Intimate partner violence: Opening the door to a safer future

These recommendations can help you to identify patients at risk of violence, create an environment where they feel comfortable disclosing their experiences, and help them plan for their safety.

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THE CASE

Louise T* is a 42-year-old woman who presented to her family medicine office for a routine annual visit. During the exam, her physician noticed bruises on Ms. T's arms and back. Upon further inquiry, Ms. T reported that she and her husband had argued the night before the appointment. With some hesitancy, she went on to say that this was not the first time this had happened. She said that she and her husband had been arguing frequently for several years and that 6 months earlier, when he lost his job, he began hitting and pushing her.

HOW WOULD YOU PROCEED WITH THIS PATIENT?

**The patient's name has been changed to protect her identity.*

Intimate partner violence (IPV) includes physical, sexual, or psychological aggression or stalking perpetrated by a current or former relationship partner.[1] IPV affects more than 12 million men and women living in the United States each year.[2] According to a national survey of IPV, approximately one-third (35.6%) of women and one-quarter (28.5%) of men living in the United States experience rape, physical violence, or stalking by an intimate partner during their lifetime.[2] Lifetime exposure to psychological IPV is even more prevalent, affecting nearly half of women and men (48.4% and 48.8%, respectively).[2]

Lifetime prevalence of any form of IPV is higher among women who identify as bisexual (59.8%) and lesbian (46.3%) compared with those who identify as heterosexual (37.2%); rates are comparable among men who identify as heterosexual (31.9%), bisexual (35.3%), and gay (35.1%).[3] Preliminary data suggest that IPV may have increased in frequency and severity during the COVID-19 pandemic, particularly in the context of mandated shelter-in-place and stay-at-home orders.[4-6]

IPV is associated with numerous negative health consequences. They include fear and concern for safety, mental health disorders such as posttraumatic stress disorder (PTSD), and physical health problems including physical injury, chronic pain, sleep disturbance, and frequent headaches.[2] IPV is also associated with a greater number of missed days from school and work and increased utilization of legal, health care, and housing services.[2,7] The overall annual cost of IPV against women is estimated at $5.8 billion, with health care costs accounting for approximately $4.1 billion.[7]

CONTINUED

Family physicians can play an important role in curbing the devastating effects of IPV by screening patients and providing resources when needed.

FACILITATE DISCLOSURE USING SCREENING TOOLS AND PROTOCOL

In Ms. T's case, evidence of violence was clearly visible. However, not all instances of IPV leave physical marks. The US Preventive Services Task Force (USPSTF) recommends that all women of childbearing age be screened for IPV, whether or not they exhibit signs of violence.[8] While the USPSTF has only published recommendations regarding screening women for IPV, there has been a recent push to screen all patients given that men also experience high rates of IPV.[9]

Utilize a brief screening tool. Directly ask patients about IPV; this can help reduce stigma, facilitate disclosure, and initiate the process of connecting patients to potentially lifesaving resources. The USPSTF lists several brief screening measures that can be used in primary care settings to assess exposure to IPV (**TABLE 1**[8,10-17]). The brevity of these screening tools makes them well suited for busy physicians; cutoff scores facilitate the rapid identification of positive screens. While the USPSTF has not made specific recommendations regarding a screening interval, many studies examining the utility of these measures have reported on annual screenings.[8] While there is limited evidence that brief screening alone leads to reductions in IPV,[8] discussing IPV in a supportive and empathic manner and connecting patients to resources, such as supportive counseling, does have an important benefit: It can reduce symptoms of depression.[18]

Screen patients in private; this protocol can help. Given the sensitive nature of IPV and the potential danger some patients may be facing, it is important to screen patients in a safe and supportive environment.[19,20] Screening should be conducted by the primary care clinician, ideally when a trusting relationship already has been formed. Screen patients only when they are alone in a private room; avoid screening in public spaces such as clinic waiting rooms or in the vicinity of the patient's partner or children older than age 2 years.[19,20]

