Intimate partner violence: Diagnosis and screening

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INTRODUCTION

Intimate partner violence (IPV) is a serious, preventable public health problem affecting more than 32 million Americans [1]. IPV can affect anyone, but women are more often victims than men. Lifetime estimates for IPV involving women in the United States range from 22 to 39 percent [2,3]. In countries around the world, 10 to 69 percent of women report physical assault by an intimate partner at some time in their life [4].

The term "intimate partner violence" describes actual or threatened psychological, physical, or sexual harm by a current or former partner or spouse. IPV can occur among heterosexual or same-sex couples and does not require sexual intimacy.

All too frequently, IPV is undiagnosed since patients often conceal that they are in abusive relationships. The clues pointing to abuse may be subtle or absent. Many groups advocate screening all patients, or all female patients, for IPV.

This topic will discuss the clinical presentation and diagnosis of IPV and issues related to population screening with recommendations of various groups. The epidemiology and health consequences of IPV and management of patients in whom IPV is identified are discussed separately. Elder mistreatment is also addressed separately. (See "Intimate partner violence: Intervention and patient management" and "Intimate partner violence: Epidemiology and health consequences" and "Elder mistreatment: Abuse, neglect, and financial exploitation".)

CLINICAL PRESENTATION

Victims of intimate partner violence (IPV) are found among people of all ages, socioeconomic classes, ethnicities, gender identities, and sexual preferences. While certain risk factors have been identified (younger age, female, lower socioeconomic status, family history or personal history of violence), IPV should be considered in all patients who present with a history or findings consistent with undisclosed violence. (See "Intimate partner violence: Epidemiology and health consequences".)

Certain aspects of the history or observations made during the clinical encounter should heighten the clinician's suspicion of IPV. These include [5]:

- 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 [6].
- 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 (reproductive coercion) [7].
- 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 or rectal examination, or difficulty with these examinations.

Common presenting complaints — IPV is associated with a perception of overall poor health. This was shown in a multi-country report, sponsored by the World Health Organization (WHO), based on surveys of women aged 15 to 49 years [8]. Although confounding issues may account for some of the observed associations, violence is associated with difficulty in ambulation, difficulty with daily activities, memory loss, dizziness, emotional distress, and pelvic complaints.

Gynecologic conditions that are seen more frequently in abused patients include premenstrual syndrome, sexually transmitted diseases including human immunodeficiency virus (HIV) infection, unintended pregnancy (via reproductive coercion) [9], and chronic pelvic pain. (See "Causes of chronic pelvic pain in nonpregnant women".)

Somatic complaints associated with IPV include chronic pain, irritable bowel syndrome, headaches, and musculoskeletal pain.

Psychological conditions associated with IPV include:

- Depression, suicidality (see "Unipolar depression in adults: Assessment and diagnosis")
- Anxiety and panic disorder (see "Generalized anxiety disorder in adults: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis" and "Panic disorder in adults: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis")
- Eating disorder (see "Eating disorders: Overview of epidemiology, clinical features, and diagnosis")
- Substance use (see "Clinical assessment of substance use disorders")
- Posttraumatic stress disorder (see "Posttraumatic stress disorder in adults: Epidemiology, pathophysiology, clinical manifestations, course, assessment, and diagnosis")
- Dissociative disorders (see "Dissociative aspects of posttraumatic stress disorder: Epidemiology, clinical manifestations, assessment, and diagnosis")

Health consequences associated with IPV are discussed in detail separately. (See "Intimate partner violence: Epidemiology and health consequences", section on 'Health effects'.)

Concerning physical findings — The physical examination can present clues that abuse may be present.

The presence and location of injuries are important. Any injury without a good explanation, particularly involving the head and neck, teeth, or genital area, should raise suspicion. Typically, the victim of domestic violence sustains injuries on the central part of the body such as the breasts, abdomen, and genitals. Wounds on the head and neck, particularly neck bruising, may arise from attempted strangulation (picture 1). Wounds on the forearms often occur when a victim is in a defensive position. Bruises of different ages may be due to repeated abuse.

There may be evidence of sexually transmitted diseases (including HIV infection) or unintended pregnancy.

ASSESSMENT

The assessment for intimate partner violence (IPV) in patients who present with complaints or findings that suggest underlying abuse is considered a diagnostic evaluation. This is to be distinguished from a screening evaluation, which involves questioning all patients who are seen for care, regardless of whether they present with a history or examination that raises concerns about possible abuse.

