Intimate partner abuse: identifying, caring for and helping women in healthcare settings

Intimate partner abuse (IPA) is experienced by around one in three women at some stage during their lifetime, and has serious health consequences. This paper reviews how clinicians can best identify when a woman is experiencing IPA, and provide appropriate care and assistance. Research supports use of sensitive inquiry about IPA when conditions or situations that can be associated with IPA are present. Subsequent responses recommended include validation, affirmation and support, safety assessment and planning (both for the woman and any children), counseling and referral to IPA specialist services. Better training is needed for clinicians in these areas. Future research is needed to compare identification methods, and further assess psychological, advocacy and safety planning interventions, primary prevention and perpetrator interventions.

Keywords: domestic violence • healthcare settings • identification • intervention • intimate partner abuse • intimate partner violence • primary healthcare • screening • women's health

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LEARNING OBJECTIVES

Upon completion of this activity, participants will be able to:

• Assess useful questions to patients about possible intimate partner abuse
• Evaluate the best practice for newly diagnosed intimate partner abuse
• Evaluate treatment options for women experiencing intimate partner abuse
• Analyze how to manage perpetrators of intimate partner abuse
Intimate partner abuse (IPA) is defined by the WHO as, “any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in that relationship” [1]. In the context of violence against women, it refers to “the range of sexually, psychologically, and physically coercive acts used against adult and adolescent women by current or former ... intimate partners” [2].

These behaviors may include [1]:

- Physical aggression, such as hitting, kicking or beating;
- Psychological and/or emotional abuse, such as intimidation or humiliation;
- Forcing or coercing intercourse or other sexual activity;
- Controlling behaviors, such as financial control, monitoring movements, restricting access to services and isolation from friends, family and other social supports.

IPA is a major public health issue, with serious social, economic and health consequences. It has been found to pose at least as high a health risk to women of child bearing age as raised blood pressure, tobacco use and obesity [3], and is a leading contributor to death, disability and illness for women in this age group [4]. IPA frequently contributes to a wide range of common health issues, including depression, anxiety, chronic pain, post-traumatic stress disorder, gynecologic and general health issues [5–11]. These health consequences can be both short and long term, may persist even after the abuse has ended, and are unlikely to be adequately treated unless the underlying IPA is also addressed [8].

A recent global systematic review of research on IPA [4] found that 30% of all women who have ever been in a relationship have experienced IPA. Around 38% of women murdered between 1982 and 2011 had been killed by an intimate partner [4]. IPA results in an estimated annual cost of more than US$8.3 billion in the USA [12], £GBP5.5 billion in the UK [13] and AUS$13.6 billion in Australia [4]. These figures are likely to be underestimates, as they do not include all possible avenues of economic burden.

Healthcare clinicians are often the first or only point of contact for women experiencing IPA [5,16]. However clinicians often do not inquire about IPA and women are often reluctant to disclose without this direct inquiry [17,18]. Research has found that only 12–20% of women report being asked by their doctor about IPA, with barriers to inquiry including clinician uncertainty about how to ask, lack of knowledge and training about IPA, and insufficient time [17–19]. Barriers to disclosure by women include both internal factors (shame, normalization and minimization) and external factors (perception that others cannot help, judgmental attitudes, previous negative responses from health professionals). Additionally, women are not always at a point where they feel comfortable to disclose [20,21]. Given the high impact of IPA on women's health, it is imperative that healthcare clinicians are equipped to identify and respond appropriately to IPA as part of their everyday clinical practice [22,23].

The aim of this paper is to provide a general overview of relevant literature to assist healthcare practitioners in identifying and working with women who have experienced IPA. The most recent systematic reviews [24] and international guidelines [4,22,23] in the area have been included, along with additional literature to supplement understanding and practical implementation of these reviews and guidelines. The context in which practical implementation takes place will vary according to the background skills and experiences of individual practitioners, and the particular settings in which they practice (although a detailed discussion of recommendations specific to specialized settings is beyond the scope of the current paper). This paper focuses on the experiences of women as survivors of IPA, in line with the focus of this journal. Although it is acknowledged that men may also experience IPA,
the power disparities present in most cases of IPA mean that women are more often survivors than perpetrators, and that the community health and economic burdens of IPA lie primarily with women as a group [2,4].

