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Postprint: Identification and Management Skills for Intimate Partner Violence

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Abstract

Abstract: Intimate partner violence (IPV) is the most common form of domestic violence, which not only endangers victims' physical and mental health and safety, but also leads to adverse outcomes for marriages, families, and children's development. China currently lacks official guidelines for IPV screening and management. This article provides an evidence-based summary and review of IPV identification and management, and discusses how to apply this evidence in the Chinese context.

Full Text

Preamble

Title: Recognizing and Management Skills of Intimate Partner Violence

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Abstract: IPV (Intimate partner violence) is the most common kind of domestic violence, which not only harms the physical and mental health and life safety of the victim but also leads to the misfortune of marriage, family, and children's development. There are no official guidelines for the diagnosis and treatment of IPV in China. This paper summarizes the evidence on IPV recognition and management and attempts to discuss how this evidence can be applied to China.

Keywords: Intimate Partner Violence, Domestic Violence, IPV screening tool, Family Medicine

Domestic violence refers to all forms of violent behavior occurring within family relationships. China's 2016 Anti-Domestic Violence Law defines it as physi-

cal and psychological harm inflicted between family members through beating, binding, mutilation, restriction of personal freedom, as well as frequent verbal abuse, intimidation, and other means[1]. Intimate partner violence (IPV) constitutes one type of domestic violence. The World Health Organization defines IPV as behavior by an intimate partner that causes physical, sexual, or psychological harm, including physical assault, forced sexual activity, psychological abuse, and controlling behavior. Abusive relationships typically begin with verbal and emotional abuse, with some progressing to physical and sexual abuse. Although IPV can occur in intimate relationships of any sexual orientation, the majority involves male perpetrators and female victims[2].

1 Epidemiology

IPV is the most common form of domestic violence, widely prevalent across various socioeconomic, religious, and cultural groups. In 2018, the World Health Organization analyzed prevalence data from 2000-2018 across 161 countries and regions, finding that approximately 30% of women worldwide have experienced physical and/or sexual violence by an intimate partner[3]. The lifetime prevalence of IPV is approximately 20% in the Western Pacific region, 22% in Europe, 25% in the Americas, and 33% in Africa. According to 2014 statistics from the U.S. Centers for Disease Control and Prevention, approximately 35% of women in the United States have experienced IPV during their lifetime, and about 10% have been raped by an intimate partner[4]. A 2013 survey by the United Nations Population Fund in China showed that approximately 39% of women have experienced IPV, and about 10% have been raped by an intimate partner[5]. Data released by the All-China Women's Federation in November 2020 indicated that in China, a woman is beaten by her husband every 7.4 seconds on average, and 157,000 women commit suicide annually, with 60% of these cases attributed to IPV. Since the outbreak of COVID-19 at the end of 2019, increased economic pressure, transformed social patterns, and the dismantling of traditional support networks due to isolation measures have further heightened women's risk of experiencing IPV[6].

2 Clinical Manifestations

Although the vast majority of patients do not present with IPV as their chief complaint, IPV is not uncommon in general practice clinics. Among female patients in U.S. general practice clinics, approximately 38% have experienced IPV[7]. How to quickly identify potential IPV among various nonspecific symptoms and signs represents both a priority and a challenge for clinicians. While physicians often think of traumatic injuries when considering IPV, patients are more likely to seek care for various sequelae of IPV[8]. Below are common IPV-related symptoms.

2.1 Chronic Pain

Multiple types of chronic pain, including headaches, neck pain, back pain, and abdominal pain, are associated with IPV[9]. In Canada, 35% of IPV patients experience severe chronic disabling pain, with pain locations averaging more than three sites[10]. Due to chronic pain, IPV patients are more likely to experience activity limitations disproportionate to their age[11].

2.2 Digestive System Diseases

Many gastrointestinal diseases, including but not limited to peptic ulcers, irritable bowel syndrome, gastroesophageal reflux disease, chronic constipation, and chronic diarrhea, are associated with psychosocial factors. Sustained stress may be the reason for increased digestive system diseases among IPV patients[12]. IPV patients visit gastroenterology departments more frequently, undergo imaging or invasive examinations more often, and are even more likely to receive abdominal surgical procedures[13].

