Medical Management of Intimate Partner Violence Considering the Stages of Change: Precontemplation and Contemplation

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ABSTRACT

BACKGROUND We undertook a study to understand how women who are victims of intimate partner violence (IPV) want physicians to manage these abusive relationships in the primary care office.

METHODS Thirty-two mothers in IPV shelters or support groups in southwestern Ohio were interviewed to explore their abuse experiences and health care encounters retrospectively. The interviews were taped and transcribed. Using thematic analysis techniques, transcripts were read for indications of the stages of change and for participants' desires concerning appropriate physician management.

RESULTS Participants believed that physicians should screen women for IPV both on a routine basis and when symptoms indicating possible abuse are present, even if the victim does not disclose the abuse. Screening is an important tool to capture those women early in the process of victimization. When a victim does not recognize her relationship as abusive, participants recommended that physicians raise the issue by asking, but they also warned that doing more may alienate the victim. Participants also encouraged physicians to explore clues that victims might give about the abuse. In later contemplation, victims are willing to disclose the abuse and are exploring options. Physicians were encouraged to affirm the abuse, know local resources for IPV victims, make appropriate referrals, educate victims about how the abuse affects their health, and document the abuse. Participants identified a variety of internal and external factors that had affected their processes.

CONCLUSIONS In hindsight, IPV victims recommended desired actions from physicians that could help them during early stages of coming to terms with their abusive relationships. Stage-matched interventions may help physicians manage IPV more effectively and avoid overloading the victim with information for which she is not ready.

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BACKGROUND

In the primary care office, 11% to 22% of women are currently experiencing physical abuse.[1-3] Studies show that intimate partner violence or abuse (IPV) affects the physical and mental health of victims[4-12] and of children who witness it.[13-18] Because IPV is commonplace and the consequences of IPV are serious, professional organizations recommend that physicians routinely screen the woman alone without her spouse or children.[19-23] The value of screening for IPV when effectiveness has not been proved remains subject to controversy.[24,25] Rhodes and Levinson[26] remind us, however, that physicians will continue to see both men and women who are abused and that the recognition of abuse may influence the evaluation of the patient's complaints as well as the outcomes of care.

Studies show that physicians are not screening.[27-29] The reported barriers

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to screening include time constraints, discomfort with the subject, fear of offending the patient, frustration with patient's denial, lack of skills and resources to manage IPV, and the fear of opening Pandora's box.[3,29-31]

One barrier not mentioned in the literature is that children are often with their mothers in the office. Sometimes children accompany their mothers to her medical appointments (8%), and often mothers bring children to their pediatric visits (85%).[32] The purpose of this study was to understand the preferences of mothers who were IPV victims and the identification and management of their abuse in the health care setting, particularly when their children were present, as well as their experiences in seeking help for themselves.

METHODS

Participants

Thirty-two mothers who were victims of IPV and who were staying in local (urban and small-town) shelters or participating in community IPV-support groups in southwestern Ohio were invited to participate in the study through flyers distributed by agency staff during March 2000 and September 2001. Shelters and support group locations were chosen for their diverse pool of subjects with ethnic (African American or white), geographic (urban and small town), and socioeconomic variation.

Interview Protocol

Interviews were conducted privately without children present by the same female physician. Each interview lasted approximately 1 hour. After obtaining consent and collecting demographic information, the conversation was audiotaped and transcribed. Participants were asked to "describe the situation that brought you here," which usually elicited the abuse story. They were then questioned about their experiences when seeking health care and their preferences about IPV screening in front of their children. Interviews were conducted until we had heard no new information about preferences for screening with the children present (not analyzed in this study). Interview questions are listed in Appendix 1, which is available online at: http://www.annfammed.org/cgi/content/full/2/3/231/DC1.

