51. Screening for Family Violence

RECOMMENDATION

There is insufficient evidence to recommend for or against the use of specific screening instruments to detect family violence, but recommendations to include questions about physical abuse when taking a history from adult patients may be made on other grounds (see ***Clinical Intervention***). Clinicians should be alert to the various presentations of child abuse, spouse and partner abuse, and elder abuse.

Burden of Suffering

Family violence is a serious public health problem for many Americans. Family violence includes child abuse (physical and sexual abuse), domestic violence (physical or sexual abuse of spouse or intimate partner), and elder abuse (abuse or neglect of older persons).[1] Because many cases of family violence go unreported, the true magnitude of the problem can only be estimated.[2]

Child Abuse. In 1993, child protective service agencies substantiated maltreatment of over 1 million children in the U.S. (a rate of 14/1,000 children); over 1,028 deaths due to child maltreatment were reported in 1993.[3] Intentional injury is the leading cause of injury-related death in children under 1 year of age.[4] Parents or other relatives are responsible for over 90% of reported cases of child maltreatment.[3] In addition to physical injuries, children who have been victims of or witnesses to violence often experience abnormal physical, social, and emotional development; adolescents and adults who were abused as children are more likely to abuse tobacco and alcohol, attempt suicide, and exhibit violent or criminal behavior.[2,5–7]

Approximately 140,000 cases of child sexual abuse were reported in 1993,[3] but the true incidence has been estimated to be as high as 450,000 cases per year.[8] In sexual abuse cases where the abuser was known to the child, over two thirds involved abuse by family members.[9] Girls are victims of sexual abuse two and a half times more frequently than boys.[10] Child sexual abuse often results in severe psychological trauma,[11] has been associated with a variety of psychological problems persisting into adulthood, and can cause medical complications such as sexually transmitted diseases. Teens who had been sexually abused were significantly more likely than

nonabused controls to be sexually active, to abuse alcohol or drugs, and to have attempted suicide.[7,12]

A number of parental and family characteristics have been identified as risk factors or risk markers for child physical abuse—poor social support, low socioeconomic status, single parent family, and unplanned or unwanted pregnancy[13]—but abuse is usually the result of multiple interacting factors.[14] Abuse of drugs or alcohol, although not clearly an independent risk factor, often coexists with conditions (poverty, social isolation, etc.) that increase the risk of abuse.[15] Abusive mothers are often themselves victims of physical violence by their spouse or partner,[16] and abusive parents often experienced abuse as children. A poor understanding of normal child development, poor anger control, and use of physical punishment as a discipline technique are more common among abusive parents.[13] In contrast, demographic or family characteristics are of little value in predicting risk of child sexual abuse.[17]

Domestic Violence. Estimates of the prevalence of domestic violence among couples vary depending on the source of data and definition of violence.[18] A national survey of 50,000 households conducted in 1992 and 1993 estimated that over 1 million women (9.3/1,000) and nearly 150,000 men (1.4/1,000) are victims each year of assault, robbery, or rape committed by their spouse, ex-spouse, or intimate partner;[19] over half of these incidents result in minor injury, and 3% in serious injury (broken bones, loss of consciousness, hospitalization, etc.).[20] This estimate may be conservative due to underreporting. In a comprehensive survey of family violence, involving detailed interviews of a total of 8,145 families in 1975 and 1985, 16% of couples reported instances of violence in the previous year (including shoving, slapping, or grabbing); 40% of these episodes involved more serious actions such as kicking, punching, or use of a weapon.[21,22] In recent surveys, 2–3% of women reported being kicked, bitten, or hit with fist or some other object by their partner in the preceding year.[22,23] Family studies indicate that both men and women engage in violence against partners, but women are the primary victims of chronic battering and episodes leading to injury.[24] In 95% of episodes of domestic violence leading to criminal investigation,[20] and 59% of spouse murders,[25] women were the victims. The prevalence of domestic violence is also high among female patients in clinical settings: 15% of women visiting an emergency department[26] and 12–23% of women in family practice settings[27,28] reported having been physically abused or threatened by their partner within the last year. Domestic violence tends to be repetitive—female victims reported an average of six violent incidents per year.[22] The psychological consequences of abuse can be as important as physical injuries: abused women may suffer from posttraumatic stress disorder, and they are more likely than

nonabused women to be depressed, attempt suicide, abuse alcohol or drugs, and transfer their aggression to their children.[29,30]

