Screening Women and Elderly Adults for Family and Intimate Partner Violence: A Review of the Evidence for the U.S. Preventive Services Task Force

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As many as 1 to 4 million women are physically, sexually, or emotionally abused by their intimate partners each year in the U.S.,[1,2] with 31% of all women reporting lifetime abuse.[3] Prevalence rates of abuse in clinical samples range from 4% to 44% within the past year and from 21% to 55% over a lifetime.[4–14] The incidence of acute cases in emergency care settings ranges from 2% to 7%.[15] Approximately 20% of female teenage survey respondents reported being physically and/or sexually abused by a dating partner.[16] Although violence by women against men also occurs, women are 7 to 14 times more likely to suffer severe physical injury from an assault by an intimate partner.[17]

Approximately 551,000 older adults in domestic settings were abused and/or neglected in 1996.[18] A random-sample survey of a community population indicated a prevalence rate of 32 per 1000 for physical violence, verbal aggression, and neglect.[19] Complicating these estimates, however, is the difficulty in defining and quantifying elder abuse. Abuse of the elderly takes many forms, including physical, sexual, psychological, and financial exploitation, and neglect.[20] Available data indicate that the highest rates of elder abuse are among women and those aged 80 and older.[18] In 90% of cases, the perpetrator is a family member, most often an adult child or spouse.[18]

Many health problems are associated with abuse and neglect at all ages. These include repercussions of acute trauma, including death, and unwanted pregnancy, as well as long-term physical and mental problems, such as depression, post-traumatic stress disorder, somatization, suicide, and substance abuse.[16,21–30] Children who witness intimate partner violence are at risk for developmental delay, school failure, psychiatric disorders,[31,32] and violence against others.[33]

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The clinician's role in identification and intervention is considered a professional responsibility by physician and nursing organizations.[34,35] Reporting child and elder abuse to protective services is mandatory in almost all states; 4 states (California, Colorado, Rhode Island, and Kentucky) have laws requiring mandatory reporting of intimate partner violence. Hospitals are also required to address abuse for accreditation.[36]

Whether screening leads to a decline in abuse is unknown. In the mid-1990's, after several medical organizations recommended screening for intimate partner abuse, rates of abuse declined.[37] A systematic review reported that most studies of screening for intimate partner violence in health care settings found that screening detected more abused women than no screening.[38] Surveys indicate that 43% to 85% of female respondents consider screening in health care settings acceptable, although only one-third of physicians and half of emergency department nurses favored screening.[38] The evidence on how to screen and effectively intervene once problems are identified is limited, and few clinicians routinely screen patients who do not have apparent injuries.[39–44]

In 1996, the U.S. Preventive Services Task Force (USPSTF) concluded that there was insufficient evidence to recommend for or against the use of specific screening instruments to detect family or intimate partner violence, although including questions about abuse in the routine history could be recommended based on prevalence of abuse among adult women and potential value of the information to clinicians.[45] This report is an update of the current literature on family and intimate partner violence focusing on studies of the performance of screening instruments designed for the clinical setting and the effectiveness of clinical-based interventions for women and elderly adults. A separate report on screening for family violence in children is available elsewhere.[46]

Methods

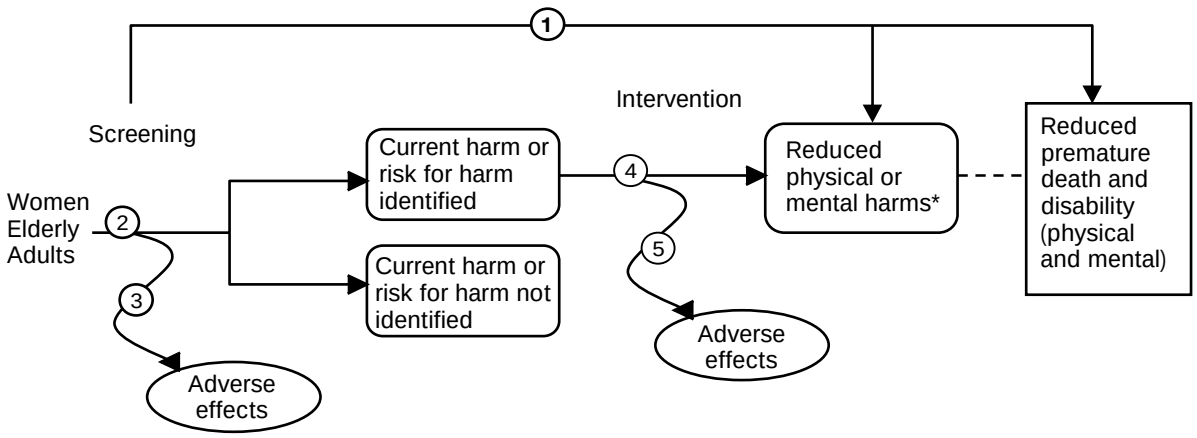
The analytic framework and key questions guiding this review are detailed in Figure 1. Relevant studies were identified from multiple searches of MEDLINE® (1966 to December 2002), PsycINFO (1984 to December 2002), CINAHL (1982 to December 2002), Health & Psychosocial Instruments (1985 to December 2002), AARP Ageline (1978 to December 2002), and the Cochrane Controlled Trials Register (Appendix 1). Additional articles were obtained by reviewing 2 recent systematic reviews,[38,47] reference lists of pertinent studies, and by consulting experts.

We defined screening as an assessment of current harm or risk for harm from family and intimate partner violence in asymptomatic persons in a health care setting. Universal screening means assesses everyone; selective screening assesses only those who meet specific criteria. The target populations for this review are women and elderly victims of abuse, where abuse is directed toward them by family members, intimate partners, caretakers, or others with similar relationships. The USPSTF focused this review on these populations because they are the largest at-risk groups in general primary care settings.

Studies included in this review had English-language abstracts; were applicable to U.S. clinical practice; described abuse and violence against women or elderly adults; were conducted in or linked to primary care (ie, family practice, general internal medicine), obstetrics/gynecology, or emergency department settings; and included a physician or other health care provider in the process of assessment or intervention. We excluded studies about patients presenting with trauma. All eligible studies were reviewed, including those published prior to the 1996 USPSTF recommendation.

Assessment studies were included if they evaluated the performance of verbal or written questionnaires or other assessment procedures, such as physical examinations, that were brief and applicable to the primary care setting. Included studies described the study sample, the screening instrument or procedure, the abuse or neglect outcome, and the collection of data. Outcomes included indicators of physical abuse, neglect,

Figure 1. Analytic Framework and Key Questions



Key Questions

Arrow 1: Does screening for family and intimate partner violence reduce harm and premature death and disability?
Arrow 2: How well does screening identify current harm or risk for harm from family and intimate partner violence?
Arrow 3: What are the adverse effects of screening?
Arrow 4: How well do interventions reduce harm from family and intimate partner violence?
Arrow 5: What are the adverse effects of intervention?

