American College of Emergency Physicians®

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Intimate Partner Violence

An Information Paper

In an effort to provide members with timely tools to care for patients, the Public Health and Injury Prevention Committee of the American College of Emergency Physicians produced this resource. We hope that the following materials and case discussions will aid emergency department (ED) physicians in practical and appropriate care of patients suffering from intimate partner violence (IPV).

Background

Intimate partner violence (IPV) is a complex pattern of coercive behaviors perpetrated by an individual to gain dominance and control over a current or former intimate partner. Perpetrators may use physical harm, sexual assault, and psychological abuse in the form of threats, economic control, denigration, social isolation, and stalking. IPV ranges from a single incident to an ongoing pattern of abuse often fluctuating in frequency and increasing in severity over time. IPV affects adult, adolescent, heterosexual, same-sex, and transgender relationships. The perpetrator and the victim may be dating, married, separated, or divorced; cohabiting or living apart.

Though this paper targets the ED entry point, all providers see and must respond in caring for patients suffering from IPV. According to the Centers for Disease Control and Prevention (CDC), medical and mental health care costs account for $4.1 billion of the more than $5.8 billion total annual cost of IPV against women alone in the United States.[1] According to the 2010 National Intimate Partner and Sexual Violence Survey (NISVS), a large population-based survey developed by the CDC, more than 12 million U.S. residents report intimate partner violence each year.[2] More than one in three women (35.6%) and more than one in four men (28.5%) reported physical violence, rape, and/or stalking by an intimate partner in their lifetime. Women are 1.7 times more likely than men to experience severe physical violence (24.3% vs. 14%) and twice as likely as men to experience sexual violence (16% vs. 8%) by an intimate partner.[2] The lifetime prevalence of IPV is even more common among lesbian women (44%) and bisexual women (61%). Similarly, NISVS found the lifetime IPV prevalence to be 26% among gay men and 37% among bisexual men.[2] This violence often starts at a young age. The data shows that among those who experience any form of lifetime IPV, 22.4% of women and 15% of men first experience IPV between the ages of 11 and 17 years.[2] The 2011 National Youth Risk Behavior Survey found that approximately 10% of high school students report experiencing physical violence by an intimate partner.[3]

In its most extreme form, IPV may be fatal. Intimate partners perpetrate 14% of all homicide in the U.S., and a striking 45% of all intimate partner homicides (IPH) involving a female victim (versus 5% involving a male victim).[4] Women are 2.3 times more likely than men to be killed (1.07 vs. 0.47 per 100,000) by an intimate partner.[4] In addition to intimate partner deaths, 20% of IPV-related deaths involve corollary victims—family members, friends, new intimate partners—and more than one third (38%) of family corollary victims are younger than 12 years old.[5]

IPV has profound short- and long-term impacts on the health of abused individuals and their exposed children. Health consequences of IPV include physical injuries such as burns, lacerations, fractures, and head trauma; reproductive health problems such as sexually transmitted infections, unintended pregnancies,

and violence-related miscarriages; and mental health outcomes such as depression, anxiety, posttraumatic stress disorder, and suicide.[6-8] EDs demonstrate the highest prevalence rates of IPV among general symptom ambulatory settings.[9-11] The ED visit represents a unique opportunity for providers to screen for IPV and assist patients suffering from this form of violence.

Screening

Emergency departments provide a unique opportunity for healthcare professionals to screen for IPV in patients who may lack access to regular care and those in crisis. EDs may protocolize screening for IPV by the triage team or assigned nurse. Many professional and governmental entities encourage universal screening for IPV, including the U.S. Preventive Services Task Force, which recommends that providers screen women of childbearing age for IPV, and provide or refer women who screen positive to intervention services.[12] Though the Joint Commission mandates that hospitals have policies and procedures to screen, these are variably applied in the ED setting.[13] Emergency care providers often fail to identify individuals after such violence. In the ED setting it is important of have a high index of suspicion and be willing to ask about abuse. Even one question such as "do you feel safe?" may save the person's life. Though many screening methods have been suggested there remains no standard and simply asking with empathy and in privacy can suffice for the majority of patients.

This information paper provides emergency providers with specific tools to use in the identification and risk stratification of patients suffering from IPV. **Table 1** offers established screening questions that may be used for identification as well as danger assessment references and tools that may be used by both providers and patients. The following case discussions illustrate implementation of these tools with real ED patients. Though all of the cases involve female victims, ED physicians will encounter IPV in all genders and within same-sex or opposite-sex relationships and must address this with equal compassion and sensitivity.

