

ORIGINAL ARTICLE

Barriers to Screening for Domestic Violence Among Public Health Nurses :
A Descriptive Study

Farbood F^{*a}, Adelman T^b, Mckinnon T^c



Farbood F

A San Jose State, University (SJSU) alumnus.

b Associate Professor, The Valley Foundation School of Nursing at San Jose State, University (SJSU)

c Lecturer, The Valley Foundation School of Nursing at San Jose State University (SJSU)

ABSTRACT

Background: Domestic violence is a public health issue and public health nurses are in the best position to track it, provided they can overcome certain screening barriers. This study aimed to identify the main barriers public health nurses face while screening patients for domestic abuse.

Methods: A quantitative, descriptive survey was distributed to public health nurses stationed in three regional public health offices in a large, urban county in Northern California. Thirty-two nurses responded to the survey. Pender's Health Promotion Model was utilized as a theoretical framework to test and improve nurses' screening skills by identifying perceived barriers to action and by assessing situational influences.

Results: The study results showed three main identified barriers among public health nurses to be a lack of privacy, negative feelings and attitudes regarding screening, and a lack of time.

Conclusion: By providing in-service training, educational materials, and accessible computer applications, public health departments can help nurses overcome these barriers.

Keywords: Barriers; Domestic Violence; Public Health Nurses; Screening

***Corresponding Author**

C/O Dr. Toby Adelman, The Valley Foundation School of Nursing, One Washington Square- San Jose, CA, 95192-0057, U.S.A. e-mail: fataneh.farbood@gmail.com

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Introduction

Intimate partner, or domestic, violence is defined as physical, sexual, or psychological threats or harm inflicted by a current or former partner or spouse (National Centre for Injury Prevention and Control, 2003). Domestic violence causes about two million injuries per year in the United States (NCIPC, 2003). According to the first ever World Health Organization (WHO) study on domestic violence, intimate partner abuse can significantly affect women's lives and women are more likely to suffer violence within rather than outside their homes (WHO, 2005). Domestic violence has enormous effects on women's physical and mental health; therefore, WHO researchers have asked health care providers to treat domestic violence as a major public health issue. As nurses are often the first point of contact for survivors of domestic violence, they need to be well prepared to identify, manage, and prevent this major health problem. Unfortunately, they have not yet achieved enough success in this endeavor. A number of barriers still exist that prevent them from effectively screening their patients for domestic violence.

Background / Literature Review

The purpose of this section is to review studies that have been done to identify obstacles that prevent nurses from reporting cases of domestic violence. A variety of barriers have been cited either by nurses or by researchers. One of the most common barriers is a lack of knowledge.

In 2009, Natan and Rais conducted a study to assess the knowledge, attitudes, and workplace routines of Israeli nurses and to determine how these factors correlate with their ability to identify cases of domestic violence. The sample group consisted of 100 hospital and community nurses within the age range of 22-64. Nine percent of them were male and ninety-one percent were female. In terms of education, 30% of the participants were registered nurses, 55% had bachelor's degrees in nursing, and 13% had master's degrees in nursing. The participants had to answer a questionnaire created to identify barriers to screening for domestic violence, and which contained demographic and professional questions. The study showed a positive correlation between nurses' knowledge and their attitudes toward identifying domestic violence.

On the other hand, in spite of the fact that American nursing students receive education regarding screening for domestic violence, researchers have noted some inconsistencies between their knowledge and attitudes and their screening behaviour. In 2009, Johnson, Klingbeil, Melzer- Lange, and Humphrey suggested that an effective curricular program on preventing domestic violence might fill this gap and promote self-efficacy and the ability of nurses to better perform their screening role. Participants in that study included 68 paediatric nurses at a children's hospital in Wisconsin. Ninety-six percent of the respondents were female and four percent were male. Their ages ranged between 18 and 50, and approximately 94% of them were white. The Intimate Partner Violence Questionnaire, a 24 - item questionnaire, was administered before, directly after, and three months following their training. A factor analysis on the baseline of the self-efficacy questionnaire was then completed. Results suggested nurses' fear factor had been significantly decreased after participation in the training program ($P = .0176$). Like Natan and Rais' study, Johnson and colleagues (2009) could not check nurses' practical ability to perform screening for potential victims of domestic violence, especially after the training program, and listed this as a limitation of their study. This was due to missing data in the post screening and later in the three-month follow-up screening for behaviour measurements. In the end, the report implied that, regardless of the necessity of education, actual practice is needed to develop the belief that a nurse can be effective in his or her screening role.

