Screening for Intimate Partner Violence in the Primary Care Setting: A Critical Review

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Intimate partner violence* has widespread public health ramifications in the United States among all ethnic and socioeconomic groups. It is defined as actual or threatened physical or sexual violence, or psychological/emotional abuse by a spouse, ex-spouse, boyfriend/girlfriend, ex-boyfriend/ex-girlfriend, or date [1]. Both men and women experience intimate partner violence, but women are the victims in 85% of the cases [2]. Lifetime prevalence among U.S. women ranges from 25% to 54%, with 1.5% to 15% of women reporting having been victimized within the previous 12 months [3–6]. Further studies have shown that women who have experienced violence have more general health and mental health problems [7–12]. Survivors of violence are more likely to report worse health status, greater disability, and higher levels of depressive symptoms and are more likely to have a diagnosis of anxiety or depression than women without a history of violence [7]. Furthermore, abuse has been associated with increased health care utilization [8,11] and higher annual health care costs [12].

Primary care physicians can offer validation, evaluate for psychological and medical sequelae, and offer mental health and domestic violence referrals to survivors of abuse. However, they can only offer such help if intimate partner violence is identified. Identification of a history of abuse is most effective when direct questioning is used, either in routine screening of all patients or questioning when there is suspicion of abuse. Studies show that routine screening in primary care practice greatly increases identification of intimate partner violence [13,14]. However, most primary care physicians do not routinely screen their patients for abuse [15,16]. A survey of primary care attending physicians found that only 10% reported routinely screening for intimate partner violence during new patient visits and 9% at periodic check-ups [16]. A nationwide survey found that less than one third of women with a history of domestic violence report having discussed their trauma history with their doctor [7].

The purpose of this article is to review practical methods for routine screening of intimate partner violence in the primary care setting. We define routine screening as inquiry about intimate partner violence in all patients, regardless of the physician’s level of suspicion that the patient may be a survivor of abuse. We include a discussion of the importance of screening, screening tools, appropriate ways to manage disclosures of abuse, and common barriers to screening. Although the intent of this article is to discuss routine screening, many of the concepts reviewed also may be helpful in case identification when abuse is suspected.

Importance of Screening

The main benefit of screening for intimate partner violence is that it allows the health care provider to identify the patient as a survivor of abuse. The provider is then able to bear witness to the patient’s experience of suffering, offer empathy to the patient, document the history, and offer referrals to mental health and community resources. Furthermore, the physician can screen for comorbid psychiatric conditions, which may be treatable with medications or other interventions. These types of clinical interventions will be described later in this review.

Patients endorse the practice of physician screening for intimate partner violence. A survey of female patients at an ambulatory VA clinic revealed that 77% of women with a history of abuse and 70% of women without a history of abuse believed that physicians should do routine screening [17]. In a telephone survey of urban women enrolled in an HMO, 86% of respondents believed routine screening would make it easier for abused women to get help, and 96% of respondents believed that women would be glad someone took interest [18].

Several professional medical organizations formally recommend the practice of routine screening for intimate partner violence. Guidelines have been set forth by the American College of Obstetricians and Gynecologists (ACOG) [19] and the American Medical Association (AMA) [20] that recommend

*Other common terms that describe intimate partner violence are domestic violence, spouse abuse, domestic abuse, battering, marital rape, and date rape.
asking specific questions about violence during routine visits. The U.S. Preventive Services Task Force guidelines published in 1997 state that routine screening can be substantiated because of the high prevalence of abuse, the potential impact in the care of the patient, and the low cost and low risk of harm to the patient from screening [21]. However, these guidelines stop short of offering a definite recommendation to screen because of the lack of efficacy studies on interventions. Such studies evaluating the effectiveness of early intervention after detecting intimate partner abuse are currently in progress.

**Screening Environment**

Patients may be more comfortable disclosing a history of personal violence if they feel that the office environment is accepting and nonjudgmental. Displaying posters, brochures, and wallet-sized cards with information about resources for survivors of intimate partner violence in the waiting room, bathroom, and clinical areas has been used to increase disclosure [22]. The actual screening itself should take place in a private area to ensure patient comfort and confidentiality. Any persons accompanying the patient on the visit should be asked to leave the room prior to screening.

**What is the Best Screening Strategy?**

Two strategies can be employed for identifying abuse: (1) routine screening, where all patients are asked about abuse, and (2) targeted case identification, where the physician inquires only when there is reason for suspicion (eg, the patient presents with suspicious injuries). However, a targeted case identification approach is problematic because providers cannot always identify which patients are at risk. Patients do not usually present to primary care providers with acute injuries, and the primary care physician may miss cues that would lead to suspicion. Freund and colleagues compared a routine screening protocol (a single written screening question on a health history form) with leaving the decision to screen to the discretion of the provider. It was found that identification of domestic violence was 11.6% in the universally screened group compared with 0% in the control group [14]. In another study, a chart reminder to ask about violence in the emergency department increased detection from 2% to more than 3.4% [23].

