethical issues prevent the important longitudinal studies of effective intervention from readily fitting the classic randomized control trial model. However, best practices, as informed by IPV advocates, IPV survivors, researchers, and medical providers, include acknowledging the problem, assessing safety, referring to appropriate resources, and documenting appropriately in the medical record.

Acknowledge the Problem

Providers must respectfully but effectively convey to their patients that they consider IPV to be a serious health issue. Directly relating the effect that the IPV is currently having on a patient's health is often useful: "Your frequent asthma exacerbations may be related to the stress of what you are experiencing at home." Discussing the linkages between depression or substance use issues and IPV may help patients begin to see connections with their health. Taking an injury prevention stance and discussing the risk of future, potentially worse injuries can be appropriate. Whatever the approach, the message that patients must hear is that this is a serious health issue and their medical providers are concerned.

Assess Safety

Before the patient leaves the office, a safety assessment is critical. The assessment informs the type of resources that the patient needs; for instance, are they safe to go home or do they need to access a domestic violence shelter? The assessment

provides the additional benefit of educating the patient about making a safety plan. In addition, it can be used as a tool to assess whether the patient is in significant danger of serious or fatal injury.

The safety assessment can be done by the medical provider, nurse, social worker, or by providing the patient with a private area in which they can call the local domestic violence organization if one is available. Although others in the clinical area can do the assessment, it is important for providers to have a general knowledge of assessing safety. Patients do not always want to talk with the social worker, may be under time constraints, or the nurse or social worker may be unavailable.

Important safety questions to address:

- Do you feel safe to go home?
  - If not, can you stay with a friend or family member safely?
  - Otherwise, refer to a domestic violence shelter
- Do you have a plan if the violence recurs?
  - Can you plan an escape route out of each room of your house, avoiding the bathroom because of lack of egress and the kitchen because of the availability of knives and other objects?
  - Do you have access to money and transportation?
  - Can you make copies of important documents (birth certificates, passports, green cards, marriage license) and put them in a safe place in case you need to leave suddenly?
  - Do you have a plan with your children about what to do if violence starts?
  - Do you know how to call 911 (this is especially important to problem solve if the patient is non–English speaking)?
- Do you believe your partner is capable of killing you?

The last question, if answered positively, could indicate a situation in which the victim may be in greater danger. A danger assessment tool was developed by Campbell and colleagues[84] to assess the likelihood of future severe injury or death and was refined down to 5 questions to increase its utility in a busy clinical environment such as an ED.[85] If 3 of the following 5 questions are answered positively, it is predictive that the patient is at risk of severe injury or death with 83% sensitivity:

1. Has the physical violence increased in frequency or severity over the past 6 months?
2. Has he ever used a weapon or threatened you with a weapon?
3. Do you believe he is capable of killing you?
4. Have you ever been beaten by him while you were pregnant?
5. Is he violently and constantly jealous of you?

If the patient has multiple risk factors for serious injury, the medical provider must frankly discuss the situation with the patient and encourage a strong safety plan. Ultimately it is the patient's decision regarding the next steps to take but, as with any health risk, patients need to be fully informed when making their decisions.

It is not always feasible to do the safety planning during the clinic visit but patients can be educated regarding safety and provided with basic information for formulating a plan. Many small, wallet-sized cards are available that have a detailed safety plan, but patients must decide whether having the card found on them might increase their danger. Importantly, the medical provider must listen to the patients to learn what the patients have tried in the past and are currently doing to keep themselves and their families safe. Supporting the patients and emphasizing their strength and resilience goes further than authoritatively laying out a plan that may not be workable.

Referral

Every medical clinic and ED would ideally have specific staff members who are well trained in addressing IPV with patients. However, this is not the reality for many practice sites. For those lucky enough to be well resourced, a warm hand-off from provider to the staff member goes a long way in helping patients engage in care. For those clinics without on-site resources, the organization Futures Without Violence has developed an excellent guide for helping health care settings develop a protocol for responding to IPV. The National Consensus Guidelines on Identifying and Responding to Domestic Victimization in Health Care Settings can be downloaded from their Web site at www.futureswithoutviolence.org/.[86]

Knowledge of the local IPV resources is imperative. The small investment of time required to become familiar with community resources and how to quickly and effectively access them saves enormous time and frustration at the moment when referrals are needed. Having the local domestic violence agency or shelter present at a staff meeting makes collaboration and communication easier. Patients also sense that they are being referred to a known resource in which the provider has confidence.

Referral to couples therapy may seem appropriate, but should only be done in selective cases with extreme caution. Couples therapy can only be done safely and effectively if both partners feel safe, both come committed to developing an abuse-free relationship, and if the therapist is experienced with issues regarding IPV. Both partners must be equally empowered for counseling to be helpful, which is a situation that does not exist if one person uses violence to control their partner.

At a minimum, have the numbers to the 24-hour crisis line, the local domestic violence agency, the state domestic violence hotline, and/or the National Domestic Violence Hotline (1-800-799-7233) readily available.

