# Chapter 68– Intimate Partner Violence

## Episode Overview:

1) List 7 risk factors for Intimate Partner Violence (IPV) victimization as well as list 3 concerning presentations for IPV
2) List the 3 typologies of the perpetrators generally seen
3) List 5 clues on history and physical exam of IPV
4) List 4 features of physician behaviours that encourage disclosure of IPV
5) List 4 historical features for strangulation. List 6 physical examination findings of strangulation.
6) Describe one tool for partner violence screening
7) Describe the physician role in the management of disclosed IPV
8) List 5 patient types of IPV exposure and corresponding appropriate interventions
9) List 2 ethical considerations in IPV
10) Describe the key elements in documentation for IPV patients.

## Rosen's in Perspective:

Emergency room physicians are very good at addressing the glaring chief complaint, but this often leads us to missing opportunities to help people at risk of IPV, who may be presenting for a multiple of un-related complaints. The value of learning about IPV can help us move beyond the obvious IPV with physical signs, the so called "tip of the iceberg" and facilitate earlier intervention, reducing morbidity and mortality in this at risk population.

IPV is defined by the center of disease control as "the threat or infliction of physical or sexual violence by a current or former adolescent or adult intimate partner or spouse. This can range from obvious mechanisms such as hitting, slapping, and strangulation, to less obvious mechanisms such as controlling access to food or medications, refusal to use condoms or isolation from friends and family.

Victims tend statistically to be women (24% of women experience IPV in their lifetime vs 11% of men), although risk factors we'll discuss later can vastly increase prevalence in certain groups. Accordingly, homicide is one of the top five leading causes of death for females 1-34! As emergency room physician's we need to have a very high index of suspicion in order to reduce morbidity and mortality of this often silent presentation.

## 1) List 7 risk factors for IPV victimization and 2 concerning presentations for IPV

1. Female
2. Younger age
3. Exposure to childhood familial violence
4. Physical or mental disability
5. Use of alcohol by either party
6. Lower socioeconomic status
7. Immigrants

1. Woman with injuries to head face or neck (MC injury type)
2. Female patient who has attempted suicide (90% of hospitalized suicide attempts in women report current severe IPV)

## 2) List the 3 typologies of the perpetrators generally seen

- Note: these typologies come from research on men who have committed violent acts and may be biased

1. Borderline or dysphoric individual
2. Antisocial of generally violent individual
3. Non-violent outside home with no psychopathology. Often evidence of passive dependency or Obsessive Compulsive Personality Disorder

## 3) List 5 clues on history and physical of IPV

1. Admission of IPV
2. Vague or changing history
3. Injuries inconsistent with history
4. Statement that patient is “accident prone”
5. Past history of injuries

1. Centrally located injury (ie. trunk, breasts)
2. Bilateral injuries
3. Defensive injuries
4. Patterned injuries
5. Head, face, neck injuries

## 4) List 4 features of physician behaviours that encourage disclosure of IPV

1. Attentive listening
2. Conveyance of compassion and concern
3. Nonjudgmental
4. Respect women’s right to autonomy in decision making
5. BONUS: Educational material around ED

Note: Gender of physician does not appear to be factor in disclosure.

## 5) List 6 physical examination findings of strangulation

- Strangulation occurs in upwards of 40% of IPV patients and is the most common predictor of homicide. A woman is murdered by her current/ex-partner every 6 days in Canada.
    a. Hoarse voice
    b. Dysphagia or odynophagia
    c. Difficulty breathing
    d. LOC
    e. Incontinence
    f. Confusion
    g. Chronic concussive symptoms (from “shaken adult syndrome”)

## 6) Describe one tool for intimate partner violence screening

- emphasize UNIVERSAL screening

**Box 68-1 Abuse Assessment Screen**

Have you ever been emotionally or physically abused by your partner or someone important to you?
Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone? If yes, by whom?
Within the last year has anyone forced you to have sexual activities? If yes, who?
Are you afraid of your partner or anyone mentioned above?

**Box 68-2 Partner Violence Screen**

Have you been hit, kicked, punched or otherwise hurt by someone within the past year? If yes, by whom?
Do you feel safe in your current relationship?
Is there a partner from a previous relationship who is making you feel unsafe now?

- Example: Partner violence screen (Box 68-2)
    - Have you been hit, kicked, punched or otherwise hurt by someone within the past year? If yes, by whom?
    - Do you feel safe in your current relationship?
    - Is there a partner from a previous relationship who is making you feel unsafe now?

A few other screening phrases:

- "With your history of depression, previous suicide attempts, multiple episodes of injuries, I was wondering if your home situation was stressful or unsafe; perhaps because of a partner who threatens or hurts you; is this or has this been true for you?"
- ….intro to the subject: "Because of the impact of violence on women's health, I ask ALL my female patients these questions…"

**Risks for lethal IPV:**

- Stalking and harassment
- Estrangement
- Access to firearms by perpetrator
- History of forced sex
- Physical abuse during pregnancy

See page. 880 for a short list of these questions.

