Opportunities for Prevention: Addressing IPV in the Health Care Setting

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Introduction

Intimate partner violence (IPV) is one of the most common, preventable threats to women’s health. IPV can be defined as the actual or threatened physical, sexual, psychological, or economic abuse of an individual by someone with whom they have or had an intimate relationship (Family Violence Prevention Fund, 2004). One in four American women have been physically or sexually assaulted or stalked by an intimate partner in their lifetime (Tjaden & Thoennes, 1998). An estimated 5.3 million IPV victimizations occur to women age 18 or older (National Center for Injury Prevention and Control, 2003). The cost of IPV is conservatively estimated at $5,800,000,000 per year. This figure includes $4,100,000,000 for medical and mental health care; $900,000,000 in lost productivity; and another $900,000,000 in lost earnings from women murdered by their partners. These estimates do not include law enforcement, legal, or judicial costs and the medical care costs of the long-term health consequences of IPV. Clinic-based studies indicate that women experiencing IPV have 50% higher medical care costs compared with women not currently experiencing IPV (Coker, Reeder, Fadden, & Smith, In Press; Ulrich et al., 2003).

The immediate or short-term health consequences of IPV are well characterized. Briefly, physical and sexual assaults by partners can result in a range of injuries including bruises, cuts, concussions, broken bones, internal injuries and bleeding (Tjaden & Thoennes, 2000), and murder (Brock, 2003). Research has begun to describe the long-term mental and physical health effects of IPV (Campbell, 2002). Mental health consequences of physical, sexual, and/or psychological IPV include posttraumatic stress disorder (Astin, Lawrence, & Foy, 1993; Browne, 1993), depression (Campbell, Kub, & Rose, 1996; Coker et al., 2002), other anxiety disorders (Browne, 1993), suicide ideation and actions (Campbell & Lewandowski, 1997), and substance abuse (Kantor, 1997; Kantor & Asdigian, 1997). Psychological, physical, and sexual IPV are also associated with the following health outcomes: chronic pain (Campbell et al., 2002; Coker, Smith, Bethea, King, & McKeown, 2000; Weinbaum et al., 2001) neurological disorders as a consequence of head injuries and/or strangulation (Corrigan, Wolfe, Mysiw, Jackson, & Bognar, 2003; Muelleman, Lenaghan, & Pakieser, 1996), gastrointestinal disorders, particularly irritable bowel syndrome (Campbell, 2002; Coker et al., 2000; Drossman et al., 1990), sexually transmitted infections and urinary tract infections (Coker et al., 2000; Plichta & Abraham, 1996; Weinbaum et al., 2001), migraine headaches (Campbell, 2002; Coker et al., 2000), and a range of disabilities, (Coker et al., 2000; Hathaway et al., 2000; Plichta & Abraham, 1996; Plichta & Falik, 2001).
We now know that lifetime IPV experiences have significant short- and long-term health consequences. Concerted efforts toward prevention are needed to identify methods to reduce the impact of IPV on health (secondary or tertiary prevention) and to prevent IPV (primary prevention). The focus of this article is the health care system’s role in prevention for IPV.

**Secondary Prevention**

Secondary prevention typically includes efforts to identify a disease or condition early in its course when the disease is asymptomatic. Neither the patient nor the health care provider can identify the disease without screening. Screening for diabetes, cancer, and hypertension are common examples widely implemented in medical care. The nature of IPV challenges this concept of screening because, in most cases, the patient is very aware of the physical or psychological violence she is experiencing but may not realize the health impact of the violence. The patient may or may not be symptomatic, but may not disclose abuse because she does not understand how the violence affects her health. There are, of course, other reasons why women may not disclose abuse (Bauer & Rodriguez, 1995; Gerbert et al., 1996; Hathway, Willis, & Zimmer, 2002; Nicolaidis, 2002). These reasons may include fear of the partner or discomfort and fear in talking about violence with a provider. The health provider who is aware of the health threat posed by IPV can identify this risk by inquiring about IPV with patients.

