Screening for Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults: U.S. Preventive Services Task Force Recommendation Statement

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Description: Update of the 2004 U.S. Preventive Services Task Force (USPSTF) recommendation statement on screening for family and intimate partner violence (IPV).

Methods: The USPSTF commissioned a systematic evidence review on screening women for IPV and elderly and vulnerable adults for abuse and neglect. This review examined the accuracy of screening tools for identifying IPV and the benefits and harms of screening women of childbearing age and elderly and vulnerable adults.

Population: These recommendations apply to asymptomatic women (women who do not have signs or symptoms of abuse) of reproductive age and elderly and vulnerable adults.

Recommendation: The USPSTF recommends that clinicians screen women of childbearing age for IPV, such as domestic violence, and provide or refer women who screen positive to intervention services (B recommendation).

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening all elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect (I statement).

Ann Intern Med. 2013;158:478-486. www.annals.org

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* For a list of USPSTF members, see the **Appendix** (available at www.annals.org).

This article was published at www.annals.org on 22 January 2013.

The U.S. Preventive Services Task Force (USPSTF) makes recommendations about the effectiveness of specific clinical preventive services for patients without related signs or symptoms.

It bases its recommendations on the evidence of both the benefits and harms of the service and an assessment of the balance. The USPSTF does not consider the costs of providing a service in this assessment.

The USPSTF recognizes that clinical decisions involve more considerations than evidence alone. Clinicians should understand the evidence but individualize decision making to the specific patient or situation. Similarly, the USPSTF notes that policy and coverage decisions involve considerations in addition to the evidence of clinical benefits and harms.

Summary of Recommendations and Evidence

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen women of childbearing age for intimate partner violence (IPV), such as domestic violence, and provide or refer women who screen positive to intervention services (B recommendation). This recommendation applies to women who do not have signs or symptoms of abuse. See the Clinical Considerations for more information on effective interventions.

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening all elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect (I statement). See the Clinical Considerations for suggestions for practice regarding the I statement.

See the **Figure** for a summary of the recommendation and suggestions for clinical practice and **Tables 1** and **2** for the USPSTF grades and classification of levels of certainty about net benefit.

See also:

Print
Summary for Patients I-28

Web-Only
CME quiz
Consumer Fact Sheet

Rationale

Importance

Intimate partner violence and abuse of elderly and vulnerable adults is common in the United States but often remains undetected. Nearly 31% of women and 26% of men report having some form of IPV in their lifetime. Approximately 25% of women and 14% of men have experienced the most severe types of IPV in their lifetime (1–3). These estimates likely underrepresent actual rates because of underreporting. In addition to the immediate effects of IPV, such as injury and death (4, 5), there are

Figure. **Screening for intimate partner violence and abuse of elderly and vulnerable adults.**

Annals of Internal Medicine

U.S. Preventive Services TASK FORCE
www.USPreventiveServicesTaskForce.org

SCREENING FOR INTIMATE PARTNER VIOLENCE AND ABUSE OF ELDERLY AND VULNERABLE ADULTS CLINICAL SUMMARY OF U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATION

Population	Asymptomatic women of childbearing age	Elderly or vulnerable adults
Recommendation	Screen women for intimate partner violence (IPV), and provide or refer women who screen positive to intervention services. Grade: B	No recommendation. Grade: I statement

Risk Assessment	While all women are at potential risk for abuse, factors that elevate risk include young age, substance abuse, marital difficulties, and economic hardships.	
Interventions	Adequate evidence from randomized trials support a variety of interventions for women of childbearing age that can be delivered or referred by primary care, including counseling, home visits, information cards, referrals to community services, and mentoring support. Depending on the type of intervention, these services may be provided by clinicians, nurses, social workers, nonclinician mentors, or community workers.	
Balance of Benefits and Harms	Screening and interventions for IPV in women of childbearing age are associated with moderate health improvements through the reduction of exposure to abuse, physical and mental harms, and mortality. The associated harms are deemed no greater than small. Therefore, the overall net benefit is moderate.	The USPSTF was not able to estimate the magnitude of net benefit for screening all elderly or vulnerable adults (i.e., adults who are physically or mentally dysfunctional) for abuse and neglect because there were no studies on the accuracy, effectiveness, or harms of screening in this population.
Other Relevant USPSTF Recommendations	The USPSTF has made recommendations on screening for depression in adults and screening and counseling to reduce alcohol misuse in adults. These recommendations are available at www.uspreventiveservicestaskforce.org	