2.3 Sexually Transmitted Diseases

Sexually transmitted diseases have a significant correlation with IPV[9]. According to statistics from a San Francisco STD clinic, 11% of patients had experienced IPV in the past year, and 24% had experienced IPV at least once. The incidence of sexually transmitted diseases among IPV patients doubles, possibly because IPV patients are more likely to be coerced into unprotected sexual behavior. Based on U.S. epidemiological data, IPV patients are inferred to be more susceptible to HIV infection, with an OR value of 3.4[14]. However, such observational studies cannot confirm a causal relationship between sexually transmitted diseases and IPV. Additionally, considering the bias and confounding factors in observational studies, an OR less than 4 makes it difficult to confirm significance.

2.4 Alcohol and Drug Abuse

Various addictive substances show significant correlation with IPV[15]. In the United States, IPV patients have a fivefold increased probability of being diagnosed with substance abuse[16]. Alcohol and drug abuse are also established risk factors for IPV[17]. Given their significant correlation, if a patient is diagnosed with IPV, physicians should routinely screen for alcohol and drug abuse, and vice versa.

2.5 Post-Traumatic Stress Disorder

The incidence of post-traumatic stress disorder (PTSD) among IPV patients can be as high as 85%[18]. Severe and frequent physical and sexual violence, and even psychological abuse, can exacerbate PTSD symptoms. Symptoms such as intrusive memories, negative alterations in mood and cognition, avoidance and

arousal states, and decreased occupational and social functioning can persist for many years after IPV has ended. PTSD also commonly co-occurs with depression and substance abuse[19].

2.6 Depression and Suicide

Both physical and psychological victimization expose IPV patients to long-term high stress, making them more susceptible to symptoms such as low mood, loss of interest, insomnia, appetite changes, and difficulty concentrating. Women who have experienced IPV have a sevenfold increase in suicidal ideation. Among women with IPV who present with chronic pain symptoms, the proportion with suicidal ideation reaches as high as 31%[20]. Similar to alcohol and drug abuse, depression should also be screened for in IPV patients. Given the suicidal tendencies associated with IPV, we recommend routinely using PHQ-9 rather than PHQ-2 as the initial screening tool.

2.7 Trauma

Among IPV patients presenting to emergency departments, head, face, and neck trauma are most common, followed by chest and abdominal trauma, while extremity trauma is relatively uncommon[21]. Compared with accidental injuries, IPV-related trauma is more likely to involve multiple injuries. For non-traffic-related multiple injuries, physicians should be more vigilant for IPV. Additionally, considering that IPV patients often suffer from long-term repeated beatings, physical examination should focus on assessing whether multiple injuries are at different stages of healing[22].

Disease reviews typically use likelihood ratios to evaluate the importance of symptoms and signs for a condition. However, all the symptoms mentioned above are neither specific nor sensitive for IPV, with positive likelihood ratios almost certainly less than 1, offering no guidance for clinical practice. Compared with the symptoms themselves, various suspicious elements discovered in the medical history are more helpful. For example, IPV patients are more likely to present with various unrelated symptoms and signs, even with inconsistent findings that are difficult to explain by a single diagnosis; IPV patients often delay seeking care or frequently cancel appointments; IPV patients typically have recurrent symptoms with poor response to symptomatic treatment, and some IPV patients are accompanied by family members throughout the visit who answer questions on their behalf.

3 Recognition

China currently has no guidelines to instruct physicians on IPV screening. In 2018, the U.S. Preventive Services Task Force recommended screening women of reproductive age for IPV because its main harm occurs during pregnancy and postpartum, with this recommendation receiving Grade B evidence[23]. However, for non-reproductive-age women, the Task Force concluded that there

was insufficient evidence to recommend routine IPV screening. It should be noted that whether national guidelines recommend screening for a disease considers not only disease characteristics such as incidence, harm, and intervention benefits, but also weighs socioeconomic factors including health insurance (particularly commercial insurance interests) and healthcare resource accessibility. Therefore, a guideline's recommendation against screening does not necessarily mean screening is unnecessary; clinical practice should still involve individualized assessment of patients before making decisions. For situations where the pre-test probability of IPV is significantly increased (when patients present with the various clinical manifestations mentioned above), we recommend broadening screening indications given the significant harm involved.

