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TRENDS

Dentists' attitudes and behaviors regarding domestic violence

The need for an effective response

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ABSTRACT

Background. The authors examined the attitudes and behaviors of a national sample of dentists regarding domestic violence and the barriers dentists face in intervening to help victims.

Methods. The authors surveyed a national random sample of 321 dentists by mail from November 1997 to March 1998 about their attitudes and clinical practice behaviors related to domestic violence. Survey items were developed based on the domestic violence and health care literature. The authors used the Total Design Method to maximize the response rate and analyzed data to determine differences between dentists who had received domestic violence education and those who had not.

Results. Eighty-seven percent of responding dentists never screened for domestic violence; 18 percent never screened even when patients had visible signs of trauma on their heads or necks. Overall, respondents intervened only minimally to help patients whom they had identified as victims. Respondents reported that the major barriers to screening were the presence of a partner or children (77 percent), lack of training (68 percent), concern about offending patients (66 percent) and their own embarrassment about bringing up the topic of abuse (51 percent). Respondents who had received domestic violence education were significantly more likely to screen for domestic violence and to intervene.

Conclusions. Dentists face many barriers to identifying and helping patients who are abuse victims, yet these data suggest that education about domestic violence could help them overcome some of these barriers.

Clinical Implications. We suggest that dentists follow the AVDR model when approaching abused patients in their practice: Ask about abuse, provide Validating messages, Document presenting signs and Refer victims to domestic violence specialists.

Domestic violence, historically considered a private problem between the victim and the batterer, recently has been recognized as one of our nation's most serious public health issues.[1-4] Although some men are abused, primarily by their male partners, the majority of partner violence is perpetrated by men against their female partners.[5] One study estimates that approximately 1.5 million women are raped, physically assaulted or both by an intimate partner in the United States annually[5]; another study estimates that two to four million women are abused by their partners each year—one every 12 seconds.[6] Women in the United States face a 20 to 30 percent lifetime risk of battery[7] and, contrary to commonly held beliefs, abuse happens to women of all ages, races, religions, income and education levels, and sexual orientations.[5,8,9]

Domestic violence has been recognized as one of our nation's most serious public health issues.

The health consequences of domestic violence are severe. It is the most common cause of serious injury to women and accounts for more than 50 percent of all female homicides.[6] In addition to traumatic injury, domestic violence can cause short- and long-term mental and physical health consequences.[10-12] Recognizing the public health consequences of domestic violence, the American Medical Association and the American College of Obstetricians and Gynecologists have called for physicians to act as agents of change in battered women's

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lives.[13,14] These organizations have put forth guidelines and mandates outlining how physicians should intervene with battered women; these guidelines include conducting routine screening, validating patients' experiences, assessing safety, developing safety plans, documenting the abuse, and referring to specially trained staff or outside resources.[14-16]

While efforts to improve physicians' responses to women who are domestic violence victims should be applauded, these efforts must be expanded to include oral health care professionals if as many victims as possible are to be reached. A 1998 national survey showed that 16.7 percent of women who sought health care for rape injuries visited dentists and that 9.2 percent of women who sought care for physical assault by an intimate partner saw a dentist.[5] In addition, researchers have found that 23 percent of head and neck injuries that were not caused by automobile accidents were a result of domestic violence and that 94 percent of domestic violence victims had head or neck injuries or both.[17] Another study showed that 68 percent of women who were battered by their partners suffered head and neck injuries, including lacerations, bruising and fractures.[18] The authors concluded that this type of trauma could be a "marker" for domestic violence. Given that oral health care professionals routinely assess patients' heads and necks, they have the opportunity to recognize that a woman is being abused and to intervene. In 1996, the American Dental Association enacted a policy to increase efforts to educate dental professionals on how to identify abuse and neglect of adults.[19]

Our data could support policy-making and educational efforts in domestic violence and dentistry, an area of intervention currently in its infancy.

