What barriers prevent health professionals screening women for domestic abuse? A literature review

Leah Kirk and Kim Bezzant

ABSTRACT

Background: Domestic abuse is known to affect one in four women (although it is difficult to quantify) and has significant short- and long-term health implications. As people who often have regular contact with women in a variety of circumstances, including routine appointments, health professionals, particularly nurses and midwives, are in an ideal position to screen women for domestic abuse. However, it is recognised that there is a reluctance by some health professionals to undertake this important role. Aim: To identify the potential barriers preventing health professionals from screening women for domestic abuse and to consider how these barriers could be overcome. Method: A literature review of electronic databases using predetermined search terms and inclusion/exclusion criteria was undertaken. Seven studies were identified for review, consisting of five qualitative and two quantitative pieces of research. Conclusion: Several barriers to screening by health professionals were identified, including lack of training, education, time, privacy, guidelines, policies and support from the employer, with the most prevalent of these being a lack of training and education. Further research is required, specifically within the UK, to provide more details about how these barriers might be addressed.

Key words: ■ Domestic abuse ■ Domestic abuse screening ■ Domestic violence ■ Intimate partner violence ■ Literature review

Several terms are used to describe the abuse of a partner in a domestic setting, including 'domestic abuse', 'domestic violence' and 'intimate partner violence (IPV)' (World Health Organization (WHO), 2013; Department of Health (DH), 2013). For the purposes of this article, the term 'domestic abuse' will be used to encompass all these terms. It is recognised that there are varying definitions of domestic abuse, domestic violence and IPV (DH, 2013; WHO, 2013). The following definition, from the National lnstitute for Health and Care Excellence (NICE), which is currently used to frame national research and guidance, guided the enquiry described in this article:

> **'The term "domestic violence and abuse" is used to mean any incident or pattern of incidents of controlling behaviour, coercive behaviour or threatening behaviour, violence or abuse between those aged 16 or over who are family members or who are, or have been, intimate partners. This includes psychological, physical, sexual, financial and emotional abuse. It also includes "honour"-based violence and forced marriage.'**
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> ***NICE, 2016a***

Domestic abuse can manifest in a number of ways. It can include coercive control (for example, when a pattern of behaviour is used to exert power and control), sexual abuse (for example, unwanted sexual contact or pressure to have sex), physical abuse (for example, punching, shoving, kicking, burning or throwing things at a partner), psychological abuse (for example, making threats, humiliating a partner, name-calling), economic abuse (for example, controlling access to money or resources) and tech abuse (for example, sending abusive texts, tracking or sharing images online) (National Domestic Abuse Helpline, 2020).

What is arguably central to all these manifestations of domestic abuse is an abusive partner's desire to control and coerce. Indeed, coercive or controlling behaviour within an intimate relationship is established as a specific offence in the Serious Crime Act 2015, where it is described as acts that are aimed at making a victim subordinate or dependent. Coercive and controlling behaviour does not necessarily involve acts of physical abuse and is often less easy to spot because it can masquerade as 'caring', with victims becoming so worn down that they and others in the environment do not identify that abuse is occurring. Controlling behaviour aims to make an individual dependent by isolating them from support, removing their independence and exploiting them, while regulating their everyday life (Women's Aid, 2019). Pregnant women may also be victims of reproductive coercion when their pregnancy is not of their choosing, having been coerced into it by a partner or having their birth control sabotaged (Miller et al, 2010). This

Leah Kirk was a Postgraduate MSc Top-Up Student at the University of Southampton and is now a Midwifery Lecturer, University of Central Lancashire, Preston

Kim Bezzant, Independent Nurse Teacher, South East England

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may be an indicator that they are experiencing domestic abuse of other types (Miller et al, 2010).

The prevalence and impact of domestic abuse is recognised as an ongoing and major public health issue (Baird et al, 2015; NICE, 2016b), with the Office for National Statistics (ONS) reporting that, in the year ending March 2018 in England and Wales, approximately 2 million people aged 16 to 59 experienced domestic abuse (ONS, 2018a). This represents a growth in numbers of 23% on the previous year, although it is thought that this rise may be due to increased levels of reporting. It is acknowledged that domestic abuse has always been, and continues to be, significantly under-reported because victims often remain silent, meaning that actual numbers are likely to be higher (Lazenbatt et al, 2009; ONS, 2016a; 2016b; 2018a).

