Intimate Partner Violence Screening Practices of Certified Nurse-Midwives

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It is estimated that 324,000 pregnant women are abused by their partners in the United States each year. The purpose of this qualitative study was to explore the intimate partner violence-screening practices of certified nurse-midwives (CNMs). In-depth interviews were conducted with a sample of CNMs, and the data were analyzed by using with-case and across-case methods. The findings demonstrate that the midwives were inconsistent in their intimate partner violence-screening practice during pregnancy and increase or decrease screening in response to a woman’s cultural background. Screening in a culturally competent manner is expected of all clinicians, but the demands of an increasingly complex, culturally diverse practice environment make it difficult. Consistent intimate partner abuse screening in a culturally competent manner is a challenge for all primary care providers. J Midwifery Womens Health 2006;51:216–221 © 2006 by the American College of Nurse-Midwives.

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INTRODUCTION

It is estimated that 3 million incidents of abuse are committed by men against their female partners each year.1 In the year 2001, 20% of the violence against women was a result of intimate partner violence.2 Pregnant women are not immune to the ravages of intimate partner violence. Prevalence rates of intimate partner violence in pregnant adolescents are reported to be 21% and 14% in populations of pregnant adult women.3 Other research has reported that as many as 324,000 pregnant women are abused annually.4 Women who are abused during pregnancy more frequently have low birth weight babies as well as low maternal weight gain, infections, and anemia.5 In addition, there is a significant relationship between abuse and late entry into prenatal care, and use of alcohol, street drugs, and tobacco throughout pregnancy.3,5–7

Two studies have reported information on the domestic violence-screening practices of certified nurse-midwives (CNMs).8,9 According to a survey conducted by Murphy, CNMs assessed patients for abusive relationships 61% of the time during routine prenatal care.8 One study of women who received care in a single large university hospital found that women with histories of abuse comprised a larger percentage (12.2%) of the population seen in the CNM private practice than the population seen in the physician’s private practice (8.5%).9 However, there is no other information on the intimate partner violence-screening practices of CNMs during prenatal care.

In addition to limited knowledge about how often midwives screen for intimate partner violence, little is known about actual screening practices.8 A knowledge gap exists about how midwives adhere to the recommended universal screening clinical practice guidelines; the American College of Obstetricians and Gynecologists (ACOG) clinical guidelines for screening throughout pregnancy; or the extent of their reliance on clinical judgment and other indicators to screen for abuse. The purpose of this study was to describe the intimate partner violence-screening practices of CNMs during prenatal care.

BACKGROUND

Universal Screening

Professional organizations have responded to domestic violence with recommendations for universal screening for all women and with position articles advocating zero tolerance for domestic violence.10–16 The American College of Nurse-Midwives (ACNM) approved a position paper “Violence Against Women” in November 1995 and revised the paper in August 1997.11 ACNM, “supports a policy of zero tolerance for violence against women as well as the development of health care policies that promote universal screening for the possibility of past or current violence.”11

Universal screening means asking every woman aged 14 and older, regardless of their socioeconomic status, educational level, or ethnicity, about their exposure to intimate partner violence. A growing body of evidence supports the efficacy of universal screening in a prescribed manner for optimal detection of domestic violence.12,15 Universal screening includes 1) asking the same direct questions about abuse, whether symptoms are present or the provider suspects abuse; 2) asking the questions with sensitivity and in person instead of using a written questionnaire; 3) asking the questions in complete privacy to ensure the woman’s safety, with no children over the age of 2 present; 4) asking the questions using a standardized tool, such as the Abuse Assessment Screen; and 5) asking the questions in a culturally
Cultural competency means the screener is aware of his or her own biases but still is able to approach screening with an understanding of cultural differences. In addition, ACOG and the Family Violence Prevention Fund recommend screening at the initial prenatal examination, once each trimester, and once at the postpartum visit. It is better to screen more frequently because abuse can begin at any time during pregnancy, and women are hesitant to disclose abuse when initially asked. The pattern of abuse can increase during pregnancy, with one study observing that about half of the participants with histories of prior abuse reported that the battering increased in frequency and severity and resulted in injury more often than in the time prior to pregnancy.

METHODS

The research question that guided this study was: What are the intimate partner violence-screening practices of CNMs? Specifically, 1) How do CNMs adapt universal screening clinical practice guidelines and ACOG clinical guidelines into their practices? 2) In what ways do CNMs use clinical judgment and other indicators to screen for domestic violence? 3) What do CNMs believe about their screening efficacy? Intimate partner violence-screening practices were defined as either the use of universal screening clinical practice guidelines and ACOG clinical guidelines and/or the use of clinical judgment and other indicators to identify abuse.

