# Violence against women: integrating the evidence into clinical practice

**Harriet L. MacMillan, C. Nadine Wathen**

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Violence against women is common and is associated with major physical and psychological impairment.[1,2] Along with recognition of woman abuse as a serious public health problem[3,4] has come the call for clinicians to find ways to identify and help their abused female patients.

However, before advising physicians to screen routinely for woman abuse, we must first establish that screening does more good than harm. Two key elements must be considered: does the screening identify the target condition (in this case exposure to or risk of violence in women) and does the subsequent "treatment" intervention, be it some form of counselling or referral to local services, lead to a favourable outcome (i.e., reduction of violence)?

The first question is easily answered. Several screening instruments with acceptable psychometric properties are available to detect violence against women, including brief forms for use in primary and emergency care settings and for pregnant women.

For the second question, there is a lack of good evidence to guide clinical decision-making, and no studies have linked screening to treatment intervention in a way that allows us to determine whether routine screening for violence against women does more good than harm.[5]

The broad range of programs that are being recommended to reduce violence against women, including primary care counselling, referral to shelters and referral to personal and vocational counselling, have not been sufficiently evaluated to determine their effectiveness in reducing violence.[6] In terms of batterer treatment, the only high-quality study using a randomized controlled design[7] found no difference in abuse outcomes between the treatment groups (group sessions for men alone, sessions with their partners or rigorous monitoring) and the control group. Because this study was conducted with a sample of United States Navy couples, the results cannot necessarily be applied to the general population. In contrast, several other studies of lesser quality have suggested that such interventions for batterers are effective. The evidence remains conflicting.

The only program for which there is some evidence of effectiveness in reducing violence, a structured program of advocacy services, is specific to women who are leaving a woman abuse shelter.[8] The study evaluating the program did not address the issue of screening (as women in the study were not screened) nor the question of whether going to a shelter itself is beneficial in reducing subsequent abuse; indeed at least one study[9] has suggested that women seeking immediate safety in shelters may be exposed to reprisal violence once they leave the shelter. In sum, if violence against women is identified through primary care screening, no intervention to which women can be referred has been shown to be effective in reducing that violence.

For these reasons, and because the potential harms of screening and treatment have also not been sufficiently evaluated, the Canadian Task Force on Preventive Health Care (CTFPHC) has concluded that there is insufficient evidence to recommend for or against routine screening for violence against women and for referral to counselling or to shelters (see page 582).[10] This differs from several existing guidelines,[11–14] but not from more recent evidence-based examinations of this issue.[15]

Given the insufficient evidence for screening for abuse, should primary care practitioners ask women about exposure to or risk of violence? The answer to this difficult question depends on many factors unique to each clinical encounter. These include what services might be available in the community as well as the woman's specific situation, including the severity of abuse, her immediate concerns regarding her own safety and that of her children, and her own assessment of the benefits and risks of disclosing abuse — for example, whether she currently feels able to seek help or whether she fears reprisal violence from her abuser if she decides to do so. The clinician should maintain a degree of awareness about the issue of family violence and be sensitive to clinical signs and symptoms associated with abuse (for excellent summaries of such manifestations see Ferris and colleagues[3] and Campbell[16]).

It is also necessary to distinguish between *routine universal screening* of all women, which "implies a standardized assessment of patients, regardless of their reasons for seeking medical attention"[17] (p. 551), and *diagnostic assessment* (medical or psychiatric), which involves asking patients presenting with specific signs or symptoms about abuse. Despite the lack of evidence to support routine screening, the CTFPHC concluded that the prevalence of and significant impairment associated with violence against women make it important for clinicians to maintain a high index of suspicion when assessing patients.

Furthermore, not asking women about exposure to violence during certain diagnostic assessments (e.g., investigation of chronic pain) may lead to misdiagnosis and a path of inappropriate investigations or treatments that will not address the underlying problem.[17] For a discussion of approaches to asking about woman abuse and subsequent management, we recommend *A Handbook Dealing with Woman Abuse and the Canadian Criminal Justice System: Guidelines for Physicians*.[3] Details about indicators of risk for violence against women can be found in Table 1 of the systematic review detailing the evidence base for the CTFPHC's recommendations.[5]

Until we can determine whether the potential benefits of routine screening for woman abuse outweigh the potential harms, the best course of action for primary health care providers is to be alert for the signs and symptoms of abuse, and to question women about this issue if it might be related to a clinical problem. Fortunately, studies funded by the National Center for Injury Prevention and Control, the Agency for Healthcare Research and Quality, the US Centers for Disease Control and Prevention, the Canadian Institutes of Health Research and the Ontario Women's Health Council are underway to provide evidence to answer this question.

Dr. MacMillan is Associate Professor in the Departments of Psychiatry and Behavioural Neurosciences and of Pediatrics, McMaster University, the Canadian Centre for Studies of Children at Risk, Hamilton Health Sciences — Chedoke Site, Hamilton, Ont. Ms. Wathen is Coordinator, Canadian Task Force on Preventive Health Care, London, Ont.

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***Correspondence to:*** *Dr. Harriet L. MacMillan, Departments of Psychiatry and Behavioural Neurosciences and of Pediatrics, McMaster University, and the Canadian Centre for Studies of Children at Risk, Patterson Building, Chedoke Site, Hamilton Health Sciences, 1200 Main St. W, Hamilton ON L8N 3Z5; fax 905 383-8068; macmilnh@mcmaster.ca*