

La faisabilité du dépistage de la violence conjugale effectué dans le cadre des visites à domicile post-partum

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Il existe peu de preuve démontrant l'efficacité du dépistage systématique de la violence conjugale et un débat est présentement en cours à ce sujet. Cette étude descriptive et qualitative vise les objectifs suivants : étudier les perceptions des infirmières en santé publique (ISP) en matière de dépistage de violence conjugale; explorer la faisabilité, selon le point de vue des ISP, du dépistage de la violence conjugale dans le cadre des visites à domicile; et décrire les pratiques de dépistages des ISP et la formation qu'elles reçoivent sur le thème de la violence conjugale. Six ISP discutent de leurs expériences d'intervention en lien avec la violence conjugale, tant dans un contexte d'essai randomisé destiné à évaluer les méthodes de dépistage que dans un contexte de visite à domicile générale. Selon les résultats, le dépistage systématique de la violence conjugale, effectué à l'aide d'un questionnaire standard, est difficilement réalisable dans un contexte de visite à domicile auprès d'une population générale de femmes nouvellement mères. Les ISP qui visitent les familles à grand risque dans le cadre du programme Bébés en santé, enfants en santé ont pour pratique courante d'identifier les mères à risque de subir de la violence conjugale à l'étape de l'évaluation familiale approfondie. Cette approche évaluative, utilisée pour identifier les femmes à risque de subir ce type de violence, est axée sur la recherche de cas plutôt que sur le dépistage.

Mots clés : dépistage systématique, mères

The Feasibility of Screening for Intimate Partner Violence during Postpartum Home Visits

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There is ongoing debate and limited evidence on the effectiveness of universal screening for intimate partner violence (IPV). The objectives of this descriptive qualitative study were to examine public health nurses' (PHNs') perceptions of screening for IPV; explore the feasibility, from the perspective of PHNs, of IPV screening during home visits; describe PHNs' screening practices; and describe PHN training in relation to IPV. Six PHNs discussed their experiences of addressing IPV both in the context of a randomized trial to evaluate screening methods and in the context of their general home visitation practices. The findings indicate that universal screening for IPV using a standard set of questions is difficult to implement during home visits to a general population of new mothers. For PHNs visiting high-risk families as part of the targeted Healthy Babies Healthy Children program, the standard practice is to assess for mothers' exposure to IPV during in-depth assessment of the family; the nature of in-depth assessment favours a case-finding rather than a screening approach to identifying women exposed to IPV.

Keywords: domestic violence, universal screening, public health nursing, home care services, mothers

Introduction

Intimate partner violence (IPV) against women is a serious public health, social, and criminal justice problem. In Canada, a national telephone survey, the 2004 General Social Survey, found that 7% of females 15 and older with a partner currently or in the preceding 5 years had experienced some form of spousal violence, and 4% of those currently in a marital or common-law relationship had experienced either sexual or physical abuse perpetrated by their partner in the preceding 5 years (Statistics Canada, 2005). While both women and men may experience IPV, for women the severity, frequency, and impact are significantly greater (Statistics Canada, 2005). Intimate partner violence is associated with considerable impairment. Campbell and colleagues (2002) found that abused women were much more likely than non-abused women to

have increased gynecological, central nervous system, and stress-related problems. In a meta-analysis, Golding (1999) concluded that a woman's exposure to IPV increases her risk for depression, suicide, substance abuse disorders, and post-traumatic stress disorder.

Primary target populations for public health nurse (PHN) home visitation include women who are pregnant or are in the early postpartum period. Estimates of 1-year prevalence of IPV against pregnant women in the United States and other developed countries vary from 0.9% to 20.1%, with most ranging between 3.9% and 8.3% (Gazmararian et al., 1996). Muhajarine and D'Arcy (1999) report a 6% to 8% prevalence rate for physical abuse amongst pregnant Canadian women. In a sample of 3,542 women in North Carolina, Martin, Mackie, Kupper, Buescher, and Moracco (2001) estimate a 3.2% prevalence rate for physical abuse during a mean postpartum period of 3.6 months. However, past abuse is a strong predictor of postpartum abuse. In a study of Canadian women with a history of physical abuse during pregnancy, 90% of the participants reported physical abuse in the first 3 months after delivery (Stewart, 1994).

