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Practical Implications of Research on Intimate Partner Violence Against Women

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This report addresses the public health problem of intimate partner violence (IPV) which, for more than 30 years, has been observed every October as Domestic Violence Awareness Month by IPV-related public awareness campaigns, community gatherings, and outreach efforts. Research on IPV has also rapidly expanded to include broader concerns, and the incendiary and poignant #MeToo movement has drawn public attention and empowered women to disclose sexual abuse and IPV. Increased public attention to IPV, and growing likelihood of survivor disclosure, further stimulate interest in integrating IPV screening and intervention practices into routine healthcare (Iverson et al., 2019). But studies suggest that practitioners often don't know how to address IPV in ways that are consistent with the research findings — this is true across disciplines and services, including mental health (Howard et al., 2010). It is therefore important that clinicians, healthcare leaders and policy makers are knowledgeable about IPV, including its definition, prevalence, health consequences, and best clinical practices for screening and intervention. This report summarizes the current knowledge to guide clinical care for women who experience IPV, as the need for effective dissemination and implementation is urgent for this population.

Defining and Understanding IPV

While domestic violence includes IPV (and the terms are sometimes used interchangeably), domestic violence is a broader term that refers to any violence that occurs in the domestic sphere (e.g., child abuse, elder abuse, sibling abuse). IPV is a specific form of domestic violence that refers to violence and aggression between past and current intimate partners (e.g., spouse, girlfriend/boyfriend, dating or sexual partner). Although individuals of any gender identity may experience IPV, women are disproportionately affected with elevated prevalence, chronicity, and severity of IPV and more pronounced physical, mental, and social health impacts (World Health Organization, 2013). IPV is the most common form of violence against women worldwide and includes physical violence, sexual coercion and abuse, psychological abuse (including coercive and controlling behaviors), and stalking by past or current intimate partners (Smith et al., 2018).

Prevalence. The CDC's National Intimate Partner and Sexual Violence Survey indicates that 1 in 4 women and 1 in 10 men experience physical violence, rape, or stalking by an intimate partner that results in health-related impacts such as injury, need for medical care, or posttraumatic stress symptoms (Smith et al., 2018). Women are three times as likely as men to be injured by IPV (41.6% vs. 13.9%) and are much more likely than men to experience severe forms of physical violence at the hands of an intimate partner (e.g., strangled, beaten, assaulted with a weapon; 24.3% vs. 13.8%) (Smith et al., 2018). These troubling numbers do not even include psychological IPV, which is difficult to measure with precision. Further, research on stigmatized topics like IPV often underestimate prevalence since individuals can decline to report or respond 'do not know' to survey items, which may reflect ambivalence to acknowledge or discuss IPV. Women experiencing the most severe IPV may not feel safe responding to research. Prevalence rates vary by age, race/ethnicity, and income levels. Although differences in clinical settings, study methods, definitions, and measurements make it difficult to compare prevalence across studies, available data demonstrate between 11% and 29% of women healthcare patients experience past-year IPV (Feltner et al., 2018), and close to half (44%) of healthcare patients experience IPV during their lifetime (Thompson et al., 2006).

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Psychological IPV. Public perception and discussion of IPV often focus on physical forms and impacts of violence (e.g., hits and black eyes). Yet, the majority of women who experience physical or sexual forms of IPV also experience psychological IPV that includes verbal aggression, threats, intimidation, coercion, and controlling behaviors (Follingstad et al., 1990; Thompson et al., 2006). Some women experience psychological IPV without physical or sexual violence, but the reverse is rare (Dichter et al., 2017; Thompson et al., 2006). Research has long-noted, and continues to substantiate, that psychological IPV can have particularly adverse impacts (Coker et al., 2002; Dichter et al., 2017). Women have frequently reported that psychological abuse, including social isolation, tactics to reduce women's self-esteem, and cruel manipulations (i.e., gaslighting; "I'm not lying, you are imagining things") is the worst part of their IPV experience (Follingstad et al., 1990). Thus, in addition to sexual and physical violence, it's critical to address and not minimize the effects of psychological IPV on women's lives.

Biopsychosocial Consequences and Correlates of IPV

More than three decades of research have established the significant biopsychosocial consequences of IPV. There is indisputable evidence that IPV can cause and exacerbate acute and long-term physical, mental health, and social problems (Miller & Mccaw, 2019). Physical health conditions associated with IPV include direct injuries and chronic pain, along with gynecological, reproductive, cardiovascular, gastrointestinal, musculoskeletal, and neurological problems, as well as adverse pregnancy-related outcomes (Ellsberg et al., 2008; Miller & McCaw, 2019). A rapidly growing body of evidence indicates traumatic brain injuries from head-blows and strangulation-induced anoxia from IPV is common among abused women and has strong implications for physical and psychosocial health (Haag et al., 2019). The psychological toll of IPV on women's health cannot be understated. IPV is strongly associated with PTSD, depression, anxiety, substance misuse, and mental health multi-morbidity in community and clinical populations (Bonomi et al., 2009a; Dichter et al., 2017; Golding, 1999; Iverson et al., 2013). IPV is also associated with increased risk of eating disorder pathology and suicide attempts as well as social health needs like housing instability and unemployment (Iverson et al., 2013; Huston et al., 2019; Pavao et al., 2007).

Screening and Education

Consistent with the multitude of health issues associated with IPV, women who experience IPV have increased healthcare utilization across a range of services, especially mental health care (Bonomi et al., 2009b). Thus healthcare encounters, regardless of purpose, present opportunities to identify, support, and connect patients with services related to IPV impacts. Although mental health clinicians are theoretically well-positioned to effectively address IPV with patients, they often avoid asking about it or ask in ways that aren't conducive to open disclosure (e.g., "You're not a victim of domestic violence, are you?") (Rhodes et al., 2007). It's critical that practitioners across disciplines know how to ask questions in ways that make it easier for patients to disclose this stigmatized experience. It's also critical for practitioners to avoid minimizing psychological IPV – the stereotypical "it's not like he's hitting her or anything like that" simply isn't consistent with research indicating that psychological IPV can be just as traumatic, and often more debilitating, than physical IPV. Clinicians should evaluate psychological IPV in addition to sexual and physical IPV, as each of these forms of violence contribute to health needs (Coker et al., 2002; Bonomi et al., 2009b; Dichter et al., 2017). Additionally, clinician knowledge of the different forms of IPV allows them to better understand their patients' experiences and tailor their interventions to their needs. Examples of screening questions for psychological IPV include "How often does your (ex)-partner keep you from seeing friends or family?," "How often has a past or current partner put you down or called you names," and "Are there times when you do not express your opinion because you are afraid your partner might punish you in some way?"

The US Preventive Services Task Force (USPSTF, 2018) recently updated their IPV screening recommendations, supported by a systematic review (Feltner et al., 2018). The USPSTF concludes that appropriate screening is effective in identifying IPV in women of reproductive age and that screening does not cause adverse effects. The USPSTF identified several brief and accurate tools for screening women for past-year IPV (e.g., Hurt, Insult, Threaten, Scream [HITS] and the Humiliation, Afraid, Rape, Kick [HARK]). The USPSTF recommends providing or referring women who screen positive for ongoing support services. Despite this evidence and support for screening among both patients and providers (Feder et al., 2006; Dichter et al., 2015), there is slow and incomplete integration of universal IPV screening programs into routine care (Alvarez et al., 2017). Nonetheless, there is evidence of the impact of recent and increased national media coverage on sexual abuse, harassment, and IPV against women, which further legitimizes, and in some cases, prioritizes IPV as a primary health issue for identification and intervention among women healthcare patients (Iverson et al., 2019).

