

Intimate Partner Violence

About the Guideline

- This Clinical Practice Guideline (CPG) from the Emergency Nurses Association (ENA) focuses on screening and interventions for intimate partner violence (IPV).
- After a thorough literature review, the Clinical Practice Guideline Committee established this CPG using ENA's classification of levels of recommendation for practice.

Key Clinical Considerations

Background and Significance

- IPV is a global public health issue that can negatively impact an individual both physically and psychologically.
- IPV is defined as behaviors that occur within an intimate relationship that cause physical, psychological, or sexual harm within the relationship (World Health Organization [WHO], 2012).
- Both men and women may be victims of IPV, and it is not confined to any single socioeconomic, religious, or cultural group.
- Nurses working in the ED should be trained to recognize, assess, and intervene when patients present with suspected IPV.

Forms of IPV (Nelson, Bougatsos, & Blazina, 2012)

- Physical violence, such as hitting, slapping, kicking, or beating
- Sexual violence, such as forced/coerced sexual activity
- Psychological abuse, such as insults, belittling, intimidation, humiliation, harmful threats, or threats to take away the children
- Controlling behaviors, such as isolation from friends and family, stalking, restricting access to resources such as finances, employment, education, or medical care

IPV Prevalence

- Approximately 30% of women age 15 years and older have experienced some form of physical and/or sexual IPV during their lifetime (Devries et al., 2013).
- A chart review of 1550 female patients found 75 (4.8%) patients, between 19 and 60 years of age, were currently in relationships involving domestic violence (DV) and 351 (27.5%) patients had previously experienced DV (Hugl-Wajek, Cairo, Shah and McCreary, 2012).
- Statistics vary internationally.

IPV Risk Factors (WHO, 2012)

- General risk factors
 - Unemployment
 - Increased financial stress
 - Minority groups
 - Early child abuse or neglect (small, but significant association)
 - Men and women are both likely to perpetrate IPV
 - Substance abuse (alcohol, cannabis, cocaine, stimulants, or opioids)

- Individual factors that contribute to men committing IPV
 - Young age
 - Low level of education
 - Witnessing or experiencing violence as a child
 - Heavy use of alcohol and drugs
 - Personality disorders
 - Acceptance of violence
 - History of abusing partners
- Individual factors that impact women's increased likelihood of experiencing IPV
 - Low level of education
 - Exposure to violence between parents
 - Sexual abuse during childhood
 - Acceptance of violence
 - Exposure to other forms of prior abuse
- Relationship factors
 - Conflict or dissatisfaction in the relationship
 - Male dominance in the family
 - Economic stress
 - Male having multiple partners
 - Disparity in education (when the less-dominant partner has a higher level of education)
- Community and societal factors
 - Gender-inequitable social norms
 - Weak legal sanctions against IPV within marriage
 - Lack of women's civil rights
 - Broad social acceptance of violence as a way to resolve conflict
 - Poverty
 - Low social and economic status of women
 - Weak community sanctions against IPV
 - Armed conflict and high levels of general violence in society

IPV and Pregnancy

- IPV affects the pregnant mother and the health and development of the unborn child.
- IPV towards mothers results in higher use of primary care, specialty care, mental health, and pharmacy care by the children, even when the IPV stopped before their birth. If IPV continued during childhood, use of the ED and primary care facilities greatly increased and children of IPV victims are three times more likely to use mental health services as compared to children of mothers who didn't experience IPV.

IPV and Men

Research on IPV screening in men is limited. Screening tools such as the Hurt, Insult, Threatened with Harm (HITS) and the Partner Violence Screen (PVS) are not sensitive enough as compared to the Revised Conflict Tactics Scale (CTS-2).

