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Screening women for intimate partner violence:

Creating proper practice habits

Abstract: Intimate partner violence continues to be a challenge for advanced practice registered nurses to address and manage in their daily practice. This article reviews current healthcare concerns in heterosexual, bisexual, transgender, and lesbian women, and explores screening guidelines and resources for developing successful screening habits. Additionally, the article discusses how the Transtheoretical Model and Stages of Change offers insight into the behavior of women who experience intimate partner violence and provides safety strategies for these women.

By Beth Knox, DNP, APN, AOCN

Intimate partner violence (IPV) causes health disparities in both men and women and contributes to physical, sexual, and mental health problems.[1-3] It is estimated that 50% of women mistreated by an intimate partner between 2002 and 2010 sustained physical injuries.[4] Approximately 10% received some form of medical treatment from a hospital, clinic, health unit, or medical office, whereas 8.3% obtained some form of treatment at home or at the scene by a neighbor or friend.[4]

In recent years, healthcare concerns for IPV among lesbian, gay, bisexual, transgender, and queer (LGBTQ)

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populations have been explored.[5,6] The National Intimate Partner and Sexual Violence Survey identified that bisexual women (61.1%) reported a higher lifetime prevalence of violence, stalking, or rape by an intimate partner compared with heterosexual (35%) and lesbian women (43.8%).[6]

Bisexual and heterosexual women reported being slapped, shoved, having their hair pulled, being hit with a hard object, kicked, choked, beaten, burned, or threatened with a knife or gun. The survey also addressed IPV in men, revealing that bisexual men (37.3%) reported physical violence, stalking, and rape more often than gay (26.0%) or heterosexual men (29.0%). Expressive and coercive psychological aggression were reported by both men and women in the survey as well.[6]

Screening guidelines for IPV

A number of organizations have recommendations for IPV screening.[1,3,7-11] Most recommendations focus on screening women for IPV and have not addressed the LGBTQ community. In 2013, the U.S. Preventive Services Task Force (USPSTF) updated their recommendations for screening women for IPV. They now support screening all females of childbearing age (14 to 46 years), including women who are without signs and symptoms of IPV.[9,10]

In addition to screening, the updated clinical guideline directs healthcare providers (HCPs) to ensure all women who screen positive for IPV receive interventional guidance and referrals as needed. These services may include counseling, information cards identifying a personalized safety plan, or referrals to other community services, such as shelters or psychosocial services.[9]

The Patient Protection and Affordable Care Act adopted the USPSTF recommendations for IPV screening to support IPV preventive services for women.[11] The World Health Organization (WHO) recommends screening women for IPV when there is evidence of conditions associated with IPV (see *Symptoms and other factors associated with IPV*).[2,3,12,18]

The Family Violence Prevention Fund National Consensus Guidelines endorse screening all adolescent and adult patients. These guidelines support screening of both men and women of any sexual orientation but suggest that HCPs screen women first. The concern is that perpetrators may recognize the routine screening as a threat to discovery of IPV in the relationship and prevent their partners' access to healthcare or threaten their partner if they suspect disclosure to the provider; they may become familiar with safety plans given to their victims as well.[12]

Once the HCP gains experience and demonstrates proficiency in victimization assessment of women, practice policies can be reviewed and modified to address practice concerns related to expanding screening to heterosexual men, gay men, and bisexual men.[12]

Symptoms and other factors associated with IPV[2,3,12,18]

- **General**: Chronic unexplained pain: bruises of variable stages of healing; lethargy: injuries to head, neck, or other sites
- **Neurologic**: Headaches, memory loss, dizziness, impaired concentration, unexplained hearing loss
- **Sexual and reproductive**: Multiple urinary tract infections, menstrual irregularities, many unintended pregnancies, vaginal bleeding, sexual dysfunction, sexually transmitted infections, and chronic pelvic pain
- **Gastrointestinal (GI)**: Diarrhea, constipation, irritable bowel syndrome, chronic abdominal pain, and chronic GI symptoms
- **Mental health**: Depression, anxiety, panic disorder, posttraumatic stress disorder, eating disorders, sleep disorders, alcohol or drug misuse, suicide thoughts or attempts, self-harm, social isolation
- **Cultural**: Isolated immigrant women; Indian–Tamil culture
- **Other**: Frequent ED visits or hospitalizations, delay in seeking medical attention, abuse of child in family, in-law abuse, missed appointments or failure to follow up, an overattentive partner during encounter, recent divorce or separation from former partner.

