

Perspective

The Intersection of Intimate Partner Violence and HIV: Detection, Disclosure, Discussion, and Implications for Treatment Adherence

Available data indicate that 55% of women and 20% of men living with HIV infection experience intimate partner violence (IPV) and that 24% of women experience abuse by their partners after disclosing their HIV serostatus. IPV increases the risk of HIV acquisition and often interferes with victims' engagement in and adherence to HIV care. The processes of integrating IPV screening as part of a health-centered approach in the HIV clinic are discussed. This article is based on a presentation by Tami P. Sullivan, PhD, at the 2018 Clinical Conference at the National Ryan White Conference on HIV Care & Treatment in December 2018.

Keywords: intimate partner violence, IPV, HIV, psychological abuse, screening, disclosure, domestic violence

Intimate partner violence (IPV) can impact an individual's ability to engage in HIV care and adhere to treatment recommendations. A better understanding of this issue is needed to create an environment that supports engagement of individuals who experience IPV in care and fosters their emotional and physical well-being.

IPV includes but is not limited to physical abuse. It is important to dispel any misconceptions that all individuals who experience IPV are women and are fragile, helpless, have low self-esteem, or fear for their lives daily, and that their abusers are all men who could easily be identified in a single interaction. Although these scenarios are true for some individuals, a one-size-fits-all approach does not hold true for IPV. Men also experience IPV, and IPV occurs in same-sex as well as heterosexual relationships.

IPV can be defined as the use or attempted use of physical, sexual, verbal, emotional, economic, or other forms of abusive behavior with the intent to harm, threaten, intimidate, control, isolate, restrain, or monitor another person. Physical abuse includes grabbing, pushing, hitting, punching, choking,

or holding an arm against someone's neck. Sexual abuse includes unwanted sexual interactions (can be through verbal coercion, use of physical force, or other means such as alcohol or drug use). Psychological abuse includes belittling remarks, threats, making someone afraid by using looks, gestures or actions, controlling what someone does or who they see, or monitoring of someone's whereabouts.

Daily Patterns of IPV

A study among women who experienced IPV assessed patterns of abuse over a period of 2778 days during which women had face-to-face contact with their partners.¹ No abuse was reported on 62.1% of days; psychological abuse alone was reported on 27.1% of days; psychological and physical abuse on 6.3% of days; psychological, physical, and sexual abuse on 2.3% of days; and psychological and sexual abuse on 1.2% of days. These findings indicate that the women were subjected to combined abusive behaviors on more than one-third of days during the study period. Sexual abuse alone was reported on 0.6% of days, physical abuse alone on 0.3% of days, and physical and sexual abuse together (without the co-occurrence of psychological abuse) was not reported. The results of this study have several implications.

First, the finding that on most days no IPV occurred may help to explain the ambivalence that some individuals experience about ending an abusive relationship. Often, individuals state that they do not want the relationship to end, although they do want the IPV to stop. Second, the time between incidents of IPV may minimize problems in the relationship and instill hope that abusive partners will change their abusive behavior.

Third, presentations of IPV in media often depict women undergoing frequent and severe physical abuse. Such presentations do not accurately represent the range of individuals who experience IPV and may do a disservice to the range of adults, children, and families who could benefit from or are in need of assistance. This underscores the importance of addressing psychological IPV, given that it is the most frequently occurring form of abusive behavior.

Connection Between IPV and HIV

Individuals who experience IPV are more likely to become infected with HIV than those who do not experience IPV. One study has shown that persons who experience IPV are 48% more likely to be infected with HIV than those who do not. If an abusive partner has HIV infection, they can increase HIV risk in the abused partner in a number of ways: they can force or coerce sex (protected or unprotected) or they can force or coerce engagement in high-risk behaviors or themselves be engaged in high-risk behaviors (eg, injection drug use). Approximately 10% of women currently experiencing IPV are infected with HIV,² a prevalence that is almost 10 times that of women in the general population. Available data indicate

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Table 1. Screening Tools for Intimate Partner Violence

