Screening for Interpersonal and Domestic Violence

Clinical Recommendations

The Women's Preventive Services Initiative recommends screening adolescents and women for interpersonal and domestic violence, at least annually, and, when needed, providing or referring for initial intervention services. Interpersonal and domestic violence includes physical violence, sexual violence, stalking and psychological aggression (including coercion), reproductive coercion, neglect, and the threat of violence, abuse, or both. Intervention services include, but are not limited to, counseling, education, harm reduction strategies, and referral to appropriate supportive services.

Implementation Considerations

The Women's Preventive Services Initiative recommends as a preventive service, screening adolescents and women for interpersonal and domestic violence. There are multiple screening tools that have shown adequate sensitivity and specificity for identifying intimate partner violence and domestic violence in specific populations of women. Minimum screening intervals are unknown; however, based on the prevalence of interpersonal and domestic violence as well as evidence demonstrating that many cases are not reported, it is reasonable to conduct screening at least annually although the frequency and intensity of screening may vary depending on a particular patient's situation.

EVIDENCE MAP

Screen adolescents and women for interpersonal and domestic violence.

Systematic Reviews	Additional Studies	USPSTF; Bright Futures (covered by ACA)
Screening effectiveness (health outcomes): • 2012 USPSTF review1:[1] cluster RCT indicated no differences between screened versus non screened women[2]. • Cochrane review[3]: included an additional RCT indicating no differences between screened versus non-screened women[4]. Screening harms: • 2013 USPSTF review[1]: included 1 cluster RCT indicating no harms[2]. Accuracy of screening instruments: • 2012 USPSTF review[1]: included 7 studies of 5 instruments[5-11] with fair to high diagnostic accuracy in detecting current or recent IPV; 1 study[12] of the PVS accurately predicted future IPV; 1 study[13] identified past childhood abuse; and 2 studies[14,15] of mothers in pediatric settings reported low sensitivity/high specificity in predicting IPV	1 new study of 80 VA women reported accuracy of the HITS instrument[16].	• USPSTF[17]: Women of childbearing age: Screen women of childbearing age for intimate partner violence (IPV). (Level B; 2013; update in progress) Elderly or vulnerable adults: Insufficient evidence to assess the balance of benefits and harms of screening all elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect. • Bright Futures[18]: Discuss intimate partner violence at the prenatal, newborn, 1-month, 9-month, and 4-year visits and discuss interpersonal and dating violence at the middle and late adolescence health supervision visits. Consider screening mothers at child health supervision visits when signs or symptoms raise concerns, or if the mother has a new intimate partner. Consider screening adolescents if they have a new intimate partner, when signs or symptoms raise concerns, or during prenatal visits.

Evidence map continued on page 119.

When needed, provide or refer for intervention services.

Systematic Reviews	Additional Studies	USPSTF; Bright Futures (covered by ACA)
Studies of interventions with IPV outcomes: • 2012 USPSTF review[1]: included 6 RCTs[19-26] reporting IPV outcomes; 2 reported reduced recurrent IPV episodes during pregnancy and postpartum for the intervention groups (counseling and mentor support) versus usual care;[19,20,23,26] 1 study of home visitation[21] reported lower rates of IPV; 1 study of counseling[25] reported decreased pregnancy coercion; use of a wallet-size referral card in 1 study[24] showed no differences. • Cochrane review[27] of education or skill-based interventions reported no differences. • Cochrane review of advocacy versus usual care (10 RCTs)[28] found no differences in incidence of abuse. • Cochrane review of any intervention versus usual care in pregnant women (10 RCTs)[29] reported decreased partner abuse. Harms: • 2012 USPSTF review1: included 2 RCTs[21,24] and 11 descriptive studies[30-40] reporting harms; 1 trial reported no harms while another reported increased verbal victimization following home visitations; descriptive studies reported low rates of harms, but some women voiced concerns.	• 1 review of advocacy interventions versus usual care (12 RCTs)[41] reported decreased incidence of physical and psychological abuse. • 1 review of counseling techniques (12 RCTs)[41] reported mixed results. • 1 review of home visitation versus usual care (6 studies)[42] reported mixed results. • 2 reviews of any intervention versus usual care: a review of studies of pregnant women (9 RCTs)[43] reported decreased partner abuse; a review of women seen in multiple settings (17 studies)[44] indicated that 13 out of 17 studies reported ≥1 benefit. • 3 RCTs,[45-47] 2 of motivational interviewing and 1 of case manager versus computer driven interventions, found no differences in outcomes.	• USPSTF[17]: Women of childbearing age, clinicians provide or refer women who screen positive to intervention services. (Clinical Considerations provide more information on effective interventions.) (Level B; 2013; update in progress) • Bright Futures[18]: No recommendation regarding intervention services.

