Intimate Partner Violence

How Clinicians Can Be an Asset to Their Patients

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ABSTRACT

Intimate partner violence (IPV) has emerged as a public health concern. It does not consist of physical violence alone, but includes psychological and emotional issues as well. IPV cuts across all cultures, age groups, and socioeconomic classes and necessitates numerous health care visits. It is often difficult to identify those who are affected by IPV when assessing during health care services. This difficulty may be overcome as health care providers become aware of the need to integrate screening as part of the initial assessment. Although it can be difficult to measure the impact of IPV, several organizations have been able to determine that the economic cost to society is significantly increased when IPV is present. Because nurses are the largest class of health care providers, their ability to perform screening activities is paramount to early detection and management of IPV.

Intimate partner violence (IPV) is defined as physical, sexual, psychological, or emotional abuse or the threat of abuse from a current or former intimate partner (Erickson, Gittelman, & Dowd, 2010). Although abuse is often viewed within sexual and physical contexts, perpetrators often engage in other behaviors in an attempt to maintain control of the victim's actions and relationships. These behaviors include financial restrictions, limits on contact with friends and family members, and the monitoring of activities (Hegarty & O'Doherty, 2011).

IPV can occur in any intimate relationship; however, the focus of this article is on male perpetrators and female victims. A review of literature was conducted in CINAHL and MEDLINE with combinations of the following keywords: *domestic violence*, *violence*, *intimate partner violence*, and *marital discord*. Articles were searched with a focus on male perpetrators and female victims of IPV; only articles published after 2006 were included in the search criteria. Additionally, articles inclusive of IPV assessment, intervention, and education were examined for content relevant to health care providers.

IPV is one of the most common forms of violence against women by either a husband or an intimate male partner (World Health Organization, 2010). IPV occurs in all societies, irrespective of social class. It can occur as a single episode or as pervasive behavior. The nature of the underlying intimate partner relationship presents a distinctive dynamic of IPV, as the victim is emotionally involved with the perpetrator and often financially dependent.

The impact of IPV against women has implications not only to the victim, but to the family, community, health care system, and society at large. The physical as well as psychological well-being of victims is often compromised. For women of childbearing age in the United States, IPV is the number one cause of serious injury and is the second leading cause of death (Hewitt, Bhavsar, & Phelan, 2011). Although physical health problems associated with IPV can be acute or chronic, the psychological problems associated with IPV are often chronic. Psychological effects can linger long after the relationship has terminated.

ETIOLOGY

Women who experienced abuse as a child are more likely to be victims of IPV. Victims of IPV typically are not facing IPV for the first time; instead, IPV is commonly recidivistic. Victims often will return to the same person who perpetrated violence against them on a continual basis (Brykczynski, Crane, Medina, & Pedraza, 2011).

Married women who are victims of IPV have reported feelings of inadequacy. These feelings include blaming themselves for poor appearance, sexual frigidity, and marital friction. Women who are married may have a belief structure in which violence within the marital setting is not considered grounds for separation or divorce; this subsequently keeps women in the relationship. There may be a perception that if the woman leaves the abuser, she will be the one who is blamed by friends and relatives. This can lead to feelings of inadequacy, bitterness, poor self-concept, lack of self-confidence, and feelings of worthlessness (Zarif, 2011).

Perpetrators often have a history of abuse as a child and are more likely to have come from a background in which violence is part of the family dynamic (Hegarty & O'Doherty, 2011). The perpetrator is likely to be a drug abuser, be unemployed, and have poor coping mechanisms (Zarif, 2011). Erickson et al. (2010) identified several risk factors consistent with violence occurring during adolescent dating relationships. Some of the risk factors identified include exposure to violence within the home, use of alcohol and drugs, cigarette smoking, history of psychiatric illness, sexually risky behavior, and a history of sexually transmitted diseases (STDs).

EXTENT OF THE PROBLEM

IPV occurs within all cultures, races, and among all socioeconomic classes. It accounts for a number of physical and psychological problems among the victims. IPV is estimated to affect 37% to 54% of women at some point in their lifetime (Erickson et al., 2010). Women are five to eight times more likely than men to be the recipient of violence, and IPV continues to be a major cause of death and injury for women (Erickson et al., 2010). Snider, Webster, O'Sullivan, and Campbell (2009) reported that of the 4.8 million IPV-related assaults against women quoted in the National Violence Against Women Survey, 2 million resulted in an injury and 25% required medical attention. It is estimated that 2.2% to 12% of emergency department (ED) visits by women are a direct result of IPV. Thirty percent of the homicides against women are committed by an intimate partner or a former intimate partner; 20% of these women have sought emergency care for injuries inflicted by intimate partners during the prior year.

