EHHOP MHC Communiqué

Intimate Partner Violence (IPV)

* All text sourced from UpToDate and abridged

Intimate partner violence (IPV) is a serious, preventable public health problem affecting more than 32 million Americans.

Screening

Certain aspects of the history or observations made during the clinical encounter should heighten the clinician's suspicion of IPV:

- An inconsistent explanation of injuries
- Delay in seeking treatment
- Frequent ED or urgent visits
- Missed appointments
- In pregnancy, late initiation of prenatal care
- Repeated abortions
- Medication nonadherence
- Inappropriate affect
- Overly attentive or verbally abusive partner
- Apparent social isolation
- Reluctance to undress or have a genital, rectal, or oral examination, or difficulty with these or other examinations.

Patient Expectations

- Health care professionals who are nonjudgmental and compassionate
- Assurance of confidentiality
- Recognition of the complexities of violence and the difficulty of a quick resolution
- Avoidance of “medicalizing” the issue
- Discussion that is not rushed or hurried
- Confirmation that the violence is undeserved
- Supportive listening and feedback to bolster the patient’s confidence
- Ability to progress at their own pace
- No pressure to disclose, leave the relationship, or press charges
- Shared decision-making and respect for the patient’s decisions

Normalize by framing

- Violence can be a problem in many people’s lives, so I now ask every patient about trauma or abuse they may have experienced in a relationship.
- Many patients I see are coping with an abusive relationship, so I’ve started asking about intimate partner violence routinely.
- When people have the symptom you are experiencing, and the approaches you’ve tried don’t make it better, I wonder if they could have been hurt at some point in their life. Has anything like this ever happened to you?

Such statements may then be followed with specific questions.

SAFE questions

Safety: Do you feel safe in your relationship?

Afraid: Have you ever been in a relationship where you were threatened, hurt, or afraid?

Friend/**F**amily: Are your friends/family aware you have been hurt?

Emergency Plan: Do you have a safe place to go and the resources you need in an emergency?

Patients for whom IPV is suspected but not acknowledged should be asked again at subsequent visits. There are some data to suggest that patients are more likely to disclose information after they have been asked about violence repeatedly in the health care setting, thereby normalizing inquiry

Speaking to Victims of IPV

Guiding principles

1. Survivor safety – Being always aware that the primary concern is to maximize safety and not increase risk for further harm
2. Survivor empowerment – Facilitating the patient’s ability to make their own choices
3. Perpetrator accountability – Framing the violence as occurring because of the perpetrator’s behavior and not the survivor’s
4. Advocacy for social change – Collaboration and advocacy beyond the healthcare setting

Empathy

- "I am very sorry this is happening to you."
- "I am glad you were able to tell me."
- "This is a common problem."

Validation

- "You do not deserve this, it is not your fault."
- "You must be very strong to have been able to go through this and now to ask for help."

Assistance

- "I want to help you through this any way I can.”
- "I have worked with others with this problem and can assist you in improving your health and with resources to support you through working on this problem."

Do not...

- DO NOT frighten, intimidate, or shame a patient. Avoid using terms like “victim,” “abused,” or “battered.” Instead, mirror the patient’s own word choices or use words like “hurt,” “frightened,” or “treated badly.”
- DO NOT inquire about abuse in the presence of the partner, friends, or family members.
- DO NOT disclose or discuss your concerns with the patient’s partner.
- DO NOT ask the patient what they did to bring on the abuse.
- DO NOT ask why the patient has not left the partner, or why they may have returned to the batterer.

Safety planning

If any significant risk factor is present, it is imperative to devise a safety plan, as the patient may be at risk of serious harm or death. Depending on availability, a hospital or community domestic violence advocate, hospital social worker, or local domestic violence hotline can provide advice about the recommended plan in the community. The patient may need access to a shelter.

A safety plan should include the following elements:

- Preparing an emergency kit with important documents, keys, money, and other essential items, to be stored outside the home in case they need to escape urgently
- A place to go (friends, family, shelter)
- A signal to alert children/neighbors to call 911
- During times of escalating conflict, avoiding rooms with potential weapons (kitchen) or risk for increased injury (hard bathroom surfaces)

Resources

SAVI Advocates are available in the Mount Sinai Hospital Emergency Room. Trained Volunteer Advocates are on-call around the clock to provide immediate crisis intervention, emotional support, and information to survivors of rape, sexual assault, incest, and domestic violence.

Web-based resources:

- www.futureswithoutviolence.org/
- www.ncadv.org/learn-more/resources
- www.womenshealth.gov/relationships-and-safety/get-help
- www.cdc.gov/ViolencePrevention/intimatepartnerviolence/index.html

Telephone resources:

- National Domestic Violence Hotline: 1-800-799-SAFE (1-800-799-7233)
- The National Sexual Assault Hotline: 1-800-656-4673
- The National Teen Dating Abuse Hotline: 1-866-331-9474

Bottom Line

1. Screen every patient
2. Make MHC C/L Senior aware, come up with a plan
3. Screen for depression, anxiety, and substance use
4. Follow the patient’s lead
5. If the patient requests, provider can accompany patient to Emergency Room