

Online Journal of Health Ethics

Volume 11 | Issue 1

Article 5

Intimate Partner Violence Screening and Implications for Health Care Providers

Lori Maria Walton PhD, DPT, MPH (s)
Andrews University, waltonl@andrews.edu

Femke Aerts DPT
femkeaerts@gmail.com

Haley Burkhart DPT
yoder@andrews.edu

Teresa Terry DPT
tiaterry1126@gmail.com

Follow this and additional works at: <http://aquila.usm.edu/ojhe>

 Part of the [Rehabilitation and Therapy Commons](#), and the [Women's Health Commons](#)

Recommended Citation

Walton, L. M., Aerts, F., Burkhart, H., & Terry, T. (2015). Intimate Partner Violence Screening and Implications for Health Care Providers. *Online Journal of Health Ethics*, 11(1). <http://dx.doi.org/10.18785/ojhe.1101.05>

This Article is brought to you for free and open access by The Aquila Digital Community. It has been accepted for inclusion in Online Journal of Health Ethics by an authorized administrator of The Aquila Digital Community. For more information, please contact Joshua.Cromwell@usm.edu.

Introduction

Intimate Partner Violence (IPV) is a global concern that is recognized as a priority by the World Health Organization's Millennium Development Goals which aim to address issues related to IPV, such as extreme poverty, lack of education, gender inequality, child and maternal mortality, HIV/AIDS. The Centers for Disease Control defines IPV as a preventable public health issue that includes any physical, psychological, or sexual abuse by a former or current spouse or partner. It is estimated that one out of three women will be physically, sexually or psychologically abused in their lifetime by a male intimate partner. Annually, IPV related health expenditures are close to \$4.1 billion³ and resulted in a loss of nearly 8 million paid work days. It is estimated that 5.3 million incidences of IPV victimizations of women occur each year, of which 550,000 result in injuries requiring medical intervention. Women who are victims of IPV tend to have worse health outcomes and are more likely to utilize health care resources than non-abused women.¹ Women who were physically abused had 42% higher annual health care costs than women who were not abused.¹ IPV can result in many health consequences including physical injury, depression, chronic pain, psychological trauma, increased incidence of substance abuse, and permanent disability.¹⁻³ Other long-term effects can include neurologic disorders, migraine headaches, gastrointestinal ailments, post-traumatic stress disorder, and

suicidal tendencies ^(Nelson). IPV occurring during pregnancy also affects the unborn baby; IPV has been correlated with premature birth and low birth weight of the newborn. ^(Nelson) While women who are victims of IPV rarely seek out help from police, they will seek out healthcare services during their lifetime.¹ This places healthcare professionals in a unique and vital position to screen for IPV and provide resources for victims of IPV.

The purpose of this systematic review is to understand the importance of screening, barriers to IPV screening, education for IPV within healthcare curriculums, and effective screening tools for IPV that are currently supported by the literature. The review will utilize this information to make recommendations for IPV education within Allied Health Care Provider curriculum.

Importance of Screening for IPV by healthcare providers

Healthcare providers can play a critical role for victims of IPV. Several factors exist to support screening for IPV by healthcare professionals including: professional associations recommending universal screening, the evidence that victims change with the help of healthcare professionals and women's support for universal screening.

Current controversy exists as to the relevance of universal screening for IPV due to a lack of sufficient evidence for screening tools and subsequent interventions. ^{Zink, 2004} In 2004, the U.S. Preventive Services Task Force concluded that there was insufficient evidence to make a recommendation for universal

screening by healthcare professionals for IPV.^{Nelson, 2012} Also, a systematic review by Ramsey et al (2002) found that there was insufficient evidence to support universal screening due to inadequate evidence for interventions for IPV. Ramsey et al also noted that there was a lack of studies to support that no harm occurred to victims of IPV as a result of screening. However, a subsequent update by Nelson et al (2012) was designed as an update to the U.S. Preventive Services Task Force. Nelson et al found that screening tools do exist that can accurately identify women who are victims of IPV. The validity of these screening tools for IPV will be addressed further in this paper. Nelson et al also concluded that there is minimal harm to victims of IPV as a result of screening. Through an analysis of 3 trials, 11 descriptive studies, and 2 systematic reviews, Nelson et al reported increased discomfort, loss of privacy, feelings of depression, concerns about being judged by the provider, and concerns about increased violence as the most common adverse effects of IPV screening. Therefore, Nelson et al reports that, “screening women for IPV could reduce IPV and improve health outcomes depending on the population screened.” Furthermore, many professional organizations have taken positions to support universal screening for IPV. Professional organizations that support universal screening include the American Medical Association, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, the American College of

Emergency Physicians, the American Academy of Nurse Practitioners (Todahl, 2011 & Rhodes, 2003).

