Practical approaches to screening for domestic violence

Studies have shown that health care providers are unlikely to screen regularly for domestic violence. The reasons include lack of time, fear of offending patients, a sense of futility, and lack of training.

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Domestic violence, more correctly termed intimate partner violence (IPV), is a serious problem in America today. The CDC defines IPV as actual or threatened physical, sexual, psychological, or emotional abuse by a spouse, ex-spouse, boyfriend, girlfriend, ex-boyfriend, ex-girlfriend, or date.[1] IPV results in an estimated 2 million injuries and 1,300 deaths yearly in this country and costs more than $5.8 billion a year, about 75% of which goes for direct medical costs and the remainder for lost productivity.[1] In addition, battered women have 2.5 times higher outpatient medical costs than their nonabused counterparts.[1]

IPV tends to be a gender-specific issue, and some controversy exists regarding its exact prevalence. The controversy is due to the protean definitions of "abuse," which sometimes is defined as acts of violence and other times as any negative encounter between intimate partners, even when physical violence does not occur. In a random telephone survey of a representative sample of the United States population, 25% of women and 7.6% of men reported having been raped or physically assaulted by an intimate partner during their lifetime.[2] In addition, of those surveyed, 41.5% of women suffered an injury in their most recent violent interaction, compared with 19.9% of men.[2] However, if "psychological or verbal abuse" is included in the definition of IPV, the numbers shift dramatically—as evidenced by a similar-

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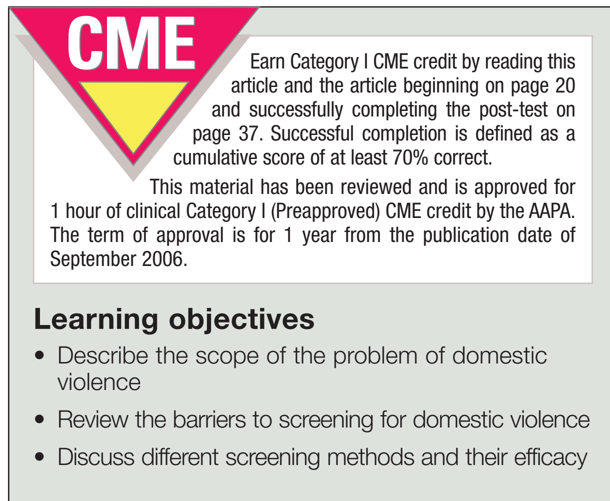
ly executed telephone survey that sought to estimate the lifetime prevalence of IPV using this expanded definition.[3] The authors of this survey found that 29% of women and 22% of men had experienced some form of abuse during their lifetime.

Researchers do agree that females experience more chronic assaults and suffer far more injuries than do males. According to the CDC, 20% of nonfatal violence against women in the year 2001 was attributed to IPV, as compared to 3% of nonfatal violence against men.[4] This information is corroborated by the US Department of Justice, which collected detailed crime information via random telephone interviews of 49,000 nationally representative households as part of the National Crime Victimization Survey (NCVS). The NCVS defined IPV as including "murder, rape, robbery, assault, and sexual assault" and found that 85% of all victims of IPV were female.[5] In addition, other prevalence surveys showed that 1 out of 5 female adolescents has experienced physical or sexual violence in a relationship.[6]

IPV and medical problems

IPV is a significant public health problem, accounting for a large number of acute injuries and chronic diseases alike:

- According to the American College of Emergency Physicians (ACEP), IPV is the most common cause of injury to women aged 15 to 44 years.[7]
- Multiple studies have shown associations between IPV and chronic diseases such as depression, headache, chronic back pain, and irritable bowel syndrome (see Table 1, page 32).[8,9]
- Postulated health effects range from stress-related hypertension and dysmenorrhea to possible immune dysregulation, which has the potential to cause more frequent symptoms of infection.[9]
- IPV may increase the incidence of seizures because of repeated head trauma.[9]
- A potential increase in HIV infection rates may result from IPV.[9]
- IPV is so well recognized as posing an increased risk of injury and death that some insurance companies have denied health coverage to battered women, citing IPV as a preexisting condition.[8]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Learning objectives

- Describe the scope of the problem of domestic violence
- Review the barriers to screening for domestic violence
- Discuss different screening methods and their efficacy

IN THIS ARTICLE

Key Points

- Domestic violence, more correctly termed intimate partner violence (IPV), is the most common cause of injury to women 15 to 44 years old.
- Multiple studies have shown associations between IPV and chronic diseases such as depression, headache, chronic back pain, and irritable bowel syndrome.
- Screening for IPV can show empathy, introduce the victim to resources, reinforce that she is not alone, and mitigate physical and psychological damage.
- According to studies done in the primary care setting, fewer than 15% of patients are routinely screened for abuse

Competencies

Competency	Rating
Medical knowledge	◆◆◆
Interpersonal & communication skills	◆◆◆◆◆
Patient care	◆◆◆◆◆
Professionalism	◆◆◆◆◆
Practice-based learning and improvement	◆◆
Systems-based practice	◆◆

For an explanation of competencies ratings, see the table of contents.

