Screening for Intimate Partner Violence by Health Care Providers

Barriers and Interventions

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Introduction: Routine screening for intimate partner violence (IPV) is endorsed by numerous health professional organizations. Screening rates in health care settings, however, remain low. In this article, we present a review of studies focusing on provider-specific barriers to screening for IPV and interventions designed to increase IPV screening in clinical settings.

Methods: A review of published studies containing original research with a primary focus on screening for IPV by health professionals was completed.

Results: Twelve studies identifying barriers to IPV screening as perceived by health care providers yielded similar lists; top provider-related barriers included lack of provider education regarding IPV, lack of time, and lack of effective interventions. Patient-related factors (e.g., patient nondisclosure, fear of offending the patient) were also frequently mentioned. Twelve additional studies evaluating interventions designed to increase IPV screening by providers revealed that interventions limited to education of providers had no significant effect on screening or identification rates. However, most interventions that incorporated strategies in addition to education (e.g., providing specific screening questions) were associated with significant increases in identification rates.

Conclusion: Barriers to screening for IPV are documented to be similar among health care providers across diverse specialties and settings. Interventions designed to overcome these barriers and increase IPV-screening rates in health care settings are likely to be more effective if they include strategies in addition to provider education.


Introduction

In recent years, intimate partner violence (IPV) (also referred to as domestic violence, spouse abuse, and battering) has gained recognition as a serious public health problem. Recent estimates show that 1.5 million women in the United States are physically or sexually assaulted each year by an intimate partner.1

Recognizing the significant morbidity from IPV and the opportunities for health professionals to identify and refer victims of IPV, many health care organizations recommend routine screening2 of patients for IPV.2–12 These recommendations emphasize that appropriate referral and treatment of IPV victims are essential components of any screening protocol.

Although numerous health professional organizations endorse screening for IPV, evidence suggests that actual screening rates in health care settings remain low. One study that examined screening rates found that only 13% of victims of acute IPV presenting to an emergency department (ED) were asked by a doctor or nurse about violence.13 Others have found that only 1.5% to 12% of patients seen at primary care clinics had ever been asked by their physician about possible abuse.14,15 Although reproductive health organizations have been among the most active in endorsing IPV screening, definitions of “routine screening” vary widely, ranging from screening only when a patient is suspected to be a victim of IPV to screening every patient at every visit.

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screening of patients, a recent survey showed self-reported routine screening rates of only 10% among obstetricians and gynecologists.

Reasons for the gap between recommendations for IPV screening and their implementation have been the subject of numerous commentaries. Although some studies have been designed to determine barriers to implementation of screening, few have evaluated interventions to improve IPV screening and referral practices among health care providers. In addition, although gaps between screening and treatment recommendations and clinical practice have been a common focus in many other areas of preventive health care, few studies focusing on IPV screening reference findings from this broader context.

In this report, we identify and summarize studies involving original research on: (1) barriers to IPV screening as perceived by health care providers, and (2) interventions designed to increase identification and referral of IPV victims in health care settings.

Methods

The MEDLINE, PsychLIT, and Sociological Abstracts databases from 1966 to January 1999 were searched by crossing several subject headings (violence, domestic violence, spouse abuse, and battered women) or text words (abuse + domestic, female, marriage, marital, partner; physical, spouse, wife, wives, woman; violence + domestic, family, female, marital, marriage, partner, physical, spouse, wife, wives, woman; batter + female, partner, spouse, wife, wives, woman; assault + behavior, sexual). Citations were limited to English language. Secondary searches of reference lists of the retrieved articles were also performed.

Studies included for review were either studies that assessed barriers to screening as reported by providers, or studies of interventions designed to change provider behaviors related to IPV screening. Intervention studies were limited to those directly comparing pre-intervention and post-intervention IPV-screening rates determined by medical record review or patient report. Studies were excluded if their primary focus was evaluation of screening tools or determination of incidence or prevalence of IPV, or their reported screening rates were determined by provider self-report.

After review of titles and abstracts, 22 articles were determined to meet the inclusion criteria. A secondary search of reference lists of these articles, as well as relevant review articles, resulted in identification of an additional two articles not included in MEDLINE or other databases.