In a study by Chang et al (2010), a descriptive qualitative analysis was performed of 61 women who were current or past victims of IPV through the use of focus groups and individual interviews. The study focused on identifying turning points or factors that contributed to women changing their IPV situation. By compiling the responses of the women in the study, Chang et al identified 5 common themes leading to change including: “protecting others from the abuse, increased severity/humiliation with abuse, increased awareness of options/access to support and resources, recognition that the abuser was not going to change, and partner betrayal”^{Chang, 2010} The third theme provides evidence for healthcare professionals’ screening and support due to women changing their situation when receiving sufficient guidance from healthcare professionals. Women in the study describe how interactions with healthcare providers affected, “how they viewed themselves, the violence, and their relationship with their abuser. They described how when a health provider expressed concern and support, they would feel a sense of validation and begin to recognize that they deserved and could strive for safety and a better situation”^{Chang, 2010}

Besides the previously mentioned evidence for IPV screening, a clear indication for universal screening is the support victims have for screening. In a retrospective study by Zink et al (2004), 32 women were interviewed to gather

data about their IPV experiences and interactions with health care. Zink et al used the stages-of-change model to analyze what women expected and wanted from their physicians during the pre-contemplation and contemplation stages of change. Women stated that during the precontemplation stage, during which they do not recognize the abuse as abnormal, they wanted IPV pamphlets or information available and for physicians to ask basic screening questions, both on a routine basis or when symptoms of abuse were present. During the contemplation stage in which women see the problem of the abusive relationship, women expected physicians to be able to provide information about local resources for IPV victims, educate victims on the effects of IPV, and acknowledge that the abuse exists. The study by Zink et al demonstrates that while women expect different actions from healthcare professionals depending on the stage of change they are in, victims of IPV expect professionals to be aware of and able to address their IPV through various options. A qualitative study by Caralis et al (1997) of 434 women found that 85% of women agree that physicians should screen for abuse while 50% *strongly* agree that physicians should screen. In a systematic review by Ramsay et al (2002) to assess the effectiveness of screening for IPV in various healthcare settings, 4 surveys included found that 43-85% of women supported screening for IPV in healthcare settings. In a study by Renker et al (2006), 519 women were surveyed through computer interviews within maternity units to

understand their views on IPV screening. Of the 519 women, 97% were not offended and denied anger or embarrassment about being screened for IPV.

Thus it can be concluded that screening for IPV is important within healthcare settings. Specifically, this review will explore the role health care providers (HCP) can play in IPV screening.

The Role of the HCP and IPV Screening

Health Care Providers are in a unique position to screen and identify victims of IPV. According to a US Centers for Disease Control study, an estimated 1 million Allied Health Care Provider visits occur annually as a result from Nonfatal Intimate Partner Rape and Physical Assault.² In a position paper, “Family Violence” (2009) published by the American Physical Therapy Association (APTA), the organization supports that, “Health Care Providers are in an ideal position to provide intervention through routine screening and the identification of abuse, can serve as sympathetic listeners, and be a central referral source for other resources in the community.”⁴ The APTA also actively supports the education of its members for screening & recognizing IPV and the development of protocols in institutions for practitioners to deal with patients who were victims of IPV.⁴ In 1997, the APTA recognized the importance of IPV education and published the book, *Guidelines for Recognizing and Providing Care for Victims of Domestic Violence*, which provides readers with guidelines

for screening and information on the role of HCPs to advocate for victims of IPV.⁵

As health care providers continue to move toward autonomous practice and direct access, they will need to be competent in detecting and reporting IPV to refer to those with expertise in IPV. Health Care Providers must be educated and have an entry level competence with regard to sensitive topics such as IPV to provide the skills necessary for direct access. However, in most Allied Health Professions, little is known regarding the reported incidence of IPV and screening for women on a daily basis. In a survey completed by Clark, McKenna and Jewell (1996), only 8% of HCPs reported that they screened patients for IPV.⁸ Lack of education, reluctance to intrude in the life of the patient and the lack of information regarding resources, were cited as top reasons for this oversight.⁸

The prevalence of IPV coupled with the lack of HCP IPV screening, call for an evaluation of the education requirements for new therapists. By improving education for IPV, new clinicians can be better prepared for detecting and reporting IPV once they are practicing HCP. Despite the requirements for IPV education with Allied Health programs by the Accreditation Agencies, research is limited concerning the methods by which HCP students are instructed in IPV screening.

