

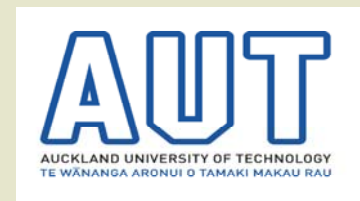
Interdisciplinary Trauma Research Unit

**Women's Perceptions of
Partner Violence Screening
in Two Aotearoa New
Zealand Healthcare Settings:
"What Took You So Long "**



Te wairere au noa

Interdisciplinary
Trauma
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**Women's Perceptions of Partner Violence Screening
in Two Aotearoa New Zealand Healthcare Settings:
"What Took You So Long"**

Jane Koziol-McLain, PhD, RN
Lynne Giddings, PhD, RN, RM
Maria Rameka, BAppSc, RGON
Elaine Fyfe, RN, RM

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Interdisciplinary Trauma Research Unit
Auckland University of Technology
Private Bag 92006
Auckland, New Zealand 1020

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EXECUTIVE SUMMARY

Recent systematic reviews have concluded there is insufficient evidence supporting intimate partner violence (IPV) screening effectiveness. While awaiting findings from randomized controlled trials, we had the opportunity to explore women's experience of healthcare site-based IPV screening to determine screening acceptability, usefulness and harm.

A qualitative descriptive study involving a semi-structured telephone or face-to-face interview following a screening intervention was conducted. Two south Auckland healthcare settings were used: an emergency department (adult and pediatric) and a primary care Māori health provider clinic. Thirty-six women, aged 20 to 72 years (average age 39), 44% emergency department and 56% clinic, were interviewed. Fifteen (42%) of the women had screened positive for IPV, an additional 13 experienced lifetime IPV (but screened negative; 36%), and 8 (22%) had not experienced IPV.

Women perceived IPV screening and intervention as non-threatening and safe. From the women's perspective, there was no risk of any greater harm because of the screening, and the intervention had a therapeutic and educational quality. Women without a history of violence cautioned that IPV screening may be threatening to those who are abused; whereas those who reported abuse thought IPV screening was essential *"to stop it happening."* The attitude and approach of the person asking the intervention questions was critical.

This study challenges the commonly held assumption among health professionals that IPV screening is offensive to women and may increase their potential for danger from their abusers. Women were appreciative of the opportunity to tell their abuse stories in a safe and supportive context. These women challenged the healthcare system to implement intimate partner screening and intervention asking, *"What took you so long?"*

BACKGROUND

Intimate partner violence (IPV) is recognized internationally as a significant public health problem, especially for women and children (Conway, 2004; Heise, Ellsberg, & Gottemoeller, 1999; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; Morris, Reilly, Berry, & Ransom, 2003; Tjaden & Thoennes, 1998). As well as injuries, disabilities and death, women who have been abused may experience long-term health effects such as post-traumatic stress disorder, depression, sleep problems, anxiety and frequent headaches (Campbell, 2002; Coker et al., 2002; Coker, Smith, Bethea, King, & McKeown, 2000). Acknowledging the personal, psychological, social and medical costs of IPV, healthcare systems have developed policies for routine IPV identification (screening) and interventions. Instituting screening within healthcare systems, however, has been difficult. Common barriers cited in the literature include lack of provider education, fear of offending patients, limited time, and a lack of effective interventions (Sugg & Inui, 1992; Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000). These barriers have placed violence within relationships in the "too hard basket." This is unacceptable given the high prevalence and significant health consequences of IPV.

Studies indicate that women do not mind being asked questions about abuse (Caralis & Musialowski, 1997; Friedman, Samet, Roberts, Hudlin, & Hans, 1992; Taket et al., 2003), but few of the women in these studies have experienced healthcare site-based IPV screening. There is room, therefore, to question how women are affected by screening and whether screening can result in harm (Ramsay, Richardson, Carter, Davidson, & Feder, 2002). Four recent systematic reviews (Anglin & Sachs, 2003; Nelson, Nygren, McInerney, & Klein, 2004; Ramsay et al., 2002; Wathen & MacMillan, 2003) all concluded there is a lack of evidence supporting screening and intervention effectiveness, not because studies have found screening ineffective, but because "adequate" studies have not been conducted. Randomized controlled trials are currently being planned that will quantify selected effects of screening and intervention.

Equally as important as collecting quantitative outcome measures, however, is women's experience of screening and intervention; information best captured using qualitative methods. The role of qualitative approaches in assessing effectiveness and appropriateness of health and social interventions is now widely recognized (Giacomini & Cook, 2000; Popay, ; Sandelowski, 2004), though qualitative studies are rarely included in systematic reviews. Lachs recently suggested that for family violence interventions, "Perhaps the type of evidence we demand for this kind of healing should be different from what we demand for the efficacy of anticoagulation in a trial fibrillation" (Lachs, 2004). We would advocate for both quantitative and qualitative approaches informing IPV screening and intervention, "combining stories and numbers" often providing the most compelling evidence (Berman, Ford-Gilboe, & Campbell, 1998).

Two studies were recently conducted in Aotearoa New Zealand to estimate the prevalence of IPV among women seeking healthcare (Koziol-McLain et al., 2004; Rameka, Koziol-McLain, Fyfe, Giddings, & King, 2005). These studies provided the opportunity to access women who had been screened (and received a brief intervention if screen positive) and ask them how they felt about healthcare site-based screening and how it affected them and their children. We wanted to give voice to women's experiences so that they too can inform policy.