Abbreviations: ACA=Affordable Care Act, USPSTF=U.S. Preventive Services Task Force, VA=Veteran's Administration

SUMMARY OF EVIDENCE

Introduction

Interpersonal violence includes and domestic violence and, including intimate partner violence (IPV). IPV refers to physical, sexual, or psychological harm by a current or former partner or spouse.[48] Women and adolescents of all ages experience intimate partner violence. It can occur among heterosexual and same-sex couples and does not require sexual intimacy. The Centers for Disease Control and Prevention (CDC) identifies four main types of IPV (**Table 1**):[49]

Table 1. Types of IPV

IPV Type	CDC Definition[49]
Physical violence	The intentional use of physical force with the potential for causing death, disability, injury, or harm. May include (but not limited to): scratching; pushing; shoving; throwing; grabbing; biting; choking; shaking; aggressive hair pulling; slapping; punching; hitting; burning; use of a weapon; and use of restraints or one's body, size, or strength against another person. Also includes coercing other people to commit any of the above acts.
Sexual violence	Attempted or completed: • Rape or penetration of victim • Victim was made to penetrate someone else • Non-physically pressured unwanted penetration • Unwanted sexual contact • Non-contact unwanted sexual experiences (unwanted sexual events that are not of a physical nature that occur without the victim's consent) All of these acts occur without the victim's consent, including cases in which the victim is unable to consent due to being too intoxicated (e.g., incapacitation, lack of consciousness, or lack of awareness) through their voluntary or involuntary use of alcohol or drugs.
Stalking	A pattern of repeated, unwanted, attention and contact that causes fear or concern for one's own safety or the safety of someone else (e.g., family member or friend).
Psychological aggression	The use of verbal and non-verbal communication with the intent to harm another person mentally or emotionally, and/or to exert control over another person.

Current Recommendations and Coverage of Services

The gap in services provided under the provisions of the Patient Protection and Affordable Health Care Act of 2010 previously identified by the Institute of Medicine (IOM) Committee was that interpersonal and domestic violence screening and counseling were not included. In 2013, the U.S. Preventive Services Task Force (USPSTF) issued new recommendations for screening for intimate partner violence and providing or referring women who screen positive to intervention services[17] (**Table 2**). Recommendations regarding screening for violence apply to women and adolescents who do not have signs or symptoms of abuse, and generally involve clinicians asking a series of questions.

Table 2. Summary of Recommendations Currently Covered under the Affordable Care Act

IOM Committee[50]	Coverage for screening and counseling for interpersonal and domestic violence. This involves elicitation of information from women and adolescents about current and past violence and abuse in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems.
USPSTF[17]	Screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services (Level B 2013).
Bright Futures[18]	Discuss intimate partner violence at the prenatal, newborn, 1-month, 9-month, and 4-year visits and discuss interpersonal and dating violence at the middle and late adolescence health supervision visits. Consider screening mothers at child health supervision visits when signs or symptoms raise concerns, or if the mother has a new intimate partner. Consider screening adolescents if they have a new intimate partner, when signs or symptoms raise concerns, or during prenatal visits.

