Confronting Barriers to Universal Screening for Domestic Violence

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Nationally, domestic violence has reached epidemic proportions. Universal screening is a vital means to identify those women who suffer in abusive relationships with intimate partners. Collaborative efforts between a community shelter for abused women and a local medical center’s emergency department resulted in the development and implementation of a universal screening process. Barriers encountered by the emergency department nursing staff during the initial phase of screening included lack of information about domestic violence issues as well as about the tool, personal perceptions and feelings about domestic violence, and institutional barriers such as lack of time, space, and privacy in the emergency department. Of these, informational and affective barriers of nursing staff are viewed as the most significant. Discussion includes a call for emphasis on domestic violence in the curricula of nursing programs and those of other health care providers and use of universal screening to identify and assist abused women. Interdisciplinary methods of formal education, in-service training, and continuing education are encouraged to augment existing universal screening, as well as to assist those who have yet to implement such a process. (Index words: Domestic violence, Universal screening, Abused women, Nursing education, Emergency departments) J Prof Nurs 17: 313-320, 2001. Copyright © 2001 by W.B. Saunders Company

AN ESTIMATED 3.9 million women, up to 76 per cent of all women in this country, are assaulted by intimate partners every year (Centers for Disease Control and Prevention, 1999; Family Violence Prevention Fund, 2000; National Coalition Against Domestic Violence, 1999; Tjaden & Thoennes, 2000), with rates continuing to escalate. In fact, domestic violence is noted as the number one health risk for women between the ages of 15 and 44 (Nursing Trends, 1997). Still, the incidence of domestic violence continues to be minimized. In response to this national crisis, Healthy People 2010 emphasizes the need to reduce domestic violence incidents through specific focus objectives (U.S. Department of Health and Human Services, 2000).

Domestic violence can affect any woman, regardless of socioeconomic status, educational attainment, or ethnicity (McGee, 1997; Nieves-Khouw, 1997; Pennsylvania Coalition Against Domestic Violence, 1998). In short, no typical profile of an abused woman exists. Regardless, abused women may be stereotyped as helpless, poor ethnic minorities. In one study, fewer than half of the physicians surveyed believed that domestic violence was an issue for their female patients (Reid & Glasser, 1997).

Although abused women rarely seek medical assistance for an injury resulting from abuse, they will seek health care for other medical conditions that have been found among abused women in particular (Campbell, 1998; Olsen, 1996). These symptoms may present as an overall syndrome and include headache, gastrointestinal disease, depression, and fatigue (Gremillion & Kanof, 1996). In health care settings, nurses are usually the first outsiders with whom abused women are in contact, and so they are in the best position to identify abused women.

The literature shows that one of the most critical ports of entry for abused women is hospital emergency departments because 20 to 50 per cent of all women treated in emergency departments are victims of intimate partner violence (Ellis, 1999; Ernst, Weiss, N ick, Castalletto, & Garza, 2000; Poirier, 1997; World Health Organization, 1997). Yet, the research literature also shows that emergency departments do not effectively identify abused women (H oury, Feldhaus, Nyquist, Abbott, & Pons, 1999; McLeer, Anwar, Herman, & Macquilling, 1999; Spedding, McWilliam, McNicholl, & Dearden, 1999). In a study of 1,000

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abused women, health care providers ranked lowest of all groups, including social services, clergy, community services, law enforcement, and legal services, in providing assistance (Sisley, Jacobs, Poole, Campbell, & Esposito, 1999). Health care providers continue, mistakenly, to disregard domestic violence as a significant health problem, particularly in light of what is known about its prevalence (Tilden, Schmidt, Limandri, Chiodo, Garland, & Loveless, 1994). These researchers declare, “abuse is a hidden health care problem, and the unsuspecting stance of health professionals allows the problem to remain undetected much of the time” (Tilden et al., p. 632).

These are alarming findings, particularly when many health-related agencies and various associations have targeted domestic violence reduction through education and screening. These include the American Association of Colleges of Nursing (1999), the American Nurses Association (1997), the American Medical Association (2000), and the American College of Obstetricians and Gynecologists (1999), to name a few. Furthermore, the Joint Commission on Accreditation of Healthcare Organizations now requires emergency departments to develop practice guidelines for the identification and treatment of abused women (Joint Commission on Accreditation of Healthcare Organizations, 1997).

