

# Issues in the identification of all members of a family affected by intimate partner violence in primary care



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## Background

Intimate partner violence (IPV) is a common health issue, and members of families affected by violence frequently present to primary care. There are, however, barriers to general practitioners (GPs) identifying survivors, their children and those who use IPV.

## Objective

This article explores the challenges of identifying family members affected by IPV in primary care. It also provides GPs with practical strategies in identifying IPV so that they can support affected families within their clinics.

## Discussion

Survivors of IPV and their children might present to primary care with psychological, physical and social health issues. People who use violence might be less noticeable in the primary care setting. It is recommended that all family members presenting with potential indicators of IPV be asked about IPV, if safe to do so. A trauma- and violence-informed approach is recommended with a non-judgemental attitude, addressing confidentiality, safety and sensitivity.

**INTIMATE PARTNER VIOLENCE** (IPV) refers to any behaviour within an intimate relationship that causes physical, psychological or sexual harm between current or former partners.<sup>1</sup>

IPV is common globally and is gendered in nature. One in 4 women and one in 14 men in Australia have been subjected to physical or sexual IPV,<sup>2</sup> and 23% of women and 14% of men have experienced emotional abuse by an intimate partner since the age of 15 years.<sup>2</sup> Tragically, IPV also has a mortality rate, with one woman killed every 11 days by a partner in Australia.<sup>3</sup> Women are more likely than men to experience a pattern or combination of abuse tactics such as physical, sexual, emotional, financial, spiritual, reproductive coercion and technology facilitated abuse. This is often referred to as coercive control, and is primarily perpetrated by male partners.<sup>4,5</sup> This paper concentrates on IPV against cisgender women by men, acknowledging that Aboriginal and Torres Strait Islander women experience the highest levels of gender-based violence in Australia.<sup>6</sup>

Structural inequities underpin IPV for many families. We know that the high prevalence experienced by Indigenous women is on a foundation of racism, colonialism and service systems bound to oppression.<sup>7</sup> Evidence about identification of people in same-sex relationships, non-binary or transgender individuals is limited, but for these survivors, discussions about IPV will

be complicated by the common assumption within the health system and by healthcare professionals that all people are cisgender and/or heterosexual.<sup>8</sup> Migrants and refugees, people living with a disability and those who live rurally also have additional barriers to accessing health services that might impede identification of IPV.<sup>9</sup>

Survivors of IPV are more likely to use health services, especially primary care, than people who have not been subjected to abuse.<sup>10,11</sup> It is estimated that Australian general practitioners (GPs) who work full time will be seeing approximately five current survivors of IPV per week.<sup>11</sup> Yet, historical data suggest that only one in 10 GPs in general practice clinics ask about IPV, and most survivors are never asked by their GPs about IPV abuse.<sup>12</sup> This article outlines important issues in the identification of IPV in clinical practice for all members of a family.

## Barriers to identifying survivors of IPV

There are both systemic and personal barriers that stop healthcare professionals from asking about IPV.<sup>13,14</sup> A lack of time and privacy, lack of training and societal norms enabling the victim to be blamed have all been identified as structural barriers to identification of IPV.<sup>13</sup> Personal barriers include believing a health professional should not get involved, frustration

when survivors do not take the healthcare professional advice and belief that it is not the healthcare professional’s responsibility as IPV is a social issue rather than a health issue.<sup>13</sup> However, when healthcare professionals are supported by the health system, have a personal commitment, advocate for survivors, foster trust in the doctor–patient relationship and collaborate with a team, there is an increased perceived readiness of healthcare professionals to address IPV.<sup>15</sup>

### Health effects of IPV

IPV is a significant health issue. It is the largest risk to health for women in the 18- to 44-year age group in Australia and forms 7.9% of the overall health burden.<sup>16</sup> This is higher than hypertension, smoking or obesity. Survivors of IPV have a higher rate of physical, psychological and social health issues than those who have not been subjected to IPV.<sup>1,17,18</sup>

### Who to ask?

#### Survivors

There is insufficient evidence to support universal screening for IPV in general practice.<sup>1,19</sup> Instead, healthcare professionals need to ask patients who demonstrate evidence-based physical, psychological, reproductive and social health risk indicators (Table 1).<sup>1</sup> The exception to this is antenatal care, where screening all pregnant patients has been shown to significantly increase identification of IPV and improve outcomes in pregnancy, which is a high risk time for both mother and baby because of potential escalation of violence.<sup>19</sup>

There is a significant link between being a survivor of IPV and depression and other mental health conditions.<sup>23</sup> Thus, it is important for GPs to ask all patients

presenting with mental health issues about the possibility of IPV. There are also social and behavioural indicators that can indicate that IPV is occurring. IPV should be considered if a patient is always accompanied by their partner, particularly if the partner does all the talking for them in the consultation.