METHODS

The aim of this study was to determine women's perceptions of acceptability, usefulness, and harm of healthcare site-based screening. To this end a qualitative descriptive approach using semi-structured interviews was used. Women who had participated in two prior studies measuring IPV were eligible to be interviewed in this follow-up study.

Original Prevalence Studies

The original prevalence studies were conducted in two healthcare sites in Aotearoa New Zealand, an emergency department (adult and pediatric; n=174) and a community primary care Māori (indigenous people of Aotearoa New Zealand) health provider clinic (n=109). The screening and intervention protocol was the same across the two sites and was consistent with Aotearoa New Zealand and United States partner violence intervention guidelines (Family Violence Prevention Fund, 2004; Fanslow, 2002). Eligibility criteria were consistent with "routine" or "universal" screening; exclusion criteria were limited to severe injury or illness (based on triage category in the emergency department), non-English speaking and unable to participate in informed consent process (due to impairment). Trained nurse research assistants administered the study protocol during randomly selected time periods. Screening questions used in a study testing screening accuracy (Feldhaus et al., 1997) were used. The questions are listed in the box below. Following screening, with a referent period of the last 12 months, the questions were repeated, with reference to the events occurring "ever" by an intimate partner.

Screening Questions

1. Within the past year have you been hit, slapped, kicked or otherwise physically hurt? (If so, by whom)
2. Within the past year have you been forced to have sexual activities against your will? (If so, by whom)
3. Is there a current or past partner that is making you feel unsafe?

Women who screened positive were given affirming messages (such as "No one deserves to be hit" and "It is not your fault"), assessed for safety, and offered a social work or community referral. At the conclusion of the screening interview women were asked if they could be contacted for a follow-up interview. In the emergency department setting only women who reported a history of abuse (current or lifetime; n=77) were invited to participate; all women who were screened in the clinic were invited (n=109). For the 67 (36%) women who agreed to follow-up, a safety plan was made for a telephone or face-to-face interview in two to eight weeks time. A regional ethics committee (IRB) approved the research protocol covering the original prevalence phase as well as follow-up. The participant information sheet is included as Appendix A.

Follow-up Study Process

Data collection occurred within two to eight weeks after the women's initial healthcare visit. Interviews were conducted by trained researchers. Because several researchers had collected data in the original prevalence study, we ensured that no one interviewed women they had screened. Face-to-face interviews occurred in a private prearranged location. Some women could not be contacted, having changed household address or an unconnected phone number. Telephone conversations began with, "*Is this a quiet, private time to talk?*" All follow-up interviews revisited informed consent, including that the interview would be audio-tape recorded and subsequently transcribed.

An interview schedule was administered that included 17 questions divided into four domains. The domains with an exemplar question are listed on the following page.

Qualitative Interview Domains

- ◆ Screening process
 - *What was it like to be asked questions about violence in your relationship?*
- ◆ Intervention
 - *Some women describe nurses' attitudes as judgemental. Was that the case for you?*
- ◆ Usefulness
 - *Has being asked the questions and being provided information and referrals changed anything for you?*
- ◆ Safety
 - *For some women, the process could result in increased danger from their partner. Did this happen for you?*

The interview schedule is provided as Appendix B. The schedule guided the interviewer but was not rigidly followed. Although some of the questions could be answered "Yes" or "No," general probes were used to encourage the women to explore and reflect on their experience (such as "Can you tell me more about that?"). Women were given a koha (gift) valued at \$20 for their time.

Analysis

The interview transcriptions and interviewer notes were analyzed using descriptive content analysis (Denzin & Lincoln, 1998; Sandelowski, 1996). Data were entered into QSR NVivo, a code-and-retrieve computer software package for managing qualitative data (Bazeley & Richards, 2000). Prior to beginning the analysis transcriptions were checked for accuracy. The second author (LG) read the transcripts two or three times to get an overall picture of the content, then proceeded to assign a descriptive code for the prescribed (yes/no) questions (such as "*Since your visit, have you discussed the topic of family violence with anyone?*"). A second level of content analysis was then conducted in which words, phrases and exemplary stories that captured the participants' responses within the four domains were identified. Finally, the women's stories were considered holistically and emergent themes identified. Co-investigators met to discuss and validate the credibility of the findings.

FINDINGS

Among 186 eligible women from the prevalence study, 67 had agreed to follow-up and 36 of the 67 (54%; 20% of all eligible) were successfully interviewed. Compared to all eligible women, women who participated in the current follow up study were somewhat older, less likely to report their primary ethnic identify as Maori and less likely to have screened positive (see Table 1). No women successfully contacted refused to be interviewed. Interview time varied from 10 to 45 minutes.

Among the women interviewed, 16 had been screened in the emergency department and 20 in the clinic. The mean age of the women was 39 years (range, 20–72). Follow-up participants included 17 women who identified as Māori, 13 Caucasian (Pakeha/European) and 5 Pasifika women with one woman's ethnic identity unknown. Of the 36 women, 15 (42%) had screened positive for IPV, an additional 13 experienced lifetime IPV (but screened negative; 36%), and 8 (22%) had not experienced IPV.

