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A Secondary Data Analysis of the WomanKind/ Centers for Disease Control Evaluation A Study of Hospital Staff s ability to Engage, Assess and Refer Victims of Domestic Abuse

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CERTIFICATE OF APPROVAL

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ABSTRACT

A SECONDARY DATA ANALYSIS OF THE WOMANKIND/CENTERS FOR DISEASE CONTROL EVALUATION: A STUDY OF HOSPITAL STAFF'S ABILITY TO ENGAGE, ASSESS AND REFER VICTIMS OF DOMESTIC ABUSE

VICTORIA M. HANSON

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This is a secondary data analysis of an evaluation of a domestic violence program in a hospital setting in the Midwest. Hospital staffs in five hospitals who work in either the Emergency Department, Intensive Care, or Perinatal/Ob/Gyn were surveyed to evaluate their knowledge, attitudes, beliefs, and behaviors regarding domestic abuse. This secondary data analysis looked at the results of the 320 completed baseline surveys to examine if hospital staff who have a high concordance with feminist principles perceive themselves as having a high ability to engage, assess, and refer victims of domestic abuse.

Multiple regression was used to compare practitioner values with their skills in engagement, assessment, and referral of battered women. I found in this research that a high concordance with feminist principles is not a strong predictor of physician and registered nurses self-perception of their ability to engage, assess and refer victims of domestic abuse. In this study physicians and registered nurses both felt most confident in their referral skills than in their engagement and assessment skills. These findings suggest that hospital staff need to be educated on engaging and assessing victims of domestic abuse.

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INTRODUCTION

I first became interested in domestic violence when, as an undergraduate, I completed an internship at a battered women's shelter. The women I saw there impressed me. I guess I had always expected battered women to look like victims. What I did see were women just like the ones I see in church, at the grocery store, and at my job. I was shocked by the pervasiveness of the problem of domestic abuse. I was also shocked that often these women had to seek refuge in a shelter to get relief from the abuse.

In graduate school I began working in a hospital. I was also surprised by what I saw there. Here again I saw that domestic abuse is a concern and that hospital staff are in a unique position to help domestic abuse victims.

Statement of Problem

Domestic violence is a problem in the United States that today involves one in four families (Sabatino, 1992). Every year close to 6 million women in the United States are physically abused by their partners (Chez, 1989). "The medical community—along with the criminal justice system—is the most likely to see women victims and as such constitutes a frontline of identification and intervention" (Council on Scientific Affairs, 1992, p. 3184).

Physicians, even more than police officers, are likely to have contact with victims of family violence more than anyone else (Brandt, Hadley & Holtz, 1996; McAfee, 1994). Hospitals are in a position to help stop the abuse by being one of the few places victims may go for help. As a result of this unique position, hospitals have the responsibility to engage, assess, and refer victims of domestic abuse.

Research Question

The research question for this study is: Do hospital staff persons who have a high concordance with feminist principles perceive themselves as having a high ability to engage, assess, and refer victims of domestic abuse? High concordance with feminist principles is the staff's understanding of abusive relationships and their understanding of four basic feminist principles. Self-perception of ability to engage, assess, and refer victims is the staff's belief in their ability to identify victims of abuse and interact appropriately with them; belief in their ability to make appropriate referrals for victims of abuse and their intent to do so.

Purpose of the Research

Using data from the Centers for Disease Control evaluation of the WomanKind program I examine hospital staff's ability to engage, assess, and refer victims of domestic abuse. The results of this study will be used to inform practitioners of hospital staff's skills when working with battered women.

REVIEW OF THE LITERATURE

This literature review consists of three sections. The first section is a brief description of the terms used in the study. The second section addresses the hospital staff's knowledge, attitudes, beliefs and behaviors. The third and final section describes what limited literature is available on staff knowledge of domestic abuse and their skill level when dealing with the victims.

Research Question

The research question for this study is: Do hospital staff persons who have a high concordance with feminist principles perceive themselves as having a high ability to engage, assess, and refer victims of domestic abuse?

Definitions

Many terms in the literature of domestic violence deserve definition before moving forward with further analysis. Furthermore, many of the terms are interrelated.

Several definitions of domestic violence are present in the literature. The definition of domestic violence I have chosen to employ is that of the Council on Ethical and Judicial Affairs' (1992): the actual or threatened behavior that occurs between persons who have or have had an intimate or romantic relationship.

Actual, indirect or threatened behavior is called battering. That means that a punch or even the threat of one can constitute battering. Stark (1984) expanded on this basic definition: battering is "repeated episodes of physical abuse, usually by a spouse, ex-spouse, lover, or dating partner may be accompanied by sexual assault, threats, verbal abuse, the destruction of property, child abuse, stalking, degradation, isolation from friends and family, and a pattern of 'coercive control' over key aspects of the victim's

life, including money, food, sexuality, physical appearance, social life, transportation, work, religion, or access to help" (p. 3).

The majority of evidence indicates that domestic violence is predominantly perpetrated by men against women (Bureau of Justice Statistics, 1983; Dobash & Dobash, 1978). Therefore reference will be made only to female victims. Additionally, the impact on the health of female victims of domestic violence is generally much more severe than the impact on the health of male victims (Council on Scientific Affairs; Frieze & Brown, 1989; Straus & Gelles, 1986).

Effects of Domestic Violence

Women in the United States are more likely to be victimized through assault, battery, rape, or homicide, by a current or former male partner than by family or strangers combined (Browne & Williams, 1989; Council on Scientific Affairs; Finkelhor & Yllo, 1985). For this reason, the Surgeon General, in 1995, designated spouse abuse as the number one health risk for women (Senate Subcommittee on Children, Family, Drugs, and Alcohol, 1990). The rate of injury to women from battering surpasses that of car accidents and muggings combined (McClear & Anwar, 1987; Stark, 1984; & Strause, 1988).

The number one reason for emergency department visits by women is battering by boyfriends or husbands. Although few emergency departments adequately screen injured women to determine if they are or were victims of domestic violence, rough estimates by those who do indicate that domestic violence accounts for nearly 37% of all emergency department visits by women (Fighting domestic violence, 1996; Randall, 1990).

Today one percent of battered women seen in a hospital setting are identified correctly as victims of domestic violence (Abel, 1997). The Council on Scientific Affairs notes that the percentage of actual abuse is much more than that of reported abuse, "At least one in five women seen in emergency departments has symptoms relating to abuse. However, physicians frequently treat the injuries only symptomatically or fail to recognize the injuries as abuse" (Council on Scientific Affairs, 1992, p. 3184). This gap between actual abuse rates and reported abuse rates has a direct impact on domestic violence.

