This is to certify that the

thesis entitled

PORTRAIT OF AN ABUSED WOMAN: DO PRIMARY HEALTH CARE PROVIDERS RECOGNIZE HER?

presented by

Deborah Kay Johnson

has been accepted towards fulfillment
of the requirements for

Master of Science degree in Nursing

Linda Beth Tuttle
Major professor

Date June 6, 1997

PORTRAIT OF AN ABUSED WOMAN: DO PRIMARY HEALTH CARE PROVIDERS RECOGNIZE HER?

By

Deborah Kay Johnson

A THESIS

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

MASTER OF SCIENCE IN NURSING

College of Nursing

1997

ABSTRACT

PORTRAIT OF AN ABUSED WOMAN: DO PRIMARY HEALTH CARE PROVIDERS RECOGNIZE HER?

By

Deborah K. Johnson

This study was based on a previous study by McClure (1993) and describes primary health care providers' assessment practices related to domestic violence. Variables studied included knowledge of the prevalence of domestic violence, possible indicators of domestic violence and referral resources in the community; screening and exam practices of providers; potential barriers to assessment; and the use of referral resources. A questionnaire was mailed to 213 physicians and 38 advanced practice nurses in a tri-county area of Michigan. Twenty-five percent of the physicians (49) and 66% of the advanced practice nurses (25) returned completed questionnaires. Frequency statistics revealed that providers in the study rarely to sometimes assessed for domestic violence and a multivariate ANOVA unveiled that apparent differences in assessment scores between physicians and nurses were related to gender. Females in the study tended to assess more frequently for domestic violence than males. Implications for advanced practice nursing are discussed.

I wish to dedicate this thesis to my parents, Tom and Sharon Johnson, for all their support, praise and encouragement throughout my graduate degree pursuit.

ACKNOWLEDGMENTS

I wish to thank all of the very important people who helped make the production of this thesis possible. I would like to thank Dr. Kathleen Cowling and Dr. MaryJo Wagner, for writing a second cover letter encouraging providers' participation in the study. I would also like to thank Dr. Cowling and Dr. David Pugh for reviewing and critiquing portions of the questionnaire. And, a very special thank you to my parents, Tom and Sharon Johnson, and also to my friends Michael Lounsbery and Vicki German for helping review mailing lists, make copies, stuff envelopes and prepare the surveys for mailing.

TABLE OF CONTENTS

Table of Contents (cont.)

LIST OF TABLES

LIST OF FIGURES

INTRODUCTION

My name is Samantha and I am forty-two. I have been married for twelve years to an executive at an advertising agency. We have three beautiful children. Life is good right now except for these headaches I have been having. I've seen my doctor, but he doesn't seem to know what is causing them. All the tests have come back negative. I wish he could tell me what is wrong with me.

My name is Ann and I am thirty-one. My boyfriend and I have been living together for the past year and are planning to get married next month. He has been so good to me and my little boy Jason. I don't know where my son and I would be living if it weren't for him. Everything is going great right now. Except I seem to be a little clumsy lately. Two months ago I tripped and fell down the stairs and broke my right arm, and now just yesterday I lost my balance again and bumped my left eye. I suppose it's just all the excitement planning for the wedding.

My name is Christy and I am seventeen. Steve and I have been dating since the beginning of school this year. He is the captain of the football team and everyone is envious of me. I am so lucky. Mom and dad don't really like Steve. They think he is too rough with me. It's only

a couple of bruises and he didn't mean to hurt me. We were just playing around. He was so sorry afterward. He even sent me flowers. It's not like he broke my arm or anything.

The purpose of this study was to describe primary health care providers' assessment practices regarding domestic violence. This study identified to what extent primary care providers assessed for domestic violence and whether or not knowledge and barriers had an impact on the assessment practices of primary health care providers. This study also examined the use of referral resources by providers and, lastly, compared advanced practice nurses and physicians with regard to knowledge, barriers, assessment practices, and use of referral resources.

