CME

Putting intimate partner violence on your radar

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ABSTRACT

Intimate partner violence is a preventable health problem that affects more than 12 million people in the United States each year. Those affected can be of any sex, race, ethnicity, socioeconomic status, religion, education level, or sexual orientation. All clinicians should screen for intimate partner violence as part of the routine history and physical examination. This article describes the dynamics of intimate partner violence and the 2013 screening guidelines from the US Preventive Services Task Force.

Keywords: intimate partner violence, domestic violence, education, preventive healthcare, screening guidelines, US Preventive Services Task Force

Learning objectives

- Define intimate partner violence and discuss its effect on patients and society.
- Categorize the stages of intimate partner violence.
- Discuss screening and preventive measures for intimate partner violence.

One expert recently described intimate partner violence, also known as domestic violence, as an epidemic in the United States.[1] The US Preventive Services Task Force (USPSTF) defines intimate partner violence "as the physical, sexual, or psychological harm by a current or former partner or spouse. Stalking also is a form of intimate partner violence."[2] An estimated 31% of women and 26% of men experience intimate partner violence in their lifetimes. This serious preventable public health problem affects more than 12 million Americans each year but is one of the most underreported crimes in the United States (**Table 1**).[2-4] Every minute, 20 people become victims of physical violence by a partner.[4] In 2010, according to the FBI, 37.5% of murdered

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DOI: 10.1097/01.JAA.0000471606.69408.ac

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Key points

- Intimate partner violence is a preventable health problem that affects more than 12 million people in the United States each year.
- Health professionals must regularly and repeatedly screen all patients for intimate partner violence, per the USPSTF recommendations.
- Providers must help victims understand that they are not alone and build support so the victim eventually can hold the abuser accountable and end the cycle of violence.

women were killed by an intimate partner.[5] Pregnant women and those who were recently pregnant are more likely to be victims of a homicide than to die from any other cause, making intimate partner violence the leading cause of maternal mortality and adverse health outcomes.[6] Women ages 16 to 24 years are most at risk for abuse.[7] Teen victims of physical dating violence are more likely than their nonabused peers to smoke, use illicit drugs, engage in risky sexual behaviors, and attempt or consider suicide.[8] They also are more likely to engage in unhealthful behaviors such as bulimia or ingesting diet pills and laxatives. An estimated 15.5 million children live in households in which partner violence occurred in the past year.[9,10]

AN ECONOMIC AND HEALTH BURDEN

The direct and indirect economic costs of intimate partner violence to society are estimated at $8.3 to $12.6 billion annually.[11,12] Direct costs are related specifically to the abuse, and include physical and mental healthcare, hospital costs, and ambulance transportation.[11] Indirect costs are related to lost productivity (lost work days and housekeeping days) caused by injury, disability, and death.[11]

These costs do not include the healthcare provided to patients for many of the chronic and debilitating adverse health sequelae of intimate partner violence (**Table 2**). These sequelae constitute about 9% of the total disease burden in US women up to age 45 years.[13]

Although many victims will repeatedly seek medical care through EDs and outpatient clinics for injuries and illnesses sustained from abuse, healthcare providers only detect a very small percentage of cases.[1] Despite intimate partner violence being a chronic, escalating, and pervasive health problem, patients typically do not announce the abuse to healthcare providers. Because intimate partner violence rarely is a patient's chief complaint, health professionals must screen for it regularly and repeatedly. This underlies the importance of the 2013 USPSTF intimate partner violence screening recommendations.[2]

DYNAMICS OF INTIMATE PARTNER VIOLENCE

Intimate partner violence is a pattern of assaultive and/or coercive behaviors occurring over multiple episodes during a relationship. This includes physical harm or overpowering behaviors; unwanted or abusive sexual advances; psychologic threats, intimidation, isolation, and emotional abuse; and economic dependence. Intimate partner violence often is learned when abusers see others, such as family members or friends, carry out these coercive behaviors. The behavior is reinforced when the abuser gains control over or compliance from an intimate partner.[1] Intimate partner violence does not require sexual intimacy: it can occur among heterosexual or same-sex couples, adults, and adolescents.

