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CLINICAL SCREENING AND INTERVENTION IN CASES OF PARTNER VIOLENCE

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Abstract

Partner violence is a long-term health risk factor that can potentially have far-reaching, negative consequences on both those abused and their loved ones. The term "partner" is used to define opposite and same sex couples who are in relationships on a continuum ranging from casually dating to marriage. Partner violence includes physical, sexual, psychological, and economic abuse, as well as stalking behaviors. Even though the American Medical Association recommends screening for partner violence at multiple levels, there are many shortcomings of the current screening and intervention practice. Several factors facilitating the ineffectiveness of current practice include a lack of information related to the prevalence, duration, and severity of partner violence; physician's misguided beliefs regarding a victim's desire to disclose; and barriers that the victim faces when deciding whether to disclose partner violence. This article addresses these shortcomings and identifies nurses as an invaluable resource that has been under-utilized for screening and responding to partner violence. Also highlighted is one technique known by the acronym "RADAR" that is designed to address issues of both screening and intervention. Finally, resources for both health care practitioners and victims of abuse are provided.

Key words: partner violence, domestic violence, family violence, rape, psychological abuse, stalking, sexual assault, spousal abuse, violence, clinical screening, safety plan, nursing interventions

Introduction

Partner violence is a potentially life threatening health risk factor. It is a primary cause of traumatic injury to women and one of the leading causes of death for pregnant women. Horon and Cheng (2001) found that 20.2% of pregnancy-associated deaths were caused by homicide during pregnancy or within 365 days of delivery. Homicide was the number one cause of death

during pregnancy and during 43 – 365 days following delivery or termination of pregnancy. In contrast, among women 14 – 44 years old who are not pregnant, homicide dropped to the 5th leading cause of death. The number of injuries women sustained as a result of partner physical assault exceeded the total number of injuries sustained by women from car accidents, muggings, and rapes combined, making battering the most prevalent cause of traumatic injury to women in the United States ([Alpert, Freund, Park, Patel, & Sovak, 1998](#)). These findings illustrate just a fraction of the growing body of research justifying an urgent need for clinical screening, intervention, and support for victims of partner violence. This article is a brief overview that addresses what partner violence is, why nurses are needed to clinically screen for violence, how to maximize disclosure of abuse, and appropriate actions to take when partner violence has been positively identified. The article concludes with suggestions for reliable sources on the Internet for professional growth as well as resources for women experiencing violence.

What is Partner Violence?

The word "partner" applies to same and opposite sex couples, in married, engaged, or cohabiting relationships, and to more casual relationships such as acquaintances or dating partners. Because of the wide range of perpetrators who can be involved, and because of the multiple forms of violence they commit, the term "partner violence" is more precise than alternatives such as domestic violence, wife beating, or wife battering. Partner violence may occur as isolated occurrences, but most typically multiple forms of abuse are occurring that create a pattern of control by one partner and generate fear and submission by the other partner. The acts that comprise partner violence are physical, sexual, psychological, stalking, and economic abuse.

- Physical assault includes but is not limited to: pushing, slapping, punching, kicking, choking, beating, assault with a weapon, tying down or restraining, leaving the woman in a dangerous place, and refusing to allow access to medical care when the woman is sick or injured.
- Sexual assault includes acts such as degrading sexual comments, using coercion to compel a person to perform sexual acts when they have stated they don't want to, intentionally hurting someone during sex, including use of objects intravaginally, orally, or anally, pursuing sex when a person is not fully conscious or is afraid to say no, and coercing someone to have sex without protection against pregnancy or sexually transmitted diseases. Rape, the most serious form of sexual assault, is characterized by three key elements: lack of consent, penetration, no matter how slight and independent of whether ejaculation occurred, and compelling participation by force, threat of bodily harm, or with a person incapable of giving consent due to intoxication or mental incapacitation. Rape is variously referred to as stranger rape, date rape, acquaintance rape, and marital rape, but under the law, rape is rape, no matter what the relationship of the victim and perpetrator.
- Psychological abuse refers to acts such as humiliation, intimidation and threats of harm, intense criticizing, insulting, belittling, ridiculing, and name calling, verbal threats of harm or torture directed at the victim or family, children, friends, companion animals, stock animals, or property, physical and social isolation that separates a person from their social support networks, extreme jealousy and possessiveness,

accusations of infidelity, repeated threats of abandonment, divorce, having an affair if the person does not comply with abuser's wishes, monitoring movements, and driving fast and recklessly to frighten the victim ([American Medical Association, 1992](#)).