Table 1. Sample Characteristics

	Emergency Care Centre		Hauora/Clinic	
	Eligible n= 77	Participants n=16	Eligible n=109	Participants n=20
Age				
Mean (SD)	34 (15)	35 (11)	39 (14)	43(13)
Range	16-82	20-57	17-82	27-72
Ethnicity*				
Pakeha (European)	36 (49%)	8 (50%)	16 (15%)	5 (26%)
Maori	20 (27%)	5 (31%)	78 (75%)	12 (63%)
Pasifika	15 (21%)	3 (19%)	9 (9%)	2 (11%)
Other	2 (3%)	0	1 (1%)	0
IPV Status				
Screen Positive	37 (48%)	12 (75%)	25 (23%)	3 (15%)
Lifetime Positive	40 (52%)	4	60 (55%)	9 (60%)
Negative	0	0	24 (22%)	8 (40%)

Notes: For emergency care centre, lifetime and screen positive women were eligible; for Hauora all women were eligible. Some numbers do not total sample size due to missing data.

Excerpts from the participants' responses and stories follow, categorized into each of the four domains. Long quotes and stories are indexed with a pseudonym and where appropriate, reference is made to IPV status and ethnic identity. The grouped responses are framed by truncated versions of the interview questions in tables.

Experience of the Screening Process

Women were asked what it was like and how it felt to be asked questions about IPV at a healthcare facility, specifically in relation to feeling safe during the process. Responses are summarized in Table 2 and described in the text below.

Table 2. Experience of the screening process

Truncated Question	Representative Responses
What was it like?	<ul style="list-style-type: none"> <input type="checkbox"/> <i>It was fine</i> <input type="checkbox"/> <i>Okay</i>
How did you feel?	<ul style="list-style-type: none"> <input type="checkbox"/> <i>Comfortable</i> <input type="checkbox"/> <i>All-right</i> <input type="checkbox"/> <i>Initially embarrassed / ashamed</i> <input type="checkbox"/> <i>Initially surprised / shocked</i> <input type="checkbox"/> <i>Stressed</i>
Did it feel safe?	<ul style="list-style-type: none"> <input type="checkbox"/> <i>Yes</i> <input type="checkbox"/> <i>Fine</i> <input type="checkbox"/> <i>Lacked privacy</i>
Did you feel offended?	<ul style="list-style-type: none"> <input type="checkbox"/> <i>No, not at all</i> <input type="checkbox"/> <i>No, no way</i>

What was it like?

The responses of the women to being asked questions about IPV were generally positive. The most commonly used expression was "*It was just fine.*" Other responses varied from "*It didn't worry me none ... I didn't think anything of it,*" a comment from Pauline with no abuse history, to Lote who had screened positive:

I nearly started crying (laughs) when she started questioning me on those things, because I could still remember as though it was yesterday. Then I

felt comfortable. I guess it was her, the person interviewing me. She was very understanding.

Women who screened negative (n = 8) generally agreed screening was "okay" but a number of them commented on how "It might be upsetting for those who have experienced abuse."

How did you feel?

The most commonly used expressions were "comfortable" and "all right." A number of the women who screened positive reported that they were initially "embarrassed" or "ashamed" as it "brought back painful memories." This was especially so for women who had "tried to put it behind me." Some women were "shocked" or "surprised": "I was initially surprised because it's been a number of years since I had that experience and it's a new era and those things aren't supposed to be happening any more" (Mel, lifetime positive).

Only one woman reported feeling stressed by the process of being asked questions. June (screen positive) was interviewed in the pediatric emergency department when her baby was being admitted to hospital:

My baby was unwell and added on top of that having to think about what happened in the past, it was a bit stressful. I hadn't really dealt with those feelings ... but it's a good idea to ask people, but maybe not when your child is in hospital.

Did it feel safe?

Thirty-five women reported that being asked questions about IPV felt safe; one woman was unsure – she did not elaborate on why. Most common responses were "yes" and "fine." Although Kate and three other women (all except one had a positive screen) overall felt safe, they expressed concern about being interviewed with one side of the room curtained: "I was concerned about who was looking behind the curtains. It wasn't that private."

For other women it was the first safe space they had ever had to talk about violence in their lives. Caroline (Pasifika) remarked:

I did feel safe [being asked the questions] and believe it or not it felt good to finally release it [talk about abuse]. I've never been able to express it before. I've told a few ones about having been abused, but not going into the details and all that.

Did you feel offended?

All the women (100%) said the questions and being asked them did not offend. They responded with comments such as, "No, not at all," "I didn't feel there was anything offensive about the questions at all," and "Oh, no way." Helen (screen positive) expressed relief that someone had asked her about IPV, "No, I didn't [get offended], it helped a lot. All these years I thought it was my fault; I had caused it."

Responses to Attitude and Approach of Interviewer (Screener)

The responses of the women to questions concerning the attitude and approach of the nurse who interviewed them in the healthcare setting were very positive. General descriptive terms were used such as "nice woman," "caring person," "comfortable," and "she was okay". Responses are summarized in Table 3.

Table 3. Responses to attitude and approach of interviewer

Truncated Question	Representative Responses
Did you feel 'culturally safe'?	<ul style="list-style-type: none"> <input type="checkbox"/> <i>I didn't feel singled out</i> <input type="checkbox"/> <i>Absolutely fine</i> <input type="checkbox"/> <i>It didn't make any difference</i> <input type="checkbox"/> <i>Better if same culture</i> <input type="checkbox"/> <i>Better if not same culture</i>
Interviewer supportive?	<ul style="list-style-type: none"> <input type="checkbox"/> <i>She listened to what I said</i> <input type="checkbox"/> <i>Supportive and gentle</i> <input type="checkbox"/> <i>Very careful about how she treated me</i>
Interviewer's attitude judgmental?	<ul style="list-style-type: none"> <input type="checkbox"/> <i>No, not at all</i> <input type="checkbox"/> <i>I felt as if she cared</i> <input type="checkbox"/> <i>Keen to help</i>
Interviewer response to violence in life?	<ul style="list-style-type: none"> <input type="checkbox"/> <i>She wasn't shocked or anything</i> <input type="checkbox"/> <i>Good talking with a knowledgeable stranger</i>
Received information needed?	<ul style="list-style-type: none"> <input type="checkbox"/> <i>Informative</i> <input type="checkbox"/> <i>Helpful</i>
Did you see a social worker during your visit (if relevant)?	<ul style="list-style-type: none"> <input type="checkbox"/> <i>Three women were seen prior to the screening interview</i>

Did you feel culturally safe?

