In the United States, as many as one in four women will be physically assaulted or raped by a current or past partner or date during her lifetime. Violence can be any pattern of psychological, economic, verbal, physical, or sexual abuse, including sexual coercion. The vast majority of victims are women.

The impact of Intimate Partner Violence (IPV) on women is far-reaching. The most devastating consequences are serious injury and death. Beyond this, women exposed to IPV face a myriad of co-morbidities such as depression, anxiety, and post traumatic stress disorder. IPV has been associated with increased incidence of substance abuse and utilization of substance abuse resources. Victims are more likely to have somatic complaints, such as abdominal pain, headaches, musculoskeletal discomfort and chronic pain syndromes.

IPV places a burden on the health care system. Women in abusive relationships are more likely to utilize medical services and to access out-patient care, mental health and emergency services. It has been estimated that in the United States, IPV results in the expenditure of $5.8 billion annually with $4.1 billion for direct medical and mental health care.

Screening for IPV is a first step in addressing this epidemic. The American College of Obstetrics and Gynecology, the American Medical Association, and the American Academy of Family Physicians endorse routine screening. Data indicate that patients also support regular IPV screening. Nevertheless, the rate of screening remains around 10%. Although physicians are encouraged and even mandated to screen for IPV, limited office-based resources exist to address the needs of women who screen positive. Lack of time, training, reimbursement or infrastructure are major barriers to physician screening.

**Intervention: IPV Desk Reference**

We propose a step-by-step protocol for physicians to implement when patients disclose a history of IPV. This protocol was created through a literature review of qualitative studies and primary interviews conducted with non-physician health professionals in the Rhode Island community who work with victims of partner violence. This protocol, including screening questions for IPV, was formatted as a desk reference to be distributed to primary care physicians in RI. (Table 1) We hypothesize that this resource will increase screening and detection rates of IPV by addressing the sense of “powerlessness” that many physicians may feel when faced with possible victims of IPV. Ultimately, the goal is to empower both physicians and patients to optimize resources and improve health outcomes.

**Screening**

Patient barriers to universal screening include the social stigma surrounding IPV, cultural and language barriers, past failures with the medical and legal systems, shame, denial, fear of losing custody of children, economic hardship and desire to protect the perpetrator.

Physician barriers may include lack of training in screening for IPV, time constraints, lack of compensation, and general discomfort with the issue. Some physicians may feel that they are not responsible for addressing “a social work issue.” Data suggest that many physicians feel ill-equipped to react to patients who screen positively, so they simply do not ask the questions.

Women of all racial, ethnic, socioeconomic, and educational backgrounds confronted IPV, though this may not be readily apparent to victims or health care providers. Therefore, universal screening is the only effective way to screen for partner abuse. Screening must begin with a commitment to confidentiality. Provider discussions about possible IPV should begin after any accompanying partners, children, or friends are directed to leave the exam room. An initial leading question can be, “Are you in an intimate relationship? If so, do you feel safe in your relationship and at home?” The patient may or may not disclose abuse at this time. Most providers who screen for IPV stop at this point. But many victims will not disclose abuse unless they are questioned further. If the patient denies abuse, the physician should follow up with simple questions. (Table 1, Screening section) In summary, every female patient should be briefly screened. This protocol involves a general inquiry about feeling safe at home, followed selectively with specific questions about physical and sexual abuse.

**Approach to the Patient**

When a patient discloses a history of past or present IPV, a provider must first demonstrate support and empathy. Statements such as “Nobody deserves to be abused,” and “This is not your fault, you did not cause this,” and “Partner violence is wrong and illegal” are extremely helpful to women who disclose a past or current history of IPV. IPV can have a deleterious impact on self-esteem and be extremely disempowering. Supportive statements attempt to empower the patient and re-build her sense of self-worth.

It is important to assess a patient’s readiness to change her situation or leave an abusive partner. Research has shown that the Transtheoretical Model (stages of change model), which has been widely applied to smoking cessation, alcohol cessation and weight loss, can also be applied to survivors of IPV. The Transtheoretical Model addresses an individual’s readiness to change his/her behavior in five stages; precontemplation, contemplation, preparation, action and maintenance. This model recognizes that each patient’s situation is unique; to be effective, interventions need to be tailored to the individual. (Table 1, Screening, #5)

For most survivors of IPV, the process of leaving an abusive relationship is complex. Health care providers who feel frustrated when women stay in abusive relationships must understand that, in leaving, many women face social isolation, financial instability, cultural barriers, fear of retribution by the abuser and the prospect of being a single parent to their children. Health professionals should assess the victim’s stage of change, and attempt to help her reach “preparation” or “action” while recognizing that this journey can be arduous.
Partner abuse can be a medical emergency. Health care providers must act decisively when a patient discloses that she is a victim. From 1996 to 2005 the US Department of Justice estimates that homicides against women were committed by intimate partners in 30.1% of cases compared to 5.3% of homicides against men. Consequently, safety or risk assessment is an important part of interventions. Risk factors for serious injury and lethality include the perpetrator’s access to a firearm, previous threat with a weapon, previous threats to kill the patient, and use of illicit drugs. One study indicated that having a child living in the home who is not the perpetrator’s biologic child more than doubles the risk of femicide.

A safety or risk assessment has two purposes: to help determine the risk of lethal injury and to facilitate the patient’s awareness of her situation and its potential for danger. The Danger Assessment, a validated tool, can be accessed at www.dangerassessment.org. While providers may not have enough time to implement this tool in its entirety, they can utilize portions of it in their clinical practice. (See Table 1) If a provider believes that a patient is at immediate risk of serious injury or death, he/she should make this very clear to the patient. While the police should never be called without a patient’s permission, this option can be discussed with the patient.

Referral and Follow-up
Clinicians are often the bridge between the patient and domestic violence advocacy organizations. Offering information about local agencies is one of the most powerful things that a provider can do. Raising awareness about IPV potentially helps a patient move from a place of denial and self-blame to a point where she may be ready to make a change.

In our state, the Rhode Island Coalition Against Domestic Violence oversees the six local domestic violence agencies. (Table 2) Also in Rhode Island is a 24-hour hotline called the Victims of Crime Helpline (1-800-494-8100) which patients or their providers can access. With the patient’s permission, a physician may call this hotline to help her take this first step. Health care providers and patients should understand that referral to a local agency does not result in immediate shelter placement. These organizations advise clients in court advocacy and affordable housing. They will assist with shelter placement if requested by the victim. They may also provide support groups and psychological services.
After patients identified as abuse victims are informed about resources, physicians should schedule a close follow-up appointment. This gives the patient time to think about her options. In recommending follow-up, the provider is sending a clear message of support and concern. Lastly, the provider should document a disclosure of abuse or suspected abuse in the patient’s chart. If the patient has injuries as a result of IPV, these should be documented and photographed if possible. Such documentation can be extremely important if legal action is taken for protection, prosecution or child custody.

**CONCLUSION**

Intimate partner violence is a major public health problem that can have devastating consequences for women and their families. Every physician has a responsibility to screen female patients for IPV and take appropriate steps if a patient screens positively. Our project aims to guide physicians in a plan to assist their patients who are victims. Our hope is that this desk reference will empower physicians to screen for IPV and ultimately improve health outcomes for victims of partner violence.

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The authors have no financial interests to disclose.

**CORRESPONDENCE**

Edward Feller, MD
Box G- 5121-2
Brown University
Providence, RI 02912
Phone: (401) 863-6149
e-mail: Edward_Feller@brown.edu