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Testing the Woman Abuse Screening Tool to Identify Intimate Partner Violence in Indonesia

Livia Iskandar, MSc, DrPH¹, Kathryn L. Braun, DrPH¹, and Alan R. Katz, MD, MPH¹

¹University of Hawaii, Honolulu, USA

Abstract

Intimate Partner Violence (IPV) is a global public health problem. IPV prevalence in Indonesia has been estimated to be less than 1%, based on reported cases. It is likely that IPV prevalence is underreported in Indonesia, as it is in many other countries. Screening for IPV has been found to increase IPV identification, but no screening tools are in use in Indonesia. The aim of this study was to test the translated Woman Abuse Screening Tool (WAST) for detecting IPV in Indonesia. The WAST was tested against a diagnostic interview by a trained psychologist on 240 women attending two Primary Health Centers in Jakarta. IPV prevalence and the reliability, sensitivity, and specificity of the WAST were estimated. Prevalence of IPV by diagnostic interview was 36.3%, much higher than published estimates. The most common forms of IPV identified were psychological (85%) and physical abuse (24%). Internal reliability of the WAST was high ($\alpha = .801$). A WAST score of 13 (out of 24) is the recommended cutoff for identifying IPV, but only 17% of the Indonesian sample scored 13 or higher. Test sensitivity of the WAST with a cutoff score of 13 was only 41.9%, with a specificity of 96.8%. With a cutoff score of 10, the sensitivity improved to 84.9%, while the specificity decreased to 61.0%. Use of the WAST with a cutoff score of 10 provides good sensitivity and reasonable specificity and would provide a much-needed screening tool for use in Indonesia. Although a lower cutoff would yield a greater proportion of false positives, most of the true cases would be identified, increasing the possibility that women experiencing abuse would receive needed assistance.

Keywords

Asia; battered women; domestic violence; reliability; sensitivity and specificity

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Corresponding Author: Kathryn L. Braun, Office of Public Health Studies, John A. Burns School of Medicine, University of Hawaii, 1960 East-West Road, Biomed D-204, Honolulu, HI 96822, USA. kbraun@hawaii.edu.

The research was approved by the Institutional Review Board of the University of Hawaii, by the Indonesian Ministry of Health, and the Jakarta Governor's Office. The first author was a doctoral student at the University of Hawaii, and these data were collected as part of her dissertation research. The coauthors were chair and member of her dissertation committee. All three were involved in conceptualization of the research, data interpretation, and writing of this manuscript. Livia Iskandar and Kathryn Braun have had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Introduction

Intimate Partner Violence (IPV) has been declared a global public health problem and a violation of human rights (Harvey, Garcia-Moreno, & Butchart, 2007), which is associated with significant, negative physical health and psychological consequences for women (Campbell, 2002). IPV prevalence in Indonesia has been estimated to be less than 1%, based on cases reported by service providers to the Indonesian National Commission on Violence Against Women (2011, 2012). About 91% of reported cases were considered psychological in nature (feeling put down, humiliated, or controlled). It is likely that overall IPV prevalence in Indonesia is underreported. Results from a multicountry household survey by the World Health Organization (WHO) suggest a lifetime IPV prevalence of 13% in Japan, 23% in urban Thailand, and 40% in urban Bangladesh (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005), and a survey of 765 women in rural Java found a lifetime prevalence of 22% for sexual violence and 11% for physical violence (Hayati, Högberg, Hakimi, Ellsberg, & Emmelin, 2011). Possible reasons for not reporting IPV in Indonesia and other countries include shame, gender inequality in married couples, fear of reprisal, economic circumstances, and perceptions that help may not be available (Hayati et al., 2011; Hyman, Forte, Du Mont, Romans, & Cohen, 2009).