Initial Analysis

Using immersion-crystallization techniques,[33] a team of 4 researchers with qualitative experience (2 family physicians, 1 anthropologist, and 1 psychologist) read and coded the 32 transcripts. While performing these initial analyses about the mothers' preferences about screening with the children present, we learned that deciding to come to a shelter or join a support group was a process and that participants had taken a number of steps and weighed a variety of factors, including considering whether their relationships were abusive, before taking action.[34]

Given these findings, we reviewed the IPV literature and discovered several models of how victims come to terms with IPV.[35-38] One model was the stages of change (transtheoretical model),[39,40] which is familiar to many primary care physicians for helping patients make behavior changes. There are 5 stages of change: precontemplation, contemplation, preparation, action, and maintenance. In attempting to make a change, an person cycles through the stages, often moving back and forth between contemplation, action, and maintenance.[39]

The stages-of-change model matches modifications in attitude and behavior with tools used by the individual altering his or her behavior.[41] Prochaska et al[39,40] identified 10 tools that are cognitive-affective or behavioral activities. The cognitive-affective tools (consciousness-raising, dramatic relief, self-reevaluation) are used during precontemplation and contemplation. Behavioral tools are used in the action and maintenance stages. Using the right tool for each stage is important.

Several authors have examined the stages-of-change model applied to behavior change in IPV, both with the abuser[42,43] and the victim.[38,44,45] No study has examined the victim's perceptions of physician management in light of the stages of change. Whereas many factors shape the victim's process of managing the abuse, the victim clearly has some control over how he or she chooses to respond to the abuse, and it is, therefore, important that victims' processes be carefully described and examined.

Subsequent Analysis of Stages-of-Change Model

To organize this analysis,[33] our team purposefully chose 4 of the 32 transcripts to create an initial codebook.[46] The 4 transcripts were chosen because of the participants' rich descriptions of their experiences, as well as their diverse backgrounds (ethnicity, socioeconomic status, urban and small town, and shelter resident and living with abuser). The team read the 4 transcripts independently, and then met to discuss the initial codebook. The remaining 28 transcripts were then divided between the 4 team members, with the principal investigator (PI) reading all of the transcripts. The PI met with each researcher to discuss coding within the individual transcripts, and disagreements were resolved by consensus. After all 32 transcripts had been read and coded independently and cooperatively by at least 2 researchers, the entire team met again to discuss thematic development.[33,46,47] Segments of the transcripts were coded for the stage of change (precontemplation, contemplation, action, maintenance) represented by the victim's thoughts or behaviors. Within each stage

we identified the victims' opinions about the care they received or wished they had received from physicians. Although all mothers had taken the action of seeking help (shelter or support group), some were mandated to do so by the court or child protective service. As a result, victims' stories focused on their early processes of understanding that their relationships were abusive (precontemplation) and of weighing the pros and cons of how to manage the abusive relationship (contemplation). We therefore concentrated on these stages. Victims described a variety of factors that had or continued to affect their decisions. We categorized these into factors internal or external to the abusive family.

Finally, we reexamined our evolving model in light of the stages of change and IPV victims' process literature. Drafts were presented to a convenience sample of 10 primary care physicians who were chosen because of their familiarity with the stages of change. As a result of these meetings, minor changes were made to improve clarity.

Table 1. Demographic Characteristics of Study Participants (n = 32)

Characteristic	No. (%)
Age (mean), y	32
Race	
White	16 (50)
African American	16 (50)
Socioeconomic status below federal poverty level[48]	24 (75)
No health insurance	7 (22)
Children	
Mean number of children	3, range 1–7
Age range children, y	1-26
Current pregnancy	3
Participants whose children heard or saw the abuse	31 (97)
Relationship issues	
Average length of abusive relationship, y	6.7, range 1–28
Abusive relationship ongoing	9 (28)
Previous abusive relationship	16 (50)
Grew up in home with IPV, child abuse, or sexual abuse	22 (70)

IPV = intimate partner violence.

RESULTS

Demographics

The mean age of our sample (n = 32) was 32 years (range 18–45 years). The average length of the abusive relationship was 6.7 years, (range 1–8 years); 28% had an ongoing relationship with the abusive partner. Additional demographic information is displayed in Table 1.