Given the prevalence and impact of IPV, some organizations in Canada (e.g., Cherniak, Grant, Mason, Moore, & Pellizzari, 2005; Registered Nurses' Association of Ontario, 2005) and the United States (e.g., American Nurses Association, 2000; Family Violence Prevention Fund, 2004) recommend that health-care support staff routinely ask all female patients about exposure to IPV — a procedure referred to as universal screening. There is ongoing debate in the field about this issue. Some authors highlight the lack of current evidence on the effectiveness and the potential harm of screening for IPV (Nelson, Nygren, McInerney, & Klein, 2004; Ramsay, Richardson, Carter, Davidson, & Feder, 2002; US Preventive Services Task Force, 2004; Wathen & MacMillan, with the Canadian Task Force on Preventive Health Care, 2003). A key issue is the lack of evidence regarding effective interventions to which health-care providers can refer women once IPV has been identified (Wathen & MacMillan, 2003).

Universal screening must be distinguished from case-finding; there is general agreement on the importance of asking about IPV when signs and symptoms or other factors indicate the need to do so as part of a diagnostic assessment (Cole, 2000; Ferris, 2004). A number of indicators — characteristics of women, men, and their relationships — have been significantly correlated to abuse status. These include depression; post-traumatic stress disorder and somatic complaints in women; drug and alcohol use by male partners; unemployment or underemployment of male partners; and type of relationship, including common-law and

recently separated (Coker, Smith, McKeown, & King, 2000; Dearwater et al., 1998; Kyriacou et al., 1999; Magdol, Moffitt, Caspi, & Silva, 1998). It should be noted that the available data on risk indicators are primarily correlational — that is, the indicators are present at the time when abuse is assessed. It has not yet been determined which indicators precede or succeed abuse. It has also been argued that routine health assessments (Janssen, Dascal-Weichhendler, & McGregor, 2006) and inquiries (Taket et al., 2003) should include questions about exposure to violence in addition to questions about alcohol consumption and smoking (Janssen et al., 2006) for the purpose of identifying health hazards known to be correlated with IPV (e.g., chronic pain, depression).

The McMaster University Violence Against Women research group conducted a randomized trial testing three methods of screening for IPV, to determine which method should be used in a trial examining screening effectiveness. This involved a comparison between a face-to-face interview conducted by a health-care provider, written self-report, and computer self-report (MacMillan et al., 2006). Two short screening instruments were used: the Partner Violence Screen (PVS; 3 items) (Feldhaus et al., 1997), and the Woman Abuse Screening Tool (WAST; 8 items) (Brown, Lent, Brett, Sas, & Pederson, 1996). The original intention was to include PHN home visitation as one setting for the trial; however, it quickly became clear that this context is very different from health care provided in clinics and that this warranted the separation of public health home visitation and clinic settings. The length of home visits and the average number of clients carried by each PHN precluded the powering of the home visitation setting to obtain data on screening format that were specific to nurse home visits.

The three screening methods and two screening instruments were assessed through Healthy Babies Healthy Children (HBHC), a visitation program delivered by a public health unit in central-west Ontario. The HBHC program is a comprehensive network of services and support funded by the government of Ontario and coordinated through its 36 public health units to promote child and parent development amongst pregnant women and families with children under 6 years of age. Nurse home visitation is a core component. For the majority of women, referral occurs during universal postpartum screening conducted in hospital. Consenting women receive a brief assessment of maternal and newborn well-being by telephone within 48 hours of discharge. All mothers are offered a single postpartum home visit (60–90 minutes) by a PHN for the purpose of: (1) assessing infant and maternal health status and family adjustment, (2) dispensing information

on community supports, and (3) providing information to encourage the adoption of health-promoting behaviours.

At any point of contact with public health services, pregnant women or families who are identified as having children at risk for developmental delay, due to either poor parenting or social or physical factors, may receive an additional home visit during which the PHN conducts an in-depth family assessment (IDA). Based on this comprehensive assessment, families with high-risk children may be eligible to participate in a voluntary blended home visitation program. This targeted component of the HBHC program provides families with home visits by both professional PHNs and lay home visitors.

