

Universal screening for domestic violence in a department of obstetrics and gynaecology: a patient and carer perspective

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Aim: This study aimed to examine the effect of knowledge, department routine, and attitudes of physicians and nurses on the identification of female victims of domestic violence in Israel, as well as the patients' attitudes regarding the screening process.

Background: Every seventh woman in Israel is reported to have been victimized by her intimate partner at least once in her lifetime. Routine screening for intimate partner violence is endorsed by the Ministry of Health in Israel; however screening rates in healthcare settings remain low.

Methods: Correlative, cross-sectional design was utilized based on a sample of 100 physicians and nurses from an obstetrics and gynaecology department in a central Israel hospital and a stratified simple random sampling to recruit 100 former female patients.

Findings: Both medical and nursing staffs were reluctant to screen women for domestic violence, although the patients interviewed for the study claimed that screening is crucial for preventing domestic violence. Past experience with assessing violence and intention to screen were the most significant predictors of screening behaviour. Several factors impede screening by medical and nursing staff, although it is legally mandated.

Discussion: Nurses' and physicians' screening of women about domestic violence is a fundamental intervention with implications for health care in general and basic human rights in particular; however attitudes and beliefs must also be considered.

Conclusions: Screening women about domestic violence is an intervention not usually implemented by physicians and nurses. Understanding barriers to screening may help form feasible policies for improving the quality of services offered to women.

Keywords: Attitudes, Domestic Violence, Israel, Knowledge, Nurses, Physicians, Screening

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Introduction

'Battered women' are defined as those who have suffered assault, repeated violence or any other cruel treatment at the hands of an intimate partner (Garcia-Moreno et al. 2006; Hoffstetter et al. 2005). The abuse may be manifested in any aspect of life: physical

and/or sexual abuse, including beating, non-consensual sexual relations, sexual comments; emotional or mental abuse such as social isolation, accusations, constant criticism of appearance; property offences such as breaking and throwing objects and also financial restriction (Conner 2010).

Research performed in the USA indicates that domestic violence is a significant cause of morbidity and mortality (Hoffstetter et al. 2005). In the USA, violence is the major cause of injury or hospitalization of women. Forty-two per cent of all female murder victims were murdered by their male spouses. Injuries inflicted on battered women are, at least, as serious as injuries caused by ninety per cent of other violent offences (Conner 2010).

Identification of battered women is very important since their abuse affects others as well and its effects are not short term. Rather, it may endanger others, for example, children or family who attempt to protect the victim, and it may have long-term complications, which will emerge in the future (Hoffstetter et al. 2005; Resnick 2001). It is crucial to identify pregnant women who have been subjected to abuse since the consequences affect the foetus as well. Additionally, there is a possibility of short- and long-term damage, as well as pregnancy complications, such as peritonitis, fetal–maternal haemorrhage, fetal distress often leading to fetal death and early labour (Datner et al. 2007; Modiba et al. 2011; Rabinerson et al. 2006).

Background

The estimated number of battered women in Israel is 145 000–200 000 (Ben Natan & Rais 2010; Goldblatt 2009). According to the data, every seventh woman has been victimized by her intimate partner at least once in her lifetime, and once a month, on average, a woman is murdered by her spouse. Despite this information, the exact extent of domestic violence is unknown.

As part of the attempt to cope with domestic violence in Israel, its Ministry of Health issued Director General Circular no. 20/90 (2003), which states that every woman admitted to a hospital should be questioned by the medical, nursing or social staff to screen for abuse, and, if identified as a victim of abuse, should be treated immediately and alone, unescorted – with consideration of her comfort and special needs. In addition, signs of previous injuries should be noted, prior information clarified and all findings should be recorded in her file and on the report form. The social worker on call must be summoned. The victim may be hospitalized for 24 hours for purposes of protection and shelter if no other means of protection is available. According to the law against family violence (1991), if there is probable cause for suspicion that the patient's former or current spouse committed a violent offence against her, the healthcare worker must provide the patient with the address and phone numbers of the Department of Social Services or Center for Treatment and Prevention

of Violence in the vicinity of her home, as well as informing her of her right to turn to the police for help (Makias 1995).

