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Screening For Domestic Violence By Nurse Practitioners In The Primary Care Setting

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SCREENING FOR DOMESTIC VIOLENCE

BY NURSE PRACTITIONERS

IN THE PRIMARY CARE SETTING

by

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by Nurse Practitioners in the Primary Care Setting

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Abstract

Domestic violence produces major health care problems for women. The prevalence and serious nature of this problem mandates recognition and intervention. Research has demonstrated that health care providers either overlook or fail to recognize or address potential domestic violence issues and situations during health care encounters. This descriptive study was designed to examine the screening practices of nurse practitioners for domestic violence certified and practicing in Louisiana. The theoretical framework for the research was based on the Health Promotion Model (Pender, 1987), which focuses on the integration of health-promoting behavior into lifestyles. The research question for this study was as follows: Do nurse practitioners screen for domestic violence against women in the primary care setting? The setting for this study was the state of Louisiana. A sample of 158 family, adult, acute care, women's health, and gerontologic nurse practitioners, and certified nurse midwives, registered with the Louisiana State Board of Nursing were surveyed using the Revised Education/Experience Questionnaire. Descriptive statistics were generated to describe demographic characteristics of the nurse practitioners in addition to beliefs, perceptions, and screening practices for domestic violence. Responses to the questionnaire were analyzed using frequency distributions and percentages. Data analysis revealed that the majority of nurse practitioners do not routinely ask questions focused on domestic violence issues in the primary care setting. A major implication for nursing which emerged was that the need for inclusion of extensive domestic violence content in the formal educational programs for nurses at all levels. Further research was recommended to determine why nurse practitioners do not screen for domestic violence in the primary care setting.

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we did make it through this year! I love you both. Thank you from the bottom of my heart.

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Chapter I

The Research Problem

Domestic violence produces major health care problems for women. Statistics reveal between two and four million cases of reported abuse yearly (U.S. Dept. of Health and Human Services, 1994). A greater number of injuries appear to be caused by domestic violence than by automobile accidents, muggings, and rape combined (Flitcraft, 1990). Conservative reports estimate that at least one third to one half of all women will experience some abuse in their lifetime (Bohn & Holz, 1996). Flitcraft reported that 20% of the women who presented to the emergency department sustained injuries from a significant other, husband, or male friend. Flitcraft also reported that 25% of women utilizing an obstetric clinic were abused. Recent studies surveying a substantial number of women found alarming prevalence rates of abuse to women (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995; McCauley, Kern, Kolodner, Dill, Schroeder, DeChant, Ryden, Bass, & Derogatis, 1995; Plichta & Weisman, 1995).

Domestic violence is the use of abuse to gain power and control over another individual. Physical injury or harm, sexual abuse, social isolation, economic control, mental and emotional manipulation, threats, and intimidation are examples of abuse (Alpert, 1995; Butler, 1995; Flitcraft, 1990; King & Ryan, 1996; Orloff, 1996). Self-esteem, self-confidence, and self-worth are replaced with the sense of powerlessness, failure, blame, shame, and humiliation. Victims feel trapped in a hopeless situation.

Domestic violence is an ongoing process which escalates in frequency and severity across time (Warshaw, 1993). According to Orloff, victims may believe that violence is normal in a relationship, that abuse is deserved, and that no one will help them change their oppressive life.

Based on the widespread prevalence of domestic violence and its potential for serious or devastating health effects, universal screening for violence should be considered the norm in all women's health care provider's practice (Paluzzi, 1996; Poirier,1997). Abuse detection rate by physicians is disappointingly low (Abbott et al., 1995; Martins, Holzapfel, & Baker, 1992; McCauley et al., 1995). Primary health care providers, whether physicians or nurse practitioners, are in a key position to identify women involved in domestic violent situations with appropriate and explicit abuse screening questions and physical exam (King & Ryan, 1989). The focus of this study was to determine if nurse practitioners screen for domestic violence in the primary care setting.

Establishment of the Problem

Domestic violence has existed in society for centuries. Martins et al. (1992) reported evidence of abuse 2,000 to 3,000 years ago in female Egyptian mummies. In the 1970s, the feminist movement brought the issue of domestic violence into the public forum (Poirier, 1997). Yet today, abuse against women is still a denied, ignored, or downplayed issue. Significant improvement in the overall condition of women has not evolved, in part because domestic violence has remained a private issue in the United States. Domestic violence is considered a worldwide phenomenon. King and Ryan (1996) confirm that women of every social class, sexual orientation, age, marital status,

color, culture, and ethnicity can be subject to victimization and abuse. There is no specific set of abuse indicators, risk factors, or identifying characteristics, and if there is no telltale evidence of violence, there is no way to determine the presence or severity of abuse.

Why, then, if domestic violence is so widespread, is there not more recognition of this problem by health care professionals? Early detection and intervention are of utmost importance in clinical practice. Discovering domestic violence is necessary for effective intervention (King & Ryan, 1989). Health care professionals chronically overlook or fail to identify women who are experiencing violence in their lives possibly due to knowledge and skill deficit or subject matter discomfort. Medical problems, acute or chronic, as a result of domestic violence are treated symptomatically while the social issue of abuse is not addressed. The medical establishment may be permitting a potentially fatal and chronic problem to exist and flourish by allowing domestic violence to remain private and personal (Yam, 1995).

Women seek medical attention for regular care in addition to attention for abuse-related injuries (Hamberger, Saunders, & Hovey, 1992). Women involved in domestic violence situations come to health care providers for treatment of their immediate problem, but the cause of the problem often goes unrecognized (Plichta & Weisman, 1995). An abused woman's complaints in the emergency department or office setting may be acute or chronic physical/medical injuries or problems, psychological problems, or self-destructive behavior (McCauley et al., 1995).

Domestic violence is a social public issue that begins with recognition of the problem (Hoff, 1993). Screening for violence is the first step in intervention. Health care

providers must begin to routinely screen for domestic violence with abuse-specific questions at each health care interaction (King & Ryan, 1996; Poirier, 1997). Women do not routinely volunteer to disclose abuse to their primary care provider but may answer honestly to a sensitively asked question (McFarlane, Christoffel, Bateman, Miller, & Bullock, 1991). Health care professionals have a moral, legal, and ethical obligation to address domestic violence (Orloff, 1996). The purpose of this study was to determine whether nurse practitioners screen for domestic violence in the primary care setting.

Significance to Nursing

Nursing practice. Domestic violence has been recognized in the literature as a monumental health care problem, but one which is neglected in clinical practice because of the sensitive, embarrassing, and private nature of the matter. Injury due to domestic violence is treated, but the cause of the injury is ignored or overlooked. Nurse practitioners are recognized as professionals providing health care to those in need. Inherent to the role are the medical, legal, and ethical responsibilities of delivering quality client care (Orloff, 1996).

Victims of domestic violence remain in regular contact with health care professionals no matter where they are along the abuse continuum. Recognition of domestic violence begins in the primary care setting by all health care providers with the message that abuse is not normal and will not be tolerated by society (Orloff, 1996). Screening for domestic violence should entail abuse-specific questioning of every female client at all health care interactions. Asking questions about domestic violence is the first step in early intervention (King & Ryan, 1989).

Nursing research. Nursing has addressed the impact of domestic violence on the female victim, her environment, and society through numerous journal articles. Research by nurses has revealed effective interview techniques for abuse disclosure (McFarlane et al., 1991). However, there is currently a lack of research data concerning nurse practitioners' screening practices for domestic violence. Findings from this study may serve as a primary empirical resource for other studies on this same topic and may generate increased awareness of the importance of the subject matter.

Nursing theory. This study is guided by Pender's Health Promotion Model. Pender (1987) focuses on the willingness of a person to make changes in behavior to promote a healthy lifestyle. Women in domestic violence situations must first be identified by nurse practitioners through vigilant screening practices before changes can be initiated. The nurse practitioner can assist with health-promoting behavior through intervention and client empowerment. The nurse practitioner serves as a supporter, not a facilitator (Blair, 1986). The client through self-choice and desire must make changes in behavior that increase health and well-being.

Nursing education. Awareness of the scope and impact of domestic violence is gained through education. This topic should be included in all nursing program curricula. Nurses in all levels and fields of care will encounter domestic violence at some time in their practices. Education should provide a comfort level with the subject and allow for accurate and effective screening measures and intervention.

Theoretical Framework

Pender's Health Promotion Model served as the theoretical framework guiding this study. The Health Promotion Model was chosen because health is viewed as a positive

state and individuals willingly move toward a healthier lifestyle through behavior changes. Pender (1987) described health promotion and behavioral change as motivated by the desire for increased levels of health and well-being coupled with elevating self-actualization. Pender reported that undesirable patterns must be replaced with new health-promoting and wellness behavior: "Health-promoting behavior represents man acting on his environment as he moves toward higher levels of health rather than reacting to external influences or threats posed by the environment" (p. 60). The focus of the model was on increased or improved health and well-being through individual behavior changes.

The Health Promotion Model is divided into three components of health-promoting behavior: (a) cognitive-perceptual factors (individual perceptions), (b) modifying factors, and (c) variable factors affecting the likelihood of action. Cognitive-perceptual factors are the primary motivational mechanisms for health-promoting behavior. These factors include the importance of health, perceived control of health, perceived self-efficacy, definition of health, perceived health status, perceived benefits of health-promoting behavior, and perceived barriers to health-promoting behavior. Pender (1987) believes that people will seek information about healthy behavior or lifestyle modifications if health is viewed as important. Health promotion and wellness will be increased if individuals perceive control over the environment and have the desire to enhance their health. People must strongly believe that they are able to change behaviors in order to promote a healthier lifestyle. Health is an individual matter and that personal definition influences health-promoting behavior. The positive side of health and wellness may be the motivation needed to maintain a healthy state. Healthy benefits from behavior changes must be obvious in order for a person to be willing to participate. Behavior

changes that promote health promotion and wellness might not be possible for everyone (Pender, 1987).

Modifying factors act indirectly on the cognitive-perceptual mechanisms. These include demographic factors, biological factors, interpersonal influences, situational factors, and behavioral factors. Demographic factors include age, race, sex, ethnicity, income, and educational level. Biological factors include all that is inherited that makes the individual unique. Interpersonal factors that influence healthy behavior include interactions with family members, health care personnel, and significant others. Health-seeking behavior can be impacted by previous interactions with the health care system or professionals. Situational factors are options, opportunities, willingness, or availability and access by the individual to health-promoting choices or alternatives. Behavioral factors include past experience with health-promoting behavior (Pender, 1987).

Cues to action, whether internal or external, promote health-promoting behavior. Cues trigger action that results in a specific behavior. Behavioral changes will be guided by client readiness (Pender, 1987).

Women in domestic violence situations seek health care on a regular basis as well as for abuse-related injuries. These women must be convinced that abuse is wrong and that someone cares about them before health-promoting behavior can begin. Pender's (1987) model directs the nurse practitioner toward client empowerment. Women in abusive situations make lifestyle choices and assume responsibility for these choices. The first step, screening for domestic violence, can possibly facilitate health care behavior changes.