IPV is commonly associated with a range of physical symptoms that frequently present to general practice.<sup>18</sup> These include pain syndromes such as chronic headaches, chronic pelvic pain, chest pain and chronic abdominal pain.<sup>1</sup> There is also an association between psychosomatic and/or unexplained symptoms and IPV.<sup>1</sup> All these physical symptoms should still be properly evaluated; however, they should lead the GP to ask about abuse and violence. This is especially the case for unexplained symptoms that are not improving with treatment. An Australian study showed that the more physical symptoms a woman experiences, the more likely they are to be a survivor of IPV in the last 12 months.<sup>18</sup>

When physical injuries present to general practice, the possibility of IPV should be considered. Head, neck and facial injuries are strongly associated with IPV.<sup>24</sup> In Victorian emergency departments, 40% of IPV presentations were for head injuries.<sup>25</sup> Non-fatal strangulation is also common in IPV and is associated with a risk of stroke, traumatic brain injury and death.<sup>26,27</sup>

#### Children

Children are commonly affected by IPV, with 40% of Australians exposed to IPV as children, with significant health impacts during childhood and later in life.<sup>28,29</sup> Experiencing IPV, either directly or indirectly, can cause behavioural, psychological, social and physical issues in children, as both are forms of child abuse (Table 2).<sup>29,30</sup> It is also important to be alert to the possibility of child physical or sexual abuse, and neglect, as it is common for IPV and direct child abuse to co-occur.<sup>31</sup>

**Table 2. Indicators for a child exposed to intimate partner violence (IPV)<sup>29,30</sup>**

#### Indicators for a child experiencing IPV according to age

<b>Preschool child</b>	<ul style="list-style-type: none"> <li>• Poor sleep</li> <li>• Separation anxiety</li> <li>• Eating issues</li> <li>• Bedwetting</li> <li>• Behavioural issues</li> </ul>
<b>School-age child</b>	<ul style="list-style-type: none"> <li>• Somatic complaints such as abdominal pain</li> <li>• Behavioural issues</li> <li>• Anxiety</li> <li>• Bedwetting</li> </ul>
<b>Adolescent</b>	<ul style="list-style-type: none"> <li>• Substance use</li> <li>• Suicidality</li> <li>• School refusal</li> <li>• Conduct disorder</li> </ul>

**Table 1. Evidence-based health indicators of intimate partner violence<sup>1,18,20-22</sup>**

Physical symptoms	Psychological symptoms	Reproductive issues	Social issues
<ul style="list-style-type: none"> <li>• Physical injuries</li> <li>• Chronic pain</li> <li>• Chronic diarrhoea</li> <li>• Tiredness</li> <li>• Psychosomatic complaints</li> </ul>	<ul style="list-style-type: none"> <li>• Depression</li> <li>• Anxiety</li> <li>• Insomnia</li> <li>• Post-traumatic stress disorder</li> <li>• Substance use</li> <li>• Suicidality</li> </ul>	<ul style="list-style-type: none"> <li>• Sexually transmissible infections</li> <li>• Chronic pelvic pain</li> <li>• Post-natal depression</li> <li>• Premature birth</li> <li>• Low birth weight baby</li> </ul>	<ul style="list-style-type: none"> <li>• Accompanying partners</li> <li>• Delays in seeking care</li> <li>• Frequent presentations</li> <li>• Unusual explanations for injuries</li> </ul>

## People using violence

GPs have an important role to play in identifying people who use IPV and helping to prepare them for behavioural change through referrals.<sup>32,33</sup> People using violence rarely disclose these behaviours unprompted, so GPs must be aware of risk indicators for use of IPV (Table 3). People using violence might have similar patterns of behaviour within the consultation as at home or might also present as charming and likeable. Associations with the use of violence include a previous history of childhood abuse or violence, co-occurring addiction, unemployment and mental illness.<sup>34</sup> GPs might learn that a patient is using violence through disclosure from a partner or family member. GPs working with someone suspected of using IPV must be careful not to inadvertently suggest that the survivor has disclosed, as this could escalate risk of IPV. Further, there should be practice-wide systems to ensure that survivors and people using violence are seen by different GPs if possible.

