

Intimate Partner Violence Screening and Brief Intervention: Experiences of Women in Two New Zealand Health Care Settings

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The identification of intimate partner violence (IPV) against women as a public health problem has led to routine health care site-based screening and brief intervention policies. However, there is a lack of evidence supporting the usefulness and safety of such policies. Our objective was to ascertain the acceptability, usefulness, and harm of a brief health care site-based screening intervention. In this qualitative study, semistructured interviews were conducted with 36 women several weeks after a standardized screening intervention in either an emergency department (adult and paediatric) or primary health care setting. The majority of women (97%) welcomed the IPV screening intervention and perceived it as nonthreatening and safe. The women reported no increased risk of harm because of the screening. The responses showed that the intervention had a therapeutic and educational quality, and the attitude and approach of the person asking the intervention questions was critical to a positive outcome. Women without a history of violence cautioned that IPV screening may be offensive to those who are abused, whereas those who reported abuse thought IPV screening was essential “to stop it [from] happening.” Our findings challenge concerns that IPV screening is offensive to women and increases their potential for danger. Participants were appreciative of the opportunity to tell their abuse stories in a safe and supportive context, and challenged the health care system to implement IPV screening, asking “What took you so long?” *J Midwifery Womens Health* 2008;53:504–510 © 2008 by the American College of Nurse-Midwives.

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INTRODUCTION

Intimate partner violence (IPV) is recognized internationally as a significant public health problem, especially for women and children.^{1–4} In addition to injuries, disabilities, and death, women who have been abused may experience long-term health effects such as post-traumatic stress disorder, depression, sleep problems, anxiety, and frequent headaches.^{5,6} Acknowledging the personal, psychological, social, and medical costs of IPV, health care systems have developed policies for routine IPV screening and interventions. Instituting screening within health care systems has been difficult. Common barriers cited in the literature include a lack of provider education, fear of offending patients, limited time, and a lack of effective interventions.^{7,8} These barriers have placed violence within relationships outside of routine health care practice. This is unacceptable given the high prevalence and significant health consequences of IPV.

Studies indicate that women do not mind being asked questions about abuse.^{9–11} A recent meta-analysis of 25 qualitative studies cited women’s desire for health professionals to be “nonjudgmental, nondirective, individually tailored and appreciative of the complexity of partner violence.”¹² However, across these qualitative

studies, few women had actually experienced health care site-based IPV intervention within a screening program. It is therefore important to determine how women in the health care setting are affected by screening and whether screening can result in harm.¹³ Four recent systematic reviews^{13–16} all concluded that there is a lack of evidence supporting screening and intervention effectiveness, not because studies have found screening ineffective, but because “adequate” studies have not been conducted. Randomized controlled trials are currently being planned that will quantify selected effects of screening and intervention. However, it is important to gain an understanding of women’s experience of screening and intervention, and this information is best captured using qualitative methods. The role of qualitative approaches in assessing the effectiveness and appropriateness of health and social interventions is now widely recognized,¹⁷ although qualitative studies are rarely included in systematic reviews. Lachs¹⁸ recently suggested that for family violence interventions, “Perhaps the type of evidence we demand for this kind of healing should be different from what we demand for the efficacy of anticoagulation in atrial fibrillation.” The authors of the current study would advocate for both quantitative and qualitative approaches informing IPV screening and intervention based on their belief that “combining stories and numbers” provides the most compelling evidence.¹⁹

Two studies were recently conducted in Aotearoa/New Zealand to estimate the prevalence of IPV among women seeking health care.^{20,21} This paper reports the findings

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of a third study in which the women in the two previous studies, who had been screened for IPV and received a brief intervention, were asked how they felt about health care site-based screening and how it affected them and their children. This study was conducted to give voice to women's experiences so that they too can inform policy.

METHODS

The aim of this study was to determine men's perceptions of the acceptability, usefulness, and harm of a health care site-based screening for IPV. A qualitative descriptive approach using semistructured interviews was used. Women who had participated in two previous studies measuring IPV prevalence were eligible to be interviewed in this follow-up study.

