

## IPV: DO ASK, DO TELL

**I**F YOU SEE patients, you've provided care to someone who has suffered violence at the hands of an intimate partner—whether you knew it or not. There is a lively debate in the medical community regarding what role clinicians should take in screening for intimate partner violence (IPV). Is it your job to ask patients if they have been victimized? If so, how do you do it? And what do you do if your patient says yes? This issue of the *CD Summary* reviews the problem of IPV and suggests ways to approach this disquieting situation.

### HOW BIG IS THE PROBLEM?

IPV is pervasive. A recent survey found that 10% of Oregon women, age 20–55, had been physically and/or sexually assaulted by an intimate partner in the past five years—over 85,000 women. Almost 30,000 Oregon women (3%) reported these types of assaults in the past 12 months.

### HOW IS IPV ASSOCIATED WITH PATIENT HEALTH?

Numerous studies show that IPV is associated with short-term and long-term physical and mental health problems. These include chronic illnesses or pain (e.g., back pain, headaches, irritable bowel syndrome), genitourinary problems, STDs, and mental health problems (e.g., depression, anxiety, PTSD).<sup>1,2</sup> A recent study found that female IPV victims had a 50–70% increase in gynecological, central nervous system, and stress-related problems.<sup>2</sup>

Consistent with national data, Oregon women who had experienced IPV reported twice as many days of poor physical health and almost four times as many days of poor mental health. Specifically, twice as many IPV victims reported chronic depression, over three times as many reported anxiety, and almost four times as many report-

ed post-traumatic stress disorder. Women who had experienced IPV were also twice as likely to have considered suicide in the past month and were more likely to report current use of alcohol and other drugs.

### IPV-RELATED INJURIES

Injuries are the most obvious health consequence of physical and sexual assault. In the Oregon survey, half of physical assault victims and 43% of sexual assault victims sustained injuries as a result of the most recent incidents. Of those who sought medical care, only 40% of physical assault victims and about 50% of rape victims spoke to clinicians about the fact that their injuries were IPV-related.

Most reported injuries are minor. However, approximately 25% of physical assault victims were knocked unconscious, about 20% sustained black eyes or busted lips, 11% had bones broken or joints dislocated, 7% sustained head injuries, and 6% suffered lacerations or knife wounds. Finally, one third of rape victims reported internal injuries.

And let's not forget—for some victims IPV is fatal. Homicide is the seventh leading cause of premature death for all American women and the leading cause of death among African American women aged 15–45. About 40–50% of female homicide victims are killed by intimate partners.<sup>3</sup> In Oregon, about 18 intimate partner homicides occur each year.

### TO SCREEN OR NOT TO SCREEN?

Although evidence regarding the effectiveness of universal IPV screening is currently lacking,<sup>4,5</sup> many advisory bodies have determined that inquiring about IPV is justified because of the severity and prevalence of IPV, the potential for helping victims, and the low cost and low risk associated with asking about abuse. IPV screening

is considered acceptable by a majority of women, including those who have never been abused.<sup>6</sup> Moreover, qualitative data indicate that asking about violence helps patients recognize IPV as a problem even if it is one which they are not yet ready to address.<sup>7</sup>

### PRACTICAL SUGGESTIONS FOR IMPLEMENTING IPV SCREENING

Clinicians have identified many barriers to asking about IPV, including lack of time, resources, and education or training, fear of offending the patient, and frustration with victims' nondisclosure.<sup>8</sup> Some primary care physicians have equated broaching the topic of IPV with patients as "opening Pandora's box."<sup>9</sup> However, other physicians say they have been successful in identifying and referring for IPV.<sup>10</sup> The physicians who felt successful with IPV screening came from varying medical specialties, but their processes were similar and are relevant to all clinicians:

- *Framing screening questions carefully to reduce patient discomfort and fear:* staff "normalized" questions about IPV by emphasizing that they ask all patients about violence and/or by including them among other safety questions (e.g., seat belt use).
- *Actively identifying cases based on the literature:* clinicians were especially alert to "accident-prone" patients, those with poorly-explained injuries, and those who presented with conditions strongly associated with IPV (e.g., stress-related conditions, chronic pain, multiple gynecological problems).
- *Fostering trust:* body language (stop writing, make eye contact), using personal statements ("I'm concerned about you"), and not pressuring the patient for immediate disclosure ultimately led to the most disclosures. Qualitative studies of IPV



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### IPV: DON'T ASK, DON'T TELL IS NOT THE SOLUTION

IPV affects Oregon women in ways that extend far beyond acute injuries resulting from assault. With 10% of Oregon women reporting recent IPV, it is likely that patients in your practice are experiencing IPV right now. However, many more may be suffering long-term consequences of past abuse, and knowing about that history of violence may help you formulate an appropriate treatment plan. Clinicians are uniquely positioned to identify IPV, refer victims to services, and provide important preventive antiviolence messages to all patients. Asking the question is an important intervention.

victims have identified empathic listening and “being sincerely present for the client” as qualities that inspired enough confidence in providers to disclose abuse.<sup>7,11</sup>

- *Redefining success to avoid burnout:* unlike other health conditions, clinicians may never know whether a patient’s situation has improved—or even whether their assessment of IPV was correct. This requires a change in focus from “knowing” or “fixing it” to an emphasis on offering preventive messages.

#### WHAT TO DO WHEN A PATIENT SAYS YES

Although lack of time is a real barrier, clinicians can make a large difference by sharing this important message with patients: IPV is common in our community, no one deserves to be a victim of violence, and there are resources to help you if you need them.

IPV is usually chronic, and a woman’s need for help and receptivity to receiving it will vary. Once abuse is clearly identified, it is important to assess the woman’s immediate risk of

danger. Risk factors for IPV homicide include a perpetrator’s access to guns, previous threats with a weapon, and estrangement, especially from a controlling partner.<sup>3</sup> Linking a woman with support services (listed below), where trained advocates can assist women in safety planning, is critical for women in imminent danger.

#### RESOURCES FOR CLINICIANS

Clinical guidelines for IPV are available from just about every medical association. Check the web site of your favorite body for the latest.

The Family Violence Prevention Fund provides educational materials, screening protocols, and technical assistance (including linkage to a national network of specialists) on IPV for health care professionals at <http://endabuse.org/programs/display.php3?DocID=41> or 888/RX-ABUSE.

Information about IPV-related services in Oregon can be found at <http://www.co.multnomah.or.us/dchs/dv/dyman/victims.html> or by calling the Portland Women’s Crisis Line (no matter where you are in Oregon) at 888/235-5333.

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