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1969-2019 50 YEARS

Intimate Partner Violence

An official position statement of the Association of Women's Health, Obstetric and Neonatal Nurses.

AWHONN 1800 M Street, NW, Suite 740 South, Washington, DC 20036, (800) 673-8499.

Approved by the AWHONN Board of Directors, June 2001. Revised and reaffirmed as "Mandatory Reporting of Intimate Partner Violence," December 2007. Revised and reaffirmed as "Intimate Partner Violence," January 2015. Revised and reaffirmed November 2018. The previous version was published in the *Journal of Obstetric, Gynecologic, & Neonatal Nursing* (AWHONN, 2015).

Position

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) opposes laws and other policies that require nurses to report the results of screening for intimate partner violence (IPV) to law enforcement or other regulatory agencies without the consent of the woman who experiences the IPV. Nurses and other health care professionals, however, should become familiar with laws on mandatory reporting in their states and comply as applicable. To protect the woman's safety, AWHONN supports policies that require a woman's consent before reporting occurs.

Women should be universally screened for IPV in private, safe settings in which health care is provided. In cases of IPV, a lethality assessment should be conducted to determine the degree of risk of serious harm and/or femicide.

AWHONN maintains that gun ownership should be prohibited for those who have been convicted of perpetrating intimate partner violence and supports enhanced and consistent background checks before gun purchase in all venues: online, retail gun enterprises, gun shows, and private sales from unlicensed dealers.

Background

Intimate partner violence, also called domestic violence, is a serious, sometimes fatal, preventable, public health problem. The term *intimate partner violence* is used to describe physical violence, sexual violence, stalking, and psychological aggression by a current or former intimate partner, to include current or former spouses, boyfriends/girlfriends, dating partners, or sexual partners (Breiding, Basile, Smith, Black, & Mahendra, 2015). Although IPV can occur against men, 74% of all IPV is directed toward women and is perpetrated by current or former partners (Truman & Morgan, 2014). Approximately 1 in 3 women in the United States experience rape, physical violence, and/or stalking by intimate partners during their lifetimes (Smith et al., 2017). An estimated 4.5 million U.S. women alive today at one time were threatened with guns by their intimate partners, and almost 1 million were shot or shot at by intimate partners (Sorenson & Schut, 2018). Tragically, approximately 50 women in the United States are murdered by intimate partners with firearms every month (U.S. Department of Justice, 2017).

While IPV affects women of every age, race, ethnicity, and socioeconomic group, specific populations are at greater risk or may have unique challenges in accessing IPV treatment and services (see Table 1).

Data from the National Intimate Partner and Sexual Violence Survey indicated that 57% of multiracial women, 48% of American Indian/Alaska Native women, 45% of Black women, 37% of White women, 34% of Hispanic women, and 18% of Asian-Pacific Islander women experienced IPV (Smith et al., 2017). Compared to heterosexual women, bisexual women are 1.8 times more likely to report IPV and 2.6 times more likely to report intimate partner sexual violence (Brown & Herman, 2015). Individuals with physical or mental disabilities have nearly double the lifetime risk of IPV (Hahn, McCormick, Silverman, Robinson, & Koenen, 2014).

The true prevalence of IPV is difficult to determine because many survivors do not disclose their experiences. Current and past experiences with IPV can have profound effects on women's physical and emotional health. In addition to the often visible injuries such as cuts, bruises, scratches, welts, and broken bones, victims are more likely to experience chronic medical conditions, including arthritis; asthma; chronic pain; cardiovascular, gastrointestinal, reproductive, and nervous system disorders; depression; anxiety; posttraumatic stress disorder; substance use; and sexual dysfunction (Smith et al., 2017). Short-term effects of physical violence can include unintended pregnancy, disruptions in sleep, sexually transmitted infection, and pregnancy complications (Office on Women's Health, 2017).

Screening Recommendations

Because of the numerous, deleterious effects that IPV can have on physical and mental health, experts agree that women should be screened for IPV. However, specific recommendations vary based on age, health status, frequency, and location (setting) of screenings. Universal screening, which AWHONN supports, involves a standard assessment for all women regardless of their age, reason for seeking medical care, health status, and history of IPV.

Screening for IPV should be conducted in a private and safe setting with assurances of confidentiality. The Centers for Disease Control and Prevention provides a

TABLE 1 SPECIAL POPULATIONS AT RISK FOR INTIMATE PARTNER VIOLENCE (IPV)

Certain populations are at greater risk of experiencing IPV or may have specific challenges in accessing treatment and services. Access to affordable and acceptable health care services is a basic human right (AWHONN, 2017), and AWHONN supports programs that work to eliminate the barriers noted herein.

