Managing Intimate Partner Violence in the Emergency Department

Esther K. Choo, MD, MPH*; Debra E. Houry, MD, MPH

*Corresponding Author. E-mail: esther_choo@brown.edu, Twitter: @choo_ek.

INTRODUCTION

Intimate partner violence is a pattern of assaultive or coercive behaviors perpetrated by someone who was or is in an intimate relationship with the person. It includes injury, psychological abuse, forced social isolation, intimidation, threats, and stalking. Few health conditions affect as many people as profoundly as intimate partner violence: in the United States, more than one third of women and one fourth of men will experience physical violence, threats, and rape by a partner during their lifetimes.1

Major medical organizations, including The Joint Commission, the American College of Emergency Physicians,2 and the US Preventive Services Task Force,3 have advocated screening by health care providers at point of contact, and the Institute of Medicine has recommended incorporating intimate partner violence screening as part of preventative care.1 However, in practice, screening rates are low, even after training initiatives and triage protocols,5 and providers demonstrate uncertainty in regard to screening and counseling.6 The identification and management of intimate partner violence requires only a few straightforward actions, but they must be conducted consistently and with sensitivity to the difficulty of disclosing abuse and the potentially complex needs of the individual being abused.

SCREENING

Despite the challenge of demonstrating improved patient-centered outcomes from emergency department (ED) screening, it can be accomplished safely and effectively without endangering patients7 and has the potential to identify patients at future risk for violence.8 A sample of brief validated screening tools appropriate for use in the ED is available9-12 (Figure 1); complete information about screening instruments is available from the Centers for Disease Control and Prevention (CDC) (Figure 2). Suggested language to use during screening is shown in Figure 3, including informing patients about the limits of confidentiality and using a brief normalizing statement. There are conflicting recommendations about whether health care organizations should provide universal or targeted screening: however, because of the high prevalence of intimate partner violence in the ED, and because screening, by definition, is looking for a condition before it is overtly symptomatic, we recommend screening every patient whenever possible. Doing so in a busy ED requires that screening support be built into the system, whether through standardized intake processes or electronic medical records.

Screening must be conducted in a setting and manner that facilitates divulging abuse.5,13 This includes asking screening questions in a private place and without any visitors present, using respectful and nonjudgmental tone of voice and body language, and having ready responses when screening reveals the presence of abuse.6,14 Screening is typically implemented by nurses, with positive screen results leading to prompt physician notification; however, physicians should also consider performing their own secondary screen, especially for high-risk patients, such as those with head, neck, and facial injuries; depressive symptoms; suicidal ideation; repeated visits; or substance use disorders.15 Training and system-level procedures are subject to attrition.5 Therefore, administrators should regularly review any protocol put into place for screening and intervention to ensure it is being followed, and staff
must receive ongoing training to maintain their skills and knowledge. Medical illness and altered mental status, whether through intoxication or other condition, may make screening on arrival difficult or impossible. Many patients will miss first-pass screening; unfortunately, often they are individuals at higher risk of intimate partner violence.19 Ideally, the electronic medical record and nursing protocols should be designed to prompt providers to screen closer to the end of the ED visit for patients who miss triage or entry screening.

RESPONSE TO IDENTIFICATION OF PARTNER ABUSE

Responding to a positive screen result adequately involves a simple set of actions at the bedside. First, the screen must be followed with confirmation, which is simply allowing the patient to explain the abuse he or she is experiencing. This is elicited by an open-ended question (Figure 3). Providers must validate and legitimize the patient.20 Patients experiencing intimate partner violence are subject to controlling and coercive partner behaviors and often experience isolation and shame, believing that they are to blame for the abuse. Validation statements20,21 (Figure 3) provide immediate affirmation that disclosing abuse was welcome and appropriate. The ED provider should seek to encourage and empower patients to speak to health care providers and to overcome any reluctance to seek help for their abuse, both during the current visit and in the future. Patients may be divulging abuse for the first time and may experience it as emotional, embarrassing, and frightening.

ADDRESSING IMMEDIATE SAFETY CONCERNS

Assessing the immediate safety concerns of the patient for themselves and for any children in the household will determine the next critical steps.22 Patients should be asked whether they feel safe to leave the ED; a brief formal danger assessment tool may be used as a follow-up to a positive screen result to calculate risk of severe future intimate partner violence and may perform better than self-assessment of risk (Figure 4).23 If the patient does not feel safe to go home, he or she will need to be placed in contact with domestic violence agencies to seek alternative housing.24 Given the shortage of domestic violence shelter beds, patients may need to consider alternative housing through friends or family for the short term; some hospitals will admit patients in danger of violent victimization who do not feel safe to go home and have no other options. Child protective services must be consulted if there is concern for the safety of children in the household. Patients experiencing abuse should be offered the opportunity to receive assistance in contacting law enforcement to make a report and initiate the process of obtaining a restraining order. If they do not wish to initiate this process while in the ED, they should be given information on how to do so and made aware that domestic violence agencies’ services include navigating law enforcement and legal aid.

