

Recommendations for intimate partner violence screening and interventions

By Jackie Cavner, DNP, RN, WHNP-BC

In October 2018, the United States Preventive Services Task Force issued updated recommendations regarding screening for intimate partner violence in reproductive-aged women. The author summarizes these recommendations and reviews screening and intervention recommendations from other professional organizations as well. Practice implications and research needs are identified.

The CDC defines *intimate partner violence* (IPV) as physical violence, sexual violence, stalking, or psychological aggression by a current or former intimate partner.¹ Psychological aggression may include threats of violence, degradation, deprivation, isolation,

sexual or reproductive coercion, and exploitation of a vulnerability (e.g., immigration status, disability, undisclosed sexual orientation).

According to a recent survey, 37% of women in the United States experience IPV in the form of physical violence, sexual violence, or stalking at least once in their lives²; this proportion may be even higher, given that IPV is undetected or underreported in many cases. This survey showed that 47% of women report experiencing psychological aggression by an intimate partner at least once in their lives.

Females of all ages (including adolescents), races, ethnicities, education levels, and income levels may experience IPV.³ The immediate and long-term effects of IPV on females include acute or chronic psychological and physical health consequences, unintended pregnancy, adverse maternal and fetal effects during pregnancy, and death.^{3,4}

Recommendations from U.S. organizations

The U.S. Preventive Services Task Force (USPSTF) recommends that healthcare providers (HCPs) screen for IPV in all reproductive-aged women *and*, for those who screen positive, provide or refer them for ongoing services.⁵ The recommendation focuses on reproductive-aged women because evidence demonstrating the benefit of IPV interventions and ongoing support has come predominantly from studies of this population. The USPSTF found inadequate evidence upon which to base any IPV screening and intervention recommendations for men. Likewise, the task force found inadequate evidence to assess the accuracy of screening tools to detect elder abuse in the absence of recognized signs or symptoms (S/S). Of note, the USPSTF did not find adequate evidence that screening in itself can reduce IPV or its physical and mental harms. However, the task force did find adequate evidence that effective interventions that provide or refer for ongoing support services can reduce IPV and its physical and psychological harms.

Numerous professional health organizations recommend screening all women for IPV. In 2016, the Women's Preventive Services Initiative (WPSI) was launched by the American College of Obstetricians and Gynecologists (ACOG); it is overseen by an Advisory Panel comprised of representatives from ACOG, the American Academy of Family Physicians, the American College of Physicians, and the National Association of Nurse Practitioners in Women's Health.⁶ In 2018, the





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WPSI issued recommendations for well-woman care that includes IPV screening for adolescent females and women of all ages, including pregnant women and postpartum women, as part of preventive services, and, when needed, providing or referring for intervention services.⁷ Evidence is lacking regarding appropriate screening intervals.⁵ According to the WPSI, given the prevalence of IPV, it is reasonable to screen nonpregnant women at least annually and pregnant women at the initial visit, during each trimester, and at the postpartum visit.⁷

Screening tools

The USPSTF reviewed 15 studies evaluating the accuracy of IPV screening tools. Most of the studies included only females, and the settings of the studies ranged from emergency/urgent care departments to primary care clinics to mail/phone surveys. Five screening tools were found to have accuracy in detecting violence over the past year in adult women: Humiliation/Afraid/Rape/Kick (HARK); Hurt/Insult/Threaten/Scream (HITS); Extended-Hurt/Insult/Threaten/Scream (E-HITS); Partner Violence Screen (PVS); and Woman Abuse Screening Tool (WAST).⁵

Arkins et al.⁸ conducted a systematic review of 36 studies evaluating IPV screening tools, with a focus on identifying the areas of IPV—physical, sexual, and psychological—that each tool screened, assessing the psychometric properties of these IPV screening tools, and identifying which clinical population groups had been included in testing the tools. Of 10 IPV screening tools identified, this review found only three—the Abuse Assessment Screen, the HARK, and the WAST—that screened for all three areas of IPV abuse and that had been validated with an appropriate reference standard. Of these three, only the HARK tool had strong psychometric properties. The review noted that the PVS and the HITS tool do not assess for sexual abuse. The E-HITS tool, although not discussed in the review by Arkins et al.,⁸ adds a sexual violence-oriented question to the HITS tool.⁵

Barriers to screening for IPV

Despite recommendations to screen women routinely for IPV, a substantial proportion of HCPs report not following this recommendation. A recent systematic review found that although rates of routine screening varied, they were typically low, with 2%-50% of HCPs who *almost always* or *always* screen for IPV.⁹