POWER AND CONTROL

The prevalence of intimate partner violence can be attributed to the power that abusers have over their victims. They exhibit behaviors and actions that control and manipulate their partners. The abuse can be physical, sexual, verbal, psychologic, and economic, as shown on the Duluth Power and Control Wheel (www.theduluthmodel.org/training/wheels.html). An abuser seeks to control every aspect of the victim's life, dominating the relationship and making the victim subservient, dependent, and isolated from close family and friends. The emotional and verbal abuse continues with behaviors and actions intended to humiliate the victim. Common behaviors include publicly insulting and verbally assaulting the victim, with the intent of diminishing the victim's feelings of self-worth and self-esteem. Intimidation tactics and threats may include warnings of violent consequences, displaying weapons, destroying personal property, and threats to harm the victim's loved ones, or even threats of self-harm by the

TABLE 1. Lifetime incidence of intimate partner violence[3]

	Women	Men
Sexual violence victimization (excluding rape)	43.9%	23.4%
Rape	19.3% (more than 23 million)	1.7% (2 million)
Unwanted sexual contact	27.3%	10.8%
Noncontact unwanted sexual experience (such as verbal sexual harassment)	32.1%	13.3%
Stalking	15.2% (18.3 million)	5.7% (6.5 million)
All violence experienced before age 25 years	54.8%	47.7%

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abuser if the victim leaves. Abusers commonly blame their victims, telling them that the abuse would not have taken place if they had just obeyed.

CYCLE OF ABUSE

Intimate partner violence often follows a cycle or pattern, which occurs in four stages:

- **Tension-building phase.** This phase begins with victims feeling apprehensive of their and their abusers' behavior. They feel as though they are walking on eggshells, afraid of what will happen next. They actively avoid triggers that may incite an incident of abuse, such as discussing a topic that tends to initiate conflict or mental stress.
- **Incident/explosion phase.** Regardless of the victims' actions, abusers become violent. Incidents can present in any form of power and control. The abuse may include screaming, punching, rape, captivity, or any form of psychologic, emotional, physical, or economic abuse.
- **Reconciliation phase.** Because abusers must maintain power and control over their victims, abuse is followed by an apology, placing the blame on outside situations, or promises that the abuse will never happen again. Some abusers may also threaten self-harm to obtain empathy from victims.
- **Honeymoon phase.** During the honeymoon phase, the abuser exhibits behaviors that reinforce love and affection for the victim.

The cycle repeats, although the length of the phases can vary. Over time, the cycle becomes shorter and the incidents become more violent and intense.

TABLE 2. Health sequelae of intimate partner violence[1,4,19]

- Cardiovascular disorders: stroke, hypertension
- Respiratory disorders: asthma
- Gastrointestinal disorders: irritable bowel syndrome
- Central nervous system disorders: seizures, headaches
- Reproductive disorders: pelvic inflammatory disease, sexual dysfunction, sexually transmitted infections, delayed prenatal care, preterm delivery, perinatal death, low birth weight, pregnancy complications, vaginitis, unintended pregnancy
- Psychologic disorders: anxiety, depression, post-traumatic stress disorder, antisocial behavior, suicidal behavior, low self-esteem, sleep disturbances, emotional detachment, mood disorders
- Renal and urinary tract infections
- Chronic pain syndrome
- Fibromyalgia
- Headache disorders
- Risky health behaviors: substance abuse, high-risk sexual behaviors, early sexual initiation, multiple sex partners, tobacco use, eating disorders

PREVENTIVE RECOMMENDATIONS

Since 2013, the USPSTF has designated screening for intimate partner violence for all women of childbearing age (ages 14 to 46 years) as a grade B recommendation.[2] However, they are not the only vulnerable population affected by intimate partner violence, because partners in same-sex relationships, men in heterosexual relationships, and older adults also can be victims. Many of the screening tools and interventions can be applied to all patients, and screening for intimate partner violence is a standard of care recommendation that supports prevention efforts. Despite new recommendations for screening in a variety of medical settings, studies suggest that fewer than 13% of providers in primary care, emergency care, or obstetrics and gynecology screened patients for intimate partner violence during new or subsequent periodic visits.[14,15] Barriers to screening are not due to patient reluctance, rather they are primarily provider-based and include lack of education in intimate partner violence screening skills, insufficient time to screen, uncertainty of diagnosis, and feeling powerless or helpless to intervene.[9,14]

Studies have found that 44% of women who were victims of intimate partner violence-related homicide were seen in the ED in the 2 years before their deaths.[9,10]

SCREENING

Physician assistants and other primary care providers are the gatekeepers in medicine, often serving as the patients' first introduction into the healthcare system. They are the single most important entity in screening and diagnosing intimate partner violence.

Screening must be patient-centered, focusing on the patient as an individual. Culture, religion, sex, disability, sexual orientation, and age have a significant effect on how intimate partner violence is defined and understood. Screening is most successful when done in a face-to-face conversation with the patient, in a safe environment that ensures confidentiality, and using direct, nonjudgmental questions. The Massachusetts Medical Society developed the RADAR acronym as a universal screening approach to help providers remember the steps to effectively screen in any healthcare setting (**Table 3**).[16]

Clinicians who identify intimate partner violence should document the conversation and physical examination findings in the patient's chart. Assess the patient's safety—is there any immediate danger to the patient or to children? Finally, review the patient's options and provide referrals and resources (**Table 3**).

