

Screening for Domestic Violence in the Health Care Setting

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Domestic violence is a pattern of assault and controlling behavior perpetrated by one partner against the other. It can include physical, sexual and psychological attacks, as well as emotional intimidation, verbal abuse, stalking, destruction of pets and property, marital rape, and social isolation.

Epidemiologic Factors

Domestic violence can be found in all age groups and socioeconomic strata and occurs in same-sex as well as heterosexual relationships. Historically most of those oppressed by domestic violence have been women.

Law enforcement officers trained in intervening in domestic disputes report an increasing proportion of men who say that they have been struck by their female partners during a dispute, but it is not clear in most cases whether the alleged assaults originated as self-defense or mutual combat. A recent study of male "victims" of partner abuse ⁽¹⁾ indicated that about half had been arrested for domestic violence perpetration.

The prevalence of domestic violence has been confirmed by physicians in a wide variety of clinical settings. According to a recent study ⁽²⁾, almost 30% of women treated in two urban emergency departments reported that they had been in a violent intimate relationship within the previous year; 13.7% of the women had gone to the emergency department in acute stress as a result of domestic violence. The American College of Obstetricians and Gynecologists educated its members about screening for domestic violence in 1989 and provided an update in 1995 ⁽³⁾, after the Centers for Disease Control and Prevention estimated that up to 7% of pregnant women suffer such abuse ⁽⁴⁾. Pediatricians and staff members of state child welfare agencies are becoming aware that more than 50% of mothers of abused or neglected children are themselves victims of domestic violence ⁽⁵⁾.

Female victims of adult abuse are as much as twice as likely as non-victims to abuse street drugs or alcohol ⁽⁶⁾. About one third of homeless women have been abused by their current or most recent partner ⁽⁷⁾, and nearly half of female murder victims are killed by a current or previous male partner ⁽⁸⁾. Unfortunately, victims of domestic violence are often not identified by their healthcare providers. A study conducted by the Medical College of Pennsylvania during the 1970s and 1980s ⁽⁹⁾ measured the rates of identification of domestic violence victims before and after emergency department triage nurses were instructed to ask all injured women whether their injury was the result of intimate-partner violence. Before that intervention, 5.6% of injured women disclosed that their injuries had been sustained during domestic disputes. After emergency department triage nurses began routinely screening for domestic violence, the rate of identification increased to 30%. A few years later, when the nurses were no longer trained to ask about domestic violence, the identification rate decreased to 7.7%. Women who are victims of domestic violence are not likely to disclose the source of their injuries unless they are asked directly. In a Texas study ⁽¹⁰⁾, the self-report rate for

domestic violence in women was found to be 7.3%, whereas an interview conducted by a nurse elicited a reported rate of 29.3%.

Barriers to disclosure

Physicians face many barriers when trying to provide the kind of patient care that they themselves would expect to receive. Lack of time – to establish rapport with a patient, to hear in detail about all of her problems, and to ask a multitude of questions for further diagnostic clarification – is a commonly cited reason for not routinely screening for domestic violence in primary care practice. Physicians do not want to open a Pandora's box of complicated social and psychological issues that could not possibly be evaluated in an allotted 30 minutes or less. Also, for some physicians, such a discussion may trigger memories of their own violent relationships; in such cases, the well-recognized survival technique of distancing oneself from a patient's pain may be ineffective.

Physicians who have identified domestic violence as an important issues for a patient are often frustrated when they realize that this problem does not have an easy solution. Often, physicians cannot understand why a victim does not leave an abusive relationship immediately ⁽¹¹⁾. As a result, they may inadvertently blame the victim instead of holding the perpetrator responsible and helping the victim increase her safety in a manner that enables self-determination.

Patients also face barriers to disclosing violent relationships. The perpetrator may have threatened to beat the victim more severely if she discloses information, or he might have implied that their children would be taken away. If the victim reported abuse in the past, she may have been blamed for the situation or the abuse may have escalated. Perpetrators may not allow victims who disclose information to participate in appropriate medical follow-up care. In some cases, a victim's cultural background may have taught her that she must accept her situation and that she should not question or discuss the subservient role into which she has been forced by the perpetrator ⁽¹²⁾.