Nearly all of the women (97%) when asked about the cultural sensitivity of the interviewer and the interview process answered 'yes' – with comments like *"I didn't feel singled out," "It was absolutely fine,"* and *"It didn't make any difference."* Some issues were raised within the interview discussion concerning cross-cultural interviewing. Four women who identified as Māori made the following comments: *"Because I'm Māori there are other ways to deal with these things ... There could be some better processes for Maori women (Hiriana screen negative)."*

Lorna agreed: *"I think it has to be Maori to Maori. Maori getting together explain things more."* Although Mel thought being from the same culture was ideal, what was important to her was that *"there are people out there like you who are trying to make something happen for our people."* And Stella agreed: *"It doesn't matter what colour you are, there is violence everywhere."*

One woman (Pasifika - screened positive) thought that: *"It was better she [interviewer] was Palangi [European] because some people from the Islands are really hard when there are problems with hitting and that"* (Ann). Caucasian women (Pakeha/European) who made up 22% of the participants made few comments regarding their cultural safety. Both the interviewer's questions and the respondent's answers tended to focus on personal characteristics rather than cultural difference.

Was the interviewer supportive?

All the women (100%) reported feeling supported by the nurse research assistant interviewers. They made comments such as, *"She listened to what I said," "supportive and gentle,"* and *"Oh yes, very caring, and very careful about how she treated me."* Paula (screen positive, aged 51) commented: *"I think it was her approach. She said what she was doing. She was in the older age group and I felt relaxed with that."*

Was the interviewer's attitude judgmental?

All the women (100%) felt that their interviewer was non-judgmental. The most common responses to being asked whether they feel judged were *"No, I didn't"* and *"I certainly did not."* They used words to describe the interviewer's attitude like *"neutral"* and *"unbiased."* One woman felt *"as if she cared"* and another perceived her interviewer as *"keen to help."*

What was the interviewer's response to violence in your life?

The women who talked about violence in their life did not report sensing negative responses to their disclosure, "*She wasn't shocked or anything.*" Two women felt it was easier to talk to a stranger. Bev (screen positive): "*Talking with somebody that I don't know is pretty good. She knows these things and it made it easier for me. Instead of somebody like family, telling me 'you'll be all right' when deep down I know I won't.*"

Did you receive information about IPV?

Most of the women (97%) remembered receiving information both verbally and in pamphlet form. A number found the conversation and pamphlets "*informative*" and "*a big help.*" Women also distributed the pamphlets to others: "*I gave it to my friend,*" "*gave them to my sister,*" "*put them around for the kids,*" and one woman took them to her next clinic and "*put them on the counter.*" A few women could not remember what they had done with the pamphlets, "*left them at the hospital on the bed*" or "*I think I threw them away.*"

Did you see a social worker during your visit?

One participant whose emergency department visit was for acute IPV injuries had been referred to a social worker. Bev felt "*It didn't help you know. I was still in pain while she was talking to me, so I didn't pay any attention.*"

Perceived Usefulness of Screening

The majority of the women (64%) reported that being screened for IPV taught them something, whether about themselves or the society in which they lived. For a few women the experience brought about a change in their attitudes toward themselves and violence within their families and communities (see Table 4).

Table 4. Perceived Usefulness of Screening

Truncated Question	Representative Responses
What did you learn?	<ul style="list-style-type: none"> ❑ <i>It was not my fault</i> ❑ <i>Not only me</i> ❑ <i>It's still happening</i> ❑ <i>Violence isn't only physical</i> ❑ <i>A lot more help out there than realised</i>
Screening interview changed anything?	<ul style="list-style-type: none"> ❑ <i>Knowing there is help out there</i> ❑ <i>It made me feel finally released of that burden and pain</i> ❑ <i>Reminded of past abuse and determined "it won't happen again"</i> ❑ <i>It helped me understand about abuse and things</i>
Screening interview improved your safety?	<ul style="list-style-type: none"> ❑ <i>Now I know how to walk away from it</i>
Discussed family violence with anyone?	<ul style="list-style-type: none"> ❑ <i>They didn't believe that I went through that kind of thing</i> ❑ <i>Why didn't you tell us before?</i>
Has screening changed anything for your children?	<ul style="list-style-type: none"> ❑ <i>Oh mum. Why didn't you tell us before?</i>

What did you learn?

For a few women the screening interview gave them a new perspective on their personal experience of IPV. Helen (aged 39 years, screen positive) felt "*finally released of that burden and pain ...all these years I have felt it was my fault, that I had caused it.*" Fiona (aged 52 years) did not disclose her previous experience of IPV during the screening, yet she reflected during the follow-up interview: "*I've learned [from the screening interview] it was not only me that went through that kind of situation, there is plenty of others maybe worse off than me.*" Sheila (aged 29, lifetime positive) said she had learned "*quite a bit*" from the interview and the pamphlets she was given; "*I learned that there is different types of violence and is not necessarily always physical.*" For Beth (aged 35, screen positive): "*I learned that there is a lot more help out there than a lot of women actually realize.*"

Did the interview change anything for your children?

