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A pioneer in menopause research, Dr. Utian founded the world's first menopause clinic in Cape Town, South Africa, in 1966 and established the Cleveland Menopause Clinic in 1983.

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## Domestic Violence and Menopause

A patient of mine committed suicide in the early 1970s. I had not seen her for several months, but when I heard the sad news I reviewed her chart: "Seems to be somewhat depressed, but denies that. No other concerns expressed." Shortly thereafter I saw a friend of hers, who was attending for an annual visit. She asked if I had heard the news about the suicide. When I expressed surprise and sorrow that it had happened, the friend responded, "Well, it was always a race between whether she did it to herself or her husband killed her first." This was my traumatic introduction to domestic violence (DV). It was also a lesson to me that although I had picked up on a clue to a problem, I had failed to probe its cause by not asking the right questions.

The fact is, violence is "hidden behind the doors of family homes in all countries and across all borders—in rich and poor homes..."<sup>1</sup>

Awareness of DV, also known as intimate partner violence (IPV), has been escalating over the last two decades. Unfortunately, domestic violence remains a highly

### Special note from Dr. Utian

Like all of you, we at NAMS, members and Central Office alike, watched with shock and horror as the Hurricane Katrina disaster unfolded.

Many of us recall that the NAMS meeting of 2002 was the first major convention to be held in New Orleans after 9/11, and have fond memories of how well we were received by everyone we came in contact with, from the Hilton Hotel staff to people in the street. Now it is our turn to reciprocate with assistance by every means we personally are able, especially as time passes and national attention fades, yet needs remain great.

Many NAMS members lived and

worked in the devastated areas, and our first response was to attempt to make contact with them, and hopefully hear from them that they and their loved ones were safe and sound. NAMS will be providing complimentary membership through the end of 2006 to all NAMS members affected in the devastated areas. If we have not been able to make contact with you, please let us know where you are.

To all those affected, on behalf of all NAMS members, we express our sadness at what has happened, our hope for a speedy return to a normal life, good health, and our offer of assistance to the best of our ability.

devastating public health problem. More than 85% of the victims of IPV are female. The statistics are astounding. Between 20% and 30% of women and 7.5% of men are estimated to have been victims of IPV during their adult lives. IPV crosses all boundaries—urban, suburban, rural, social, economic, ethnic, and religious—and exists among both American-born and refugee populations.<sup>2</sup>

Mazza et al<sup>3</sup> tried to assess the extent of any such problem in a community-based sample of Australian middle-aged women. Their findings that 28.5% of the women had experienced some form of physical or emotional violence during their lifetime, matching the US number, did indicate that a significant amount of DV had occurred earlier in life. Mazza et al concluded that their “findings of a high prevalence of violence experienced by women over their lifetime suggest that doctors practicing in all areas of medicine need to recognize and explore violence issues when considering middle-aged women’s reasons for presenting with ill-health.”<sup>3</sup>

### An Often-Hidden Problem

The negative outcomes of DV/IPV may reach the evening news or the columns of your local newspaper, but most cases remain invisible except to the victims and their immediate families. Moreover, the clinical presentation will invariably not be a black eye, a bruise, a laceration, or a broken bone. Conditions affected and clinical presentations range from arthritis, chronic neck or back pain, headache, and STDs (including HIV/AIDS), to chronic pelvic pain, peptic ulcer, and irritable bowel syndrome.<sup>2</sup> In other words, a woman in your office with an apparently primary medical condition may have a hidden IPV problem.

It is difficult to evaluate whether

there is a direct relationship between menopause and IPV. As a simplistic hypothesis, one could speculate that aversion to sexual intercourse because of vaginal atrophy and dyspareunia could lead to negative partner interactions. But is there more to the relationship between menopause and IPV? Allsworth et al<sup>4</sup> attempted to determine the extent to which violence at some time during the life course accelerates the onset of menopause. They reported that there appeared to be a delay in the time of the onset of changes related to perimenopause.<sup>4</sup> They hypothesized that physical and sexual abuse may lead to some form of neuroendocrine disruption.<sup>5</sup>

### Approaching Domestic Violence as Physicians

How should we, as practicing clinicians, approach DV? What are the questions we need to be asking? How does one do this in a supportive, sensitive, non-threatening way? And once we get the information, what do we do with it?

For many of the answers to these questions, I direct your attention to two excellent publications, the *National Consensus Guidelines of the Family Violence Prevention Fund (FVVPF)*<sup>2</sup> and a section on IPV and DV in the American College of Obstetrics and Gynecology (ACOG) publication *Special Issues in Women’s Health*.<sup>6</sup> Both contain a wealth of information. Just a few of their pertinent recommendations are highlighted below. A good resource is the National Domestic Violence Center [(800) 799-7233].

*When to inquire.* Questions about past and present IPV and DV should be part of the routine health history or standard health assessment, during every new patient encounter.<sup>2</sup> Inquiry should be part of periodic comprehensive health visits, during a visit for a new chief complaint, and whenever

signs and symptoms raise concerns.

*How to ask the questions.* Questions that introduce the issue in a way that makes the discussion of the topic more comfortable are known as framing questions. Some examples of framing questions are as follows:<sup>2</sup>

- “I don’t know if this is (or ever has been) a problem for you, but many of the patients I see are dealing with abusive relationships. Some are too afraid or uncomfortable to bring it up themselves, so I’ve started asking about it routinely.”
- “Because violence is so common in many people’s lives, I’ve begun to ask all my patients about it.”
- “I am concerned that your symptoms may have been caused by someone hurting you.”

Direct verbal questions that can be asked include:<sup>2</sup>

- “Are you in a relationship with a person who physically hurts or threatens you?”
- “Do you (or did you ever) feel controlled or isolated by your partner?”
- “Do you ever feel afraid of your partner?”

*Other steps to take.* To be able to get the information in a sensitive way, and have mechanisms to deal with the information if it should be shared with you, the FVVPF consensus recommends that you prepare your practice by taking steps such as the following:<sup>2</sup>

1. Allow for confidential interviewing.
2. Have posters on IPV and DV that are multicultural and multilingual and that present available resources.
3. Place brochures in exam rooms and private places such as bathrooms.

ACOG states that the physician’s responsibility with regard to disclosure of IPV and DV is to acknowledge the

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