Abbreviations: IOM=Institute of Medicine; USPSTF=U.S. Preventive Services Task Force

Background

A survey by the CDC in 2011 indicated that 32% of women experienced physical violence in their lifetimes, and 22% reported severe physical violence by an intimate partner. In addition, 47% experienced psychological aggression, including expressive aggression (i.e., name calling, insults, and/or humiliation) and coercive control (i.e., behaviors intended to monitor, control, or threaten).[51] Also, 19% of women experienced rape and 44% experienced sexual violence besides rape. Of those raped, 45% were raped by an intimate partner.

Health effects of intimate partner violence include death and nonfatal traumatic injuries including contusions, fractures, and traumatic brain injury that can result in chronic health conditions.[52] Sexual violence may cause sexually transmitted infections, sexual dysfunction, unintended pregnancy, pregnancy complications including preterm delivery, delayed prenatal care, and pelvic inflammatory disease. Chronic health effects include

exacerbation of asthma, urinary tract infections, cardiovascular disease, fibromyalgia, irritable bowel syndrome, and chronic pain syndromes including headaches.[53]

Associated psychological conditions include anxiety, depression, posttraumatic stress disorder, antisocial behavior, suicidal ideation and behaviors, low self-esteem, fear of intimacy, emotional detachment, sleep disturbances, and inability to trust others.[52,54-57] Social repercussions may include restricted access to services, strained relationships with health providers and employers, isolation from social networks, and homelessness.[56-58]

Screening methods to identify women exposed to IPV have been developed for administration in a variety of healthcare settings (e.g., obstetrics visits, primary-care settings, emergency department) (**Table 3**). Some instruments demonstrated high sensitivity (>80%) in accurately detecting IPV in studies, however results differed across studies and populations.[1]

Table 3. Clinical Screening Instruments for IPV Evaluated in Studies[1,5]

Measure	Components	Sensitivity; specificity
HITS	4 item (hurt, insult, threaten, scream), 5-point Likert scale, self-report or clinician administered survey; score ranges from 4-20 points, ≥11 indicates abuse.	86%; 99%
PSQ	3 items (physically hurt or threatened, afraid, order for protection), dichotomous scale; score ranges from 0-3.	19%; 93%
OVAT	4 item (threaten, beaten, would like to kill you, no respect), dichotomous scale; score ranges from 0-4.	86-93%; 83-86%
SAFE-T	5 items (secure at home, accepted by partner, family likes partner, even disposition of partner, talks with partner to resolve differences), dichotomous scale; score ranges from 0-5.	54%; 81%
PVS	3 items (past physical violence, perceived personal safety), dichotomous scale, clinician administered; score ranges from 0-3, with ≥1 indicates IPV.	49%; 94%
WAST	8 item (physical, sexual, and emotional abuse), 3-point response (0=never, 1=sometimes, 2=often) scale; scores range from 0-16; ≥4 indicates exposure to IPV. Short form includes 2 questions about tension in the relationship and how arguments are resolved.	47-88%; 89-96%
STaT	3 item (pushed or slapped, threatened with violence, partner has thrown, broken, or punched things), dichotomous, self-report scale; score ranges from 0-3.	96%; 75%

Table 3 continued on page 123.

Measure	Components	Sensitivity; specificity
AAS	5 item (sexual coercion, lifetime abuse, current abuse, abuse during pregnancy), dichotomous scale, clinician administered survey; scores range from 0-5, with any positive response considered a positive screen.	32-93%; 55-99%
HARK	4 item (humiliation, afraid, rape, kick, dichotomous scale, self-report survey, adapted from AAS; scoring ranges from 0-4.	81%; 95%
Modified CTQ-SF	28 item (abuse and neglect in childhood), 8-point Likert scale, self-report survey; positive response (anything other than never) indicates exposure to IPV.	85%; 88%
OAS	5 item (threaten, beaten, would like to kill you, no respect), dichotomous scale; scores range from 0-5.	60%; 90%

Abbreviations: AAS=Abuse Assessment Screen; CTQ-SF=Conflict Tactics Scale-Revised Short Form; E-HITS=Extended Hurt/Insult/Threaten/Scream tool; HARK=Humiliation, Afraid, Rape, Kick tool; HITS=Hurt/Insult/Threaten/Scream tool; OAS=Ongoing Abuse Screen; OVAT=Ongoing Violence Assessment Tool; PSQ=Parent Screening Questionnaire; PVS=Partner Violence Screen; SAFE-T=Secure, Accepted, Family, Even, Talk measure; STaT=Slapped, Threatened, and Throw measure; WAST=Woman Abuse Screening Tool.

