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Women battering in primary care practice

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Background. The organization of health care system to emphasize managed care has placed the primary care provider in an ideal position to assess the impact of intimate partner violence (IPV) on the health of women. Primary care practice provides a setting in which women can develop an ongoing relationship with their health care provider in which they feel safe to discuss IPV and possible options to improve their lives. Women's health and safety could be dramatically improved if primary care providers were prepared to assess, intervene and appropriately refer women who are in violent relationships.

Objectives. The purpose of this article is to describe the prevalence of intimate partner violence in primary care populations and review the known physical, mental health and pregnancy consequences of abuse as well as discuss the implications of intimate partner violence on primary care practice.

Keywords. Battering, implications for practice, intimate partner violence, prevalence, primary care practice.

Introduction

The organization of the health care system to emphasize managed care has placed the primary care provider in an ideal position to assess the impact of intimate partner violence (IPV) on the health of women. Much of the earlier work on IPV in health care settings has focused on battered women's injuries and their use of emergency departments (ED) and prenatal clinics. Less attention has been given to the physical and non-physical complaints of battered women who seek primary health care.

Primary care practice provides a setting in which women can develop an ongoing relationship with their health care providers where they feel safe to discuss IPV and possible options to improve their lives. Women's health and safety could be dramatically improved if primary care providers were prepared to assess, intervene and appropriately refer women who are in violent relationships. The purpose of this article is to describe the prevalence of IPV in primary care populations and review the known physical, mental health and pregnancy consequences of abuse. The implications of women battering on primary care practice will be described. For the purposes of this paper, IPV (domestic violence or battering) means repeated physical and/or sexual assault from an intimate partner within a context of coercive control.[1] It is estimated that approximately 90% of all intimate partner violence is battering of the female partner, 6–7% is mutual violence and 2–3% is battering of the male partner.[1,2]

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Intimate partner violence in primary care

Each year in the United States approximately 4 million women are battered by an intimate partner.[2,3] Among these women, a large number are regularly seen by primary care providers for health care related to illness, routine health maintenance and prenatal care. Recent research has begun to document the extent to which battered women are seen in primary care settings.

Estimates of the prevalence of patients in primary care practices who are currently experiencing IPV range from 12 to 29%.[4–8] The lifetime prevalence of IPV in primary care settings, that is patients who have experienced IPV sometime in their lives, ranges from 20 to 39%. Rath, Jarett and Leonardson[8] found that 44% of battered women in two urban primary care practices had experienced "minor" physical abuse and 28% had experienced "severe" physical abuse. Research reporting prevalence of abuse has been based on questions

included in the patient history form, distribution of questionnaires specifically about IPV or patient report on questioning. Table 1 summarizes the relevant studies. These studies suggest that women who use primary care practice clinics experience high levels of battering.

Few women are asked directly about physical violence by their primary care provider. Ferris and Tudivier[9] reported that 70% of providers in their survey believed fewer than 50% of the battered women in their practices were identified. In a study by Hamburger, Sanders and Hovey,[6] only 2% of female patients surveyed had been asked directly about physical violence. However, as many as one-third of women reported that their physicians had asked them about relationship problems or stressors in their lives.[6] Further, studies have documented that less than 4% of the identified IPV cases had been documented in the patient's medical record.[7,8] Freund, Bak and Blackhall[10] described the dramatic increase in identification of IPV cases by providers, from zero cases documented in medical records to 12% identification rate during their study of identification in an internal medicine clinic. Elliot and Johnson[4] found that none of the women who reported currently being in a battering relationship were seen for routine health maintenance visits, while more than half of the women "never battered" were seen for routine health maintenance.

Intimate partner violence and prenatal care

There are now many studies documenting physical abuse in pregnant women. Incidence of abuse during pregnancy is reported to range from 1 to 17%, and the prevalence of abuse in the year before pregnancy ranges from 3 to 9%, with the lowest prevalence found in a private prenatal clinic in an affluent community.[11–14] However, in two additional studies using both private and public patients, income level did not affect prevalence.[13] Parker and colleagues[15] found a significantly higher prevalence of battering during pregnancy in adolescents (20.7%) than in adult women (15%). However, the severity of the abuse was greater for adult women than for adolescents.

