Women's responses to screening for domestic violence in a health-care setting

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**Background:** interest in the health impact of domestic violence is increasing and routine screening for violence in health settings has been recommended. However, there are limited data about how women feel about such screening.

**Aim:** to investigate women's responses to being screened for domestic violence during a routine clinic visit.

**Method:** a cross-sectional cohort study. Women (1500) from five Queensland hospitals were asked to complete a self-report questionnaire during the visit following the consultation at which they had been screened for domestic violence. Sealable envelopes and a 'posting box' were provided to ensure anonymity of returned envelopes.

**Findings:** of the 1313 respondents, 98% believed it was a 'good idea' to screen for domestic violence. Over 96% felt 'OK' during the process and 77% of the 30 women who felt uncomfortable still agreed that it was a good idea to screen. Women from rural and remote areas of Queensland had similar responses to those of their city counterparts.

**Conclusion:** women in Queensland found screening for domestic violence acceptable and, where health providers are suitably educated, it should be included when taking a routine health history.

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**INTRODUCTION**

The effect of domestic violence on women’s health is receiving increased attention from local and international policy makers (WHO 1997, Queensland Government 1999) and from the health-care community (Warshaw 1997, Rodriguez et al. 1999). This is partly due to an increased awareness of the prevalence of abuse (Gazmararian et al. 1996) and also because more is now known about the impact of domestic violence on health (Roberts et al. 1998, Letourneau et al. 1999, WHO 2000). Injury is an obvious manifestation but it accounts for only a small proportion of adverse health outcomes. Recent reports indicate that a wide range of conditions are associated with domestic violence including urinary tract infection, vaginitis (Muehlenman et al. 1998), sexually transmitted diseases (Martin et al. 1999), asthma, epilepsy, miscarriage (Webster et al. 1996), gastrointestinal disorders (Drossman et al. 1995), severe depression (Scholle et al. 1998), carotid artery dissection (Malek et al. 1999) and other somatic complaints (Koss & Heslet 1992). Suicide and homicide are also more prevalent amongst women who have experienced domestic violence (Hillard 1985, Wadman & Muelleman 1999).

Health-care providers have an important role in identifying the women at higher risk for these adverse outcomes. However, it is well known that most health carers find it difficult to ask about domestic violence; they feel inadequately trained to do so, believe it is not their core business or that they do not have the skills to deal with a positive response (Hamberger et al. 1992, Sugg & Inui 1992). To make this easier, screening guidelines have been developed that include suggested ways to ask about domestic violence which are non-judgemental, professional and sensitive to women’s feelings (Flitcraft et al. 1992). Despite this, it is still rare for women to be screened for domestic violence when they visit a primary or tertiary health care setting (Isaac & Sanchez 1994) and it is unusual for women to say that they are experiencing
domestic violence unless specifically asked (Gerbert et al. 1999).

Pregnancy is an ideal time to screen for domestic violence. Midwives and doctors are in recurring contact with women who would not normally enter the health-care system. In Australia, where rates of domestic violence are not unlike those from other Western countries (Webster et al. 1994) approximately half of all confinements occur within the public system. This means that women receive all of their prenatal care in a hospital clinic or ‘share care’ between the hospital and their general practitioner. Opportunities to introduce health-care initiatives are made easier because of this system. In 1999, the Queensland Health Department supported a project to develop, test and evaluate a system to routinely screen all women attending either a public prenatal clinic or an emergency department (Queensland Government 1999).

Five Queensland hospitals (two based in the capital city, one in a large regional centre, one in rural Queensland and one in a remote setting) agreed to participate in phase 1 of the Domestic Violence Initiative (DVI). Representatives from each of the participating hospitals were invited to join the DVI Reference Group and meetings were held monthly through videoconference links. This provided an opportunity for input from the ‘coal face’ and for support and feedback to midwives who would be involved in screening. Following a literature review, the domestic-violence screening questions were developed and endorsed by the Reference Committee (Appendix). In line with recommended practice, questions were to be asked directly, in a conversational way, as part of the routine ‘booking in’ history. Before screening began, all staff who would be asking about domestic violence attended a four-hour inservice education session. Sessions were led by midwives and social workers with backgrounds in domestic violence education. Role-play, using the domestic-violence questions, was an important component of the education and training, and so was making sure that participants were aware of referral options in their local community. Staff safety and safety of the women were emphasised.