Assumptions

For the purposes of this study, the following assumptions were made:

1. Domestic violence is criminally, morally, and ethically wrong.

2. Nurse practitioners can choose to screen or not screen for domestic violence in their clinical practice.

3. Screening practices of nurse practitioners can be measured.

4. Client abuse disclosure can lead to health-promoting behavior and increased well-being.

Statement of the Problem

Domestic violence is a serious health care problem that impacts women's lives medically, socially, and psychologically. Women utilize health professionals for regular health care in addition to abuse-related sequelae. Domestic violence remains a private or taboo subject, often overlooked during health care encounters. Abuse-specific questions need to become a part of regular practitioner-client interaction. Screening for domestic violence will aid in recognition, thereby making this a public issue and beginning the first step in intervention. Asking the question informs the client/woman that someone cares. Validation and empowerment promote healthy behavior changes (Paluzzi & Houde-Quimby, 1996). Therefore, the problem addressed in this study was whether nurse practitioners screen women for domestic violence in the primary care setting in the state of Louisiana.

Research Question

The following research question serves to guide this study: Do nurse practitioners screen for domestic violence against women in the primary care setting?

Definition of Terms

For the purpose of this study, the following terms were defined as follows:

1. Nurse practitioner:

Theoretical definition: A nurse practitioner is a certified advanced practice nurse prepared to deliver care in the specific area of family, adult, acute care, women's health, or gerontology or as a nurse midwife through a formal educational program that meets established guidelines determined by the profession (American Nurses Association, 1996).

Operational definition: A nurse practitioner in the state of Louisiana whose name appears on the list of nurse practitioners who are currently certified as family, adult, acute care, women's health, gerontologic, or nurse midwife practitioners.

2. Screen:

Theoretical definition: To screen is to separate or distinguish pertinent or valuable information by some process (Stein, 1973).

Operational definition: Specific abuse-related questions will be asked at every health care meeting or encounter by the nurse practitioner to all women who present to the office for regular health care.

3. Domestic violence:

Theoretical definition: Domestic violence is a pattern of power and control involving physical, emotional, psychological, sexual, economic, and social abuse and isolation (Alpert, 1995).

Operational definition: A male partner (husband/current/past significant other) using physical, sexual, emotional, economic or verbal abuse on his current/past female partner.

4. Women:

Theoretical definition: The female gender.

Operational definition: All female persons.

5. Primary care setting:

Theoretical definition: Outpatient or community setting where basic level of accessible, comprehensive, coordinated, continuous and accountable health care is provided that emphasizes the client's general health needs (Hickey, Ouimette, & Venegoni, 1996).

Operational definition: The practice sites of the nurse practitioners who responded to the Revised Education/Experience Questionnaire.

Summary

Domestic violence produces major health care problems for women. Recognition and intervention of this problem should begin in the primary care setting with the nurse practitioner. If specific abuse-screening questions were a part of every practitioner-client interaction, then domestic violence would become a public rather than private issue to health care professionals. This chapter provides an introduction to the research problem by exploring domestic violence and the role of the nurse practitioner in screening for domestic violence in the primary care setting.

In chapter II, literature pertinent to this study will be reviewed and discussed. The method for empiricalization of this study will be described in chapter III. A presentation

of the findings of the research and a summary of the data will be presented in chapter IV. Finally, in chapter V, findings from the research will be interpreted, and conclusions drawn from the interpretations will be presented with implications for nursing.

Chapter II

Review of the Literature

A review of the literature revealed extensive documentation on the incidence and prevalence of domestic violence. This foundational literature was important for the current study because it revealed the need for recognition of women in domestic violence situations or lifestyles through screening and detection. These same studies documented that domestic violence was considered a private issue and would remain so until attitudes, policies, and techniques regarding domestic violence change. No research was found on screening practices of health care professionals, especially nurse practitioners, for domestic violence in the primary care setting. Therefore, this chapter provided a basis for the current study of screening women for domestic violence by nurse practitioners in the primary care setting.

Domestic violence represents a serious health hazard to women. A study by Abbott et al. (1995) provided information about women seeking care in the emergency department for domestic violence-related problems. The researchers determined the incidence, 1-year prevalence, and cumulative prevalence of domestic violence among female emergency department patients. The study was undertaken to answer four questions about violence by male partners against women: (1) What is the incidence of acute domestic violence in an unselected female emergency department population? (2) What is the cumulative prevalence of domestic violence exposure, recent or past, in

females seeking medical attention in an emergency department? (3) Can women with previous domestic violence exposure be identified by clinical or demographic attributes? and (4) What proportion of women who seek care in an emergency department after acute domestic violence exposure are detected by emergency department staff?

This descriptive study surveyed women ($N = 833$) who presented for care in five study sites in metropolitan Denver, Colorado, during the designated surveillance periods. Of the five locations, three were emergency departments: (a) a municipal level I trauma center with a census of 45,000 visits a year; (b) a teaching hospital emergency department with 45,000 visits a year; and (c) a private hospital emergency department servicing a middle- and upper-class community with a census of 25,000 visits yearly. The other two locations were walk-in clinics: (a) the city's episodic care clinic with a census of 27,000 visits yearly, and (b) a non-acute clinic servicing 4,000 non-urgent clients yearly. Women less than 18 years of age or those who had participated in the study during a previous emergency department visit were excluded. Data were collected in 30 randomly selected 4-hour time blocks in April and May of 1993 for a total of 120 hours of surveillance at each site.

The researchers developed a seven-page 34-item written questionnaire prepared in both English and Spanish. Survey items addressed acute (incidence) and non-acute domestic violence (1-month and cumulative prevalence), demographics, ethanol use, frequency of medical care visits, marital status, prior suicide attempts, presence of guns in the house, possible pregnancy, employment status, and education.

All eligible women who presented to the emergency departments or clinics during the designated time blocks were invited to participate in the study. Trained research

assistants explained the study and obtained informed consent. Assistance was available for survey completion. Written pamphlets on domestic violence and local resource telephone numbers were offered to all participants.

Abbott et al. (1995) reported a 78% survey response rate (648 of 833 surveys completed). Survey completion responses varied by site; 72% were completed in the private and university emergency departments, while 90% were completed at the university clinic. Respondents were (a) young with the median age being 34 years, (b) 62% were unemployed, (c) 48% were non-white, (d) 49% had annual household incomes less than $10,000, (e) 65% were involved with a male partner at the time of the study, (f) 7% were pregnant, and (g) 50% had prior suicide attempts, home firearm storage, and problems with ethanol use.

Data analysis on incidence, 1-month, and cumulative prevalence rates of domestic violence were calculated with 95% confidence intervals (CIs), and correlates of domestic violence were examined. Of a sample size of 418 (65% of $\underline{n}$ = 648) women involved with a male partner during the survey period, 403 answered questions about acute domestic violence. Women with partners presented to the emergency department 11.7% (95% CI, 8.7% to 15.2%) due to the incidence of acute domestic violence. There were no significant correlations between the acute incidence of domestic violence and race, age, income, education, past suicide attempts, alcohol use, or pregnancy. Domestic violence incidence rates differed between the private emergency department (9%) and the city emergency department (17%) (P = .56). Only 19 study participants (2.6%) reported being asked or volunteering information about acute domestic violence to health care providers.

Chart review of every available medical record (828) for the diagnosis of domestic violence revealed that acute domestic violence was recorded in only two charts.

Abbott et al. (1995) also found that 351 women (cumulative prevalence, 54.2%; 95% CI, 50.2% to 58.1%) out of the sample (n = 648) had been threatened or physically injured by a male partner at some time in their lives. Cumulative prevalency rates were different between the city clinic (48%) and the university clinic (61%) (p = .10). Women with past domestic violence exposure (cumulative prevalence) had positive correlations between suicide attempts (81%), excessive alcohol intake (71%), and younger age (34.4 +/- 12.1 years). The researchers also found that 77 women (11.9%; 95% CI, 9.5% to 14.6%) had been threatened or injured within the past month (1-month prevalence).

Abbott et al. (1995) concluded that 11.7% (1 in 9) of the women with male partners who presented to the emergency department on any given day were there because of acute domestic violence, i.e., physical assault or threat or fear of assault. Cumulative prevalency rates for domestic violence were strikingly high in that 54.2% of study participants had been assaulted, threatened, or made to feel afraid by partners at some time in their lives. Twelve percent of the sample had experienced domestic violence within the past month. The study also verified that women exposed to domestic violence were involved in other harmful behaviors such as alcohol problems and suicide attempts and exhibited feelings of fear, danger, isolation, and entrapment. The study confirmed that domestic violence was not restricted to the indigent, uneducated, minority women using public hospitals for care. The study also demonstrated that physicians did poorly on detection and documentation of domestic violence patients.

The researchers felt this study may be more representative of the current status of domestic violence due to large sample size and multiple sample sites. Almost all patients, critical and non-critical, were included in the study. The sample tool was carefully designed to separate incidence prevalence (Abbott et al., 1995).

Domestic violence and its sequelae are a frequent reason for women presenting to the emergency department for medical care. This study by Abbott et al. (1995) was relevant to the current study as it verified that health care providers are not screening for domestic violence and strengthened the need for early detection by health care providers. The researchers also verified that all women regardless of race, age, social class, culture, and marital status could be potential victims of domestic violence. Therefore screening is necessary for recognition.

Women with injuries or illnesses related to acute and chronic domestic violence often go unrecognized in their quest for medical care. The San Francisco Family Violence Project, established to provide legal, social, and psychological support to victims of domestic violence, has been San Francisco General Hospital Medical Center's referral source since 1983. Information on the victim, the batterer, the victim's children, and the injuries incurred are collected on standardized data forms through staff-led structured personal interviews. Berrios and Grady (1991) reviewed information on women who presented to the emergency department with injuries due to domestic violence. Data analysis was performed to describe the risk factors and outcomes of domestic violence.

Study results were based on 218 cases ($\underline{N} = 492$). Lack of questionnaire completion due to victim decline or unavailability of subject for interview completion constituted the

remaining excluded cases (n = 274). Results based on means, standard deviations, medians, and ranges were calculated using the Statistical Analysis Software package.

Berrios and Grady (1991) found that the age range of women was from 16 to 66 years (median age, 29 years; standard deviation, 10 years); the age range of the assailants was from 19 to 72 years (median age, 31 years; standard deviation, 10 years); the victims and batterers were ethnically heterogeneous; and 27% of women were employed, 27% received public assistance, and 7% depended solely on the batterer for financial support. The researchers also verified that the majority of victims were current or former girlfriends (51%) or wives (42%) of the batterer. Length of relationships was between 1 month and 30 years (median time, 3 years) and 67% of the women were living with the batterer at the time of the incident. Alcohol and drugs were commonly identified by the victims as batterer problems (48%) and were involved in past episodes of domestic violence (43%).

Repeat abuse was found to be common by Berrios and Grady (1991). Women reported at least one previous episode of abuse (86%) with medical attention (40%) or hospitalization (13%) required. Pregnancy was not a deterring factor in domestic violence. Abuse was reported during a current pregnancy (10%), during a past pregnancy (30%); or as causing a miscarriage (5%). Suicide attempts were made by 16% of the victims. The researchers also noted that children lived in households where domestic violence took place (51%), had witnessed abuse (35%), and had been abused by the batterer (10%).