Identification of battering varied according to how the question was asked and who made the inquiry. The highest reporting occurred when the primary prenatal care nurse asked patients during each visit the four questions on the Abuse Assessment Screen.[16] Also, the identification rate increased from 7 to 29% using interview assessment during each visit rather than self-report on intake or history form.[16]

The prevalence of battering during pregnancy is equal to or greater than many other possible complications of pregnancy (e.g. toxaemia). Women who are abused during pregnancy experience more frequent and severe violence and have increased risk factors for homicide than women battered prior to but not during their pregnancy.[17] Battering during pregnancy warrants routine assessment for abuse as standard prenatal and postpartum care.

Health effects of abuse during pregnancy

Substance abuse, smoking, less than optimal weight gain and eating an unhealthy diet were correlates of battering in pregnancy.[18] These may be interpreted as factors related to stress. These risk factors further increase a woman's risk of poor pregnancy outcome when she enters prenatal care during the last trimester.

There are now at least two studies that have documented an association of low birth weight (LBW) with battering during pregnancy while controlling for other risk factors.[18,19] Newberger and colleagues[20] hypothesized that there is a direct causal path to LBW through abdominal trauma and consequent placenta damage, uterine contractions and/or premature rupture of membranes. There may also be the risk of infection related to forced sex. Trauma or the stress associated with abuse may also cause exacerbation of hypertension, diabetes or other chronic conditions of the mother. Indirect causes of LBW from abuse would be through the mechanisms of stress and through the association of abuse with other risk factors for LBW such as smoking, substance abuse, poor weight gain and late entry into prenatal care. In Bullock and McFarlane's[19] study, there was a stronger association of LBW with women delivering in a private hospital than those delivering in a public hospital. The authors suggest that the presence of fewer risk factors for LBW in middle class women may strengthen the detectable effect of battering on infant status. This explanation is consistent with findings from the Gielen and O'Campo[21] study of low-income women, where no association was found between LBW and abuse during pregnancy. There have also been indications of abuse related to inadequate prenatal care in at least two studies.[12,22]

A search of the literature has not revealed studies on postpartum depression that specifically measured partner abuse, although lack of support from a partner is a risk factor for post-partum depression.[23] Given the association of battering and depression in other women, it is reasonable to assume that some women diagnosed as manifesting postpartum depression may be experiencing abuse from an intimate partner.

In the only longitudinal study of abuse throughout the prenatal and postpartum periods, investigators Gielen and O'Campo[24] found that 10% of 265 women experienced moderate or severe violence prenatally, compared with 19% in the first 6 months postpartum. For the 69 women who experienced abuse during the childbearing years, 23% experienced abuse only prenatally, 16% experienced abuse in both prenatal and postpartum periods, and 61% experienced abuse only in the postpartum period.

TABLE 1 *Research overview of domestic violence (DV) prevalence and identification in primary care practices*