Follow-up education and training has continued at regular intervals to make certain that new staff are educated and trained and that the momentum does not wane amongst those already screening.

Evaluation of the first year of the Initiative included: (i) an investigation of staff responses using focus groups, (ii) a record review at all sites to establish the rate of screening and (iii) an assessment of the training programme. We also surveyed women’s responses to being asked about domestic violence to make sure that they did not object to being screened. The aim of the present paper is to report on the quantifiable aspects of these responses.

METHODS

The evaluation commenced three months after screening had started and included all women attending the prenatal clinic at participating sites. Approval to incorporate questions about domestic violence into the prenatal history was obtained from each facility at the beginning of the Initiative. As we were evaluating a change to routine practice, written consent was not required. However, the purpose of the study was explained to the women and verbal consent obtained. Those who could not read or write English were excluded, unless they had responded to the original questions through an interpreter and an interpreter was available to assist with the evaluation. A target number of women to be surveyed, based on the annual expected birth rate for each site, was set for each hospital (n=1500). Data collection continued until the target number had been achieved. At the beginning of the visit following the booking in visit, the woman’s pregnancy health record was checked to make sure that the domestic violence screening questions had been asked. Where evidence existed, she was asked to complete a short, self-administered questionnaire. The questionnaire, developed for the study and tested on several women and members of the reference group for readability and relevance, could be completed in approximately two minutes and included both open-ended and closed choice items (Box 1). No names were required and a sealable envelope and ‘posting box’ were provided to ensure anonymity. As with the screening questions, care was taken to make certain the woman was safe by giving her the questionnaire when she was alone. For statistical analyses SPSS version 10.0 (SPSS 10.0 for Windows 1999) was used.

FINDINGS

Of the 1500 questionnaires distributed 1313 (87.5%) were returned. This represents 13.2% of the annual birth rate of all hospitals included in the study. Most of the respondents, 1263 (98%), believed it was a good idea to ask women about domestic violence when visiting a hospital. There were no difference in the responses from either rural, remote or inner city sites (range 98.6-95.5%, χ²=7.38, df 4, P=0.117). Nor were there differences between sites in terms of how women felt when asked domestic violence questions (χ²=8.68, df 8, P=0.37). Three responses were possible: 1197 (96.1%) felt OK about being
Women's responses to health-care screening for domestic violence

Box 1  DVI Evaluation

Reason for this survey
At your first antenatal visit, we asked you some questions about anyone at home who hurt you physically or emotionally or who threatened to hurt you. We asked these questions because emotional or physical abuse may affect your health and possibly the health of your baby. What we don't know is how women feel when talking about these issues with health care providers. It would help us and other women having babies, if you would answer the following questions

(Please tick box)

1. Did you attend antenatal clinic at:
   - The Royal Women's Hospital
   - The Mater Hospital
   - Kirwan Hospital
   - Cairns Base Hospital
   - Mt Isa Hospital

2. Do you remember being asked questions about domestic violence at your first hospital antenatal clinic visit?
   - Yes, I was asked questions
   - No, I wasn't asked questions

3. Please tick how you felt when you were asked questions about domestic violence.
   - I felt OK about being asked
   - I felt relieved to be able to talk about my problems
   - I felt uncomfortable about being asked
   - Not applicable
   - Other feelings (please comment)...........................................

4. Do you think it is a good idea to ask women about domestic violence when they are pregnant?
   - Yes
   - No

   Why
   ...............................................................................................................
   ...............................................................................................................

5. Who do you think should ask questions about domestic violence? (You may tick more than one box)
   - My own GP
   - Hospital clinic doctor
   - The midwife in clinic
   - A social worker
   - No-one

   Other (please list name/s)...........................................

6. Is there a better way to ask these questions? (You may use the back of the form if you wish)
   ...............................................................................................................
   ...............................................................................................................

7. Is there anything else we should ask about?
   ...............................................................................................................

8. Did anyone help you to complete this form?
   - Yes
   - No

9. If 'yes' who helped?
   .................................................................................................................................................................................................