The naturalistic inquiry approach of Lincoln and Guba, in conjunction with the case study structure, was the method used for this descriptive study. The case study structure consists of the identification of the problem within the context of the participants’ worldview, along with a holistic picture of the issues identified, and an analysis of the lessons learned. A within case and cross-case analysis is used to explore the similarities and differences of domestic violence screening among CNMs. This design was chosen because the research questions being asked can best be answered by an inquiry method that solicits opinions from the participants.

Data collection methods included audiotapes of interviews with the CNMs responding to open-ended questions and a two-page written demographic survey. The researcher developed the survey and interview questions. The questions and the order in which they were asked were planned prior to the interviews. The participants were asked questions such as, “Can you tell me about experiences you have had with pregnant women who are in abusive relationships?” The midwives were given as much time as they needed to respond to each question. The purpose of the questions was to learn about their experiences and opinions about domestic violence screening and to listen to what actually happens in clinical practice.

The audiotapes of the interviews were transcribed verbatim and stored in a Microsoft Word file and on a backup floppy disk. The procedure consisted of five steps. 1) Reading each case and the initial development of categories: Each case was analyzed and a list of coded categories was developed from the transcripts. 2) Categorical aggregation: The categories were examined for analogous meanings and redundancy and condensed into the final coded categories to use for the analysis. For example, the code “gut reaction” was used to bracket words, phrases, and sentences that discussed any signs or symptoms of physical or emotional domestic violence and cultural indicators of domestic violence. 3) Identification of patterns across cases: The researcher compared the coding categories for similarities and differences among the eight transcripts. 4) Development of themes and 5) Composite description of the screening practices of CNMs.

The CNMs were invited to take part in this research through a recruitment letter and were asked to contact the researcher via e-mail if they were interested. Permission to use ACNM mailing list was obtained from ACNM. The selection criteria required the participants to be certified through ACNM and in current practice.

The study protocol received Institutional Review Board approval from Rush University Medical Center, Chicago, Illinois. Informed, written consent was obtained from each CNM before the collection of data. The researcher outlined steps to ensure confidentiality. This report describes a composite picture of the screening practices of the participants.

RESULTS

One hundred recruitment letters were mailed on May 13, 2004, to midwives in a Midwestern state, with four midwives responding to this initial recruitment effort. A second mailing of 50 letters was sent a month later, with a response of one midwife. The additional three midwives in the study were recruited by network sampling and were referred by other midwives in the study. The researcher believes the poor response to the recruitment effort was due to the fact that the letter was asking midwives to contact the researcher for an interview and not merely responding to a mail-back questionnaire. The researcher wanted to conduct in-person and in-depth interviews, which required a time commitment from busy clinical midwives.

Eight CNMs participated in the study. The CNMs are members of ACNM and live and practice in the Midwest. The CNMs are all employed in full-time clinical practice,
are female, and Caucasian. They ranged in age from 30 to 56, with a mean age of 41 years. Their clinical practice experience ranged from 6 months to 32 years, with a mean of 8.6 years of clinical practice. Six CNMs were educated at the master’s degree level, whereas two were educated at the postmaster’s certificate level. Seven have received domestic violence education, and one has not. They received their educations at seven different universities throughout the country. They reported working in both private practice (three midwives) and public clinics (five midwives) and working with 13 different cultural groups of women.

Screening Patterns

One midwife reported screening sometimes, whereas seven reported not screening during the second and third trimesters. One midwife reported she always screened at the postpartum visit; three screen some of the time; and four do not screen postpartum.

Five major themes were identified, which describe the screening practices of the eight CNMs. The title of each theme was generated from the words of the midwives and serve as a metaphor for concepts inherent in how they screen. The five themes to the midwives screening practices are as follows: 1) We Should Screen Everyone; 2) Honestly, Just a Gut Reaction; 3) Relationships With Women; 4) Planting Seeds; and 5) Lost in the Maze.

Theme 1: We Should Screen Everyone

This initial theme describes the midwives’ understanding of universal screening clinical guidelines, and ACOG clinical guidelines, and how these guidelines are or are not implemented into practice. Every midwife in the sample (n = 8) agreed that universal screening should be conducted, and all reported screening during initial prenatal examinations. When asked about her universal screening practice throughout the four recommended times during pregnancy, a private practice midwife replied:

“Well, the population [middle to upper socioeconomic Caucasian and African American women] that I deal with, it seems like overkill. Um, I’m, you know, what I’m doing right now is just initial visits, and then if I pick up any verbal cues or physical cues, then I may pursue further.”

Another midwife offered the following comments on why screening is not done consistently.