For a summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement, and supporting documents, please go to www.uspreventiveservicestaskforceorg.

other health consequences, many with long-term effects, including sexually transmitted diseases (6), pelvic inflammatory disease (7), and unintended pregnancy (8). Rates of chronic pain, neurologic disorders, gastrointestinal disorders, migraine headaches, and other disabilities (9–11) are also increased. Intimate partner violence in pregnant women is associated with preterm birth, low birthweight, and decreased gestational age (12–14). Individuals experiencing IPV often develop chronic mental health conditions, such as depression, posttraumatic stress disorder, anxiety disorders, substance abuse, and suicidal behavior (15–19). For adolescents and young adults, the effects of physical and sexual assault are associated with poor self-esteem, alcohol and drug abuse, eating disorders, obesity, risky sexual behaviors, teen pregnancy, depression, anxiety, suicidality, and other conditions (20, 21).

Little information is available on the prevalence of abuse among noninstitutionalized elderly or vulnerable adults, although reported rates range from 2% to 25% (22, 23).

Detection

For IPV, there is adequate evidence that available screening instruments can identify current and past abuse or increased risk for abuse. Several instruments used in more than 1 study were highly sensitive and specific.

The USPSTF found inadequate evidence on the accuracy of screening instruments for elderly or vulnerable adults.

Benefits of Detection and Early Intervention

The USPSTF found adequate evidence that effective interventions can reduce violence, abuse, and physical or mental harms for women of reproductive age.

The USPSTF found inadequate evidence that screening or early detection reduces exposure to abuse or reduces physical or mental harms or mortality for elderly and vulnerable adults.

Harms of Detection and Early Intervention

For IPV, the USPSTF found adequate evidence that the risk for harm to the individual from screening or interventions is no greater than small.

For elderly and vulnerable adults, the USPSTF found inadequate evidence on the harms of screening or interventions.

Table 1. **What the Grades Mean and Suggestions for Practice**

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer/provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer/provide this service.
C	*Note: The following statement is undergoing revision.* Clinicians may provide this service to selected patients depending on individual circumstances. However, for most individuals without signs or symptoms, there is likely to be only a small benefit from this service.	Offer/provide this service only if other considerations support offering or providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the Clinical Considerations section of the USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Assessment

The USPSTF concludes with moderate certainty that screening women of childbearing age for IPV has a moderate net benefit.

The USPSTF concludes that the benefits and harms of screening elderly or vulnerable adults for abuse are uncertain and that the balance of benefits and harms cannot be determined.

CLINICAL CONSIDERATIONS

Patient Population Under Consideration

These recommendations apply to asymptomatic women of reproductive age and elderly and vulnerable adults. Reproductive age is defined across studies as ranging from 14 to 46 years, with most research focusing on women age 18 years or older. The term "intimate partner violence" describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy (24). A vulnerable adult is a person age 18 years or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired because of a mental, emotional, long-term physical, or developmental disability or dysfunction or brain damage. Definitions vary by state and sometimes include the receipt of personal care services from others. Types of abuse that apply to elderly and vulnerable adults include physical abuse, sexual abuse, emotional or psychological abuse, neglect, abandonment, financial or material exploitation, and self-neglect.

Child abuse and neglect is addressed in a separate recommendation.

Assessment of Risk

Although all women are at potential risk for abuse, factors that elevate risk include young age, substance abuse, marital difficulties, and economic hardships.

Screening Tests

Several screening instruments can be used to screen women for IPV. Those with the highest levels of sensitivity and specificity for identifying IPV are Hurt, Insult, Threaten, Scream (HITS; English and Spanish versions); Ongoing Abuse Screen/Ongoing Violence Assessment Tool (OAS/OVAT); Slapped, Threatened, and Throw (STaT); Humiliation, Afraid, Rape, Kick (HARK); Modified Childhood Trauma Questionnaire–Short Form (CTQ-SF); and Woman Abuse Screen Tool (WAST).

The HITS instrument includes 4 questions, can be used in a primary care setting, and is available in both English and Spanish. It can be self- or clinician-administered. HARK is a self-administered 4-item instrument. STaT is a 3-item self-report instrument that was tested in an emergency department setting.

