

## DOMESTIC VIOLENCE SCREENING AND INTERVENTION IN HEALTH CARE SETTINGS

### Research

Among 253 male and female family practice patients, 10% of women in relationships “reported being physically hurt by a partner in the past year and 39% in their lifetimes. Among men in relationships, 7% reported physically hurting their partner in the past year and 16% in their lifetimes. Nearly all respondents, including 100% of victims and perpetrators of violence, [believed physicians should ask about family conflict \(96%\), and that physicians could be helpful \(93%\)](#). Two thirds of the sample reported that their physician had never asked them about family conflict. Investigators used qualitative analysis to summarize patients' advice to physicians. Responses clustered around 3 general themes: communication, assistance, and cautions or encouragement. [Patients want physicians to ask about family conflict, listen to their stories, and provide information and appropriate referrals](#)” (pp 248).

Burge SK, Schneider FD, Ivy L, Catala S. Patients' advice to physicians about intervening in family conflict. *Ann Fam Med*. May-Jun 2005;3(3):248-254.

”A total of 26 abused women from a larger study participated in five focus groups at three agencies on ‘how a hospital or doctor's office can be most helpful to a woman who is experiencing domestic violence.’ Women identified seven preferences for responses: (a) treat me with respect and concern, (b) protect me, (c) documentation, (d) give me control, (e) immediate response, (f) give me options, and (g) be there for me later. These findings indicate that [women prefer an active role by health care providers when responding to disclosure](#)” (pp. 234).

Dienemann J, Glass N, Hyman R. Survivor preferences for response to IPV disclosure. *Clin Nurs Res*. Aug 2005;14(3):215-233; discussion 234-217.

Results from a meta-analysis of twenty-nine articles reporting 25 studies (847 participants): “The emerging constructs were largely consistent across studies and did not vary by study quality. We ordered constructs by the temporal structure of consultations with health care professionals: before the abuse is discussed, at disclosure, and the immediate and further responses of the health care professional. Key constructs included [a wish from women for responses from health care professionals that were non-judgmental, nondirective, and individually tailored, with an appreciation of the complexity of partner violence. Repeated inquiry about partner violence was seen as appropriate by women who were at later stages of an abusive relationship](#)” (pp. 22).

Feder GS, Hutson M, Ramsay J, Taket AR. Women exposed to intimate partner violence: Expectations and experiences when they encounter health care

professionals: A meta-analysis of qualitative studies. *Arch Intern Med.* Jan 9 2006;166(1):22-37.

329 abused women at urban public health prenatal clinics received Brief, Counseling, and Outreach interventions. “Severity of abuse decreased significantly across time...for all intervention groups. Violence scores at 2-months postdelivery were significantly lower for the Outreach group...compared to the Counseling only group, but not significantly lower than the Brief intervention group. At 6-, 12-, and 18-month follow-up there were no statistically significant differences among the intervention groups. The use of lay outreach for abused pregnant women merits further research. Abuse screening by itself, however, may be the most effective intervention to prevent abuse to pregnant women” (pp. 443).

McFarlane J, Soeken K, Wiist W. An evaluation of interventions to decrease intimate partner violence to pregnant women. *Public Health Nurs.* Nov-Dec 2000;17(6):443-451.

Among 148 battered women seeking a protection order, 68% had been sexually assaulted by their abusive partner. “Receiving medical care decreased the woman's risk of further sexual assault by 32%” (pp. 99).

McFarlane J, Malecha A, Watson K, et al. Intimate partner sexual assault against women: frequency, health consequences, and treatment outcomes. *Obstet Gynecol.* Jan 2005;105(1):99-108.

360 abused women in urban public primary care clinics received either a wallet-sized domestic violence referral card or a 20-minute case management session provided by a nurse. “Two years following treatment, both treatment groups of women reported significantly...fewer threats of abuse..., assaults..., danger risks for homicide..., and events of work harassment... Compared to baseline, both groups of women adopted significantly...more safety behaviors by 24 months...however, community resource use declined significantly...for both groups...There were no significant differences between groups” (pp. 52).

