Intimate partner violence: Intervention and patient management

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INTRODUCTION — Intimate partner violence (IPV) is a serious, preventable public health problem affecting more than 32 million Americans [1]. Although IPV affects both sexes, more women than men experience IPV. Lifetime estimates for IPV involving women in the United States range from 22 to 39 percent [2,3]. In countries around the world, 10 to 69 percent of women report physical assault by an intimate partner at some time in their life [4].

The term "intimate partner violence" describes actual or threatened psychological, physical, or sexual harm by a current or former partner or spouse. IPV can occur among heterosexual or same-sex couples and does not require sexual intimacy.

Care of the patient experiencing IPV requires a team approach involving medical, institutional, and community resources. The clinician's role is to make the diagnosis, provide ongoing medical care and emotional support, assess patient safety, counsel the patient about the nature and course of domestic violence, educate the patient about the range of available support services, document findings, make appropriate referrals, and assure follow-up.

This topic will discuss the clinician's role in managing the patient in whom IPV has been identified. The clinical manifestations of IPV, and screening and diagnosis of IPV are discussed separately. (See "Intimate partner violence: Diagnosis and screening" and "Intimate partner violence: Epidemiology and health consequences".)

INITIAL APPROACH TO THE PATIENT — The Family Violence Prevention Fund has identified four guiding principles of intervention for clinicians [5]:

- Survivor safety – being always aware that the primary concern is to maximize safety and not increase risk for further harm
- Survivor empowerment – facilitating the patient's ability to make his or her own choices
- Perpetrator accountability – framing the violence as occurring because of the perpetrator's behavior and not the survivor's.
- Advocacy for social change – collaboration and advocacy beyond the healthcare setting

When IPV has been identified, the most important first consideration is to offer support to the patient. It is crucial that providers affirm their understanding of how difficult it must be for the patient to share this information, recognize the patient's strength in doing so, and provide assurance that they will be available to the patient for the future. This should be immediately followed by an assessment of the victim's safety.

Support — The immediate expression of empathy, acknowledgement, and continued ability to support and assist the patient are the most important components of care after a patient has disclosed abuse. Some suggest explicitly thanking the patient for the trust shown by their willingness to share difficult information [6]. Close follow-

up is often warranted, especially if the patient is in crisis.

Empathy may be shared with the following comments:

- "I am very sorry this is happening to you."
- "I am glad you were able to tell me."
- "This is a common problem."

Validation may be expressed with the following statements:

- "You do not deserve this and it is not your fault."
- "You must be very strong to have been able to go through this and now to be able to ask for help."

Assistance can be offered by the following:

- "I want to help you through this in any way I can."
- "I have worked with others with this problem and can assist you in improving your health and with resources to support you through working on this problem."

Patients may not be ready to take action at the initial disclosure, but may be helped to move toward action, with understanding of their stage of readiness on a continuum of stages:

- Precontemplation — The patient is not concerned about the situation
- Contemplation — The patient has considered change but is not ready to take action
- Determination — The patient has decided to make changes in their situation
- Action — The patient is actively seeking help and taking steps to address the IPV

The physician should help the patient along this continuum and assure the patient that he or she will not be abandoned, regardless of where they are in the process of change. Not all patients will move in a linear fashion through these stages. Clinicians should support the patient in making changes for which they are ready, and not re-create the dynamics of power and control by insisting on progress through the stages to departure.

Assessing for safety — The clinician must assess the safety of all patients who are experiencing IPV. Although the vast majority of patients are not in imminent danger and are not planning to leave their relationship, it should not be overlooked that IPV can result in death. Assessing for safety and making a safety plan can decrease the risk of mortal harm. (See "Intimate partner violence: Epidemiology and health consequences", section on 'Homicide'.)

The clinician should ask the patient how afraid they are and what they think are their immediate and future safety needs. Unfortunately, many people minimize or deny their danger. Clinicians may be surprised or frustrated with the severity of abuse patients are willing to tolerate and should understand that love and other family concerns, such as children in the home and economic factors, often confound the picture.

