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Intimate Partner Violence
Recognizing and Responding Safely

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Intimate partner violence (IPV) is a major public health problem. Also known as *domestic violence*, IPV refers to any behavior by an intimate partner or ex-partner that causes physical, sexual, or psychological harm, including controlling or coercive behaviors.[1] Any adult can experience IPV; women are most at risk for severe forms of violence. It is estimated that more than 1 in 3 women in the US have experienced some type of IPV in their lifetime.[2]

IPV is often not obvious; patients may present with nonspecific signs and symptoms (Box).[3] Clinicians across all health care settings must be aware of the indicators of IPV and incorporate the principles of trauma-informed care into their practice. These principles include understanding that any patient may have experienced violence and taking care not to retraumatize the patient during clinical interactions (eg, by touching a patient without permission) or encounters within the larger system (eg, lack of privacy at reception). The goal should not be about obtaining a disclosure, but about creating a safe space where patients can be asked about intimate partner relationships. The environment, approach, and response model[3] outlines key elements of creating safe environments and interactions when recognizing and responding to IPV. For example, at the environment level, consider the safety and privacy of the interaction; IPV should only be discussed if it is safe to do so, which needs to be carefully evaluated. At the approach level, use language that is not stigmatizing or judgmental, and avoid making assumptions about why a patient is in a violent relationship. At the response level, tailor the response to the specific needs of the patient; for example, the person may want to focus on the well-being of their children rather than on IPV.[3]

Author Audio Interview

Conversations about IPV can be challenging for patients and clinicians. Most of what is known is based on studies of women who have experienced violence committed by men and studies involving mainly women of reproductive age.[2] Many principles that follow are thought to apply across genders, but studies need to consider analyses based on gender and age. There is no evidence that universal screening for IPV improves women's health outcomes or reduces violence, based on findings from a systematic review that included 3 randomized controlled trials.[4] This does not mean that asking about IPV when it is safe and appropriate to do so should be avoided; it means not administering standard IPV questions to all patients regardless of presentation. Findings from a meta-analysis showed that female patients want IPV raised in ways that are compassionate and nonjudgmental and that they do not want to be pressured to disclose.[5] The topic of IPV should only be raised when the clinician is certain that the discussion is private. The patient's safety may be compromised if the abusive partner learns of the disclosure. When there are possible indicators of IPV (Box), the clinician should begin with the presenting concern and general questions about the patient's well-being before asking about safety in the home. This also provides the opportunity to explain the limits of confidentiality before asking questions that may lead to a concern about a child's

Box. Recognizing and Responding to Intimate Partner Violence

Clinical Indicators of Intimate Partner Violence (IPV)

General
Presenting with vague signs and symptoms; history not consistent with examination findings; delay in seeking care; repeated cancelled visits; partner always present for visits; patient seems fearful or defers to partner

Physical health
Injuries, including bruising, especially if multiple and at different stages of healing and typically involving the head, face, and neck

Chronic physical conditions, including sleep disturbance, pain, and functional symptoms

Mental health
Depression; anxiety; posttraumatic stress symptoms

Substance use; suicidal thoughts and behavior; self-harm

Reproductive health
Sexually transmitted infections; sexual dysfunction

Unwanted pregnancy; prenatal and postnatal complications including fetal injury

Examples of Questions and Responses for a Phased Approach to Inquiry About IPV and Assessment of Immediate Safety

To prompt discussion about IPV
How are things at home?

How do you and your partner get along?

To explore further when indicated
Are there times when you don't feel safe at home?

Does your partner control or restrict the things you do? (eg, seeing friends or family members, access to finances)

Has your partner ever physically hurt or threatened to hurt you?

Sometimes a partner can say or do things that hurt a person emotionally or physically. Does this happen in your relationship?

To respond when an adult discloses IPV
Thank you for telling me what has been happening.

Everybody deserves to feel safe.

I'm concerned that this may be affecting your health.

Talking like this is an important step.

To assess immediate safety
Do you worry about your safety or the safety of your children?

Have others, such as friends or family members, said that they are worried about your safety?

Have there been any significant changes in your partner's (or ex-partner's) life, such as a recent job loss or increase in use of alcohol or drugs?

Has the frequency or severity of any harm you are experiencing increased?

(continued)

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Box. (continued)

Has your partner (or ex-partner) used a weapon or threatened to use a weapon against you?

Has your partner (or ex-partner) attempted to strangle you?

Has your partner (or ex-partner) threatened to kill you?

If the answer to any of the above is "yes," consider important follow-up questions

Do you feel safe to return home right now?

Should we talk to someone who can provide more advice on how to protect you (and your children)?

Specific safety strategies and examples of questions to ask

If you need to leave your home in a hurry, where could you go? How would you get there?

What is your plan regarding your children (if any)? Have you discussed this with them?

What is your plan regarding your pets (if any)?

What important things would you need to take with you? Where can you put them that will be safe or who can you leave them with just in case you need to get them quickly?

For more detailed information, please see the VEGA family violence education resources.[3]

exposure to harm as a result of IPV and the requirement for mandatory reporting in some jurisdictions. A phased approach is useful when asking about exposure to IPV, beginning with questions such as "How are things at home?" and "How do you and your partner get along?"[3] The Box lists examples of additional questions to ask about IPV and assess safety. This approach demonstrates the clinician's willingness to hear about the patient's problems. These questions do not include words such as "violence" or "abuse" because some patients may not perceive what is happening to them in these terms.

The World Health Organization outlines 5 tasks to guide the clinician in responding to the emotional and practical needs of the patient experiencing IPV: listen (closely with compassion), inquire (about needs and concerns), validate (show that you understand), enhance safety (discuss a plan for future safety), and support (connect to information and services) (LIVES).[1] Enhancing safety involves an assessment of safety and risk of immediate danger, including whether it is safe for the patient to return home. The clinician's response will depend on the practice context, but should include sharing concerns about risk with the patient and discussing needs, preferences, and immediate options, such as connecting the patient with a local domestic violence/IPV service.[1] This should only be done with the patient's consent, and it is often helpful to offer to make this contact together. Patients should be asked about any children in the home and about their exposure to IPV between caregivers. Clinicians need to be aware of their mandatory reporting legislation. If the local child protection services agency must be contacted, it is important to support the nonabusive partner (often the mother) and to advocate for the needs of both the child and the caregiver being abused. Interactions with patients experiencing IPV should be documented in detail, including follow-up plans.

After assessment of the patient who has experienced IPV, follow-up care should be offered based on the patient's most important needs and preferences and considering the local resources that can best meet these needs.[1] This often entails connecting the patient with advocacy services, which provide IPV-specific support to address safety, housing, financial, and legal needs. Familiarity with community resources and assisting patients with system navigation (eg, arranging a referral to a mental health provider or facilitating a connection with advocacy services) are important in assisting patients to access resources. There is some evidence that structured brief advocacy interventions may be helpful to women in improving mental health outcomes and reducing abuse, especially for pregnant women and those experiencing less severe IPV.[6] Various psychological therapies, when provided to women who experience IPV, appear to reduce depression and may reduce anxiety symptoms, however, it is unclear whether such approaches improve other aspects of women's mental health and well-being.[7] Clinicians should be aware that the mental and physical health consequences related to IPV may persist long after the violence has ended.

IPV is complex; clinicians need to support a patient's autonomy, tailor their responses to the individual patient, and be prepared to provide emotional and practical support. Even if specialist resources are not immediately available, clinicians can focus on reducing impairment and enhancing the safety of their patients by following the principles outlined above.

ARTICLE INFORMATION

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