Screening for IPV has been found to increase IPV identification (Nelson, Bougatsos, & Blazina, 2012; Taft et al., 2013). However, the use of routine IPV screening is not widespread and may be controversial. In the United States, the Institute of Medicine (2011) recommended routine screening of women and adolescents, the U.S. Preventive Services Task Force (USPSTF; 2013) recommended routine screening of women of childbearing age, and the American Medical Association (AMA) believes that IPV is sufficiently prevalent and serious “to justify routine screening of all women patients in emergency, surgical, primary care, pediatric, prenatal, and mental health settings” (R. Brown, 2002, p. 11). However, routine screening is not endorsed by the WHO (2013), and a 2013 Cochrane review found insufficient evidence to justify universal screening in health care settings, although the authors also concluded that routine screening does no harm (Taft et al., 2013).

In 2004, Indonesia passed a law criminalizing IPV (Indonesia Department of Justice, 2004) and is making efforts to identify and assist patients attending Primary Health Centers (PHCs) who experience IPV (Indonesia Ministry of Health, 2009). For example, district PHCs are required to accept and manage referrals for IPV supportive services from subdistrict PHCs and to have a private exam room for IPV counseling. However, no IPV screening tools or protocols have been put in place. PHCs, found in districts and subdistricts in all 33 provinces of Indonesia, are analogous to Community Health Centers in the United States, serving the lower socioeconomic strata of the population. (Wealthier Indonesians prefer to receive health care from private physicians and clinics.) PHCs serve many clients each year; for example, the two PHCs participating in this study together documented 87,382 patient visits in 2009.

Based on a review of IPV screening tools (Basile, Hertz, & Back, 2007), the Woman Abuse Screening Tool (WAST) was felt to be the best IPV screening tool to use in Indonesian PHCs because (a) it asks about psychological as well as physical and sexual abuse, (b)

several studies have reported that the WAST has high reliability, (c) the English-language version has good specificity and fairly good sensitivity, and (d) in addition to its full eight-item format, the WAST can be applied in a short form, or the WAST-Short, which may be useful in a busy PHC setting. The WAST was also used successfully by Wong and Othman to screen women in Malaysia (Wong & Othman, 2008). These authors found an IPV prevalence of 5.6% in their sample of 710 female patients, and the WAST was found acceptable among the women screened.

Although the WAST has demonstrated good sensitivity and specificity in U.S. study populations, the sensitivity and specificity of an Indonesian language version of the WAST has not been established. The best way to establish validity of IPV screening tools is to compare a self-administered tool against a clinician-administered face-to-face interview, which is considered superior to written screening questions (Anderst, Hill, & Siegel, 2004). Thus, the purpose of this study was to test the sensitivity, specificity, and reliability of the WAST translated into Indonesian and to estimate the prevalence of IPV among women in an Indonesian population. The study was approved by the Institutional Review Board of the University of Hawaii and by the Indonesian Ministry of Health, with the provision that services be offered to any woman identified with IPV.

Method

Sample

Power calculation estimated a sample size of 240 women would be needed to estimate the prevalence of IPV with $\alpha = .05$ and $\beta = .20$. An eligible woman was (a) a client of one of two participating PHCs in Jakarta, (b) age 18 years or older, (c) married or involved with a male partner, (d) unaccompanied by husband/partner at the time of the study, (e) in good physical condition (self-reported), (f) able to read and write Indonesian, and (g) willing to spend 20 to 30 min for the study. Women were recruited in waiting rooms of the PHC in February to March 2012. Of 250 women who were approached and found eligible, 240 (96%) agreed to participate and completed a consent form. The 10 who did not consent said they were too busy (3), could not participate because they had children they needed to attend to (5), and/or had their husbands waiting for them in the PHC's parking lot (2).

Participants were assigned randomly to one of two study arms. In one arm, women first completed the WAST, and then were interviewed by a psychologist (Method 1). In the other arm, participants were first interviewed by the psychologist, and then completed the WAST (Method 2). This was done to test whether taking the WAST before the interview might increase the likelihood of identifying IPV. The psychologist interview was done in a private room. Psychologists were blinded to assignment, as well as to WAST results for women who completed the WAST before the interview. Study participants received a package of basic food necessities (rice, sugar, flour, salt, soy sauce) for their participation.