Case #1

Anna, a 19-year-old-woman with no past medical history presents to the ED with the chief complaint of facial pain and difficulty breathing. During an argument, Hector, her boyfriend, hit her several times in the face before strangling her, at which point she lost consciousness. When she awoke, Hector was gone, and she called 911. On arrival to the ED, Anna is tachycardic and tachypneic, with normal temperature, BP, and pulse oximetry. She has marked facial ecchymosis and swelling, especially to her right orbit and cheek. There are no facial petechiae noted, but there are small bilateral sub conjunctival hemorrhages. Her neck reveals linear bruising on the right side; the remainder of her physical exam is normal.

In the ED, chest radiograph reveals a 25% right sided pneumothorax. CT scan of the head is negative. CTA of the neck reveals no vessel or laryngo-tracheal injury. A percutaneous pneumothorax drainage catheter is inserted without difficulty and the patient is admitted to trauma service under an alias for her protection. She has an uneventful recovery and is discharged from the hospital four days later. Initially, Anna did not want police notified and, in her state, notification is prohibited without patient consent. A social worker met with Anna and administered the Danger Assessment. She was found to be in extreme danger. Armed with this information, the social worker counseled Anna and contacted the local domestic violence hotline; they arranged for a crisis counselor to come to the hospital to talk to Anna. With Anna's permission, police were notified. The agency helped her secure a legal protective order with law enforcement and assisted her with seeking alternative housing upon hospital discharge.

The Danger Assessment (DA) is used to estimate the risk of being killed by an intimate partner in a violent intimate relationship.[14-16] The tool consists of two parts. In the first part, the victim quantifies the approximate dates the partner inflicted physical abuse in the past year and rates the severity of each assault. In the second part, the patient completes a 20-question yes/no weighted instrument of risk factors associated with intimate partner homicide. An online process is available to certify correct DA administration and scoring. The results are grouped as follows:

- <8 Variable Danger
- 8-13: Increased Danger
- 14-17: Severe Danger
- >18: Extreme Danger.

Since its creation, modifications to the DA include one for same-sex relationships,[17] immigrant women,[18] and a simplified version for ED use.[19] A recent modification of the DA by the Maryland Coalition Against Domestic Violence called the Maryland Lethality Assessment Program is designed to be used by first responders and can encompass a wider array of professionals.[20] The tool consists of 11 yes/no questions. A positive response to any of the first three questions, or to four of the remaining questions, triggers activation of the protocol (referral to IPV program) as these victims are at high risk for homicide.

Why is the DA important? Every year 1500-1600 women are killed by an intimate partner accounting for 40-50% of all femicides committed in the U.S.[4] About 67-80% of intimate partner homicides involve physical abuse of the female by the male prior to the murder.[16] Perpetrators employ a firearm most often in the homicide. The use of the Danger Assessment or Maryland Lethality Assessment Program can help to identify woman at the greatest risk for intimate partner homicide.

Factors associated with a higher risk for intimate partner homicide[16,21]

Risk Factor	Adjusted OR
Abuser unemployment	5.09
Access to firearm	7.59
Abusers use of illicit drugs	4.76
Highly controlling abuser and separation after living together	8.98
Threats with a weapon	4.08
Victim left abuser	4.04
Victim left abuser for another partner	4.91
Strangulation	6.70 (attempted homicide) 7.48 (completed homicide)
Abuser used a gun	41.38

We recommend performance of a lethality assessment with ED patients who present following an IPV assault. Hospitals should have 24/7 access to a social worker or representative from the local IPV advocacy

center available to come to the ED, administer the assessment, and provide the patient information and options regarding safety planning. Telephonic consultation may also be a reasonable option. Because of the training needed and time to administer, the Danger Assessment may be impractical for solo ED physician use. The shorter, M-LAP is a good option as it takes less time, is easier to score, and can be administered by ED personnel. In memory of a woman killed by her intimate partner, developers have created an electronic application, "One Love," using DA questions[22] and providing instant scoring. This application is free to download and provides all persons with the tools to assess danger in a patient, friend, or themselves within a violent relationship.

All ED staff should know what resources are available to help victims of IPV and how they can assess patients for danger (**Table 2**). As emergency care porviders caring for IPV victims we must anticipate needs beyond ED care (danger assessment). In this case the consequences of not knowing can be lethal.

