

The Family Violence Prevention Fund's  
Review of the US Preventative Services Task Force  
Draft Recommendation and Rationale Statement on  
Screening for Family Violence

Submitted By:  
The Family Violence Prevention Fund's Research Committee

Elaine Alpert, MD, MPH  
Associate Professor  
Of Public Health and Medicine  
Boston University, School of Public Health

Ann Burgess, RN, NnSC  
Boston College School of Nursing

Jacquelyn Campbell, Ph.D, RN, FAAN  
Vice-Chair,  
Anna D. Wolf Endowed Professor  
Johns Hopkins University School of Nursing

Linda Chamberlain, PhD, MPH  
Director  
Alaska Family Violence Prevention Project

Ann L. Coker, PhD, MPH  
Associate Professor of Epidemiology  
School of Public Health  
University of Texas Health Sciences Center

Jeanne Hathaway MD, MPH  
Research Scientist  
Harvard School of Public Health

Lisa James, MA  
Program Manager  
Family Violence Prevention Fund

Dean Kilpatrick, PhD  
Professor and Director  
National Violence Against Women Prevention  
Resource Center  
National Crime Victims Research and Treatment  
Center  
Medical University of South Carolina

Debbie Lee  
Director of Health  
Family Violence Prevention Fund

Judith McFarlane, RN, DrPH, FAAN  
Parry Chair in Health Promotion and Disease  
Prevention  
Texas Women's University  
College of Nursing

Donald W. Parsons, MD,  
VP Physicians for a Violence-Free Society  
VP & Medical Director  
eHealth Solutions Group Inc.

Stacey B. Plichta, ScD, PhD  
Ass Professor  
Program in Urban Health Services  
College of Health Sciences  
Old Dominion University Norfolk

Robert Reece, MD  
Clinical Professor of Pediatrics  
Tufts University School of Medicine  
Visiting Professor of Pediatrics  
Dartmouth Medical School

Michael Rodriguez MD, MPH  
Associate Professor, UCLA  
Dept of Family and Community Medicine

Nancy Sugg, MD, MPH  
Associate Professor of Medicine  
University of Washington

Carole Warshaw, MD  
Director  
Mental Health and Public Policy Initiative  
Co-Director  
Hospital Crisis Intervention Project

Rebecca Whiteman  
Program Manager  
Family Violence Prevention Fund

Therese Zink MD, MPH  
Associate Professor  
Department of Family Medicine  
University of Cincinnati

**The Family Violence Prevention Fund**  
**383 Rhode Island Street, Suite 304**  
**San Francisco, CA 94103**  
**[www.endabuse.org](http://www.endabuse.org)**  
**415-252-8900 phone**  
**415-242-8900 fax**

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**Review of the US Preventive Services Task Force**  
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*In the fall of 2003, the Family Violence Prevention Fund (FVPF) was asked to comment on the U.S. Preventive Services Task Force Evidence Report on screening for family violence and proposed recommendation statement. The following was the FVPF's response.*

On behalf of the FVPF and the community of researchers who sit on our Research Committee (*please see roster attached*) who reviewed the document at our request, we want to thank you for the opportunity to comment on the USPSTF Draft Recommendation Statement on screening for family violence. We hope that by consolidating the comments and perspectives of prominent researchers in the field we will have substantially enhanced the breadth of the peer review process for this important topic. Although the statement covers three forms of family violence, we have confined our comments to issues of intimate partner violence (IPV) where our primary expertise lies, and which we feel should be drawn out into a separate review. While all are forms of family violence, IPV, child abuse, and elder abuse are radically different in terms of the population at-risk, health consequences, interventions, reporting requirements, and research implications.