In addition to victims of IPV seeking care in EDs, many victims visit primary care providers. IPV is a leading contributor to morbidity and mor-

tality in women of childbearing age. It is a common occurrence for a primary care provider to see up to five women per week who have experienced IPV within the previous year (Hegarty & O'Doherty, 2011). Up to 5 years after IPV exposure, costs incurred through utilization of health care services is approximately 20% higher in female IPV victims than in women who have not experienced IPV (Fishman, Bonomi, Anderson, Reid, & Rivara, 2010).

IMPACT OF IPV

The psychological dynamics associated with IPV involve many themes, most frequently those of control and power. One's level of functioning within the nuclear family and concept of gender roles influence the relationship with the significant other. The belief that men are dominant and control the family and all resources can lead to rigidity in family structure and functioning. The need for the man to maintain control through enforcing extremely rigid boundaries within the family can lead to psychological and physical assault. Dysfunction in the relationship between the man and woman can escalate into roles of perpetrator and victim. Control from the perpetrator leads to a loss of independence and autonomy for the victim. The victim is often in the position of being unable to make decisions related to finances, family situations, working outside the home, participation in social activities, and in some cases, any activities outside of the home (Antai, 2011).

Although the physical injuries are more apparent, psychological abuse occurs more often than other types of abuse, and its effects often go unnoticed. Female victims frequently perceive themselves as experiencing more chronic health problems and verbalizing more physical complaints than non-victims. Negative self-perception can lead to poorer means of coping and an array of subsequent sequela. Low self-esteem, impaired social functioning, depression, suicidal thoughts and gestures, anxiety, and posttraumatic stress disorder are some of the most prevalent psychological problems associated with IPV (Johnson & Zlotnick, 2009; Montero et al., 2011; Temple, Weston, & Marshall, 2010). Additionally, victims are more likely than non-victims to use prescription drugs, illegal drugs, or both as a means of alleviating psychological and physical problems (Montero et al., 2011).

The consequences of IPV can hinder daily tasks associated with jobs, families, and self-care. Overall productivity can diminish, resulting in a decline in performance and negative appraisal from others, which validate low self-esteem in the victim. Further decompensation can reinforce the victim to remain in the abusive relationship because of the lack of psychological resources needed to increase independence. Physical and mental fatigue can hinder motivation needed to plan and leave the abusive relationship. Fear of being stalked, re-victimized, harassed at work, and becoming homeless are just some of the concerns victims face when attempting to leave the abusive relationship (Johnson & Zlotnick, 2009).

The responsibilities of child care and child safety present additional stress for IPV victims. An estimated 15% of children in the United States have witnessed IPV in the home (Durand, Schraiber, Franca-Junior, & Barros, 2011). Children who are directly or indirectly exposed to IPV can externalize symptoms in the form of behavioral problems or internalize symptoms resulting in depression and anxiety, as well as other forms of mental distress. Problems in school, delays in psychosocial development, running away from home, and physical aggression directed to the mother, siblings, or grandparents can occur in children who have been exposed to IPV (Durand et al., 2011; Kennedy, Bybee, Sullivan, & Greeson, 2010). Men who witnessed IPV during childhood are twice as likely to become adult abusers of partners and children (National Coalition Against Domestic Violence [NCADV], 2007). Women carry the extra burden of trying to alleviate behavioral and psychosocial problems incurred by children as a result of exposure to IPV in the home. Attempts to terminate the relationship and flee become more complicated when planning for the safety of children.

The decision to seek help is complex. Termination of an abusive relationship takes energy and careful planning. Safety of family members, responses from family and friends, and the threat of repercussions from the perpetrator are some of the issues experienced by women who seek help. The process of termination itself can intensify depression, anger, and other forms of mental distress. The chronicity of IPV extends well beyond the period of time violent acts occur and continues to take a toll on the victim. Issues surrounding trust, control, and self-perception intensify, and suppressed emotions can surface (Temple et al., 2010). The victim may be at a loss when trying to work through emotions while adapting to a new environment. The formation of new relationships can be difficult because of lack of trust and issues with intimacy. Due to difficulty maintaining steady employment, job instability can be a contributing factor in the victim returning to the perpetrator (Johnson & Zlotnick, 2009).