Violence between spouses or partners can occur in families from all demographic and economic strata of society,[22] but risk of physical assault appears higher for some groups of women. Women who are under age 35, have not attended college, are of lower socioeconomic status, or are unmarried are more likely to report being victims of domestic violence.[20] A review of 52 studies found that only one risk marker—witnessing parental violence as a child or adolescent—was consistently associated with being a battered spouse.[31] Childhood family violence and alcohol problems are more common among abusive partners.[22] In general, however, the primary care physician is not able to predict reliably which patients are likely to be affected by domestic partner violence.[32]

Pregnant women are also at risk from domestic violence.[33,34] In surveys of pregnant women (primarily from urban, public clinics), 7–18% of women reported physical abuse (including forced sexual activity) during the current pregnancy.[35–38] Many studies have reported an association between violence and worse outcomes in pregnancy. Battered women are more likely to register late for care, suffer preterm labor or miscarriage, or have low birth weight infants than nonabused controls.[35–39]

Elder Abuse. Elderly persons are also vulnerable to physical or psychological abuse or neglect by family members or other caregivers.[40,41] Community surveys in Boston and Canada estimated that 3–4% of persons over age 65 are victims of physical abuse, neglect, or regular verbal abuse.[42,43] Factors that appear to increase vulnerability to abuse among older persons include poor or failing health, cognitive impairment, and lack of family, financial, or community support.[41] The abuser is usually a relative, most often the spouse.[44] Family members who have a history of substance abuse, mental illness, or violence, or who are financially dependent on the elder person, are more likely to be abusive.[41] Accurate estimates of the medical consequences of elderly abuse (patient visits, hospitalizations, or costs of care) are not available.[42] It is estimated that less than 1 in 5 cases of elder abuse is reported, due to denial or minimization of the problem by the victim, abuser, or health professionals.[45] In one report, up to 60% of elder abuse victims admitted for acute medical care remained permanently institutionalized.[46] The incidence of mistreatment of elders in institutions is not known. A survey of nursing home staff revealed that 36% of the staff had witnessed physical abuse, and 81% had witnessed psychological abuse of patients.[47]

Accuracy of Screening Tests

Family violence may come to attention when it results in severe injuries, but ongoing abuse often goes unrecognized in the clinical setting. The

clinician can identify victims of domestic violence through the patient interview, use of a standardized questionnaire, or the physical examination.

There are few reliable techniques for screening for child abuse. Questionnaires can identify risk factors for child abuse and neglect, but the potential to falsely label families as "potential abusers" is a limitation to their use in clinical practice.[48] Eliciting evidence of child physical or sexual abuse through patient interview is difficult. Young children may not be able to answer reliably, both child and parent may be ashamed or fearful of admitting to abuse, and some abusive parents may not regard their use of physical punishment as abuse. Most authorities recommend exploring for potential problems with open-ended, nonjudgmental questions about parenting and discipline (e.g., "What do you do when he misbehaves? Have you ever been worried that someone was going to hurt your child?").[14,49] The value of standardized questions or screening instruments to improve the detection of child abuse is not known. Physical findings suggestive of abuse noted during routine or symptomatic examinations have been described.[50] Burns, bruises, and other lesions can be suggestive due to their appearance (e.g., patterns resembling hands, belts, cords, and other weapons) or location (buttocks, lower back, upper thighs, and face). Multiple traumatic injuries without a plausible explanation are also suspicious. At the same time, accidental injuries may produce similar findings in children, and many abused children (especially victims of sexual abuse) have no obvious physical findings. In a survey of studies of sexually abused children, normal examinations were reported in up to 73% of girls and 82% of boys.[51] Neither the sensitivity nor specificity of screening for abuse with physical examination is known.

Some studies report that less than 10% of battered women are accurately diagnosed by physicians, even in hospitals with an established protocol for this problem.[30,33] The routine patient interview often fails to detect abuse in adult patients, in large part because physicians do not routinely ask about domestic violence. Only a third of physicians in one survey felt that routine questions on abuse should be part of the annual examination.[52] Many physicians are reluctant to ask about abuse, out of fear of offending their patients, inability to "fix" abusive relationships, frustration in dealing with resistant patient behavior, and lack of time to deal with the problem.[53] Both victim and abuser may deny abuse for a variety of reasons—embarrassment, psychologic repression, or fear of reprisal, abandonment, or legal consequences.