To provide all patients with an opportunity for private and safe IPV screening, clinics are encouraged to develop a clinic-wide policy whereby patients are routinely escorted to the exam room alone for the first portion of their visit, after which any accompanying individuals may be invited to join.[21] Clinic staff can inform patients and accompanying individuals of this policy when they first arrive. Once in the exam room, and before the screening process begins, clearly state reporting requirements to ensure that patients can make an informed decision about whether to disclose IPV.[19]

Set a receptive tone. The manner in which clinicians discuss IPV with their patients is just as important as the setting. Demonstrating sensitivity and genuine concern for the patient's safety and well-being may increase the patient's comfort level throughout the screening process and may facilitate disclosures of IPV.[19,22] When screening patients for IPV, sit face to face rather than standing over them, maintain warm and open body language, and speak in a soft tone of voice.[22]

Patients may feel more comfortable if you ask screening questions in a straightforward, nonjudgmental manner, as this helps to normalize the screening experience. We also recommend using behaviorally specific language (eg, "Do arguments [with your partner] ever result in hitting, kicking, or pushing?"[16] or "How often does your partner scream or curse at you?"),[13] as some patients who have experienced IPV will not label their experiences as "abuse" or "violence." Not every patient who experiences IPV will be ready to disclose these events; however, maintaining a positive and supportive relationship during routine IPV screening and throughout the remainder of the medical visit may help facilitate future disclosures if, and when, a patient is ready to seek support.[19]

It's helpful to ask questions such as: "Do arguments [with your partner] ever result in hitting, kicking, or pushing?" and "How often does your partner scream or curse at you?"

CRITICAL INTERVENTION ELEMENTS: EMPATHY AND SAFETY

A physician's response to an IPV disclosure can have a lasting impact on the patient. We

TABLE 1

USPSTF-recommended instruments to screen for IPV[8, 10-17]

Instrument[8]	Constructs assessed	Length	Response format	Cutoff score	Sensitivity & specificity
Extended Hurt/Insult/Threaten/Scream (E-HITS)[10]	Frequency of psychological, physical, and sexual IPV	5 items	Self-report or clinician-administered; 5-point Likert scale	Varies across studies	Sensitivity: 75%-98% Specificity: 82%-95%[10,11]
Humiliation, Afraid, Rape, Kick (HARK)[12]	Presence or absence of psychological, physical, and sexual IPV	4 items	Self-report; Yes/No	≥ 1[12]	Sensitivity: 81% Specificity: 95%[12]
Hurt/Insult/Threaten/Scream (HITS)[13]	Frequency of psychological and physical IPV	4 items	Self-report or clinician-administered; 5-point Likert scale	≥ 10.5[13]	In the original family medicine sample of women: sensitivity: 96%, specificity: 91%[13] Across a range of samples: sensitivity: 30%-100%, specificity: 86%-99%[14]
Partner Violence Screen (PVS)[15]	Physical IPV and safety	3 items	Clinician-administered; Yes/No	Positive response to any item indicates presence of IPV	Sensitivity: 65%-71% Specificity: 80%-84%[15]
Woman Abuse Screening Tool (WAST)[16]	Psychological, physical, and sexual IPV	8 items	Self-report; 3-point Likert scale	≥ 4[17]	Sensitivity: 88% Specificity: 89%[17]

IPV, intimate partner violence; USPSTF, US Preventive Services Task Force.

encourage family physicians to respond to IPV disclosures with empathy. Maintain eye contact and warm body language, validate the patient's experiences ("I am sorry this happened to you," "that must have been terrifying"), tell the patient that the violence was not their fault, and thank the patient for disclosing.[23]

Assess patient safety. Another critical component of intervention is to assess the patient's safety and engage in safety planning. If the patient agrees to this next step, you may wish to provide a warm handoff to a trained social worker, nurse, or psychologist in the clinic who can spend more time covering this information with the patient. Some key components of a safety assessment include determining whether the violence or threat of violence is ongoing and identifying who lives in the home (eg, the partner, children, and any pets). You and the patient can also discuss red flags that would indicate elevated risk. You should discuss red flags that are unique to the patient's relationship as well as common factors that have been found to heighten risk for IPV (eg, partner engaging in heavy alcohol use).[1]