There are also other reasons cited by nurses for the lack of proper screening. Ellis (1999) looked for factors that hinder emergency room nurses from identifying cases of domestic violence. Participants in this quantitative survey included 40 female RNs aged 20-59 years, 60% of whom had 10-19 years of job experience in nursing. The nurses were given a thirty- item questionnaire that contained specific questions about practices and barriers to screening for domestic violence. The research findings identified three main barriers nurses face in screening patients: 1) lack of privacy in the health care setting; 2) lack of enough time to screen patients for domestic violence; and, 3) not knowing how to ask patients about domestic violence.

Similar to Ellis (1999), Yonaka, Yoder, Darrow, and Sherck (2010) noted the importance of how to ask questions about abuse in the emergency depart-

ment. They aimed to find out what barriers may affect nurses' ability to ask about domestic violence. In a quantitative study in 2010, Yonaka and colleagues administered a twenty-five item questionnaire to 33 RNs aged 20-60, primarily females who worked in emergency rooms. Forty-nine percent of participants were white and 51% were either Filipino or of other ethnicities. The study suggested that the highest ranking barrier to screening for domestic violence was the language barrier. Other barriers included a personal family history of abuse and a lack of training. Also, as in Ellis' study, time limitation was reported as a barrier to screening for domestic violence.

In another study, Smith, Rainey, Smith, Almare, and Grogg (2008) researched the effect of education on domestic violence. A sixteen-item questionnaire was mailed to 1000 RNs. Of 184 respondents, 176 were female, 68% had bachelors' degrees, and 75% were Caucasian. Among these nurses, 73 (39.7%) said that they had reported abuse in the past. Of these 73 respondents who reported abuse among their patients, 44.8% cited personal experience of abuse, themselves. In contrast to Yonaka's study, Smith's did not consider a nurse's personal experience of abuse as a barrier to screening for domestic violence. On the contrary, the study suggested nurses with personal experience of domestic abuse might be better advocates for victims. The study also insisted on the importance of multi-disciplinary training in combating domestic violence.

Isaac and Pualani (2001), in a qualitative study, assessed medical records of 86 women who made 772 visits to obtain care from practitioners of various disciplines (physicians, nurses, psychologists, etc.) due to domestic violence. The records showed lack of proper documentation in terms of picture taking, body mapping, as well as nurse and/or physician notes and reports. Due to the increasing number of domestic violence cases, these researchers suggested developing a protocol to try to improve the way domestic violence is documented.

Research Question

Although the reviewed articles support the importance of training and education in increasing the ability of nurses to identify and report cases of domestic violence, they acknowledge other barriers to this approach. These barriers differ depending on the setting in which domestic violence is screened for. Recent studies have focused on emergency departments, paediatric

hospitals, and general hospitals, yet the public health setting is another area that needs to be investigated for these obstacles. Due to the nature of public health services, which assist families in minimizing disabilities and maximizing positive lifestyles and habits, public health nurses can play an enormous role in tracking cases of domestic violence as long as they can overcome their screening barriers. Therefore, the aim of this study was to answer the following question: What are the main barriers public health nurses, who work in perinatal services, face in screening patients for domestic violence?

