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Intimate Partner Violence Screening and Counseling: An Introductory Session for Health Care Professionals

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Abstract

Introduction: Intimate partner violence is a serious public health concern in the United States. Despite recommendations that physicians should routinely screen their patients, research has shown that lack of specific training has resulted in many health care professionals feeling unable to adequately perform this difficult but vital task. Though many educational resources exist to teach intimate partner violence screening, they often lack specific guidance on how to navigate this difficult conversation. In addition, they often lack formal teaching on how to counsel and refer patients who are victims of intimate partner violence. **Methods:** This unique module, intended for a small-group setting of four to eight students, contains an intimate partner violence checklist with sample language that covers both screening and counseling using a motivational interviewing framework. Additional materials include a checklist companion for tips on how to navigate the conversation, two cases for role-play, a facilitator guide, and an objective structured clinical encounter case and assessment rubric. **Results:** This module was given to 260 second-year medical students at the Warren Alpert Medical School between 2015 and 2017 and was rated highly by almost 90% of students. **Discussion:** After completing this module, learners will be able to appropriately screen for intimate partner violence as well as counsel and refer patients who have screened positive. By implementing this module, educators can increase the number of health care professionals able to broach this difficult conversation with patients who may be in need of help and may otherwise go unaided.

Keywords

Counseling, Intimate Partner Violence, Motivational Interviewing, Clinical Skills Training

Appendices

- A. IPV Screening and Counseling Checklist.pdf
- B. IPV Checklist Companion .pdf
- C. IPV Faculty Guide.pdf
- D. IPV Case 1.pdf
- E. IPV Case 2.pdf
- F. IPV Local Resources.pdf
- G. IPV OSCE Case.pdf
- H. IPV OSCE Grading Rubric .pdf

All appendices are peer reviewed as integral parts of the Original Publication.

Educational Objectives

By the end of this session, learners will be able to:

1. Recognize signs and symptoms of intimate partner violence.
2. Utilize interview techniques to screen patients for intimate partner violence.
3. Navigate potential roadblocks during the patient interview, such as denial and resistance to change, using the motivational interviewing framework.
4. Identify resources to support victims of intimate partner violence.

Introduction

Intimate partner violence (IPV) is a serious public health concern in the United States. An estimated 20 Americans per minute are victims of physical violence by an intimate partner, with 43.9% of women and 23.4% of men experiencing sexual violence victimization other than rape over the course of their lifetime.¹ As of 2013, the U.S. Preventive Services Task Force recommends “that all clinicians screen women of childbearing age for intimate partner violence . . . and provide or refer women who screen positive to intervention services.”²

Research has shown that screening, counseling, and referring IPV victims to treatment constitute a promising initial step towards addressing the problem of IPV in health care settings.^{3,4} A 2015 Cochrane review found that provider intervention and advocacy were particularly beneficial in populations of

pregnant women, also noting that studies on IPV screening and counseling showed improved overall quality of life and reduction in depression and “may help women make safety plans, deal with abuse, and access community resources.”⁵ A randomized control trial by Klevens, Sadowski, Kee, and Garcia found that providing counseling and formal screening, in addition to resources, increased female patients’ awareness that the violence is not the victim’s fault.⁶

Health care providers are in an excellent position to screen, counsel, and recommend treatment for IPV victims. However, many providers do not feel comfortable having this difficult conversation with patients. A recent review article by Sprague and colleagues examined barriers to IPV screening and found that provider-related barriers were the major and most frequent ones in comparison to patient-related barriers.⁷ The provider-related barriers included “personal discomfort with the issue, lack of knowledge, and time constraints.”⁷ A 2001 study by Jonassen, Mazor, and Sefton found that medical students and residents who felt competent in screening for IPV were more likely to screen, indicating that training to improve competence may increase rates of provider-initiated screening for IPV.⁸

Many resources have been developed to teach medical students and residents how to screen for IPV.^{9,10} However, such resources often are missing two key components. First, they lack specific guidance on how to navigate the difficult conversation that often follows after screening questions are performed. Second, they lack formal teaching on how to counsel and refer patients who screen positive for IPV. Our module addresses these issues by providing specific guidance on how to screen for IPV, counsel a victim of IPV, navigate the conversation, anticipate and respond to problems that may arise in the conversation, and successfully refer the patient to local services for IPV. To our knowledge, none of the existing resources covers all of these objectives within the same curriculum.

This self-contained module for health care professionals can be inserted into any graduate or postgraduate medical curriculum and provides learners with a more comprehensive approach to successfully screen, counsel, and refer patients who are victims of IPV. Although no specific prerequisite knowledge or experience is required, this curriculum would be best implemented within an established educational program (such as medical school or a residency program) where learners have experience conducting a medical interview and providing patients with educational materials and referrals. Educators can utilize this curriculum to teach medical students, residents, practicing physicians, and other health care providers how to address IPV in a variety of clinical settings. Increasing the number of providers who are trained to effectively screen, counsel, and refer victims of IPV for services can continuously improve efforts to address this important and vital topic.

