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School of Applied Social Studies,
University College Cork,
Ireland

The Benefits, Risks and Barriers for Screening for Domestic Abuse in all Health Care Settings

Aisling Murphy, Bachelor of Social Work.

Abstract

Drawing on research conducted for a Dissertation in the Bachelor of Social Work, this article explores violence against women and in particular addresses the issue of screening for domestic abuse in all health care settings. The research explores the benefits, risks and barriers of mandatory screening and queries if this concept is justified. The paper also considers how transitional societal viewpoints regarding domestic abuse influences attitudes towards routine screening. This investigation includes an examination of current policy and questions its sufficiency in terms of empowering women who experience abuse. Using the constructivist grounded theory in combination with the feminist perspective; this paper considers the evidence provided by two women who have experienced abuse, and by one professional who works alongside women who have or who still are experiencing abuse. Several conclusions are drawn. Firstly, there are correlations between socially accepted definitions of domestic abuse and attitudes towards domestic abuse. Secondly, routine screening for domestic abuse in all health care settings is not a 'one glove fits all solution'. Finally, a cultural shift is required and intervention in relation to domestic abuse needs to concentrate on the micro – meso - and macro - level.

Keywords: Domestic violence; domestic abuse; intimate partner violence; routine screening; health care settings; constructivist grounded theory; gender-based violence.

Introduction

While it is acknowledged that men experience abuse in intimate relationships by women, as do same sex-couples, this article focuses on women's experiences of abuse in intimate relationships by men. Intimate partner violence (IPV) against women is a personal experience which over time, and according to culture, has been 'condoned, tolerated, denied, stigmatised, pathologised, and criminalised' (Allen, 2012, p.12).¹⁷ However, while it may have similarities to other types of violence, IPV against women is distinct in its 'context, repetitiveness, intentionality and effects' (Hennesy, 2011, p. 58). IPV against women has also been subject to re-labelling and re-construction, resulting in a range of associations and consequences. For example, the term 'woman battering' invokes an image of a woman lying beaten, while 'spouse abuse' implies the relationship between the parties is that of legally married partners (Allen, 2012).

The gender-based nature of this violence can be seen in common proverbs from around the world which legitimate violence as a means of control over women, for example: 'A spaniel, a woman and a walnut tree, the more they're beaten the better they be' (Grant, 1999, p.164). Feminist viewpoints articulate that within patriarchal societies the socialisation process dictates a power differential between men and women that is believed to be the main cause of IPV (Allen, 2012; Dobash & Dobash, 1977; Lenton, 1995; Walker, 1984; Yllo, 1988). It could be suggested that this power differential is reflected in health care settings regarding attitudes towards screening for domestic abuse (DA). A study carried out by Natan *et al* (2011) supports this view and shows significant variance between doctors (90% of whom were male) and nurses (75% of who were female) in their attitude towards screening for DA. Some 16% of doctors agreed with the statement that women are the reason for the violence perpetrated against them compared to 1% of nurses. In addition, 30% of doctors answered that there are more important issues than violence compared to 2.5% of nurses. Furthermore, 45% of doctors responded they do not have enough time to assess abuse as opposed to 11.5% of nurses. Understanding terminology and all aspects of IPV is important when one considers the detection of violence against women in health care settings without protocols for routine

¹⁷ The terms intimate partner violence (IPV), domestic violence (DV) and domestic abuse (DA) are referred to interchangeably throughout this article.

IPV screening. As noted by Shipway (2005, p. 3) professionals may focus on the signs of physical injury ‘unaware of the reality’ resulting in many women experiencing other forms of abuse going un-noticed for long periods of their lives.

Defining Violence against Women

Historically, the term ‘battered woman’ or ‘battered wife’ has been acceptable terminology used by many to describe violence against women. Such terms places emphasis on physical force and ignores psychological and emotional effects of other forms of abuse such as financial and sexual abuse. These forms of abuse may be continual and may not accompany bruises and broken bones (Shipway, 2005). Natan *et al* (2011) suggests women tend to avoid reporting such abuse, but, if asked through routine screening they are more likely to disclose. In contemporary Irish society ‘domestic violence’ is the term traditionally used in legislation and policy documents, nevertheless, this term is contested. Some authors suggest that ‘domestic violence’ is cloaked under ‘family violence’, thus, minimising the direct impact of abuse on the individual and taking the emphasis off the perpetrator. In addition, the seriousness of the abuse is reduced by authorities with the perceived notion that it is ‘just another domestic’ (Holt, 2003, P. 54). The term ‘intimate partner violence’ is gender neutral and centres on abuse between adults within an intimate relationship. Intimate partner violence is broadly used in the Irish and international context.