The 24 studies identified as meeting the inclusion criteria were divided into two broad categories: (1) 12 studies that examined barriers to screening from the provider’s perspective and (2) 12 studies of interventions designed to change provider IPV-screening behaviors. Studies focusing on interventions were further divided into those that involved an educational component only (four studies) and those that introduced clinical guidelines, protocols, or other enabling strategies in addition to an educational component (eight studies). The 24 studies were conducted in a variety of health care settings and among practitioners from a variety of specialties, including physicians, nurses, dental health care workers, and other health care professionals. Specialties represented in the studies were among those whose professional organizations recommend routine IPV screening.

Results

Barriers to IPV Screening

Table 1 shows results of the 12 studies identifying barriers to IPV screening among different groups of health care providers. Five studies used qualitative methods with results reported as lists of barriers abstracted from interview transcripts. In all five studies, respondents reported that their greatest concern was the lack of effective interventions for IPV once patients were identified by the provider, followed by fear of offending patients, lack of provider education about IPV, and limited time to conduct screening. Barriers cited in only one study included: “the abused play a role in eliciting abuse” and “it is not appropriate [for the health care professional in my specialty] to intervene” (dental health care workers), “fear for own safety” (nurses), and “domestic violence is a psychological issue rather than a medical one” (Australian doctors and nurses).

In seven studies using self-administered questionnaires asking respondents to select or rank precoded lists of potential barriers to IPV screening, the most commonly reported barriers were lack of provider education about IPV, patient nondisclosure, patient fear of repercussions, limited time, and patient noncompliance. Barriers cited in single studies included: patient population not likely to be at risk for IPV (obstetricians/gynecologists), forgetting to ask (family practice physicians), and screening not seen as part of professional responsibility (pediatric emergency medicine fellows).

Intervention Evaluation Studies

All 12 studies evaluating interventions designed to increase IPV screening by health care professionals included provider education as at least part of the intervention. Although most studies did not describe the content of their educational programs in detail, all were generally characterized as brief (ranging from 1 hour to ½ day) and didactic in nature (lectures). Analyses focused on the results of pre- and post-intervention evaluations designed to determine whether the intervention had the desired effect of increasing providers’ understanding of IPV, screening for IPV, or identification of IPV. Evaluations were typically performed 1 month to not more than 1 year following the
intervention. Analytic methods used to determine the impact of the intervention, study definitions, and numbers of providers included in the evaluations varied among the studies.

Interventions with Provider Education Only

Table 2 summarizes the methods and findings of the four studies that evaluated the impact of interventions focusing exclusively on provider education.44-47 In one of the studies, a 1-hour educational program resulted in a statistically significant increase in scores on a test of IPV knowledge among doctors and nurses in an Australian ED.45 However, investigators noted that after the educational session, more than 50% of physicians continued to show lack of adequate understanding of the ability to intervene, victims’ willingness to discuss IPV, and whether emotional abuse was worse than physical abuse.

The three other studies measuring changes in provider behavior following interventions limited to provider education showed no increase in identification of IPV victims (Table 2).44,46,47 However, in the study by Mandel et al.,44 attendance at the education session was associated with increases in extent of psychosocial history-taking and extent of treatment for patients who were identified as victims of violence.

Interventions Combining Provider Education with Clinical Guidelines or Protocols

Six studies examined the effect of interventions utilizing strategies (e.g., screening protocols, referral lists, other aids) in addition to educating providers to improve screening rates and identification of IPV victims (Table 3).48-53 All but one of these studies included a standard set of screening questions.52 In all six studies, the effect of the intervention was evaluated by comparing baseline rates of identification to post-intervention rates assessed within 1 year of the intervention. In one of the studies, screening rates were assessed again 8 years following the intervention.51

Three of the four studies conducted in EDs showed a significant increase in identifying IPV victims after introducing a protocol.51-53 One study assessing the long-term effect of this type of intervention, however, showed that the identification rate, which had significantly increased 1 month after the initial intervention, had returned to baseline 8 years later.51 In the one study showing no increase in identification rate, the investigators noted a trend toward improved documentation and referral for identified victims following the interventions.49