The significance of screening for domestic violence of women has been widely documented. Women tend to avoid reporting having suffered abuse; however, when asked, they are more inclined to consent to report such incidents (Yonaka et al. 2007). Zink et al. (2006) showed that only 7.3% of women self-report domestic violence, compared with 29.3% revealed the following nurse inquiries. Most battered women are not identified by physicians and nurses despite their wish to be questioned and their willingness to talk. Some women will admit that they are victims of abuse if asked (Garcia-Moreno et al. 2006). Nicola et al. (2005) indicated that women expressed higher satisfaction with the quality of care when asked about domestic violence. Nelson et al. (2004) emphasized the significance of conducting inquiries at an early stage of the medical encounter as a tool for evaluating current or future damage resulting from domestic violence, with particular emphasis on patients who do not arouse suspicion.

Many varied factors prevent doctors and nurses from screening patients about violence. There is no one recognized reason; however, doctors and nurses are known to hold controversial attitudes towards screening battered women. Various studies reveal the following attitudes: discomfort, frustration, ineptitude, embarrassment, inability to find a remedy, fear of losing control, denial, guilt and lack of awareness, the belief that inquiries constitute an invasion of privacy and that the situation is too complex to treat, feelings of hopelessness and helplessness, the feeling that it is easier to suppress the problem than to cope with it, as well as healthcare workers' lack of trust in the support system (Garcia-Moreno et al. 2006; Rabinerson et al. 2006; Yonaka et al. 2007).

Physicians share a number of pervasive societal misconceptions about screening for domestic violence that undermine the medical response to battering. The most harmful of these misconceptions include the following: (1) domestic violence is rare, (2) violence does not occur in relationships that appear 'normal', (3) domestic violence is a private matter that should be resolved without outside intervention and battered women are responsible for their abuse (Gutmanis et al. 2007). Physicians' lack of awareness of the prevalence of domestic violence contributes to their reluctance to consider abuse in the differential diagnosis and to disbelieve that abuse has occurred even when the signs are evident (O'Reilly et al. 2010). Surveys in the USA indicate that 85% of female nurses consider screening in healthcare settings acceptable, although only half of emergency department nurses favoured screening (Yonaka et al. 2007). One of the common reasons nurses did not screen for intimate partner violence was the fear of offending the patient (Robinson 2010; Yonaka et al. 2007).

Work procedures and department routines regarding patient screening are a significant factor in doctors' and nurses' decision whether to question battered women. Studies indicate that compliance with conducting inquiries diminishes when the management is not supportive and when intervention is impractical, due to disruption of the work environment, lack of privacy, inability to isolate the patient from other patients or from those accompanying her, or if the carer's schedule is not conducive (Garcia-Moreno et al. 2006).

Lack of knowledge is a crucial barrier to actual screening. Doctors and nurses do not know how to screen or what to ask. They are not trained and do not know the signs to look for to identify battered women. In addition, they are not aware of the legal aspects or services that provide a response to the needs of these women. All these problems hinder and disrupt or prevent screening (Garcia-Moreno et al. 2006; Gutmanis et al. 2007). Gutmanis et al. (2007) studied the issue of nursing care of battered women. Nurses reported that their work was affected by a lack of comprehension of abuse and its effects. A lack of formal education regarding abuse was also reported. However, O'Reilly et al. (2010) found in their article that education of professionals on domestic violence and on screening for domestic violence did not lead to a rise in the identification of women victims of abuse nor to a sustainable improvement of identification.

Accordingly, the purpose of the current study is to add a new comprehension of the decision-making process of medical and nursing staff on screening women for domestic violence, and to examine the effect of knowledge, departmental routines and doctor and nurse attitudes on the identification and treatment efficacy of battered women in Israel as perceived by staff and patients.

Method

This correlative, cross-sectional study examined the effect of level of knowledge, departmental routine, and attitudes of doctors and nurses, on their processes of decision making concerning the screening of women victims of domestic abuse in Israel, as well as the patients' attitudes regarding the screening process.

