Intimate Partner Violence

Joint Position Statement

INTERNATIONAL ASSOCIATION OF Forensic Nurses

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Intimate Partner Violence

Description

Intimate partner violence (IPV) is a significant global public health crisis that occurs in all settings and across all age, socioeconomic, cultural, and religious groups (Miller & McCaw, 2019). IPV describes physical violence, sexual violence, stalking, and/or psychological abuse (e.g., coercion, controlling behaviors, intimidation) by an intimate partner (CDC, 2024b). Intimate partners include current or former spouses, boyfriends/girlfriends, dating partners, or ongoing sexual partners and do not require cohabitation or sexual intimacy (Breiding et al., 2015; CDC, 2024b). Traditionally, the burden of IPV has been viewed as overwhelmingly borne by women and perpetrated by men (Miller & McCaw, 2019; WHO, 2021). More recently, research and data collection has included additional populations who experience IPV, including men, teenagers and adolescents, the LGBTQIA2S+ community, and older adults (Gilchrist et al., 2023; International Association of Forensic Nurses [IAFN], 2024; Khurana & Loder, 2022; Laskey et al., 2019). These groups may experience different abuse patterns, injury patterns (if physical violence is involved), coping mechanisms, and support systems when compared to women who experience violence from male intimate partners (Laskey et al., 2019). IPV can be a single event or an ongoing pattern of events used to control, harm, or manipulate the recipient, causing significant emotional, physical, and psychological distress (CDC, 2024b).

IPV results in numerous negative short- and long-term physical, psychological, and epigenetic health outcomes for victims, families, and the community at large (Felitti et al., 1998; Gonzalez-Martinez et al., 2024; WHO, 2021). Some of the most serious consequences of IPV are risky health behaviors (e.g., smoking, drinking, substance use), poor physical health (which may be related to injury, substance use disorders, eating disorders, sexually transmitted infections, gynecologic, or pregnancy complications), mental health disorders (including anxiety, depression, post-traumatic stress disorder, self-harm or suicidal ideation), family dissolution, incarceration, and death (Phares et al., 2019). IPV not only directly harms the individuals involved, but it also has significant long-term effects for those who witness it. Children who grow up in environments where there is IPV, household dysfunction, or abuse are at increased risk for mental health challenges, substance use disorder, heart disease, and other chronic conditions as they grow older (Cui et al., 2024; Felitti et al., 1998). Approximately 1 in 15 children are exposed to IPV, almost 50% of these children witness severe violence, and up to 60% of IPV perpetrators also abuse children within the household (Butala et al., 2022; IAFN, 2024; National Domestic Violence Hotline, n.d.). The trauma experienced during childhood can profoundly shape physical and emotional well-being and lead to lifelong consequences (Cui et al., 2024).

People experiencing IPV do not always report their abuse but are often treated in emergency departments where emergency and forensic nurses have the opportunity to assess them and provide assistance and resources. Barriers to reporting may include shame and self-blame, financial dependence on the perpetrator, lack of trust in others, fear of further harm, and negative past disclosure experiences, as well as fear of not being believed, fear of stigma or discrimination, or fear of losing their children (Lustig et al., 2022). Systemic barriers to reporting include the time, acuity, and privacy constraints of emergency departments; language barriers; as well as clinician education, training, confidence, perceptions, and attitudes. Navigating and overcoming these barriers is necessary for the identification, care, and support of patients experiencing IPV and is a first step toward effective advocacy (Korab-Chandler, 2022; Phares et al., 2019; Ziola et al., 2024).

ENA and IAFN Position

It is the position of the Emergency Nurses Association and the International Association of Forensic Nurses that

1. In the emergency department, nurses routinely, consistently, and privately screen all adult and adolescent patients for IPV.

2. Nurses utilize a trauma-informed, patient-centered approach considering safety, confidentiality, and compassion when caring for those experiencing IPV.

3. Nurses use available resources, such as forensic nurses and other specialized care providers, to assist in the identification of and interventions for patients experiencing IPV.

4. Nurses report IPV according to jurisdictional laws and institutional policies, understanding that patients may have the right to decline legal intervention.

5. Nurses collaborate with other community professionals and/or healthcare disciplines when caring for individuals at risk for or exposed to IPV. Together they develop and implement strategies, protocols, and education for improved identification, reporting, protection, safe discharge, and primary prevention.

6. Nurses use evidence-based tools and educational resources to facilitate and validate the approach to screening and caring for patients who are affected by IPV.

7. Hospitals take a proactive role in implementing culturally sensitive measures to promote public awareness of IPV—for example, with posters and/or information cards in public restrooms and waiting rooms—and develop procedures to ensure the safety of patients, staff, and visitors.