Women exposed to IPV may benefit from interventions aimed at reducing exposure to IPV and its negative health effects. Interventions generally include advocacy and safety planning, education, and counseling. Several professional organizations recommend screening for IPV (**Table 4**).

Table 4. Recommendations of Professional Organizations

Organization	Recommendation
American College of Obstetricians and Gynecologists (ACOG)[60]	Screen all women for intimate partner violence at periodic intervals, such as annual examinations and new patient visits. Screening during obstetric care should occur at the first prenatal visit, at least once per trimester, and at the postpartum checkup.
American Medical Association (AMA)[61]	Questions to assess risk for family violence should be included within the context of taking a routine social history, past medical history, history of present illness, and review of systems as part of emergency, diagnostic, preventive, and chronic care management.
American Academy of Family Physicians (AAFP)[62]	Screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services.
American College of Emergency Physicians (ACEP)[63]	Assess patients for family violence in all its forms, including that directed toward children, elders, intimate partners, and other family members.
Emergency Nurses Association (ENA)[64]	Routinely screen patients for intimate partner violence.
American Academy of Pediatricians (AAP)[65]	Remain alert to the signs and symptoms of exposure to intimate partner violence in caregivers and children and consider attempts to identify evidence of intimate partner violence either by targeted screening of high-risk families or universal screening.

UPDATE OF EVIDENCE

The 2013 USPSTF recommendation was based on a systematic review of evidence of effectiveness of IPV screening in reducing subsequent IPV and adverse health outcomes; diagnostic accuracy of screening instruments; and effectiveness of interventions to reduce IVP.1

Effectiveness of Screening on Subsequent IPV and Health Outcomes

Trials were limited by heterogeneity, lack of true control groups, high loss to follow-up, self-reported measures, and lack of accepted reference standards.

USPSTF systematic review

A large (n=6,743) cluster randomized controlled trial (RCT) in Canada assessed outcomes of abuse and quality

of life measures at 18 months for women randomized to either screening or non-screening groups.[2] Clinicians, at their discretion, discussed positive findings from the screening instrument (Woman Abuse Screening Tool) with patients, and provided them with referrals and/or treatment as they saw necessary. During follow-up, no statistically significant differences were found between screened and non-screened groups in the numbers of women accessing additional health care services; with reduced IPV recurrence, posttraumatic stress disorder symptoms, or alcohol problems; and on scores for quality of life, depression, or mental health.

This trial has several methodological limitations. Women with positive screenings were not offered a specific intervention, and few women who had positive screening results actually participated in discussions about IPV with their clinicians during their clinic visits. Women who were randomly assigned to the nonscreening group were provided with information cards of locally available resources for women with IPV, which constitutes an intervention in other studies. Women in the nonscreening group had extensive questioning about IPV over the 18 months of the trial which could increase their self-awareness of IPV, affect their utilization of services, and influence outcomes of the trial by creating a substantial Hawthorne effect (i.e., the phenomenon that study participants change their behavior as a result of being involved in the study).

Relevant studies published since the USPSTF systematic review

A Cochrane review[3] identified two RCTs reporting outcomes of reduced IPV after screening including the Canadian trial[2] and a trial conducted in Japan that also found no statistically significant differences in IPV 3 months after screening.[4]