Domestic violence was once thought of as merely a private matter between the two people involved or as a legal matter only for the police to address. While domestic violence remains a significant legal issue, it is increasingly becoming a major public health problem. Recent studies show that domestic violence results in more injuries requiring medical attention than rape, auto accidents, and muggings combined; and it may in fact be the most common cause of injury to women (Council on Scientific Affairs, AMA, 1992). Domestic violence is reaching epidemic proportions in the United States. Each year approximately 2 to 4 million women suffer domestic violence (Novello, Rosenberg, Saltzman, & Shosky, 1992; Straus, Gelles, & Steinmetz, 1980). Broken down into dimensions of time, a

woman is abused every 7 seconds (McLeer, Anwar, Herman, & Maquiling, 1989). Although the actual incidence is not known, it has been cited suggested that on average 20% of U.S. woman have been physically or sexually assaulted at some point in their lives by a male significant other (Strauss & Gelles, 1990; Council on Scientific Affairs, 1992; AMA, 1992). Injuries related to domestic violence are likely to be more serious and result in more episodes of loss of consciousness than injuries sustained in stranger violence (Chambliss, Bay, & Jones, 1994). One study showed that 16% to 30% of women reporting to an emergency room with injuries were identified as victims of battering (McLeer et al., 1989). Two to four thousand women die each year after being assaulted (AAFP, 1994), representing 42% of murdered women killed by their significant others (Analysis by the Center for the Study and Prevention of Violence).

Domestic violence is not a one-time occurrence. According to the Bureau of Justice Statistics, 32% of women who reported an incident of domestic violence were battered again in 6 months (Smikle, Satin, Dellinger, & Hankins, 1995). The American Medical Association guidelines report similar findings in that 47% of husbands who beat their wives do so at least three times a year (ACOG, 1995). Twenty percent of battered women will make at least 11 office visits to their physician for incidents of trauma (American Medical Association, 1994), making it a costly problem as well.

Domestic violence does not discriminate. It cuts across all demographic lines and includes women of all racial, socioeconomic, religious, and ethnic backgrounds (Neufeld, 1996). Smikle et al. (1995), surveyed 531 employed, middle-class women and discovered 72 (13.5%) reported histories of physical abuse, 37 (7%) sexual abuse, and 40 (7.5%) both physical and sexual abuse, a total of 28% abused overall. In another study of 787 medical students and faculty, 17% of the females reported experiencing physical or sexual abuse in their adult life (deLahunta & Tulsky, 1996).

Victims of domestic violence are affected in many ways. The most obvious, of course, is by the visible injuries of broken bones and bruises. The most common sites for injury include the head, neck, face, breast or abdomen (AMA Diagnostic and Treatment Guidelines on Domestic Violence, 1994). Permanent injuries include those due to: burns, loss of vision or hearing, bite and knife wounds, and damage to the joints (ACOG, 1995). Woman battering is not only physical. The emotional and psychological abuse endured at the hands of the batterer results in many primary care and psychiatric complaints. Common medical problems frequently associated with abuse victims include: headache, abdominal and pelvic pain, irritable bowel syndrome, sexual dysfunction, myalgia, arthralgias, insomnia, eating disorders, depression, and chemical dependency (Friedman, Samet, Roberts, Hudlin, & Hans, 1992). In addition, an

estimated 26% of women who attempt suicide have experienced domestic violence (Melvin & Brunton, 1995).