But it's important to note that even the most effective screening methods won't capture every case. Even when asked directly by trained providers, women may choose not to disclose IPV for various reasons, including, but not limited to, distrust, lack of comfort with the provider, mandated reporting concerns, shame, privacy, and safety/retaliatory violence concerns (Dichter et al., 2015; Feder et al., 2006; Iverson et al., 2014; Rhodes et al., 2007). Thus, while screening increases identification of IPV, experts in the field call for universal education about the health impacts of IPV and available resources and services even in the absence of IPV disclosure (Miller & McCaw, 2019). When conducted sensitively, even women who screen negative or decline referrals may benefit from universal IPV education.

Referral, Documentation, and Follow-Up

Whether screening occurs routinely or through case finding (i.e., inquiry based on clinical presentation or suspicion), it is an ethical imperative that women who disclose IPV are offered follow-up discussions, resources, and referrals. A practitioner's non-response or minimization of disclosures could be harmful to patients by contributing to their self-blame or giving the impression that their experience is normative and acceptable. As stated by a woman who participated in focus groups on IPV screening and counseling preferences, *"You can't make the woman answer…but if she tells you and you don't follow up, then in the back of her mind, she's saying, "Well, I told them and they don't seem to care…I guess it's just like he says. I deserve it."* (Iverson et al., 2014).

Research offers several practical tips for responding to IPV disclosures and providing possible interventions (Miller & McCaw, 2019). Women with IPV experiences want sensitive acknowledgement and supportive statements, and they prefer open-ended follow-up questions to determine personal circumstances and service preferences (Feder et al., 2006). They want practitioners to respect their autonomy in what, when, why, and how much they disclose (Iverson et al., 2014), as well as information about relevant resources, appropriate referrals, and shared decision-making about what is documented in the electronic health records (Dichter et al., 2015; Feder et al., 2006; Iverson, et al., 2014). Documentation in the era of electronic medical records is tricky for patients and providers alike as there can be safety concerns regarding documentation of IPV if an unsafe partner were to access their medical records, as well as concerns about other providers viewing this sensitive health information (Dichter et al., 2015; Iverson et al., 2014). However, discussing issues around documentation and honoring women's preferences for documentation is a feasible trauma-informed practice (Iverson et al., 2019).

Since privacy concerns or partner interference with healthcare may limit women's ability to make and keep clinic appointments, providers should be aware of alternative resources that provide information and safety planning. For example, myPlan is a free and private interactive decision-support aid, available as a mobile app and secure website, which guides individuals experiencing IPV in clarifying their priorities, weighing risks and benefits, evaluating their safety risk, and making informed decisions about safety planning and resources (www.myplanapp.org). This tool has been shown to increase safety behaviors and reduce psychological and sexual IPV for some women (Glass et al., 2017). Providing women with information about this and other accessible tools could benefit not only those who disclose, but also those who aren't comfortable disclosing, or aren't even sure if they are experiencing IPV. Such tools may be particularly helpful to women whose abusive partners interfere with their ability to access health and social services through controlling and manipulative tactics (McCloskey et al., 2007).

Appropriate referrals for IPV should be tailored for women's specific circumstances, so practitioners should have consolidated lists of potentially relevant resources and referrals. Interventions to support healing, empowerment, and safety among women experiencing IPV can include advocacy, legal support, emergency shelter and transitional housing, social services, and counseling. Research indicates that multifaceted programs rooted in institutional support can improve IPV screening practices and increase disclosure rates (O'Campo et al., 2011). Successful healthcare-based IPV assistance programs address practitioner competency and self-efficacy by including ongoing training, multi-level leadership support, evidence-based tools embedded within the electronic health records to facilitate trauma-informed IPV screening, structured assessment and response practices, immediate access to IPV experts and/or co-located social work and mental health services well-equipped to provide follow-up care such as safety planning, advocacy, and mental health services (Iverson et al., 2019; Miller et al., 2015).

Evidence-based Psychotherapies. Currently there is no gold-standard psychotherapy or 'one-size-fits all' intervention for women dealing with IPV, because women are heterogeneous in their priorities, circumstances, and mental health needs. While IPV is not itself a mental health condition, there are several promising evidence-based psychotherapies for women who experience IPV-related distress (Arroyo et al., 2017).

PTSD is one of the most common consequences of IPV and can persist years after abuse has ended. PTSD treatment related to past IPV can be accomplished with front-line trauma-focused PTSD psychotherapies, such as Cognitive Processing Therapy, Prolonged Exposure, and Eye Movement Desensitization and Reprocessing (ISTSS, 2019). Among female interpersonal trauma survivors, including those who have experienced past IPV, such treatments appear to have the added benefit of reducing risk for future IPV (Iverson et al., 2011). Each of these front-line psychotherapies for PTSD have been validated in randomized controlled trials that have included women IPV survivors within their samples. However, there is a critical lack of research to understand how well these treatments work in the context of current and severe abusive relationships. It is especially important to understand the effectiveness and implementation of these trauma-focused psychotherapies for treating IPV-related PTSD when the woman is in an ongoing relationship with the abusive partner who caused the PTSD. To date, two psychotherapies have been developed specifically for IPV-related PTSD and rigorously evaluated in randomized clinical trials, and are described next.

Kubany and colleagues developed Cognitive Trauma Therapy for Battered Women (CTT-BW) for women with PTSD secondary to IPV who are no longer in abusive relationships. CTT-BW is delivered in 8-12 individual therapy sessions focusing on psychoeducation about PTSD, exposure and cognitive therapy techniques, and four modules specific to IPV (trauma-related guilt; other trauma histories; managing ongoing contact with abusive ex-partners; and risk for revictimization). A randomized controlled trial of CTT-BW with 125 ethnically-diverse women who had been out of IPV relationships for an average of 5 years found that the majority of treatment completers (87%) experienced significant reductions of PTSD symptoms (to nondiagnostic levels) and depressive symptoms (Kubany et al., 2004). These improvements were maintained at 3- and 6-month follow-up, and CTT-BW worked equally well when delivered by clinically vs. non-clinically trained interventionists. This finding has implications for enhancing the reach of CTT-BW in non-clinical settings such as community IPV programs, social service agencies, and shelters. Although CTT-BW is a promising intervention for women dealing with PTSD from *past* IPV, this treatment has not been evaluated with women still involved in abusive relationships or who are separated but considering reconciliation. Future investigations should assess whether adaptations are required for effective delivery of CTT-BW with a broader population of IPV survivors.

Johnson and colleagues developed Helping Overcome PTSD through Empowerment (HOPE) with women residing in IPV shelters (Johnson et al., 2011; Johnson et al., 2016). HOPE is an empowerment-based cognitive-behavioral therapy targeting PTSD symptoms and concurrent clinical needs of women residing in shelters. HOPE is delivered in up to 12 individual sessions that include psychoeducation, cognitive restructuring, empowerment strategies including prioritization of individual goals, assertiveness with safety planning, self-care skills, and accessing resources. In an

RCT of HOPE with 70 women assigned to HOPE plus standard shelter services versus standard shelter services alone, HOPE was associated with significant improvements in depressive symptoms, empowerment, social support, and lower likelihood of IPV 6 months after leaving shelter (Johnson et al., 2011). However, HOPE did not produce greater reductions in PTSD symptoms than the control group except that women who received HOPE reported less emotional numbing symptoms. At post-treatment, nearly half (46%) continued to meet full or partial criteria for PTSD. Given these modest outcomes, the treatment developers expanded HOPE to a 16-session intervention that continued in the 3-months after leaving the shelter (Johnson et al., 2016). Expanded HOPE sessions included re-evaluation of goals and safety after leaving shelter, ongoing case management, expanded modules on substance relapse and emotional numbing, and two booster sessions. In a sample of 60 women, expanded HOPE had significant effects for PTSD as well as depression symptoms, empowerment, employment, and resource gain. Additionally, results showed the acceptability and feasibility of adding IPV-related treatment to standard shelter services. This intervention holds promise for use in other settings where women who experience IPV are commonly seen, such as community-based IPV programs. Future research should evaluate both the effectiveness and implementation of HOPE in other settings.