- Stalking refers to repeated harassing or threatening behaviors that an individual engages in such as following a person, appearing at a person's home or place of business, making harassing phone calls, leaving written messages or objects, or vandalizing a person's property. These actions may or may not be accompanied by a credible threat of serious harm, and they may or may not be precursors to an assault or murder ([Tjaden & Thoennes, 2000](#)).
- Economic abuse is restricting access to resources such as bank accounts, telephone communication, and transportation, or refusing the right to work or attend school that have the effect of keeping a victim without resources and under the control of the abuser.

Clinical Screening

American Medical Association's Practice Guidelines for Physicians ([1992](#)) recommends screening for partner violence at all portals of entry to the health care system. Screening for partner violence is important because when unidentified and unameliorated, the consequences of violence are usually ongoing, escalating, and involve a wide range of general medical injuries, psychological illness, and social problems. The Joint Commission on the Accreditation of Health Care Organizations (JCAHO) has recently required the development of partner violence protocols and this, along with proposals made by the American Medical Association (AMA), have led to a greatly improved (although still not to the degree that is necessary) level of response to partner violence. Clearly, the first step in treating partner violence is to properly identify cases in which it is an issue.

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Barriers to Screening

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There is modest cohesion in the medical community regarding the level of need for clinical intervention in cases of partner violence. But for various reasons including the relative lack of information regarding the prevalence, incidence, duration, and severity of violence experienced by medical patients, it is difficult to definitively state the services that are needed to address these problems sufficiently. The result of a lack of information and other barriers inherent in the

pressures of today's health care environment has been a relatively low level of success in convincing health care providers to routinely screen and treat partner violence.

One of the major problems facing health care today is that physicians are not taking the time to ask patients questions regarding their social environment. There are many reasons for this backing away from the biopsychosocial approach that once guided informed health care provision. Physicians often feel time pressures, do not want to invade an individual's privacy, believe that they do not know what to do if the individual discloses abuse, and may think that physicians cannot make a difference anyway. Rodriguez, Bauer, McLoughlin, & Grumbach (1999) reported that only 10% of physicians routinely screen for intimate partner abuse during new patient visits and 9% screen during periodic checkups. The only time physicians consistently asked about intimate partner abuse was in cases that involved physical injuries (79% reported asking questions). The fear of invading patient privacy that physicians articulate flies in the face of data suggesting that most victims of partner violence are receptive to questions from medical personnel concerning abuse (Stark, 2000). Those health management facilities that have enacted a few standard questions related to partner violence in a confidential screening have shown a marked increase in disclosure and identification of cases of partner violence.

The Role of Nurses in Identifying and Responding to Violence

One of us (MPK) in conjunction with her internist-husband Paul Koss, MD, as well as many other advocates across the country, have worked for over 10 years to educate physicians about why violence is a health issue, to raise consciousness of the practice guidelines, and to teach clinical screening and intervention. Examining the most recent information that 10% of physicians are routinely screening suggests that the accomplishments have been modest. When training programs are introduced, screening rates go up. When the study ends, they go back down again. When physicians are given resources including on-site consultants to address the excuse that they are not screening because they don't know what to do when they find abuse, their rates of screening still do not reach acceptable levels. It is more reasonable to keep up the work, by focusing on medical students, interns and residents, who may be more receptive, than trying to alter the practice styles of mature physicians. However, the payback might be higher by turning to other provider groups who accord partner violence a higher priority and whose professional norms value working with the whole patient. We believe that nurses could implement a level of consistency in screening patients for partner violence.