*Including physical trauma (fractures, dislocations, brain injury, etc.); unwanted pregnancy and sexually transmitted diseases; mental trauma; social isolation and its repercussions, such as depression, anxiety, nightmares, among others.

emotional abuse, and/or sexual abuse and any reported related health outcomes (ie, depression).

Intervention studies were included if they measured the effectiveness of an intervention in reducing harm from family and intimate partner violence compared with nonintervention or usual care groups. We excluded studies that tested the effectiveness of interventions to educate health care professionals about family violence or to increase screening rates in institutions. We also excluded studies about mandatory reporting laws, descriptions of programs, the accuracy of physician diagnosis and reporting of abuse, and physician factors related to reporting.

From each included study, we abstracted the study design, number of participants, setting, length and type of interventions, length of follow-up, outcomes, methods of outcome measurement, and study duration, among others. Two reviewers independently rated each study's quality using criteria specific to different study designs developed by the USPSTF (Appendix 2).[48] When reviewers disagreed, a final score was reached through consensus.

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Results

Intimate Partner Violence Against Women

Screening

Of 806 abstracts identified by database searches, 14 met inclusion criteria. These included 6 studies

that compared one instrument with another, 3 that compared an instrument to a directed interview, 2 that measured inter-rater reliability and/or internal consistency, and 3 that compared methods of administration. None evaluated the performance of a screening instrument or procedure using verified abuse outcomes. Screening instruments are described in Appendix 3.[49–61]

Six studies compared brief screening instruments with previously validated instruments and were rated good or fair in quality (Table 1).[15,53,54,56,57,62] Brief instruments were generally correlated to longer instruments and in some cases performed better.

The Hurt Insulted Threatened or Screamed at (HITS) instrument includes 4 questions.[54] When administered to 259 women in family practice clinics, it demonstrated fair internal consistency (Cronbach's alpha = 0.80), and its results correlated with the previously validated 19-item Conflict Tactics Scales (CTS) (r = 0.85). In urban emergency department settings, the Partner Violence Screen (PVS), consisting of 3 questions, was compared with the 30-item Index of Spouse Abuse (ISA) (sensitivity 64.5%; specificity 80.3%) and the CTS (sensitivity 71.4%; specificity 84.4%).[53] However, the CTS may not have undergone sufficient testing of its validity to qualify as a gold standard in these studies.

A study of 1,152 predominantly African American women presenting for care at university-affiliated family practice clinics found that the 10-item Women's Experience with Battering (WEB) Scale had a higher detection rate (16%) than the 15-item ISA-Physical Scale (10%).[56] Another trial studying predominantly white women in family practice clinics found that the 8-item Woman Abuse Screening Tool (WAST) was correlated to the 25-item Abuse Risk Inventory (r = 0.69).[57] A study of pregnant women in public prenatal clinics tested the 3-item Abuse Assessment Screen (AAS) against the ISA.[62] Women identified as abused on the AAS also scored significantly higher on the ISA than non-abused women.

The previously validated AAS was modified to detect ongoing abuse, rather than abuse within the previous 12 months, for use in the emergency department setting, and was renamed the Ongoing Abuse Screen (OAS).[15] Women presenting to an emergency department were screened with both instruments as well as with a single question about present abuse. The AAS was positive in 59% of women screened, and the OAS was positive in 16%. Asking the single question, "Are you presently a victim of intimate partner violence?" was positive in 3% of women.

Three studies comparing a screening instrument to an interview were rated as poor quality.[51,52,55] The major limitation of these studies was that no protocol for the directed interview was identified. These studies reported higher detection rates with questionnaires than with interviews.

Two fair-quality studies measured the internal consistency of screening instruments. The Partner Abuse Interview, an 11-item questionnaire modified from the CTS, showed fair internal consistency (Cronbach's alpha = 0.82) when tested in 90 women at a suburban family practice clinic and university hospital.[49] The WEB Scale, which was tested in primary care clinics and community groups, showed good internal consistency (Cronbach's alpha = 0.99).[63]

Three fair-quality studies compared methods of administration of screening instruments.[42,50,58] A study of 4,641 women presenting to 11 community emergency departments found that the prevalence of past-year and lifetime violence was significantly higher when a questionnaire containing items from the AAS was self-administered than when it was administered by a nurse.[42] In another study conducted in an emergency department, reports of abuse were similar when a questionnaire was given as part of a face-to-face-interview (16%) and when a taped-recorded questionnaire with a written self-reported answer sheet was provided (15%).[58] In a study at a Planned Parenthood clinic using 4 questions, rates of reported abuse were higher on a nurse-conducted interview (29%) than by self-report (7%).[50]

Table 1. Studies of Screening Instruments about Intimate Partner Violence against Women

Study, Year	Population: N Age Ethnicity Socioeconomic Status Pregnancy Status	Setting	Screening Instrument(s)	Findings	Quality Rating Comments
Comparison of Screening Instruments					
Coker et al, 2001[56]	N: 1,152 age: mean 38 (range 18–65) ethnicity: 62% African American, 38% White socioeconomic status: 100% insured (medicaid or managed care), 89% high school graduate or greater pregnancy status: NR	2 university-affiliated family practice clinics	1) WEB, 10 items 2) ISA-P, 15 items All participants screened with both instruments	Higher detection rate with WEB scale (16%) than ISA-P (10%)	Fair Questions asked by graduate students (not health care professionals); used modified version of reference standard; administered verbally although designed as written questionnaires
Brown et al, 2000[57]	N: 307 age: mean 46 (range 18–86) ethnicity: 98% White socioeconomic status: 59% employed, 59% with annual household income > $30,000, 45% with post secondary education pregnancy status: NR	20 family practice offices	1) WAST, 8 items 2) ARI, self-report, 25 items	1) WAST and ARI results were correlated (r = 0.69, P = 0.01) 2) WAST internally consistent (Cronbach's alpha = 0.75)	Fair An additional question was added to the original 7-item WAST
Sherin et al, 1998[54]	N: 259 all other demographic information: NR	Family practice offices, urban/suburban population	1) HITS, written, 4 items 2) CTS, verbal, 19 items	1) HITS internally consistent (Cronbach's alpha = 0.80) 2) HITS and CTS results were correlated (r = 0.85)	Good

continue

AAS, Abuse Assessment Screen; ARI, Abuse Risk Inventory; CTS, Conflict Tactics Screen; DAS, Danger Assessment Screen; HITS, Hurt, Insulted, Threatened, and Screamed at; IPV, Intimate Partner Violence; ISA, Index of Spouse Abuse; ISA-P, Index of Spouse Abuse—Physical Scale; NR, not reported; OAS, Ongoing Abuse Screen; PVS, Partner Violence Screen; WAST, Women Abuse Screening Tool; WEB, Women's Experience with Battering Scale.