The assessment scenario is similar to the common practice of asking patients about their smoking behaviors. The patient knows that he or she smokes but the health care provider may not. When the patient discloses smoking, the provider can then provide counseling, support, and resources to help the patient stop smoking. The provider understands that smoking cessation can be a long-term process that requires patience and support for those times the patient returns to using tobacco. A part of the assessment for smoking that is crucial is educating the patient that smoking is a health threat and resources are available to help the patient address the health threat. One important difference in the analogy between assessment for smoking and partner violence is while a patient has control over his or her own smoking behavior, the patient experiencing IPV does not have control over the abusive behaviors of their current or former partner. However, patients experiencing IPV can take action to improve their health and safety, increase control of their lives, and plan for a violence-free future for themselves and their children. These efforts require community resources that now exist in most communities throughout the USA.

The most important secondary prevention effort that health care providers can take is universal assessment of violence with all patients. While both men and women need to be screened, the issues related to screening differ by gender and are discussed separately starting with women. Both abused and non-abused women accept universal assessment for IPV (Stenson, Saarinen, Heimer, & Sidenvall, 2001; Webster, Stratigos, & Grimes, 2001). Furthermore, not asking women about IPV may adversely affect trust and confidence in the patient–provider relationship (Plichta, Duncan, & Plichta, 1996). Physician and
nursing organizations consider their role in identifying violence and making appropriate referrals for services as a professional responsibility (American Medical Association, 1992; Emergency Nurses Association, 1996). Universal assessment, asking all patients about current and past physical, sexual, and psychological violence over a patient’s lifespan, is essential because (a) all three types of violence have similar short- and long-term health effects (Campbell et al., 2002; Coker et al., 2002; Coker et al., 2000), and (b) many patients experiencing violence do not show signs of overt violence (e.g. injuries, posttraumatic stress disorder symptoms, depression). Clearly the counseling and specific intervention for current versus past violence and for psychological versus physical violence will differ yet the assessment can be very similar. Many screening tools exist and several have been validated (Brown, Lent, Schmidt, & Sas, 2001; Coker, Pope, Smith, Sanderson, & Hussey, 2001; Feldhaus et al., 1997; McFarlane, Parker, Soeken, & Bullock, 1992; Sherin, Sinacore, Li, Zitter, & Shakil, 1998). The focus of IPV assessment with respect to secondary prevention is early identification and services referral (treatment) with the goal of being safer and healthier individuals and families.

While men do experience IPV, the frequency of violence and severity is less than for female victims (Tjaden & Thoennes, 1998). However, male victims do experience many of the same health effects (Coker et al., 2002). Universal assessment of lifetime IPV may be as important for men as it is for women because societal norms do not validate the experience of male victims who may then be less likely to disclose abuse without being asked. The challenge for health care providers who assess male patients for IPV is where to refer men for community services as few exist for male victims. This group of victims should not be ignored. As with most community services for violence victims, funding for these non-profit agencies comes largely from private donations from the secular and religious communities with local and national governments providing much smaller proportions of the funding. Health care providers can play an important role in the ongoing advocacy work that is needed to help local, state, and federal government understand their responsibility in supporting community-based services for male and female victims of IPV to create survivors.

Primary Prevention

Primary prevention examples include: (a) changing social norms promoting hostility or violence toward women; (b) questioning use of controlling behaviors (including threats as well as physical or sexual violence) with intimate partners; (c) changing male roles that promote aggression and control and the suppression of emotion; (d) promoting policies that raise the status of women in society through education and jobs; (e) supporting men as involved co-parents, sons, partners, and husbands; (f) developing mass media programs to include messages to raise the public’s awareness of partner violence. Although much of this is beyond the scope of most health care settings, providers do have a role because patients come to them for help with specific health conditions as well as information about promoting health. Patients look to and value their health care providers’ views including those on healthy intimate relationships. Primary prevention strategies that health
care providers can employ to address IPV include talking with patients about healthy relationships, parenting skills, and the warning signs of an abusive relationship.

