Domestic violence is a serious, preventable public health problem that will present in your practice. It doesn't matter what you do or what types of patients you will see, you are likely to see pathology and social issues related to domestic violence, and if you aren't paying close attention - you will miss it.

Intimate partner violence or IPV is the more frequently used terminology to describe threatened psychological, physical or sexual harm by a current or former partner or spouse. IPV is frequently under-recognized since patients often conceal that they are in unsafe or abusive relationships, and hints may be subtle.

1. **In a patient with new, obvious risks for domestic violence, take advantage of opportunities in pertinent encounters to screen for domestic violence (e.g., periodic annual exam, visits for anxiety/depression, ER visits).**

We aren't entirely sure where this objective is going with "new, obvious risks" for domestic violence, but I think it's important to reiterate that anyone of any socioeconomic background, culture, race, gender identity or sexual orientation is unfortunately at risk for IPV.

The John's Hopkins school of nursing has a handy tool you can check out called the Danger Assessment tool https://www.dangerassessment.org/uploads/DA_NewScoring_2019.pdf It's a checklist of questions you can ask the victim that suggest increased risk of homicide from Intimate Partner Violence.

However, there are some frequent clinical presentations from Intimate Partner Violence in Practical Gynecology: A Guide for the Primary Care Physician should heighten a clinician's suspicion of IPV. These include:

- An inconsistent explanation of injuries.
- Delay in seeking treatment.
- Frequent emergency department or urgent visits. Typically, abusers do not want their victims to form an ongoing allegiance with one clinician. They may feel the victim will be less likely to find an ally in an emergency department where care may be more fragmented.
- Missed appointments. The patient may not keep appointments because the abuser will not allow medical attention. In one study, 17 percent of victims of IPV felt that their partner interfered with their access to practitioner visits, compared with 2 percent of those not suffering from abuse
- In pregnancy, late initiation of prenatal care

- Repeated abortions. Unplanned pregnancy may result from sexual assault and/or not being allowed to use birth control, which is referred to as reproductive coercion
- Medication nonadherence. Victims may not take medicines because the batterer has taken them away or not allowed the partner to fill prescriptions.
- Inappropriate affect. Victims may appear jumpy, fearful, or cry readily. They may avoid eye contact and seem evasive or hostile. A flat affect or dissociated appearance may suggest posttraumatic stress disorder.
- Overly attentive or verbally abusive partner. The clinician should be suspicious if the partner is overly solicitous or answers questions for the patient. If the partner refuses to leave the examination room, the clinician should find a way to get the partner to leave before questioning the patient. Partner reluctance to leave the patient alone is an important sign.
- Apparent social isolation.
- Reluctance to undress or have a genital, rectal, or oral examination, or difficulty with these or other examinations.

IPV is associated with overall poor health and often non-specific mental and physical health issues. Somatic complaints often associated with IPV include chronic pain, irritable bowel syndrome, headaches, and musculoskeletal pain. Think about screening for IPV in patients with psychological conditions including depression, suicidality, anxiety and panic disorder, eating disorders, substance use disorders, PTSD, and dissociative disorders.

It's important to talk and think about creating settings in which patients feel safe and comfortable to disclose a history of intimate partner violence, especially since we know so much of it is not disclosed. Patients are more likely to disclose their experience when practitioners are ready to listen, use open-ended questions and give patients space to speak. Questioning should be done in privacy, with very select individuals present. If practitioners assure confidentiality (of course unless someone is in imminent danger or a minor is involved), they are usually more successful in creating trust with patients.

A 2006 meta-analysis of qualitative studies identified expectations of women in regard to assessment for IPV. These may be helpful to integrate in your next case where you suspect intimate partner violence is present. Some of the patient's expectations included:

- 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

2. **In a patient in a suspected or confirmed situation of domestic Violence: Assess the level of risk and the safety of children (i.e., the need for youth protection), and Advise about the escalating nature of domestic violence.**

There aren't any child specific risk assessment tools used in medicine that we could identify in our research for this topic.

However, there are a number of risk assessment tools that are used by the justice system to predict future violence and assess level of risk of harm to the individual. What's most important is to establish if there is imminent danger to the patient or to minors, and also tell the patient that you will have to report this information if disclosed.

The ODARA tool is the Ontario Domestic Assault Risk Assessment, which correlates depending on the score to the proportional risk of future assaults within an average of 5 years. They are a list of questions including history or prior domestic assault against a partner or the children, prior nondomestic assaults, sentencing, failures of conditional release, threat to harm or kill, confinement of victim, history of children together, substance use problems, and assault on victim during pregnancy.

