



SCREENING FOR ABUSE: BARRIERS AND OPPORTUNITIES

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Domestic abuse is the leading cause of injuries and death among women of childbearing age in the United States. The broad purpose of this research is to discover how pregnant women's psychological and behavioral responses to abuse affect birth outcomes. To select

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a diverse sample of women, we identified 8 prenatal care sites and completed the human subjects approval process with each.

Rates of screening for abuse range from all but 12 women over a 2-1/2-year period at one site to no screening for abuse at another site. In this article, we will review pertinent literature and discuss the supports and barriers we observed when implementing an abuse screening program using the Abuse Assessment Screen, a well-tested and valid clinical instrument. Suggestions will be made for improving the screening rates at those sites where screening is absent or inconsistent.

The incidence, prevalence, and severity of domestic violence have serious implications for the health care professions. The National Crime Victimization Survey reported that more than 2 million women experience violence annually, and 29% of all violence against women was committed by an intimate. In about half of those couples, assaults took place three or more times per year. Physical violence has been found in one of three marriages (Bachman & Saltzman, 1996). Around the world, from 10% to 50% of women surveyed reported being physically harmed by an intimate partner sometime in their lives (Heise, Ellsberg, & Gottemoeller, 1999).

Researchers have identified domestic violence as a significant medical and public health problem. Battered women seek care for their injuries in all health care settings, including primary care, gastrointestinal specialties, dental, and obstetrics and gynecology (Muelleman, Lenaghan, & Pakieser, 1998). Goldberg and Tomlanovich (1984) found a 22% rate of domestic violence in a sample of male and female patients seen in an emergency setting. Several investigators have identified a significant number of battered women in primary practice settings (Bullock, McFarlane, Bateman, & Miller, 1989; Gin, Rucker, Frayne, Cygan, & Hubbell, 1991; Quillian, 1996). The prevalence of domestic violence in one primary care study was found to be 1 in 12 women (8.2%) (Bullock et al., 1989), and these women reported experiencing more social problems and feelings of stress. Freud, Bak, and Blackall (1996) found an 11.6% prevalence of battered women in a primary care setting. McGrath, Hogan, and Peipert (1998) studied 397 pregnant and nonpregnant women presenting to an obstetrics and gynecology urgent care unit and found that 46% of the women surveyed reported abuse in the past and 10% reported recent abuse.

Health care providers may not be aware that they are treating injuries resulting from domestic violence. Efforts have been undertaken to educate these providers about domestic violence in their patient populations.

Even when providers acknowledge the incidence of domestic violence, frequently they do not ask patients about the cause of their injuries.

In this article, we will review the literature on screening and discuss our impressions and observations of the supports, barriers, and opportunities for screening women during pregnancy for domestic violence. These impressions and observations come from our experiences in an ongoing study of abuse during pregnancy over the past 4 years.

BACKGROUND AND SIGNIFICANCE

Several investigators have documented the value of incorporating routine abuse screening into practice settings (McGrath et al., 1998; Wiist & McFarlane, 1998). In a recent survey of abused and nonabused female patients in urban settings, the investigators found both sets of women agreed that providers should screen women for domestic violence (McNutt, Carlson, Gagen, & Winterbauer, 1999). Nevertheless, reports indicate that health care providers are inconsistent in implementing violence screening protocols.

Detection of Abuse. A number of researchers have focused on health care agencies' and providers' lack of response to screening and providing care for victims of domestic violence. Several studies were conducted in emergency or urgent care departments because the investigators believed these to be sites where battered women would seek care. Olsen and colleagues (1996) uncovered a poor record of detection for domestic violence in settings lacking domestic violence education and protocols. McLeer and Anwar (1989) found that detection increased from 5.6% to 30% following staff training and protocol implementation. Freud and colleagues (1996) found the addition of a screening question increased identification rates from 0% in the control group to 11.6%. In their study, McGrath and colleagues (1998) asked a sample of 397 women about their histories of past or recent abuse and any screening by a clinician. Only 18% of the women recalled ever having been asked about domestic violence by a health care provider.