There is ample research to support mnemonics as a useful learning tool in medicine. A study specific to teaching IPV screening found that students who received a mnemonic-based teaching module demonstrated “a trend towards improved performance on all measures compared to those in the control group.”¹¹ Historically, IPV teaching at our institution focused only on screening. After several iterations of the original screening curriculum, we discovered a critical missing link: the need to respond and counsel appropriately when patients screen positive for IPV. To address this gap, we designed a checklist that incorporated both screening and counseling recommendations using the motivational interviewing (MI) framework, which was already in place for various other components of our curriculum, such as alcohol abuse and smoking cessation counseling. We based our checklist on recent literature that utilized MI techniques for IPV screening in the emergency department.¹² We modified the original five major steps to intervention (assess, advise, agree, assist, and arrange) of MI to better fit a discussion for IPV. The five major steps we utilized are (1) ask about IPV, (2) assess readiness to make a change, (3) advise on next steps, (4) assist and provide resources, and (5) arrange for follow-up. We also incorporated the HITS mnemonic, an IPV screening tool developed for use in family practice that was found to have a specificity of 86%-99% and a sensitivity of 30%-100%, into the new checklist.¹³ This screening tool uses a 5-point Likert scale (1 = *never*, 5 = *frequently*) and asks patients how often their intimate partner has ever physically

hurt, insulted or talked down to, threatened physically, or screamed or cursed at them.

We chose a checklist format for our main teaching tool as students are familiar with this format from other common clinical skills topics, such as medical interviewing and physical examination. The checklist includes sample language for learners to use as they practice navigating these difficult conversations. The IPV Screening and Counseling Checklist (Appendix A) is the main teaching tool in this module and can be used to teach learners how to screen, counsel, and refer victims of IPV to appropriate resources.

We used these resources to teach IPV screening and counseling to second-year medical students at the Warren Alpert Medical School of Brown University. Though this session was originally designed for an existing small-group-based clinical skills course that meets once weekly for 3 hours, the session can be inserted into any existing curriculum for graduate or postgraduate learners and can be adjusted based on time constraints.

Methods

Utilizing a flipped classroom model, learners were first asked to complete a reading assignment prior to the initial session.¹⁴ This prereading material can be adapted to meet the needs of the individual institution and/or curriculum. Learners were also given the IPV Screening and Counseling Checklist (Appendix A) and asked to review it before the session. Students were put into small groups of eight students, and each group had one physician faculty member and one social-behavioral science (SBS) faculty member who taught as a pair. The SBS faculty could come from various backgrounds, including social work, nursing, pastoral care, psychology, and health care administration.

A resource for faculty preparation, the IPV Faculty Guide (Appendix C), was created to help facilitators run the session. Faculty were also asked to read and prepare to role-play IPV Case 1 (Appendix D) and IPV Case 2 (Appendix E). These role-play cases were designed for learners to practice screening and counseling an IPV victim with either a faculty member or standardized patient (SP) playing the role of the patient.

Using the existing clinical skills course structure at our institution, this session is typically structured as follows:

- First hour: small-group discussion on readings and IPV materials.
- Second hour: Group one (four students) practices IPV screening and counseling with SBS faculty, and group two (four students) practices the physical exam with physician faculty.
- Third hour: Group one practices the physical exam with physician faculty, and group two practices IPV screening and counseling with SBS faculty.

This session may be inserted into an existing curriculum in any 1-hour time block for only four students, or potentially eight students if there are two faculty preceptors. Also, please note two important points. First, the concurrent physical exam practice mentioned above does not have to directly relate to the IPV curriculum and is not considered a part of the IPV session. Second, though physician faculty do not participate in this particular IPV session in our curriculum, they do observe the students performing IPV screening and counseling at a later date and provide direct feedback at that time. This session is specifically designed to be led by physician and nonphysician faculty members.

We have structured the introductory hour differently from year to year based on student feedback. Some years, we have organized a forum with a panel of providers who treat patients who are victims of IPV, while other years, the time has been spent in small groups reviewing the assigned reading and materials. Individuals using this module can decide whether an introductory hour is needed and, if so, whether a panel of local providers or a small-group discussion would fit better into the existing curricular structure. Alternatively, the small-group discussion may be omitted completely in favor of solely practicing the role-

plays.

For the role-plays, the students broke into two groups of four. The first group practiced IPV screening with one faculty member, while the second group practiced physical exam skills. The groups switched after 1 hour. Students in the IPV group were given 10-12 minutes each to practice screening and counseling an IPV victim, using IPV Case 1 (Appendix D) and IPV Case 2 (Appendix E), with the role of the patient played by the SBS faculty. It is imperative that a faculty member (or SP) play the role of the patient, as learners may have personal experience with IPV and playing the role of an IPV victim in a simulated setting may be triggering for the learner.