This can be helpful to go through with a patient as a documentable risk assessment score, and can be accessed for free on the internet. We will include a link to this scoring sheet in the shownotes. https://grcounseling.com/wp-content/uploads/2016/08/domestic-violence-risk-assessment.pdf

We've mentioned a couple of available tools you can use in this episode, but as a point of consideration, The Justice Department of Canada did a review of some of these risk assessment tools in 2012 and found little reliable validation for them, and recommended you also consider other sources to assess risk, including the Victim's own evaluation of risk. https://www.justice.gc.ca/eng/rp-pr/cj-jp/fv-vf/rr12_8/rr12_8.pdf

Safety of children is particularly important because this is where practitioners have a duty to report. It's best to know your specific province or territory policies, but they are largely similar in that children and minors must be protected from any physical, sxueal or emotional abuse, neglect (whether that is physical, medical, emotional, educational or supervisory), and that they are **protected from exposure to domestic violence**.

If a person has a reason to believe that a child or minor needs protection by law because they are or may be experiencing these mentioned issues, Child welfare agencies must be contacted, like the Ministry of Child and Family Development.

If you do have to make a report, be prepared to give your name, role and contact info, demographic information including names and birthdates of caregivers and children involved, as well as objective details about child protection concern in basic and non-medical language. Also be sure to document everything in their health records right away.

b) Advise about the escalating nature of domestic violence.
Patients who experience violence towards them may downplay, deny, or may even have normalized the situation they are in.

It's important to be able to recognize and explore with the patient their risk and future safety needs.

One of my preceptors early in medical school, Dr. Elaine Alpert, wrote an extensive guide on the identification, assessment, intervention and prevention on intimate partner violence, for the Massachusetts medical society. She describes key features to the history and can indicate escalating risk and therefore increased need for safety planning and follow-up. These include:

- An increase in the frequency or severity of threats or assaults
- Increasing or new threats of homicide or suicide by the partner
- The presence or availability of a firearm or other lethal weapon
- New or increasingly violent behavior outside the relationship by the perpetrator

3. **In a situation of suspected or confirmed domestic violence, develop, in collaboration with the patient, an appropriate emergency plan to ensure the safety of the patient and other household members.**

Your local domestic violence program can be a great resource for this kind of information, including emergency contact numbers and locations of safe spaces for people to go if they are in imminent danger.

In order to even develop an appropriate emergency plan, the patient's resources, current living situation, and support network need to be established.

Do they have a cell phone, a car, driver's license, access to finances, children in the home, trusted family or friends?

Most shelters and intimate partner violence resources recommend that a person keep a list of trusted emergency contacts, cash, credit and debit cards, original and photocopies of personal documents including passport and driver's license, keys, medications, clothes, and any important children's items in a safe and secure place that is readily accessible.

It is a good idea to include children in the conversation, especially if school-aged and able to call on the telephone. Recommendations are to have 'safe words' with children and trusted friends or family, to know when to call the police. Encourage the patient to reach out to local support telephone lines and know where local shelters are, should they need them. There are also emergency protection orders, restraining orders, and other kinds of protection that the justice system can offer should the patient want this.

4. **In a patient living with domestic violence, counsel about the cycle of domestic violence and feelings associated with it (e.g., helplessness, guilt), and its impact on children.**

The most impactful thing that we can offer as health care providers is validation and support, for patients to be able to make change if they are at that stage. Dr. Alpert gives some examples of phrases you may use to help validate patient's experience while also communicating empathy:

- "I believe what you are telling me"
- "There is nothing wrong with you"
- "You are not alone"
- "You are not at fault or to blame"
- "You deserve better than this"
- "No one should ever deserve this"
- "This must be so difficult"
- "You have tremendous courage"

It is also important to convey concern about safety - because this is ultimately what everyone fears. Making sure that the patient understands that you care about their safety and wellbeing, feels welcome and safe to disclose information, and that they can always come back if something changes.

Children can be very negatively affected by observing intimate partner violence. Witnessing IPV is one of the most commonly experienced adverse childhood events, which can impact not only childhood development, but also adult physical and mental health.

Patients may often downplay or not even recognize how aware children are to violence, but there is evidence that children as young as infants can be affected by family violence,

particularly in situations of toxic stress, which adversely affects developing brains of a young child exposed to prolonged, severe or repeated adverse events (Alpert). As adolescents and adults, these experiences can negatively impact their relationships, substance use, as well as risk of experiencing intimate partner violence themselves.

ODARA Tool: https://grcounseling.com/wp-content/uploads/2016/08/domestic-violence-risk-assessment.pdf

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