McFarlane JM, Groff JY, O'Brien JA, Watson K. Secondary prevention of intimate partner violence: a randomized controlled trial. *Nurs Res.* Jan-Feb 2006;55(1):52-61.

75 abused women who had applied for a protection order received 6 phone calls from nurses over 8 weeks, during which they discussed safety-promoting behaviors. “Women in the intervention group practiced significantly...more

safety-promoting behaviors than women in the control group at each assessment” (pp. 40).

McFarlane J, Malecha A, Gist J, et al. Increasing the safety-promoting behaviors of abused women. *Am J Nurs*. Mar 2004;104(3):40-50; quiz 50-41.

Of 2,465 women surveyed in health care settings (ob/gyn office, emergency department, primary care office, pediatrics, and addiction recovery), 14% had experienced domestic violence in the previous year, and 37% disclosed lifetime prevalence. “Among women who disclosed abuse to their health care provider, 50% reported receiving direct interventions or services as a result” (pp. 712).

McCloskey LA, Lichter E, Ganz ML, et al. Intimate partner violence and patient screening across medical specialties. *Acad Emerg Med*. Aug 2005;12(8):712-722.

132 outpatient women who had been abused in the previous year were interviewed about violence, interventions received, and abuse disclosure to health care providers. At the time of the interview, 44% had left the abusive relationship. “Among those who were no longer with their partner, 55% received a domestic violence intervention (e.g. advocacy, shelter, restraining order), compared with 37% of those who remained with their partner. Talking to their health care provider about the abuse increased women's likelihood of using an intervention... Those who received interventions were more likely to subsequently exit...and women no longer with the abuser reported better physical health...than women who stayed” (pp. 435).

McCloskey LA, Lichter E, Williams C, Gerber M, Wittenberg E, Ganz M. Assessing intimate partner violence in health care settings leads to women's receipt of interventions and improved health. *Public Health Rep*. Jul-Aug 2006;121(4):435-444.

## Commentary

In their 2006 commentary, Janssen et al caution providers against “interpreting ‘insufficient evidence for screening’ to mean that inquiry about intimate partner violence has no place in a routine health assessment” (pp. 413). They state that while The Canadian Task Force on Preventive Health Care (in 2003) and The US Preventive Services Task Force (in 2004) concluded that “there is insufficient evidence for or against routine universal screening for intimate partner violence...professional practice organizations, including the American Medical Association, American Academy of Family Physicians, and the American College of Obstetricians and Gynecologists, have published guidelines promoting screening” (pp. 413).

Janssen P, Dascal-Weichhendler H, McGregor M. Assessment for intimate partner violence: where do we stand? *J Am Board Fam Med.* Jul-Aug 2006;19(4):413-415.

Marks & Cassidy (2006) and Coker (2006) support universal screening in their commentaries. Plichta, 2004, also makes a case for universal screening at the end of her review of the physical health impact of domestic violence.

- Coker AL. Preventing intimate partner violence: how we will rise to this challenge. *Am J Prev Med.* Jun 2006;30(6):528-529.
- Marks JS, Cassidy EF. Does a failure to count mean that it fails to count? Addressing intimate partner violence. *Am J Prev Med.* Jun 2006;30(6):530-531.
- Plichta SB. Intimate partner violence and physical health consequences: Policy and practice implications. *Journal of Interpersonal Violence.* Nov 2004;19(11):1296-1323.

In 2002, Esta Soler, President of the Family Violence Prevention Fund, testified before the Subcommittee on Public Health Committee on Health, Education, Labor and Pensions (HELP), U.S. Senate, and made a plea for routine domestic violence screening in the medical setting.

<http://www.endabuse.org/programs/publicpolicy/files/HealthTestimony.pdf>

*This is recent and could be useful:*

MacMillan HL, Wathen CN, Jamieson E, et al. Approaches to screening for intimate partner violence in health care settings: A randomized trial. *Jama.* Aug 2 2006;296(5):530-536.

*It is about how to screen for DV in medical setting.*

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Mar. 1, 2007

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