Research on physicians' responses to domestic violence tells us that identifying women who are being abused can be difficult. Domestic violence victims' reluctance to disclose abuse to their physicians mainly is the result of shame, humiliation, fear of their partner's retaliation, denial about the seriousness of the abuse and concern about confidentiality.[20-23] The potential loss of confidentiality threatens patients' safety and their responsibilities to their families and raises economic concerns and fears about police interference.[21] However valid the reasons, patients' evasiveness and failure to disclose information is a major barrier to the identification of domestic violence, according to physicians.[24-26]

Physicians also are reluctant to broach the topic of abuse with patients. The most frequently reported barriers are lack of time to raise the issue, support resources, education or training; fear of offending the patient; and frustration with lack of change in the patient's situation or the patient's unresponsiveness to advice.[27-33] Primary care physicians in one study characterized talking about domestic violence with patients as "opening Pandora's box" and associated the act of even asking about abuse with unleashing their own fears and discomforts.[32] These physicians described feelings of powerlessness regarding their inability to "fix it" and a sense of loss of control over patients' decisions and outcomes.

While these and other studies have focused primarily on physicians' responses to domestic violence and the barriers they face, few studies have focused on dentists' responses to domestic violence victims. One study, which examined a sample of Oregon dentists' responses to suspecting spousal abuse, found that suspecting abuse rarely triggered any intervention.[34] A study of Colorado dentists found that although 30 percent of dentists had suspected at least one case of domestic violence, only 3 percent had ever reported a case to authorities.[35]

We wanted to examine the attitudes and behaviors of a national sample of dentists regarding domestic violence and to describe the barriers dentists face in intervening to help victims. In addition to encouraging further research, these data could support policy-making and educational efforts in domestic violence and dentistry, an area of intervention currently in its infancy.

METHODS

We conducted the study from November 1997 through March 1998. We selected a random sample of practicing general dentists from the American Dental Association's national list of members and nonmembers and mailed each of them a packet including a cover letter, information sheet and survey. We developed survey items based on the domestic violence and health care literature, and they covered participants' attitudes and clinical practice behaviors in four content areas related to domestic violence: screening and assessment; barriers to identification and

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referral; response behaviors, including presence of protocols; and domestic violence education. We also asked one question about the presence of written protocols for child abuse and included questions to assess participants' backgrounds, work settings and patient panel characteristics. The 60-item survey had been pilot-tested for face validity, ease of administration and readability. It took approximately 15 minutes for participants to complete.

To maximize the survey response rate, we followed the Total Design Method.[36] We sent postcards to people who did not return the survey within three weeks to remind them of the study and alert them that a new copy of the survey would be mailed to them shortly. The second mailing included a copy of the survey and a cover letter with a handwritten note requesting dentists' cooperation. After another three weeks, we sent nonrespondents a third cover letter and survey. Finally, we attempted to call nonrespondents to encourage them to complete the survey and return it by mail or facsimile; when convenient, some surveys were completed over the telephone.

We analyzed survey data using SAS statistical software (Version 7.0, SAS Inc.). We used the Fisher exact test and the Mann-Whitney test to compare dentists who had received domestic violence education with those who had not; we defined having received domestic violence education as having more than zero hours of professional education in the area of domestic violence in dental school or in continuing education within the last three years. We also compared dentists who graduated from dental school since 1980 with those who graduated earlier, and we used multivariate logistic regression to model the effects of this and domestic violence education simultaneously on the likelihood of intervention (ever vs. never). We did not receive enough responses to conduct multivariate analysis on the intervention of filing a police report.

RESULTS

We mailed 615 surveys, 22 of which were returned as undeliverable and 17 of which were returned with an indication that the dentist was retired. We received 321 completed surveys, yielding a response rate of 56 percent (321/576). The respondents' characteristics are presented in Table 1. Forty-three percent of the respondents had received some domestic violence education.

