

The Challenge of Managing Families With Intimate Partner Violence in Primary Care

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Since 1992, the American Medical Association has encouraged physicians to ask patients about intimate partner violence (IPV).¹ Although this recommendation has existed for 15 years, studies show that there is room for improvement, with less than 10% of physicians routinely asking about IPV.² A variety of studies have identified time constraints, discomfort with the subject, fear of offending the patient, frustration with patient denial, lack of skills and resources to manage IPV, and personal issues as barriers for physicians.³⁻⁵ In this issue, Heru et al.⁶ point out the complexity of relationships with IPV in adult suicidal inpatients. These relationships include mutual perpetration of violence, poor anger management skills, and limited communication. It is no wonder that physicians do not want to open Pandora's box.

Physicians have many issues to deal with in their practices. Most physicians do not have the psychosocial training to manage the complexities of IPV, and the "fix" does not occur overnight. Why ask questions about something that one cannot treat or that seems unfixable? Physicians become frustrated with the victim's reluctance to follow up on referrals.³⁻⁵ Despite the violence, the dysfunctional dance of the relationship is familiar. There are many reasons why victims do not want to end the relationship and why couples frequently want to continue the relationship despite the victim's frustration and physical and emotional injuries.

There are no easy answers, but living with IPV affects the health of all members of the family: the victim, the perpetrator, and the children. Exposure to IPV and household dysfunction as a child is associated with unintended pregnancy, sexually transmitted diseases, alcohol abuse, smoking, suicide, depression, and risk factors for heart disease, chronic lung disease, and liver disease in adulthood.⁷⁻¹¹ Victims of IPV have poorer health than do nonvictims.¹²⁻¹⁴ Conditions such as chronic pain, somatization, headaches, abdominal pain, irritable bowel syn-

drome, pelvic pain, back pain, and fatigue are commonly seen in IPV victims.¹³ Symptoms of posttraumatic stress disorder occur 5 times more often among victims of IPV than in the general population.¹⁵ Other mental health conditions are also more common among IPV victims. These conditions include depression (2 to 4 times more common among IPV victims than in the general population), alcohol dependence and abuse (up to 3 times more common), anxiety (3 times more common), and suicide ideation and attempts (up to 4 times more common).¹⁵ The consequences of pregnancy-related IPV include later entry into prenatal care, low-birthweight babies, premature labor, fetal trauma, unhealthy maternal behaviors, and postnatal issues such as postpartum depression and breastfeeding difficulties.¹⁶

Although less is known about perpetrators, substance abuse is often a problem. Perpetrators have high rates of depression and other mental health problems.¹⁷ Children in homes with IPV have behavioral problems such as acting out, school problems, withdrawal, aggressiveness and disrespect toward the mother, increased involvement in risky behaviors (drugs, sex, and alcohol), chronic physical complaints, and psychological problems such as depression, anxiety, posttraumatic stress disorder, and eating disorders.^{18,19} A study of 5-year-old twins demonstrated that children exposed to high levels of domestic violence had IQs that were 8 points lower than those of unexposed children and that a dose-response relationship existed with the intensity of violence.²⁰ (Studies of lead poisoning document a loss of approximately 4 IQ points among exposed children.²⁰) Urban children exposed to IPV had higher scores on the Child Behavior Checklist, indicating behavior problems, than did nonexposed children.²¹ In other words, these are patients whom physicians are seeing for a variety of issues. We are managing the repercussions of IPV, so why not work upstream?

Instead of suturing up lacerations, casting broken bones, managing suicide attempts, and writing prescriptions for a variety of physical and mental health complaints, clinicians should help patients see the link between living with violence and their health. The process is more complex than ask, identify IPV, and refer.

First of all, some patients do not know that their relationship is abusive. For many patients, IPV is intergenerational; this is what they grew up with, the norm.