## How to ask different members of the family

### Asking survivors

In general, survivors want to be asked about their experiences of abuse and violence provided they are asked sensitively and non-judgementally.<sup>35</sup> In fact, survivors disclose to GPs more than any other professional including the police, most likely because of their positive relationship with their GP.<sup>36,37</sup> However, there are many barriers

for survivors to disclose, including negative attitudes from healthcare professionals and survivors' perception of safety and concerns about what might happen if they do disclose.<sup>38</sup> Survivors suggest that healthcare professionals need to have increased awareness of their reactions to disclosure and avoid mirroring perpetrators minimisation of abuse, especially by using similar coercive control or emotionally abusive tactics.<sup>39</sup> Further, survivors view the following factors as important facilitators: (1) providing universal education such as posters in the waiting room and general discussions about healthy relationships; (2) creating a safe and supportive environment for disclosure; and (3) asking about IPV non-judgementally and empathetically.<sup>39</sup>

For the safety of a survivor, privacy must be assured.<sup>1</sup> A GP should be alone with the patient before asking about IPV for safety reasons. If the partner is present, you could either state that it is practice policy that you always see patients on their own at some point during their management and ask them to wait in the waiting room, or you could ask them to leave so you can perform a procedure or examination like a cervical screening test if the patient is due for one.<sup>40</sup> If there are any children above the age of 2 years present, it is safest not to ask about IPV in case the child inadvertently says something to the perpetrator at a later time that increases risk for the survivor. In that situation, you might consider asking another staff member to look after the children so that you can ensure privacy of your consulting room.

The World Health Organization outlines the conditions that should be met prior to a patient being asked about IPV, which includes having a protocol, training, a private setting, a system for referral and being able to ensure confidentiality.<sup>1</sup> However, confidentiality might need to be breached in certain circumstances, as discussed in Table 4.

After ensuring that the environment is appropriate, there are several ways to ask a patient about the possibility of IPV. First, a funnelling approach asking broad, open-ended questions that move to more specific questions can be taken (Table 5).<sup>40</sup> Another approach is to tie the line of questioning to the presenting condition so that they understand why you are asking about IPV. For example, in a patient presenting with depression, a GP might say something like: 'It is not uncommon that when I see a patient with low mood, there may be difficulties occurring at home, maybe even with their partner. Is this something that is happening for you?'. A final approach is to use the ACTS tool (Afraid/Controlled/Threatened/Slapped or physically hurt), which is a set of four questions that can be used to ask about IPV (Table 5).<sup>41</sup> The ACTS tool is validated in antenatal care but can also be useful in other settings.<sup>41</sup> Whichever approach is taken, not pressuring survivors to disclose or to disclose more than they feel ready to is important, along with believing survivors when they do disclose.

### Asking children

This is a challenging area and depends on GPs' skills and training with children and sensitive issues. Children aged over 8 years can be asked questions directly (eg how safe do you feel at home?) depending on a clinician's professional judgement as to their capacity, maturity and ability to understand the questions.<sup>42</sup> Other sources of information can also be sought from a protective parent, guardian, school or family violence services. Whether a child is asked on their own or with a protective carer present will depend on their age and developmental stage (Table 5).

### Asking people who use IPV

GPs are often concerned that asking patients about use of IPV will damage the doctor-patient relationship or put themselves at risk of violence. However, research suggests 90% of men presenting to GP clinics

**Table 3. Indicators of risk of use of IPV<sup>34</sup>**

#### Presentations to general practice associated with increased risk of using IPV

- Depression, anxiety, suicidal ideation
- Alcohol and/or substance use
- Chronic pain or unexplained somatic symptoms
- Reporting 'anger management issues'
- Recent separation or 'relationship difficulties'
- Childhood experience of abuse
- Unexplained injuries – especially to face and groin

#### Other sources of information about potential or confirmed use of IPV

- Controlling behaviour observed by reception staff or in consultations with partners/family members
- Partner or family member has disclosed to GP or other staff
- Information disclosed through another organisation such as a discharge summary or report from a child's school

GP, general practitioner; IPV, intimate partner violence.

**Table 4. Confidentiality issues when asking about IPV in Australia**

There are limits on confidentiality when asking about IPV in Australia and it is important that patients understand these limits before they disclose so that they are given an informed choice about whether to do so.

