INTRODUCTION

Woman abuse, wife assault, domestic violence, relationship terrorism, and intimate partner violence (IPV) are all terms that have been used to describe the violence that occurs between two people in an intimate relationship. Although domestic violence includes IPV, it also refers to violence against other family members; therefore, for the purpose of this chapter, the term IPV will be defined as the intentional use of tactics to gain and maintain power and control over the thoughts, beliefs, and conduct of an intimate partner. The term partner may be defined as a current or former girlfriend, boyfriend, spouse, or common-law person.

Tactics used to gain control in IPV create fear, isolation, and the entrapment of one partner. The Duluth Model Power and Control Wheel (Figure 14.1) illustrates some of the controlling and violent behaviors used by perpetrators of IPV.

The majority of nonfatal intimate partner victimizations occur at home. The EMT is in the unique position to attend to the patient in the home and observe the environment in which the violence took place, as well as the behaviors of the victim and abuser along with their interactions with each other. Being aware of these behaviors will allow the EMT to identify situations in which abuse may not yet have escalated to physical violence, thereby allowing early intervention.

SCOPE OF THE PROBLEM

Violence against women is well documented by the World Health Organization (WHO). IPV occurs in all countries, regardless of social, economic, religious, or cultural status. Although it is recognized that violence occurs against men in both opposite and same-sex relationships, the prevalence of women as victims is overwhelmingly greater than men. Therefore, this chapter will focus on male violence against female partners. The General Social Survey 1999 showed that when compared with males, females were:

- Seven times more likely to be sexually assaulted (20% versus 3%).
- Three times more likely to report physical injury (40% versus 13%) and five times more likely to require medical attention.
- More likely to fear for their lives (38% versus 7%).
- More likely to be killed by someone with whom they had an intimate relationship (52% versus 8%).

The U.S. Bureau of Justice Statistics reported that on average between 1993 and 2004, nonfatal intimate partner victimizations represented:

- 22% of nonfatal violent victimizations against females 12 and older. Approximately 97% of females experiencing nonfatal IPV were victimized by a male and about 2% reported that the offender was another female.
- 3% of nonfatal violent victimizations against males age 12 and older. About 84% of males experiencing nonfatal IPV were victimized by a female, and about 12% of males reported that the offender was another male.
- Intimate partners commit 30% of all female homicides and 5% of male homicides.
Physical and sexual assaults, or threats to commit them, are the most apparent forms of domestic violence and are usually the actions that allow others to become aware of the problem. However, regular use of other abusive behaviors by the batterer, when reinforced by one or more acts of physical violence, make up a larger system of abuse. Although physical assaults may occur only once or occasionally, they instill threat of future violent attacks and allow the abuser to take control of the woman’s life and circumstances.

The Power & Control diagram is a particularly helpful tool in understanding the overall pattern of abusive and violent behaviors, which are used by a batterer to establish and maintain control over his partner. Very often, one or more violent incidents are accompanied by an array of these other types of abuse. They are less easily identified, yet firmly establish a pattern of intimidation and control in the relationship.

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FIGURE 14.1
HIGH RISK GROUPS

Part of identifying IPV is awareness of the high-risk groups. Although it already has been established that women, because of their gender, are a risk group, within that group there are subgroups that are at even higher risk.

- Females age 20 to 24 are at the greatest risk of nonfatal IPV.3
- Females who were separated or divorced report higher rates than females of other marital status.3
- The average annual rate of nonfatal IPV from 1993 to 2004 was highest for American Indian and Alaskan native females, higher for black females than white females, and higher for females in all racial groups than their male counterparts.3
- Immigrant women report a rate of 5%.6
- Women with disabilities are 1.5 to 10 times as likely to be abused as nondisabled women, depending on whether they live in the community or in institutions.7
- One in six pregnant women are abused during pregnancy.1
- Men living with male partners experience abuse at a rate of 23%, whereas the rate for lesbian couples is 11%.8

UNDERSTANDING INTIMATE PARTNER VIOLENCE

Before any effective screening or intervention can be performed, it is important to understand the dynamics of an abusive relationship including types of abuse and the cycle of violence. Abuse often begins in a close, mutual relationship, which over time becomes exclusive, allowing the abuser to isolate the victim. Violence can appear gradually or suddenly, but generally there is a period of “testing.” This may begin with verbal abuse and then progress to sexual and physical abuse. Shoving and pushing can escalate to punching, kicking, and assault with blunt and penetrating weapons.