The study was conducted in collaboration with PULIH Center for Trauma Recovery and Psychosocial Empowerment, a nongovernmental organization in Jakarta with a mission to assist victims of violence and disaster. PULIH psychologists were contracted to conduct interviews with the 240 women in the study. Each of six licensed psychologists from PULIH

had at least 3 years of experience working with women experiencing IPV in Indonesia. The two participating PHCs were within the service district of PULIH, so women identified with IPV could easily be referred to PULIH for further assistance.

Measures

WAST—The English-language version of the WAST has good reliability and validity (J. B. Brown, Lent, Brett, Sas, & Pederson, 1996; J. B. Brown, Lent, Schmidt, & Sas, 2000; Ernst, Weiss, Cham, & Marquez, 2002; Wathen, Jamieson, & MacMillan, 2008). In U.S. studies, Brown and colleagues (the tool developers) reported good internal consistency (Cronbach's $\alpha = .75$), and that the WAST correctly classified 100% of nonabused women and 91.7% of abused women (J. B. Brown et al., 1996; J. B. Brown et al., 2000). Moreover, more than 90% of woman reported being comfortable or very comfortable when the WAST was administered to them (J. B. Brown et al., 2000). The full WAST includes eight items, scored 1 (*never or none*) to 3 (*a lot or often*). Total scores range from 8 to 24, and the tool developer recommended a cutoff of 13 to indicate presence of abuse. This cutoff score also was used in Wong and Othman's (2008) IPV study in Malaysia.

However, the WAST was designed as a two-part screening tool. The screener starts by asking the first two questions, which inquire about the level of tension a woman feels in her intimate partner relationship and the amount of difficulty she experiences working out conflicts with her partner. Only if the woman answers these two questions with "a lot of tension" and "great difficulty," respectively, will the screener ask her to complete the other six WAST items. The latter six items ask specifically about a woman's experience with feeling put down or frightened or being physically, emotionally, or sexually abused. As PHC workers may feel overburdened and may be reluctant to spend extra time with patients, the WAST-Short can be the critical point of buy-in for PHC workers. In this study, we used the eight-item version of the WAST so that we could correlate the score of the first two items with the score on the last six items, as well as with the psychologist's determination of IPV. The principal investigator (L.I.), an Indonesian native speaker, translated the WAST into Indonesian; it was then back-translated into English by an Indonesian bilingual certified translator.

Psychologist Interview, guided by the Domestic Violence Initiative Screening (DVIS)—The judgment of a licensed psychologist conducting a diagnostic interview was considered the gold standard against which to validate the translated WAST. To standardize the diagnostic interview, six female PULIH psychologists experienced in identifying and assisting IPV clients were trained in the DVIS interview guide (Basile et al., 2007) by the principal investigator. As with the WAST, forward and backward translation was used to translate the guide into Indonesian. Following the DVIS, psychologists opened the interview with this introduction,

At this health service, we are concerned about your health and safety, so we ask all women the same questions about violence at home. The reason is because violence is very common, and we want to improve our response to families experiencing violence.

Then the psychologist asked the women to answer yes or no to four questions: (a) Are you ever afraid of your partner? (b) In the last year, has your partner hit, kicked, punched, or otherwise hurt you? (c) In the last year, has your partner put you down, humiliated you, or tried to control your actions in any way? and (d) In the last year, has your partner threatened to hurt you physically or sexually? If the respondent did not understand or was reluctant to answer, the PULIH psychologists were instructed to rephrase the question. For example, if the woman didn't grasp the word *merendahkan* (Indonesian for "put you down"), the psychologist might substitute the phrase *membuat Ibu merasa kecil* (made you feel smaller). Based on the diagnostic interview conducted by the psychologist, women who reported being physically, emotionally, or sexually abused by their partners were categorized as experiencing IPV. In a 1-day training in the DVIS, the psychologists demonstrated high agreement in their diagnoses during role-play.