CULTURE AND INTERVENTIONS

Clinicians must be cognizant that women from different cultures define IPV differently. Women in numerous cultures place a great deal of emphasis on childrearing and maintenance of a home environment. They often can look at the failure to maintain a healthy relationship as a failure on their part. This can present clinicians with a challenge in the determination of what interventions are the most appropriate for a particular patient at a particular time. Clinicians must take into account the cultural aspects of the patient in determining what interventions are acceptable and appropriate

for the patient (Taft & Hegarty, 2010). The complexities involved in relationships carry over into the manner in which interventions are exercised.

Women who are early in the process of dealing with IPV will need different interventions than women who have experienced IPV in the past. Women with children will need to have the safety and financial aspects of caring for their children recognized and included in an intervention. A woman who is planning to continue in the relationship has different needs than a woman who has decided to terminate the relationship (Glass, Eden, Bloom, & Perrin, 2010).

Relationships involve complex interactions, and the introduction of IPV only adds to the complexity. Issues such as the victim's financial dependency, emotional stability, and decision-making ability can impact how health care providers intervene when IPV is discovered. If the woman has decided to leave the relationship, the process can be long and may include multiple attempts to terminate the relationship (Glass et al., 2010). The complexity involved along with the long-term nature of terminating a relationship is a challenge for the clinician who is attempting to intervene for the health of the victim of IPV.

TABLE

INTIMATE PARTNER VIOLENCE (IPV): WHAT TO LOOK FOR, QUESTIONS TO ASK, AND STRATEGIES FOR COMMUNICATION

Risk Factors for IPV
1. Witnessing IPV in the home during childhood.
2. Extremely rigid family structure and functioning.
3. Feelings of powerlessness in one partner and dominance in the other partner.
Questions to Ask During IPV Assessment
1. Has your significant other participated in any behavior that brought physical harm to you in anyway?
2. Has your significant other actually threatened you directly or indirectly?
3. Have you ever felt threatened by your significant other?
4. Does your significant other use alcohol or drugs?
5. Has your significant other been diagnosed with a mental illness?
6. Does your significant other engage in sexually risky behavior?
Strategies for Therapeutic Communication
1. Look for opportunities to establish and maintain trust.
2. Demonstrate a non-judgmental attitude by separating the person from behavior.
3. Convey empathy by offering support without reinforcing powerlessness.

SCREENING

The screening process for IPV is not an easy task. Nurses are often one of the first health care professionals with whom a victim interacts, which provides the opportunity for nurses to screen for IPV. It is common to encounter reluctance among many patients to open up to the health care provider regarding victimization. The subject may be avoided, denied, or elicit an angry response from the victim who is being screened.

Although it is common for an IPV victim to visit the ED for treatment of an injury or trauma, many patients may have their first encounter with the health care system in a primary care setting. In addition to family medicine clinics, patients may need gynecological or obstetrical care, psychiatric care, or pediatric care. Thus, regardless of the setting, the nurse should be aware of the signs of IPV and have the ability to initiate the appropriate screening for IPV (Gerlock, Grimesey, Pisciotta, & Harel, 2011).

Types of Screening

Common signs and symptoms of IPV victims include physical injuries, which range from scratches and bruises to lacerations, dislocations, sprains, broken bones and teeth, burns, head injuries, loss of hearing and/or vision, stab wounds, and bullet wounds (Antai, 2011; Hewitt et al., 2011). Although many physical injuries are acute, long-term physical disability can occur as a result of IPV. All injuries, particularly those chronic in nature and involving ongoing care, can impede attempts to terminate the abusive relationship and re-establish independence due to lack of financial resources.

Two approaches to the screening process should be considered: (a) the brief screen and (b) the indicator-based screen. The *brief screen* simply determines whether risk factors for IPV are present (Hunt, 2009). This type of screen is conducted on all women who visit a health care provider; it involves screening questions and follows guidelines based on the results of the screen. The brief screen includes questions related to risk factors such as exposure to violence within the home, use of alcohol and drugs, cigarette smoking, history of psychiatric illness, sexually risky behavior, and a history of STDs (Erickson et al., 2010).

The *indicator-based screen* is initiated when signs or symptoms of IPV are found during a health care visit. For example, this may occur when a woman seeks treatment for asthma, and bruising is discovered on several areas of the body. A screen based on an indicator is less likely to be as effective as a brief screen, as the selectivity of an indicator-based screen may fail to identify IPV

victims who do not have a distinct indicator (Gerlock et al., 2011).