Participants

A questionnaire was distributed to the entire medical and nursing staff of the obstetrics and gynaecology (ob/gyn) department of a large medical center located in Central Israel ($n = 133$). A random sample was taken from the list of women who had been hospitalized in the hospital's ob/gyn department in 2010. The sample included every 35th woman. The entire study population consisted of 5301 women. Of these, 150 were selected to be sampled and were approached by phone but only 100 agreed to participate in the study.

Research tools

This study used two research tools: the first was a questionnaire designed by Parsons et al. (1995). Appropriate permission for using this instrument was obtained from Parsons, the original author. The questionnaire was translated to Hebrew using back and forth translation methods. To ensure content and technical equivalence of the English and Hebrew versions, two reviewers with expertise in instrument development and testing reviewed and confirmed the accuracy and readability of the final translated version of the instrument. The instrument consisted of 49 items on the following topics: professional training, experience caring for battered women, attitudes towards violence, departmental norms, departmental routines, intention to screen in the future and actual screening of women. The following is a description of the items. One item on whether professional instruction had been provided and five items on location of instruction. Items were examined on a 'yes'-'no' scale. One item on experience caring for battered women at shelters for battered women was also examined on a dichotomous 'yes'-'no' scale. There were 13 items on attitudes towards violence, such as 'there is no way to identify violence', with replies rated on a scale of 'completely disagree' - 1 to 'absolutely agree' - 6 ($\alpha = 0.82$) for a maximal score of 78. One item was included on departmental norms, asking whether screening for victims of violence is a departmental routine, with replies on a scale of 'completely disagree' - 1 to 'absolutely agree' - 6. There was one item on future intention to screen for violence and one item on actual screening of women, with replies on a scale from 'completely disagree' - 1 to 'absolutely agree' - 6. Respondents were further asked to what degree they agree that they perform the nine operations mandated by regulations when treating a female victim of violence, for example, 'provide telephone numbers to appeal for help and support'. Respondents were asked two closed-end knowledge questions about the legal obligation to report abuse for a maximal score of 2.

For example: What is your obligation at the time that a woman reports that she has been abused but refuses to involve others?

- 1 Immediate report to the police
- 2 Notification to the welfare department
- 3 Information to the woman regarding advice and support services
- 4 I am forbidden to do anything

Respondents were asked one question on the estimated number of violent incidents identified in the department and one question on how many victims of violence were identified by respondents. Finally, there was one question on universal screening during recent months and reasons for non-implementation.

The second research tool targeting female patients was a random telephone questionnaire consisting of nine items on actual screening and on patients' feelings about screening. Two

items used a dichotomous 'yes'–'no' scale and examined whether any of the staff members had asked whether they were exposed to domestic violence and whether they received printed material and guidance on appealing to community-based organizations treating domestic abuse. A third question was open-ended and afforded an opportunity to provide details on further care provided on site if patients answered positively to questions concerning violence. There were also six questions on patients' feelings about screening. Examples of feelings about screening include adequate, insulting and helpful. Replies were on a scale of 'completely disagree' – 1 to 'absolutely agree' – 6.

Data collection

Having received the approval of the local Helsinki Committee, the questionnaire examining knowledge and attitudes of the medical and nursing staff on universal screening was administered to the medical and nursing staff of the ob/gyn department by the researchers. Later, the researchers randomly sampled women treated over the past year based on hospital records. The telephone interview proceeded once respondents were assured that data would remain anonymous and personal demographic data would not be used. Both medical and nursing staff and telephone interviewees gave their informed consent to participate in the study.

Statistical analysis

Data analysis was performed with the Statistical Package for Social Sciences (SPSS-PC, version 14, SPSS Inc., Chicago, IL, USA). Descriptive statistics was used to depict the demographic characteristics of the sample and responses to items and subscales. Means and standard deviations (SD) of responses were calculated. Chi-square testing was done to find the differences between responses of doctors and nurses. Pearson correlation and linear regression were used to determine the relationship between demographic characteristics and responses to the questionnaire.