Domestic abuse is thought to affect one in six men and one in four women in England (DH, 2017). Women are known to be more likely than men to be the victims of domestic abuse, with an estimated two women a week being killed as a result of domestic violence in England and Wales (DH, 2017). Although acknowledging that both sexes are affected by domestic abuse, this article focuses on women.

Domestic abuse is recognised as having significant long-term health implications, both physically and psychologically, including post-traumatic stress disorder, depression and anxiety (Chambliss, 2008; Cunningham, 2008; Sarker, 2008; Cerulli et al, 2012). Moreover, the NHS is identified as often being the first point of contact for women suffering from domestic abuse (Alshammari et al, 2018, IRIS, 2020). Such women often have a higher rate of contact with health professionals than other women (Plichta, 2007), reporting that they consider health professionals as people whom they trust most to disclose abuse to (WHO, 2013). Given that health professionals are likely to have contact with women at risk of domestic abuse, it is clearly important that they have the confidence and skills to be able to screen for this risk and respond appropriately.

The WHO (2013) recommended that health professionals should ask about domestic abuse when there is an identified risk or assessed condition that may have been caused by domestic abuse. Additionally, certain specialties are required by UK national guidance to routinely screen for domestic abuse even in the absence of obvious risk indicators. NICE (2014) stated that health professionals from disciplines including maternity services, sexual health, drug and alcohol misuse, child and vulnerable adult services, and mental health services should ask the individual whether they have experienced domestic abuse, even when no indicators are present. In particular, pregnant women who experience domestic abuse are known to be at an increased risk of an adverse birth outcome (Donovan et al, 2016) and so it is particularly important for midwives to feel confident in raising this issue at appointments (routine and otherwise).

To aid assessment, health professionals can use screening tools, which, when used within a supportive environment with direct simple questioning, can facilitate the disclosure of abuse (Olive, 2007; DH, 2017). Although it is uncommon for women to voluntarily make a disclosure, the advantage of universal screening is that it prevents women from feeling stigmatised (Bacchus et al, 2003; Baird et al, 2013) and may encourage disclosure.

Table 1. Literature search inclusion criteria

Inclusion criteria	Rationale
Published in the years 2005 to 2017	The Department of Health published a handbook for professionals in 2005 *Responding to Domestic Abuse: A Handbook for Health Professionals* (Department of Health, 2005). It was anticipated that this may have stimulated research focused on this issue
Empirical/primary research	This type of research holds a higher position in the hierarchy of evidence than anecdotal or expert opinion and the description of the study is written by those who conducted the research (Rees, 2011; Polit and Beck, 2014), ensuring that summaries are accurate
Articles published in English language, full-text papers	In view of time constraints for this masters module, only English language, full-text articles were included, although the best practice would have been to view all relevant literature, irrelevant of language (Aveyard and Sharp, 2013)
Articles from the UK, Ireland, Australia, New Zealand, Europe, USA	These countries publish mainly English-language papers

However, despite these requirements and the evidence to suggest that screening is useful in identifying domestic abuse (O'Doherty et al, 2015), it would seem that health professionals, especially those in generalist settings, may not always respond effectively (Gregory et al, 2010; McGarry and Nairn, 2015), and it is acknowledged how challenging it can be for a health professional to ask women about a history of domestic abuse, either routinely or if a risk is identified (Baird et al, 2013). In particular, health professionals can fear that broaching this topic will harm their relationship with the woman (Finnbogadóttir and Dykes, 2012), despite the fact that when a professional does receive and effectively respond to a disclosure, their relationship with the woman has the potential to be strengthened (Dennis, 2014).

Aim

Given the duties to screen for domestic abuse and the advantages to women of doing so, a question arises as to why health professionals might be reluctant to do this. Research was reviewed to identify the potential barriers preventing health professionals from screening women for domestic abuse and to consider how these barriers could be overcome.

Method

The Bluff and Cluett (2006) critiquing tool was used to assist the enquiry. In order to investigate this a literature search of relevant research was undertaken.