A systematic review of 22 studies of HCP-perceived barriers to IPV screening revealed multiple barriers.¹⁰ The most frequently reported barriers were related to

lack of resources—for example, time constraints, lack of knowledge/education regarding screening for IPV, and inadequate follow-up resources and support staff to assist victims. Personal barriers reported by HCPs included discomfort with the topic of IPV, fear of compromising patients' privacy, and fear of offending patients if they were not abused. Attitudes and perceptions reported by HCPs included believing that it is not their role to screen for IPV and that HCPs have more pressing problems to address. Other reported perceptions were that victims would not want a referral and that they would stay with the abuser despite the situation. The authors concluded that education and training for HCPs should focus on increasing awareness and exploring misperceptions regarding IPV to reduce barriers.¹⁰

Specific elements within healthcare settings have been positively associated with HCP comfort level and confidence in addressing IPV. These elements include systematic prioritization of IPV and resources, on-site resources, adequate time, focused IPV training, and a team approach.¹¹ A positive move under the Affordable Care Act is the mandate for health plans to reimburse for IPV screening and counseling as part of preventive healthcare services.¹²

Key points for screening for IPV

Regardless of which screening tool is used, recommendations for screening also address the best approach to be used. HCPs should screen patients for IPV only in a private, safe setting, without any partner, friend, family member, or caregiver in the room. HCPs can normalize



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screening with an introductory statement letting the patient know that they screen all patients for safety in relationships as an important component of healthcare. HCPs should assure patients of confidentiality within the limits of any legal reporting requirements. Stigmatizing terms such as *abuse*, *battered*, or *violence* should be avoided. HCPs should use a professional interpreter if needed rather than someone whom patients know.^{3,12}

Although IPV screening questions may be embedded in self-administered health history forms, asking the questions face to face is also recommended. Patients' responses to these questions can help inform HCPs about the best way to proceed relative to interventions, health risks, and safety concerns.^{12,13} Some patients may not feel safe or comfortable disclosing IPV when asked. Regardless of whether patients disclose IPV, screening is an opportunity to provide education about IPV and available resources.¹²

Interventions

Initial care for IPV victims includes attention to immediate physical and mental health-related needs, danger assessment, safety planning, emotional support, and referrals for other short-term care needs.^{3,4} Beyond attention to victims' immediate needs, evidence suggests that provision of ongoing support services is more effective in reducing recurrent IPV episodes than are brief interventions with information about referral options.⁵ Of note, studies demonstrating the benefit of ongoing support services have focused on pregnant or postpar-

tum women. For the most part, studies of interventions in nonpregnant women have included only brief counseling, provision of information, and referrals, but not ongoing support services. Therefore, the USPSTF extrapolated the study findings evidencing the benefit of ongoing support services for pregnant and postpartum women to all reproductive-aged women.⁵

These studies have shown that effective interventions include ongoing support that addresses multiple, individual risk factors (not just IPV); provides behavioral and social services; and includes emotional support.¹⁴⁻¹⁶ Two studies found lower rates of IPV in women who participated in home-visit interventions, although the results of only one of these studies reached statistical significance.^{17,18} Home-visit components included tailored IPV materials based on each woman's needs, with services related to emotional support, problem-solving skills, parenting, prevention of child abuse, and utilization of community services. Delivery of ongoing support interventions, whether in the clinical setting or through home visits, requires interactions with a multidisciplinary team.

Implications for practice and research

Screening tools for IPV that have acceptable accuracy and that include questions for each potential major area of IPV (e.g., physical, sexual, psychological) have been identified. HCPs can choose a tool or tools that best fit within their practice setting and the population served. Screening should be conducted in a safe, private environment that respects a woman's choice to disclose or not disclose IPV. Because current evidence favors ongoing support services in reducing IPV, HCPs should identify healthcare, behavioral, and social service resources within the community for an interdisciplinary team approach that provides individualized care, both short- and long-term, for IPV victims. HCPs and administrators within healthcare settings should identify barriers to screening and interventions and seek to reduce these barriers.

A need persists for further research and HCP education regarding evidence-based protocols for screening and effective interventions for IPV victims. More research is also needed regarding effective strategies to eliminate barriers and facilitate screening and interventions within healthcare settings. Furthermore, research is needed on specific ongoing support services and intensive interventions that address multiple risk factors. Because initial studies of home visits have shown some promise in helping IPV victims, more research in this area would be helpful.

To date, most research on screening and interventions has focused on pregnant and postpartum women and has excluded other reproductive-aged women, younger adolescent females, and women beyond reproductive age. Knowledge about the benefits and risks of screening for IPV in men and in older adults who do not present with S/S of abuse is limited. Finally, more information is needed with respect to preventing and caring for victims of IPV from vulnerable populations such as LGBTQ individuals, individuals with disabilities, and individuals from varying cultural/ethnic backgrounds. ●

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