Understanding different stages & needs in each woman’s journey
Women experiencing IPA face many complex challenges and risks, and thus their individual needs can vary substantially. One such area of variability is the extent to which the survivor has recognized the abusive behavior as IPA and how ready and confident they feel about wanting and/or being able to make changes. It is therefore essential that healthcare clinicians have a sound understanding and practical knowledge in how to best identify and respond to women experiencing IPA as an underlying cause of various psychological and physiological symptoms and conditions (Table 1) [6,8].

What can clinicians do?
Identification of women experiencing IPA
Women experiencing IPA are usually unlikely to volunteer this information unprompted, and, as discussed above, may not have even come to a point of identifying these experiences as IPA [21]. Even where women recognize the abuse, only a small proportion seeks specialized IPA services [32]. Healthcare clinicians, in particular those in primary healthcare, may be the first or only point of contact for the vast majority of women experiencing IPA [33]. Presentations of IPA may not be immediately obvious; instead IPA may be indicated as an underlying cause of various psychological and physiological symptoms and conditions (Table 1) [6,8]. It is therefore essential that healthcare clinicians have a sound understanding and practical knowledge in how to best identify and respond to women experiencing IPA [22,23].

There has been some speculation and debate over whether this identification should take the form of universal screening (giving all patients a standardized set of questions), or more targeted identification strategies [23,34,33,34]. Those in favor of universal screening for IPA have argued that this may allow identification in situations where the clinician might not otherwise inquire or the woman not otherwise disclose, especially where the clinician lacks accurate knowledge about IPA. Those not in favor of universal screening argue that more targeted identification strategies encourage greater thought and flexibility from the clinician, are less burdensome on the healthcare system and avoid identification becoming a mere box-checking exercise. The current WHO consensus [23] is that more targeted forms of identification should be used instead of universal screening, given that there is insufficient evidence to...
justify IPA screening of all women attending healthcare services. However, a low threshold for asking about IPA is recommended, even where no other signs of IPA are evident, or the woman appears to be ‘fine’ [23].

A recent systematic review identified 11 trials (including 13,027 participants in total) assessing the effect of universal, routine IPA screening of women in healthcare settings, without subsequent intervention beyond information giving, safety planning or referral that was offered to women immediately following identification [24]. The review found that screening increased the identification of women who had experienced IPA, although identification was still low compared with estimated prevalence rates (six studies: [35–40]). Screening also showed some evidence for reduced depression (one study: [41]), and did not cause any known adverse effects (one study: [41]). However, no statistically significant results were found for increased referrals to IPA support services (three studies: [37,39,42]) or reduction in IPA (two studies: [41,43]). It is important to note that the review excluded studies where screening was followed by an intensive intervention. Further research is needed to assess the effectiveness of screening followed by advocacy, counseling and/or other interventions, particularly in comparison to more targeted methods of identification [24].

More targeted identification strategies involve asking a woman about IPA if they present with psychosocial or physical symptoms that often occur as a result of IPA, or are in a high-risk category [44]. These are often referred to as case-finding, diagnostic or selective inquiry strategies. Table 1 includes a list of risk factors, along with symptoms, issues or conditions that could be warning signs of underlying IPA, and which therefore warrant asking about IPA. While universal screening of all women who present to a health service may not be warranted (unless mandated by law), asking all women who present with chronic pain, depression or any of the other symptoms listed is advisable [23]. Routine inquiry about IPA is also recommended for all women who are pregnant, due to the increased risk women experience during this time [23].

Clinicians should use a ‘funneling’ technique for asking about IPA, beginning with more general questions about relationship problems, then moving to more specific questions. Sensitivity is required, as, although research has shown women are generally comfortable being asked about IPA [24], this can depend on the method used.

Possible questions to ascertain the presence and nature of IPA include [16,45]:

- How are things at home?
- What happens when your partner gets angry?
- Are you afraid of your partner (or ex-partner)?
- Sometimes partners use physical force. Is this happening to you?
- Has your partner ever physically threatened or hurt you?
- Have you felt humiliated or emotionally hurt by your partner?
- In the past year have you been forced to have any kind of sexual activity by your partner?