Routinely asking about IPV significantly increases its detection in certain clinical situations (table 1). In one study, for example, 5.6 percent of 359 female trauma victims were identified as having injuries due to IPV before institution of a screening protocol in the emergency department, compared with 30 percent of 412 patients following use of the protocol [10].

General principles — The setting in which questioning occurs is important. The clinician must assure that the patient feels safe and comfortable. Clinicians should not display hesitancy, judgment, or discomfort, and they should avoid using the phrases "domestic violence" or "victim" but rather should ask about being hurt or experiencing violence.

Patients are more likely to disclose their experience of violence when [11,12]:

- Practitioners are ready to listen and use open-ended questioning.
- Questioning is done in privacy. Others present should be asked to leave for the interview and examination. Resistance to leave may be important diagnostic information.
- Practitioners assure confidentiality, unless someone is in grave danger, when reporting may be necessary. (See "Intimate partner violence: Intervention and patient management", section on 'Mandatory reporting'.)
- One or only a few questions are posed.

The relational aspect of the questioning (eg, concern, eye contact), rather than the particular words used, may be the most important factor in assisting patients with disclosure.

Patient expectations — A meta-analysis of qualitative studies identified the following expectations of women in regard to assessment for IPV [13]:

- 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

Another study found that women prefer a patient-centered interview format in which the clinician follows up on the patient's own cues, rather than a structured interview following tool-driven checklists [14]. One qualitative study found that women did not want to be counseled in a directive way to leave their relationship, go to a shelter, or be told they would be reported to the police [15]. They wished to be acknowledged and supported in their autonomy, the complexity of their life situations, and evaluated for where they were in stages of change.

Caveats — It is essential to avoid frightening, intimidating, or shaming a patient. Patients who have been involved with IPV are likely to be extremely vulnerable and may misinterpret the practitioner's best intentions. The Massachusetts Medical Society has proposed the following caveats [16]:

- 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.

Patient denial — Abused patients may deny the abuse for several reasons. They may not be emotionally ready to admit the reality of the situation; they may blame themselves, or feel like a failure if they admit to being abused. They may fear rejection by the clinician, be ashamed, believe that the abuse will not happen again, fear reprisal by the abuser, believe that they have no alternatives, or lack knowledge of resources that could help. There may be language or cultural barriers between clinicians and patients that interfere with communication, and discomfort with using an interpreter to discuss sensitive issues.

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 [17,18].

DIAGNOSIS AND SCREENING

Many tools have been proposed to detect or screen for intimate partner violence (IPV) [19]. There is no “gold standard” available, analogous to a biopsy, to determine the true sensitivity or specificity of these tools. The 39-item Conflict Tactics Scale-Revised (CTS-2) [20] is the most widely used reference standard for IPV in the social science and medical literature for evaluating IPV screening tools [21]. However, lengthy tools, ideal for nuanced research, are impractical in a busy clinic setting.

Several short survey tools are available for practicing clinicians (see 'Short surveys for clinicians' below). Framing the inquiry is important as a lead-in to the questions.

Framing the inquiry — Before questioning a patient about abuse, it can be helpful to "normalize" the inquiry, setting the tone and framing the questioning about emotional and/or physical/sexual violence as a routine part of everyday practice (eg, this is in our purview of providing a safe environment and being concerned about health).

Sample framing statements include [16]:

- 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.

Short surveys for clinicians — Samples of several short survey tools available for practicing clinicians include the following:

- **SAFE** questions [22]:
    - **S**tress/Safety – Do you feel safe in your relationship?

- **A**fraid/Abused – Have you ever been in a relationship where you were threatened, hurt, or afraid?
- **F**riend/Family – Are your friends aware you have been hurt?
- **E**mergency Plan – Do you have a safe place to go and the resources you need in an emergency?

- The **Massachusetts Medical Society** Committee on Violence advises that a single question, asked routinely and without judgment, can increase the detection rate of IPV in office practice [23]. The following questions are suggested as options, to be adapted for individual practices:

  - "At any time, has a partner hit, kicked, or otherwise hurt or threatened you?"
  - "Has your partner or a former partner ever hit or hurt you? Has he or she ever threatened to hurt you?"
  - "Do you ever feel afraid of your partner?"
  - "Do you feel safe in your relationship?"
  - "Every couple has conflicts. What happens when you and your partner have a disagreement? Do conflicts ever turn into physical fights or make you afraid for your safety?"
  - "I see patients in my practice who have been hurt or threatened by someone they love. Is this happening to you?
  - "Has anyone ever hurt you emotionally, physically, or sexually?"