“I am tired. I am having a bad day. I have too many patients. I just gloss over it. I am just routinely asking questions more than I would like to admit. I screen well, but I am not perfect.”

Theme 2: Honestly, Just a Gut Reaction

After their initial domestic violence screening, the midwives in this study depended on three types of clues to trigger this “gut reaction,” which was subsequently used throughout their patients’ pregnancy, during labor, and the postpartum period to detect abusive relationships. The three triggers leading to a “gut reactions” were 1) behavioral clues, 2) physical signs and symptoms, and 3) cultural clues. The behavioral triggers consist of interactions between the woman and her partner or interactions between the midwife and the woman. The midwives used the following phrases to describe their observations about the interaction between the women and their male partners and talked about what they perceive as “normal husband/wife relationship.” Behaviors of men that make midwives suspicious included “demeaning behavior,” “the yelling, the swearing at the children,” men who are “very charming and manipulative,” men who exhibit “very aggressive behaviors” during prenatal visits, and “overly controlling” men or “whenever the male figure or the partner speaks for the patient, that makes me nervous because there is that control thing.”

One midwife described behavioral clues as follows:

“Sometimes, honestly, just a gut reaction and the gut reactions of my coworkers as well, the other midwives I work with. And as we are meeting and we are discussing patients we say...something is not right here so it is that gut. Yes, which absolutely I cannot describe, and if that is all we relied on, we would miss opportunities...It’s just, it’s a subjective kind of thing, but the subjective assessment comes from, you know, talking with a lot of them, knowing, having observed what behaviors are when people have a problem.”

The physical signs and symptoms reported by the interviewees are fairly self-evident, and consisted of bruises, bumps, and other physical indications of trauma, which all the participants in this study were highly attuned to. In the third trigger, identified as cultural clues, the midwives singled out specific cultures that make them suspicious of potential abuse behaviors. One midwife commented:

“I think that people of Arabic descent concern me because the men are so dominant and the women are submissive. They do not have lot of independence in terms of culture as far as I can tell. But, then again, it is hard. We had a couple that was Mexican, where he did all the talking because she hardly spoke any English, but it turns out when he was not around, she spoke pretty well.”
Theme 3: Relationship With Women

Relationship with women was reported by all midwives in the study as one of the foundations of their professional practice and how they establish rapport and trust with women. The midwives reported the ability to discuss a range of sensitive subjects with women because they gave time to listen to the women.

“You have to be really in a trusting relationship. If she is willing to open up about it, if she is really, really sad about it, then you can usually talk with her. You need a relationship, yes, I think so, I think so. I think they will not just let go, with the topic just to a total stranger. Being the midwife and establishing a relationship with women who are in abusive relationships is critical. Because there are really very few situations where the victim can have an intimate relationship with another adult and have the opportunity to trust that person. So I feel honored and I feel privileged to provide that connection. That is why I do what I do.”

Theme 4: Planting Seeds/Health Promotion

Planting seeds is a symbol for the domestic violence health promotion activities the midwives were engaged in with their clients. They provided graphic descriptions of abusive behaviors and reinforced that these behaviors are not acceptable. For example, one midwife tells women that, “their kids grow up with this, do you want that for your kids? Boys learn to be abusive and girls learn to be victims.”

Another told of a situation where a “woman came in because her mother had beat her with a broom...a broom, okay? But the fact that her mother was hitting her and she was pregnant, like 7 months pregnant. I mean that’s bad.” They tell women “abuse is a crime and it is wrong.” This midwife discussed not just physical abuse, but also emotional maltreatment.

“I get pretty specific with them. And then I say, ‘Have you ever been emotionally abused? Have you ever felt that someone has threatened you or belittled you?’ Like I’m giving them examples because some of them, believe it or not, do not even know the meaning of that word, emotional abuse.”

Theme 5: Lost in the Maze

Lost in the maze symbolizes the challenges of responding to a positive disclosure for domestic violence in health care systems and the lack of outcomes data on screening practices. One midwife reported the following classic clinical tale. Her client denied abuse during the initial history, but on examination, the midwife noted bilateral bruising on her arms. After requesting, the woman admitted to being in an abusive relationship, and the midwife tells her story.

“It was a hard situation. Of course, they always happen late Friday afternoon, kids running rampant in the exam room, the rest of the support staff has gone home, all those sorts of things. She only speaks Spanish. I do speak medical Spanish, and I do pretty well, but when I delve this area [domestic violence] my Spanish gets a little shakier. I go find domestic violence information in Spanish to give her, if I am going to hook her up with a hotline, I have to make this happen... all the people who translate for me are gone, so it is frustrating. Yes, it is very frustrating... I have to say, I make myself do screening because I believe it, but I cannot say I would love doing it because I do fear the moments that I get positive responses, then I have to do something about it, not that I don’t want to do anything about it, but just because the system is not set up for it to be a streamline process...”