Women experiencing IPV were offered brief intervention by a psychologist, which included counseling, providing information on IPV services, helping the women develop a safety plan and other necessary safety promoting behaviors, and referring the women to appropriate service providers as requested. Psychologists also provided women identified as experiencing IPV with wallet-sized hotline cards with a Trauma Recovery Center's contact details and flyers explaining the different types of IPV. If further assistance was requested, women were linked to the PULIH office.

Demographic and Help-Seeking Questionnaire—On another form, respondents were asked to indicate their age group (18–24, 25–34, 35–44, 45–54, 55–64, and 65+ years), educational attainment (elementary, middle school, high school, and > high school), employment status (yes/no), ethnicity (Jakartan/Javanese, Sumatran, and other), years of marriage, and number of children. Because we were interested in IPV help-seeking patterns, a final question asked, "If you ever experienced Intimate Partner Violence, what would you do?" Women were asked to select one response. Options included the following: visit a PHC, visit an Emergency Response Unit, visit a service provider, call a hotline service, report to a policewoman's desk, and other (specify).

Data Analysis

Data were analyzed using SPSS version 19. IPV prevalence was estimated based on the psychologist diagnostic interview. We examined whether prevalence varied by whether the participant was interviewed before (Method 1) or after (Method 2) completing the WAST. To determine the sensitivity and specificity of the WAST, two-by-two tables were constructed, noting proportions of true and false positives and negatives when comparing the psychologist's determination against the WAST determination (Weiss, 2008). Although the recommended WAST cutoff for IPV is 13, we calculated sensitivity and specificity at cutoffs from 9 to 13. Reliability of the WAST was measured using Cronbach's coefficient alpha. Pearson correlation was used to correlate the score from the WAST-Short (the first two items) with the score from the other six WAST items. We compared women who experience IPV against those that did not by sociodemographic variables and clinic using χ^2 and unpaired *t* tests. Responses to the help-seeking question were tallied, and the "other" responses were post-coded. All responses then were organized into "would report" and

“would not report.” Subcategories for the former included report to PHC, visit emergency service, talk to service provider, go to a policewoman’s desk, and call a hotline service; subcategories for the latter included talk to family and friends, remain quiet, leave my husband, and practice self defense.

Results

Demographic Characteristics of the Research Participants

Approximately 6% of participants were aged 18 to 24, 46% were 25 to 34, 33% were 35 to 44, and 15% were older. Almost half (48%) had graduated from high school, 14% had some college education, and 80% were unemployed. The majority (87%) said they were Jakartans or Javanese, and 11% said they were Sumatran (Table 1). On average, women had been married 13 years and had 2 to 3 children (not shown in table).

Help-Seeking for IPV—Of the 240 participants, 83 (34.6%) said they would report IPV if it happened to them, 148 (61.7%) said they would not report it, and 9 (3.7%) did not answer this question. Looking at subcategories, about 11% would visit a PHC, about 10% would report to a policewoman’s desk, and about 8% would visit a service provider, while about 44% would talk to family and friends, and about 13% would remain quiet (Table 2).

Prevalence of IPV

The prevalence of IPV as determined by psychologist diagnostic interview was 36.3% (87 of 240), with no significant difference in prevalence by clinic or between those women who completed the WAST before the interview and those women who completed it after the interview ($p = .50$). Based on the DVIS, 24% of IPV cases reported physical abuse, 30% reported that their partner threatened to hurt them physically or sexually, 66% at times felt afraid of their partners, and 85% reported being put down, humiliated, or controlled (Table 3).

In comparison, only 17% of women had a WAST score of 13 or higher, the recommended cutoff for IPV determination. In examining demographic characteristics that might distinguish women experiencing IPV from those who were not, only one variable was significant. Specifically, of the 87 women who were determined to be experiencing IPV, 31.4% were working outside the home, whereas 13.6% of women who were not determined to be experiencing IPV were working outside the home ($p < .001$, not shown in table).