Test Name	Available At
HARK: Humiliation, Afraid, Rape, Kick	https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2034562/
HITS: Hurt, Insult, Threaten, Scream	https://www.stfm.org/FamilyMedicine/Vol46Issue3/Shakil180
E-HITS: Extended Hurt, Insult, Threaten, Scream	https://journals.sagepub.com/doi/pdf/10.1177/102490791001700202
PVS: Partner Violence Screen	https://medicine.uiowa.edu/familymedicine/sites/medicine.uiowa.edu/familymedicine/files/wysiwyg_uploads/PVS.pdf
WAST: Woman Abuse Screening Tool	http://womanabuse.webcanvas.ca/documents/wast.pdf

that 55% of women and 20% of men living with HIV experience IPV.^{3,4}

Does IPV Matter to HIV Treatment Planning and Adherence?

One study queried women with HIV infection who experienced current or past IPV about how it affected their ability to engage in HIV care. Review of the data revealed that:

- Abusive partners can actively or passively interfere in HIV care (eg, by keeping their partner from taking medications or going to appointments).
- A person's self-worth can be so affected by IPV that they do not engage in self-care (eg, an individual becomes depressed and does not take his or her medications).
- Physical harm may impact relationships with health care practitioners (eg, if an individual wants to hide the signs of abuse from their doctor).

There are numerous barriers to disclosure of IPV for individuals who experience IPV, including:

- Shame or stigma
- Fear
- Gender, race, or sexual orientation
- Previous negative disclosure experiences
- Investment in the abusive relationship
- The belief that the abuse is not serious enough

- Potential mismatch of goals (ie, the reasons that a health care worker might want to screen for IPV might not be the same reasons an individual wants to disclose IPV)
- A victim's belief that the health care practitioner cannot help them
- Media portrayals of victims

Despite such barriers, about 8 of 10 patients who experience IPV want their health care practitioners to ask them about it (privately).⁵ Individuals who were asked about IPV were 4 times more likely to use an intervention and 2.6 times more likely to leave the abusive relationship.⁵ Given such data, health care practitioners can make a difference in the lives of these individuals. Most people who experience IPV never encounter a domestic violence service provider or talk with a victim advocate in the court system (because most abusers are never arrested), but they do come into contact with clinicians.

Screening for IPV

Clinicians should screen for current and past IPV, but only if they are prepared to adequately respond to a patient's disclosure. The goal of discussing IPV does not need be victim disclosure or detection of abuse. It can be to provide education and resources about IPV and to normalize the topic, so that the patient may feel more at ease about disclosing and not feel coerced by someone in a position of power (the clinician).

The US Preventive Services Task Force recommends IPV screening and referral to ongoing support services.^{6,7} Emphasis must be placed on referral to support services, as screening without access to such services is not likely to be of benefit. Direct screening can be performed using various screening tools: Humiliation, Afraid, Rape, Kick (HARK); Hurt, Insult, Threaten, Scream (HITS); Extended Hurt, Insult, Threaten, Scream (E-HITS); Partner Violence Screen (PVS); and Woman Abuse Screening Tool (WAST) (Table 1). The practitioner should investigate these tools and determine which is most appropriate for the clinical setting and patient.

IPV Resources

Futures Without Violence in collaboration with U.S. Department of Health and Human Services partners, the Administration for Children and Families' Family and Youth Services Bureau, the HRSA Bureau of Primary Health Care, and the HRSA Office of Women's Health, have worked to create a comprehensive website, www.ipvhealthpartners.org, of resources on IPV for community health centers working in partnership with domestic violence programs.⁸ The website provides educational videos and printable resources for health center staff about how to talk with potential victims of IPV, without detection of IPV being the primary goal. One such resource is the Confidentiality, Universal Education and Empowerment, and Support (CUES) intervention (Table 2).