Berrios and Grady (1991) documented types and location of injury or abuse. A significant number of women required hospital admission for treatment of injuries (28%)

and major surgical interventions (13%). Treatment modalities included (a) radiographic studies (41%), (b) stitches or casting (25%), and (c) medications (27%). Injuries included (a) loss of consciousness (11%); (b) permanent disfigurement, hearing loss, or visual impairment (5%); (c) bruises (70%); (d) lacerations (39%); (e) choking or strangulation (23%); (f) musculoskeletal injuries (bone fracture, tendon or ligament injuries, or joint dislocation[25%]); and (g) internal injuries (13%). The face, skull, upper trunk, and extremities were the frequently assaulted areas of the body. Weapons such as knives, clubs, or guns were involved in one third of the injuries.

Berrios and Grady (1991) concluded that domestic violence crossed all racial borders and that victims ranged in all ages. The researchers recommended that the possibility of abuse be considered as the cause of injury in all women regardless of age or background. Fear or psychological dependence should be considered as reasons why women remain in abusive situations since financial dependence was not a key factor in this study. Domestic violence intervention to include physical separation from the batterer did not guarantee victim protection, as not all victims were living with their abusers at the time of their injury. The researchers suggested that women leaving abusive relationships were not receiving adequate police and judicial protection.

The study revealed that domestic violence caused considerable morbidity, with 28% of the participants requiring hospitalization. In addition, pregnancy was found to possibly increase the risk of abuse. Berrios and Grady (1991) recommended that abuse-directed questions be asked to all pregnant women with injuries. Another recommendation was that child abuse questions be asked in any domestic violence episode.

Domestic violence was documented as a recurrent problem in the study with 86% of the victims being abused in the past and 40% needing medical attention. The study suggested that repeated violence may cause chronic abuse-related medical problems and psychological disorders such as depression and alcohol and drug dependency. The researchers further recommended that all primary care providers and emergency department personnel consider the possibility of abuse if injuries are centered in the areas of the head, trunk, or extremities, and if similar injuries were sustained in the past (Berrios & Grady, 1991).

This research was relevant to the current study as it reiterates the magnitude of the problem and the severity and chronicity of injuries and medical sequelae related to domestic violence. It reinforced the need for recognition of women involved in domestic violence situations by the primary care provider. Health care will be enhanced if health care providers become more aware and alert to the prevalence and risk factors of domestic abuse (Berrios & Grady, 1991).

Plichta and Weisman (1995) conducted a study to determine the relationship of abused women to the use of health care services and to unmet needs for health care. The researchers hypothesized that abused women would have an increased utilization of health care services and would experience higher unmet needs for care. Health care services are delivered for the injury or complaint. Unmet needs for care are not addressed because the physicians routinely fail to identify violence as the source of the woman's health care problem.

This descriptive study used data from a nationwide telephone cross-sectional survey conducted between February 10, 1993, and March 21, 1993. Sampling was by

stratified random sample of all households in the United States. Plichta and Weisman (1995) used data analysis based on 1,324 surveyed women (N = 2,525) who were under the age of 65 and involved during survey sample time with a male partner.

For this study, use of health care services by women was measured by predisposing, enabling, and need factors. Use of health care services for the past year was measured by the number of physicians seen, the number of physician visits made, and whether medical care had been needed but not obtained (unmet needs for care). Predisposing variables included age, ethnic background, education level, marital status, and children under the age of 18 in the household. Enabling variables measured income level, welfare benefits, health insurance, geographic location, use of emergency department for regular care, regular medical physician, and self-esteem levels. Need variables included a self-rating of physical health (based on a scale of poor to excellent), the presence of a disability, having a chronic condition, having a diagnosis of anxiety or depression within the last 5 years, having depressive thoughts, or having suicidal thoughts in the past year.

Plichta and Weisman (1995) oversampled to insure a good representation of the African-American and Latina population. Chi-square tests were used to measure statistical differences between women exposed and not exposed to violence when variables were both categorical (nominal or ordinal). T-tests were used when one variable was continuous and the other was categorical. Multiple logistic regression was used for multiple predictors of dichotomous outcomes. A P-value of 0.05 or less was considered to be statistically significant.

Plichta and Weisman (1995) found that women reported abuse exposure (8.4%) to severe abuse (3.2%) by their live-in partner in the past year. Based on the 1991 U.S. Census, the researchers estimated that 4.409 million women were physically abused by their significant other and that 1.680 million of those same women were exposed to severe abuse. The researchers also found that abuse exposure was significantly related to the predisposing, enabling, and needs factors. Abuse was reported within the past year by younger, African-American, less educated, cohabiting females with children under the age of 18. Women with incomes less than $15,000 yearly, receiving welfare supplements, living in the central city or rural areas, having no insurance, having no regular physician, using the emergency department for regular medical care, and having low self-esteem reported more abuse exposure. Positive correlation was found between need variables and abuse exposure with the exception of having a disability. Plichta and Weisman found no significant difference in the number of physicians seen or the number of physician visits in the past year between abused and non-abused women. Women in abusive relationships were three times more likely to have unmet needs for medical care within the past year.

Multiple logistic regression analysis modeled the predictors of unmet need for care with predisposing, need, and enabling factors related to victim abuse and unmet need for care. Controlling for all factors, victim abuse or exposure created unmet needs for care by a factor of 2.19. Need variables significantly related to unmet need for care included having a disability or a diagnosis of depression or anxiety. Predisposing and enabling variables with significant correlation to unmet need for care included living in the central city, low self-esteem, no health insurance, no regular source of income, and younger age.

Plichta and Weisman (1995) concluded that abuse victims' needs for medical care were not being met regardless of other reasons for seeking care. Abused women, who had a greater need but a poorer access to health care, were younger (under 25 years) and nonwhite, had lower education levels and incomes, lived in central city or rural settings, had no health insurance, accessed the emergency room for regular medical care, had low self-esteem, and had more mental problems. The researchers suggested that women with health care needs due to domestic abuse or violence do not have access to health care for their health care needs. Plichta and Weisman also concluded that women involved in domestic violence maintain contact with health care providers for problems not associated with abuse-related injuries.

This research was relevant to the current study in that it validates the prevalence of domestic violence and its impact on the health care of women. The study acknowledged that women in abusive situations are not having needs met and that these same women use health care providers for non–abuse-related injuries. Plichta and Weisman (1995) recommended that all women accessing the health care system should be routinely screened for domestic violence. If domestic violence remains a private issue, women in abusive situations will continue with needs unmet by health care professionals and the health care system.

Domestic violence has been recognized as a serious health care problem. McCauley et al. (1995) conducted research on domestic violence in one of the largest primary care patient populations. The extensive sample population allowed the researchers to declare similarities between the sample and the United States population in regards to percentage of married women, percentage of women with private insurance, and percentage of

women in each income level. This study was performed to determine domestic violence prevalence among female patients and identify clinical and demographic characteristics between abused and non-abused patients.

This descriptive study (McCauley et al., 1995) surveyed the adult female population of four community-based primary care internal medicine practices in the Baltimore, Maryland, area. The four clinics served over 23,000 adult patients. Cross-sectional data collection took place for one to two months in each clinic between February and June 1993. A total of 3,203 female patients presented to the clinics during the study time. Study participants (n = 1,952) came from those eligible patients (N = 2,392) who had been approached during the study period and had completed the survey tool. Office nurses requested patient participation after determining participant eligibility. Study purpose was explained, anonymity was guaranteed, and survey completion was done in private before the patient was seen by the physician.

McCauley et al. (1995) developed a self-administered questionnaire called The Women's Health Questionnaire. The tool consisted of approximately 85 questions and took 5 to 7 minutes to complete. Two questions identified whether current domestic violence was present or not. Questions on the frequency and severity of present abuse, physical or sexual abuse as a child or adult, alcohol abuse, and emotional status were identified on the survey. Questions on demographic characteristics, physical symptoms, psychiatric history, street drug use, current medications, and medical history were also included.

McCauley et al. (1995) found from the total sample (n = 1,952) that 108 (5.5%) women had experienced domestic violence during the past year; 418 (21.4%) had been

physically or sexually abused at some time in their adult life; 429 (22.0%) had been physically or sexually abused before 18 years of age; and 639 (32.7%) had been physically and sexually abused as an adult and child. The researchers identified abuse (n = 108) experienced during the past year as "high-severity" (threatened or hurt with a weapon, choked, burned, hit, kicked, or sustained injuries with broken bones or head or internal trauma [49%]) or "low-severity" (threatened, grabbed, pushed, cuts or sprains, slapped, hit, or kicked with or without bruises [51%]). Demographic characteristics found to be associated with current domestic violence included younger age (less than 35 years of age); single, separated, or divorced; living with a male or family members other than husband; no health insurance or receiving medical assistance; and annual income of less than $10,000. Additional risks included higher depression ($p < 0.001$), anxiety ($p < 0.001$), somatization ($p < 0.001$), lower self-esteem ($p < 0.001$), partner with a chemical dependency problem (43%) or victim with a dependency problem, suicide attempts (21.5%), use of the emergency department for care within the past 6 months (34.9%), and more physical symptoms associated with abuse (loss of appetite, frequent or serious bruises, nightmares, vaginal discharge, eating/vomiting cycle, diarrhea, broken bones/sprains/serious cuts, pelvic/genital pain, fainting/passing out, abdominal/stomach pain, urinary problems, chest pain, sleeping problems, shortness of breath, and constipation). Logistic regression found that specific sociodemographic variables (age < 36 years, separated or divorced, and with no health insurance or using public assistance), psychosocial variables (any emotional symptom, chemical dependency problem, or

suicide attempt), and physical variables (broken bones/sprains/serious cuts, diarrhea, and vaginal discharge) were associated with a higher level of abuse ($p < 0.001$).

McCauley et al. (1995) felt that due to sample size, the study represented a diverse segment of the population in terms of age, race, education, marital status, and family income. Study results supported the concept of the "battering syndrome" in which increased medical and emotional complaints and problems followed physical abuse. The researchers concluded that currently abused women had more physical complaints, higher emotional problems, lower self-esteem, more likelihood of being abused by a partner on alcohol or drugs or themselves using alcohol or drugs, more suicide attempts, or more use of the emergency department within the last 6 months for medical care. In addition, nine sociodemographic, psychological, and physical risk factors had a higher association with abuse as the number of risks increased. Abusive disclosure to physicians by patients was reported by only 15.7% of patients. In addition, McCauley et al. found that 1 out of every 20 women had past exposure to domestic violence, 1 out of every 5 women had exposure to violence in her adult life, and 1 out of every 3 women had exposure to violence as an adult or child.

This study was evidence of the severity and magnitude of the problem of domestic violence. Due to the significant medical health problem, McCauley et al. (1995) recommended that physicians screen all women for domestic violence, especially those female patients who present with multiple somatic symptoms or emotional distress. Detection of domestic violence by physicians and other health care professionals may change diagnostic and treatment modalities for these women.

Hamberger et al. (1992) designed a study to identify the incidence and prevalence of spousal abuse among women who utilized a family practice clinic for health care needs. The researchers hypothesized that about 20% of the women surveyed would report being victimized within the past year and that 50% would report being victimized some time in their lives. The researchers also hypothesized that physician inquiry detection rates would be one tenth the reported rate of violence.

This descriptive study surveyed the female population within a community-based family practice residency training clinic in a medium-sized Midwestern community. Cross-sectional data collection occurred in the summer of 1991. A total of 476 potentially eligible women attended the clinic during the study period.

