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Screening for Domestic Violence: Performance and Barriers

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Abstract

Domestic violence is a major medical and sociological problem for women. The purpose of this study was to describe the incidence of and barriers to domestic violence screening by health care providers in one urban county in northern California.

A convenience sample of 71 physicians and nurse practitioners with specialties in family practice, OB/GYN, and internal medicine provided the data. Descriptive statistics were used to analyze the results of responses to a questionnaire.

The majority of the providers agreed that screening for domestic violence was appropriate and reported being comfortable with the subject. However, the majority did not address the subject directly or indirectly with female patients, and many underestimated the incidence of domestic violence. Among the identified barriers were inadequate time, difficulty in solving the problem, and discomfort in asking. It was concluded that efforts must be made to overcome barriers and educational programs developed to enhance knowledge. It is recommended that this study be replicated with a larger sample size and target more than one county in Northern California.

Introduction

October is designated as National Domestic Violence Awareness month and Breast Cancer Awareness month. Both domestic violence and breast cancer are seen as major medical problems with the greatest incidence occurring among women. There is, however, a difference in the approach to prevention and treatment of these two diseases. Although listed in Healthy People 2000 (United States Department of Health and Human Services, 1992) as a health problem, domestic violence is often not addressed in the clinical primary health care setting with women, whereas breast cancer is inquired about in most health histories. The enormity of the issue of domestic violence against women leads to a concern: How are primary health care providers' involved in screening or inquiry related to this health problem?

It is important to the community as a whole to understand the issues that face health care providers as they deal with the effects of violence on their female patients. Screening for present or past abuse may not be a usual practice because of real or perceived barriers. These barriers, if known by the community, can be evaluated. Procedures, programs, inservices, and other educational methods can then be instituted by the community to assist primary health care providers in removing the obstacles leading to the disclosure and treatment of domestic violence.

Domestic violence is seen as a major societal problem in Santa Clara County, as noted in the Public Health Report 1997. A violence prevention program has been instituted by the Public Health Department to help eliminate the problem. Physically and emotionally injured women seek health care providers for relief and cure of their abuse-related medical problems. Even though the medical community is only one part of this

county's health care system, on the issue of domestic violence, it is one of the first groups that comes in contact with the problem through treatment of female patients. What better way to serve the female patient population than to detect, acknowledge, and address the medical and societal problem of domestic violence?

The purpose of this study was to quantify the incidence of screening women for domestic violence on a routine basis and to identify barriers to screening, in the primary health care setting. Domestic violence is one major medical health problem that faces women of all ages. If screening is not occurring by their primary health care provider, there is a lack of a first line defense against this growing health concern.

Background

Domestic violence has increased substantially within the past three decades in the United States, and women are the most frequent victims of domestic violence (Quillian, 1996). According to Healthy People 2000 (United States Department of Health and Human Services, 1992), between two and four million women are physically battered each year by partners including husbands, former husbands, boyfriends, and lovers. An estimated 21% to 30% of all women in the United States have been beaten by a partner at least once. In a recent study, Abbott, Johnson, Koziol-McLain, and Lowenstein (1995) report that the cumulative lifetime prevalence of domestic violence exposure was 54.2%. McCauley et al. (1995) note that in a large, diverse, community population, 1 of every 20 women had experienced domestic violence in the previous year, 1 of every 5 had experienced violence in their adult life, and 1 of every 3 had experienced violence either as a child or as an adult.