Screenings are used to determine whether a risk factor is present. If a risk factor is confirmed, a full psychosocial assessment is indicated. If IPV is found, the clinician must assess the patient and determine the severity of the risk factors. If the assessment reveals imminent danger, contact with law enforcement is warranted. If imminent danger is not a concern, the clinician must determine what community-based resources are available to both the victim and the perpetrator, ascertain if the victim is willing to initiate changes, and schedule the victim for follow-up care. The clinician must be supportive of the patient an encourage the patient to follow through with plans to seek support and assistance (Gerlock et al., 2011).

Education regarding IPV is needed within two distinct categories: (a) health care providers must be educated in the procedure to conduct screenings and (b) educational materials must be freely available to the patients within the health care setting. Educational materials need to be available in discreet areas such as bathrooms, waiting rooms, and in the areas where vital signs and weight are measured (Zarif, 2011).

Barriers to Screening

Barriers to implementation of IPV screening include lack of knowledge about IPV and appropriate interventions, perceived lack of support from the health care system, and lack of confidence concerning patient adherence to a treatment regimen. Clinicians may feel uncomfortable when attempting to ask IPV-related questions because of ineffective communication skills, fear related to retaliation by the perpetrator, confidentiality issues, and legal implications. Lack of confidence in communication skills, such as determining the best way to ask sensitive questions in an empathetic and objective manner and how to offer support in a potentially highly charged emotional situation, can create resistance to screening for some clinicians. The ability to remain objective without personal feelings influencing communication can be an obstacle to therapeutic intervention. If clinicians have experienced IPV directly or indirectly, intrusive emotions can distort the therapeutic process.

Discussion of IPV is a difficult subject for many clinicians and patients alike. The subject is considered an intimate and intrusive topic, which must be introduced into the clinician–patient relationship tactfully. Guillery, Benzies, Mannion, and Evans (2012) identified several barriers to screening for IPV.

Education about IPV should be integrated throughout all health care–related curricula within academic settings.

The barrier most frequently identified by nurses in a postpartum setting was the lack of knowledge regarding the screening process. One possible explanation for this deficit is a lack of content regarding IPV in formal nursing education. Nurses who have not received training in the extent of IPV and the appropriate screening process may be reluctant to engage in the screening process with patients. Schools of nursing can introduce the concept of IPV and the screening process as part of the curricula. Health care facilities can address this deficit with in-service education regarding the screening process and the community resources available to victims of IPV. Another barrier is systemic and includes the lack of a screening protocol, lack of privacy, and time constraints, which preclude the development of a trusting relationship with the patient. Although some barriers were identified, most of the nurses readily agreed that screening was within their scope of nursing practice (Guillery et al., 2012).

IMPLICATIONS FOR NURSING

IPV is a growing epidemic that touches many lives. Victims of IPV are encountered in a variety of health care settings; therefore, IPV screening should be incorporated into basic health assessments. It is imperative that clinicians become aware of their own thoughts and feelings associated with IPV and work through any issues that could prevent screening and therapeutic interventions from occurring. Clinicians need to incorporate IPV screening as part of the initial assessment (Gutmanis, Beynon, Tutty, Wathen, & MacMillan, 2007).

In 1992, the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) initiated mandatory IPV screening (Sims et al., 2011). Screening assists in identifying those involved in IPV and provides opportunity for treatment. Female patients who have experienced IPV suggest that women want to be questioned about IPV and clinicians should screen for it routinely. Because women do not readily disclose information related to IPV, clinicians must ask questions related to verbal abuse, threats to physical safety, and actual physical and sexual assaults. Clinicians should focus questions to determine the extent of the violence and underpinning family dynamics when IPV is suspected (**Table**). Despite the mandatory JCAHO requirement for IPV screening, documentation in medical records is lacking (Sims et al., 2011). The rate of screening for IPV occurs at approximately 5% to 10% in primary care facilities and from 5% to 25% in EDs (Gutmanis et al., 2007).

Education about IPV should be integrated throughout all health care–related curricula within academic settings. Theoretical content should

include the definition, prevalence, and impact of IPV, steps toward prevention, risk factors, therapeutic approaches to assessment, actual questions used for screening, legal implications, and implementation of appropriate interventions. To bridge the knowledge–practice gap, it is vital that theoretical content related to process and technique of therapeutic communication be provided, along with simulated laboratory experience. Students can practice communication skills and explore thoughts and feelings when case studies are provided. Educators should provide students with opportunities to practice IPV screening, explore feelings associated with IPV, and discuss possible barriers to screening while in the simulation laboratory. Students can demonstrate therapeutic communication techniques during simulated interview sessions that would involve clinicians and IPV victims, perpetrators, and other family members. Students can also sharpen observation skills by identifying verbal and nonverbal communication that may signal IPV risk factors (Edwardsen, Dichter, Walsh, & Cerulli, 2011).

