Intimate Partner Violence: An Ophthalmology Concern

A third of women and 1 in 10 men in the United States experience intimate partner violence (IPV) in their lifetime, and 45% of their injuries involve the eyes, said Erin M. Shriver, MD, FACS, at the University of Iowa in Iowa City. That makes it an ophthalmology concern, or at least it should, she said. However, she noted that many ophthalmologists overlook signs of IPV—as she, too, did in the past. Now, she recognizes those signs in the pattern of patients' injuries and in the stories that patients tell, or do not tell, about how they occurred. She urges her colleagues in ophthalmology to recognize the signs of abuse, to support patients at risk for IPV, and to offer them information about available resources. Doing so could save patients' eyesight and perhaps their lives.

More Than Meets the Eye

Although ophthalmologists will be most aware of its physical damage, IPV encompasses a wider range of abuse. The CDC defines IPV as abuse or aggression perpetrated by a current or former spouse or dating partner.[1] It includes:

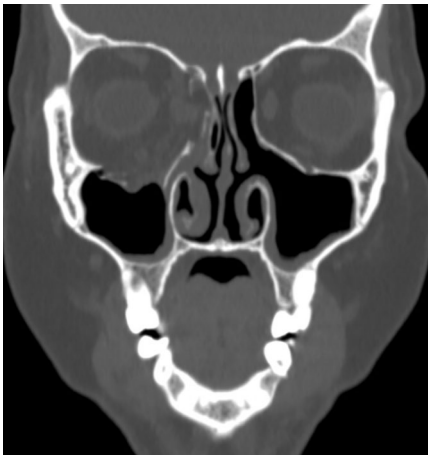
- Physical violence
- Sexual violence
- Psychological aggression, which may be verbal or nonverbal, intended to hurt or control the partner
- Stalking

The shadow pandemic. Patricia L. Turner, MD, MBA, FACS, of the American College of Surgeons (ACS) and the University of Chicago, noted that rates of IPV rose during the COVID-19 pandemic. Among the aggravating factors that she cited: the admonitions to stay home to prevent serious illness kept people cooped up with their abusers, while many people faced added pressures, such as lost income, trouble getting essential supplies, and children constantly underfoot. This increase in IPV has been so significant and pervasive around the world that a United Nations report has named it "the shadow pandemic."[2]

Turning Points

Sometimes it can take a tragic event to bring home the reality of IPV. Dr. Turner became involved in IPV prevention after a friend, who was a transplant surgeon, was murdered by her husband. Dr. Turner had seen her friend just a month before but had no idea she was being abused. Turning grief into action, she helped spearhead efforts at the ACS to address the "substantial public health crisis" of IPV. This, she said, is "something that all of us will likely encounter in one form or another, in a colleague or in a patient."

As for Dr. Shriver, she began researching IPV after feeling unprepared by her ophthalmology training to interact with a patient whose boyfriend had assaulted her, causing an orbital fracture. A study at the University of Iowa found that assaults by an intimate partner are the third leading cause of orbital fractures in women.[3] Yet in years of repairing orbital and ophthalmic fractures, she had never discussed IPV with a patient because the thought of doing so made her uneasy.



Courtesy of Ron Pelton, MD, PhD

CT SCAN. *Orbital fracture in an IPV patient.*

Red Flags for Physical IPV

"Sometimes it is pretty obvious that someone has been assaulted," said Ron Pelton, MD, PhD, an oculofacial plastic surgeon in Colorado Springs, Colorado. The following signs should raise suspicions of abuse:

A distinctive pattern of injuries. Dr. Pelton suspects IPV in female patients who come in with broken teeth, black eyes, swollen jaws, or other signs of having been hit in the face. Broken ribs or an arm in a cast provide further clues,

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as does seeking emergency care for the same kind of injuries multiple times.

Complex, serious injuries to the face or eyes. A literature review out of the University of Iowa found that female survivors of IPV often suffer multiple, severe injuries to the face or eye area.[4] Furthermore, abusers often hit with enough force to cause scleral lacerations or ruptures that require enucleation. Even the bigger, stronger bones around the eyes, such as the zygomatic complex, are frequently damaged in cases of abuse. Injuries from IPV typically appear on patients' left side because perpetrators are often right-handed.

No good explanation. All three physicians suspect IPV when patients cannot explain how their injuries happened, when their explanation makes no sense, or when their story does not match their injuries. For example, a patient with a chipped tooth, black eyes, and broken bones might say she slipped and fell on ice, but her injuries suggest otherwise, said Dr. Pelton.

Physician Silence Breeds Patient Silence

"We're often not good at screening because we have not been taught to think about this as a health care problem," Dr. Turner said. She would rather ask and learn that her suspicions are wrong than "miss the opportunity to ask the question and have something dreadful happen as a result of me prioritizing my embarrassment over someone else's safety."

Notably, only 8% of patients[5] say they would feel uncomfortable discussing IPV with their health care provider, Dr. Shriver said. Yet, many do not disclose abuse unless asked. She said that it's important for physicians to broach the subject because women who talk to their health care provider about IPV are more likely to seek an intervention, which increases their likelihood of leaving their abuser.[6] Moreover, she said, "Over half of the women who are killed by an intimate partner had presented to the emergency department in the two years preceding that, so we have an opportunity to catch these before the injuries escalate."