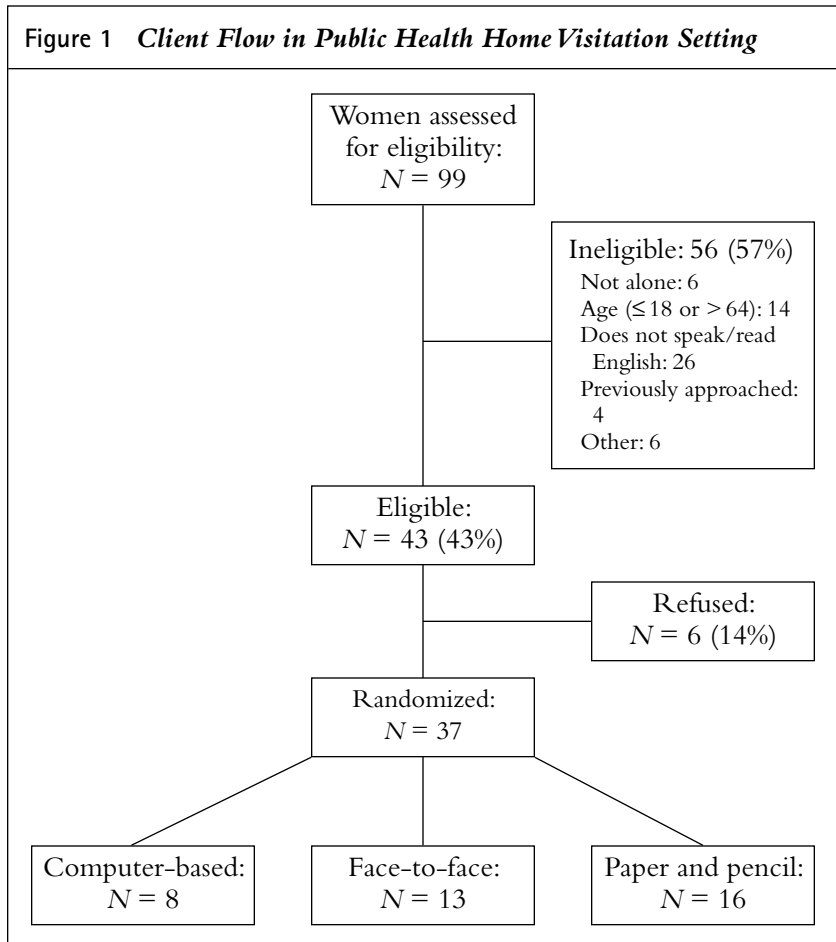
Because the home visitation care was substantively different from care in a clinic setting, and since only 37 women were recruited over 6 months, we conducted a follow-up qualitative study to examine PHNs' perceptions and experiences of asking about IPV during home visits. The objectives were to: (1) examine PHNs' perceptions of screening for IPV; (2) explore the feasibility, from the nurses' perspectives, of screening for IPV during home visits, including identifying barriers to screening; (3) describe the circumstances under which PHNs ask about IPV; and (4) describe PHNs' training with respect to addressing IPV. This article presents the nurses' perceptions of screening for IPV and the feasibility of universal screening in the context of postpartum home visits. The nurses reflect on their experiences related to both their involvement in the study and their usual home visitation practices.

Methods

A fundamental qualitative descriptive design (Sandelowski, 2000) was used to explore PHNs' perceptions and experiences of screening for IPV during home visits. This type of design is employed in order to provide a comprehensive summary of facts and events using the surface language of the participants; it is commonly used by researchers and decision-makers who require direct answers to questions about specific events, phenomena, or programs (Sandelowski, 2000). Compared to data generated through descriptive, interpretative qualitative methods such as grounded theory or phenomenology, fundamental descriptive data are interpreted with less inference and with minimal theorizing (Sandelowski, 2000).

All six PHNs taking part in the trial agreed to participate in this qualitative study. The nurses were asked to reflect in general on the process for the randomized trial, including the experience of assessing participants for eligibility, and then to specifically reflect on the home visits with the 37 women who participated in the trial. Over a 6-month

period, the PHNs assessed the eligibility of all of their new and existing clients receiving home visits. A woman was eligible to participate if she was 18 to 64 years of age receiving a home visit for herself and her infant, able to separate herself from other individuals in the home, able to speak and read English, well enough to participate, and able to provide informed consent (MacMillan et al., 2006). The 37 women were drawn from a total of 43 who met the eligibility criteria, for a response rate of 86%. Six of the 43 who met the criteria chose not to participate. The trial flow diagram is presented in Figure 1. These women were recruited from postpartum, IDA, and long-term HBHC home visits. Nurses were also asked to consider their experiences with asking about IPV in their usual clinical work.