Author/Year	Design	Variables	Sample	Intervention	Findings
Bullock *et al.* (1989)[52]	Descriptive analysis of completed self-report health history forms	Prevalence of DV	(n = 793) Health history forms at four Planned Parenthood clinics over 1 month	Adding DV question to health history form	Current prevalence = 8.2% Battered women reported greater emotional, financial and legal problems, and changes in living arrangements, stress and parenting difficulties
Elliot and Johnson (1995)[4]	Descriptive structured interview	DV prevalence, reasons for clinic visit, patterns of violence	(n = 42) All consecutive women scheduled for morning appointment at family practice clinic over a 3-week period	None	Lifetime prevalence = 36% Current prevalence = 12% None of the battered women were being seen for health maintenance visits. More than half never battered women being seen for health maintenance visits
Ferris and Tudiver (1992)[9]	Descriptive mailed questionnaire	Physician's identification rate, barriers to identifying abuse, perceived role in management	(n = 505) Family physicians living in one urban and two rural Canadian communities	None	70% believed that they identified fewer than 50% of battered women in their practice
Freund, Bak and Blackhall (1996)[10]	Descriptive pre- and post-measure of intervention	Health provider identification rate	(n = 689) All consecutive new patients at internal medicine clinic serving women	Addition of one question about DV to health history form	Identification rate increased from 0% in the pre-intervention period to 12%. For 24% of those responding yes, violence was a current concern. Medical and psychosocial problems such as headaches, depression, alcohol use, dyspareunia and sexual dysfunction were more common in victims of domestic violence.
Gin, Rucker, Frayne, Cygan and Hubbell (1991)[5]	Descriptive self-report questionnaire	Prevalence of DV and identification by physicians	(n = 453) All women patients on random days from three university-hosptial-affiliated internal medicine clinics	None	Current prevalence = 14% Lifetime prevalence = 28% Less than one-third had discussed their situation with physician
Hamburger, Sanders and Hovey (1993)[6]	Descriptive self-report questionnaire	History of DV, physician inquiry about DV, and prevalence	(n = 394) All women patients attending a family practice clinic for regular appointments during a 2-month period	None	Incidence rate = 22.7% Lifetime prevalence = 38.8% Injury rate for women assaulted in last year = 13.4%; lifetime injury rate = 24.7%. 6.5% were asked about relationship problems by the physician, 2% were asked about verbal abuse and 1.7% were asked about physical assault
Martins, Holzapfel and Baker (1992)[7]	Descriptive self-report questionnaire & record review	Prevalence of DV and identification by physicians	All women patients seen during a 2-week period at a family practice clinic (n = 275) plus review of 383 charts	None	Prevalence = 7% Identification (4 of 383 charts)
McCauley *et al.* (1995)[76]	Descriptive self-report questionnaire	Prevalence of DV and medical needs	(n = 1952) All women patients using four community-based primary care internal medicine clinics over a 6-month period	None	Lifetime prevalence = 21.4% Incidence 5.5% in previous year Currently abused women had a higher incidence of depression, substance abuse and physical symptoms
McFarlane *et al.* (1991)[17]	Descriptive comparison of self-report (four questions about DV on health history) and nurse interview (same four questions were asked verbally)	Identification rates of DV	(n = 477) Women patients attending Planned Parenthood clinics during a 1-month period and (n = 300) randomly selected women patients at Planned Parenthood clinics	None	Identification rate using questions on health history form = 7.3% Identification rate when patients were asked directly by the nurse = 29.3% When women were responding affirmatively only to the question about forced sexual activity the prevalence increased to 34.6%
Rath, Jarratt and Leonardson (1989)[8]	Descriptive self-administered questionnaire and chart review	Prevalence, identification rate and associated demographic factors	Women patients and women whose children were patients in two primary care clinics (n = 218); 100 charts randomly selected	None	28% reported severe physical abuse, 44% minor physical abuse. Identification rate in records = 4%; one-third of medical records showed evidence of physician inquiry about stressors in the patient's life

Another aspect of outcomes of abuse during and after pregnancy is the risk of child abuse. There appears to be a significant overlap of child abuse and wife abuse.[25] Logically, the risk of child abuse would be especially severe in families where wife abuse began or became more severe during pregnancy, during the postpartum period or where the anger was directed toward the unborn child during pregnancy.[26]

Physical health sequelae from battering

Battering is a significant risk factor for a variety of physical health problems frequently treated by family physicians. Data from a national random survey reveal that severely battered women had almost twice the number of days in bed due to illness than other women and were significantly more likely to describe their health as fair or poor.[3] Injuries or the aftermath of injuries from abuse such as pain, broken bones, lacerations, facial trauma (e.g. fractured mandibles), tendon or ligament injuries, and arthritis are usually followed in out-patient settings.[27–30]

Since battered women frequently report untreated loss of consciousness because of abuse, the chronic headaches often described by battered women may be inadequately diagnosed sequelae of neurological damage from battering.[3] Undiagnosed hearing, vision and concentration problems reported by battered women also suggest possible neurological trauma resulting from battering.[31,32]

Symptoms and conditions associated with the stress and fear of living with an abusive partner result in health complaints that bring battered women into contact with their providers for such conditions as chronic irritable bowel syndrome, sleep disorders and hypertension.[33–38] Although suppression of the immune system from chronic stress has been investigated in other populations, the role of stress in the aetiology of the frequent communicable diseases in battered women and their children has not been investigated.[35]