Diagnostic Accuracy of Screening Instruments

USPSTF systematic review

Seven studies of five screening instruments[5-11] demonstrated fair to high diagnostic accuracy in detecting current or recent IPV (summarized in Table 3 above). A study evaluating risk for future IPV reported that positive responses on the Partner Violence Screen predicted verbal aggression (risk ratio [RR] 7.3; 95% confidence interval [CI], 3.2 to 16.2) and violence (RR 11.3; 95% CI 4.8 to 26.3) during the 4 months after screening.[12] A study of the modified Childhood Trauma Questionnaire-Short Form to identify adult women who had past childhood physical or sexual abuse reported high diagnostic accuracy (sensitivity 85%; specificity 88%).[13] Two studies evaluated mothers in pediatric settings screened with either the Parent Screening Questionnaire[14] or five questions asked by clinicians.[15] Both methods had low sensitivity, but high specificity in predicting IPV (sensitivity: 19% to 29% and 40%, respectively; specificity: 91% to 93% and 91%, respectively).

Relevant studies published since the USPSTF systematic review

A study of 80 women veterans compared the diagnostic accuracy of the 4-item Hurt/Insult/Threaten/Scream (HITS) instrument and an extended HITS (E-HITS) version that included a sexual IPV item with the Revised Conflict Tactics Scale (CTS-2), which was the reference standard.[16] Using a cutoff score of 6 on the HITS and 7 on the E-HITS resulted in the best balance of sensitivity (75% for both) and specificity (83% for HITS and 82% for E-HITS).

Effectiveness of Interventions

Studies of the effectiveness of interventions were generally limited by their heterogeneity, lack of true control groups, high loss to follow-up, use of self-reported measures, and lack of accepted reference standards. Results need to be interpreted with these limitations in mind.

USPSTF systematic review

Six RCTs[19-26] reported outcomes after interventions to reduce IPV; three trials targeted pregnant and postpartum women and three trials included primary care patients. Two trials[19,20,23,26] reported statistically significant differences between women receiving interventions (counseling, mentor support) versus usual care for the number of recurrent episodes of IPV during pregnancy and postpartum, birth outcomes (fewer very preterm infants, lower rates of very low birth weight infants, and increased mean gestational age), reduced abuse scores, and odds of experiencing violence at follow-up.

A trial of home visitations for women who recently gave birth to an infant at risk for maltreatment[21] reported lower rates of IPV victimization and IPV perpetration, although results were of borderline statistical significance. A cluster RCT[25] indicated that women receiving counseling who reported IPV at baseline had decreased pregnancy coercion at follow-up, and all women in the intervention group, regardless of recent IPV status, were more likely to discontinue unhealthy or unsafe relationships compared with women receiving usual care. A RCT[24] of a wallet-size referral card compared with a nurse management protocol showed no differences at 2-year follow-up, although both groups had fewer threats of abuse, assaults, danger risks for homicide, and events of work harassment.

Relevant studies published since the USPSTF systematic review

Seven reviews of the effectiveness of interventions in reducing exposure to IPV included advocacy,[28,41] cognitive behavioral therapy (CBT),[41] home visiting,[42] educational or skill-based interventions,[27] or any type of intervention.[29,43,44] Many studies included in these reviews did not meet inclusion criteria for the USPSTF review for various reasons including lack of comparison groups, no IPV or health outcomes, and low relevance to clinical settings.

The two reviews comparing the effectiveness of advocacy interventions with usual care included seven of the same trials. One review included ten RCTs in the analysis, but was unable to pool most of the studies due to clinical and methodological heterogeneity.[28] The review found no significant differences between the intervention and usual care groups in the reduction of physical abuse (standard mean difference [SMD] 0.00; 95% CI -0.17 to 0.16; 3 trials) or sexual abuse (SMD -0.12; 95% CI -0.37 to 0.14; 2 trials). The review reported a significantly decreased risk of developing depression for those receiving a brief advocacy intervention compared with usual care (odds ratio [OR] 0.31; 95% CI 0.15 to 0.65; 2 trials). However, there were no differences in reduced depression at 12 months (mean difference -0.14; 95% CI -0.33 to 0.05; 3 trials) or 2 years (SMD -0.12; 95% CI -0.36 to 0.12; 1 trial) after an intensive advocacy intervention compared with usual care. The other review included six RCTs in the analysis and reported decreased incidence of physical abuse (SMD -0.13; 95% CI -0.25 to -0.00; 5 trials) and psychological abuse (SMD -0.19; 95% CI - 0.32 to -0.05; 4 trials) after an

advocacy intervention compared with usual care.[41] There were no differences in incidence of sexual abuse (SMD -0.20; 95% CI -0.43 to 0.02; 2 trials) or any IPV (SMD -0.32; 95% CI -0.69 to 0.04; 1 trial).