The study was approved by the Hamilton Health Sciences/McMaster University Faculty of Health Sciences Research Ethics Board. All of the PHNs who participated in the trial received 1 hour of training in responding to IPV from the study coordinator and an experienced social worker who served as coordinator of the local hospital-based domestic violence program. They also received a training binder that included information about IPV and community resources for women exposed to IPV. Data were collected between November 2004 and January 2005. Each PHN took part in a single in-depth, semi-structured interview that lasted from 60 to 90 minutes. An interview guide was developed based on the study objectives. It was revised following each interview so that emerging concepts and themes could be explored in subsequent interviews. The PHNs were given a \$5 gift certificate in appreciation of their participation. Data collection and analysis took place concurrently. The audiotaped interviews were transcribed verbatim and the primary investigator (SJ) compared each transcript to the tape for accuracy. Given the exploratory nature of the study, data were analyzed using qualitative content analysis (Miles & Huberman, 1994; Woods, Priest, & Roberts, 2002). A process of first-level, or line-by-line, coding was conducted whereby key phrases were matched with one or more codes. Second-level coding was then carried out to identify subcategories and properties of each category and to establish relationships and links across categories (Priest, Roberts, & Woods, 2002). Once data were reduced, key themes were developed through a process of interpreting participants' responses (Priest et al., 2002).

To ensure data credibility, all interviews were conducted by the primary investigator, a nurse researcher with expertise in qualitative methods and with clinical experience as a PHN. Once all interviews were transcribed and coded, a written summary of the emergent themes was circulated to all interviewees for their comments on the data interpretation. All six PHNs participated in this process of member checking, and all agreed that the themes, interpretations, and conclusions were accurate and representative of their experiences (Krefting, 1991). A presentation of the key themes from the study was given to all HBHC PHNs in the public health unit; there was consensus that the findings were reflective of their experiences with discussing IPV during home visits. Strategies to strengthen the dependability or consistency of the findings included peer examination of the research design and implementation and discussion of the key findings with a multidisciplinary team of researchers working with Violence Against Women. Additionally, transcripts were independently coded by the primary investigator and a 4th-year baccalaureate nursing student. The investigator and the student

then met to discuss emerging concepts and categories and to reach consensus on code labels.

Results

All the nurses held a minimum of an undergraduate degree in nursing and three held a university degree (one a master's degree and two an undergraduate degree). Their mean age was 41 years. Their mean number of years of overall nursing experience was 19 (*range* = 4 to 28 years) and mean number of years of home visitation experience was 7 (*range* = 1 to 25 years). All of the nurses had experience conducting home visits with both postpartum and long-term (high-risk) clients. During the randomized trial, four of the PHNs recruited participants from either their postpartum (initial home visit) or long-term caseloads. Two of the PHNs were members of the client assessment team and study participants were recruited on their home visits following completion of the IDA tool.

Public Health Nurses' Perceptions of Universal Screening for IPV

The PHNs expressed the opinion that it was their role to focus on family health promotion and, because they generally worked with physically healthy populations, that home visitation is an appropriate setting for identifying and addressing psychosocial issues such as IPV. All of the PHNs believed that routine IPV screening for women receiving home visits would benefit their clients. The nurses explained that the process of asking all women about their exposure to IPV would: (1) increase client awareness about the issue, (2) help women exposed to violence to define their experiences as abusive, (3) create more opportunities for women to disclose incidents of IPV to health-care providers, and (4) facilitate discussions between health-care providers and clients about health issues related to violence. It was anticipated that with frequent discussion of IPV women would grow more comfortable disclosing situations of abuse during encounters with health-care providers. As one nurse explained, it is the responsibility of the nurse to present the issue of IPV in a "matter of fact" manner and to tell the client, "We do this with everybody," the rationale being

...the next time another health-care provider asks her, maybe eventually she'll start thinking, "Well, maybe this [IPV] isn't such a terrible thing for me to admit to, because people seem to think that it is quite common."

Some of the nurses cautioned that screening for IPV during all health-care interactions could result in some practitioners asking questions in a very rushed and perfunctory manner, creating an environment that is not conducive to disclosure. However, one nurse acknowledged that a policy of universal screening would serve to identify abused

women at risk of “falling through the cracks” because they might not be viewed by the PHN as at risk for abuse.

Feasibility of Screening in Home Visiting Practice

Despite the value that they placed on IPV screening, PHNs identified multiple barriers to the screening of all women receiving PHN home visits. In the randomized trial, nurses were instructed to determine client eligibility and enrol eligible clients during their regular home visits. What emerged during the in-depth qualitative interviews was that the term home visiting cannot be used generically; we quickly became aware of substantial differences in purpose, intensity, and frequency across postpartum, IDA, and long-term home visits.