Consistent use of screening protocols significantly improves the detection of abuse as a cause of trauma,[54] and similar measures have been shown to increase the detection of domestic violence affecting pregnant and nonpregnant outpatients. The large majority of abuse victims favored routine questions about abuse, and half indicated that they would volun-

teer information about domestic violence only if specifically asked.[52] Directly asking individuals about the occurrence of abuse has been shown to elicit more positive reports (29% vs. 7%) than the use of a written self-report.[55] The Abuse Assessment Screen, containing five questions on the frequency and severity of past and current physical abuse and forced sexual activity, has been validated against more comprehensive instruments in pregnant women.[56] Incorporation of this instrument into the standard social service interview of pregnant patients significantly increased the detection of recent abuse compared to historical controls (15% vs. 3%).[35]

There are fewer studies on screening for elder abuse. The value of the patient interview may be limited if the abuser is present. A 15-item instrument for detecting elder abuse had a sensitivity of 64% and specificity of 91% in a pilot study, but has not been validated for screening in routine practice.[57]

Effectiveness of Early Detection

The repetitive nature of family violence suggests that early detection may be important in preventing future problems from abuse. Specifically, patients can be counseled about the nature and course of family violence, given information about available resources (community counseling and support groups, shelters, protective service agencies, etc.), and counseled about means to prevent further abuse. Psychological counseling, by either the primary care clinician or a mental health professional, may help the patient terminate personal relationships with violent individuals. The clinician may also identify individuals who are at increased risk of committing abuse in the future. Such persons may be referred for psychiatric counseling or family therapy to learn stress management and nonviolent alternatives for conflict resolution. Finally, the clinician is able (in many instances, required) to report suspected cases of abuse and neglect to appropriate protective service agencies for further evaluation and intervention.

Intervention studies in child abuse have concentrated on primary prevention.[48] Two randomized clinical trials have shown that home visits to high-risk families decrease the rate of child abuse and the need for medical visits early in life.[58,59] Interventions may need to be ongoing to retain effectiveness: extended follow-up of one of these trials found no effect of intervention on the rate of abuse and neglect later in life (ages 25–50 months).[60] Unfortunately, most clinicians do not have the option of providing this level of intervention. Studies evaluating the effectiveness of treatments for abused children are limited, and their results have been mixed.[61] Recurrent abuse despite interventions may occur in up to 60% of cases.[62] The effectiveness of treating sexual abusers of children remains controversial; one outpatient program reduced recidivism by half.[63]

The effectiveness of early intervention for domestic violence is also difficult to determine. Most interventions for spouse abuse (e.g., shelters, legal action) are crisis oriented and have been directed at women who have already been injured by domestic violence. The options available to women are often limited by associated factors common in abusive relationships: financial dependence on an abusive partner, fear of retribution, alcohol or drug problems, or psychological vulnerability.[22,64] As a result, many abused women decline offers of help.[65] For women who do attempt to terminate an abusive relationship, the available resources to assist them are often limited and temporary. In a controlled study of battered women leaving a shelter, women who received services of an advocate for 4–6 hours per week reported better overall quality of life, but no significant difference in levels of physical abuse, compared to controls.[66] Whether treatment of abusive men is effective in reducing domestic violence remains controversial. A randomized trial of group therapy (vs. standard care) for convicted wife-abusers showed that repeat abuse was significantly lower for the treatment group.[67] Effective approaches to couples who engage in mutual, less severe violence (pushing, shoving, etc.) have not been developed. A large controlled study is under way to examine whether an integrated program to improve detection and management of domestic violence in the primary care setting leads to better clinical outcomes.[68]

Effective interventions for elder abuse may also be limited, in large part because the abuser is often the primary caregiver to the victim.[41] If the only alternative is nursing home placement, victims may be reluctant to give up their independence in order to escape abuse. A review of elder physical abuse victims in Illinois reported that most victims received few tangible services from social service agencies other than case management (primarily monitoring).[69] Among abused elders, an advocate program decreased social isolation and improved services, but a reduction in subsequent abuse was not demonstrated.[70]

Recommendations of Other Groups

The American Academy of Pediatrics,[71] American Medical Association,[72,73] American Academy of Family Physicians (AAFP),[74] and the Bright Futures guidelines[49] all recommend that physicians remain alert for the signs and symptoms of child physical abuse and child sexual abuse in the routine examination. Bright Futures suggests including questions about child discipline, and abuse of the child or parents, at the discretion of the clinician. The AMA's Guidelines for Adolescent Preventive Services (GAPS) recommend that teens should be asked annually about a history of emotional, physical, and sexual abuse.[75] The use of screening devices to identify families at risk for child maltreatment is not recommended by the Canadian Task Force on the Periodic Health Examination (CTF).[48] Legislation in all

states requires health care professionals to report suspected cases of child abuse.[73]