Types of Abuse

**Physical:** Use of physical force often resulting in injury (e.g., hitting, slapping, punching).

**Verbal:** Attacking someone’s self-esteem by calling her derogatory names (e.g., stupid, slut).

**Emotional/psychological:** Emotional trauma experienced by the victim (e.g., making threats, putting her down, blackmail, or continuous blaming).

**Sexual:** Any form of sexual activity with another person without their consent.

**Spiritual:** Denying the ability to practice or express her religion or spirituality or being forced to practice another religion.

**Financial/material:** Controlling someone through the restriction of financial or necessary material items (e.g., not being able to work or being forced to hand over her paycheck, being denied material things such as food and/or medications).

Cycle of Violence

Many abusive relationships undergo a cycle of violence, which occurs in three stages.9

| Tension Building | Honeymoon | Violence |

Phase One: Tension builds and the woman increases her efforts to please the abuser in hopes of avoiding violence. Women may intentionally trigger the abuse at a time when she feels the violence is inevitable to 1. decrease the stress she feels about the impending violence or 2. to be the one in control as to where and when the violence will occur.

Phase Two: Violence erupts. Violence may increase in frequency and severity over time.

Phase Three: In this “honeymoon” phase, the abuser apologizes for the abuse, may purchase gifts, blames the victim, and offers rationalizations e.g. “If you only didn’t… I wouldn’t….” This phase may become shorter over time.

Understanding this dynamic will assist the provider in assessing and caring for the patient. EMS is most likely to be called during phase two, during the violence or shortly afterward; this is an appropriate time for interventions.
The cycle of violence can also occur generationally because it is passed through the family. Children witnessing abuse learn that it is tolerated or even appropriate behavior and a way of gaining power and control, and therefore may repeat the behavior in their relationships.

**INTIMATE PARTNER VIOLENCE AS A HEALTHCARE ISSUE**

Studies report that about one in four women seeking care in the emergency department (ED) for any reason is a victim of violence (one in three treated for trauma), and 37% of female patients who are treated in the ED for violent injury have been injured by an intimate partner.10

Recently there has been a move to introduce universal screening in the ED and primary healthcare settings. This means that all women over the age of 12 are asked about abuse, not only those in whom injuries appear suspicious. The National Violence Against Women survey revealed that 125,000 (17.5%) of female victims of assault used ambulance services.11 Because EMTs are often the first responders to situations that involve violence, it is critical to be able to identify, ask about, and respond appropriately to the unique situations that involve IPV. If violence can be identified early then there is an opportunity to intervene, thereby improving the health and lives of women and children and stop the cycle of abuse.

**HEALTH EFFECTS OF ABUSE**

Many women living with abuse experience more than just physical injuries such as fractures and soft tissue injuries; they may present with psychiatric and medical conditions such as1:

- Eating disorders
- Depression
- Anxiety
- Insomnia
- Headaches
- Chronic (often abdominal or pelvic) pain
- Gastrointestinal problems
- Substance abuse
- Self harm, suicide, overdose, and
- Homicide at the hands of the abuser.

Between 1993 and 2004 the U.S. Bureau of Justice Statistics reported12:

- Fewer than one fifth of victims reporting an injury sought treatment following the injury.
- Approximately 9% of female and 8% of male victims were treated at the scene of the injury or in the home.
- Females who experienced an injury were slightly more likely than their male counterparts to seek treatment at a hospital.

EMTs might be called to a scene at which the patient is experiencing any of the aforementioned conditions. Through noticing the environment, patient injuries, and/or interactions between the patient and her partner at the scene, the EMT may be able to identify IPV.

**EMS PROVIDER SAFETY**

If EMS is activated through a 9-1-1 call for IPV, it is important to have law enforcement secure the scene before EMT access. If the EMT arrives at the scene of a undisclosed IPV situation and feels that the crew is at risk, then law enforcement should be called. EMT safety is paramount and a necessary precondition to be able to provide care to the patient. Once the scene is secure, the provider can proceed with assessing safety in the immediate area where the patient is located to provide medical assistance. Patients should be assessed in the appropriate sequence with the primary survey, ABCs, and life-saving interventions undertaken, followed by a secondary survey and further history.

