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SPECIAL ARTICLE

Intimate Partner Violence (IPV)

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Intimate partner violence (IPV) is defined as any behavior that causes physical, mental, sexual, emotional or social isolation or abuse to the victim, who is in an intimate relationship with the abuser. It is the most common form of violence experienced by women. The World Health Organization (WHO) Multi-Country Study of Women's Health and Domestic Violence Against Women indicates that the lifetime prevalence of IPV varies significantly by country and region, ranging from 13% to 71%.[1] The prevalence of IPV in Thailand is not accurate owing to underreporting. However, the prevalence rates among pregnant and adolescent women appear to be greater. All women, regardless of socioeconomic status, race, sexual orientation, age, ethnicity, health status, and presence or absence of current partner, are at risk for IPV.

IPV can cause serious long-term health effects.[2] It significantly increases the risk of mental health problems such as depression, post-traumatic stress disorder, anxiety, and suicidal ideation.[3] Women who experience IPV are also more likely to suffer disability from cardiovascular and musculoskeletal problems, chronic pain, arthritis, or respiratory problems.[4] Undetected IPV may result in misdiagnoses, improper testing, and inappropriate treatment or management of health conditions.[5,6] In conclusion, women experiencing IPV have an increased risk for substance abuse, mental disorders, chronic physical disorders, and sexual health complaints. It is a significant cause of morbidity and mortality for women. Women abused during pregnancy are more likely to be depressed, suicidal, and experience pregnancy complications and poor outcomes, including maternal and fetal death. Children whose mothers experience IPV are at greater risk of developmental difficulties and may themselves be abused. Women who are immigrants or refugees, lesbians, and women who have disabilities may experience IPV differently, and may have more barriers to disclosure than mainstream women. Health care professionals should be sensitive to the manifestations of IPV in populations with differing needs

Health care providers play a critical role in identifying and referring victims of IPV. Screening has been shown to increase disclosure and facilitate referral, and surveys indicate that most patients want their provider to inquire about IPV.[7-9] Routine inquiry, on-going dialogue, and establishing patient trust are vital to patient disclosure.

Addressing IPV in a clinical setting

Screening

All women should be asked about IPV and encouraged disclosure. Display IPV posters, safety cards, and patient education materials, including referral information, in exam or waiting rooms, toilets

or with discharge instructions.

Consider screening for IPV at the initial patient visit; during routine exams; at prenatal care and immediate postpartum visits; if a patient mentions a new intimate relationship; when a patient presents with symptoms (Table 1) or trauma (Table 2) consistent with IPV.

Table 1. Clinical indicators potentially consistent with IPV*[9,10]

General physical findings
• Complaints of headache (including migraine), back pain, chronic neck pain, vague complaints, and psychogenic pain.
• Digestive problems (e.g., nausea, abdominal pain, diarrhea, constipation).
• Appetite disturbance, significant weight gain or loss.
• Assault injuries consistent with IPV (Table 2).
Obstetric and gynecologic findings
• Complaints of painful intercourse and/or sexual dysfunction.
• Injuries during pregnancy, fetal injury, or miscarriage.
• Sexually transmitted infections including HIV, and signs/symptoms of infection such as vaginal pain, itching, or discharge.
• Urinary tract infection, pain on urination.
Mental health findings
• Symptoms of depression, anxiety, post-traumatic stress disorder, insomnia.
• Inappropriate affect (e.g., lack of expressiveness, minimal eye contact).
• Eating disorders (e.g., anorexia, bulimia).
• Frequent use of prescribed anxiolytics or pain medications.
• Abuse of drugs, alcohol, or tobacco.
• Suicidal or homicidal ideation or attempts.

*One or more of these findings may be present.