The analysis and subsequent draft Recommendations Statement is problematic in several aspects:

- 1) The approach is based on screening as a medical consultation for identification of asymptomatic patients, rather than as a behavioral assessment tool. IPV is viewed by experts in the field as a chronic, recurrent, and usually escalating problem – much like alcohol abuse – that is not easily divided into symptomatic and non-symptomatic patients. In many cases, health problems that may be associated with abuse (such as depression, chronic pain, STI's, pelvic inflammatory disease, pregnancy complications, etc.) may not be addressed appropriately unless the clinicians ask about abuse. Therefore, listing the “symptoms” of IPV and then discerning what constitutes a medical screen vs. a diagnostic is complicated. Assessment and brief counseling about abuse should be considered in the framework of other important health risks and behaviors such as substance use, unintended pregnancies and safety practices, for which the USPSTF recommends interventions by clinicians.
- 2) Because the issue is approached in the USPSTF draft statement as a medical screen, all studies that involved patients presenting with trauma were excluded in assessment research related to all types of violence, whether it be child abuse and neglect, intimate partner violence or elder abuse. However, the exclusion criteria for the literature related to IPV is especially and inappropriately restrictive.
  - The Evidence Report indicates that of 806 abstracts related to screening that were identified in a literature search, only 14 met their inclusion criteria.
  - Of 667 abstracts on intervention studies, only 2 met their inclusion criteria, both related to pregnant women, studies that are later minimized as “too narrow to be applicable to a general population. Even an AHRQ funded study conducted by Robert Thompson and highlighted by the IOM Report on Assessing Interventions for Family Violence as a noteworthy example of a quasi-experimental study of the effectiveness of interventions, seems not to be included in the review.

As a consequence of this overly narrow approach to what the most relevant research questions are, an important body of studies related to IPV was not considered. The

outcomes most closely focused on are harm, death and disability. In contrast, most researchers in the field would expect that measurable benefits (desirable outcomes) would include improved health and safety of the patient and their children, enhanced protective factors and decreased frequency and severity of physical and/or emotional abuse.

- 3) The draft statement also has what we view as an undue emphasis on potential harms of screening that is unsupported by any evidence. Any speculation on possible harms that is not suggested by research evidence should be deleted as simply opinion.

#### Suggested Approach to Strengthening the Recommendation Statement:

We urge the task force to take the additional time necessary to consider a review (separate from child abuse and elder abuse) of the fuller body of research related to the impact of intimate partner violence. We also urge you to examine assessment and counseling for intimate partner violence as a behavioral health practice using the same standards applied to other behavioral health recommendations before proceeding with a final recommendation.

Given the lack of evidence about potential harms of screening, and using an analytical framework that goes beyond harm, death and disability, the validity of the assessment tools should be examined within the framework of effective behavioral health practice. We offer suggestions from the FVPF's Research committee – all knowledgeable researchers in the field of IPV -- about what measurable outcomes are likely to be significant and would look forward to an opportunity to collaborate with you in the future.

#### 1. Behavioral Assessment vs. Medical Screen

**We suggest that the task force view IPV identification as a behavioral assessment as opposed to a medical screen and evaluate it's potential for risk reduction and public health benefit within the context behavioral health assessment and counseling.**

The likelihood of a victim of abuse or their children experiencing multiple psychosocial health problems substantiates the need for more comprehensive psychosocial assessments to ensure the highest quality of care. Recognizing this, the Maternal and Child Health Bureau has a special initiative on assessing pregnant women for domestic violence, depression, and substance abuse. In addition, most major professional health associations (including AMA, ANA, AAP, ACOG,) also endorse IPV assessments and interventions. However, because the USPSTF defines screening as those preventive services in which a special test or standardized examination procedure is used to identify asymptomatic patients requiring special intervention, tests involving symptomatic patients are not considered screening tests.

The usual definition of a medical screen doesn't fit well here due to the nature of IPV. For IPV, assessments identify asymptomatic patients as well as symptomatic patients (patients with unexplained injuries, chronic pain, conditions outlined in the health effects of IPV literature.) Clinicians who screen are attempting to identify the undiagnosed patient who is experiencing IPV in order to link them with resources. Based on the current evidence in the literature linking health effects and IPV, Rhodes (Rhodes, Levinson, 2003) asserts that physicians will continue to see patients who are abused and that the identification of the abuse may influence the evaluation of the presenting complaints as well as the outcomes of care. (Rhodes, Levinson, 2003).

