Domestic Violence Training Program for Residents

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Domestic violence is occurring in epidemic proportions in the United States. Recent surveys have shown there is a need for educational programs for health care professionals. This report presents the results of a domestic violence workshop developed to increase knowledge and improve attitudes and skills in working with victims of domestic violence. The results of the workshop, measured by preintervention and postintervention attitude, knowledge, and skills surveys, are promising. There was a significant improvement in knowledge, self-assessed skills, and attitudes after the workshop. Although the full magnitude of the changes was not sustained over time, there was still significant improvement after 6 months in knowledge and attitude. Rates of detection and documentation did not change. Future educational programs will need to address maintaining routine screening for domestic violence in the primary care setting and to highlight more clearly the role of health care professionals in the detection and treatment of domestic violence.

KEY WORDS: abuse; domestic violence; training program for residents; screening.

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Approximately 4 million women in the United States are battered by their partners each year, resulting in 4,000 deaths.¹ It has been shown repeatedly that approximately one third of women seeking medical care in emergency departments are victims of domestic violence.² In primary care settings, 14% to 28% of female patients are domestic violence victims.³ Recently, domestic violence has been more highly publicized, leading to an increased public awareness of this epidemic. However, most physicians lack the knowledge, skills and attitudes necessary to correctly identify and care for domestic violence victims.^{2,4-7} Several medical centers have developed domestic violence training programs for residents and students.⁸ However, there have been few, if any, evaluations of the efficacy of domestic violence training on the subsequent behaviors and attitudes of trainees.⁹

In this study, we evaluated the impact of a 4-hour domestic violence training workshop on knowledge, behavior, and attitudes of medical residents. We hypothesized that the educational intervention would significantly

increase residents' knowledge, skills, and attitudes and increase the number of patients screened, detected, and documented in medical records.

METHODS

Fifty-five residents participated in this study; 34 (62%) were male and 21 (38%) were female. All were residents in the 3-year Medical College of Pennsylvania Internal Medicine Residency of the Allegheny University of the Health Sciences. Each resident was required to attend one domestic violence workshop. Five identical workshops were held over a 2-week period, each replacing one continuity clinic session.

The Intervention

The 4-hour workshop included the following:

Surveys. Participants filled out a Doepel Domestic Violence Survey,¹⁰ before and after the workshop. This survey measured residents' knowledge, attitudes and self-assessed skills. The survey consists of multiple-choice questions, true/false questions, and attitude items that require a response on a 5-point Likert scale. These surveys were distributed and collected by a nonstudy staff member using code numbers for each participant to ensure anonymity and to correlate preworkshop surveys with the two post-workshop surveys (immediately after and at 6 months) for each participant.

Brief Video. After a brief introduction, a portion of the video entitled "Defending Our Lives" (Cambridge Documentary Film, Cambridge, Mass.) was shown. The excerpt highlighted interviews with survivors of domestic violence who described their experiences both during and following their abuse.

Didactic Lecture. A 30-minute slide presentation reviewed the epidemiology of domestic violence in the United States; the psychodynamics of partner abuse; the impact of domestic violence on the health of the patient and its implications for the health care provider; and the RADAR mnemonic for screening—i.e., Remember to Ask direct questions, Document, Assess safety, Review options and referrals.¹¹ Screening techniques and various ways to "ask the question" were emphasized.

A Personal Account. A survivor of domestic violence told the audience the story of her abusive marriage and its impact on her emotional and physical well-being and that of her children.

A Panel Discussion. Representatives from Women Against Abuse, the Philadelphia Police Department, and Menenergy

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(a counseling program for men with a history of domestic violence) presented information on local support services and provided further insight into the reality of abuse in our culture. An open panel discussion followed the presentations, during which participants from the audience asked questions concerning each representative's work and experiences.

Role Playing of Taking a Domestic Violence History. Fictional cases were used in a role-playing exercise. The audience was divided into groups of three or four members. Participants in these groups each played the roles of the patient, the physician, and the observer. The goal was to have each participant ask about domestic violence in a forthright and supportive manner, and feel what it is like to be asked. The observers were asked to provide feedback to the "role-playing" physician. The seminar leaders (ENK, GS) circulated among the groups as facilitators.

Postworkshop Doepel Domestic Violence Survey. Each participant completed the survey prior to leaving the workshop site. This survey was identical to the preworkshop survey.

Outcome Measures

The following outcomes were measured before the workshop and 6 months later:

Chart Review for Documentation of Domestic Violence.

Inclusion criteria for patients whose charts were reviewed were female gender (because the emphasis of the educational program was on women), aged 16 years and over, with a Primary Care Profile completed by the resident. The Primary Care Profile is the problem list, which includes a checklist of specific problems and risk factors including smoking, alcohol use, drug dependence, domestic violence, depression, advanced directives, and occupational expo-

sure. A Primary Care Profile must be completed on all new patients prior to presenting the patient to the attending physician. All Primary Care Profiles from the 18 months prior to the educational intervention were reviewed for documentation of screening for domestic violence. All new Primary Care Profiles meeting the inclusion criteria were examined for domestic violence screening for the 7 months following the intervention.