Summary and Future Directions

Patients are entering a range of health care settings with IPV experiences. Thus, practitioners across disciplines need to be knowledgeable about the impact of IPV in order to ask the right questions at the right time, thoughtfully refer to evidence-based services, and follow-up appropriately. Appropriate screening should occur at least in preventive care, primary care, mental health, and emergency settings. Research indicates what women want in terms of provider response to IPV disclosure: listening without judgment, validation, providing options without pressure, and tailored referrals.

Psychosocial and mental health interventions can play an important role in helping women recover from the psychological wounds of IPV. Although there is no universal approach to address IPV, two cognitive-behavioral psychotherapies have demonstrated efficacy specifically for women with IPV-related PTSD. Future research should evaluate the dissemination and implementation of CTT-BW and HOPE in routine care settings. Additional IPV-specific psychosocial interventions are currently being developed and evaluated (Arroyo et al., 2017), but we must accelerate the protracted timeline between intervention testing and implementation into routine care. There is also a need for systematic research to identify how to best apply front-line trauma-focused treatments for PTSD in the context of ongoing IPV, especially in situations of IPV-related PTSD.

Although there is significant knowledge about the health and social consequences of IPV, and a number of promising practices for IPV screening and intervention, the translation of IPV research into routine practice remains significantly under-developed. In particular, there's a need to better understand *how* to increase integration of evidence-based screening and intervention practices into routine care. There is also a need for researcher-practitioner collaborations and more stakeholder engagement (including the voices of women who experience IPV) during the development, evaluation, and scale-up of IPV programs.

FEATURED ARTICLES

Arroyo, K., Lundahl, B., Butters, R., Vanderloo, M., & Wood, D. S. (2017). **Short-term interventions for survivors of intimate partner violence: A systematic review and meta-analysis.** *Trauma, Violence, & Abuse, 18,* 155–171. doi:10.1177/1524838015602736
Intimate partner violence (IPV) impacts millions of adults and children every year and can result in homicide, legal proceedings, the involvement of child welfare, and the need for emergency shelter for survivors and their families. Survivors of IPV may develop psychological and somatic symptoms to the trauma, including anxiety, depression, and other mental health related disorders in addition to facing numerous safety, financial, and social challenges. To reestablish stability, effective short-term interventions are needed in order to address these issues survivors face. This systematic review and meta-analysis summarizes the extant literature on short-term interventions for survivors of IPV. Twenty-one studies are included in the analysis and overall effect sizes calculations and moderator analysis were conducted. On average, effects sizes were large (g = 1.02) suggesting that most sort-term interventions are effective, however CBT-based interventions that were tailored to IPV survivors achieved the largest effect sizes. Results of this study are presented in a question and answer format with the intent to guide practitioners, researchers and policy makers. IPV survivors access services in a variety of shelter and outpatient settings and present diverse needs. Although this study contributes a systematic review of the existing literature on IPV, there are relatively few rigorous outcome studies and even fewer that reflect the diversity in this population and the complexity of responding to IPV in real-world settings.

Bonomi, A. E., Anderson, M. L., Reid R. J., Rivara, F. P., Carrell, D., & Thompson, R. S. (2009a). **Medical and psychosocial diagnoses in women with a history of intimate partner violence.** *Archives of Internal Medicine, 169,* 1692–1697. doi:10.1001/archinternmed.2009.292 *Background:* We characterized the relative risk of a wide range of diagnoses in women with a history of intimate partner violence (IPV) compared with never-abused women. *Methods:* The sample comprised 3568 English-speaking women who were randomly sampled from a large US health plan and who agreed to participate in a telephone survey to assess past-year IPV history using questions from the Behavioral Risk Factor Surveillance System (physical, sexual, and psychological abuse) and the Women's Experience with Battering Scale. Medical and psychosocial diagnoses in the past year were determined using automated data from health plan records. We estimated the relative risk of receiving diagnoses for women with a past-year IPV history compared with women with no IPV history. *Results:* In age-adjusted models, compared with never-abused women, abused women had consistently significantly increased relative risks of these disorders: psychosocial/mental (substance use, 5.89; family and social problems, 4.96; depression, 3.26; anxiety/neuroses, 2.73; tobacco use, 2.31); musculoskeletal (degenerative joint disease, 1.71; low back pain, 1.61; trauma-related joint disorders, 1.59; cervical pain, 1.54; acute sprains and strains, 1.35); and female reproductive (menstrual disorders, 1.84; vaginitis/vulvitis/cervicitis, 1.56). Abused women had a more than 3-fold increased risk of being diagnosed with a sexually transmitted disease (3.15) and a 2-fold increased risk

of lacerations (2.17) as well as increased risk of acute respiratory tract infection (1.33), gastroesophageal reflux disease (1.76), chest pain (1.53), abdominal pain (1.48), urinary tract infections (1.79), headaches (1.57), and contusions/abrasions (1.72). *Conclusion:* Past-year IPV history was strongly associated with a variety of medical and psychosocial conditions observed in clinical settings.

Bonomi, A. E., Anderson, M. L., Rivara, F. P., & Thompson, R. S. (2009b). **Health care utilization and costs associated with physical and nonphysical-only intimate partner violence.** *Health Services Research, 44,* 1052–1067. doi:10.1111/j.1475-6773.2009.00955.x *Objective:* To estimate health care utilization and costs associated with the type of intimate partner violence (IPV) women experience by the timing of their abuse. *Methods:* A total of 3,333 women (ages 18–64) were randomly sampled from the membership files of a large health plan located in a metropolitan area and participated in a telephone survey to assess IPV history, including the type of IPV (physical IPV or nonphysical abuse only) and the timing of the abuse (ongoing; recent, not ongoing but occurring in the past 5 years; remote, ending at least 5 years prior). Automated annual health care utilization and costs were assembled over 7.4 years for women with physical IPV and nonphysical abuse only by the time period during which their abuse occurred (ongoing, recent, remote), and compared with those of never-abused women (reference group). *Results:* Mental health utilization was significantly higher for women with physical or nonphysical abuse only compared with never-abused women—with the highest use among women with ongoing abuse (relative risk for those with ongoing abuse: physical, 2.61; nonphysical, 2.18). Physically abused women also used more emergency department, hospital outpatient, primary care, pharmacy, and specialty services; for emergency department, pharmacy, and specialty care, utilization was the highest for women with ongoing abuse. Total annual health care costs were higher for physically abused women, with the highest costs for ongoing abuse (42 percent higher compared with nonabused women), followed by recent (24 percent higher) and remote abuse (19 percent higher). Women with recent nonphysical abuse only had annual costs that were 33 percent higher than nonabused women. *Conclusion:* Physical and nonphysical abuse contributed to higher health care utilization, particularly mental health services utilization.