The CDC has created a compendium of the available intimate partner violence screening tools. Examples are the Woman Abuse Screening Tool, Partner Violence Screen, HITS (Hurt, Insulted, Threatened with Harm, and Screamed), and the Abuse Assessment Screen.[17]

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TABLE 3. Using the RADAR mnemonic

R = routinely screen every patient
- Face-to-face conversations are best.
- Ask questions in a private setting, separate from partner, family, and friends.
- Use trained translators as needed.

A = ask direct, nonjudgmental questions that can be answered yes or no
- Frame questions in the past and present tense and include previously mentioned behaviors such as, a history of violence, safety concerns, financial dependence, and psychological abuse.
- Sample questions include: Are you in a relationship where you have been physically hurt or threatened? Do you feel like your partner controls your activities, money, or children? Do you feel safe at home? Have you ever been forced to have sex? Have you and your partner ever had physical fights?
- If the patient answers no, follow up each of the previous questions with, *"have you ever..."* to assess past history of intimate partner violence.

D = document your findings
- Review the patient's social history and previous medical history. Look for warning signs of intimate partner violence, such as past injuries, chronic somatic complaints, and depression.
- Document the behaviors and clinical presentation of the patient and partner.
- Use the patient's own words in quotations.
- In the medical note, document:
  - the four Ws (who, what ,when, and where)
  - past medical history, including hospitalizations, ED visits, psychiatric history, and trauma history
  - social history, including previous history of abuse, drug use, weapons in the home
  - family history, including children and household dynamics
  - physical examination: Have the patient undress. Perform a complete physical examination. Describe any injuries.
- Assess for suicidal or homicidal ideation
- Assess for readiness to change

A = assess patient safety
- Assess for immediate danger in the clinical setting and in the home. If the patient is in immediate danger, contact law enforcement and crisis intervention. Obtain the patient's consent to involve the police. Consent is not needed if children are involved.
- If the patient is in immediate danger, do not let her or him leave the clinic until you have made arrangements.
- Develop and document safety plans.
  - At home, the patient should know where to go to stay safe, such as a room with a door that locks. Patients should stay out of places with access to weapons or potential weapons, such as the kitchen.
  - Patients should develop an escape plan for when violence escalates. Prepack a bag with essential documents, cash, and phone numbers, and hide the bag outside the home. If children are involved, plan to take them to a location unknown to the abuser.
- Tell patients to establish and use code words to inform family and friends of immediate danger.

R = review options and provide referrals
- Be discreet. Materials and referrals you provide to a victim may place the person in danger.
- Know your resources: Familiarize yourself with social work agencies, local or state shelters, and crisis phone numbers. Offer your clinic phone to patient.
- Make a follow-up appointment and document it.
- Know and follow state laws for mandatory reporting of intimate partner violence, child abuse, elder abuse, and abuse of those with disabilities. Remember to stay compliant with HIPAA.

LEAVING IS A PROCESS

Change is difficult. Leaving is a process, and every patient's situation is different. A victim may leave and return to a relationship multiple times. A woman is at a higher risk of being assaulted or killed during the act of leaving the abuser, and she is 70% more likely to be killed in the first 2 weeks after leaving.[14] Victims have many reasons for not leaving an abusive relationship, including fear, threats made by the abuser toward the victim or family members, low self-esteem, feelings of isolation, and fear of judgment from exposing the abuse. Victims want the violence to end, but they struggle with wanting to keep the relationship. More than 50% of survivors do eventually leave their abusive situations.[14] They leave when they are ready and they feel it is safe to do so.

Success and progress can be defined in many ways. Success can simply be defined as getting the patient to disclose abuse, improving the victim's perceptions of self-worth, or accepting resources. Start small and build support, offering options and following the victim's time frame for motivation to change. Healthcare providers must be supportive and affirm a victim's autonomy, giving the victim full control over making the decision to leave.

CONCLUSION

Intimate partner violence is a preventable health problem that affects more than 12 million people in the United States each year.[18] Victims can be of any sex, race, ethnicity, socioeconomic status, religion, education level, or sexual orientation. Despite the USPSTF category B recommendation to screen for intimate partner violence in women ages 16 to 49 years, fewer than 13% of healthcare providers are actually doing so. The literature suggests that barriers to screening include lack of knowledge and confidence in screening skills among healthcare providers. As a society and a community, we should stop asking why victims stay and start asking why abusers are allowed to harm their victims. Abusers need to be held accountable for their

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actions and behaviors. Being the abuser is a choice. Because intimate partner violence is a preventable health concern, screening must be a part of every patient's routine history and physical examination.

Healthcare providers must seek to empower victims to understand the destructive nature of an abusive relationship and its negative effect on their health. Our duty is to help victims understand that they are not alone and to help them hold the abuser accountable so the cycle of abuse can end. **JAAPA**

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