Steps to screening

IPV initiation by advanced practice registered nurses (APRNs) varies by practice setting and the type of practice. The following are essential to promoting successful care of those faced with IPV: the presence or absence of an IPV screening policy, APRN familiarity of community resources for referral, literature/brochures fostering open communication, and education and experience in providing a personalized safety plan. An APRN's level of efficacy for IPV screening is likely determined by his or her initial and ongoing IPV education, institutional support, ease of access to resources, and use of effective screening protocols and tools.[13]

APRNs should participate in selecting the type of screening and screening tool that best fits their

practice setting. The USPSTF did not indicate the frequency of screening women of childbearing age; therefore, the APRN and collaborative coworkers can establish a policy for the frequency of screening within the practice.[9] Common patterns for screening include universal screening at each visit, screening only with suspicion of abuse, and screening during an annual physical.

Six screening tools with the highest level of specificity and sensitivity were recommended for use by the USPSTF:

- Hurt, Insult, Threaten, Scream (HITS; English and Spanish versions)
- Ongoing Abuse Screen and Ongoing Violence Assessment Tool
- Slapped, Threatened, and Throw
- Humiliation, Afraid, Rape, Kick
- Modified Childhood Trauma Questionnaire–Short Form
- Woman Abuse Screening Tool.[9]

The HITS tool, a four-question instrument, was recommended for use in the primary care setting.[9] Once the type and method of screening have been established, they should be incorporated into an IPV policy/procedure for the practice. Futures Without Violence offers additional suggestions for creating and sustaining IPV policies in a toolkit created for health centers (see *Essential elements for an IPV policy*).[14]

Prior to initiating screening for IPV, the APRN should become familiar with local, county, state, and national victim-centered services, such as hotlines, shelters, counselors, and crisis intervention centers that provide medical and legal services (see *Hotlines and resources*). Once resources are identified, the information should be compiled into a quick reference guide for use in the practice and periodically reviewed and updated.

The APRN also should seek out literature to use during screening to promote healthy relationships and provide safety plans for patients. IPV education literature and posters can be acquired from Futures Without Violence or other national or state resources.[14,15]

Finally, the APRN should reflect on the type and method of IPV education completed during his or her nursing education. A lack of sufficient IPV education and training is a significant barrier to successful screening.[16] Educational training through roleplay exercises, practice with immediate feedback, and teaching effective communication skills theoretically promote ownership and increase confidence in the

Essential elements for an IPV policy

- Build partnerships with domestic violence/sexual assault programs
- Adopt the CUES:
  - **C Confidentiality:** Disclose the limits of confidentiality before discussing IPV with patients
  - **U Universal education:** Help all patients understand healthy and unhealthy relationships and their impact on health (using a safety card)
  - **E Empowerment:** Give each patient two cards to promote health and healing and so they can help a friend or family member
  - **S Support:** Offer the patient harm reduction strategies and a warm referral to an advocate when appropriate to promote safety
- Select IPV literature, such as patient safety cards, to promote wellness and safety
- Provide training to healthcare providers and staff
- Educate patients about IPV and their health
- Periodically evaluate the policy and update annually

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Hotlines and resources

National Domestic Violence Hotline
www.thehotline.org
1-800-799-SAFE (7233)
TTY 1-800-787-3224

National Sexual Assault Hotline
www.rainn.org
1-800-656-HOPE (4673)

Futures Without Violence: The National Health Resource Center on Domestic Violence
www.futureswithoutviolence.org.

Love Is Respect
www.loveisrespect.org
1-866-331-9474
TTY 1-866-331-8453
Text **"loveis" to 22522**
Chat Online: www.loveisrespect.org

National Coalition Against Domestic Violence
www.ncadv.org
1-303-839-1852

Stop Abuse for Everyone
www.stopabuseforeveryone.org
(661) 829-6848

screening. An APRN with limited or no clinical experience in screening should consider viewing "Educational Videos for Health Professionals and Advocates," found on the Futures Without Violence website or YouTube.[17] These 29 videos offer a variety of vignettes for HCPs to learn how to screen, detect, and address IPV in their patients.

Patients should be screened in a quiet, private area away from their perpetrators. The APRN may choose to advocate for patient privacy by implementing a practice policy that all patients are seen alone in an exam room. It is important to maintain a nonjudgmental attitude while screening to build a trusting relationship.

The APRN should introduce the IPV screening tool as a set of routine questions asked of all patients in the practice, similar to collecting sexual or smoking history.