This impact is felt not only by the victims of abuse but by the hospital systems as well. Family violence injuries cost the hospitals bed space and millions of dollars in medical expenses. The following table (2.1) shows the direct impact domestic violence had on hospitals and healthcare system in 1992:

Table 2.1

Direct Impact on Hospitals

Annual estimates from reported family violence injuries:
$44,393,700 total annual medical costs
21,000 hospitalizations; 99,800 days of hospitalization
28,700 emergency department visits
39,000 physician visits

Source: (WomanKind Inc., 1992)

Staff Interactions with Domestic Violence Victims

A victim of abuse is exposed to several different hospital staff in the typical emergency room visit. Emergency nurses are most involved in the role of identification and emotional support for patients who have been abused (Hotch, Grunfeld, Mackay, & Ritch, 1996). By virtue of this fact hospitals are in a unique position to help stop the abuse. These facts make it imperative that the hospital setting not only recognizes the abuse victim but that it becomes the first step in the solution to the domestic violence problem.

It is important that medical staff know they cannot simply treat the physical wounds they may see on an abused woman, but that it is also important to acknowledge the violence and tell the victim that it is not her fault. This is important so that the victim can empower herself to break free from the abusive relationship. Currently over 30% of women who are seen in the emergency room for injuries resulting from a violent relationship continue on in that relationship (Jezierski, 1996).

Medical staff need the proper training and education to give victims information on resources available to help women in the community. The victim will appreciate knowing that the medical staff person cared enough to ask in a nonjudgmental way and to give information on what resources are available. The medical profession has received lower effectiveness ratings from battered women than have lawyers, clergy, police, social service agencies, battered women shelters, and women's groups (Bowker & Maurer, 1987). Most studies have found that medical staff is not properly identifying victims who enter their care with the symptoms common of an abuse victim (Kurz, 1987; Stark, Flitcraft & Frazier, 1979; Warshaw, 1989).

Some physicians believe that battering is not a medical issue. Stark et al. (1979) documented this misunderstanding twenty years ago when they found that physicians report that only one in 35 of their patients are victims of domestic abuse. The actual figure approaches 25% (Stark, Flitcraft, & Frazier 1979). Additionally, what physicians described as a rare occurrence was in reality a problem of prevalent scope (Stark, Flitcraft, & Frazier 1979). Kurz (1987) found that in 40% of emergency department staff interactions with battered women, the staff did not ask about abuse. Warshaw (1989) examined the medical records of encounters among medical staff and women whose injuries were highly indicative of abuse and found nondetection, nonintervention and nonreceptiveness to be the norm. That means that with regard to the typical abuse patient the medical staff likely failed to detect the abuse, failed to intervene on the patient's behalf and failed to be receptive to the victim's needs.

Medical staff's poor ability to diagnose abuse can be attributed to misinformation, to sexism, and to a medical model of disease that focuses on biological or psychiatric causes that overlooks the political and social contexts in which health problems arise (Jecker, 1993). Misinformation can come from any number of misconceptions. The Journal of American Medical Association (1992) stated that the most harmful misconceptions are, "(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 (4) battered women are responsible for their abuse" (p. 3191). Sexism is, "a static dimension of a socialization process which trains and permits men to be aggressive and women to act as objects" (Stark, Flitcraft & Frazier, 1979, p. 463). Physicians also fail to detect or intervene because they regard the

problem as intractable and persistent (Flitcraft, 1992; Jecker, 1993; Stark, Flitcraft & Frazier, 1979; Warshaw, 1989). They experience time constraints that deter asking probing questions and hold battered women themselves responsible for taking charge of violent relationships (Flitcraft, 1992; Jecker, 1993; Stark, Flitcraft & Frazier, 1979; Warshaw, 1989).

Treating only the physical signs of abuse and failing to ask a victim if she has been abused does nothing to stop the cycle of abuse. Victims of violence by intimates are much more likely to be re-assaulted within six months than are those attacked by non-intimates (Langan & Innes, 1982). When untreated, battering often escalates in frequency and severity over time (Dobash & Dobash, 1981; Walker, 1984). The risk of reoccurrence and increased severity necessitate that medical staff receive the education necessary in order to learn how to identify and not be afraid of asking any woman if she has been or is currently a victim of domestic violence. As stated above, medical staffs share many of society's misconceptions of domestic abuse. With the proper education and training these staff members can feel more competent when working with a woman they suspect is a victim of domestic abuse.

Gaps in the Literature

The research that has been done concerning the interactions between medical staff and domestic violence victims states that in order to improve in the identification of abuse victims medical staff need education (Novello, Rosenberg, Saltzman & Shosky, 1992).

The area that has not been researched and studied is the skill level these individuals have, coupled with the education, when working with domestic abuse victims.

The hypothesis that may be drawn from this gap in the literature, which is also the hypothesis for this study, is: Do hospital staff persons who have a high concordance with feminist principles perceive themselves as having a high ability to engage, assess, and refer victims of domestic abuse?

There also seems to be a far greater amount of literature available on physician interactions with domestic abuse victims then there is literature available on registered nurse interactions with domestic abuse victims. For this reason, this research paper studies registered nurse's self-perception of their ability to engage, assess, and refer victims of domestic abuse and compares those findings with physician skills.

Theoretical Framework

There are several different theoretical perspectives one can apply to domestic violence, including, but not limited to, psychoanalytic and sociological perspectives. The theory that is appropriate for the purpose of this study is the feminist theory. I have identified four basic principles held by feminists regarding domestic violence.

The first principle held by feminists regarding domestic violence is that men abuse women far more than women abuse men. They observe that women only are violent in self-defense situations (Kurz 1993).

The second principle of feminist theory related to domestic violence is that men use violence as a way to control women. Specifically, feminists believe that men use violence to control their female partners (Kurz 1993). This violence comes in many forms. In their study of domestic violence, Dobash and Dobash (1979) found that throughout marriages batterers control wives through intimidation, isolation, anger, and

psychological abuse. The battering incidents occur when men try to control their female partners.

The third feminist principle is the existence of a patriarchal family structure. "Feminists claim that marriage still institutionalizes the control of wives by husbands through the structure of husband-wife roles" (Kurz, 1993, p. 259). This control includes every element of the woman's life, particularly finances.

