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Original article

A Randomized Trial of Screening for Relationship Violence in Young Women

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Abstract

Objectives: We conducted a randomized controlled trial of three screening approaches to assess relationship violence disclosure among young women as well as patient and provider satisfaction.

Methods: Reproductive healthcare patients (n = 699) aged 15 to 24 years completed one of three approaches to violence screening, that is, basic, healthy relationship, and bidirectional. Screening was embedded in a comprehensive health history using an audio-assisted computer interview (ACASI). Afterward, the patient met with the provider, who reviewed screening results. The patient and provider independently completed an assessment of the process.

Results: Medical and violence screening took about 8 minutes with those in the basic screening finishing significantly more quickly. We did detect a significant difference by screening approach for recent *physical* violence victimization, but no other significant differences emerged between screening approaches. Although patients' or providers' satisfaction and comfort with the screening process were positive, no differences were detected.

Conclusions: An approach that frames questioning within a birectional context enhances detection of recent physical victimization, and can be completed in busy reproductive healthcare setting. All screens were equally and highly regarded by participants and adequately rated by providers.

Keywords: Relationship violence; Physical; Sexual; Screening; Randomized trial; Young women

Relationship violence among adolescents and young adults is common and troubling [1].

As many as one in three adolescents report experiencing physical violence by a romantic partner [2], with higher prevalence estimates found in clinical samples [3]. These data underscore the importance of systematic screening for violent relationships, but how to conduct these efforts and with what measures remains unexamined [4,5].

The integration of research documenting the effectiveness of universal screening for relationship violence with policy directives and women's views of screening presents an ongoing challenge for public health and healthcare professionals. There is inadequate evidence that screening reduces partner violence, minimizes sequelae, and, most importantly, improves women's well-being. Further, the effectiveness of interventions utilized by practitioners following a positive screen has not been examined [6–8].

Despite the lack of evidence for effectiveness of screening and limited success documenting implementation of screening, health professional organizations continue to advocate universal screening as an important strategy to decrease violence [9–11]. Moreover, women worldwide support provider screening for partner violence [12]. It is therefore critical to understand the most effective way to screen for partner violence. One key obstacle to overcome is the difficulty of personal disclosure, especially in the

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population at greatest risk: women aged 16 to 24 years [4,10]. Among adult women, MacMillan et al [13] conducted a randomized trial to determine the optimal screening method for intimate partner violence. These researchers found that prevalence estimates varied depending on methodology used, that is, face-to-face, paper/pencil self-report, or computer screening. Although women in this study preferred self-completed approaches to direct questioning, computer-based screening methods did not increase the proportion of women who disclosed violent events.

Despite national recommendations to include adolescents and young adults, evaluation of partner violence screening approaches has focused on adult women. Young women report a higher prevalence of partner violence than older women, yet few investigations have focused on how to engage this population to facilitate disclosure of relationship violence to a healthcare provider [5,12]. Recent data found that young women aged 15 to 24 years overwhelmingly supported universal screening for relationship violence in a healthcare setting, and that the healthcare provider was the most popular adult figure to inquire about possible relationship violence [14]. Further, the use of computer-based methodology for screening appears promising, as reports have indicated greater disclosure of health-risk behaviors among adolescents [15] as well as among adult women disclosing partner violence when compared to traditional screening methods [16,17].

The purpose of this study was to conduct a randomized control trial of three different screening approaches using computer-based screening methodology to assess relationship violence among adolescent and young adult women and to gain information on patient and provider satisfaction with these approaches. Screening for relationship violence was one portion of the routine health history completed by the patient prior to the medical visit. These questions were included to convey that relationship violence screening was similar to other common health conditions routinely asked during a medical encounter. We set our primary outcomes to include both lifetime and recent physical and sexual partner violence, including sexual violence from anyone at any time. We hypothesized that disclosure rates of violence would be highest when the screening approach was placed within a relationship as opposed to simply inquiring about violent behaviors from partner. Because comfort with the screening process itself is important both to women and the providers who conduct it, we set secondary outcomes to include the participants' satisfaction with the three screening approaches, and to determine if health providers rated one approach more favorably relative to effectiveness, efficiency, and comfort with use.

Methods

Study design and population

A randomized nonblinded controlled trial design was used to evaluate three different screening approaches to relationship violence among young women who presented for care at a reproductive health facility in Manhattan. Young women aged 15 to 24 years who presented to a busy urban reproductive healthcare setting between April 2005 and October 2006 were eligible to participate. This facility's clinics provide reproductive health services to approximately 20,000 women aged 15 to 24 each year, making the consideration of the specific needs of young women an essential part of any policy or programming initiative. We consecutively recruited patients during clinic sessions that historically had high numbers of adolescent and young adult women. Although a total of 740 patients were eligible to participate during these sessions, only 699 young women elected to participate. The major reason given for declining participation was extra time required to complete study measures ($n = 35$). We did not detect any demographic (age, race/ethnicity, employment status) differences between those who refused and those who participated in this trial.

Young women at the registration desk or in the clinic waiting area were asked if they wanted to participate in a study examining screening approaches about relationships. Trained research assistants talked with interested patients to explain eligibility criteria and study goals. We used an institutional review board-approved protocol, that included waiver of parental consent for those patients under 18 years of age where each young woman who expressed interest and met eligibility criteria received detailed information and provided oral informed consent. Prior to seeing a provider, each young woman completed the routine clinic health history, which, for this study, was computerized and included random assignment to one of three different screening approaches to relationship violence. We employed an audio-assisted computer interview (ACASI) methodology in English that randomized the women electronically to one of three screening approaches because this approach improves detection of sensitive information [15,17]. Each subject listened to the question on headphones, read it on the computer screen protected with a privacy hood, and entered her responses on a laptop. The patient's entire medical history, including responses to the violence screening questions, were printed and attached to the patient's chart. Printed responses were reviewed by the provider, trained in both partner abuse and the study protocol, who did an additional face-to-face assessment subsequent to reviewing the screening responses. At the conclusion of the medical exam, the research assistant gave the young woman a brief evaluation form to evaluate her satisfaction and comfort with the screening process. This form did not include her name but a unique study number linking it to her screening results. After completing the survey, each participant received a $10 gift certificate to a popular clothing or music and video store. Following the clinical visit, the provider documented on a structured form an assessment of whether relationship violence was present, and evaluated the screening process also anonymous but linked by study number to the participant's data.