

## PART I | INTRODUCTION

For over a decade, the Family Violence Prevention Fund (FVPPF) through its publications, practices, educational programs, and outreach efforts, has promoted routine assessment for domestic violence and effective responses to victims in health care settings. Other health professional organizations including the American Medical Association, American College of Obstetricians and Gynecologists, American Academy of Family Physicians, American Psychological Association, American Nurses Association, American Academy of Pediatrics, the Joint Commission on the Accreditation of Health Care Organizations, and the Institute of Medicine, have promulgated policy statements, position papers, guidelines and monographs about this important health issue.

In 1999, in collaboration with an expert advisory committee, the FVPPF published *Preventing Domestic Violence: Clinical Guidelines on Routine Screening*. This document endorsed a set of national guidelines on screening for abuse and offered recommendations on whom to screen, how often and in what settings. As inquiry for domestic violence becomes more widespread, the need to expand these guidelines to include guidance regarding assessment and response has become apparent. It is critical that providers understand how to respond to domestic violence victims once they are identified, including providing appropriate health and safety assessment, intervention, documentation and referral.

Research indicates that the vast majority of victims of abuse in intimate relationships are women whose partners are men. Emerging research has not only confirmed earlier findings, but also has indicated that men in same-sex relationships experience domestic violence at rates at least equal to that of women in heterosexual relationships, and that lesbians and some men in heterosexual couples also experience abuse. Therefore, these Guidelines have been expanded to recommend assessment of all female and male adolescent and adult patients for domestic violence victimization.

*The National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization present recommendations on how inquiry for domestic violence victimization, assessment, documentation, intervention and referrals should occur in multiple settings, and in various professional disciplines. They do not however, address inquiry for perpetration. Part I of the Guidelines reviews current findings regarding the prevalence and health impact of domestic violence, presents a rationale for regular and routine inquiry and response, and underscores the importance of culturally competent practice in addressing domestic violence. Part II outlines the recommendations for identification and response. Part III offers continuous quality improvement goals to help monitor the impact and implementation of abuse identification and response protocols. The appendices contain additional recommendations and resources for providers including bibliographies, websites, and telephone numbers of organizations that can provide assistance.*

To develop these Guidelines, the FVPPF partnered with advisors from the National Health Care Standards Campaign on Domestic Violence: a coalition of health care providers, public health and policy leaders, and domestic violence advocates from 15 states working to promote improved health care responses to victims of abuse. The FVPPF also invited the Advisory Committee from the 1999 *Preventing Domestic Violence: Clinical Guidelines on Routine Screening* to be reviewers. Advisory Committee members worked assiduously to develop and revise the Guidelines. These recommendations reflect the combined decades of their experience in the field as well as results from current research.

### Definitions and Rationale

During the past fifteen years, there has been a growing recognition among health care professionals that domestic violence (DV), also known as intimate partner violence (IPV) is a highly prevalent public health problem with devastating effects on individuals, families and communities. Most Americans are seen at some point by a health care provider, and the health care setting offers a critical opportunity for early identification and even the primary prevention of abuse. Studies show that assessing for IPV in medical settings has been effective in identifying women who are victims<sup>1</sup> and that patients are not offended when asked about current or past IPV.<sup>2</sup> A host of professional health care associations have issued position statements to their members describing the impact of IPV on patients and suggesting strategies for assessment and identification of abuse. These statements represent important steps in raising awareness about IPV in health care settings. Generally, however, they offer neither specific guidelines for intervening and responding, nor criteria that promote the utilization and evaluation of recommended practice. These guidelines offer specific recommendations for assessing for and responding to IPV that may be applied to multiple health settings.

The term “family violence” has been used to describe acts of violence between family members, including adult and adolescent partners; between a parent and a child (including adult children); between caretakers or partners against elders; and between siblings. While sometimes used interchangeably, the term “domestic violence” is generally seen as a subset of family violence between intimates. While all forms of family violence are harmful, these Guidelines focus only on IPV and use the following definition:

*Intimate partner violence is a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other.*<sup>3</sup>

## DEFINITIONS

Legal definitions of IPV reference state or federal laws and generally refer specifically to threats or acts of physical or sexual violence including forced rape, stalking, harassment, certain types of psychological abuse and other crimes where civil or criminal justice remedies apply. Laws vary from state to state. Since non-physical forms of IPV can have many medical, psychological, behavioral and developmental effects, the definition used in these Guidelines is better suited for the identification and treatment of IPV in the health care setting.