Fourteen of the screen positive women had children living in their home. The majority of these women, even though many had reported change in their own lives following screening, felt that their experience had not changed anything for their children. For a few women, however, screening gave them permission to talk with their children about their experience of IPV, in some instances for the first time. After being screened, Helen (aged 39, screen positive) went home and talked with each of her children (aged between 7 and 23 years) about what had happened between her and their father: *"They were quite stunned and shocked"* and told her *"Oh, Mum, why didn't you tell us before."* Helen felt that they now *"understand why I was very negative in the way I was bringing them up ... I can talk with my girl now."*

For Lote (aged 28, screened positive) screening changed things for herself and her children: *"those questions woke me up to things that my children probably saw when they were younger."* She recalled receiving information about free counseling services for her children and *"I feel this tremendous weight off my shoulders that I can make up for things that I made them see when they were younger."* When Lote talked with her son about *"Daddy hurting me,"* they were watching television. She pointed out the violence that is on TV and told her son that he must *"change the channel. And he then goes, 'can you give up smoking?' He said straight out 'because smoking hurts you like Dad hurt you.' Straight away the next day I gave up. It's been two weeks now."*

Have you discussed family violence with anyone since?

Just under half (42%) of the women talked with someone about family violence after they had been screened. Helen and Lote talked to their children. Ann (screen positive) went straight home and told her husband who abuses her:

...what that lady said, but he don't like it. But I told him, 'when you're hitting me, that's why I need to talk to someone.' He insulted me ... But I told him, you give me any argue and I ring and tell that lady.

Fiona who had not disclosed IPV in the screening interview, decided to tell some close friends: *"actually they were surprised and shocked ... they saw a different side of me and they didn't believe that I went through that kind of thing."* Other women were less specific and talked about *"talking to a friend," "told my mum," "and talked to my sister-in-law," and "quite a few people."*

Safeness of the Screening Process

All of the women (100%) reported that the screening process was safe (see Table 5).

Table 5. Safety of the Screening Process

Truncated Question	Representative Responses
Feel after the interview?	<input type="checkbox"/> <i>I felt that people cared</i>
What could have made it better?	<input type="checkbox"/> <i>I needed more than one interview</i>
Increased danger from partner?	<input type="checkbox"/> <i>No, it didn't</i>

How did you feel after the interview?

Most women used positive words like "good," "happy," "relaxed and relieved," "lucky," and "pleased." Caroline (lifetime positive) felt "as if a burden had just been taken off my shoulders" and Dana (lifetime positive) "I felt relaxed, like I had opened up to the nurse and it was good to get that off my chest sort of thing." Sam (screen positive) felt that the screening showed that "people cared ... I wouldn't want my worst enemy to go through that ... I am really glad you are doing something like that."

For a few women "it stirred things up" and they "felt a little unsettled." Jen (lifetime positive) felt "angry," not because of the interview but "to think that I could be a person who could be treated like that ... getting beaten for little things that you can't understand why...and I ended up abusing my foster son." Although Jen and her son have had counseling, she still gets "angry, because it is people in high places that do it ...and no one believes you ...it's a hidden fact." Sam (screen positive) felt "good" and "sad":

It's a funny sort of feeling because I am safe now, but it's sad it went on for so long. It just made me realize that I didn't have to put up with it for so long ...but it made me feel safe really because I am out of it now... but I'm glad I am not there now ... I'm lucky.

What could have made it better?

The majority of women felt that the screening process was "OK," "good," "fine," "excellent," "sensitively done," and "comfortable." A few women (14%) made

suggestions as to how to improve the screening process. Four of them expressed concern about privacy, noting that there was only a curtain between them and other people (see also "Did it feel safe"). Meg (screen positive) felt she "*needed more than one interview, it was not long enough for me.*" She appreciated the follow-up interview where she felt she had given "*quite a spiel.*"

Did the interview improve your safety?

The majority of the women who screened positive for IPV reported feeling more informed, and as a consequence: "*safer.*" Zoe (screen positive) reflected that "*In a way it did. It made me feel more reassured.*" Having information to take away was important for some: for Ann (screen positive) it was having the pamphlet with contact details; Paula (screen positive) commented "*I know that's there [the pamphlet] if I need it.*"

Information given during the interview supported strategies that June (screen positive) had already put in place: "*I don't need to see him while he's drunk now. I'll see him when he's not drunk and he's fine but there is no reason for me to see him while he's drunk.*" Helen (screen positive) found what she learned taught her "*how to avoid those situations, kind of thing. Like before, before I use to walk straight into it. Now I know how to walk away from it.*"

Did it increase the danger from your partner?

No women (0%) reported that the screening and intervention increased their risk of harm. The majority response was "No, it didn't." Screening empowered one woman to challenge her abuser: "*I told him if you give me another argue I ring you to this lady [the interviewer]*" (Ann, screen positive).

Emergent Themes

Three themes emerged from the analysis of the women's responses and the stories they told during the follow-up interview.