TABLE 1

RESPONDENTS' CHARACTERISTICS, N = 321.*

CHARACTERISTIC	PERCENTAGE (NUMBER)
Sex	
Male	91 (921)
Female	9 (28)
Age (Years)	
39 or younger	28 (89)
40-49	36 (114)
50-59	25 (81)
60 or older	12 (37)
Year of Graduation	
1969 or earlier	24 (78)
1970-79	33 (107)
1980-89	32 (102)
1990 and later	11 (34)
Race/Ethnicity	
American Indian	1 (3)
Asian American	5 (16)
Black	0 (1)
Hispanic	4 (11)
White	89 (280)
Mixed/Other	1 (3)
Practicing More Than 30 Hours Per Week	
Yes	87 (276)
No	13 (40)
Practice Setting	
Private practice, solo	73 (229)
Private practice, group	23 (72)
Other	4 (13)
Percentage of Child Patients	
0-25	60 (189)
26-50	34 (107)
51-100	6 (18)
Percentage of Uninsured Patients	
0-25	47 (150)
26-50	41 (130)
51-100	12 (37)
Domestic Violence Education	
In dental school and continuing education	9 (28)
In dental school only	20 (62)
In continuing education only	14 (43)
Not in dental school nor in continuing education	57 (173)
Would Like More Domestic Violence Education	
Yes	61 (192)
No	39 (124)

* Denominator varies owing to missing data.

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TABLE 2

RESPONDENTS' SCREENING BEHAVIORS, N = 321.*				
SCREENING BEHAVIOR	**OVERALL PERCENTAGE (NUMBER)**	**ANY DOMESTIC VIOLENCE EDUCATION PERCENTAGE (N)**	**NO DOMESTIC VIOLENCE EDUCATION PERCENTAGE (N)**	**MANN-WHITNEY *P* VALUE FOR ANY VS. NO DOMESTIC VIOLENCE EDUCATION**
Screened New Patients for Domestic Violence				
Never	87 (268)	77 (99)	95 (157)	
Sometimes	12 (36)	21 (27)	4 (7)	.0007
Often or always	2 (5)	2 (3)	1 (2)	
Screened for Domestic Violence at Checkups				
Never	85 (262)	72 (93)	94 (156)	
Sometimes	14 (43)	26 (33)	5 (9)	.0001
Often or always	1 (4)	2 (3)	1 (1)	
Screened for Domestic Violence When Multiple Injuries Present				
Never	19 (56)	10 (12)	26 (40)	
Sometimes	40 (116)	38 (48)	42 (64)	.0042
Often or always	41 (121)	52 (66)	32 (48)	
Screened for Domestic Violence When Injury to Head or Neck				
Never	18 (54)	8 (10)	27 (42)	
Sometimes	43 (126)	41 (51)	42 (65)	.0065
Often or always	39 (115)	51 (64)	31 (48)	

* Denominator varies owing to missing data.

The majority of respondents had not received any education related to domestic violence in dental school (71 percent) or in continuing education courses (77 percent). Sixty-one percent reported that they would like more training in this area. We found that year of graduation was strongly associated with having had domestic violence education, rising from 29 percent for those graduating before 1970 to 34 percent for those graduating 1970 through 1979, 53 percent for those graduating 1980 through 1989 and 79 percent for those graduating 1990 or later ($P < .0001$). Current age also was associated with having had domestic violence education, but less so than year of graduation.

Screening behaviors. Table 2 shows respondents' screening behaviors. Overall, 47 percent of the sample reported that they had suspected a patient to be a domestic violence victim, yet only a small minority of the respondents reported that they ever screened their patients for domestic violence at new patient visits (14 percent) or at periodic check-ups (15 percent). Screening behaviors increased when patients had signs of traumatic injuries associated with domestic violence (for example, injuries to the head or neck). Forty-one percent of respondents often or always screened for abuse in these cases, while 19 percent reported that they did not screen for domestic violence even when patients had visible signs of trauma. Although screening appeared to be more frequent among those who graduated since 1980, this did not seem to be an important predictor when we included it with domestic violence education in multivariate models of never vs. sometimes, often or always; education, however, did remain statistically significant.