#### 2. Public Health Benefits of Assessment and Counseling for Intimate Partner Violence

The current draft statement notes that the Task Force cannot support screening because no direct evidence was found that assessing for IPV leads to decreased disability and premature death. The inclusion criteria emphasized randomized clinical trials. We recognize the value of randomized clinical trials in establishing both the benefit and potential harm of screening and other interventions in health care settings. However because using a control group that receives no intervention may be considered unethical, we feel a behavioral health assessment model that focuses on public health benefits and risk reduction is more appropriate.

We do not regard a lack of RTC studies as a fatal weakness in the literature on IPV, just as it has not been so applied in other USPSTF work. The USPSTF recommends assessment and counseling for a variety of health risks in the absence of major evidence from randomized clinical trials on the basis that these interventions, even if modest in terms of effectiveness, are likely to have enormous public health benefit and potential for risk reduction. Examples of clinical preventive services that are similar to IPV and recommended by previous Task Force reports are assessment of adolescents for drinking and drug use and counsel on alcohol and drug abstinence; assessment of adolescents for tobacco use and provide anti-tobacco message or advice to quit, assess oral health practices and provide counseling; assessment of the safety practices of all person aged 4 years or older and provide counseling; counseling for unintended pregnancy.

Assessment and brief counseling for domestic violence should be evaluated within the same framework that has been applied to these other important health risks and behaviors. By way of another example, the USPSTF has recommended that clinicians counsel for unintended pregnancy and noted that “Although their ability to influence patient sexual behavior may be limited, clinicians can offer information about contraceptive options...the public health benefits of better contraceptive practices would be enormous...” A similar rationale can be used to support assessment and brief counseling for domestic violence. The public health benefit of identifying a history of victimization within the context of other psychosocial health problems and risk behaviors, giving supportive messages to patient who disclose abuse, and providing appropriate referrals could prevent future injuries, illness, and improve overall quality of care.

**Based on our recommendation to evaluate IPV within context of a behavioral health assessment, we urge the task force to extend its review of the literature before proceeding with a final Recommendation Statement.**

This will permit the Task Force to consider the literature on risk reduction and public health benefits of IPV assessments and to examine studies that look at the impact of referral to support services, safety planning, on-site advocacy etc. as opposed to RCT's for medical screening. Because we have had less than two weeks to provide our review, our Research Committee had too little time to begin the kind of comprehensive review need, nor would that necessarily be helpful to you given your need for independent assessment. However, we can make a few suggestions on expanded directions: (Short, Johnson & Osattin, 1998; Harris, M.H. and M. Weber (2002); Hathaway, J.E., G. Willis, et. Al. (2002).; Krasnoff, M. and R. Moscati (2002); McCaw, B., W.H. Berman, et al. (2001); Muelleman, R.L. and K.M. Feighny (1999); Short, L.M., S. M. Hadley, et al., 2002; Sullivan CM, Bybee DI. 1999).

### 3. Completing the Picture of the Public Health Impact of IPV

Our proposal for a broader approach to the Task Force is supported by the large body of research in the field about the long-term public health impact of IPV on victims and their children. In addition to injuries, disability and death normally associated with IPV, women who have been victimized by an intimate partner and children raised in violent households are more likely to experience a wide array of chronic physical and mental health conditions including frequent headaches, gastrointestinal problems, depression, anxiety, sleep problems and Post Traumatic Stress Disorder (PTSD). (A.L. Coker, Smith, Bethea, King, McKeown 2002; Campbell, JC,

Lewandowski LA. 1997; Lehmann P. 2000; Graham-Bermann SA, Levendosky AA, 1998) A substantial body of research has documented the correlation between domestic violence and other psychosocial health problems and risk behaviors including smoking, drinking, drug use, unintended pregnancy, and increased risk of being diagnosed with a sexually transmitted disease. Recent studies have demonstrated a connection between IPV and eight out of ten of the Leading Health Indicators (LHI's) for the federal Healthy People 2010 Initiative. We urge the task force to consider the body of research that examines these connections such as those studies listed in **Attachment A**.

