The clinical implications of screening for violence against women

Violence against women affects an estimated 1.5 million US women annually, with one in four experiencing violence from a male partner at some point during her lifetime [1]. Violence occurs in all socioeconomic groups, in every race, ethnic group, religion and also in same-sex relationships.

Despite the prevalence of violence against women, female victims of personal physical and emotional abuse often go unrecognized by the health care system. Fewer than 15% of female patients report being asked about violence or abuse by health care professionals [2,3]. Surveys of barriers to screening for violence have revealed that health care professionals do not evaluate their patients for violence due to insufficient training, time constraints and perceived lack of effective intervention [4].

The physical manifestations of violence can be obvious but are sometimes more subtle in presentation and difficult to diagnose. This editorial is written to raise awareness among reproductive health clinicians about the severity of this issue, and to give them simple tools and key resources to quickly screen for violence when providing contraceptive care and during women’s health exams. The primary message is that screening for violence is an important part of reproductive health care and represents one of the few opportunities to positively affect patient care outcomes. Health care professionals can make a difference by screening all of their patients for past and current histories of abuse to effectively treat conditions arising from the violence as well as conditions impacted by the abuse.

1. Case study 1

An 18-year-old woman presented to her family physician for an initial obstetric examination. Preliminary history revealed that she was a gravida 1, para 0, at 16 weeks of gestation and lived in a mobile home with her partner. She was strongly considering giving up her baby for adoption because of “financial and other” reasons. Answers to screening violence history questions indicated that she had been beaten by her father from preschool age until she was 13 years of age; her parents then divorced. The patient stated that her current partner had “slapped her around” on several occasions, and once she was “accidentally dragged by his truck” during an argument. On further questioning, the patient confirmed that she was not happy in this relationship and, in fact, did not feel safe. However, she stated that she “had no place else to go” and expressed optimism about the future because her partner had begun to attend church and said he wanted to be a good father [5].

Between 0.9% and 21.0% of pregnant women are battered [1]. Studies reveal that battering is frequent during pregnancy [6] and is more common if, as in the above case, the pregnancy is unintended [7].

2. Case study 2

A 37-year-old white woman from an affluent upper middle-class suburb came to the emergency department (ED) complaining of pelvic pain. Her medical record revealed multiple hospitalizations to rule out structural abnormalities and endometriosis and several series of MRIs and CT scans including a recent vaginal sonography. Her medical record noted that all past tests were negative or inconclusive. The ED physician did not routinely screen women for abuse, but when the clinical diagnosis was confusing, she would ask more detailed questions about the woman’s social history, including a standard question about potential abuse. In this case, she uncovered years of previously undisclosed emotional, physical and sexual abuse by the spouse. The woman’s primary care physician did not routinely screen for violence regardless of unexplained diagnostic history and frequency of clinical visits. Her primary care physician expressed surprise when the ED physician told him about the abuse history.

Chronic pelvic pain is estimated to have prevalence of 3.8% in women aged 15–73 years, which is higher than the prevalence of migraine (2.1%) and is similar to that of asthma (3.7%) or back pain (4.1%) [8]. Several studies have also found that abused women have an increased incidence of menstrual disturbances, dyspareunia, chronic pelvic pain and sexual dysfunction compared with women who have not been abused [9].

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3. Defining violence against women

Violence against women is also known as or associated with gender-based violence, intimate partner violence and domestic violence. In general, this violence is defined to be any act of physical, sexual or psychological abuse, or the threat of such abuse, inflicted against an individual by a person intimately connected to them through marriage or family relation [10]. It involves the use of verbal, emotional, psychological, sexual, economic and physical forms of abuse by one individual or group of individuals to maintain power and control over another person [11].

The clinical manifestations of violence on women’s health include both direct (acute) physiological effects and indirect (chronic) effects and are outlined in Table 1 [5].

4. Barriers

Barriers to screening for violence are regularly identified in emergency medicine, obstetric and family medicine literature. The barriers cited are often the most amendable, and include the clinician’s lack of education, insufficient training and experience in screening for violence, as well as a lack of knowledge of community resources available for collaboration to address this major public health threat.

