Abstract

This study focuses on the competency level of nurses who work on maternal units in addressing matters of domestic abuse among pregnant and postpartum women. Barriers to screening for intimate partner abuse were also identified. The study consisted of a convenience sample of 25 Registered Nurses from UNC Women’s Hospital in Chapel Hill, North Carolina. Participating units included the Labor and Delivery unit, the Mother/Baby (Postpartum) unit, and the Obstetrics and Gynecology unit at UNC Women’s Hospital. Participants completed an anonymous survey containing questions regarding their knowledge and comfort level in addressing issues of domestic abuse, as well as barriers to screening for intimate partner abuse on their unit. Of the 80 percent of participants (n=20) who indicated that they have encountered patients who have disclosed being a victim of domestic abuse, 95 percent (n=19) indicated that they felt prepared to handle the situation within their scope of practice. However, a number of participants identified insufficient screening time, and lack of privacy as barriers to screening. It was concluded that further research is needed on identifying time efficient, confidential screening techniques on domestic abuse that can safely be incorporated with patients regardless of the presence of other visitors.
Introduction

The purpose of this study was to learn about the competency level of nurses who work on maternal units in addressing issues of domestic abuse among pregnant and postpartum women. This study is needed because “1 in 6 female patients are intimate partner violence victims” (Deboer, Kothari, Kothari, Koestner, Rhos, 2013, p. 159). Domestic abuse, also known as intimate partner abuse, is defined as “when one person in an intimate relationship or marriage tries to dominate or control the other” (Smith and Segal, 2014). Pregnancy is a risk factor for domestic abuse. According to international research, 25 percent of women experience their initial episode of physical abuse during pregnancy (Ring, 2010). Domestic abuse during and surrounding the time of pregnancy is an important public health issue that not only affects the mother, but also poses significant health risks to the unborn child (Menezes Cooper, 2013). With nurses being a consistent presence at the bedside on maternal units, it is essential for nurses to be able to properly identify and intervene for patients who are victims of domestic abuse in order to promote optimal health outcomes for the victims involved. While the literature indicates that nurses view their role as being vital in assessing for domestic abuse, many have indicated that further training is needed to better identify and intervene for victims (DeBoer et al., 2013). It was my hope that this study would further reveal the competency level of nurses working on maternal units concerning addressing domestic abuse issues among patients. Barriers to screening were also identified in hopes that necessary adjustments are made to further enhance the care received by maternal patients who are victims of domestic abuse.
Literature Review

Current Findings

The Center for Disease Control and Prevention (CDC) identifies intimate partner violence (IPV) as a major public health problem affecting 3 out of every 10 women in the United States. Wong and Mellor (2014) indicate that there is a one in four chance of women experiencing domestic abuse, with 4 to 8% of IPV experienced by the pregnant population. According to the CDC, IPV includes physical violence, sexual violence, threats, and emotional abuse (CDC, 2012). The CDC states that the usual progression of intimate partner violence begins with emotional abuse, then proceeds to physical or sexual abuse; however, multiple types of abuse may occur simultaneously (CDC, 2012). The CDC defines emotional abuse as “threatening a partner or his or her possessions or loved ones, or harming a partner’s sense of self worth” (CDC, 2012, p. 1). Physical violence occurs “when a person hurts or tries to hurt a partner by hitting, kicking, or other type of physical force” (CDC, 2012, p.1). Sexual violence is defined as “forcing a partner to take part in a sex act when the partner does not consent” (CDC, 2012, p. 1). Threatening is also considered a facet of IPV, and involves “the use of words, gestures, weapons, or other means to communicate the intent to cause harm” (CDC, 2012, p. 1).

Findings from world health organizations consider domestic abuse during pregnancy a major global health concern requiring increased attention in order to foster greater health results for mothers and their children after birth (Menezes Cooper, 2013). Findings from the World Health Organization (WHO), Healthy People 2020, and the CDC, have all acknowledged intimate partner violence as being a “leading health concern and cause for traumatic death to mothers and their unborn infants” (Cooper, 2013, pg. 31). According to Cooper (2013), domestic abuse during pregnancy can lead to injury or death to the infant, premature birth, and can also
negatively affect the mother’s physical and mental health. Some of the health risks of domestic abuse include post-traumatic stress disorder, substance abuse, depression, chronic pain, traumatic brain injury, and gastrointestinal disorders (Wong & Mellor, 2014). In regards to domestic abuse during pregnancy, decreased mental health, high blood pressure, sexually transmitted diseases, and urinary tract infections were said to be associated with domestic violence during pregnancy (Wong & Mellor, 2014).