*Child exposure to IPV is a term encompassing a wide range of experiences for children whose caregivers are being abused physically, sexually, or emotionally by an intimate partner. This term includes the child who observes a parent being harmed, threatened, or murdered, who overhears these behaviors from another part of the home, or who is exposed to the short- or long-term physical or emotional aftermath of a caregiver's abuse without hearing or seeing a specific aggressive act. Children exposed to IPV may see their parents' bruises or other visible injuries, or witness the emotional consequences of violence such as fear or intimidation, without having directly witnessed violent acts.*<sup>4</sup>

This term also includes children who are used by the perpetrator to intimidate and abuse the adult victim, as well as those who are forced by the perpetrator to participate in the abuse of an adult victim. The impact of IPV on children varies greatly depending on the nature and frequency of the perpetrator's abusive tactics, the development stage and gender of the child, and the presence of protective factors.

The vast majority of victims of IPV are women. The latest United States Bureau of Justice Statistics report on intimate violence found that 85 percent of victims are female.<sup>5</sup> Most of the research that has been conducted to date has measured the prevalence and impact of abuse on women and children; the references in these guidelines are reflective of that body of research. However, it is important to note that IPV also occurs in same-sex relationships, and that some victims of IPV are men in heterosexual relationships.

## RATIONALE

### Prevalence of Intimate Partner Violence

IPV is a health problem of enormous proportions. It is estimated that between 20 and 30% of women and 7.5% of men in the United States have been physically and/or sexually abused by an intimate partner at some point in their adult lives.<sup>6,7,8</sup> Heterosexual women are five to eight times more likely than heterosexual men to be victimized by an intimate partner.<sup>9</sup> From 1993 to 1998, victimization by an intimate accounted for 22% of the violent crime experienced by females and 3% of the violent crime sustained by males.<sup>10</sup> Women aged 16-24 experience the highest per capita rate of IPV.<sup>11</sup> For adolescents, the rates of experiencing some form of dating violence vary from 25-60%.<sup>12,13,14</sup> While studies indicate that boys and girls may accept physical and sexual aggression as normative in dating and intimate partner relationships, adolescent females are more likely to receive significant physical injuries than boys and are more likely to be sexually victimized by their partners.<sup>15</sup>

No one is immune from the risk of abuse. The National Center on Elder Abuse estimates that 818,000 elderly Americans were victims of domestic abuse in 1994.<sup>16,17</sup> There are far fewer data on lesbian, gay, transgender, and bisexual (LGTB) victimization. However, the available literature suggests similarly high rates for LGTB adolescent and adult populations<sup>18,19</sup> with higher rates in male same-sex relationships than female.<sup>20</sup> IPV occurs in every urban, suburban, rural and remote community; in all social classes, and in all ethnic and religious groups including immigrant and refugee populations. Consequently, all health care settings and professionals providing care to patients are treating patients affected by IPV and are in a position to identify and intervene on behalf of victims.

The estimates of children exposed to IPV vary from 3.3 million to ten million per year, depending on the specific definition of witnessing violence, the source of interview, and the age of child included in the survey.<sup>21</sup> In the Adverse Childhood Experiences (ACE) Study, conducted on a large sample of members (30,000 adults) of the Kaiser Health Plan in California, 12.5% of respondents indicated childhood exposure to IPV and 10.8% indicated a personal history of child abuse including physical, sexual and emotional abuse.<sup>22</sup> This research and other studies indicate that children who witness IPV are seen with both frequency and regularity in the health care system as children and as adults.

### Health Effects of Intimate Partner Violence

In addition to injuries sustained by women during violent episodes, physical and psychological abuse are linked to a number of adverse medical health effects including arthritis, chronic neck or back pain, migraine or other types of headache, sexually transmitted infections (including HIV/AIDS), chronic pelvic pain, peptic ulcers, chronic irritable bowel syndrome, and frequent indigestion, diarrhea, or constipation.<sup>23</sup> Six percent of all pregnant women are battered and pregnancy complications, including low weight gain, anemia, infections, and first and second trimester bleeding, are significantly higher for abused women, as are maternal rates of depression, suicide attempts, and substance abuse.<sup>24</sup>