Coker, A. L., Davis, K. E., Arias, I., Desai, S., Sanderson, M., Brandt, H. M., & Smith, P. H. (2002). **Physical and mental health effects of intimate partner violence for men and women.** *American Journal of Preventive Medicine, 23,* 260–268. doi:10.1016/S0749-3797(02)00514-7 *Background:* Few population-based studies have assessed the physical and mental health consequences of both psychological and physical intimate partner violence (IPV) among women or men victims. This study estimated IPV prevalence by type (physical, sexual, and psychological) and associated physical and mental health consequences among women and men. *Methods:* The study analyzed data from the National Violence Against Women Survey (NVAWS) of women and men aged 18 to 65. This random-digit-dial telephone survey included questions about violent victimization and health status indicators. *Results:* A total of 28.9% of 6790 women and 22.9% of 7122 men had experienced physical, sexual, or psychological IPV during their lifetime. Women were significantly more likely than men to experience physical or sexual IPV (relative risk [RR]=2.2, 95% confidence interval [CI]=2.1, 2.4) and abuse of power and control (RR=1.1, 95% CI=1.0, 1.2), but less likely than men to report verbal abuse alone (RR=0.8, 95% CI=0.7, 0.9). For both men and women, physical IPV victimization was associated with increased risk of current poor health; depressive symptoms; substance use; and developing a chronic disease, chronic mental illness, and injury. In general, abuse of power and control was more strongly associated with these health outcomes than was verbal abuse. When physical and psychological IPV scores were both included in logistic regression models, higher psychological IPV scores were more strongly associated with these health outcomes than were physical IPV scores. *Conclusions:* Both physical and psychological IPV are associated with significant physical and mental health consequences for both male and female victims.

Ellsberg, M., Jasen, H. A. F. M., Heise, L., Watts, C. H., & Garcia-Moreno, C. (2008). **Intimate partner violence and women's physical and mental health in the WHO multi country study on women's health and domestic violence: An observational study** *The Lancet, 371,* 1165–1172. doi:10.1016/S0140-6736(08)60522-X *Background:* This article summarises findings from ten countries from the WHO multi-country study on women's health and domestic violence against women. *Methods:* Standardised population-based surveys were done between 2000 and 2003. Women aged 15–49 years were interviewed about their experiences of physically and sexually violent acts by a current or former intimate male partner, and about selected symptoms associated with physical and mental health. The women reporting physical violence by a partner were asked about injuries that resulted from this type of violence. *Findings:* 24 097 women completed interviews. Pooled analysis of all sites found significant associations between lifetime experiences of partner violence and self-reported poor health (odds ratio 1·6 [95% CI 1·5–1·8]), and with specific health problems in the previous 4 weeks: difficulty walking (1·6 [1·5–1·8]), difficulty with daily activities (1·6 [1·5–1·8]), pain (1·6 [1·5–1·7]), memory loss (1·8 [1·6–2·0]), dizziness (1·7 [1·6–1·8]), and vaginal discharge (1·8 [1·7–2·0]). For all settings combined, women who reported partner violence at least once in their life reported significantly more emotional distress, suicidal thoughts (2·9 [2·7–3·2]), and suicidal attempts (3·8 [3·3–4·5]), than non-abused women. These significant associations were maintained in almost all of the sites. Between 19% and 55% of women who had ever been physically abused by their partner were ever injured. *Interpretation:* In addition to being a breach of human rights, intimate partner violence is associated with serious public-health consequences that should be addressed in national and global health policies and programmes.

Feder, G. S., Hutson, M., Ramsay, J., Taket, A. R. (2006). **Women exposed to intimate partner violence. Expectations and experiences when they encounter health care professionals: A meta-analysis of qualitative studies.** *Annals of Internal Medicine, 166,* 22–37. doi:10.1001/archinte.166.1.22 *Background:* The appropriate response of health care professionals to intimate partner violence is still a matter of debate. This article reports a meta-analysis of qualitative studies that answers 2 questions: (1) How do women with histories of intimate partner violence perceive the responses of health care professionals? and (2) How do women with histories of intimate partner violence want their health

care providers to respond to disclosures of abuse? *Methods:* Multiple databases were searched from their start to July 1, 2004. Searches were complemented with citation tracking and contact with researchers. Inclusion criteria included a qualitative design, women 15 years or older with experience of intimate partner violence, and English language. Two reviewers independently applied criteria and extracted data. Findings from the primary studies were combined using a qualitative meta-analysis. *Results:* Twenty-nine articles reporting 25 studies (847 participants) were included. The emerging constructs were largely consistent across studies and did not vary by study quality. We ordered constructs by the temporal structure of consultations with health care professionals: before the abuse is discussed, at disclosure, and the immediate and further responses of the health care professional. Key constructs included a wish from women for responses from health care professionals that were nonjudgmental, nondirective, and individually tailored, with an appreciation of the complexity of partner violence. Repeated inquiry about partner violence was seen as appropriate by women who were at later stages of an abusive relationship. *Conclusion:* Women's perceptions of appropriate and inappropriate responses partly depended on the context of the consultation, their own readiness to address the issue, and the nature of the relationship between the woman and the health care professional.

Feltner, C., Wallace, I., Berkman, N., Kistler, C. E., Middleton, J. C., Barclay, C., . . . Jonas, D. E. (2018). **Screening for intimate partner violence, elder abuse, and abuse of vulnerable adults: Evidence report and systematic review for the US Preventive Services Task Force.** *JAMA, 320,* 1645–1647. doi:10.1001/jama.2018.13212 *Importance:* Intimate partner violence (IPV), elder abuse, and abuse of vulnerable adults are common and result in adverse health outcomes. *Objective:* To review the evidence on screening and interventions for IPV, elder abuse, and abuse of vulnerable adults to inform the US Preventive Services Task Force. *Data Sources:* MEDLINE, Cochrane Library, EMBASE, and trial registries through October 4, 2017; references; experts; literature surveillance through August 1, 2018. *Study Selection:* English-language randomized clinical trials (RCTs), studies evaluating test accuracy, and cohort studies with a concurrent control group assessing harms. *Data Extraction and Synthesis:* Dual review of titles and abstracts, full-text articles, and study quality; qualitative synthesis of findings. Data were not pooled, primarily because of heterogeneity of populations, interventions, and outcomes. *Main Outcomes and Measures:* Abuse or neglect, morbidity caused by abuse, test accuracy, and harms. *Results:* Thirty studies were included ($N = 14\,959$). Three RCTs ($n = 3759$) compared IPV screening with no screening; none found significant improvements in outcomes (eg, IPV or quality of life) over 3 to 18 months and 2 ($n = 935$) reported no harms of screening. Nine studies assessed tools to detect any past-year or current IPV in women; for past-year IPV (5 studies [$n = 6331$]), sensitivity of 5 tools ranged from 65% to 87% and specificity ranged from 80% to 95%. The accuracy of 5 tools (4 studies [$n = 1795$]) for detecting current abuse varied widely; sensitivity ranged from 46% to 94% and specificity ranged from 38% to 95%. Eleven RCTs ($n = 6740$) evaluated interventions for women with screen-detected IPV. Two enrolling pregnant women ($n = 575$) found significantly less IPV among women in the intervention group: 1 home visiting intervention (standardized mean difference [SMD], −0.34 [95% CI, −0.59 to −0.08]) and 1 behavioral counseling intervention for multiple risks (IPV, smoking, depression, tobacco exposure) (SMD, −0.40 [95% CI, −0.68 to −0.12]). No studies evaluated screening or interventions for elder abuse or abuse of vulnerable adults. One study assessing a screening tool for elder abuse had poor accuracy (sensitivity, 46% and specificity, 73% for detecting physical or verbal abuse). *Conclusions and Relevance:* Although available screening tools may reasonably identify women experiencing IPV, trials of IPV screening in adult women did not show a reduction in IPV or improvement in quality of life over 3 to 18 months. Limited evidence suggested that home visiting and behavioral counseling interventions that address multiple risk factors may lead to reduced IPV among pregnant or postpartum women. No studies assessed screening or treatment for elder abuse and abuse of vulnerable adults.