While on the scene the EMT should keep the following in mind:

- Avoid confronting the abuser.
- Do not place yourself physically between a couple who is arguing.
- Ensure that an escape route such as the door is available.
- Do not let the abuser get between you and your escape route.

Be aware of your jurisdiction’s legal requirements with respect to reporting to law enforcement. Some states require EMTs responding to an injury sustained during a crime to report to police; others will allow or mandate the patient to decide the best action to take.
ASSESSMENT AND EXAMINATION

On the initial interaction with the patient the EMT may find there was a delay in seeking help and/or that this patient may have experienced repeated calls and visits to the ED for injuries.

Physical Assessment

The physical assessment may reveal injuries such as abrasions, bruises, burns, dislocations, lacerations, bites, fractures, abrasions or marks on the neck consistent with strangulation, petechial hemorrhage in eyes, a combination of old and new injuries, and/or patterned injuries to the head, face, neck, throat, chest, breast, back, abdomen, or genitals. Injuries that suggest a defensive posture, such as those found on the hands or ulnar aspect of the arms, are suspicious. Patients may also experience mouth and dental trauma. It may also be found that the patient’s or partner’s description of accident is inconsistent with the observed injury. If this is the case, the EMT should document both what is reported and objective observations.

Other physical indicators may include:

- Pregnancy,
- Unwanted pregnancy, miscarriage, abortion, or stillbirth,
- Fatigue, vague physical complaints,
- Chronic pain: chest, back, pelvic, headache/migraine, abdominal,
- Substance abuse: alcohol, drug, sleeping aids,
- Clumps of missing hair.

Behavioral Assessment

Once the patient is medically stable, the EMT should observe the environment as well as the behaviors and interactions between the people at the scene.

The partner’s behavior may include, but not be limited to: hovers over her, insists on being present while she is being examined, answers for the woman, is overly friendly with the care provider, or appears kind or overconcerned. Conversely he may also minimize the injury, lack sympathy, make remarks about her, or blame her for the violence/accident.

The women’s behavior may be evasive and guarded interactions, including saying nothing in front of her partner, minimizing the seriousness of her injury, avoiding eye contact, and looking to her partner for guidance.

Asking about Abuse

Once the EMT has made a determination that this call or injury could be a result of IPV, as part of the overall patient assessment, the EMT should ask about abuse in a confidential environment, and respond appropriately to support the patient.

The goal of asking about abuse is to make a supportive connection and convey the message that abuse is a health issue. This may help to lessen the patient’s isolation. Options may then be reviewed so that the patient is empowered to make informed choices for herself and her children. If the patient denies abuse, she will at least be left with the awareness that she can access EMS assistance when required, if and when she chooses to disclose.

Separating Couples

Asking about abuse must be done in private, away from anyone who may intimidate the victim. Ideally children should not be present because they may repeat information they hear to others. This could create a dangerous situation if disclosed information were repeated to the abuser.

Separating the abuser may require some creativity and is a challenge in the out-of-hospital setting. Two options are to have one EMT take the partner into another room to ask more health history questions or wait until the patient is alone in the back of the ambulance. It is important to make clear to the partner beforehand that the ambulance is for patients only.

There is no question that will elicit a positive response if the patient does not want to disclose. Do not force a disclosure if she is not ready. Should the EMT suspect abuse based on physical or behavioral observations, use the observation in the question, such as, “I am concerned that this injury may have been caused by someone hurting you. Did someone hurt you?” or “I noticed your partner doesn’t like to leave you alone, how do you feel about that?” If the EMT is practicing universal asking/screening, then something that contextualizes the question would be more appropriate such as, “Violence against women has become a health care issue; therefore, I ask all my female patients if they have ever experienced abuse/violence as a child, adolescent, or adult.”

The EMT should be conscious of what he or she is saying and tone of voice. Do not inadvertently give messages that the patient is to blame or...
should follow your advice, such as saying, “What did you do to cause this?” or “How can you love this guy?”