8. Hospitals and healthcare systems provide ongoing culturally sensitive, trauma-informed education and training to all staff to ensure awareness of IPV

Background

The global pervasiveness of IPV contributes to significant human toll and financial burden (Peterson et al., 2024; Phares et al., 2019). It is estimated that 1 in 3 women and 1 in 10 men experience some form of IPV in their lifetime (CDC, 2024a; WHO, 2024, March 25). Members of the LGBTQIA2S+ community experience disproportionately high levels of violence when compared with individuals who are heterosexual, and people who are transgender are more than two times more likely than those who are cisgender to experience IPV (Chen et al., 2023). It is estimated 1 in 4 men identifying as gay or bisexual, 4 in 10 women who identify as lesbian/queer, as well as 5 in 10 women who are bisexual experience severe IPV during their lifetimes (Chen et al., 2023). Among adolescent girls who have been in a relationship, nearly 25% will experience physical and/or sexual IPV before the age of 20 (WHO, 2024, July 29). When IPV occurs in adolescence, it is referred to as teen dating violence (CDC, 2024b).

Given the high prevalence of IPV and the associated adverse health outcomes and cost, it is critical to address this problem. The WHO (2021) describes IPV as a public health crisis, necessitating a concerted response from healthcare providers and systems. Major healthcare organizations, including the American Nurses Association (2000), American College of Emergency Physicians (ACEP) (2019), The Joint Commission (2022), and the U.S. Preventative Services Task Force (2025) advocate for point of contact healthcare providers to screen for IPV as part of preventative care. Due to the prevalence of IPV in patients presenting to the emergency department, ACEP (2019) recommends that all patients be screened. The American Academy of Pediatrics also recommends that children and their caregivers are

screened for exposure to IPV because abused caregivers are more likely to seek medical care for their children than for themselves (2023; Doswell et al., 2025). Despite these recommendations, there remain a number of actual and perceived barriers to screening for IPV by emergency department clinicians. These include lack of treatment protocols, fear of offending the patient, lack of time or resources to address screening results, being unable to meet expectations of what can be done to help, and lack of training to address disclosures (Camarda et al., 2023). Only about 25% of patients in the emergency department are screened for IPV (Ahmad et al., 2017; Karnitschnig & Bowker, 2020).

Failure to screen for IPV leads to missed opportunities for intervention, provision of safety resources, and prevention of future violence (National Academies of Science, Engineering, and Medicine, 2024). In the United States, among IPV-related homicides, approximately one in 10 victims experienced some form of violence in the month preceding their death, and 44% of female victims had visited an emergency department within two years of their death. A person experiencing IPV is five times more likely to be killed when the perpetrator has access to a firearm. Alarmingly, IPV-related homicides rose 58% between 2014 and 2020 (Tobin-Tyler, 2023). History of strangulation is also a risk factor for IPV-related homicide. Victims of strangulation have a 750% increased risk of being killed by their abuser (Training Institute on Strangulation Prevention, n.d.). Emergency department visits provide an opportunity to identify persons experiencing or at risk for IPV, to reduce IPV-related morbidity and mortality (Duchesne et al., 2023).

Prevention and intervention can substantially decrease the public health burden of IPV and improve the health and well-being of patients in the healthcare system (Drexler et al., 2022). Healthcare organizations that utilize more comprehensive approaches to IPV have been effective in increasing their screening rates by including validated screening protocols, thorough and ongoing training for staff, immediate access or referral to support services, and institutional support for IPV care (Camarda et al., 2023; Drexler et al., 2022). Technology can facilitate the identification and support of patients experiencing IPV. For example, computer/tablet systems may enable patients to self-report IPV confidentially and follow-up visits may be conducted virtually via telemedicine (Fagen et al., 2025; Ziola et al., 2024). Comprehensive approaches also include planning for safe discharge, while respecting patient autonomy (Clery et al., 2023; Wallace et al., 2023). It is imperative for nurses to understand jurisdictional patient rights, including the right to decline reporting to law enforcement. Increasing awareness assists nurses in becoming more knowledgeable about IPV and more committed to assimilating the skills of identification, assessment, intervention, prevention, documentation, reporting, and safe discharge into their practice.

Emergency department visits serve as a safety net for persons experiencing IPV, provided that staff are knowledgeable and committed to the assessment, treatment, and support of identified patients, improving patient-centered outcomes while maintaining patient safety (Karnitschnig & Bowker, 2020). This requires institutional support, the development and implementation of IPV-related policies and protocols, ongoing education and training in best practice guidelines, and understanding of the intersection of patient rights and public policy. Patterns of IPV may not be broken during a single emergency department visit. However, identifying, educating, and providing resources concerning IPV increases patient recognition, understanding of risk, and safety planning and improves overall health outcomes (Spangaro et al., 2022).

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