3.1 Screening Preparation

When suspecting IPV and preparing to initiate screening, physicians must ensure that only the patient is present in the consultation room. Most patients will only provide a complete history when their privacy and safety are guaranteed. If family members are unwilling to leave the consultation room, this tests the physician's communication skills. First, we recommend "setting the agenda" before the interview, informing both patient and family members that private consultation is part of routine procedure to reduce family members' vigilance. Second, physicians can ask family members to leave during the physical examination and take the opportunity to inquire about historical details. Finally, if family members still refuse to leave, physicians may consider using excuses such as "rechecking vital signs" to bring the patient to another room for consultation.

3.2 Interview Techniques

The interview should begin with routine social history questions, such as "How is life at home? How are your relationships with family members?" Based on the patient's responses, the physician can then decide whether to ask further details, such as "Do you ever feel unsafe at home? Does your partner control or restrict you from doing anything? Has your partner ever hurt you or threatened to hurt you?" If the patient discloses any details of IPV, the physician should further assess the patient's safety situation, such as "Are you concerned about your own and/or your children's safety? Have there been any significant changes in your partner's life recently, such as job loss, alcohol abuse, or drug use? Has the frequency or severity of harm you've experienced increased recently? Has your partner threatened to kill you or your children?"

3.3 Screening Scales

Although no scale has been validated for effective IPV screening, screening scales still have irreplaceable advantages. First, for less experienced junior physicians, screening scales can guide the interview and avoid missing important alarm symptoms. Second, screening scales can standardize the diagnostic process, facilitating follow-up comparison and subsequent research. Most importantly,

highly sensitive screening scales can increase IPV diagnosis rates. Common screening scales are summarized below.

SAFE Scale[24]. This scale includes four questions and was originally developed to assess domestic violence, not specifically for IPV. “Do you feel safe in your relationship with your partner? Have you ever been threatened or hurt by your partner? Do your family and friends know you have been hurt? Do you have a safe place to go in case of emergency?”

AAS Scale[25]. This scale uses five questions to assess whether pregnant women have experienced IPV. “Have you experienced physical abuse by your partner? In the past year, have you been hit, slapped, kicked, or otherwise physically hurt? Since you became pregnant, have you been hit, slapped, kicked, or otherwise physically hurt? In the past year, has anyone forced you to have sexual relations? Are you afraid of your partner?” Any “yes” answer is considered positive.

HITS Scale[26]. This scale includes five questions, each scored based on frequency from 0-4 representing “never,” “rarely,” “sometimes,” “often,” and “frequently.” A total score greater than 10 is considered positive. “In the past year, how frequently has your partner: been physically violent to you? insulted or talked down to you? threatened to harm you? screamed or cursed at you? forced you to have sexual relations?”

PVS Scale[27]. This scale is commonly used in emergency departments for rapid assessment of possible IPV. “In the past year, have you been hit, kicked, or otherwise hurt by someone? Do you feel safe living with your current partner? Have any previous partners made you feel unsafe now?”

HARK Scale[28]. Any “yes” answer to the four questions in this scale is considered positive. “In the past year, have you been humiliated or emotionally abused in any way by a partner or ex-partner? Are you afraid of your partner or ex-partner? Have you been raped by a partner or ex-partner? Have you been beaten by a partner or ex-partner?”

STaT Scale[29]. This scale surveyed IPV patients and selected the three questions with the largest area under the ROC curve from 43 candidate questions to assess IPV. “Has your partner ever pushed you or slapped you? Has your partner ever threatened to harm you? Does your partner destroy property?” When the score is \$ \$1, \$ \$2, and 3, the sensitivity of STaT for IPV detection is 96%, 89%, and 64%, respectively; specificity is 75%, 100%, and 100%, respectively.