Intervention responses to domestic violence victims. Of the 321 participants, 167 responded to the following statement: "Please answer the following questions based on your experience of what you did when you identified a patient as a victim of domestic violence." Participants who had not identified a battered patient in their practices were asked to skip to the next section. (We never directly asked dentists whether they had identified battered patients, and we cannot account for the fact that 167 dentists

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TABLE 3

RESPONDENTS' INTERVENTION RESPONSES TO IDENTIFIED DOMESTIC VIOLENCE VICTIMS, N = 167.*				
INTERVENTION BEHAVIOR	OVERALL PERCENTAGE (NUMBER)	ANY DOMESTIC VIOLENCE EDUCATION PERCENTAGE (NUMBER)	NO DOMESTIC VIOLENCE EDUCATION PERCENTAGE (NUMBER)	MANN-WHITNEY *P* VALUE FOR ANY VS. NO DOMESTIC VIOLENCE EDUCATION
Made a Note in the Chart and Observed Over Time				
Never	36 (58)	25 (18)	45 (38)	
Sometimes	40 (66)	44 (31)	39 (33)	.0057
Often or always	24 (39)	31 (22)	16 (14)	
Told Patient I Was Concerned About His or Her Safety				
Never	46 (75)	41 (29)	52 (44)	
Sometimes	32 (52)	24 (17)	37 (31)	.017
Often or always	22 (35)	34 (24)	11 (9)	
Filed a Police Report				
Never	90 (143)	88 (59)	92 (77)	
Sometimes	9 (14)	12 (8)	6 (5)	.50
Often or always	1 (2)	0 (0)	2 (2)	
Gave Information About Shelters or Victim Services				
Never	70 (114)	64 (44)	76 (65)	
Sometimes	22 (36)	22 (15)	21 (18)	.042
Often or always	7 (12)	14 (10)	2 (2)	
Facilitated Arrangements for Safety				
Never	87 (138)	82 (54)	92 (77)	
Sometimes	9 (14)	12 (8)	6 (5)	.073
Often or always	4 (6)	6 (4)	2 (2)	

* Denominator varies owing to missing data.

responded to this section compared with 150 who reported having "suspected" domestic violence.)

Table 3 presents participants' responses to patients whom they had identified as domestic violence victims. Overall, participants intervened only minimally to help patients whom they had identified as victims. The interventions most commonly reported by participants were making a note in patients' charts (64 percent) and expressing their concern about patients' safety (54 percent). Participants generally did not intervene further; only 29 percent offered referral sources, 13 percent arranged for patient safety, and 10 percent filed a police report. Ninety-four percent of participants reported that they did not have a written domestic violence protocol.

Participants with domestic violence education were more likely to make a note in the patient's chart (P = .0057, Mann-Whitney test), express concern for the patient's safety (P = .017), give referrals (P = .042) or arrange for a patient's safety (P = .073). Although more participants who had any domestic violence education than those who did not reported that they had ever filed a police report (12 percent vs. 8 percent), this comparison did not approach statistical significance (P = .5). In multivariate regression models that controlled for graduation since 1980, we found that domestic violence education reached a higher level of statistical significance than the P value shown for the univariate analyses. We did not observe this increased statistical significance in