#### 4. Balancing Harm and Benefits of Assessing for Family Violence:

The draft recommendation statement claims that because there are no studies that address the harms of screening and interventions for IPV, the Task Force could not determine the balance between the benefits and harms of screening. Indeed, since the 1996 recommendation, we know of no research to suggest that assessment and/or interventions in health care settings are harmful to patients. Yet, the draft statement suggests that potential harm of interventions “*may include psychological distress, an escalation of abuse, loss of contact with established support systems, loss of personal residence and financial resources, loss of autonomy for the victims, lost time from work, and increased abuse and stress*” without citing specific studies to support the statement. In the systematic evidence review, the review by Ramsay et al. (Ramsay, Richardson, Carter, Davidson, and Feder 2002) is referenced. In reviewing this manuscript, we see no study reference that notes that screening is harmful. The authors do note that additional research (randomized clinical trials) “is needed to test the effectiveness and safety of interventions for violence in health care settings”. We are therefore unclear why screening may be viewed as harmful based on this citation.

Statements about potential harms are also refuted by the research cited in the report: “Most women who were asked about domestic violence in a study of screening in antenatal clinics believed it was a good idea (98%) and felt “OK” during the process (96%) when asked at a subsequent visit. There is clear evidence from a range of studies that women endorse assessment for violence. In one study cited in the USPSTF report, eighty three percent of both abused and not abused women said it would be easier for abused women to get help if health care providers routinely screened for violence (Gielen, et al., 2000). While about half these same women reported that they might be embarrassed by the questions (Gielen, et al., 2000) they still endorsed being asked. Qualitative work with victims shows that victims want health care providers to ask about IPV even if the victims chose not to disclose their IPV. Studies from over 200 victims had the recurring theme advising health care providers to ask about IPV (Bauer & Rodriguez, 1995; Gerbert, Abercrombie, Caspers, Love, & Bronstone, 1999; Gerbert et al., 1996; Gielen et al., 2000; Grunfeld, Larsson, Mackay, & Hotch, 1996; Hathaway, Willis, & Zimmer, 2002; McCauley, Yurk, Jenckes, & Ford, 1998; Nicolaidis, 2002; Rodriguez, Quiroga, & Bauer, 1996; Zink, Jacobson, & Elder, 2003)

#### 5. Health Consequences of Missed Opportunities to Screen

In addition, emerging literature notes “missed opportunities” for interventions in health care. These missed opportunities for identification could mean the difference between life and death for victims of abuse. Sharps (Sharps, et al. 2001) notes that two-thirds of women had sought medical care (50%) in the year prior to the murder. Similarly, Wadman and Muelleman (Wadman, R.L. 1999) found that homicide victims are not identified or appropriately referred in emergency departments. Finally, Coker et al. (A.L. Coker, Bethea, Smith, Fadden, & Brandt 2002) found that only 17% of women who reported partner violence in personal interviews with study staff, had any indication of violence noted in their medical record. These illustrations of missed opportunities are crucial to our position that harm is done when assessment for family violence is *not* under taken.

As noted below, research is currently being conducted to address the impact of assessments and interventions. Two prospective intervention trials do not find evidence that assessment and intervention are harmful and both find that assessment alone is as effective as assessment with an intervention in reducing violence over time (McFarlane, Soeken, & Wiist 2000; Parker, McFarlane, Soeken, Silva, & Reed, 1999). Existing research finds that assessing for family violence is an effective intervention in and of itself. As the Task Force Evidence review indicates, after medical associations endorsed assessing for IPV, rates of abused declined by 21% (Cole, 2000). Assessment can be viewed as a first step of an intervention continuum. Intervention studies cited in recommendation statement report significantly lower levels of violence following intervention. In short, more data is available to support assessing for violence but the recommendation places emphasis on the potential (and unsupported) harms of routine inquiry.