Screening

- Screening is the initial step in the intervention process.
- Simple, direct questioning is an effective way for survivors to disclose IPV episodes, however routine screening hasn't always been successful.
- The goal of screening is to identify victims of IPV who are currently involved in an IPV event or have recently experienced IPV.
- Several organizations, including The Joint Commission, the American Medical Association, the American Congress of Obstetricians and Gynecologists, the American Nurses Association, and the U.S. Preventive Services Task Force (USPSTF) recommend routine IPV screening.
- The WHO (2013) doesn't recommend universal screening; it is recommended that healthcare providers should screen if there are signs of physical and psychological abuse.

Types of Screening

- Universal screening: Standardized questions administered to all women who present to a healthcare organization.
- Selective screening: Question only those in high risk groups, such as pregnant women.
- Routine inquiry: All are asked about IPV, but the questions vary among healthcare workers.
- Case Finding: Ask IPV questions only when indications are present.

The Research

- Women are more likely to disclose physical abuse in a face-to-face interview (Svavarsdóttir, 2010).
- Women in the ED are more likely to disclose emotional and sexual abuse when using a self-reported instrument (Svavarsdóttir, 2010).
- Women at a high-risk prenatal care clinic are more likely to disclose emotional and sexual abuse regardless of the method used (Svavarsdóttir, 2010).
- Programs that use several screening methods (i.e. screening protocols, initial and ongoing training, access or referral to support services) were more effective in increasing IPV screening and disclosure/identification rates (O'Campo et al., 2011).
- Screening identifies more women who have experienced IPV, however, it doesn't result in an increase in referrals, re-exposure to IPV, change in health status, or harmful effects three to-18 months after screening (O'Doherty, 2015).

Screening Tools

IPV screening tools to be utilized in the ED should be short, simple, and sensitive enough to detect a lifetime of physical, sexual, emotional (and mental) abuse. Due to the limited number of research studies conducted in healthcare settings and the complexity of IPV, there isn't a gold standard screening tool. Healthcare workers should choose a screening tool that works best in their environment, whether it's by paper-and-pencil format, computerized format, or an interview.

The Hurt, Insult, Threaten, and Scream (HITS), Woman Abuse Screening Tool (WAST), Partner Violence Screen (PVS), Abuse Assessment Screen (AAS), and the STaT screening tools can be used in clinical settings.

Computerized screening

- An effective, time-efficient, and an acceptable screening method.

- May result in opportunities to discuss IPV and improve the detection of women at risk.
- IPV survivors are more likely to disclose IPV with a computer-assisted self-administered screening tool than with face-to-face interviews or self-administered written tools.
- IPV tools can be incorporated into obtaining a health history without disrupting the clinical flow.
- Women are comfortable providing information about abuse/drug use via the computer, but prefer interventions through human interaction.

Effective IPV screening

- Ask direct questions about the patient's past and current experiences.
 - Three questions are very sensitive in detecting IPV (Paranjape, 2003):
 - Have you ever been in a relationship where your partner has pushed or slapped you?
 - Have you ever been in a relationship where your partner has thrown, broken, or punched things?
 - Have you ever been in a relationship where your partner has threatened you with violence?
- Exhibit compassion and understanding.
- Ensure privacy.

Screening Barriers

- Lack of time
- Lack of education
- Language/cultural barriers
- Presence of the victim's partner
- Inability to offer appropriate support and advice
- Lack of appropriate training to deal with disclosures
- Personal issues: self confidence
- Fear of offending the patient
- Patient non-disclosures
- Patients' resistance to accepting help
- Absence of specific treatment protocols
- Inability to meet patients' expectations of what you can do to help

Strategies to address screening barriers

- Education on how to respond and intervene
- Multi-agency training on what services are available
- Professional experience with IPV
- IPV policies that are accessible to staff
- Presence of an IPV advocate
- Standardized procedures and professional tools for dealing with IPV
- Directing patients to independent domestic IPV advisory services, community resources and professional support

IPV screening in the ED

- Routine or universal screening for IPV results in higher identification rates.
- Women who screen positive are more likely to experience IPV in the next few months.