The context and purposes of the IDA and long-term HBHC visits differed from those of the postpartum visits. In the former types of home visit, the PHNs were delivering services to clients at high risk of exposure to IPV; it was therefore normal for them, even prior to the trial, to use an assessment or case-finding approach in identifying and discussing the issue of IPV with the client. The PHNs explained that, as rapport and trust were slowly established with long-term clients, they found it natural to weave questions about the quality of the client’s relationships and her exposure to IPV into the conversation. Some PHNs believed that disclosure could be facilitated by slowly building up to a discussion of relationship violence and using a conversational approach to assessment. They said that the direct approach required when screening for IPV using a face-to-face standardized questionnaire might not be conducive to discussing one’s experiences of IPV. These PHNs also explained that when using the screening tools they felt compelled to ask the questions in the tool and did not have an opportunity to explore the client’s responses in depth.

While the universal postpartum home visit is targeted to a general population of new mothers, there are multiple barriers to IPV screening during a home visit of this type. These barriers include the following: (1) the presence of the partner during the visit; (2) the presence of other family members, including children over the age of 18 months; (3) lack of time; (4) the nurse’s respect for the client’s time and priorities; and (5) language barriers. The conditions for safely and privately screening for IPV were frequently lacking during postpartum home visits. One nurse described the ideal screening environment:

The husband is not around, there’s a quiet environment, the baby isn’t crying or fussing, and there are no other children around and no other visitors. [Then] you know that a comfortable relationship has been established.

One common restriction on PHNs' abilities to screen for IPV during postpartum home visits was the presence of other individuals. The protocol for screening required that all questions related to IPV be posed only when the woman was free to answer, so that her response remained private and was disclosed only to the nurse. In some cases, the nurses were unable to complete the screening because the woman's partner had taken leave from work following delivery and wished to participate in the nurse's initial visit:

The majority of the time, for postpartum home visits, the mothers have just been discharged from the hospital, and the partner is always there — always, always there.

Grandparents were also frequently in the home, to provide support to the new mother, and also participated in the visit. During discussions of general home visiting practice, the nurses said that the home setting may enhance a client's level of comfort in discussing intimate issues but can also inhibit discussion of IPV, particularly for abused women who fear that the visit will be overheard or disrupted by the abuser.

The presence of the infant's siblings limited the nurses' ability to screen for IPV, for two reasons: It was study protocol to not screen for IPV in the presence of children over the age of 18 months; and the presence of active toddlers or preschoolers precludes the development of an environment conducive to the discussion of sensitive issues.

The trial protocol estimated that eligibility determination, the securing of informed consent, and the IPV screening process would take approximately 30 minutes. To facilitate the conduct of the study, the PHNs were given the flexibility to extend the time per home visit. The PHNs admitted that the amount of time allocated to a postpartum home visit would be a factor in their decision whether or not to screen for IPV. They reported that an average home visit of 60 to 90 minutes consists of the following interventions: (1) assessment of maternal-infant health status, (2) education of families in infant development and well-being, and (3) promotion of family awareness of local community resources and services. For breastfeeding mothers, considerable time is spent addressing problems related to latch and discussing infant hydration and elimination.

The nurses stated that a discussion of IPV with a client is qualitatively different from, more emotion-laden than, and more time-consuming than a discussion of any traditional health promotion topic. One nurse commented:

You know darn well that if somebody tells you something about abuse...it's not going to be a short little issue. So it's not like when you talk about an issue like preventing SIDS [sudden infant death syndrome]

and then move on to the next thing. This is something that's going to be very time-consuming.

The nurses explained that a discussion of violence requires time, so that the nurse can: (1) fully engage with the woman in order to sensitively introduce the topic into the conversation, (2) complete the screening, and (3) respond to the results of the screening. The nurses were candid about their lack of time during regular postpartum home visits to complete these tasks in a therapeutic manner. Also, most PHNs are expected to make two home visits per half day and lack the flexibility to extend the time between visits in order to respond to any disclosure of IPV. One nurse likened discussing IPV with clients to “opening up a can of worms” and admitted that if she was pressed for time “I’m not going to ask them [about their exposure to IPV].”