- *Pregnant women.* Pregnant women, especially those who have unplanned pregnancies, are more likely to experience IPV than women who are not pregnant (World Health Organization, 2011). A history of IPV can increase the risk of complications in pregnancy, including low weight gain, anemia, infections, bleeding, maternal depression, and suicide attempts (Alhusen, Ray, Sharps, & Bullock, 2015).
- *Women with low income.* Intimate partner violence is more prevalent in poor families than in middle- and high-income families. Women who are poor are less likely to have insurance or access to certain services, may be more isolated, are less likely to have the education and job experience necessary to be self-sufficient, and may stay in violent relationships for longer periods as a result (Capaldi, Knoble, Shortt, & Kim, 2012).
- *Women who live in rural areas.* Women who reside in small, rural, and isolated areas experience a higher prevalence of IPV than women who live in urban areas and face distinct barriers to obtaining help (Peek-Asa et al., 2011). The numbers of shelters, social services, and health care services are often limited in rural areas. Access to limited resources is further exacerbated by lack of public transportation and great geographic distances between providers (Peek-Asa et al., 2011). Maintaining confidentially in rural areas is another challenge because health care providers in these areas may personally know or be related to the survivor or the perpetrator (Townsend, 2010).
- *Adolescents.* Adolescents are at particular risk for IPV because of their young age and inexperience with intimate relationships; this inexperience may normalize physical and or verbal abuse. Early exposure to abuse can place individuals at a higher risk of experiencing abusive relationships in the future. (Muller, 2016). In addition, abuse may undermine the adolescents' psychological health and cause depression and suicidal ideation (Decker et al., 2014).
- *Older women.* Current data on the prevalence of IPV in women 60 years of age or older are underreported and may be underestimated because of the difficulty in distinguishing between IPV and elder abuse (Crockett, Brandl, & Dabby, 2015). Additionally, no valid and reliable screening tools for use in screening older adults for abuse exist (U.S. Preventive Services Task Force, 2018).
- *American Indian and Alaska Native (AI/AN) women who reside on reservations.* These women have the greatest rates of IPV compared to all other groups. It is estimated that more than 4 in 5 AI/AN women experienced some type of violence during their lifetimes: 56.1% experienced sexual violence by intimate partners; 55.5% experienced physical IPV; 48.8% were stalked; and 66.4% experienced psychological IPV (Rosay, 2016). American Indian women who reside on reservations are at increased risk for IPV and are more likely to be injured than women of any other ethnicity. Further, when they do report IPV, AI women face more legal barriers than other women (Rosay, 2016).
- *Veterans/women in the military.* Epidemiological data indicated a particular prevalence of IPV in veterans and women in the military (Iverson, Wells, Wiltsey-Stirman, Vaughn, & Gerber, 2013). Cumulative trauma exposure may increase their risk for IPV, and complex symptom presentation may create additional screening barriers (Iverson et al., 2013). Intimate partner violence is known to exacerbate mental health symptoms such as PTSD and substance abuse that are more common in female veterans (Iverson et al., 2013).
- *Women who are immigrants.* Language differences between health care providers and the women they serve may compromise efforts to screen for IPV. In some circumstances, the woman's translator may also be her abuser. For undocumented, immigrant women, lack of knowledge about the legal system and fear of deportation or losing their children may further compound this effect. Women who are immigrants may not realize they can obtain restraining orders against perpetrators even if they are not citizens or legal, permanent residents of the United States (Office on Women's Health, 2018).
- *Individuals who are lesbian, gay, bisexual, transgender, and/or queer/questioning (LGBTQ).* Intimate partner violence statistics indicate that women in nonheterosexual relationships experience IPV at equal to or greater than those in heterosexual relationships (Edwards, Sylaska, & Neal, 2015). However, women who identify as LGBTQ are less likely to report abuse because of fear of stigmatization, isolation, and discrimination. Access to appropriate services and shelters may be limited to LGBTQ survivors of abuse, especially in the transgender community (Advocates for Human Rights, 2013).
- *Non-Hispanic, Black women.* According to the Centers for Disease Control and Prevention, non-Hispanic, Black women experience some of the highest rates of physical violence at the hands of intimate partners (Breiding et al., 2014). In addition, statistics indicate that Black women are more likely to be murdered by their partners than White women (Petrosky et al., 2017).

comprehensive list of well tested screening tools for use in the healthcare setting (Basile, Hertz, & Back, 2007), and validated screening tools for use in pregnancy and the postpartum period exist as well (Deshpande & Lewis-O'Connor, 2013). The use of an IPV screening tool does not negate the importance of a face-to-face conversation between nurse and the woman about abuse since the presence of meaningful, therapeutic, provider-patient relationships allow for more open disclosing episodes of abuse.

When a woman discloses abuse, an additional component of screening is a lethality assessment to determine her level of risk for femicide. Use of the lethality screen, a component of the Lethality Assessment Program, allows the provider to determine risk status, i.e., high danger or not high danger (Messing, Campbell, Wilson, Brown, & Patchell, 2017). These results should be shared with the woman to impart the seriousness of the situation. While the lethality assessment screening was designed for use by first responders, other health care providers should be aware of this screening option and develop competence in its use (Messing et al., 2017).