Prevalence of violence against Women

Violence against women has been the subject of many international studies. However, domestic abuse and violence against women has remained relatively hidden in the Irish context (Holt, 2003). In the recent Policy on Domestic, Sexual and Gender based Violence (2010) the Health Service Executive (HSE) highlighted the following statistics: One woman in 11 experience physical abuse in relationships. One woman in 12 experience sexual abuse in relationships. One woman in 13 experience severe emotional abuse. Sexual Abuse and Violence in Ireland (SAVI) research shows ‘adult sexual assault’ is perpetrated against approximately 1 in 4 Irish women. The perpetrator was a partner or ex-partner for about (23.6%) of those women.

The Impact of IPV on Women

Domestic violence encompasses a wide range of harms including physical, emotional, sexual and financial (McGarry, 2010). In terms of physical injury, Shipway (2005) notes, women who have been abused suffer broken bones, fractures, bites, attempted strangling and internal injuries. Studies also show that increased incidences of urinary tract infections and sexually transmitted diseases such as HIV are interconnected with IPV (He, McCoy, Stevens, & Stark 1998; McGarry, 2010). However, the impact of IPV on women goes beyond physical injury. Women who have been abused often say that the emotional and psychological abuse they experience is for them the most ‘destructive element’ (Shipway, 2005, p. 22). Holt (2003) illustrates the link between IPV and mental health problems such as depression. Similarly, Shipway (2005) shows women who have experienced abuse employ coping mechanisms such as alcohol and drug misuse. However, more alarmingly, Webster *et al* (2011) note that since 1996, 166 women were murdered in Ireland; the majority of these women were murdered in their own homes. At this juncture it is important to note that women are at greatest risk of homicide at the point of separation or after leaving a violent partner (Daly & Wilson, 1988).

The Development of Policy regarding IPV

Historically, Domestic Violence and /or Sexual Violence responses were provided by the Non-Governmental Organisation (NGO) sector. As noted by Kearns *et al* (2008, p. 6) it is only in recent years that the issue of domestic violence ‘appeared on the political agenda’. Shipway (2004) notes traditionally, policy-makers at local, national and international level have been predominately male-orientated and suggests this may be one of the reasons for a delay in domestic violence policies. This argument has much in common with the work of Atkinson *et al* (1993) which suggests oppressed women’s struggles are rooted in suppressive social, political, and cultural powers.

National policy relating to domestic violence underwent significant change in the 1990’s with the establishment and report of the National Task Force on Violence against Women (1997). The Task Force report (1997) outlined various recommendations which are of particular importance to this piece of research. For example, the Task Force report (1997) did, although not explicitly, suggest the importance of screening for DA in the following recommendations: ‘Recognising that health care professionals will play a significant part in detecting domestic violence, training and appropriate guidance should be provided for such staff; The integration

of medical social workers into Accident and Emergency core staff; The provision by community based health services of information and to act as a gateway for service referral' (Kearns *et al* 2008, p.14).

Following on from the formation of COSC the National Office for the Prevention of Domestic, Sexual and Gender-based Violence in 2007, the HSE published a policy on Domestic, Sexual and Gender-based Violence in 2010. The aim of the policy is to 'implement an integrated and co-ordinated health sector response to Domestic Violence and/or Sexual Violence' (Health Service Executive, 2010, p. 9). This policy outlines goals and actions over a three year period and focuses on the promotion of preventive measures such as routine screening in all health care settings. While this is a welcomed development in theory, the question needs to be addressed as to whether this policy is in actual practice within service provision, and if so, how effective is it to date?

Screening for IPV in Health Care Settings

On the basis of this research it is clear that violence has palpable effects on many women. Women come in contact with the health services frequently via numerous routes for example: maternity services or in their roles as carers for children and older people. Health services may offer the only possible contact point with professionals who could identify, get involved in the situation and offer support to abused women (Davidson *et al* 2001). Unfortunately, as noted by Hamberger & Phelan (2004, p.4) 'research on rates with which health care providers screen, identify, and help partner violence victims is not optimistic'. In a recent study, Natan *et al* (2011) shows that out of sample of 100 physicians and nurses who treated over 100 patients per month combined; only eight of them on average were screened for DA. In fact, some commentators ascertain that the implementation of screening programmes for DA in health care settings cannot be justified (Ramsay *et al*, 2002). It seems that healthcare practitioners do not respond effectively to domestic abuse, therefore, the question one must ask is – why not?

