

POSITION STATEMENT

Intimate Partner Violence



The National Association of Nurse Practitioners in Women's Health (NPWH) affirms that intimate partner violence (IPV) is a significant public health issue that must be addressed at individual, relationship, community, and societal levels. Sectors that must work individually and together at each of these levels include but are not limited to healthcare, education, social services, government, and legal and justice services. NPWH endorses a comprehensive multilevel and multisector approach to prevent IPV, remove barriers to disclosing IPV and seeking services, promote universal screening to identify individuals who have or are currently experiencing IPV, provide trauma-informed and culturally sensitive care, and ensure the availability and accessibility of immediate and ongoing support services. NPWH recognizes that individuals of all genders may experience IPV and/or be perpetrators of IPV.

NPWH advocates for laws and policies that promote confidential, person-centered care and that protect the safety and rights of individuals affected by IPV. The organization encourages the repeal of laws and policies that mandate reporting of identified IPV by healthcare providers to law enforcement and other regulatory agencies without the requirement of consent of the individual who has experienced the IPV. NPWH supports federal and state laws that prohibit gun ownership for those who have been convicted of perpetrating IPV. NPWH champions ongoing reauthorization of the

BACKGROUND

The Centers for Disease Control and Prevention (CDC) defines IPV as physical violence, sexual violence, stalking, and/or psychological aggression by a current or former intimate partner.¹ The CDC provides definitions for each of these components of IPV (*Box*). Intimate partners include spouses, domestic partners, boyfriends/girlfriends, dating partners, and ongoing sexual partners.¹

Violence Against Women's Act (VAWA) with expansion to ensure that all individuals who are victims or survivors of IPV have access to safety and justice.

NPWH recognizes a need for extensive research to address gaps in knowledge and to identify evidence-based practices for IPV prevention, screening, and interventions. Strategies must be studied to improve prevention and identification of IPV as well as support for individuals exposed to IPV. Research is needed to help us better understand the unique needs of diverse populations and the variety of settings in which IPV prevention, screening, and interventions should be provided. As well, more research is needed to understand what causes individuals to perpetrate IPV and what types of perpetrator intervention programs are effective in reducing further IPV.

NPWH provides leadership and collaborates with other organizations and agencies to deliver education and skills training for women's healthcare nurse practitioners (WHNPs) and other advanced practice registered nurses (APRNs) who provide healthcare for women, develop policies, and support research in a concerted effort to prevent, screen for, and identify IPV, as well as implement a trauma-informed approach that reduces adverse outcomes and promotes the health and well-being of individuals who have experienced IPV.

IPV is more prevalent among women, although both women and men experience it. In the United States, about 1 in 4 women (25.1%) have experienced sexual violence, physical violence, and/or stalking by an intimate partner in their lifetime and reported some form of IPV-related impact.² Over one-third of women (36.4%) have experienced psychological aggression by an intimate

partner during their lifetime.² Women of all ages have been exposed to IPV. Yet, most women first experience IPV before age 25 (71.1%) and 1 in 4 (25.8%) prior to age 18.²

IPV affects women across all demographics. However, social, cultural, and structural barriers can place specific populations at increased risk for experiencing IPV and can cause them to have challenges in accessing needed services. Data from the National Intimate Partner and Sexual Violence Survey indicate multiracial, American Indian/Alaska Native, and Black women have lifetime experiences of IPV higher than Hispanic, non-Hispanic White, and Asian American women.³ Immigrant women experiencing IPV can face difficulties in accessing needed services because of language barriers, fear of legal retribution related to immigration status including separation from children and deportation, and lack of knowledge about legal protections.^{4,5} Individuals who identify as lesbian, gay, bisexual, transgender, and/or queer/questioning (LGBTQ) experience IPV at the same or higher rates than do heterosexual and cisgender individuals.⁶ They may be less likely to report IPV because of fear and/or experiences of stigmatization and discrimination.⁷ Women living with physical or mental health disabilities have nearly double the lifetime risk of IPV victimization.⁸⁻¹⁰ The intersection and overlap among these social, cultural, and structural barriers further limit some individuals' ability to make decisions about safety and obtaining crucial services.¹¹