Sugg, Thompson, Thompson, Maiuro, and Rivara (1999) found from their sample of physicians and physician assistants in primary care clinics at a large urban health maintenance organization that 1 in 10 of these clinicians and nearly half of the nurses or assistants had never identified an abused person. Forty-five percent of these staff members seldom or never asked about domestic violence when examining injured patients. Parsons, Zaccaro, Well, and Stovall (1995) reported that the majority of obstetrician-gynecologists do not screen their patients for current or past abuse.

Impetus for Screening. In 1992 the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) developed new standards for emergency departments, mandating training and protocol development for victims of physical assault and elder and partner abuse. JCAHO revised their standards in 1995 to mandate that all departments of a health care organization develop protocols and training for victims of violence. The American Medical Association, American College of Obstetricians and Gynecologists, and the American Nurses Association have called attention to this serious problem. Yet, even with mandates and heightened awareness, domestic violence continues to be unrecognized or under-recognized in health care settings and the response to domestic violence less than adequate (Cohen, DeVos, & Newberger, 1997; Issac & Sanchez, 1994).

Preparation of Providers. Clinicians' attitudes toward domestic violence may be affected by lack of knowledge. There is a dearth of comprehensive and uniform content about family violence in core curriculums for the health professions (Chambliss, Bay, & Jones, 1995; Ellwood & Rey, 1996; Henricks-Matthews, 1997; Short, Cotton, & Hodgson, 1997).

Henricks-Matthews (1997) assessed inclusion of family violence in the curriculums at Virginia's three medical schools. Responses were received from 48 (70%) of the residency programs within the three schools. The curriculums varied both in content and instructional methods. Twenty-six (54%) of the residency programs indicated that they had some course content on family violence, but they were unable to identify an expert in the mental health consequences or violence prevention. Wodtli and Breslin (1996) surveyed violence-related content in nursing curriculums in the United States. Among responses from 298 nursing programs, 40%–60% indicated they included instruction for two hours or less.

In Reid and Glasser's (1997) sample of physicians, 96% believed that domestic violence should be included in medical education. More than half of their respondents (57%) believed that their education had prepared them inadequately to care for victims of violence. However, after acknowledging this lack of education, nearly half of these respondents stated they would not participate in a domestic violence conference to update their skills. Because responding to domestic violence is not included in educational programs, it has not been considered a valued professional behavior (Kurz, 1987).

Protocols for Screening. Many health care settings continue to lack written protocols for domestic violence and still underestimate injuries related to battering (Isaac & Sanchez, 1994; Lee, Lettlier, McLoughlin,

& Salber, 1993; Morrison, 1987). Isaac and Sanchez (1994) sent questionnaires to all 90 emergency departments in Massachusetts to determine the prevalence of written protocols for domestic violence. They received a response rate of 79%. Only 14 emergency departments (20%) reported having written protocols. Half reported seeing victims of domestic violence in less than 2% of their patient population.

Introduction of domestic violence protocols should improve health care providers' awareness of the problem and strengthen the clinical skills needed for effective intervention (McLeer & Anwar, 1989; Tilden & Shepard, 1987). However, success has been limited even with such protocols and training (Wright, Wright, & Isaac, 1997). McLeer, Anwar, Herman, and Maquiling (1989) found that the introduction of a domestic violence protocol increased identification of battered women from 5.6% to 30%, but on follow-up, the identification rate had dropped to 7.7%.

Waller, Hohenhaus, Shah, and Stern (1996) introduced an emergency department screening and referral protocol. Of the 595 female patients who were eligible, only 114 were screened. Of those screened, 4 (3.5%) patients were confirmed victims of domestic violence. Lee and colleagues (1993) surveyed 397 emergency departments and received a response rate of 87%. Respondents reported having protocols in place (54%), and that they had few battered women in their patient populations. Most of the protocols did not meet JCAHO requirements, and only 14% were comprehensive. Success of the protocols was very limited because of poor staff compliance, confusion about the protocols, and time constraints.