There is limited research that supports the training of new HCP on IPV within Bachelors, Masters, and Doctoral Programs. The goal of this study is to

examine similar successful programs in health related professions as they relate to IPV and clinical screening. The literature review will focus on IPV training for other healthcare providers, specifically physicians and nurses. These two healthcare professions were chosen because of their prominence in the literature and their contact with IPV victims.

Current Screening Practices

The importance of IPV screening by healthcare professionals has been established, with many professional organizations recommending universal screening. However, the research has demonstrated that healthcare professionals are not providing universal screening for all patients. As mentioned previously, in a study by Clark et al (1996), only 8% of HCP routinely screen for IPV. Low screening rates have also been identified among physicians. In a study by Caralis et al (1997), 406 women were interviewed about IPV screening and experience with healthcare practitioners. Of the 406 women, only 20% could remember being screened for IPV. Lapidus et al (2002) conducted a survey of 438 physicians including both pediatricians and family physicians providing pediatric care. In this survey, 12% of participants screened for IPV consistently at well-child care visits, 61% reported screening “selectively,” and 30% denied screening for IPV. Similar rates have been found in several studies. Elliot et al (2002) surveyed 1,103 physicians of which 10% screened for IPV. Richter et al (2003) conducted an analysis of emergency department charts, in which screening had occurred in

29% of cases. Finally, in a study by Glass et al (2001), 4,641 female emergency department patients were surveyed and less than 25% remembered being screened for IPV. These statistics and screening rates are consistent with an analysis by Renker et al (2006), in which the authors reported an overall screening rate of 1.5% to 39%, which varied depending on the healthcare setting. The low rate of screening for IPV requires an analysis of barriers that may exist which are preventing healthcare professionals from screening.

Healthcare Provider Barriers to Screening

Challenges exist in the healthcare field in the screening of patients for IPV: including (1) differing cultural perspectives on IPV, (2) time constraints, (3) language barriers (4) lack of knowledge and (5) healthcare practitioners negative perceptions.¹⁰⁻¹² In a review of the literature by Montalvo-Liendo (2008), cross-cultural factors for IPV screening were researched, with a focus on Mexican-American women.¹⁰ Montalvo-Leindo concluded that women of various cultures, including Asian, African-American, and American cultures have differing opinions regarding the definition of IPV.¹⁰ For example, “Mexican-American women define abuse in a more general way when compared with white women.”¹⁰ Research has also shown however that women’s disclosure of IPV varies based on culture. This raises the importance of educating healthcare practitioners in cultural competence in order to be more effective in screening for

IPV. Montalvo-Liendo suggests that this requires: “increased efforts are needed to address multicultural services and recommended that individuals develop: (1) awareness of their own assumptions, values and biases, (2) an understanding of the worldview of the culturally different client and (3) appropriate intervention strategies and techniques to work with culturally diverse clients.”¹⁰

Provider barriers to IPV screening were also analyzed by Waalen et al (2000) through a systematic review of 12 studies. The most frequent provider-related barriers included “lack of provider education regarding IPV, lack of time, and lack of effective interventions.”¹¹ In addition, Waalen et al mentioned concerns of offending the patient as another factor impacting screening. Guillery et al (2012) performed a cross-sectional study of 96 postpartum nurses and their perceptions of barriers to IPV screening. Guillery et al state that “lack of knowledge was the most important barrier to screening”.¹⁵ Lack of knowledge included what IPV is and how to screen for it. This study also found that language barriers present a greater likelihood that a patient will not be screened for IPV. Guillery et al concluded that these barriers must be addressed in order to increase rates of IPV screening.¹⁵

Similar to the findings by Guillery et al, Furniss et al (2007) created a survey for 380 nurses and identified the following as the most common barriers to IPV screening: “lack of privacy and time, need for resources and protocols, legal

questions, and personal belief issues.”^{T6} Of these barriers, lack of time was the most prominent while language barriers were frequently listed.