## 6. Protecting Pregnant Women

We would also encourage a reevaluation of the studies on intervention in light of the fact that no data suggests that interventions are harmful to the patient. The Recommendation statement notes one randomized clinical trial (McFarlane, et al., 2000) and one non-randomized intervention (Parker, et al., 1999). Both studies were interventions to reduce violence among pregnant women. Both studies showed a significant reduction in reported frequency and severity of abuse following a randomized trial comparing 3 interventions. No harmful events of assessment were observed in either study (Parker, et al. 1999; McFarlane, et al 2000). The USPSTF report noted the narrow population (pregnant women) and reliance of self-report data as justification for the fair quality rating. However, due to the nature of partner violence, and as with other behavioral health issues (such as substance use, sexual practices, etc), we must rely on self-reports by the victim for disclosure for victimization. The victim is the only source of these data.

The USPSTF also notes that the pregnant patient populations studied are too narrow, meaning that the findings lack generalizability to other (larger) populations. Our reaction to this is that pregnant women are a fairly large population of interest, albeit one with specialized needs and importance to society. Further, there is good evidence that pregnant women are a higher risk than the general population and it is of critical importance to identify violence victims before harm to the fetus also results.

## 7. Validity of Assessment Tools and Intervention:

### **Evidence supporting the benefits of existing assessment and counseling tools as reviewed by the Task Force should be re-examined using a new behavioral health framework.**

The current USPSTF draft recommendations state that no assessment questions are validated against a measurable outcome. We respectfully submit that there is a literature documenting the reliability and validity of several assessment tools. Several studies have compared brief assessment tools to previously validated instruments and were rated good or fair in quality (Brown, Lent, Schmidt, & Sas, 2000; A.L. Coker, Pope, Smith, Sanderson, & Hussey, 2001; Feldhaus et al., 1997; McFarlane, Parker, Soeken, & Bullock, 1992; Pan, Ehrensaft, Heyman, O'Leary, & Schwartz, 1997; Sherin, Sinacore, Li, Zitter, & Shakil, 1998; Smith, Earp, & DeVellis, 1995). These instruments include the Abuse Assessment Screen, Partner Violence Screen, the Women's Experience with Battering Scale, Woman Abuse Screening Tool, and the HITS Scale.

We also question the statement that "no screening instrument demonstrated 100% sensitivity and specificity" (top of page 13) because in fact no assessment tool can have both perfect sensitivity and specificity (Gordis, 2000). To illustrate, the widely used Pap smear has a 50% sensitivity and an 80% specificity relative to the cervical biopsy (Fahey, Irwing, & Macaskill, 1995; Nanda, McCrory, & Myers, 2000). Based on the literature cited by the USPSTF the summary statement

“None [of the studies], however, have been evaluated against measurable intimate partner violence outcomes” is puzzling since the majority of the referenced studies compare the screening tools to the Conflict Tactics Scale or the Index of Spouse Abuse, two now standard instruments that have been widely validated (Attala, Hudson & McSweeney 1994; Straus, Hamby, Boney, McCoy & D.B 1996; Hamby, Poindextery & Gray-Little 1996). Again, it is important to note that assessment tools for IPV are of considerably higher quality and supported by significantly more research than assessment practices recommended by the USPSTF in other behavioral health arenas including assessing adolescents for drug use and assessing oral health practices.

#### 8. Consideration of New Research

**We would like to see a reexamination of the literature include preliminary results from an important intervention trial currently underway that was sponsored by the Agency for Health Research & Quality (AHRQ).**

In FY 2000, AHRQ funded several major intimate partner screening and intervention studies, yet the purpose and objectives of these studies were not addressed by the report. The first year results of a study based in Houston were reported at a recent conference sponsored by University of Kentucky. To summarize, a randomized, two arm, clinical trial is being completed in public primary care clinics in Houston to test two levels of intervention: assessment and a wallet-size information card or assessment and a 20-minute nurse case management protocol that focuses on safety planning and community resource use.

