

Improving the Effectiveness of Intimate Partner Violence Screening: Results From a Local Needs Assessment

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Background

Intimate partner violence (IPV) is a serious, preventable public health problem that affects millions of Americans. The term “intimate partner violence” describes physical violence, sexual violence, stalking and psychological aggression by a current or former intimate partner¹. An intimate partner is a person with whom one has a close personal relationship that can be characterized by emotional connectedness, regular contact, ongoing physical contact and/or sexual behavior, identity as a couple, or familiarity and knowledge about each other’s lives (Centers for Disease Control and Prevention, 2015).

IPV has both immediate and long-term physical and mental health effects. Immediate health effects include physical injuries, sexually transmitted diseases, HIV, unintended pregnancies, psychological distress, and even death (Nelson, Bougatsos, & Blazina, 2012). Long-term health impacts include panic attacks, depression, anxiety, post-traumatic stress disorder, substance abuse, gastrointestinal disorders, chronic pain, headaches, difficulty sleeping, activity limitations, asthma, and diabe-

tes (Breiding, Chen, & Black, 2014; Center for Disease Control and Prevention, 2014; Nelson, Bougatsos, & Blazina, 2012). In addition, children who are exposed to IPV are at increased risk for abuse and neglect, mood and anxiety disorders, post-traumatic stress disorder, substance abuse, and school-related problems (Wathen & MacMillan, 2013).

An estimated 36.4% of women and 33.3% of men in the United States experience physical violence, sexual violence, or stalking by an intimate partner at some point in their lives (Centers for Disease Control and Prevention, 2015). Heterosexual women are five to eight times more likely than heterosexual men to be victimized by an intimate partner, and for adolescents, the rates of experiencing some form of dating violence vary from 25-60%. These numbers may underrepresent the true rates of abuse because IPV is often underreported for a variety of reasons, including shame, fear, and reprisal (Catalano, 2012). Consequently, all healthcare settings and professionals providing care are likely treating patients affected by IPV and are in a position to screen, identify, and intervene on behalf of victims.

IPV survivors access health care at higher rates than the

¹ Physical violence is defined as the intentional use of physical force with the potential for causing death, disability, injury, or harm. Sexual violence includes: 1) Use of physical force upon someone to engage in a sexual act against his or her will, whether or not the act is completed; 2) Sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act. Psychological or emotional violence involves trauma to the victim caused by acts, threats of acts, or coercive tactics. Psychological or emotional abuse can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other basic resources (Centers for Disease Control and Prevention, 2015).

general public, but IPV screening remains challenging. Major medical organizations recommend screening. In 2013 and again in 2018 the U.S. Preventive Services Task Force recommended providers screen for IPV with moderate evidence. This was a reversal of their previous recommendation not to screen due to insufficient evidence. An effective IPV screening program must include a screening tool with sound psychometric properties. A systematic review conducted to summarize IPV screening tools tested in healthcare settings, and provide a discussion of existing psychometric data and an assessment of study quality, concluded that no single IPV screening tool had well-established psychometric properties (Rabin, Jennings, Campbell, & Bair-Merritt, 2009). Only a small number of studies evaluated even the most common tools. Sensitivities and specificities varied widely within and between screening tools. Further testing and validation are needed.

While most healthcare professionals report that they believe IPV is a healthcare issue (Richardson et al., 2001), providers report many barriers to screening. Barriers include: time constraints, lack of knowledge and training on what to do for the victim, lack of policies and procedures for screening, discomfort with the topic, fear of offending the patient or partner, need for privacy, perceived lack of power to change the problem, belief that the victim will not leave the abusive relationship, misconceptions regarding the patient population's risk of IPV, lack of referral options, different health priorities, and a lack of evidence for effective interventions (Hamberger, Rhodes, & Brown, 2015; Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000; Garcia-Moreno, Jansen, Ellsberg, & Watts, 2014; Hegarty, Feder, & Ramsay, 2006).

These findings coupled with varying levels of commitments to screen for IPV at some institutions have led to inconsistencies in care. While experts have identified that “many research questions remain unanswered regarding the range of optimal approaches to IPV screening,” some major healthcare organizations have made recommendations on screening practices (Miller, McCaw, Humphreys, & Mitchell, 2015, p. 94)

For example, the American College of Obstetricians and

Gynecologists' recommendations for healthcare providers include:

1. Screen for IPV in a private and safe setting.
2. Prior to screening, offer a framing statement to show that screening is done universally and that the screening will be confidential.
3. Incorporate IPV screening into the routine medical history so all patients are screened regardless of if abuse is suspected.
4. Develop partnerships with agencies that offer IPV services.
5. Regularly offer IPV training to staff.
6. Have printed resource sheets available.
7. Use non-judgmental language that makes the patient comfortable (American College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women, 2012).