Approximately 40–45% of all battered women are forced into sex by their male partners.[39] Forced sex has been associated with increased pelvic inflammatory disease, increased risk of sexually transmitted diseases, including HIV/AIDS, vaginal and anal tearing, dysmenorrhea, bladder infections, sexual dysfunction, pelvic pain and other genital–urinary-related health problems documented in several studies of battered women.[33,38–40] Eby and colleagues[32] reported that battered women experienced increased risk for sexually transmitted diseases (STDs), including HIV/AIDS. Sixty-seven per cent of the women interviewed reported not using protection during intercourse either because of their partner's insistence or when sex was forced.[32] This percentage was higher than reported by women who have multiple casual sexual partners or intravenous drug use. That study also specifically linked violent forced sex by batterers with physical health problems of women, a link not displayed elsewhere because of a general failure to examine sexual abuse within the context of intimate partner abuse.[32] Recent evidence that cervical cancer is a viral disease that may be secondary to STDs may have implications for the health care of battered women, given their potential exposure from their partners.[41]

The battered women in Hamberger, Saunders and Hovey's[6] study reported unexplained vaginal bleeding. But the possible links of abuse with conditions such as fibroids or other pathology that may result in hysterectomies has not been investigated. The Mexican-American women in Rodriguez's[40] study specifically listed hysterectomy as a health problem resulting from abuse. Battered women frequently will not report to health care providers sex-related injuries. However, women will respond to questions related to forced sex without objection when directly asked, suggesting the importance of including sexual abuse assessment by health professionals.

Mental health consequences of battering

The mental health problems resulting from abuse prompt many women to seek health care services as frequently as for physical health problems. Depression is the primary mental health response of women who are or have been battered, and depression is frequently treated in managed care settings. In a sample of 394 adult women seeking medical care at a primary care practice medical center, depression was the strongest indicator of intimate partner abuse.[42] Gleason[43] found a significantly higher prevalence of major depression in 62 battered women than in a comparison group of non-battered women. The same study reported a higher prevalence of major depression (63%) than post-traumatic stress disorder (PTSD) (40%) in the sample of women.[43] In comparison, depression in the general population of women is estimated at 9.3% point prevalence and 20–25% lifetime risk.

Controlled studies using a variety of instruments in health care settings have reported battered women to be consistently more depressed than other women.[44–46] Significant predictors of depression in battered women include the frequency and severity of abuse, stress and women's ability to care for themselves.[47–49] These predictors are more strongly related to depression than prior history of mental illness or demographic, cultural or childhood characteristics. Another important correlate of depression in battered women is low self-esteem, often occurring because women blame themselves for the abuse. In a military sample of violent couples, 30–40% of the women blamed themselves for the relationship violence.[50]

Suicide attempts are correlated with IPV. Higher rates of PTSD have also been documented in battered women using shelters than in other women.[43,51] However, the association of PTSD and battering has primarily been documented only in the violence literature rather than in health or mental health literature. In primary practice settings, PTSD may manifest itself as irritability, sleep disorders or lack of concentration. It is probable that a significant number of women who have symptoms which indicate PTSD are being missed by their primary provider because the presence of battering has never been assessed.

Substance abuse is a frequent manifestation of PTSD and may be another indicator of battering.[52] Abuse of alcohol, prescription or illegal drugs was found to be a correlate of battering during pregnancy.[11,12,18] There have been surprisingly few investigations of substance abuse in battered women. However, two medical emergency room studies (one American and one Swedish) do show an association between alcoholism and being assaulted by a partner. Using patient records in a psychiatric emergency department, Stark and Flitcraft[53] found that 16% of battered women were alcoholic compared with 1% in the general population. Seventy-four per cent of women's alcoholism emerged after the onset of intimate partner abuse. Stark and Flitcraft[53] also found there was no more drug abuse in battered women before physical abuse began than in non-battered women. However, they found nine times greater than expected rates of drug abuse after the onset of battering. Bergman and colleagues[54] found in interviews with 49 emergency department patients who had been battered that 51% reported heavy alcohol use and 25% admitted alcohol dependence. These women also used sedatives and hypnotics.[54] These findings may reflect a tendency for battered women who use emergency rooms to have greater problems with substance abuse.