Table 1. Studies of Screening Instruments about Intimate Partner Violence against Women (cont)

Study, Year	Population: N Age Ethnicity Socioeconomic Status Pregnancy Status	Setting	Screening Instrument(s)	Findings	Quality Rating Comments
Feldhaus et al, 1997[53]	N: 322 age: mean 36 ethnicity: 45% White, 19% African American, 30% Hispanic socioeconomic status: 54% uninsured, 49% employed, 64% annual income < $15,000, 67% education level high school or greater pregnancy status: NR	2 urban, hospital-based emergency departments	1) PVS, verbal, 3 items 2) ISA, written, 30 items 3) CTS, verbal, 19 items	PVS had a higher sensitivity and specificity when compared to the ISA (65% and 80%) or CTS (71% and 84%)	Good Screening done by research assistant (not health care professional)
McFarlane et al, 1992[62]	N: 691 age: 31% teenagers, 57% age 20–29 ethnicity: 39% African American, 34% Hispanic, 27% White socioeconomic status: 95% below poverty level pregnancy status: 100% pregnant	Public prenatal clinics	1) AAS, 3 items 2) ISA 3) CTS 4) DAS	Women identified as abused on the AAS also scored significantly higher on the ISA, CTS, and DAS	Good
Ernst et al, 2002[15]	N: 488 age: median 36 ethnicity: 47% White, 26% African American, 11% Hispanic socioeconomic status: NR pregnancy status: NR	Large metropolitan emergency department	1) AAS 2) OAS 3) Single question "Are you presently a victim of IPV?"	The OAS had a sensitivity of 30%, a specificity of 100%, and a positive predictive value of 100%	Good
Comparison of Screening Instrument to Interview					
Morrison et al, 2000[55]	N: 1,000 all other demographic information: NR	Charts reviewed in emergency department, tertiary care hospital	1) Emergency Department Domestic Violence Screening Questions, 5 items 2) Standard interview, chart review	1) Retrospective review of charts identified 4 patients (0.4%) as past or present victims of domestic violence 2) Higher detection rate with questionnaire (4% acute, 7% probable, 4% past abuse)	Poor Inappropriate reference standard (interview not defined)

Table 1. Studies of Screening Instruments about Intimate Partner Violence against Women (cont)

Study, Year	Population: N Age Ethnicity Socioeconomic Status Pregnancy Status	Setting	Screening Instrument(s)	Findings	Quality Rating Comments
Canterino et al, 1999[51]	N: 224 age: mean age 24 ethnicity: 54% African American, 30% White, 11% Hispanic socioeconomic status: 36% employed pregnancy status: 100% pregnant	Prenatal clinic, community-based tertiary care center	1) Domestic Abuse Assessment Questionnaire, self-report, 5 items 2) Directed interview	Self-report questionnaire yielded higher detection rate (85% vs 59%; $P = 0.03$)	Poor Inappropriate reference standard (interview not defined)
Norton et al, 1995[52]	N: 334 age: mean 23 ethnicity: 50% White socioeconomic status: 42% uninsured pregnancy status: 100% pregnant	Prenatal visit, interviewed by social services	1) AAS, 5 items 2) Standard interview, chart review	More frequent detection of violence using AAS (41%) compared with interview (14%)	Poor Inappropriate reference standard (interview not defined)
Internal Consistency of Screening Instrument					
Pan et al, 1997[49]	N: 90 age: mean 38 ethnicity: 82% White, 6% African American, 7% Hispanic, 3% Asian socio-economic status: 13.7 yrs average education, $32,000 mean annual family income, 38% employed pregnancy status: NR	Suburban family practice clinic, tertiary care university hospital	1) Partner Abuse Interview, 11 items, (modified CTS)	Internally consistent (Cronbach's alpha = 0.82)	Fair Small sample size, inappropriate reference standard (not compared to another method)
Smith and Marth, 1995[63]	N: 389 age: NR ethnicity: 85% White socioeconomic status: 68% employed, 61% education level high school or greater pregnancy status: NR	Various primary care clinics and community groups	1) WEB Scale, 10 items	High internal consistency (Cronbach's alpha for full sample = 0.99; battered = 0.93; non-battered = 0.86)	Fair Inappropriate reference standard (not compared to another method)

continue

Table 1. Studies of Screening Instruments about Intimate Partner Violence against Women (cont)

Study, Year	Population: N Age Ethnicity Socioeconomic Status Pregnancy Status	Setting	Screening Instrument(s)	Findings	Quality Rating Comments
Comparison of Methods of Administration of Screening Instrument					
Glass et al, 2001[42]	N: 4,641 age: 18 and older all other demographic information: NR	Emergency departments at 11 community hospitals	1) AAS as part of intake survey; patients chose whether to self administer or have it read by a nurse interviewer	Prevalence of lifetime and past-year abuse was higher with self administered questions	Fair Patients self-selected method
Furbee et al, 1998[58]	N: 175 age: mean 34 all other demographic information: NR	Emergency department, rural university-affiliated	1) Face-to-face interview 2) Tape-recorded questionnaire with written answer sheet	Comparable results (16% prevalence of abuse detected with face-to-face interview compared with 15% detected with taped interview)	Fair Narrow spectrum of patients
McFarlane et al, 1991[50]	N: 777 age: 59% in age range 20–29 ethnicity: 47% African American, 34% White, 17% Hispanic socioeconomic status: NR pregnancy status: NR	Planned Parenthood clinic	1) Self-Report, 4 items 2) Interview, 4 items	Higher prevalence of abuse was detected by nurse-conducted interview (29%) than by self-report (7%)	Fair Narrow spectrum of patients

Interventions

Of 667 abstracts identified by database searches, only 2 met inclusion criteria (Table 2). These fair-quality studies evaluated interventions for abused, pregnant women and reported lower levels of violence after delivery even when a minimal or "brief" intervention was performed. Neither study had a nonintervention control group.[64,65]

In 1 study, 329 pregnant Hispanic women in a prenatal clinic who tested positive for abuse on a screening questionnaire (AAS) were randomized into 1 of 3 groups: "brief" (given wallet-sized card listing community resources); "counseling" (unlimited access to counselor in the clinic); or "outreach" (counseling plus a "mentor mother" in the community).[64] At 2-month follow-up, violence scores measured using the Severity of Violence Against Women Scale were significantly lower in the outreach group compared with the counseling group, but not compared with the brief group. However, at the 6-, 12-, and 18-month follow-up, violence scores were decreased in all groups without statistically significant differences between groups.