Training Providers to Screen. Even with implementation of training and on-site services for victims of interpersonal violence, McKibben and colleagues (2000) reported that maternal-child health care providers in two Boston community health centers failed to provide consistent screening. Barriers to screening included clinicians' perceptions of interpersonal violence as a problem beyond their scope of practice and lack of systems' approaches and policies to increase accountability for screening.

Roberts, McKibben, Hathaway, and Robinson (1996) studied the implementation of domestic violence training with a variety of health care professionals. The training curriculum was evaluated through the use of a pretest, a post-test immediately after training, and a 6-month follow-up survey to assess knowledge, attitudes, and practices. Of the 357 health care providers surveyed, 204 returned the follow-up survey. After the training, knowledge and attitude scores improved and screening rates increased from 21% to 37%. Although they reported improvement in their knowledge after training, the health care providers indicated that their feelings did not change. They still found caring for victims of domestic violence to be frustrating and difficult.

Caring for Victims. Health care providers' responses to patients whom they have identified through screening are not always therapeutic, and their interventions at times have been perceived by battered women as inadequate or nonexistent (Campbell, Pliska, Taylor, & Sheridan, 1994; Sugg & Inui, 1992). Campbell and colleagues (1994) found that half of the battered women in their study reported negative experiences in the emergency departments. The women felt humiliated, blamed for their abuse, had abuse minimized, and were offered insufficient referral information. Health care provider bias can negatively influence the care of battered women (Campbell et al., 1994). There is resistance to the medicalization of battering; providers have reported that caring for victims of domestic violence takes away from the real work of health care (Kurz, 1987). Even with the heightened awareness in the health care community, domestic violence has not been viewed as a legitimate area for medical intervention (Campbell et al., 1994).

Victims of domestic violence have reported experiencing institutional and provider biases in health care. Gerbert and colleagues (1996) conducted 31 in-depth interviews to assess battered women's perspectives on medical care. In 14 of the 26 encounters, women stated that the health care provider was uninterested, uncaring, and uncomfortable. Some of the women felt trivialized, stigmatized, ignored, or ridiculed. Warshaw (1989), in a study of provider behaviors in an emergency room, noted that nurses and physicians tended to medicalize their responses to victims by focusing on the patients' pathology, but ignoring the reasons for the injury. Barriers to exploring the patient's abusive situation included provider beliefs that the psychosocial aspects of abuse were outside the realm of medical intervention, limited time availability, as well as concerns about dealing with unpleasant feelings and social service agencies if abuse was disclosed. Warshaw suggested that practice based on the medical model was inappropriate with abuse victims and only reinforced the victimization women had experienced in abusive situations.

Barriers to Screening. In addition to individual attitudes and bias, other barriers include the following: lack of education, belief that domestic violence is not a problem for their patients, lack of time, lack of comfort with the topic, a personal history of abuse, and fear of offending patients (Kurz, 1987; Parsons et al., 1995; Rodriguez, Quiroga, & Bauer, 1996; Sugg & Inui, 1992). Cullinane, Alpert, and Freud (1997) found that 38% of the first-year medical students in their survey had a personal history of family violence. Fishwick (1998) discussed several possible reasons nurses might be hesitant to screen. Stereotyped images of abused women, a belief that screening for abuse is outside the scope of practice, lack of confidence in dealing with women's disclosures, and nurses'

personal or family experiences with abuse are potential barriers. Other barriers included language and cultural differences between nurses and patients. Moore, Zaccaro, and Parsons's (1998) findings support those of Fishwick (1998). In their survey of nurses in perinatal practice in hospitals, public health, and private offices, Moore and colleagues found nearly 50% of their sample had no education about domestic violence and nearly one-third reported abuse of themselves or of family members.