In a review of the literature for risk markers of battered women, three studies found a positive association between drug abuse (mainly prescription drugs) and IPV, while two found no association.[55] One study seeking to describe the history of violence among drug-abusing women found that the prevalence of abuse was higher than in the general population.[56] The results are limited since they did not discriminate sexual and physical abuse or specify whether the abuse occurred during childhood or adulthood. A controlled study of female alcoholics found significantly higher rates of intimate partner violence than in a random sample of women in the community.[19] Spouses of the alcoholic women were also more likely to be problem drinkers.[19]

Cultural variations in intimate partner violence

There has been limited research investigating the relationship of race, ethnicity and culture to intimate partner violence, and even less research that assists health professionals in providing culturally competent interventions for abused women.

Studies of intimate partner abuse during pregnancy have used samples of low-income White[14] and African-American women.[12,24] These studies reported no differences in prevalence, correlates or dynamics according to ethnicity in utilization of health care or health status. However, McFarlane, Parker, Soeken and Bullock[22] recruited a low-income, ethnically diverse sample to examine similarities and differences among White, African-American and Latina (primarily Mexican-American) women. The study found a prevalence of physical and/or sexual abuse during pregnancy similar for both African-American and White women (19%) but a significantly lower (although still high) prevalence (14%) in Latina women. Using the Index of Spouse Abuse (ISA), the authors also found White women to be the most severely and frequently abused, followed by Latina women, with African-American women reporting to be the least seriously abused.

In the National Institute of Justice's National Crime Survey,[2] there was no significant difference in incidence of intimate partner violence among the three major racial groups represented: White, African-American and Latino. However, there was significantly more intimate violence against poor women. Generally, the differences in rates of abuse between racial and ethnic groups disappear when income is controlled for.[57]

In communities that fear and distrust law enforcement officers and other official systems and for women who are recent or illegal immigrants, there is likely to be significant underreporting of intimate partner violence. It is clear that additional research is needed in this area, and until a more extensive body of knowledge is accumulated, definite statements about the influence of race and ethnicity on the prevalence, severity or effects of intimate partner violence are premature.[58]

Medical care utilization and cost

Battered women who are unidentified or do not receive appropriate interventions have increased health problems compared with women who are not battered. Unaddressed health-related needs result in increased ED visits, hospitalizations and use of out-patient health care facilities.[28,29,33] In an 18-year longitudinal study period of 117 abused women, Bergman, Brismar and Nordin[59] found that there were 70 hospital admissions for traumatic diagnoses and 284 admissions for non-traumatic diagnoses compared with 18 and 96 admissions respectively for a matched control group. Goldberg and Tomlanovich[27] found that most ED patients who reported previous IPV were being treated for medical complaints such as joint and muscle pain or inability to sleep, rather than for trauma. Forty per cent of battered

women seen in an ED, the most expensive setting for health care delivery, had previously required medical care for their abuse.[60] Battered women and their children were found to use Health Maintenance Organizations (HMO) 6–8 times more often than did controls.[8]

According to a study conducted at Rush Medical Center in Chicago, the cost of health care services averages $1633 per patient per year.[61] This translates to an estimated national cost of $857 million that is attributable to intimate partner violence.[62] These findings highlight the overwhelming economic cost of IPV. Early identification and interventions do not only provide a means for preventing further stress and injury, but also can significantly reduce long-term suffering, disability and health care costs. These findings further demonstrate the need to assess for abuse in all primary care settings and intervene as early as possible.

Implications for primary care practice

The tremendous effect of battering on women's health has major implications for primary care practice. Three areas will be discussed**:** eliminating barriers to identification, assessing IPV and education.