Finally, feminists believe that violence against women is condoned and tolerated by the larger society. "Feminists argue that important social and legal norms still support the use of violence against women as a means of control in marriage" (Kurz, 1993, p. 259). This relates to medical staff in that many abuse victims seek medical treatment at one time or another in the course of an abusive relationship. "Feminist researchers point out that both historically and in the present, major institutions have permitted and condoned the use of physical abuse by husbands to control wives" (Kurz, 1993, p. 259). By not questioning patients if they are victims of domestic violence, hospital staff may be perpetuating this problem. The hospital becomes the institution that appears to permit and condone the use of abuse by husbands to control their wives. This condoning is particularly dangerous in light of hospitals' unique position to help.

Hospitals are in a position to help abuse victims, but to do so the staff must keep the hospital from becoming one of the institutions perpetuating husbands controlling wives. Women in abusive relationships become dependent on their partner. Kurz (1993) expands on this notion, "Feminists argue further that the use of violence for control in marriage is perpetuated not only through norms about a man's rights in marriage but through women's continued economic dependence on their husbands, which makes it

difficult to leave a violent relationship" (p. 260). Many women do not know that there is housing, financial and advocacy services that can assist them if they ever want to escape their abusive situation. Hospital staff can help women leave their abusive relationships by giving them the information on the resources available to them. Hospital staff sees these victims everyday and can offer these resources to the patients. Many hospital staff do not offer this information because they do not inquire about the woman's situation related to battering. Hospitals and medical personnel can be re-educated about woman battering, yet battering remains either invisible or a low priority (Kurz, 1987; Kurz & Stark, 1988; McLeer, Anwar, Herman, & Maquiling, 1989; Stark et al., 1979). If the hospital staff have the education about domestic violence then they will feel more comfortable in addressing the issue with their patients. If the hospital staff feel more comfortable and competent in addressing abuse with their patients, then they may be able to offer them the necessary resources that they need to escape their abusive relationship. Feminist policy recommends making women more economically independent in order to give them alternatives to violent marriages (Dobash & Dobash, 1979; Pagelow, 1987; Stark et al., 1979).

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has recommended a national health objective for the year 2000 to have hospital emergency departments to have protocols for routinely identifying, treating, and referring victims of domestic violence. "Feminists also favor reforms to make institutions more responsive to battered women and public education campaigns to arouse support for those reforms" (Kurz, 1993, p. 261). Medical staff can be an important part of the battered woman's life if they feel competent addressing the abuse with the patient.

METHODOLOGY

The methodology chapter reviews the method in which the research study will be conducted. The chapter consists of the research design, research question, operational definitions, sample selection, measurement issues, collection instrument, data analysis, protection of human subjects, strengths and limitations of the study and concludes with implications for practice, policy and the field of social work.

Research Design

The overall intent of the WomanKind evaluation was to determine: 1) the extent to which the WomanKind program increases health care providers' capacity and motivation to identify cases of intimate partner violence and initiate a course of positive change through referral to WomanKind in-house services; and 2) the extent to which the WomanKind program provides assistance to the women referred. In addition to identifying the outcomes associated with the program and how they are implemented, for purposes of replication and adaptation in other settings.

A longitudinal survey research design was used to collect and compare information from the three hospitals where the WomanKind program operates and from two comparison hospitals where there was no formal program to address intimate partner violence. To comprehensively assess the WomanKind program, a variety of quantitative and qualitative research methods were employed.

For the purpose of this study only quantitative research methods will be used. The method used is analyzing a single method employed during the WomanKind evaluation by the Center for Disease Control which is collecting and analyzing survey data from hospital staff.

Research Question

The research question for this study is: Do hospital staff persons who have a high concordance with feminist principles perceive themselves as having a high ability to engage, assess, and refer victims of domestic abuse.

Purpose of the WomanKind Evaluation

The purpose of the WomanKind evaluation was to assess the effectiveness of the WomanKind program. Through education and training, WomanKind creates a hospital-based network of physicians, nurses, social workers and volunteers who work together to identify cases of intimate partner violence and channel them appropriately to existing community services. The WomanKind program strives to increase health care providers' capacity and motivation to identify abuse and initiate a course of action through referral to WomanKind's in-house services. WomanKind's paid program staff and volunteer advocates then work with the victims to evaluate their situations, develop plans for change, facilitate decision making, and mutually identify and access community services as needed.

The evaluation sought to determine the extent to which these program goals were achieved and to document the design and implementation of the program for purposes of strengthening the existing program and, more importantly, to develop recommendations for replication and adaptation in other medical settings.

Operational Definitions

The key variables of this research are: a high concordance with feminist principles and self-perception of ability to engage, assess, and refer victims of domestic abuse.

- **High concordance with feminist principles** – Staff understanding of abusive relationships and their understanding of four basic feminist principles.
- **Self perception of ability to engage, assess, and refer victims** – belief in their ability to identify victims of abuse and interact appropriately with them; belief in their ability to make appropriate referrals for victims of abuse and their intent to do so.

The independent variables are feminist principles while the dependent variables are the hospital staff's self-perception of their skills to engage, assess, and refer.

Schematic drawing of hypothesis:

$$\uparrow FP = \uparrow E$$
$$\uparrow A$$
$$\uparrow R$$

Key: FP = feminist principles

A= assess R = refer

E = engage

Sample Selection

Three populations were studied for the WomanKind evaluation effort: WomanKind volunteer advocates, hospital staff and female victims of intimate partner violence (clients). The hospital and client populations were drawn from a total of 5 hospitals, all of which are located in the greater Minneapolis, Minnesota metropolitan area. The experimental sites were the three hospitals in the Fairview Hospitals and Healthcare Services System where the WomanKind program is in place. Two additional hospitals were selected to participate in the study as comparison sites, based on their similarity to the experimental sites in size and population served. These two hospitals,

Ridgeview Medical Center and Abbott Northwestern Hospital, had no formal domestic violence program in place during the study period.

The population used for the purpose of this study consisted solely of the hospital staff. There was no sampling method used. The hospital staff who participated in the surveys were those who attended the staff training. Within each hospital, medical staff affiliated with the following three departments were eligible to participate in the study: emergency department (ED), intensive/special care unit (ICU), and the obstetric/gynecology or perinatal unit (OB/Gyn). The one exception was that the Ob/Gyn staff members in Abbott Northwestern were excluded from the study because of their participation in a similar study examining staff opinions regarding workplace violence. Forty-eight percent of eligible staff participated in surveys. A total of 115 staff participated in the surveys. Table 3.1 presents specific information on staff who participated in surveys.