---

**Figure 1.** Examples of intimate partner violence screening tools. HITS, Hurt, insult, threaten, scream; PPV, physical and psychological victimization; PVS, Partner Violence Screen; ISA, Index of Spouse Abuse. *Copyright Kevin Sherin. Permission obtained for reproduction; not to be distributed for commercial use.* †Tested in an urban, ED, black, female population; PPV compared with the ISA. ‡Sensitivity and specificity compared with the ISA.
Laws on mandatory reporting of domestic violence by health care providers differ from state to state. Most states have some requirement to report domestic violence (or any other types of violence) in certain circumstances, such as when guns or other weapons are used. Individual state laws can be accessed through local police departments or online (Figure 2). Child abuse and elder abuse, in contrast, must be reported; if these are revealed to coexist with partner violence, providers cannot ensure confidentiality.

In the majority of cases, patients will be returning home, rather than to a shelter. Anticipating and understanding this, remaining supportive and encouraging, and avoiding responses of frustration, disbelief, or disapproval will ensure that the patient does not feel judged or looked down on and may increase the possibility that he or she will seek help from health care providers in the future. It can take many attempts at leaving before someone leaves an abusive relationship permanently.

<table>
<thead>
<tr>
<th>Resource</th>
<th>Source</th>
<th>Web Site and Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detailed Information about a variety of IPV screening instruments</td>
<td>CDC</td>
<td><a href="http://www.cdc.gov/ncipc/pub-res/images/ipvandsvscreening.pdf">http://www.cdc.gov/ncipc/pub-res/images/ipvandsvscreening.pdf</a></td>
</tr>
<tr>
<td>Compendium on state statutes and policies for mandatory reporting</td>
<td>Futures Without Violence</td>
<td><a href="http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Compendium%20Final.pdf">http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Compendium%20Final.pdf</a></td>
</tr>
<tr>
<td>Hotline for information about IPV, advocates continuously available over the telephone and through online chat to provide counseling, safety planning, and referrals</td>
<td>National Domestic Violence Hotline</td>
<td>National Domestic Violence Hotline <a href="http://www.thenhotline.org">http://www.thenhotline.org</a> 1-800-799-7233</td>
</tr>
<tr>
<td>Free materials for health care providers, including physician training materials, patient brochures and posters, and safety planning cards</td>
<td>Futures Without Violence</td>
<td><a href="http://www.futureswithoutviolence.org">http://www.futureswithoutviolence.org</a> (Under &quot;Resources and Events&quot; → &quot;Order Material&quot;)</td>
</tr>
</tbody>
</table>

Figure 2. Resources for managing intimate partner violence in the ED. IPV, Intimate partner violence.

SAFETY BEHAVIORS

Ideally, patients should be instructed in a variety of steps they can take to keep themselves and their children safe and to allow them to leave the home quickly in case violence should escalate (Figure E1, available online at http://www.annemergmed.com). A brochure or card may help the provider review safety behaviors with the patient or create a personalized safety plan; however, the patient should be encouraged to learn more about safety behaviors with domestic violence agencies as an outpatient.

DOCUMENTATION

Partner abuse or suspected partner abuse should be clearly documented so that future providers know to follow up on the issue. If injuries are present, these should be photographed and included in the patient chart in case legal evidence is needed later. ED providers should contact primary care providers whenever possible to ensure continuity of care in regard to abuse because it is likely to be an ongoing problem and can result in chronic medical conditions.

REFERRALS

Patients experiencing intimate partner violence should receive at a minimum referrals to local or national domestic violence hotlines. General resources and links to local domestic violence agencies are available online (Figure 2). Although all these sites have a “quick exit” button, patients need to be reminded that they must delete stored browsing histories.

Screening for associated high-risk conditions, including mental health problems and substance use, and asking about basic needs, such as primary care providers for the patients and their children and financial and housing support, can guide appropriate referrals to health care and other services. Although comprehensive services (job training, legal aid, childcare, etc) will also be addressed through domestic violence agencies, a simple resource such

---

Figure 3. Suggested language for screening and discussing intimate partner violence.
as a handout with contact information for local services may help address the many barriers that can keep patients dependent on abusive relationship and thus with limited options for improving their safety and well-being. To ensure a patient’s safety, these resources should not be labeled “domestic violence” but rather women’s health issues, general social services, or other more general terms.