The original prevalence studies were conducted in two Aotearoa/New Zealand health settings: an adult and pediatric emergency department (N = 174; 80% response rate; 21% IPV screen-positive; 44% lifetime IPV history) and a Māori (indigenous people of Aotearoa/New Zealand) health provider community clinic (N = 109; 77% response rate; 23% IPV screen-positive; 78% lifetime IPV history). The screening and intervention protocol was the same across the two sites and consistent with international guidelines.^{22,23} The protocol details have been specified in earlier publications.^{20,21} Eligibility was consistent with routine or universal screening policies; exclusion criteria were limited to severe injury or illness (based on triage category in the emergency department), non-English speaking, and unable to participate in the informed consent process because of impairment. Trained nurse research assistants administered the screening and intervention protocol during randomly selected time periods. Screening questions included the following: "Within the past year, have you been hit, slapped, kicked or otherwise physically hurt? If so, by whom?"; "Within the past year, have you been forced to have sexual activities against your will? If so, by whom?"; and "Is there a current or past partner that is making you feel unsafe?" Women who screened positive were given affirming messages (such as "No one deserves to be hit" and "It is not your fault"), assessed for safety, and offered social work or community referrals. At the conclusion of the screening interview, women

were asked if they could be contacted for a follow-up interview. In the emergency department setting, only women who reported a history of abuse (current or lifetime; n = 77) were invited to participate. All women who were screened in the Māori health care clinic were invited (n = 109) to participate so as to purposively oversample Māori. For the 67 women (36%) who agreed to follow-up, a safety plan was made for a telephone or face-to-face interview. The Auckland Ethics Committee approved the research protocol.

Trained researchers conducted the interviews 2 to 8 weeks after the women's initial health care visit. No researcher interviewed women they had screened in the prevalence studies, and only two interviews were conducted face-to-face. Numerous attempts were made to reach each woman, except in cases where women had indicated a safety concern. Interviewers were aware of emergent and nonemergent safety actions and referrals. Telephone conversations began with, "Is this a quiet, private time to talk?" Informed consent was revisited, and the women were reminded that the interview would be audio recorded and subsequently transcribed. The semistructured interviews were guided by a list of 17 items addressing four domains (experience of screening, response to interviewer, perceived usefulness, and safety).

Interview transcripts were checked for accuracy and entered into NVivo, version 2 (QSR International Pty Ltd; Doncaster, Victoria, Australia), a code-and-retrieve computer software package for managing qualitative data.²⁴ The second author (L.G.) categorized discrete data then carried out a descriptive content analysis²⁵ for words, phrases, and exemplary stories that captured the participants' responses within the four identified domains. Finally, the women's stories were considered holistically and emergent themes were identified. The co-investigators met to discuss and validate the credibility of the findings.

RESULTS

Among the 67 women involved in the prevalence study who agreed to follow-up, 30 could not be contacted (14 phone numbers answered by machine only, 11 numbers no longer in service, 5 answered but woman not in); one contacted woman declined to participate; and 36 (54%) were successfully contacted and interviewed. The interviews ranged from 10 to 45 minutes in length. Compared to all potentially eligible women for this follow-up study (n = 186), women who consented to follow-up and were successfully interviewed (n = 36) were somewhat older, less likely to report their primary ethnic identity as Māori, and less likely to have screened positive for IPV (Table 1). Of the 36 women interviewed, 16 had been screened in the emergency department and 20 in the clinic. The mean age of the women was 39 years (range,

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Table 1. Sample Characteristics

	Emergency Care Center		Clinic	
	Eligible ^a (n = 77)	Participants (n = 16)	Eligible ^b (n = 109)	Participants (n = 20)
Age (yrs)				
Mean (SD)	34 (15)	35 (11)	39 (14)	43 (13)
Range	16–82	20–57	17–82	27–72
Ethnicity, n (%)				
Pakeha (European)	36 (47)	8 (50)	16 (15)	5 (25)
Maori	20 (26)	5 (31)	78 (72)	12 (60)
Pasifika	15 (19)	3 (19)	9 (8)	2 (10)
Other	2 (3)	0	1 (<1)	0
Missing	4 (5)	0	5 (5)	1 (5)
IPV status, n (%) ^c				
Screen positive	37 (48)	12 (75)	25 (23)	3 (15)
Lifetime positive	40 (52)	4 (25)	60 (55)	9 (45)
Negative	0	0	24 (22)	8 (40)

^aFor the emergency care center sample, only women who had screened positive for current or lifetime IPV were eligible for the current study.

