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What Are Barriers to Nurses Screening for Intimate Partner Violence?

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ABSTRACT

Intimate partner violence (IPV) causes serious injury and death each year in the United States. Estimates show that up to 16% of patients are current victims of IPV. The Joint Commission requires patients admitted to the hospital be screened for IPV. Nurses play a pivotal role in this screening process. The goal of this study was to identify nurses' attitudes and perceived barriers to screening. A survey was distributed to clinical nurses caring for inpatients at a level I trauma center. A total of 82.6% of nurses reported taking care of 2 or less victims of IPV in the last year, and 45.8% reported not caring for a single IPV victim in the last year. Most nurses in this study have reported that screening for IPV is important, that it is their responsibility to screen their patients, and that they experience few work environment barriers to screening. Among study respondents, the most common identified barrier to screening is the lack of training.

Key Words

Barriers, Intimate Partner Violence, Screening

Intimate partner violence (IPV) is a well-documented problem of modern society. Each year, women experience approximately 4.8 million IPV-related physical assaults and rapes, and men are the victims of approximately 2.9 million IPV-related physical assaults.[1] It has been estimated to be the leading cause of serious injury and the second leading cause of injury and death in the United States among women of childbearing age.[2] Women in the United States suffer a lifetime prevalence rate of 35.6% and many long-term consequences, including chronic pain, anxiety, depression, somatic concerns, and substance abuse.[3]

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Prevalence estimates of IPV victimization in the preceding year among women presenting to the emergency department for any reason have been substantial, ranging from 15% to 30%.[4] One study published by Melnick et al[5] revealed that a recent history of IPV was a common comorbidity among injured female patients admitted to a general surgery trauma service, with 18% screening positive. It was important to note that very few of those subjects presented for treatment as a direct result of IPV; in fact, most were blunt motor vehicle injuries.

In spite of this common mechanism of injury, the response of the medical and trauma communities to domestic violence has been characterized as slow and inconsistent.[6,7] Nurses are the largest group of health care professionals, and are in a prime position to protect the health of victims of IPV through routine assessment and effective intervention.[8] Numerous professional organizations including the American Nurses Association, the American Medical Association, the American College of Surgeons, the American College of Emergency Physicians, along with the Joint Commission, support the practice of screening patients for IPV. The Emergency Nurses Association's position statement on IPV supports universal screening and recognizes that identifying victims of IPV is the first step toward patient advocacy.[9]

The purpose of this study was to identify what nurses perceive as barriers to screening patients for IPV. Perceived potential barriers to screening include the lack of time, lack of training, lack of privacy, fear of offending the patient, and issues surrounding personal experience with domestic violence.

METHODS

This was an anonymous cross-sectional survey study of hospital-based nurses from a 450-bed level I trauma center. Survey Monkey®, a web-based data collection tool, was used for this descriptive study. There were also hard-copied versions of the survey distributed to registered nurse (RN) staff over the duration of the collection period. It was composed of 7 demographic and 22 attitude, barrier, and knowledge-based questions, and was adapted with permission from a previous survey administered to nurses in Israel.[10] There were several multiple-choice questions, and a section composed of 15 self-evaluating statements using a 6-point Likert scale. Responses on the

scale ranged from "highly disagree" to "highly agree." Balanced keying (statements worded both positively and negatively) was used to reduce acquiescence bias. Approval of this study was granted by the Borgess Medical Center Institutional Review Board, and informed consent was implied by completion of the survey.

Registered nurses involved in the study were those employed in inpatient and emergency care areas. They included the emergency department, 4 critical care units, labor and delivery, 4 general medical/telemetry floors, the inpatient psychiatric unit, the case management team, and the nursing resource team. Registered nurses must have been in positions where they provide direct patient care, and this included nurses at the bedside and RNs in care management positions. Registered nurses excluded from this study were those employed in outpatient care and procedural areas such as the operating room, cardiovascular laboratory, outpatient short stay, cardiac short stay, interventional radiology, and neurointerventional laboratory. All data collected in this study were self-reported by the participants.

Participants were recruited through department meetings and other routine unit communication via the intranet/e-mail system, and hard copy surveys were made available for ease of completion over a 4-week period. Periodic reminders were sent via e-mail and face-to-face interactions on the different units. To maintain the respondent's confidentiality, no participant identifiers were included on the returning envelopes.