In a recent survey of primary care physicians in California, Rodriguez, Bauer, McLoughlin, and Grumbach (1999) found that the physicians routinely screened injured patients for intimate partner abuse, but few screened new patients, prenatal patients, or patients presenting for periodic check-ups. Barriers commonly cited by the physicians included the patients' fears of retaliation and police involvement (California has mandatory reporting of domestic violence), lack of patient disclosure and follow-up, and cultural differences between physicians and patients. Physicians practicing in public clinics were more likely to screen than those practicing in private offices or health maintenance organizations, suggesting stereotyped images of abused women.

Sugg and colleagues (1999) found that a quarter of the clinicians in their sample believed that the abused person's personality led to the violence, and slightly more believed they lacked strategies to help abused persons. About 20% of the clinicians identified concern for their own personal safety as a barrier to discussing domestic violence.

D'Avolio and Mahoney (1998) identified the following barriers to screening in their study of a community health center's staff responses to domestic violence: language or cultural values (52%), time constraints (46%), and frustration that the victim may not act upon their suggestions (31%). More than half of the participants stated that more resources were needed to assist them in their roles as health care providers. The additional resources identified were more printed resources for the patients and health care providers; more mental health and social services; and 59% were unclear about the role of employee assistance in addressing domestic violence.

Sometimes victims of domestic violence choose to remain silent even when providers do ask. Rodriguez and colleagues (1996) conducted qualitative interviews with battered women. Several themes emerged that contributed to victims' silence about the abuse. Victims often do keep silent due to fear of escalating the violence and economic dependency. The reported health care barriers include the high cost of medical care, long waiting periods, embarrassment, concerns about police, and the lack of trust in the health care provider. Their participants identified the need for health care providers to establish a relationship of respect and trust with their patients.

INITIATING A SCREENING PROTOCOL AS PART OF A RESEARCH STUDY

The broad purpose of our research project is to discover how pregnant women's psychological and behavioral responses to abuse affect birth outcomes. To select a diverse sample of pregnant women, we identified 8 prenatal care sites and completed the human subjects approval process with each. The sites are a major public hospital, a small city hospital, a large managed care system, a community health center, 2 hospital-based prenatal care programs, and 2 hospital-based perinatal programs with satellites in community health centers. The pregnant women come from Hispanic, Haitian, Southeast Asian, and Brazilian backgrounds, as well as being African Americans, Asian Americans, and European Americans. They range in age from their teens to thirties.

The protocol for the study has, as its foundation, screening of every pregnant woman for abuse using the Abuse Assessment Screen (AAS) developed by the Nursing Research Consortium on Violence and Abuse (McFarlane, Parker, Soeken, & Bullock, 1992). The AAS is a 5-item tool that asks pregnant women about frequency and type of current and past domestic violence and includes physical, sexual, and emotional abuse. The AAS can be completed in less than a minute.

The screening is done by clinicians who are nurses, nurse-midwives, and nurse practitioners, at each of the 8 prenatal care study sites. Members of our research team trained all persons responsible for screening women at each study site, as well as any other interested staff members, in the use of the AAS. This training included techniques for screening and how to intervene if women reveal abuse and request help. In addition, we provided brochures to help the women and health care providers with identification of the cycle of violence, resources and making a safety plan, posters on domestic violence, laminated cards for the clinicians with hints on screening and domestic violence hotline numbers, and an annotated compendium of domestic violence resources for the entire eastern half of Massachusetts.

RATES OF SCREENING AND BARRIERS TO SCREENING

Rates of screening have ranged from all but 12 women over a 4-year period in one site to no screening for domestic violence at another study site. To date, 41% (n = 1,671) of women in the cohorts cared for by the study sites (N = 4,330) have been screened for abuse and 59% (n = 2,659) have not. Among the women screened with the AAS (n = 1,671), 16.3% (n = 267) admitted to ever having been emotionally or physically abused and 7.2% (n = 115 of 1,601) in the past year. Fifty

eight (4.3%) of the women screened positive for abuse while pregnant. Abuse screening by nurses has continued to be inconsistent even after we provided retraining and positive reinforcement for screening.