Follingstad, D. R., Rutledge, L. L., Berg. B. J., Hause, E. S., & Polek, D. S. (1990). **The role of emotional abuse in physically abusive relationships.** *Journal of Family Violence, 5,* 107–120. doi:10.1007/BF00978514 Two hundred thirty four women were interviewed to assess the relationship of emotional abuse to physical abuse. Six major types of emotional abuse were identified. Analyses determined if the types of emotional abuse were related to the frequency and severity of physical abuse. Women in long-term abusive relationships were contrasted with women experiencing only short-term abuse. Other comparisons consisted of: women who thought emotional abuse was worse than physical abuse vs. women who thought the opposite; and women who could predict physical abuse from the emotional abuse were compared with those who could not. The extent to which the women believed the men's threats and ridicule or thought their abusive behavior was justified was used as a factor to determine the impact of emotional abuse. Future research should investigate emotional abuse patterns in nonbattering relationships for comparison with battered women's experiences.

Glass, N. E., Perrin, N. A., Hanson, G. C., Bloom, T. L., Messing, J. T., Clough, A. S., . . . Eden, K. B. (2017). **The longitudinal impact of an internet safety decision aid for abused women.** *American Journal of Public Health, 52,* 606–615. doi:10.1016/j.amepre.2016.12.014 *Introduction:* Women experiencing intimate partner violence (IPV) navigate complex, dangerous decisions. Tailored safety information and safety planning, typically provided by domestic violence service providers, can prevent repeat IPV exposure and associated adverse health outcomes; however, few abused women access these services. The Internet represents a potentially innovative way to connect abused women with tailored safety planning resources and information. The purpose of this study was to compare safety and mental health outcomes at baseline, 6 months, and 12 months among abused women randomized to: (1) a tailored, Internet-based safety decision aid; or (2) control website (typical safety information available online). *Design:* Multistate, community-based longitudinal RCT with one-to-one allocation ratio and blocked randomization. Data were collected March 2011–May 2013 and analyzed June–July 2015. *Setting/participants:* Currently abused Spanish- or English-speaking women ($N = 720$). *Intervention:* A tailored Internet-based safety decision aid included priority-setting activities, risk assessment, and tailored feedback and safety plans. A control website offered typical safety information available online. *Main outcome measures:* Primary outcomes were decisional conflict,

safety behaviors, and repeat IPV; secondary outcomes included depression and post-traumatic stress disorder. *Results:* At 12 months, there were no significant group differences in IPV, depression, or post-traumatic stress disorder. Intervention women experienced significantly less decisional conflict after one use (β= –2.68, p=0.042) and greater increase in safety behaviors they rated as helpful from baseline to 12 months (12% vs 9%, p=0.033) and were more likely to have left the abuser (63% vs 53%, p=0.008). Women who left had higher baseline risk (14.9 vs 13.1, p=0.003) found more of the safety behaviors they tried helpful (61.1% vs 47.5%, p<0.001), and had greater reductions in psychological IPV ((11.69 vs 7.5, p=0.001) and sexual IPV (2.41 vs 1.25, p=0.001) than women who stayed. *Conclusions:* Internet-based safety planning represents a promising tool to reduce the public health impact of IPV.

Haag, H. L., Jones, D., Joseph, T., & Colantonio, A. (2019). **Battered and brain injured: Traumatic brain injury among women survivors of intimate partner violence—A scoping review.** *Trauma, Violence, & Abuse.* Advance online publication. doi:10.1177/1524838019850623 *Objectives:* The objective of this scoping review is to examine the extent, range, and nature of literature targeting health-care professionals on the prevalence and outcome of intimate partner violence (IPV)-related traumatic brain injury (TBI). The purpose is to gain an understanding of prevalence, investigate screening tool use, generate IPV/TBI-specific support recommendations, and identify suggestions for future research. *Method:* The review was guided by Arksey and O'Malley's five stages for conducting a scoping review. A comprehensive search of nine databases revealed 1,739 articles. In total, 42 published research papers that focused specifically on TBI secondary to IPV were included in the study. *Synthesis:* The literature reports inconsistencies in prevalence rates from IPV-related TBI. There are no current standardized screening practices in use, though the literature calls for a specialized tool. Frontline professionals would benefit from education on signs and symptoms of IPV-related TBI. Empirical studies are needed to generate reliable data on prevalence, experience, and needs of brain-injured survivors of TBI. *Conclusions:* Findings from this study demonstrate the need for the development of an IPV-sensitive screening tool, more accurate data on prevalence, an interprofessional approach to care, and raised awareness and education on the diffuse symptoms of IPV-related TBI.

Howard, L. M., Trevillion, K., Khalifeh, H., Woodall, A., Agnew-Davies, R., & Feder, G. (2010). **Domestic violence and severe psychiatric disorders: Prevalence and interventions.** *Psychological Medicine, 40,* 881–893. doi:10.1017/S0033291709991589 *Background:* The lifetime prevalence of domestic violence in women is 20–25%. There is increasing recognition of the increased vulnerability of psychiatric populations to domestic violence. We therefore aimed to review studies on the prevalence of, and the evidence for the effectiveness of interventions in, psychiatric patients experiencing domestic violence. *Method:* Literature search using Medline, PsycINFO and EMBASE applying the following inclusion criteria: English-language papers, data provided on the prevalence of or interventions for domestic violence, adults in contact with mental health services. *Results:* Reported lifetime prevalence of severe domestic violence among psychiatric in-patients ranged from 30% to 60%. Lower rates are reported for men when prevalence is reported by gender. No controlled studies were identified. Low rates of detection of domestic violence occur in routine clinical practice and there is some evidence that, when routine enquiry is introduced into services, detection rates improve, but identification of domestic violence is rarely used in treatment planning. There is a lack of evidence on the effectiveness of routine enquiry in terms of morbidity and mortality, and there have been no studies investigating specific domestic violence interventions for psychiatric patients. *Conclusions:* There is a high prevalence of domestic violence in psychiatric populations but the extent of the increased risk in psychiatric patients compared with other populations is not clear because of the limitations of the methodology used in the studies identified. There is also very limited evidence on how to address domestic violence with respect to the identification and provision of evidence-based interventions in mental health services.

Iverson, K. M., Adjognon, O., Grillo, A. R., Dichter, M. E., Gutner, C. A., Hamilton, A. B., . . . Gerber, M. R. (2019) **Intimate partner violence screening programs in the Veterans Health Administration: Informing scale-up of successful practices.** *Journal of General Internal Medicine. 34,* 2435–2442. doi:10.1007/s11606-019-05240-y *Objectives:* Screening women for intimate partner violence (IPV) is increasingly expected in primary care, consistent with clinical prevention guidelines (e.g., United States Preventive Services Task Force). Yet, little is known about real-world implementation of clinical practices or contextual factors impacting IPV screening program success. This study identified successful clinical practices, and barriers to and facilitators of IPV screening program implementation in the Veterans Health Administration (VHA). *Design:* Descriptive, qualitative study of a purposeful sample of 11 Veterans Affairs Medical Centers (VAMCs) categorized as early and late adopters of IPV screening programs within women's health primary care clinics. VAMCs were categorized based on performance measures collected by VHA operations partners. *Participants:* Thirty-two administrators and clinician key informants (e.g., Women's Health Medical Directors, IPV Coordinators, and physicians) involved in IPV screening program implementation decisions from six early- and five late-adopting sites nationwide. *Main Measures:* Participants reported on IPV screening and response practices, and contextual factors impacting implementation, in individual 1-h semi-structured phone interviews. Transcripts were analyzed using rapid content analysis with key practices and issues synthesized in profile summaries. Themes were identified and iteratively revised, utilizing matrices to compare content across early- and late-adopting sites. *Key Results:* Five successful clinical practices were identified (use of two specific screening tools for primary IPV screening and secondary risk assessment, multilevel resource provision and community partnerships, co-location of mental health/social work, and patient-centered documentation). Multilevel barriers (time/resource constraints, competing priorities and mounting responsibilities in primary care, lack of policy, inadequate training, and discomfort addressing IPV) and facilitators (engaged IPV champions, internal and external supports, positive feedback regarding IPV screening practices, and current, national attention to violence against women) were identified. *Conclusions:* Findings advance national

efforts by highlighting successful clinical practices for IPV screening programs and informing strategies useful for enhancing their implementation within and beyond the VHA, ultimately improving services and women's health.