A variety of tools are available to assist with the identification and assessment process, however, a

### Table 1: Possible indicators of intimate partner abuse.

| Physical Symptoms | Gynecological/Reproductive Symptoms | Psychosocial Symptoms | Situational Symptoms |
|-------------------|-------------------------------------|-----------------------|---------------------|
| Chronic gastrointestinal symptoms | Chronic pelvic pain | Anxiety | Frequent healthcare service use and/or hospital admissions |
| Chronic diarrhea | Sexual dysfunction | Depression | Frequent/high-level medication use |
| Chronic abdominal pain | Vaginal bleeding (especially repeated cases) | Eating disorders | Abuse of a child in the family |
| Chronic back pain | Frequent bladder or kidney infections | Panic disorders | Delays in seeking treatment |
| Chronic headaches | Sexually transmitted infections | Post-traumatic stress disorder | Not following through with treatment and/or appointments |
| Other chronic pain, especially where unexplained | Multiple unintended pregnancies/terminations | Sleep disorders | Inconsistent, implausible or vague explanation of injuries |
| Unexplained hearing loss | Miscarriages | Somatoform disorders | Partner who is intrusive or overattentive in consultations |
| Injuries, especially to head/neck or multiple regions | Delayed prenatal care | Alcohol or other substance misuse | Social isolation |
| Bruises in various stages of healing | Low infant birth weight | Suicide ideation or attempts | Recent separation or divorce from (ex)partner |
| Lethargy | Chronic back pain | Self-harm | |
| | Chronic abdominal pain | |
| | Chronic diarrhea | |
| | Chronic gastrointestinal symptoms | |

Data taken from [6,8,23].
full discussion of these is beyond the scope of this paper (see Rabin et al. [46] for a systematic review of tools available). Some of the most studied tools [46] include the Hurt, Insult, Threaten and Scream tool (HITS) [47], the Woman Abuse Screening Tool (WAST) [48], the Partner Violence Screen (PVS) [49] and the Abuse Assessment Screen (AAS) [50]. However further research is needed to more fully evaluate the psychometric properties of these tools when used in clinical settings [46]. Some other tools are used to assess risk of serious injury or homicide, for example, the Danger Assessment Tool [51], while others are used to assess the type and severity of IPA experienced, for example, the Composite Abuse Scale [52], mostly in research studies. As some tools have been developed for particular communities or contexts, practitioners should ensure the tool chosen is useful for their patient group.

Practitioners need to take particular care when documenting IPA in patient records. Thorough and detailed documentation can assist with continuity of care and provide support in legal cases. However this needs to be done in a manner which does not potentially compromise patient privacy or safety, especially in light of the growing trend toward electronic health records [53]. Practitioners also need to take care not to put the patient at increased risk when providing information, resources or other communication. Some strategies used by practitioners to minimize risk include obtaining a safe address from patients to which information can be sent and providing a general list of women’s well-being resources which includes, but is not limited to, IPA resources.

Validation, affirmation & support of women experiencing IPA

The initial response to disclosure of IPA should be one of validation, affirmation and support, followed by an assessment of the woman’s immediate safety [22,23]. First, it is imperative that the clinician validate the woman’s experience of abuse, indicating that they are believed, and are not to blame. Second, the clinician has a key role to play in affirming that IPA is not acceptable behavior, and that it could affect the health and safety of the woman and any children. Third, the clinician can show support by expressing their concern for the woman’s well-being and their commitment to supporting the woman whatever she may decide. Even if a woman is not yet ready to pursue further assistance or changes in her situation, this initial response may set the scene for pursuing these things at a later time.

Possible validation statements to use in response to disclosure intimate partner violence include [16]:

- Everybody deserves to feel safe at home;
- No-one deserves to be hit or hurt;
- I am concerned about your safety and well-being;
- You are not to blame. Abuse is common and happens in all kinds of relationships. Once it starts it tends to continue;
- Abuse can affect your health and that of your children in many ways;
- I will be with you through this, whatever you decide. Help is available.

Safety assessment & safety planning

It is important that the immediate safety of a woman and her children be assessed at the time IPA is disclosed [22,23]. This includes checking with the woman whether it is safe for her, and any children she has, to return home. The clinician should also ask about whether the level of abuse has recently increased, whether any threats of deadly violence have been made and whether the perpetrator may have access to a weapon, as these have been found to be predictors of domestic homicide [54]. In instances where it is not safe for the woman to return home, there are crisis services in many countries that can assist her to the police, legal options and alternative housing. One thing for clinicians to be aware of is that leaving a partner can increase the short-term risk of violence from the perpetrator [55]. Therefore the survivor may need to take additional steps to ensure safety of themselves and their children if they plan to leave.

Some questions to consider in assessing safety of a woman experiencing IPA [16] include:

- How safe does she feel?
- What does she need in order to feel safe?
- Have the frequency and severity of the abuse increased?
- Has she been threatened with a weapon?
- Is there a weapon present in the house?
- Is her partner obsessive and/or jealous about her?
- Are there children also at risk?