Universal screening, by using direct questions, is the most effective method to identify and assist abused women (American College of Obstetricians and Gynecologists, 1999). Universal screening means that the same questions are asked of every woman despite demographics, such as socioeconomic status, ethnic group, or educational attainment. The literature emphasizes that direct questioning provides opportunities for disclosure that otherwise may not have occurred (Centers for Disease Control and Prevention, 2000). As Skoglund (1992) emphasizes, “Asking about violence and abuse is the single most important thing that health providers can do” (p. 217). Although no federal legislation mandates universal screening, some states are beginning to recognize the significant role health care providers can play in universal screening. California, for example, requires all health care facilities to develop and implement universal screening and protocols for providing assistance and referrals (Nudelman, 1999).

This article describes the introduction of a domestic violence universal screening project developed by an emergency department in a large medical center in Pennsylvania. The consequent barriers encountered by the nursing staff and how they dealt with those barriers are discussed in depth.

**Development of the Domestic Violence Screening Tool**

The development of the domestic violence universal screening project by the emergency department began with initial meetings of a newly formed ad hoc committee. The eight members included nursing administrators and community members involved with local services for abused women, including the training staff of the local shelter for abused women. Also involved were hospital social services, clergy, and interested emergency department nursing staff, which had voted in favor of implementation of the project. Planning sessions began in the fall of 1998 to develop a tool and protocols for providing referral services for those women who identified themselves as having abusive experiences.

The ad hoc committee formulated the universal screening tool early in the process. Although the tool may appear similar to others, the committee preferred a tool designed to reflect the community the hospital served (see Appendix). The purpose was to identify women coming into the emergency department with abuse experiences, yet seeking services for other health concerns. The ad hoc committee wanted to keep the tool simple but at the same time directly retrieve information from patients who may have abuse experiences. The goal was to identify these women and then to guide them to the appropriate support services.

The criteria for screening included the following patient characteristics. All registered emergency department patients 18 years of age and older would be screened. Both men and women would receive screening, though the literature verifies that most intimate partner abuse, 85 per cent to 95 per cent, is experienced by women (Centers for Disease Control and Prevention, 2000). Only trauma patients and those considered critically ill were excluded.

The nursing staff was responsible for distributing and collecting the screening tool. Nurses also provided explanations to patients regarding the purpose of the tool and how to fill it out. They also stressed the confidential nature of the completed tool. After the tool and protocols were developed, the appropriate hospital groups were approached for approval. These included the emergency department as a whole, nursing administration, medical records, and the legal office. Once
approval was obtained, the committee planned to educate the emergency department nursing staff through an 8-hour training course.

Although the committee initially proposed the training course as a requirement for all emergency nursing department staff, the nurse manager decided that only 7 of the 40 nursing personnel would take part and ask for volunteers. Only one of the seven reported having a past domestic violence experience. The seven trainers ranged in clinical experience from 2 to 15 years. These seven self-chosen nurses then became the "trainers" for the remaining 33. Financial constraints affecting the operation of the emergency department influenced this decision. In the end, this decision created a number of problems that became barriers to effective screening and delayed full implementation for more than 1 year.

Individuals employed by the local community shelter for abused women, who had expertise in providing this type of training, developed and implemented an 8-hour course. The course included an overview of domestic violence, available statistics, incidence, and prevalence of the problem. Presenters provided information about state and community initiatives, available resources, and legal issues, along with information about how and why universal screening is effective and necessary. They also covered sexual assault in this session. In addition, they reviewed community referral sources. The remaining hour of the session provided these seven nurse trainers with detailed information on how to present in-service training to the remainder of the emergency department staff.

The process and the flow-sheet were also reviewed and included the following information: If a woman identified herself as abused, the nurse would contact the hospital social worker, provided this occurred during workday hours. The social worker would talk with the patient and assess the patient's safety level. She would be provided with community referrals, depending on her individual needs. These included legal services, the hot-line for the local shelter, and counseling services. If a woman identified herself after workday hours, the clergy on call would be contacted. All the clergy were involved in the initial development of universal screening and showed the ability to fill the role of the social worker.

After the course, the seven nurse trainers provided in-service sessions for the rest of the nursing staff in the emergency room by using educational materials provided by the universal screening committee. Over a 6-week period, the entire nursing staff received this training. The trainers provided information about referrals to services in the community that offered assistance to women with domestic violence experiences. The universal screening tool and the schematic flow sheet for the process of screening were posted on readily visible educational bulletin boards for staff from the beginning of the in-service process and remained available as resource materials for staff reference. Furthermore, the clergy widely publicized their availability to talk with nurses individually about personal feelings experienced during the universal screening process.

Feedback from the trainers indicated that the nursing staff had sufficient information to initiate the screening, and the ad hoc committee decided that screening would begin.