In addition, the healthcare system itself presents barriers to disclosure, such as the short amount of time allotted for patient-physician appointments and the lack of privacy for obtaining personal information. When a perpetrator accompanies his victim to an appointment, his overly solicitous behavior (e.g., answering every question for the victim, insisting he be in the room during the examination, etc.) may be due to his desire to ensure that the "correct" history is given (i.e., one indicating that the patient's injuries were caused accidentally). To establish privacy for the interview with the victim, the physician may need to separate the partners by adopting a ruse, such as ordering radiographic studies that are not medically indicated. Emergency department triage desks that are located near waiting rooms lack the necessary privacy. In one study ⁽¹³⁾, only 24% of battered women said that they would disclose the cause of their injury if asked during emergency department triage. Many healthcare providers depend on hospital social service department staff to provide victims of domestic violence with emergency counseling, including referrals to shelters, support groups, and legal services and information about resources and welfare assistance. However, in one study ⁽¹⁴⁾, 88% of victims of domestic violence presented to an urban emergency

department when social services staff were not routinely available (i.e., at night and on weekends). Physicians can overcome some of the barriers to disclosure by becoming comfortable with routine screening for domestic violence. Many physicians have overcome similar barriers by routinely asking patients about alcohol use, sexual practices, tobacco use, and substance abuse. Because domestic violence is so prevalent, the Family Violence Prevention Fund ⁽¹⁵⁾ recommends routine screening of all female patients over age 14 who are treated in the primary care, obstetric or gynecologic, emergency medicine, inpatient, pediatric, or mental healthcare setting.

How to screen for domestic violence

Before asking a patient about abuse by an intimate partner (e.g., nonconsensual sexual intercourse), the physician needs to establish patient rapport in a safe, private setting. This can be difficult to accomplish when one or more family members accompany the patient into the examination room. The physician may need to indicate that part of the interview will be conducted in private, according to hospital policy.

A frequently used screening technique is to ask a series of questions (e.g., about allergies, medications, the last menstrual period, cigarette use) that are clearly asked of all patients. Then the interviewer can ask a “framing question,” such as, “I don’t know if this is a problem for you, but many of the women I see as patients are dealing with abusive relationships. Some are too afraid or uncomfortable to bring it up themselves, so I’ve started asking about it routinely. Are you in a relationship now with a person who physically hurts or threatens you?”

Asking this type of open-ended question in a nonjudgmental manner may enable a reluctant victim to disclose abuse, although the patient may instead laugh inappropriately, say nothing, avoid eye contact, give an evasive answer, or shrug the shoulders. Direct questions may identify the types of violence experienced by the patient; for example, “Has your partner ever hit you?” or “Has your partner ever forced you to have sex when you didn’t want to?” Additional examples of screening questions might include:

- Almost one third of women are victims of violence at the hands of their intimate partner at some point in their life, so I’m asking all of my patients, “Is this happening to you?”
- Is anyone in your home being hurt, hit, threatened, frightened, or neglected?
- Do you feel safe in your current relationship?
- Do you ever feel afraid at home? Are you afraid for your children?
- Sometimes patients tell me that they have been hurt by someone close to them. Could this be happening to you?
- I noticed that you have a number of bruises. Could you tell me how they happened? Did someone hit you?
- You seem frightened of your partner. Has he ever hurt you?
- You mentioned that your partner loses his temper with the children. Does he lose his temper with you? Does he become abusive when angry?
- Have there been times during your relationship when you have had physical fights?

- Do your verbal fights ever include physical contact?
- Have you been hit, punched, kicked, or otherwise hurt by someone within the past year? If so, by whom?
- You mentioned that your partner uses alcohol (drugs). How does he act when drinking (on drugs)?
- Does your partner consistently control your actions or put you down?
- Sometimes when others are overprotective and as jealous as you describe, they react strongly and use physical force. Is this happening in your situation?
- Your partner seems very concerned and anxious. Was he responsible for your injuries?
- Is there a partner from a previous relationship who is making you feel unsafe now?

The above questions should be culturally and linguistically sensitive. Finding a non-family member to translate may be necessary, because a patient is less likely to disclose information if she thinks that a family member who serves as the translator might share details of the interview with the perpetrator.

What to do if a suspected victim denies abuse

A victim of domestic violence may choose not to disclose information about an abusive relationship during a patient interview. Physicians need to accept the patient's response and right of self-determination and to emphasize that such questions are asked routinely because of the prevalence of domestic violence. Physicians can let the patient know that they are available as a resource for her or for someone who might be abused. Physicians need to recognize that the victim may have been subjected to years of demeaning verbal abuse and that they may be the first to tell her that no one deserves to be beaten. She may be considering the information that she is being given but may not be ready to disclose abuse.

What to do if the patient discloses abuse

Affirmative answers to domestic violence screening questions should elicit a well-rehearsed response by the healthcare support staff. Of immediate concern to both the patient and the staff is an assessment of whether the patient is in immediate danger. For example, if the perpetrator is armed with a weapon and is exhibiting aggressive behavior in the waiting room, then local police as well as hospital security officers must be summoned. If the pattern of abuse has recently escalated from verbal to physical, the patient's safety is also at risk. Other family members or family pets may have been threatened or harmed. The office staff must be trained to summon help in such situations.