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Often patients are aware of IPV but choose not to disclose the violence when asked about it. Sometimes patients feel that they have no options. In these instances, clinicians can be helpful. Asking about IPV demonstrates that it affects health and that it is an issue that can be discussed in the medical office. Posters and IPV resource materials in the office communicate the same message and also provide patients with options. Victims are often isolated, and the doctor's office may be one place where they can learn about their options and garner outside support.

In most medical settings, especially ambulatory care, treatment of the IPV victim is a process; it takes time for the victim to come to terms with the abusive relationship and to decide how to respond. Since IPV may often be a chronic problem, much of the treatment can be planned as nonemergent care.^{22,23} This treatment requires ongoing management by the clinician, demanding many of the same skills and supports needed for managing chronic illnesses.^{24,25} Thinking about IPV in the same manner that we do about other chronic health care issues such as diabetes, asthma, and depression might help clinicians pace their interventions and encourage health systems to put the supports in place to assist families with IPV. The Planned Care Model (PCM), formerly called the Chronic Care Model, is 1 popular approach that reorganizes the system of care to improve the management of a variety of chronic illnesses using both evidence-based and best practices.²⁶ Asthma management using the PCM involves a team approach with a role for the clinician, the development of an asthma action plan, reinforcement by asthma educators, and efforts to empower the patient to make decisions about the status of his or her asthma and about what management is appropriate.²⁷ While IPV is not a disease, putting systems in place for better identification and management may provide better care for victims and their families. These systems might include training for clinicians, making IPV resources easily accessible to patients, and screening for IPV in a number of patient interactions such as by the clinician during participation in a telephone support line and by case managers when addressing certain health issues such as chronic pain or depression.

In addition, thinking about IPV using the Stages of Change Model²⁸ may help clinicians choose an intervention that is appropriate for where a patient is in his or her process. Prochaska's model,²⁸ familiar to many primary care physicians, identifies 5 stages for changing a behavior: precontemplation, contemplation, preparation, action, and maintenance. When attempting to change a behavior or attitude, an individual will cycle through the stages, often moving back and forth between contemplation and action. Targeting the appropriate intervention to the patient's stage can assist patients and help clinicians to be more efficient. This model has been examined with

a number of health-risk behaviors including weight management, smoking, and substance abuse.^{29,30}

It is important to remember that the IPV victim has no control over the perpetrator, but the victim can choose how to respond to the violence by, for example, taking the violence or seeking assistance.³¹ A victim in precontemplation does not see the relationship as abusive, so talking about leaving the relationship or extensive safety planning may not be helpful. Instead, helping the patient to understand that no one deserves to be hurt and to see how the violence is affecting his or her health is more appropriate management. During contemplation, a victim is weighing the pros and cons of the options. Education about local resources, referrals to appropriate counselors, and discussions about steps to take to improve safety, as well as reinforcing how the violence affects health, are important intervention steps. During preparation, the victim needs details about resources and assistance with safety planning. The physician can usually have support staff or local advocacy services assist the victim at this time. Action and maintenance require ongoing support about actions taken.^{31,32}

Heru et al.⁶ explore the relationship dynamics of suicidal patients who live with IPV. The direction of causality is unknown. As Heru et al.⁶ point out, either the patient's illness has led to the deterioration of family function and violence has occurred in the relationship, or violence in the relationship has led to the patient's suicidality. Either way, these are patients with complex mental health issues whom primary care physicians cannot manage alone. System-wide and community supports are imperative. There should be assistance for the victim, perpetrator, and children in order to help families live healthier lives.

To date, few studies demonstrate the efficacy of clinician inquiry and interventions for the IPV victim.^{33,34} Less is known about assisting perpetrators and children. Studies do show that a majority of patients want their physicians to ask about IPV. Male perpetrators often seek care in the medical setting and will admit to IPV if questioned.^{17,35} Women will take action when they realize that IPV is affecting their children, such as when a child is injured or makes comments about the violence.³⁶ Interpersonal violence is complex, costly, and difficult to research, and much more work is needed. In the meantime, given the prevalence of IPV and the effects on health, we cannot afford to ignore it in the care of our patients.

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