Findings

Staff sample

The sample consisted of 100 physicians and nurses. The response rate was 75%. Supporting Information Table S1 indicates that most respondents were women (85%); most were born in Israel (66%), 25% were born in the former Soviet Union and the rest in other countries. Eighty-seven per cent were Jewish and 13% were from the Arab sector, reflecting the overall population of patients. Participants' age range was 23–65, with a mean of 40 (standard deviation = 10 years). Nurses comprised 80% of respondents (half of these were registered nurses with a Bachelors' Degree) and 20% were doctors. Sixty-four per cent had completed their nursing/medical studies more than 10 years pre-

viously. There was a significant difference in gender distribution between nurse and doctor populations, with most doctors being male (90%) and most nurses being female [75%; $\chi^2(1) = 35$, $P < 0.01$]. Respondents were employed at various locations: 37.5% in the gynaecology department, 26% in the delivery room, 26% in the maternity ward, and the rest in high-risk obstetrics, in vitro fertilization and the women's clinic. Some 68% of respondents had over 5 years of experience in their current department.

As reported by the research population, the mean annual number of cases in which patients reported violent incidents was 11.5 (SD = 19), with a range of 0–100. When asked, 'How many of the women you treated over the past month did you ask about domestic violence?' the mean was 8.1 (SD = 24.8) cases, with a range of 0–100, where over 100 people had been treated per month during the year. However only 57% of respondents agreed with the statement that they screen for and identify women victims of violence, with a mean of three cases of violence identified (SD = 4) and a range of 0–20. When respondents were asked about their future intention to question women regarding violence, 31% responded negatively and 69% affirmatively.

Knowledge and attitudes as affecting screening of women for violence

Some of the respondents (68%) claimed that they had never received instruction regarding violence. Of those who had, 60% had received instruction during their nursing/medical studies, 15% during graduate studies and the rest in other settings (advanced courses, private courses and in-service education). Of all the respondents, 74.2% knew that when there is a risk of child abuse in addition to domestic abuse, they are required to report to the welfare officer. However, only 48% knew that if women refuse to share their situation with others despite being abused, they must only be informed of support and counselling services.

This study shows significant variance between the populations of doctors and nurses in their attitude towards screening on domestic violence and about violence. Some 16% of doctors agreed with the statement that women are the reason for the violence perpetrated against them [vs. some 1% of nurses; $\chi^2(4) = 11$, $P < 0.01$]. In addition, 30% of doctors agreed with the statement that there are more important issues than violence [vs. 2.5% of nurses; $\chi^2(4) = 23.857$, $P < 0.01$]. Forty-five per cent of doctors answered that they do not have enough time to assess abuse, vs. some 11.5% of nurses [$\chi^2(5) = 16.251$, $P < 0.01$].

On the issue of care provided once women victims of domestic violence have been identified based on the Director General Circular, variance is evident between the two populations despite the requirements of doctors and nurses in the care regulations. Findings show that some 85% of nurses reported that they provide information on help and counselling services to battered women, vs. some 40% of doctors [$\chi^2(5) = 25.46$, $P < 0.01$].

Eighty three per cent of nurses reported that they record in the files data on battered women, vs. 37% of doctors [$\chi^2(5) = 31.22$, $P < 0.01$]. Seventy-five per cent of nurses reported that they set follow-up appointments for battered women, vs. 45% of doctors [$\chi^2(5) = 15.69$, $P < 0.01$].

A Pearson correlations test found positive significant correlations between behaviour (actual screening) and all other variables, aside from attitudes towards violence. Supporting Information Table S2 shows that the strongest correlations were found between the following variables: between past experience with assessment of the problem of violence and behaviour ($r = 0.472$, $P < 0.01$) and between intention to screen and behaviour ($r = 0.434$, $P < 0.01$). To predict which variables affect actual screening among medical and nursing staff, a multivariate linear regression analysis was performed in the enter method, as presented in Supporting Information Table S3. According to the findings presented above, the following variables were entered into the regression: departmental norms, attitudes towards screening, department constraints, knowledge regarding violence, past experience with assessing the problem of violence and intention to screen. Only past experience with assessing the problem of violence and intention to screen were found to predict the behaviour of actual screening. Supporting Information Table S3 shows that the model predicts some 41% of the total variance in actual screening.