In a study of community health centers,50 the rate of
<table>
<thead>
<tr>
<th>Study (reference)</th>
<th>Population</th>
<th>Educational comment</th>
<th>Assessment</th>
<th>Results</th>
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</table>
| Mandel44         | Resident physicians (family medicine) (n=16) | 2 seminars including:  
- learned helplessness model  
- scope of IPV problem  
- interviewing techniques  
- interventions  
- checklist for history taking, education and support of patient, and assistance in formulating a plan | Simulated patient visit | Similar rate of identification of IPV victims among residents who attended educational session compared with those who did not attend* |
| Roberts45        | Emergency department staff (n=68) | 1-hour program covering:  
- scope of IPV problem  
- case presentation  
- protocol  
- interventions  
- referral | Test of knowledge about IPV | Significant increase in post-intervention test scores for both doctors and nurses |
| Roberts46        | Emergency department staff (n=239) | Workshops and case presentations (not otherwise described) | Blinded chart review of IPV victims independently identified in prevalence study | Similar rate of identification of IPV victims experiencing abuse in the prior 24-hour period pre- and post-intervention* |
| Saunders47       | Physicians (residents and faculty) in family medicine or internal medicine residency program (n=39) | 2-hour program including:  
- scope of IPV problem  
- testimony from former IPV victims  
- discussion of physicians’ personal attitudes about IPV | Simulated patient visit | No significant difference in how soon IPV was detected, percent of interview covering psychosocial issues, extent of history-taking, or extent of planning for victims’ safety between physicians who attended educational session and those who did not attend* |

*Tests for statistical significance not performed in study.  
IPV, intimate partner violence; ED, emergency department; FM, family medicine; IM, internal medicine
<table>
<thead>
<tr>
<th>Study (reference)</th>
<th>Population</th>
<th>Educational component</th>
<th>Protocol</th>
<th>Resultsa</th>
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<tbody>
<tr>
<td>Covington48</td>
<td>Maternal care coordinators in prenatal clinics (n not indicated)</td>
<td>Baseline: Instruction to ask about violence in home</td>
<td>Baseline: Checkbox for “violence in home”</td>
<td>No significant change in identification of IPV victims with 1-time AAS assessment compared with baseline</td>
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<td>Intervention: Didactics including:</td>
<td>Intervention: Abuse Assessment Screen (AAS) involving 5 questions administered 3 times during pregnancy (form included in chart)</td>
<td>Significant increase from baseline in identification of IPV victims with AAS assessments at each trimester</td>
</tr>
<tr>
<td>Fanslow49</td>
<td>ED staff (n=66)</td>
<td>4-hour program including:</td>
<td>Included:</td>
<td>No significant difference in overall proportion of women identified as IPV victims in control vs intervention EDs</td>
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<tr>
<td></td>
<td></td>
<td>• introduction of protocol</td>
<td>• opening questions</td>
<td>No significant change in overall proportion of women identified as IPV victims at intervention site</td>
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<td></td>
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<td>• presentations by police, shelters, and experts in cultural issues</td>
<td>• details of abuse</td>
<td>Trend toward increased documentation, referrals, and other interventions at intervention site</td>
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<td></td>
<td></td>
<td>• trauma theory</td>
<td>• assessment of risk to children</td>
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<td>• model interviews</td>
<td>• interventions including safety planning</td>
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<td></td>
<td></td>
<td>• presentations from representatives of local community IPV resources</td>
<td>• pocket card with screening questions</td>
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<td></td>
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<td></td>
<td>• abuse assessment form</td>
<td>Significant increase in IPV screening rates, safety assessments completed, and referrals to outside agencies.</td>
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<td></td>
<td>• stamp on patient charts</td>
<td>No significant change in positive identification of IPV victims in medical chart</td>
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<td></td>
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<td></td>
<td>• referral cards for patients</td>
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<td>Harwell50</td>
<td>Staff at community health centers (n not indicated)</td>
<td>3- to 6-hour training session including:</td>
<td>• list of 30 questions covering:</td>
<td>Significant increase in female trauma patients identified as positive for abuse when evaluated 1 year after intervention</td>
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<td></td>
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<td>• trauma theory</td>
<td>• details of abuse</td>
<td>No significant change in IPV identification rates from baseline when evaluated 8 years later</td>
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<td>• model interviews</td>
<td>• assessment of resources</td>
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<td>• presentations from representatives of local community IPV resources</td>
<td>• assessment for child abuse</td>
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<tr>
<td>McLeer51</td>
<td>ED staff (n not indicated)</td>
<td>“Staff training” (not otherwise described)</td>
<td></td>
<td>Significant increase in female trauma patients identified as positive for abuse when evaluated 1 year after intervention</td>
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<tr>
<td>Olson52</td>
<td>ED staff (n not indicated)</td>
<td>1-hour program (not otherwise described)</td>
<td>Stamp on each chart:</td>
<td>Significant increase in adult female patients identified as positive for abuse after introduction of stamp</td>
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<td></td>
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<td>“Is this patient a victim of domestic violence?”</td>
<td>No significant change in IPV identification with educational intervention (following introduction of stamp)</td>
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<tr>
<td>Tilden53</td>
<td>ED nursing staff (n=22)</td>
<td>½ day program including:</td>
<td>Included:</td>
<td>Significant increase in female trauma patients identified as victims of abuse</td>
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<td>• model interviews</td>
<td>• details of abuse</td>
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<td>• assessment of IPV victim, present resources and plans</td>
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<td>• nursing management plan, including offer of appointment with psychiatrist or to community agencies</td>
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aPost intervention unless otherwise indicated. Assessment in all cases involved chart review.