**Preliminary results:** Differences in number of threats, assaults, danger risks for homicide, events of work harassment, safety behaviors adopted and use of community resources, between groups showed that at six and 12 months following treatment both groups of women reported significantly less violence. The researchers concluded that women in public health clinics who disclosed intimate partner violence on a two-question two-minute screen reported decreases in abuse, regardless of treatment group – nurse case management or a simple information card. The report is presently being reviewed by JAMA. No harmful effect of the assessment or intervention was noted in this study. Assessment was as effective as assessment and interventions in reducing violence.

#### 9. Implications of Current USPSTF Draft Recommendations for Family Violence Screening for public and Medical Health Professionals:

**The USPSTF rating for family violence will have significant impact on existing efforts to identify and prevent violence. Assessing for abuse is a crucial strategy towards secondary prevention or early identification of violence that has the potential to improve health, prevent injuries and save lives.**

We are very concerned that the health care provider communities will interpret the USPSTF recommendations to mean that assessing for and responding to victims of abuse should not be undertaken by health care professionals. However, these professionals are under some pressure to develop and implement protocols to meet JCAHO and numerous professional organizations' recommendations. Considerable effort has already been invested to help health care providers understand the value of asking about partner violence. We fear that these efforts of professional organizations and health care systems to ensure that women are assessed for IPV will be undermined or cancelled. What health care system would undertake an IPV assessment program at some cost in the face of a Task Force report that states, without good foundation, about possible harm to patients?

It is interesting to note that when the Task Force reviewed this issue in 1996 and family violence assessment was analyzed as a medical screen, it was rated a "C." Although the 1996 recommendations could not recommend the use of specific screening instruments, these did encourage screening *and* noted that screening increased identification (refs). The 1996 recommendations cited additional factors that support screening (costs, burden of suffering, repetitive nature of abuse etc). Research published since the 1996 recommendations (Ulrich, et al. 2003; Control, 2003; Wisner, Gilmer, Saltzman & Zink 1999) document the cost of violence and illustrate the implications of child and partner violence over the life span (A.L. Coker, 2002; Desai, Arias, Thompson & Basile, 2002; Dube et al., 2001; Felitti JV, Anda, Nordenberg, et al. 1998). These newly published studies bolster the 1996 recommendations and further support the need for assessment and intervention.

#### 10. Conclusion of Peer Review

The USPSTF draft statement is too limited in approach and in assessment of what literature was relevant. We feel strongly that a valid analysis must include the growing a body of evidence published since 1996 recommendations that support the need for assessment and brief counseling for family violence as part of a behavioral health assessment. Women continue to accept routine inquiry, evidence exists to indicate that assessments can improve identification and some health outcomes and the public health benefits resulting from such assessments are significant. Based on our experience and the additional relevant studies in the field, we would expect the Task Force to increase its rating to a B, not move to an I recommendation.

**Again, we urge the task force consider IPV as a separate category from elder abuse and child abuse and we urge you to take the additional time necessary to consider a fuller body of research related to assessment for intimate partner violence before proceeding with a final recommendation.**

We offer collaboration with the FVPF's Research Committee about what measurable outcomes are likely to be significant. We would welcome a chance to meet with Task Force members and/or staff if there are questions about our comments or the relevant issues involved.

Thank you for the opportunity to review and respond to the draft recommendations.