Case #2

Maria, a 21-year-old native Mexican woman, presents to a Texas ED with the complaint of vaginal bleeding, accompanied by her much older appearing Caucasian husband. Upon further questioning in English while husband translates, Maria states she is a G4P0, T0P0A3L0. In tears, she states that she has lost her babies during each of her previous pregnancies, around the same time. She is currently 11 weeks gestation by last menstrual period.

The emergency provider feels it is odd that Maria's husband wants to stay in the room and translate even when asked to leave. The provider removes the husband from the room by asking registration to talk to him regarding insurance and other administrative tasks, in order to get a more accurate history using the translator phone. During this time, the emergency physician is able to ask Maria directly about IPV.

With her husband out of the room, and through the anonymity of a telephonic translator, Maria tells the emergency physician that this marriage was arranged, and her husband paid for her to come to the United States three years ago. Her husband is a distant friend of her parents in Mexico, and he promised them that he could provide her a better life in the United States. She describes him trying to control all situations and is both financially and emotionally abusive. At first, he was supportive and nurturing, but that quickly changed as she became pregnant within a couple of months of their marriage, and he began to hit her. He doesn't allow her to have her own money nor is she able to do anything that costs more than $20 without his okay. This is her fourth pregnancy in four years. He doesn't allow her to use birth control, but he doesn't want any children, and she says, "he takes it out on me every time I get pregnant." During the exam, the emergency physician visualizes multiple bruises and observes a labial tear during the genital part of the pelvic exam. Patient admits, in tears again, that he forced her to have sex last night and subsequently threw her down the stairs. She began to bleed heavily this morning. He has threatened many times to kill her if she tells anyone about the abuse.

During her ED stay, the emergency physician used the DA "One Love" mobile app with the patient, along with the translator phone, to provide risk estimate. Due to her injuries and the patient's admission regarding the intimate partner abuse, Maria was admitted to the hospital under the OB/GYN service and was seen by social workers with whom she underwent counseling. There was also concern that Maria was a victim of human trafficking. Her husband used the relationship of trust with her family to his advantage. Social workers, with the help of local law enforcement as well as the FBI, focused on helping to end the abuse and exploitation Maria had suffered by addressing both issues of intimate partner violence as well as human trafficking. The Violence Against Women Act (VAWA) provides resources for victims of human

trafficking, including those of immigrant populations. Emergency physicians are at the frontline of identifying victims of intimate partner violence and human trafficking.

Maria is ultimately admitted to the hospital and accepts further counseling and help from the social workers and the local IPV advocacy workers during the stay. This help would not have been possible without identification by the emergency care team initially.

Case #3

Kim presents for evaluation after trying to end her own life by taking 60 acetaminophen tablets. Her boyfriend found her taking the pills and called 911. When the police arrived, they transported Kim and her boyfriend to the ED.

As Kim's nurse helps her change into a hospital gown, she notices bruises on Kim's arms bilaterally. With the ED doctor at bedside, Kim's nurse asks about the bruises. Kim refuses to talk about this or answer any questions about her motivation to attempt suicide. Even with private questioning in a sensitive way using screening methods described in Table One, Kim is unwilling to discuss the injuries or her relationship.

When the police learn about Kim's bruises, they question her boyfriend, who admits grabbing and shoving her, at which point they take him to the police station for further inquiry.

Though Kim declined to discuss her situation in the ED, she eventually spoke about it during her psychiatric hospitalization. After her boyfriend was arrested and with further gentle questioning, she described to her treating psychiatrist an emotionally and physically abusive relationship with her boyfriend. Both Kim and her boyfriend recently emigrated from Korea. Despite the severity of the abuse, Kim felt overwhelming shame at the thought of failure in her intimate relationship. Kim suffered in a classic abusive relationship marked by control and violence and, due to misogynistic cultural stigma, she saw no way to end the relationship with her honor intact, other than suicide. Kim's situation emphasizes several factors associated with suicide attempts in the context of IPV.

Multiple international studies using WHO data show an increased suicide risk in individuals subject to IPV.[23] Abusers typically use economic and physical control strategies in addition to controlling access to psychiatric medications, purposely overdosing the victim, threatening to take children, and forcing the victim to participate in crimes. These activities are focused on discrediting the victim to the public or giving the perpetrator legal leverage to control the victim.