Iverson, K. M., Gradus, J. L., Resick, P. A., Suvak, M. K., Smith, K. F., & Monson, C. M. (2011). **Cognitive-behavioral therapy for PTSD and depression symptoms reduces risk for future intimate partner violence among interpersonal trauma survivors.** *Journal of Consulting and Clinical Psychology, 79,* 193–202. doi:10.1037/a0022512 *Objective:* Women who develop symptoms of posttraumatic stress disorder (PTSD) and depression subsequent to interpersonal trauma are at heightened risk for future intimate partner violence (IPV) victimization. Cognitive–behavioral therapy (CBT) is effective in reducing PTSD and depression symptoms, yet limited research has investigated the effectiveness of CBT in reducing risk for future IPV among interpersonal trauma survivors. *Method:* This study examined the effect of CBT for PTSD and depressive symptoms on the risk of future IPV victimization in a sample of women survivors of interpersonal violence. The current sample included 150 women diagnosed with PTSD secondary to an array of interpersonal traumatic events; they were participating in a randomized clinical trial of different forms of cognitive processing therapy for the treatment of PTSD. Participants were assessed at 9 time points as part of the larger trial: pretreatment, 6 times during treatment, posttreatment, and 6-month follow-up. *Results:* As hypothesized, reductions in PTSD and in depressive symptoms during treatment were associated with a decreased likelihood of IPV victimization at a 6-month follow-up even after controlling for recent IPV (i.e., IPV from a current partner within the year prior to beginning the study) and prior interpersonal traumas. *Conclusions:* These findings highlight the importance of identifying and treating PTSD and depressive symptoms among interpersonal trauma survivors as a method for reducing risk for future IPV.

Johnson, D. M., Zlotnick, C., & Perez, S. (2011). **Cognitive behavioral treatment of PTSD in residents of battered women's shelters: Results of a randomized clinical trial.** *Journal of Consulting and Clinical Psychology, 79,* 542–551. doi:10.1037/a0023822 *Objective:* This study was designed to explore the acceptability, feasibility, and initial efficacy of a new shelter-based treatment for victims of intimate partner violence (IPV; i.e., Helping to Overcome PTSD through Empowerment [HOPE]). *Method:* A Phase I randomized clinical trial comparing HOPE (n = 35) with standard shelter services (SSS) (n = 35) was conducted. Primary outcome measures included the Clinician-Administered PTSD Scale (CAPS; D. D. Blake et al., 1995) and the Conflict Tactic Scales-Revised (M. A. Straus, S. L. Hamby, S. Boney-McCoy, & D. B. Sugarman, 1996). Participants were followed at 1-week, 3- and 6-months postshelter. *Results:* Participants reported HOPE to be credible and indicated a high degree of satisfaction with treatment. Only 2 women withdrew from treatment. Both intent to treat (ITT) and minimal attendance (MA) analyses found that HOPE treatment relative to SSS was significantly associated with a lower likelihood of reabuse over the 6-month follow-up period (OR = 5.1, RR = 1.75; OR = 12.6, RR = 3.12, respectively). Results of hierarchical linear model analyses found a significant treatment effect for emotional numbing symptom severity in the ITT sample, $t(67) = -2.046$, $p < .05$, and significant treatment effects for effortful avoidance symptom severity, $t(49) = -2.506$, $p < .05$, and arousal symptom severity, $t(49) = -2.04$, $p < .05$, in the MA sample. Significant effects were also found for depression severity, empowerment, and social support. *Conclusions:* Results support the acceptability and feasibility of HOPE and suggest that HOPE may be a promising treatment for IPV victims in shelter. However, results also suggest that modifications to HOPE may be required to improve treatment outcomes.

Johnson, D. M., Johnson, N. L., Perez, S. K., Palmieri, P. A., & Zlotnick, C. (2016). **Comparison of adding treatment of PTSD during and after shelter stay to standard care in residents of battered women's shelters: Results of a randomized clinical trial.** *Journal of Traumatic Stress, 29,* 365–373. doi:10.1002/jts.22117 This study explored the acceptability, feasibility, and initial efficacy of an expanded version of a PTSD treatment developed for residents of battered women's shelters, Helping to Overcome PTSD through Empowerment (HOPE) in women who received standard shelter services (SSSs). A Phase I randomized clinical trial comparing HOPE + SSSs (n = 30) to SSSs (n = 30) was conducted. Primary outcome measures included the Clinician-Administered PTSD Scale (Blake et al., 1995) and the Revised Conflict Tactic Scales (Straus, Hamby, Boney-McCoy, & Sugarman, 1996). Participants were followed at 1-week, and 3- and 6-months posttreatment. Only 2 women dropped out of HOPE + SSS treatment. Latent growth curve analyses found significant treatment effects for PTSD from intimate partner violence (IPV) ($\beta = -.007$, $p = .021$), but not for future IPV ($\beta = .002$, $p = .709$) across follow-up points. Significant effects were also found for secondary outcomes of depression severity ($\beta = -.006$, $p = .052$), empowerment ($\beta = .155$, $p = .022$), and resource gain ($\beta = .158$, $p = .036$). Additionally, more women in HOPE + SSSs were employed at 3- and 6-month follow-up compared to those in SSSs only. Results showed the acceptability and feasibility of adding IPV-related treatment to standard services. They also suggested that HOPE may be a promising treatment for residents of battered women's shelters. Further research with a larger sample, utilizing more diverse shelter settings and a more rigorous control condition, is needed to confirm these findings.

Kubany, E. S., Hill, E. E., Owens, J. A., Iannce-Spencer, C., McCaig, M. A., Tremayne, K. J., & Williams, P. L. (2004). **Cognitive trauma therapy for battered women with PTSD (CTT-BW).** *Journal of Consulting and Clinical Psychology, 72,* 3–18. doi:10.1037/0022-006X.72.1.3 This article describes a second treatment-outcome study of cognitive trauma therapy for battered women with posttraumatic stress disorder (PTSD; CTT-BW). CTT-BW includes trauma history exploration: PTSD education; stress management; exposure to abuse and abuser reminders; self-monitoring of negative self-talk; cognitive therapy for guilt; and modules on self-advocacy, assertiveness, and how to identify perpetrators. One hundred twenty-five ethnically diverse women were randomly assigned to immediate or delayed CTT-BW. PTSD remitted in 87% of women who completed CTT-BW, with large reductions in depression and guilt and substantial increases in self-esteem. White and ethnic minority women benefited equally from CTT-BW. Similar treatment outcomes were obtained by male and female therapists and by

therapists with different levels of education and training. Gains were maintained at 3- and 6-month follow-ups.