Table 3.1

Hospital Staff Who Participated in Surveys

	Fairview Southdale	Fairview Ridges	Fairview Riverside	Totals
Emergency Room				
Eligible	47	52	37	136
Surveys	43	36	31	169
Intensive Care				
Eligible	38	13	30	136
Surveys	13	5	1	19
Perinatal/ Ob/Gyn				
Eligible	60	32	70	162
Surveys	26	20	18	64
Totals				
Eligible	145	127	137	409
Surveys	82	61	50	193

*Fairview Ridges is a small suburban hospital which employs a larger number of part-time staff than the other hospitals participating in the study, this total number of staff eligible to participate was slightly higher than the other hospitals.

Measurement Issues

Measurement error occurs in any study. In this study, there is systematic error in that individuals who take the KABB survey may not want to answer the questions honestly. There is probably a degree of social desirability bias in that members of the sample population may choose to answer the questions in a manner that will make them appear knowledgeable and agreeable to the issue of domestic violence in order to please the researcher. They may not answer the questions honestly but instead may answer in a way that they think is the right answer.

The KABB survey consisted of 51 items, using an anchored seven-point Likert scale, ranging from "Strongly Disagree" to "Strongly Agree." The level of measurement of individual items is ordinal. However, aggregated items will be assumed to be interval level measurement. This is due to the fact that the different attributes can be rank ordered. The attributes represent relatively more or less of the variable (Rubin & Babbie, 1997). The variables in this study are discrete in that they contain only a finite number of values. This means the variables can be guaranteed at a measurable distance from one concept to another.

Random error may be present in this study due to respondent fatigue. A 51-question survey may have been too long for some participants and they may have answered the questions randomly in order to complete the questionnaire quickly. Another issue that may affect the validity is that when doing a secondary data analysis, there is no assurance that the original data will be appropriate to this researcher's interests (Rubin and Babbie, 1997).

Collection Instrument

A 51-item KABB survey was used to measure the hospital staffs' knowledge, attitudes, beliefs, and behaviors related to domestic violence. To assess the impact of the training, the surveys were analyzed for those who had participated in the training, using the baseline survey as a training pre-test. For the purpose of this study only the baseline survey data will be analyzed. The 51 items on the survey form seven conceptual domains or scales, which were used for the analysis. A sample of the survey is found in Appendix A.

The KABB survey consisted of 51 items, using an anchored seven-point Likert scale, ranging from "Strongly Disagree" to "Strongly Agree." The individual items formed seven conceptual domains or scales, based upon a review of relevant issues from the professional literature on domestic violence, and the explicit objectives of the WomanKind program. The authors of the executive summary state that the scales were empirically tested through factor analysis of the baseline surveys, which confirmed the conceptualized factor pattern. The executive summary did not give any more information on the method or motivation behind the method. The resulting seven factors addressed the following areas:

- Self-efficacy for identification and interaction with victims of abuse: belief in their ability to identify victims of abuse and interact appropriately with them.
- Self-efficacy for referral and services: belief in their ability to make appropriate referrals for victims of abuse and their intent to do so.
- Staff understanding of abusive relationships: their understanding of the myths, realities and dynamics of abuse.

- Staff responsibility to address intimate partner violence: beliefs about the role of medical staff to identify and address domestic violence.
- Self-reported behaviors: behaviors related to asking patients about abuse and documenting how injuries occur in patients' charts.
- Staff preparation: beliefs around the extent to which medical staff have the training, time and knowledge to address domestic violence.
- Victim autonomy: attitudes and beliefs concerning victims' needs and rights to make their own decisions about their situations.

Scale Development

This thesis is a secondary data analysis of the WomanKind evaluation done with the Centers for Disease Control. Certain questions taken from the KABB survey will be analyzed to answer the research questions for this study. Those questions fall into two categories: **High concordance with feminist principles** – staff understanding of abusive relationships and their understanding of four basic feminist principles; and **Self perception of ability to engage, assess, and refer victims** – staffs' belief in their ability to identify victims of abuse and interact appropriately with them; belief in their ability to make appropriate referrals for victims of abuse and their intent to do so.

The questions, which will be analyzed for a concordance with feminist principles, are questions numbered 2, 9, 12, 17, 22, 23, 24, 33, and 42 and can be grouped with the following principles, which are not mutually exclusive categories.

- Men abuse women far more than women abuse men. They believe that women only are violent in self-defense situations (Kurz 1993).

- Men use violence as a way to control women. Specifically, feminists believe that men use violence to control their female partners (Kurz 1993).
- The existence of a patriarchal family structure. "Feminists claim that marriage still institutionalizes the control of wives by husbands through the structure of husband-wife roles" (Kurz, 1993, p. 259).
- Violence against women is condoned and tolerated by the larger society. "Feminists argue that important social and legal norms still support the use of violence against women as a means of control in marriage" (Kurz, 1993, p. 259

Question 2: I cannot understand why any victim of abuse would choose to remain in the relationship.

Question 9: Sometimes there are justifiable reasons for victims being hit by their partners.

Question 12: Abusers would not be violent if they weren't provoked.

Question 17: If victims of abuse remain in the relationship after repeated episodes of violence, they must accept some responsibility for that violence.

Question 22: Victims of abuse may have valid reasons for remaining in the abusive relationship.

Question 23: Sometimes there are justifiable reasons for a woman being hit by her partner.

Question 24: Abusers are not always responsible for their violent behavior.

Question 33: Victims of abuse could leave the relationship if they wanted to.

Question 42: Victims of abuse are not responsible for the abuse they receive.

The questions which will be analyzed for staff self perception of their ability to engage, assess, and refer victims are questions numbered 5, 25, 26, 27, 28, 30, 31, 39, 47, 48, and 50.

Engagement:

Question 5: I can put victims of abuse at ease.

Question 26: I can create an environment that builds trust, so that a patient can discuss domestic abuse with me.

Question 39: I can provide support to victims of abuse.

Question 50: I feel comfortable discussing domestic abuse with my patients.

Assessment:

Question 25: I am capable of identifying victims of domestic abuse.

Question 27: I am able to gather the necessary information to identify domestic abuse as the underlying cause of patient injuries.

Question 28: I am able to gather the necessary information to identify domestic abuse as the underlying cause of patient illnesses.

Referral:

Question 30: I can make appropriate referrals within the hospital for victims of domestic abuse.

Question 31: I can make appropriate referrals to services within the community for victims of domestic abuse.

Question 47: There are services within our own hospital for victims of domestic abuse.

Question 48: There are services within our own community for victims of domestic abuse.