Service learning is a philosophy that allows students to learn while serving members of their community. The goal is to reinforce the student's civic responsibility while the student provides a meaningful benefit for other people. It offers opportunities to implement theoretical knowledge through therapeutic communication, screening, and interventional activities. Incorporating service learning into health care curricula provides a means for students and faculty to offer help to victims while improving competency in care and eradicating misconceptions surrounding IPV.

In health care settings, educational content related to IPV and screening should be incorporated into the orientation process at the time of hire and as part of required annual in-service education. Education involving strategies for violence prevention and intervention are crucial for the safety of the victim, patients, and staff. Follow-up education can be accomplished by placing informational materials at strategic locations within the health care setting. Leaflets and documents are more likely to be read when content is kept brief and posted in convenient places to see (e.g., bulletin boards, bathrooms, break rooms).

KEYPOINTS

Daniel, M.A., & Milligan, G. (2013). **Intimate Partner Violence: How Clinicians Can Be an Asset to Their Patients.** *Journal of Psychosocial Nursing and Mental Health Services, 51*(6), 20-26.

1. Intimate partner violence (IPV) is defined as physical, sexual, psychological, or emotional abuse or the threat of abuse from a current or former intimate partner.
2. IPV is one of the most common forms of violence against women by either a husband or an intimate male partner, and it occurs in all societies, irrespective of social class.
3. IPV is estimated to affect 54% of women at some point in their lifetime.
4. Issues such as the victim's financial dependency, emotional stability, and decision-making ability can impact how health care providers intervene when IPV is discovered.

Do you agree with this article? Disagree? Have a comment or questions? Send an e-mail to the Journal at jpn@healio.com.

IMPLICATIONS FOR EMPLOYEES AND EMPLOYERS

The effects of IPV reach the community level through costs associated with medical treatment, decreased productivity in the workplace, and expense related to the utilization of the legal system. In turn, these costs impact the U.S. health care system and economy. Approximately 21% of full-time employees have had involvement with IPV, and roughly 8 million workdays are lost each year because of IPV (Pollack, Austin, & Grisso, 2010). It is estimated that in the United States, IPV costs in excess of $5.8 billion annually. Medical treatment for injuries sustained during episodes of IPV result in approximately $2.2 million annually (NCADV, 2007). Because the psychological and physical aftermath of IPV can continue beyond exposure, many women seek treatment for years following the abuse.

In employment settings, educational assistance programs (EAPs) offer assistance to those who have been involved with IPV. EAPs offer advantages not only to those affected by IPV, but employers as well. Some of the advantages for employees include enhanced mental health and job performance, whereas advantages for employers include increased employee job productivity and less work time lost due to physical and/or mental illness and disability. EAPs are provided in a safe, confidential setting and can provide mental health counseling and community referrals to victims when needed. EAPs can also offer education regarding perpetrators of IPV. Identification of risk factors that could lead to perpetration creates opportunities for early intervention such as workshops on conflict resolution, how to communicate and problem solve more effectively, and how to manage anger appropriately. Connections between employees and community agencies (e.g., shelters, programs for substance abuse) can be made through EAPs. Both employers and employees benefit from EAPs through the creation of a safer work environment (Pollack et al., 2010).

SUMMARY

IPV is a growing public health problem in the United States with many social and health care implications. Misconceptions and lack of knowledge continue to prevail, despite statistics that indicate the percentage of women who experience IPV continues to increase. The majority of interventional programs available to victims of IPV provide help following actual assaults. Safe houses, shelters, community health care agencies, EDs, inpatient settings, and law enforcement agencies are available for victims, but are usually involved in post-assault treatment. Social misconceptions, victims' feelings of inadequacy and subsequent lack of early reporting, and clinicians' lack of knowledge on how to screen and treat IPV perpetuate abuse and inadequate treatment. Screening for IPV, increased social awareness, integration of risk factors, screening techniques, interventions in health care curricula, and improved patient–clinician communication about family relationships and associated risk factors are steps that can be taken toward the prevention of IPV. Clinicians working in inpatient and outpatient settings, as well as home and school settings, should incorporate a brief IPV assessment as part of a routine assessment.

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