Miller, E., & McCaw, B. (2019) **Intimate partner violence.** *The New England Journal of Medicine, 380,* 850–857. doi:10.1056/NEJMra1807166 Intimate partner violence is common, costly, and associated with increased morbidity and mortality. Research over a period of several decades has revealed the short- and long-term effects of violence on the physical and mental health and social well-being of affected persons and their children. The health care system plays a central role in education about and prevention of intimate partner violence, as well as in identification of affected persons, intervention, and recovery. The system also has contributed to the crafting of social and legislative policies related to intimate partner violence. Such violence is more prevalent during a woman's lifetime than conditions such as diabetes, depression, or breast cancer, yet it often remains unrecognized by health professionals. This review focuses on women as the victims of partner violence because the prevalence of serious consequences of violence is higher among women than among men, serious injury is more likely for women, and research has shown both the health consequences of violence by a partner and the value of interventions, particularly among women of reproductive age.

O'Campo, P., Kirst, M., Tsamis, C., Chambers, C., & Ahmad, F. (2011). **Implementing successful intimate partner violence screening programs in health care settings: Evidence generated from a realist-informed systematic review.** *Social Science & Medicine, 72,* 855–866. doi:10.1016/j.socscimed.2010.12.019 We undertook a synthesis of existing studies to re-evaluate the evidence on program mechanisms of intimate partner violence (IPV) universal screening and disclosure within a health care context by addressing how, for whom, and in what circumstances these programs work. Our review is informed by a realist review approach, which focuses on program mechanisms. Systematic, realist reviews can help reveal why and how interventions work and can yield information to inform policies and programs. A review of the scholarly literature from January 1990 to July 2010 identified 5046 articles, 23 of which were included in our study. We identified studies on 17 programs that evaluated IPV screening. We found that programs that took a comprehensive approach (i.e., incorporated multiple program components, including institutional support) were successful in increasing IPV screening and disclosure/identification rates. Four program components appeared to increase provider self-efficacy for screening, including institutional support, effective screening protocols, thorough initial and ongoing training, and immediate access/referrals to onsite and/or offsite support services. These findings support a multi-component comprehensive IPV screening program approach that seeks to build provider self-efficacy for screening. Further implications for IPV screening intervention planning and implementation in health care settings are discussed.

Rhodes, K. V., Frankel, R. M., Levinthal, N., Prenoveau, E., Bailey, J., & Levinson, W. (2007). **"You're not a victim of domestic violence, are you?" Provider–patient communication about domestic violence.** *Annals of Medicine, 147,* 620–627. doi:10.7326/0003-4819-147-9-200711060-00006 *Background:* Women who are victims of domestic violence frequently seek care in an emergency department. However, it is challenging to hold sensitive conversations in this environment. *Objective:* To describe communication about domestic violence between emergency providers and female patients. *Design:* Analysis of audiotapes made during a randomized, controlled trial of computerized screening for domestic violence. *Setting:* 2 socioeconomically diverse emergency departments: one urban and academic, the other suburban and community-based. *Participants:* 1281 English-speaking women age 16 to 69 years and 80 providers (30 attending physicians, 46 residents, and 4 nurse practitioners). *Results:* 871 audiotapes, including 293 that included provider screening for domestic violence, were analyzed. Providers typically asked about domestic violence in a perfunctory manner during the social history. Provider communication behaviors associated with women disclosing abuse included probing (defined as asking ≥1 additional topically related question), providing open-ended opportunities to talk, and being generally responsive to patient clues (any mention of a psychosocial issue). Chart documentation of domestic violence was present in one third of cases. *Limitations:* Nonverbal communication was not examined. Providers were aware that they were being audiotaped and may have tried to perform their best. *Conclusion:* Although hectic clinical environments present many obstacles to meaningful discussions about domestic violence, several provider communication behaviors seemed to facilitate patient disclosure of experiences with abuse. Illustrative examples highlight common pitfalls and exemplary practices in screening for abuse and response to disclosures of abuse.

Smith, S. G., Zhang, X., Basile, K.C., Merrick, M. T., Wang, J., Kresnow, M-J., & Chen, J. (2018). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2015 data brief.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/violenceprevention/pdf/2015data-brief508.pdf Sexual violence, stalking, and intimate partner violence are serious public health problems affecting millions of people in the United States each year. These forms of violence are associated with chronic physical and psychological adverse health conditions, and violence experienced as a child or adolescent is a risk factor for repeated victimization as an adult. First launched in 2010 by CDC's National Center for Injury Prevention and Control, the National Intimate Partner and Sexual Violence Survey (NISVS) is an ongoing, nationally representative survey that assesses sexual violence, stalking, and intimate partner violence victimization among adult women and men in the United States. This brief report presents the highlights from the 2015 data year of NISVS. Data tables are presented at the end of the report.

Thompson, R. S., Bonomi, A. E., Anderson, M., Reid, R. J., Dimer, J. A., Carrell, D., & Rivara, F. P. (2006). **Intimate partner violence: Prevalence, types, and chronicity in adult women.** *American Journal of Preventive Medicine, 30,* 447–457. doi:10.1016/j.amepre.2006.01.016 *Background:* Most intimate partner violence (IPV) prevalence studies do not examine the relationships between IPV types and the chronicity and severity of abuse. *Objectives:* Delineate prevalence, chronicity, and severity of IPV among adult

FEATURED ARTICLES *continued*

women. *Design:* Retrospective cohort study conducted by telephone survey. Data were collected in 2003 to 2005 and analyzed contemporaneously. *Participants:* English-speaking women (*n* =3568) aged 18 to 64 years enrolled in a U.S. health maintenance organization for 3 or more years. Response rate was 56.4%. *Main Exposure:* Physical, psychological, and sexual IPV were assessed using five questions from the Behavioral Risk Factor Surveillance Survey and ten items from the Women's Experience with Battering (WEB) scale. *Results:* Most (3429) of the respondents had at least one intimate partnership as an adult. Of these, 14.7% reported IPV of any type in the past 5 years, and 45.1% of abused women experienced more than one type. Prevalence was 7.9% in the past year, while during a woman's adult lifetime, it was 44.0%. Depending on IPV type, 10.7% to 21.0% were abused by more than one partner; duration was <1 year to 5 median years; while in 5% to 13% of the instances, IPV persisted for >20 years. IPV rates were higher for younger women, women with lower income and less education, single mothers, and those who had been abused as a child. *Conclusions:* The high prevalence of IPV across women's lifetimes in the previous 5 years and the previous year are documented. The present investigation provides new information of IPV chronicity, severity, and the overlap of IPV types over a woman's adult life span.

ADDITIONAL CITATIONS

Alvarez, C., Fedock, G., Grace, K. T., & Campbell, J. (2017). **Provider screening and counseling for intimate partner violence: A systematic review of practices and influencing factors.** *Trauma, Violence, & Abuse, 18,* 479–495. doi:10.1177/1524838016637080 The authors present a systematic review of research on providers' screening practices for IPV with the aim of informing best practices and strategies increasing screening and improve the health-care sector response to IPV. They discuss several clinic, provider, and patient-level factors that shape the process and outcomes of provider screening practices. The findings suggest that overall, health-workers remain challenged to adopt routine IPV screening. Solutions such as incentivizing health-care settings are discussed.

Dichter, M. E., Wagner, C., Goldberg, E. B., & Iverson, K. M. (2015). **Intimate partner violence detection and care in the Veterans Health Administration: Patient and provider perspectives.** *Women's Health Issues, 25,* 555–560. doi:10.1016/j.whi.2015.06.006 This qualitative study describes female patients' and provider' perspectives on barriers to IPV screening and response practices in the Veterans Health Administration. Patients indicated reluctance to disclose IPV in the absence of direct inquiry or when asked in a rushed or uncaring way, reinforcing the importance of routine screening that is sensitive and validating. Patients and providers alike voiced concerns about a lack of privacy with documentation because the information can be viewed by other providers or potentially accessed by an abusive partner through an electronic patient portal.