^bFor the clinic sample, all women were eligible for the current study.

^cScreen positive refers to abuse limited to the past 12 months. Lifetime positive refers to historical abuse (but not in the past 12 months).

20–72). Follow-up participants included 17 women who identified as Māori, 13 as white (Pakeha/European), 5 as Pasifika, and one woman whose ethnic identity was unknown. Of the 36 women, 15 (42%) had screened positive for IPV, 13 (36%) experienced lifetime IPV but screened negative for current IPV, and 8 (22%) had not experienced IPV. Excerpts from the participants' responses and stories follow, categorized into each of four domains. Where appropriate, reference is made to IPV status and ethnic identity.

Experience of the Screening Process

Women generally accepted being asked questions concerning IPV. The most commonly used expression was "It was just fine." Some women who had experienced IPV in the past expressed that they were surprised, embarrassed, or ashamed when initially asked about abuse:

I nearly started crying [laughs] when she started questioning me on those things, because I could still remember as though it was yesterday. Then I felt comfortable. I guess it was her, the person interviewing me. She was very understanding.

One woman reported feeling stressed by the process of being screened; she had been interviewed in the pediatric emergency department when her baby was being admitted to hospital:

My baby was unwell and added on top of that having to think about what happened in the past, it was a bit stressful. I hadn't really dealt with those feelings [...] but it's a good idea to ask

people, but maybe not when your child is sick in hospital.

Thirty-five women reported that being asked questions about IPV felt safe; one woman was unsure—she did not elaborate why. Several women expressed some concern about their privacy when interviewed in a room with one side curtained. For other women, it was the first safe space they had ever had to talk about violence in their lives. A Pasifika woman commented:

I did feel safe and believe it or not it felt good to finally release it. I've never been able to express it before. I've told a few ones about having been abused, but not going into the details and all that.

A number of women who screened negative commented on how screening might be offensive for those who have experienced abuse. Yet all the women (n = 36), regardless of violence history, said that neither the questions nor being asked them was offensive.

Responses to Attitude and Approach of Interviewer

The responses of the women to questions concerning the attitude and approach of the nurse who interviewed them in the health care setting were very positive. While nearly all of the women (97%) felt culturally safe, women who identified as Māori asked for more culturally informed care:

Because I'm Māori there are other ways to deal with these things [...] There could be some better processes for Māori women.

Some felt interviewer client ethnic matching was ideal ("I think it has to be Māori to Māori. Māori getting

together explain things more.”) However, a Pasifika woman took a different position: “*It was better she [the interviewer] was Palangi [European] because some people from the Islands are really hard when there are problems with hitting and that.*” But regardless of cultural match, that something was being done was recognized as important: “[. . .] *there are people out there like you who are trying to make something happen for our people.*” White women (Pakeha/European), who made up 22% of the participants, made few comments regarding their cultural safety. Both the interviewer’s questions and the respondent’s answers tended to focus on personal characteristics rather than cultural differences.

All of the women (n = 36) reported feeling supported by the nurse research assistant interviewers; none felt they had been judged. Women commented that they felt listened to, that the interviewer was supportive, caring, and did not respond negatively to their disclosure.

Perceived Usefulness of Screening and Intervention

The majority of the women (64%) reported that being screened for IPV taught them something, whether about IPV (such as the different types of abuse), themselves, or the society in which they lived. Some women felt they had gained a new perspective, such as realising that the abuse was not their fault or that it happened to many women:

I feel finally released of that burden and pain [. . .] It helped a lot. All these years I have felt it was my fault, that I had caused it.

I’ve learned [from the screening interview that] it was not only me that went through that kind of situation; there are plenty of others maybe worse off than me.

Women also reported that screening provided permission for them to talk about the abuse with others, such as their partner, friends, mothers, sisters, and children. One woman went straight home and told her husband who abuses her:

But I told him, “When you’re hitting me, that’s why I need to talk to someone.” He insulted me [. . .] But I told him, “You give me any argument and I will ring and tell that lady.”