The impact of IPV is both immediate and long term. IPV can result in serious physical injury or death. Unintended pregnancy and sexually transmitted infection can be consequences of sexual violence and psychological aggression used to control reproductive or sexual health. Women who are experiencing IPV are more likely to start prenatal care late in their pregnancy and to miss appointments. IPV during pregnancy is associated with preterm birth and low birth weight. Associated maternal effects include higher rates of perinatal depression and suicide.^{12,13} Long-term impacts from IPV among all women include anxiety disorders, depression, post-traumatic stress disorder, substance abuse, chronic pain, and other chronic health conditions.^{3,12}

Immediate and long-term needs for individuals who have experienced IPV include physical and mental healthcare, legal services, housing services, and other advocacy.² In 1994, the VAWA was first passed and has supported a comprehensive response to intimate partner violence

for over 25 years. The VAWA established the Office on Violence Against Women within the US Department of Justice. Resources funded through the VAWA include but are not limited to community violence prevention programs, hotlines, rape crisis centers, shelters and housing, and legal aid. Although the title of the act refers to women, the operative text is gender neutral. The funded programs recognize the special needs of vulnerable populations to include individuals who are immigrants, individuals with disabilities, and LGBTQ individuals. The VAWA has been reauthorized in 2000, 2005, and 2013. The House of Representatives passed a bill reauthorizing VAWA in April 2019. Negotiations in the Senate halted in November 2019.¹⁴ The VAWA Reauthorization Act of 2021 was introduced in the House of Representatives in March 2021.

Most states have laws mandating healthcare providers to report crime-related injuries. Some states have mandatory IPV reporting laws. These laws vary by state as to what situations are reportable, who must report them, and to what agency they must report.¹⁵ Few states with mandatory reporting laws require consent of the individual who has experienced IPV prior to reporting.¹⁶ The intention of mandatory IPV reporting laws is to protect individuals from further violence. Studies have shown, however, that mandatory IPV reporting laws may cause unintended harm. Women may be reticent to seek assistance and needed services for IPV when they know that their case will be reported if they disclose abuse.^{16,17} This reticence often comes from fears regarding involvement with the criminal legal system, immigration authorities, child protection services, and the potential for compromising housing, financial, and family stability. As well, many women fear retaliation from the abusive partner that could escalate violence and jeopardize future safety.^{16,17}

Intimate partner violence can be lethal. IPV accounts for nearly half of homicides involving women each year in the United States.^{18,19} Of these women, approximately 1 in 8 had experienced an episode of IPV in the past month.^{18,19} Of these homicides, approximately 50% were committed with firearms.¹⁷ Current federal law makes it unlawful for individuals subject to a court restraining order related to IPV or who have been convicted of a misdemeanor or felony crime of IPV to possess firearms. Several states have enacted laws that mirror federal laws and explicitly authorize state law enforcement to remove

or seize firearms.²⁰ Studies have demonstrated that intimate partner homicide has been reduced in states with laws limiting access to firearms for individuals under IPV restraining orders and that require them to relinquish firearms in their possession.^{21,22}

The US Preventive Services Task Force (USPSTF) recommends that healthcare providers screen all reproductive-age women for IPV and provide or refer women who screen positive for ongoing services.¹² The Health Resources and Services Administration-sponsored Women's Preventive Services Initiative (WPSI) recommends that well-woman care include IPV screening for adolescent females and women of all ages, including pregnant and postpartum women, as part of preventive services with provision or referral for intervention services as needed.²³ WPSI recommends this universal screening be done at least annually for nonpregnant women, at initial prenatal visits and each trimester for pregnant women, and at postpartum visits.²³ The Affordable Care Act requires that private insurance and Medicaid cover this screening without any cost sharing for the patient.²⁴

Despite the recommendations of USPSTF, WPSI, and other professional organizations, routine screening and intervention for IPV is not a widespread practice in healthcare settings.²⁵⁻³⁰ Barriers include concerns about time, disruption of clinic/office operations, lack of staff

training, and the absence of protocols and processes that enable healthcare providers to screen, intervene, and make referrals as needed.²⁸⁻³¹ Commitment at the organizational level to IPV screening and intervention as a priority in all clinical settings is a major facilitator.²⁸⁻³¹ Two systematic reviews of studies on IPV screening found the most effective efforts to improve screening and disclosure/identification rates require a combination of organizational support, effective screening protocols, staff training that is ongoing, and access to onsite and/or referral support services.^{28,32}

Although data are limited and inconsistent regarding what types of IPV perpetrator intervention programs are effective in reducing further IPV, a growing body of evidence does support several primary IPV prevention strategies to prevent IPV before it begins.²⁰ These strategies reach across individual, relationship, community, and societal levels. Examples of evidence-based strategies include teaching safe and healthy relationship skills, engaging influential adults and peers, disrupting the developmental pathways toward partner violence, creating protective environments, bystander training, and strengthening economic supports for families.²⁰ The key to the success of these strategies is a comprehensive approach across multiple sectors to reduce underlying IPV risks and strengthen protective factors.