Methods²

Despite widespread recommendations for providers to screen for IPV, screening rates remain low in healthcare settings (Waalén et al., 2000; O'Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011). To address this gap in practice, we conducted a community needs assessment of IPV screening practices in Houston, Texas (Correa, 2018). The goal of this assessment was to understand current practice and identify opportunities to improve the screening, identification, and referral of survivors of IPV. We interviewed 26 local experts on IPV, agencies that provide IPV services, and organizations that screen for IPV. We consulted with a local agency that convenes organizations that provide services to survivors of IPV to identify organizations and people to interview.

In addition to interviews with key stakeholders, we conducted three focus groups with 17 survivors of IPV to understand how to improve the effectiveness of IPV screening and connect survivors with resources. Three agencies that offer services to survivors of IPV aided in the recruitment of participants. Baylor College of Medicine provided IRB approval. The interview guide is available by request to the authors, and a detailed write-up of the methodology and results is under review by

² Adopted from Correa, 2018. An assessment of screening for intimate partner violence. Texas Children's Hospital and Baylor College of Medicine. Accessed April 18, 2018. Available at <https://www.texaschildrens.org/sites/default/files/uploads/IPV%20Assessment%20Final.pdf>

the *Journal of Interpersonal Violence*.

Results of the Local Assessment

Interviews

The assessment revealed inconsistent practices both between and within institutions. While some institutions had created standard protocols, the screening protocols varied dramatically between the sites with regard to who was screened, who did the screening, how the patient was screened, how often the patient was screened, and which screening tool was used. For example, some practices screened verbally while other practices used a paper screener; some practices used validated screening tools while other practices had developed their own questions.

Most of the local healthcare organizations that the research team interviewed were unable to provide data to determine the number of patients screened, the rate of positive screens, the follow-up to the positive screens, and the outcomes of patients referred to services. Some of the organizations provided estimates, which ranged from just a few positives each year to 5% of the patient population.

However, locally there was consistency in the response to a positive screen, which included: referral to a social worker, nurse, or designated internal IPV advocate; safety assessment; and connection to an IPV agency if the patient consents. IPV agencies reported that they received some referrals from healthcare organizations, but the number of referrals was relatively small.

Focus Groups

We conducted three focus groups with survivors of IPV. The participants ranged from 22 – 70 years of age and 65% were receiving public assistance. The participants were a diverse group of women and 36% identified as white, 29% Hispanic, 29% Black, and 6% American Indian. The focus groups resulted in the identification of five themes. One of the identified themes addressed that screening in health care must be improved to effectively identify and refer survivors. Approximately half of the participants reported they had been screened for IPV by a healthcare professional, but the participants shared many reasons as to why they did not disclose the abuse

to a healthcare provider and ways that screening can and should be improved:

- Screen alone. Many of the participants said their abuser was with them when they were screened for IPV so they were unable to answer truthfully.

“It’s hard to fill out forms when they’re right next to you, watching you... Number one, you have to admit to yourself that there’s a problem at home. You know, and you don’t want to do that. Number two, they’re right there next to you and you’re like, ‘Mmmm, no issues!’ You know? So, you just kind of have to just hope for the best.”

“You can’t even, like, signal to them because it’s scary. It’s, it’s like you’re being held hostage. You can’t tell nobody.”

- Tell patients what you will do if they respond “yes” before you screen. Some of the participants expressed fear of not knowing what would happen if they responded truthfully to the screen, and suggested that they would be more likely to disclose if they knew what would happen next. In addition, many participants shared that they did not understand the legal system and were fearful of losing custody of their children if they disclosed.

“Then he finds out you told them and it’s like all like hell broke loose again.”

“You’re always faced with the question of, ‘Should I tell or should I not?’”

“The, ‘Do you feel safe?’ [question]. No, I, because I couldn’t see past that question. If I said yes, ‘No, I don’t feel safe. No.’ Then what happens?”

- Improve rapport. Many of the participants reported that they would be more likely to disclose if the providers had better rapport such as listening, making eye contact, and caring for the patient.

“Early identification of IPV is complicated because there is shame. Screening must be authentic, compassionate, and realistic. Survivors are scared of being reported to authorities. It must be realistic because the available services are limited.”

- Ask more specific questions. Many of the participants did not realize they were in abusive relationships for years because the abuse was not physical. Some participants reported having to sign their paychecks to their abusers and losing their jobs because they weren't allowed to return to work until their bruises healed. The participants recommended asking specific and direct questions that included questions on non-physical abuse.