Literature search

Databases used to assist the enquiry were CINAHL Plus with full text, PsycINFO, Medline and Web of Science. This allowed a range of research related to domestic abuse to be identified and

Table 2. Articles included in the review

Authors and title	Methodology	Location
DeBoer et al (2013) What are barriers to nurses screening for intimate partner violence	Quantitative study using an anonymous cross-sectional survey study	USA
Eustace et al (2016) Midwives' experiences of routine enquiry for intimate partner violence in pregnancy	Qualitative descriptive design using telephone interviews	Australia
Finnbogadóttir and Dykes (2012) Midwives' awareness and experiences regarding domestic violence among pregnant women in Southern Sweden	Inductive qualitative design using focus group interviews	Sweden
Henriksen et al (2017) 'It is a difficult topic'—a qualitative study of midwives' experiences with routine antenatal enquiry for intimate partner violence	Qualitative study using semi-structured interviews	Norway
Mauri et al (2015) Domestic violence during pregnancy: midwives' experiences	Phenomenological/hermeneutical qualitative study using semi-structured interviews	Italy
Sundborg et al (2017) To ask, or not to ask: the hesitation process described by district nurses encountering women exposed to intimate partner violence	Qualitative study using grounded theory approach and open in-depth interviews	Sweden
Yonaka et al (2007) Barriers to screening for domestic violence in the emergency department	Quantitative study using a questionnaire	USA

included articles produced for a range of disciplines, including nurses, midwives and doctors (including GPs). For pragmatic reasons this was not widened further to include other health professions. The inclusion criteria are detailed in *Table 1*.

The search initially produced 141 articles. After removal of duplicates and a review of the articles to focus on relevance to this enquiry, seven studies were selected for an in-depth review (*Table 2*).

Ethics

Six of the studies reported that the research had been approved by a research ethics committee, considered to safeguard participants during the research process (Steen and Roberts, 2011). The study by Yonaka et al (2007) did not report on ethical approval; however, it is anticipated that this was gained due to it been a journal requirement.

Study design

Five studies conducted qualitative research (Table 2). Data collection methods included semi-structured (Mauri et al, 2015; Henriksen et al, 2017) and focus group interviews (Finnbogadóttir and Dykes, 2012). Two further studies used what were described as semi-structured interviews, although not explicitly stated (Eustace et al, 2016; Sundborg et al, 2017). These were all conducted in person, except the study by Eustace et al (2016) who used telephone interviews. The remaining two studies conducted quantitative research and collected the data using a hard copy questionnaire (Yonaka et al, 2007) and a web-based and hard copy survey (DeBoer et al, 2013).

Semi-structured interviews allow a degree of flexibility, enabling the participant to discuss elements that may not have been anticipated, but also allow the researcher to remain in control of the interview (Tod, 2015). Focus groups can obtain several and varied viewpoints on a phenomenon in a time-efficient manner (Parahoo, 2014; Moule et al, 2017); however, some individuals do not feel comfortable expressing their experiences or views in the presence of a group and may not provide their actual opinion (Morse, 2012; Polit and Beck, 2014). A limitation that should be acknowledged is that all participants in the identified studies were health professionals and therefore may have provided professionally acceptable answers rather than answering honestly (Rees, 2011). It should also be recognised that a challenge for the researcher is balancing the flexibility and standardisation of the interview (Parahoo, 2014).

The questionnaire and survey used by Yonaka et al (2007) and DeBoer et al (2013) used a combination of multiple-choice, closed, Likert and Likert-type scale questions. This type of data collection is cheap and quick, protecting the anonymity of the participant (Rees, 2011; Polit and Beck, 2014), possibly encouraging a more open response. The significant limitation of questionnaires and surveys in this format is that the researcher has no opportunity to ask participants to expand or clarify their answers and, consequently, the data collected can be less exploratory (Parahoo, 2014). The qualitative approach favoured by most researchers' studies suited this type of enquiry, where participants were asked to share experiences of their practice. This is key to understanding the barriers to delivering evidence-based practice.

Overall, a range of designs were used within the identified studies. Despite the acknowledged limitations, the studies all offered valuable insights into the barriers that health professionals

encountered when considering screening for domestic abuse, and some clear trends were identified.

Results

Identified barriers

The most prevalent barrier, identified in all studies, was the lack of training and education received by health professionals. Health professionals identified barriers as a of lack knowledge and feeling unsupported, unprepared and unconfident, particularly in relation to a positive disclosure and lack of knowledge of the services or referrals that were available to assist the person disclosing (Finnbogadóttir and Dykes, 2012, Mauri et al, 2015; Eustace et al, 2016). In particular, Henriksen et al (2017) described a lack of motivation by health professionals to screen women, because of a feeling of insecurity regarding what to do if abuse was disclosed. The lack of guidelines, policies and support from employers was widely reported by health professionals, which caused them anxiety about a potential disclosure (Finnbogadóttir and Dykes, 2012; Eustace et al, 2016; Henriksen et al, 2017).