Trials comparing cognitive behavioral therapy with usual care indicated decreased incidence of physical abuse (SMD -0.79; 95% CI -1.26 to -0.33; 2 trials) and psychological abuse (SMD -0.80; 95% CI -1.25 to -0.36; 2 trials), but not sexual abuse (SMD -0.35; 95% CI -1.73 to 1.03; 1 trial) or any type of IPV (SMD 0.09; 95% CI -0.05 to 0.23; 1 trial).[41]

A review assessed home visitation interventions compared with usual care in six trials and reported mixed results.[42] Three trials reported statistically significant reductions in IPV for mothers in the short-term, but the other three trials showed no benefit for the intervention group.

A Cochrane review assessed the effectiveness of education or skill-based interventions aimed at preventing dating or relationship violence in adolescents (12-18 years) or young adults (19-25 years) in any setting.[27] The review found no differences between intervention and usual care groups in reducing episodes of relationship violence (RR 0.77; 95% CI 0.53 to 1.13; 8 trials).

Three reviews assessed the effectiveness of any intervention for preventing or reducing IPV; two exclusively in pregnant women[29,43] and one in women seen in multiple settings.[44] Both reviews of pregnant women included predominantly the same studies and found limited evidence for reduced IPV exposure. One of the reviews included five studies reporting statistically significant decreases in physical, sexual, and/or psychological partner violence (ORs from 0.47 to 0.92).[43] The other review reported fewer episodes of partner violence during pregnancy in the intervention group in one trial (RR 0.62; 95% CI 0.43 to 0.88).[29] The third review of any type of intervention included 17 trials.[44] The review reported that 13 studies demonstrated more than one intervention-related benefit. Six of the 11 studies measuring IPV persistence found reductions in future violence; two of five studies measuring safety-promoting behaviors found increases; and six of ten studies measuring IPV/community resource referrals found enhanced use. Some studies also documented health improvements.

Three RCTs that were not included in the reviews reported effectiveness of interventions to reduce exposure to IPV; two involved motivational interviewing[45,46] and one compared a case manager driven intervention with a computerized intervention.[47] Neither study of motivational interviewing reported significant differences between groups at either 4 or 12 months follow-up in depressive symptoms, self-efficacy, abuse, or heavy drinking. The study comparing the case manager driven intervention with a computerized intervention also found no differences between groups from baseline to 3-month follow-up for identification of IPV or improvement in receipt of IPV services, social support, IPV self-efficacy, and abstinence from drug use.

Harms of Screening or Interventions

USPSTF systematic review

Three trials[2,21,24] and 11 descriptive studies[30-40] reported outcomes related to harms of IVP screening or interventions. Two trials found no harms,[2,24] while another trial indicated increased verbal abuse victimization and perpetration over long-term follow-up among women assigned to home visitations because their infants were considered at risk for maltreatment.[21] The descriptive studies generally reported low levels of harms that included discomfort with screening, particularly among those with prior IPV; infringement of privacy; worries about increasing abuse by disclosing IPV; feelings of sadness and depression; and general concerns with IPV screening.[59] Only a minority of respondents voiced these concerns. No new studies reported adverse effects of IVP screening or interventions.

CONCLUSIONS

Two trials evaluating screening for IPV in clinical settings and its effects on health outcomes are inconclusive. Several brief screening instruments to identify women exposed to IPV in healthcare settings (obstetrics visits, primary-care settings, emergency department) have high sensitivity (>80%), although results vary across studies and populations. Studies of interventions focus primarily on pregnant women or women seeking obstetric care. Results indicate generally beneficial outcomes, but studies are heterogeneous and most enrolled small numbers of women limiting applicability.

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