Physicians also have reasons for not screening patients that may be victims of IPV. Jaffee et al (2005) surveyed almost 150 physicians and found that there were greater perceived barriers if the responding physician was male or if the physician was in a private practice setting. Fewer barriers were perceived if the physician was an obstetrician/gynecologist or had 5-10 years in practice. Thus, physician barriers for IPV screening are directly related to the physician’s perception, gender, specialty, and years in practice. Similar to Jaffee et al, Garimella et al (2002) found physicians have negative feelings toward helping female victims of IPV. Surveying 150 physicians in four specialties: emergency medicine, family practice, obstetrics-gynecology, and psychiatry, Garimella et al found that only 11% had overall positive feeling scores about assisting victims of IPV. The majority of physician responders felt that assisting victims of IPV was significant work, difficult, low-paying and stressful. Garimella et al concluded that graduate medical education and training programs need to address the association of negative feeling with helping women harmed by IPV, as these feelings may interfere with appropriate screening, referral, and treatment for these victims

Gutmanis et al (2007) used a modified Dillman Tailored Design approach to survey 1000 nurses and 1000 physicians. Of the 931 questionnaires returned

(597 by nurses and 328 by physicians), 32% of nurses and 42% of physicians reported routinely initiating the topic of IPV in practice. Amongst all the constructs reported “preparedness” emerged as a key component as to whether respondents routinely initiated the topic of IPV. Gutmanis et al concluded that inadequate preparation, both educational and experiential in a key barrier that impedes clinicians’ decisions to routinely address the issue of IPV with their female patients.

In a study by Liebschutz et al (2008), it was reported that when patients are familiar with the clinician requesting information, they are more likely to disclose information regarding IPV.¹¹ Liebschutz et al interviewed 27 female victims of IPV who had interactions with healthcare practitioners in a variety of settings including the Emergency Department, Obstetrician visits, and Primary Care. IPV disclosure was found to be more common in healthcare specialties where patients have a chance to develop a comfort level with their healthcare provider.¹¹ In the same study, it was found that establishing healthy patient-clinician relationships, particularly therapeutic relationships were more effective compared to situations where abuse was an isolated question from the clinician.¹¹ Liebschutz et al stated that, “The benefits of disclosure reported here went beyond simply providing information, as might have been expected, but suggest an impact on patient selfworth and empowerment. This suggests that the relationship between clinician and patient can itself be a point of healing, and should reassure

clinicians that extensive training in domestic violence or counseling is not as important as nurturing the relationship with a patient.” Furthermore, Liebschutz et al found that, “participants were more likely to disclose IPV and find disclosure beneficial if clinicians (1) respectfully addressed the abuse, (2) ensured participants' physical safety after an assault, (3) assured participants of confidentiality regarding disclosed information, (4) provided patient choices for action and (5) demonstrated emotional support.” Therefore, it is important to consider each of these standards in IPV education for the training of healthcare professionals.

From these studies it can be concluded that lack of knowledge, cultural barriers, time constraints and negative perceptions are all barriers to screening by healthcare practitioners. Thus, an analysis is needed of current educational practices to infer if these barriers are a result of a gap in the instruction of IPV screening.

Healthcare Provider Education

Educational techniques for IPV screening were analyzed in order to recommend the most effective methods to HCPs. This section will compare certain healthcare professions and how they are taught to assess, detect and screen for IPV.

Research is limited in the education of IPV screening within HCP students' education. Research does exist however in teaching overall medical

screening and the process for patient referral. In a study by Boissonnault et al (2004), 51 Master of Physical Therapy students participated in a comparison of two teaching methods for medical screening of 4 cardiopulmonary case studies. Students were divided into groups and instructed through either Traditional Lecture (TL) or student/faculty role-playing (RP). The TL students received instruction for 2 hours through lecture on 4 case studies with instruction for how to communicate with the physician. The RP group each were assigned to one of 4 cases with 10 minutes to review, 20 minutes to interview the patient, and 15 minutes to discuss the significant results with other students. Finally, the RP group students had the chance to role-play the telephone contact with the “physician.” The results demonstrated that the RP group received significantly higher scores on the medical screening written examination ($p=.01$). Also, the RP group reported higher self-confidence in medical screening and providing a referral to a physician ($p<.05$). Finally, the RP group was more satisfied with the instructional experience of this module ($p=.0001$). This study by Boissonnault et al demonstrates the effectiveness of role-playing in educating HCP students in medical screening and referral. This type of model could be used to instruct in IPV screening in order to practice a patient interview and screening and subsequent telephone contact with a physician.