IPV also affects children

More than 3 million children aged 3 to 17 years witness IPV each year, and about 40% are also physically abused. Some are injured while being held by a parent, while others are "caught in the line of fire" while attempting to intervene. A number of children are hit intentionally. These children are also at increased risk for psychological and emotional damage, including anxiety, depression, developmental delays, nightmares, sleep disturbances, somatic complaints, violent behaviors, and drug and alcohol use. Significantly, they have a twofold higher risk of IPV in their future relationships, beginning with teenage dating.[10]

Mandatory reporting

Whether it should be mandatory to report IPV has been the subject of intense debate. Assault is a crime,

and if the abused partner should choose to press charges, state criminal laws do provide for restraint orders and punishment of abusers. Some experts feel that mandatory reporting protects victims and discourages further attacks by perpetrators, while others allege that it raises barriers to care, is deleterious to the safety of the victim, and interferes with the victim's right to decide how to respond to the abuser as well as with provider-patient confidentiality.[11]

At present, the following states have mandatory reporting laws for IPV involving two competent adults: California, Colorado, Kentucky, New Hampshire, Rhode Island, and New Mexico.[11] However, violence involving a child younger than 18 years in which the child either witnesses abuse or is suffering as a result of abuse must be reported to the local department of social services. Similarly, abuse involving a disabled person can be reported to the state department of social services, and abuse of a person older than 60 years (elder abuse) must be reported to the local Elder Abuse Hotline.[12]

TABLE 1
Chronic health effects of IPV

Chronic health effects of IPV
Central nervous system
Fainting
Migraine headaches
Tension headaches
Gastrointestinal
Constipation, diarrhea, nausea
Irritable bowel syndrome
Loss of appetite
Gynecologic
Chronic pelvic pain
Dyspareunia
Pregnancy-related violence
Sexual dysfunction
Urinary tract infections
Vaginal bleeding
Vaginal infections and sexually transmitted diseases
Musculoskeletal
Chronic back pain
Chronic neck pain
Psychiatric
Depression
Posttraumatic stress disorder
Suicide attempts
Risky health behaviors
Alcohol abuse
Cigarette smoking
Drug abuse

Data from Sisley A et al,[8] and Campbell JC.[9]

Do clinicians screen?

Although many professional medical organizations endorse and recommend screening, including ACEP, the American College of Obstetricians and Gynecologists, American Academy of Family Physicians, American Medical Association, American College of Physicians, and American Academy of Pediatrics, actual screening rates by health care providers remain dismal. This is discouraging because prevalence studies suggest that at least 1 in 5 female patients in the primary care setting have been victims of IPV at some point in adulthood.[13] Health care providers are uniquely positioned to intervene.

Unfortunately, according to studies done in the primary care setting, fewer than 15% of patients are routinely screened for abuse.[14] For example, a survey done in California sampling 400 primary care offices found that only 10% of physicians in those offices routinely screened for IPV in the absence of any signs of physical injury.[14] Strikingly, even in the presence of obvious injuries, only 79% of physicians stated that they would question the patient regarding partner violence.[14]

Emergency department (ED) screening rates for IPV are also very low. Only 13% of patients presenting with injuries due to IPV were screened in studied EDs.[15] Low ED screening rates are of great concern since 44% of women murdered by an intimate partner had a previous ED visit within 2 years before the homicide and 93% had at least one prior contact with emergency personnel for an injury.[16]

Barriers to screening

According to studies that surveyed health care providers, major barriers to screening for IPV include lack of effective interventions once victims are identified, fear of offending the patient by asking, lack of provider education about IPV, some provider bias, and limited time to conduct the screening.[17-19] Notably, these barriers are the same ones cited by providers for their failure to provide other types of preventive health care interventions, such as counseling about smoking cessa-