Implementation of Screening

At first, the results of the initial screening period were daunting. During a 4-week period, 100 patients were screened. Of those, 30 per cent reported intimate partner abuse. Of these, 27 per cent were physically abused, 29 per cent emotionally abused, and 15 per cent sexually abused. Often, physical and emotional abuse are not separate incidents and occur simultaneously. In addition, 13 per cent reported feeling unsafe at home. Despite these convincing numbers, the nurses declined to continue the project, because they perceived the training as inadequate. Through informal feedback, members of the ad hoc committee learned that nurses felt they lacked sufficient information about referral sources, legal issues, and follow-up for those women who identified themselves as having abusive experiences.

Because these issues were presumably covered during the training sessions, a variety of barriers were identified as needing to be addressed before screening resumed. These barriers were categorized as informational, institutional, and affective. Each is described here, related to the staff's concerns and how each was ultimately managed by the ad hoc committee.
Barriers

INFORMATIONAL BARRIERS

The nursing staff most often cited lack of education related to domestic violence issues as a barrier despite the in-service provided by the nurse trainers. Although these issues were covered in the training sessions, many nurses felt ill-prepared to assist patients who desired help or who requested referrals. Most of the nurses found referrals to be the most challenging informational barrier during the process of universal screening. In addition, informal conversations with the staff revealed that the nurse trainers provided insufficient information to the staff and often the training included little more than distribution of the tool with brief instruction on its use.

Because of the data collected in the 4-week period that universal screening was conducted and the concerns expressed by the staff, the nurse manager agreed that full training of all staff was essential. The trainers from the local shelter for abused women came back and provided additional training for the entire staff through a 2-hour lecture on domestic violence. The lecture was videotaped and made available for the staff at their convenience. All those who either attended the second training session or viewed the video session were tested before and after to ascertain improvement in their ability to conduct universal screening, thus, reassuring the ad hoc committee.

INSTITUTIONAL BARRIERS

Interestingly, the barriers that fall under this heading are diverse, yet related. First, the reluctance of the nurse manager to allow trainers from the local shelter to teach the entire emergency department staff in the beginning was a major barrier to the universal screening process and created an adverse impact on how the staff perceived the training and the consequent screening. Once the nurse manager was convinced of the necessity of continuing universal screening based on the data collected, she reconsidered the initial suggestion to allow shelter trainers to educate the entire staff and the staff stopped resisting. In essence, her authority had the effect of a stamp of approval on universal screening for domestic violence among the nursing staff.

The physical layout of the emergency department itself did not lend itself to the privacy needed for conducting screening in which confidentiality is a major concern. Throughout the department, as in many emergency departments, curtains are the only physical barrier between patients. Also, it is common for family members to accompany patients back to treatment areas. A locked door between the waiting and treatment areas now prevents anyone from entering without a nurse escort. Also, a new policy allows the patient to be seen alone initially for the nurse to conduct screening. After the screening is completed, family members may be brought into the treatment area.

Although the tool only contained five direct, yes-or-no questions, some nurses found screening time consuming. These nurses felt that explanations to the patient on how and why to complete the tool required too much time. After completing additional education and training, however, these same nurses voiced more comfort with using the tool and found it less time consuming. Additional training also helped the nurses accommodate referral requests in a timely way.

AFFECTIVE BARRIERS

Only a few of the emergency department nurses expressed comfort in using the universal screening tool. The nursing staff listed lack of comfort, feelings of inadequacy, and powerlessness among affective barriers to universal screening. Although the initial 8-hour course addressed personal comfort and psychosocial concerns related to domestic violence, it is clear that this information was not communicated in the subsequent training. In addition, past personal experiences of abuse, may have prevented some nurses from examining these issues in more depth. Again, the additional attention of the community shelter trainers enabled these nurses to deal with conflicting emotions and use the tool in a more constructive manner.

In addition, some of the nurses expressed frustration when an identified abused woman refused referrals or additional assistance. The clergy offered support and counseling to any nurse involved in the universal screening process. According to these clergy, however, no nurse took advantage of this opportunity to process their feelings or frustrations.