The research previously discussed by Waalen et al, which reviewed 12 surveys in order to identify barriers to screening, also showed that the education

of providers had no significant effect on screening or identification rates.^{T11}

However, significant increases in identification rates were seen when screening methods included providing specific screening questions or key phrases to use when dealing with IPV. Thus, Waalen et al suggests that since barriers to screening for IPV seem to be similar throughout the available research, then perhaps the interventions used to overcome these barriers would be utilized to a higher degree if providers were also given strategies to do so, not just the education.^{T11}

Tufts et al (2009) addressed the importance of adding IPV screening to the nursing curriculum; however, this study states that there are challenges that prevent nurse educators from being educated on IPV. Tufts et al takes education on IPV to the next level by seeking out the educators' knowledge base and their beliefs about IPV. If the prospective nurse educator community receives "formal education in a supportive environment" about IPV then their ability to pass on their skills to future nurses will increase. A very important statement is made within this article that states, "targeting educational efforts at nurses who are pursuing the academic role is an important first step toward raising the collective consciousness of nurses to the point that IPV education becomes an integral component of the nursing curriculum."^{T9} This statement is true for all healthcare professions, especially those who have first contact with a patient such as nurses

and those who have a continuous relationship with a patient such as physical therapists.^{T9}

Plunkett et al (2009) suggested that many healthcare facilities lack the planning and provisions needed to annually train its employees on appropriately caring for possible IPV victims. Thus, this study tested “the efficacy of an existing IPV training curriculum on participants, perception of knowledge, cultural competence, confidence (self-efficacy), and attitudes related to identifying and responding to victims of IPV.”^{T10} Twenty-three registered nurses and one social work intern completed a pre-training, post-training, and pre-Training, post-training, and six weeks follow-up evaluative measure. Participation in this one day training program showed an increase in perceived level of knowledge, confidence, positive attitudes towards screening for IPV and positive attitudes towards victims of abuse.^{T10}

Jonassen et al (2003) found similar results in their study of 294 first-year medical residents. A questionnaire consisted of four different scenarios where variables were held constant except for patient age and presence or absence of abdominal bruising. The survey also included a self-assessment of IPV screening competence. Self-assessed competence was a strong predictor for IPV screening. Residents with the highest self-assessed IPV screening competence were most likely to screen for IPV regardless of the patient’s age or bruising.

In 2005 Short et al. published their research on PREMIS, a tool used to measure physician readiness to manage IPV. PREMIS (Physician Readiness to Manage Intimate Partner Violence Survey) is a 15 minute survey that Short et al. found to have good internal consistency and reliability. PREMIS is more current and comprehensive than previous standardized IPV assessment tools. After revising the tool several times and testing it in multiple settings it has shown to be reliable and valid. Short et al. believe PREMIS has the potential to be useful in a number of different ways: “(1) as a pretest and needs assessment to measure physician knowledge, attitudes, beliefs, behaviors, and skills that may need to be addressed during training or other on-site intervention; (2) as a training adjunct to orient physicians to the topic and expose them to the complexity of IPV issues; (3) as a posttest to determine changes in physician KABB (changes in knowledge, attitudes, beliefs, and self-reported behaviors) over time or as the result of training; and (4) as a comparative instrument to assess differences in KABB between physicians who have received training and those who have not.”

According to Short et al. the Centers for Disease Control and Prevention (CDC) has developed criteria for developing, enhancing, and evaluating programs that are effective in training health care providers to recognize and meet the needs of IPV victims. Recommendations include beginning to train while in professional school and continuing in the health care setting, multidisciplinary

curriculum that “provides information, promotes clinical skills, and effectively links providers with resources.”