These questions all gather quantitative data. This data will be analyzed for the answers hospital staff gives at the baseline phase of the WomanKind evaluation process. I ran frequency distributions of each of these questions to see trends in how participants may have answered the questions. Only one question, question 23, needed to be thrown out because it is too highly skewed. Because this study is multivariate, I use multiple regression to assess the relationship between the independent and dependent variables. I also use t-tests to assess, at the baseline level, the relationship between staff gender, and staff position/specialty when engaging, assessing, and referring domestic violence victims.

Protection of Human Subjects

As this is a secondary data analysis, no new information will be gathered from human subjects. The original WomanKind evaluation asked the following demographic questions: age, gender, position/specialty, hire date, and percent full-time equivalent. However, numbers, chosen by the participant, so as not to identify that person tracked the surveys. For the purpose of this study, the identifying information will be used only if frequency distributions show that more than five participants answered in the same way so as not to identify anyone. The WomanKind evaluation done by the Centers for Disease Control completed the IRB process and received an approval number: 0920-0379.

Strengths and Limitations of the Study

A longitudinal evaluation of a program such as WomanKind is one that requires a large-scale survey, a great amount of time, money and resources. The use of a secondary data analysis enables the researcher to pursue a research interest while avoiding the large

amount of time and resources such an evaluation requires. For the purpose of this study, this researcher is able to use a wealth of information in order to research and discuss a hypothesis of her choosing. Secondary data analysis of the WomanKind/Centers for Disease Control study, allows the benefit from the work of professionals in a field that is of great interest to this researcher (Rubin & Babbie, 1997). One deficit of this method is that the researcher doing the secondary data analysis may not have access to all of the information.

As mentioned above, an issue that may affect the validity of the study is that when doing a secondary data analysis, there is no assurance that the original data will be appropriate to the researcher's interests (Rubin & Babbie, 1997).

Implications for Practice, Policy and the Field of Social Work

Every practitioner must be aware of the problem of domestic violence. Every social worker should be aware of domestic abuse and the way domestic abuse victims are treated during each phase of their abuse situation. The hospital is one critical area where intervention can take place. Practitioners need to be aware of the areas of strength in their practice as well as areas that need more attention. This study should provide some awareness into both.

PRESENTATION OF FINDINGS

Overview

This chapter presents the findings from the analysis of the questionnaire data. The data source for this study is the survey results of the WomanKind/Centers for Disease Control evaluation. I will present findings on the population characteristics and on staff's self-evaluations of feminist principles, ability to engage, assess, and refer victims of domestic violence. Finally I will present findings as they relate to the final question: Do registered nurse's attitudes toward feminist principles support their perceived ability to engage, assess and refer victims of domestic violence. The findings will be presented in the following order: characteristics of the population, correlation between physicians and registered nurses, group statistics by gender and position, t-tests, and finally multiple regression statistics on the registered nurses alone.

Characteristics of the Population

The population consisted of 200 staff in three Fairview Hospitals surveyed. Within each hospital, medical staff affiliated with the following three departments were eligible to participate in the study: emergency department, intensive/special care unit, and the obstetric/gynecology or perinatal unit. There were 115 registered nurses and 39 physicians. The majority of study participants, 79 percent, were female while only 21 percent of study participants were male (see Table 4.1).

The registered nurses and physicians ranged in age from 20 to 64 years old. Nearly one-third (55 respondents) of the population were between the ages of 45-59 while just under one-quarter were between 35-39 years old (32 respondents) and only

slightly fewer 40-44 years old (29 respondents). The 20-24 year age group had the lowest percent (.6%) of respondents (see Table 4.1).

Table 4.1

Position, Gender and Age of Hospital Staff Surveyed at Three Fairview Hospitals

	N	(%)
Position		
Registered Nurse	115	74.7
Physician	39	25.3
Gender		
Female	121	78.6
Male	32	20.8
Missing	1	-
Age		
20-24	1	.6
25-29	15	9.7
30-34	19	12.3
35-39	32	20.8
40-44	29	18.8
45-59	55	35.7
60-64	3	1.9

Correlation between Variables

To determine relationships between variables correlation can be computed. The variables – feminist principles, engagement, assessment, and referral – were tested applying a Pearson's Correlation using the combined registered nurse and physician respondents. The table (4.2) below shows the relationships using correlation coefficient.

Comparison of the relationships between referral, assessment and engagement resulted in three different correlations. The strongest, and positive, of these three relationships is between engagement and assessment (.65). The relationship between engagement and referral is next strongest (.40). The weakest relationship is between assessment and referral (.29).

The following table (4.2) also shows the relationships between feminist principles and the other variables. The strongest correlation is between feminist principles and the skill of referral (.32). Feminist principles and engagement demonstrate a less positive relationship (.21). The weakest correlation is between feminist principles and assessment (.04) (see table 4.2).

Table 4.2

Correlation of Feminist Principles, Engagement, Assessment and Referral for Medical Staff at Three Fairview Hospitals

	Feminist Principles	Engagement	Assessment
Engagement	.209	-	-
Assessment	.041	.653	-
Referral	.317	.398	.294

N = 154

	Feminist Principles	Engagement	Assessment	Referral
Means	5.4	4.59	4.14	5.82
Standard Deviation	.77	.87	1.03	.93

Comparing Physicians and Registered Nurses

I computed the mean and standard deviation for both physicians and registered nurses on feminist principles, assessment, engagement and referral (see table 4.3). The table also shows the level of agreement each position has with the variables.

This thesis is a secondary data analysis of the WomanKind evaluation done with the Centers for disease Control. Certain questions were selected from the KABB survey to answer the research question in this study.

The variable in which both the nurses and physicians rated themselves highest is referral (MD: m = 6.12, RN: m = 5.96). Both groups rated the feminist principles variable second highest (MD: m = 5.44, RN: m = 5.44). Third highest for both groups is engagement (MD: m = 4.86, RN: m = 4.55). Assessment received the lowest ranking (MD: m = 4.02, RN: m = 4.74).

No gap exists between the two professions when ranking their skills in relationship to feminist principles. A gap exists between the professions when ranking all other variables. The smallest gap is present in the ranking of referral skills. The next smallest is present in the ranking of engagement. The variable assessment shows the largest gap in self-perceived skills between the two groups of professionals with physicians perceiving themselves as more confident assessing domestic abuse victims than do registered nurses (see table 4.3).