Stages of Change and Physician Management

We organized this section to present 3 insights related to the stages of precontemplation and contemplation: (1) the definition, (2) the tools the victim used to make changes during that stage, and (3) management actions by physicians that participants found helpful or thought would have been helpful during a particular stage. Finally we discuss insight about the internal and external factors that affected the victims' management of their abusive relationships. Understanding these factors may give physicians some insight into "why she won't just leave."

Precontemplation

Victims in precontemplation do not recognize their partner's behavior as abusive and see their relationships as normal.[38,44,45] By inquiring about IPV, the physician is raising awareness. When asked how she would respond to a physician screening for IPV, one participant responded:

P. *I would probably wonder, like, what does this have to do with why I'm here? Like, with my stomach, the irritable bowel syndrome, because maybe that could work me up or something.... I would kind of wonder why they're asking.*

This participant's comments suggest that she may not have made the connection between the abuse and her medical condition.

Because physicians generally cannot tell which patients are in abusive relationships unless there are warning signs or diagnoses (illnesses frequently found in patients with IPV) or an abusive interaction between the patient and her partner is observed, guidelines recommend routine screening for IPV.[49] Some participants told us that at times they were offended or did not understand why they were asked about abuse. Reflecting on precontemplation, other participants who were screened by physicians appreciated being asked, and if they had not been screened, they wished that they had been. One participant remarked, "It might have sped up my process."

Participants also indicated that they wanted IPV pamphlets available in examination rooms and bathrooms. They suggested, however, that doing anything beyond asking the appropriate screening question (raising the issue) and having resources available might be unproductive. Participants wanted physicians to be nonjudgmental and to indicate that screening for IPV was common practice.

Contemplation

During contemplation the victim sees the abusive relationship as a problem and has an increasing awareness of the advantages and disadvantages of change. Contemplation can last for years.[38,44,45] In our sample,

contemplation could be divided into 2 phases: nondisclosure and disclosure

Nondisclosure

In this phase participants recognized the relationship as abusive but were unwilling or unable to disclose the abuse to others.

TZ: *And what was your reason for not wanting to admit it [the abuse to the doctor]?*

P: *I didn't feel that it was really at the point where we needed to be talking about it.*

As this participant's comment suggests, the abuse is recognized but not divulged. When she was asked why she did not disclose the abuse when she had gone to the emergency department to seek care for an injury, she said, "I lied because I knew I was going back home, and I didn't want, you know, it to flare up none."

Although this participant clearly had good reason for not divulging the abuse, we found little evidence that such queries were unwanted. In fact, most participants reported wanting to be screened for IPV despite their nondisclosure, as reflected by her response:

TZ: *Was it helpful to have people ask you?*

P: *Oh yeah. It was real comforting to know that someone cared.... You knew that the door was open.*

During this phase of nondisclosure, several participants talked about giving physicians hints about the abuse through the display of an upset affect or other indirect actions (eg, lingering at the end of an appointment.) Participants reported wanting physicians to pick up on these clues, as illustrated in the following comments:

P. *It would be good if she (midwife) gave me some comfort [by saying] if you need to talk or need help....*

P. *If she'd (physician) spend a few more minutes, people (victims) would probably tell ... they (victims) are clammy and want someone to talk to.*

Participants told us that in acknowledging the victim's emotional distress, the physician provides an opportunity for the victim to be heard and sends the message that the office is a safe place to talk, that help is available.

Another participant described how her physician's inquiry after observing her husband's behavior was helpful.

P. *He (husband) went to an appointment with me once, and he was drinking ... he had attitude. She (the doctor) asked me if I could stay for a breast-feeding class, and she asked me about him. I didn't feel embarrassed.*

Participants stressed, however, that these inquiries should be done in a tactful manner, without condemning the partner or blaming the victim.

Disclosure

Once participants began to acknowledge the abuse, they also began to have expectations about how physicians should react to what they learned. We identified 4 expectations that we believed were relevant: affirm that the abuse is real, know and inform victims about local IPV resources, educate victims about the effects of the abuse on themselves and their children, and document injuries in the medical record.