In another study of pregnant women in prenatal clinics with positive results on the AAS, 132 received 3 counseling sessions and 67 were offered wallet-sized cards listing community resources.[65] At 6 and 12 months post delivery, less violence occurred in the intervention group, as measured by the ISA and Severity of Violence Against Women Scale ($P = 0.052$).

Elder Abuse and Neglect

Screening

Of 1,045 abstracts identified by database searches, 3 studies of elder abuse screening instruments met modified inclusion criteria (Table 3).[60,61,66] None were developed or tested in traditional clinical settings. However, because the care of elderly adults occurs largely outside these settings, studies were included if it appeared that they could be adapted to clinical settings.

A screening instrument for caregivers was tested in 3 groups: abusive and non-abusive caregivers from a social service agency, and non-abusive caregivers from the community.[61] The Caregiver Abuse Screen (CASE) is based on yes or no responses to 8 items. Scores on the CASE distinguished abusers from non-abusers (Cronbach's alpha = 0.71), and correlated with the previously validated Indicator of Abuse (IOA) ($r = 0.41$; $P < 0.001$), and Hwalek-Sengstock Elder Abuse Screening Test (HSEAST) ($r = 0.26$; $P < 0.025$).

Two studies described screening elderly adults. One study evaluated 3 groups: victims of abuse, individuals who were referred to adult protective services and were found not to be abused, and non-abused elderly adults from a family practice clinic.[60] The 15-item HSEAST was administered to all groups and correctly classified 67% to 74% of cases ($P < 0.001$). The HSEAST was also evaluated in a study of elderly adults living in public housing in Florida.[66] Abuse status (past abuse or none) was reported by participants and verified by a social worker reviewing their records at the housing authority. Scores for the abused and non-abused were significantly different (mean total score, 4.01 for abused group vs 3.01 for non-abused group; $P = 0.049$). This study also indicated that a 9-item model, rather than 15, performed as well as the longer version, correctly identifying 71.4% of abuse cases with 17% false-positive and 12% false-negative rates.

Interventions

Of 1,084 abstracts identified by database searches, 72 articles were retrieved for further review; however, none provided data about effective interventions. Some papers provided descriptions of individual elder abuse programs, but none included comparison groups or health outcome measures.

Adverse Effects of Screening and Interventions

No studies were identified that provide data about the adverse effects of screening or interventions. No screening instrument demonstrated 100% sensitivity and specificity. False-negative tests may hinder identification of those who are truly at risk. False-positive tests,

Table 2. Studies of Interventions for Intimate Partner Violence Against Women

Study, Year	Design	Population/ Setting	Intervention/ Outcome Measure	Results	Quality Rating/ Comments
McFarlane et al, 2000[64]	Randomized trial comparing 3 interventions	329 pregnant, Hispanic women at prenatal clinics in SW U.S. All women were screened using the AAS; those with positive responses were randomized to intervention groups; outcomes were determined by the SVAWS at each follow-up visit	1) "Brief" (wallet-sized card with resources) 2) "Counseling" (unlimited access to counselor in clinic), 3) "Outreach" (counseling plus "mentor mother" in community), monitored at 2-, 6-,12-, and 18-mos post-delivery	Abuse decreased significantly in all groups; there were no statistically significant differences between the 3 groups at 6, 12, and 18 mos; at 2 mos, scores were significantly lower for the outreach group compared with the counseling group, but not compared to the brief group	Fair Narrow patient population, outcomes by self-report
Parker et al, 1999[65]	Non-randomized trial comparing 2 interventions	199 Pregnant women at prenatal clinics in Texas and Virginia; 35% African American, 33% Hispanic, 32% White women were screened with AAS; those with positive responses were eligible for interventions; outcomes were determined by SVAWS and ISA at each follow-up visit.	1) 3 counseling sessions 2) Wallet-sized card with resources (intervention vs minimal intervention), monitored at 6 and 12 mos post-delivery	Less violence occurred in the intervention group at 6 and 12 mos, (SVAWS [$P = 0.052$], ISA [$P = 0.007$])	Fair Non-random assignment, outcomes by self-report, poor attendance at support groups

AAS, Abuse Assessment Screen; ISA, Index of Spouse Abuse; NR, not reported; SVAWS, Severity of Violence Against Women Scale.

Table 3. Studies of Screening Instruments about Elder Abuse and Neglect

Study, Year	Population: N Age Ethnicity Socioeconomic Status	Setting	Screening Instrument(s)	Findings	Quality Rating Comments
Caregiver Screen					
Reis and Nahmiash, 1995[61]	N: 139 age: mean 61 ethnicity: NR socioeconomic status: mean annual income $20,000	3 groups of caregivers: 44 abusive and 45 non-abusive from social service agency, 50 non-abusive from community	CASE, 8 items (yes/no)	Scores distinguished abusers from non-abusers (Cronbach's alpha = 0.71); other characteristics were similar; CASE scores correlated with IOA (r = 0.41, P < 0.001); CASE scores correlated with HSEAST (r = 0.26, P < 0.025)	Fair Small sample size, administered as part of a social services project, not in a clinical setting
Elder Screen					
Neale et al, 1991[60]	N: 259 age: mean 77 ethnicity: mostly White socioeconomic status: NR	3 groups of elders: 170 victims of abuse, 42 referred to APS and found not to be abused, 47 from a family practice clinic	HSEAST, 15 items	Scores distinguished abused from non-abused (P < 0.001; Cronbach's alpha = 0.29); correctly classified 67%–74% of cases; 6 items were strongly related to abuse	Fair Small sample size
Moody et al, 2000[66]	N: 100 age: ≥ 60 all other demographic information: NR	Convenience sample of elderly living in public housing in Florida	1) HSEAST, 15 items 2) IOA Screen, 29 items	Scores for abused and non-abused were significantly different (P < 0.049); correctly classified 71% of cases; discriminates abuse cases 84.4% of the time and non-abuse cases 99.2% of the time	Fair Small sample size, intended for social service practitioners

APS, Adult Protective Services; CASE, Caregiver Abuse Screen; HSEAST, Hwalek-Sengstock Elder Abuse Screening Test; IOA, Indicator of Abuse; NR, not reported.

most common in low-risk populations, can lead to inappropriate labeling and punitive attitudes. Additional possible adverse effects include psychological distress, escalation of abuse and family tension, loss of personal residence and financial resources, erosion of family structure, loss of autonomy for the victim, and lost time from work. Women who leave an abuser can become the target of retaliatory responses that can lead to homicide.[67]

There has been concern that patients may feel uncomfortable or threatened if asked questions about family and intimate partner violence. Most women in a study of screening in antenatal clinics believed it was a good idea (98%) and felt "ok" during the process (96%) when asked at a subsequent visit.[68] In another study, only 3% of women found 3 screenings, during and after pregnancy, with the AAS unacceptable.[69] Although most women presenting with their children to a pediatric emergency department believed screening for intimate partner violence was appropriate, many indicated their willingness to disclose might be affected by fear of being reported to child protective services.[70] This concern was confirmed by clinicians in the study who indicated that they would feel obligated to report a child if violence was present in the home.