- **Abuse Assessment Screen** – The three-question Abuse Assessment Screen (AAS) was found to be as sensitive as more extensive questionnaires in identifying physical or sexual abuse in pregnancy [24]. The questions are:

  - "Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?"
  - "Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?"
  - "Within the last year, has anyone forced you to have sexual activities?"

- **HITS questions** [25] – Each HITS question is scored on a five-point scale (never, rarely, sometimes, fairly often, and frequently, with a score >10 indicating likely victimization).

  - How often does your partner:

    - **H**urt you physically?
    - **I**nsult you or talk down to you?
    - **T**hreaten you with harm?
    - **S**cream or curse at you?

- **Partner Violence Scale** – The Partner Violence Scale (PVS) assesses physical violence and safety and is appropriate for screening in the emergency department and other urgent care settings [26]:
    - Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?
    - Do you feel safe in your current relationship?
    - Is there a partner from a previous relationship who is making you feel unsafe now?
- **HARK** questions – One point is given for every yes answer [27]
    - Within the last year, have you been:
        - **H**umiliation – Humiliated or emotionally abused in other ways by your partner or your ex-partner?
        - **A**fraid – Afraid of your partner or ex-partner?
        - **R**ape – Raped or forced to have any kind of sexual activity by your partner or ex-partner?
        - **K**ick- Kicked, hit, slapped or otherwise physically hurt by your partner or ex-partner?
- **STaT** – **S**lapped, **t**hreatened and **t**hrow (things) [28]
    - Have you ever been in a relationship where your partner has:
        - Pushed or **s**lapped you?
        - **T**hreatened you with violence?
        - **T**hrown, broken or punched things?
- **Woman Abuse Screening Tool - WAST** [29]
    - In general, how would you describe your relationship? A lot of tension, some tension, no tension.
    - Do you and your partner work out arguments with: Great difficulty, some difficulty, no difficulty.
    - Do arguments ever result in you feeling down or bad about yourself? Often, sometimes, never.
    - Do arguments ever result in hitting, kicking or pushing? Often, sometimes, never.
    - Do you ever feel frightened by what your partner says or does? Often, sometimes, never.
    - Has your partner ever abused you physically? Often, sometimes, never.
    - Has your partner ever abused you emotionally? Often, sometimes, never.
    - Has your partner ever abused you sexually? Often, sometimes, never.

Other tools used in the clinical setting are the Ongoing Abuse Screen, which assesses current abuse [30], and the Modified Childhood Trauma Questionnaire-Short Form (CTQ-SF).

Comparative analyses have found that several tools studied have high sensitivity and specificity, and no one tool stands out as best. In a systematic review, high sensitivity and specificity were found for tools including HITS (English and Spanish versions), STaT HARK, CTQ-SF, and WAST [2].

In a meta-analysis of several surveys, none was clearly superior for clinical use compared with others studied: the HITS survey had sensitivity of 30 to 100 percent and specificity of 86 to 99 percent; WAST, sensitivity 47 percent, specificity 96 percent; PVS, sensitivity 35 to 71 percent, specificity 80 to 94 percent; and AAS, sensitivity 93 to 94 percent, specificity 55 to 99 percent [30].

There are no studies available that address the issue of false-positive results (people reporting abuse that has not occurred).

Computer-based screening — Evidence suggests that patients may be more likely to reveal IPV when questionnaires are self-administered. Randomized trials have evaluated use of a computer-based tool in a variety of settings and patient populations:

- In an academic hospital-based family practice clinic, computer-based screening increased the detection of IPV compared with usual care for the control population, and computer screening was acceptable to patients [31].
- Computer-based tools led to increased rates of disclosure of IPV, compared with usual care, in emergency department settings [32,33].
- In a prenatal clinic, women were screened by a combination of computerized questionnaire and a semi-structured interview [34]. Of women who disclosed IPV (36 percent of the cohort), two-thirds disclosed in both formats, but one-third disclosed in only one of the two methods for screening; women who returned for follow-up interviews recommended that screening take place using both methods.

One study found that a discussion of possible IPV was initiated in only 48 percent of encounters where the computer prompted need for such evaluation [33]. However, this is not dissimilar to rates of discussion between practitioners and patients following positive screens with verbal inquiry.