Limits on confidentiality	Explanation
Mandatory reporting of child abuse	All states and territories of Australia have mandatory reporting laws; however, the law is different in each jurisdiction. It is important for all GPs who identify IPV to ask about the safety of children
Mandatory reporting of domestic violence	In the Northern Territory, all adults must report serious domestic violence to the police. In New South Wales and Tasmania, it is mandatory to report when children are exposed or suspected to be exposed to domestic violence
Survivor at imminent risk of harm (assessed as patient feeling unsafe to go home that day, use of weapons against the patient, threats to kill or harm the patient or their children)	If a survivor is deemed to be at imminent risk of serious injury or death, a GP should work with the survivor and offer appropriate referrals to family violence services and/or the police. If the survivor declines the referral the GP must break confidentiality; however, it is very important to let the survivor know about this so that they can keep themselves safe as well as to organise a safety plan

An example of how to discuss confidentiality with your patient prior to asking about IPV:

*What you say will remain confidential, unless you tell me something that indicates there are serious safety concerns for you or your children. If that was the case, I would talk to you about that first, wherever possible*

GP, general practitioner; IPV, intimate partner violence.

believe it is acceptable and appropriate for GPs to ask about use of IPV.<sup>43</sup> GPs with experience and training in this area and who suspect a patient might be using IPV should adopt a non-judgemental approach to exploring this with patients, which increases the likelihood of meaningfully engaging the person on a pathway to change. Use of funnelling questions (Table 5) involves moving from broad questions to increasingly specific questions depending on the patient’s responses and understanding of the potential impact on partner’s safety.<sup>44</sup> Motivational interviewing techniques can be used to explore perceptions of the patient’s behaviour and motivations to change. Most people using violence will attempt to minimise or justify their behaviour or even blame the survivor for it. Avoid colluding with these defensive narratives, as this is a barrier to accountability and behaviour change.

Overall, it is important for GPs to use a trauma- and violence-informed approach when enquiring about and responding to IPV to improve the psychological safety of survivors and their children.<sup>45,46</sup> In the event of disclosure, GPs should conduct a brief risk assessment and offer referrals to specialist services.<sup>47</sup> This includes further behavioural change support for those using IPV such as the Men’s Referral Service or a Men’s

**Table 5. Asking members of the family about IPV<sup>39-41</sup>**

**How to ask those experiencing and those using IPV:**

**Asking adult survivors about IPV**

- How are things at home?
- Do you feel safe at home?
- Have you ever felt unsafe in the past at home?

**ACTS tool for specifically asking about IPV:**

- Are you afraid of your partner (or a family member)?

Does your partner (or family member):

- Control your daily activities or humiliate you?
- Threaten to hurt you?
- Slap, hit, kick or otherwise physically hurt you?

**Asking children about IPV**

- Is there someone at home that makes you feel safe?
- Do you feel unsafe or scared of anyone living at home?
- Have you ever tried to stop your parents arguing?
- How safe do you feel at your mum’s house and your dad’s house? (if separated)

**Asking those who use IPV**

- How are things at home? How is your relationship?
- Have you ever shouted, said or done things you regret in your relationship?
- Have there ever been times where you think your partner (or child) may have been in fear of you?
- Have you ever threatened to hurt someone?
- Have you ever thrown things or broken things at home?
- Is it possible that your partner (or child) may have felt compelled to do something in a certain way because of you?
- Have you ever slapped, hit, kicked or otherwise hurt your partner (or child)?

ACTS tool, Afraid/Controlled/Threatened/Slapped or physically hurt tool; IPV, intimate partner violence.

Behavioural Change Program.<sup>44</sup> GPs should provide concurrent support in managing any co-existing health issues, especially those that might be contributing to patterns of IPV, such as alcohol or substance use.<sup>48</sup>

## Conclusion

IPV is a common and significant health issue. GPs play an important role in the identification of IPV by being aware of the indicators of IPV and asking about violence and abuse in a trauma-informed way. In general, survivors would like to be asked by their GPs about IPV, provided they are asked non-judgementally and confidentially. GPs are ideally positioned to support survivors and their children, as well as provide referrals to patients who use IPV because of their long-term relationships with patients.

## Key points

- It is recommended for GPs to use a case-finding approach when identifying family members affected by IPV.
- Indicators of IPV can include psychological, physical and social issues.
- GPs must consider the environment, including confidentiality and its limits, before asking about IPV.
- There are several approaches to asking about IPV including a ‘funneling’ approach.
- Approaches to asking children about IPV depend on their age and maturity.

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Competing interests: None.

Funding: None.

Provenance and peer review: Commissioned, externally peer reviewed.

AI declaration: The authors confirm that there was no use of artificial intelligence (AI)-assisted technology for assisting in the writing or editing of the manuscript.

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