A telephone survey of abused and non-abused women in 11 U.S. cities indicated that abused women were less likely to support mandatory reporting compared with non-abused women (59% vs 73%; $P < 0.01$). Respondents believed victims would be less likely to disclose abuse, would resent someone else having control of the situation, and reporting would increase the risk for perpetrator retaliation.[71,72]

Conclusions

We identified no studies that directly addressed the effectiveness of screening in a health care setting in reducing harm from family and intimate partner violence or the adverse effects of screening and interventions.

Several instruments have been developed for intimate partner violence screening; some have demonstrated fair to good internal consistency, and some have been validated with longer instruments, although none have been evaluated against measurable violence or health outcomes. The optimal methods of administration have not been determined. Few intervention studies have been conducted, and these focused on pregnant women. Outcomes were based on scores on questionnaires and suggest benefit; however, study limitations restrict interpretation.

Few screening instruments have been developed to identify potential elderly victims of abuse or their perpetrators. These instruments performed fairly well when administered in studies, but have not been tested in health care settings. We found no studies of interventions in the elderly.

Other systematic reviews of interventions for victims of intimate partner violence found few studies with outcomes other than the health outcomes we sought.[38,47] Referrals to community resources, shelters, social workers, and police often increased when abused women were identified. However, it is not known if these interventions improved violence or health outcomes because the studies had inadequate study designs to answer these questions and provided inconsistent results.[38,47]

The prevalence of abuse and the sensitivity and specificity of screening instruments depend on definitions of abuse (physical, sexual, emotional, combinations) and acuity (current, past, any). These definitions are not standardized across instruments. Performance characteristics of screening instruments are difficult to determine because comparisons of scores from instruments with actual episodes of abuse are lacking and the accuracy of self-report varies widely. The effectiveness of specific screening methods and interventions could also vary by setting, delivery, culture, and population.

Self-reported abuse by the elderly may be compromised by cognitive impairment and overshadowed by other medical problems addressed in health care settings. A more comprehensive approach, including physical examination, caretaker and home evaluations, as well as direct questioning, may be more effective.

There are many gaps in the evidence.[73] Definitions and measures of abuse, neglect, severity, and chronicity need to be standardized across studies. Existing screening instruments require more testing and validation in medical settings and in languages other than English.[74] Little is known about the course of violence during pregnancy and postpartum periods, health implications for the mother and child, the role of violence on reproductive decision-making, and what screening and intervention strategies are most effective for pregnant women.

Studies of the effectiveness of treatment programs for abused victims, as well as for perpetrators,[75–77] would provide needed evidence that identification and intervention can lead to improved health outcomes. These outcomes should include not only measures of reduced violence, but also improved quality of life, mental health, social support, self-esteem, productivity, and others.

The feasibility of screening procedures and interventions in health care settings requires evaluations that consider costs, time, resources, clinician consistency, barriers, and patient compliance. Strategies enlisting and evaluating health systems and community programs are needed.[78]

Although the literature on family and intimate partner violence is extensive, there are few studies providing data on its detection and management to guide clinicians. As a result, clinicians confront difficulties fulfilling their role in prevention and treatment of the adverse health effects of violence.

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Appendix 1: Search Strategies

Intimate Partner Violence Screening Instruments

Databases: MEDLINE® (1966–2002), PsycINFO (1984–2002), Health & Psychosocial Instruments (1985–2002)

1 spouse abuse/ or domestic violence.mp. or battered woman.mp. [mp = title, abstract, heading word, table of contents, key phrase identifiers]

2 (screening or identity or early detection).mp.

3 questionnaires.mp.

4 physicians, family/ or "family physicians".mp.

5 primary health care/ or "primary care".mp.

6 family practice/ or "family practice".mp.

7 2 or 3 or 4 or 5 or 6

8 1 or 7

9 limit 8 to (human and English)

Intimate Partner Violence Interventions

Databases: MEDLINE (1966–2002), CINAHL (1982–2002)

1 spouse abuse/ or domestic violence.mp. or battered women.mp.

2 ((intimate partner or life partner or partner or wife or husband) and (violence or abuse)).mp.

3 1 or 2

4 internal medicine.mp.

5 Physicians, Family/ or family physicians.mp.

6 exp Primary Health Care/ or primary care.mp.

7 Family Practice/ or family practice.mp.

8 EMERGENCIES/ or emergency.mp.

9 exp emergency service, hospital/ or emergency department$.mp.

10 OBSTETRICS/ or "OBSTETRICS AND GYNECOLOGY DEPARTMENT, HOSPITAL"/ or obstetrics.mp.

11 4 or 5 or 6 or 7 or 8 or 9 or 10

12 3 and 11

13 pc.fs. or prevent$.mp. or intervention.mp. or assessment.mp.

14 exp counseling/ or counsel$.mp

15 (patient education or questionnaire$).mp.

16 questionnaires/

17 interviews/ or interview$.mp.

18 exp clinical trials/ or clinical trial$.mp.

19 13 or 14 or 15 or 16 or 17 or 18

20 12 and 19

21 limit 20 to (human and English language)

22 from 21 keep 1–151

Database: PsycINFO (1984–2002)

1 exp Partner Abuse/ or spouse abuse.mp.

2 exp Battered Females/

3 exp Family Violence/ or exp Victimization/ or exp Emotional Abuse/ or battered women.mp.

4 3 and (women or females).mp.

5 ((intimate partner$ or life partner$ or partner or wife or husband) and (violence or abuse)).mp.

6 1 or 2 or 4 or 5

7 internal medicine.mp.

8 exp Family Physicians/ or family physicians.mp.

9 exp Primary Health Care/ or primary care.mp.

10 exp Family Physicians/ or family practice.mp.

11 exp emergency services/ or emergenc$.mp.

12 exp OBSTETRICS/ or obstetrics.mp.

13 exp GYNECOLOGY/ or gynecology.mp.

14 7 or 8 or 9 or 10 or 11 or 12 or 13

15 6 and 14

16 (prevent$ or intervention or assessment).mp.

17 exp counseling/ or counsel$.mp.

18 exp Client Education/ or patient education.mp.

19 questionnaires/ or questionnaire$.mp.

20 exp interviews/ or interview$.mp.

21 clinical trial$.mp.

22 exp at risk populations/ or cohort study$.mp.