The American Medical Association began a campaign against family violence in 1991, making diagnosis and prevention of family violence one of its top public health priorities. The problem remains immense and, although much of societal violence lies outside medical practice, there remains a major role, if not a responsibility, for all physicians to intervene where violence is causing physical and emotional injuries to patients (McAfee, 1995). Health care providers are the first points of contact for the largest number of women on a continuum of violence that often begins with emotional abuse manifesting as stress and stress-related illnesses, and later culminates in physical injuries or death (Verhoek-Oftedahl, Lindenmayer, & Perez, 1996). According to Poirier (1997), primary care providers can increase the detection of potential and ongoing abuse and intervene before the patient becomes just another statistic. Poirier recommends universal screening and education of all women, not just those who present with symptoms of abuse or fit the stereotypical picture of an abused woman. Screening tests are used to identify persons with clinically significant and serious common medical disorders for which an intervention can improve the outcome (Chescheir, 1996). The physician should learn the dynamics of domestic violence, common associated injury patterns, and the social and legal resources available. Screening and treatment protocols should be developed, and informative literature placed in women's restrooms and waiting rooms (McCoy, 1996).

Although the literature is replete with statistics regarding the extent of domestic violence against women and screening is recommended by many medical advisors, there are few studies regarding the frequency of primary health care providers addressing the issue. Hamberger, Saunders, and Hovey (1992) found that practicing physicians

demonstrate low rates of inquiry about domestic violence with their patients. Their health care provider asked only 6 of 364 women surveyed who had sought care about abuse. In the study by Abbott et al. (1995), only 6 (13%) of 47 women who had experienced acute domestic violence said they had been asked about domestic violence or had told the health care provider about domestic violence. The investigators state that without active screening, only 10% of domestic violence victims will be identified. Although 76% of the providers surveyed by Molliconi & Runyan (1996) indicated that they believed identification of abuse is an appropriate activity for health care providers, on an average their respondents asked fewer than 1 in 13 about the possibility of abuse. The stated belief of 73% of these providers was that fewer than 10% of their female patients had experienced any abuse during the past year. Grisso, Schwarz, Miles, and Holmes (1996) found few data recorded in the medical records about the circumstances of violent injuries. They felt this gap might indicate that few clinicians asked detailed questions about even those incidents that were reported to be a result of violence. Sassetti (1993) states that women are routinely screened for breast cancer, thyroid problems, hypertension, and colon cancer. However screening is nearly nonexistent for domestic violence, which is as common as breast cancer.

The literature does provide some solutions to this issue. The addition of a single question about domestic violence to a self-administered health history form increased identification of this common problem from 0% to 11.6% (Freund, Bak, & Blackhall, 1996). This was a lower rate than expected, and they attributed it to the written questionnaire. Pennsylvania triage nurses found that simply by asking about the history of abuse, they increased their identification of domestic violence victims by 60% (Buel,

1995). Jones (1993) reported that prior to making inquiry about abuse a routine, only a few cases per year were identified. Now by asking directly, the author finds two or three cases per week. McAfee (1995) stated that 85% of Americans believed they would tell a physician if they had been either a perpetrator or a victim of domestic violence, suggesting that physicians may not be adequately screening for domestic violence. Battered women expect health care providers to initiate discussion about abuse (Delahunta, 1995). Bolin and Elliott (1996) studied the effect of physicians wearing buttons saying "It's OK to talk to me about family violence and abuse." They found that wearing the buttons increased conversations about family violence and made physicians more consistent in talking about violence with patients.

Despite widespread recognition of domestic violence as a public health problem, many clinicians have difficulty integrating routine inquiry about domestic violence into their day-to-day practice (Friedman, Samet, Roberts, Hulin, & Hans, 1992). To explore the reasons why, Sugg and Inui (1992) interviewed 38 physicians, mostly family practitioners, to determine the barriers to recognition and intervention with domestic violence victims. One finding indicated that physicians found exploring domestic violence analogous to "opening Pandora's box." (p. 3158). Alpert (1995) discussed the following obstacles to working effectively in the care of battered patients. First is the fantasy of the perfect family. "It is often difficult to acknowledge the possibility of abuse in persons who are so much 'like us.' " (p.779). Another obstacle is the provider's previous experience with abuse. Also cited as barriers to screening in this study were fears of offending patients, time constraints, powerlessness in efforts to help, and lack of education on the subject.