How to Ask About Partner Violence

Many of the medical, social, and behavioral problems associated with partner violence go untreated not because appropriate screening questions are omitted, but because the setting in which screening is done and the specific phrasing of the questions neither stimulated recall nor created a comfortable disclosure climate. For example, asking a woman if she is "abused at home", could elicit a response of, "no"; whereas asking the same woman whether her significant other has hit her could elicit a response of, "yes". To maximize safety and comfort it is important to interview in private, without the partner or children present. Screening for partner abuse in the presence of other family members is not only futile, it can even put the patient at risk of injury if the partner is informed and intervenes to silence the victim.

The best questions to use avoid words like "domestic violence", "abused",

"battered", or anything else that sounds demeaning or judgmental or is in reality a technical term that those lacking professional training may fail to understand fully. An example of a single, comprehensive question is the following: "At any time, has a partner hit, kicked or otherwise hurt, frightened, threatened or demeaned you?" This question covers a lot of situations. If time permits, it is better to use multiple questions. Doing so allows more opportunities for patients to disclose and offers them more details about the types of situations you want to identify.

It is unwise to put any blame or judgment on the victims. Rather simply ask specific questions that allow you to accurately document what has happened and make it clear that you are someone they can look to for guidance if they invest their trust in you and disclose their experiences. Weiss (2000) suggests that clinicians should be aware of the symptom presentations that are suggestive of domestic violence, such as injuries in various stages of healing, pattern injuries (where an object is outlined on the body...i.e. a hand, finger, belt, etc.), abdominal pain, pelvic pain, headache, dizziness, panic, and insomnia. Injured patients should always be asked to explain how it happened and clinicians must be alert for answers that don't explain the injuries.

Barriers to Disclosing Partner Violence

Failure to identify partner violence in medical settings stems from either a lack of adequate screening practices or hesitancy by victims to disclose acts of partner violence when asked. The barriers preventing women from disclosing are very real to the victims and must be addressed for any screening method to give accurate results.

Fear is the first of the barriers most victims must overcome when making the choice to disclose partner violence.

- Fear is the first of the barriers most victims must overcome when making the choice to disclose partner violence. This fear is multidimensional in that, not only is the victim usually fearful of the abuser retaliating against her for telling family secrets, but she is also often afraid of involving the clinician or the police in her personal situation. She may fear if she discloses, she will lose whatever control she has over the situation, or be blamed or stigmatized by the authorities or the clinician inquiring about the abuse. Many women have learned from unfortunate encounters with police responding to domestic violence calls that assertions of partner violence still too often meet a high level of skepticism. In legal proceedings skepticism may continue even in the presence of physical evidence supporting the claim. Thus, many women try to avoid involving others, believing that they cannot or will not help them.
- Cultural Differences is a second barrier many women face when deciding whether to disclose partner violence. They may feel the clinician would not understand their specific culture or may have a culturally shaped worldview that accepts the partner's behavior as normative. Culture shapes what people define as acceptable and unacceptable in intimate relationships, what they feel causes violence that goes beyond minimal levels, what the appropriate response to violence is, and who is in the best position to help resolve the situation. What is not considered acceptable in one culture may be normative in

another culture. For example, Heise, Ellsberg, & Gottemoeller, (1999) recounted that, "a study of female homicide in Alexandria, Egypt, found that 47% of all women killed were murdered by a relative after they had been raped" (p. 10). Such "honor killings" are essentially tolerated where cultural practices dictate that murdering the woman is the only way to reclaim the family name after a rape has occurred. However, in many other societies the idea of killing a family member because she was raped is unspeakable. Although the cultural issues are not always so extreme, there are different expectations within different households, and many victims of partner violence maintain a culturally based world-view that minimizes the abuser's behavior.