DeBoer et al (2013) and Stenson et al (2005) stated that health professionals should make it routine practice for women to be seen privately at some point during their contact and NICE (2016a) concurred with this, stating that this supports individuals to make disclosures and to discuss individual concerns related to the disclosure. However, lack of time, privacy and resources were common barriers identified in all the studies. DeBoer et al (2013) highlighted the difficulties that cubicles and patient bays can have, particularly as family and friends are often present. A particularly challenging barrier is when the partner is present or reluctant to leave the room (Mezey et al, 2003; Lazenbatt et al, 2009; Finnbogadóttir and Dykes, 2012; Baird et al, 2013; DeBoer et al, 2013; Eustace et al, 2016; Henriksen et al, 2017). This is especially relevant to midwifery, as partners are often encouraged to attend appointments (Ellberg et al, 2010). These concerns were associated with anxieties about the impact a positive disclosure could have on the woman, such as retaliation from her partner (Mauri et al, 2015). Health professionals expressed fears about not being able to manage the potential danger of perpetrators exacting revenge on victims or their families (Finnbogadóttir and Dykes, 2012; Eustace et al, 2016).

Some health professionals reported the fear of being perceived negatively or offending women when they asked about domestic abuse and the impact this could have on their relationship (Finnbogadóttir and Dykes, 2012; Mauri et al, 2015). Other health professionals were concerned that they would react emotionally and/or become too deeply involved or distressed if they heard about an abusive experience. Some said that they did not ask questions because they feared making a fool of themselves or embarrassing the women (Sundborg et al, 2017). Yonaka et al (2007) further identified that a personal family history of abuse could result in health professionals feeling personally affected by disclosures.

Discussion

The overarching theme linking all the identified barriers was the lack of training and education health professionals receive in relation to domestic abuse, leading to them feeling unprepared, unconfident and concerned about the impact of the service-user/health professional relationship. This key barrier has also been identified in other studies (Mezey et al, 2003; Stenson et al, 2005; Roelens et al, 2006; Sprague et al, 2012; Beynon et al, 2012; Alshamarri et al, 2018). It is of note that research demonstrates that, where education programmes have been trialled, they have been positively received by participants, increasing confidence and awareness and improving knowledge and skills (Salmon et al, 2006; Baird et al, 2013; IRIS, 2020). Eustace et al (2016) suggested that healthcare providers needed to explore with their health professionals what training would benefit them, but it should at the very least include the signs of domestic abuse and how to communicate with women regarding this sensitive issue in a professional and respectful manner.

Domestic abuse is a major safeguarding issue, with all health professionals having a key role in increasing overall awareness and acting appropriately when concerns become apparent (Royal College of Nursing (RCN), 2017). Many health professionals, particularly in generalist settings, have had little or no training about domestic abuse and are unsure about the required actions following a disclosure (Feder et al, 2011). A specialist domestic abuse nurse or midwife, a role described in a study by Mezey et al (2003), may be a useful resource for health professionals to help them access support and guidance when they feel unsure or have a particularly difficult case (McGarry et al, 2014). However, with the financial challenges in the NHS, the development of these posts may prove increasingly challenging (Mooney, 2011; Wenzel, 2017). Therefore, guidelines, policies and support from employers for all health professionals are essential in order to ensure the provision of evidence-based practice (Bradbury-Jones and Taylor, 2013; Skela-Savic et al, 2017; DH, 2017). Further support for health professionals in what are often emotionally highly challenging situations could be provided in the form of group supervision sessions, either formal or drop in, to debrief and learn from each other's experiences, and to help manage the distress that may be felt in such circumstances (van der Wath et al, 2013). It has been suggested that a strategy of initial and ongoing training, alongside organisational supervision and support, is effective (O'Campo et al, 2011; DH, 2017).

Additionally, the importance of including education related to domestic abuse in undergraduate health professional programmes (highlighted in research by Eustace (2016) as being minimal) has been suggested as a key feature in ensuring that health professionals are prepared for disclosure in their professional lives (Alshammari et al, 2018). Undergraduate training programmes present an ideal opportunity to raise the awareness of future registered health professionals about domestic abuse (DH, 2017), but it is currently not clear how this is being addressed in such programmes nationally. This would be a useful area for future research in order to clarify and assess current provision.