The USPSTF found no valid, reliable screening tools to identify abuse of elderly or vulnerable adults in the primary care setting.

Screening Interval

The USPSTF found no evidence on appropriate intervals for screening.

Interventions

Evidence from randomized trials support various interventions for women of childbearing age, including counseling, home visits, information cards, referrals to community services, and mentoring support. Depending on the type of intervention, these services may be provided by clinicians, nurses, social workers, nonclinician mentors, or community workers. Counseling generally includes information on safety behaviors and community resources. In addition to counseling, home visits may include emotional support, education on problem-solving strategies, and parenting support. One study used a 20-minute nurse case management protocol focusing on a safety plan, supportive care, and guided referrals. No intervention studies were identified for elderly or vulnerable adults. See the following discussion for suggestions for practice in this population.

Suggestions for Practice Regarding the I Statement for Elderly or Vulnerable Adults

Potential Benefits

The estimated prevalence of elder abuse ranges from 2% to 10% according to various definitions, methods, and sampling strategies (22). One study indicated that 1 in 10 elderly adults may experience abuse, but only 1 in 5 or fewer cases are actually reported (23).

Potential Harms

Although there is no direct evidence, the existing evidence about the lack of harms resulting from IPV screening suggests that the harms of screening elderly and vulnerable adults might also be small. Some potential harms of screening include shame, guilt, self-blame, fear of retaliation or abandonment by perpetrators, and the repercussions of false-positive results.

Costs

There is no evidence about the costs of screening for or interventions to reduce elder abuse.

Current Practice

Screening practices for elder abuse are limited for many reasons. Currently, there are no standards about how clinicians should ask elderly patients about possible abuse. In addition, there are varying definitions of abuse, a wide variety of mechanisms of elder abuse, no universal screening tools, wide-ranging risk factors, unclear guidance about whom to screen and what to do if abuse is identified, physician discomfort with screening, and time constraints. Screening is not done routinely and varies by locality. However, all providers should be aware of the laws in their states for reporting suspected abuse. Not all states mandate reporting, and some provide clear guidance about what type of injuries should arouse suspicion.

Useful Resources

The USPSTF has several recommendations that may be relevant, including screening for depression (25) and alcohol misuse (update in progress) (26).

Other useful resources include Web sites that contain materials useful to primary care providers. Providers often need guidance on how to address concerns about IPV with sensitivity and clarity and how to screen for IPV and provide follow-up care. Intimate partner violence introduces significant safety issues that compel a provider to be fully informed on such aspects as sensitivity. Providers also need easy access to available tools, specific guidelines, and other related materials to help them develop a clinical environment dedicated to the safety of their patients. Guidance is also available on how providers can work with local community-based domestic violence programs to receive training, information, and other resources to ensure effective management of patients who are victims of IPV.

Providers should also be aware of their state and local reporting requirements. The laws vary from one jurisdiction to another, with differences in definitions, whom and what should be reported, who should report, and to whom. Although reporting suspected elder and child abuse is mandated in all 50 states and the District of Columbia, this is not the case with IPV. In addition, providers also need to be familiar with requirements in the privacy regulations of the federal Health Insurance Portability and Accountability Act, which require that patients be advised on health information use and disclosure practices. Again, state laws around privacy issues or concerns vary.

Table 2. **Levels of Certainty Regarding Net Benefit**

Level of Certainty*	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as: the number, size, or quality of individual studies; inconsistency of findings across individual studies; limited generalizability of findings to routine primary care practice; and lack of coherence in the chain of evidence. As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: the limited number or size of studies; important flaws in study design or methods; inconsistency of findings across individual studies; gaps in the chain of evidence; findings that are not generalizable to routine primary care practice; and a lack of information on important health outcomes. More information may allow an estimation of effects on health outcomes.

* The USPSTF defines *certainty* as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general primary care population. The USPSTF assigns a certainty level on the basis of the nature of the overall evidence available to assess the net benefit of a preventive service.

The Centers for Disease Control and Prevention (CDC) has resources available for those needing additional information at www.cdc.gov/ViolencePrevention/intimatepartnerviolence/resources.html.

Other Considerations

Research Needs and Gaps

Evidence on the use of newer screening approaches would be useful. Computerized screening and intervention increase rates of domestic violence discussion, disclosure, and service provision (27–29). Furthermore, computerized screening has been found to be more acceptable for patients (30, 31). Patients perceive use of an audio questionnaire as more private and less likely to increase risk for abuse (27–29). Further evaluation of the accuracy, efficiency, and acceptability of these methods is needed.