The medical school curriculum at UCLA was studied by Moskovic et al (2009). They found that IPV education has been handled in three ways, by: “(1) imbedding IPV curriculum into an established course on psychosocial issues in the first 2 years, (2) promoting a strong institution-wide approach to patients affected by IPV to shape the environment of the clinical years, and (3) supporting and evaluating elective experiences in IPV for interested students.” Through these the goal is for all students to be able to conduct a culturally sensitive history, assist the patient in developing a safety plan, know the mandatory reporting requirements, know local resources available, and empathize with the victim enough to understand their viewpoint and possible barriers to seeking help.

Valid and Reliable Screening Tools for IPV

The importance of educating healthcare professionals on IPV screening is evident from the literature. However, the best method of screening for health professionals that is both valid and reliable needs further research. Rabin et al conducted a systematic review of IPV screening tools in order to find the ones that possess “sound psychometric properties”.^{T12} The screening tools were chosen by prevalence in the literature. The most studied were the Hurt, Insult, Threaten, and Scream (HITS), the Woman Abuse Screening Tool/Woman Abuse Screening

Tool-Short Form (WAST/WAST-SF), the Partner Violence Screen (PVS), and the AAS. The articles containing the most common screening tools were then evaluated based on a 14 point scale. Papers scoring 13–14 were rated excellent, 10–12 good, 7–9 fair, and ≤ 6 poor. As a result “No single IPV screening tool had well-established psychometric properties. Even the most common tools were evaluated in only a small number of studies. Sensitivities and specificities varied widely within and between screening tools. Further testing and validation are critically needed.” (SEE APPENDIX FOR TABLE OF RESULTS) ^{T12}

In a study by Sherin et al, two questionnaires were created and distributed to 160 female family practice patients who were in living with a partner for 12 months. The first questionnaire was the Conflict Tactics Scale (CTS) and the second was the HITS. The next phase of the study gave the HITS questionnaire to 99 self-admitted victims of IPV. Results showed HITS showed concurrent validity with the CTS. Also, the HITS was shown to have good internal consistency and construct validity in its ability to differentiate family practice patients from IPV victims.^{t9}

A study was conducted by Nelson et al (2012) to review current evidence for various IPV screening instruments used to identify victims of current or recent IPV in order to update the U.S Preventive Services Task Force. An analysis was done on fifteen studies that assessed the diagnostic accuracy for 13 screening tools. Nelson et al concluded that 5 screening tools were considered to have

diagnostic accuracy including the Humiliation, Afraid, Rape, Kick (HARK) instrument, Hurt, Insult, Threaten, and Scream (HITS) instrument, Slapped, Threatened, and Throw (STaT), Ongoing Violence Assessment Tool (OVAT), and Woman Abuse Screening Tool (WAST). The HARK screening tool demonstrated specificity of 95% and sensitivity of 81% when studied in general practice settings. The HITS tool demonstrated sensitivity and specificity greater than 85% among studies. The OVAT demonstrated greater diagnostic accuracy than the Ongoing Abuse Screen or Abuse Assessment Screen when used in an Emergency Department Setting. Lastly, the WAST demonstrated 88% sensitivity and 89% specificity during a study of 5,607 women.

Nelson et al also noted that women are more likely to report IPV through the use of self-administered methods than direct face-to-face screening. Women are more likely to admit to being victims of IPV and discuss the IPV through the use of computerized screening. However, in a qualitative study by Wilson et al (2007), written surveys and face to face interviews resulted in different responses. 25 women at a crisis center in North Carolina were instructed to complete a written survey and were then interviewed by staff members at the crisis center. Women reported worse overall health status during interviews and were prone to report more health problems during the interview. Women were especially likely to report mental illness or mental stress during the open-ended interview versus a

written survey. Wilson et al concluded that an important part of screening for IPV is including a qualitative component when assessing health needs and concerns.

IPV is a major public health concern with a healthcare cost of nearly \$4.1 billion and affects nearly 1/3 of women during their lifetime.¹⁻³ As victims of IPV seek out healthcare resources, healthcare practitioners must be prepared to screen for and address IPV with their patients. As demonstrated, current screening practices do not reflect the recommendations made by professional organizations, with screening rates less than 30% among physicians. Time constraints, cultural barriers, lack of education, and negative perceptions have been identified as barriers for IPV screening.