Theme 1. The painful memories came back

Many of the women who had been abused talked of the screening questions triggering painful memories that had made them feel "*stirred up,*" "*tearful,*" or "*angry.*" A sub-theme was "*anything can trigger it.*" Sue captured this experience well:

It was somewhat hard because it brought back some old feelings and stuff. When she said 'abuse in relationships' those words brought back some bad memories. When you're going through a healing process I think anything can trigger it if you are not fully over the situation. Being asked the questions felt fine, and I didn't feel unsafe answering them or anything, but I had to deal with the flashbacks ... It is a touchy subject and you guys are doing fine.

Moana stated that being asked the questions about IPV had "stirred up things in my mind." She noted that she could be triggered at any time during her day, "around the house or in the supermarket can set it off ... [the fear] it's only for a minute you feel like that."

Theme 2. It's long overdue

Many of the women, especially if they screened positive, were adamant that screening takes place in the healthcare setting. A sub-theme was "pleased to be involved." Sam (aged 31, screen positive) was initially shocked:

... to hear what you are doing [the research] because it's long overdue ... I felt a bit embarrassed at first but she [the interviewer] was good. I didn't feel singled out or anything [as a Maori]. I think just doing that research made me feel a lot better in myself, because then others are more aware.

Kate (aged 32, screen positive) reflected that, "I have been there myself years ago and I didn't know who I could tell without having to go back to him, without getting another hiding. I wish we had this back then." Lote (aged 26, screen positive) wished "it had been done five years ago."

Paula (aged 57, screen positive) expressed similar feelings:

I was actually quite pleased that these sorts of interviews are actually taking place. When I was like in my twenties in my first marriage it was very violent physically. I felt helpless because I didn't know where to go or what to do. I am really pleased that this sort of thing is now more in the open.

Pauline (aged 50) although she screened negative:

I wish it had been done a long time ago, because I knew people who were being abused. When your hands are tied and you don't know what on earth to do ... I wish I had known then about lots of things I learned down at the clinic, but it's too late [for them] now.

Theme 3. You need to tell the women

Women challenged health professionals to incorporate IPV screening into women's care. A sub-theme was "*you [health professionals] do it; you're the first to see it.*" For many of the women who screened positive, screening for IPV made the "hidden fact" of abuse and violence in their lives visible.

Erin felt that screening started people "*talking about it a lot more than people will think it is OK to talk about it.*" Caroline (life-time positive) thought it was important that women were asked about IPV by health professionals because it may be "*the only place they are away from their partners ...women in abusive situations, they think that's all there is, there is no other relationship and they don't see beyond that.*" Lote (screen positive) who was surprised but pleased when screened noted: "*you don't get it from the doctors, you don't get it from the nurses ...and women need to know.*"

Other women talked of it being "*a door open for someone to talk about it*" and "*it is needed so people can get through their problems.*" Sam (screen positive):

They need to make people aware that there are others out there that can help. And also there are others like myself that don't know that there is help there or people who are going through the same situation ...I just think them doing that research made me feel a lot better in myself, because then others are more aware. It's just that acknowledging that violence [pause] that it is a big thing and letting especially young women know that there is help available.

Carol (lifetime positive) agreed that health professionals need to ask questions about violence in people's lives because "*they are usually the first people to see it ... and when you treat the patient, it's not just the physical side but also their psychological side as well.*" She went on to argue that health professionals should be "*trained*" and they too "*shouldn't accept violence.*"

DISCUSSION

Findings

Qualitative approaches are needed to inform and complement randomized controlled trials testing the effectiveness of healthcare site-based IPV screening and brief intervention. In this study 36 women described the impact of an IPV screening protocol on their lives. Our findings are summarized below.

MAJOR FINDINGS

- ◆ Women supported routine healthcare site-based intimate partner violence screening and brief intervention.
- ◆ Abused women reported screening provided an opportunity to learn about IPV and the resources that are available.
- ◆ Women appreciated being given permission to openly talk about the abuse in their lives, affirming their ability to face the trauma and move beyond it, for themselves and for their children.
- ◆ There was no evidence among women in our sample that intimate partner violence screening increased women's risk of harm from an abuser.
- ◆ Along with early identification and intervention for abused women, routine intimate partner violence screening in the healthcare setting serves to make violence in the home visible in our communities, thus serving as a primary prevention strategy.

While we certainly cannot offer a guarantee of safety, a standardized screening protocol based on empowerment and holding safety paramount, administered by trained health professionals, did not increase harm and was found to have a positive impact on women's lives.

The women we interviewed supported healthcare provider IPV screening and intervention, yet their stories affirmed that such screening is distinctly different from other routine medical inquiries. Unlike most other screening programs, IPV screening is likely to bring to the surface "painful memories" among women who have been abused.

While the abused women in our study acknowledged that screening brought to the forefront painful memories, they were equally adamant in accepting screening - in

that they had learned something from it and there had been positive outcomes (instigating a discussion with their children for example) - and in encouraging the continuation of routine screening. The strength and resilience among our study participants highlights the importance of letting abused women speak for themselves in planning policy.

Sugg was recently quoted, "I do want to make sure that what we are doing about intimate partner abuse is the right thing. Are we really doing what we should do? That's my question, not should we do it at all" (Cole, 2000). In this study we discovered some important qualifications for how we can screen safely. For example, we realized that greater skill was needed in judging the timing for when mothers (or female caregivers) could be sensitively screened in the pediatric emergency department setting. The importance of privacy was also affirmed. Although visitors were routinely escorted to the waiting room prior to screening, the emergency department private rooms, with a single curtained side, still lacked the absolute privacy that would maximally promote disclosure of abuse. Finally, it was evident from the feedback of women that the one-day training and mentoring of nurses as research assistants successfully prepared them to safely and sensitively conduct IPV screening.