Elder Abuse Screening Instruments

Databases: MEDLINE (1966–2002), PsycINFO (1984–2002), Health & Psychosocial Instruments (1985–2002)

1 elder abuse.mp.

2 (domestic violence or family violence).mp.

3 (elder$ or aged or old or ageing).mp.

4 (vulnerable or disabled or handicapped).mp.

5 (2 or 4) and 3

6 1 or 5

7 mass screening/ or screening.mp.

8 questionnaires/ or questionnaire$.tw.

9 interview/ or interview$.tw.

10 7 or 8 or 9

11 6 and 10

12 limit 11 to (human and English language)

13 from 12 keep 1–1009

Database: AARP Ageline (1978–2002)

1 elder abuse.mp.

2 ((family or domestic) and (abuse or violence)).mp.

3 (elder$ or old or ageing or aging or aged or geriatric).mp.

4 2 and 3

5 1 or 4

6 (internal medicine or geriatrics or family physicians or family practice).mp.

7 (primary care or emergency or emergency services).mp.

Elder Abuse Interventions

Databases: MEDLINE (1966–2002), CINAHL (1982–2002)

1 elder abuse.mp.

2 (domestic violence or family violence).mp.

3 (elder$ or aged or old or ageing).mp.

4 2 and 3

5 (vulnerable or disabled or handicapped).mp.

6 1 or 4 or 5

7 GERIATRICS/ or geriatrics.mp.

8 Internal Medicine/ or internal medicine.mp.

9 Physicians, Family/ or family physicians.mp.

10 exp Primary Health Care/ or primary care.mp.

11 Family Practice/ or family practice.mp.

12 EMERGENCIES/ or emergency.mp.

13 exp Emergency Service, Hospital/ or emergency department.mp.

14 7 or 8 or 9 or 10 or 11 or 12 or 13

15 6 and 14

16 limit 15 to (human and English language)

17 pc.fs. or prevent$.mp. or intervention.mp. or assessment.mp.

18 exp COUNSELING/ or counseling.mp.

19 patient education.mp.

20 questionnaires.mp.

21 QUESTIONNAIRES/

22 INTERVIEWS/ or interviews.mp.

23 exp clinical trials/ or clinical trial$.mp.

24 17 or 18 or 19 or 20 or 21 or 22 or 23

25 16 and 24

26 from 25 keep 1–129

Database: PsycINFO (1984–2002)

1 elder abuse.mp.

2 (domestic violence or family violence).mp.

3 (elder$ or aged or aging or ageing or old or geriatric).mp.

4 (vulnerable or disabled or handicapped).mp.

5 3 or 4

6 2 and 5

7 1 or 6

8 exp GERIATRICS/ or geriatrics.mp.

9 internal medicine.mp. or exp Physicians/

10 exp Family Physicians/ or family physicians.mp.

11 exp Primary Health Care/ or primary care.mp.

12 exp Family Physicians/ or exp General Practitioners/ or family practice.mp.

13 exp emergency services/ or emergency$.mp.

14 8 or 9 or 10 or 11 or 12 or 13

15 7 and 14

16 limit 15 to (human and English language)

17 prevention/ or prevent$.mp. or intervention.mp. or assessment.mp.

18 exp counseling/ or counsel$.mp. or assess$.mp.

19 exp Client Education/ or patient education.mp.

20 questionnaires/ or questionnaire$.mp.

21 exp interviews/ or interview$.mp.

22 clinical trial$.mp.

23 exp at risk populations/ or exp cohort analysis/ or cohort stud$.mp.

24 17 or 18 or 19 or 20 or 21 or 22 or 23

25 16 and 24

26 from 25 keep 1–36

Database: AARP Ageline (1978–2002)

1 elder abuse.mp.

2 ((family or domestic) and (abuse or violence)).mp.

3 (elder$ or old or ageing or aging or aged or geriatric).mp.

4 2 and 3

5 1 or 4

6 (internal medicine or geriatrics or family physicians or family practice).mp.

7 (primary care or emergency or emergency services).mp.

8 6 or 7

9 5 and 8

10 from 9 keep 1–75

Appendix 2: Study Quality Rating Criteria

Diagnostic Accuracy Studies

Criteria:

- Screening test relevant, available for primary care, adequately described.
- Study uses a credible reference standard, performed regardless of test results.
- Reference standard interpreted independently of screening test.
- Handles indeterminate results in a reasonable manner.
- Spectrum of patients included in study.
- Adequate sample size.
- Administration of reliable screening test.

Definition of ratings based on above criteria:

Good: Evaluates relevant, available screening test; uses a credible reference standard; interprets reference standard independently of screening test; reliability of test assessed; has few or handles indeterminate results in a reasonable manner; includes large number (>100) broad-spectrum patients with and without disease.

Fair: Evaluates relevant available screening test; uses reasonable although not the best standard; interprets reference standard independent of screening test; moderate sample size (50–100 patients) and a "medium" spectrum of patients.

Poor: Has important limitations such as: uses inappropriate reference standard; screening test improperly administered; biased ascertainment of reference standard; small sample size of narrow selected spectrum of patients.

Randomized Controlled Trials (RCTs) and Cohort Studies

Criteria:

- Initial assembly of comparable groups: RCTs—adequate randomization, including concealment and whether potential confounders were distributed equally among groups; cohort studies—consideration of potential confounders with either restriction or measurement for adjustment in the analysis; consideration of inception cohorts.
- Maintenance of comparable groups (includes attrition, cross-overs, adherence, contamination).
- Important differential loss to follow-up or overall high loss to follow-up.
- Measurements: equal, reliable, and valid (includes masking of outcome assessment).
- Clear definition of interventions.
- Important outcomes considered.
- Analysis: adjustment for potential confounders for cohort studies, or intention-to-treat analysis for RCTs.

Definition of ratings based on above criteria:

Good: Meets all criteria: comparable groups are assembled initially and maintained throughout the study (follow-up ≥ 80%); reliable and valid measurement instruments are used and applied equally to the groups; interventions are spelled out clearly; important outcomes are considered; and appropriate attention to confounders in analysis.

Fair: Studies will be graded "fair" if any or all of the following problems occur, without the important limitations noted in the "poor" category below: generally comparable groups are assembled initially, but some question remains whether some (although not major) differences occurred in follow-up; measurement instruments are

acceptable (although not the best) and generally applied equally; some but not all important outcomes are considered; and some but not all potential confounders are accounted for.

Poor: Studies will be graded "poor" if any of the following major limitations exist: groups assembled initially are not close to being comparable or are not maintained throughout the study; unreliable or invalid measurement instruments are used or not applied at all equally among groups (including not masking outcome assessment); and key confounders are given little or no attention.