Participants wanted physicians to affirm or validate that their relationships were abusive, and that no one, no matter what they did, deserved to be abused.

P. *So, I think I wanted that [the abuse], you know, validated.... But then when they [physicians and nurses] would talk about, you know, if anyone mentioned pressing charges or anything, I usually backed out.*

This comment also shows the importance of understanding the woman's complex feelings about the abuser and respecting her timeline. Even so, several participants reported feeling supported when physicians confirmed that the abuser's observed behavior was inappropriate.

Most women wanted their physicians to address the abuse and to know about IPV resources. When asked what she wanted her physician to know about abuse, one participant responded:

P. *I don't think that health care professionals should just ignore the situation if they know that it's going on.... But again, the problem is a lot of time people do not know how to handle it. Just being direct and maybe referring them to a shelter or give them a phone number where they can talk to somebody, I think that is a great help.*

Some participants reported wanting information about how the abuse affected them and their children:

P. *I understood that I had very high blood pressure during my pregnancy, and the stress [from the abuse] seemed to make it worse.... I was hospitalized ... twice.*

P. *How early do children detect abuse? Tell me what signs to look for in my infant.*

Educating victims (consciousness-raising) is critical to helping women in the contemplation stage to move into action.[39,40] Even in precontemplation, the participant quoted was struggling to understand the link between her irritable bowel syndrome, "being worked up (worried)," and IPV.

One participant talked about the importance of documentation in the medical record for legal purposes.

P. *If they see a situation [abuse] like that ... make sure that you do something.... Make sure it's documented.*

In contemplation women were aware of the importance of documentation because they looked at legal recourse as an option, but proper documentation is also important in precontemplation.

Safety Assessment and Planning

When we checked our model with physicians knowledgeable about the stages of change, they asked where safety assessment and safety planning fit in. None of

our participants described a physician doing either a safety assessment or reviewing a safety plan, and none volunteered that they wanted this done by physicians. We did not probe about safety issues, however. We did find that some participants did not expect physicians to know much about IPV, as reflected in one participant's statement, "…a lot of times people [including physicians] do not know how to handle it."

Factors Affecting the Victim's Process of Changing

Unlike for other behavior changes, such as quitting smoking, which may be seen as predominantly an individual struggle to change, a variety of internal and external factors had affected participants' processes with IPV. Although the IPV victim cannot change the abuser's behavior, she has some control over her response. Participants described the following factors internal to the abusive family that affected their choices: (1) the victim's realities (ie, finances, education), (2) the abuser and the victim's attachment vs perceived threat or degree of harm, and (3) the children. These factors appeared to have either helped or hindered participants' efforts to create safety. We will present examples of each.

Victim's Realities

The victim's ability to create an independent life for herself and her children depended on such realities as her self-esteem, her health, the support she had from family and friends, her internal resources such as prayer, and her financial situation, which included health insurance, job stability, and level of education. In addition, exposure to IPV as a child or previous abusive relationships seemed to play a role. Here are several examples:

P. *My self-esteem was so low, I couldn't walk around without looking at the ground because I was afraid he would turn around and backhand me, thinking I was looking at somebody else.*

P. *I didn't have any friends. He took away all my friends. He didn't let me use the phone, didn't let me go out. (He) took away all of my freedom.*

P. *I am afraid of being alone with my health, I got AIDS, I got diabetes, I got arthritis. I found out I will be blind in my right eye in 2 years.*

P. *I'm really learning to pray every day. Night and day … and that has been my strength and my health. Thank God for that, because sometimes you need something to rely on and depend on.*

Participants described seeking support and assistance from family, friends, or community organizations to address these realities, either strengths or deficits, so that they could move away from their abusive relationships.