Barriers to screening for IPV

Shipway (2005) outlines several reasons as to why healthcare practitioners may not respond as effectively to domestic abuse as they should. The author asserts that historically in health care settings, senior positions were predominately held by men, while the majority of the

workforce is female. According to the author this structure reflects ‘the lack of commitment to instigating effective policies, procedures and protocols’ and ‘not perceiving domestic abuse as a public health issue’ (*ibid*, 2005, p. 55). The author ascertains that statistically one in four women have experienced abuse, therefore, it is likely that a significant number of female employees are experiencing abuse at home. In turn, it is not surprising that some female employees avoid confronting the issue. Equally important, it can be argued that if one in four women are abused, and is generally abused by a man, it is reasonable to suggest that several men within an organisation are abusers (*ibid*, 2005). A study conducted Parsons *et al* (1995) noted the following reasons why healthcare practitioners did not intervene in cases of abuse: 71% of staff claimed that they failed to intervene due to lack of time. 55% interviewed said that they feared offending the patient. 50% reported feelings of inadequacy and frustration in offering appropriate intervention or because they felt they lacked training. The Department of Health (2000) also suggest that practitioners do not ask the question because they may believe: ‘Some women deliberately choose violent men; domestic violence is not a serious matter or that it is a ‘private one’ and domestic violence is not a healthcare issue’ (Shipway, 2005, p. 56). Nevertheless, as Shipway (2005, p. 57) stresses ‘research has revealed a multiplicity of reasons why healthcare personnel do not ‘ask the question’, or fail to explore the underlying issues of an assault – None is acceptable’.

The Benefits of Screening for IPV in Health Care Settings

In a correlative cross-sectional study Natan *et al* (2012) found that the patients interviewed claimed that screening is crucial for preventing domestic violence. Similar to Robinson & Spilsbury (2008), Natan *et al* (2012) found that women want to be asked whether they are subjected to domestic violence. Moreover, the study highlighted how women saw screening as an important initial way of sharing, as the subject of domestic violence is perceived by society as embarrassing and personal (*ibid*). These findings correlate with a study conducted by Richardson *et al* (2002, p. 273), which concluded that women who experienced violence suggest screening programmes should be seen as a way of ‘uncovering and reframing a hidden stigma’. This study also reported that 42% of women said that they would find it easier to discuss these issues with a female doctor and 3% with a male doctor. Natan *et al* (2012) highlights further benefits to screening for IPV. The author articulates that the identification of IPV is very important as it affects others, for example, children or family who attempt to protect the victim. Furthermore, it is critical to identify pregnant women who

been abused since the consequences affect the foetus as well (*ibid*). Finally, Nurse *et al* (2002) notes that the routine questioning of patients attending hospital emergency departments is one option for assessing the levels of violence in a local community.

The Risks of Screening for IPV in Health Care settings

The work of Davidson *et al* (2001) states that universal screening for IPV may have negative consequences. Bewley *et al* (1997) reiterates this point and argues that research on IPV has failed to take into account the risks of health care based interventions for victims of IPV. As noted, women appear to be at the highest risk of being murdered by their abusers at the time of leaving the abusive relationship. Therefore, if health care workers encourage the woman to leave the abusive situation without adequate supports and safeguards they might put her at risk of being killed in the process. Supports and safeguards include a safe place to live, financial support and counselling to aid transition and build on self-esteem. Furthermore, O'Shea (2011) has pointed out that leaving an abusive relationship is a process. If a woman leaves an abusive relationship and she is not psychologically ready to do so, she will return to escalating abuse. Other negative effects of universal screening pointed out by Davidson *et al* (2001) include: feelings of demoralisation and stigmatisation on behalf of the woman, and lost opportunity costs within the health service.

IPV and the cost incurred by the Health Service

International research points to the huge cost incurred by the health service in terms of caring for women who have experienced violence. Wisner *et al* (1999) compared annual costs of health care for abused and non-abused women and found that abused women consumed over \$1,700.00 more per year than non-abused women. Similarly, a US study in 2003, indicated that the largest component of DA related costs was healthcare, which accounted for more than two thirds of the total costs (Health Service Executive, 2010). There is also evidence that healthcare utilisation is up to 20% higher five years after the women's abuse has ceased, compared to women who have not experienced IPV (Rivara *et al* 2007).