In an open ended way, patients should be asked about their concerns and fears. A 20-item Danger Assessment tool has been developed and validated to predict the likelihood of lethality or near lethality in an IPV relationship [7]. In a validation study, the sensitivity of the tool for attempted femicide was 38 percent for scores between 14 and 17, and 85 percent for scores 18 to 20.

Patients should be offered referral to someone to talk to about options and safety. For patients who are not ready or are too fearful to proceed with referral, support and concern should be discussed on subsequent visits, and the patient should again be asked to consider referral to someone to help him or her think about their options.

Risk factors for escalating abuse — The Danger Assessment tool identifies risk factors for violence and includes perpetrator and victim factors.

Perpetrator factors — Perpetrator factors associated with increased danger to a patient include [7]:

- Violent outside the home
- Violent to children

- Threatening to kill victim, children, self
- Escalating threats
- Using drugs - especially phencyclidine (pcp), crack cocaine, amphetamines, or alcohol
- Abusive during pregnancy
- Obsessive controlling relationship
- Has provoked serious prior injury
- Owns weapons, especially handguns
- Threatened others, including friends and/or family

Victim factors — Victim factors associated with increased danger include [7]:

- Attempting to leave the relationship
- Has sought outside intervention
- Acknowledgment that he or she is afraid for their life
- Suicidal (with a plan, or with prior suicide attempts, or has means)
- Homicidal

Safety plan — If any significant risk factor is present, it is imperative to devise a safety plan as the patient may be at risk of serious harm or death. Depending on availability, a hospital or community domestic violence advocate, hospital social worker, or local domestic violence hotline can provide advice about the recommended plan in the community. The patient may need access to a shelter.

A safety plan should include the following elements:

- Preparing an emergency kit with important documents, keys, money, and other essential items, to be stored outside the home in case they need to escape urgently (figure 1)
- A place to go (friends, family, shelter)
- A signal to alert children or neighbors to call 911
- During times of escalating conflict, avoiding rooms with potential weapons (kitchen) or risk for increased injury (hard bathroom surfaces)

INTERVENTION, COUNSELING, AND REFERRAL — Providers should assure the abused patient that they are available for support. In addition the patient should be offered referral for counseling about options and safety, often to an onsite or local domestic violence agency where available. Patients may be reluctant or resistant to talking with anyone else because of fears about safety. On subsequent visits, you may emphasize ongoing support and concern and ask the patient again to consider referral to someone who can help think about options.

Caution should be taken in providing the patient with written materials since safety may be jeopardized if the batterer finds this material. One institution provides an unidentified phone number for the Family Violence Program as one of many important numbers printed on the back of physician business cards. If brochures are distributed, it should be made clear that the patient has a place to keep them that would not be accessible to the perpetrator.

DO NOT confront the perpetrator, as this can endanger patients and, potentially, providers.

Effectiveness of intervention — The effectiveness of intervention for domestic violence has been studied, showing benefit for some, but not all, outcomes [1].

- A systematic review found insufficient evidence to determine if advocacy (providing information, support, and resource access) in healthcare settings is effective for women who live with their abusing partners [8]. Intensive advocacy for women in shelters decreased physical abuse, but its effect on depression, quality of life, and psychological distress was uncertain.

- In a 2012 meta-analysis of six trials, counseling interventions for IPV reduced IPV, improved birth outcomes for pregnant women, reduced IPV in the post-partum period, and reduced unsafe relationships and pregnancy coercion for women seen in family planning clinics [2].

Counseling the victim — Counseling may strengthen the victim's sense of self-worth and provide ongoing support, although objective evidence to support these benefits is limited. Counseling can also assess the degree of danger for victims and their children, and help them develop a safety plan. Brief advocacy has been shown to increase the use of safety behaviors by abused women [8].