WAST Scale[30]. This scale has eight questions with no fixed positive threshold. “Is your relationship with your partner tense? Do you and your partner have difficulty problem-solving when facing arguments? Do arguments with your partner make you feel very frustrated? Does your partner kick, hit, or push you during arguments? Have you been frightened by your partner’s words or actions? Have you been physically abused by your partner? Have you been emotionally abused by your partner? Have you been sexually abused by your

partner?”

According to a 2012 systematic review by the U.S. Preventive Services Task Force, the HITS, STaT, HARK, and WAST scales have relatively good specificity and sensitivity[31]. According to a systematic review in preventive medicine[31], among common screening questionnaires, HITS has sensitivity of 30%-100% and specificity of 86%-99%; WAST has sensitivity of 47% and specificity of 96%; PVS has sensitivity of 35%-71% and specificity of 80%-94%; AAS has sensitivity of 93%-94% and specificity of 55%-99%.

We do not recommend any particular screening scale for the following reasons: (1) All common screening scales were developed based on small-sample studies, and both internal and external validity require further verification. (2) The so-called high sensitivity and specificity of all screening scales were calculated separately in low-quality studies without comparison through high-quality research. Therefore, differences in performance between scales may or at least cannot be excluded from being due to different research methodologies. (3) No screening scale has been validated for screening efficacy in Chinese populations; these scales were developed based on Western populations, and although we attempted to adapt them during translation, their accessibility cannot be guaranteed. (4) When no officially endorsed unified scale exists, recommending a particular scale does not facilitate communication between physicians. (5) Using any scale may leave a trace, and whether in paper form or discovered in medical records by family members, this may further endanger patient safety. (6) No studies have evaluated the false positive rate of any scale.

Rather than directly using a particular scale, understanding the logic behind the scales and integrating it into the interview may be a better current approach. Synthesizing various scales, their core questions mainly address: whether there is physical and/or psychological abuse and whether there is safety threat. The former corresponds to how to identify IPV, while the latter is the most critical issue requiring management in IPV.

4 Management

4.1 Responding to Patients

When facing positive screening results, physicians should first respond to the patient directly, aiming to demonstrate empathy and support, assure the patient of confidentiality, and simultaneously connect their health consequences to IPV. For example: “Thank you for telling me this; facing the problem is the best start to overcoming IPV. Everyone deserves a safe living environment, and I will keep this confidential and help you address these issues. IPV is a serious problem and is likely the cause of your current multiple symptoms.”

4.2 Safety Assessment

The purpose of safety assessment is twofold: first, to determine whether the patient can safely return home today. For example: “Do you feel safe going home today? If not, can you stay temporarily with friends or other family members?” Second, to help the patient develop a safety plan to address potential future safety threats. For example: “Can you plan an escape route in advance? If you are victimized at home, which room is relatively safe? Generally, bathrooms or bedrooms have single exits that are not easy to escape from, living rooms are relatively easier to escape from, and kitchens are relatively more dangerous due to knives. Can you prepare a backup phone and some money? Where are your important documents, and can you secretly take them out or make copies in advance? Can you place these important items in a safe location outside your home? How can you protect your children if violence occurs? Do you have trusted friends or family who can call the police for you? Do you have a code word to inform your friends or family that you are facing a death threat?”

4.3 Referral

Although China does not have a clear referral mechanism to help IPV patients, certain departments can potentially help patients. For specialists, we recommend referring patients to family medicine. Family medicine services are person-centered, family-based, and community-oriented, enabling more convenient “long-term continuous care.” For all IPV patients, with their consent, they should be referred to psychology and/or psychiatry departments. According to China’s Anti-Domestic Violence Law[1], physicians have an obligation to report IPV patients’ situations to neighborhood committees, village committees, sub-district offices, women’s federations, and other institutions. Relevant institutions should conduct investigation and dispute resolution for past IPV, maintain records and prevention for potential IPV, and promptly stop ongoing IPV and report to local public security authorities.