Eliminating barriers to identification

There are a number of barriers that prevent women from disclosing and physicians from asking about IPV. Even where battered women have been identified within the health care system, several researchers have found evidence of an inappropriate response from providers, such as being treated impersonally or insensitively, and/or having their abuse minimized.[31,54,63,64] Health care professionals have also been found to focus only on the physical results of battering, to be paternalistic and distancing, and to subtly blame battered women for the abuse.[63,65,66] In addition, a survey of 74 battered women who had been treated in EDs, 45% revealed that the type of insurance they had influenced how the ED staff treated them and 22% felt that racism affected their treatment.[31]

Sugg and Inui[67] related asking women about IPV to opening 'Pandora's box'. In their interviews with 38 primary care practice physicians they found that "close identification with their clients", "fear of offending patients", "frustration and feelings of inadequacy when discussing interventions" and the "constraints of time in a busy primary care practice" were common feelings preventing physicians from discussing IPV with their patients.

Many women report finding it difficult to start a discussion with health care providers about violence but are willing to disclose the abuse if asked.[68] McFarlane and her colleagues[16] found that four times as many women reported experiencing intimate partner violence when asked by a nurse than responded positively to questions about abuse on a history or intake form.

Fear that patients do not want to be asked about IPV appears to be unfounded. Seventy-eight per cent of the women surveyed favoured being directly asked about physical abuse and 68% favoured routine inquiry about sexual abuse.[60,69] Reluctance to reveal abuse can be due to fear of being blamed, shame, or concerns about loss of confidentiality or health insurance. The lack of education has left many providers unsure or unprepared to address IPV in their practices.

Assessing intimate partner violence

Primary care settings offer an ideal place for identification of and interventions with battered women, but first the client must develop a trusting relationship with the provider. Many women in the early stages of battering are not yet ready to identify themselves as abused and often do not associate their physical and mental symptoms with battering. As with other diagnostic challenges, the primary care provider who has developed a trusting relationship with the patient is in an ideal position to take a thorough history, assess mental and physical health, including the psychosocial context, and link physical symptoms with the underlying abuse. Also, pregnancy offers a particular "window of opportunity" in which early intervention and prevention of battering can be practiced.[22] Three innovative hospital-based intimate partner violence programmes have found that many abused women clients state that they prefer to obtain interventions for abuse in a health care setting rather than a shelter.

The research on health care providers' responses to intimate partner violence has documented a lack of appropriate identification of battered women in primary care settings.[6,27] Of nearly 400 women, only six reported they had been asked about violence by their provider.[1] Several prior studies suggest that neither women nor their health care providers accurately link many health problems to prior or ongoing intimate partner abuse, and battered women frequently report health problems for which they are not being treated.[31,37,38,70]

Intimate partner violence presents in many forms in primary care practice, and therefore all patients should be routinely questioned about abuse as part of any health assessment, not just those who present with an injury or a history of injuries. Abuse assessment screening should be completed at every visit as patients may be reluctant to reveal IPV when first questioned or their abuse status may change between visits.[71]

Research has shown that training combined with screening can significantly increase the detection of battered women.[63,72,73] After the addition of one intimate

partner violence question to a health history form in a primary care clinic, Freund and colleagues[10] found that their rate of identification of abused women increased from 0 to 12%. Similar results have been found in other settings: McFarlane and her colleagues[16] found a 17% increase in prenatal care settings and Tilden[74] found a 21% increase in an emergency department setting. However, periodic educational updates are needed: for example, a follow-up of one emergency department found that identification rates had slipped back to near pre-training levels after 8 years.[71]

When questioning women about abuse, direct questions are the most effective. Patients who are informed that abuse assessment screening is routine are less likely to be opposed to such questioning. The Abuse Assessment Screen (Figure 1) is being used in many primary care settings to screen for abuse. It has psychometric support, has been translated into Spanish and has been recommended for use by the March of Dimes.[22] The Abuse Assessment Screen is made up of three to five questions and can be easily used in clinical settings. Reports of abuse are best documented on the record in the patient's own words (e.g. "My husband hit me") and include the partner's name if it is a boyfriend. Research on documentation of abuse in the medical records in primary care clinics has found that less than 10% of the records indicated that the patient had been asked or reported intimate partner violence.[6] Any risks to the patient's safety should also be documented in the record. It is not known if identification or lack of identification varies by ethnicity, but it has been documented that health care professionals are more likely to assess for child abuse if families are poor and/or of minority ethnic heritage.[75]