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Optimal management of other chronic illnesses such as asthma, HIV/AIDS, seizures, diabetes, gastrointestinal disorders, and hypertension can be problematic in women who are being abused or have been abused in the past. Often times the perpetrator controls the victim's access to and compliance with health protocols. Emerging research shows that women who are abused are less likely to engage in important preventive health care behaviors such as regular mammography and are more likely to participate in injurious health behaviors including smoking, alcohol abuse, and substance abuse.<sup>25</sup> In many controlled studies, IPV significantly increases the risk for serious mental health consequences for victims including depression, traumatic and posttraumatic stress disorder, anxiety, and suicidal ideation.<sup>26, 27, 28, 29, 30</sup> The health consequences of abuse can continue for years after the abuse has ended. IPV can also result in homicide; in 1996, 1,800 murders were attributed to intimates.<sup>31</sup>

Adolescents also suffer devastating and often lifelong effects from dating violence. In one study, female adolescents who reported experiencing sexual or physical dating violence were 2.5 times as likely to report smoking, 8.6 times more likely to attempt suicide, and 3.4 times more likely to use cocaine than their non-abused peers. In addition, abused teens were 3.7 times more likely to use unhealthy weight control behaviors such as using laxatives or vomiting.<sup>32</sup> The experience of interpersonal violence is also correlated with repeated pregnancy and higher rates of miscarriage among low-income adolescents.<sup>33</sup>

More than 100 studies have explored the short and long-term effects of IPV on children.<sup>34</sup> In 30 to 60% of families affected by IPV, children are also directly abused.<sup>35</sup> Children exposed to IPV, particularly chronic abuse, often show symptoms associated with posttraumatic stress disorder. One study found that a child's exposure to IPV (without being directly assaulted) was sufficiently traumatic to precipitate moderate to severe symptoms of posttraumatic stress in 85% of the children surveyed.<sup>36</sup> Although physical health problems have seldom been measured in children exposed to IPV, one study found that they are more likely to exhibit physical health problems including chronic somatic complaints, and behavioral problems such as depression, anxiety, and violence towards peers.<sup>37</sup> Another study found that children exposed were also more likely to attempt suicide, abuse drugs and alcohol, run away from home, engage in teenage prostitution, and commit sexual assault crimes.<sup>38</sup> There is a growing body of research regarding the impact of violence on early brain development that could have implications for children growing up in violent homes.<sup>39</sup>

There is an urgent need to address family violence over the lifespan because the health effects of victimization often persist for years after the abuse has ended.<sup>40</sup> Adults who were abused as children, witnessed IPV, had a parent with a mental illness, or parental substance abuse are at significantly high risk for obesity, heart disease, hepatitis, diabetes, depression, and suicide.<sup>41</sup> These adverse childhood experiences frequently cluster in

households and have a cumulative effect—the more adverse exposures in a household, the higher the likelihood of long-term health problems as an adult.

### Identifying and Responding to Abuse Can Make a Difference

The health care system plays an important role in identifying and preventing public health problems. Models developed to identify other chronic health problems can effectively be applied to IPV. Routine inquiry, with a focus on early identification of all victims of IPV whether or not symptoms are immediately apparent, is a primary starting point for this improved approach to medical practice for IPV.<sup>42</sup>

Regular, face-to-face screening of women by skilled health care providers, markedly increases the identification of victims of IPV, as well as those who are at risk for verbal, physical, and sexual abuse.<sup>43,44</sup> Routine inquiry of all patients, as opposed to indicator-based assessment increases opportunities for both identification and effective interventions, validates IPV as a central and legitimate health care issue and enables providers to assist both victims and their children. When victims or children exposed to IPV are identified early, providers may be able to break the isolation and coordinate with DV advocates to help patients understand their options, live more safely within the relationship, or safely leave the relationship. Expert opinion suggests that such interventions in adult health settings may lead to reduced morbidity and mortality.<sup>45</sup> Talking with patients about IPV provides a valuable opportunity for providers to learn about their experiences with abuse. Battered women report that one of the most important aspects of their interactions with a physician was being listened to about the abuse.<sup>46</sup> Even if a patient chooses not to disclose being abused, the provider's inquiry can often communicate support and increase the likelihood of future discussion of the issue.

Assessment for exposure to lifetime abuse has major implications for primary prevention and early intervention to end the cycle of violence. Victims are often unaware of the co-occurrence of incest in homes with IPV. Assessing for IPV provides an opportunity to educate victims about the increased risk of child abuse and the health effects of childhood exposure to violence. Adolescents who grow up in violent households are more likely to engage in fighting, carry a weapon, attempt suicide, and become part of an escalating epidemic of dating violence.<sup>47,48,49</sup> Adolescent males who witnessed IPV are more likely to become teen fathers.<sup>50</sup> Adolescent girls who witness IPV are more likely have unintended and rapid, repeat pregnancies, have sex with a partner who have multiple partners, and use alcohol or drugs before having sex.<sup>51,52,53</sup> Routine assessment for lifetime abuse is part of a larger trend to meet the psychosocial needs of patients while moving towards prevention.