SCREENING RECOMMENDATIONS

We suggest inquiring about intimate partner violence (IPV) in patients who present with suspicious symptoms or signs (table 1), pregnant women, and patients on initial primary care and obstetrician-

gynecologist visits. In addition, we suggest inquiring about IPV on visits to the emergency department and on hospital admissions.

IPV is widely prevalent and is often longstanding prior to diagnosis. Identifying patients who are exposed to violence provides clinicians with insight in order to appropriately address medical problems that may be sequelae of violence and to intervene to prevent bodily harm. Educating patients about violence by making it a part of the medical conversation may make it more likely for reticent patients to disclose at a subsequent visit. It also sends a message about prevention to victims and perpetrators by heightening awareness that practitioners feel this behavior is wrong and that they are willing and able to assist.

Any of the short questions discussed above would be appropriate for screening. (See 'Short surveys for clinicians' above.)

General population — Given the high prevalence of IPV and the lack of harm and potential benefits of screening, we suggest routine screening for all patients on initial visits to primary care clinicians, to obstetrician-gynecologists, to the emergency department, and on hospital admission. In addition, all people who present with an injury or conditions that have been associated with IPV should be asked about it (table 1). Interventions for acknowledged or suspected IPV are discussed separately. (See "Intimate partner violence: Intervention and patient management".)

Benefits and harms — Studies have found that routine screening of asymptomatic patients increases the detection of IPV [35-38]. A systematic review of eight randomized trials evaluating the effect of screening for IPV in health care settings found that, compared with usual care, screening increases the identification of women experiencing IPV (odds ratio [OR] 2.95, 95% CI 1.8-4.9), particularly for pregnant women (OR 4.5, 95% CI 1.8-11.3) [38].

However, most studies have not shown that screening improved health outcomes for the abused or the perpetrator [35,39-42]. Evidence for the impact of screening for IPV on patient outcomes is limited by methodologic and ethical challenges. These include the inability to withhold intervention from control group participants identified with IPV, reliance on self-reported measures, lack of a reference standard, a high loss to follow-up among this patient population, and inability to conduct a double-blind trial. The results of a meta-analysis of 11 randomized or quasi-randomized studies, including more than 13,000 patients, suggest that screening increases identification of IPV [35]. However, the included studies did not show that screening leads to long-term benefits except possibly in antenatal populations. A previously reported systematic review by the US Preventive Services Task Force (USPSTF) found similar results but concluded that screening should be recommended because the limitations of the studies did not rule out a potential benefit [2,43,44].

No adverse effects of screening and intervention for IPV were identified in two of three trials that included adverse effects as on outcome event [39,45]. One trial involving home visitation for at-risk new mothers suggested an increase in verbal abuse for women randomly assigned to the intervention, although the difference was not statistically significant compared with women in the control group [46]. Up to 20 percent of women patients in surveys of general practices in London and Ireland objected to screening for domestic violence [37]. Discomfort with screening was greatest among women who experienced physical or sexual violence related to IPV [47]. Concerns raised by survey respondents included loss of privacy, worries about provoking abuse with disclosure, emotional distress, fear of judgment by the practitioner, and disappointment in the practitioner's response. This highlights the fear and sensitivity of victims of abuse and the need for assuring safety and support with screening.

Barriers to implementation — Both practitioners and patients have expressed discomfort with screening for IPV. Though many national groups have recommended routine screening, rates of screening in primary care settings have been low (less than 13 percent in one internal medicine clinic) [48].

In a systematic review evaluating the most common provider barriers to screening for IPV, five categories were identified: personal barriers, resource barriers, perceptions and attitudes, fears, and patient-related barriers [49]. The most commonly cited provider concerns were personal discomfort, lack of knowledge, and time constraints. Other issues underlying clinician reluctance to integrate routine screening into practice include uncertainty regarding how to offer assistance if IPV is identified as well as privacy, legal, and personal safety concerns. In a study evaluating providers by subsets, male clinicians and those in private practice expressed more discomfort with IPV screening, and gynecologists, hospital-based providers, and clinicians practicing for 5 to 10 years expressed more comfort with screening [50].

A systems model approach can improve screening uptake and patient referral for services [51-53]. This may involve staff training (including medical and mental health clinicians, social workers, and administrative staff), providing materials for distribution to female patients, implementing computer-based or other self-administered screening tools, alerts on patient charts reminding providers to inquire about IPV or follow-up when IPV is identified, and identifying and coordinating with community referral resources and advocates.