Universal screening resumed in the emergency department in early 2000, almost a year after its initiation. During the first month alone, 841 patients were screened. Of these, 252 (30 per cent) reported an experience with domestic violence, and of these, 58 (7 per cent) requested a referral for additional information and assistance.
Discussion and Recommendations

When the screening resumed, a clearer representation of the needs of women in the community was reflected in the number who reported abuse and, most importantly, in the number who requested assistance and otherwise would have left the emergency department without it. In addition, even though nursing staff supported universal screening initially, many felt overwhelmed and powerless when women requested referrals. The entire project faced imminent termination because nurses experienced critical barriers to progressing further with universal screening. This dilemma has also been found by others (Davies, Harris, Roberts, Mannion, McCoy, & Anderson, 1996). These barriers should have been explored from the onset of the program. Indeed, the literature shows many examples of the types of barriers that may be experienced by addressing domestic violence issues, particularly in health care settings (Gremillion & Kanof, 1996; Jezierski, 1996; Olsen, 1996; Reid & Glasser, 1997).

There are few social issues that affect us as deeply and in such personal ways as domestic violence. For nurses, informational needs are easier to express, more socially acceptable, and also more concrete. The exploration of personal feelings, either because an individual nurse has had a past or current experience as an abused person or possesses some bias against those who have been abused, is far more difficult.

Discomfort with domestic violence issues is not uncommon, particularly if an individual has a past experience or has a close association with someone with an abusive experience (Larkin, Hyman, Mathias, D'Amico, & Macleod, 1999; Shea, Mahoney, & Lacey, 1997). Domestic violence issues often bring forth a well-spring of unresolved emotions and conflicts from individuals, including health care providers (Olsen, 1996). Yet, Reid and Glasser (1997) found that of the 148 health care providers in their study, female health care providers had more knowledge, showed more sensitivity, and expressed the most comfort in interactions with abused women. Older, male physicians were the most apt to disregard domestic violence as a major health concern and were also the most resistant to universal screening.

Regardless of the sex or age of emergency department health care providers, they should have access to counseling or debriefing when universal screening detects abused individuals. Certainly, personal feelings related to abuse should be addressed through self-awareness and self-examination well before the process of universal screening begins in any health care facility. Not only is this good self-care, but unexamined personal biases and feelings related to abuse can very well interfere in the care-giving relationship and interactions with an abused woman seeking assistance.

Feelings of bias may be the most difficult to deal with of all. It is not uncommon for people to question why a woman would stay in an abusive situation, hence, people find the victim the easiest to blame. In addition, there may be underlying feelings of contempt for individuals who would allow themselves to be involved in such situations. Abused women themselves have voiced distress in at least one study in which they described the barriers to relating their abusive experiences to health care providers (Gerbert, Johnston, Caspers, Bleecker, Woods, & Rosenbaum, 1996). These barriers are manifestations of bias and include perceived disinterest, lack of sympathy, minimalizing, abruptness in care, and lack of time. These are all areas that indicate a real need for in-depth education for health care providers.

The majority of the barriers experienced during the introduction of the screening could have been prevented by a number of measures, including intensive education and information. Without question, the 8-hour training course should have been mandatory for all nursing personnel because many of the more experienced nurses may not have had sufficient content presented in their nursing education programs. Although financial constraints were the most likely reason why all of the nurses were not initially trained, this was not a prudent decision. By making the course a requirement from the beginning, all of the nurses would have had the same information, enabling them to support each other as well as to share information.

Information about domestic violence may not be emphasized either in formal or informal educational settings for health care providers despite the policies of those organizations that help in formulating curricula. The American Association of Colleges of Nursing explicitly recommends that “faculty in educational institutions preparing nurses in baccalaureate and higher-degree programs ensure that the curricula contain opportunities for all students to gain factual information and clinical experiences regarding domestic violence” (1999, p. 2). One study clearly shows that health care providers who receive formal education about domestic violence improve their sensitivity and ability to identify those who are abused (Roberts, Raphael, Lawrence, O'Toole, & O'Brien, 1997). Nevertheless, health care providers may not screen patients for domestic violence because they do not identify
violence issues and screening concerns. As Cowley, Rush, for health care providers and others to discuss domestic violence. Not only does this approach lend breadth and depth to domestic violence issues, it provides a forum for health care providers and others to discuss domestic violence issues and screening concerns. As Cowley, Rush, for health care providers and others to discuss domestic violence issues, it provides a forum for health care providers and others to discuss domestic violence issues and screening concerns.

continues in many institutions of higher learning. However, educators of the health professions in formal programs may not be in the best position to provide the extensive, in-depth instruction related to domestic violence that is needed for future health care providers. The time pressures of including even more content into already overburdened curricula may be overwhelming. An interdisciplinary approach is recommended, in which the many components of domestic violence are examined. The disciplines of sociology, social work, and psychology contribute essential background and research that enhance exploration into domestic violence issues. Through an interdisciplinary curricula, educators can equip future health care providers with a template for accessing and working with their counterparts on employment in health care settings.