Screening for suicide and providing resources may be especially important for IPV patients because victims are often socially isolated by the abuser and need education about intimate partner abuse, as well as shelters, support groups, and mental health service. In a rural area, these resources might be limited; providers have the option of contacting the National Domestic Violence Hotline by calling 800-799-7233 or at http://www.thehotline.org. This service provides screening for IPV and suicidal ideation and offers victims immediate counseling resources, safety planning, potential shelter referrals, and victim advocate networks. The telephone hotline operates 24/7 with online chat services also available from 7am to 2am Central t ime.

The second and third cases illustrate how cultural issues and IPV intersect. Cultures with strong traditional male-female roles may accept partner violence as normal and unavoidable. Marriages or partnerships where

the parents chose a woman's mate may be unequal, and ripe for abuse. The dissolution of marriage may be seen as a failure or the victim bringing shame to themselves and their family. Ethnic groups who perceive discrimination from law enforcement or government may feel that it is useless to report the abuse or feel that their partner or they would be at grave risk by authorities if reported. Many victims feel shame and may view reporting as a sign of weakness.

It is important when working with other cultures to tailor resources to the victims by providing advocates who speak the language of the victim and from the same community if available. Providers must be aware of personal biases and understand cultural differences when screening patients for IPV and suicidal ideation.

After Kim eventually disclosed to her psychiatrist that her partner had been restricting her access to friends and family and was both physically and sexually violent to her the psychiatrist connected her with the hospital social worker and a local IPV advocate who provided education and support. Both Kim and her boyfriend learned that his physical violence was illegal in the United States. This intervention provided Kim with tools and support to end the relationship safely and move on with her life.

Conclusion

We hope the case examples and the referenced tools provide emergency practitioners with tools to screen patients for intimate partner violence and to assess the relationship for lethality risk. As demonstrated by our cases, screening and identification are the first steps to providing information and providing victims access to help. The majority of women eventually killed by a partner in violent relationships have accessed the medical system within a year of the murder with the ED being a major portal of this contact. Danger Assessment with preplanned interventions provides the ED team with the tools and resources necessary to assess for and attenuate this deadly risk.

Table 1
Screening Resources for Providers

Partner Violence Screen (PVS)
Davis JW, Parks SN, Kaups KL, Bennink LD, Bilello JF.(2003). Victims of domestic violence on the trauma service: Unrecognized and underreported. Journal of Trauma, 54, 352-55.
https://www.michigan.gov/documents/mdch/Partner_Violence_Screen_435069_7.pdf
Link provides access to the three question PVS assessment tool.

Woman Abuse Screening Tool (WAST)
Brown JB, Lent B, Brett PJ, Sas G, Pederson LL. Development of the Woman Abuse Screening Tool for use in family practice. Fam Med 1996; 28(6):422–8 Copyright 1996.
http://womanabuse.webcanvas.ca/documents/wast.pdf
Link provides accesss to the with eight question WAST assessment tool.

Abuse Assessment Screen (AAS)
McFarlane, J, et al. Abuse Assessment Screen-Disability (AAS-D): Measuring frequency, type, and perpetrator of abuse toward women with physical disabilities. J of Women's Health and Gender-Based Medicine 2001;10(9):861-866.
https://www.acog.org/About-ACOG/ACOG-Departments/Women-with-Disabilities/Abuse-Assessment-Screen

Link provides access to the five question AAS assessment tool.

Danger Assessment

- Danger Assessment Information: https://www.dangerassessment.org/
- Danger Assessment Tool: https://www.dangerassessment.org/uploads/pdf/DAEnglish2010.pdf
- Danger Assessment App: http://www.joinonelove.org/my_plan_app

Lethality Risk Assessment

- Lethality Risk Assessment Tool: https://www.marincourt.org/PDF/LethalityRisk.pdf

Table 2
Resources for Patients

- Futures Without Violence, https://www.futureswithoutviolence.org/health/national-health-resource-center-on-domestic-violence/
- GLBT National Help Center, 1-888-843-4564, www.glbthotline.org
- GLBT National Youth Talkline, 1-800-246-7743, www.glbthotline.org/youth-talkline.html
- National Domestic Violence Hotline,1-800-799-SAFE (7233), www.thehotline.org
- National Coalition Against Domestic Violence, www.ncadv.org
- National Network to End Domestic Violence, www.nnedv.org
- National Resource Center on Domestic Violence, www.nrcdv.org
- National Teen Dating Abuse Helpline, 1-866-331-9474, TTY 1-866-331-8453, www.loveisrespect.org
- Partnership Against Domestic Violence, www.padv.org

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