Studies of the diagnostic accuracy of screening instruments are limited by the lack of accepted reference standards. Further development or validation of an accepted standard would allow more accurate assessment of performance measures and allow instruments to be more readily compared with each other. The broad and inconsistent definitions of abuse pose challenges for creating screening instruments, especially for detecting abuse and neglect in elderly and vulnerable populations.

Although there are significant challenges in this research field, additional studies are needed to determine the effectiveness of different postscreening interventions. For the elderly and vulnerable adult populations, good-quality randomized, controlled trials focusing on both screening and interventions are needed. Because many elderly and vulnerable adults may not have sufficient physical, mental, or financial abilities to engage in screening functions, instruments need to be framed around third-party responses (32, 33). Other challenges to research in this population include legal requirements related to disclosure, underlying medical conditions, and dependence on the perpetrators. It is important to note that this includes patients who have dementia or other cognitive deficiencies, as well as those with developmental disabilities. The USPSTF recognizes that these patients are particularly vulnerable to abuse because most live in a care-taking environment.

Another important gap recognized by the USPSTF is the absence of evidence of effective interventions for middle-aged women who are past childbearing age but not yet elderly. Similar to the research needs for elderly and vulnerable adult populations, research is also needed to inform practice for this group of women.

The USPSTF recognizes that a significant body of evidence is lacking for other populations, especially men. The CDC has conducted studies demonstrating the prevalence and importance of IPV against men perpetrated by women and other men. Research is needed in all areas related to screening and treatment in men, as well as reporting, safety, community linkages and supports, legal ramifications, and cultural aspects.

Discussion

Burden of Disease

Intimate partner violence is considered to be a significant and largely unaddressed public health problem. The CDC estimates that nearly 31% of women and 26% of men report experiencing some form of IPV in their lifetime and that approximately 25% of women and 14% of men have experienced the most severe types of IPV. On the basis of data from the CDC's Behavioral Risk Factor Surveillance System, in 2005 23.6% of women reported a lifetime history of abuse (2).

In 1 study, abuse occurred in 11% of postmenopausal women (3). In another study, 1.3% to 4.6% of pregnant women reported abuse during the pregnancy. In a large study in 1 health care system, the prevalence of abuse was 7.9% in the preceding year and 14.7% in the preceding 5 years (4). Many factors make it difficult to obtain true estimates. Because of the stigma of abuse, including fear, shame, and reprisal, many cases go unreported (5, 6). Only a minority of women (35.6%) injured during their most recent rape or during their most recent physical assault (30.2%) actually received medical treatment of any kind (7).

Among older and vulnerable adults, a recent study estimated that 14% of noninstitutionalized older adults had experienced physical, psychological, or sexual abuse; neglect; or financial exploitation during the past year (34). Women with disabilities are 4 times more likely to experience sexual assault in the past year than women without disabilities (35).

Risk Factors

The CDC has developed a comprehensive list of risk factors for IPV, which are organized into 4 categories (36): individual (such as low self-esteem), relationship (such as marital conflict and instability), community (such as poverty and associated factors), and society (such as traditional gender roles).

Scope of Review

In updating its 2004 recommendation, the USPSTF commissioned a systematic evidence review on screening women for IPV and elderly and vulnerable adults for abuse and neglect. This review examined the accuracy of 14 screening tools for identifying IPV. Published literature on randomized, controlled trials and other systematic reviews were searched for evidence on the benefits and harms of screening adult women of childbearing age and elderly and vulnerable adults.

Accuracy of Screening Tests

This review (37) included a total of 15 studies of 13 screening instruments to identify IPV in women, and 3 met criteria for good quality (38–42). Most of the tools

assessed current or past abuse rather than risk factors for future abuse.

All of the screening instruments include questions for patients and are administered in various ways: self-administered on paper or by computer, or interviews by various clinicians. Examples of questions from the instruments are, "In the past year, have you ever been afraid of a partner?" and "Have you ever been in a relationship where your partner pushed or slapped you?"