For another woman, IPV screening was the impetus for talking with some close friends about the abuse she had experienced:

Actually they were surprised and shocked; [. . .] they saw a different side of me and they didn’t believe that I went through that kind of thing.

While women with children living in their home (n = 14) felt that their experience of IPV screening and

intervention had not changed anything for their children, it had initiated conversations, in some instances for the first time:

They were quite stunned and shocked and they said, “Oh, Mum, why didn’t you tell us before?” Now they understand why I was very negative in the way I was bringing them up [. . .] I can talk with my girl now.

Most of the women (97%) remembered receiving information both verbally and in pamphlet form. A number found the conversation and pamphlets informative and helpful. Women reported sharing the pamphlets with others, including friends, relatives, children, and at their place of employment. The timing of IPV interventions, however, was not always optimal. The one participant whose emergency department visit was for acute IPV injuries had been referred to a social worker during her visit:

[The social work referral] didn’t help, you know. I was still in pain while she was talking to me, so I didn’t pay any attention.

Safety of the Screening Process

All of the women reported that the screening and brief intervention was safe; no one reported that the process had increased their risk of harm. Women commented that during screening they felt relaxed, cared for, reassured, and for those no longer experiencing abuse, sometimes relieved:

I felt that people cared. It’s a funny sort of feeling. It’s sad [that the abuse] went on for so long. But [the screening] made me feel safe really because I am out of it now. I’m lucky.

The majority of the women who screened positive for IPV reported that the screening and intervention resulted in them feeling more informed, and as a consequence, safer. Having information including referral contact details was important for some. Information given during the interview supported safety strategies:

I learned how to avoid those situations, kind of thing. Like before, before I use to walk straight into it. Now I know how to walk away from it [. . .]. I can decide.

A few women (14%) made suggestions as to how to improve screening. Four expressed concern about privacy, noting that there was only a curtain between them and other people. One woman indicated she would have liked more time with the interviewer:

More information, I could have done with a lot more. I would have liked that and then maybe everything would have come out of me, but it was

just a quick, more or less quick, interview. It wasn't long enough for me.

accept violence. I think violence is a community issue it's not just a thing to worry about on your own.

Emergent Themes

Theme 1: The Painful Memories Came Back

Many of the women who had been abused talked of the screening questions triggering painful memories, while acknowledging that anything can trigger their flashbacks:

It was somewhat hard because it brought back some old feelings and stuff. When she said "abuse in relationships," those words brought back some bad memories. When you're going through a healing process, I think anything can trigger it if you are not fully over the situation. Being asked the questions felt fine, and I didn't feel unsafe answering them or anything, but I had to deal with the flashbacks [. . .]. It is a touchy subject and you guys are doing fine.

[The screening] stirred up things in my mind [. . .] when you are around the house or in the supermarket something can set that off [. . .] it's only for a minute you feel like that.

Theme 2: It's Long Overdue

Many of the women, especially if they had experienced IPV, thought that screening in the health care setting should have been implemented earlier and were glad it was finally being done:

I was actually quite pleased that these sorts of interviews are taking place. When I was like in my twenties in my first marriage it was very violent physically. I felt helpless because I didn't know where to go or what to do. I am really pleased that this sort of thing is now more in the open.

Theme 3: You Need to Tell the Women

Women challenged health professionals to incorporate IPV screening into women's care. In addition to raising awareness, IPV screening indicated that health professionals were taking women's safety seriously and doing something about it:

[Health professionals] need to make people aware that there are others out there that can help [. . .]. It's just that acknowledging that violence [pause] that it is a big thing and letting especially young women know that there is help available.

[Health professionals] are usually the first people to see it [. . .] and when you treat the patient, it's not just the physical side but also their psychological side as well [. . .]. I think as long as they are trained it's more that it's known that we don't

DISCUSSION

Qualitative approaches are needed to inform and complement randomized controlled trials testing the effectiveness of health care site-based IPV screening and brief intervention. In this study, 36 women described the impact of an IPV screening protocol on their lives. We found that this IPV screening and brief intervention was welcomed by women. Abused women reported that screening provided an opportunity to learn about IPV and available resources. They also appreciated being given permission to openly talk about the abuse in their lives, affirming their ability to face the trauma and move beyond it, both for themselves and their children. While safety can never be guaranteed, a standardized screening protocol based on empowerment, holding safety paramount, and administered by trained health professionals, did not increase harm and had a positive impact on women's lives.