IMPLICATIONS FOR WOMEN'S HEALTHCARE

WHNPs and other APRNs who provide healthcare for women in any setting can identify individuals who are currently or have in the past experienced IPV. Several short screening tools have been found to have acceptable accuracy in detecting IPV over the past year in adult women.²² Whatever tool is used, screening needs to be conducted in a private, safe setting without any partner, family member, or friend in the room. When needed, professional interpreters are more appropriate to provide translation than someone the client knows. Screening questions may be included in self-administered health history forms. Asking the client questions face to face is also recommended. Finally, the client needs to be assured about confidentiality within the limits of any legal reporting requirements.

NPWH recommends incorporating principles of trauma-informed and culturally sensitive care into all aspects of IPV screening, assessment, and interventions. In addition

to assessment and interventions for immediate physical and mental health needs, a danger assessment, safety planning, emotional support, and referrals for short-term needs are crucial. Current evidence indicates interventions that include providing or referring those who screen positive to ongoing support services is more beneficial than brief interventions.¹² It is important to identify support services (eg, housing, social and legal services, counseling, behavioral health services) within the community and adopt a multidisciplinary approach that will meet the short- and long-term needs of individuals who have experienced IPV. Ongoing support services can lessen or reduce negative consequences for individuals who have experienced IPV and prevent future experiences.

NPWH encourages WHNPs and other APRNs who provide healthcare for women to become leaders as change agents within their organizations to achieve support for

IPV screening as a priority and to apply best practices for IPV screening, assessment, and interventions. Additionally, they can advocate for any needed changes in state laws

and policies so that consent is required from the individual experiencing IPV before any reporting is done.

NPWH LEADERSHIP

NPWH endorses a comprehensive multilevel and multisector approach to prevent IPV, remove barriers to disclosing IPV and seeking services, promote universal screening to identify individuals who have or are currently experiencing IPV, provide trauma-informed and culturally sensitive care, and ensure the availability and accessibility of immediate and ongoing support services to include mental healthcare. NPWH will provide leadership to ensure:

- Continuing education (CE) programs and resources are available for WHNPs and other APRNs to be able to screen for IPV and provide trauma-informed, culturally sensitive interventions and care for individuals who have experienced IPV.
- CE programs and resources are available to support WHNPs and other APRNs in acting as change agents within organizations and communities to promote screening, intervention, and prevention strategies.
- Public health policies and legislation promote the rights, health, and safety of individuals who have or are currently experiencing IPV.
- Research progresses in all aspects for prevention and reduction of harms from IPV.

BOX. IPV DEFINITIONS¹

- **Physical violence** – intentional use of physical force with the potential for causing death, disability, injury, or harm.
- **Sexual violence** – sexual act that is committed or attempted by another person without freely given consent or against someone who is not able to consent or refuse.
- **Stalking** – pattern of repeated, unwanted attention and contact that causes fear or concern for one’s own safety or the safety of someone close to them (family member, close friend). This includes but is not limited to:
 - Repeated, unwanted contact through letters, phone calls, text messages, and other social media
 - Spying with a listening device, camera, or GPS [global positioning system]
 - Showing up in places (eg, home, work, school) when the individual does not want to see them
 - Leaving strange or potentially threatening items for the individual to find
 - Damaging personal property, harming or threatening to harm a pet
- **Psychological aggression** – verbal or nonverbal communication with intent to cause mental or emotional harm and/or exert control over another person. This includes but is not limited to:
 - Expressive aggression (name-calling, humiliating, degrading)
 - Coercive control (limiting access to transportation, money, friends, or family; excessive monitoring of person’s whereabouts and communications)
 - Threat of physical or sexual violence
 - Control of reproductive or sexual health (sabotage of contraception use, coerced pregnancy/pregnancy termination)
 - Exploitation of individual’s vulnerability (immigration status, disability, undisclosed sexual orientation)

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