With the patient's permission, collaboratively construct a safety plan that details how the patient can stay safe on a daily basis and how to safely leave should a dangerous situation arise (**TABLE 2**[9,24]). The interactive safety planning tool available on the National Domestic Violence Hotline's website can be a valuable resource (www.thehotline.org/plan-for-safety/).[24] Finally, if a patient is experiencing mental health concerns associated with IPV (eg, PTSD, depression, substance misuse, suicidal ideation), consider a referral to a domestic violence counseling center or mental health provider.

Move at the patient's pace. Even if patients are willing to disclose IPV, they will differ in their readiness to discuss psychoeducation, safety planning, and referrals. Similarly, even if a patient is experiencing severe violence, they may not be ready to leave the relationship. Thus, it's important to ask the patient for permission before initiating each successive step

TABLE 2

Recommend patients take these steps as part of an IPV safety plan[9,24]

Things to do in advance
• Ensure (if possible) that firearms and other weapons are stored safely
• Be prepared to move to an area of the home that does not contain weapons if an argument arises
• Identify several exits (eg, doors, windows, fire escapes) and practice using them
• Identify trusted individuals that you can contact for help; have their contact information accessible (eg, in your phone or wallet)
• Establish a code word you can use to signal to others that you need help
• Ask a neighbor to call the police if they suspect that you are in danger
• Teach your children how to dial 911 to get help
• Make a plan for childcare and pet care in case of an emergency
• Store important documents and belongings in an easily accessible container or have a trusted individual store them outside your home
• Store extra cash and a change of clothes at a friend's/neighbor's home
• Identify safe places you can go outside the home in an emergency (eg, a friend's home, domestic violence shelter, emergency department). Store these phone numbers/addresses in your phone and/or wallet; put them under a false name if there are significant safety concerns
• Consider opening a separate savings account
Crisis resources
• Emergency/police: Dial 911
• National Domestic Violence Hotline: (800) 799-SAFE (7233)
• Local resources (eg, domestic violence shelter, emergency department)

IPV, intimate partner violence.

of the follow-up intervention. You and the patient may wish to schedule additional appointments to discuss this information at a pace the patient finds appropriate.

You may need to spend some time helping the patient recognize the severity of their situation and to feel empowered to take action. In addition, offer information and resources to all patients, even those who do not disclose IPV. Some patients may want to receive this information even if they do not feel comfortable sharing their experiences during the appointment.[20] You can also inform patients that they are welcome to bring up issues related to IPV at any future appointments in order to leave the door open to future disclosures.

THE CASE

The physician determined that Ms. T had been experiencing physical and psychological IPV in her current relationship. After responding empathically and obtaining the patient's consent, the physician provided a warm handoff to the psychologist in the clinic. With Ms. T's permission, the psychologist provided psychoeducation about IPV, and they discussed Ms. T's current situation and risk level. They determined that Ms. T was at risk for subsequent episodes of IPV and they collaborated on a safety plan, making sure to discuss contact information for local and national crisis resources.

Ms. T saved the phone number for her local domestic violence shelter in her phone under a false name in case her husband looked through her phone. She said she planned to work on several safety plan items when her husband was away from the house and it was safe to do so. For example, she planned to identify additional ways to exit the house in an emergency and she was going to put together a bag with a change of clothes and some money and drop it off at a trusted friend's house.

Ms. T and the psychologist agreed to follow up with an office visit in 1 week to discuss

any additional safety concerns and to determine whether Ms. T could benefit from a referral to domestic violence counseling services or mental health treatment. The psychologist provided a summary of the topics she and Ms. T had discussed to the physician. The physician scheduled a follow-up appointment with Ms. T in 3 weeks to assess her current safety, troubleshoot any difficulties in implementing her safety plan, and offer additional resources, as needed. JFP

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