**SPECIAL POPULATIONS**

Women in heterosexual couples are not the only ones experiencing intimate partner violence; provider assumptions should not prevent screening of other groups of patients. Intimate partner violence is just as prevalent in male and female single-sex couples as in heterosexual couples and may be more prevalent. Men are often assumed to be the only perpetrators of intimate partner violence but also experience victimization and are at increased odds for mental and physical health sequelae of abuse. Domestic violence shelters are generally not available for men. However, most domestic violence agencies will provide counseling and other services for male survivors.

Women with undocumented or dependent immigration status are particularly vulnerable to partner abuse, given their social isolation and their financial, emotional, and psychological dependence on their partner, traditional gender norms, and stresses around the process of acculturation. Cultural norms or fear of authorities may encourage women not to report intimate partner violence. Screening is critical for immigrant women and should be conducted privately and with assurance for confidentiality, using, if possible, a culturally specific interpreter.

**IDENTIFYING ROLES IN THE ED FOR ADDRESSING INTIMATE PARTNER VIOLENCE**

Who performs these functions varies widely by hospital and state. Counseling and referrals for patients experiencing partner violence may be a designated role for an ED nurse or social worker. In some areas, the local or regional domestic violence agency may have an on-call crisis team that will travel to any ED and provide in-person counseling, assist with safe housing, and provide active linkages to domestic violence agencies for follow-up. In other cases, individual ED providers will be managing all aspects of care for abused patients. However, in all cases, ED providers will need to understand how to identify intimate partner violence and how to gain rapport with patients so that they feel comfortable discussing abuse, be familiar with available resources, and know whom to consult for further care and referrals. Physicians should take advantage of free online intimate partner violence training and patient resource materials (Figure 2) and intimate partner violence–related didactic instruction at national emergency medicine conferences.

**CONCLUSIONS**

Intimate partner violence is common among ED patients. It is important to incorporate pertinent screening into triage or as part of physician care, particularly for patients with high-risk presentations. ED care for patients experiencing partner abuse involves only a few steps, and many potential obstacles to intimate partner violence management have straightforward solutions (Figure 5). Although the abuse is not “fixable” in a single ED visit, these steps can make a difference and may provide patients the support and resources and confidence they need to increase their safety, well-being, and overall health.
Managing Intimate Partner Violence in the Emergency Department

**Funding and support:** By Annals policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article as per ICMJE conflict of interest guidelines (see http://www.icmje.org). The authors have stated that no such relationships exist and provided the following details: Dr. Choo is supported by National Institute on Drug Abuse (NIDA) grant K23DA031881.

**REFERENCES**


## APPENDIX

<table>
<thead>
<tr>
<th><strong>If you are still in the relationship:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Think of a safe place to go if an argument occurs; avoid rooms with no exits (bathroom) or rooms with weapons (kitchen).</td>
</tr>
<tr>
<td>Think about and make a list of safe people to contact.</td>
</tr>
<tr>
<td>Keep change with you at all times.</td>
</tr>
<tr>
<td>Memorize all important numbers.</td>
</tr>
<tr>
<td>Establish a code word or sign so that family, friends, teachers, or coworkers know when to call for help.</td>
</tr>
<tr>
<td>Establish a code word or sign with your children that will tell them call for help or leave the house immediately.</td>
</tr>
<tr>
<td>Think about what you will say to your partner if he or she becomes violent.</td>
</tr>
<tr>
<td>Remember, you have the right to live without fear and violence.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>If you have left the relationship:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Change your telephone number.</td>
</tr>
<tr>
<td>Screen calls.</td>
</tr>
<tr>
<td>Save and document all contacts, messages, injuries, or other incidents involving the batterer.</td>
</tr>
<tr>
<td>Change locks if the batterer has a key.</td>
</tr>
<tr>
<td>Avoid staying alone.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Plan how to get away if confronted by an abusive partner.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have to meet your partner, do it in a public place.</td>
</tr>
<tr>
<td>Vary your routine.</td>
</tr>
<tr>
<td>Notify school and work contacts.</td>
</tr>
<tr>
<td>Call a shelter for battered women.</td>
</tr>
</tbody>
</table>

**If you leave the relationship or are thinking of leaving, you should take important papers and documents with you to enable you to apply for benefits or take legal action.**

Important papers you should take include the following:
- Social security cards and birth certificates for you and your children
- Marriage license
- Leases or deeds in your name or both your and your partner’s name
- Checkbook
- Credit cards
- Bank and charge account statements
- Insurance policies
- Proof of income for you and your spouse (pay stubs or W-2s)
- Any documentation of past incidents of abuse (photos, police reports, medical records, etc)

**Figure E1.** Recommended safety behaviors. Adapted from the National Coalition Against Domestic Violence (http://www.ncadv.org/protectyourself/SafetyPlan.php).