Thank you for answering these questions.
Please place the form in the envelope and leave it in the box in the clinic.
Your name is not required; your answers are anonymous

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asked, 18 (1.4%) felt relieved to be able to talk to someone about their problem and 30 (2.4%) felt uncomfortable. Twenty-three (76.7%) of the women who felt uncomfortable, still agreed that it was a good idea to ask about domestic violence. When asked about which health careers should screen for domestic violence, multiple responses were possible: 1068 (64.9%) of the women nominated midwives, 1055 (64.1%) nominated general practitioners, 809 (49.2%) selected social workers and 771 (46.9%) selected hospital doctors. Only 42 (2%) thought no one should ask. A number of women wrote comments such as ‘anyone who cares should ask’. When analysed by hospital, respondents from the remote area site were less likely to select the hospital midwife ($\chi^2 = 17.2$, df 4, $P = 0.002$) or the general practitioner ($\chi^2 = 18.2$, df 4, $P = 0.001$) than those from either rural or city hospitals. Of those responding, 122 (9.4%) stated that they were not asked the questions at their first visit, a further 5 (0.4%) indicated that they were probably not asked because their partner was present and 52 women (4.0%) stated that they could not remember whether they had been asked about domestic violence or not.

DISCUSSION

Little information exists about pregnant women's views of screening for domestic violence (Stenson et al. 2001). Our study was restricted to one Australian State and only included women within the public hospital system. This means that privately insured women were not screened so findings may be biased towards the views of those from a lower socioeconomic group. Despite these limitations, findings of our study reinforce earlier work, which quite clearly
indicates that women do not mind being asked about domestic violence, in fact they welcome it (Caralis & Musialowski 1997, Stenson et al. 2001). The rate of agreement with the statement ‘do you think it is a good idea to ask about domestic violence’ was higher than has previously been reported. When McNutt et al. (1999) asked a comparable question only 75% of respondents thought screening was appropriate. This may reflect a different client population. Women in the McNutt study were of reproductive age but not necessarily pregnant. Similarly, 80% of Swedish women responding to an open-ended question about violence screening in antenatal clinic found it acceptable (Stenson et al. 2001). However, looked at another way, only 3% of these women found such screening unacceptable, a result consistent with our findings. It seems probable that protecting the baby may be a strong motivator in women’s endorsement for domestic-violence screening.

Our study was also larger and had a higher response rate than has been previously reported. Of those approached, only 13% did not return the evaluation form. At two of the hospitals the response rate was close to 100%. Women from these hospitals held views that were no different to those from other sites further confirming the validity of our findings. This convincing support from women provides a persuasive mandate for universal screening for domestic violence when taking a routine history. Of course some women will choose not to disclose at the time of screening, but it is important for women to know that, when they are ready, they will be listened to and their experience validated. Being asked about domestic violence may also raise the woman’s awareness of the seriousness of the problem and act as a catalyst for change (Gerbert 1999).

The high rate of support for screening suggests that women believe the health-care setting is a safe place to respond openly to questions about domestic violence. It also implies a belief that health-care providers may be able to help. Unfortunately, evidence shows that this is often not the case.Insensitive responses and an inability to provide assistance or useful information at the time of disclosure have been reported (McNutt 1999). In these situations women may be left wondering why they were asked and reduce the likelihood of telling other professionals about partner violence again. Because midwifery and medical education rarely includes information about how to support women experiencing domestic violence (Rodriguez et al. 1999) and because the consequences of disclosure, without a suitable response may be devastating we believe that screening should not occur unless staff have received appropriate education. We found that careful preparation, including the four-hour training session, development of simple resources and a clear understanding of referral options help to make screening easier for staff. Role-play and practicing direct questioning techniques are important in developing the skills and confidence needed to screen for domestic violence (Bates & Brown 1998).