badapted from March of Dimes/Nursing Research Consortium on Violence and Abuse54

ED, emergency department; IPV, intimate partner violence
documentation of IPV status in the medical chart did not change, despite increases in the rate of IPV screening and referrals for patients identified as IPV victims following the intervention. In a study conducted in a prenatal clinic, Covington et al.58 found that instructing providers to ask screening questions at a single visit during prenatal care did not significantly increase identification of IPV among pregnant adolescents. However, instructing providers to ask the screening questions at each trimester resulted in a significant increase in the identification rate.

**Interventions Combining Provider Education with Other Types of Interventions**

Two additional studies reported the results of interventions combining provider education with other strategies to increase the identification of IPV victims in clinical settings. In one of these studies, the effect of having a staff member (physician assistant) designated as an IPV-victim advocate in an ED was evaluated.56 Higher rates of identification of IPV victims (with victim status confirmed by self-administered survey) were observed among ED staff in the hospital with the advocate (47%) compared with ED staff in the three control hospitals (11%).

A second study evaluated changes in attitudes and practices by nurses working at a health department prenatal clinic after an initial education program and introduction of IPV screening questions.57 Changes in attitudes were assessed during 5- to 10-minute debriefing sessions conducted at the end of each clinic day during a 12-week period. The debriefing sessions also served as opportunities to provide performance feedback to the nurses. Abstraction of nurses’ responses during the 12 weeks revealed that the nurses went through identifiable stages toward acceptance of the protocol. The nurses were shown to progress from “forgetting to ask” in the first weeks to giving excuses for not asking (Weeks 2 and 3) to asking screening questions but attributing the need to ask to someone else (Weeks 4 and 5). By the final debriefing session (Week 12), the authors noted that all the nurses had accepted personal responsibility for asking IPV screening questions.

**Discussion**

We identified 24 studies addressing barriers to IPV screening by health care providers by either identifying the barriers or evaluating interventions designed to increase screening. In the 12 studies on barriers to IPV screening as perceived by health professionals, similar lists of barriers were found despite differences in methods and provider population. Lack of effective interventions and lack of provider education were the most commonly mentioned barriers in both open-ended interviews and written surveys. Limited time was a frequent response in open-ended interviews; patient nondisclosure and patient fear of repercussions were barriers identified more frequently in written surveys.