The literature reveals that more nursing education on identifying and referring domestic abuse victims, along with presenting evidence-based methods for bedside nurses concerning addressing issues of domestic abuse is needed to advance the care of pregnant and postpartum women (Henry, 2010). A study on nursing attitudes towards domestic abuse screening disclosed that nurses were able to identify domestic abuse victims; however, they “lacked the confidence in performing an in-depth assessment and in the victim actually finding help” (Henry, 2010, p. 1). Also, the nurses felt that they had inadequate training on domestic violence. Based on the results of the study, it was concluded that education on identifying and referring domestic abuse victims, along with presenting evidence-based methods for bedside nurses in dealing with issues of domestic abuse is needed to help advance the care of women who admit to the maternal unit of the hospital (Henry, 2010). An additional study conducted at a Level I trauma center suggested that an improvement in domestic abuse training was needed by nurses (Deboer et al, 2013).

**Perceived Barriers to Screening for Domestic Abuse**

In regards to barriers to screening for domestic abuse, the literature suggests that insufficient time, fear of bringing discomfort to the patient and the patient’s partner, and fear of causing an abusive situation to become worse are barriers for healthcare professionals (Menezes...
Cooper, 2013).

A study done at a Level I trauma center focused on identifying what nurses perceived as barriers to screening for intimate partner violence (Deboer et. al, 2013). Some of the perceived barriers described were, “lack of time, lack of privacy, fear of offending the patient, and issues surrounding personal experience with domestic violence” (Deboer et. al, 2013, pg. 155).

**Method**

**Subjects**

Eligibility for participation in the study involved being a Registered Nurse currently working on a maternal health unit. A convenience sample of 25 Registered Nurses from UNC Women’s Hospital in Chapel Hill, North Carolina participated in the study. The sample included nurses who are currently working on either the Labor and Delivery unit, Mother/Baby (Postpartum) unit, or the outpatient Obstetrics and Gynecology unit at the UNC Women’s Hospital. Of those who completed the survey, 22 participants indicated that they currently work on an inpatient unit and 3 participants indicated that they currently work on an outpatient unit. When asked about the duration of time one has practiced as a registered nurse, 6 participants indicated that they have been practicing for 0-5 years, 5 respondents selected 6-10 years, 5 respondents selected 11-15 years and 9 participants selected >15 years. In reference to the amount of time participants have been practicing as a Registered Nurse on the Maternal units at UNC Hospitals, 12 participants selected 0-5 years, 8 participants selected 6-10 years, 3 participants selected 11-15 years, and 2 participants selected >15 years.

**Instrument**

An online survey tool powered by Qualtrics Survey Software was used to collect data for this study. Hardcopies of the survey were also provided as an additional option for participants.
Participants were asked to complete an anonymous survey that addressed their knowledge and comfort level regarding addressing issues of domestic abuse with patients on their unit. The survey was developed by the researcher and consisted of ten questions that were a mix of both multiple choice and open-ended response questions. During recruitment for survey participants, each of the participants were informed that their responses to the survey were completely voluntary and confidential. Participants were also informed that the results from the survey would be used for an undergraduate honors project.

As indicated above, specific survey questions addressed the length of time participants have been practicing as a Registered Nurse, as well as the length of time they have been practicing as a Registered Nurse on the Maternal units at UNC Hospitals. In regards to domestic abuse, survey respondents were asked how they viewed their role in handling domestic abuse issues with admitted patients, and whether or not they have encountered a situation where a patient disclosed to being a victim of domestic abuse on their current unit. Furthermore, participants were asked to indicate if they felt that they have received adequate training on how to handle issues of domestic abuse and whether or not they feel competent in addressing issues of domestic abuse with patients on their unit. Finally, survey respondents were asked to identify any barriers to screening for domestic abuse and to add any additional comments related to the study. See Appendix A for the survey questions used to obtain data.

Procedures

The approval process for conducting this study first involved obtaining support from the Institutional Review Board at UNC Chapel Hill. During the approval process through the Institutional Review Board, official letters of consent were obtained from the nurse managers of the participating units to survey the nurses on their unit. After final approval from the
Institutional Review Board was obtained, approval from the Nursing Research Council of UNC Hospitals was gained in order to move forward with the project. Participants on the Labor and Delivery, and Obstetrics and Gynecology units were recruited through an electronic recruitment letter explaining the purpose of the study and how the results of the study would be used. Participants were informed that participation was completely voluntary and responses were confidential. The link to the anonymous online survey was included in the recruitment letter. Participants on the Mother/Baby unit were recruited by meeting face to face with each available nurse on the unit and requesting their voluntary participation in the study. Participants on the Mother/Baby unit were given a verbal explanation of the purpose of the study. The nurses were also presented with hard copies of the recruitment letter obtaining the online survey link.