Neufeld (1996) reports that physicians need to know about the problem of domestic violence. They also need to examine their attitudes about the issue and obtain the skill to identify and treat victims. This clinician suggested using the SAFE questions. The SAFE questions address four areas when interviewing a patient: stress/safety, afraid/abused, friends/family, and emergency plan. Gremillion and Kanof (1996) concluded that undergraduate and graduate training programs incorporate the clinical and economic dimensions of domestic violence. Society, professional schools, and health care providers must address the barriers that impede response. These barriers are not insurmountable. Rosenberg, Fenley, Johnson, and Short (1997) suggest that incorporating public health principles into medical education and medical practice not only can reduce the severity of this epidemic by strengthening efforts in early detection and expert intervention, but also can create effective primary prevention, an important necessary step toward eradication of this health problem.

Chescheir (1996) feels it would be a tragedy to miss an opportunity to improve women's health. "The most important response by clinicians to domestic violence is to respond. If you are providing care to women, you are providing care to battered women. It is critical that you include domestic violence in your screening program." (p. 768).

The literature supports the fact that many times the primary health care provider is remiss in performing routine screening of women for domestic violence. Many barriers are listed as obstacles to performing this task effectively. It could be very beneficial for health care providers to know the incidence of and barriers to routine screening. This would provide the community with information to use as impetus for supporting and assisting providers in the care of victims.

The following research questions are proposed: (1) Are primary health care providers in Santa Clara County routinely screening women for domestic violence; (2) If not, what are the barriers that impede this screening?

Conceptual Framework

The study followed an ecological model from the perspective of health promotion. According to McLeroy, Bibeau, Steckler, and Glanz (1988), five factors influence behavior. They are intrapersonal factors, interpersonal processes, institutional factors, community factors, and public factors. These all have a role in how the health care provider addresses domestic violence against women and if routine screening is practiced. Intrapersonal factors relate to each individual's thoughts, feelings, knowledge, and experiences with abuse. Interpersonal processes are the social networks and support systems that influence behavior. Institutional factors, such as educational systems and regulations, govern the knowledge with which a provider begins and dictates procedure. Community factors, like the incidence of abuse and the awareness of constituents, can affect health care providers addressing abuse and subsequent intervention. Public factors include policy instituted to assist providers with health care to the community.

Domestic violence against women is a societal problem. This ecological model was the framework for this study. It provides a basis to discover if health care practitioners are screening women for domestic violence, and if not, what are the barriers that impede screening? The barriers could be from intrapersonal, interpersonal, institutional, community and/or public problems. Each of these may affect how the health care provider views domestic violence, and subsequently considers it as a credible medical problem. The providers' personal feelings, clinical settings, educational

backgrounds, community support, and public awareness of the incidence of abuse are integral components used in the practice of health care.

Methodology

The study was descriptive and quantitative in design. A survey was used to gather data. A convenience sample of 280 practicing physicians (M.D.), nurse practitioners (N.P.), and physician's assistants (P.A.) in family practice, OB/GYN, and internal medicine in Santa Clara County of Northern California was chosen from current Pacific Bell Yellow Pages and Kaiser Provider Directory. The survey (a questionnaire developed by the author) was mailed to the selected subjects with a letter informing the participants of the anonymity of their responses. The questionnaire consisted of 17 questions requiring either short answer or a response on a Likert scale. In addition, there were four demographic questions regarding gender, type of licensure, years in practice, and specialty. The time commitment for completion of the survey was approximately five to ten minutes. A return envelope was provided.

Statistics

From the 280 mailed questionnaires, 19 were returned unopened because providers had relocated. The final sample consisted of 71 completed surveys, or a return of 25%. Descriptive statistics and frequencies were used to evaluate data from the responses to each question.

Results

The respondents were 34 (48%) male and 33 (47%) female; four participants deleted that information. M.D.s consisted of 54 (76%), of which 32 (64%) were male and 18 (36%) female. N.P.s consisted of 16 (23%) all who were female. Only 1 P.A. (female)

was included because none were specifically listed in the directories. Sixty-two percent (n=44) of respondents had been in practice for 11 years or more. The specialties accounted for the following: family practice 44%, OB/GYN 24% and internal medicine 23%.