If she says “Yes” the EMT can respond with the following questions:
“Are you safe now?” (Determine the location of the perpetrator.)
“Would you like to talk about it?” (If the EMT does not have the time, then provide 24-hour IPV hotline/helpline numbers for support.)
“Have you talked to anyone else about this?” (This helps determine the patient’s support systems or just how isolated she may be.)
“What do you need right now?” (Demonstrates that the EMT is focused on her and her needs at this time and can pass the information to ED staff.)

If she says “No” the EMT can respond with the following message:

“I ask all my patients about violence and want to make sure they are aware of resources that are available to them in case their relationship changes.” The patient may deny abuse because she is experiencing barriers to disclosure such as fear the abuser will find out, fear the police and/or a child protection agency will become involved, or shame and embarrassment. Or she may not have actually been abused; in any case, most patients appreciate the question. Again, do not force a disclosure.

When people experience IPV their power and self-determination is taken away. EMT care should endeavor to empower the patient. Ways in which this can be done are explaining and asking permission before performing medical procedures, if the patient’s condition allows; sitting at or below the patient’s eye level; building trust by being direct and compassionate in responding to her questions; and being clear about violence against women being a crime and that this was not her fault.

Even in the out-of-hospital environment, women need a supportive, nonjudgmental atmosphere in which to feel safe disclosing abuse. Expressing concern, conveying that you believe her and providing validation for her experience are effective ways of offering support. If possible, provide options such as a sexual assault/domestic violence care or response center, police involvement, safety planning, and shelter referrals. The EMT should respect the decisions the patient makes; it might not be what the provider would have done given the situation, but the patient is the expert of her life and knows what she can deal with at this time.

High-Risk Indicators and Concerns
Factors that have shown to be related to increased risk of further violence in relationships include increasing frequency and severity of violence, using or threatening to use a weapon or to kill the woman, access to guns, perpetrator using drugs and alcohol excessively, and violence in pregnancy.15

Women who have been injured through IPV often decline transport to the hospital.11 Therefore, they will not have the availability of resources such as nurse examiners or social workers to provide them with support or referrals. Hence, the EMT’s knowledge of safety plans and the resources in the local community may be beneficial.

Safety Planning
Women seek strategies aimed at preventing and responding to violence.16

The EMT should ascertain what she has done in the past to keep herself safe, what is working, and what is not working. Because a woman’s level of risk may change over time, safety plans need to be flexible. Assess what the patient’s major concerns are at this time by asking open-ended questions such as, “What are you worried about most right now?” This aids in building a trusting relationship and views the patient not as a victim, but as a strong capable participant in her future. The more she directs the safety planning the more likely she is to adhere to it. Safety planning may range from a short-term emergency escape plan (keeping a packed bag of clothing, medications, important papers, and such things at a friend’s place and having an emergency exit route planned) to longer term (gaining enough financial independence to leave). The resources listed at the end of this chapter provide more information about safety planning.

Referrals
There are many options that EMS and other emergency providers may offer to victims of IPV. Persons in these situations often feel powerless and are unable see alternatives. If an EMT is authorized to offer referrals, he or she should do so in a way as to empower the patient to make her own decisions. The person in the situation is the best judge of what is safe to do right now.

• Sexual assault/domestic violence care or response centers can offer crisis intervention and support, documentation of injuries and photographs, safety
planning and risk assessments, referrals to shelters, and other advocacy services.

- Women’s hotline/emergency numbers are generally located in the front pages of the telephone book. They provide phone support, safety planning, and referrals.
- Police (be aware of any mandatory reporting policies in your jurisdiction).
- Shelters usually have counselors available 24 hours a day and provide a safe place for someone to flee relationship violence.
- Child protection agency (be aware of any mandatory reporting policies in your jurisdiction).
- Legal agency.

Preserving Evidence and Documentation

When performing a physical assessment the EMT may note patterns of blunt injury, lacerations, or penetrating wounds. It is therefore important to know these patterns and appropriately document if the injury does not fit the mechanism described. Be careful not to disturb the crime scene or destroy possible evidence, such as by removal of the patient’s clothing. If anything needs to be removed to attend the patient, describe the condition and place it in a paper bag. Cut around bullet holes or stab wounds, not through them. The manner in which clothing is removed or altered should be noted (e.g., “during resuscitation, patient’s shirt torn open, tearing off four buttons.”) If any material things such as furniture need to be moved to get to the patient, this should also be documented.