Pregnancy — Screening for IPV is a recommended part of prenatal care. The American College of Obstetricians and Gynecologists (ACOG) advises that all women be screened for IPV at periodic intervals, including during obstetric care (at the first prenatal visit, at least once per trimester, and at the postpartum checkup) [54]. Clinicians should offer ongoing support and review available prevention and referral options. (See "Prenatal care: Initial assessment", section on 'History'.)

Two systematic reviews have concluded that screening for IPV may improve health outcomes for pregnant women [2,35]. A randomized trial in 1044 pregnant African American women in Washington, DC compared usual care with perinatal counseling addressing IPV-related danger assessment as well as other health and safety practices [55]. The study found that women in the intervention group had decreased rates of recurrent IPV (OR 0.48, 95% CI 0.29-0.80) as well as better birth outcomes and decreased rates of depression.

Recommendations of others — Groups making recommendations suggest that clinicians be more alert to the possibility of IPV, particularly in specific clinical situations (table 1). Many, but not all, groups suggest screening all women for IPV, regardless of the setting. The frequency of screening has not been addressed.

- The USPSTF issued revised recommendations for screening for IPV in 2013 [43,44]. The guideline recommends that clinicians screen women of childbearing age (14 to 46 years old) for IPV and provide or refer women to intervention services when appropriate. The guideline is based on a systematic review published in June 2012 on behalf of the USPSTF that found that several instruments detect IPV at a high rate and that screening is associated with minimal harms and many potential benefits [2]. In a 2004 guideline, citing lack of proven effectiveness for screening instruments and lack of evidence that screening improves clinical outcomes, the USPSTF concluded that there was insufficient evidence to support screening for IPV in asymptomatic populations [56]. This generated much controversy and dispute about the importance of the outcomes that were evaluated.

- The World Health Organization (WHO) issued guidelines in 2013 that advise against routine screening for IPV in women but do recommend that women who are at significantly increased risk or who present with signs or symptoms suggesting possible IPV (eg, unexplained injuries or depression) be asked about possible IPV exposure [57]. Their recommendation against routine screening is based on lack of evidence that screening in the general population reduces the risk of IPV or improves health outcomes in women.

- The Institute of Medicine, as of July 2011, recommends that all women and girls be screened for IPV due to the magnitude of potential IPV harms [58].

- The Joint Commission on Accreditation of Healthcare Organizations recommends that hospitals use criteria to identify possible victims of abuse and neglect upon hospital entry and on an ongoing basis, educate staff about how to recognize signs of abuse, assist with referrals of possible victims, and report abuse in accordance with law and regulation. They include domestic abuse in their list of abuse conditions [59].

- The American Medical Association (AMA) recommends that all patients be routinely screened for IPV, with inquiry about any history of family violence [60]. Safety should be assessed when IPV is identified, before the patient leaves the office; appropriate referrals should be made, and clinicians should be aware of local resources. They also recommend that clinicians become involved in appropriate local programs designed to prevent violence and its effects at the community level.
- The Canadian Task Force on Preventive Health Care found insufficient evidence (in 2003) to recommend for or against routine universal screening for violence against either pregnant or nonpregnant women but recommends that clinicians be alert to symptoms and signs of abuse [61]. The Task Force found fair evidence that women who have spent at least one night in a shelter should be referred to a structured program of advocacy services, and it found conflicting evidence regarding batterer interventions (with or without partner participation).

DETECTING PERPETRATORS

Detecting perpetrators and working towards intimate partner violence (IPV) prevention is an important goal, but it is uncertain how best to detect and treat perpetrators of violence. Practitioners have been skeptical about detecting a problem for which they cannot offer helpful assistance and may grapple with their own discomfort when caring for these patients.

Many perpetrators also have been victims, further complicating a sensitive issue. Childhood adversity and adult stressors are causal for both perpetration of abuse and victimization in men and women [62,63].

Several studies note an association with substance use, particularly alcohol [64-69], and suggest that practitioners inquire if the patient has done things while under the influence that they subsequently regret. A longitudinal study in New Zealand suggests that alcohol may be causal in 4 to 9 percent of IPV events [67]. One survey suggested that problem drinking in perpetrators was associated with an eightfold increase in IPV [69]. Many, but not all, studies have been done in male college students, raising some question of generalizability. If a woman is drinking excessively she may be more at risk for both perpetration and victimization relationships [65].

One study found that use of alcohol and cocaine, both independently and together, was associated with IPV perpetration, whereas cannabis and opioid use disorders were correlated with victimization [66].