Once initial safety has been assessed, the woman should be assisted to further plan toward maintaining her own safety and that of any children she has. This could be facilitated at the time of disclosure, at a subsequent appointment soon after, or via referral to a support agency (although not all women will feel ready for referral). Safety planning discussions have shown some effectiveness in increasing women’s safety behaviors [56–60], improving postnatal physical...
functioning and depression outcomes and decreasing the level of psychological and nonsevere physical abuse [60,61].

The safety planning should be tailored to the individual needs of the woman and include the elements listed in Box 1, in addition to any other elements needed. If the woman has children, strategies to safeguard their safety will also need to be incorporated into this plan [62]. It may also be useful to include a plan for retrieval and care of pets, as fear of perpetrator retaliation toward pets can also have an impact on a woman’s decision-making (e.g., she may stay with the perpetrator for fear that the pet will be abused or killed if she leaves) [63,64].

Counseling & psychological interventions

Both short-term and long-term psychological interventions show promise in supporting women who have experienced IPA, although further research in this area is needed [23,65,66]. A recent WHO review [23] found that interventions incorporating aspects of cognitive behavioral therapy could reduce depression and post-traumatic stress disorder symptoms for women no longer experiencing IPA, although no effects were found for overall quality of life. The review emphasized the need for any pre-existing or consequent psychological issues to be addressed by clinicians who have a sound understanding of IPA and its effects.

Additionally, a recent cluster randomized controlled trial involving 52 family doctors and 272 female patients found that a brief doctor-administered counseling intervention could reduce depressive symptoms for women experiencing recent IPA [29]. The intervention was also successful in increasing doctor inquiry about the safety of the women and their children, although no significant differences were found between the intervention and comparison groups on anxiety or more global measures of well-being. Half of the doctors had received 8 h of training on IPA identification and response, and their participating patients (n = 137) were invited to attend one to six counseling sessions. Key features of the counseling training included:

- Active listening exercises [67];
- Attitudinal exercises [68];
- Role playing different ‘readiness for change’ scenarios, utilizing simulated patients [26,69];
- Use of survivor’s voices [68];
- Modeling of respectful behaviors by clinicians in their interactions with patients [68].

Referral & ongoing support

Although clinicians have an essential role in supporting women who have experienced IPA [22,23,29], further referral may often be necessary for more intensive, ongoing support. Specialist IPA services can provide a level of support and expertise beyond the scope of most health clinicians, including advocacy, longer-term counseling and practical advice on legal, financial, housing and safety matters as needed [22]. These services can be of assistance both to those currently experiencing IPA and to those who have experienced IPA in the past. Best practice guidelines suggest that healthcare providers establish clear referral pathways and protocols to these specialist services. Prior research has shown that not all women may feel ready for referral to these specialized services [21]. However a supportive, tailored approach from the clinician will open opportunities for referral once she is ready.

According to a systematic review of nine controlled studies (four of which were randomized controlled studies), use of IPA advocacy services can reduce abuse, increase social support and quality of life and increase use of safety behaviors and community resources [65]. The studies reviewed mainly included women who had

| Box 1. Examples of safety planning questions and tasks. |
|--------------------------------------------------------|
| **Questions to guide safety planning** |
| - Where would be a safe place for her (and her children) to go in a crisis, and how would she safely get there? |
| - Who are the family and friends who can provide support? |
| - How can she ensure cash is available in a crisis/when needed? |
| - Where could she leave a spare packed bag, keys and money, somewhere other than home? |
| - How could she be contacted safely (e.g., by the clinician or by a supportive friend)? |
| - Where would be a safe place for her to receive mail? |
| **Tasks to consider in making a safety plan** |
| - Make a list of emergency numbers and safe contacts and keep a spare copy |
| - Hide money and a spare set of house and car keys. |
| - Set up a code (word or signal) with family and/or friends to notify them when in danger |
| - Ask neighbors to call the police if they hear or see the violence beginning/occurring |
| - Ensure there are no weapons in the house |
| - Keep a packed bag with extra clothing in a hidden or separate location |
| - Ensure quick and safe access to important documents and items, including: |
|   - Important telephone numbers; |
|   - ID, driver’s license and birth certificates (of woman and any children); |
|   - Bank account numbers; |
|   - Insurance policies and numbers; |
|   - Medicare and tax file numbers; |
|   - Rent and utility receipts; |
|   - Marriage license; |
|   - Valuable jewelry. |
already actively sought assistance from professional services or were in a refuge setting. Some evidence exists to support similar benefits for women identified in general healthcare settings, although, due to the limited number and design of these studies, further research is needed to strengthen this area [65].