Over the 4 years of the project, we have formed impressions and observations about the barriers to screening at the study sites. These barriers appear to exist both at the system and individual provider levels. Changes forced by chaos in health care that pose impediments to screening include frequent turnover of administrators, mergers among health care agencies and institutions, new ownership of study sites and prenatal care practices, and focus on cost-driven care. If administrators who are committed to screening do not communicate such a commitment to clinicians, screening may fall to the bottom of their lists of priorities.

Many system-level barriers to screening are common to all study sites, such as cost-driven care resulting in significant time constraints for providers. System-specific barriers varied predictably with the complexity of the individual health care system. In the major public teaching hospital, systematic barriers to screening with the AAS included multiple part-time temporary prenatal care providers (that is, students and residents) who were not available for training on the principles and protocol for domestic violence screening; subdivisions within the obstetrics department, each with different practice styles and protocols; and inconsistent entry into care, meaning that many patients bypassed the prenatal intake nurse, a consistent screener, because of late access to care, comorbidity, or an ongoing alcohol or substance abuse problem. To the extent that screening was done, additional barriers existed in documenting the screening by the AAS. Some prenatal care providers screened for domestic violence using questions other than the AAS and documented as such. As an additional form, the AAS, even when used, often did not make it into the patients' permanent medical records. At one study site, we were asked to put the AAS in each new patient record to facilitate screening. The AAS consistently disappeared from the charts, suggesting that providers were unwilling or uninterested in screening.

Barriers to screening at the provider level are multiple and complex, and result from both internal and external struggles. Many providers at the study sites directly attribute their screening practices to their personal experiences with family violence, responding to either feelings of futility or passionate advocacy. Some providers did not screen specifically to avoid "difficult feelings" for themselves and their patients, while others screened universally and remained protective of their patients, to the point of not involving additional providers in cases of identified domestic violence. Barriers to screening at the provider level that result from external forces include lack of resources for appropriate referral and lack of confidence in governmental systems of support, such as the state de-

partment of social services. Some providers use a "Don't ask, don't tell" policy to avoid mandated involvement of a system they do not trust. This censorship parallels women's "Don't tell" behavior based on a similar lack of trust in their providers.

Among providers, there is also a lack of consensus as to when in pregnancy to screen and whether to screen more than once during pregnancy, a perceived lack of time to do the screening, and a lack of belief in the importance of screening. If a prenatal care site lacked a consistent person doing prenatal care intakes who was deeply committed to screening, it often was not done. Health care providers voiced fears about what to do if a woman admits abuse, perceived lack of administrative support for screening, suffered under increasing demands to see more patients per time slot, believed that domestic violence is not a problem in their patient populations (the not in my patient population [NIMPP] syndrome), were unwilling to help women who admit to abuse, and lacked patience with women who are unwilling to leave abusive relationships. Campbell (1998) echoed our beliefs that these barriers represent missed opportunities to uncover domestic violence because the "perinatal period provides the critical 'window of opportunity'" when women repeatedly return to health care settings (p. 185).

OPPORTUNITIES

Through our observations and experiences, we have identified several opportunities for and keys to implementing a screening program. If screening can be integrated into a routine of care, clinicians are more likely to screen. Having one nurse do all the intake prenatal screening may mean that all women will be screened. The commitment of key people is instrumental in assuring that screening becomes the standard of care. Clinicians who believe help is available if they uncover abuse are more likely to screen. Convincing clinicians to give screening a try by demonstrating it with them is important. If clinicians are confident that they will be able to respond appropriately when a woman reveals abuse, they are much more likely to screen.