Whom and How to Screen

Dr. Shriver noted that IPV is the chief cause of serious injury and death in women ages 18 to 25, but men are abused, too. She said some data suggest that 1 in 4 gay men and 4 in 10 bisexual men experience IPV in their lifetime. Dr. Turner stressed that IPV "can affect literally anyone." She said no one is too financially successful, too educated, or too *anything* to suffer abuse.

Know the relevant laws. Before screening, physicians should learn about any mandatory reporting laws in their state. To that end, Futures Without Violence (see "Resources") offers a compendium of relevant state and federal laws. Dr. Pelton suggested contacting a lawyer or malpractice insurance carrier for advice if needed. If physicians are required to report injuries, they should tell patients up front. That way, patients can choose whether to make a possibly life-changing disclosure, Dr. Shriver said.

Train staff. According to Dr. Shriver, any member of the team, regardless of gender, can learn to screen for IPV. "It doesn't have to be the physician."

Talk privately. In some cases, patients are accompanied by their partners, whose presence often inhibits the patient from being forthcoming, Dr. Turner said. In that case, she would take the patient to someplace more private. Dr. Shriver tells the partner that she needs to do a part of the exam down the hall and that they will be right back.

Ask direct questions. "Screening calls for a conversation, not a checklist," said Dr. Shriver. She first normalizes the conversation by framing the questions as a standard part of an exam. She then asks, "Have you been physically, sexually, or emotionally abused by an intimate partner?" and, if appropriate, follows up with "Are your current injuries the result of this kind of abuse?" It felt awkward at first, she said, but became easier with practice.

Convey that you care. When patients understand that the physician cares about them and wants to do what's best for them, they are more likely to open up about their situation, said Dr. Pelton. He asks questions like, "Do you feel safe at home?" and "Do you need more help than just getting these broken bones fixed?"

Don't take it personally. "Even when you do everything right, not everybody is going to open up," Dr. Pelton said. Dr. Turner agreed, noting that abusers often intimidate their partners, sometimes by using children "as pawns," to prevent the abuse coming to light.

Physician as Connector

"You can still make a big difference even if patients don't disclose," Dr. Shriver said. She explained that ophthalmologists need not become IPV experts; rather, they should just counsel briefly and connect potentially abused patients to sources of help. Following are some specific steps to take:

Validate and support without judging. If patients disclose abuse, Dr. Shriver says something like, "I'm glad you shared this with me. I'm sorry that happened to you. This is not your fault. You are not alone." She tells them help is available. She asks whether they feel safe going home and whether children live there.

Be careful what you say. Dr. Shriver cautioned against telling patients to leave their abuser. "Leaving is the most dangerous time in the relationship," she warned. Before survivors can move out, they might need to make plans to shore up their finances or find safe shelter.

Find community resources. It can be helpful to identify local resources for IPV survivors. In Colorado Springs, where Dr. Pelton practices, patients can go to a women's shelter, out of their abuser's reach, and "get basically everything they need." Many cities have something similar, he said. To identify available resources, Dr. Pelton advised contacting the emergency department, whereas Dr. Shriver and Dr. Turner would contact the social work department at a hospital.

Refer patients for help. Dr. Shriver discreetly gives patients a phone number for a domestic violence crisis center. She asks if they want to call together from the exam room.

Patients can also enter the number into their cell phone, perhaps under a friend's name, since abusers sometimes check survivors' phones.

Suggest a follow-up. Dr. Shriver offers a follow-up appointment, even if not otherwise needed, when she suspects IPV. She recalled one woman whose husband was in jail at the time of the first visit. By the second visit, he was out, alarming the patient. The follow-up appointment afforded an opportunity to get a crisis center involved.

Document objective findings. Document what you discussed, what the patient said, what you did, and any clinical findings. "You don't want to be in a situation where someone could say, 'You knew what was going on, and you did nothing,'" Dr. Pelton said. However, he cautioned against using the chart to express opinions like, "I think she's married to a violent man."

Ophthalmologists have an ethical duty to protect patients from IPV, said Dr. Pelton. One of his patients, whose husband was abusing her, tells him every time she sees him, "You absolutely saved my life, and I'll never forget that."

1 CDC. Fast Facts: Preventing Intimate Partner Violence. www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html. Accessed Dec. 16, 2022.

2 www.unwomen.org/en/news/in-focus/in-focus-gender-equality-in-covid-19-response/violence-against-women-during-covid-19. Accessed Jan. 16, 2023.

3 Clark TJ et al. *Ophthal Plast Reconstr Surg.* 2014;30(6):508-511.

4 Cohen AR et al. *Curr Opin Ophthalmol.* 2017; 28(5):534-538.

5 Sprague S et al. *J Bone Joint Surgery Am.* 2013; 95(13):e91.

6 McCloskey LA et al. *Public Health Reports.* 2006;121:435-443.

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For full disclosures, see this article at aao.org/eyenet.

RESOURCES

The National Domestic Violence Hotline gives free support. It helps survivors create a safety plan and connects them to community services. Contact information: phone, 1-800-799-SAFE (7233); TTY, 1-800-787-3224; website, www.thehotline.org/

The Academy offers a newly updated CME course on IPV: aao.org/course/intimate-partner-violence

The American College of Surgeons prepared a toolkit for identifying and addressing IPV: www.facs.org/for-medical-professionals/professional-growth-and-wellness/ipv/toolkit/

Futures Without Violence, which runs The National Health Resource Center on Domestic Violence, provides resources and technical help to health care providers: www.futureswithoutviolence.org/what-can-the-nhrc-provide/