During a home visit, a PHN provides the family with a large amount of information in a relatively small amount of time. As a result, the PHNs were extremely sensitive to the impact of a single, intensive home visit to a new mother with an infant less than 1 week old. The PHNs reported that by the end of a postpartum home visit, once the required content was covered, most mothers — already struggling to quickly adapt to caring for an infant — were overwhelmed by the amount of information presented to them. Many of the nurses indicated that the postpartum home visit is not the ideal time to screen for IPV. The PHNs said that if they managed to complete a screening questionnaire at all, it was at the end of the visit. Some made the decision not to screen for IPV because they received numerous cues from the mother that it was time to end the visit. In some situations the nurse observed that the mother was exhausted or in physical discomfort:

The mothers would say, “The baby’s hungry” or “I need to feed the baby now” or “The kids are going to be coming home soon,” or the toddlers would have woken up from their naps and she was saying, “I’ve got to get supper on now.” The postpartum home visit would be long and involved enough, and many of the moms were just plain tired. They’re worn out at that point. So I really do not find that good timing [to screen for IPV].

The ability of participants to speak and read English was one of the inclusion criteria for the trial, and the screening tools were available in English only. As illustrated in Figure 1, this criterion meant that 26% of clients were not eligible to participate in the study. In the qualitative interviews, the PHNs confirmed that language barriers did limit the number of women they could recruit, as many of their clients were new immigrants to Canada or spoke English as a second language. The PHNs stated that this was characteristic of their home visiting practice and that

they could not always discuss culturally sensitive issues such as IPV with non-English-speaking clients. They frequently relied on interpreters to accompany them on home visits. The PHNs said they would be hesitant to have an interpreter ask a client questions related to IPV exposure, mainly because interpreters are frequently drawn from the same community or cultural group as the client and the client may be uncomfortable or fearful disclosing a violent situation. One PHN explained that non-English-speaking postpartum clients may view an interpreter as “someone in their own community” and be hesitant about disclosing IPV,

...especially if they're from a community where abuse and control issues are not that uncommon. So are they going to be sharing that? Not if they're thinking that this person is going to go and tell everybody else in the community.

PHN Education Related to IPV

Throughout the interviews it became apparent that the nurses perceived that a policy of universal screening for IPV would benefit women only if the health-care providers responsible for screening were knowledgeable about and skilled in responding to disclosure of physical, emotional, or sexual abuse:

I think universal screening is only as good as the training you give the person who is asking the questions and the subset of people that you have in place to refer that person to.

Four of the PHNs commented that the training session constituted an excellent overview of IPV. They considered the training binder provided as part of the trial's safety protocol a valuable resource and said they would continue to use it to inform their clinical practice and their work with women at risk for or exposed to IPV.

None of the PHNs could recall learning, in their undergraduate nursing programs, about the scope of IPV in Canada or receiving training in nursing interventions for women exposed to IPV. Some of the nurses reported that their undergraduate education included opportunities to develop communication and assessment skills but not skills related to screening for IPV. All of the PHNs acknowledged that the majority of their IPV knowledge had been obtained through workshops or through the public health agency's orientation program; however, most discussions of IPV during the orientation sessions were embedded in presentations on child welfare.

Overall, the PHNs who participated in the study felt that they had adequate knowledge and skills to screen women for exposure to IPV and

to respond to disclosure of abuse. However, some of the PHNs admitted that prior to the training for the trial they lacked the confidence and skills to respond appropriately to disclosure of IPV. One PHN summarized her fear this way:

I just think, you know, gosh, what if she does disclose? What am I going to do? And I guess I get scared.

During a discussion about general home visitation practice, another nurse said that even when a PHN possesses the knowledge and skill to ask about and respond to IPV while on a home visit, she may be unable to screen properly because of her limited personal capacity or her own exposure to IPV:

If the nurse herself has experienced some abuse and hasn't dealt with it, she might be scared of asking those kinds of questions because she isn't in a space where she could deal with it herself.

Discussion

Findings from this qualitative study indicate that universal screening for IPV using a standard set of questions, while valued in principle by PHNs, is difficult to implement during postpartum home visits for a general population of new mothers. For PHNs visiting high-risk families as part of the targeted HBHC program, the standard clinical practice has been to assess for mothers' exposure to IPV by integrating questions about violence and relationship into the overall in-depth assessment of the family.