SOLUTIONS TO THE SCREEN-NO SCREEN DILEMMA

Training clinicians in screening and response techniques and providing them support has increased the rates of screening in some study sites, as does providing resources and training in how to respond to a positive screen. Offering clinical practice in screening with a mentor may help to increase the implementation of screening programs. When administrators require documentation of screening, clinicians are held accountable

and follow through with screening. Noting that screening for domestic violence is part of the standards of care alerts clinicians to their responsibility to screen. Using a consistent tool for screening takes the onus off the clinician for creating random questions and makes screening part of the routine prenatal data collection. When we provide refresher training at the study sites and interact one-on-one with nurses responsible for screening, the rates of screening go up. A personal investment in the problem of domestic violence seems to influence whether clinicians believe it is important to screen every woman.

Training undergraduate and graduate nursing students in screening and response techniques as part of health assessment courses has the potential to add to the cadre of health care professionals who consider screening for abuse as a routine part of care. We can provide leadership in training other health care professionals such as occupational therapists (OT) and OT assistants, physical therapists (PT) and PT assistants, emergency medical technicians, and physician assistants. Fishwick (1998) noted that universal screening will evolve when a generation of nurses has been educated about domestic violence and observe that their nurse preceptors model the behavior in a manner that benefits victims of abuse.

CONCLUSIONS

The health care community continues to do little to improve its response for victims of violence (Cohen et al., 1997). Advocacy for victims of violence traditionally has come mainly from social service agencies and professionals. The exceptions to this are individual clinicians who advocate for their patients in spite of an inadequate institutional response and very little institutional preventive effort. The health care providers who screen for domestic violence and then care for victims often feel marginalized and report lack of support, as well as other disincentives to screening. According to Larkin and colleagues, "Protocols and education, alone or in tandem, are insufficient to increase victim identification rates. . . . Lack of comfort, fear of offending, feelings of powerlessness, and time constraints . . . [are] major barriers to provider interventions" (1999, p. 673).

In prenatal care settings, there are opportunities to address concerns of women and their unborn babies and the potential to break the cycle of violence. If screening can be integrated into the routine of prenatal care, rates of screening are very high. Lack of institutional commitment has been cited as one possible reason for failing to screen (McLeer & Anwar, 1989). Persons in administrative and clinical positions committed to screening appear to be key to fulfilling the professional standard of screening every pregnant woman. Wiist and McFarlane (1999) concluded

from their study of the effectiveness of an abuse assessment protocol that such a protocol "integrated into the routine procedures of a public health prenatal clinic can lead to increased detection of abuse, referral, and documentation in the maternity medical record" (p. 1220).