It seems that there are positive and negative consequences for universal screening of IPV in health care settings. Still, to reiterate, many women who have been abused expressed the view that they wanted someone to ask. In response to this fundamental issue, the Health

Service Executive has outlined a Public Model for Domestic Violence and/or Sexual Violence Prevention (adapted from Wolfe & Jaffe, 1999) and, a Model of need and Intervention (adapted from Hardikar, Exton & Barker 1991).

Primary Research Findings and Analysis

Remaining consistent with the principles of the guiding theories, qualitative methods were employed for the purpose of the primary research. The interviews were approached with flexibility as the main aim was for the participants to tell their own stories. Data gathered was comprehensive and highlighted other issues and probable gaps in current research relating to IPV. However, three core themes emerged from enabling participants to articulate their feelings and experiences. These include: terminology, asking the question and cultural change. Participants' views are central and expressed throughout by way of quotations which are elicited directly from interviews.

Terminology

This is a topic that provoked considerable interest and response from interviewees. Findings show terms such as 'domestic violence' traditionally used in Irish legislation and policy documents influence professionals' attitudes towards screening for IPV. Emma*¹⁸ (professional) talking on this point suggests that an appropriate definition of IPV is very important and said 'It's domestic because it happens within closed intimate relationships. Traditionally, GPs would not have done routine screening, would have been quite dismissive of domestic abuse, the very nature of the word domestic, it's nothing to do with me, it's in the home so I don't have to worry about it, that mind-set is changing, it's everyone's issue, it's everybody's problem, The H.S.E policy uses the UN definition... this policy isn't the best I've seen but it's a start' (Interview 1, dated, 29/03/2012).

Furthermore, findings suggest that terminology influences abused women's perception of their own situation. Linda* (survivor of abuse) said 'It was only after the relationship had finished that I realised that I had been in a very abusive relationship but I didn't realise it at the time because I simply didn't realise that financial abuse and mental abuse was domestic violence because it simply wasn't physical all the time' (Interview 2, dated, 24/04/2012). Mary* (survivor of abuse) added 'I thought I was just in an unhappy marriage and if I worked

¹⁸ The asterix is used to indicate that pseudonyms have been used to protect anonymity.

on it, it would get better'. The above findings draw a parallel to the findings of Shipway (2005) which suggests focus may be placed on the signs of physical injury resulting in many women experiencing other forms of abuse going un-noticed for long periods of their lives. Speaking on the point of societal viewpoints regarding IPV Mary* (survivor of abuse) offered an insight of her thoughts regarding how she believed professionals would perceive if she asked for help. 'You make your bed you lay in it was how I thought people would see me, after the marriage ended I told someone [professional] and he called me a martyr, looking back I don't think he was insulting me, but I was ashamed, embarrassed and very angry'. My primary research and desk top research correlate at this juncture. Accumulated findings suggest a definite connection between terminology exercised regarding IPV both in terms of survivors of abuse perception of IPV and societies view of IPV.

Asking the question

Strong evidence highlighted through the literature review suggests that women want to be screened for IPV (Robinson & Spilsbury 2008; Natan *et al* 2012). Emma* (professional) agreed and identified screening for IPV as a tool for early intervention and reduced health care costs because the woman does not become the 'revolving door patient'. However, she also verified Davidson's *et al* (2001) finding that there are certain risks associated with routine screening 'The A& E department's concern would be if there was routine screening...I figure if they [perpetrator] thought the question was going to be asked, there was even a remote chance that the person would say yes, that, that person would never get near the A&E department again'. Emma* (professional) added that screening for IPV is not yet applied in all health care settings as outlined in the HSE (2010) policy document. However, she noted that policy is influenced by international standards and is continuously developing'. Conversely, Linda* (survivor of abuse) described how she did not want to be asked if she was being hurt mainly because she wanted to present 'a very together front to the outside world'. Similarly, Mary* (survivor of abuse) expressed fear regarding disclosing the abuse and said she would have denied the abuse if she was asked directly. She also felt that it may have been easier to discuss the issue with a female doctor as proposed by Richardson *et al* (2002). Linda* (survivor of abuse) added that the approach to questioning is very important and that her GP had numerous opportunities to ask how supportive her relationship was which may have led to a disclosure. Questions outlined in the A&E policy for Domestic Violence such as 'Has someone hurt you?' and 'Do you ever feel afraid?' seems to be

interpreted by women who have experienced abuse as ‘pointing the finger’ and results in women concealing IPV out of fear or embarrassment. Linda* (survivor of abuse) offered the following alternative ‘How happy are you in your relationship?’

