

## SCREENING FOR VIOLENCE AGAINST WOMEN IN A RURAL HEALTH CARE CLINIC

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### ABSTRACT

The purpose of this study was to compare the incidence of violence against women served at a rural health care center after introducing a violence screening protocol. All women 18-years and older who were served in the clinic in a one-year period (N=1690) were asked about episodes of violence. The number of positives responses was assessed in a retrospective chart review of all women's charts seen in the clinic before and after an educational intervention and screening protocol were added to the intake procedures. Previous to the intervention, no charts of women were identified who reported current violent against them. A second retrospective chart review was conducted after the intervention. Six women were identified and referred to support agencies for violence against them. The investigators concluded that education of staff and adding the screening protocol about violence against women visits can increase the ability to identify violence against women.

### INTRODUCTION

Violence against women is the most common source of injury to women. Violence against women affects 1 to 4 million women in the United States each year (Asher, Crespo & Sugg, 2001). However, the true incidence of violence may be low because most violence does not come to the attention of health care providers or the legal system (Zust, 2000). The problem of violence against women occurs among women of all racial and ethnic groups, educational backgrounds and income levels. The issues of violence against women are receiving increased attention by government services and researchers (Tjaden & Thoennes, 2000). Healthy People 2010 goals include reduction of the rates of physical violence between intimate partners, sexual assault without rape, rape and attempted rape (United States Department of Health and Human Services, 2000). Yet, there is little research describing the issues of violence against women living in rural areas (Ulbrich & Stockdale, 2002).

In violence against women physical abuse is often accompanied by sexual and psychological abuse. Although physical violence may be more readily identified, women who have experienced physical violence often report that the psychological and emotional abuse were far more damaging (Zust, 2000). Many women in violent

situations do not want to be seen by health care providers to avoid the shame of their physical, psychological or sexual abuse. Often they use several different emergency rooms, miss office visits and move among health care providers. Vague, chronic symptoms, somatic complaints, depression and anxiety may be the symptoms a woman will most often discuss with her health care provider, rather than admitting to violence in her home (Asher et al. 2001; Dienemann, Boyle, Baker, Resnick, Wiederhorn & Campbell, 2000).

Health providers may be aware of the obvious signs and symptoms of physical violence. Multiple injuries are usually present and often appear on the upper extremities when women are trying to defend themselves. Other sites of frequent injuries are on the abdomen, back, head, neck, face, breast, or genitals, but physical signs may not be apparent (Asher et al. 2001). Health care providers need to recognize that women may not be ready to report the problem so the abuser may not easily be identified.

Developing methods for screening all women for violence is essential to address the needs of abused women, yet most primary health care clinics do not screen for violence against women (Asher et al. 2001; Campbell, 1998). The purpose of this study was to identify the incidence of violence against women before and after the introduction of a screening protocol on a health intake form in a nurse managed rural health care clinic. Violence against women was defined as intimate partner violence or domestic violence.

## **REVIEW OF THE LITERATURE**

### *Issues of Violence Against Women in Rural Communities*

There are few studies of violence against women in rural communities (Ulbrich & Stockdale, 2002). Websdale (1998) conducted an ethnographic study through interviewing battered women (n=50) living in rural Kentucky. He also interviewed other service providers for battered women (n=46) including police officers, judges, social workers and domestic violence shelter personnel. Although the types of violence women reported in this study were not different than the violence experienced by women living in urban areas, there were issues of physical isolation, social isolation, and the use of guns and knives that were unique to violence against women living in rural areas.

Physical isolation is the most significant difference between women living in urban rather than rural areas (Ulbrich & Stockdale, 2002). Women living in rural communities are often isolated from neighbors and friends. Sources of immediate help in a crisis are not readily available. Rural areas lack public transportation and taxis, forcing the woman to depend on a car to leave the abusive environment. Yet to leave the abuser may be difficult when a car is not available, or the car keys are lost, or hidden by the abuser. Physical isolation may mean that the distances to health facilities may be as far as 20 to 30 minutes away by car. Telephones are present in most homes in urban areas, but telephone service may be limited in a rural area. Domestic violence abuse centers may not be readily available. Treatment programs and services for psychological counseling are limited in rural areas (Adler, 1996; Websdale, 1998).

The second issue impacting violence for women living in rural areas is social isolation. Women hesitate to contact hot line numbers because a relative or friend of the abuser may be staffing the hot line. Humiliation and fear are concerns for women who are

in violent situations, but the fear of contacting sources of help and not having an assurance of safety, makes it very difficult for the woman to seek help. Social isolation can keep her away from church and community centers that could provide assistance. Abusers may prevent women from having friends and close relationships with family members or access to agents of the state such as police officers, social workers and health care providers (Adler, 1996). In industries that are seasonal, an abuser may be out of work for long periods of time allowing him/or her to watch every activity in the home making it difficult to have privacy or to contact help (Websdale, 1998; Ulbrich & Stockdale, 2002).