Routine screening strategies can entail verbal methods (interview by a physician or other staff member) or self-administered methods (eg, written, computer-assisted, tape-recorded) [13,14,24,25]. A study by McFarlane and colleagues found higher rates of detection with routine verbal screening (29.3%) compared with routine self-administered written screening (7.3%) [24]. This suggests that the more effective strategy may be a verbally administered method. However, the benefit of routine self-administered methods is that all patients will be screened. Verbal methods rely on the provider to remember to administer the screen. Each individual provider will therefore need to decide which strategy best fits into his or her practice. It is most important to choose a method the provider is comfortable with and to use it consistently. Use of enablers for the provider such as cue cards, chart reminders, and intimate partner violence screening questions on health questionnaires may be useful [14,22].

Whether using verbal or written screening strategies, an introductory statement can prepare the patient for the questions to come. An example is, “One of the things I ask all my patients about is their experiences of violence.” Such a statement lets the patient know that all patients in the practice are asked about violence. Letting the patient know that these questions are routine may help her feel more comfortable with the inquiry and help relieve any feelings of shame she might have about disclosing a history to the provider. The clinician should also reiterate that the interview is entirely confidential.

Some clinicians may prefer not to use specific tools with direct questions like those described in the next section but may prefer using open-ended questions to screen for intimate partner violence. Some examples are, “Do you feel safe at home?” and “How does your partner treat you?” Although these types of questions have not been validated, some experts prefer this method.

**Screening Tools**

Screening tools for the detection of intimate partner violence that can be used in a primary care setting are available (Tables 1 and 2). Other tools have been developed for specific populations, such as pregnant women [26] and physically disabled women [27], but they will not be discussed here. Screening instruments that are felt to be too long for practical use in the primary care setting also are not discussed here. We based our review on whether the instruments meet the following criteria: (1) availability of published comparison data to a reference standard, (2) availability of adequate sensitivity and specificity data, (3) appropriate population sample used in development of the instrument, and (4) ease of use in the primary care setting.

The development of any type of screening tool should ideally include validation by comparing it to an accepted reference standard. There is no universally accepted reference standard for intimate partner violence, so validation studies of screening tools have used a number of different standards for comparison. The Index of Spouse Abuse (ISA) is a 30-item assessment designed to measure the severity and magnitude of physical and nonphysical abuse inflicted upon a woman by her spouse or partner [28]. It has been partially validated in a sample of 107 women. Other screening tools use the Conflict Tactics Scales (CTS), a 19-item scale that measures the use of reasoning, verbal aggression, and physical violence in resolving family-based conflicts [29]. It evaluates violence and aggression only in the context of settling conflicts or disputes.
Its advantage is that it is a widely used measurement for quantifying physical abuse against women. One instrument reviewed here uses the 25-item Abuse Risk Inventory (ARI) [30] as a reference standard. Using a MEDLINE search, we were unable to find other references for the ARI. A structured clinical interview is also used as a reference standard.

A written instrument, HITS, was developed to identify current physical or verbal abuse in the family practice setting [31]. It is composed of 4 questions, each with a 5-point Likert response scale. It was tested among 2 study groups: 160 female patients visiting a family practice clinic, and 99 women self-identified as victims of violence from domestic violence crisis shelters and emergency departments. Among the family practice patients, HITS scores were found to be correlated with their CTS scores ($r = 0.85$). A HITS score of greater than 10.5 had sensitivity of 96% and a specificity of 91% in correctly differentiating the patients in the family practice clinic from the self-identified violence victims. These validity measures should be interpreted with caution since they use the subjects’ study group status (family practice patient vs. self-identified victim) as the reference standard for comparison. Advantages of HITS include the written format, which allows for use on self-administered history intake forms, and the easy-to-remember acronym (Hurt, Insults, Threatens, and Screams). Interpretation of the HITS instrument requires calculation of a score based on the patient’s responses. Although the scoring system is straightforward, it may be cumbersome in a busy clinic setting.