Working with other members of the family
It is not uncommon for a clinician to be involved with treating multiple members of the same family, especially in primary care or family medicine settings. This brings with it special challenges when supporting a woman who has experienced IPA.

Children
IPA can have a significant impact on children, and also often co-occurs with child abuse [62,70]. Therefore, it is important for clinicians to assess the impact on children wherever possible, where IPA has been disclosed [22]. Likewise, the clinician should be mindful of the possibility of IPA in situations where child abuse is present. Note that a woman’s experiences of IPA should be assessed privately if at all possible, without the child in the room, especially for verbal age children [71].

Where safe to do so, the clinician can assess child safety by asking the survivor about their children’s safety and their perception of the impact of the abuse on the children [22]. They can also ask older children independently about their own safety and level of support. It is important that children are offered confidential support (subject to mandatory reporting laws) and referral where possible, and reassured that the IPA is not their fault. According to a systematic review [72], parenting interventions may also be helpful in improving emotional and behavioral outcomes for survivors and their children.

Where child abuse is clearly present, clinicians will need to be aware of any mandatory reporting obligations under the law in their area, including any laws which include mandatory reporting of the child’s exposure to IPA [22]. Clinicians should also be mindful that some perpetrators may use the family court system as a way to gain control over the survivor’s actions, for example, by threatening to gain sole legal custody of the children should the survivor leave the relationship [73]. Clinicians therefore need to be careful in the way any report of child abuse is worded, and support the nonoffending parent in pursuing options to improve the safety of both their children and themselves.

Perpetrators
The clinician should take steps to ensure that their own relationship with the perpetrator does not cloud their identification of any underlying IPA, assessment of the survivor’s situation, nor their subsequent response, as this has been found to be a concern in previous studies [74]. Those who perpetrate IPA are a heterogeneous group from a range of backgrounds, and may not meet the clinician’s own preconceptions of how a perpetrator might present.

Perpetrators may use joint consultations as a means of monitoring the information a survivor gives to the clinician, and evading detection of the abuse. Therefore it is important that clinicians encourage separate appointments whenever IPA could be an underlying issue [23]. Once IPA is identified, it is imperative that the survivor be seen separately to the perpetrator, and that their privacy and confidentiality be protected (within the limits of the law) [23,44]. This may require a certain level of forethought and sensitivity from the clinician, for example, ensuring that the survivor has a neutral reason for increased attendance, should she be questioned by the perpetrator.

A clinician should never attempt to raise the issue of IPA with the perpetrator, unless they first have explicit permission from the survivor [16]. Even then, potential risks to the survivor should be considered, and her safety given paramount priority. There is also risk that the perpetrator may self-harm or harm others in the family [75]. Couples counseling should also not be attempted by the clinician, as this may bring with it additional risks which require a high level of expertise available only (if ever) through specialist IPA agencies [16].

Clinician training
Implementation of the above strategies needs to be supported by sound training of clinicians, equipping them with the knowledge and skills needed to appropriately identify and respond to experiencing IPA [22]. However this training has been severely lacking to date, with few universities including adequate IPA education in their prevocational clinical degrees [76–78], and few clinicians undertaking professional development in the area [79]. Even a moderate amount of training can improve clinician confidence and ability in identifying and responding appropriately to IPA [29,80,81]. Given the prevalence of IPA, and the rate at which it is a precipitating factor in other common health conditions among women, this training should form an integral part of clinical training programs [23].

Conclusion
In conclusion, around one in three women will experience IPA at some stage in their lifetime, with IPA contributing to a significant health burden. The resulting health consequences cannot be fully addressed unless the IPA itself is also identified and addressed. Clinicians should therefore include sensitive inquiry about
IPA as part of the diagnostic process when conditions or situations that can be associated with IPA are present. Research has shown the usefulness of responding to IPA through validation, affirmation and support, safety assessment and planning, and referral to IPA specialist services. Counseling and other psychological interventions have also shown some effectiveness in supporting women experiencing IPA, and further research is warranted in this area. The safety and needs of any children involved should also be simultaneously addressed, in a way that supports both mother and child. Research shows that training clinicians to identify and respond to IPA has positive effects, and that great improvement is needed in the extent to which this training is offered and implemented.