While most studies examining screening and intervention effectiveness limit outcomes of interest to effects on women currently abused (and their children), our study, using a qualitative open-ended approach, found evidence that IPV screening serves a broader role. The women who were screened in our study went home and talked to others, they talked to their children, other family members, friends, and they passed along resource information. This was evident for women whether or not they had a history of IPV. Allowing women the opportunity to recognize violence in the home and make it visible in their communities is an intervention that can contribute to transforming our communities toward peace. Rodriguez found that abused migrant women who participated in an action research study similarly became change agents (Rodriguez, 1999).

In some cases women informed us that they had confronted their partner about his abuse in response to having been screened and having a brief intervention. For example, Ann went home and told her husband, "... *when you're hitting me, that's why I need to talk to someone...I told him, you give me any argue and I ring and tell that lady.*" Readers are likely to be concerned that this action could result in severe danger, and perhaps cite it as a reason for not implementing screening. Ann, and others, however, would disagree. Ann stated that she had felt safe at the time of the screening and that she continued to be safe at the time of the follow-up interview. The paradox of providing an intervention to empower women, then being concerned that women's "sticking up for themselves" will serve to endanger them is something that service providers, researchers and policy makers will need to openly address. No one would disagree that confronting an abuser involves risk, but we need to ask ourselves who can judge the degree of risk, and - given the appropriate safety and referral information - whose responsibility is it to take risks?

Rodriguez (1999) is clear that her aims in working with abused migrant farmworker women include support for women's personal emancipation and the development of a power base for women to support and take care of one another. Whether you call it "the power of the collective" (Rodriguez, 1999), "catalytic validity" (Lather, 1991), "conscientization" (Freire, 1995), or primary prevention, we believe healthcare site-based screening offers a fulcrum for creating safer communities by bringing the violence in our communities out from behind closed doors.

Limitations

There are some important limitations of this study to consider. First, we studied a small group of women from two locations in Auckland New Zealand. We would argue, however, that the findings are likely to be similar in other healthcare settings. The 36 women's life-stories are diverse (influenced by age, culture and social class), but share the experiences of suffering, pain and courage. They capture meaning that can be recognized across cultural, social and regional boundaries. More stories may refine or expand their interpretation, but to show women's experience who engage with IPV screening - they are adequate (Morse, 1998).

Second, our study design and processes allowed women to "opt out" of participation at both the point of healthcare screening and at the point of choosing to participate in a follow-up interview, thus introducing the threat of selection bias. Some non-participants may have judged the study to have the potential to increase their risk of danger. Others may have been unable or unwilling to speak about their violence because it would be too hard, too traumatizing. There may be some who chose not to acknowledge the violence in their lives as being abusive. This study, based on a framework of empowerment and holding safety paramount, allowed women to choose whether or not to participate or to disclose violence. It suggests that in practice, screening protocols that respect women's rights enables women to keep themselves safe.

Future Areas of Inquiry

The findings from this study indicate some important concerns for future research examining IPV screening and intervention effectiveness. We identified that non-abused women often sought to speak for abused women. Like uneducated healthcare providers, their responses reflect dominant culture thinking in that the marginalized, abused women in this case, need protecting. Abused women, however, can ably speak for themselves. Research asking non-abused women to speak for abused women should not be condoned. Suggestions for future work are outlined below.

Implications for Future Work

- ◆ A large part of our interview schedule addressed screening acceptability. Future research is needed to provide a more comprehensive (wider scope) examination of outcomes. We did not, for example, inquire specifically about safety planning. An interview schedule could be theoretically driven by the short-term goals theorized to increase self-care explicated by Campbell et al (2004).
- ◆ There is a need for research that explores more in-depth the relationship between screening processes and women's experience. Grounded theory would be a useful methodology as demonstrated in studies of women's experience leaving abusive relationships (Merritt-Gray & Wuest, 1995; Wuest & Merritt-Gray, 2001; Wuest, Merritt-Gray, & Ford-Gilboe, 2004).
- ◆ This study indicates that IPV screening is an intervention. Therefore, intervention trials that screen all women (including those in the control group) introduce a significant threat to internal validity. And finally, we encourage future systematic reviews of IPV screening and intervention to take a quantum leap and include evidence from qualitative research approaches to more fully consider IPV screening usefulness.

Conclusion

Interviewing women who had experienced screening and brief intervention for intimate partner violence, we discovered concerns that screening for intimate partner violence would be too sensitive a topic and may increase women's potential for danger are unfounded. Indeed, women supported the opportunity to express their trauma in a safe and supportive context. Women's responses demand that we in healthcare implement IPV screening and intervention. They are asking: *"What took you so long?"*

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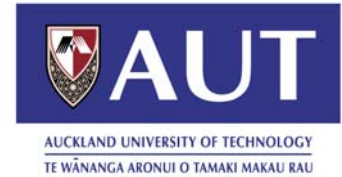
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APPENDIX

A. Participant Information Sheet



Information Sheet

Project Title: Women Seeking Healthcare: Prevalence of Intimate Partner Violence and Screening Acceptability

Invitation:

Kia ora, you are invited to take part in this study. We wish you to know that:

- Your receiving the care you need for your health visit today is a priority and will not be affected by participation or non-participation in this study;
- At any time, whether you choose to participate in this study or not, you may talk to your healthcare worker about problems you are having in your relationship. You may ask for a referral to the hospital or clinic social worker at any time while in the healthcare facility;
- This information sheet explains the research study. Please ask about anything you do not understand. If you have no questions now, you may ask later; and
- Your participation is voluntary and can be declined without giving a reason or being disadvantaged.