Each case was designed with a specific barrier to counseling IPV patients in mind. Only the faculty members knew the details of the case; the learners were given just a one-line chief complaint and asked to begin the interview with a social history and then transition to IPV screening/counseling. In the first part of IPV Case 1 (Appendix D), the barrier being addressed was a patient's resistance to intervention. The first student was allowed 10-12 minutes to interview the patient, using the checklist to guide the discussion. The faculty member played the role of the patient, and the other three learners observed the interaction. After the first student finished, he or she received feedback from faculty and peers. The faculty member then led a brief discussion about the common challenge of resistance to treatment and provided students with advice on how to navigate that challenge. Suggested tips and suggestions were included with each case description. Next, a second student was allowed 10-12 minutes to practice the interview using the second part of IPV Case 1. This time, however, the student employed the newly acquired skill of managing resistance to change, and the faculty member (playing the role of the patient) responded to this attempt by agreeing to the student's proposed interventions. This case was followed by another brief discussion with the group as well as feedback for the learner.

The second case, IPV Case 2 (Appendix E), was taught in a similar fashion over the remaining 30 minutes, giving the third and fourth students 10-12 minutes each to practice the interview, with discussion and feedback after each interview. The major challenge in this case was the patient's denial that a problem existed. Following the third student's interview, feedback was provided to the student, and the faculty member led a discussion on how to navigate this conversation with a patient exhibiting denial.

The overall time line for the 1-hour session can be structured as follows:

- 10-12 minutes: student one interview; IPV Case 1 (Appendix D), first part.
- 3-5 minutes: feedback and discussion.
- 10-12 minutes: student two interview; IPV Case 1 (Appendix D), second part.
- 3-5 minutes: feedback and discussion.
- 10-12 minutes: student three interview; IPV Case 2 (Appendix E), first part.
- 3-5 minutes: feedback and discussion.
- 10-12 minutes: student four interview; IPV Case 2 (Appendix E), second part.
- 3-5 minutes: feedback and discussion.

The learners were also provided with local and national resources for IPV victims that could be used during the practice sessions. These included a safety planning packet (including a personal safety plan) to complete with the patient, as well as a list of IPV Local Resources (Appendix F). An excellent example of a personal safety planning packet in English and Spanish is available from the Domestic Violence Resource Center.¹⁵ We strongly advise that educators using this module seek out their own state-specific resources for IPV that can be compiled into a handout or pocket card, similar to Appendix F. A natural starting point would be to ask local domestic violence organizations, departments of social work, or the local department of health.

One month after the IPV session, students completed a summative 20-minute objective structured clinical encounter (OSCE). SPs, playing the role of an IPV victim, were trained using the IPV OSCE Case (Appendix

G). Students were asked to interview and counsel the SPs using the method taught in the checklist. The SPs graded students using the IPV OSCE Grading Rubric (Appendix H). During the OSCE, students were provided with the local and national resources mentioned above.

After the first year of implementation, we found that the checklist alone left students with specific concerns such as why certain questions were asked and why we recommended certain language in the checklist. This realization was based on qualitative comments from final course evaluations. Students suggested that we provide additional tips on how to navigate the conversation as well as options for modifying the language to make it more practical for patients in various clinical settings. With this in mind, we created the IPV Checklist Companion (Appendix B), a teaching tool that can be used in combination with the IPV checklist to better understand the nuances of the interview. The IPV Checklist Companion contains two sections. In the clinical pearls section, we provide learners with suggestions for how to avoid common pitfalls when discussing IPV with patients. The general tips section walks learners through the checklist step-by-step, explaining why certain language is or is not used. The IPV Checklist Companion provides learners with the freedom to adapt and personalize the language of the checklist for use in various patient scenarios.

Results

This updated module was taught to 122 second-year medical students in the 2015-2016 academic year and 139 students in the 2016-2017 academic year (though the topic of IPV had been taught at our institution for several years prior). After the 2015-2016 course, 108 out of 122 students completed the course evaluation. Students were generally pleased with the IPV session, with 88.5% (96 out of 108) rating the module as “effective” or “very effective” in teaching IPV. Students also performed well on the IPV OSCE, with an overall first-time pass rate of 97.5% (119 out of 122). Furthermore, 86.1% of students (93 out of 108) rated the OSCE as an effective way to demonstrate this clinical skill.

After the 2016-2017 course, 126 out of 139 students completed the course evaluation. Of these, 89.7% (113 out of 126) rated the module as “good,” “very good,” or “exceptional.” The first-time pass rate on the IPV OSCE was 97.6% (123 out of 126). Finally, 85.7% (108 out of 126) of students rated the OSCE as an effective way of demonstrating this clinical skill.