Datasets were exported to Excel files and then converted into SPSS format. SPSS version 18.0 was used for database management and data analysis. Comparisons were conducted using χ^2 and t test. Correlations were conducted using Spearman test and Pearson.

RESULTS

Of the 494 nurses surveyed, 156 (32%) completed the survey. Of responders, 142 (91%) were female and the mean age was 43.2 years (range 20-68 years); 143 (93%) were white and the mean years of experience was 16.8 years. As illustrated in Table 1, the majority (82.6%) of nurses reported taking care of 2 or less victims of IPV in the last year. Overall, almost half (45.8%) reported not taking care of a single IPV victim in the last year.

TABLE 1 Interactions: Victims of Domestic Violence (n = 156)

You Have Been Involved With at (This Hospital) in the Last Year	%
0	45.8
1-2	36.8
3-5	7.7
>5	9.7

Questions for this study were grouped into 3 major categories: nurses' perceptions of work environment barriers, knowledge or training barriers, and attitude-based barriers.

There were 2 questions regarding work environment. The majority of nurses agreed with the statements that "I have enough time to screen patients for IPV" (81% agreed). Fewer (60%), but still a majority, agreed with the statements that "my work environment provides me the opportunity to screen my patients for IPV" (see Table 2).

The results in Table 3 show that nurses were split regarding training; 56% agreed that they were "adequately trained to recognize signs and symptoms of IPV," and 44% disagreed. To further assess their knowledge base, nurses were queried about risk factors and common assumptions regarding IPV. Nurses correctly ranked poverty and addiction as major risk factors for IPV (see Table 4). However, nurses incorrectly ranked pregnancy above adolescence as a risk factor. There is strong evidence that adolescence is a significant risk factor,[3] while the evidence regarding pregnancy as a trigger for violence is mixed, with some studies finding pregnancy may actually be protective.[11,12] The vast majority of nurses correctly recognized that all patients needed to be screened for IPV, regardless of whether they presented with injuries or not (92% agreed), and that "upper class women" were also victims of IPV (97% agreed). Survey participants were more divided in regard to whether it was "difficult to identify victims" of IPV (43% agreed vs 57% disagreed) (see Table 3).

TABLE 2 Environment

	Highly Agree, %	Agree, %	Agree Somewhat, %	Disagree Somewhat, %	Disagree, %	Highly Disagree, %
My work environment provides me the opportunity to screen my patients for IPV.	7.1	27.9	25.3	18.2	17.5	3.9
I have enough time to screen patients for IPV.	21.3	41.3	18.7	11.0	6.5	1.3

Abbreviation: IPV, intimate partner violence.

TABLE 3 Knowledge

	Highly Agree, %	Agree, %	Agree Somewhat, %	Disagree Somewhat, %	Disagree, %	Highly Disagree, %
I have been adequately trained to recognize signs and symptoms of IPV.	5.8	22.6	27.1	20.0	20.0	4.5
Patients only need to be screened when they present or are admitted with an injury.	2.6	1.3	3.9	11.8	45.4	34.9
It is difficult to identify victims of IPV.	3.2	16.1	36.8	27.7	14.2	1.9
Upper class women are not victims of IPV.	0.7	1.3	0.0	1.3	34.0	62.7

Abbreviation: IPV, intimate partner violence.

Nurses' attitudes about questioning patients on the subject of IPV were broken down into 3 subgroups, which were broadly categorized as ownership (ie, should nurses be screening), RN–patient relationship, and causality. On the subject of ownership, there were 3 questions. RNs strongly agreed with the statements "It is my business if the patient is a victim of IPV" (95%) and "I feel IPV screening is an important aspect of my nursing practice" (90%) (see Table 5). In addition, they disagreed with the statement "Identification of IPV is the responsibility of the physician not the nurse" (95%). In regard to the nurse–patient relationship, nurses agreed with the statement "I am comfortable asking the screening questions for IPV" (77%), but disagreed with the statement "I would lose the patient's trust if I asked questions about IPV" (93%) (see Table 6). Finally, 2 survey questions that were asked pertained to the subject of causality. The vast majority (98%) highly disagreed or disagreed with the statement that "women often bring the violence on themselves." Similarly, 89% of RNs highly disagreed or disagreed with the statement that "a small amount of physical violence exists in every normal family," (see Table 7).