The third issue of violence against women living in rural areas is that firearms are often present in the home (Adler, 1996; Websdale, 1998). The rate of homicide is lower in rural communities, but the use of guns and knives in threatening exchanges toward women is higher. Physical isolation, social isolation, and the increase use of guns and knives in violence against women contribute to unique issues for women living in rural communities. Research is needed to determine the ways to identify and support women living in rural areas who are threatened by violence (Websdale, 1998; Ulbrich & Stockdale, 2002).

### ***Screening for Violence Against Women***

The Violence against Women Act in 1994 increased the level of screening for violence toward women in emergency rooms, primary care services and clinics (Dienemann et al. 2000; Ulbrich & Stockdale, 2002). Multiple health care settings should also screen women for violence. General practice offices, prenatal services and pediatric health care services all have the ability to screen for violence (Amiel & Health, 2003). In a retrospective chart audit of community health centers, Magnussen et al. (2004) found that 31 (9%) of 337 charts had documentation of intimate partner violence.

Screening for violence has been suggested by many professional organizations. The American Medical Society and the American Academy of Pediatrics have supported using screening methods to detect violence (Borowsky & Ireland, 2002; Calonge, 2004). Clinical guidelines for nurse practitioners recommend screening for violence through health assessment questions and physical examination of the patient (Uphold & Graham, 2003). Screening tools have been used to identify violence against women but at present no consistency exists regarding which tools to use for screening. Most tools do not have established reliability and validity (Furbee, Sikora, William & Derek, 1998; Nelson, Nygen, McInerney & Klein, 2004).

Though professional organizations and clinical guidelines suggest screening for violence against women, analysis of studies have indicated that screening does not routinely occur in most pediatric and family physician's practices, primary care clinics and health care facilities (Borowsky & Ireland, 2002). The most common reasons stated by health professional for not screening is that they lack education and skills for addressing violence against women (McCarney & McKibbin, 2003). Not all health professionals have received education regarding violence against women (Heinzer & Krim, 2002). Understanding physical and sexual abusive outcomes are obvious to most practitioners, but the psychological components of this relationship are not immediately evident (Wingood, DiClemente & Raj, 2000).

## RESEARCH QUESTIONS AND PURPOSE

This study was conducted to determine if adding a screening protocol into a primary health care clinic would increase the identification of violence against women. The purpose of this study was to compare the incidence rates of violence against women for women 18-years or older served at a nurse managed rural health care clinic. Institutional review board (IRB) approval was obtained for the pretest and posttest procedures of the study. Anonymity was essential since calling women who were at risk for family violence at their homes to obtain consent for the chart review may put them in greater danger of physical or emotional harm.

## DESIGN AND METHODS

The investigators used a quasi-experimental pretest-posttest intervention design. A pre-test was conducted using a retrospective chart audit. The chart audit (N=1690) was conducted through a computer search of the medical records of all women seen at the clinic from January 1, 2000 to December 31, 2000. A second retrospective chart audit (N= 859) evaluated the incidence of violence against women identified after introducing an educational program in 2001 to the staff and adding a screening question to the intake procedures.

The pretest study was conducted to determine the incidence of violence against women encountered in a rural community health care clinic. The clinic was located in a rural Midwest County and serves women through both scheduled and same-day appointments. The clinic was staffed by nurse practitioners that served families in three rural counties. The computerized medical record database allowed the investigators to complete a text word search to identify women over 18-years-of age that had been seen at the clinic. Charts of women served during 2000 were reviewed for patient characteristics documented in the progress notes. The search words were: abuse, rape, assault, battery, altercation, fight, argument and domestic violence. No charts were located in this search that identified women who were treated or referred for episodes of violence directed toward them. A further informal inquiry of the nurse practitioners was done to determine if they remembered any client they had referred to violence counseling in the year. No clients were identified for abuse during the time of the assessment by the nurse practitioners.

The investigators discussed the results of the study with the clinic staff to begin the intervention phase of the study. After determining that no women with violence episodes were identified in the medical records for the previous year, the staff at the clinic discussed the need for appropriate care for these patients, starting with identification. After repeated discussions, the staff members identified a need for improving their knowledge of local community resources. Due to staff interest, two local agencies that support women in violent situations in-serviced the members of the clinic in order to provide background information, local statistics, resources available and the processes for referrals.

## PROCEDURES

The history form given to all patients seen at the clinic was modified to include 'abuse' in the list with other identified health risks, such as hypertension. In addition, all women over the age of 18 years of age were personally asked, 'Is anyone hurting you?' during the intake process of every visit. Policies on how to manage patients responding 'yes' to the question were developed and all the staff members were in-serviced accordingly. The question was added to the paper form as well as to the electronic medical record. In order to create an environment in which violence against women identification would be fostered, a kiosk was placed in the front lobby with health information, including identification and referrals for violence. In addition, posters were placed in every exam room describing the unacceptability of domestic violence and local referral numbers were visible.

A re-evaluation process occurred after 6 months of implementation in several phases. First, records were evaluated randomly for charts missing the screening question response. None were identified. In addition to vigilance and commitment by the nursing staff, this 100% adherence is likely due to the electronic medical record characteristic that demands input at the specified site during data entry. The clinic staff members were further encouraged by the positive feedback received from the staff and representatives from the community agencies regarding the program.