Education

In a survey of battered women who had ended the violence in their lives, women reported that medical professionals were the least-effective source of help among all formal support systems encountered.[76] Most health care providers have received little formal education on violence. A national survey of violence education in primary care practice residency programmes found that nearly 60% of the programmes surveyed reported that violence education was not present or minimally present in their formal curriculum.[77] This study noted that most programmes did report having teaching activities related to child abuse. The presence of child abuse and the legal obligation to report identified and suspected cases of child abuse may explain this phenomenon. A survey of medical schools in the United States and Canada found less than half included any curriculum content concerning family violence.[78]

Tilden and her colleagues[74] found that in a survey of 1521 health care providers, including social workers, one-third had no educational content in child, spouse or elder abuse. Rose and Saunders[68] found that physicians and nurses from several settings did not find the label 'abuse of women' justified; however, the degree of negative attitudes toward abused women was related to the gender of provider and general attitudes toward women more than to specific discipline or degree of training. The results suggested that those with positive attitudes toward women were more likely to seek out training. A survey of medical personnel in the Army Medical Corps found that more than half (57%) of the nurses, physicians and corpsman surveyed reported having no professional experience with IPV. These studies highlight one of the major barriers in identifying and intervening in battering, the absence of awareness and the lack of formal education on the health consequences of intimate partner violence.

Intervention

The role of the primary care provider in intervening in battering is to support women's decisions about the relationship and with the patient, review options and develop a plan for safety. Women's options include staying in the relationship and getting treatment for the abuser, referral to support groups and advocacy programmes for the woman, or ending the relationship. Some women may have already ended the relationship before seeking health care. Providers need to be aware that women are at greatest risk of homicide after ending or leaving a battering man.[79] Identifying dangers and helping women develop a strategic response will help to reduce the risk of danger whether or not the woman stays in the relationship.

Often an abuser will harass a woman after she leaves the relationship. An abuse hotline number can be a valuable resource to the woman should harassment occur (1-800-799-SAFE). Identifying specific resources available in the patient's community and how she can contact these resources is essential. Women desire greater referral and discussion of community resources.[60] Possible resources may include local shelters, support groups, counselling, victim advocacy groups, court companion or legal services.

The causes, consequences and remedies for IPV must be seen within the context of a society that permits violence and/or fails to punish individuals that perform acts of violence against women.[1] Primary prevention of health problems is now a key focus of health care. Prevention of violence against women should be no different. Community-based primary prevention and educational programmes need to be available to members of our society.

ABUSE ASSESSMENT SCREEN

Within the last year, have you ever been hit, slapped, kicked, or otherwise physically hurt by someone? YES NO

If YES, by whom (circle all that apply)

Husband Ex-husband Boyfriend Stranger Other Multiple

Total number of times _____

Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone? YES NO

If YES, by whom (circle all that apply)

Husband Ex-husband Boyfriend Stranger Other Multiple

Total number of times _____

Mark the area of injury on the body map: SCORE

Score each incident according to the following scale:
1 = Threats of abuse including use of a weapon
2 = Slapping, pushing; no injuries and/or lasting pain
3 = Punching, kicking, bruises, cuts and/or continuing pain
4 = Beating up, severe contusions, burns, broken bones
5 = Head injury, internal injury, permanent injury
6 = Use of weapon; wound from weapon
(If any of the descriptions for the highest number apply, use the higher number.)

Within the last year, has anyone forced you to have sexual activities? YES NO

If YES, by whom (circle all that apply)

Husband Ex-husband Boyfriend Stranger Other Multiple

Total number of times _____

FIGURE 1 *Abuse assessment screen*

Summary

Identification of those at high risk for battering or those with a history of battering is important in ensuring that health care interventions can be initiated early, focusing on eliminating the abuse. Primary care practice provides a profile of the battered woman very different from the stereotyped image of a woman with injuries being seen in the emergency department. Identification and treatment of battered women in primary care centres is a challenge and opportunity that has only recently been recognized by health care professionals. Over the past five years it has become the standard of care to identify abused women in emergency departments. The potential role of primary care provider in preventing further abuse has only begun to be examined. Primary care practice providers may be the first opportunity for a battered woman to find support, assistance or protection.

Appropriate intervention can prevent more serious and continued health care problems.

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