The Likert scale was used in six questions. The scale range was from 1-7 in a positive direction, i.e., not appropriate-very appropriate, uncomfortable-comfortable, never-always. Providers responded by 84% (n = 59) with 5 or above regarding the appropriateness of screening for domestic violence (mean 5.73 with a standard deviation of 1.21). Sixty-two percent of the respondents (n = 44) reported ≥ 5 that they were comfortable addressing the issue of domestic violence.

Two questions asked if health care providers inquired about domestic violence. When responding if they asked if female patients if they feel safe in their home, 62% responded with ≤ 3, (n = 70, mean 3.2, standard deviation 1.42). Fifty-eight percent reported they seldom asked if a woman had been threatened or assaulted, (n = 69, mean 3.3, standard deviation 1.54).

The other Likert scale questions dealt with the amount of information providers had regarding the issue of domestic violence. Seventy-eight percent responded they were aware of resources and referrals for abused females, (n = 70, mean 5.1, standard deviation 1.61). A mean of 3.4 (standard deviation 1.34) regarding the amount of education received in training facilities about domestic violence meant the providers felt the subject was inadequately taught.

(Insert Table 1)

The perceived incidence of domestic violence was explored, as was personal experiences with domestic violence. These could have an effect on providers' inquiry and response to an abused patient. Twenty-five percent (n = 15) stated they believed 10% of their patient population was abused; 51% (n = 31) reported ≤ 8% was abused. Twenty-seven percent (n = 19) responded with yes to having had a personal experience with domestic violence.

Sixty-eight percent (n = 48) stated there is no standard question regarding abuse or domestic violence on their health history form. Only 41% (n = 29) of the respondents have domestic violence literature available in their clinics.

Seventy-eight percent (n = 55) of the subjects know the mandatory reporting procedures in Santa Clara County. Their response to wanting more information about domestic violence was 51% (n = 36) yes.

The respondents were asked to list the barriers that existed to screening female patients for domestic violence. Thirty-three of the 71 replied with a written answer. Fifty-eight percent (n = 18) listed time as a major barrier. Four indicated the problem was difficult to solve so they didn't address it. Three reported feeling uncomfortable asking about the issue. Other reasons were not in the routine (2 responses), not a pertinent problem, not relevant, it is a legal societal problem, not medical, lack of information, were all singularly listed and one response was that the patient population was already knowledgeable in this area.

Discussion

The results of this study were comparable with those in the literature. The subjects indicated that it is very appropriate for health care providers to screen female patients for

domestic violence (84%). This demonstrates concern for this problem. However, while the providers profess the appropriateness of the subject, the majority (68%) has no question regarding domestic violence on their health history form. Whereas breast cancer is always listed as a problem on the health history form, it would seem that domestic violence is not considered as high a priority in a woman's health assessment.

Responses to the questions regarding health care providers performing screening for domestic violence were disappointing, but agreed with previous studies. The mean on both questions, do you feel safe in your home and have you been threatened or assaulted, was 3.2 and 3.3 respectively on the Likert scale. This indicates that more than half (62% and 58%) rarely or never approach the issue. Interestingly, a large percentage (62%) reported being comfortable in addressing the problem. Why then is the incidence of screening so low?