Many victims of abuse are not ready to leave their abusers because of fear of reprisal, economic dependence on the abuser, especially if there are children, no acceptable place to go, belief that the abuse will stop, or belief that the abuse is their fault. Victims may believe expressions of remorse and promises that the abuser will change his or her behavior. Drop-out rates from treatment programs are high [9].

Attempting to or leaving a relationship with a perpetrator often increases the risk of injury. Providers should not encourage their patients to leave a relationship [10]. If patients come to their own decision to terminate a relationship, close attention should be paid to devising and implementing a safety plan, and seeking assistance from hospital and community resources where available.

Clinicians should screen the patient for possible psychologic issues (depression and anxiety) as well as substance abuse [6]. In addition to concerns about the patient, clinicians should consider whether child protective services are required. (See "Childhood exposure to intimate partner violence".)

Local resources — If a patient appears in danger, referral to in-house and/or community resources is important. Referral should also be considered, in the absence of imminent danger, for those who screen positive for current IPV. (See 'Assessing for safety' above.)

Familiarize yourself with local resources for referral. These may include:

- Hospital programs
- Community hotlines
- Shelters
- Group support, including batterers' groups
- Legal Aid
- Social welfare services
- Support for specific groups: immigrants requiring interpreters, victims in same sex relationships, victims with physical or intellectual disabilities

Resources in the US — Governmental resources at the state and federal level are available. Some helpful resources web-based resources include:

- www.futureswithoutviolence.org/
- www.ncadv.org/resources/FactSheets.php
- http://www.womenshealth.gov/violence-against-women
- http://www.cdc.gov.ezproxylocal.library.nova.edu/ViolencePrevention/intimatepartnerviolence/index.html

Telephone resources include:

- National Domestic Violence Hotline: 1-800-799-SAFE (1-800-799-7233)
- The National Sexual Assault Hotline: 1-800-656-4673
- The National Teen Dating Abuse Hotline: 1-866-331-9474

Intervention for the perpetrator — Court-mandated interventions to assist batterers have been minimally successful, decreasing recidivism by only 5 to 7 percent according to two meta-analyses [11,12]. Attrition rates from batterer intervention programs are high (about 50 percent), and those who drop out are most likely to be

involved in IPV again [13].

Suggestions for improvement of these programs include shifting the program from court-mandated group therapy to models based on stages of change or individually tailored treatment. Further suggestions include concurrent substance use and/or mood disorder therapy or treatment of couples together [12,14].

LEGAL ISSUES

Documentation — Careful documentation is important if the patient seeks legal redress. Reports of abuse need to be specific and detailed.

The following data should be recorded:

- Quotes from the patient about the occurrence, nature, and time of abuse.
- Quotes that identify the perpetrator, where permitted by the patient. Patients do have the right to ask that information regarding IPV not be included in their chart. Often information in the chart can help with incriminating the perpetrator; however in situations where perpetrators have access to the records (shared children) this information may increase danger to victims.
- Findings from the physical examination
- If possible, photographs of any physical injuries after obtaining the patient's signed consent. The photograph must include the patient's face or identifying features with the injury to be useful as evidence. If a camera is not available, the physician should make a sketch of the injuries.
- Orders for appropriate laboratory and radiology studies.
- Comments on comorbidities, if present, and degree of disability.

Language should be chosen carefully. Words such as **denies** or **claims,** although commonly used in medical records, suggest the clinician may not believe the patient. It is helpful to state: "Patient reports that she does not drink or use drugs" in lieu of "Patient **denies** alcohol or drug use."

Where relevant, rape kits such as those facilitated by Sexual Assault Nurse Examiners (SANE nurses) should be obtained and documented.

Mandatory reporting — The clinician needs to be familiar with state or country law regarding situations for which reporting is mandated. Requirements for reporting vary by state, with mandatory reporting required in only a minority of states as of 2012.

Domestic violence programs, either hospital-based or in the community, can often provide assistance with reporting and/or guidance about whether reporting is indicated.