REFERENCES

- Bachman, R., & Saltzman, L. E. (1996). Violence against women: Estimates from the redesigned survey. *Bureau of Justice special report*. (NJC No. 154348). Washington, DC: U.S. Department of Justice.
- Bullock, L., McFarlane, J., Bateman, L. H., & Miller, V. (1989). The prevalence and characteristics of battered women in a primary care setting. *Nurse Practitioner, 14*, 47–55.
- Campbell, J. (1998). Abuse during pregnancy: Progress, policy, and potential. *American Journal of Public Health, 88*, 185–187.
- Campbell, J. C., Pliska, M. J., Taylor, W., & Sheridan, D. (1994). Battered women's experiences in the emergency department. *The Journal of Emergency Nursing, 20*(4), 280–288.
- Chambliss, L. R., Bay, R. C., & Jones, R. F. (1995). Domestic violence: An educational imperative? *Journal of Obstetrics and Gynecology, 172*, 1035–1038.
- Cohen, S., DeVos, E., & Newberger, E. (1997). Barriers to physician identification and treatment of family violence: Lesson learned from five communities. *Academic Medicine, 72*(1 Suppl.), s19–25.
- Cullinane, P. M., Alpert, E., & Freud, K. M. (1997). First-year medical students' knowledge of, attitudes toward, and personal histories of family violence. *Academic Medicine, 72*, 48–50.
- D'Avolio, D., & Mahoney, M. A. (1998). *Integrated community response: Domestic violence action plan*. Unpublished manuscript, Northeastern University, Boston.
- Ellwood, A. L., & Rey, L. D. (1996). Awareness and fear of violence among medical and social work students. *Family Medicine, 28*, 488–492.
- Fishwick, N. J. (1998). Assessment of women for partner abuse. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 27*, 661–670.
- Freud K. M., Bak, S. M., & Blackall, L. (1996). Identifying domestic violence in primary practice. *Journal of Internal Medicine, 11*, 44–46.
- Gerbert, B., Johnston, K., Caspers, N., Bleecker, T., Woods, A., & Rosenbaum, A. (1996). Experiences of battered women in health care settings: A qualitative study. *Women and Health, 24*, 1–17.
- Gin, N. E., Rucker, L., Frayne, S., Cygan, R., & Hubbell, F. A. (1991). Prevalence of domestic violence among patients in three ambulatory care internal medicine clinics. *Journal of General Internal Medicine, 6*, 317–322.
- Goldberg, W. G., & Tomlanovich, M. C. (1984). Domestic violence victims in the emergency department: New findings. *Journal of the American Medical Association, 251*, 3259–3264.
- Heise, L., Ellsberg, M., & Gottemoeller, M. (1999). Ending violence against women. *Population Reports*. (Series L, No. 11). Baltimore, MD: Johns Hopkins University School of Public Health, Population Information Program.

- Henricks-Matthews, M. K. (1997). A survey of family-violence curricula in Virginia medical schools and residencies at university medical centers. *Academic Medicine*, 72(1), 54–56.
- Isaac, N. E., & Sanchez, R. L. (1994). Emergency department response to battered women in Massachusetts. *Annals of Emergency Medicine*, 23, 855–858.
- Joint Commission on Accreditation of Health Care Organizations (JCAHO). (1995). *Accreditation Manual for Hospitals*. Oakbridge Terrace, IL: Author.
- Kurz, D. (1987). Emergency department responses to battered women: Resistance to medicalization. *Social Problems*, 34, 69–81.
- Larkin, G. L., Hyman, K. B., Mathias, S. R., D'Amico, F., & MacLeod, B. A. (1999). Universal screening for intimate partner violence in the emergency department: Importance of patient and provider factors. *Annals of Emergency Medicine*, 33, 669–674.
- Lee, D., Lettlier, P., McLoughlin, E., & Salber, P. (1993). *California hospital emergency departments' response to domestic violence: Survey report*. San Francisco: Family Violence Prevention Fund.
- McFarlane, J., Parker, B., Soeken, K., & Bullock, L. (1992). Assessing for abuse during pregnancy: Severity and frequency of injuries and associated entry into prenatal care. *Journal of the American Medical Association*, 267, 3167–3178.
- McGrath, M. E., Hogan, J. W., & Peipert, J. F. (1998). A prevalence survey of abuse and screening for abuse in urgent care patients. *Obstetrics and Gynecology*, 91, 511–514.
- McKibben, L., Hauf, A. C., Must, A., & Roberts, E. L. (2000). Role of victims' services in improving intimate partner violence screening by trained maternal and child-health care providers—Boston, Massachusetts, 1994–1995. *Morbidity and Mortality Weekly Report*, 49(6), 114–117.
- McLeer, S. V., & Anwar, R. A. (1989). A study of battered women presenting in an emergency department. *American Journal of Public Health*, 79, 65–67.
- McLeer, S. V., Anwar, R. A., Herman, S., & Maquiling, K. (1989). Education is not enough: A systems failure in protecting battered women. *Annals of Emergency Medicine*, 18, 651–653.
- McNutt, L. A., Carlson, B. E., Gagen, D., & Winterbauer, N. (1999). Reproductive violence screening in primary care: Perspectives and experiences of patients and battered women. *Journal of the American Medical Women's Association*, 54, 85–90.
- Moore, M. L., Zaccaro, D., & Parsons, L. H. (1998). Attitudes and practices of registered nurses toward women who have experienced abuse/domestic violence. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 27, 175–182.
- Morrison, L. J. (1987). The battering syndrome: A poor record of detection in the emergency department. *The Journal of Emergency Medicine*, 6, 521–526.
- Muelleman, R. L., Lenaghan, P. A., & Pakieser, R. A. (1998). Nonbattering presentations to the ED of women in physically abusive relationships. *American Journal of Emergency Medicine*, 16, 128–131.
- Olsen, L., Ancil, C., Fullerton, L., Brillman, J., Arbuckle, J., & Skalar, D. (1996). Increasing emergency physician recognition of domestic violence. *Annals of Emergency Medicine*, 27, 741–746.
- Parsons, L. H., Zaccaro, D., Well, B., & Stovall, T. G. (1995). Methods of and attitudes toward screening obstetrics and gynecology patients for domestic violence. *American Journal of Obstetrics and Gynecology*, 173, 381–386.