Victims of domestic violence are not only spouses or intimate partners. When a woman becomes pregnant there are two victims. Frequently abuse may begin or escalate during pregnancy (Bohn, 1990), and it is often the cause of miscarriage, stillbirths, and premature delivery (Bullock, McFarlane, Bateman, & Miller, 1989). In addition, battered women are twice as likely to begin prenatal care in the third trimester than their nonabused counterparts (McFarlane, Parker, Soenken, & Bullock, 1992). According to Helton (1987), infants born to women who experienced abuse during pregnancy may develop feeding difficulties and failure to thrive. The children that do survive frequently grow up in violent environments witnessing the abuse or being physically abused themselves. As a result, these children are at increased risk of developing childhood behavioral problems or aggressive tendencies in future relationships (ACOG, 1995; Wolfe, Jaffe, Wilson, & Zak, 1985). "Sadly the cycle of abuse continues to turn. Violent fathers pass their violent heritage along to their sons, and daughters often find themselves in relationships that mirror the abusive one they saw modeled at home" (Easley, 1996, p. 762).

Given the prevalence of domestic violence and that it is not a one time occurrence, undoubtedly domestic violence victims are being seen in primary health care settings. The

unique relationship between the primary care provider and patient frequently allows for multiple contacts on a regular basis and often times includes more than one member of the family. This grants the primary health care provider an exceptional opportunity for the identification and intervention of domestic violence. The question is, *Are victims of domestic violence being recognized in the primary health care setting?* The current literature seems to indicate that the answer is *no* (Chambliss et al., 1995; Hamberger, Saunders, & Hovey, 1992; Bokunewicz & Copel, 1992; deLahunta, 1995; Brown, Lent, & Sas, 1993; Randall, 1990; & AMA, 1994). This, then, lends itself to the next obvious question, *why?*

Research Questions

The following research questions have been devised for this research project.

1. To what extent do primary health care providers verbally and physically assess for domestic violence?
2. Is there a relationship between knowledge regarding domestic violence and the assessment practices of primary health care providers?
3. Is there a relationship between barriers identified and the assessment practices of primary health care providers regarding domestic violence?
4. Is there a relationship between assessment practices of primary health care providers and the use of referral resources?

5. Is there a difference between advanced practice nurses and physicians regarding assessment practices for domestic violence?
6. Is there a difference between advanced practice nurses and physicians regarding knowledge of domestic violence?
7. Is there a difference between advanced practice nurses and physicians regarding barriers to domestic violence assessment?
8. Is there a difference between advanced practice nurses and physicians regarding use of referral resources?

LITERATURE REVIEW

The following terms will be conceptually defined: *domestic violence*, *primary health care*, *primary health care setting*, *primary health care provider*, *knowledge*, *assessment practices*, *referral resources*, and *barriers*.

Domestic violence. "Domestic violence is a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners" (Ganley, 1996, p. 16). This author recognizes that domestic violence also occurs against men; however, the U.S. Department of Justice estimates that in 95% of reported assaults, men are the perpetrators (Douglas, 1991) and often are not in need of treatment. Therefore, within the context of this paper, *domestic violence* included

any physical, sexual, or psychological attacks by a male against a female intimate partner.

Primary health care. Primary health care is defined by the Institute of Medicine's Committee on the Future of Primary Care (Donaldson, Yordy, & Vanselow, 1994) as follows:

> Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs developing a sustained partnership with patients, and practicing in the context of family and community. (p. 1).

In his definition of primary health care, Silver (1977) emphasizes that primary care should be based "on a firm foundation which integrates knowledge of the medical, biological, physical, social, psychological, and behavioral sciences." He also believes that regardless of who is delivering the care, the provider "should assume responsibility and accountability for the coordination, integration, and continuing management of the patient's total health care and services" (p. 151).

In her book, Primary Care. Concept, Evaluation and Policy, Starfield (1992) describes primary care as "the basic level of care provided equally to everyone." She states it "addresses the most common problems in the community by providing preventive, curative, and rehabilitative services to maximize health and well-being.

It is care that organizes and rationalizes the deployment of all resources, basic as well as specialized, directed at promoting, maintaining, and improving health" (p. 4).