Convenience sampling was used to access the population. The sample represented all ethnic, racial, and socioeconomic groups from the community. Two groups of women, victims and nonvictims, were screened for eligibility and participation. Prospective participants were approached before the physician visit. If this protocol could not be followed, participants were approached before leaving the clinic after the visit or contacted at home on the day of the visit. Participants were informed of the nature of the study, asked if they would be willing to participate, and screened for inclusion in the study. Criteria for study inclusion were women between the ages of eighteen and twenty-five in a committed relationship of at least six months, willing to participate in the study, free of dementia, and able to speak English. Informed consent was obtained and questionnaires were administered (Hamberger et al., 1992).

Survey questionnaires for demographic data focused on age, race, religion, and educational attainment. Relationship status, history of domestic assaults, physician visits,

and physician inquiry about relationship stress and abuse were also assessed through survey questionnaires. The Conflict Tactics Scale was used to assess verbal and physical aggression, current or lifetime, during an intimate relationship. Participants ($N = 374$) completed the entire survey for a response rate of 78%.

Pertinent variables were not well identified or operationalized in the study. Domestic violence was never defined. Spousal abuse was based on the Conflict Tactics Scale. Nineteen items presented in order of increasing abuse measured the severity and frequency of intimate violence. The definition of "at risk" included women in the past year who were involved in intimate relationships, recently separated, or divorced. Office visits were operationalized during the course of the study as brief or extended. Extended visits for complete histories, physical examinations, first obstetrical (OB) screenings, or psychosocial assessment/counseling sessions were more conducive to questions of abuse or abusive relationships.

Hamberger et al. (1992) found that differences in race and educational attainment were not significant between recently battered and nonbattered women. There were significant differences in age, marital status, and length of relationships. Victims were younger (age 28.9 versus age 37, $p < .0001$), more likely to be separated or divorced ($p < .0001$), and in relationships of shorter duration (7.6 years versus 14.5 years, $p < .001$). The researchers identified women at risk ($n = 85$) who had been assaulted in the past year for an incidence rate of 22.7%. An incidence rate of 25.1% was found when those at-risk women were compared with the total at-risk population ($N = 338$). Domestic assault injury rate in the past year for all women in the study was 13.3% versus 14.8% injury rate for at-risk women.

A 38% prevalence rate of abuse was found based on 335 responses; 130 women reported some degree of physical abuse in their lifetime. A 24.7% lifetime injury rate was reported based on 351 responses. Injury included anything from bruising to severe injury.

Based on a sample size of 365, physicians asked 6.5% of the women about their relationships, 2% of the women about verbal abuse, and 1.7% about physical abuse. Further analysis of those women who could document an extended visit ($n = 111$) showed higher inquiry rates for relationship problems, 15.8%; verbal abuse, 9.4%; and physical abuse, 7.7%. Recent victims of abuse were more likely to have been asked about general relationship problems than nonvictims, 20.5% versus 7.5% respectively ($p < .002$).

Hamberger et al. (1992) concluded that study results and predictions were fairly comparable. The study predicted a 20% incidence rate of domestic abuse. Twenty-three percent of all eligible women surveyed and 25% of at-risk women were subject to abuse within the past year. A 38% prevalence rate of abuse was obtained while a 50% rate had been predicted. Predicted physician inquiry rates, one tenth of victimization rates, were between 2% and 5%. The rate of verbal and physical abuse inquiry was considerably higher for extended visits than the rate of inquiry for all visits, verbal 9.4% and physical 7.7% versus verbal 2% and physical 1.7%, respectively.

Hamberger et al. (1992) verified that current and lifetime abuse rates in an outpatient setting were consistent with studies of women using emergency rooms for episodic events of violence. Physician inquiry and detection rates were low, especially for physical abuse. Women most in need of recognition were those in current or recent abusive relationships due to safety issues. Low verbal and physical inquiry levels

confirmed physician needs for domestic abuse training programs to identify, assess, and intervene.

Hamberger et al. (1992) recommended that the study be replicated in different clinics, including private clinics, to obtain a more diverse and representative population. Extended office visits should be the index for physician inquiry assessment. A reasonable time frame for extended office visits should be operationalized so memory does not bias the study.

This study emphasized the need for recognition and screening of domestic violence. Physicians may not routinely address the sensitive issue of domestic violence possibly due to lack of training, skill, and knowledge. Abuse inquiry may be difficult, but if women are screened at every health care interaction a comfort level will be reached (Poirier, 1997). Health care providers have a moral and legal responsibility to actively screen for domestic violence (Orloff, 1996). Asking direct nonjudgmental abuse questions to all clients as the first step in intervention allows the women the opportunity to break the silence (Blair, 1986).

Routine abuse-directed questions should be an essential part of any practitioner-client interaction. McFarlane et al. (1991) designed a study to compare the most effective screening format for abuse disclosure. The researchers utilized two methods of assessment, a self-report instrument versus a nurse interview, to determine which would permit more open abuse disclosure by female patients.

This descriptive exploratory study surveyed women ($N = 777$) scheduled for initial or annual medical visits needing contraceptive measures at the Planned Parenthood clinics of Houston and Southeast Texas. Two groups of women with similar demographic

characteristics took part in the study. One group (n = 477) comprised the self-report sample. The second group (n = 300) comprised the nurse interview sample. Most (81%) of the women were under thirty years of age and never married. White, Black, and Hispanic ethnicity were proportionally similar.

To determine the self-report abuse group, 793 social history and abuse-focused question assessment forms were evaluated over a one-month period. Women (n = 477) at the chosen clinic reported abuse through self-report intake forms. Clients completed forms in the waiting room before being seen by the health care provider. Forms were reviewed in private, and appropriate counseling, education, and referral information were offered.

No data collection time was given for interview format. Random selection provided sampling of women (N = 300). The purpose of the interview was explained and informed consent obtained. Confidentiality was guaranteed, as was assurance that study participation could be withdrawn without loss of Planned Parenthood services. Social history and abuse-focused questions identical to those on the self-report forms were asked. Along with a private environment, confirmation of no right or wrong answer, and freedom to ask questions during the interview, responses were recorded. Upon completion of the interview process, the women were allowed to ask questions before being given information on available community resources.

McFarlane et al. (1991) found that response rates to abuse disclosure were significantly higher with interview format than with self-report. Women reported more physical abuse by their significant other through interview (29.3%) than through self-report (7.3%). Women reported more abuse during pregnancy through interview (8.3%)

as compared to self-report (1.5%). Interview format (14.7%) revealed more sexual abuse than did self-report (1.3%). Women reported more fear of their partner by interview (22.7%) as compared to self-report (2.1%). More overall information was obtained by interview, with abuse questions producing the most notable difference.

McFarlane et al. (1991) concluded that face-to-face interview produces significantly higher rates of abuse disclosure than does self-report. Abuse, described as extremely personal and highly embarrassing, requires trust and rapport for sensitive information disclosure. This rapport and trust cannot be established through self-report. Women are more likely to discuss abuse if they perceive the interviewer as responsive, trustworthy, and nonjudgmental.

This study was relevant as it verified that comprehensive and effective abuse screening takes place through direct questioning in a safe, non-threatening environment. The McFarlane et al. (1991) study was significant to the current study because it verifed that nurse practitioners are in a unique position to recognize and intervene in this destructive pattern of violence during routine and initial health care meetings by asking abuse-specific questions. Health care professionals in all settings must actively assess for domestic violence at each health care interaction and offer education, counseling, and referral information (McFarlane et al., 1991).

Martins et al. (1992) defined wife abuse as physical, emotional, psychological, sexual, or economic behavior that maintains power, control, fear, or intimidation in a relationship. They verified that it has been identified in all socioeconomic, ethnic, and racial groups of women. Detection, documentation and intervention by health care providers have been disappointingly low and have not kept pace with occurrences.

Women use primary care providers for regular medical care in addition to abuse-related injuries (Hamberger et al., 1992).

The researchers (Martins et al., 1992) designed a study to compare the prevalence of wife abuse with frequency of documentation by family physicians. A simple descriptive study surveyed women in an urban teaching hospital family practice unit. Cross-sectional data collection took place over a two-week period at Women's College Hospital Family Practice Unit, University of Toronto.

Screening for eligibility was by chart review and was completed one day prior to patient physician contact. Information obtained from the charts included chart number, patient's age, marital status, documentation of wife abuse, and the number of office visits between 1989 and 1990. Subject exclusion criteria included women under sixteen years of age, single, less than two office visits, and unable to speak English. Letters of introduction and questionnaires were placed on eligible charts after completion of a thorough chart review. Patients completed surveys in private before meeting with physicians and sealed surveys in envelopes to assure confidentiality.

The Conflicts Tactics Scale served as a model for the questionnaire. Twenty-six questions asked basic demographic and abuse information. Abuse was divided into mental and physical abuse. There was a 72% response rate (275 of 383 surveys returned). Ninety-four percent ($N = 274$) of the returned surveys were missing no information. Medical and nursing staff were briefed in anticipation of study-related sequelae. Statistical analysis was done using Statistical Analysis Software package.

Martins et al. (1992) found that the average age of participants was 36.2 years by patient survey and 38.1 years by chart survey. Eighty-two percent of the participants were

married, 12% were involved in common-law arrangements, and both groups cohabited an average of 9.7 years. Thirty-five percent of the women answered yes to one (23%) or more (12%) mental abuse questions. Twelve percent of the participants answered yes on one physical abuse question, while 7% answered yes to two or more questions. This 7% served as the prevalence rate of abuse. Only 1% of the surveyed women were admitted to emergency room treatment for abuse. There were no significant differences between married and common-law participants for either the mental or the physical abuse categories. Participants ranked physicians high on caregiving skills yet did not feel comfortable with abuse disclosure. Reasons given focused on health record confidentiality or the sensitive, private nature of abuse. Documented wife abuse on surveyed charts ($N = 383$) was extremely low ($n = 4$), 1% ($p = .0001$).

Martins et al. (1992) concluded that physician documentation was unsatisfactory and deficient, while physical and mental abuse results, 7% and 23% respectively, were consistent with past studies. Martins et al. suggested that easy access to patients' charts by medical personnel could jeopardize patient confidentiality, therefore affecting documentation. The researchers also recognized that physician education and training about female abuse has been neglected. The authors proposed that wife abuse detection would increase if designated programs and protocol were established and practiced consistently by health care providers.

This study by Martins et al. (1992), although limited, was applicable to the current research. The researchers acknowledged that identification of women in domestic violence situations is challenging to all health practitioners. Domestic violence detection requires a standard screening protocol and direct abuse inquiry (Poirier, 1997). Health

care professionals have a moral, legal, and ethical obligation to their patients to question/screen and document real or potentially harmful situations (Orloff, 1996). The first and hardest step is asking (Flitcraft, 1990; Warshaw, 1993).

Summary

In conclusion, the review of the literature addressed research focused on domestic violence. The common theme that emerged was the lack of recognition of women involved in abusive situations by health care professionals. All studies recommended that routine domestic violence screening be made a part of practitioner-client interaction. Abbott et al. (1995) verified that women in abusive relationships used emergency departments for medical care. Berrios and Grady (1991) documented that domestic violence was a recurrent problem with severe and chronic injuries and medical sequelae. Plichta and Weisman (1995) concluded that health care needs of women involved in domestic violence were going unmet due to lack of recognition of the problem. McCauley et al. (1995) and Hamberger et al. (1992) reported that domestic violence was common in the primary care setting and presents a significant medical public health problem. McFarlane et al. (1991) described effective screening format for abusive disclosure in the primary care setting. Martins et al. (1992) confirmed that physician documentation of domestic abuse was deficient on chart review.