SUMMARY AND RECOMMENDATIONS

- Victims of intimate partner violence (IPV) are found among people of all ages, socioeconomic classes, ethnicities, gender identities, and sexual preferences. While not all patients experiencing IPV exhibit symptoms or signs, certain features should heighten suspicion of IPV. These include inconsistent explanation of injuries, delay in seeking treatment or missed appointments, frequent emergency department visits, late prenatal care, inappropriate affect, overly attentive partners, and reluctance to be examined. IPV is associated with a perception of overall poor health with somatic (often gynecologic) and psychologic impact. (See 'Clinical presentation' above.)

- Routinely asking about IPV significantly increases its detection in certain clinical situations (table 1). In questioning a patient in whom IPV is suspected, practitioners should be cognizant of patient's expectations for nonjudgmental, compassionate listening that allows the patient to progress at their own pace, with shared decision-making, respect for the patient's decisions, and no pressure to disclose, leave the relationship, or press charges. Terms like "victim," "domestic violence," "abused," or "battered" should be avoided. (See 'Patient expectations' above.)

- Abused patients may deny the abuse for multiple reasons. Patients for whom IPV is suspected but not acknowledged should be asked again at subsequent visits. (See 'Patient denial' above.)

- Before questioning a patient about abuse, it can be helpful to "normalize" the inquiry and frame the questioning as a routine part of everyday practice. Possible statements include "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" or "Many patients I see are coping with an abusive relationship, so I've started asking about intimate partner violence routinely." (See 'Framing the inquiry' above.)

- Several short tools have been developed for use in screening for IPV. Single questions may be sufficient for screening. Self-administered questionnaires, including computer-based assessment tools, may be more effective that face-to-face questioning. (See 'Short surveys for clinicians' above and 'Computer-based screening' above.)

- Multiple professional organizations endorse screening for IPV but differ in suggested target populations and do not address screening frequency. We suggest routine screening for IPV for all patients on initial visits to primary care clinicians, to obstetrician-gynecologists, to the emergency department, and on hospital admission (**Grade 2C**). All pregnant women and patients presenting with concerning symptoms or signs (table 1) should be asked about IPV. (See 'Screening recommendations' above.)

- Methodologic problems intrinsic to studies of IPV make it difficult to design a randomized trial to determine the effectiveness of screening on patient outcomes. Screening appears to increase the identification of IPV and does not appear to cause harm. (See 'Benefits and harms' above.)

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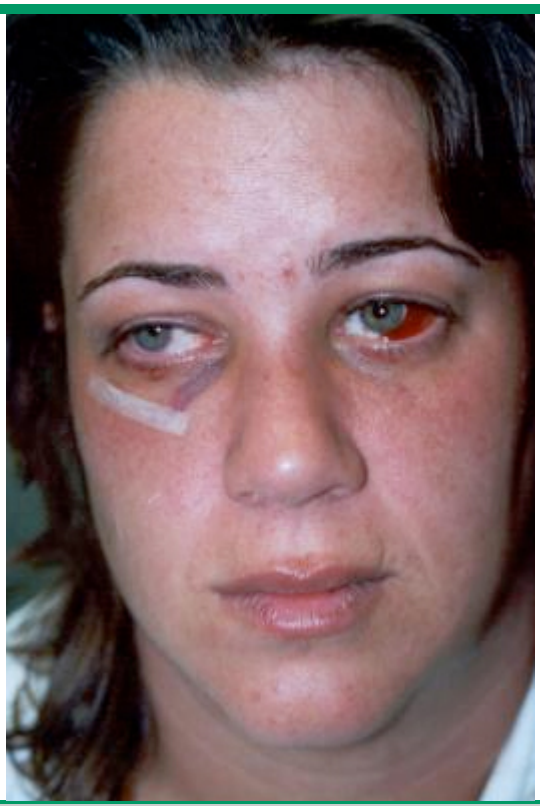
Topic 15294 Version 28.0

GRAPHICS

Facial findings following strangulation attempt



Left subconjunctival hemorrhage is a sign after strangulation.

Courtesy of Amy Weil, MD, FACP.

Graphic 86280 Version 2.0

Patients who should be asked about intimate partner violence

Women with injuries
Women with chronic unexplained abdominal pain
Women with chronic unexplained headaches
Women with sexually transmitted diseases
Older adults with evidence of neglect
Older adults with injuries

Graphic 53373 Version 4.0

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