It was interesting to note that the barrier related to health professionals' own personal experiences of domestic abuse highlighted by Yonaka et al (2007) was not reported by the other reviewed studies. This may have been because Yonaka et al's data were collected anonymously so participants felt that they could be completely honest. However, this issue has been highlighted in other studies (Mezey et al, 2003; Alvarez

et al, 2017) and is identified as a key issue for team managers in national guidance (DH, 2017). Given that one in four women is affected by domestic abuse (DH, 2017) this is likely to include a proportion of health professionals, and the training and education provided needs to also acknowledge the impact of personal experiences, including where to access support. The RCN (2017) acknowledges this and offers member support, but it may be that local healthcare providers could offer this support to their health professionals.

Mauri et al (2015) and Finnbogadóttir and Dykes (2012) found that an interdisciplinary approach in responding to domestic abuse was essential, and this was confirmed by the DH in its resource supporting health professionals in responding to suspicion of domestic abuse (DH, 2017). All health professionals need to seek training to understand their part in responding to domestic abuse, but also to be able to recognise their limits of competence and to know when to seek advice from, and refer to, colleagues from other disciplines (DH, 2015; Nursing and Midwifery Council, 2018). Crucially, it is of paramount importance that an initial disclosure of domestic abuse elicits a sensitive reaction from whichever individual health professional receives it because an insensitive reaction can result in the woman feeling judged and anxious about the consequences, ultimately increasing the suffering she is experiencing (Plichta, 2007). An interprofessional working group could be created in each local area, to ensure equal training across all professions. Interdisciplinary conferences are also ideal places in which health professionals can share best, evidence-based practice.

Limitations

The findings of this enquiry need to be considered in the light of its limitations. Only four databases were searched, due to time restraints, with a narrow inclusion criteria and a limited range of health professions being considered. It is recognised that best practice would be to search all databases and explicitly include a wider range of health professionals. Additionally, all articles selected for critique were from outside the UK. The enquiry has applied a UK definition used for domestic abuse and has drawn conclusions about practice in the UK, which should therefore be considered cautiously. This enquiry has also focused broadly on all women. It is acknowledged that there are some groups of women who are at higher risk within this group, including women who have a long-term illness or disability, are bisexual, identify as mixed/multiple ethnicity, live in households with an income of less than £10 000 or live in social housing (ONS, 2018b). This enquiry has not focused on the specific issues for these highly vulnerable groups and this is an important area for further research.

Conclusion

This review of seven studies identified in the literature search found some consistent barriers identified by health professionals that prevented them from screening women for domestic abuse.

The most frequently occurring barrier identified was lack of training and education, with resultant feelings of a lack of competence and confidence among health professionals. Although education programmes have been trialled and received positively by participants, further research is required specifically to develop training and education that responds to the expressed needs of health professionals on this issue. Raising awareness of domestic abuse within undergraduate programmes nationally would be an ideal starting point for all health professionals' development in this key area of practice, with ongoing updates and support to enable continual development of skills and maintenance of confidence in this area. Training programme providers should be cognisant of health professionals' own personal needs as well as their educational needs.

Additional findings were that health professionals felt that they were not able to access guidelines and policies and support with managing emotional difficulties in what are often highly emotive and challenging circumstances. The development of such guidelines and policies needs to be a priority, to ensure the women receive a consistently high standard of evidence-based care. The provision of specific supportive structures by employers for this issue would help health professionals to feel prepared and confident when disclosures occur and when they are screening women, and to be able to cope with the emotional toil that invariably accompanies this issue. Further research would be useful to review what types of support and information would most benefit health professionals. **BJN**

Declaration of interest: none

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KEY POINTS

- Domestic abuse is a major public health concern, resulting in a significant impact on health
- Barriers exist that prevent health professionals from screening women for domestic abuse
- A lack of training and education is the most common barrier to screening for domestic abuse identified by health professionals
- Appropriate training and education would enable health professionals to feel more confident and competent in screening women for domestic abuse

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CPD reflective questions

- Does your employer have policies or guidelines about domestic abuse? If so, do you know where to access these, are they up to date and do they provide contact details for local support services?
- What training or education would benefit your practice in screening for domestic abuse and what would help build your confidence and make you feel competent in having this conversation with a woman? How would you go about accessing this training/education?
- If a woman disclosed domestic abuse to you, would you know where and how to refer, and where to signpost her for additional support? If you do not know, what steps would you take to find out?