The procedure for screening included mechanisms for referring women to agencies dealing with violence. The women were provided support at the time of the initial positive response to the question. Women received further evaluation of physical, sexual and psychological conditions related to violence. Once the evaluation was completed in the clinic, women received referrals to community organizations that could provide a shelter, counseling or other services.

The post-test consisted of a second retrospective (N=859) chart review to determine the incidence of violence against women after the intervention program and screening protocol was instituted. When the charts of the women were identified, two investigators examined the progress notes, the history forms and the problem list of the visit in which the abuse was identified and the visit after the initial identification of the violence. The charts were reviewed for further information regarding the age, race/ethnicity, presenting complaint, past medical history, current medical history, referral and any follow-up information. Two investigators reviewed the charts together and independently to accurately identify the data derived from the chart.

## FINDINGS

A computer search determined which women had answered 'yes' to the question 'Is anyone hurting you?'. The computer search also identified any notation of abuse in the progress notes, history form or problem list over a one year period 2002. Six women were identified in the computer search of the women seen in the clinic that year. The women ranged in age from 27 to 57 years (mean 45.5). Two women were Hispanic and four women were Caucasian. The presenting complaints were: flank pain (1), headache (2), hypertension (2), and a work physical (1). The past medical history of the women included: vaginal infection and pelvic inflammatory disorder (4), myocardial infarction

(1), hepatitis (1), surgery (1), asthma (1), suicide potential (1), headaches/migraines (2), obesity (1), learning disability (1). Five women had symptoms of depression in their current medical history. Other problems identified in the current medical history of the women were: headaches (3), hypertension (1), chest pain (1), and alcohol/drug abuse (1). No woman identified a presenting complaint that was specifically associated with violence.

Only two women answered 'yes' on the history form to the question about abuse. The other four women discussed abuse with the nurse practitioner during the routine physical exam. One woman admitted that she could hurt herself. She was immediately referred to the local hotline and the national hotline number. Further, immediate treatment consisted of providing medication for depression.

The past and current medical history for the six women demonstrated some similarities. Four women (66%) had treatment for vaginal infections or sexually transmitted diseases. Four women (66%) had a current or past history of depression. One woman had a cholecystectomy, a hysterectomy, a myocardial infarction, and hypertension. Two women had a history of headaches and migraines. The high level of pathology in the past and current medical history of these women suggests that women had been seen in the health care system frequently and may not have discussed the episodes of violence in their lives.

### **FOLLOW-UP PROCEDURES**

Five women were referred to violence shelters, local and national hotline numbers, or local drug treatment facility. A psychiatrist was currently treating one woman for depression. Another woman had left the abusive relationship and felt she had managed to remove herself from harm. One woman was treated for depression and returned to the clinic after removing the abusive relative from her home and achieving a therapeutic response from depression medication. This woman no longer feared self-harm and she was continuing counseling with the abusive relative. One woman lived in the local area and was often in another state so the national hotline number was also given to her. She was also given medication for depression. Another woman was referred to the violence center in the area or the drug rehabilitation program. One woman was under treatment for depression and she was encouraged to discuss the abuse with her psychiatrist. One woman was abused by her daughter; and one woman was abused by a mother. Four women were abused by their male partners. No stranger abuse was identified by the women in the clinic.

### **CONCLUSIONS AND NURSING RECOMMENDATIONS**

Asher et al. (2001) estimated that one in four women experience violence directed against them in their lifetime. The number of women identified in this clinic over a one-year period was lower than that than one in four. Magnussen et al. (2004) also reported a lower incidence of intimate partner violence (9%) in a retrospective chart audit. Since the screening protocol had been initiated in the previous year, and women may not immediately report violent episodes directed at them, the nurse practitioner and nursing

staff were confident that an increased the number of women would be identified in the future.

The limitation in this study is that there was no comparison or control group. There is no way to identify the number of violence against women episodes that occurred during 2002 in the community served by the clinic. Yet the number of women identified with the screening protocol was similar to other studies using retrospective chart audits. The findings of this study supported previous research findings that education and providing specific tools to health providers increased the potential for identifying domestic violence in families (Gadomski, Wolff, Tripp, Lewis & Short, 2001). The study also adds to the limited research on violence against women in rural communities. The nursing staff became advocates for introducing screening when they quickly found women were receptive to being asked about abuse. Women were able to discuss the issues and seek support from the nursing staff. Nurses can provide intervention services by sending women to a domestic violence shelter, referring them to counseling services, and scheduling health care visits for support and counseling.

Hopefully, the results of this study will offer health providers in health centers the support to overcome uneasiness they feel regarding screening women in all areas of health care for violence. Screening methods should be introduced into all primary health care services to increase the identification and service to women exposed to violence in their home (Amiel & Heath, 2003). Health providers can make an impact on women, children and men by providing preventive care to decrease the incidence of violence against women.

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