Prevalence of intimate partner violence and related interventions in family medicine: a review with special emphasis on the state of affairs in Slovenia

P Selic*

Abstract
Introduction
Several family doctors [general practitioners (GPs)] may lack awareness of intimate partner violence (IPV) as a major public health problem. This review aims to identify, collate and summarize research findings relevant to family medicine as a basis for further study and/or interventions related to IPV and to assess the current body of research in Slovenia. Research questions on the prevalence and the main health consequences of IPV along with feasible interventions used in primary care and the current state of affairs regarding IPV in Slovenian family medicine were addressed.

Conclusion
GPs have often missed opportunities to detect victims of abuse in a variety of clinical situations. The detection of domestic violence by GPs might alter both the diagnostic and the treatment plans for these patients. It is, therefore, of utmost importance for GPs to receive proper IPV-related education and comprehensive training to enable them to understand and recognize IPV and its health effects on their patients. Furthermore, it could be beneficial to introduce and develop IPV-related referral resources and policies in family medicine guidelines and protocols.

Introduction
Intimate partner violence (IPV) is the physical, sexual or emotional abuse with coercive control of a victim by the partner or ex-partner. It is a common problem, with a detrimental effect on health and well-being of the victim. The definition introduced by the American Medical Association is often used, describing IPV as a pattern of coercive behaviours that may include repeated battering and injury, psychological abuse, sexual assault, progressive social isolation, deprivation and intimidation, referring to any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those within the relationship. IPV, also known as domestic violence (DV), can be considered a leading public health problem affecting approximately 50% of women during the course of their lifetimes. Aside from its serious health consequences for women and children, a significant societal impact, including high financial costs, has been shown.

Search methods: The MEDLINE database was searched using the following key words: IPV, DV, prevalence, health, intervention, screening and family practice. The time scale was set from 1990 to 2012. The selection criteria were text availability, language and type of article (original research), except for IPV prevalence studies in Slovenia.

The relevant manuscripts with prevalence data were reviewed, collated and summarized by the author; the present review is to be strictly considered as a subjective creation, reflecting the interest and mindset of the author.

This review has two specific aims: (i) To identify, collate and summarize research findings relevant to family medicine, irrespective of study designs, upon which further studies and/or interventions related to IPV could be based and (ii) to assess whether the current body of research in Slovenia is sufficient for the implementation of any systematic intervention (e.g. screening for IPV) in family medicine settings.

Four questions are being raised: (1) What is the prevalence of IPV? (2) What are the main health consequences of IPV identified by the studies? (3) Which are the feasible interventions used in primary care? (4) What is the state of affair in Slovenian family medicine?

Discussion
The author has referenced some of its own studies in this review. These referenced studies have been conducted in accordance with the Declaration of Helsinki (1964), and the protocols of these studies have been approved by the relevant ethics committees related to the institution in which they were performed. All human subjects, in these referenced studies, gave informed consent to participate in these studies.

Prevalence of IPV
Estimates of the prevalence of physical or sexual IPV in women across their lifetimes range from 15% to 71%, with past-year estimates ranging from 4% to 54%, showing women to be at a far greater risk of physical or sexual violence from her partner.

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than from others. In Canada, the incidence of DV resulting in emergency department (ED) presentation on the day of the data collection was 2%. In women, almost 1 in 10 has previously been threatened or injured by their partners; physical DV was experienced by 40% of women, the previous-year prevalence was 26% and as many as half of Canadian women reported some form of physical or mental abuse over the course of their lifetimes. This is consistent with rates in the United States, where at least 1 in every 20 women had experienced DV in the previous year; one in five had experienced violence in their adult lives and one in three had experienced violence either as a child or as an adult.

The prevalence of IPV 25 years ago within same-sex relationships had not been thoroughly researched; recent studies reveal similarities in the prevalence, type of abuse and various dynamics between opposite- and same-gender DV. These results indicate that IPV is widespread, although the comparability of the data may be limited due to methodological differences among the studies. Varying estimates of the prevalence and odds of lifetime and past-year DV exposure could be more due to psychological factors than real experience or lack thereof. As emphasized by Feder et al., both measures are potentially problematic, that is recall bias may be present in studies that measure lifetime DV, while participants in studies of past-year violence may have had insufficient time to acknowledge or identify their abuse experiences.

Undoubtedly, IPV was shown to be the most common type of violence against women, affecting an estimated one in four women across their lifespans. Often a considerable overlap could be found between physical, emotional and sexual violence. The estimated lifetime prevalence of physical and/or sexual violence is higher in societies where the use of violence in many situations is a socially accepted norm; therefore, to a large degree, women’s experiences of violence reflect specific cultural contexts.