Situations that commonly require reporting are:

- **Abuse of disabled persons** — Harm to disabled persons must be reported to the Disabled Persons Protection Commission.
- **Weapon use** — In most states, injury resulting from assault with a firearm or knife or causing "grave bodily harm" is reportable.
- **Elder abuse —** Many states have mandatory reporting laws for elder abuse. (See "Elder mistreatment: Abuse, neglect, and financial exploitation".)

Abuse involving children — Within the United States, domestic violence involving a child must be reported if the following criteria are met:

- Under the age of 18, and
- Abuse or neglect of the child is suspected.

State-specific guidelines about what constitutes the need to report and who is mandated to report are available through the Child Welfare Information Gateway.

Health providers and law enforcement officers, as well as teachers and child care providers, are mandated reporters in most states. State policies differ on whether the situation in which a child witnesses a parent being abused is considered child abuse. There has been concern that mandated reporting may be a barrier to the parent's being willing to reveal abuse or even be a barrier to clinic attendance by parents. (See "Child abuse: Social and medicolegal issues" and "Childhood exposure to intimate partner violence".)

Protection order — Patients who feel they are in danger may consider initiating a Domestic Violence Protective Order (DVPO), legally preventing perpetrators from contact with patients. In general, a community advocate or legal advisor will assist the patient with obtaining this document. Evidence of the effectiveness of protection orders in preventing recurrent violence is inconsistent [15,16]. In one US retrospective study, compared to abuse victims who did not obtain a protection order, women who were granted a temporary (usually two week) restraining order were more likely to be subsequently psychologically abused in the 12 months following the index incident, while women who obtained a permanent protection order (12 months) were less likely to be physically abused in the 12 months [17].

MANAGING THE CHALLENGING PATIENT — Patients with a history of prior, rather than current abuse, may present with chronic health problems. It should be recognized that it is generally difficult for patients to disclose abuse situations.

Some patients with an abuse history present with comorbid depression and somatic complaints, including chronic pain. It is important not to abandon these patients, even if their problems continue to be difficult to solve. There is some evidence that somatic complaints may decrease after disclosure and that well being may improve when root causes are addressed [18].

Clinicians should be careful not to re-create the dynamics of power and control, typical of classic IPV, in the provider-patient relationship. The clinician must ensure trust and continuity, but also be alert to appropriate boundaries. Patients should be allowed to make autonomous decisions regarding health advice. Focusing care on the patient's safety and health, rather than life choices, can be helpful.

Frequent scheduled follow-up as well as referral to mental health clinicians for cognitive behavioral (CBT) or dialectical behavioral (DBT) therapies may be helpful, as can ongoing contact with community or hospital-based advocates. (See "The difficult patient encounter" and "Somatization: Treatment and prognosis".)

CURBING SOCIETAL VIOLENCE — There is an increasing move to work at the societal level to change cultural norms that perpetuate violence. Legal and policy reforms have little impact without first addressing change in cultural attitudes and institutional practices [9].

Attempts to impact cultural norms include efforts targeted by and for men such as the White Ribbon campaign to change social norms away from power and control and towards equality. The White Ribbon campaign has organizations in multiple countries, including the United States, Canada, Scotland, England, and Australia.

Increasingly, culturally-specific community based groups are trying to assist their members in ways that are acceptable within their life contexts. Partner violence organizations geared to specific groups include SEARAC for IPV survivors of Asian descent, Wafa House in New Jersey for survivors who are Muslim, and Alianza for Latina women.

Worldwide, there has been attention given to stiffen penalties for violence and so decrease its occurrence. As an example, legislative action has been proposed in the United States to evaluate country-specific policies about

violence against women in making decisions about foreign aid and diplomacy [19]. In 2012, the US Department of State and the US Agency for International Development (USAID) announced an official strategy to prevent and respond to gender-based violence globally, to coordinate efforts between multiple governmental groups, integrate gender violence prevention in US government work, and improve data collection and research efforts [20].