Case Control Studies

Criteria:

- Accurate ascertainment of cases.
- Nonbiased selection of cases/controls with exclusion criteria applied equally to both.
- Adequate response rate.
- Diagnostic testing procedures applied equally to each group.
- Measurement of exposure accurate and applied equally to each group.
- Appropriate attention to potential confounding variable.

Definition of ratings based on criteria above:

Good: Appropriate ascertainment of cases and nonbiased selection of case and control participants; exclusion criteria applied equally to cases and controls; response rate equal to or greater than 80%; diagnostic procedures and measurements accurate and applied equally to cases and controls; and appropriate attention to confounding variables.

Fair: Recent, relevant, without major apparent selection or diagnostic work-up bias, but with response rate less than 80% or attention to some but not all important confounding variables.

Poor: Major selection or diagnostic work-up biases, response rates less than 50%, or inattention to confounding variables.

Appendix 3: Screening Instruments Intimate Partner Violence Against Women

The Partner Abuse Interview[49]

"Many people, at one time or another, get physical with their partner when they're angry. For example, some people threaten to hurt their partners, some push or shove, and some slap or hit. I'm going to ask you about a variety of common behaviors, and I'd like you to tell me if your partner did these during the past year."

For each behavior answered "no," put a "zero" in the appropriate box and ask if the patient was bruised or injured in any other way.

If the answer is "yes," code "1" for no injury, "2" for possible injury, and "3" for injury.

Has your partner...	Yes/No	Injury Codes
1. Thrown something at you	☐	1 2 3
2. Pushed, grabbed, or shoved you	☐	1 2 3
3. Slapped you	☐	1 2 3
4. Kicked, bit, hit you with a fist	☐	1 2 3
5. Hit or tried to hit you with an object	☐	1 2 3
6. Beat you up	☐	1 2 3
7. Threatened you with a gun or knife	☐	1 2 3
8. Used a gun or knife	☐	1 2 3
9. Forced you to have sex when you didn't want to	☐	1 2 3
10. Other	☐	1 2 3

Ask the following question if the answer to any of the above questions is anything other than "zero."

11. "Some people are afraid that their partners will physically hurt them if they argue with their partners or do something their partners don't like. How much would you say you are afraid of this happening to you?"

☐ Not at all (1)

☐ A little (2)

☐ Quite a bit/Very afraid (3)

Screening Questions for Domestic Violence[50]

Have any of the following ever happened to you? Answer "yes" or "no."

1. Has your male partner (husband, boyfriend) hit, slapped, kicked or otherwise physically hurt you?
2. If you are pregnant, has your male partner hit, slapped, kicked, pushed, or otherwise physically hurt you since you've been pregnant?
3. Has your male partner forced you to have sexual activities?
4. Are you afraid of your male partner?

A "yes" response to any question is considered positive for partner violence.

Domestic Abuse Assessment Questionnaire[51]

Answer "yes" or "no."

1. Have you ever been emotionally or physically abused by your partner or someone important to you?
2. Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
3. Since your pregnancy began, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
4. Within the last year, has anyone forced you to have sexual activities?
5. Are you afraid of your partner or anyone else?

A "yes" response on any question is considered positive for partner violence.

Abuse Assessment Screen (AAS) for Use in Pregnancy[52]

1. Have you ever been emotionally or physically abused by your partner or someone important to you? Yes No

2. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone? Yes No

   If yes, by whom? (circle all that apply)

   Husband Ex-husband Boyfriend Stranger Other Multiple _____No. of times

3. Since you've been pregnant, have you been hit, slapped, kicked or otherwise physically hurt by someone? Yes No

   If yes, by whom? (circle all that apply)

   Husband Ex-husband Boyfriend Stranger Other Multiple _____No. of times

   Mark the area of injury on the body map (map included).

   Score the most severe incident to the following scale:

   1 = Threats of abuse including use of a weapon

   2 = Slapping, pushing; no injuries and/or no lasting pain

   3 = Punching, kicking, bruises, cuts, and/or continuing pain

   4 = Beaten up, severe contusions, burns, broken bones

   5 = Head, internal, and/or permanent injury

   6 = Use of weapon, wound from weapon

4. Within the past year, has anyone forced you to have sexual activities? Yes No

   If yes, by whom? (circle all that apply)

   Husband Ex-husband Boyfriend Stranger Other Multiple _____No. of times

5. Are you afraid of your partner or anyone you listed above? Yes No

Responses are recorded on a data collection form, no other scoring information was provided.

Partner Violence Screen (PVS)[53]

1. Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?
2. Do you feel safe in your current relationship?
3. Is there a partner from a previous relationship who is making you feel unsafe now?

A "yes" response on any question is considered positive for partner violence.

The HITS Scale[54]

The HITS scale is a paper-and-pencil instrument that is comprised of the following 4 items: "How often does your partner: physically **H**urt you, **I**nsult you or talk down to you, **T**hreaten you with harm, and **S**cream or curse you?"

Patients respond to each of these items with a 5-point frequency format: never, rarely, sometimes, fairly often, and frequently. Score values could range from a minimum of 4 to a maximum of 20.

Emergency Department Domestic Violence Screening Questions[55]

1. Does anyone in your family have a violent temper?
2. During an argument at home, have you ever worried about your safety or the safety of your children?
3. Many women who present to the emergency department with similar injuries or complaints are victims of violence at home. Could this be what has happened to you?
4. Would you like to speak to someone about this?
5. Were any of the previous visits to the emergency department prompted by an injury or symptom suffered as a victim of violence at home?

A "yes" response to question 3 or "yes" to 1 or 2 and 4 would classify a person as being a victim of partner violence. A "yes" response to question 1 or 2 or both would classify a person as probably being a victim of partner violence. A "yes" response to question 5 would classify the person as having been a victim of partner violence.

Women's Experience with Battering (WEB) Scale[56]

Description of How Your Partner Makes You Feel	Agree Strongly	Agree Somewhat	Agree a Little	Disagree a Little	Disagree Somewhat	Disagree Strongly
1. He makes me feel unsafe even in my own home.	6	5	4	3	2	1
2. I feel ashamed of the things he does to me.	6	5	4	3	2	1
3. I try not to rock the boat because I am afraid of what he might do.	6	5	4	3	2	1
4. I feel like I am programmed to react a certain way to him.	6	5	4	3	2	1
5. I feel like he keeps me prisoner.	6	5	4	3	2	1
6. He makes me feel like I have no control over my life, no power, no protection.	6	5	4	3	2	1
7. I hide the truth from others because I am afraid not to.	6	5	4	3	2	1
8. I feel owned and controlled by him.	6	5	4	3	2	1
9. He can scare me without laying a hand on me.	6	5	4	3	2	1
10. He has a look that goes straight through me and terrifies me.	6	5	4	3	2	1

Scoring: To score WEB Scale, sum responses for items 1–10. Range of scores is 10–60. Score $\geq$ 20 indicates battering.