4.4 Medical Record Documentation

To avoid family members copying medical records, physicians must instruct patients not to sign authorization forms for family members, preventing further harm to patients after family members view the records. Detailed medical record documentation can legally protect both physicians and patients. If trauma occurs, physicians should document the injury mechanism, describe injuries in detail, and use a “body map” to mark all injury locations when necessary. With patient consent, injuries may also be photographed and uploaded to the medical record system. Screening forms for depression, suicide, PTSD, and substance abuse should be copied and retained in the medical record. The medical record should document that a safety plan has been discussed with the patient to protect the physician.

4.5 IPV in China

Although IPV is a thorny problem anywhere in the world, China faces particular difficulties. First, traditionally Chinese people consider IPV a family dispute rather than a crime, and this cultural tolerance further exacerbates the harm of IPV. Second, China has neither official professional IPV assistance agencies for physician referral nor official medical guidelines to guide healthcare institutions in diagnosis and treatment, resulting in a dilemma where even when IPV is identified, patients cannot be helped. Most importantly, although China's Anti-Domestic Violence Law clearly requires physicians to identify and manage IPV and report to public security authorities, in reality, due to the lack of clear reporting standards and reward-punishment mechanisms, physicians tend to adopt a “avoid trouble when possible” mentality and are unwilling to actively report and further help patients.

5 General Practice Perspective

5.1 Recognition

IPV has insidious onset, and involved symptoms are often neither specific nor limited to a single system. Except for acute trauma, it is difficult to identify at initial diagnosis. General practitioners should utilize the continuity and comprehensiveness of family medicine to find possible IPV clues from suspicious elements in medical history, physical examination, and consultation patterns. Considering the high incidence and serious harm of IPV, general practitioners should lower the threshold for IPV screening.

5.2 Prevention

IPV and many diseases are mutually causal. Family medicine emphasizes disease prevention, and when helping patients manage alcohol abuse, drug abuse, anxiety, depression, and other conditions, this is actually primary prevention of IPV, and vice versa. Additionally, general practitioners can provide medical care to every family member, and if IPV risk factors can be identified early, problems can be nipped in the bud.

5.3 Management

After contracting patients, general practitioners maintain long-term relationships with them. This medical stewardship-like characteristic increases patient trust and represents the best role for helping IPV patients. IPV often requires long-term management to help patients stay away from threats and gradually overcome psychological shadows. Family medicine emphasizes “long-term continuous care” for patients, which better leads IPV patients to overcome violence. General practitioners should also serve as medical liaisons, fully utilizing accessible medical resources including psychology, psychiatry, physiotherapy, and

coordinating other resources within and outside the community to help patients when necessary.

5.4 Legal Aspects

General practitioners should pay attention to protecting patient privacy and ensure one-on-one consultations. Medical records should be both detailed in documentation and carefully stored, protecting patient interests while avoiding escalating conflicts. When facing ongoing IPV and potential life threats to patients, physicians should encourage patients to call the police and seek legal assistance.

6 Summary and Outlook

IPV has high incidence and great harm, is not easily recognized clinically, and lacks standardized management methods in China. General practitioners should understand common clinical manifestations of IPV, make good use of screening scales, and appropriately lower screening thresholds to better identify IPV. For identified IPV, general practitioners should assess patient safety, make timely referrals, and help patients seek legal assistance. China should promptly develop official diagnosis and treatment guidelines to clarify the responsibilities of medical workers in IPV, thereby better preventing and stopping IPV.

Literature Search Strategy: This article first searched PubMed using (“intimate partner violence” [MeSH Major Topic] AND ((y_{10}[Filter]) AND (review[Filter]))) as primary references. Then searched PubMed using (“Intimate Partner Violence/diagnosis” [Majr] OR “Intimate Partner Violence/epidemiology” [Majr] OR “Intimate Partner Violence/prevention and control” [Majr] OR “Intimate Partner Violence/therapy” [Majr]) as references for IPV recognition and management.

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