Sensitivity and Specificity

Sensitivity and specificity for the WAST and the associated positive predictive values (the proportion of positive test results that are true positives) at different cutoff values are shown in Table 4. At a cutoff point of 9, the sensitivity of the WAST was 91.9% and the specificity was 35.7%. At increasingly higher cutoff points, the specificity increased, but the sensitivity decreased. For example, at a cutoff of 13 (recommended by WAST developers) the sensitivity was 41.9%, and the specificity was 96.8%.

Reliability of the WAST and Interscale Correlations

Cronbach's coefficient alpha to test the reliability of the WAST yielded the following results: .801 for the eight items, .713 for Items 3–8, and .667 for Items 1 to 2. As shown in Table 5, correlation between the WAST-Short (Items 1–2) and the WAST-Long (Items 1–8) was moderate ($r = .799, p < .001$). Correlations between the WAST and DVIS (Items 1–4) scores and the psychologist's determination were also examined. All correlations were significant at $p < .001$. However, the correlation between the psychologist's determination and the WAST-Short was only .410, compared with .564 for the WAST total, and .0811 with the DVIS total score.

Discussion

The 36.3% IPV prevalence found through the psychologist diagnostic interview indicates that IPV is much more common among PHC patients than expected based on reports provided to the Indonesian National Commission on Violence Against Women (2011, 2012) and earlier studies of women in Malaysia (Wong & Othman, 2008) and rural Java (Hayati et al., 2011). Because we confined our study to two PHCs in South Jakarta, these findings may not be generalizable to other parts of Jakarta or to rural areas of the Indonesia. A probability household sample would be able to provide a more accurate estimate of IPV prevalence in the country. Geographically, Indonesia is an archipelago consisting of 17,506 islands with more than 300 ethnic groups and 365 active languages spoken. Thus, the prevalence of IPV is likely to vary by region. However, the type of IPV most commonly found in our study—psychological abuse—concurs with the type of IPV most commonly reported to the Indonesian National Commission on Violence Against Women (2011, 2012). Of the 212,455 reported cases of domestic violence in 2010 and 2011 (combined), 91% were psychological in nature.

In our study, the overall prevalence of IPV identified by the psychologist diagnostic interview (gold standard) was 2 times higher (36.3%) than prevalence estimated by the WAST when using the recommended cutoff score of 13 (17.1%). This is higher than estimates of lifetime prevalence in the United States (31%) and of prevalence estimated in a sample of women seeking care at a trauma center in Ontario (30.5%; Moyer, 2013; Sprague, Madden, Dosanjh, Petrisor, Schemitsch, & Bhandari, 2012). We considered the possibility that the psychologists, based on their background with PULIH, may have overdiagnosed IPV. However, in all cases, women's experience of IPV was confirmed during the provision of brief intervention. This was offered to all women identified as experiencing IPV based on the DVIS. In this brief intervention session, psychologists provided counseling, gave information on IPV services, helped the women develop a safety plan, and referred the women to appropriate service providers as requested.

We experienced a high rate of participation in the research (96%), and found women very willing to talk with our research psychologists about IPV. It could be that women were attracted to the study because of the opportunity to consult with a female psychologist at the PHC, to consult at no cost, and to receive the free bag of basic food commodities. Moreover, psychologists prefaced their interviews with an acknowledgment that family violence is common and that the PHC wanted to learn how to assist women experiencing violence,

which may have encouraged women to talk openly about IPV. In the Malaysia study, Wong and Othman (2008) found that 67% women in their study would be willing to voluntarily disclose experience of IPV if asked by their doctor. J. B. Brown et al. (2000) also found that women would be willing to discuss IPV with their physicians if they were asked in a respectful and caring manner.