Conceptual Framework

Pender's Health Promotion Model provides a method to assess patients in order to promote a healthier pattern of behaviour. To achieve its goal, Pender's model guides nurses in evaluating patients for prior related behaviour such as perceived self-efficacy, perceived barriers to action, perceived benefits of action, and activity-related effect. Also, the model assesses interpersonal and situational influences relevant to the selected health behaviour (Peterson & Bredow, 2009). Pender's model can also be used as a framework to promote nurses' behaviour by identifying perceived barriers to action and by assessing situational influences that might affect nurses' behaviour.

Methodology

Design

The research design for this study was a descriptive, cross-sectional, quantitative survey. The study tool utilized an anonymous questionnaire that asked public health nurses working in three regional public health offices in Northern California about their perceived barriers to screening for domestic violence.

Sample / Setting

A convenience sample of 32 public health nurses employed in perinatal services in three regional public health offices in Northern California were invited to participate in this research study.

Data Collection

After contacting one of the supervisors of a large public health department in Northern California and receiving IRB permission to conduct the research, the questionnaire was administered to the sample popu-

lation during one of their team meetings. Participants were briefed on how to complete the study questionnaire and informed of the purpose of the research, the anonymity of the questionnaire, and the confidentiality of their information.

Instrumentation

Barriers to domestic violence were assessed with a questionnaire originally used in a study by Moore, Zaccaro, and Parsons (1998) when looking at specific behaviours as barriers to screening for domestic violence. In 1999, Ellis adapted this tool for her study on barriers to screening for domestic violence among emergency room nurses. After the adaptation, the questionnaire was tested for validity. In addition, it was checked for reliability by distributing it among 19 registered nurses in a rural community hospital (Critical Care Nursing Quarterly, 1999). Permission for use of the adapted questionnaire was obtained from the owner.

This questionnaire consisted of 29 items, and took approximately ten minutes to complete. Five of the questions asked for demographic information such as gender, age, degree, years in nursing, and years in public health nursing. There were fourteen questions regarding barriers to screening for domestic violence that were to be answered with a “yes” or “no” response. Participants could also indicate an extra “other” option to report barriers that had not been cited. There were five questions related to the level of preparedness of nurses to intervene in screening. To answer these questions, participants could select their answers among three options: “prepared”, “somewhat prepared”, and “not prepared”. Lastly, there were four optional questions asking for any personal experience with domestic violence, and one extra question that asked nurses for ideas for further improvement in screening skills.

Operational Definition

Domestic violence is defined as physical, sexual, or psychological threats or harm inflicted by a current or former partner or spouse (National Centre for Injury Prevention and Control, 2003). A public health nurse is a nurse with a baccalaureate degree and training in public health nursing theory and practice. A barrier is an obstacle that prevents communication. Screening is defined as identifying health risks or problems by means of taking history, examining the patient, and using other procedures. The research tool is an anonymous questionnaire containing closed and open-ended questions.

Data Analysis

Data analysis was performed by using the Statistical Package for Social Sciences (SPSS) Version20. Descriptive statistics were used to represent demographic characteristics of the sample population.

Results

Table 1. Demographics of Respondents (n=32)

Characteristics	Number
Gender	
Female	30
Male	02
Age (yr)	
20-29	01
30-39	09
40-49	08
50-59	06
≥60	03
Years in Nursing	
1-9	06
10-19	18
20-29	06
≥30	02
Years in Public Health Nursing	
1-9	14
10-19	17
≥20	01
Level of Education	
Bachelor	21
Master	11

Among the 32 public health nurses who completed the study questionnaire, 30 (94%) were female and two (6%) were male. Their ages ranged between 25 and 67-years-old, with a mean of 39 years of age. Twenty-six (81%) of the respondents had more than ten years of nursing experience and fifty-six percent had more than ten years of job experience in public health nursing. In terms of educational background, twenty-one nurses (65.6%) had bachelor’s degrees, and eleven (34.4%) had master’s degrees. Unfortunately, due to the small sample size (n=32), no relationships between years in nursing, years in public health nursing, and level of education, could be detected.