TABLE 4 Risks

Circumstances That Would Put a Woman at the Greatest Risk of Domestic Violence (3 Choices per Surveyed Participant)	%
Pregnancy	47.9
Poverty	75.3
Adolescence	17.1
Minority race	20.5
Being an immigrant	4.1
Addiction	66.4
Criminal record	17.1
Children from another partner	30.1
Other	15.6

DISCUSSION

Most nurses in this study have reported that screening for IPV is important, that it is their responsibility to screen their patients, and that they experience few work environment barriers to screening. Yet, the vast majority in this study have estimated that they have taken care of only 2 or less victims of IPV in the last year. Large population studies suggest that the 1-year prevalence of IPV in the hospital setting is close to 16%. A study by Melnick et al[5] demonstrated that a simple, standardized IPV screening tool used to screen patients admitted to a general trauma service yielded a result of 18% positive screens. The National Violence Against Women Survey, conducted by the National Institute of Justice and the Centers for Disease Control and Prevention, estimated that the *cumulative lifetime prevalence* of IPV of women seen in the emergency department was 54%.[2] Understanding this discrepancy between reality (incidence of IPV = 16%) and perception ("cared for 0 victims of IPV in the last year") is important in improving the identification and management of these patients.

Because of budgetary constraints, electronic medical documentation requirements, and state and federal mandates, RN responsibilities have increased dramatically in the last decade. Despite these changes, more than 80% of nurses surveyed felt they had time to screen patients for IPV. Traditionally, "not enough time to screen" has been cited as a common obstacle to screening.[13] Our survey participants were more likely to note that they did not have an opportunity to screen than they did not have time (40% vs 20%). Many organizations support the practice of allowing family members to be present during all stages of care including invasive procedures and even resuscitation during cardiac arrest.[14] Although family presence may work to increase patient and family satisfaction, it can present challenges to health care workers when trying to address sensitive issues such as IPV. Also, patient care areas within the hospital are not always conducive to asking questions about IPV. Cubicles in emergency departments are sometimes only made "private" by the

TABLE 5 Ownership

	Highly Agree, %	Agree, %	Agree Somewhat, %	Disagree Somewhat, %	Disagree, %	Highly Disagree, %
It is my business if the patient is a victim of IPV.	56.1	33.5	5.8	3.9	0.0	0.6
I feel IPV screening is an important aspect of my nursing practice.	26.5	45.2	18.7	4.5	1.3	3.9
Identification of IPV is the responsibility of the physician not the nurse.	0.6	1.3	3.2	12.9	40.6	41.3

Abbreviation: IPV, intimate partner violence.

presence of curtains, and quite often patients are accompanied by a family member or friends. Many facilities do not have private rooms on their general medical floors, so patients frequently have roommates. To be most effective, questions related to IPV need to be conducted in a private setting, with only the patient and the health care provider present. Registered nurses need to make it a practice to ask for alone time with patients, even if that means restricting visitors during initial admission and routine daily assessments. It also requires flexibility on the nurses' part. If the lack of privacy does not allow the opportunity to screen for IPV initially, the nurse may have to go back and revisit certain topics.

Among study respondents, the most common identified barrier to screening is the lack of training. This is consistent with other studies' findings that the lack of education and instruction on how to ask domestic violence questions poses a significant obstacle to IPV screening.[15] In a review of the literature by Waalen et al,[16] 7 studies using self-administered questionnaires asking respondents to select or rank precoded lists of potential barriers to screening for domestic violence, the lack of provider education about IPV was one of the most commonly reported barriers. Woodtli and Breslin[17] conducted a major national survey of baccalaureate nursing programs accredited by the National League of Nurses. The survey revealed that most curricula included a total of 2 hours or less of violence-related content, and that many respondents indicated that this type of content was mostly through reading assignments.