STaT is a 3-item tool designed to detect lifetime intimate partner violence, including physical, sexual, and emotional abuse [32]. It was developed by verbally administering a 43-item questionnaire to 75 female emergency department patients (Paranjape et al, 2002) [32]. The 3 items that had the highest validity measures for intimate partner violence were then selected for STaT. The reference standard used for intimate partner violence was a structured clinical interview. It was found that the sensitivity
and specificity of a positive response to 1 of the 3 questions was 96% and 75%, respectively; to 2 of the 3 question was 89% and 100%, respectively; and to 3 of the 3 questions was 64% and 100%, respectively [32]. Therefore, a positive response to any one question makes a history of violence likely, whereas a negative response to all 3 questions essentially rules it out. Although none of the questions specifically addresses sexual abuse, the STaT questions were found to be more sensitive in identifying a history of sexual abuse than direct questions about sexual abuse. The acronym (Slapped, Thrown, and Threatened) helps the clinician to remember the short instrument. STaT was studied with a relatively small sample; further study with a larger sample is pending.

The Woman Abuse Screening Tool (WAST), a 7-item verbally administered tool developed to screen for current physical and emotional abuse, was tested in 307 female family practice patients [33,34]. The WAST scores were found to be significantly correlated with the ARI ($r = 0.69$ [$P = 0.01$]) [34], but there are no published sensitivity and specificity measures for the WAST. Both physicians and patients were very comfortable using the WAST in this study [29]. In a smaller study of 48 patients, the authors determined that using just the first 2 questions of the WAST, called the WAST-Short, can also identify abused from non-abused women (sensitivity of 91.7% and specificity of 100%) [33]. The WAST-Short was significantly correlated with the WAST (Spearman $r = 0.86$ [$P < 0.001$]) and the ARI (Spearman $r = 0.90$ [$P < 0.001$]) [33]. The WAST lacks practicality because it is too long (7 items) for many clinicians to remember, but the WAST-Short provides a concise 2-item alternative.
The Partner Violence Screen (PVS) is a 3-item tool designed to detect current physical and nonphysical violence for use in the emergency department or other urgent care settings [35]. It was administered to a large sample of female patients presenting to emergency departments. The PVS was found to have a sensitivity of 64.5% and 71.4% compared with the ISA and CTS, respectively, for detecting partner violence. In a separate study of predominately Hispanic and African-American women in an urban setting, the sensitivity of the PVS was found to be only 33.4% [36]. These sensitivity values are lower than desired for a screening tool. An advantage of the PVS is that it is short and easy to use, taking an average of only 20 seconds to administer [35].

After reviewing these instruments, we recommend use of the HITS instrument, since it adequately met our pre-established criteria for a screening tool for intimate partner violence. STaT and WAST-Short are promising tools, but both need validation in a larger sample. The PVS initially looked promising, but recent data showing low sensitivity measures limit its usefulness [36].

Clinical Interventions

The clinician will need to be prepared for disclosures of abuse. Primary care providers have the advantage of being able to develop long-term relationships with their patients, which can be therapeutic for the abuse survivor. The role of the primary provider is to initiate this therapeutic role, perform a safety assessment to detect any immediate danger to the patient, and provide appropriate referrals and follow-up.

When a patient reveals that she has been a survivor of intimate partner violence, the clinician bears witness to the patient’s suffering by listening and acknowledging that the patient has been heard and is believed. This disclosure and acknowledgement of abuse in and of itself can serve as an important therapeutic intervention to counteract the isolation and shame experienced as part of intimate partner violence. Often the victim believes that the abuse has been deserved and that it is her fault. The validation and acknowledgement alone can empower the patient by confirming her sense that what has happened to her is violence and not deserved. Because it may be traumatic for the patient to recount violent experiences, the provider should avoid pressing the patient to divulge details she is uncomfortable with discussing.

Next, the physician can perform a safety assessment. The safety assessment should determine the presence of an imminent threat of violence, suicidality, or psychological sequelae resulting from the trauma. Assessing for imminent danger of violence can be difficult because severe abuse can occur when it is least expected [37].

The following situations may be associated with times of heightened danger: (1) a change in the status of the relationship (eg, breaking up of the relationship, a sense that the victim plans to leave, the perpetrator developing extramarital sexual relationship) [37], (2) drug or alcohol abuse in the perpetrator, (3) recent escalating violence, (4) a history of threats with weapons/possession of firearms, and (5) a pattern of intense jealousy in the abuser. The physician should inquire about suicidality in the patient. Finally, the patient can be evaluated for psychological sequelae commonly experienced by trauma victims such as anxiety, depression, and post-traumatic stress disorder.

The clinician should carefully document the history given by the patient. This can include exact words used by the patient as well as the clinician’s own impressions. If the patient presents with injuries, pictures or drawings can be used to document these occurrences. Careful documentation can be helpful if the patient decides to pursue legal action against the perpetrator. The clinician should be respectful if the patient does not want the history in the medical record, even after a discussion of the benefits of documentation.