Dichter, M. E., Butler, A., Bellamy, S., Medvedeva, E., Roberts, C. B., & Iverson, K. M. (2017). **Disproportionate mental health burden associated with past-year intimate partner violence among women receiving care in the Veterans Health Administration.** *Journal of Traumatic Stress, 30,* 555–563. doi:10.1002/jts.22241 The

ADDITIONAL CITATIONS *continued*

authors examined the associations between subtypes of past-year IPV (psychological, physical, and sexual violence) endorsed during clinical screening and mental health diagnoses among nearly 9,000 women seen in the Veterans Health Administration. Each IPV type was significantly associated with having a mental health diagnosis (adjusted odds ratios = 2.25-2.37) and mental health multimorbidity (adjusted odds ratios = 2.17-2.78). Associations remained when adjusting for military sexual trauma and combat service. Findings reinforce the importance of screening for, and attending to, psychological and sexual IPV, in addition to physical IPV.

Golding, J. M. (1999). **Intimate partner violence as a risk factor for mental disorders.** *Journal of Family Violence, 14,* 99–132. doi:10.1023/A:1022079418229 This 'classic' article was among the first and most comprehensive reviews demonstrating that IPV increases risk for mental health problems. Women with a history of IPV had mean prevalence rates of 63.8% for PTSD, 47.6% for depression, 18.5% for alcohol misuse, and 17.9% for suicidality. The strongest associations between IPV and mental health problems tended to be found in general population samples, emphasizing the importance of general population studies in understanding IPV and its health and social costs.

Huston, J. C., Grillo, A. R., Iverson, K. M., & Mitchell, K. S. (2019). **Associations between disordered eating and intimate partner violence mediated by depression and posttraumatic stress disorder symptoms in a female veteran sample.** *General Hospital Psychiatry, 58,* 77–82. doi:10.1016/j.genhosppsych.2019.03.007 This study examines the link between intimate partner violence (IPV) experiences and eating disorder (ED) pathology among a sample of women veterans. The direct association between IPV and ED symptoms were not significant, rather IPV assessed at Time 1 was associated with Time 3 ED symptoms via PTSD and depression symptoms at Time 2. The authors discussed that ED symptoms may function as a maladaptive coping mechanism for psychological distress experienced in the aftermath of IPV.

International Society for Traumatic Stress Studies (ISTSS). (2018). *ISTSS PTSD prevention and treatment guidelines: Methodology and recommendations.* Retrieved from http://www.istss.org/getattachment/Treating-Trauma/New-ISTSS-Prevention-and-Treatment-Guidelines/ISTSS_PreventionTreatmentGuidelines_FNL.March-19-2019pdf.aspx These guidelines were established by an expert committee of the International Society for Traumatic Stress Studies. The Guidelines are based on a systematic review and metanalysis of the PTSD clinical research literature and meant to assist clinicians who provide prevention and/or treatment interventions to children, adolescents, and adults who have PTSD and those at risk of developing PTSD.

Iverson, K. M., McLaughlin, K. A., Gerber, M. R., Dick, A., Smith, B. N., Bell, M. E., … Mitchell, K. S. (2013). **Exposure to interpersonal violence and its associations with psychiatric morbidity in a U.S. national sample: A gender comparison.** *Psychology of Violence, 3,* 273–287. doi:10.1037/a0030956 This study examined gender differences in the prevalence of nine types of interpersonal violence exposure and investigated the associations between interpersonal violence and lifetime mental health disorders and suicide attempts. Women were much more likely than men to experience physical

assaults by an intimate partner (13.3% of women, 1.5% of men). Physical IPV had some of the strongest and most consistent associations with mental health outcomes, including PTSD (odds ratio = 2.29), substance use disorders (odds ratio = 2.31), and suicide attempts (odds ratio = 2.41).

Iverson, K. M., Huang, K., Wells, S. Y., Wright, J. D., Gerber, M. R., & Wiltsey-Stirman, S. (2014). **Women veterans' preferences for intimate partner violence screening and response procedures within the Veterans Health Administration.** *Research in Nursing & Health, 37,* 302–311. doi:10.1002/nur.21602 This qualitative study identified women's preferences for IPV screening and counseling. Women supported routine screening across different health care settings and believed screening and response practices that were respectful of women's autonomy and readiness to disclose would positively impact women's satisfaction with care. However, women cautioned that without appropriate acknowledgement and support following disclosure, screening could be harmful. Women expressed preferences for having a choice regarding what to disclose, when and how to disclose, and to whom to disclose. Women want a voice in what is documented in their electronic medical records.

McCloskey, L. A., Williams, C. M., Lichter, E., Gerber, M., Ganz, M. L., Sege, R. (2007). **Abused women disclose partner interference with health care: An unrecognized form of battering.** *Journal of General Internal Medicine, 22,* 1067–1072. Survey findings from women attending health care clinics demonstrated that partner interference with health care is a significant problem for women in abusive relationships. Among women with past-year physical IPV, 17% reported that a partner interfered with their health care compared to 2% of women without IPV. Women who experienced partner interference had 1.8 times higher odds of poor health.

Miller, E., McCaw, B., Humphreys, B. L., & Mitchell, C. (2015). **Integrating intimate partner violence assessment and intervention into healthcare in the United States: A systems approach.** *Journal of Women's Health, 24,* 92–100. doi:10.1089/jwh.2014.4870 The authors present a systems approach to implementation of IPV screening and counseling with a focus on integrated health care through use of electronic health record tools. The authors suggest that implementing electronic health record tools facilitate IPV screening by providing standardized screening IPV questions, note templates, and increased confidentiality. Policy and practice recommendations highlight system-level interventions, patient-centered interactions, connecting patients to community support and services, and using the electronic health records to facilitate care and quality improvement.

Pavao, J., Alvarez, J., Baumrind, N., Induni, M., & Kimerling, R. (2007). **Intimate partner violence and housing instability.** *American Journal of Preventive Medicine, 32,* 143–146. doi:10.1016/j.amepre.2006.10.008 The authors analyzed housing instability and IPV in a population-based sample of women. After rigorous adjustment for age, race/ethnicity, poverty, marital status, and other risk factors, the association between past-year IPV and housing instability remained robust (adjusted odds ratio: 3.98, 95% CI: 2.94 –5.39).

US Preventative Services Task Force. (2018). **Screening for intimate partner violence, elder abuse, and abuse of vulnerable adults. US Preventive Services Task Force Final Recommendation Statement.** *JAMA, 320,* 1678–1687. doi:10.1001/jama.2018.14741 The US Preventive Services Task Force (USPSTF) makes evidence-based recommendations for clinical preventive services based on the evidence regarding effectiveness, benefits, and harms of the services. As summarized in this publication, based on a review of the IPV screening literature, the USPSTF recommends that clinicians routinely screen for IPV in women of reproductive age and provide or refer women who disclose IPV to support services.

World Health Organization (WHO), 2013. *Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines.* Shetty, P & Howe, P. (Eds.) Geneva: World Health Organization. The WHO provides an in depth look at IPV across the globe and provide recommendations for clinical practice and policy. The report focuses primarily on women since they experience more physical, sexual, and psychological coercion and control than men. Guidelines are included with the aim of providing evidence-based practice and policy to model appropriate responses to IPV disclosure.