The National Domestic Violence Hotline assist patients in finding resources in their area. Their Web site, www.thehotline.org/, also has a chat room for patients to ask questions of an advocate. However, patients should be alerted that computer use can be monitored by an abuser and it is not possible to wipe out all traces of a search. Other options are to use a computer at a public library or community center to protect themselves. The National Domestic Violence Hotline has linkages to all the state domestic violence coalitions, national organizations, and resources specific to teens and LGBT individuals. They are also a valuable resource to obtain IPV brochures and posters. Again, brochures can be informative, but make sure that they do not increase the danger for patients who have them on their persons.

Other Web sites for resources and education:

American Congress of Obstetrics and Gynecology: www.acog.org/
The National Coalition against Domestic Violence: www.ncadv.org/
The National Resource Center on Domestic Violence: www.nrcdv.org/
National Network to End Domestic Violence: www.nnedv.org/
Futures without Violence: www.futureswithoutviolence.org/.

Documentation

Good documentation is vital for many reasons. Documentation helps coordinate care between multidisciplinary providers, including primary care, ED, inpatient, and mental health providers as well as chemical dependency counselors and social workers. It provides legal protection for providers when it is clear that IPV was addressed appropriately. Prosecutors also rely on the documentation in court to bring perpetrators to justice and victims depend on accurate documentation for custody and other legal issues.

If patients are willing to divulge the identity of their assailants, record the name and the relationship of the assailant to the victim (eg, “Patient said to have been stabbed by boyfriend, John Doe …”). This statement does not mean that the provider is accusing John Doe or that the provider has knowledge that the event occurred as stated, only that this is an accurate recording of what the patient stated while in the process of receiving medical care.

If injuries are involved, specify the mechanism of injury (eg, “hit with bat” or “strangled with hands”). Describe all injuries, old and new. Use a body map or, with the patient’s permission, take photographs that can be entered into the electronic health record (EHR). If strangulation has occurred, describe any loss of consciousness or near syncope, describe any bruising or swelling around the neck, and describe any hoarseness or vocal changes. If sexual assault has occurred, a rape kit should be done if possible.

Over the course of assessing the patient, which may take more than one visit, document screening for other associated medical conditions, such as depression, PTSD, suicidal ideation, substance abuse, or alcohol dependence.

In the assessment and plan, document that IPV was discussed, safety issues addressed, and resources were made available for the patient. This documentation protects the provider by documenting appropriate responses to IPV and informs other providers who may provide care in the future.

The EHR has made some important improvements in documentation, but, with sensitive issues such as IPV, some caution is needed. Written summaries of the visit are often printed out to give the patient. These summaries may include the problem list. IPV needs to be on the problem list so other members of the care team are alerted; however, it is important for it not to appear on the summary for the patient because it may be acquired by the perpetrator. Similarly, many patients now have open access to their full health records, including visit notes, via computer. Care must be exercised to make sure that confidential information cannot be accessed by the abuser.

LEGAL ISSUES

Laws and mandates around IPV vary from state to state and sometimes from county to county. Knowledge of local laws applicable to the health care setting is essential. Patients should have access to information on how to obtain protection orders. Mandatory arrest is the standard policy in certain regions, requiring police to arrest the primary perpetrator if called for a domestic disturbance. The perpetrator is often kept in jail for 24 hours, allowing the victim time to get assistance from domestic violence advocates. In some states prosecutors can prosecute perpetrators of severe IPV without the victim being present in court, which allows victims to be able to escape a significant abuser and not be retraumatized in court. Medical documentation can be used establish the seriousness of the assault in court.

Mandatory reporting laws are also variable from state to state. Mandatory reporting for elder and child abuse is fairly uniform across the United States. Most states require a police report for any injury by a gun or knife regardless of the perpetrator. Some locales include felony assaults, such as broken bones or injuries requiring hospital admission, as mandated for reporting. A few states require all IPV cases to be reported regardless of the preference of the primary victim. If in doubt about the requirements, a call to Adult Protective Services or the local prosecutor’s office is advised.

SELF-DETERMINATION

Just as a medical provider would not start a medication for hypertension and then not schedule a follow-up visit, the diagnosis of IPV requires ongoing monitoring

and support. IPV is a complex issue and 1 approach does not fit all patients. Patient-centered care is paramount, providing support and education but ultimately allowing patients to determine the pace and process for change. The resources the patient needs will also change over the course of time. A patient may initially need more safety planning, but later may need help with PTSD symptoms.

Many providers express frustration when a patient does not leave a violent relationship but it is important to understand some of the barriers victims face:

- Fear of death, for themselves or their families
- Fear of reprisal
- Fear of loss of child custody
- Fear of deportation
- Protection of the perpetrator from arrest or deportation
- Religious prohibitions
- Cultural isolation and language barriers
- Lack of job skills
- Poor self-esteem
- Depression

Leaving the relationship is not the only path to safety for patients; other options may exist and providers should be open to these possibilities. Providing a safe, respectful, compassionate place where a patient can reveal IPV is an important first step. Providing education and support in a nonjudgmental and caring manner empowers patients to make healthy changes and end the violence in their lives.

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