The information obtained through the review of the literature served to verify the need for screening for domestic violence. The need exists for research on the topic of nurse practitioner screening practices as no information is available at this time. The current study will attempt to verify nurse practitioner domestic violence screening practices within the state of Louisiana.

Chapter III

The Method

The purpose of this study was to determine whether nurse practitioners screen for domestic violence against women in the primary care setting within the state of Louisiana. The empiricalization of the study is discussed in this chapter. The limitations are explained and the setting, population, and sample are identified.

Design of the Study

The research design for this study was descriptive survey research. Data collection through observation, description, or classification was utilized to obtain information about a particular event of interest. Face-to-face interview, telephone interview, or questionnaire are forms of data collection used in survey research (Polit & Hungler, 1995). Using questionnaire format to collect information about nurse practitioner domestic violence screening practices within the state of Louisiana, the study qualified as descriptive survey.

Variables. For this study, the variable of interest was the screening practices of nurse practitioners for domestic violence against women within the primary care setting. Controlled variables included the geographic location of the study and the professional certification status of the partcipants. Intervening variables may have included the degree of nurse practitioner honesty on question response and subject biases based on previous or present life experiences with the research.

Setting, Population, and Sample

The setting for this sample was the state of Louisiana. A recent report of data gathered from the U.S. Census, state agencies, population surveys, the National Center for Health Studies, and the Internet showed striking statistics about the female population in Louisiana. Louisiana ranked Number 1 in the percentage of women residents who live in poverty. Women in Louisiana have the third highest rate of unemployment nationwide, and proportionally more end their formal education with high school then do women nationwide. Even with the increased notoriety of domestic violence, no statistics on the subject could be found. State laws mandate reporting of domestic violence (Treadway, 1998). Nurse practitioners are found from the rural to the urban setting delivering quality health care and are required to report domestic violence.

The accessible population consisted of all family, adult, acute care, women's health, and gerontologic nurse practitioners and all certified nurse midwives currently listed with the Louisiana State Board of Nursing and residing in the state. Advanced practice nurses in Louisiana are not classified according to professional certification; therefore, questionnaires were mailed to all 451 nurse practitioners registered with the Louisiana State Board of Nursing. A convenience sample was utilized and included 158 participants who returned the designated questionnaire and who met the inclusion criteria for the study (family, adult, acute care, women's health, and gerontologic nurse practitioners and certified nurse midwives residing in and certified to practice in the state of Louisiana by the Louisiana State Board of Nursing).

Method of Data Collection

Instrumentation. The instrument selected for recording data in the study was the Education/Experience Questionnaire. The Education/Experience Questionnaire was originally developed by Dr. Christine King in 1988. Written permission to use and modify this tool was requested from the author (see Appendix A). Telephone permission was obtained and a follow-up letter confirming permission was sent (see Appendix B).

The researcher added seven questions to the original questionnaire and discarded questions that focused on basic nursing demographics. Questions 5, 6, 7, 9, and 10 solicited pertinent nurse practitioner demographic data pertaining to specialty area, certification, current practice setting, years in practice and location of practice. Question 15 addressed comfort level with domestic violence questioning. Question 16 surveyed whether nurse practitioners asked questions on domestic violence. The terminology in six questions—8, 11, 12, 14, 18, and 19—was altered or modified. Question 8 required different catagories of practice settings to incorporate the expanded role of the nurse practitioner in the state of Louisiana. In question 11, "basic nursing curriculum" was changed to "any degreed program" to allow for the required and enlarged spectrum of higher learning. One potential answer to question 12 that addressed ways to obtain information on domestic violence was discarded due to the narrow time frame for responses. Questions 14 and 19 had the wording changed from "nursing practice" to "nurse practitioner practice." Question 18 was shortened. To establish face validity, a panel of three expert researchers and nurse practitioners reviewed the changes and evaluated the questionnaire for clarity and ease of administration. Construct validity had been established by its use in two previous research studies. Revisions to the survey tool

were noted with the word "Revised" placed before the original name. For study purposes the tool was addressed as the Revised Education/Experience Questionnaire.

The Revised Education/Experience Questionnaire (Appendix C) was designed for self-administration as a 30-item questionnaire. The questionnaire measured relevant information on nurse practitioner subject level, abuse education and training, feelings, screening practices, and awareness of domestic violence among client population. The first ten questions solicited demographic and clinical experience data. Questions 11 through 13 focused on domestic violence education. Questions 14 through 21 were directed at screening practices and personal exposure to abuse. Questions 22 through 24 used a 7-point Likert scale to measure skill and awareness levels toward domestic violence. Question 25, as an open-ended question, requested information on needs for skill or knowledge upgrading. Questions 26 through 29 were in a 7-point Likert format and measured the participant's personal feelings and satisfaction in dealing with women involved in domestic violence. No total score was calculated as each item stood alone. The last question provided the participant an opportunity to share any additional information on a voluntary basis.

Procedures. Institutional approval by Mississippi University for Women's Committee on Use of Human Subjects in Experimentation (Appendix D) was obtained prior to beginning research. The participants were mailed a questionnaire packet containing the Revised Education/Experience Questionnaire, a cover letter explaining the research (Appendix E) and information for contacting the investigator, and a stamped return envelope. The participants were guaranteed confidentiality and were informed that

voluntary completion and mailing of the survey implied consent to participate. The research covered a three-week time period from May to June 1998.

Methods of Data Analysis

Descriptive statistics were employed to measure sample characteristics and to document pertinent nurse practitioner domestic violence screening practices. Scores were analyzed using measures of central tendencies. Likert scale questions were scored according to nonsupportive, neutral and supportive responses. Content analysis of responses to the open-ended questions, numbers 13, 25, and 30, was conducted, and information was incorporated in the body of the text for the final chapters.

Summary

In this chapter, the empiricalization of this research study exploring nurse practitioners' screening practices for domestic violence in the primary care setting was described. The design of the study, the variables, and the limitations, as well as the setting, population, and sample, were reviewed. The instrument and methods of data collection and data analysis were explained. In chapter IV the research findings will be presented, with a discussion of the findings and conclusions drawn from the research following in chapter V.

Chapter IV

The Findings

The purpose of this study was to determine whether nurse practitioners screen for domestic violence against women in the primary care setting. A survey design was implemented for this descriptive study. Questionnaire format was utilized to gather data from the nurse practitioners regarding their screening practices on domestic violence and to compile demographic and clinical information. The data was analyzed using frequency distributions and percentages as well as content analysis. The findings from the study are presented in this chapter.

Description of the Sample

The accessible population for the study consisted of all family, adult, acute care, women's health, and gerontologic nurse practitioners and certified nurse midwives residing in the state of Louisiana. A total of 451 surveys were mailed to all nurse practitioners currently listed with the Louisiana State Board of Nursing. One hundred ninety-three nurse practitioners (42%) responded to the questionnaire. As pediatric and neonatal nurse practitioners treat infants and children in their practice, and not women, surveys completed by these respondents were ineligible and discarded. No surveys were discarded from the study if not fully completed; if respondents met survey inclusion criteria, all available data were factored into the study totals. This resulted in a final

sample of 158 nurse practitioners for the study. The breakdown of the respondents (N = 158) represented 35% of the nurse practitioners surveyed.

The majority of the nurse practitioners were female (89%), White (90%), and married (69%). The mean age of the respondents was 43.8 years, with a range from 27 to 72 years of age. Six nurse practitioners chose not to answer the age question. Distribution of the nurse practitioner demographic characteristics by sex, age, ethnic background, and marital status can be found in Table 1.

Table 1
Demographic Characteristics of the Nurse Practitioners by Frequency and Percentage

Variable	f	%
Sex		
Female	141	89
Male	17	11
Age (Years)[a]		
27-30	5	3
31-40	48	32
41-50	75	49
51-60	21	14
> 60	3	2
Race		
White	142	90
Black	12	8
Hispanic	0	0
Asian	1	1
Other	3	1
Marital status		
Married	109	69
Divorced	26	17
Single	13	9
Widowed	5	3
Separated	3	2

Note. N = 158.
[a]n = 152.

The nurse practitioners were asked to indicate their specialty area, certification, and current position of practice. Out of six potential specialty areas, family was the primary specialty area chosen by the majority of the nurse practitioners. Twenty-two (14%) participants reported double specialty certifications, while 139 (86%) reported single certification. For single status certification, the majority (70%) of the nurse practitioners were certified in family. In addition, most survey participants (59%) indicated that they

were functioning as a family nurse practitioner. Distribution of the nurse practitioners by primary specialty, certification, and current position can be seen in Table 2.

Table 2
Distribution of Nurse Practitioners According to Primary Specialty Area, Certification, and Current Position of Practice by Frequency and Percentage

Description of practice	f	%
Specialty area[a]		
Family	95	61
Adult	20	13
Women's health	18	11
Midwife	16	10
Acute care	6	4
Gerontology	2	1
Single certification[b]		
Family	96	70
Midwife	16	12
Women's health	15	11
Adult	8	4
Gerontology	3	2
Acute care	1	1
Current position[c]		
Family NP	90	59
Adult NP	25	16
Women's health NP	16	11
Midwife	15	10
Acute care NP	3	2
Gerontology	3	2

Note. N = 158.
[a]n = 157. [b]n = 139. [c]n = 152.

The participants were asked to indicate their current practice setting from the nine listed on the questionnaire. Thirty-seven participants reported employment under the "Other" category and specified their work setting as rural health, nursing education, school health, industrial/occupational medicine, or mental health. Twenty-five

respondents were employed in a specialty clinic or practice which included internal medicine, outpatient clinics, community health, multi-specialty clinics, and mobile health units. Distribution of the practice site locations can be found in Table 3.

Table 3
Distribution of Nurse Practitioners According to Primary Specialty Area, Certification, and Current Position of Practice by Frequency and Percentage

Practice site	f	%
Family practice	40	26
OB/GYN	17	11
Public health clinic	11	7
Hospital setting	11	7
Private NP practice	6	4
Emergency department	4	2.5
College health	4	2.5
Other	37	24
Specialty clinic/practice	25	16

Note. n = 155.

The number of years in the nurse practitioner role ranged from 0 to 30. Forty-nine percent of the sample had two or less years of experience as an advanced practice nurse. Nurse practitioners were well distributed over the rural, suburban, and metropolitan settings. Distribution of the nurse practitioners according to experience and setting can be found in Table 4.

Table 4
Distribution of Nurse Practitioners According to Years in Practice and Location of Practice by Frequency and Percentage

Variable	f	%
Years in practice		
0-2	78	49
3-5	40	25
6-8	8	5
9-10	2	1
11-15	14	9
16-20	8	5
21-30	7	4
Location of practice[a]		
Rural	49	32
Suburban	38	24
Metropolitan	67	44

Note. N = 158.
[a]n = 154.

The majority of nurse practitioners were provided information about domestic violence while in a degree program. Information ranged from 1 to 25 hours, with an average number of 6 hours and a median number of 3 hours received. Participants identified lectures, women's health issues, domestic violence modules, speakers, student lead seminars, graduate school, and nurse practitioner training as sites of information while in school. Participants reported personal experience, personal contacts, and volunteer service under the category of "Other." The most usable information about domestic violence was obtained from books, journals, conferences, television, and personal experience. Table 5 identifies how nurse practitioners acquired educational information on domestic violence.