Abuser

The intensity of the victim's attachment to the abuser was balanced against her fear or perceived threat. For example, one participant noted, "I mean it's almost gotten to the point where I just want to leave, but then, you know, I do love my husband and it's hard to leave." On the other hand, another participant told us, "I had to leave because for one he was either going to kill me, or I was goin' to wind up seriously [hurt] ... or I was goin' to probably kill him, you know, defending myself."

Children

Participants talked a lot about the role their children played in their management decisions. For example, several talked about being pregnant and waiting until after the child was born to seek help. Others delayed leaving their relationships because a son "adored him [the abuser]" or the victim "wanted a father" for her sons. More than one half of the participants reported seeking help when a child was injured in a fight between the adults, when a child commented on the abuser's behavior ("why do you put up with him?"), or when a child started imitating the abuser ("my daughter started calling me 'stupid bitch' and smacking me"). Another participant told us, "The physical abuse is tolerable compared to the risk of losing my children." The children's impact on the mother's process is discussed in another article generated from these data.[34]

Our participants also discussed factors external to the abusive family, such as professionals and community organizations that both facilitated and inhibited their attempts to create safety. For example on participant told us:

P. *I went to the police at one point and asked them for help and they said well … just move out. That was it. They were not helpful at all.*

On the other hand, another participant described the acceptance she felt from the IPV advocacy agency:

P. *I went to the IPV support group, and … no matter what I said, I never got any negative feedback. Anything I told them, whether I thought it was dumb, I felt dumb, stupid … they always made something positive out of whatever I said, which was, like, the first time in years.*

Other examples of facilitation included a physician who had IPV pamphlets, a helpful interaction with the police, and local laws that convicted the abuser without the victim's presence. Negative encounters included a physician who did not ask how an injury occurred in a caring manner, or a minister who did not understand IPV and stressed the importance of commitment in marriage. These types of episodes seemed to have temporarily slowed participants' progress toward ending the abuse.

It is important that physicians understand the diverse and competing factors that victims are juggling to understand why "she just doesn't leave." Sometimes the abuse is of lower priority than these other factors, as illustrated in the following comments.

P: *My husband's family knew [about the abuse]. They were afraid that he would be arrested and put in jail. So, it was kind of a peer-pressure thing. They were making me feel like it [the abuse] was my fault, that I deserved.... And the police and everybody [else] was wanting me to have him arrested and [wanted me] go to the hospital . . . numerous times, and I just wouldn't do it.*

TZ: *So, you were kind of between a rock and a hard place?*

P: *Right. I had nobody there, and then I had to take care of my daughter.*

Clearly, this participant was thinking about and managing many factors. In addition, participants told us that if physicians pushed them beyond what they were ready for, they "would back out" or "quit coming to the office."

DISCUSSION

We examine how our findings expand current IPV guidelines and differ from other stage-matched IPV models.

Current IPV Guidelines

Guidelines for managing victims of IPV grew out of the emergency medicine literature[50,51] For the most part, these guidelines recommend screening and identification, safety planning, and referral.[51] These physician interventions are generally targeted to victims who have disclosed the abuse and are seeking options to end the abuse. Based on our data, we are concerned that these guidelines[19-21,51] might not adequately outline the management skills physicians need in earlier stages.

During precontemplation and contemplation, victims might not be ready to take such steps as calling a hotline or joining a support group. Instead, in earlier stages victims use cognitive and affective tools: consciousness-raising, dramatic relief, and self-reevaluation.[38] Table 2 displays examples from our data. Consciousness-raising occurs, for example, when physicians screen for IPV. Giving feedback on an abuser's observed behavior also raises the victim's awareness about IPV. Dramatic relief happens when a physician verbally recognizes an emotional state or helps the victim express an emotion. These emotions can often be picked up from hints given by the patient. Levinson has called these direct or indirect comments that patients make about the personal aspects of their lives clues. When physicians picked up on clues during a patient encounter, they actually saved time and arrived at a more accurate patient assessment.[52] Self-reevaluation occurs when the patient has enough information to examine her situation and its consequences. Physicians can assist by having resources available and educating about how abuse affects health (her own or her child's).