If the WAST is to be used as an IPV screening tool in Indonesia, applying a cutoff score of 13 would miss many cases of IPV. With 10 as the cutoff score, the WAST had a sensitivity of 84.9% and specificity of 61.0% in this Indonesian population. At this score, 55.4% of women screened would be identified as abused, yielding more false positives than desired, but assuring that most of the true cases would be correctly identified. Because the PHC setting is very busy, it was gratifying that a self-administered screening tool, such as the WAST, can be used to identify IPV (rather than a psychologist interview, which is more time-consuming and expensive). However, because the WAST-Short score did not correlate as well with the gold standard determination ($r = .410$), it is recommended that the full eight-item WAST be used as a screening tool, and a cutoff of 10 be used to identify women who may be experiencing IPV.

The research literature suggests that there is no perfect IPV screening tool (Rabin, Jennings, Campbell, & Bair-Merritt, 2009), and choosing one depends on the context of use. In a systematic review of IPV tools, the USPSTF found that the Hurt, Insult, Threaten, Scream (HITS) scale, the Ongoing Violence Assessment Tool (OVAT), the Slapped, Threatened, and Throw tool, the Humiliation, Afraid, Rape, Kick (HARK) tool, the Modified Childhood Trauma Questionnaire–Short Form, and the WAST had the highest levels of sensitivity and specificity for identifying IPV. A review in the United Kingdom found that the HITS had the best predictive power, followed by the Women's Experience With Battering Scale (WEB), the OVAT, and Partner Violence Screen (PVS). In reviewing tools (HITS, WAST, WEB, OVAT, HARK, and the Index of Spouse Abuse–Physical Scale) for potential use in Pakistan and Afghanistan, Vogel (2013) determined that the WAST-Short and the OVAT might be the most useful because of their brevity and their ease of administration for busy health care providers. Findings from a review by Hussain and colleagues (2013) suggested that higher rates of disclosure may be obtained using computer assisted self-administered screens than from face-to-face interview and self-administered written screens, but patient access to this technology may be limited.

Other IPV screening questionnaires may work equally well or better in the Indonesian context. For example, the four-item DVIS might be a good screening tool for use in PHCs, as it is shorter than the eight-item WAST. Sprague and colleagues (2012) found that asking the three “direct” questions about abuse from the WAST (Has your partner ever abused you physically? Has your partner ever abused you emotionally? and Has your partner ever abused you sexually?) led to a higher estimate of IPV prevalence (30.5%) than using the eight-item WAST with the 13-point cutoff (12.4%) or using the PVS (9.2%). In both cases, a short inventory of “direct” questions could be administered by a clerk, and a “yes” to any of the items could trigger a referral to a health professional. Future research in Indonesia should test translated versions of these shorter tools in PHC settings.

Institutionalizing universal IPV screening in PHCs would require more than the identification of a valid screening tool. A systematic review of studies testing the sustainability of universal IPV screening in health care settings suggests that successful programs also must garner institutional support, put screening protocols in place, train providers in tools and protocols, and facilitate immediate access or referrals to services for clients experiencing IPV (O'Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011).

Although some professional bodies, including the AMA and the USPSTF, recommend universal screening of women for IPV, the 2013 WHO guidelines do not. WHO recommendations, based on the review of available evidence, raise several important issues. For example, implementing universal screening can place a high burden on health center staff. In understaffed settings, universal screening may meet with resistance from clinicians, who may ignore or perfunctorily complete screening forms. Women who do not experience IPV may find repeated screening a waste of time. Women who do may become discouraged or resentful if repeated screening does not lead to improved conditions. Finally, questions are raised as to the ethics of identifying women in need of assistance in communities that have no IPV support services. Proponents of universal screening counter that screening programs are not harmful to patients, and that providers who are not knowledgeable about IPV may miss its signs and symptoms in the absence of screening (WHO, 2013).