The American College of Obstetricians and Gynecologists (ACOG),[76] the U.S. Surgeon General,[77] the American College of Physicians,[78] and the AAFP[74] all recommend that clinicians be alert to the possibility of domestic violence as a causal factor in illness and injury. ACOG and AMA guidelines on domestic violence recommend that physicians routinely ask women direct, specific questions about abuse.[79,80] ACP and AAFP guidelines are currently under review. An expert panel convened by the National Research Council and the Institute of Medicine (Washington, DC) to evaluate the effectiveness of family violence interventions is scheduled to publish its findings in 1996. Healthy People 2000, a report of national health objectives,[81] and the Joint Commission on Accreditation of Healthcare Organizations[82] recommend that all emergency departments use protocols to improve the detection and treatment of victims of domestic violence.

The CTF determined that there was insufficient evidence to include or exclude case-finding for elder abuse as part of the periodic health examination, but recommended that physicians be alert for indicators of abuse and institute measures to prevent further abuse.[44] The AMA recommends that physicians routinely ask elderly patients direct, specific questions about abuse.[83] Many states require reporting of domestic violence[84] and elder abuse.[41]

Discussion

Family violence is an important cause of physical and psychological harm in children and adults, yet it often goes undetected by clinicians. Identifying victims of domestic violence provides important information to clinicians and may allow early intervention to reduce the risk from future abuse. Although the benefit of routine screening has not been directly assessed, several factors support greater efforts by clinicians to detect domestic violence between spouses or sexual partners: the substantial prevalence of violent behavior among couples, the repetitive nature of domestic violence, and its high medical and societal costs.[1] Contrary to common perceptions, most patients appreciate being asked about possible abuse, and direct questioning may substantially increase reporting of episodes of domestic violence.

At the same time, clinicians face important obstacles in preventing violence or sexual abuse within the family. The etiology of domestic violence is multifactorial and is a function of social conditions, family conflict, cultural attitudes, and biologic factors. Interventions for physical or sexual abuse, mostly outside of the medical domain, vary greatly in effectiveness.

Although crisis interventions (arrests, referral to shelters) are appropriate to protect victims in specific cases, there are few adequately controlled studies to determine the effect of counseling or referral on the long-term outcome of family violence. Appropriate screening methods for child abuse and elder abuse are also uncertain. Screening for abuse through the patient history is problematic with young children, may be unreliable if the abuser is also present, and can be complicated by denial in all age groups. Errors in diagnosing abuse are of great concern because of the serious emotional, legal, and societal implications of either failing to take action in cases of abuse or of incorrectly accusing innocent persons.

Despite the limited and imperfect options for detecting and intervening in domestic violence, the benefits are substantial for those families where the cycle of abuse can be interrupted. It is also important for clinicians to maintain a high index of suspicion when examining other persons at risk of physical or sexual abuse (e.g., children and the elderly), to assess potential risk factors for domestic violence, and to refer abuse victims and perpetrators to other professionals and community services to help prevent future incidents.

CLINICAL INTERVENTION

There is insufficient evidence to recommend for or against the use of specific screening instruments for family violence, but including a few direct questions about abuse (physical violence or forced sexual activity) as part of the routine history in adult patients may be recommended on other grounds ("C" recommendation). These other grounds include the substantial prevalence of undetected abuse among adult female patients, the potential value of this information in the care of the patient, and the low cost and low risk of harm from such screening. All clinicians examining children and adults should be alert to physical and behavioral signs and symptoms associated with abuse and neglect. Various guidelines are available to help clinicians in recognizing abuse and neglect in children,[71–73] spouses/partners,[80] and elders.[81] In all states, suspected cases of child abuse or neglect must be reported to local child protective services agencies. In most states, suspected elder abuse must also be reported. [41] All individuals who present with multiple injuries and an implausible explanation should be evaluated with attention to possible abuse or neglect. Injured pregnant women and elderly patients should receive special consideration for this problem. Suspected cases of abuse should receive proper documentation of the incident and physical findings (e.g., photographs, body maps); treatment of physical injuries; arrangements for counseling by a skilled mental health professional; and the telephone numbers of local crisis centers, shelters, and protective service agencies. The safety of children of victims of abuse should also be ensured.

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