A further strength of the study was that it tested the opinions of women from inner city, rural and remote areas of Queensland. There is some evidence that domestic violence is more hidden in rural and remote areas because women are more isolated and because they want to protect their partners in communities where members are well known to each other (Alston 1997). To some extent, our data support this view. Women from the remote site in this study were certainly less likely to select their local midwife or general practitioner to screen for domestic violence, and this may be because the respondents knew them. On the other hand, these women agreed with their rural and city counterparts that screening for domestic violence was an appropriate part of health care; they were also prepared to reveal experiencing domestic violence at a similar rate to other women. Results from a related part of the evaluation showed that the rate of disclosure at the remote hospital was 10.5% compared with an average of 7.3% for all hospitals surveyed (Queensland Health 2000). Screening may be particularly important in parts of the country where few services are available, especially if the health-care provider has had some education and training in counselling for domestic violence. Even providing minimal help, such as ensuring that the woman knows the domestic-violence help-line number so she can call when she is ready and when it is safe to do so, may be vital.

The finding that most of the women who felt uncomfortable when asked about domestic violence still believed it to be a good idea is not surprising. Questions may have aroused unpleasant memories or feelings, yet they still wanted to be asked. Barbara Gerbert discusses the same ambivalence when she talks about the ‘dance of disclosure’ and the emotions associated with domestic-violence being raised in a health-care context (Gerbert 1999). Understandably, if the woman’s partner was nearby she may have been fearful or concerned that the disclosure would not be kept confidential. Some women may believe that it is not the business of health-care providers, they may be embarrassed or worried that they would be judged for staying in the relationship. Another concern for many women experiencing violence is that their children may be removed.

It is difficult to explain why 122 of the women surveyed stated that they were not asked ques-
tions about domestic violence during their book-
ing in visit, even though evidence of questions being asked was part of the inclusion criteria. Midwives in the clinic were responsible for identifying eligible women. Relief and agency staff are often employed in the area, so some midwives may have been unaware that not all women were to be included. It is even harder to understand why 52 women did not remember if they had been asked about violence at all. The questions would have been quite unexpected and confronting so the finding is quite surprising. We did consider not including these responses in the analysis, however, responses to other questions were relevant.

Screening for domestic violence in pregnancy demonstrates to women that midwives and doctors are concerned about the potential health impact of domestic violence on her and her unborn child. Moreover, it has been shown that asking women about violence and acknowled-
ging the issue can be a positive intervention in itself (Parker et al. 1999). Any overt expression that domestic violence is taken seriously may help the women to feel more confident about disclosing and seeking help. A workforce familiar with the prevalence and impact of domestic abuse and comfortable about discussing associated issues may also help to reduce the shame some women feel about their situation and assist in the efforts to make violence a public rather than a private problem.

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APPENDIX

Domestic Violence Initiative
Screening Questions

(Questions below can be introduced in a conversational style.)

In this hospital we are concerned about your health and safety, so we ask All Women a few questions.

**Whatever you reply will remain strictly confidential**

<table>
<thead>
<tr>
<th>Question</th>
<th>Possible Answers</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you ever afraid of your partner?</td>
<td>Yes, No</td>
<td></td>
</tr>
<tr>
<td>2. In the last year, has anyone at home hit, kicked, punched or otherwise hurt you?</td>
<td>Yes, No</td>
<td></td>
</tr>
<tr>
<td>3. In the last year, has anyone at home often put you down, humiliated you or tried to control what you can do?</td>
<td>Yes, No</td>
<td></td>
</tr>
<tr>
<td>4. In the last year, has anyone at home threatened to hurt you?</td>
<td>Yes, No</td>
<td></td>
</tr>
<tr>
<td>5. (If any answers are yes) Would you like help with any of this now?</td>
<td>Yes, No</td>
<td></td>
</tr>
<tr>
<td>6. This could be important information for your health care. May we send a copy of this form to your own doctor?</td>
<td>Yes, No</td>
<td></td>
</tr>
</tbody>
</table>

Name of Doctor: ........................................... Signature of client
Address ........................................................ Post code . ................ Date ................

Action:
- Woman declined assistance at this time
- Referred to Social Work Department
- Referral to other agency/program

Information:
- Woman declined information at this time
- No information required
- Help line number
- Information about domestic violence

Other – please indicate

Print name . . . . . . . . . . . . . . . . . . . Date . . . . . . . . . . . . . . . . . . . .
Position . . . . . . . . . . . . . . . . . . . Signature . . . . . . . . . . . . . . . . . . . .