Table 2. Assault injuries consistent with IPV [9]

• Patterned injuries, such as injuries to both wrists.
• Multiple or frequent injuries (contusions, abrasions, minor lacerations, human bites) in various stages of healing.
• Sprains or fractures, especially fractured or subluxated teeth, fractures to the mandible, maxilla, orbit, and spiral wrist fractures.
• Burns (cigarette or rope burns), gunshot/stab wounds.
• Localized hair loss and scalp injury.
• Detached retina, perforated tympanic membrane.
• Concussion, subdural hematoma, or cerebral bleeding associated with bruising to neck and back of head from choking or head banging.
• Signs of sexual assault, injuries to genitalia and breasts.

Use standardized screening tools such as the Abuse Assessment Screen (Table 3), which are effective in identifying women suffering from IPV.[11]

Table 3. Abuse Assessment Screen*[11]

1. Have you ever been emotionally or physically abused by a partner? If so, by whom?
2. Within the past year, have you been hit, slapped or otherwise physically hurt? If so, by whom?
3. Within the past year, have you been forced to have sex against your will? If so, by whom?
4. Are you afraid of your partner?

*Adapted from Agency for Healthcare Research and Quality. Guide to Clinical Preventive Services, 2005.

Positive Response: If a patient answers "yes" to one or more questions, conduct clinical assessment (Table 4) and offer referral(s).

Negative Response: If a patient answers "no" to each of the abuse screening questions in Table 3: respect her responses; let her know that you are available should the situation ever change; if you believe she may be at risk, offer information and resources ("If you should ever experience something like this…"); and assess again as circumstances allow.

If current or past IPV victimization were suspected despite a lack of patient disclosure, screening should be done and results should be documented. Documentation of this concern may prompt the physicians to ask again at future visits. Include the reasons for concern, such as "physical findings are not congruent with history or description," or "patient presents with evidence of violence."

To encourage patient disclosure: examine the patient in private; ask clear, direct questions, and use non-judgemental words, tone, and body language. If language is an obstacle, locate a trained female interpreter. It is important to communicate your desire to help. For some women, acknowledging IPV and taking action to get help can be a slow process. Initiate the conversation with some leading statements or questions such as: "Since violence is common in many people's lives, I ask all my patients about it." or "Do you feel safe and happy at home?"

Screenings should be conducted without the partner, friends, or relatives (except children under 3 years of age) present. When a partner accompanies the patient, be aware of the partner's behavior. He or she may insist on staying close and may try to answer many of the questions posed to the patient. Partners may also show evidence of hand injuries (e.g., skin discolorations indicative of ecchymosis, lacerations).

Assessment of patients with suspected or confirmed IPV

Conduct a full clinical assessment immediately after patient disclosure of recent abuse, or if you suspect abuse based on clinical signs or symptoms consistent with IPV (Tables 1 and 2). The clinical assessment (Table 4) should first determine whether the patient is in immediate danger. Indications of immediate danger include:

- An escalation in the frequency or severity of violence;
- Recent use or threatened use of weapons by the abuser during IPV episodes;
- Threats by the abuser of homicide or suicide;
- Stalking of the patient.

If a patient is in immediate danger, the physician or staff should help the patient call the police or an IPV hotline.

Table 4. Clinical assessment of patients disclosing abuse[12]

Safety assessment	• Evaluate severity: "Are you in immediate danger? Are you afraid to go home?" • Assess for escalation: "Has the violence gotten worse or is it getting scarier?" • Listen for threats of homicide, suicide, weapon use, or stalking. • Identify whether the patient has somewhere safe to go.
General history	Inquire about: • Abuse in childhood or IPV in a previous relationship. • History of miscarriage. • Child abuse in current family. • Lack of money and/or documents (e.g., passports, visas).
History of physical trauma	• Take a history of physical injuries (include dates, times, locales, and circumstances). • Note if there is an unexplained delay between the occurrence of the injury and medical treatment. • Determine if injuries are inconsistent with the given explanation. • Use direct quotes whenever possible to identify abuser and describe the assault circumstances.
Mental health assessment	• Screen for depression. • Ask about alcohol and substance use; rule out substance abuse or dependence. • Assess for suicidal ideation.
Physical exam	• Examine for scars, injuries, or any other findings consistent with trauma. • If patient reports recent sexual abuse, refer her to rape crisis services and to appropriate emergency department care for a Sexual Assault Forensic Exam (SAFE), which includes a pelvic exam and forensic specimen collection. Written consent must be obtained for specimen collection. • Use body maps to note old and new wounds and to document severity. • Offer the option to be photographed (written consent recommended). Photographs can be important evidence for future legal actions to protect the victim.

