

## ASK THE HARD QUESTIONS: INTIMATE PARTNER VIOLENCE AND HEALTH-CARE PROVIDERS

**M**ANY CLINICAL ISSUES compete for health care providers' time. However, one condition affecting as many as one out of ten women in their practices is often overlooked. This omission is unsettling, as the clinician could have possibly prevented serious morbidity or even death. Fewer than one in four Oregon women who are victims of intimate partner violence (IPV) report that they discussed the abuse with their physician.<sup>1</sup> This issue of the *CD Summary* describes some of what we know about the risks of IPV in Oregon, and makes the case that clinicians should increase their efforts to identify and respond to patients at risk for IPV.

### HOW BIG A PROBLEM IS IPV?

While we know that many people are affected by IPV, it's difficult to measure precisely how many. While visible physical injury inflicted by a partner might seem to be a relatively objective outcome to measure, most who have studied the phenomenon of IPV see emotional abuse, psychological abuse, sexual coercion, threats of physical or sexual violence and physical violence that does not cause a visible injury as extremely debilitating and common manifestations of IPV—even if no physical injury has occurred. These manifestations of IPV can be more difficult to measure since they depend on the victim's perceptions—on “symptoms” rather than on objective “signs”. Another aspect of IPV that makes it difficult to measure is the social stigma surrounding IPV. Stigma may make it difficult for women to admit to themselves that they are in an abusive relationship, and also may make women reluctant to disclose their predicament to others.

Telephone surveys have the potential to elicit information about individual perceptions of risk or threat, and therefore have the potential to capture some

of the common forms of IPV that do not include physical injury. The anonymity of a telephone survey also may help overcome some of the stigma surrounding IPV. Of course, the estimates generated by such surveys depend on which categories of violence they include and what questions they ask. With a focus on physical violence, Oregon's Behavioral Risk Factor Surveillance Survey (BRFSS)<sup>2</sup> shows the annual prevalence of physical violence by an intimate partner to be about 2% among women and 1% among men—about 25,900 women and 12,300 men statewide. Using a much broader definition of IPV, the 1998 Oregon Needs Assessment found that 13% of 18–64 year-old Oregon women—over 132,000 women—suffered physical and/or sexual violence by an intimate partner in 1998, and 5%—almost 50,000 women—were physically injured as a result of this abuse.

### IPV HOMICIDES IN OREGON, 1999–2000

Sadly, some IPV incidents lead to death. In order to quantify and characterize IPV homicides in Oregon, we used death certificate data to identify a total of 170 homicides among Oregonians over the age of eleven—46 among women and 124 among men. Using Medical Examiner reports to identify the perpetrator and circumstances of these homicides we were able to ascertain that 27 (59%) of the female homicide victims and seven (6%) of the male homicide victims were killed as a result of IPV.

The women's median age was 37 years (range 14–78 years); the men's, 39 (range 22–59 years). Overall, women were 3.7 times more likely to be killed by an intimate partner than were men (average annual, sex-specific IPV homicide rates were 0.93/100,000 for women and 0.25/100,000 for men over 11 years old). Three of seven men killed, but no women, were IPV perpetrators killed by

their partners in self-defense.

Excluding the three men killed in self-defense, we looked more closely at the remaining 31 IPV homicide victims. Over three-quarters (n=24, 77%) were married: over half (n=17, 55%) were killed by their spouse. Seven persons (23%) were killed by a separated or divorced spouse; one, by a third party in collusion with the victim's spouse. In the remaining six (19%) cases, victims were killed by a partner (n=5) or ex-partner (n=1) of the opposite sex.

Firearms were the most commonly used weapons. All male victims killed by women were killed with handguns or other short guns. Twenty (74%) of 27 female victims were killed with various types of firearms; four (13%), by strangulation. Other means of death included stabbing, striking with a blunt object, poisoning, and falling.