- Dependence on the abuser is a third barrier that a woman may face when deciding whether to disclose partner violence. Dependence can be economic, social, psychological, or any combination of these types of reliance. Where will she live if she discloses violence to the physician or authorities? Perhaps her abuser prevented her from getting a job and therefore she has no money of her own to meet her basic needs and those of her children. Who will support her decision to leave if her abuser has forced her to cutoff or avoid her family and former friends? These are just a few examples of fears that may go through the victim's mind as she contemplates placing her trust in a medical provider.
- Feelings of failure are common for victims of partner violence who often feel responsible for the abuse. This belief can arise from the abuser blaming the victim, the authorities asking questions that imply blame (e.g. "What did you do to provoke the attack?" or "Why don't you leave your abuser?"), or even from internalized scripts that cast women as responsible for harmony in the home. If a victim is experiencing feelings of failure related to abuse, she may not feel comfortable confiding in anyone else, preferring to work harder to try and change what is happening.
- Promise of change or hope is the final barrier. Perhaps the abuser acts remorseful and seems greatly apologetic for the abuse, making excuses and explaining why it will never happen again, bringing gifts or offering to work extra hard to make up for what he has done. Although abusers may be sincere at the time, few are able to cease their violence without outside help (for a list of Web sites with state-certified programs for batterers go to <http://www.ncadv.org/>). The majority of perpetrators, however, use remorse as one more tool to manipulate their victims into putting up with more abuse, staying with them, and not reporting the crime to the authorities.

Following Up Positive Identifications

It is important to listen nonjudgementally and validate the disclosure by telling the patient how sorry you are about what is happening and that no one has the right to treat another person that way. These steps in and of themselves are healing and empowering, but they are not enough. Judith Alpert and her colleagues (1998) developed a guide to recognize and treat victims of partner violence. This resource uses the acronym "RADAR" to summarize the clinical tasks required. The acronym "RADAR" stands for Remember, Ask, Document, Assess, and Review. If followed, the RADAR action steps greatly increase the quality of care. Both *remembering* to routinely ask patients about partner violence and *asking* them directly with

specific questions increase the success of screening for abuse. The next three steps of the RADAR system structure clinical response and include *documenting* the injuries, *assessing* the victim's safety, and *reviewing* possible options with the woman.

Document Findings in Medical Records

Document your findings in the medical records when taking information from someone whom you suspect has been a victim of partner violence. Stark (2000) points out that documentation can serve multiple purposes including:

- 1) Alerting other health care providers of ongoing domestic violence in a patient's life
- 2) Serving as objective documentation that injuries not consistent with accidental origin have been observed
- 3) Assisting those who monitor quality of care to determine the rates of screening that is occurring
- 4) Contributing data to hospital and clinic policy decisions so that scarce resources are allocated to the problems that patients are most typically presenting.

The clinician may consider taking photographs of the injury on a Polaroid or digital camera to place in the victim's file, providing visual evidence to support the written documentation. This is one of the most important steps medical providers can take to increase the safety of victims. Patients may not be ready to take legal steps initially or even for a substantial length of time. But when and if that point is reached, the documentation will be there to lend credibility.

Assess Perpetrator Lethality

Assessing your patient's safety is a vital role in responding to disclosures of partner violence. Alpert and colleagues (1998) suggest asking the woman if there are weapons in the house, if the violence is increasing with time, or if the children are in danger. Another factor that should be taken into consideration is the level to which the woman feels like she is entrapped. Being isolated from support other than the abuser can interfere with medical access and complicate discovery of future injuries or abuse to the woman. Gaining a better picture of what the situation is at home is important in offering resources such as specialized community services or support groups.

Like many ongoing health issues that providers address, partner violence cannot be resolved in a single appointment. It is important to not pressure the woman to do what she does not want to do. Each visit offers a new opportunity to take stock of the violence and move the patient along the change continuum. However, if there is eminent danger, clinicians may offer to telephone the police or shelter to arrange for protection and transportation. Some states such as California and many tribal nations mandate that authorities must be notified if a health care provider suspects partner violence has occurred. It is important to inform yourself of what is required of you as a health care provider in your state.

Make a Safety Plan With the Victim and With Children

A safety plan is something that goes beyond just making sure that a woman is safe in her current home environment. Above and beyond assessing whether a woman or her children are in danger in the home, it is important to have a plan that they can follow if placed in a dangerous situation by the abuser. Safety plans include a myriad of things, such as having a place to stay or housing available should they need to leave the home suddenly; having access to a separate bank account; always keeping a bag packed with copies of important documents or immigration papers, as well as a change of clothes; having access to legal services; having an understanding with the school regarding who specifically is allowed to pick up the children; and any other number of things that must be addressed in individual cases to insure that a woman and the children can leave on a moments notice.