The following should be included in the patient evaluation and documented in the medical record (Table 4):

1) Evaluation of patient safety;
2) History, including trauma history;
3) Evaluation of mental health, specifically suicidal ideation;
4) Physical examination.

The medical record should be prepared with care, as it may be used during medical/legal proceedings or required for the procurement of social services. Document the patient's statements and avoid pejorative or judgmental language (e.g., write "patient states" rather than "patient alleges"). Health care professionals should make clear, legible, and objective clinical notes, using the woman's own words about abuse and adding diagrams and photographs when appropriate.

Screening and assessments should not occur if:

- There is no way to conduct the assessment in private;
- There are concerns that assessing the patient would place the patient or provider at risk;
- There is a language barrier and the provider is unable to secure an appropriate interpreter.

If screening and assessment do not occur and you suspect that the patient is experiencing IPV, note in the patient's chart that inquiry was not completed and schedule a follow-up appointment or referral to another provider.

Referrals and Follow-up

All women who disclose current or past IPV should be offered referral to supportive social and legal services such as a social worker, counselor, or other designated staff. Designated support staff should call the proper IPV advocacy hotline to link the patient with the appropriate support services within the community. When possible, refer patients to organizations that address their unique needs, such as primary language other than Thai. There are also organizations that specialize in working with specific populations such as lesbian, gay, bisexual, or transgender clients, teens, elderly, disabled, or unauthorized immigrants.

Sexual violence

Patients who report experiencing recent sexual violence (i.e., within the past 96 hours) should be referred to the nearest emergency department with specialized services for sexual violence victims. These services include a Sexual Assault Forensic Exam (SAFE), rape crisis services, and comprehensive medical, forensic, and psychosocial care. Patients who disclose sexual violence that occurred more than 96 hours ago should also receive information about rape crisis services.

Safety planning

After a patient discloses current or past abuse, offer at least one follow-up visit. Ask if it is safe for the patient to receive appointment reminder calls at home or if there is an alternate number—this facilitates trust. For patients currently in abusive relationships, use each follow-up visit as an opportunity to:

- Ask what resources the patient has accessed;
- Inquire about the nature of the current violence;
- Determine whether the violence is escalating in frequency or severity;
- Communicate ongoing concern about your patient's safety and health.

Potential follow-up questions include:

- "Has the abuse gotten worse, or does it happen more often?"
- "What services are helping you, such as counseling, a support group, or other assistance?"
- "Whom have you talked with, such as a family member or a friend, about the abuse?"

If the patient is still not ready to act, restate her options (e.g., individual safety planning, talking with friends or family, advocacy services and support groups, transitional/temporary housing) and ensure that the patient has access to appropriate health care.

Legal requirements

Children, Abuse, and IPV

IPV and child maltreatment often co-exist. Studies indicate that in 30%–60% of families where mothers are battered, children also suffer abuse.[13,14] Health professionals should enquire about the well-being and safety of children whose mothers' are experiencing IPV.

In summary, IPV is a serious public health concern. Health care providers can play a critical role in identifying and helping at-risk patients. When IPV screening and dialogue are part of routine patient visits, disclosure is more likely to occur. Identifying IPV may help reveal the cause behind non-specific complaints and improve chronic disease management. Once IPV is disclosed, providers may help patients reduce subsequent health risks and prevent further escalation of violence.

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