Three recommendations can be made for Health Care Provider Programs based on various models for IPV education. 1) Experiential learning should be incorporated into IPV screening education within competence in HCP education 2) Adaptation of specific screening tools for utilization and introduction in HCP education are needed and 3) The utilization of specific screening tools in educating HCP students on IPV screening should be considered, with recommendation of the PREMIS tool. Specifically, the Hurt, Insult, Threaten and Scream (HITS), Ongoing Violence Assessment Tool (OVAT), Woman Abuse Screening Tool (WAST), and Partner Violence Screen (PVS) are the recommended screening tools.

Screening tools have not been specifically designed for utilization by Allied HCPs within the clinical setting. In order to make conclusions about the validity and reliability of IPV screening tools for utilization by HCP, validity and reliability studies must be considered for practical utilization of these tools. Future research should consider current IPV education practice in HCP Programs.

Conclusion

In conclusion, IPV is a major public health concern with a healthcare cost of nearly \$4.1 billion and affects nearly 1/3 of women during their lifetime.¹⁻³ As victims of IPV seek out healthcare resources, healthcare practitioners must be prepared to screen for and address IPV with their patients. As demonstrated, current screening practices do not reflect the recommendations made by professional organizations, with screening rates less than 10% among physicians. Time constraints, cultural barriers, lack of education, and negative perceptions have been identified as barriers for IPV screening. Various models for IPV education have been explained for physician and nurses.

References

1. Chibber KS, Krishnan S. Confronting intimate partner violence: a global health priority. *Mt Sinai J Med*. 2011;78(3):449-57.
2. National Center for Injury Prevention and Control. *Costs of Intimate Partner Violence Against Women in the United States*. Atlanta (GA): Centers for Disease Control and Prevention; 2003.
3. Phelan MB. Screening for intimate partner violence in medical settings. *Trauma Violence Abuse*. 2007;8(2):199-213.
4. American Physical Therapy Association. Position Statement on Family Violence. <http://www.apta.org/FamilyViolence/>. Updated May 1, 2012.
5. American Physical Therapy Association. *Guidelines for Recognizing and Providing Care for Victims of Domestic Violence*. 2005.
6. American Physical Therapy Association. Vision 2020. <http://www.apta.org/vision2020/>. Updated September 18, 2012.
7. Plichta, S.B. Intimate partner violence and physical health consequences: Policy and practice implications. *Journal of Interpersonal Violence*. 2004; 19 (11), 1296-1323.
8. Clark T, McKenna L. Physical therapists' recognition of battered women in clinical settings. *Physical Therapy* [serial online]. January 1996;76(1):12. Available from: Academic Search Complete, Ipswich, MA.

9. Dalton A. Family Violence: Recognizing the Signs, Offering Help. (Cover story). *PT: Magazine Of Physical Therapy* [serial online]. January 2005;13(1):34-40.
10. Montalvo-Liendo N. Cross-cultural factors in disclosure of intimate partner violence: an integrated review. *Journal Of Advanced Nursing* [serial online]. January 2009;65(1):20-34.
11. Liebschutz J, Battaglia T, Finley E, Averbuch T. Disclosing intimate partner violence to health care clinicians - what a difference the setting makes: a qualitative study. *BMC Public Health* [serial online]. January 2008;8:229-236.
12. Tower L. Barriers in Screening Women for Domestic Violence: A Survey of Social Workers, Family Practitioners, and Obstetrician–Gynecologists. *Journal Of Family Violence* [serial online]. May 2006;21(4):245-257.
13. Tufts KA, Clements PT, Karlowicz KA. Integrating intimate partner violence content across curricula: developing a new generation of nurse educators. *Nurse Education Today*, Jan 2009; 29(1): 40-7.
14. Plunkett, S.E. Training health care providers as first responders to victims of intimate partner violence. Indiana University, 2009; Ph.D. (189 p) doctoral dissertation - clinical trial, research.