The ecological framework (McLeroy, 1988) proposes five factors that influence behavior. Each of these has a role in every health care providers' practice. Intrapersonal factors such as previous experience with domestic violence affect how providers feel about the subject. Twenty-seven percent indicated having had some personal experience with domestic violence. These providers could be abusers, victims, friends or family of victims. Having previous feelings about the subject could change the way of approaching it. This could make one more sensitive to the issue, or result in denying the problem. The interpersonal factors, such as social systems, relate to how one addresses an issue. One person responded, "patient population is already knowledgeable about the subject." This provider may feel knowledge equates to the ability to manage the problem, or because patients know about the subject, they are responsible for it. Institutional factors consist of

educational programs and the clinical practice areas. The amount of training providers receive on a subject and the procedures they are expected to follow affect the providers' screening performance. Seventy-nine percent responded four or less on the Likert scale, which meant they felt the subject was not adequately taught. Lack of time was indicated by a majority as a barrier; the clinical setting dictates the time spent with patients. Community factors, such as the awareness of the problem in the practice area, affect the screening. If a provider does not realize the incidence of domestic violence, there will be less inclination to address it. This study found the respondents underestimated the occurrence of domestic violence against women. The majority reported their incidence is $\leq 8\%$, quite a difference from the lifetime incidence of 54%. They also indicated by 50.7%, a need for more knowledge on the subject. This points to the need for more community education about domestic violence. Public policy dictates the reporting of abuse and also the resources available to victims. This somewhat affects the management of female patients. A majority of providers (68%) reported they were aware of the mandatory reporting laws and referrals for abused patients in Santa Clara County. While this figure is greater than half, it still leaves one third without the knowledge required for each health care provider to adequately treat an abused woman.

Comparing responses of male doctors, female doctors, and nurse practitioners, the latter responded higher on the scale in the frequency of inquiry about domestic violence. The reported comfort level of the three groups was similar; however, the nurse practitioners indicated more education regarding the subject was obtained through their educational facilities. This alludes to a need for more training on domestic violence and its implications to health care for women.

This research illuminates a major deficiency: That health care providers in Santa Clara County are not routinely screening for domestic violence. In addition, several barriers were identified as to why this health care problem is not addressed.

This study was limited by use of a convenience sample and self-report questionnaire, designed by the author. The respondents could have been only providers that had interest in the subject of domestic violence. Also more in depth information could be gathered by personal interviews. It is recommended that this study be replicated with a larger sample size and target more than just Santa Clara County.

Domestic violence is a societal and health problem. Health care providers in Santa Clara County need to be aware of its incidence, to have knowledge of how to address the problem, and to screen for it in a routine manner. It is as common as breast cancer, and needs to be given as much attention, in order to improve the health of all women. The barriers that impede the health care providers from inquiry into this issue need to be overcome. It is not reasonable to give lack of time, lack of knowledge, lack of comfort, or lack of routine as excuses: Patients suffer. Health care providers have the responsibility to get informed, make the time, find the resources, and address the health problem. They are one of the first to see a woman in a private setting and have the ability to screen for domestic violence. Women should demand this standard of care.

The community can assist providers by promoting the subject, supplying literature, and having resources available. The subject of domestic violence needs to be further drawn out of the closet. Greater awareness will lead to familiarity and comfort for health care providers. It will also enlighten the abusers, the victims and the public that

this is a problem that will not be tolerated. When people in the community work together, the solutions to domestic violence will be found.

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Table 1

Comparison of Responses Between Male M.D.s, Female M.D.s, and Female N.P.s.

	Male M.D.			Female M.D.			Female N.P.		
	n	Mean	S.D.	n	Mean	S.D.	n	Mean	S.D.
Question 4 *Range 1-7* Do you personally ask your patients if they feel safe in their home?	32	3.0	1.37	18	3.0	1.27	16	3.8	1.81
Question 5 *Range 1-7* Do you personally ask your female patients if they have ever been threatened or assulted by an intimate partner?	32	3.1	1.47	18	2.8	1.18	16	3.9	1.73
Question 6 *Range 1-7* Do you feel comfortable in addressing the issue of domestic violence with your female patients?	34	4.9	1.20	18	4.3	1.26	16	4.7	1.70
Question 11 *Range 1-7* How much about the subject of domestic violence and/or abuse was taught at your educational facility?	34	3.3	1.22	18	3.1	1.63	16	3.6	1.31