Finally, the clinician should provide the patient with appropriate referrals. Before handing written referrals to the patient, the physician should first ask whether it is safe for the patient to have domestic violence materials on her person. It should be recognized that treating all aspects of intimate partner violence is beyond the realm of the usual primary care provider. Although the interventions discussed here can be integral to the initial management of the patient, the primary care provider should rely on referrals to broaden the scope of the intervention. The patient’s history and responses to the safety assessment may help determine what referrals are appropriate. The clinic should have a referral list that can be given to the patient that includes mental health and domestic violence–specific services. As survivors of abuse have different coping mechanisms, many will have already found ways to reconcile their issues on their own or with the help of family and friends. These individuals may not benefit from seeking a mental health professional, but the referral should be offered in case they wish to seek services at a later time. The clinician should find mental health professionals that have trauma counseling backgrounds. Local domestic violence coalitions may be able to provide a list of these resources for clinicians.

The clinician should also have a list of domestic violence–specific resources in the community, such as shelters or safe homes, and legal advocacy services. To find these resources, the clinician can ask local agencies, such as social work services at local hospitals and medical centers, for their listings of violence-specific referrals. The local police department and state medical societies are also good sources for information. The Feminist Majority Foundation’s Web site
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(www.feminist.org/911/crisis.html) provides contact information for state and national domestic violence coalitions and organizations. The Family Violence Prevention Fund’s Web site (www.endabuse.org) also has useful information for providers. The referral list can also include hotline numbers for violence victims. If local hotlines are not available, the National Domestic Violence Hotline is available from anywhere in the United States (1-800-799-SAFE).

Barriers to Screening

Both physicians and patients may have barriers that inhibit the disclosure of a violence history. Provider barriers to screening for violence have been described in both ethnographic and quantitative survey studies [16,38,39]. Commonly cited barriers are lack of provider education, lack of time, and perceived lack of effective interventions [40]. Other reasons are lack of comfort, fear of offending, patient unresponsiveness, and lack of initiative by the physician [38,39]. Several steps can be initiated to begin minimizing these barriers for physicians. Implementing didactic and skills-based educational programs on intimate partner violence and screening methods are warranted to improve physician knowledge, comfort, and awareness of available techniques and interventions. It should be emphasized to physicians that patients wish to be asked about intimate partner violence [17,18] and that patients are much more likely to volunteer a history of violence if directly asked [14].

Limited time is a barrier for implementing many aspects of preventive health care, not only screening for intimate partner violence. If a history of violence is disclosed during a limited office session, physicians can schedule a follow-up appointment to complete the assessment once safety is assured. Having handouts describing local resources also will save time. Physicians should understand that their role is not to resolve a situation of violence for a patient, but to acknowledge the abuse, perform a safety assessment, and offer necessary referrals.

Providers should be aware of barriers that patients may have to disclosing a history of violence. The patient may fear that the physician will report the disclosure to the police or other authorities [18]. Providers should be aware of mandatory reporting laws in their state and discuss them with their patients when appropriate. (Individual state information can be found through state domestic violence coalitions, which are listed at www.feminist.org/911/crisis.html.) The patient may fear retaliation if the abusive partner were to learn of the disclosure, so the provider should emphasize that confidentiality will be preserved. The patient may feel shame or lack trust in the provider. Women from different cultural backgrounds may have different beliefs about reporting abuse or may not recognize such behaviors as abusive. These issues should be considered when screening for intimate partner violence so the provider can be sensitive to the barriers and concerns that the patient may have while working within the framework of the law.

Summary

Intimate partner violence is a prevalent problem that is underdetected by the medical community. Survivors can have significant medical and psychological sequelae resulting from their exposure to violence. Routine screening by primary care physicians can increase the detection of abuse and allow initiation of appropriate interventions. Screening in this setting incurs minimal time, cost, or other negative consequences, and can have potential benefit for the patient. Recommendations have been set forth by several medical organizations advocating for routine screening for intimate partner violence.

Upon initiating a routine screening protocol, a primary care practice should provide a comfortable environment with confidential screening areas. The physician should select and consistently use a screening method that is most appropriate for their practice. There are a number of screening tool options, including HITS, a validated 4-question screen with good psychometric properties. Once intimate partner violence is detected, physicians can offer validation, evaluate for safety and psychological and medical sequelae, and offer other medical, mental health, and community resources to the patient. These practices will lead to increased detection of intimate partner violence and potentially help survivors of abuse obtain increased access to the medical and community resources that are available to them.

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