TABLE 2

How to screen

Direct question	"Many people have had problems with violence in the home. Is anyone hurting you?"
PVS	"Have you been hit, kicked, punched, or otherwise physically hurt by someone in the past year? If so, by whom?"
WAST short questions	1. In general, how would you describe your relationship? (a lot of tension, some tension, no tension) 2. Do you and your partner work out arguments with…(great difficulty, some difficulty, no difficulty)?
Mnemonics	**HITS** "How often does your partner…**H**urt?…**I**nsult?…**T**hreaten?…**S**cream?
	SAFE **S**tress/safety: Do you feel safe in your relationship? **A**fraid/abused: Have you ever been threatened/hurt/afraid? **F**riends/family: Are friends/family aware/supportive? **E**mergency plan: Do you have a safe place/resources?
	RADAR (what to do) **R**outine screening **A**sk direct questions **D**ocument your findings **A**ssess patient safety **R**eview patient options and referrals
Reminders to screen	Chart stamp: Domestic violence ____Yes ____No on each encounter page

Key: PVS, partner violence screen; WAST, Woman Abuse Screening Tool.

Data from Sillman JS,[12] Brown JB et al,[22] Sherin KM et al,[23] Ashur ML,[24] and Harwell TS et al.[26]

tion, cholesterol screening, cancer screening, and alcohol and substance abuse screening and counseling.[17-19]

Most studies to date show that educating clinicians through lectures or written materials does not effectively increase screening rates. Similarly, amending charts without educating providers and addressing their concerns has not worked either. However, provider education is more successful when it is coupled with additional chart modification. Screening for IPV can show empathy, introduce victims to resources, reinforce that they are not alone, and mitigate physical and psychological damage.

How to screen

First, consider the setting. Before screening for IPV, the clinician should take care to ensure privacy. Ideally, every patient should have time alone with the medical provider. The easiest way to accomplish this is to simply ask anyone who has accompanied the patient into the examination room to leave before the physical examination. Then ask about possible partner violence in a nonjudgmental, matter-of-fact manner. There is no single foolproof method by which to screen, and different people have different styles of communication, but here are a few screening options from the peer-reviewed literature.

The direct question remains the simplest and possibly most effective screening method. An informal question would be, "Many people have had problems with violence in the home. Is anyone hurting you?"[12]

Screening questions or surveys present other options for the clinician. Validated screening questionnaires measured against the gold-standard 20-item questionnaires in comparison trials include the Partner Violence Screen (PVS), Woman Abuse Screening Tool (WAST)-short, HITS, and SAFE presented in Table 2. Recent literature suggests that some patients may prefer the relative anonymity of paper-based screening tools.[20] However, use of these tools must take into consideration the practice population's literacy, education level, and comfort with the written word. The patient-provider relationship should be such that the patient is assured of complete confidentiality and support no matter which means of screening is employed.

- The PVS, which asks two direct questions regarding whether someone has physically hurt the patient and who did it, was measured in comparison with two previously validated, much lengthier scales (the Index of Spouse Abuse and the Conflict Tactics

TABLE 3
Things to remember when screening for IPV

Do	Do not
Ensure privacy	Intrude
Be nonjudgmental	Confront abuser
Offer emotional support	Criticize
Encourage a safety plan	Advise patient to "just leave"
Express concern for patient's safety	

Data from Seimer BS,[6] and Taft A et al.[18]

TABLE 4
Resources

National Domestic Violence Hotline
http://www.ndvh.org/
(800) 799-SAFE or (800) 787-3224 (TDD)

National Coalition Against Domestic Violence
http://www.ncadv.org/
(303) 839-1852

National Resource Center on Domestic Violence
http://www.nrcdv.org/
(800) 537-2238

Domestic Violence (Medline Plus from the National Library of Medicine and the National Institutes of Health)
http://www.nlm.nih.gov/medlineplus/domesticviolence.html

Scale) and was found to be about equally accurate in predicting IPV.[21]

- The WAST-short, which measures levels of tension in the relationship as well as difficulties in resolving arguments, is statistically reliable in assessing abuse.[22] In the referenced study, nonabused women never answered "a lot of tension" or "great difficulty." The WAST-short also has the advantage of having the most innocuous questions.[22]
- HITS, a four-item survey that asks about partner behavior, is actually meant to be a paper-based questionnaire for patients. A scale of five possible answers would follow each question: 1: never, 2: rarely, 3: sometimes, 4: fairly often, 5: frequently. The answers are then tallied. A score of 10 or higher is predictive of abuse.[23]
- The SAFE questions, an additional set of screening questions, were proposed in a letter to the editor of *JAMA* as a simple mnemonic that can help clinicians remember what to ask the patient. This mnemonic has an additional advantage in that it also prompts the provider to inquire about and encourage the patient to develop friends and other support and reminds the patient of the need for emergency planning should the violence escalate.[24]