In over half (n=15, 56%) of the 27 cases where a woman was killed, the man subsequently committed suicide. In no case did a woman kill herself after killing her partner. Medical Examiner reports documented the presence of children in 2 (6%) of the 31 IPV homicides. However, the absence of children was not consistently documented, so more than two homicides might have been witnessed by children.

### IPV AND THE HEALTH CARE SETTING

As with any medical condition, sound diagnosis is the basis for good treatment decisions. The first challenge to clinicians is to identify which women are at risk for IPV. Research indicates that physicians often screen when they see physical evidence of possible IPV, such as unexplained bruises.<sup>3</sup> Because the prevalence of IPV among assault or injury patients in the emergency room setting is high (studies suggest that as many as 10–30% of emergency room patients with injuries may be IPV vic-

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tims<sup>4-6</sup>) this kind of screening is particularly valuable in the emergency room setting. However, many IPV victims, particularly in the primary care setting, will have no physical stigmata. The only way to identify these women is to ask them about their risk of IPV.

How questions about IPV are asked is an important factor in determining whether or not an IPV victim will disclose what she is experiencing. As for many health conditions, establishing rapport with the patient and giving cues that you are there to listen rather than to judge are key to getting an accurate history. Some commonly asked questions like, "Why don't you just leave?" or "Why do you let him do that to you?" may be perceived as blaming the victim, and should therefore be avoided. Assessing the patient in private—away from family members—also is important both to allow disclosure of abuse, and to assure safety.

Universal screening is recommended for female patients by a variety of medical authorities, including the American Medical Association, and the American College of Obstetricians and Gynecologists. There is insufficient information to recommend universal screening for men, but providers should be sensitive to the fact that men can be IPV victims as well, and that such victimization also is likely to be surrounded by stigma and shame.

Often just listening, acknowledging, and letting the patient know they are not alone are therapeutic maneuvers in and of themselves. In addition, helping someone develop a safety plan can be lifesaving. Either working with the patient yourself or referring the patient to someone who

can help them make a plan is vital in a risky situation. Given the frequency with which firearms are involved in IPV homicides, assessing the availability of firearms may be an important indicator of a patient's risk. Knowing the domestic violence resources in your area allows for appropriate referrals. Documenting abuse in the medical record also can help your patients. Medical records can be an important tool for the prosecution of the abuser, and can help patients seeking legal protection from a bad situation.

There are numerous resources available to help clinicians screen for IPV and respond. Recommendations for screening are available from the American Medical Association (<http://www.ama-assn.org/ama/pub/article/2036-5298.html#RECOMMENDATION>). Some recommended screening tools are available from the American College of Obstetrics and Gynecology ([http://www.acog.org/from\\_home/departments/category.cfm?recno=17&bulletin=1476](http://www.acog.org/from_home/departments/category.cfm?recno=17&bulletin=1476)). Information about IPV-related services in Oregon is available from the Oregon Guide to Domestic Violence Services ([http://170.104.17.50/SVC\\_DIR/dvmap2.html](http://170.104.17.50/SVC_DIR/dvmap2.html)). And guidance about how to best document IPV in the medical record is available from the U.S. Department of Justice (*Documenting Domestic Violence: How Healthcare Providers Can Help Victims* (<http://www.ojp.usdoj.gov/nij/pubs-sum/188564.htm>)). Additional information about IPV is available from our Intimate Partner Violence Surveillance Program (503/731-4025).

## IN SUMMARY

From emotional abuse to murder, IPV's effects range from subtly debilitating to lethal. Although the numbers of Oregonians affected is difficult to estimate precisely, we do know that at least 34 people were killed because of IPV during 1999 and 2000, and 25,000–132,000 Oregon women are subjected to IPV each year. To take action against this problem, you should ask your female patients if they are being abused. If they are, provide information on IPV resources, help them formulate a safety plan if appropriate, and document abuse in the medical record. Your actions can make a critical difference in the lives of Oregonians suffering in abusive situations.

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For vaccine supply updates go to:  
[www.healthoregon.org/imm/provider/welcome.htm](http://www.healthoregon.org/imm/provider/welcome.htm)