Future perspective

Key areas in need of further research include comparison of targeted IPA identification strategies, such as case-finding, with routine inquiry and screening, and the effectiveness of psychological, advocacy and safety planning interventions in reducing the frequency, severity and effects of IPA [23,24]. Further randomized controlled trials in this area are needed in which measurement tools and sample size are carefully selected to allow for sufficient statistical power during analysis [82]. Advances in technology may provide further opportunities to enhance and assess ways of assisting women experiencing IPA. For example, online decision aids incorporating safety planning tools show promise for helping women navigate competing priorities and complex decision-making when planning for the safety of themselves and their children [83]. Online safety decision aid trials are currently being conducted in the USA, Canada, New Zealand and Australia.

Other areas of growing interest in the IPA research field include primary prevention strategies and health-system-based interventions for perpetrators of IPA [4]. In all of the above research, there is a need to assess the effects of the IPA research process itself, including strategies to monitor and address the safety of research participants who have experienced IPA [29,41,84].

Executive summary

Rationale
- In total, 30% of all women who have ever been in a relationship have experienced intimate partner abuse (IPA).
- IPA frequently contributes to a wide range of common health issues, both physical and psychological.
- Healthcare clinicians may be the first or only point of contact for women experiencing IPA.

Identification
- IPA may be indicated as an underlying cause of various psychological and physical symptoms.
- Use a ‘funneling’ technique to inquire about IPA where these are present, and as a routine part of prenatal care.

Response
- Initial response
  - Validate, affirm and support the woman’s experience, assess her (and her children’s) immediate safety and assist her to plan toward maintaining this safety.
- Counseling
  - Can help reduce depression and post-traumatic stress disorder symptoms when delivered by clinicians trained to respond to IPA.
- Referral
  - Specialized services can provide advocacy, longer-term counseling and practical legal, financial, housing and safety advice.
- Children
  - Assess and address impact on children and child safety; IPA often co-occurs with child abuse.
- Privacy
  - Take special care to protect the woman’s privacy, especially where the perpetrator attends the same clinic or service. Appointments should always be kept separate.

Training
- There is a strong need for further focus on training clinicians to identify and respond to IPA.

Future perspective
- Key areas in need of future research include:
  - Comparison of targeted IPA identification strategies with universal screening;
  - Effectiveness of psychological, advocacy and safety planning interventions for IPA;
  - Uses of technology to assist in identifying and responding to IPA;
  - Primary prevention strategies;
  - Health-system-based interventions for perpetrators of IPA.
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Intimate partner abuse: identifying, caring for and helping women in healthcare settings

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Activity evaluation: where 1 is strongly disagree and 5 is strongly agree.

| The activity supported the learning objectives. | 1 | 2 | 3 | 4 | 5 |
|------------------------------------------------|---|---|---|---|---|
| The material was organized clearly for learning to occur. | 1 | 2 | 3 | 4 | 5 |
| The content learned from this activity will impact my practice. | 1 | 2 | 3 | 4 | 5 |
| The activity was presented objectively and free of commercial bias. | 1 | 2 | 3 | 4 | 5 |

1. You are seeing a 28-year-old woman who complains of nearly 1 year of bilateral headaches, central abdominal pain, and fatigue. She does admit to having increased stress but does not want to elaborate on the source of that stress. You consider that this patient might be experiencing intimate partner abuse (IPA). What is the most appropriate opening question to identify potential IPA in this patient?
   - A. Has your partner ever beaten you?
   - B. Do you know about intimate partner abuse?
   - C. Has your partner tried to limit your contacts with friends and family?
   - D. How are things at home?

2. The patient reluctantly describes several episodes of IPA in the past year, including physical abuse. What is the first thing to address after the patient discloses this IPA in her history?
   - A. Address her current level of safety
   - B. Validate her experience of abuse
   - C. Assess if the same perpetrator has abused other women
   - D. Alert law enforcement authorities
3. What should you consider regarding the treatment of women experiencing IPA?

- A  Cognitive behavioral therapy can relieve depression and posttraumatic stress disorder
- B  Cognitive behavioral therapy can improve quality of life
- C  Brief physician-administered counseling is ineffective
- D  IPA advocacy services are ineffective in preventing abuse

4. The patient comes to the next appointment with her husband, the perpetrator of the IPA. What is the best way to proceed with this clinic visit?

- A  Confront the perpetrator with his IPA directly
- B  Suggest a trial of couples therapy in your practice
- C  Verify details of the IPA with the perpetrator
- D  Find a reason to separate the woman and the perpetrator during the interview