For purposes of this paper, *primary health care* was defined as holistic care that encompasses comprehensive, cost effective, and quality care throughout the lifespan. The goals of primary care are that of illness prevention, health promotion, and optimal health maintenance, and these goals are achieved through the use of teamwork and the efforts of collaboration, consultation, and integration of other health care providers.

Primary health care setting. Much of the research done on domestic violence reflects frequent visits by victims to emergency rooms and very little has been published on other health care settings. Although many patients use the emergency room as a provider of primary care, emergency departments are not the only health care setting impacted by domestic violence. Battered women are also seen in family practice offices. One study conducted by Hamberger, Saunders, & Hovey (1992), reported 23% of women seen in a family practice clinic had been physically abused by their partners within the past year and 39% had been physically abused by an intimate partner at some time in their lives. Another study conducted in an internal medicine practice cited similar but lower ratings. Six percent of female respondents reported domestic violence the previous year, 21% some time in their adult lives, and 33% either as an

adult or child (McCauley, Kern, Kolodner, Dill, Schroeder, DeChant, Ryden, Bass, & Derogatis, 1995). And in a review of thirteen studies measuring the prevalence of abuse in pregnancy, statistics ranged from 0.9% to 20.1%, making it an obstetrical and gynecological practice site issue as well (Gazmararian, Lazorick, Spitz, Ballard, Saltzman, & Marks, 1996). For purposes of this paper, *primary health care settings* included family practice, internal medicine, and obstetrics and gynecological practices.

Primary health care provider. Providers of primary health care include physicians, either MDs or DOs, and advanced practice nurses (APN). Safriet (1992) defines the advanced practice nurse as a registered nurse with additional training and education either in the form of a certificate or master's degree. According to the National Council of State Boards of Nursing (NCSBN, 1992), "the skills and abilities essential for the advance practice role within an identified specialty area include: providing patient/client and community education; promoting stress prevention and management; encouraging self help; subscribing to caring; advocacy; accountability, accessibility; and collaboration with other health and community professionals" (Mezey & McGivern, 1993, p. 5). For purposes of this study, *primary health care providers* were defined as an MD, DO, or an APN.

Knowledge about domestic violence. Webster (1990), defines knowledge as, "the specific extent of what is known

about something, as by an individual" (p. 406). This author referred to *knowledge* as the specific extent to which a primary health care provider knows about domestic violence. This knowledge included the prevalence of domestic violence in the primary health care setting, possible signs and symptoms of domestic violence, potential behaviors indicating the presence of domestic violence, and available referral resources in the community. This knowledge could be gained through clinical experience or from formal education--either medical or nursing school, through the attendance at a conference, seminar or lecture, or gathered from published literature and professional journals.

Assessment practices. Assessment has been defined as "the deliberate and systematic collection of data to determine a client's current health status and to evaluate his [or her] present and past coping patterns" (Carpenito, 1983, p. 24). According to Carpenito, the data is obtained through an interview, physical examination, observations, and review of records and reports. According to Sassetti (1993), screening for domestic violence is a necessary assessment practice for primary health care providers in the detection of domestic violence, not only when abuse is suspected, but also annually during routine health maintenance exam (Sassetti, 1993) and with each new client visit (McClure, 1996). Primary health care providers "must learn to recognize the signs and symptoms of abuse and simply *ask* the women presenting with such complaints if they

are suffering from violence in their homes" (Sassetti, 1993, p. 299). Since no reliable indicator of abuse exists (Sassetti, 1993) and because some women are not likely to report they are being abused (American Medical Association, 1994), it is equally important to assess all women even if they do not present with specific signs and symptoms of abuse. Within the context of this paper, *assessment practices* were defined as the routine screening by primary health care providers for domestic violence either through questions on an initial intake or history form, inquiring directly, or by findings on physical exam.