Table 4.3

Group Statistics by Position of Registered Nurses and Physicians at Three Fairview Hospitals

	N	Mean	Standard Deviation
Feminist Principles			
RN	115	5.44	.78
MD	39	5.44	.76
Engagement			
RN	115	4.55	.93
MD	39	4.86	.77
Assessment			
RN	115	4.02	1.11
MD	39	4.74	.76
Referral			
RN	115	5.96	.83
MD	39	6.12	.8

Upon seeing the results of the group statistics by position, I was curious about the results by gender. The impetus for this curiosity was the fact that most nurses are female while most physicians are male. The gender split in this study is 121 females and 32 males. Only seven of the 115 registered nurses are male while 25 of the 39 physicians are male. In table 4.4 I present the mean and standard deviation for males and female on the same four variables as in table 4.3.

When the rankings are broken down and analyzed by gender it becomes clear that male and female participants ranked themselves similar in their three strongest variables (feminist principles, engagement and referral) but different in their one weakest (assessment). Upon visual examination of the means, there appears to be no difference between male and female mean scores for these variables (see table 4.4).

Table 4.4

Group Statistics by Gender of Registered Nurses and Physicians at Three Fairview Hospitals

	N	Mean	Standard Deviation
Feminist Principles			
Female	121	5.48	.78
Male	32	5.27	.72
Engagement			
Female	121	4.60	.88
Male	32	4.67	.96
Assessment			
Female	121	4.05	1.09
Male	32	4.74	.86
Referral			
Female	121	6.00	.84
Male	32	6.09	.79

I also wanted to look at the difference between physicians and registered nurses to compare their beliefs and skill assessment results with each variable. To do this I used a t-test to find the statistical significance of the relationship. The t-tests show that assessment and engagement are statistically significant variables (see table 4.5). On both measures physicians were more confident of their ability to engage and assess women experiencing domestic violence.

Table 4.5

Independent Samples Test of Registered Nurses and Physicians

	t-test for Equality of Means		
	t	df	Significance (2-tailed)
Feminist Principles			
Equal variances not assumed	-.001	66.88	1.000
Engagement			
Equal variances not assumed	-2.080	78.68	.041
Assessment			
Equal variances not assumed	-4.541	95.47	.000
Referral			
Equal variances not assumed	-1.589	67.99	.117

Registered Nurse Relationship to the Variables

Upon examining the data from the study, I found that registered nurses were the highest represented population in the study (74%). Because of the lack of attention paid to them in the literature I examined their endorsement of feminist principles as a predictor of their self-assessment to engage, assess, and refer victims of domestic abuse. For this reason, I selected only the registered nurse population and used multiple regression for the variables feminist principles, engagement, assessment and referral. The results of this test showed that R Square = .062 and the Adjusted R Square = .036 (F=2.433; df 3&P>.05) (see table 4.6).

Table 4.6

Multiple Regression Statistics for Registered Nurses at Three Fairview Hospitals

Model	Sum of Squares	df	Mean Square	F	Significance
Regression	4.244	3	1.415	2.433	.069
Residual	64.536	111	.581	-	-
Total	68.780	114	-	-	-

Summary of Findings

This section outlined the findings in this study. At this time I will summarize the major findings of this study. The population consisted of 115 nurses and 39 physicians. Of the total population studied, the majority (79%) was female. The largest portion of respondents ranged in age from 45-59 years old.

Testing for correlation among the variables reveals that the strongest relationship is between engagement and assessment, while the weakest is between assessment and referral. When looking at feminist principles in relation to the other variables the strongest correlation is between feminist principles and referral while the weakest is between feminist principles and assessment.

Testing for mean and standard deviation shows that both nurses and physicians identify referral as the variable with which they have the highest level of agreement. Assessment received the lowest ranking. For the variables engagement, assessment and referral physicians ranked themselves higher than nurses.

Analyzing the data using multiple regression revealed no significant relationship between knowledge of feminist principle's and a nurse's self-perceived ability to engage, assess and refer victims of domestic abuse.

DISCUSSION

The previous section presented the findings of this study. In this chapter I will present the key findings and how these findings relate to the literature review. Implications for social work practice, limitations of the study and recommendations for future research will also be discussed.

Key Findings

This study looked at the relationship between hospital staff's self-perceived ability to engage, assess and refer victims of domestic abuse and their belief in feminist principles related to domestic violence.

Self-perception of ability to engage, assess, and refer victims of abuse refers to staffs' belief in their ability to identify victims of abuse, belief in their ability to interact appropriately with victims and belief in their ability to make appropriate referrals for the victims of abuse.

There are four main principles of feminist theory regarding domestic violence that were included in this analysis. As a quick review, I have included a brief explanation of each here. The first principle is that men abuse women far more than women abuse men. Additionally, feminist theory embraces the notion that women only are violent in self-defense situations (Kurz 1993).

Violence as a method of control employed by men over women is the second principle of feminist theory related to domestic violence. Specifically, feminists believe that men use violence to control their female partners (Kurz 1993). This violence takes on many forms as Dobash and Dobash (1979), in their study of domestic violence, found.

The forms include intimidation, isolation, anger and psychological abuse. The battering incidents occur when men try to control their female partner.

Existence of a patriarchal family structure is the third principle. The family structure continues to serve, feminists believe, as an institutionalizing agent in control of wives by husbands by persisting in traditional male-female roles (Kurz, 1993). This control includes every element of the woman's life, particularly finances.

The fourth, and final principle, is a belief that violence against women is both condoned and tolerated by the larger society. As Kurz states, "Feminists argue that important social and legal norms still support the use of violence against women as a means of control in marriage" (1993, p. 259). Because hospitals are institutions that often reflect the values and beliefs of society and many abuse victims seek medical treatment at one time or another in the course of an abusive relationship the hospital may be inadvertently perpetuating the problem. Kurz echoes this sentiment, "Feminist researchers point out that both historically and in the present, major institutions have permitted and condoned the use of physical abuse by husbands to control wives" (1993, p. 259).

Correlation between Variables

Testing for correlation reveals which relationships are strong and which are weak. The strongest correlation is between hospital staff's ability to engage with and to assess risks in women who are battered. Hospital staff's ability to engage and assess is related. This means that there is a strong association between staff's self-perception of their engagement and assessment skills. The weakest correlation is between hospital staff's ability to assess risks in, and refer victims of abuse to resources inside and outside of the

hospital. There is little connection between their skills in assessment and their skills in referral. Employing this data to improve workplace skills would result in a recommendation that engagement and assessment could be combined in further training, but that there should be a separate training for referral skills. Implementing this recommendation would allow the Hospital's employees to strengthen their weaknesses and solidify their strengths.

There is a stronger correlation between engaging and assessing skills than there is between combined referral and engagement skills. Therefore, it will be most helpful when further training physicians and nurses to pair the skills together for training so they can work on the skills together and be confident with all instead of certain ones separately.