**Health consequences of IPV**

Since over the past decades violence against women has become recognized as a serious public health issue, considerable research has been carried out in order to demonstrate the high prevalence and wide range of health consequences of IPV. Abused women are more likely to have poorer health than nonabused women and may suffer the health consequences of violence long after the abuse has ended. In particular, they have more gynaecological, chronic stress-related, central nervous system and total health problems. The long-term consequences of IPV include health risks, post-traumatic stress disorder, depression and staggering economic costs for the health care of victims.

Indirect health consequences are often related to the perpetrators’ behaviour, for example abusers compromising their partners’ health by withholding medication, changing a prescription, cancelling appointments or keeping partners awake. These (indirect) consequences of IPV include stomach ulcers and other gastrointestinal disturbances, heart disease, hypertension, unwanted pregnancy, low birth weight and premature labour. Fatal outcomes include homicide, suicide, maternal mortality, antepartum haemorrhage, abortion, stillbirth and AIDS. Murder is the most tragic outcome of DV, but besides homicide, 60% of female DV victims suffer direct (i.e. injuries: cuts, bruises, fractures) and indirect health consequences of the abuse.

From the psychological aspect, these women are four to six times more likely to suffer from depression than women who have not been exposed to DV. The impact on a woman of even a single incident of physical violence in an intimate relationship should, therefore, not be underestimated. Use of any violence in a relationship can dramatically alter the balance of power, destroying respect, openness and trust and resulting in a permanent sense of inequality, threat and loss. Moreover, cumulative abuse impacts powerfully on health. Recent findings suggest that the mental effects of violence last long after the violent episode. A study set in New Zealand, England and the United States found that over 50% of women traumatized by IPV suffered from a psychiatric disorder; one-third of those with a psychiatric disorder had been involved in IPV. Individuals involved in severe partner violence had elevated rates of a wide spectrum of disorders, of which the most notable were the elevated rates of mood and eating disorders. Similarly, in an English primary health care context, IPV was shown to have a strong association with most mental health conditions, which increased in the past year.

**Intimate partner violence: How has it been addressed in health care?**

Since many health problems are associated with abuse and neglect at all ages, DV victims may be considered as a special group of primary care patients. Routine universal screening and sensitive in-depth assessment of women presenting with frequent gynaecological, chronic stress-related or central nervous system complaints are needed to support disclosure of DV; abused women have a 50–70% increase in these problems, with sexually and physically abused women being most likely to report them. The health care system in general and the ED in particular are important in this regard, as it is an opportunity for IPV victims to obtain not only necessary medical care, but also entry into the social services, mental health and judicial systems.
In the United States, female ED patients are receptive to being asked about IPV, and up to 64% of police-identified IPV victims presented to an ED at least once, compared with only 21% of age-matched controls. More than a third of women who had very recently been abused, and 76% of women who acknowledged experiencing physical or sexual IPV within the past year, reported that they did not come to the ED for treatment of an injury. Although the majority of women (76–90%) agreed with the concept of health care providers reporting IPV to the police, women abused very recently were significantly less likely to support this practice. Police-identified IPV victims utilize emergency care at extremely high rates, usually without identification or referral to IPV resources. The incidence of acute IPV was less common in women visiting an ED than expected, although the cumulative prevalence of DV is strikingly high. Women who have experienced DV are seldom identified by ED professionals. However, because they use the ED so frequently, 23% of IPV victims were eventually identified.

IPV screening was documented in approximately one-third of the ED visits, but resulted in less than 6% positive screens. However, when IPV victims were identified in the ED, 35% of victims contacted the community resources provided within 3 months.

Although there have been practice guidelines encouraging the screening of patients for IPV available for several years, it remains unclear how well and in which circumstances physicians adhere to them. These actions have been assessed as acceptable to the majority of both abused and nonabused women seen in the ED; the findings should be considered as important for health care providers who are seeking to improve their identification of and care for abused women.

However, there have also been many findings suggesting family doctors [general practitioners (GPs)] have missed opportunities to screen patients for intimate partner abuse in a variety of clinical situations. A survey aiming to identify the prevalence, determinants of, and barriers to clinician–patient communication about IPV was carried out in the United States. Over 40% of the patients reported having communicated with a clinician about abuse; the most significant independent predictor of communication was direct GP questioning about IPV. Barriers significantly associated with lack of communication were patients’ perceptions that GPs did not ask directly about abuse, beliefs that clinicians lack time and interest in discussing abuse, fears about involving the police and courts and concerns about confidentiality. Another study showed the main barriers to asking about IPV were lack of time, behaviours attributed to victims of abuse, lack of training, language/cultural practices and partner presence. Commonly cited barriers to identification and referral included the patients’ fear of retaliation, police involvement, lack of patient disclosure, follow-up, and cultural differences. The most frequently report- ed facilitators were training, community resources and professional tools/protocols/policies. Overall, 32% of nurses and 42% of physicians in the study conducted by Gutmanis et al. reported routinely initiating the topic of IPV in practice.