The results suggest that the nature of the health interaction, including time available, other tasks to be accomplished, and the expectations and experiences of both the woman and her health-care provider, might be the ideal determinant of the best approach to asking about abuse. The descriptions provided by PHNs in the present study suggest that when and how to ask about IPV during postpartum home visits is an integrated process; nurses read the situation, determine whether there are immediate signs or symptoms of abuse (i.e., the case-finding approach), and then decide whether and how best to ask questions about violence. Specific issues considered by PHNs include the following: Will I have subsequent visits with this client? If the woman does disclose, will I have time to discuss the next steps? Am I prepared to offer guidance with respect to interventions? Given the lack of evidence about whether universal screening by health-care providers leads to interventions that reduce violence or improve quality of life, and given these contextual realities, we conclude that routine universal screening during postpartum home visits has limited acceptability and feasibility. The nurses should

decide when and how to ask about IPV, using their expertise, judgement, and knowledge about the signs and symptoms. This approach is consistent with emerging qualitative evidence regarding women's preferences with respect to how discussions of IPV are raised during health-care interactions (McCord-Duncan, Floyd, Kemp, Bailey, & Lang, 2006).

The PHNs identified the issue of IPV as a public health concern and as a topic to be included in home visiting protocols. They believed that universally "asking about" exposure to IPV can benefit women by raising awareness about the issue, helping to define abusive situations as such, facilitating discussion of sensitive issues, and providing frequent opportunities for disclosure. These benefits are consistent with the findings of other qualitative studies examining the effects of screening from the woman's perspective. Generally, female patients report that when health-care providers are able to ask about exposure to violence sensitively and confidentially, they feel supported and relieved that the issue is being addressed (Feder, Hutson, Ramsay, & Taket, 2006). The interaction validates their experiences, represents an opportunity for them to obtain information, and helps them to make links between their health status and the quality of their relationship (Cherniak et al., 2005). In a case-control study, abused and non-abused women ($n = 1,988$) agreed that screening would make it easier for abused women to seek assistance (86.1%) and women would be glad that their provider is concerned about their exposure to violence (95.6%) (Gielen et al., 2000). However, the study also revealed the potential harms of screening; 43% of the women agreed that the intervention could place abused women at increased risk for violence. While both clients and health-care providers are able to identify the benefits of IPV screening, the effects of screening on women's long-term health remain unknown (Wathen & MacMillan, 2003).

In the present randomized trial, some women did not meet the eligibility criteria for IPV screening because they could not be seen alone or did not speak or read English. In home visitation practice, the PHNs frequently could not screen properly for IPV because of the presence of others, language barriers, time constraints, the need to focus on client-identified priorities, or immediate concerns such as maternal or infant health. Although this sample of PHNs was confident about their IPV knowledge and their ability to screen for IPV, some PHNs expressed concern about the ability of PHNs in general to respond to IPV disclosure, including providing information about interventions.

Other health-care providers, such as physicians, have identified similar barriers to IPV screening, including a lack of interventions, time constraints, fear of offending the woman, lack of education about IPV, limited knowledge of support services for abused women, fear of reper-

cussions for the woman, and child-protection concerns (Taket et al., 2003; Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000). Additional barriers stemming from the nature of home visits were identified by the participants in the present study. Nurse home visitation is a unique mode of health-service delivery, unlike traditional nursing or medical services delivered via community or acute-care facilities. Care is offered in the client's private space and the family acts as a gatekeeper. In addition, health risks and needs are identified by the nurse, so that care is frequently offered to families rather than sought by them; access to health promotion interventions may be a low priority for parents experiencing multiple stressors (Chalmers, 1992; Kitzman, Cole, Yoos, & Olds, 1997). Public health nurses have little control over who participates in the home visit; the presence of a newborn often leads to other family members being at home when the nurse visits, creating a risky environment in which to ask the woman about IPV. The newborn's siblings may also be present during the visit. For safety reasons the PHNs were instructed not to screen in the presence of children over 18 months of age, again limiting the feasibility of in-home postpartum screening. However, screening for IPV in the presence of young children has been successfully conducted in other clinical settings. In a general pediatric clinic, a sample of female caretakers of children seeking medical care were screened for IPV; the protocol was that participants could be screened in the presence of children over the age of 3 only if they could be interviewed alone or were able to complete the written response form (Holtrop et al., 2004). It was estimated that, with this approach, female caretakers could be screened in 75% of the visits. This result provides further support for screening women using self-completed approaches (MacMillan et al., 2006). However, Zink (2000) cautions that the placing of IPV screening results in pediatric charts can threaten confidentiality as caretakers/guardians may have access to the information.