**Results**

Many of the nurses who responded to the survey mainly viewed their roles as providing screening and providing referrals when handling domestic abuse issues with admitted patients. Ninety-two percent of respondents (n= 23) selected both “Provide Screening” and “Provide referrals” as their role in addressing domestic violence issues with patients. Twenty percent of respondents (n= 5) selected “Provide Counseling” and 16 percent of respondents (n= 4) provided other roles in addressing domestic abuse issues among patients. Some of the open ended responses included “Providing minimal counseling, but more comfort”, “advocate” “pray for these families”, and “listen”.

Eighty percent of the respondents (n= 20) indicated that they have encountered patients who have admitted to being a victim of domestic abuse while working on the Maternal unit at UNC Hospitals. Twenty percent (n= 5) indicated that they have not. Of those respondents who specified that they have encountered patients who disclosed being a victim of domestic abuse, 95
percent (n=19) felt that they were prepared to handle the situation within their scope of practice. The other 5 percent (n=1) specifically specified that they did not feel prepared to provide referrals.

When asked whether or not the participants have received adequate training on handling issues of domestic abuse with patients, 8 percent of respondents (n=2) selected “Strongly Agree”, 56 percent (n=14) selected “Agree”, 12 percent (n=3) selected “Neither Agree nor Disagree”, 20 percent (n=5) selected “Disagree” and 4 percent (n=1) selected “Strongly Disagree”. However, one respondent who selected “Disagree” indicated that their training was received elsewhere. See Figure 1 below. When asked whether or not the participants feel competent in addressing issues of domestic abuse with patients, 13 percent (n=3) of respondents selected “Strongly Agree”, 71 percent (n=17) selected “Agree”, 8 percent (n=2) selected “Neither Agree nor Disagree”, 8 percent (n=2) selected “Disagree” and 0 percent selected “Strongly Disagree”. See Figure 2 below. There was no significant difference among nurses who work on inpatient vs. outpatient units regarding their competency levels in addressing matters of domestic abuse among patients. There was also no significant difference among nurses who denoted having more years of nursing experience than those who do not.

In regards to barriers to screening for intimate partner violence, “Insufficient Time” was the most popular survey response with 53 percent (n=10). Thirty-two percent of respondents (n=6) selected “Fear of bringing discomfort to the patient and/or the patient’s partner”, 32 percent (n=6) selected “Fear of causing an abusive situation to become worse”, and 37 percent (n=7) described other barriers to screening”. See Figure 3 below.

There was an overwhelming amount of open-ended responses that addressed a lack of privacy as a barrier to screening for intimate partner violence with patients. The open ended
responses were as follows, “intimate partner continuously present during appointments”,
“difficulty getting the patient alone long enough to ask in depth questions without the significant
other around”, and “difficulty being able to separate patient from visitors for screening”.
Additionally, respondents stated, “Sometimes the patient’s partner is present in the room, so
screening may not happen immediately upon the patient’s arrival to the unit. Once the partner
has left the patient’s room or is asked to leave the room, screening can then take place”. Other
responses included, “New infant birth creates an environment often where the patient is not
alone; family members/friends are present and timing is important to get patient alone to speak
with confidentiality”.

As indicated earlier, participants were given the opportunity to add additional comments
regarding the study topic. Again, these open ended responses leaned heavily towards the barrier
of lack of privacy. For example, a respondent stated that screening is “hard to do on Labor and
Delivery when the partner is with the patient”; the nurse “must wait for a time when the partner
steps out of the room or they have to do it (provide screening) on postpartum”. One respondent
stated that “perpetrators do not leave their victims alone…I point to the domestic violence sign in
the bathroom silently to my patients when I help them ambulate to the restroom”. A participant
also disclosed that “only a few patients open up” when screening for domestic abuse.
**Figure 1.** Please rank your level of agreement with the following statement. "I have received adequate training on how to handle issues of domestic abuse with admitted patients who disclose being a victim of intimate partner abuse."

![Bar chart showing responses to Figure 1](chart1.png)

**Figure 2.** Please rank your level of agreement with the following statement. "I feel competent in handling issues of domestic abuse with admitted patients who disclose being a victim of intimate partner abuse."

![Bar chart showing responses to Figure 2](chart2.png)
Figure 3. Are there any barriers to screening for intimate partner violence on your unit?

Discussion

It is clear from the results of the survey that the majority of nurses who participated in the study feel adequately trained and competent enough to address issues of domestic abuse with patients within their scope of practice. However, there were still some nurses who indicated that they do not feel adequately trained nor prepared to address this subject among patients. One may propose that continued education and more focused training be placed on the care of pregnant/postpartum women dealing with intimate partner violence. More education and training would help to ensure that nurses consistently receive updated information regarding this subject matter and would also promote increased confidence in identifying and addressing matters of domestic abuse among patients. According to McClure (1996) one of the primary interventions for preventing negative health effects that arise from domestic violence is education of health care professionals concerning the impact of intimate partner violence as well care for affected patients (McClure, 1996). Overall, incorporating more nursing education and training on
addressing issues of domestic abuse may lead to improved care for women suffering from intimate partner abuse.