****Assessing risk factors for possible lethal outcome is crucial.** Based on one study **50% of women did not accurately perceive their risk of being killed by their partner.**

## 7) Describe the role of the physician in the management of disclosed IPV

- Safety planning is key here. Many victims may not leave at the time that they are seen, which can be really frustrating for us as physicians. We cannot

report to police if the patient doesn't want us to do so (mandatory CAS reporting again however). The important thing is to let someone know that they can always return to the ED for help.

- VictimLinkBC is a toll-free, confidential, multilingual telephone service available across B.C. and the Yukon 24 hours a day, 7 days a week at 1-800-563-0808. It provides information and referral services to all victims of crime and immediate crisis support to victims of family and sexual violence, including victims of human trafficking exploited for labour or sexual services.

Remember that fear keeps many individuals in these violent situations - and the cost of disclosure or making a change may simply seem to exceed the benefits. (e.g. risk of deportation, poverty, abandonment from their social circles, child well-being). Giving the person detailed informed choice and respecting that may leave the door open in the future for reconsideration. Re-abuse using our professional power by making disparaging remarks is not helpful.

Helping the patient plan for safety - especially if the patient is in the precontemplation/contemplation stages - are important. Such as getting into a protected room (with an escape) while the person has an outburst, having a "go-bag", having a safety plan, etc.

## 8) List 5 types of IPV exposure and corresponding appropriate interventions

1. No history of suspicion of IPV
2. Prior history but no current exposure
    a. Add history of IPV to medical record
3. Recent or current abuse but no injuries and no elements of danger on assessment
    a. Add IPV to problem list and give educational materials
4. Current abuse with injuries on findings on danger assessment
    a. Complete history, involve third parties as required (police, social services, IPV advocate)
5. Suspicion but denies IPC
    a. Consider involving social services or IPV advocate and give educational materials

## 9) List 2 ethical considerations in IPV

1. Confidentiality
    a. For our US friends: HIPAA you can release information to government authorities or social service however patients may specifically request non release. It's complicated, know your local laws.
        i. This is especially tricky when the abuse is sheltered under the abuser's health insurance...How does the victim obtain treatment and counseling without their partner being notified?
2. Informed consent and autonomy
    a. IPV victims are free to disclose or not
    b. However, some states (California) require physicians to report patients with injuries suspected to be assault related to law enforcement

## 10) Describe the key elements in documentation for IPV patients.

- Like sexual assault patients, these have a high likelihood of going to court and have to be meticulously documented. It is also really important to list IPV

as the discharge diagnosis. The preferred CDC term is “intimate partner violence”; whereas “adult maltreatment” is used by ICD - whether suspected or confirmed
    - It is not prejudicial and can help future ED visit physicians understand why the patient has returned and put any injury/complaint in context.

- See table 68-3 for key elements but in general think about key elements in the history (verbatim statements, assailant details, past IPV and potential strangulation), comprehensive documentation of physical exam including MSE, new and old injuries and signs of strangulation, and resources/safety planning and law enforcement (if involved) for discharge.
    - Key to assess for risk factors for fatal outcomes in IPV

**Table 68-3 Key Elements in Medical Record Documentation for Intimate Partner Violence (IPV) Cases**

| KEY ELEMENTS IN THE HISTORY | KEY ELEMENTS IN THE PHYSICAL EXAMINATION | KEY ELEMENTS IN THE DISCHARGE PLAN |
|---|---|---|
| A verbatim or near-verbatim statement by the patient regarding cause of injuries | Brief description of state of mind or demeanor of patient | Care instructions for medical or traumatic complaints |
| The relationship of the assailant to the victim | Mental status examination, including brief cognitive assessment for mild traumatic brain injury | Arrangements for follow-up for medical and IPV intervention |
| The current whereabouts of the assailant (immediate safety check) | Poststrangulation: results of direct or indirect laryngoscopy | Safety planning: Where can the patient go now that is safe? What to do if safety is placed at further risk? |
| Detailed account of how current assaultive injury occurred | Narrative description of new injuries | How to access victim advocate? |
| Symptoms of current and past abuse-related injuries | Narrative description of sequelae of old injuries, such as chronic pain, decreased range of motion, or hearing loss | How to apply for Victims of Crime restitution? |
| Poststrangulation: patient description of voice change, if any | Diagrammatic and/or photographic documentation of injuries (digital photography is acceptable for medical or forensic use) | If law enforcement is notified, badge name and number of officer contacted |
| IPV assessment as outlined in Table 68-1 by physician or consultant | | |