WHO (2103) does recommend that providers respond to women who disclose IPV and be alert to symptoms of IPV in vulnerable populations, including pregnant women and those that have physical or mental disabilities. Epidemiological studies may identify other "flags." For example, although 80% of women in our study were not employed, being employed outside the home helped distinguish women with IPV from those without. This concurs with the findings of Hayati et al. (2011) who found that women in rural Java who experienced sexual violence were more likely to have some amount of financial independence from their husbands. The Hayati findings also suggest a high degree of gender inequality in Indonesian couples. They found that a woman's exposure to physical violence was associated with the husband's childhood witnessing of abuse of his mother and the husband being unfaithful, using alcohol, or fighting with other men. These findings also confirm that gender-based violence is a complex issue. Some investigators are seeing success in changing gender-based expectations during adolescence by incorporating information on healthy relationships, power dynamics, refusal skills, and sexual health into high school health classes (O'Leary & Slep, 2012). Researchers also agree that IPV is a serious public health problem. It is estimated that 40% to 60% of murders of women in North America are committed by intimate partners (Campbell, 2002). Health problems associated with IPV include digestive problems, eating disorders, abdominal pain, bladder and kidney infections, vaginal infections and bleeding, pelvic pain, headaches, fainting, seizures, chronic neck and back pain, and hypertension (Campbell, 2002; Ellsberg et al., 2008). Lifetime experiences of partner violence is significantly associated with self-reported poor health, specific health problems in the previous four weeks, difficulty walking, difficulty with daily activities, memory loss, emotional distress, suicidal thoughts, and suicidal attempts (Ellsberg et al., 2008). Children are hurt when they witness abuse, and may experience it themselves from the same perpetrator, and children in abusive households may become abusers themselves (Langhinrichsen-Rohling, 2005). Psychological abuse is a "critical variable in the domestic

violence field” because it is may precede or be concurrent with physical violence and undermines self-esteem, self-acceptance, and/or emotional regulation (Langhinrichsen-Rohling, 2005, p. 113).

In the absence of routine inquiry from health providers, responses to our question on help-seeking suggest that women would be more likely to talk with their friends and family about their IPV experience than to introduce it with health care providers. This resonates with the Hayati et al.’s (2011) finding that 94% of the rural Javanese women in their study agreed that “family problems should only be discussed with people in the family” (p. 5).

Because many women are not likely to report IPV, and because IPV has many detrimental effects on women, children, and families, we believe that identifying IPV through universal screening is warranted. Doing so will help raise awareness about IPV in the PHC and general population and signal that the government is concerned about it. Universal screening will increase identification of IPV cases, which can help raise demand for services. Increased awareness of IPV as a negative behavior and increased demand for attention to this issue may help change social norms about gender-based violence in Indonesia and elsewhere.

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Biographies

Livia Iskandar, MSc, DrPH, graduated in December 2012 with her doctoral degree from Office of Public Health Studies, John A. Burns School of Medicine, University of Hawaii. She is from Indonesia and has returned home after living in Washington, D.C. She is the former director of PULIH Foundation, Center for Trauma Recovery and Psychosocial Empowerment in Jakarta and Banda Aceh, and currently serves as chairperson of PULIH Foundation's Board of Trustees.

Kathryn L. Braun, DrPH, is a professor and chair of the DrPH program at the Office of Public Health Studies, John A. Burns School of Medicine, University of Hawaii. She also serves as co-principal investigator of 'Imi Hale—Native Hawaiian Cancer Network and co-investigator of H K puna National Resource Center for Native Hawaiian Elders. She is known for her work in community-based participatory research in cancer and gerontology, and has published more than 150 peer-reviewed journal articles on these topics. She is a past winner of a Board of Regent's Medal for Excellence in Teaching from the University of Hawaii. She is a fellow in the Gerontological Society of America and president of the Active Aging Consortium Asia-Pacific.