Use the patient’s own words when describing how she received the injuries, who assaulted her, and when. A detailed history of all aspects of the assault need not be taken as part of immediate care. The EMT should write what is pertinent to the care and treatment of injuries.

Documentation should occur at the scene or as soon as possible after attending to the patient. Should a case go to court the patient care record will be the only documentation the EMT will have of this event.

Key aspects of documentation include:

- Location of injuries (best done on body diagrams),
- Full description of all injuries (type, color),
- Size of injuries; if no measuring device is available, compare with a well-known item like size of a quarter,
- Other injury characteristics (e.g., scabbed, bleeding, or presence of foreign body),
- Mechanism of injury,
- Areas of tenderness/pain,
- Injury patterns,
- Distinguish between her or the partner’s reports and your observations,
- Excited utterances made by the patient such as, “I really thought I was going to die this time,”
- Patient/perpetrator’s behaviors,
- Other persons (such as children) present and their behaviors,
- Police officers’ names and badge numbers,
- Any safety planning information or referrals provided, and
- If drugging is suspected, any body fluids such as emesis or urine should be collected and preserved if possible.

Documentation should be:

- Objective, without accusations or value statements.
- Accurate.
- Specific.
- Legible.
- Complete.

Recurring Questions

Once the call report is complete and the patient is discharged from the EMT’s care, the EMT may be questioning, “Why do women stay and why do men abuse?”

Domestic violence does not always end when women leave the relationship. Statistics show that the most dangerous time is when she has decided to leave or soon after she has left. Women are trapped in and may return to relationships many times for a variety of reasons before making a final break. Some reasons include:

- Fear of personal safety, and/or safety of their children/pets.
- Low self-esteem, fear of the unknown.
- Economic issues.
- Isolation, no friends, no support system.
- Cultural/religious beliefs.
- Fear of deportation, unsure of legal rights.
- Family pressures, blame for failure of the relationship.
- Unsure of options.
- Abuse may be considered “normal.”
• Threat of sexual orientation revealed.
• “He’s not always abusive.”
• Systemic barriers.

Why Men Abuse

A cultural or religious belief that it is a man’s duty or right;
He witnessed abuse or was abused in his family and/or has other male role models who abuse;
Men often sustain abuse because no one—families, friends, neighbors, the police, media, workplace, the church, or the courts—effectively intervenes;
To keep the woman from escaping: batterers inflict the greatest violence and the greatest damage when women try to leave;
A manipulative and self-serving way of resolving conflict and getting what he wants.

Realistic Expectations

It can be difficult to bear witness to abuse. Often healthcare providers feel powerless in their efforts to make a significant difference in someone’s life. It is important to remember that dealing with abuse is a process and each person has the right to set his or her own agenda and work at his or her own pace. The EMT’s role is to provide medical treatment and support and empower patients to make the decisions that are right for them at a time when they feel it is safe. EMTs cannot “fix” a victim or the situation. At times providers may not agree with the decisions patients make, but they are the experts of their lives.

Understanding why people stay in abusive relationships and how to keep them safe is key when providing care to a victim of IPV. A strong multidisciplinary team approach is essential and will result in the most appropriate and beneficial patient-focused care for people experiencing violence in their lives. Therefore, ensure that all essential information and impressions are communicated to emergency department staff.

SUMMARY

A call to a residence where IPV has taken place can be one of the most difficult calls to which an EMT responds. It is vital for the scene to be secure before the EMT enters the premises. On calls where IPV is not initially identified in the call, but is suspected once on the scene, it is the EMT’s responsibility to ask and assess the patient’s immediate safety. In instances where the patient declines transportation, a knowledgeable EMT can provide support and resources and suggest immediate safety planning. If the patient accepts transport to the emergency department, ensure that all relevant information is reported to the healthcare provider taking responsibility for the patient.