Table 5
Nurse Practitioners' Identification of Ways Information on Domestic Violence Was Acquired

Site	f	%
Degree program		
Yes	114	72
No	28	28
Additional ways[a]		
Books or journal articles	124	31
Newspapers or magazine articles	91	24
Films and television	77	19
Workshop or conference	65	16
Other	35	10

Note. N = 158.
[a]n = 392 responses. Participants were asked to select as many options as applied.

The nurse practitioners were asked whether they had clinically intervened with women involved in domestic violence issues. Eighty-nine (57%) participants reported yes, while 67 (43%) participants reported never intervening. Two participants failed to complete the question.

Eighty-six participants reported averaging six yearly encounters with women involved in domestic violence. Seventy-eight participants failed to answer this question. Only 109 nurse practitioners answered the question, "For how many years has your nurse practitioner practice including helping women involved in domestic violence situations?" Four was the average number of years nurse practitioners indicated having helped women in domestic violence situations while in practice. Forty-nine participants chose not to answer this question.

The participants were questioned about women they had personally known who had been abused. Over 82% of the nurse practitioners surveyed acknowledged personally knowing women involved in domestic violence situations. Participants also were questioned regarding their own abuse history. Eighteen nurse practitioners reported involvement in a past or current abusive relationship. These relationships ranged from 6 months to 12 years and averaged 4.9 years. Five participants chose not to share information on the number of years in an abusive relationship. Distribution by having personally known women involved in domestic violence as identified by the nurse practitioner and by the nurse practitioners' personal abuse history can be found in Table 6.

Table 6
Women Involved in Domestic Violence Known Personally by the Nurse Practitioner by Frequency and Percentage

Women	f	%
Known to the nurse practitioner[a]		
Friends	83	54
Co-workers	72	46
Neighbors	28	18
Relatives	24	15
Sisters	16	10
Mothers	12	8
Daughters	3	2
NP personal abuse history[b]		
No	139	89
Yes	18	11

Note. N = 158.
[a]n = 129. Participants were asked to select as many options as applied. [b]n = 157.

Results of Data Analysis

One research question guided this study: Do nurse practitioners screen for domestic violence against women in the primary care setting? Three questions on the Revised Education/Experience Questionnaire were central to this issue. Question 16, "Do you ask questions focused on domestic violence issues during routine screening or office visits?" specifically answered the research question. Question 14, "In your nurse practitioner practice, do you come in contact with women who are victims of domestic violence?" was considered significant because all women must be viewed as potential victims of domestic violence. Question 15, "Do you feel comfortable asking questions focused on domestic violence issues?," was considered significant because increased comfort level should lead to increased frequency of abuse-specific questions. Table 7 presents the results from the questionnaire.

Table 7
Question Analysis of Nurse Practitioner Recognition, Comfort Level, and Screening Practices for Domestic Violence by Frequency and Percentile

Question	Yes		No		Sometimes	
	f	%	f	%	f	%
In your nurse practitioner practice, do you come in contact with women who are victims of domestic violence?[a]	122	78.7	33	21.3	[b]	
Do you feel comfortable asking questions focused on domestic violence issues?[c]	118	75.2	7	4.5	32	20.4
Do you ask questions focused on domestic violence issues during routine screening or office visits?[d]	34	21.7	60	38.2	63	40.1

Note. N = 158.
[a] n = 155. [b] Participants were not offered this response. [c] n = 157. [d] n = 157.

The results of the study confirmed that nurse practitioners come in contact with women involved in domestic violence and generally feel comfortable asking abuse-specific questions. However, only 21.7% of the nurse practitioners routinely ask questions about domestic violence issues during health visits.

Additional Findings

Additional discoveries were made concerning the screening practices of nurse practitioners during data analysis. Those findings are presented in this section.

The Revised Education/Experience Questionnaire revealed pertinent information about the participant's personal beliefs regarding his or her own skills of identification, intervention, and assessment for domestic violence. In addition, data were obtained

concerning the nurse practitioner's personal feelings and satisfaction in dealing with women involved in domestic violence. Seven questions in Likert format employed a numbered scale from 0 to 6. Strength of responses moved up or down the scale depending on the question. Only one response between 0 to 6 was allowed. Zero equaled seldom, insufficient, not responsible, no sympathy, or dissatisfied, and 6 equaled always, sufficient, totally responsible, great sympathy, or totally satisfied.

To the question, "In your practice setting, do you think you can readily identify women who are victims of domestic violence?," 45 (29.1%) participants indicated that they could seldom identify women who were victims of domestic violence, 48 (31.2%) participants were neutral, and only 61 (39.6%) participants believed that they could identify women who were victims of domestic violence. Four respondents chose not to answer this question. To the question, "Do you think that you have sufficient knowledge about domestic violence to intervene effectively with abused women?," 47 (30.1%) participants indicated that they had insufficient knowledge to intervene effectively with abused women, 40 (25.6%) participants were uncommitted, and 68 (43.6%) participants indicated that they had sufficient knowledge to intervene effectively with abused women. Three respondents chose not to answer this question. In response to the question, "Do you think that you have sufficient clinical skills to assess and provide effective intervention with abused women?," 41 (26.4%) participants indicated that they had insufficient clinical skills to provide effective intervention with abused women, 41 (26.5%) participants were neutral, and 73 (47%) participants indicated that they had sufficient skills to intervene effectively with abused women. Two respondents chose not to answer this question.

In response to the question, "Do you think that abused women are responsible for their abusive relationships?," 122 (78.2%) participants indicated that the abused women were not responsible for their abusive relationships, 26 (16.7%) participants were neutral, and 8 (5.1%) participants indicated that the abused women were responsible for their abusive relationships. Two respondents chose not to answer this question. In response to the question, "Do you think that women in abusive situations are responsible for getting themselves out of their situations?," 13 (8.2%) participants indicated that women in abusive situations were not responsible for getting themselves out of their situation, 29 (18.5%) participants were neutral, and 115 (73.3%) participants indicated that women in abusive situations were responsible for getting themselves out their situation. One respondent chose not to answer this question. In response to the question, "In general, what are your feelings toward women involved in domestic violence relationships?," 1 (.6%) participant indicated no sympathy toward women involved in domestic violence relationships, 9 (5.8%) participants were neutral, and 146 (93.6%) participants indicated great sympathy toward women involved in domestic violence relationships. Two respondents chose not to answer this question. In response to the question, "Are you satisfied with your practice involving women in domestic violence situations?," 24 (23.8%) participants indicated that they were dissatisfied with their practice involving women in domestic violence situations, 41 (28.7%) participants were neutral, and 68 (47.6%) participants indicated that they were totally satisfied with their practice involving women in domestic violence situations. Fifteen respondents chose not to answer this question. Raw data for responses to the Likert questions can be seen in Appendix E.

Eighteen respondents identified themselves as involved in a past or current abusive relationship when questioned on personal abuse history. These 18 respondents' answers to the three key survey questions are presented in Table 8.

Table 8
Question Analysis of Recognition, Comfort Level, and Screening Practices for Domestic Violence by Nurse Practitioners with a Personal Abuse History by Frequency and Percentile

Question	Yes		No		Sometimes	
	f	%	f	%	f	%
In your nurse practitioner practice, do you come in contact with women who are victims of domestic violence?[a]	15	83	3	17		
Do you feel comfortable asking questions focused on domestic violence issues?[b]	15	83	0	0	3	17
Do you ask questions focused on domestic violence issues during routine screening or office visits?[c]	3	28	6	33	7	39

[a] $n = 18$. [b] $n = 18$. [c] $n = 18$.

Two questions invited respondents to comment if they desired. Content analysis was completed and is presented next. The answers to the question, "What knowledge or skill, if any, do you feel may be lacking?," were diverse, yet several common themes could be found. One hundred nine respondents chose to acknowledge this question. Heavily favored answers included referral options, community resources, communication and interview skills, counseling skills, identification of non-physical signs of abuse,

ability to pick up subtle hints of abuse, experience, ability to identify the problem, and the "ability to act on my instincts and knowledge of domestic violence."

Twenty-six participants commented on the question "Is there any additional information about domestic violence that you would like to share?" Some responses included the following:

> Currently, I work with a primarily poor, African-American population where abuse from boyfriends is not uncommon. What is frustrating is that these women seem to get little support from their own families to leave the abusers...mothers, aunts, etc. And they often say, "He was good, he didn't hit the baby....." (These are pregnant women!)
>
> It continues to go on and many women deny that they are abused for fear of losing their partner or family. Many women are quite happy to stay in the relationship thinking that it will get better!
>
> Ultimately, she is the only one who can get herself out of the situation. The NP is responsible to help empower her to do so. No one can do it for her. She knows her situation the best.
>
> Greatest problem personally was believing I could make a difference if I kept trying new approaches; disbelief that he wouldn't change with help; unbelief that he would hurt someone he claimed to love----the caring/need to help others ingrained in a nurse makes it even harder.
>
> I find that most of the time the entire family is protective of the abusive individual.
>
> I work in 95% MC clinic in rural projects-There is a great degree of DV, however
> #1 these women accept it as part of life
> #2 my superiors do not want it addressed.
>
> I did not think other families had abuse also! I do know I was raised to think that the husband had the authority to beat his wife, but I definitely do not believe that now. Further I definitely do not believe the Bible condones wife beating or child beating as acceptable.
>
> Time is sometimes a limiting factor in getting women to open up to their health care provider. Establishing a trusting and caring relationship is very important because more true and/or honest info may be elicited during follow-up appt.

> Maintaining a non-judgmental attitude is difficult when dealing with the generally low self-esteem of the victims, my own anger with the abuser and the fear for her safety!
>
> I only know personally of 1 woman - She supports financially the man who abuses her - She is not emotionally able to live alone - So to have an abusive partner is better for her than living alone - I've suggested counseling - but change is too scary for her. Other females I've encountered clinically are often trapped due to finances, children, lack of education or support. Psychological/emotional support is critical for change to occur.

Summary

Chapter IV presented the data collected and analyzed for this study. Demographic characteristics of the participants were examined. Statistical findings used to answer the research question were presented. These verified that nurse practitioners do not screen women for domestic abuse in the primary care setting. The results from the Revised Education/Experience Questionnaire revealed that nurse practitioners come in contact with women who are victims of domestic violence and feel comfortable asking abuse-specific questions, yet they do not ask abuse-specific questions during primary care visits. The following chapter contains a summary and discussion of the data described in this chapter.

licensed to practice in the state of Louisiana as either family, adult, acute care, women's health, or gerontologic nurse practitioners, or certified nurse midwives. Some participants held double specialty certifications. Additional noteworthy data included the fact that the vast majority of the sample (61%) were family nurse practitioners in a family practice setting (59%). A revealing finding was that 49% of the sample had 2 years or less of experience as a nurse practitioner. Only 18% of the nurse practitioners who responded to the survey had more than 10 years of experience in advanced practice. Most of the participants (72%) reported an average of 6 hours of educational preparation in domestic violence included in their degree program. Over 82% of the nurse practitioners also acknowledged personally knowing women involved in domestic violence situations. A small number (18%) of nurse practitioners reported a personal abuse history.