Clinical presentation

Most patients who are subjected to IPV are not likely to divulge their situation without being prompted. According to Valpeid and Hegarty, the Transtheoretical Model and Stages of Change offers insight into the behavior of these patients, and identifies five stages of change:

- Precontemplation (when a woman has yet to identify her perpetrator's behavior as abuse)
- Contemplation (when the woman recognizes the behavior as abuse but is ambivalent about the desire or ability to seek out assistance for safety)
- Preparation (when the woman has recognized that her partner's behavior will unlikely change and desires to seek safety)
- Action (when the woman takes action toward acquiring a safe place to live away from her perpetrator)
- Maintenance (when the woman is safe and living in the absence of an abusive relationship).[18]

An APRN can be a valuable support resource to women who present at any of the five stages. Women subjected to IPV can also be subjected to complex barriers that cause delay in ending the relationship and seeking help, such as emotional or financial constraints, increased threats from the perpetrator, self-blame, and lack of a safe place to live.[19] In the early stages, the APRN can offer educational materials such as literature that discusses how relationships can affect personal health.[20] It is important for the APRN to remain nonjudgmental in his or her assessment of denial of abuse or disclosure.

Some patients may never progress through all five stages of change, but the APRN should continue to offer support at any stage in a caring manner. Offering a routine approach to screening, assessment of change, and delivering a safety plan at each visit is imperative, especially during the preparation stage when the patient has voiced her desire to leave the abusive partner. Once a patient reaches the final stage of maintenance and is safe, the APRN and patient can celebrate the patient's success in leaving the abusive relationship.

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Physical findings of IPV

Patients may or may not present with obvious evidence of physical or emotional abuse; therefore, it is important for the APRN to become familiar with the presenting signs and symptoms that may be associated with abuse.[2,3,12,18] If the APRN identifies any of the symptoms or conditions associated with IPV, screening should be completed using a valid tool such as HITS if not completed prior to the APRN's visit with the patient.

If the partner is present in the exam room, a safe approach must be used to speak to the patient in private, away from the potential abuser. It is reasonable to ask the partner to step out of the room during the physical exam to give the APRN an opportunity to speak with the patient in private. Any objection from the partner is a red flag for IPV concerns.

Care pathway for IPV disclosure

The updated WHO clinical and policy guidelines provide a care pathway for IPV to guide HCPs in decision making based on IPV disclosure or nondisclosure in the presence of evidence or concerns about IPV.[3] If a woman discloses that she is a victim of IPV, the APRN should offer first-line support (see *First-line support for IPV*).[3] In addition, psychotherapy sessions should be offered to any children who have been exposed to IPV in their home.

First-line support for IPV

- Be supportive, non judgmental, and validate what the patient shares.
- Ensure consultation is completed in a private location.
- Reinforce confidentiality (exception of mandatory reporting).
- Provide practical care and support that addresses concerns but does not intrude.
- Discuss the history of violence in a caring manner without pressuring patients to talk (caution with use of interpreters and sensitive topics).
- Help patients access information about resources, such as legal and other resources that would prove helpful.
- Assist patients in developing a plan of safety for themselves and any children.
- Provide or access social support.

Source: World Health Organization. Responding to intimate partner violence and sexual violence in women: WHO clinical policy guidelines. 2013. www.who.int/reproductivehealth/publications/violence/9789241548595/en. Used with permission.

Safety strategies for living with an abusive partner[19,22,23]

1. If you have/decide to leave your home, know where you will go.
2. Tell your neighbors about the violence and request they call the police if they hear suspicious noises coming from the house or develop a visual signal they will recognize when you need help.
3. Teach your children how to get help and not get involved in the violence. Do not run to where the children are or your partner may hurt them as well.
4. Develop a code word to use with your children to signal them to get help or leave the house.
6. Practice how to get out safely. Practice with your children.
7. Keep your purse/car keys ready in a specific place in order to leave quickly.
8. Back your car into driveway; keep it fueled; keep the driver's door unlocked and other doors locked for a quick exit except when children need to enter the car.
9. Create an alternate plan of what you will do if your children tell your partner about your plan or your partner otherwise discovers your plan.
10. Keep weapons, including guns and knives, as inaccessible as possible, locked away.
11. If possible, keep a phone available and accessible and know the numbers to call for help. Know the number to the police and local shelter. Know where the nearest public phone is located.
12. Keep any written information, hotline numbers, and the like given to you in a safe place so it is not discovered by your partner.