A folded safety card can easily fit in a pocket or purse. The practitioner should review the elements on the card with the patient when providing it. Safety cards contain information on the effects of IPV on health, how one can help a friend, and some strategies that can be used to reduce harm. The back of the card features a safety plan and a 24/7 hotline with personnel who have a thorough understanding of IPV. A partial sample of a safety card is shown in Figure 1. When providing safety cards to patients, the practitioner can indicate that it is common

Table 2. Confidentiality, Universal Education and Empowerment, and Support (CUES) Intervention

C: Confidentiality
Always see the patient alone for part of the visit and discuss the limits of confidentiality before discussing intimate partner violence (IPV).
UE: Universal Education + Empowerment
Use safety cards to talk with all patients about healthy and unhealthy relationships and the health effects of violence. Give at least 2 cards to each patient so that they can share with friends and family.
S: Support
Disclosure of IPV is not the goal, but it will sometimes happen. When it does, devise a patient-centered care plan to encourage harm reduction. Refer the individual to an affiliated domestic violence service provider or in-clinic social worker, document the disclosure, and follow up with the patient at the next visit.

practice to discuss IPV with all patients, allowing an individual to accept the card without overt admission of IPV. A good practice is to give a patient 2 cards, mentioning that they can also be provided to friends and family if needed.

Detection of IPV

If detection of IPV is the focus, the practitioner can normalize the topic through nonjudgmental conversation with the patient. The practitioner should evaluate current level of danger,

violence, substance use, and general well-being; approximately 48% and 59% of current IPV victims use alcohol or illicit drugs, respectively.⁹


The patient should be supported as much as possible, but the practitioner should avoid acting as a therapist. The practitioner can respond to a patient's disclosure of IPV with appropriate resources and referral to mental health professionals and domestic violence advocates. In most states, mandatory reporting requirements do not apply to IPV victims unless they are children, elders, or vulnerable persons (such as those who are disabled).

If the patient does not disclose abuse, the practitioner should offer education and prevention information and query and assess the patient again at future visits. It is helpful to place informational posters in the clinic, including in bathrooms, and to have informational pamphlets or cards on desks in private offices.

Potential Clinic Model

In the clinic setting, a successful program for dealing with IPV among patients should include the following elements: support for clinic staff, connection of IPV to health, appropriate interventions (eg, safety cards), and having a protocol in place for support and a warm patient referral. In a warm referral, assistance is

provided to help the patient connect with the provider to whom they're being referred rather than simply giving a patient a phone number or the name of a resource they can connect to.

A system that supports clinic staff is necessary to handle the emotional load that staff may carry when assisting victims of IPV.¹⁰ For example, the clinic can provide training on vicarious traumatization, which equips staff to understand the ways in which hearing victims disclosures can affect staff personally. In turn, staff can be better prepared to minimize the effects of disclosure on their own well-being. IPV should be connected to patient health: the primary objective of the clinic. The goal is to help victims of IPV understand how IPV is impacting their health, hopefully providing them the motivation to be more engaged in this issue with the practitioner and more engaged in their own care. Finally, a protocol for warm patient referral and support must be in place. This requires having a good working relationship with local domestic violence service providers or knowledgeable consultants. It is helpful to have such providers assist in developing the IPV model for the clinic. 

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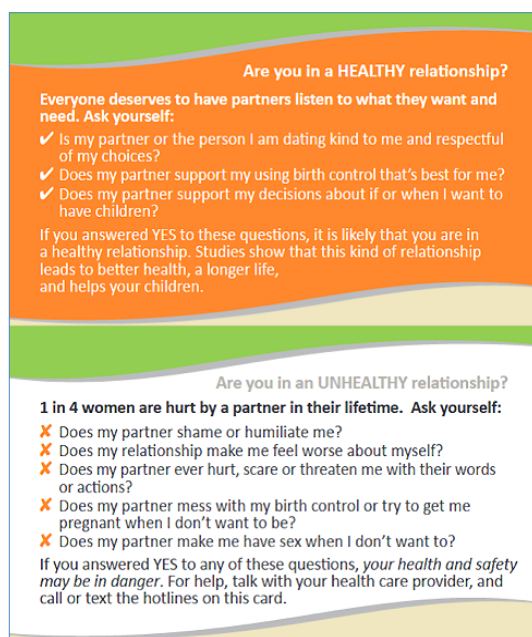


Figure 1. Example of a partial safety card available from www.ipvhealthpartners.org.¹¹

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