"Honestly, I didn't know. I really thought it was the norm and I have been dealing with it for a long time. I knew something wasn't right. I just thought it was, 'You know, he has anger because, you know, he is military. He's been deployed,' different things like that... It didn't really, like, really hit me that it was 'abusive.'"

"They, they can control you so well, they don't have to hit you."

- Tailor the referrals and follow-up from a positive disclosure to the individual patient's circumstance to decrease the risk of violence for the patient. The participants had different preferences on the safest mode of communication with the healthcare institution.

In addition to specific recommendation on the role of health care, the participants offered insights to the important role of families and communities in the recognition and response to IPV:

- Families and children are a key driver to a survivor's decision to stay or leave a violent relationship. Many of the participants reported that their family and the family of the abuser were aware of the abuse. Several participants reported that their abuser's family noticed and asked the survivor about the abuse. Many of the survivors disclosed the abuse to their own family and received a wide variety of responses ranging from not believing the survivor to providing tremendous support and a safe place for the survivor and the survivor's children to live. In other cases, it seemed that the families accepted the abuse. The participants were all in agreement

that their children were a top priority, but in some cases the children were the reason that the survivor stayed in the abusive relationship, and in other cases the children were the reason the survivor left the relationship. Participants also shared their fears of their children being taken away if they left the relationship or reported the abuse.

"I had a kid so I really didn't want to leave him 'cause kids need their dad."

"It finally started getting to the point where it was leading to physical abuse and that's when I said, 'That's it.' I have two boys and they're, one is a preteen and one is a teen. And I didn't want them to grow up feeling like that, that was normal and that's a relationship."

- Engage with communities. Participants agreed that solely screening in the healthcare setting is not sufficient and a broader community-wide strategy is needed to effectively screen, identify, and connect survivors with community resources. Participants felt that more education and public awareness is needed around IPV, especially non-physical abuse. Participants recommended a variety of venues to educate the community on IPV including public bathrooms, grocery stores, libraries, schools, daycares, hair and nail salons, churches, and pediatric offices. In addition to these venues, several participants shared that their workplace played a critical role in identifying and leaving the violent relationship. Two participants became aware that they were in an abusive relationship from a presentation and research at work. Participants also shared that their workplace played a critical role in leaving the abusive relationship by transferring them to a different office and through the services offered by an employee assistance program (EAP). In addition to increasing education and awareness of IPV in the community, most of the participants shared stories of calling the police to report abuse. A few of the participants shared positive stories about the response from law enforcement, but the majority of participants described negative experiences with law enforcement and the need for more training and

better responses.

Discussion

While we applaud providers and institutions that screen for IPV, we must consider *how* we are screening and not just if we are screening for IPV. Screening for IPV cannot merely be part of a checklist sandwiched between questions on eating and sleeping habits. Without attention to how screening is conducted, providers will inevitably receive negative responses from patients and perhaps miss opportunities to offer critical support to families in crisis.

Providers that choose to screen for IPV must screen patients alone since survivors are unable to disclose abuse in the presence of their abuser. Institutions must develop protocols and identify opportunities to isolate the patients, whether it is an institutional policy that patients are always seen by themselves for a part of the healthcare visit to discuss sensitive issues and screen for IPV or having healthcare providers escort patients to the bathroom for a urine sample if the partner refuses to leave the room.

Providers must take steps to show compassion through making eye contact and listening. Prior to screening providers need to provide an explanation as to why they are asking the questions and what they will do if the patient discloses abuse. This can be done verbally or written on a paper or electronic screener. This help builds rapport with patients, decreases perceptions of judgement, and may help alleviate fears. Fear of retaliation, safety, and losing custody of children are the most common barrier to women disclosing abuse across cultures (Montalvo Liendo, 2008). For example, prior to screening providers might state, “We care about the safety and health of all of our patients, so we ask all patients about violence in the home. If you

respond yes, I will talk to you privately about your answers and your answers will not be shared with anyone, including your partner.”

Providers must also ask specific and direct questions and avoid generic questions such as, “Do you feel safe at home?” or, “Are you in abusive relationship?” Many survivors of IPV, especially survivors that are not experiencing physical violence, may not identify their partner’s behavior as abusive, so specific and direct questions that include questions on emotional abuse are needed.

In addition, as practices incorporate IPV screening into their practice, more evaluation and research is needed to improve our understanding of the best methods to both screen and respond to IPV. While the research is clear that IPV is prevalent and providers have an opportunity to identify survivors of IPV, we must be diligent in *how* we are screening and responding to IPV to provide survivors a true opportunity to disclose and seek support.

About the Authors

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