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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

Table 1. Clinician Screening: IPV, SA, and Molestation

	IPV	SA	Molestation
2008: 28 charts			
Clinician screened	1	1	1
Not clinician screened	27	27	27
Total	28	28	28
2010: 49 charts			
Clinician screened	9	4	4
Not clinician screened	40	45	45
Total	49	49	49
2013: 14 charts			
Clinician screened	2	1	1
Not clinician screened	12	13	13
Total	14	14	14

IPV = intimate partner violence; SA = sexual assault.

clinicians screened for IPV and 4 also screened for SA and molestation. One patient disclosed a molestation history, which was documented. In 2013, 2 clinicians screened for IPV and 1 clinician also screened for sexual assault and molestation (Table 1).

In 2010, 36 patients completed the HITS survey and 13 did not. In 2013, 9 patients completed the survey and 5 did not (Table 2). In 2010, there were 25 clinical encounters in which MAs asked about IPV although the survey was completed, 11 encounters in which the MA did not screen for IPV because the survey was completed, and 13 encounters in which patients did not complete the survey and the MA, appropriately, screened for IPV. In 2013, there were 6 encounters in which the MA asked about IPV when the survey was completed, 3 encounters in which MAs did not screen for IPV when the patient completed the survey, and 2 encounters in which patients did not complete the survey and the MA screened for IPV (Table 3).

Table 2. Patient-completed Survey

	Survey		
	Yes	No	Total
2010			
Count	36	13	49
Completed	73.5%	26.5%	
2013			
Count	9	5	14
Completed	64.3%	35.7%	

Did clinicians screen for IPV when the HITS survey was completed? In 2010, there were 10 encounters in which clinicians screened for IPV when the patient completed the survey, 26 encounters in which the patient completed the survey but was not screened, and 13 encounters in which patients were not screened when the survey was not completed. In 2013, there were 2 encounters in which clinicians screened for IPV although the patient completed the survey, 7 encounters in which patients completed the survey and were not screened, and 7 encounters in which clinicians did not screen when the survey was not completed (Table 4).

Did the clinician screen for IPV when the MA screened or did not screen for IPV? In 2010, there were 10 encounters in which clinicians screened for IPV when the MA screened the patient, 28 encounters in which clinicians did not screen when the MA screened, and 11 encounters in which clinicians did not screen for IPV when the MA did not screen. In 2013, there were 2 encounters in which clinicians screened for IPV even though the MA screened, 7 encounters in which clinicians did not ask about IPV when the MA screened, and 5 encounters in which clinicians did not screen for IPV when the MA also did not screen (Table 5).

Table 3. MA Screened for IPV

	MA Asked	MA Did Not Ask	Total
2010: 49 charts			
Survey completed	25	11	36
Survey not completed	13	0	13
Total	38	11	49
MA asked/not asked	77.6%	22.4%	
2013: 14 charts			
Survey completed	6	3	9
Survey not completed	3	2	5
Total	9	5	14
MA asked/not asked	64.3%	35.7%	

IPV = intimate partner violence; MA = medical assistant.

Table 4. Clinician Screening: Survey Completed/Not Completed

	Clinician Screened	Clinician Did Not Screen	Total
2010: 49 charts			
Survey completed	10	26	36
Survey not completed	0	13	13
Total	10	39	49
Clinician screened/not screened	20.4%	77.8%	
2013: 14 charts			
Survey completed	2	7	9
Survey not completed	0	5	5
Total	2	12	14
Clinician screened/not screened	14.3%	85.7%	

DISCUSSION

Clinicians did not routinely screen for IPV in 2008 even though the US Centers for Disease Control, American Congress of Obstetricians and Gynecologists, American Academy of Family Physicians, and US Preventive Services Task Force recommend this type of screening. In 2010, IPV screening rates improved largely due to results of previous QI findings, an embedded HITS survey in the women's health template, and an IPV screening question for MAs. In 2013, IPV screening rates decreased. However, it is possible that IPV screening occurred if the clinician reviewed the HITS survey with the patient but did not document the discussion.

Most patients completed the IPV survey before their annual women's health visit. However, many clinicians did not screen for IPV when the survey was not completed. MAs, on the other hand, did ask patients about IPV, even when the survey was completed. MA screening for IPV may have occurred more frequently because it was part of patient preparation.

This QI study has shown that embedding the HITS survey increased clinician screening for IPV. However, it was not sustained in the subsequent 2013 study. One hypothesis for this decrement is that the survey is a *passive* screening instrument requiring limited clinician interpretation and involvement. In addition, the embedded HITS survey did not address SA or molestation (which may be more common), and therefore most clinicians did not screen for these issues. However, there was a small increase in some clinicians screening for SA and molestation in 2010, but this was followed by a decrease in 2013.

Table 5. Clinician Screening: MA Asking/Not Asking

	Clinician Screened	Clinician Did Not Screen	Total
2010: 49 Charts			
MA asked about IPV	10	28	36
MA did not ask about IPV	0	11	13
Total	10	39	49
Clinician screened/not screened	20.4%	79.6%	
2013: 14 Charts			
MA asked about IPV	2	7	9
MA did not ask about IPV	0	5	5
Total	2	12	14
Clinician screen/not screened	14.3%	85.7%	

IPV = intimate partner violence; MA = medical assistant.

Limitations

This QI study was designed to determine whether college health clinicians screened for IPV, SA, and molestation. QI studies are limited to the institution and thus results can only be generalized to a specific population. In addition, the sample sizes were small and differed in each follow-up study. Because the sample was limited to female patients scheduled for an annual women's health exam, future studies should address screening at other types of women's health visits as well as screening men.

CONCLUSION

Successful universal screening for IPV, SA, and molestation necessitates institutional support, education, referral systems, and effective tools.[10] In addition, questioning patients about sensitive issues may be greatly influenced by the clinician's comfort level and their belief that something can be done

upon learning that a patient has been abused, assaulted, or molested. Further, the clinician's sense that there is enough time within the visit to screen for these issues and then handle positive responses, will affect routine screening.[11] Although only 2 patients at this health center disclosed a history of sexual assault (1 patient) and molestation (1 patient), studies have shown that patients would respond to questions about IPV if clinicians disclosed their reasons for asking and offered an environment of safety and support, and if they felt they would be helped and not judged by disclosing sensitive information.[12,13]

Embedding the HITS patient survey in the women's health template potentially sets the stage for discussions about IPV, but, as this study has shown, IPV screening was inconsistent. Ensuring that patients are consistently screened for IPV, SA, and molestation necessitates charting prompts for the clinician. Screening prompts for IPV, SA, and molestation should be incorporated into annual women's health exams, women's problem visits, and physical exams. In addition, clinical staff should decide which visits would be appropriate to explore IPV, SA, and molestation with men. Moreover, developing guidelines about documenting the history of IPV, SA, and molestation is necessary to ensure that clinicians are made aware of the importance of these issues. JNP

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