Referral Resources. Referral resources are community based services which can provide a battered woman with needed support. Resources include local counseling and crisis intervention services, shelters (AMA, 1994), mental health workers, and 24 hour telephone hotline phone numbers (Alpert, 1995). In addition, referrals from providers may include access to legal information such as police departments (AMA, 1994), attorneys, court advocates, or legal services centers (Alpert, 1995). For purposes of this study, *referral resources* included a 24 hour crisis line, police force, prosecuting attorney's office, legal aid, shelter or safehouse, and counseling services.

Barrier. In summarizing the Health Belief Model, Hardy & Conway (1988), describe barriers as "impediments to taking action" (p. 379). Common barriers to assessing for abuse include the provider's lack of time, fear of offending,

feelings of powerlessness, and sense of loss of control (Sugg & Inui, 1992). For purposes of this study, this author defined a *barrier* as anything that hinders or obstructs a provider from assessing for domestic violence and/or initiating appropriate intervention and referral.

The following is a general literature review of the major components of this thesis: *assessment practices*, *knowledge*, *barriers*, and *use of referral resources*.

Assessment Practices

A story of two physicians (a cardiologist and a surgeon) illustrates the need for assessment for domestic violence. The cardiologist relates to the surgeon how much he does in the area of battered women and domestic violence. The cardiologist not only helps abused women in his practice by providing counsel and advice, but he also advocates the cause and helps to establish shelters. Upon hearing this the surprised surgeon says, "Gee, to be doing all this you really must see a lot of battered women in your practice." The cardiologist replies, "Yes, and so do you." (Rosenberg, 1995, p. 989).

In spite of the staggering statistics and the drastic consequences of domestic violence, health care providers frequently do not ask about abuse. When compared to interdisciplinary team members of the community such as; lawyers, social workers, police officers, shelter personnel and women's groups, physicians have been rated the least effective in working with battered women (Melvin & Brunton,

1995). In one study on the rates of inquiry by physicians, 394 women were seen in practice, of these 23% had been abused in the last year, 39% reported abuse at some point in their life, yet only six had ever been asked about battering by their provider (Hamberger et al., 1992). Friedman et al. (1992), reported 67% of physicians did not inquire about physical abuse at initial visits and 60% did not inquire at annual visits. In the same study, a history of physical abuse was reported in 16% of the patients, although only 7% had ever been asked; and a history of sexual abuse was noted in 17% of those surveyed, but only 6% had ever been questioned. In a more recent survey of screening behaviors of obstetricians and gynecologists, researchers concluded that the majority of the providers surveyed did not screen their patients for current or past domestic violence (Parsons, Zaccaro, Wells, & Stovall, 1995).

Direct questioning is the single most effective tool for identifying spousal or partner abuse. In a study conducted by Rodriguez, Quiroga, and Bauer (1996), 39 of 51 women (76%) with histories of domestic violence favored direct questioning about abuse, whether their injuries were obvious or their signs more discreet, or whether it was part of a routine screening. Similarly, Friedman et al. (1992) found that of 164 women surveyed, 128 (78%) favored routine physical abuse inquiry. Victims are often reluctant to initiate the topic of abuse on their own, but when asked will often times admit to being battered. Women are

relieved that someone is concerned enough to ask and welcome talking about it in a safe atmosphere (Melvin & Brunton, 1995). One study found that 8% of women reported abuse when asked on a questionnaire, but when verbally asked the same four assessment questions face to face, 29% reported abuse (McFarlane, Bateman, Miller, & Bullock, 1991). The four assessment questions most commonly reported are: 1) *Have you ever been emotionally or physically abused by your partner or someone important to you?* 2) *Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?* 3) *Within the last year has anyone forced you to have sexual activities?* and 4) *Are you afraid of your partner or anyone you listed above?* (McFarlane, Parker, Soeken, & Bullock 1992). These four questions are consistent with questions recommended by the American Medical Association when assessing for abuse (AMA Diagnostic Treatment Guidelines on Domestic Violence, 1994). In addition, the AMA also recommends considering abuse when a woman's injuries do not seem plausible, when she frequently misses appointments, and when her partner insists on accompanying her and not leaving her unattended.