Although GPs are in a unique position to identify and report IPV, detection rates are poor. Rodriguez et al. reported that common routine interventions in primary care included delaying concern for safety, referring to shelters, counseling, and documentation in the medical chart. In another study performed in Israel, the need for additional training regarding IPV was a concern described by GPs and nurses, more so by the latter. The authors reported statistically significant differences between nurses and GPs regarding both barriers and facilitators to IPV detection in primary care, most likely related to differences in role expectations and work environments.

Intimate partner violence: A challenge for family medicine in Slovenia

In Slovenia, prior to the adoption of the Law on the Prevention of Domestic Violence in 2008, the only official data on DV were collected by the police, but they only recorded data on reported crimes. According to these records, the number of victims of domestic crime grew by 95% in the period 2000–2007, using 2000 as a baseline year. According to recent police data, most women in Slovenia are victims of DV; in police statistics, a victim of violence is counted only once in the reference year, irrespective of how many times violence was reported, which could somehow blur the impression. In 2011, the number of DV victims was 1,584 and in 2010, the number was 1,909 victims, in a country with only about two million inhabitants. Women are also frequently victims of bodily harm; in 2011 there were 529 victims and in 2010, 606 victims. In 2010 and in 2011, ten women were murdered by their intimate partners in Slovenia.

There is a lack of data on the prevalence of DV in the general population before 2008; the first study in primary care was only carried out in 2006. It found that 12.8% of family care attendees admitted that they had experienced both physical and psychological violence; 5.9% reported that they had been victims of physical violence; 10.9% said that they had been victims of psychological violence; while 70.4% individuals did not report any form of DV. The study also showed that in one-fifth...
of cases, the GPs did not do anything when patients asked for help in cases of DV. Physicians suggested secondary care treatment to about a quarter of the victims, and they tried to discuss the problem with two-fifths of those seeking help\(^{33}\).

In another survey in 2007, the prevalence of IPV, the perpetrators and the readiness of DV victims to seek help was addressed\(^{33}\). Of that sample, 12.2% of individuals (7.1% of men and 15.1% of women) reported being a victim of physical violence in the previous 5 years, another 29% of patients (15.9% of men and 36.7% of women) were victims of psychological violence and 10.7% of those interviewed experienced both types of violence (4.1% of men and 14.5% of women). About 69.4% of patients (80.7% of men and 62.7% of women) did not report any kind of IPV-related experience in the previous 5 years\(^{33}\).

Another study was performed in 2009, aiming mainly to identify the determinants of exposure to psychological and physical violence in family practice patients, so that GPs would be able to detect them more accurately amongst the large numbers of patients in their practices\(^{31}\). In last 5 years, 15.3% of the patients reported experiencing some type of DV; 5.9% reported physical and 9.4% psychological abuse. Exposure to psychological violence was more prevalent than exposure to physical violence, 20.0% of females were exposed to either type of violence, compared with 8.0% of male participants. Two risk factors affecting the progression from psychological to physical violence were identified, that is the abuse of alcohol and unemployment in the patient\(^{30}\). With regard to the psychosocial determinants of IPV, the results of a prospective cohort study on a representative sample of family practice attendees in Slovenia in 2008\(^{34}\) are worth mentioning. This study showed that all forms of abuse and poverty are associated with depression\(^{34}\). To test the reliability of the data on the prevalence of IPV in primary care patients, and to determine the associated factors, a systematic cross-sectional survey was performed in 2010\(^{35}\). In the last 5 years, 17.9% of patients were exposed to psychological or physical IPV. The factors that increased the chances of exposure to psychological and physical violence were female gender and formal divorce\(^{35}\).

Despite the high prevalence of DV and the proven harmful consequences to health, there is still no consensus on prevention strategies for DV in family medicine or in Slovenia in general.

**Conclusion**

It is fair to conclude that the prevalence of IPV supports the idea that it is a significant public health problem. Increased detection of IPV by GPs might alter both the diagnostic and treatment plans for these patients. The majority of studies identify two main reasons for insufficient recognition of DV victims—time limitation in primary care practices and lack of professional knowledge. Physicians are not well informed about available recognition strategies and documenting methods, they do not feel competent to assess victims and often they do not know the best means of intervention, or about existing institutions that work with victims of violent behaviour.

In Slovenia, educating GPs about IPV presents challenges as many lack awareness of IPV as a public health problem, have limited knowledge and erroneous beliefs about the phenomenon and are not experienced enough in dealing with survivors of IPV. Our current activity in the field of family medicine is, therefore, twofold: (1) providing formal education and training in a supportive environment to enhance family medicine trainees’ knowledge and skills on IPV and (2) examining the benefits and limitations of various pedagogical approaches for teaching this critical content to trainees.

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**Abbreviations list**

DV, domestic violence; ED, emergency department; GP, general practitioner; IPV, intimate partner violence

**References**


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