Despite their frustrations and lack of knowledge about the outcomes for women, the midwives hold on to the idea of making a difference in the lives of the women they touch. When talking about her practice one midwife said, “If I can make a difference... even for one day, that she feels valued and important and loved... I am doing what I need to do.”

DISCUSSION

The results of this study indicate that the midwives are concerned, interested, and knowledgeable about intimate partner violence screening, and the participants in this study do conduct screening. However, they are inconsistent in their adherence to universal screening clinical practice and ACOG clinical guidelines for domestic violence. The participants in this study adjusted the recommended number of screenings (four) based on subjective assessment of each woman and her partner. The midwives screened less than half of the recommended time and were influenced by a woman’s culture to increase or decrease their screening frequency.
Screening from a culturally biased viewpoint causes confusion for the midwives and misinterpretations of a woman’s risk for intimate partner violence. Screening in a culturally competent manner is expected of midwives, but the demands of an increasingly complex, culturally diverse environment make it difficult. A challenge for these midwives was their inability to screen in a consistent, culturally competent manner.

None of the participants used a standardized screening assessment tool, such as the Abuse Assessment Screen, but they adapted their questions based on content in this tool and their individual clinical style. However, they all depend on clinical suspicions or that “gut reaction” throughout pregnancy, during labor, and in the postpartum period in place of routine screening to alert them to potential abusive situations.

The midwives in this study believe that they bring a unique dimension to intimate partner violence screening because they established trusting relationships with the women they encounter. The midwives gave their time, listened in a supportive manner, learned about the women’s lives in the context of their families, and established their practices as safe places where sensitive topics could be discussed in confidence. They believe that they provide safe havens in the health care system, especially for women with limited economic and supportive resources. They serve as advocates and counselors for appropriate nonviolent behaviors in relationships. Finally, they provide intimate partner violence health promotion to women on a regular basis.

The identified theme of “Relationship With Women” adds support to the qualitative research of Kennedy.22 Her phenomenological study described the experiences of women who received care from CNMs within the context of feminist ideology. Kennedy identified the “development of a caring relationship built on mutual respect, trust, and alliance”22 between the midwife and her client, as an important theme that emerged from her data. This echoes one of the fundamental philosophical tenets of the midwifery profession, which is to enter into a partnership of care with women, a tenet of practice that was repeated again and again by the midwives in this study. The ability to establish a trusting relationship is a key component for successful intimate partner violence screening and one of their greatest screening strengths.

The interviews in this study provided rich descriptive data about the intimate partner violence-screening practices of CNMs. However, because of the self-selection of the participants, the findings cannot be generalized, but they represent the opinions of this sample of midwives.

Implications for Practice

Midwives, with their multicultural practice settings, exceptional abilities to develop trusting relationships with women, and intimate partner violence knowledge base are in the forefront of identifying and advocating for victims of violence. Midwives should strive for rigor and consistency in their screening practices. Table 1 provides key screening concepts and universal screening.

There is a growing body of evidence that supports the efficacy of universal screening in a proscribed manner for optimal detection of intimate partner violence.12,15 In addition, universal screening will provide the clinician with an objective way of assessing a woman’s risk while eliminating the clinician’s cultural bias from the process. The goal of screening in a consistent, culturally competent manner is a constant challenge for clinicians and health care systems.23–25

Table 1. Recommendations for Screening for Intimate Partner Violence

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<th>Recommendation</th>
<th>Resource</th>
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<td>Ask the questions using a standardized tool.</td>
<td>Abuse Assessment Screen and Danger Assessment in both English and Spanish. Available from: <a href="http://www.nnvawi.org">www.nnvawi.org</a></td>
</tr>
<tr>
<td>Ask the questions in a culturally competent manner which requires you to be aware of your own biases.</td>
<td>National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care. Available from: <a href="http://www.endabuse.org/health">www.endabuse.org/health</a></td>
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According to Campinha-Bacote, “Cultural competence is the ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural content of the client [individual, family, community].”

Future research is planned to explore how culture influences both women and clinicians in their perceptions, attitudes, and tolerance toward intimate partner violence. The goal is to provide a clearer cultural understanding, which will help bridge the clinician’s gap between cultural inconsistency and cultural competency.

The author thanks the outstanding midwives who volunteered for this study.

REFERENCES

11. American College of Nurse-Midwives. Violence Against Women (Ad Hoc Committee) position statement [Internet].