Remembering to screen

Even the most compassionate provider committed to screening for IPV can forget to screen. The chart stamp remains the simplest and most effective reminder to screen all patients. In a study done to increase detection of IPV in an ED, the investigators found that restructuring the chart to include a specific question about IPV nearly doubled their detection rate.[25]

A more elaborate reminder system designed by the Massachusetts Medical Society used a mnemonic called RADAR (Routine screening, Ask direct questions, Document your findings, Assess patient safety, Review patient options and referrals).[26] This was meant to be an all-inclusive screening and educational tool and was much more time intensive. Although the actual trial did not yield statistically significant results compared to baseline, RADAR remains a useful mnemonic for self-motivated providers.

Other action for the screener to take

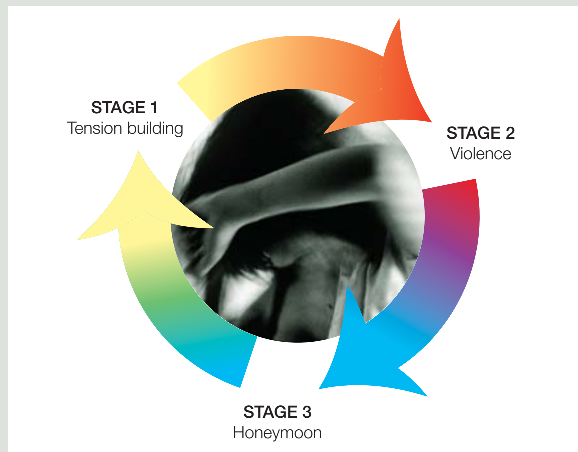
When screening for IPV, the clinician should remember these guidelines:

- If a patient discloses abuse, first provide emotional support. Emphasize that abuse is never acceptable and that no one deserves to be abused.
- Never criticize a patient for remaining in the relationship, and do not advise a patient to "just leave." One of the most dangerous moments in an abusive relationship is when the victim leaves.
- Never confront or try to counsel the abuser. Most likely, this will escalate the violence (see Table 3).
- Do urge the victim to call the National Domestic Violence Hotline at (800) 799-SAFE or (800) 787-3224 (TDD) while still in your office. This 24-hour, confidential hotline was instituted by the federal government to provide resources and referrals to victims of IPV. It is staffed by personnel trained to provide crisis assistance and give information regarding shelters, legal aid, and counseling. For other national organizations that may be helpful in obtaining materials or information, see Table 4.

In addition, take some time to counsel the patient regarding the cycle of violence (see Figure 1), which has been well characterized and can serve to educate the victim regarding the pattern of IPV. Also, question the patient regarding any children in the relationship and

FIGURE 1

Understanding the cycle of violence



IPV is typically viewed as a three-stage cycle. In the tension-building stage (stage 1), the dominant partner becomes more volatile and even violent in response to minor incidents or trivial stresses. He is more easily provoked by meaningless acts. This leads directly to violence (stage 2). The honeymoon stage (stage 3) follows closely, in which the partner is contrite and realizes he has violated the bounds of reasonable and acceptable behavior. He becomes apologetic and showers the victim with affection and possibly gifts.

Data from Chambliss LR. Domestic violence: a public health crisis. *Clin Obstet Gynecol*. 1997;40(3):630-638.

the effect that the violence has upon them. Remember to document the abuse and any injuries in the chart in case of future need for legal substantiation.

Involving office personnel

The interventions discussed in this article have had varying degrees of success in increasing assessment, detection, referral, and documentation of abuse in the medical setting. Instituting office-wide procedures will ensure uniformity of care, remind providers to screen, and provide referral protocols for staff once victims are identified. Before a global screening protocol is initiated, it is helpful to have some type of training and education for the staff as to why this is an important issue and what their roles will be. It is very important to clearly identify who stamps the chart or puts the survey in the medical record, who is responsible for questioning the patient, and who follows up. A team approach will make screening easier and improve patient care.

Conclusion

Screening for IPV is extremely important. By asking questions and listening to the responses, the clinician can remind the patient that violence is never acceptable. Studies have shown that the act of disclosure alone is therapeutic when elicited in a sensitive manner and when the abused patient's feelings are validated.[15] □

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