The 6 tools that achieved the highest levels of sensitivity and specificity were HITS (English and Spanish versions), OVAT, STaT, HARK, modified CTQ-SF, and WAST (37). Limitations of the studies were high attrition rates, enrollment of dissimilar groups at baseline, and unclear application of the reference standard. A major limitation of the evidence is the lack of an established gold standard; all of the studies compared the screening instrument with a second instrument that was usually validated and often more detailed (37).

One study evaluated the 4-item HITS instrument by comparing it with 2 others: the Index of Spouse Abuse (ISA) and the Spanish version of WAST. In a sample of women attending a family practice clinic, the sensitivity and specificity were 86% and 99% for the English version and 100% and 86% for the Spanish version, respectively.

The OAS, a 5-item instrument measuring current and past abuse, had sensitivity and specificity of 60% and 90% when compared with ISA in emergency department patients. This instrument was edited to a 4-item version, OVAT, which demonstrated sensitivity and specificity of 93% and 86% in the same population. A subsequent study comparing OVAT with ISA among patients presenting to an emergency department also reported high sensitivity and specificity (86% and 83%).

The 3-item STaT instrument was evaluated among women presenting to primary care clinics in 2 studies. Compared with a semistructured interview, STaT demonstrated sensitivity ranging from 62% to 96% and specificity ranging from 37% to 100%, depending on the reference standard and number of positive responses.

The 4-item HARK instrument was compared with the Composite Abuse Scale (CAS) among women presenting to primary care in London, United Kingdom. For a positive response on any question, the sensitivity and specificity were 81% and 95%.

Two items from CTQ-SF, an instrument designed to detect a history of physical or sexual abuse in childhood, were compared with the Evaluation of Lifetime Stressors structured interview among women in an HMO. With use of a single item from CTQ-SF, sensitivity and specificity were 70% and 94% for physical abuse and 82% and 89% for sexual abuse. Use of 2 items to screen for physical or sexual abuse resulted in sensitivity and specificity of 85% and 88%.

Results from WAST were compared with CAS results for 2461 women presenting to family practices, emergency departments, and women's health clinics in Canada. Sensitivity and specificity of WAST were 47% and 96%. In a subsequent study of a larger sample of women from Canadian clinics, WAST demonstrated higher sensitivity (81% to 88%) and specificity (89%), with CAS again used as the reference standard. In that study, WAST identified a 12-month prevalence rate of 22%, whereas CAS found a rate of 14%.

The ages of the women participating in these studies ranged from 18 to 64 years.

Effectiveness of Early Detection and Interventions

The USPSTF found that effective interventions to reduce IPV, abuse, and physical or mental harms consist of many approaches. Most of the studies were conducted with women of childbearing age in settings providing services for pregnancy or pregnancy prevention. Limitations of the studies were enrollment of dissimilar groups at baseline, high or differential loss to follow-up, recall bias, missing data, and the Hawthorne effect among control participants.

A large cluster randomized, controlled trial of the effectiveness of screening for IPV included 6743 Canadian women randomly assigned to screening or usual care groups. Primary outcomes were exposure to abuse and quality of life in the 18 months after screening. Secondary outcomes included depression, posttraumatic stress disorder, alcohol and drug abuse, mental and physical health, and use of health and social services. These outcomes were not significantly different between women in the screened versus usual care groups. Given the limited evidence in screening trials, the USPSTF considered the chain of evidence linking screening and improved outcomes from effective intervention studies.

Five randomized, controlled trials of fair or good quality were found. Trials assessed interventions to reduce exposure to IPV, physical and mental harms, or mortality in women of childbearing age. One good-quality trial compared usual care with prenatal and postpartum behavioral counseling for 1044 African-American patients who were pregnant or postpartum. The counseling emphasized safety behaviors and information on community resources. Intimate partner violence was among several outcomes measured by using an anonymous computer interview. Women in the intervention group had significantly fewer episodes of IPV during pregnancy and postpartum, as well as better birth outcomes (fewer premature neonates). Although the intervention was targeted to African-American women, the USPSTF determined that the potential benefit from the intervention could apply to other populations. Women in the intervention group had fewer recurrent episodes of IPV during pregnancy and postpartum (adjusted odds ratio, 0.48 [95% CI, 0.29 to 0.80]) (13).