Female patient sample

Random sampling of former patients gave a response rate of 66%. Analysis of telephone interviews with women treated in the ob/gyn department over the past year shows that only 12% of women were screened for domestic violence, and received printed material and guidance on the subject. None of the women reported being subjected to abuse. In addition, 82% of respondents found inquiries helpful and 79% found them appropriate. An identical percentage of respondents saw screening as an important way of sharing. In contrast, 58% of women perceived inquiries as embarrassing and 73% perceived them as insulting.

Discussion

Nurses and doctors who screen women for domestic violence are performing an extremely fundamental intervention with many consequences for health care in general and basic human rights in particular. However, the attitudes and beliefs of both those performing the screening and the women screened must also be considered. Consistent with Williamson et al. (2004), the current study as well indicates problems involving screening women for abuse. The study shows that each physician or nurse respondent treated more than 100 women per month, but screened only eight of them on average.

This study shows that one of the most influential variables concerning screening is past experience with the assessment of violence. The more experience healthcare workers have with screening and identifying women who have been subjected to violence, the greater is their tendency to do so. The literature shows that the best way of exposing staff to the subject of screening women for violence is through education programmes (Smith et al. 2008). The current study reveals another problem, whereby only 32% of respondents have received instruction on violence. Of those who received instruction, only some 60% did so during their nursing/medical studies, as found by Gutmanis et al. (2007). Education must be based mainly on practising technical screening skills and coping with conflict situations. One way is to use simulations, namely to expose staff to situations that simulate reality and thus create initial experience with screening (Smith et al. 2008).

Level of knowledge was indeed not a leading variable in this model, but it is definitely an important variable significantly related to actual screening. Similar to Rabinerson et al. (2006), the present study as well indicates the need to raise the level of knowledge in this realm so that carers will know how to treat women who have been subjected to domestic violence, be familiar with their rights and know what to do with the information received. Findings show that the staff does not know what to do with information received from abused women. For example, less than half the respondents knew that when women refuse to share their situation with others despite the violence experienced, they must be informed of support and counselling services.

Other barriers to screening that were found in this study included attitudes and attitudes towards violence. Attitudes towards violence include agreeing to statements such as 'Some women are the cause of their own violence', 'My patients have no problems with violence', 'Physical violence is normal in any family' and 'Women from higher socioeconomic classes are not subjected to violence'. These are stereotypes that are still common among the general population and among carers in particular (Robinson 2010). There is a significant difference between physicians and the nursing staff in regard to the entire subject of screening for domestic violence and caring for women identified as having been subjected to domestic violence. One of the reasons for this diversity might be the significant difference between nurse and doctor populations regarding gender distribution, with most doctors being men (90%) and most nurses women (75%). This difference attests to a variance in perceived domestic violence between men and women, unrelated to their profession. One of the common perceptions among men in general and male doctors in the current study in particular is that women who are subjected to violence are the cause of violence perpetrated against them (Owen-Smith et al. 2008). In addition,

men by nature tend to experience less empathy towards abused women and even tend to blame women for the violence perpetrated against them (Yamawaki et al. 2009).

Another factor affecting screening is departmental constraints. Consistent with Yonaka et al. (2007), the current study also identified departmental constraints as a barrier to screening women for violence. Most conspicuous is the issue of time constraints, particularly characteristic of doctors. This may stem from doctors' attitudes, as they do not see screening as part of their job and thus place it lower on their list of priorities compared with other topics, as described by Williamson et al. (2004).

