

Intimate-Partner Violence — What Physicians Can Do

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The U.S. Centers for Disease Control and Prevention (CDC) recently released a comprehensive report on the prevalence of sexual violence, stalking, and intimate-partner violence (IPV) in the United States.¹ The report relays the alarming findings that 35.6% of women in this country are raped, assaulted, or stalked by intimate partners at some point during their lives, and approximately 6% experience these events in any given year. Men are also at risk for IPV victimization: 28.5% report having been victimized at some time during their lifetime, and 5% report victimization within the past year. But the forms and consequences of IPV experienced by women and men are not the same. Women are more than twice as likely as men to experience sexual coercion in their intimate relationships (17% vs. 8%) and are twice as likely to experience severe forms of physical assault by an intimate partner, such as being choked, hit with a fist, or kicked (24.3% vs. 13.8%). The most striking differences relate to the consequences: very few men (5.2%) report ever being fearful of their intimate partners, in contrast to 28.8% of women, and

women are almost four times as likely as men to be injured by a partner (14.8% vs. 4.0%).

The costs of IPV are burdensome, for the health care system and for society. A decade ago, the CDC estimated the cost of IPV to the United States to be \$5.8 billion per year (\$10.4 billion in 2012 dollars), and it's been estimated that the cost of providing health care to adult survivors of IPV ranges from \$2.3 billion to \$7.0 billion in the first year after the assault. The annual health care costs for women who are experiencing ongoing IPV are 42% higher than those for nonabused women. This finding is unsurprising, given the evidence that IPV victimization of women increases the risks of injury, gastrointestinal disorders, chronic pain, central nervous system symptoms (including fainting and seizures), hypertension, and gynecologic problems.²

What can physicians do about IPV? All health care providers should be alert to aspects of patients' histories or symptoms that could suggest IPV and then should follow up with specific questions. According to the U.S. Preventive Services Task Force, screening

asymptomatic female patients for IPV victimization may provide benefits, with minimal adverse effects.³ As of August 2012, new guidelines under the Affordable Care Act require insurance coverage to include IPV screening and counseling as part of eight essential health services for women at no additional cost to the patient.⁴ Therefore, at a minimum, all primary care physicians should now be screening female patients 12 years of age or older for IPV. Specialty professional organizations recommend that obstetricians and pediatricians also consider performing regular IPV screening. Numerous IPV screening instruments may be used to begin a dialogue with the patient; one of them (known as HITS) is shown in the table.⁵ Another question that may be used to start a discussion about safety at home is simply, "Are you afraid of your partner or anyone else?"

There are several steps doctors should take when patients report potential IPV. First, clinicians should acknowledge the patient's admission of abuse: we advise thanking the patient for trusting the provider with the information and expressing concern about the patient's safety. Second, we suggest asking the patient if he or she would like to be connected to IPV advocacy services. If patients do want legal assistance, counseling, shelter, or other services, local domestic violence agencies affiliated with the state coalition are likely to be the most reliable resources (see box). Third, clinicians should offer the patient the National Domestic Vio-

The HITS Screening Tool for Domestic Violence.*

How Often Does Your Partner	Never	Rarely	Sometimes	Fairly Often	Frequently
Physically hurt you	1	2	3	4	5
Insult or talk down to you	1	2	3	4	5
Threaten you with harm	1	2	3	4	5
Scream or curse at you	1	2	3	4	5

* A total score of more than 10 is suggestive of intimate partner violence. This information, called R3, is available as a free Android or iPhone app. From Sherin et al.⁵

Key Resources

National Domestic Violence Hotline, www.thehotline.org/, 1-800-799-SAFE (7233). Provides crisis intervention, information, and referrals for victims of domestic violence.

Futures without Violence, www.futureswithoutviolence.org, a national organization dedicated to improving the health care response to violence; offers resources and information for providers and health care organizations.

Virtual Lecture Hall, www.vlh.com/domesticviolenceCME. Evidence-based online IPV training, free access for 30 days, \$25/credit hour for CME certificate.

National Network to End Domestic Violence, www.nnedv.org. National organization of state domestic violence coalitions.

Child Welfare Information Gateway, Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services, www.childwelfare.gov. Information and resources on child abuse and neglect.

lence hotline number (see box); the hotline makes printed, pocket-size handouts (palm cards) available to providers who wish to distribute them to patients. Fourth, clinicians should consider whether child protective services are required. In many states, the abuse of one parent by another does not necessitate a report to child protective services, so it's up to the clinician to determine whether a report is warranted. Clinicians should consider inviting the patient to make the report directly in order to increase the likelihood that staff members at child protective services agencies will view the patient as able to maintain a safe household for the children. Fifth, they should screen the patient for coexisting depression, anxiety, and substance abuse. And they should use caution when prescribing sedatives, since the sedating action may diminish patients' physical or mental ability to defend themselves or deescalate tensions.

When patients screen negative for IPV but the provider nevertheless suspects that they're experiencing abuse, it's important that the provider not force disclosure. It's not critical that the patient acknowledge IPV victimization in

order to benefit from the screening. Asking IPV-related questions signals to the patient that the provider is caring and concerned, trustworthy, and willing to discuss the topic during a future visit. Moreover, simply being asked the questions may prompt the patient to reconsider privately whether his or her relationship is healthy. And of course providers need not receive a positive screening response in order to provide universal education about IPV. Even if a patient screens negative, we would encourage the provider to state that many patients do experience IPV at some point and that there are many resources to help people who feel unsafe in their relationships. Handing palm cards with the national hotline number to all patients and encouraging them to take one for a friend if they wish, for example, may be an effective way of providing help to victims who don't feel comfortable disclosing their situations.

There are several ways in which providers can do unintentional harm to patients who are experiencing IPV. Asking no questions about IPV may signal that the provider is not a potential resource for the patient. But the

manner in which IPV victimization is documented in patient records can have ramifications for child custody cases. Detailed information about best practices for IPV documentation is available from the national organization Futures without Violence (see box). In addition, providers should refrain from telling patients who are experiencing IPV what they must do (e.g., "you need to leave"). Only trained experts in IPV advocacy are qualified to help victims determine their own best course to safety. There is a potential for lethal and injurious harm, particularly when one partner attempts to leave the relationship. For this reason, actively ensuring that the link between the patient and an IPV advocacy agency is made successfully is the best practice. Finally, it's critically important that providers respect the confidentiality of patients who are experiencing IPV. Not only do victims face stigma and prejudice, but employers and insurers could potentially discriminate against them if their status became known.

IPV is now recognized as a substantial public health problem. Health care providers can play a critical role in helping to reduce and prevent IPV by screening and referring patients to appropriate resources, familiarizing themselves with best practices related to IPV documentation and victim response, and presenting themselves as caring and trustworthy allies for their patients who are experiencing abuse. Research has established that health care-based screenings and interventions for IPV can benefit patients,³ and the Affordable Care Act ensures that preventive care will include these screenings for women and ado-

lescents. There is thus some cause for hope that we may curb the violence and play a role in creating safer homes and safer families nationwide.

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