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TABLE 4

BARRIERS TO IDENTIFYING AND HELPING DOMESTIC VIOLENCE VICTIMS, N = 321.*†

BARRIER	OVERALL PERCENTAGE (NUMBER)	ANY DOMESTIC VIOLENCE EDUCATION PERCENTAGE (NUMBER)	NO DOMESTIC VIOLENCE EDUCATION PERCENTAGE (NUMBER)	FISHER EXACT TEST *P* VALUE (2-TAILED)
Patient Accompanied by Partner or Children	77 (244)	82 (107)	74 (125)	.13
Lack Training in Identifying Domestic Violence	68 (212)	56 (73)	75 (126)	.0012
Concerned About Offending Patient	66 (207)	66 (87)	66 (111)	1.0
Patients' Cultural Norms and Customs	53 (165)	53 (70)	54 (90)	1.0
Embarrassed to Bring Up Domestic Violence	51 (160)	49 (64)	54 (91)	.41
Do Not Have a List of Referral Agencies	41 (127)	37 (48)	43 (73)	.34
Do Not Have Enough Time to Raise the Issue of Domestic Violence	36 (111)	35 (45)	38 (63)	.63
Mandatory Reporting Requirement	31 (93)	28 (35)	34 (56)	.25
Believe Patient Would Not Follow Up on Referral	29 (90)	31 (40)	29 (48)	.70
Believe Domestic Violence Is Not My Business	23 (71)	19 (24)	27 (45)	.13
Patient Is on Welfare	11 (33)	10 (13)	11 (19)	.71

* Respondent rated this item a major or minor deterrent to identification and referral.
† Denominator varies owing to missing data.

the case of expressing concern for the patient's safety ($P = .35$). In contrast, when controlling for domestic violence education, we found that graduation since 1980 tended to be associated weakly with less intervention (P values from .076 through .17), with the exception of expressing concern for the patient's safety ($P = .31$).

Barriers to identification and referral. Table 4 shows barriers to identifying patients as domestic violence victims and to offering these patients referrals. Respondents marked an average of 4.7 out of 11 barriers as a "major deterrent" or "minor deterrent" (median 5, range 0-11). The barriers most commonly reported were that the patient was accompanied by a partner or children (77 percent), lack of training in identifying domestic violence (68 percent) and being concerned about offending the patient (66 percent). Fifty-three percent reported that the patients' cultural norms and customs were barriers to discussing domestic violence, and 51 percent said they were embarrassed to bring up the topic of domestic violence. Forty-one percent of participants reported that they did not have a list of

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referral agencies, 36 percent reported that they did not have enough time to raise the issue of domestic violence, and 29 percent said they believed that patients would not follow up on referral recommendations.

We found that domestic violence education was not associated with statistically significant differences regarding these barriers, except in the case of lack of training, which was marked by more respondents who did not have domestic violence education (75 percent) than by those who had such education (56 percent). The latter, however, still marked lack of training as a deterrent, indicating that they felt they needed more training. These findings are not surprising, as by definition only one hour of education was required to meet these criteria. Although 19 percent of participants with domestic violence education reported that they did not believe that domestic violence was their business, compared with 27 percent of those who did not have domestic violence education, this did not reach statistical significance ($P = .13$).

The most hopeful finding from this study was that domestic violence education increased the likelihood that dentists would screen for abuse.

DISCUSSION

As domestic violence gains recognition as a public health issue, there is an increasing awareness that dentists, in addition to physicians, have an opportunity—and a legal and ethical obligation—to identify and make the appropriate referrals for patients who are partner-abuse victims.[20,37-40] Although reports show that the majority of victims sustain head and neck injuries,[17,18] few dentists recognize domestic violence as a problem that their patients encounter and fewer have protocols in place to facilitate intervention.[34,35,40]

The dentists surveyed in this study reported barriers to asking about abuse similar to those reported by physicians.[27-33] Yet, even those dentists who were able to query and identify victims in their practices were not prepared to intervene effectively. Many respondents reported that they sometimes, often or always noted the abuse in patients' charts and showed concern, but most did not offer referrals or arrange for patients' safety—both crucial steps in intervening. Many said that they lacked knowledge about where to refer victims in the community or did not have protocols for handling domestic violence. Contrary to reports that dentists know more about and have an easier time intervening with child abuse than spousal abuse,[34,35] protocols for child abuse intervention were no more common than domestic violence protocols. Surprisingly, only 22 percent of those respondents who reported that more than one-half of their patients were younger than 18 years of age (n = 18) had a child abuse protocol in place. Given the strong link between spousal abuse and child abuse,[41,42] methods for intervening in each area could help women and their children.