Alan R. Katz, MD, MPH, is a professor and chair of the MPH program at the Office of Public Health Studies, John A. Burns School of Medicine, University of Hawaii. His research interests include infectious diseases, including sexually transmitted diseases. He currently serves as a member of the Hawaii State Board of Health and is a staff physician and medical consultant at the Hawaii State Department of Health's Diamond Head STD Clinic. He is a fellow of the American College of Epidemiology and the American College of Preventive Medicine.

Table 1Demographic Characteristics and IPV Help-Seeking Preferences of the Sample ($N = 240$).

Age	
18–24	15 (6.2%)
25–34	110 (45.8%)
35–44	80 (33.3%)
45–54	29 (12.1%)
55–64	6 (2.5%)
Education	
elementary school	30 (12.5%)
Middle school	62 (25.8%)
High school	114 (47.5%)
> high school	34 (14.2%)
Working status	
Working	48 (20%)
Unemployed	192 (80%)
Ethnicity	
Jakartan, Javanese	208 (86.7%)
Sumatran	26 (10.8%)
Other	6 (2.5%)

Note. IPV = Intimate Partner Violence.

Table 2IPV Help-Seeking Behavior ($N = 240$).

Would report IPV	
Would visit a PHC	26 (10.8%)
Would visit an Emergency Response Unit	3 (1.3%)
Would visit to service provider	20 (8.3%)
Would report to a policewoman's desk	24 (10.0%)
Would call a hotline service	3 (1.3%)
Would report, but did not specify to whom	7 (2.9%)
Total	83 (34.6%)
Would not report	
Would talk to family and friends	106 (44.2%)
Would remain quiet	32 (13.3%)
Would leave husband	4 (1.7%)
Would practice self defense	6 (2.5%)
Total	148 (61.7%)
Did not respond to question	9 (3.7%)

Note. IPV = Intimate Partner Violence; PHC = Primary Health Centers.

Table 3

Domestic Violence Initiative Screening Items by IPV Status, as Determined by Psychologists.

	Total (N = 240)	Women With IPV (n = 87)	Women Without IPV (n = 153)	p Value
Q1. Are you ever afraid of your partner? YES	70 (29.2%)	57 (65.5%)	13 (8.5%)	<.001
Q2. In the last year, has your partner hit, kicked, punched or otherwise hurt you? YES	21 (8.8%)	21 (24.1%)	0	<.001
Q3. In the last year, has your partner put you down, humiliated you, or tried to control in any way? YES	74 (30.8%)	74 (85.1%)	0	<.001
Q4. In the last year, has your partner threatened to hurt you physically or sexually? YES	26 (10.8%)	26 (29.9%)	0	<.001

Note. IPV = Intimate Partner Violence.

Table 4

Sensitivity and Specificity at Different Woman Abuse Screening Tool Cutoff Points.

	Number of Women With a WAST Score at the Cutoff or Higher	Sensitivity	Specificity	Positive Predictive Value
Cutoff point of 9	178 (74.2%)	91.9%	35.7%	44.3%
Cutoff point of 10	133 (55.4%)	84.9%	61.0%	54.9%
Cutoff point of 11	98 (40.8%)	75.6%	78.6%	66.4%
Cutoff point of 12	63 (26.3%)	58.1%	91.6%	79.4%
Cutoff point of 13	41 (17.1%)	41.9%	96.8%	88.3%

Note. WAST = Woman Abuse Screening.

Table 5
Correlations Among WAST and DVIS Scores and the Psychologist's Determination.

	IPV as Determined by Psychologist	WAST- Short	WAST- Long	WAST Total	DVIS Total
IPV as determined by psychologist	1.0000				
WAST-Short score (two items)	.410*	1.0000			
WAST-Long score (six items)	.556*	.561*	1.0000		
WAST Total score (eight items)	.564*	.799*	.946*	1.0000	
DVIS Total score (four items)	.811*	.460*	.639*	.645*	1.0000

Note. WAST = Woman Abuse Screening Tool; DVIS = Domestic Violence Initiative Screening; IPV = Intimate Partner Violence.

* $p < .001$.