Index of Spouse Abuse, Partner Abuse Scale: Physical (ISA-P)[56]

Question	All of the Time	Most of the Time	A Good Part of the Time	Some of the Time	A Little of the Time	Very Rarely	None of the Time
1. My partner pushes and shoves me around violently.	7	6	5	4	3	2	1
2. My partner hits and punches my arms and body.	7	6	5	4	3	2	1
3. My partner threatens me with a weapon like a gun or a knife.	7	6	5	4	3	2	1
4. My partner beats me so hard I must seek medical help.	7	6	5	4	3	2	1
5. My partner beats me when he drinks.	7	6	5	4	3	2	1
6. My partner hits, punches, or kicks my face and head.	7	6	5	4	3	2	1
7. My partner beats me in the face so badly that I'm ashamed to be seen in public.	7	6	5	4	3	2	1
8. My partner tries to choke, strangle, or suffocate me.	7	6	5	4	3	2	1
9. My partner knocks me down and then kicks or stomps me.	7	6	5	4	3	2	1
10. My partner throws dangerous objects at me.	7	6	5	4	3	2	1
11. My partner has injured me with a weapon like a gun, knife, or other object.	7	6	5	4	3	2	1
12. My partner has broken 1 or more of my bones.	7	6	5	4	3	2	1
13. My partner physically forces me to have sex.	7	6	5	4	3	2	1
14. My partner badly hurts me while we are having sex.	7	6	5	4	3	2	1
15. My partner injures my breast or genitals.	7	6	5	4	3	2	1

Scoring: Sum the responses, subtract the number of questions actually answered (n = 15) and multiply by 100, then divide by 90. Scores > 2 indicate physical interpersonal violence.

Woman Abuse Screening Tool (WAST)[57]

1.	In general, how would you describe your relationship?	a lot of tension	some tension	no tension
2.	Do you and your partner work out arguments with ...	great difficulty	some difficulty	no difficulty
3.	Do arguments ever result in you feeling put down or bad about yourself?	often	sometimes	never
4.	Do arguments ever result in hitting, kicking or pushing?	often	sometimes	never
5.	Do you ever feel frightened by what your partner says or does?	often	sometimes	never
6.	Has your partner ever abused you physically?	often	sometimes	never
7.	Has your partner ever abused you emotionally?	often	sometimes	never
8.	Has your partner ever abused you sexually?	often	sometimes	never

To score this instrument, the responses are assigned a number. For the first question "a lot of tension" gets a score of 1 and the other 2 get a 0. For the second question "great difficulty" gets a score of 1 and the other 2 get 0. For the remaining questions, "often" gets a score of 1, "sometimes" gets a score of 2, and "never" gets a score of 3.

Domestic Violence Screening Tool[58]

1. Have you ever been threatened, hit, punched, slapped, or injured by a husband, boyfriend, or significant other you had at any point in the past?
2. Have you ever been hurt or frightened so badly by a husband, boyfriend, or significant other that you were in fear for your life?
3. Have you been hit, punched, slapped, or injured by a husband, boyfriend, or significant other within the last month?
4. Are you currently involved in a close relationship with a husband, boyfriend, or significant other?
5. Are you here today for injuries received from your husband, boyfriend, or significant other?
6. Do you often feel stressed due to fear of threats or violent behavior from your current husband, boyfriend, or significant other?
7. Has your current husband, boyfriend, or significant other ever hit, punched, slapped, or injured you?
8. Do you think it is likely that your husband, boyfriend, or significant other will hit, slap, punch, kick, or otherwise hurt you in the future?
9. Do you think you will be safe if you go back home to your husband, boyfriend, or significant other at this time?

A "yes" response to any question is considered positive for partner violence.

Elder Abuse and Neglect

Brief Abuse Screen for the Elderly (BASE)[59]

Please respond to every question (as well as you can estimate) concerning all clients ___ years or over who are caregivers (give regular help of any kind) or care receivers:

1. Is the client an older person or caregiver? Yes___ No___

2. Is the client a caregiver of an older person? Yes___ No___

3. Do you suspect abuse? (see also #4 and #5) Yes___ No___

   i) By caregiver (comments) _____

1	2	3	4	5
no, not at all	only slightly, doubtful	possibly, probably, somewhat	yes, quite likely	definitely

   ii) By care receiver (comments) _____

1	2	3	4	5
no, not at all	only slightly, doubtful	possibly, probably, somewhat	yes, quite likely	definitely

4. If any answer for #3 except "no, not at all," indicate what kind(s) of abuse(s) is (are) suspected.

   i) physical ☐ ii) psychosocial ☐ iii) financial ☐ iv) neglect ☐ (includes passive and active)

5. If abuse is suspected, about how soon do you estimate that intervention is needed?

1	2	3	4	5
immediately	within 24 hrs	24–72 hrs	1 week	2 or more weeks

Scoring information was not provided.

Hwalek-Senstock Elder Abuse Screening Test (HSEAST)[60]

Violation of Personal Rights or Direct Abuse

1. Does someone else make decisions about your life—like how you should live or where you should live?
2. Does someone in your family make you stay in bed or tell you you're sick when you know you're not?
3. Has anyone forced you to do things you didn't want to do?
4. Has anyone taken things that belong to you without your OK?
5. Has anyone close to you tried to hurt or harm you recently?

Characteristics of Vulnerability

6. Do you have anyone who spends time with you, taking you shopping or to the doctor?
7. Are you sad or lonely often?
8. Can you take your own medication and get around by yourself?

Potentially Abusive Situations

9. Are you helping to support someone?
10. Do you feel uncomfortable with anyone in your family?
11. Do you feel that nobody wants you around?
12. Does anyone in your family drink a lot?
13. Do you trust most of the people in your family?
14. Does anyone tell you that you give them too much trouble?
15. Do you have enough privacy at home?

A response of "no" to items 6, 8, 13, and 15 and a response of "yes" to all other score in the abused direction.

The Caregiver Abuse Screen (Reis-Nahmiash CASE)[61]

Please answer the following questions as a helper or caregiver with yes or no:

1. Do you sometimes have trouble making (___) control his/her temper or aggression?
2. Do you often feel you are being forced to act out of character or do things you feel bad about?
3. Do you find it difficult to manage (___'s) behavior?
4. Do you sometimes feel that you are forced to be rough with (___)?
5. Do you sometimes feel you can't do what is really necessary or what should be done for (___)?
6. Do you often feel you have to reject or ignore (___)?
7. Do you often feel so tired and exhausted that you cannot meet (___ 's) needs?
8. Do you often feel you have to yell at (___)?

Scoring information was not provided.

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