Comparing Physicians and Registered Nurses

In this section I will separate the variables and discuss physicians and registered nurse's self-perception of their ability to engage, assess and refer victims of domestic abuse based on their concordance with feminist principles. I will look at each variable separately to examine the confidence staff has with their skills.

Registered nurses and physicians somewhat strongly endorse feminist principles. As table 4.3 suggests, almost all of the registered nurses and physicians rated themselves at a median score of 5.4 for their belief in feminist principles. This means that half of the physicians and nurses scored themselves above this mark and half scored themselves below. Both physicians and registered nurses rated themselves highest on referral. This means that they are more confident in their skills of referring patients then they are engaging or assessing victims of domestic abuse.

Both physicians and registered nurses rated themselves the lowest in their ability to assess risks in women who are battered. This means that their confidence level is in general the lowest when it comes to assessing patients where domestic abuse is an issue. Physicians and registered nurses are least comfortable assessing patients because they feel the problem is intractable and persistent, they experience time constraints that deter asking probing questions and holding battered women themselves responsible for taking charge of violence relationships (Flitcraft, 1992; Jecker, 1993; Stark, Flitcraft & Frazier, 1979; Warshaw, 1989).

Another interesting finding is that physicians rated their skill level higher than the nurses for the skills of engaging the patient, assessing that she is a domestic abuse victim and then making the appropriate referral for the woman. As mentioned in the literature review, there is little information in the literature on nurse's response to domestic abuse victims when compare to the amount available on physicians. Perhaps the reason nurses are less confident in this sample than physicians in this sample is that physicians receive more training in this area than nurses do. An alternative explanation, however, is suggested by the fact that in this study the registered nurse sample is predominately female while the physician sample is predominately male. There may be a difference in the way males and females self-perceive their ability to engage, assess and refer victims of domestic abuse.

Comparing Males and Females

When looking at males and females instead of nurses and physicians I found different results when separating the variables to assess self-perceived skill. I did find that males perceived their skill of assessing risks in women who are battered as higher

than the self-perceived assessment skills of the females in the study. However, upon visual examination of the means, there appears to be no significant difference between male and female endorsement of feminist principles, skill level in assessing risks of battered women, or their skill in referring battered women to helpful resources. Thus, for this finding, gender does not appear to be a determinant of staff's beliefs and skill assessment.

One thing that is different when looking at gender as opposed to position is that the gap between the perceptions is smaller for the staff's ability to engage the woman, assess risks she may be facing and to make referrals on her behalf. The female sample rated themselves higher on all three variables then the registered nurses did. The male sample rated themselves lower on the variables engagement and referral then the physician sample did. This supports the possible explanation for this finding that physicians may receive more training and feel more confident in working with domestic abuse victims then registered nurses do.

Registered Nurse's Relationship to Variables

In response to the main research question, this thesis finds feminist principles do not have a strong determination on registered nurses' self-perception of their ability to engage, assess, and refer victims of domestic violence. Using multiple regression reveals that only 6% of the variation in the variable feminist principles has been explained. Therefore, something else is influencing the registered nurses' self-perceived skills in engagement, assessment and referral.

Limitations of the Study

This study had several limitations. The first is that the population of the Fairview/Womankind study was categorized by the following positions: registered nurse, physician, paramedic, other, and physician's assistant. I would have liked to evaluate the social work staff's self-perception of their ability to engage, assess, and refer but they were not a category to choose from.

A second limitation is that I only have access to the baseline data from the WomanKind/Centers for Disease Control evaluation. Following the initial survey the Fairview staff was to participate in training sessions and then re-evaluate their knowledge, attitudes, beliefs and behaviors in relation to battered women. Unfortunately I was only able to limit this study to the baseline data and will not know if the education sessions had an influence on my research questions.

Recommendations for Future Research

This study did not strongly suggest that feminist principles have a strong determination on registered nurse and physician's ability to engage, assess and refer victims of domestic abuse. Therefore, further research should be done to find what influences medical staff's self perception of their ability to engage, assess and refer victims of domestic abuse. Also, this study could be repeated with the data from the WomanKind/Centers for Disease Control evaluation following staff training to examine if staff education had an influence on the principles the staff endorses.

Because I make the argument that social workers are part of the reason registered nurses and physicians are most comfortable referring victims of domestic abuse, it would be an area that should be formally evaluated in future research. Having social workers in

the same departments at the three Fairview Hospitals respond to an identical survey and then analyzing their ability to engage, assess and refer would likely be helpful. Another method of examining the influence of social workers is to give the survey to a group of registered nurses and physicians who have little or no social work support available to them and analyze if the results match those of the hospital staff with a great deal of social work support. Because of the more extensive training social workers receive in the area of domestic violence they may have a higher concordance with feminist principles.

Implications for Social Workers

The most important finding in this study is that physicians and registered nurses feel that they are most comfortable in the skill of referral. As mentioned above, this study found that both physicians and registered nurses perceive themselves as most comfortable referring victims of domestic abuse and less comfortable with engagement and assessment. I believe that the strong presence of social workers in the emergency department, intensive/special care unit and the obstetric/gynecology or perinatal unit has a strong impact on this finding. The registered nurses and physicians feel comfortable referring domestic abuse victims to social workers because of their strong presence in these departments and their expertise in working with domestic abuse victims. Social workers in the hospitals are trained to work with domestic abuse victims by engaging, assessing and referring them to a variety of resources. These social workers are trained to advocate for the victim in and outside of the hospital.

WomanKind is an example of the support that is available to hospital staff and domestic abuse victims. WomanKind is a strong presence in the Fairview hospital system 24 hours per day, seven days per week, providing immediate and on-going

services to victims of abuse. The WomanKind program strives to increase the hospital staff's capacity and motivation to identify abuse and initiate a course of action through referral to its own in-house services. WomanKind staff then work with these women to evaluate their situations, develop plans for change, facilitate decision making and mutually identify and access community services as needed.

Based on the findings of this study, it is important that social workers present in hospitals continue to gain education regarding domestic abuse. With knowledge of the issues of domestic abuse and a strong presence in the hospitals the social workers are in a key position to educate staff and to assist women who are victims of domestic abuse.

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Appendix A

KABB Survey

Four-digit code: ___ ___ ___ ___

(Please write a number that is easy for you to remember, such as the last four digits of your social security number.)

OMB Clearance Number: 0920-0379
Expiration Date: 01/99

Medical and Hospital Staff KABB Survey

For each of the following statements, please indicate your response on the scale from "Strongly Disagree" (1) to "Strongly Agree" (7).