Other Stage-Matched Models

The interventions suggested by our participants are sometimes at odds with other proposed stage-matched models. For example, Fraiser et al[45] lists "urge patient to think seriously about the situation" and "develop a safety plan" as interventions during precontemplation. Because our data showed that women have not yet seen the abuse as a problem, "urging the patient to think seriously about the situation" might be seen as too pushy or pejorative toward the abuser. Having pamphlets about safety planning is appropriate, but a discussion may alienate the victim during early stages of change.

Table 3 displays physician interventions generated from our data in light of the current IPV guidelines.

Table 2. Tools or Processes of Change

Tool, Processes Used to Change*	Definition	Physician Interventions	Illustrative Quotations From Participants
Consciousness-raising	Increasing information about self and IPV	Ask about IPV Share observations about the relationship Educate about the impact of stress/injuries on health	They (prenatal clinic) hooked me up to a stress monitor because he (abuser) gave me a concussion and they wanted to make sure that my baby was still OK .... I did let them know [about the abuse].
Dramatic relief	Experiencing and expressing emotions about IPV	Empathize Identify emotional state	I had broken my finger. The physician said to me, "You can't break your finger that way by falling. I understand being afraid." He was real nice. I remember his name. But, he was like; "I understand fear, being afraid." He told me his professional opinion as a doctor seeing an abused woman is that "get help, you know, get out."
Self-reevaluation	Assessing how one feels and thinks about the abusive relationship	Clarify values Experiences and feelings	I just didn't, you know, want to have that useless, powerless feeling no more. I needed something to gain, and I knew I had to do something to change that, because where I was at was going to [nowhere] and nothing was going to change.

Adapted from Prochaska et al.[40] The 10 tools or processes of change are consciousness-raising, dramatic relief, self-reevaluation, self-liberation, counter-conditioning, stimulus control, reinforcement management, helping relationships, environmental reevaluation, social liberation.

IPV = intimate partner violence.

* In this article we focus on the 3 tools used during precontemplation and contemplation by the person trying to change behavior. Definitions and physician's interventions are interpreted for IPV. Quotations from our data illustrate the 3 tools.

Guidelines recommend that physicians do both a safety assessment and help the victim formulate a safety plan when they become aware that a patient is in an abusive relationship,[19-23,53] but based on our data, we think that these guidelines are focused on victims in the action stage. A safety assessment includes assessing the victim for concerns of suicide or homicide and determining whether the abuser owns a gun, has made threats about harming the victim, uses alcohol or drugs, or has hurt the children or family pets.[54]

During precontemplation or contemplation, the physician can use the safety assessment as an opportunity to raise consciousness and convey to the victim concern about her situation if safety risks are present. If abuse of the children or serious threat of harm is uncovered, then a physician should follow state mandatory reporting statutes and urge the victim to take steps toward assuring her safety. When undertaking these actions, the physician walks the fine line of potentially alienating the patient and preserving her safety.

Safety planning includes helping the victim prepare to leave.[54] Although our participants did not ask for safety planning, in a study that surveyed 115 IPV victims who had sought help from IPV agencies, 25% reported safety planning done by a physician and considered it a desirable behavior.[55] Physicians might

Table 3. Stages of Change (Precontemplation and Contemplation) for Intimate Partner Violence with Matched Physician Interventions From Study Data and Published Guidelines