After immediate danger to the patient has been ruled out, a medical assessment of the patient's injuries should be completed and other safety concerns should be addressed. For example, Will the patient be able to return for follow-up appointments? Does she have access to any community support resources? Has she told her family about the abuse? Does she have a friend whom she can call, day or night, for help? Has she spoken to an advocate from her local domestic violence agency about shelter or

obtaining a restraining (protective) order? If she has left the abusive relationship, is she being stalked? Has the perpetrator made homicidal or suicidal threats as consequences to her leaving? Are her children safe? A safety planning checklist for victims of domestic violence is provided below.

During a violent argument:

- Move to a space where you are least likely to be injured.
- Avoid the kitchen, bathroom, garage, and rooms without an outside door.

Plan ahead

- Keep emergency numbers posted.
- Work out a signal with a neighbor to call for help.
- Plan with your children. Work out a code word or signal and teach them how to call 911.
- Practice ways to get out safely.
- Park your car so that you are not blocked in.
- Make an extra set of keys and keep your gas tank full.
- Even if you don't think there will be a next time, plan three places you can go to be safe.
- Find out about legal options and protective orders before you need them.
- Open your own savings account at a separate bank.

Put things in their place

- Keep extra cash and clothes where you can access them safely (at a friend's home, at your workplace).
- Make copies of important documents and keep them somewhere safe.

If you have a protective order

- Keep a copy with you at all times.
- Give copies to your children's school or daycare facility and to your employer.
- Report all violations to the police.

If your partner no longer lives with you

- Change the locks.
- Install additional locks.
- Plan escape routes.
- Get caller ID.
- Work out a signal with a neighbor to call for help.
- Notify police so they know your situation.

Safety at work

- Use voice mail or have someone screen your calls.
- Notify security or your supervisor.
- Make a safety plan with coworkers to deal with your particular situation.

Build a network of support

- Connect with old friends. Join a support group.
- Call the local domestic violence hotline.

Alcohol and drugs

The use of alcohol or drugs reduces awareness and the ability to act quickly to protect yourself and your children. Batterers often use alcohol or drugs as an excuse for their violent behavior.

Break the silence

Tell your family members, friends, neighbors, coworkers, and physician about the abuse. Remember that isolation increases your risk.

If a physician or office staff member cannot assist the patient in making a safety plan, the staff should know how to contact an advocate from a local domestic violence agency or a social worker who can provide the patient with the proper assistance and referrals. Many emergency departments and primary care practices have educational brochures, posters, or cards from a local domestic violence agency in waiting rooms, examination rooms and even bathrooms so that victims and staff have easy access to information about local resources. These materials often provide telephone numbers of local agencies as well as the National Hotline on Domestic Violence (800-799-SAFE; TDD 800-787-3224).

Physicians need to remember that as healthcare providers, their goal is not to correct the patient's situation by insisting that she leave for a shelter immediately but to respect her right of self-determination. The patient's experience can be validated by saying, "I am glad you told me about this. We can work together to keep you safe and healthy." Helping the patient understand how common family violence is will reassure her that she is not alone. Women often stay in an abusive relationship for the sake of their children or because they think that for a variety of cultural, societal, or religious reasons, maintaining a nuclear family structure is important for child development. However, when children begin to demonstrate abusive behavior patterns or are hurt trying to protect other victims within the family unit, victims often decide that they must leave the abusive relationship to prevent further damage to their children.

Difficult situations of confidentiality and safety may arise when both victim and perpetrator are patients in the same medical practice. Those situations occur in rural communities as well as in health maintenance organizations. Physicians should be familiar with state and tribal laws about the legal obligation to report domestic violence, sexual assault, and child abuse and must realize that a patient may place herself at risk for escalating abuse if she confidentially discloses family violence. Depending on the patient's need for secrecy, the physician may choose to limit detailed descriptions of family abuse in the patient's chart but may still indicate that a discussion of personal stressors occurred and that appropriate referrals were made. A patient's medical record can become an important documentation of injuries or illnesses associated with interpersonal violence when acquired by subpoena in subsequent legal proceedings pertaining to child custody, divorce, protective orders, visitation rights, and criminal

charges of assault. In some practices, a Polaroid-type camera is used to photograph a victim's contusions or other injuries as documentation, and the photographs are stored in a separate, secure location apart from the patient's medical record.

Summary

Domestic violence involves the physical and/or psychological abuse of an intimate partner. Evidence indicates that almost one third of women treated in emergency departments have been in a violent intimate relationship within the previous year (2). For a variety of reasons, victims often do not choose to disclose that their injuries were a result of domestic violence unless they are asked directly by a physician in a safe, private setting. Constant vigilance is necessary to identify victims of such abuse who are afraid to disclose their often life-threatening secret. Instituting a routine screening policy for all female patients over age 14 enables the identification of such victims and permits the assessment of immediate danger, after which appropriate referrals can be made and effective safety planning can be accomplished.

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