The knowledge level and attitudes of the nurse practitioners toward women involved in domestic violence were reflected in responses to seven questions on the Revised Education/Experience Questionnaire. Almost 40% of the participants indicated that they could identify women who were victims of domestic violence, and 43.6% believed that they had sufficient knowledge and clinical skills to intervene effectively with abused women. While 73.3% of the respondents felt that abused women were responsible for getting themselves out of their situation, 78.2% indicated that they did not think they were responsible for their abusive relationships. Sympathy toward women involved in domestic violence relationships was indicated by 93.6% of these participants, and 47.6% were satisfied with their practice involving women in domestic violence situations.

The research question which guided the study was as follows: Do nurse practitioners screen for domestic violence against women in the primary care setting? Descriptive statistics indicated that only 21.7% of the nurse practitioners asked abuse-specific questions during primary care visits.

Discussion

Domestic violence is considered a worldwide phenomenon and all women should be considered potential candidates for abuse and victimization (Abbott et al., 1995; Berrios & Grady, 1991; King & Ryan, 1996; McCauley et al., 1995). The 1970s made domestic violence a public but poorly supported issue (Poirier, 1997). The 1990s have brought to the domestic violence arena increased notoriety and public awareness, federal support and mandated state reporting laws.

The literature confirms in an abundance of studies that health care professionals either chronically overlook, fail to recognize, or neglect to identify women who are experiencing domestic violence (Abbott et al., 1995; Hamberger et al., 1992; Martins et al., 1992; McCauley et al., 1995; Yam, 1995). Abuse-specific questioning should be included in every health care exchange to allow the client an opportunity to disclose information if so desired. No research was found or available on why domestic violence continues to go unrecognized or why health care professionals do not ask abuse-specific questions in the medical setting. Expecting women clients to disclose domestic violence voluntarily is unreasonable and poor nursing practice. Therefore, nurse practitioners as health care providers in the primary care setting should be screening for domestic violence with abuse-specific questions (King & Ryan, 1989; King & Ryan, 1996).

Certain factors have been identified as a potential barriers to screening women on domestic violence issues. They include the lack of knowledge and skill as well as discomfort with the subject matter (Paluzzi & Houde-Quimby, 1996). These same factors could explain why nurse practitioners in the state of Louisiana displayed a hesitancy in dealing with domestic violence issues. These factors are closely related and perpetuate each other.

Comfort with the subject of domestic violence begins with the education of the health care provider. Hamberger et al. (1992) confirmed the need for physician training programs on domestic abuse because of substandard detection rates for domestic violence. Martins et al. (1992) concluded that physician recognition of domestic violence was deficient because of lack of training on the subject. On an average, the nurse practitioners in this study verified those findings by indicating that they had only 6 clock hours of study devoted to domestic violence information. Most study participants cited reading materials such as books, journals, newspapers, and magazine articles as additional sources of information to increase their knowledge of domestic violence. This lack of information could impact comfort and confidence levels when dealing with women involved in domestic violence.

Over 82% of the participants reported personally knowing women involved in domestic violence situations. Seventy-eight percent of the participants indicated that they come in contact with women who are victims of domestic violence. Plichta and Weisman (1995) reported that women in abusive situations maintain contact with health care providers for problems not associated with abuse-related injuries. This personal and professional exposure to women involved in domestic violence should make these nurse

practitioners aware that domestic violence is a common occurrence and major social problem among women. However, just over 52% of the respondents reported intervening clinically with women involved in domestic violence. This researcher believes that clarification is needed on the rationale for intervention, as only 21% of the participants reported asking abuse-specific questions. The questions of whether there were overt signs and symptoms of domestic violence among clients and whether nurse practitioners intervened because of knowledge of the common occurrence of domestic violence continue to be fertile ground for future nursing research.

Over 69% of the participants felt that their assessment and intervention techniques needed improving as verified by the responses to the open-ended question regarding skills or knowledge deficits. Identification of non-physical signs of abuse, the ability to pick up subtle hints, communication skills, counseling skills, and the ability to identify the problem were frequent areas of deficits cited by the respondents. The researcher asserts that skills, whether recognition, interview, assessment, or intervention, improve with exposure and experience.

Personal comfort with domestic violence should increase with exposure and experience. Almost 50% of the nurse practitioners had less than two years experience in the advanced practice role. Yet, the majority (75.2%) of participants indicated a comfort level of asking questions about domestic violence. A contradiction was apparent when only 21.7% of the participants reported asking abuse-specific questions and over 78.3% of the participants answered "no" or "sometimes" to asking abuse-specific questions. Eighty-three percent of the nurse practitioners who indicated past or current abuse histories professed an elevated degree of comfort asking abuse-specific questions. Yet,

72% of these same practitioners never or seldom asked questions about domestic violence.

However, the study further revealed that over 73% of the nurse practitioners felt that the women were responsible for getting out of the situation. Women must strongly believe that they can leave or change an abusive relationship (Pender, 1987). Women in situations feel hopeless due to lack of self-worth, self-confidence, and self-esteem. When a nurse practitioner shows respect, caring and interest to a woman involved in a domestic violence situation, the woman may experience an empowerment to make changes in lifestyle, self expectations, and self perceptions. Nurse practitioners must be secure, comfortable, and knowledgeable about available options to guide and direct these women.

Several reasons may explain the dichotomy. Abbott et al. (1995) and Martins et al. (1992) confirmed that social class, culture, marital or financial status, age, or race did not exclude any woman from being a victim of domestic violence. Clients may not fit the stereotypical image of domestic violence. There may be difficulty in questioning women about personal and intimate family details who come from the same or elevated socio-economic backgrounds. Reluctance to ask about domestic violence may be due to fear of offending clients, producing anger, or causing misunderstanding. The nurse practitioner may also be forced to deal with his/her own unresolved history of past or current domestic violence. Once violence is disclosed, the nurse practitioner is required to intervene. Study participants indicated the need to know more about the referral sites and available community options. The lack of clearly defined site protocols or community referral sources could possibly hinder or decrease the nurse practitioner's desire or ability

to intervene with women involved in domestic violence situations. Deficiencies in the area of clearly defined guidelines could severely impact the comfort and confidence levels of the nurse practitioner when dealing with domestic violence issues, especially when the lack of advance practice experience among the sample is considered.

Health care delivery has become profit directed. Number of clients seen are reflected in salaries and continued employment. Many nurse practitioners may feel time constraints when providing care. There also may be employer or employment pressure not to pursue the domestic violence issue. Evidence of this feeling is reflected in the open-ended response by one nurse practitioner who worked in the rural projects with a high incidence of domestic violence. The practitioner stated, "#1. These women accept it as part of life. #2. My superiors do not want it addressed."

Some practitioners may follow the medical model which addresses symptoms of the abuse, not the underlying social problem of domestic violence (Yam, 1995). Assisting in non-medical interpersonal issues requires more energy and hours that would otherwise be directed toward clients with physical health care problems. Yet, time spent on repeat visits related to domestic violence sequelae is far greater in terms of time than appropriate recognition and intervention (Warshaw, 1993).

By making abuse-specific questions part of routine visits, a comfort level with the subject matter will develop. Asking is the first and most difficult step in detection/ recognition and intervention. Domestic violence will remain a private matter if the nurse practitioner allows it by not addressing the moral, legal, and ethical issues of domestic violence. McFarlane et al. (1991) found that face-to-face interviews elicited higher abuse disclosure. Nurse practitioners, by the nature of a holistic practice model, are in a position

to open the door to potential abuse disclosure through client-provider interaction and communication. As described in the Health Promotion Model (Pender, 1987), the nurse practitioner serves to empower the client to make choices toward behaviors that promote a healthy lifestyle. The client must be aware that abuse is wrong and believe that change is possible. Increased knowledge about available options and client readiness will trigger cues to action to change or modify the situation. Change is not possible without recognition through screening for domestic violence.

Conclusions

Based on results of this study, it was determined that nurse practitioners do not freely or routinely ask questions focused on domestic violence issues in the primary care setting. More respondents answered "no" (38.2%) or "sometimes" (40.1%) when instructed to confirm if abuse-specific questions were asked during routine screening or office visits. Even the majority of participants who identified themselves as having a history of personal abuse answered "no" or only "sometimes" to whether they asked abuse-specific questions. Participants (78.7%) overwhelmingly acknowledged that they came in contact with women who were victims of domestic violence and they (39.6%) could identify these same women. Participants believed that they had sufficient knowledge and clinical skills to intervene effectively with abused women and denied discomfort asking questions focused on domestic violence. Respondents overwhelmingly held the opinion that abused women were not responsible for their abusive relationships and further indicated great sympathy toward these abused women. Respondents also strongly maintained that these same women were responsible for getting themselves out of domestic violence relationships. Based on overall responses to recognition, knowledge,

and comfort level questions, screening for domestic violence should be significantly higher than presented in the current study.

Limitations

This study had limited external validity. The results may not be generalized to other settings because the population is from the state of Louisiana. The sample was chosen for convenience rather that through formal randomization. Also, the ethnic and gender characteristics of the population were very homogenous even though the setting sites were very diverse. Since the majority of the participants were White, married and female, a more diverse sample may have provided more varied responses.

Survey research also has limitations that must be considered. Information obtained in surveys tends to be superficial; therefore, cause-and-effect relationships cannot be inferred with confidence. Variables cannot be controlled with survey research. Also mail-out surveys are notorious for low completion rates. This strengthens the argument for not generalizing the study to a target population (Polit & Hungler, 1995).

Another study limitation could have been instrument presentation. A significant number of respondents were unable or unwilling to commit to a definite response with the Likert-formatted questions. The 7-point Likert scale allowed for neutral or uncommitted responses, thereby possibly biasing the results. Also, wording on certain key domestic violence questions was not well defined, again possibly creating response bias due to confusion or question misinterpretation.

Implications for Nursing

Several implications for nursing were derived from this study. Implications related to practice, research, theory, and education are described.

Nursing practice. Assuming the role of health care provider confers and demands medical, legal, and ethical responsibilities to deliver quality care to clients in all settings. Domestic violence is a universal problem, and for nurse practitioners as professionals to ignore or deny this issue due to ignorance or discomfort impacts the clients' lives in a negative way. The nurse practitioner must be centered and focused on treating the client as a total person, not as a medical complaint or problem. The goal of care is to improve or enhance quality of life through intervention. Specific and constant domestic abuse screening practices must be initiated at every health care interaction by the nurse practitioner. Also, by incorporating Pender's Health Promotion Model (Pender, 1987) into their practice, the nurse practitioners can achieve higher levels of wellness among their client populations.

Nursing research. Domestic violence has been explored and well documented in the literature from the health care provider perspective. There is currently no specific research on screening practices of nurse practitioners for domestic violence. Findings from this study strongly suggest that nurse practitioners do not ask abuse-specific questions during routine health care interactions. Reasons for not exploring this major social problem may include discomfort with the subject of domestic violence, lack of knowledge about domestic violence, lack of experience, and employment constraints. Additional research is needed to gain insights into why nurse practitioners do not regularly screen for domestic violence.

Nursing theory. Nursing theory is tested through research. The theoretical framework which guided the current study was the Health Promotion Model (Pender, 1987). The Health Promotion Model focuses on the willingness of a person to make

changes in behavior to promote a healthy lifestyle. Behavior that is aberrant, inappropriate, or misdirected must first be recognized before changes can be made. Screening for domestic violence by the nurse practitioner is linked to recognition, intervention, and empowerment. Health-promoting behavior and change becomes a client choice once the preceding steps are taken. The current study failed to substantiate this theory as nurse practitioners do not constantly and vigorously screen for domestic violence.