One fair-quality trial evaluated a 3-year home visitation program with 685 mothers who gave birth to an infant determined to be at risk for maltreatment. The visits

were conducted by paraprofessionals from 3 community agencies, with a focus on promoting child health and decreasing child maltreatment by linking families to community services. The average number of home visits in the first year was 13.6. In addition to receiving emotional support, parents were taught about child development and received role-modeling, positive parenting, and problem-solving strategies. The intervention group had lower rates of IPV victimization and perpetration and lower rates of physical assault victimization and perpetration. No differences in sexual violence, verbal abuse, or injury were found (43).

In a trial evaluating a mentoring support program versus usual care, outcomes measured were abuse, depression, well-being, parenting stress, and social support. The trial enrolled women in primary care clinics who disclosed IPV or had behavioral symptoms suggestive of abuse. Abuse scores were significantly reduced in the intervention versus comparison groups. Differences for the other outcomes were not significant (44).

Pregnancy coercion is defined as a lack of control over a woman's reproductive health, including compromised decision making or limited ability to use contraception and family planning and fear of condom negotiation (45). One trial compared a counseling intervention to reduce abuse related to pregnancy coercion with usual care. Women in the intervention group who reported IPV at baseline had decreased pregnancy coercion and were more likely to discontinue an unhealthy or unsafe relationship than women receiving usual care, regardless of recent IPV status (45).

In another trial, women were randomly assigned to receive a referral card with a safety plan and resources for IPV services or a 20-minute nurse case management protocol (March of Dimes) that included a brochure with a 15-item safety plan, supportive care, anticipatory guidance, and guided referrals (46). Both study groups reported fewer threats of abuse, assaults, risks for homicide, and events of work harassment compared with baseline.

The estimated cost of implementing the interventions studied varies widely. For example, the counseling intervention (13) achieving the best results would require fewer resources than some of the interventions requiring new technology.

Potential Harms of Screening and Interventions

Fourteen studies evaluated the adverse effects of screening and interventions. Eleven of the studies were descriptive in design and 3 were randomized, controlled trials. Of the latter 3, 1 was a large trial of 6743 women that evaluated screening versus no screening and found no harms. Two trials reported no statistically significant harms compared with the nonintervention groups. The other studies were all descriptive in design, but none reported harms from screening.

Estimate of Magnitude of Net Benefit

The USPSTF determined that screening and interventions for IPV in women of childbearing age are associated with moderate health improvements through the reduction of exposure to abuse, as well as physical and mental harms and mortality. The overall associated harms were deemed no greater than small. Therefore, the USPSTF concludes with moderate certainty that the overall net benefit is moderate. The USPSTF determined that the studies were highly consistent and that the interventions seemed to have dose–response effects.

The USPSTF was not able to estimate the magnitude of net benefit for screening all elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect because there were no studies on the accuracy, effectiveness, or harms of screening.

How Does Evidence Fit With Biological Understanding?

The evidence on screening for IPV is based on a biopsychosocial framework rather than a pure biological model. As described by the CDC, IPV should be considered by using a socioecologic model, based on 4 specific elements: individual, relationship, community, and society (36).

Ample evidence shows that a person's response to violence can cause a biological response and have lasting effects on health. In addition to the possible injuries, chronic conditions frequently associated with long-term exposure to stress are possible. These include such mental health conditions as posttraumatic stress disorder, depression, anxiety disorders, substance abuse, and suicide. Various physical conditions also stem from IPV, such as chronic pain, neurologic disorders (from injuries), gastrointestinal disorders (for example, irritable bowel syndrome), migraine headaches, and other disabilities.

Response to Public Comments

A draft version of this recommendation statement was posted for public comment on the USPSTF Web site from 12 June through 10 July 2012. Some comments expressed concerns about the lack of a focus on violence against men and other missed populations in the scope of this review. Additional comments highlighted the existence of new evidence that had been published since the initial review. Several comments requested information for additional resources or tools to assist providers in responding to patients experiencing IPV. Finally, some comments focused on the exclusion of women age 46 years and older in the recommendation. In response to these comments, the USPSTF acknowledged the prevalence of abuse against men and agreed that in addition to women older than age 46 years and the elderly, there are many understudied issues. The USPSTF also included specific information in the statement to help providers find additional resources and tools.