Among thirteen identified barriers, the four highest self-ranked barriers were: 1) a lack of privacy for screening in the health care setting, 2) feelings that the woman would end up staying in the abusive relationship anyway, 3) not being able to fix the problem, and 4) feeling uncomfortable asking the patient. Seven participants responded to the question about other barriers that nurses might perceive during screening. Two of the

respondents cited family and husband's presence as barriers, two mentioned language and cultural barriers, and the remaining three cited either a lack of available referral resources, a patient's discomfort, or a patient's fear of not being able to get their children back from Child Protection Services (CPS).

Table 2. Identified barriers (n=32)

Barriers	Fre-quency	Per-cent
There is a lack of privacy for screening in my health care setting.	11	34.4%
I feel women will end up staying with the abuser anyway.	7	21.9%
I can't fix the problem anyway.	6	19.4%
I feel uncomfortable asking.	5	15.6%
I am afraid of offending the patient.	4	12.5%
I don't know how to get the woman alone to ask the questions.	4	12.5%
I don't have enough time to ask about domestic violence.	3	9.4%
I don't know how to ask about domestic violence.	1	3.1%
I don't know what to do if the answer is yes.	1	3.1%

Table3. Level of Intervention Preparation (n=32)

Interventions	Pre-pared	Some what Pre-pared	Not Pre-pared
Make appropriate referrals for victims of domestic violence.	71.9%	25.0%	3.1%
Provide support to a woman who discloses domestic violence.	71.9%	21.9%	6.2%
Ask routine questions about domestic violence.	84.4%	9.4%	6.2%
Identify warning signs of abuse.	84.4%	12.5%	3.1%
Inform a battered woman about their legal options.	46.9%	40.6%	12.5%

A nurse's ability to intervene with victims of domestic violence was measured by a series of questions. As Table 3 illustrates, more than half of the participants (53.1%) were either not prepared or were somewhat prepared to inform a battered woman about her legal options. All respondents but two (n=30) answered the optional questions about personal experience of abuse. Half of the respondents (50%) knew someone who had been abused. The last question regarding further suggestions to improve screening skills was answered by six participants. Their suggestions included: additional training, attending seminars and workshops for domestic violence, training regarding referral re-

sources, developing a screening form specific to domestic violence, discussing the issue of domestic violence with all clients on their first home visit, and tailoring questions based on each patient's unique situation.

Table4.Response to Optional Questions (n=30)

Question	Fre-quency	Per-cent
Have you, a family member, or a friend experienced abuse?	15	50.0%
If yes who experienced abuse?		
myself	3	10.0%
parent	3	10.0%
Spouse/partner	0	0%
friend	5	16.7%
other	4	13.3%
Has anyone hit, kicked or punched you?	5	16.7%
Are you currently being hit, kicked or punched?	0	0%

Limitations

Limitations of this study included the small sample size (n=32) and utilization of a convenience sample. In addition, results may not be representative of the population as a whole. Some of the respondents did not answer all of questions, resulting in some missing values.

Discussion

Pender's Health Promotion Model may be used as a framework to improve nurses' screening skills by identifying perceived barriers to action and by assessing situational influences that might affect their behaviour and beliefs. This study's results were similar to those of past studies; the most cited barrier to screening for domestic violence being a perceived lack of privacy. Eleven (34.4%) respondents stated they did not have enough privacy, and four (12.5%) said they did not know how to find a private setting in which to question the patient. To solve this problem, nurses should be more autonomous, and they need to look for new screening strategies that can assist them to remove this situational barrier. In fall 2012, Phyllis Sharp, PhD, RN and Linda Bullock, PhD, RN started to examine the use of tablet computers in screening at-risk pregnant women for partner abuse. Nurse researchers expect that the use of computer tablets with special applications will increase the number of cases of identified domestic abuse.