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## **Appendix A:**

### **Expanding the Picture of Health Outcomes of Intimate Partner Violence**

#### **Intimate Partner Violence and Tobacco Use**

Women who experience IPV are more likely than non-abused women to abuse tobacco. In a 1998 study of 2,043 women aged 18 to 59, approximately one-half of women who reported IPV in the past year were current smokers. By comparison, only 23.5% of women who did not disclose abuse were current smokers.<sup>i</sup> In a study of 557 women, 42% of women who reported a history of lifetime IPV currently smoked cigarettes, compared to 26.2% of women did not disclose IPV.<sup>ii</sup> Adolescent girls who witnessed IPV are 2.3 times more likely to use tobacco and marijuana.<sup>iii</sup> In a 1997 sample of 5,414 public high school students, 52.8% of students who reported severe dating violence (SDV) self-identified as current smokers, compared to 34.2% of students who did not disclose SDV.<sup>iv</sup>

#### **Intimate Partner Violence and Substance Abuse**

Spousal abuse has been identified as a predictor of developing a substance abuse problem. Additionally, it has been reported that women in abusive relationships have often reported being coerced into using alcohol by their partners.<sup>v</sup> Substance abuse and high-risk alcohol use is more prevalent among women who experience IPV compared to women who have not experienced IPV. In a study of 1600 women, women who experienced physical, sexual, or psychological abuse by an intimate partner in the past 12 months were more likely to consume on average three or more alcoholic drinks per occasion at least one time per week in the previous year compared to women who did not disclose IPV.<sup>vi</sup> In another study of 557 women, women who reported having experienced lifetime IPV were three times more likely to binge drink (5+ drinks per day) compared to women who reported no instances of violence.<sup>vii</sup> In a 1997 sample of 5,414 public high school students, 34.2% of students who reported severe dating violence (SDV) admitted use of illegal drugs (excluding marijuana), compared to 17.8% of students who reported no SDV.<sup>viii</sup> Girls who reported that they had been sexually or physically abused were more than twice as likely as non-abused girls to report drinking (22 percent versus 12 percent) and using illicit drugs (30 percent versus 13 percent).<sup>ix</sup> In a study of more than 2000 prenatal patients in North Carolina victims of violence were significantly more likely to use multiple substances before and during pregnancy than women who had not experienced IPV.<sup>x</sup>

#### **Intimate Partner Violence and Responsible Sexual Behavior**

Women and adolescents in abusive relationships are often forced or coerced into unwanted sexual activity.<sup>xi</sup> This can impact their ability to care for their reproductive health. Teens who have experienced violence in a relationship may not believe that they can control what happens to their bodies and may have difficulty making choices that prevent them from exposure to further abuse or unintended sexual consequences.<sup>xii</sup> In a study of 486 women seeking an abortion, 39.5% reported abuse.<sup>xiii</sup> In a similar study on the lifetime prevalence of IPV among women seeking gynecological care, 27.3% of those seeking an abortion reported a history of abuse, compared to 8.2% of self-reporting women who were not seeking an abortion.<sup>xiv</sup> In a study of 310 HIV positive women, 68% had experienced physical abuse as adults, 32% had experienced sexual abuse as adults and 45% experienced abuse after being diagnosed with HIV.<sup>xv</sup> In a 1999 study, it was found that 40% of women with a history of physical, sexual and/or emotional abuse had been diagnosed with one or more sexually transmitted infection (STI). In comparison, 18% of non-abused women had been diagnosed with one or more STI.<sup>xvi</sup> Women with history of DV are more likely to experience pelvic inflammatory disease,<sup>xvii</sup> invasive cervical cancer and preinvasive cervical neoplasia.<sup>xviii</sup>

In sample of 5414 public high school students, grades 9 through 12, who responded to the 1997 self-administered South Carolina Youth Risk Behavior Survey, 28% of those reporting severe dating violence (SDV) reported having ever been pregnant or caused a pregnancy compared to 12.9% of those who reported no SDV.<sup>xx</sup> A 1996-1999 study of 522 single African American females ages 14-18 found that adolescents with a history of dating violence were 2.8 times more likely to have a sexually transmitted disease, 2.8 times more likely to have non-monogamous male partners, and half as unlikely to use condoms consistently.<sup>xx</sup> In a study of young mothers on public assistance, half (51 percent) reported experiencing birth control sabotage by a dating partner.<sup>xxi</sup> A 1998 Massachusetts Behavioral Risk Factor Surveillance System studying 2043 pregnant women aged 18 to 59 years old found that among women who had experienced IPV in the past 5 years, nearly 40% reported that the pregnancy was unwanted, compared to 8% of those who did not experience IPV.<sup>xxii</sup>