Interventions

- The provider’s response to a patient’s disclosure should be nonjudgmental, nondirective, and knowledgeable.
- IPV is complex and a person experiencing it may be anywhere on the change continuum. Some IPV victims may be contemplating leaving their relationship or have previously attempted to leave, while other victims may be experiencing IPV for the first time.
- Education, prevention, and early intervention may decrease the potential psychological, physical, and economic burden survivors of IPV may experience. Providing resource information and support that individuals can access privately is an important step in IPV intervention.

World Health Organization’s Violence Against Women Guidelines for Health Sector Response (WHO, 2013)

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| Women-centered care | Offer support through maintaining a non-judgmental attitude and empathetic listening, while providing privacy and confidentiality; offer resource. |
| Identification and care for IPV survivors | Inquire about IPV when patients present with conditions suspected to have been caused by IPV. |
| Clinical care for survivors of sexual violence | Provide comprehensive care including initial treatment, emergency contraception, and STI and HIV prophylaxis along with a complete health history. |
| Training healthcare providers on IPV and sexual violence | Remain educated on IPV and sexual assault. |
| Healthcare policy and provision | Ensure that policies and procedures are written into existing healthcare services. |
| Mandatory reporting of IPV | Mandatory reporting isn’t recommended; however, healthcare providers should offer IPV victims the opportunity to report the incidents if they choose. |

References:

- Devries, K. M., Mak, J. Y., García-Moreno, C., Petzold, M., Child, J. C., Falder, G., ... Watts, C. H. (2013). The global prevalence of intimate partner violence against women. *Science*, *340*(6140), 1527–1528. doi:10.1126/science.1240937
- Emergency Nurses Association. (2018). *Clinical Practice Guideline: Intimate Partner Violence – For Adult (18 and older) emergency department patients, how effective is screening and/or intervention for intimate partner violence*. Retrieved from: https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/ipvcpg.pdf?sfvrsn=7ce56a4f_4
- Hugl-Wajek, J. A., Cairo, D., Shah, S., & McCreary, B. (2012). Detection of domestic violence by a domestic violence advocate in the ED. *The Journal of Emergency Medicine*, *43*(5), 860–865. doi:10.1016/j.jemermed.2009.07.031
- Nelson, H. D., Bougatsos, C., & Blazina, I. (2012). Screening women for intimate partner violence: A systematic review to update the U.S. Preventive Services Task Force recommendation. *Annals of Emergency Medicine*, *156*(11), 796–808. doi:10.7326/0003-4819-156-11-201206050-00447

O'Campo, P., Kirst, M., Tsamis, C., Chambers, C., & Ahmad, F. (2011). Implementing successful intimate partner violence screening programs in health care settings: Evidence generated from a realist-informed systematic review. *Social Science & Medicine*, 72(6), 855–866. doi:10.1016/j.socscimed.2010.12.019

O'Doherty, L., Hegarty, K., Ramsay, J., Davidson, L. L., Feder, G., & Taft, A. (2015). Screening women for intimate partner violence in healthcare settings. *Cochrane Database of Systematic Reviews*, (7):CD007007. doi:10.1002/14651858.CD007007.pub3

Paranjape, A., & Liebschutz, J. (2003). STaT: A three-question screen for intimate partner violence. *Journal of Women's Health*, 12(3), 233–239. doi:10.1089/154099903321667573

Svavarsdóttir, E. K. (2010). Detecting intimate partner abuse within clinical settings: Self-report or an interview. *Scandinavian Journal of Caring Sciences*, 24(2), 224–232. doi:10.1111/j.1471-6712.2009.00709.x

World Health Organization. (2012). *Understanding and addressing violence against women: Intimate partner violence*. Retrieved from https://www.who.int/reproductivehealth/topics/violence/vaw_series/en/

World Health Organization (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Retrieved from: <https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/>

Link to Practice Guideline:

https://www.ena.org/docs/default-source/resource-library/practice-resources/cpg/ipvcpag.pdf?sfvrsn=7ce56a4f_4