The women we interviewed strongly supported health care provider IPV screening and intervention, yet their stories affirmed that it is distinctly different from other routine medical inquiries. Unlike other screening programs, IPV screening is likely to bring to the surface "painful memories" among women who have been abused. While the abused women in our study acknowledged these memories, they were equally adamant that routine screening continue. The strength and resilience among our study participants highlights the importance of letting abused women speak for themselves in planning policy.

Sugg was recently quoted, "I do want to make sure that what we are doing about intimate partner abuse is the right thing. Are we really doing what we should do? That's my question, not should we do it at all."²⁶ In this study, we discovered some important qualifications for how we can screen safely. For example, we realized that greater skill was needed in judging the timing for when mothers (or female caregivers) could be sensitively screened in the pediatric emergency department setting. The importance of privacy was also affirmed. Although visitors were routinely escorted to the waiting room before screening, the emergency department private rooms, with a single curtained side, still lacked the absolute privacy that would maximally promote disclosure of abuse. Finally, it was evident from the feedback of women that the one-day training and mentoring of nurses as research assistants successfully prepared them to safely and sensitively conduct IPV screening.

While most studies examining screening and intervention effectiveness limit the outcomes of interest to effects on women currently abused and their children, our study

found evidence that IPV screening serves a broader role. The women who were screened in our study went home and talked to their children, other family members, and friends, and they passed along resource information. This was evident for women whether or not they had a history of IPV. Allowing women the opportunity to recognize violence in the home and make it visible in their communities is an intervention that can contribute to transforming our communities toward peace. Rodriguez²⁷ found that abused migrant women participating in an action research study similarly became change agents. Whether you call it “the power of the collective,”²⁷ “catalytic validity,”²⁸ “conscientization,”²⁹ or primary prevention, health care site-based screening offers a fulcrum for creating safer communities by bringing the violence in our communities out from behind closed doors.

There are three important limitations of this study. First, we interviewed a small group of women from two locations in Auckland, New Zealand. The 36 women’s life stories are diverse, but the extent to which they captured a shared meaning that can be recognized across cultural and social boundaries cannot be certain. More stories may refine or expand their interpretation. Second, our study design and processes allowed women to “opt out” of participation at both the point of health care screening and at the point of choosing to participate in a follow-up interview, thus introducing the threat of selection bias. Some nonparticipants may have judged the study to have the potential to increase their risk of danger. Others may have been unable or unwilling to speak about their violence because it would be too difficult or traumatising. There may be some who chose not to acknowledge the violence in their lives as being abusive. Finally, the screen was administered by a small group of enthusiastic, trained research assistants. There may be variation in the quality of the screen and responses to IPV disclosures when administered by less motivated and inadequately trained health professionals.³⁰

Implications for Practice and Research

The findings from this study indicate some important concerns for future research examining IPV screening and intervention effectiveness. First, we identified that nonabused women often sought to speak for abused women. Like uneducated health care providers, their responses reflect dominant culture thinking in that the marginalized—abused women in this case—need protecting. Abused women, however, can ably speak for themselves. Second, a large part of our interview schedule addressed screening acceptability. Future research is needed to examine more comprehensive outcomes. For example, an interview schedule could be theoretically driven addressing self-care goals as explicated by Camp-

bell et al.³¹ Third, there is a need for research that explores in more depth the relationship between screening processes and women’s experience. Grounded theory would be a useful methodology as demonstrated in studies of child custody as experienced by women who have left an abusive partner.³² Finally, this study indicates that asking partner violence questions (screening) itself is an intervention and should be considered as such in planning clinical trials.

CONCLUSION

In interviewing women who had experienced screening and brief intervention for IPV, we discovered that women welcomed the opportunity to express their trauma in a safe and supportive context. Women’s responses demand that health professionals implement IPV screening and intervention. They are asking, “What took you so long?” Routine IPV screening by women’s health providers increases women’s knowledge of IPV, offers them support, and can contribute to creating safer communities for women and children.

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