Complete the call report as soon as possible to ensure that documentation provides an accurate, comprehensive, and timely account of the call. The EMT’s documentation of the events/injuries could be vital if and when the patient chooses to press assault charges. All providers should be aware of and compliant with local legislative requirements.

CLINICAL VIGNETTE

You have been dispatched to a middle-class neighborhood as a result of a 9-1-1 call in which the patient was experiencing shortness of breath and tightness in her chest. When you arrive, a man is standing at the door and announces that your assistance is no longer required. He goes to close the door and you notice his breath smells of alcohol. Once you are in the home, you notice that there are pillows on the floor and the lamp is knocked over. On the couch is a woman, mid 30s, who is bent forward at the hips, resting her head on her arms. You walk over and introduce yourself. She lifts her head
but does not say anything. You note that her eyes are red and puffy, and her face is flushed. As you begin to ask her questions, her partner walks closer to you and stands over her. You can see that she tenses up when he is near. You ask her to lift her t-shirt to do a proper chest assessment. She declines, saying it is not necessary, and she is feeling much better.

You listen to her chest through her shirt and note some wheezing. She has a history of asthma and environmental allergies. As you continue with auscultation, she winces and moves away. You do not notice any inhalers nearby. You are concerned that she is experiencing abuse. She discloses when asked that she has been abused and states her partner kicked her in the ribs.

What Are Your Initial Indicators for Intimate Partner Violence and How Would You Proceed?

Before asking about IPV there is something that cues you to think there might be a problem within this relationship; these cues are called indicators.

Although alcohol does not cause domestic violence, it is a contributing factor in that it can decrease a person’s inhibitions and therefore potentially make the violence experienced more serious. Other indicators on the part of the male that may cause you to suspect domestic violence are his attempts to let you know everything is fine and trying to prevent you from entering the premises. It is critical that the EMS personnel gain entry to the premises to assess the situation for themselves. Standing over his partner as you ask questions can be intimidating for the patient and a way for him to monitor what she is saying. When assessing the patient, indicators that may cause you to suspect IPV are her posture, the fact that she has been crying, the increased tension when her partner comes closer, and the pain she experiences that is not related to asthma.

When assessing for IPV the environment may also give you some important clues (e.g., it may be too neat, it may have weapons strategically placed in view). In this case there were pillows on the floor and a lamp knocked over. Also someone who has a history of asthma and is experiencing an attack would typically have attempted to self-medicate with her inhalers. It is of concern that they are not within the vicinity of the patient. Perpetrators sometimes use medication as a way to control their partners; this may mean withholding the treatment or a delayed call to EMS until the situation is more serious.

If you suspect IPV, it is essential to ask the patient if this is her situation. To do this effectively and without bringing more harm to the patient, it is imperative that the partner be separated from the patient. This can be done by one paramedic taking the patient’s partner out of hearing and visual distance if possible (without putting the paramedic at risk) and asking him some of the patient’s health history while the other partner assesses the patient. If separation is not possible, your alternative may be to ask the patient once she is alone with you in the back of the ambulance.

When asking about IPV, expand on an indicator that gave you cause for suspicion (e.g., “I noticed that you partner didn’t want to let us in and I can see that you are not okay, you look like you’ve been crying and you are hurt. I can see that something has happened here. Did he hurt you?”)

If the patient discloses abuse, the paramedic should be able to provide some simple resources such as social workers at the attending hospital, local area shelters, sexual assault/domestic violence care centers, or assaulted women’s hotline numbers.

Remember that you are required to document your assessment, suspicions, and interventions. In this case, one might document, “Male wished to prevent EMS entry to the premises. Once inside noticed that pillows were scattered on the floor, lamp knocked over. Patient appears to have been crying, face flushed, eyes red and puffy. Appears to be tense when partner nearby. Patient has history of asthma, no inhalers present. States she experienced a physical assault from her partner. Patient complains of chest pain as a result of being kicked in the ribs by partner.” Continue to describe the physical assessment as per your protocols and list resources that you discussed with the patient.
REFERENCES


Other Recommended Resources:
Peel Committee Against Woman Abuse: www.pcawa.org/rp1.php
(Safety plans in a variety of languages)
National Centre on Domestic and Sexual Violence: www.ncdsv.org/publications_wheel.html
(A variety of power and control wheels)