JNP

Screening College Students for Domestic Violence, Sexual Assault, and Molestation

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ABSTRACT

Quality improvement studies in 2008, 2010, and 2013 investigated if nurse practitioners and physicians at an urban college health center screened for intimate partner violence (IPV), sexual assault (SA), and molestation at the annual women's health exam. Medical charts from the clinic's electronic record system were reviewed and one clinician screened for IPV, SA, and molestation in 2008. In 2010, the women's health template contained an IPV survey, which patients completed. IPV screening improved but decreased in 2013. SA and molestation were still screened less. Embedding IPV questions increased screening, but not consistently. Clinician screening prompts would improve IPV, SA, molestation screening.

Keywords: domestic violence, intimate partner violence, molestation, sexual assault

"Just by asking [about domestic violence], you may be planting a seed for change. Therefore, asking may allow some women or men to reveal a history of abuse even years later."

Dr. Barbara Gerbert[1(pB1)]

Approximately 14% of American women (1 in 6) have been victims of an attempted rape or completed rape (2.8%). In the United States, women (3 in 10) and men (1 in 10) have encountered rape, physical violence, and stalking by a partner.[2] Women aged 18-24 experience the highest rates of rape and sexual assault.[3] About 20%-25% of women in college experience rape or attempted rape.[4]

A 2011 national poll about dating violence and abuse conducted with 508 college students (330 women and 178 men) revealed that 1 in 3 women had been in an abusive relationship and 1 in 5 women experienced physical abuse, sexual abuse, and verbal threats. Approximately 50% of students reported that abusive patterns of behavior among their peers were difficult to identify and many believed they would be unable to help someone in an abusive relationship.[5]

Sexual assault on college campuses is now headline news, which has become the driving force for administrators, clinicians, and students to grapple with this issue. Because there is an increased awareness of sexual violence against women, ensuring that college health clinicians screen for intimate partner violence (IPV), sexual assault (SA), and molestation may make it easier for patients (women and men) to report these incidents and then for colleges to develop screening guidelines and administrative policies to address these matters.

IPV (also known as domestic violence) is defined as "abuse that occurs between two people in a close relationship."[2(p1)] IPV includes physical abuse, sexual abuse, threats, and emotional abuse. Emotional abuse is viewed as a precursor to physical and sexual assault.[2] Women and men experiencing IPV often exhibit harmful health behaviors (eg, alcohol abuse and unsafe sex) and adverse health consequences (eg, headaches, anxiety, and insomnia).[6] Clinicians should consider IPV in patients who report substance abuse, participate in risky sexual behaviors, are repeatedly seen for somatic complaints, and present with depressive symptoms.[7] In addition, previous victims of sexual assault may be more at risk for IPV, and molestation victims may be at greater risk for IPV and sexual assault.[8]

Despite the medical implications of IPV, most clinicians are unaware of IPV risk factors, and therefore the likelihood is low that they will accurately identify and offer support for patients experiencing or perpetrating IPV. Data show that only 7%-25% of abuse cases are identified in a clinical setting, only 2%-7% of patients report abuse to their clinician, and that 60%-90% of identified abused patients are inadequately managed.[9]

Routine screening for IPV is recommended by several medical and nursing organizations (eg, American Congress Obstetricians and Gynecologists, American Medical Association, American Association of Family Physicians, and American Association of Critical-Care Nurses). These organizations also support including IPV in medical and nursing curricula.

METHODS

Design

In 2008, the author [a nurse practitioner (NP)] developed and conducted a quality improvement (QI) study to determine whether clinicians [NPs and medical doctors (MDs)] screened students for IPV, SA, and molestation at the annual women's health exam. The clinicians questioned practice at a large urban college health center. Women's health visits make up, on average, 37% of NP schedules and 25% of MD schedules. The researcher conducted the initial 2008 QI study and the follow-up QI studies in 2010 and 2013.

In 2009, a modified version of the Hit, Insult, Threaten, and Scream (HITS) survey (see Box 1) was embedded in the electronic health record (EHR) women's health template. The patient completed this questionnaire before their scheduled visit (patient received survey via e-mail and responses were populated in the EHR). If the survey was not completed on the visit date, the medical assistant (MA) was required to ask the patient about relationship abuse (single question in MA section of the template). The clinician was expected to review the survey with the patient and address positive responses for IPV, SA, or molestation.

BOX 1. Modified HITS Survey[14]

1. Within the last year, have you been hit, slapped, kicked, or otherwise hurt by someone?
2. Within the last year, have you been in a relationship with anyone who has tried to hurt by putting you down, by being jealous of you, or trying to control what you do?
3. Has anyone forced you to have sexual activities that made you feel uncomfortable?
4. Do you feel safe?

The study was repeated in 2010 and 2013 to determine whether there were changes in clinician screening for IPV, SA, and molestation. The 2008 QI tool was modified to ascertain whether screening rates were affected by clinician awareness of their screening practices (2008 QI results provided at an educational meeting), embedding an IPV survey in the women's health template, and MAs asking patients about IPV. In addition, the EHR was reviewed for positive responses to screening questions (patient experienced IPV, SA, or molestation) and whether the clinician documented this and referred the patient to counseling services, if warranted.

PARTICIPANTS

2008 sample: 28 women scheduled for an annual women's health visit during January 2007 to March 2008. Initially, 45 charts were selected (3 charts randomly selected each month per provider); 28 charts met the inclusion criteria (annual women's health visit).

2010 sample: 49 women scheduled for an annual women's health visit during April 2010 to June 2010. Initially, 51 charts were selected (3 charts randomly selected each month per provider); 49 met the inclusion criteria.

2013 sample: 14 women scheduled for annual health exam during January 2013 to May 2013. Initially, 19 charts were selected (1 chart per provider); 14 met the inclusion criteria.

The 2013 sample size was smaller because the researcher found that clinicians who consistently screened did so at every visit, and therefore one chart was representative of clinician screening rates.

RESULTS

In 2008, 1 clinician screened for IPV, SA, and molestation. One patient disclosed a sexual assault history and this was documented. In 2010, 9