Referral Resources

Once a primary health care provider identifies a battered woman, it is crucial that the health care professional create a supportive environment. The provider must listen nonjudgementally, assess the victim's situation, (ACOG, 1995), and validate her concerns (Alpert, 1995).

After providing medical support (Alpert, 1995) and inquiring about the woman's safety, options should be discussed. Counseling about emergency exit plans should be offered, as well as, group and individual counseling (Neufeld, 1996). In addition, written information regarding crisis intervention services, legal options, shelters, and community resources should also be provided (AMA, 1994). The study conducted by Rodriguiz et al. (1996) stresses the importance of conveying respect and offering referrals. Forty-five percent of the women surveyed emphasized the importance of offering referrals to shelters, counseling agencies, and social and legal services.

Knowledge

One of the most frequently cited reasons for failing to assess for domestic violence is lack of knowledge (deLahunta & Tulsky, 1996; Chambliss et al., 1995; Brown, Lent, & Sas, 1993, Gremillion & Kanof, 1996). In a study of 962 physicians, 34% said that they had no education on domestic violence and 49% felt inadequate in dealing with abuse because of the lack of training (Parsons et al., 1995). When 1994 graduating senior medical students were surveyed, 60% felt that the education received on domestic violence was inadequate (Kassebaum & Anderson, 1995). Seventy-five percent of responding program directors and chairmen of obstetrics and gynecology residencies in the United States and Puerto Rico did not identify one of 10 common clinical scenarios as being indicative of battering (Chambliss et

al., 1994). The medical professionals are not the only health care providers lacking in education on domestic violence. Limandri and Tilden (1996), studied 1,521 clinicians from six health disciplines, the majority of whom received little or no formal education on the subject of abuse. Of the 241 nurses surveyed, 56% reported a lack of education on spouse abuse. Parsons et al. (1995) determined that any education on abuse was associated with an increase in screening, including familiarity with the ACOG Technical Bulletin on the subject of domestic violence.

Research has shown that even with a working knowledge of battering in a woman, many times providers fail to respond to the abuse or follow through with interventions and referrals. One study by Kurz (1987), found that in 40% of the cases where emergency room physicians interacted with battered women they failed to address the abuse; and in another study by Warshaw (1989), emergency department physicians lacked follow-up or referral (as cited in Sugg & Inui, 1992). For this reason, this author studied knowledge more thoroughly and separately from other barriers cited in the literature.

Other Barriers

Apart from a lack of education, the reasons primary health care providers fail to assess for domestic violence are many and multifaceted. A common barrier to assessment practices cited in the literature is *time constraints* (Sugg & Inui, 1992; Titus, 1996; AMA, 1994). Providers are

concerned that asking about domestic violence will "open Pandora's Box" and consume too much of their scarce time. Another is *close identification with the patient*. Health care professionals with no personal experience of abuse often assume patients with similar social backgrounds and characteristics are likewise not at risk (Sugg & Inui, 1992). Conversely, a provider's own past experiences of abuse may preclude assessing for domestic violence in patients (Gremillion & Kanof, 1996; Alpert, 1995). A *fear of offending* (Sugg & Inui, 1992) or *invading personal space* (Gremillion & Kanof, 1996) are also barriers to assessment. Many providers feel it is not their role to intervene (AMA, 1994) and that it is a private matter (AAFP, 1994). Another frequently cited impediment to assessing for abuse is *feelings of powerlessness* (Sugg & Inui, 1992, Gremillion & Kanof, 1996; Alpert, 1995; AMA, 1994). Providers often times are frustrated with the issue because they feel inadequate and unable to "fix it." A sense of *lack of control* is also reported as a block to assessing for domestic violence (Sugg & Inui, 1992; Alpert, 1995). Providers feel their attempts at intervention are futile as they are unable to control the patient's behavior. Other barriers identified include a fear of litigation, a lack of personnel, space, or policy (Gremillion & Kanof, 1996; Alpert, 1995); and societal beliefs--the victim is responsible for the violence or cultural beliefs--support of male dominance (Gremillion & Kanof, 1996).