Women who have an IPV-related mental disorder, such as a depressive or alcohol use disorder, should also be offered psychotherapy sessions. Pregnant women who disclose IPV should be referred for empowerment counseling sessions in addition to first-line support services.[3]

Care pathway for IPV nondisclosure

If the APRN finds evidence of IPV on physical exam, the findings and concerns should be discussed with the patient in a private environment. If the patient does not confirm the presence of IPV, the APRN should not pressure her to disclose.[3] Instead, the APRN should offer information about a safety plan and available resources and services.[3]

The APRN also should discuss information about the impact of IPV on health and children (for example, the Futures Without Violence: Is Your Relationship Affecting Your Health? General Health Safety Card) with the patient.[3,20] Finally, the APRN should suggest scheduling a follow-up appointment within a short time frame to closely monitor the patient's health status (if acceptable to the patient).

Safety plans and documentation

Aside from screening, one of the most important roles of an APRN is developing a safety plan for anyone suspected of living in an abusive relationship. Time spent with a patient to develop a safety plan may strengthen the APRN-patient relationship and encourage the patient to eventually take action steps to leave her perpetrator. A number of safety plans are available to APRNs and other HCPs for use in their practice, including those developed by Futures Without Violence, Family Practice Prevention Fund, the American College of Obstetricians and Gynecologists, and the National Domestic Violence Hotline.[8,12,20-23]

These plans are designed to offer strategies to use during a violent act, when an abused patient is preparing to leave, ideas for safety measures for use once a patient has acquired her own residence, and steps that can be taken to help enforce a protection order.[8,23] The plan should be personalized for each unique situation at the time of the patient encounter (see *Safety strategies for living with an abusive partner*).[19,22,23] Similarly, the APRN may consider use of the sample safety questions (see *Safety plan strategies when preparing to leave an abusive relationship*).[18,23,24]

Once the safety plan is collaboratively developed and given to the patient, the APRN should document thorough details of the patient encounter. Content related to IPV should include IPV screening findings, patient concerns and comments using as many quotes as possible, evidence of patient disclosure or nondisclosure, elements of the safety plan, referrals, and a follow-up plan. The content also should include documentation of any actions and comments made by the perpetrator, if present. Clear documentation is important for future reference to support legal activities involving the patient and to communicate findings to other healthcare team members in the practice.

State statutes and polices

A few states have developed healthcare protocols for IPV or screening requirements.[8] Some states have laws requiring IPV training for HCPs, but the requirements vary by state. The majority of states have implemented some form of statute and/or policy for reporting IPV. As an HCP, each APRN is accountable for upholding state statutes associated with IPV. These can easily be obtained by an Internet search on IPV statutes by state.

Children can also be affected by IPV, and at times, disclosure of child abuse aids the APRN in discovering adult IPV abuse in women as well. Every state has developed child protection laws aimed at protecting children at multiple stages of abuse.[25] APRNs are required to know and enforce the mandatory reporting requirements for child abuse as well.

APRN leadership in IPV practice habits

APRNs and other HCPs are encouraged to follow evidence-based practice guidelines to improve the health and well-being of their patients. Ideally, every healthcare practice should have an "IPV Champion" on their team, a leader who can guide the development of an IPV screening policy and procedure that is acceptable to all team members and supports the process. Good practice habits include periodic review of new or updated national guidelines for all aspects of health; therefore, including screening for IPV in women should become the standard of care. The more APRNs practice IPV screening, the greater the chance it will become a permanent part of their good practice habits.

Safety plan strategies when preparing to leave an abusive relationship[19,22,23]

1. Keep important documents, keys, clothes, and money at the home of someone you trust.
2. Set money aside that friends/family will hold for you or set up an account to increase your independence.
3. Keep evidence of physical abuse (including pictures), a journal of all incidences (including dates). Keep your journal in a safe place.
4. Keep your cell phone or change for a public phone on you at all times.
5. Check with _____ and your advocate to see who would be able to let you stay with them or lend you some money.
6. If possible, acquire job skills or take courses at a local community college.
7. Contact a local shelter to identify resources and laws before having to use them in the event of a crisis situation.
8. If injured, you should visit an emergency department or a provider office for medical care and ask them to document details of your injuries.

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Beth Knox is an instructor and specialty director of the Adult Gerontology Primary Care Program at Rutgers University, School of Nursing, Newark, N.J.

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