A serious consideration of lethality is the presence of a firearm. In the United States, approximately 50 women are murdered with guns each month by intimate partners, and many more experience non-fatal gunshots (Sorenson & Schut, 2018). Federal law prohibits the possession of firearms by individuals convicted of misdemeanor crimes of domestic violence; however, it is up to the states to ensure that all firearms are relinquished. Less than one-third of all states require individuals with restraining orders to relinquish their weapons, which increases the risk of serious harm or death during a violent episode (Johns Hopkins Bloomberg School of Public Health, 2015). Additionally, while federal law requires a background check to purchase a gun from a licensed dealer, the same requirement is not applicable if a gun is purchased at a gun show or online from a private, unlicensed seller. This loophole in federal law makes it possible for individuals with records of IPV violations and who would otherwise fail background checks to legally purchase guns (Giffords Law Center, 2017).

Mandatory Reporting Requirements

Only three of 50 states in the United States do not have mandatory IPV reporting laws for health care professionals (Durborow, Lizdas, O'Flaherty, & Marjavi, 2010). Many mandatory reporting laws for IPV are modeled on child abuse laws based on the assumption that the child is unable to make an informed decision about self-protection. As competent adults, abused women should have the opportunity to determine their risk of additional violence and make decisions about their futures and relationships with the abusers. Nurses can guide and support women to make optimal decisions.

Mandatory reporting requirements threaten the confidentiality inherent in the relationship between health care professionals and their patients, further limit the victim's autonomy, negate the value of informed consent, and may deter women from seeking needed medical attention or discussing abuse. Proponents of mandatory reporting of IPV claim that these requirements ensure a process to hold offenders accountable, provide an improved tracking mechanism for IPV, and prevent violence. The World Health Organization (2013) does not recommend mandatory reporting of IPV to the police but encourages health care providers to offer to report the incident if the woman desires and is aware of her rights. It is vital that the woman participates in the development of her safety plan since she best knows her individual safety needs (McKibbin & Gill-Hopple, 2018).

Existing restraint and prosecution laws are insufficient to guarantee an abused woman's safety. Mandatory reporting can only be implemented safely if prompt criminal prosecution of the offender and protection of the abused woman are guaranteed. Mandated reporting responsibilities should always be discussed with patients who seek care before assessment for IPV. Nurses and other health care professionals should be familiar with laws on mandatory reporting of IPV in their states and comply as required by law. However, AWHONN encourages legislative bodies to rescind mandatory IPV reporting requirements.

Role of the Nurse

Nurses are ideally situated to screen, assess, and counsel women and should be aware of populations at greater risk for IPV or who may have challenges in accessing services. Researchers found that most IPV survivors (between 68%–85%) wanted their health care providers to ask them about abuse (Dudgeon & Evanson, 2014), and interventions in primary care settings resulted in benefits to physical or emotional health or reduction of violence in 76% of cases (Bair-Merritt et al., 2014). However, health care providers often do not screen women for IPV, and the most common reasons for ot screening included lack of time, lack of training, and inadequate resources (Sprague et al., 2012). The American College of Obstetricians and Gynecologists (2012) and the Institute of Medicine (2011) recommended that IPV screening and counseling be included in women's preventive health visits and at periodic intervals during prenatal, obstetric, and postpartum visits. The U.S. Preventive Services Task Force (2018) recommended that all women of childbearing age be screened but found no evidence to recommend a screening interval. Ghandour, Campbell, and Lloyd (2015) advocated for universal screening and intervention when indicated during all primary, urgent, emergent, and behavioral health care visits.

Nurses can lead efforts to increase rates of screening and provide support, information, referrals, and appropriate community resources for women who experience IPV. Nurses are inherently responsible to advocate on behalf of women at risk for and who experience IPV and to protect and support confidentiality and patient autonomy. Health care organizations and nurses should acknowledge the barriers that survivors face in seeking help so that they can tailor interventions accordingly.

Policy Implications

AWHONN supports the implementation of legislation and public health initiatives to address the complex problem of IPV. Such initiatives include the following:

 doi: 10.1016/j.jogn.2018.11.003

- Legislation that protects the rights of all people to live in violence-free, domestic situations and imposes penalties against those who perpetrate violence.
- Legislation and policies to increase public education about what constitutes intimate partner violence and access to resources such as evidence-based, victim-centered services, housing programs, and legal protections.
- Legislation that prohibits the ownership of guns for those who have been convicted of perpetrating intimate partner violence, and enhanced and consistent background checks before gun purchase in all venues: online, retail gun enterprises, gun shows, and private sales from unlicensed dealers.
- Research on intimate partner violence, its etiology and consequences, and effective means to decrease it.
- Regulation requiring regular training and competency validation in the areas of IPV screening and referral for nurses and other health care providers.
- Promotion of culturally specific, public health campaigns, particularly within populations most at-risk for IPV.
- Incorporation of IPV screening results in the electronic health record with access to all health care providers across the continuum of a woman's life.
- Repeal of federal, state, and tribal laws that require nurses and other health care providers to report the results of IPV screening without the consent of the woman.

Nurses should take leadership roles in these initiatives. Improvements in IPV screening and treatment will ultimately lead to safer, healthier women and families.

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