SUMMARY

- The expression of empathy, acknowledgement, and continued ability to support and assist the patient are the most important components of care immediately after a patient has disclosed abuse. Close follow-up is often warranted, especially if the patient is in crisis. (See 'Support' above.)
- All IPV patients should be assessed for safety. Many people experiencing IPV minimize or deny their danger. In an open ended way, patients should be asked about their concerns and fears. Patients should be offered referral to someone to talk to about options and safety. For patients who are not ready or are too fearful to follow through with referral, support and concern should be ongoing and referral options discussed on subsequent visits. (See 'Assessing for safety' above.)
- If any significant risk factor for escalating abuse is present, it is imperative to devise a safety plan as the patient may be at risk of harm or death. A hospital or community domestic violence advocate, hospital social worker, or local domestic violence hotline can provide advice about the recommended plan in the community. (See 'Safety plan' above.)
- Counseling may strengthen the victim's sense of self-worth and provide ongoing support, although objective evidence to support these benefits is limited. Counseling can also assess the degree of danger for victims and their children. The abused patient should be reassured that the provider is available for support. Caution should be taken in providing the patient with written materials since safety may be jeopardized if the batterer finds this material. DO NOT confront the perpetrator, as this can endanger the patient and, potentially, the provider. (See 'Intervention, counseling, and referral' above.)
- Careful documentation is important if the patient seeks legal redress. Reports should specify quotes from the patient about the occurrence, nature, and time of abuse, findings from the physical examination, and photographs if consented. Patients do have the right to ask that information regarding intimate partner violence not be included in their chart. Often information in the chart can help with incriminating the perpetrator; however in situations where perpetrators have access to the records (shared children) this information may increase danger to victims. (See 'Documentation' above.)
- The clinician needs to be familiar with state or country law regarding situations for which reporting is mandated. Requirements for reporting vary by state in the US. Abuse involving disabled persons, older adults, children under the age of 18, or weapon use commonly require reporting. Protection orders are intended to legally prevent perpetrators from contact with victims, but evidence of their effectiveness is inconsistent. (See 'Legal issues' above.)

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GRAPHICS

Safety packing list

If you are leaving an abusive situation, take your children and, if possible, your pets. Put together the items listed below. Hide them someplace where you can get them quickly, or leave them with a friend. If you are in immediate danger, though, leave without these items.

Identification for yourself and your children

- ☐ Birth certificates
- ☐ Social Security cards (or numbers written on paper if you can't find the cards)
- ☐ Driver's license
- ☐ Photo identification or passports
- ☐ Welfare benefits card
- ☐ Green card

Important papers

- ☐ Marriage certificate
- ☐ Divorce papers
- ☐ Custody orders
- ☐ Legal protection or restraining orders
- ☐ Health insurance papers and medical cards
- ☐ Medical records for all family members
- ☐ Children's school records
- ☐ Investment papers/ records and account numbers
- ☐ Work permits
- ☐ Immigration papers
- ☐ Rental agreement/lease or house deed
- ☐ Car title, registration, and insurance information
- ☐ Records of police reports you have filed or other evidence of abuse

Money and other ways to get by

- ☐ Cash
- ☐ Credit cards
- ☐ ATM card
- ☐ Checkbook and bankbook (with deposit slips)
- ☐ Jewelry or small objects you can sell

Keys

- ☐ House
- ☐ Car
- ☐ Safety deposit box or Post Office box

Ways to communicate

- ☐ Phone calling card*
- ☐ Cell phone*
- ☐ Address book

Medications

- ☐ At least one month's supply for all medicines you and your children are taking
- ☐ A copy of any prescriptions

Things to help you cope

- ☐ Pictures
- ☐ Keepsakes
- ☐ Children's small toys or books

* It is best not to use a card or phone that you shared with an abuser because he or she may be able to use them to find you.

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