In addition to knowledge, the affective domain of abuse should be explored. Assisting those in the health professions to process personal feelings and conflicts concerning abuse would be helpful. Also, counseling strategies and interviewing techniques can be better addressed through formal, interdisciplinary education. This is particularly important for younger nursing students who may not possess the maturity to deal with the intensity of intimate partner abuse issues. For example, exploratory group work that assists college-age students to process their feelings about abuse before they encounter such situations in real life might be beneficial.

Continuing interdisciplinary approaches to universal screening is necessary in the health care workplace. Warshaw and Alpert (1999) contend that protocols alone are inadequate in tackling the multifaceted issues of domestic violence. All parties involved—legal advocates, clergy, social services, and mental health counselors—need to work together with health care providers in not only meeting the needs of abused women identified through universal screening, but also to meet the needs of those providing the screening.

In-service education should include content on domestic violence issues and draw on interdisciplinary human service counterparts. Rittmayer and Roux (1999) believe that, through combined efforts with other auxiliary services in the community, a unified front can be achieved in reducing intimate partner violence. Not only does this approach lend breadth and depth to domestic violence issues, it provides a forum for health care providers and others to discuss domestic violence issues and screening concerns. As Cowley, Rush, Lenton, and Lukasik-Foss (1996) note, "Values and beliefs related to woman abuse can be significantly affected by an educational approach that combines information with the opportunity for dialogue, questions, and interaction" (p. 29). In addition, dialogue and debriefing are essential mechanisms for health care providers to process affective barriers discussed earlier in this article.

Health care providers, such as physicians, nurse practitioners, physician's assistants, and registered nurses, can do a better job of addressing the needs of abused women with whom they come into contact daily. It is chastening to see auxiliary services being perceived of as more helpful than those of us involved in direct patient care. Even though a primary goal of nursing is care giving, too often it is presumed that nurses have an innate understanding of what is encompassed in care-giving activities. Nursing possesses a long history of care giving, empathetic listening, and anticipatory guidance as some of its more salient trademarks. These traditional nursing values should be emphasized to meet the needs of abused women. As Furniss (1998) states, "Until all individuals become nonviolent and nonabusive, nurses need to be alert to the possibility of violence and abuse in the lives of every patient during every health encounter" (p. 194).

Often, nurses are the first health care providers who interact with a woman who has been abused. As such, nurses are in an optimal position to assist her in acquiring help. There is great support for the continuation of universal screening for domestic violence in this emergency department, and it continues today. The literature certainly provides ample evidence as to the appropriateness and importance of screening, particularly by emergency departments. In addition, there is tremendous motivation and even directives from the Joint Commission on Accreditation of HealthCare Organizations for universal screening in emergency departments. However, this project identified many valid reasons, in the form of barriers experienced by emergency department nursing staff, why universal screening may not be as widely practiced as it should be throughout all emergency departments in our country today. Although good data resulted, testifying to the importance of universal screening, it is obvious that the nursing staff had a number of significant issues that had to be addressed before the project resumed. Importantly, it is possible that other emergency departments may be experiencing similar barriers to universal screening for domestic violence. In that case, the situation in this community provides an excellent case study for those experiencing difficulties.


Sidley, A., Jacobs, L., Poole, G., Campbell, S., & Esposito,


**Appendix**

### Universal Screening Tool

We are concerned by the prevalence of violence in our community and the effect that violence has in the lives of our patients. For these reasons, we are committed to screening our patients for domestic violence and providing assistance to victims of abuse. Strict confidentiality will be maintained for all screening information. This is not a part of your medical record. The information obtained will allow us to provide you with available community services and to identify the prevalence of violence in our community. Please fill out the questions below and return this form to your nurse. Thank you.

1. Do you feel safe at home? **Yes** **No**
   
   If no, why do you feel this way?
   
   Comments:

2. Have you ever been the victim of physical abuse? **Yes** **No**
   
   (Hitting, punching, kicking, biting, burning, etc.)

   Comments:

3. Have you ever been the victim of emotional abuse? **Yes** **No**
   
   (Neglect, denied access to physical needs or financial needs, name calling, etc.)

   Comments:

4. Have you ever been the victim of sexual abuse? **Yes** **No**
   
   (Unwanted sexual acts)

   Comments:

   Referral:

5. Would you want to talk to someone about receiving help? **Yes** **No**
   
   Your Name ______ Phone Number ______ (Is it safe to call?)

   Optional Optional

   Domestic Violence Hotline [Number]

   YWCA Sexual Assault Hotline [Number]

   Office of Aging [Number]

   Assessment and Referral Services [Number]

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