Nursing education. It is essential that nurse practitioners actively screen for domestic violence in the primary care setting through abuse-specific questions. The importance, accuracy, and comfort level when dealing with recognition and intervention with women involved in domestic violence are heightened and reinforced through ongoing nursing program curricula and supplemental education. Therefore, extensive content on domestic violence should be included in formal educational programs for nurses at all levels.

Recommendations

Based on the findings of this study, the following recommendations are made by this researcher:

Nursing practice.

1. Utilization of Pender's (1987) Health Promotion Model as a framework for care when screening all women for domestic violence in the primary care setting.

2. Screening for domestic violence by asking abuse-specific questions at each health care interaction.

Nursing research.

1. Replication of the study using an improved and more focused research instrument.

2. Implementation of a study to determine why nurse practitioners do not screen for domestic violence in the primary care setting.

3. Replication of the study in two geographic locations and comparison of results.

4. Conduction of a study to determine nurse practitioners' comfort level with the subject of domestic violence.

5. Conduction of a study to determine nurse practitioners' attitudes and perceptions when dealing with victims of domestic violence.

6. Implementation of a study that correlated personal and professional experience, education, and age with the nurse practitioner and domestic violence screening.

Nursing education.

1. Publication of this study and other studies to strengthen the need for domestic violence screening by the nurse practitioner.

2. Increase in the amount of domestic violence content within the curricula in schools of nursing.

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Appendix A

Letter Requesting Permission to Use and Modify Existing Tool

Appendix A

463 Homestead Avenue
Metairie, LA 70005

November 21, 1997

M. Christine King, RN, Ed.D.
Associate Professor
School of Nursing
Arnold House
University of Massachusetts at Amherst
Amherst, MA 01003

Dear Dr. King:

I have reviewed several articles by you on domestic violence and abuse and have found them highly informative and very well written. As a graduate nurse practitioner student at Mississippi University for Women, I am pursing research in this same area. My thesis will focus on screening practices of nurse practitioners in the primary care setting.

Your Education/Experience Questionnaire was utilized by another MUW student in 1990 with your permission. I am writing to ask if I may use and adapt this same tool for my research. I would appreciate a copy of your instrument with scoring directions and your permission to adapt it to nurse practitioners.

I appreciate your time and consideration in this matter.

Sincerely,

Patty Plant

Appendix B

Letter Verifying Permission and Use of Tool

Appendix B

463 Homestead Avenue
Metairie, LA. 70005

May 29, 1998

M.Christine King, RN, Ed.D.
Associate Professor
School of Nursing
Arnold House
University of Massachusetts at Amherst
Amherst, MA. 01003

Dear Dr. King:

Let me reintroduce myself. I am presently pursing a Master of Science in Nursing with a clinical specialty as a Family Nurse Practitioner in the Graduate School of Nursing at Mississippi University for Women in Columbus, Mississippi. My thesis focuses on screening practices for domestic violence by nurse practitioners within the state of Louisiana. I again want to thank you for allowing me to use and modify your Education/Experience Questionnaire for my research and thesis. I have another week of data collection before analysis can be instituted.

Even though telephone permission was given for use of your Education/Experience Questionnaire, written permission for thesis inclusion and completeness is still lacking. Could you please confirm my use of your survey tool in writing by a note or possibly sign and return this letter indicating permission. A copy of scoring directions would be appreciated if available.

Thank you again for the use of your tool. I appreciate your time and attention to this matter.

Sincerely,

Patty Plant

Patty Plant

I give my permission to Ms. Patty Plant to use Questionnaire.

M. Chris King

Appendix C

The Revised Education/Experience Questionnaire

Appendix C

The Revised Education/Experience Questionnaire

1. Sex

   _____ Female _____ Male

2. Age _____

3. Ethnic group

   _____ White _____ Black _____ Hispanic

   _____ Asian _____ Other (specify) _____

4. Marital status

   _____ Single _____ Married _____ Divorced

   _____ Separated _____ Widowed

5. Primary specialty area (check only one)

   _____ Adult _____ Family _____ Women's Health

   _____ Acute Care _____ Midwife _____ Gerontology

6. Certification (check all that apply)

   _____ Adult _____ Family _____ Women's Health

   _____ Acute Care _____ Midwife _____ Gerontology

7. Current position

   _____ Adult NP _____ Family NP _____ Women's Health NP

   _____ Acute Care NP _____ Midwife NP _____ Gerontology NP

8. Current practice setting

   _____ Own practice _____ Family practice _____ OB/GYN practice

   _____ Public health clinic _____ Emergency room _____ College health

   _____ Hospital (specify dept.) _____ Specialty clinic or practice (specify)

   _____ Other (specify) _____

9. Years in practice as nurse practitioner

_____ 0-2 _____ 3-5 _____ 6-8 _____ 9-10

_____ 11-15 _____ 16-20 _____ 21-30

10. Location of practice

_____ Rural _____ Suburban _____ Metropolitan

11. Was information about battered women or domestic violence included in any degreed program?

_____ Yes _____ No

If yes, please specify.

_____

_____

If yes, estimate how many hours were spent on this topic. _____

12. Have you obtained information about battered women or domestic violence in any of the following ways? (Check as many as apply)

_____ Specific workshop or conference on domestic violence

_____ Books or journal articles _____ Newspapers or magazine articles

_____ Films and television _____ Other (please specify) _____

13. Where do you think you have obtained the most usable information about domestic violence?

_____

_____

14. In your nurse practitioner practice, do you come in contact with women who are victims of domestic violence?

_____ Yes _____ No

15. Do you feel comfortable asking questions focused on domestic violence issues?

_____ Yes _____ No _____ Sometimes

16. Do you ask questions focused on domestic violence issues during routine screening or office visits?

_____ Yes _____ No _____ Sometimes

17. Have you intervened clinically with women specifically involved with domestic violence issues?

_____ Yes _____ No

18. If yes, on average, how many women do you encounter?

_____ per year _____ per month

19. For how many years has your nurse practitioner practice included helping women involved in domestic violence situations? _____

20. Have you personally known any battered women? Check all of the following that apply. If more than one, please indicate the number.

_____ Friends _____ Co-workers _____ Neighbors _____ Relatives

_____ Sisters _____ Mother _____ Daughter

21. Are you currently or have you ever been involved in an abusive relationship as an adult with an intimate partner?

_____ Yes _____ No If yes, how many years? _____

22. In your practice setting, do you think you can readily identify women who are victims of domestic violence?

Seldom						Always
0	1	2	3	4	5	6

23. Do you think that you have sufficient knowledge about domestic violence to intervene effectively with abused women?

Insufficient						Sufficient
0	1	2	3	4	5	6

24. Do you think that you have sufficient clinical skills to assess and provide effective intervention with abused women?

Insufficient						Sufficient
0	1	2	3	4	5	6

25. What knowledge or skills, if any, do you feel that you may be lacking?

_____

_____

26. Do you think that abused women are responsible for their abusive relationships?

Not Responsible						Totally Responsible
0	1	2	3	4	5	6

27. Do you think that women in abusive situations are responsible for getting themselves out of their situations?

Not Responsible						Totally Responsible
0	1	2	3	4	5	6

28. In general, what are your feelings toward women involved in domestic violence relationships?

No Sympathy						Great Sympathy
0	1	2	3	4	5	6

29. Are you satisfied with your practice involving women in domestic violence situations?

Dissatisfied						Totally satisfied
0	1	2	3	4	5	6

30. Is there any additional information about domestic violence that you would like to share? If so, please do so below.

_____

_____

Appendix D

Approval of Mississippi University for Women

Committee on Use of Human Subjects in Experimentation

Appendix D

MISSISSIPPI UNIVERSITY FOR WOMEN
Columbus, MS 39701

Office of the Vice President for Academic Affairs
Eudora Welty Hall
P.O. Box W-1603
(601) 329-7142

April 8, 1998

Ms. Patty Plant
c/o Graduate Program in Nursing
Campus

Dear Ms. Plant:

I am pleased to inform you that the members of the Committee on Human Subjects in Experimentation have approved your proposed research as submitted with the suggestion that the consent form be signed and returned with the survey.

I wish you much success in your research.

Sincerely,

Susan Kupisch, Ph.D.
Vice President
for Academic Affairs

SK:wr

cc: Mr. Jim Davidson
Dr. Mary Pat Curtis
Ms. Melinda Rush

Appendix E

Cover Letter to Participants

Appendix E

Date

Dear Participant,

I am a registered nurse in the Graduate School of Nursing at Mississippi University for Women in Columbus, Mississippi. I am presently pursuing a master of Science in Nursing with a clinical specialty as a Family Nurse Practitioner. For my thesis topic, I have chosen to examine the screening practices for domestic violence by nurse practitioners within the state of Louisiana. Domestic violence as a power and control issue involving physical, sexual, emotional, economic, and verbal abuse is a sensitive yet major health care issue.

Your experience and opinions are very valuable to me and are needed to represent domestic violence screening practices within the state. I am enclosing a survey to collect pertinent information relevant to this issue. While your participation is voluntary, I value your unique perspective and hope that you would take a few minutes to respond. The survey should take approximately 15 minutes of your time to complete. Your response will be confidential and consent to participate is indicated by your voluntary return of the completed survey. In order to analyze the information in a timely fashion, please return the questionnaire by June 6, 1998. The completed survey can be returned in the self-addressed stamped envelope provided for your convenience.

Thank you very much for your prompt attention, time, and cooperation in this study. Feel free to call me at (504) 837-0875 if you have questions or reactions related to this research. Results of the study will be available in August 1998 upon request.

Sincerely,

Patty Plant, R.N., B.S.N.
463 Homestead Ave.
Metairie, LA 70005

Appendix F

Raw Data Likert Questions

Appendix E

Frequency and Percentages of Nurse Practitioners' Self-Perceptions on Interventions, Clinical Skills, and Personal Feeling and Satisfaction in Dealing with Women in Domestic Violence Situations

Question	0		1		2		3		4		5		6	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
In your practice, do you think you can readily identify women who are victims of domestic violence?	3	1.9	11	7.1	31	20.1	48	31.2	45	29.2	14	9.1	2	1.3
Do you think that you have sufficient knowledge about domestic violence to intervene effectively with abused women?	8	5.1	13	8.3	26	16.7	40	25.6	39	25.0	19	12.2	10	6.4
Do you think that you have sufficient clinical skills to assess and provide effective intervention with abused women?	5	3.2	12	7.7	24	15.5	41	26.5	47	30.3	14	9.0	12	7.7
Do you think that abused women are responsible for their abusive relationships?	52	33.3	44	28.2	26	16.7	26	16.7	3	1.9	2	1.3	3	1.9
Do you think that women in abusive situations are responsible for getting themselves out of the situation?	1	0.6	4	2.5	8	5.1	29	18.5	49	31.2	32	20.4	34	21.7
In general, what are you feelings toward women involved in domestic violence relationships?	1	0.6	0	0.0	0	0.0	9	5.8	24	15.4	52	33.3	70	44.9
Are you satisfied with your practice involving women in domestic violence situations?	4	2.8	8	5.6	22	15.4	41	28.7	30	21.0	30	21.0	8	5.6