Stage of Change	Physician Stage-Matched Interventions From Study Data and Rationale	Additional Interventions From Published Guidelines[19-21,53] Interpreted for Appropriate Stage Management
Precontemplation: the patient-victim does not see the relationship as abusive	Ask about IPV when there is an injury; ask how injury occurred Ask during pregnancy Ask routinely (annual examination) and when warning symptoms and illnesses are present* Have and make pamphlets available. Do not spend time reviewing them in detail Educate about the impact of IPV on the physical and mental health of the victim and her children Document suspicions about IPV	Ask about IPV at the annual examination Ask during each trimester of pregnancy Ask when warning symptoms and illnesses are present* Ask at well-child examination and if abuse is suspected (child abuse, failure to thrive, behavior problems, school problems, ADHD/hyperactivity, depression, teen risk-taking behaviors, worried parent) Make pamphlets with safety plan information available in the office. Assess safety.† If any risk factors are present, share concerns with the patient-victim or follow mandated reporting guidelines
Early contemplation: the patient-victim sees the relationship as abusive, but may choose not to share this with the physician	Ask about IPV as above despite nondisclosure—women want to be screened Listen and watch for clues (hints or evidence of abuse) Victims are observing whether physician is willing to discuss abuse Discuss observations about the abuser's controlling behavior—if physicians observe abuse, discuss concerns in private with the patient-victim Have and make pamphlets available. Do not spend time reviewing them in detail Educate about the impact of IPV on the physical and mental health of the victim and her children Document suspicions about IPV Document subjective and objective findings	Ask as above Assess safety.† If any risk factors are present share concerns with the patient-victim or follow mandated reporting guidelines Make pamphlets with safety plan information available in the office
Late contemplation: the patient-victim sees the relationship as abusive and is weighing the pros and cons of making a change	Ask as above Affirm abuse is occurring and that no one deserves to be abused Educate about the impact of IPV on the physical and mental health of the victim and her children Review local IPV crisis numbers with the patient-victim Offer to have the patient telephone the crisis number from a private room in the office Make referrals for counseling to a counselor knowledgeable about IPV for the patient or her children Document subjective and objective findings	Ask as above Assess safety.† If any risk factors are present share concerns with the patient-victim or follow mandated reporting guidelines Consider reviewing safety plan‡ with the patient-victim, educate staff about IPV and have them review safety plan, or refer the patient to IPV agency

IPV = intimate partner violence; ADHD = attention deficit hyperactivity disorder.

*Warning symptoms and conditions: injuries (ask about the mechanism of the inquiry, if mechanism does not make sense, consider probing further in a nonjudgmental manner); chronic pain (headache, abdominal pain, including irritable bowel syndrome, pelvic pain, back pain, etc); vague somatic complaints (fatigue, dizziness); mental health issues (depression, anxiety, post-traumatic stress disorder, substance abuse); abuser's inappropriate behavior in the office.[5-12]

† Safety assessment: evaluate suicide oe homicide risk (victim and abuser), weapons or threat to use weapons (victim and abuser), drug and alcohol use (victim and abuser), abuse of children, abuse of pets, escalating severity of abuse, threats to life.[49,54]

‡ Safety plan: where to go, important documents and items to have ready to take with such as keys, medications, children's immunizations, money.

consider doing safety planning with victims who are seeking options to the abuse in the stage of contemplation. Safety plan information should be available in the examination room, but if reviewed too early, such planning may alienate the patient.

Limitations

Our participants had already taken the action step of going to a shelter or joining a support group, so their perspectives might not accurately portray the situation of women currently in abusive relationships who have not sought help. Nevertheless, this study is grounded in the experience of women who have experienced all the stages of change up to action, and our findings provide an important window into how victims want physicians to help them. Participants were interviewed for 2 different issues: (1) desires related to screening and management with their children present, and (2) experience in the health care setting related to their abuse. Data saturation was obtained for the first issue but might not have been reached for the second issue. We believed we had good data for the precontemplation and contemplation stages.

In summary, given physicians' lack of screening and frustration with managing IPV,[3,27-31] we wondered whether tailoring the physician intervention to match the victim's stage might help to simplify management. Although a review of the literature on stages of change and patient care found no studies documenting evidence of increased efficiency or patient satisfaction when physicians use stage-matched techniques to help patients manage behavior changes, our discussions with colleagues and other anecdotal evidence suggested that stage-matched interventions might make office visits more efficient and increase physicians and patients' satisfaction. Given the complexity of the processes of change related to IPV, we hypothesize that stage-matched interventions will streamline these processes for both the physician and the patient.

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