As discussed in the results section above, there were a number of responses regarding insufficient screening time and issues of privacy being barriers to screening for intimate partner abuse. These findings are consistent with the studies described above, in which nurses identified insufficient screening time and lack of privacy as barriers to screening for domestic abuse (Menezes Cooper, 2013; Deboer, et. al, 2013). With 80 percent of participants (n= 20) indicating that they have indeed come into contact with patients who are victims of domestic abuse, as well as the literature finding showing that “1 in 6 female patients are intimate partner violence victims” (DeBoer et. al, 2013, p. 159), barriers to screening and intervening poses a critical issue in preventing negative health effects that arise from domestic abuse. As previously indicated these health problems include chronic pain, depression, substance abuse, traumatic brain injury, and possible injury and death to the mother and unborn infant (Cooper, 2013, pg. 31; Wong & Mellor, 2014). Based on the results of the study, further research is needed on identifying time efficient, confidential screening techniques on domestic abuse that can safely be incorporated with patients regardless of the presence of other visitors.
Appendix A.

Survey for Undergraduate Honors Project: Perceptions of nurses regarding their knowledge and competency levels in addressing issues of domestic abuse among pregnant and postpartum women.

The purpose of this survey is to learn about the perceptions of nurses who work on maternal units, regarding their competency level in handling issues of domestic abuse for admitted patients who disclose being a victim of intimate partner abuse. This survey includes ten questions and should take less than fifteen minutes to complete. Please be assured that your responses to this survey are completely voluntary and confidential. Completion of the online survey implies consent to participate. Responses to this survey will be used in a research study for an Undergraduate Honors Project at UNC-Chapel Hill. For more information on details regarding the survey or the Honors Project, please contact Rachel Timberlake at rltimber@email.unc.edu or the faculty advisor Dr. Shielda Rodgers at srodgers@email.unc.edu.

Thank you in advance for your participation!

Terms Defined

Domestic abuse: also known as “intimate partner abuse” occurs when one individual in an intimate partner relationship tries to control and repress the other individual. Domestic abuse can include domestic violence and emotional abuse (Smith & Segal, 2014).

Domestic Violence: The use of physical violence, physical force that causes harm or danger, in an intimate partner relationship (Smith & Segal, 2014).

Emotional Abuse: occurs when one person in an intimate partner relationship tries to demean the other person. Emotional abuse may include verbal abuse (insulting, shouting, shaming, accusing) and other controlling conduct such as intimidation, isolation, and threats of physical violence (Smith and Segal, 2014).

For the following questions, please select the best answer that applies to you.

1. How long have you been practicing as a Registered Nurse?
   a. 0-5 years
   b. 6-10 years
   c. 11-15 years
   d. >15 years

2. How long have you been practicing as a Registered Nurse on the Maternal units at UNC Hospitals?
   a. 0-5 years
   b. 6-10 years
   c. 11-15 years
3. Do you currently work on an inpatient or an outpatient unit?
   a. Inpatient unit
   b. Outpatient unit

4. How do you view your role in handling domestic violence issues with admitted patients?  
   (Choose all that apply)
   a. Provide screening
   b. Provide counseling
   c. Provide referrals (to social worker, counselor, case manager, etc)
   d. Other: please specify __________________________

5. While working on the Maternal units at UNC Hospitals, have you ever encountered patients who admit to being a victim of intimate partner abuse?
   a. yes
   b. no

6. If you answered “yes” to question #3, did you feel prepared to handle the situation within your scope of practice?
   a. yes
   b. no: please explain why __________________________

7. Please rank your level of agreement with the following statement. “I have received adequate training on how to handle issues of domestic abuse with admitted patients who disclose being a victim of intimate partner abuse.”
   a. Strongly Agree
   b. Agree
   c. Neither Agree nor Disagree
   d. Disagree
   e. Strongly Disagree

8. Please rank your level of agreement with the following statement. “I feel competent in handling issues of domestic abuse with admitted patients who disclose being a victim of intimate partner abuse.”
   a. Strongly Agree
   b. Agree
   c. Neither Agree nor Disagree
   d. Disagree
   e. Strongly Disagree
9. Are there any barriers to screening for intimate partner abuse? (deleted “on your unit”) If so, please select from the examples below.

a. Insufficient screening time  
b. Fear of bringing discomfort to the patient and/or patient’s partner  
c. Fear of causing an abusive situation to become worse  
d. Other: please specify ____________________________

10. Optional: Please feel free to add additional comments in the space below.

This completes the survey. Thank you for your participation!

Source  
References