Make Appropriate Referrals

Nurses who are interested in learning more about working with partner violence can readily find resources on the Internet.

Finally, reviewing the many options your patient has is critical in supporting her through this difficult situation. It is helpful if you have a working knowledge of the different types of community resources including shelters, support groups, and legal advocacy. It is advisable to keep a list of contact numbers in the clinical area.

Displaying brochures or pamphlets with contact numbers in the office not only sends

the message that the clinician is comfortable working with the issues, but also provides information for patients who are not yet ready to disclose. If you are giving an abused woman literature or telephone numbers, make sure that she will be safe in taking them. Some partners could react with increased violence to the threat they feel over their partner speaking to outsiders. If it is safe for the woman to take these materials, they can prove very useful as she is given the choice of using this information, but does not need to feel pressured into contacting support groups that she is not yet ready to embrace. There are also Internet resources available; but before recommending them to patients, make sure that they realize that most internet browsing software creates a list of recently visited sites that are accessible to anyone who sits down to the computer. Electronic footprints are left in multiple places on a computer after visiting any website on the Internet. To maintain safety, these sites must be deleted before shutting down ([see Fremantle Regional Domestic Violence Coordinating Committee, 2001](#)). There are also programs that delete records from a computer, preventing the abuser from tracking which websites the victim has visited ([see Historykill, 2001](#)).

Where to Learn More

Nurses who are interested in learning more about working with partner violence can readily find resources on the Internet. Some websites have information that is directly geared to victims of partner violence such as the National Coalition Against Domestic Violence (NCADV) (www.ncadv.org or 303-839-1852), the National Domestic Violence Hotline (NDVH) (www.ndvh.org or 800-799-SAFE), or the Family Violence Prevention Fund (FVPF) (www.fvpf.org or 415-252-8900). The NDVH specializes in helping

women with immediate needs and the FVPF serves as a resource for a varying range of support for different forms of partner violence. CAVNET's online forum (www.cavnet2.org) for survivors is also an excellent resource. The forum takes place between 8-10 PM Eastern Standard Time Sundays and Wednesdays and addresses sexual assault, stalking, incest and domestic violence.

Other websites offer professional resources for upgrading skills including, the Minnesota Center Against Violence and Abuse (MCAVA) (www.mincava.umn.edu or 612-624-0721), or www.vawnet.org. The American College of Obstetrics and Gynecology has a helpful website that can be found at www.acog.org. Other valuable locations on the Internet with items of local and national of interest may be easily accessed through links found on either the NCADV or the MCAVA sites.

Conclusion

Partner violence is a serious health risk that must be addressed more reliably than it has been to this point. Women are being killed, beaten, raped, and abused in a wide range of other ways without having a strong base of support in the medical care system to which they can turn to seek help. Women have more frequent contact with their health care providers than with any other formal system including law enforcement, prosecution, social service, or mental health. The nursing profession has potential for having enormous impact on the health and safety of women by taking up the challenge of routinely performing violence assessment. Nurses enjoy high patient trust, and their training in empathy and clinical rapport make them ideal receivers for the disclosure of partner violence. It is important to recognize that there are many barriers to a woman reporting partner violence and, with those in mind, use your RADAR.

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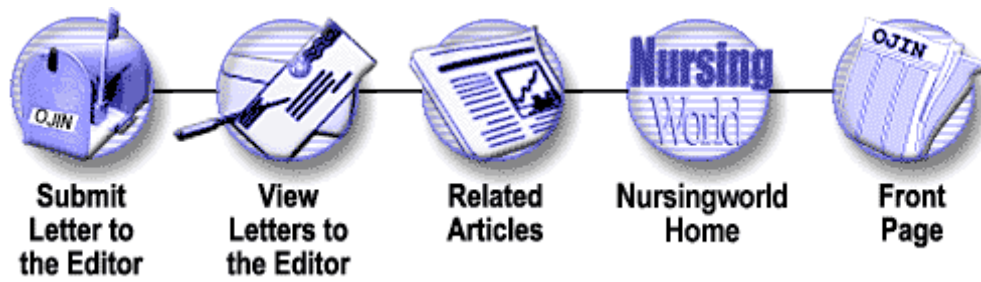
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