Nurses responding to our survey recognize that IPV screening is an important aspect of their nursing practice. They have taken ownership of the issue by identifying their role in screening for IPV. By disagreeing with the statement "identification of IPV is the responsibility of the physician…..", RNs recognize that nursing's role to identify victims of IPV is significant. Limited time, the lack of education, and ineffective interventions are all commonly cited as major barriers to providing counseling on other preventive health care recommendations such as smoking cessation, screening for cholesterol, screening for cancer, alcohol consumption, and substance abuse.[16] However, routine screening in all of these areas is frequently done by nurses. This could be attributed to the lack of knowledge about the subject of IPV such as common factors that put women at increased risk, wide-reaching effects of IPV on physical and mental well-being, and resources available within the health care system and the community once IPV is identified. In nursing schools and clinical practice, preventative health screening for more tangible comorbidities such as smoking and alcohol abuse is more commonly taught and widely accepted as universal. Although RNs in this study report that screening for IPV is an important part of their practice, the nurses may be screening on the basis of their index of suspicion, which is likely to be shaped by subjectivity as well as personal knowledge base.[18]

Nurses in this survey reported being comfortable asking these difficult questions and did not feel that they would lose the patient's trust. This is consistent with

TABLE 6 Nurse–Patient Relationship

	Highly Agree, %	Agree, %	Agree Somewhat, %	Disagree Somewhat, %	Disagree, %	Highly Disagree, %
I am comfortable asking the screening questions for IPV.	16.1	37.4	23.2	12.3	9.0	1.9
I would lose the patient's trust if I asked questions about IPV.	0.0	0.6	5.8	17.4	52.9	23.2

Abbreviation: IPV, intimate partner violence.

TABLE 7 Causality

	Highly Agree, %	Agree, %	Agree Somewhat, %	Disagree Somewhat, %	Disagree, %	Highly Disagree, %
Women often bring on the violence themselves.	0.6	0.0	0.0	1.3	18.8	79.2
A small amount of physical violence exists in every normal family.	0.6	1.9	2.6	5.8	35.3	53.8

findings from survivors' interview studies. Survivors have identified that the key component of effective domestic violence interventions by health care providers is asking direct questions, being respectful and concerned, being knowledgeable about the topic, and providing referrals to services. Survivors also report that when they receive encouragement from a health care provider and validation of the abuse, this can be life-changing if it is done without judgment.[19] Greater than 90% of women participants with a history of IPV in a study conducted by Weinsheimer et al[20] felt that it was appropriate to ask about IPV, and that women should be asked about it when in the health care setting. Seventy-one percent wished a previous health care provider would have asked them about it. There is evidence that women support being asked about their violent experiences and that health care providers including nurses can successfully screen patients and be strong advocates for changes in clinical practice, patient protocols, and institutional policies.[21]

LIMITATIONS

A common limitation to survey studies is low response rate. Although our response rate was moderately low, there was a diversity of nurses by age and inpatient units. Another limitation is that this was a single-site study. That our site was a medium-sized, community-based hospital, similar to other level I and II trauma centers in the United States moderated this limitation somewhat. In addition, the responses are the participants' perceptions rather than what may actually be occurring. We did try addressing this issue in regard to knowledge barriers. Not only were nurses asked their perception of their training but also asked specific knowledge-based questions regarding IPV.

CONCLUSION

On the whole, nurses consider IPV screening to be an important part of their job, one with few barriers. Yet, these same nurses report that they have taken care of few, if any, IPV victims in the last year—a perception that is belied by the evidence of population-based studies documenting that upwards of 1 in 6 female patients are IPV victims. Perhaps improved IPV training, which many nurses identified as a need, would change this perception as well as their screening behaviors. Organizations must take steps beyond just meeting the standards for identification of victims set forth by their accrediting body (ie, the Joint Commission). The first crucial step involves health care facilities and their professionals recognizing and understanding the magnitude of the issue. Exceeding the mandatory requirements calls for additional dedication and attention to the issue by hospital leaders—particularly RNs in leadership positions. This goes hand in hand with implementing pertinent education related to IPV and proper documentation tools. When identifying potential victims of IPV is viewed as a priority by those in positions of influence, nurses at the bedside will have the guidance and support they need to effect change in their daily practice. The expectations that the subject be addressed will increase over time, the comfort level with the topic will be enhanced, and the barriers will be fewer.

In addition to further IPV training, the authors encourage other trauma centers to evaluate current screening practices in their facility, along with reviewing their trauma registry data, to ensure accurate identification of IPV patients. Increasing awareness across all levels of care may decrease the chances of IPV being unrecognized and, therefore, underreported.

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