As client participation in the home visiting program is voluntary, it is essential that PHNs adopt strategies that promote client acceptance of the service. One strategy is to provide client-centred and client-directed care and to give priority to the family's questions and needs during the home visit. The PHNs reported that, after accommodating these needs and providing health education on a variety of topics, such as breastfeeding, they had little opportunity to introduce IPV screening at the end of a visit. Furthermore, the PHNs indicated that aspects of the provider-client relationship that might facilitate discussion of violence, such as trust and rapport, are not usually established in one visit. Discussions of IPV are best held when there is a bond of trust between the provider and the client and when the client does not feel rushed. This calls for adequate resources, to ensure appropriate levels of care, including intensity,

frequency, and length of postpartum home visits. These specifications sat in direct contrast to the PHNs' work with families in the targeted program, who received monthly home visits. Over time, as trust was developed, and when a structured screening tool was not being used, it became easier for the nurses to introduce questions about exposure to violence. It was evident that PHNs consider the topic of family violence to be distinct from general parenting or safety topics. Most of the nurses expressed a wish for flexibility so that women could choose when to disclose IPV; this is an approach that is also valued by abused women (Feder et al., 2006).

Given the PHNs' preference for integrating any discussion of IPV throughout multiple home visits, it is important to differentiate between screening and case-finding. Cole (2000) explains that screening is the process of routinely asking all women accessing health services about their exposure to violence, regardless of their reasons for seeking care. In case-finding (e.g., in-depth nursing assessment), on the other hand, questions about IPV are posed in any nursing assessment of a client who shows signs or symptoms of abuse. The nature of the HBHC program, which offers monthly PHN home visits to families with children at high risk for developmental delays, essentially presupposes a case-finding approach to identifying women exposed to violence. The maternal and family indicators that place children at high risk for developmental delays, and thus eligible for nurse home visits (McNaughton, 2004), are similar to some of the indicators for IPV exposure. Therefore, it is good clinical practice for nurses to use a case-finding or assessment approach to identifying abuse in their home visitation work.

There are several limitations to this descriptive qualitative study. The experiences and perceptions are those of only the six PHNs from one Ontario public health unit who participated in the trial and received additional training in screening for and responding to IPV. The findings are generalizable only to women in Ontario, Canada, who receive postpartum home visits. In future research, barriers to and experiences of discussing IPV should be explored with PHNs who are not involved in this type of research protocol and also with HBHC clients. While qualitative findings are not intended to be generalizable, the present findings may be transferable to other programs that offer postpartum home visits facilitated by a PHN and support program planners and clinicians in identifying barriers to universal IPV screening. Finally, it was only during the qualitative study that the investigating team learned that the unique differences amongst the postpartum, IDA, and long-term home visits significantly influenced the IPV discussions between PHN and client. Data were therefore not collected on the type of home visit the client received or the number of visits the PHN had made prior to the

screening encounter. The content of a home visit, the quality of the client-provider relationship, and the establishment of trust and rapport differ significantly between a single postpartum or assessment visit and a series of visits to identified high-risk women and children. The quality of the PHN-client relationship influences the sharing of sensitive information (Jack, DiCenso, & Lohfeld, 2005) and thus may influence a woman's willingness to disclose incidents of IPV. Researchers evaluating the effectiveness of home interventions should inquire a priori about the different types of home visit offered to families and collect data that will capture these differences.

Clearly, it is a question of not only whether to ask about IPV but also what approach to use and under what circumstances. Recent debates and guidelines have focused on screening to such an extent that issues such as how to ask about violence in the context of a case-finding approach or diagnostic assessment have received little attention (Taket, Wathen, & MacMillan, 2004). It is noteworthy that the nurses in the present study agreed in principle with the concept of universal IPV screening but identified barriers to the implementation of such screening. When information about the effectiveness of IPV screening in health-care settings becomes available from an ongoing randomized controlled trial (<http://www.fhs.mcmaster.ca/vaw>), such information should be considered in the context of the specific health-care encounter. In the meantime, information provided by the nurses suggests that education about IPV generally has been lacking — a finding that is supported by a recent report on Ontario-wide practices (Catallo et al., 2006). Whether or not IPV screening is shown to be effective, it is essential — given the prevalence and health consequences of IPV — that home-visiting nurses have appropriate training in identifying and responding to it.

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Screening for Intimate Partner Violence during Postpartum Home Visits

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