### Intimate Partner Violence and Immunization

Children of mothers experiencing abuse are less likely to complete immunizations compared to children whose mothers did not report abuse, possibly due a partner's control of health care access, and health insurance. A study of 148 pairs of mothers and children residing at five women's refuges found that 30% of the children failed to complete immunizations.<sup>xxiii</sup> Data collected on preschool children of 130 women indicated that children of battered women were less likely to be up to date on their immunizations than children of non-battered women.<sup>xxiv</sup>

### Intimate Partner Violence and Access to Health Care

Female victims of IPV are generally less likely to access preventative and injury related health care compared to non-abused women. A 2002 study by the US Department of Justice found that most victims injured by intimate partner violence did not report seeking professional medical treatment for their injuries.<sup>xxv</sup> In a 1998 Massachusetts Behavioral Risk Factor Surveillance System Survey of women aged 18 to 59, 33% of the 2043 women who reported intimate partner violence in the past year had no health insurance in the past year, as compared to 14.2% of women who did not disclose abuse.<sup>xxvi</sup> In another study, 22% of battered teens began prenatal care in the third trimester of pregnancy, compared with 7.5% of non-battered teens.<sup>xxvii</sup> A 1992 study of 691 black, Hispanic, and white pregnant women in public prenatal clinics in Houston, Texas; and Baltimore, Maryland found that abused women were twice as likely to begin prenatal care during the third trimester than women who did not disclose abuse.<sup>xxviii</sup> Older women and women with more financial resources who reported physical violence were more likely to delay entry into prenatal care than younger or less affluent nonabused women.<sup>xxix</sup>

### Mental Health

Women survivors of IPV are at increased risk for suffering serious mental health problems that can continue years after the abuse has ended.<sup>xxx</sup> We have listed the findings of an important meta-analysis summarizing the mental health affects of partner violence<sup>xxxi</sup> in the following table.

<b><u>Disorder</u></b>	<b><u>Weighted mean</u> <u>Prevalence among domestic</u> <u>abuse victims</u></b>	<b><u>Lifetime prevalence among</u> <u>general population</u></b>
Alcohol abuse/dependence	19%	5-8%
Depression	48%	10% to 21%
Drug abuse disorder	9%	5% to 6%
Posttraumatic stress disorder	64%	1% to 12%
Suicidality	18% (ideation and attempts)	Ideation 1-16% Attempts <1-4%

### Child Witness to IPV:

Intimate partner violence does not only affect the victim but her children as well. We urge the USPSTF to also review the literature addressing the impact on children of witnessing IPV. For example, research shows that four to forty percent of children in pediatric offices are currently living in homes with DV.<sup>xxxii xxxiii xxxiv</sup> An estimated 3.3-10 million children witness DV annually in the United States.<sup>xxxv</sup> The extensive literature on the impact of witnessing IPV suggests associations with attention deficit and hyperactivity, behavioral problems such as acting out, school problems, withdrawal, aggressiveness and disrespect toward the mother/victim, increased involvement in risky behaviors (drugs, sex, alcohol); psychological problems such as depression, anxiety and PTSD; and more chronic physical complaints.<sup>xxxvi xxxvii xxxviii xxxix xli xlii xliii xliv xlv</sup> A review article<sup>xlvi</sup> and a meta-analysis<sup>xlvii</sup> of the effects on children of witnessing DV concluded that children exposed to inter-parental violence fare poorer than the average unexposed child.<sup>xlviii</sup>

### Adults who Witnessed IPV as Children:

The cycle continues as children with adverse childhood experiences, including witnessing IPV, grow up to have significantly higher risk of smoking, alcoholism, substance abuse, obesity, depression and health problems relating to those issues such as chronic obstructive pulmonary disease, hepatitis, heart disease, depression, and suicide.<sup>xlix</sup>

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