Asking about IPV and having resource and referral materials in health settings also sends a prevention message that IPV is unacceptable, has serious health consequences, and provides

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the patient with important community referral information and resources. In most counties, programs serving victims of IPV include hotlines, walk-in services and shelters. These programs typically provide safety planning, confidential emergency housing, short time focused counseling, legal advocacy, housing support and help identifying financial support.

### Working Cross Culturally

IPV affects people regardless of race, ethnicity, class, sexual and gender identity, religious affiliation, age, immigration status and ability. The term culture is used in this context to refer to those axes of identification and other shared experiences. Because of the sensitive nature of abuse, providing culturally relevant care is critical when working with victims of abuse. In order to provide care that is accessible and tailored to each patient, providers must consider the multiple issues that victims may deal with simultaneously (including language barriers, limited resources, homophobia, acculturation, accessibility issues and racism) and recognize that each patient who is a victim of IPV will experience both the abuse and the health system in culturally specific ways. Disparities in access to and quality of health care may also impact providers abilities to help abused patients. For example, women who are members of racial and ethnic minority groups are more likely than white women to experience difficulty communicating with their doctors, and often feel they are treated disrespectfully in the health care setting.<sup>54</sup> English-speaking Latinos, Asians and Blacks report not fully understanding their doctors and feeling like their doctors were not listening to them.<sup>55</sup> People with cognitive or communication disabilities may be dependent on an abusive intimate partner and thus at especially high risk. In addition, some patients may experience abuse from the health care system itself and this may impact their approach to and utilization of the health care system.<sup>56</sup>

Providers also enter patient encounters with their own cultural experiences and perspectives unique from those of the victim. In a successful health care interaction within a diverse client population, the provider effectively communicates with the patient, is aware of personal assumptions, asks questions in a culturally sensitive way and provides relevant interventions. Eliciting specific information about the patient's beliefs and experience with abuse, sharing general information about IPV relevant to that experience and providing culturally accessible resources in the community, improves the quality of care for victims of violence. In addition, having skilled interpreters who are trained to understand IPV (and who are not family members, caregivers or children) is crucial when helping non-English speaking patients. Culturally sensitive questions for all patients can also facilitate discussion and help providers offer appropriate and effective interventions.

### Recent Trends

These guidelines reflect an important shift in terminology. "Assessment" has replaced the word "screening" throughout this document. The concept of screening in the medical

model usually involves use of a standardized clinical test to detect disease in asymptomatic patients. Psychosocial health issues like IPV do not fit well into a disease-based approach, particularly when identification of the health concern relies primarily on the patient's response to questions. The U.S. Preventive Services Task Force (USPSTF) uses the term "assessment" in their recommendations for many psychosocial issues such as tobacco use and alcohol consumption. The USPSTF and other prominent medical organizations have identified problems with fitting IPV into a traditional screening paradigm. The FVPF believes that using the term "assessment" will lead to a more appropriate evaluation of the importance of routine inquiry for IPV in the health care setting.

With growing recognition of the connection between IPV and other risk factors, there is a trend to integrate routine inquiry for IPV into assessment tools addressing a wide range of psychosocial issues associated with current or past victimization such as tobacco use, weight control, and access to preventive health care. This has led to innovative strategies for more comprehensive assessment and integrated service delivery. The Maternal and Child Health Bureau has funded several perinatal demonstration projects to develop an assessment tool for IPV, depression, and substance abuse. Another exciting initiative through the Substance Abuse and Mental Health Services Administration (SAMHSA) promotes coordinated services for women who experience violence, mental health problems, and have substance abuse issues.

### Future Considerations

The FVPF believes that broader recommendations for assessment for perpetration in the health care setting may eventually be demonstrated to be appropriate. However, experience in this area is still in its infancy and there is little on which to draw conclusions. Before making recommendations on how assessment for perpetration and response should be conducted, the FVPF recommends:

- The collection and analysis of research and practice data on the efficacy of programs to assess for perpetration in health care settings.
- That interested providers consider adopting assessment for perpetration in their practice, especially if this can be tied to research and data collection to demonstrate efficacy.