The second perceived barrier to action was nurses' feelings and attitudes toward screening their patients. Negative feelings reported included the feeling that the patient will end up staying with her abuser, a perceived inability to fix the problem, feeling uncomfortable asking the patient, and being afraid of offending the patient. These negative feelings and attitudes can be categorized into two parts; one part is related to nurses' negative perception about the outcome of their screening job, and the other part is related to perceived poor self-efficacy. Past research from literature reviews showed nurses' feelings of low self-efficacy could be decreased by holding in-service teaching programs. These programs need to be focused on teaching nurses more effective communication skills and on helping them better interact with sensitive subjects. Teaching strategies such as role playing and creating situational scenarios may also assist nurses in overcoming this barrier.

Knowing how to inquire about domestic violence can be considered a benefit to action. Despite past studies, almost 94% of the nurses in this study indicated that they are either prepared or somewhat prepared to ask routine questions about domestic violence. Participant demographic information such as educational degree, years in nursing, and years in public health nursing also support nurses' preparedness to ask routine questions and to make appropriate referrals. Approximately half of the participants had personal experience of abuse. In terms of informing battered women about their legal options, however, only 46.9% of the respondents said that they are prepared for this task. This lack of knowledge regarding patients' rights appears to lead to a feeling of inadequacy in helping them. Educating nurses about patients' legal options and rights can affect their screening outcomes. It may also motivate nurses to develop a positive sense of self-efficacy.

The third main perceived barrier to action reported was lack of time. To solve this challenge, nurses need to be more creative. For example, they can ask follow-up questions about domestic violence during medical examinations, and at that time, make appropriate referrals to community-based organizations as an effective way to advocate for their patients' safety.

Conclusion

As domestic violence is a public health issue, it is important for public health departments and agencies to empower nurses working in this area to overcome barriers to screening for domestic violence. Public

health nurses can be supported by their departments by being provided with in-service training classes, educational materials, and accessible computer applications. In addition, collaborative work among public health departments, interdisciplinary university institutions, and the judiciary system can help empower public health nurses in tracking cases of domestic abuse.

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SCREENING FOR DOMESTIC VIOLENCE QUESTIONNAIRE

Background information

__ Gender: 1: Female 2: Male

__ Your age:

__ Years in Nursing 1: 1-9 2: 10-19 3: 20-29

__ Years in Public Health Nursing 1: 1-9 2: 10-19

__ Level of Education 1: Diploma 2: Associate 3: Bachelor 4: Master

Questions about identified barriers

__ There is a lack of privacy for screening in my healthcare setting. 1: Yes 2: No

__ I don't have enough time to ask about domestic violence. 1: Yes 2: No

__ I don't know how to ask about domestic violence. 1: Yes 2: No

__ I don't know how to get the woman alone to ask the questions. 1: Yes 2: No

__ I feel uncomfortable asking. 1: Yes 2: No

__ I am afraid of offending the patient. 1: Yes 2: No

__ I don't know what to do if the answer is "yes." 1: Yes 2: No

__ I don't know enough about the issue of domestic violence. 1: Yes 2: No

__ I can't fix the problem anyway. 1: Yes 2: No

__ I feel the woman will end up staying with the abuser anyway. 1: Yes 2: No

__ I don't feel I have support from nursing management. 1: Yes 2: No

__ I don't feel it is really my job to screen. 1: Yes 2: No

__ I don't feel the screening box is conveniently located 1: Yes 2: No

__ (Other) please cite barriers not listed:

Questions about intervention preparation

Please **circle** selected number.

1= prepared 2=somewhat prepared 3=not prepared

<input type="checkbox"/> Make appropriate referrals for victims of domestic violence.	1	2	3
<input type="checkbox"/> Provide support to a woman who discloses domestic violence.	1	2	3
<input type="checkbox"/> Ask routine questions about domestic violence.	1	2	3
<input type="checkbox"/> Identify warning signs of abuse.	1	2	3
<input type="checkbox"/> Inform a battered woman about their legal options.	1	2	3

Optional Questions

Have you, a family member, or friend experienced abuse?

If yes, who experienced abuse? 1: myself 2: parent 3: spouse/partner 4: friend

5: other

Has anyone hit kicked or punched you?

Are you currently being hit, kicked or punched?

Do you have any suggestion for further improvement in screening skills?