Because there are extensive barriers to screening in oral health care settings, we do not recommend universal screening for domestic violence. Dentists must be enabled, however, to recognize and respond appropriately to signs of abuse.[17] The most hopeful finding from this study was that domestic violence education—even with our low criteria of one or more hours—increased the likelihood that dentists would screen for abuse. This supports the efforts of the American Dental Association to expand domestic violence education programs for dentists.[19] To address the barriers uncovered in this study, we believe this type of education needs to be standardized and incorporated into dental school and continuing education curricula, thus "normalizing" intervention with victims and making it a standard part of a dentist's professional responsibility. We also believe that domestic violence education should target specific intervention behaviors, offering dentists a feasible role aligned with their scope of practice.

AVDR model. One intervention model suggested by a team of researchers and educators is AVDR.[43] We believe that dentists could successfully follow this model when domestic violence victims appear in their offices. AVDR limits the providers' tasks to the following four areas: Asking patients about abuse; providing Validating messages acknowledging that battering is wrong and confirming the patient's worth; Documenting presenting signs, symptoms and disclosures in writing and with photographs (for example, radiographs or instant photographs); and Referring victims to domestic violence specialists in the community. This approach would standardize dentists' intervention behaviors and leave the majority of follow-up in the hands of domestic violence advocates.

Asking. Experienced providers and advocates

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recommend that health care professionals always ask about abuse in a private, confidential setting. For most dentists, this could occur in the examination room. Providers never should ask family members to translate if domestic violence is suspected and always should use nonjudgmental tones and wording when asking patients about abuse. Although many health care professionals, including the dentists in this study, report being concerned about offending patients or about risks involved in intervening with victims, research does not support these concerns; in fact, survivors and primary care patients report that they want their providers to ask about abuse.[44-46] Individual dentists need to develop their own words and styles for asking patients about abuse. One opening statement could be, "How are things at home?" The dentist then could follow up by saying, for example, "Sometimes when I see bruises like this, it means the person is being hurt by someone they love. Is this happening to you? Has this ever happened to you?"

Validating. Dentists should remember that women who are being controlled through abuse may be in denial or feel too ashamed or afraid to talk about the abuse.[20-23] They also should remember that compassionate asking in and of itself, rather than gaining direct disclosure, constitutes success. Survivors have reported that regardless of whether they had directly disclosed abuse or the health care professional had directly identified the abuse, validation helped them.[46]

When asking about abuse, dentists need to provide validating messages that show compassion and take the blame off the victim, such as, "You do not deserve to be hit or hurt no matter what happened," and, "I am concerned about your safety and well-being." In a recent study, domestic violence survivors described how validation from a provider not only provided "relief" and "comfort" but also "started the wheels turning" toward realizing the seriousness of their situation and changing it.[46]

Documenting. Physicians for a Violence-Free Society[47] recommends that charting be specific and detailed and that providers ask patients for specific names, locations and witnesses. The victim's direct words should be denoted with quotation marks, as direct quotes carry more weight than provider summary statements. The provider may need to complete body maps and take photographs or radiographs to document specific injuries. These are useful records of the abuse.

Referring. The last major step in the intervention is to refer battered patients to community advocates. Even if victims refuse referrals, repeatedly offering referrals or making them available helps survivors feel like they are not alone and that, when they are ready to seek support, it is available. Domestic violence advocates are prepared and have the skills and time to adequately address the complex psychosocial ramifications of domestic violence. We believe that expecting dentists to develop these skills is not only impractical but also unreasonable.

CONCLUSION

Oral health care professionals could play a vital role in helping patients who are being controlled by their partners through abuse. We encourage education that teaches these professionals the AVDR model; however, even a simplified response will not ease all the difficulty attached to this complex, stigmatized social problem. Dentists should remember that, according to survivors, any compassionate response from health care professionals helps alleviate their shame and break through denial.[46] We encourage dental professionals to seize the opportunity to make a difference in many patients' lives. ■

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