Comments related to the IPV session included the following:

- “IPV counseling could have more time spent on it, since it is such a sensitive topic.”
- “Topics covered [such as] IPV are essential skills to have as a physician.”
- “IPV workshop . . . was very good and effective.”
- “I like how the course gives us a lot of time to practice . . . counseling skills.”
- “The counseling portions of the course were extremely helpful and I felt comfortable in this setting.”

Discussion

Health care professionals of all types can benefit from an introduction to IPV counseling, and the MI framework used in this curriculum provides a unique format to teach this complex topic. With this module, learners come to understand how to appropriately screen, counsel, and refer patients who are victims of IPV. Though not as comprehensive as a formal training course, the module provides a foundation for health care providers, who are often on the front lines of treating patients with IPV. We believe this module contains several innovative materials that have been improved through multiple iterations and will be useful to a wide audience of educators.

The IPV Checklist Companion (Appendix B) is a helpful adjunct to the traditional method of teaching interview or exam skills with a checklist. Though checklists are useful for organizing information, they often do not provide the learner with techniques to adapt to shifting patient attitudes during an encounter and to circumstances where patients exhibit barriers to communication. The companion allows learners to

understand why certain questions are asked and why certain language is used. In essence, this allows learners to understand the nuances of the conversation that cannot be explicitly described in a checklist alone. With a deeper understanding of the reasons behind the questions and the language, learners can adapt the checklist to fit the needs of the patient and improvise as needed. For those learners who want to memorize specific language or have no experience with how to navigate such a conversation, multiple sample phrases are provided for each question. When used together, the IPV Screening and Counseling Checklist (Appendix A) and the IPV Checklist Companion are helpful tools that cater to various learning styles and patient situations.

One important change that we made to this updated module was in regard to the way we structure the 1-hour role-play sessions. Previous iterations of this session provided one unique role-play for each individual learner in the small group. We found that this was a missed opportunity to enhance learner understanding of common barriers to navigating complex discussions. When a learner works through a role-play case and receives feedback on his or her performance, that feedback often focuses on specifics of the learner's interview style, which might influence how the learner asks questions in the future. However, what most learners struggle with is not how to memorize which questions to ask but rather how to improvise and respond to what the patient is actually saying. Using one case for two learners potentially provides educators with an opportunity to tackle this challenge. With our suggested format, the first student can work through the case, practice the interview, and receive feedback from peers and faculty on his or her performance. Next, the group can discuss the common barriers that arose during that case and receive advice from the faculty member on how to navigate those specific challenges. The second student can then practice the interview skills and receive feedback while also working on the newly acquired skill of addressing the particular barrier that has been previously discussed.

Finally, though this course can be taught by various faculty members including physicians, we have found great benefit in using nonphysician faculty members. These professionals typically have more training in interpersonal skills counseling and behavior modification techniques and may have more experience navigating such discussions. They may be more equipped to answer questions that arise during the role-play exercises and likely will be able to provide advice and tips from prior experience. Furthermore, by incorporating nonphysician faculty into the session, learners can gain insight into the advantages of practicing within a multidisciplinary care team.

As with many topics in traditional clinical skills courses, more time to practice these skills is needed. This was noted in the course evaluations as well as anecdotally in feedback from faculty members. One possible solution that would minimize the need to remove existing topics in order to make additional space in a curriculum would be to incorporate IPV screening and counseling into already-existing OSCEs or medical interview cases. More time to give feedback would be ideal; however, given the 1-hour block constraints and the need to rotate four students through the practice cases, our current structure is the best option for providing direct feedback to each student in real time.

Another limitation is how to best evaluate the effectiveness of such a session. Though we have reported learner satisfaction and performance data for two cohorts of students, it is still unknown whether such a session has long-lasting impact on learners' ability to utilize these skills in the clinical setting. It might also be helpful to administer pre- and postsession questionnaires to measure changes in learner knowledge and comfort navigating this topic with patients in the clinical setting.

This session for health care professionals can be inserted into any graduate or postgraduate curriculum and provides learners with necessary training materials to learn how to screen, counsel, and appropriately refer patients who are victims of IPV. By implementing this session, educators can assist in increasing the number of health care professionals who feel confident and prepared to broach this difficult conversation with their patients, which may in turn increase nationwide screening for IPV.

Taken together, this resource's components form a comprehensive module that can be used to both teach and assess learners. By adding location-specific IPV referral materials, educators will have all of the necessary materials to teach learners to screen and counsel for IPV, as well as make appropriate referrals for interventions. To date, there are no existing educational resources that teach how to screen and counsel for IPV while providing a structured outline with guidance on how to navigate the interview. This module allows students an opportunity to practice these skills and incorporates suggestions for problem-solving some of the barriers that are commonly encountered during these conversations.

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