Telephone interviews with women treated in the ob/gyn department over the past year reflected a similar sad state of affairs in regard to screening. Only 12% of the women were asked about being subjected to domestic violence and received printed material and guidance on the subject. Current findings are compatible with another study conducted in Israel that found that only 10% of obstetricians and gynaecologists reported routinely screening women. In addition, only 17% of Israeli gynaecologists were found to screen new patients for violence (Rabinerson et al. 2006). Despite the importance and the fact that many healthcare organizations encourage screening, in reality, screening rates remain low (Yonaka et al. 2007).

Many women interviewed claimed that screening is an important intervention for battered women. However, it should be performed universally as presented in the General Director Circular (2003), so that women will not feel singled out as suspected of having been subjected to violence. In addition, the issue of formulating questions and where they should be asked arose as well. Women claimed that if they were questioned appropriately and intimately they would be more cooperative.

Similar to Robinson & Spilsbury (2008), the current study found that women wanted to be asked whether they are subjected to domestic violence. They felt that screening is helpful and appropriate. They saw screening as an important initial way of sharing. However, the subject of domestic violence is still perceived by society as embarrassing and personal. Fifty-eight per cent of women perceived inquiries as embarrassing and 73% as insulting. The subject of screening has a significant cultural component both as viewed by the questioner and by the woman questioned (Montalvo-Liendo 2009).

In summary, the caregiving staff, both medical and nursing, is reluctant to ask women whether they have been subjected to domestic violence. However, past experience with the assessment of violence, i.e. asking women whether they have been subjected to violence, and intention to screen, are the most significant variables for predicting screening behaviour. Several factors prevent screening by medical and nursing staff, although legally mandated by a Director General Circular of the Ministry of Health. Major barriers

are attitudes with mostly cultural biases, departmental constraints, attitudes towards violence and lack of knowledge.

Recommendations

Recommendations include holding training simulations on domestic violence for the staff, to both influence attitudes towards violence and raise the level of knowledge, and screening and coping skills. Holding simulations will lead to prior initial experience that will facilitate actual screening in the field. Simulations must be based on shattering myths and cultural views that prevent doctors in general and nurses as well from screening. It is necessary to impart applied screening tools together with the ability to cope with cultural barriers and the ability to screen with cultural sensitivity, particularly in a country such as Israel that incorporates citizens from many countries and cultures.

Recommendations for conducting similar studies in this field

Since the subject of departmental constraints in general and shortage of time in particular arose among doctors more than among nurses, it is necessary to examine the underlying reasons. This may stem from the basic difference between the work burdens of doctors and nurses, decisions regarding different priorities, etc. In addition, in this study, it was not possible to appreciate all the implications of the fact that most doctors are men and most nurses women, and the relationship of this fact to their different perceptions of violence. Thus, future research should focus on gender effects. However, it is also important to conduct research examining how the carers' culture affects their attitudes towards screening women for domestic violence.

Research limitations

Some limitations of the present study should be considered. These include the relatively small sample size and the fact that the questionnaire is based on nurses' and doctors' self report, without clarifying the degree of congruence between the reported and the actual practices. Thus, research results might be biased. Another limitation is related to the women interviewed by telephone. None of these (randomly selected) women reported having been subjected to violence. There is need for research cross-checking information received from respondents with information from their files to examine whether their replies are compatible with information known to medical staff. Any future studies in this area should aim to overcome these limitations. In addition, the low response rate of the women that agreed to participate in the research (66%), is problematic. The low response rate cannot provide a complete picture of Israeli women's attitudes regarding screening for domestic violence. Another factor that should be examined is the effect of confidentiality on patient cooperation with screening.

Author contributions

MB-N, GB-A, TB and MH: study conception/design, data collection/analysis, drafting of manuscript, critical revisions for important intellectual content and statistical expertise

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Supporting information

Additional Supporting Information may be found in the online version of this article:

Table S1 Descriptive characteristics of the sample

Table S2 Pearson correlation between departmental norms, departmental constraints, experience with questioning, knowledge, attitudes (towards screening and violence) and intention – and between the screening of women for domestic violence

Table S3 Linear regression between departmental norms, departmental constraints, experience with questioning, attitudes towards screening, and knowledge, and between screening of women for domestic violence

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