Preventing IPV may have important implications for reducing other types of interpersonal violence such as child abuse, intergenerational abuse, and the mental and physical health effects of childhood exposure to domestic violence. The risk of child abuse is higher in families where the mother experiences IPV (Ross, 1996). Early and effective assessment and interventions could reduce the risk of continuing child abuse, partner violence, and the range of mental and physical health consequences of this violence. Experiencing IPV in one’s family of origin (e.g. father was abusive toward mother) significantly increases the risk of that child using force in future adult intimate relationships or becoming a victim of partner violence (Coker et al., 2000; Desai, Arias, Thompson, & Basile, 2002). Thus early and effective interventions to identify IPV could reduce the risk of IPV for the children of current victims. By educating patients about the broad health implications of IPV for victims and their children and the elevated risk for multiple forms of violence in the same household, health care providers can help to end the cycle of family violence.

**Challenges Posed by the USPSTF**

How should health care providers proceed with assessing for violence given the recently released U.S. Preventive Services Task Force (USPSTF) report (Nelson, McInerney, & Klein, 2004) that does not recommend screening for IPV, elder abuse, or child abuse? The legal implications of screening for these three types of violence differ greatly as does the evidence that assessment of violence can accurately identify cases and that effective interventions exist to reduce the violence. As this paper promotes assessing for IPV in the health care setting as a prevention strategy, the remaining comments will address the challenges the Task Force report raises in the data available to evaluate the effectiveness of screening and interventions for IPV.

While the USPSTF acknowledges that tools exist to accurately assess IPV (HITS (Sherin et al., 1998), PVS (Feldhaus et al., 1997), WEB (Coker et al., 2001), WAST (Brown, Lent, Brett, Sas, & Pederson, 1996), AAS (McFarlane et al., 1992), the report concluded that there have not been any large scale and generalizable studies published to date to document whether assessment and intervention reduce violence. Furthermore, no assessment and intervention study has addressed adverse effects of assessment/screening or interventions. These are legitimate arguments against screening for IPV and should be taken as a challenge to those who do research on and provide services for IPV victims and their families. There are some unique ethical challenges to conducting studies to evaluate IPV screening as this work requires a comparison group who are not screened. Many researchers and health care providers see this neglect of screening as unethical. However, because few health care providers are currently implementing universal assessment, a randomization of patients to a screening and referral intervention relative to a no screening comparison may be ethically...
palatable if the health care setting has information about community resources widely available in bathrooms, waiting rooms, and examination rooms. Follow-up with screened and non-screened subjects would be necessary to determine the rate of violence in both populations at the time of screening, the utilization of community-based, clinical, and legal services by IPV victims in both the screened and non-screened populations at the time of screening and over time, and to prospectively assess the potential positive and negative effects of screening and the positive and negative effects of not being screened. Conducting such a large scale and widely generalizable study requires a significant commitment of resources.

The challenges of the USPSTF must be taken seriously by federal funding agencies to provide additional resources to address this important question, which has significant short- and long-term health effects for men, women, and children. There are ongoing studies to evaluate IPV interventions in health care settings (no studies comparing women screened to women not screened). These studies will provide answers to the question of which interventions work best to reduce violence and the impact of violence on health. It is important to point out that three small intervention studies have shown that assessment and intervention reduce violence (McFarlane, Soeken, & Wiist, 2000; Parker, McFarlane, Soeken, Silva, & Reel, 1999) and improve safety behaviors (McFarlane et al., 2002). Future studies may well provide support for the results from these pioneering studies.

In summary, while all the data are not yet available, there is convincing evidence that women support being asked about their experiences with violence, that IPV has significant short- and long-term mental and physical health consequences for male and female victims, and that assessment and intervention in clinical settings hold the promise that health care providers can compassionately ask about IPV using validated questionnaires and provide appropriate referrals to decrease violence and its health effects. Assessment and intervention in the health care setting can help current victims and prevent future generations from suffering the mental and physical health consequences of IPV.

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References