Update of Previous Recommendation

In 2004, the USPSTF issued an I statement for screening women for IPV and older adults or their caregivers for elder abuse. In that review, the USPSTF found no direct

evidence that screening for IPV leads to decreased disability or premature death. It also found no existing studies that determined the accuracy of screening tools. The USPSTF found limited evidence on whether interventions reduce harm to women and no studies that examined the effectiveness of interventions in older adults. In the current recommendation, the USPSTF recommends screening women of childbearing age on the basis of research showing high diagnostic accuracy in detecting current or past abuse. Research also demonstrates improved outcomes in trials of interventions to reduce exposure to abuse.

The evidence for screening elderly and vulnerable adults remains insufficient; therefore, the USPSTF was unable to make a recommendation in favor of or against screening (I statement).

Recommendations of Others

The American Congress of Obstetricians and Gynecologists recommends that physicians screen all women for IPV (47). For women who are not pregnant, screening should occur at routine obstetric–gynecology visits, family planning visits, and preconception visits. For women who are pregnant, screening should occur over the course of the pregnancy, including at the first prenatal visit, at least once per trimester, and at the postpartum checkup. The American Medical Association states that physicians should routinely inquire about physical, sexual, and psychological abuse as part of the medical history (48). Physicians should also consider abuse as a factor in the presentation of medical complaints because patients' experiences with interpersonal violence or abuse may adversely affect their health status or ability to adhere to medical recommendations. Other organizations, such as the American Academy of Family Physicians, American College of Emergency Physicians, American Academy of Pediatrics, and Emergency Nurses Association, all have statements encouraging clinicians to be especially aware of the dynamics of family violence and the risk factors commonly found with those experiencing IPV. Further, clinicians should be prepared to respond appropriately and refer patients to available community resources where possible.

In addition to recommendations for screening for IPV in all patients, some groups have specific, targeted opinion statements on screening for all forms of abuse, including screening all elderly patients for abusive or violent treatment by family, caretakers, or others. The American Medical Association and the American Academy of Neurology both have specific position statements on screening elderly patients for abuse.

From the U.S. Preventive Services Task Force, Rockville, Maryland.

Financial Support: The USPSTF is an independent, voluntary body. The U.S. Congress mandates that the Agency for Healthcare Research and Quality support the operations of the USPSTF.

Potential Conflicts of Interest: Disclosure forms from USPSTF members can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M12-3146.

Requests for Single Reprints: Reprints are available from the USPSTF Web site (www.uspreventiveservicestaskforce.org).

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Appendix: U.S. Preventive Services Task Force

Members of the U.S. Preventive Services Task Force† at the time this recommendation was finalized are Virginia A. Moyer, MD, MPH, *Chair* (Baylor College of Medicine, Houston, Texas); Michael L. LeFevre, MD, MSPH, *Co-Vice Chair* (University of Missouri School of Medicine, Columbia, Missouri); Albert L. Siu, MD, MSPH, *Co-Vice Chair* (Mount Sinai School of Medicine, New York, New York, and James J. Peters Veterans Affairs Medical Center, Bronx, New York); Linda Ciofu Baumann, PhD, RN (University of Wisconsin, Madison, Wisconsin); Kirsten Bibbins-Domingo, PhD, MD (University of California, San Francisco, San Francisco, California); Susan J. Curry, PhD (University of Iowa College of Public Health, Iowa City, Iowa); Mark Ebell, MD, MS (University of Georgia, Athens, Georgia); Glenn Flores, MD (University of Texas Southwestern, Dallas, Texas); Adelita Gonzales Cantu, RN, PhD (University of Texas Health Science Center, San Antonio, Texas); David C. Grossman, MD, MPH (Group Health Cooperative, Seattle, Washington); Jessica Herzstein, MD, MPH (Air Products, Allentown, Pennsylvania); Joy Melnikow, MD, MPH (University of California Davis, Sacramento, California); Wanda K. Nicholson, MD, MPH, MBA (University of North Carolina School of Medicine, Chapel Hill, North Carolina); Douglas K. Owens, MD, MS (Veteran Affairs Palo Alto Health Care System, Palo Alto, California, and Stanford University, Stanford, California); Carolina Reyes, MD, MPH (Virginia Hospital Center, Arlington, Virginia); and Timothy J. Wilt, MD, MPH (University of Minnesota Department of Medicine and Minneapolis Veteran Affairs Medical Center, Minneapolis, Minnesota). Bernadette Melnyk, PhD, RN, a former USPSTF member, also contributed to the development of this recommendation.

† For a list of current Task Force members, go to www.uspreventiveservicestaskforce.org/members.htm.