In the 12 studies using interventions to increase provider screening or screening behaviors, interventions limited to education about IPV did not appear to have a significant impact on screening behaviors, although provider knowledge about IPV increased.

By contrast, interventions utilizing other strategies (e.g., provision of screening questions in addition to education) appeared to be more effective in changing screening behaviors. Most of these intervention studies demonstrated statistically significant increases in asking about IPV or identifying IPV victims in the medical chart. However, in some studies that did not show significant increases in identification, health care providers were observed to provide more complete documentation and referral.

The findings on barriers to IPV screening and interventions to change IPV screening practices summarized in this analysis are notably similar to findings on barriers to and strategies for changing provider behaviors related to other preventive health care recommendations. Limited time, lack of education, and ineffective interventions are all commonly cited as major barriers to providing counseling on smoking cessation,22 cholesterol screening,23 cancer screening,24–26 counseling and screening for alcohol or other substance abuse,27,28 and providing preventive services in general.29–31 Moreover, results of the 12 studies seeking to change health care providers’ knowledge or behavior related to IPV screening parallel findings of studies seeking to change other clinical practices, particularly in preventive health care. Our findings are consistent with those of Davis et al.58 in their review of 50 clinical trials of continuing medical education programs, in which they found that interventions combining predisposing (education) and enabling strategies (additional strategies including written protocols and prompts) were more effective than those involving predisposing strategies alone in changing provider behaviors related to counseling about smoking cessation, providing immunizations, and screening for cancer.

The similarities in provider-identified barriers as well as types of interventions that are successful in changing behaviors related to screening for IPV—identified in this review—and those related to other preventive medicine practices suggest that future interventions targeting provider screening for IPV will benefit from interventions that have been shown to be successful in changing provider behaviors related to other practices. Comprehensive models incorporating predisposing, enabling, and reinforcing strategies identified as critical to successful introduction of screening and counseling programs in health care settings—including those related to smoking cessation, breast-cancer
screening, bicycle-helmet use, and immunization—are available from both private and public health care sources. 59, 60

Several factors limit the findings of this review. Most importantly, our findings are restricted to a relatively small number of studies. For analysis of intervention studies, strict inclusion criteria were used in the interest of allowing a more direct comparison of results. However, comparison of the studies remains limited because of considerable variation in study design, methods, interventions, health care settings, and provider populations. Generalizability of findings from some of the studies is also limited because of factors such as low response rates, small sample sizes, and nonrandom sampling. In our review of the IPV literature, we based our conclusions on the methods and interventions as they were described in published manuscripts. It is possible that some aspects of the research, interventions, or evaluations, particularly those relating to systems supports for the screening programs, were not fully described in the publications.

It is also important to acknowledge our still limited understanding of the most effective ways that health care providers can play a role in primary and secondary IPV prevention. IPV screening in the clinical setting involves legal and ethical issues that may not complicate other types of screening and counseling programs. Concerns about mandatory reporting laws in some states, instances of denied insurance to identified IPV victims, and fear of violating patient confidentiality are legitimate challenges to initiatives to implement routine IPV screening and documentation. These concerns were reflected in the patient-related barriers, such as fear of offending or endangering the patient, reported by providers in the studies included in this review. Unlike disclosure of smoking or other health-risk behaviors, disclosure of IPV to a health care provider has the potential to place a victim at risk of further violence if disclosure becomes known to the perpetrator. Further research is needed to determine the impact on women of disclosure of violence, and what supports beyond the health care system must be in place to ensure that women who disclose that they are victims of IPV can be offered assistance in securing safety for themselves and their children. It also remains unclear as to which interventions are best for the abused patient.

Conclusion

Despite the limitations of this study, its findings hold potential lessons for future efforts to increase IPV screening by health care providers in clinical settings. Many of the barriers to IPV screening in health care settings parallel those encountered in screening for other conditions. Thus, components of models successful in changing provider behavior related to other screening and counseling practices may be applicable to efforts to increase IPV screening. Greater attention is also needed to understand and address the types of barriers specific to IPV, including mandatory reporting laws and reluctance of health care providers to screen in settings where appropriate legal or social service follow-up is inadequate or inaccessible.

References