We suggest that the use of methods and resources as outlined below [12] will assist health care professionals in addressing these often difficult situations.

5. Clinician’s role

Despite these barriers, clinicians in the reproductive health field are in a unique role to screen for violence. For some women, their reproductive health clinician serves as their primary clinician. For other women, pregnancy may be the only time during which they seek out regular contact with a health care professional [13]. Each prenatal visit is an opportunity for health care professionals to screen for violence and to communicate key prevention and intervention messages about violence.

6. Five key clinician interventions

These five clinical interventions can result in positive outcomes for the battered patient [14]:

1. Provide essential health care services for presenting medical concerns.
2. Screen, intervene, support, document and refer (i.e., case manager, legal resources, court advocacy, victim services).
3. Assure the patient about your concern for their health and welfare.
5. Schedule follow-up appointment(s).

7. Three key screening questions

At minimum, clinicians should ask the following screening questions during every patient interview [4]:

1. Have you been hit, slapped, kicked, punched or otherwise hurt by someone within the past year? If yes, by whom?
2. Do you feel safe in your current relationship?
3. Is there a partner from your previous relationship who is making you feel unsafe now?

Many medical and health care organizations offer clinical guidelines based on both a review of the evidence and the consensus of expert opinion [15]. Guidelines on violence have been published by the American Academy of Family Physicians [16], the American Academy of Pediatrics [17], the American College of Emergency Physicians (1990–1991) [18], the American College of Obstetricians and Gynecologists [19], the Council on Scientific Affairs of the American Medical Association [20] and the AMA Diagnostic and Treatment Guidelines on Domestic Violence (1992) (Table 2).
8. Further interventions

One way to overcome these barriers is to improve the instruction and education for clinicians-in-training. Research shows that teaching reproductive health-specific content in these preservice settings helps to ensure that future clinicians are well prepared to meet patients’ comprehensive health care needs, including violence screening [21]. For educators, it may be difficult to add this information to already packed curricula or to locate reliable teaching materials to use in these settings [22]. Barriers to violence screening are notably similar to barriers to changing clinician behaviors related to other preventative health care recommendations (i.e., insufficient training, lack of knowledge of available resources) [23]. These similarities suggest that future interventions targeting clinician screening for violence will benefit from interventions that have shown success in changing clinician behaviors related to other practices.

To help address these barriers, the Association of Reproductive Health Professionals created the Curricula Organizer for Reproductive Health Education (CORE), an open-access Web-based tool featuring peer-reviewed, evidence-based teaching materials on numerous reproductive health topics. CORE provides educators with reliable, up-to-date content for teaching future health professionals about these important topics, in an effort to improve reproductive health outcomes for individual patients and the public. These materials are also useful for the clinician in practice who wishes to update or review their knowledge and skills.

9. Conclusion

Violence against women is a staggering problem within the United States and worldwide. A recent World Health Organization report provided astounding figures of physical abuse against women in 35 countries [24]. This report indicated 10–52% of women reported physical abuse; 10–30% reported sexual violence; 10–27% reported being abused sexually as a child and/or adult. Well-meaning health care professionals are at a considerable disadvantage in detecting the issue of violence in their practices due to time constraints and lack of training and awareness.

Numerous studies point out that much work remains to be done to establish whether clinician screening, counseling and referral in the primary care setting results in a decrease in violence against women [12]. Domestic violence services need to undergo rigorous evaluation to assess their effect on a variety of short- and long-term safety and quality-of-life outcomes for battered women. However, it is clear that reproductive health care professionals can prevent suffering, serious injury and death by remaining alert to the possibility of interpersonal violence and victimization when evaluating health risks during routine practice and pregnancy. Interventions can be as simple as asking a few key questions. Early intervention, including legal involvement and emergency service provision, in a context of community support, may prevent further violence and later pathologic conditions [5].

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References