Doepel Domestic Violence Survey. Knowledge, skills, and attitudes as measured by the Doepel Domestic Violence Survey (measured preworkshop, immediately postworkshop, and at 6 months postworkshop).

RESULTS

Chart Review

The prevalence of documented domestic violence in the residents' practice prior to the domestic violence workshop was 7.8% (54 of 693 patients). For the 6 months following the intervention, the prevalence of domestic violence in new female patients was 6.1% (17 of 277 new patients). The percentage of charts in which there was documentation of inquiry about domestic violence status increased only slightly from 75% (518 of 693) to 79% (220 of 277). Neither of the changes was statistically significant.

Doepel Domestic Violence Survey

The results of the knowledge, attitudes, and skills survey are displayed in Table 1. There was significant improvement in all three attributes from preworkshop to immediately postworkshop, and significant improvement in knowledge and attitude from preworkshop to 6 months postworkshop. This included initial improvements in attitude, knowledge, and skills of 8.2%, 15%, and 12%, respectively, with the sustained results at 6 months being

Table 1. Mean Changes of Attitudes, Knowledge, and Self-Assessed Skills on the Doepel Domestic Violence Survey*

	Mean Score (SD)		Mean Change (SD)	%Change	<i>t</i>	<i>p</i> Value
	Before	After				
Attitude						
Pre: Post	123.5 (16.2)	133.6 (16.3)	10.1 (9.2)	+8.2	8.80	<.0001
Pre: 6-month	123.5 (16.2)	128.8 (15.9)	5.3 (12.7)	+4.3	3.36	<.002
Knowledge						
Pre: Post	3.9 (1.8)	4.5 (1.7)	0.6 (1.6)	+15	2.93	<.005
Pre: 6-month	3.9 (1.6)	4.3 (1.8)	0.4 (1.5)	+10	2.13	<.04
Skill						
Pre: Post	6.0 (1.6)	6.7 (1.4)	0.7 (1.8)	+12	3.20	<.003
Pre: 6-month	6.9 (1.6)	6.4 (1.6)	0.4 (1.6)	+7	1.93	NS

*The knowledge subscale is composed of 10 questions (multiple choice and true/false) with a possible range in score of 0 to 10. Higher scores indicate more knowledge about domestic violence. Ten questions constitute the skills subscale, and it also has a possible range of 0 to 10. The higher the score, the more likely the resident indicates he or she will use appropriate skills in working with an abused patient. There are 25 questions in the attitude scale. Each is answered on a Likert-type scale from 1 (strongly agree) to 6 (strongly disagree.) After reversing scales for some items so that higher scores indicate more favorable attitudes, possible scores range from 25 to 150.

4.3%, 10%, and 7%, respectively. All of these changes were significant with the exception of skills from preworkshop to 6 months postworkshop.

DISCUSSION

The results of this study reveal that a limited workshop presentation can have an impact on residents' attitudes and knowledge about domestic violence (as measured by the Doepel Domestic Violence Survey) for at least 6 months following the intervention. However, the decline in self-assessed skills toward baseline at 6 months suggests the need for educational reinforcement over time. Moreover, even when significant changes were observed, the magnitude of the changes was small (e.g., less than one more correct answer to a question in both the knowledge and skills subscales).

This educational reinforcement might include additional teaching sessions as well as frequent emphasis on the importance of domestic violence detection by attending physicians. By communicating to trainees expectations of hearing about domestic violence screening in patient presentations, and demonstrating their styles of asking and counseling patients about domestic violence, physician faculty could help trainees incorporate domestic violence screening into routine workups. Therefore, faculty development should be an integral part of any domestic violence educational program.

The workshop did not appear to increase detection of domestic violence in the medical clinic. The baseline detection of women with a history of domestic violence was 7.8%, falling to 6.1% in the new female patients seen over the subsequent 6 months. We had anticipated that the workshop would improve residents' questioning abilities, increasing both the detection rate and the frequency of documented inquiries. Though we do not know the actual prevalence of domestic violence in our clinic population, other studies suggest that it could be between 11% and 15%.⁵

The challenge of attaining long-term behavioral changes is clear. We did not capture it using a questionnaire or chart review, nor were we able to assess it in a pilot study with standard patients. In that pilot, we trained six women to play victims of domestic violence as standardized patients. After obtaining consent from the residents, these women were scheduled to see the residents without the residents knowing which patients were the standardized patients. At

baseline, the history of domestic violence was correctly identified in only 56% of the cases, and one third of these were handled incorrectly. Our plan to repeat this outcome measure following the intervention was prevented by the problem of residents discovering who the standardized patients were. The residents toward the end of the intervention were told by their colleagues to "watch out for the headache patient with domestic violence," thereby increasing the correct identification but for the wrong reason.

Maintaining the initial improvement in self-reported behavior and documenting real behavioral changes is the next educational goal. It is unlikely that this can be achieved by single workshops or training programs. Ongoing reinforcement by attending physicians who model the screening behaviors in day-to-day practice and easy access to resources for positively identified domestic violence victims could help.

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