15. Rabin R, Jennings J, Campbell J, and Bair-Merritt M. Intimate Partner Violence Screening Tools. *American Journal of Preventative Medicine*. May 2009; 36(5): 439–445.e4.
- Boissonnault W, Morgan B, Buelow, J. A comparison of two strategies for teaching medical screening and patient referral in a physical therapist professional degree program. *Journal of Physical Therapy Education*. Spring 2006; 20,1: 28-36.
16. Waalen J, Goodwin M, Spitz A, Petersen R, Saltzman L. Screening for Intimate Partner Violence by HealthCare Providers; Barriers and Interventions. *American Journal of Preventive Medicine* 2000;19(4).
17. Guillery M, Benzies K, Mannion C and Evans S. Postpartum nurses' perceptions of barriers to screening for intimate partner violence: a cross-sectional survey. *BMC Nursing* 2012, 11:2.
18. Furniss K, McCaffrey M, Parnell V, Rovi S. Nurses and barriers to screening for intimate partner violence. *The American Journal of Maternal Child Nursing*, Jul-Aug 2007; 32(4): 238-43.
19. Grunfeld AF, Ritmiller S, Mackay K, Cowan L, Hotch D. Detecting domestic violence against women in the emergency department: a nursing triage model. *Journal of Emergency Nursing: JEN*: 1994, 20(4):271-274.

20. Sherin KM, MD, MPH; Sinacore JM, PhD; Li XQ, MD; Zitter RE, PhD; Shakil A, MD. HITS: A Short Domestic Violence Screening Tool for Use in a Family Practice Setting. *Family Medicine*: 1998, 30(7):508-12.
21. Nelson HD, MD, MPH; Bougatsos C, MPH; and Blazina I, MPH
Screening Women for Intimate Partner Violence: A Systematic Review to Update the U.S. Preventive Services Task Force Recommendation. *Annals of Internal Medicine* 2012 156 (11).
22. Moskovic C, Wyatt L, Chirra A, et al. Intimate Partner Violence in the Medical School Curriculum: Approaches and Lessons Learned. *Virtual Mentor* [serial online]. 2009; 11: 130-136. Available at: <http://virtualmentor.ama-assn.org/2009/02/medu2-0902.html>. Accessed January 14, 2013.
23. Short LM, Johnson D, Osattin A. Recommended Components of Health Care Provider Training Programs on Intimate Partner Violence. *American Journal of Preventive Medicine*. [serial online]. 1998; 14: 283-288. Available at: [http://www.ajpmonline.org/article/S0749-3797\(98\)00007-5/abstract](http://www.ajpmonline.org/article/S0749-3797(98)00007-5/abstract). Accessed January 14, 2013.
24. Short LM, Alpert E, Harris JM Jr., Surprenant ZJ. PREMIS: A Comprehensive and Reliable Tool for Measuring Physician Readiness to Manage IPV. *American Journal of Preventive Medicine*. [serial online]. 2007; 30: 173-180. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1451776/>. Accessed September 24, 2012.
25. Jonassen JA, Mazor KM. Identification of Physician and Patient Attributes That Influence the Likelihood of Screening for Intimate Partner Violence. *Academic Medicine*. [serial online]. 2003; 78: 20-23. Available at: http://journals.lww.com/academicmedicine/Fulltext/2003/10001/Identification_of_Physician_and_Patient_Attributes.7.aspx. Accessed September

24, 2012.

26. Garimella RN, Plichta SB, Houseman C, Garzon L. How Physicians Feel about Assisting Female Victims of Intimate Partner Violence. *Academic Medicine*. [serial online]. 2002; 77: 1262-1265. Available at: http://journals.lww.com/academicmedicine/Abstract/2002/12000/How_Physicians_Feel_about_Assisting_Female_Victims.24.aspx. Accessed September 24, 2012.
 27. Jaffee KD, Epling JW, Grant W, Ghandour RM, Callendar E. Physician-Identified Barriers to Intimate Partner Violence Screening. *Journal of Women's Health*. [serial online]. 2005; 14: 713-720. Available at: <http://online.liebertpub.com/doi/abs/10.1089/jwh.2005.14.713>. Accessed September 24, 2012.
 28. Gutmanis I, Beynon C, Tutty L, Wathen CN, MacMillan HL. Factors influencing identification of and response to intimate partner violence: a survey of physicians and nurses. *BMC Public Health*. [serial online]. 2007; 7. Available at: <http://www.biomedcentral.com/1471-2458/7/12/abstract/>. Accessed September 24, 2012.
 29. Wilson K, Silberberg M, Brown A, Yaggy S. Health Needs and Barriers to Healthcare of Women Who Have Experienced Intimate Partner Violence. *Journal Of Women's Health (15409996)* [serial online]. December 2007;16(10):1485-1498
-