Please be candid in your responses and try to record your first, instinctive answer, even if you don't think it is "politically correct". (Don't try to think about what your answers "should" be.) Your honest reactions to these statements will help us assess the need for hospital-based programs and training. These surveys are tracked by number, not by name, so feel free to answer honestly. Identifying information will be collected only to allow administration of follow-up instruments to the proper people. Lists associating names and identification codes will be maintained by Macro International, the contractor for this study, only until the study is complete.

The authority for collecting this data is Section 301 of the Public Health Service Act. Data will be safeguarded in accordance with the Privacy Act of 1974 and applicable Minnesota statutes. Your participation is voluntary, but your response will greatly assist us in evaluating this program.

Thank you for taking the time to fill out this questionnaire.

Statements	Strongly Disagree		Disagree		Agree		Strongly Agree
1. Domestic abuse is a significant problem in our society.	1	2	3	4	5	6	7
2. I cannot understand why any victim of abuse would choose to remain in the relationship.	1	2	3	4	5	6	7
3. Medical and hospital staff should not be responsible for identifying cases of domestic abuse.	1	2	3	4	5	6	7
4. Domestic abuse is less important than other health care problems.	1	2	3	4	5	6	7
5. I can put victims of abuse at ease.	1	2	3	4	5	6	7
6. Abuse victims need to make their own decisions about how to handle the situation.	1	2	3	4	5	6	7
7. Abuse can be caused by the use of drugs and alcohol.	1	2	3	4	5	6	7
8. Medical and hospital staff who see patients are in a position to identify victims of domestic abuse.	1	2	3	4	5	6	7
9. Sometimes there are justifiable reasons for victims being hit by their partners.	1	2	3	4	5	6	7
10. If a victim of abuse refuses to acknowledge the abuse, there is very little that hospital staff can do to help.	1	2	3	4	5	6	7
11. Medical and hospital staff should not pressure patients to acknowledge that they are living in an abusive relationship.	1	2	3	4	5	6	7
12. Abusers would not be violent if they weren't provoked.	1	2	3	4	5	6	7
13. Medical and hospital staff have a responsibility to ask all patients about domestic abuse.	1	2	3	4	5	6	7

Statements	*Strongly Disagree*		*Disagree*		*Agree*		*Strongly Agree*
14. Medical and hospital staff do not have the **training** to assist individuals in addressing situations of domestic abuse.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
15. Medical and hospital staff do not have the **time** to assist patients in addressing domestic abuse.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
16. Medical and hospital staff do not have the **knowledge** to assist patients in addressing domestic abuse.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
17. If victims of abuse remain in the relationship after repeated episodes of violence, they must accept some responsibility for that violence.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
18. Medical and hospital staff have an important role in addressing situations of domestic abuse.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
19. If a patient repeatedly refuses to discuss the abuse, staff can only treat the patient's injuries.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
20. Victims of abuse have the right to make their own decisions about whether hospital staff can intervene.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
21. It is not appropriate for medical and hospital staff to ask patients about domestic abuse.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
22. Victims of abuse may have valid reasons for remaining in the abusive relationship.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
23. Sometimes there are justifiable reasons for a woman being hit by her partner.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
24. Abusers are not always responsible for their violent behavior.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
25. I am capable of identifying victims of domestic abuse.	*1*	*2*	*3*	*4*	*5*	*6*	*7*

Statements	*Strongly Disagree*		*Disagree*		*Agree*		*Strongly Agree*
26. I can create an environment that builds trust, so that a patient can discuss domestic abuse with me.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
27. I am able to gather the necessary information to identify domestic abuse as the underlying cause of patient **injuries**.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
28. I am able to gather the necessary information to identify domestic abuse as the underlying cause of patient **illnesses**.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
29. I have difficulty knowing how to respond when a patient insists that suspicious injuries are not the result of abuse.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
30. I can make appropriate referrals within the hospital for victims of domestic abuse.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
31. I can make appropriate referrals to services within the community for victims of domestic abuse.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
32. I can tell if someone is an abuser.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
33. Victims of abuse could leave the relationship if they wanted to.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
34. Medical and hospital staff can identify most cases of domestic abuse without specific training.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
35. The physical, emotional and economic costs of domestic abuse justify a stronger prevention effort.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
36. I am aware of legal requirements in Minnesota regarding reporting of suspected cases of abuse.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
37. I don't have the necessary skills to discuss abuse with a victim.	*1*	*2*	*3*	*4*	*5*	*6*	*7*
38. I review patients' charts to determine possible evidence of prior abuse.	*1*	*2*	*3*	*4*	*5*	*6*	*7*

Statements	Strongly Disagree		Disagree		Agree		Strongly Agree
39. I can provide support to victims of abuse.	1	2	3	4	5	6	7
40. I ask all female patients about problems in their relationships.	1	2	3	4	5	6	7
41. Pregnant women are less likely than non-pregnant women to be hit by their partners.	1	2	3	4	5	6	7
42. Victims of abuse are not responsible for the abuse they receive.	1	2	3	4	5	6	7
43. Medical and hospital staff may need to make repeated attempts to help patients acknowledge an abusive relationship.	1	2	3	4	5	6	7
44. I document in patients' charts their statements about how the injury occurred.	1	2	3	4	5	6	7
45. I comply with the AMA recommendations and Joint Commission standards that require inquiries about domestic abuse of all female patients.	1	2	3	4	5	6	7
46. I intend to provide support and appropriate referrals to any victims of domestic abuse that I encounter in my professional practice.	1	2	3	4	5	6	7
47. There are services within our own **hospital** for victims of domestic abuse.	1	2	3	4	5	6	7
48. There are services within the **community** for victims of domestic abuse.	1	2	3	4	5	6	7
49. I am concerned about getting involved in an abused patient's case because of the time it may require.	1	2	3	4	5	6	7
50. I feel comfortable discussing domestic abuse with my patients.	1	2	3	4	5	6	7
51. There are specific things that I can do to help a victim of domestic abuse.	1	2	3	4	5	6	7

52. Respondent Profile:

Age:
- ❑ < 20
- ❑ 20-24
- ❑ 25-29
- ❑ 30-34
- ❑ 35-39
- ❑ 40-44
- ❑ 45-59
- ❑ 6--64
- ❑ 65+

Gender: ❑ Male ❑ Female

Position/Specialty: *(e.g., RN, Labor & Delivery)*

Hire date *(month/year)*:

Percent Full-time Equivalent (FTE):

Have you had any previous training in domestic violence issues? Please list any previous training below:

Thank you for participating in this study.