What is the purpose of the study?

This study will find out how many women have been hurt or threatened in their partner relationships and offer them information and support. It will also find out how women feel about being asked being hurt or threatened and about the usefulness of any help offered.

How was I chosen to be in the study?

All women who come to the hospital emergency care department or to hauora, age 16 and above are being asked to take part in the study during randomly selected time periods. We are keen to talk with all women, whether or not you have had abuse in your relationship.

How the study is being done?

If you agree to participate, you will be asked several questions about your partner relationships. This will happen during your healthcare visit. The questions will take less than five minutes.

If you answer the initial questions similar to women who have been abused, you may also be asked if you would be willing to talk about your healthcare visit experience in two to four weeks time. The follow up interview will last about 30 minutes and take place either on the telephone or at a safe place decided between yourself and the interviewer. It will be tape recorded and transcribed.

What are the risks?

Talking about your relationship may be upsetting for you. We have resources here to help you now if you need them. We will also give you referral persons to contact should you become upset once you leave the healthcare setting. To reduce the chance of harm, we ask that you do

Women's Perceptions of Partner Violence Screening

not discuss this study in the waiting room and do not place this information sheet where others may retrieve it.

What are the benefits?

All women who are asked to be in the study will be offered information about partner abuse. This information may be useful to you or someone you know. For women who answer questions like women who have been abused, the research assistant will offer additional information about Māori, Pasifika and English resources. The information we gain from this study will help us to develop and deliver the best, most effective way to offer information and help about partner violence, which is a common occurrence in New Zealand.

How is my privacy protected?

We believe privacy and confidentiality are important to keep you safe. We will keep all study information confidential and no one outside of the research team will be told of your participation in this study. The exception to this is should we find you, your children or other vulnerable person in your home to be at risk of imminent serious harm. In these instances we will notify your physician, nurse or social worker so further assessment may be made.

The study findings will be presented to the public, healthcare communities, and the hauora setting; in healthcare journals; and to the Ministry of Health's Family Violence Project. No material which could personally identify you will be used in any reports on this study.

Is there a Cost for Participating?

No, there will not be any cost to you except your time.

What if I have concerns?

Please feel free to contact the principal investigator if you have any questions about this study: Dr Jane Koziol-McLain, Associate Professor, telephone: (09) 917-9999 ext 7712.

If you have any queries or concerns regarding your rights as a participant in this study you may wish to contact a Health and Disability Advocate, telephone 0800 555 050.

Should you have any questions about ACC, contact your nearest ACC office (freephone 0800 735 566), the ACC website (www.acc.co.nz/claimscare/making-a-claim/medical-misadventure/index.html), or the investigator.

Statement of Approval

This study has received ethical approval from the Auckland Ethics Committee.

B. Interview Schedule

FOLLOW UP CONTACT QUALITATIVE INTERVIEW GUIDE (V4,02.05.03)

Study Id # _____

GENERAL PROBES: Can you tell me about that?

SECTION I – SCREENING PROCESS

1. What was it like to be asked questions about violence in your relationship?
 - a. Did being asked the questions feel safe to you?
NO [What was unsafe?] YES
 - b. How did you *feel* when you were asked the questions?
 - c. Was the interviewer sensitive to you as a _____ (European, Maori, Samoan, etc) woman?
NO YES (sensitive)
 - d. Asking the questions might be offensive to some. Was that the case for you?
NO YES (offensive)
2. Would you say you learned from the experience? (Was it informative at all? What did you learn?)
3. Would you describe the *interviewer's attitude* as being supportive of you?
NO YES [supportive - How was it supportive?]

SECTION 2 - INTERVENTION

4. Can you tell me what the research assistant's response was when you told her about the violence in your life?
5. Some women describe nurses' attitudes as judgmental. Was that the case for you [that you felt the nurse to be judgmental]?
NO YES (judgmental)
6. Would you describe the *process* of being asked questions and provided resources as supportive?
NO YES [What about it did you find supportive?]
7. Did the nurse provide you with any information?
NO YES [What information? What information was most meaningful to you?]
8. Did you have any contact with a social worker at that time of your visit?
NO YES [How was that for you?]

SECTION 3 - USEFULLNESS

9. Has being asked the questions and being provided information and referrals changed anything for you?
YES NO
10. Has it changed anything for your children?
NO YES
11. Has the process improved your safety?
NO YES
12. Since your visit, have you discussed the topic of domestic violence with anyone?
NO YES [who?]
13. How did you feel after the interview?
14. Is there anything that could have made the interview more useful or comfortable?

SECTION 4 – CLOSING

15. For some women , the process could result in increased danger from their partner. Did this happen for you?
NO YES [unsafe; What made it unsafe?]
16. Are there any questions you think I should have asked that I didn't?
17. Do you have any questions you would like to ask me?

THANK YOU

- Review resources, make referrals.
Domestic Violence Centre 24/7 crisis line 303 3939
South Auckland Family Violence Prevention Network (M-F 8.30–4) 263 6841
- Koha \$15 Petrol Voucher Bus Token Address for posting:

THAT'S ALL, THANK YOU AGAIN.

Label tape with date, study id code number, interviewer name.

Interviewer comments/thoughts/concerns (use back page as needed):