Coinciding with desktop research, Emma* (professional) identified an increase in IPV referral rates following DA training which incorporated appropriate questioning during screening for IPV. Additional referral rates were also noted when there was a designated IPV social worker within the A&E department as outlined in the Task Force Report (1997). Yet, due to a lack of resources Emma* (professional) remarks this position is no longer available. On further exploration of the subject of routine screening for IPV Linda* (survivor of abuse) offered this valuable insight ‘I think if it is going to be effective it depends on the context, it needs to be sensitive to the different layers and types of abuse. I don’t think it is a catch all situation... So I think for it to work it should be in a therapeutic setting, it needs to be more sensitive to the many facets of abuse’. Combined findings show a disparity between desk top research and my primary research insofar as, the survivors of abuse did not want to be asked about their abusive relationship. Resulting from fear, shame, or a personal interpretation of resilience, they became ‘brilliant at wearing a mask’ (Linda*) and ‘nobody would have got through the cracks unless I wanted them to’ (Mary*).

Cultural Change - The Way Forward

Desktop research points towards the benefits of routine screening for IPV (Natan *et al* 2012; Robinson & Spilsbury 2008; Richardson *et al* 2002; Nurse *et al* 2002). However, my primary research findings seem to suggest that the success of routine screening for IPV depends on context, appropriate questioning, and the individuality of the abused woman. At this point participants’ views on alternative approaches for abused women who ‘slip through’ the screening process were sought. Akin to the finding of Bewley *et al* (1997) participants unanimously agreed that counselling is crucial in building self-esteem and suggested that screening for IPV in isolation of such a support may be futile. Emma* (professional) suggests ‘it’s the real counselling and her doing it in her own time... the whole counselling relationship with somebody, building that person up to let them know that there is another way... and then having supports in place for financial dependence’. Linda’s * (survivor of abuse) reflections are similar to Emma’s* as she expresses ‘ if I had been asked by my GP and she had recommended counselling and building up alternative resilient factors, not

expressly to leave, but to work on my problems within the relationship, I think that would have been very effective'. It is also clear that specialised counselling services were most helpful to Mary* (survivor of abuse) as she recollects 'I think it was the counselling gave me the courage to stand up to him ... and to eventually ask for help'. These findings highlight that even if screening for IPV was mandatory in all health care settings, some women may need to build on their self-confidence in order to admit to the abuse and accept support.

Concluding Comments

One of the underlying goals of this research was to try and establish if there is a connection between socially accepted definitions of domestic abuse and professional's perception of domestic abuse. Research findings support this connection and suggest both professional's and abused women's interpretations of IPV is influenced by definitions such as 'Domestic Violence'. Furthermore, findings suggest that terminology greatly influences professional's attitudes towards screening for domestic abuse in health care settings.

A further aim of this research was to try to ascertain if current policy is sufficient in terms of empowering and protecting women who experience IPV. My research findings suggest policies in relation to IPV need to be developed to include an appropriate definition of IPV. Such IVP policies should, in some measure be informed by the wisdom and experience of survivors of abuse and be regularly reviewed and assessed. On-going IPV training for all professionals including those in the legal and political arena is paramount in the demystification of traditional IPV standpoints. A cultural shift is needed with emphasis on responsibility, accountability, and the prevention of IPV similar to the way professionals now contribute to the prevention of child abuse.

Two final aims of this research were to attempt to ascertain if routine screening for IPV in all health care settings is justified and to try to find out more about what works in terms of encouraging women to disclose abuse. It has been established that screening for domestic abuse in all health care settings has its benefits, including increased rates of IPV referrals and reduced health care costs. Nevertheless, screening for domestic abuse also has risks attached which may impede further on the health and well-being of victims of abuse. My accumulated

primary research findings suggest that if a woman has self-confidence, screening for IPV is not always a necessity as she may have the emotional capacity to seek change herself. Research participants unequivocally agreed that counselling services and having supports in place are key factors to rebuilding self-esteem, independence and resilience. Finally, the proposed research question ‘should routine screening for domestic abuse be adopted in all health care settings?’ remains unanswered. Further exploration on screening for domestic abuse is required before it can be justified as being a mandatory intervention method for IPV in all health care settings.

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