Critique of the Literature

Most of the research found regarding assessment practices of health care providers and domestic violence has involved emergency room care. Very few studies were found by this researcher indicating the rates of inquiry by health care providers in primary care; two were from 1992 and one was from 1995, and all surveyed only physicians. A fourth study, not yet published, McClure and Meirhenry (1995), also studied only physician assessment practices with regard to domestic violence. Although McClure (1993) studied both physicians and nurses, traditional RNs without advanced practice training were included in the results regarding nursing practice. This author intends to add to the limited existing body of research on assessment practices of health care providers regarding domestic violence. By examining the impact knowledge and barriers have on the assessment practices of primary health care providers, it is the hope of this researcher to increase the awareness of domestic violence and bring the issue to the attention of primary health care providers so that knowledge can be attained and barriers can be resolved. It is also the hope of this researcher to make primary health care providers aware of the need to become familiar with community resources available for referral. And lastly, since there is no published study yet about the assessment practices of nurses in advanced practice with regards to domestic violence, this

researcher hopes to stimulate further studies on APNs effectiveness in assessing for domestic violence.

Conceptual Framework

The Health Belief Model (HBM) provided the theoretical framework for describing the variables in this study. The HBM has been used to explore health-related behaviors at the individual's decision-making level (Mikhail, 1981) in an attempt to understand why people engage in preventive health behaviors (Pender, 1987). Since its creation, the HBM has been one of the most extensively developed models and the most useful in predicting health promoting behaviors and compliance with treatment regimens (Hardy & Conway, 1988). Research using the HBM has been conducted on a variety of patient populations to predict health-related behaviors based on patient beliefs surrounding a particular illness or disease.

The Health Belief Model developed by Becker and Maiman (1975) consists of three main dimensions: individual perceptions, modifying factors, and likelihood of action. *Individual perceptions* include perceived susceptibility, or the degree to which a person feels at risk for developing a disorder; and perceived seriousness, or the severity of the consequences of the condition (Kozier, Erb, & Blais, 1992). Together these concepts provide a measure of perceived threat of an illness to an individual (Pender, 1987).

Modifying factors affect a person's perception (Kozier, et al., 1992) and influence the inclination to take

preventive actions (Pender, 1987). These factors include demographic variables such as, sex, age, race, and ethnicity; sociopsychological variables such as social influences or pressure from peer or reference groups; structural variables such as, knowledge about the condition or prior contact with the illness; and lastly, "cues to action" (Kozier et al., 1992). These cues to action are actually triggers that stimulate the decision-making process and can be internal, such as symptoms, or external such as mass media or interpersonal communications (Janz & Becker, 1984).

The last component of the Health Belief Model is *likelihood of action*. The probability of a person performing preventative behaviors can be predicted based on a cost-benefit analysis. One must weigh the perceived benefits of action minus the perceived barriers to taking action. The benefits depend upon the beliefs regarding the effectiveness of the behavior in reducing the perceived threat (Janz & Becker, 1984). The barriers are the potential negative aspects involved in initiating the recommended behavior and therefore function to impede the undertaking (Janz & Becker, 1984). These can include time, expense, inconvenience, and unpleasantness.