- Quillian, J. P. (1996). Screening for spousal or partner abuse in a community health setting. *Journal of the American Academy of Nurse Practitioners*, 8, 155–160.
- Reid, M. A., & Glasser, M. (1997). Primary care physician's recognition of and attitudes toward domestic violence. *Academic Medicine*, 5, 153–158.
- Roberts, E. L., McKibben, L., Hathaway, J., & Robinson, L. (1996, November 18). Evaluation of domestic violence training for health providers: Implications for program planning and policy development. Unpublished report, presented at the American Public Health Association, New York.
- Rodriguez, M. A., Quiroga, S. S., & Bauer, H. M. (1996). Battered women's perspectives on medical care. *Archives of Family Medicine*, 5, 153–158.
- Rodriguez, M. A., Bauer, H. M., McLoughlin, E., & Grumbach, K. (1999). Screening and intervention for intimate partner abuse. *Journal of the American Medical Association*, 282, 468–474.
- Short, L. M., Cotton, D., & Hodgson, C. S. (1997). Evaluation of the module on domestic violence at the UCLA School of Medicine. *Academic Medicine*, 72(1Suppl.), S75–92.
- Sugg, N., Thompson, R. S., Thompson, D. C., Maiuro, R., & Rivara, F. P. (1999). Domestic violence and primary care. *Archives of Family Medicine*, 8, 301–306.
- Sugg, N., & Inui, T. (1992). Primary care physician's response to domestic violence. *Journal of American Medical Association*, 267, 3157–3160.
- Tilden, V., & Shepard, P. (1987). Increasing the rate of identification of battered women in an emergency department: Use of a nursing protocol. *Research in Nursing & Health*, 10, 209–215.
- Waller, A. E., Hohenhaus, S. M., Shah, P. J., & Stern, E. A. (1996). Development and validation of an emergency department screening and referral protocol for victims of domestic violence. *Annals of Emergency Medicine*, 27, 754–760.
- Warshaw, C. (1989). Limitations of the medical model in the care of battered women. *Gender and Society*, 3, 506–517.
- Wiist, W. H., & McFarlane, J. (1998). Severity of spousal and intimate partner abuse to pregnant Hispanic women. *Journal of Health Care for the Poor and Underserved*, 9, 248–261.
- Wiist, W. H., & McFarlane, J. (1999). The effectiveness of an abuse assessment protocol in public health prenatal clinics. *American Journal of Public Health*, 89, 1217–1221.
- Wodtli, M. A., & Breslin, E. (1996). Violence-related content in the nursing curriculum: A national study. *Journal of Nursing Education*, 35, 367–374.
- Wright, R. J., Wright, R. O., & Isaac, N. E. (1997). Response to battered mothers in the pediatric emergency department: A call for an interdisciplinary approach to family violence. *Pediatrics*, 99, 186–192.