The Health Belief Model has historically been used to predict the health promoting behaviors of patients; however, McClure (1993) developed a model (Figure 1), originally adapted from Becker and Maiman (1975), to describe the

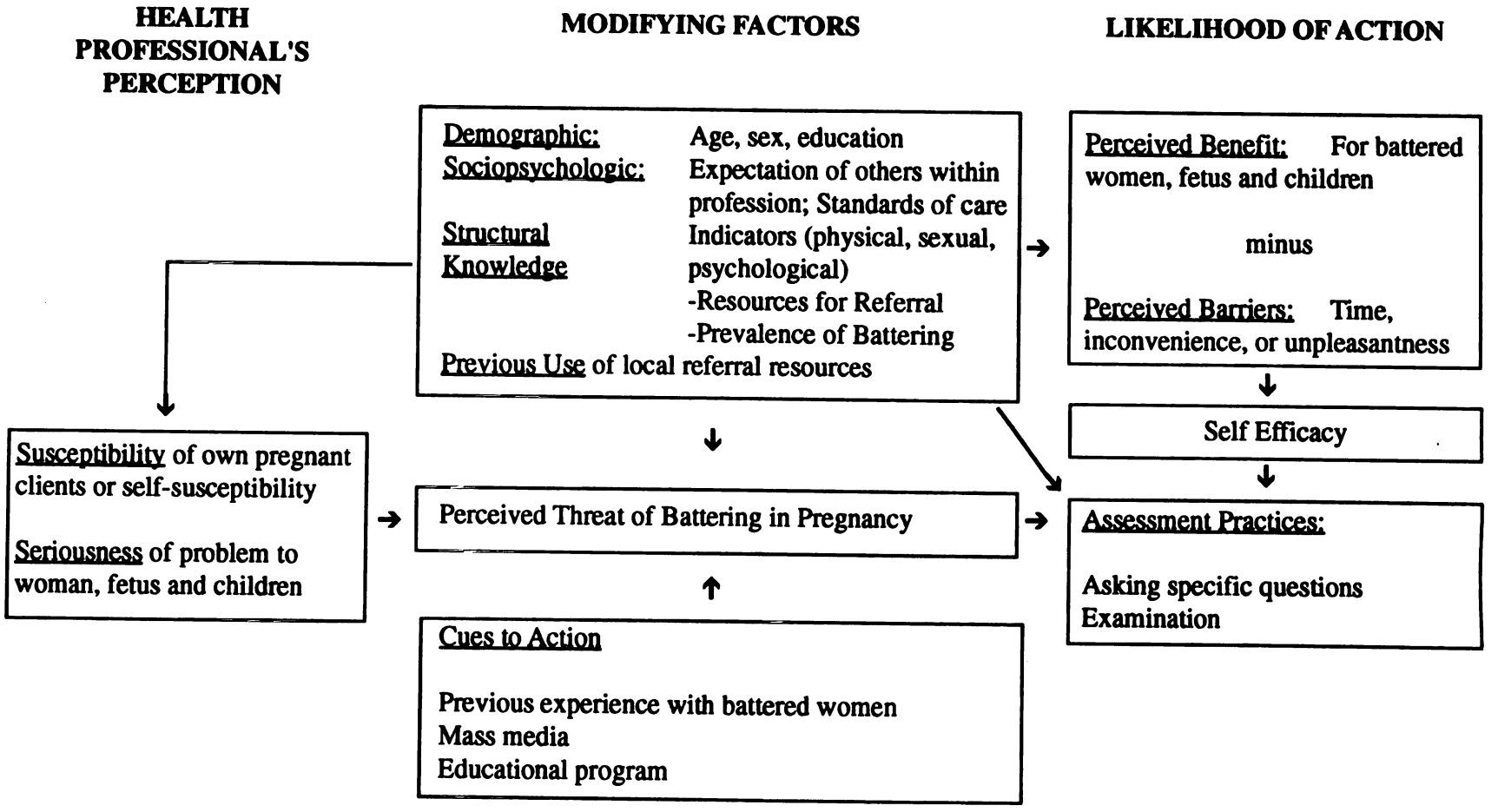

Figure 1. (McClure, 1993). Battering in Pregnancy. Application of Research Variables to the Health Belief Model

assessment practices of a health professional in primary care related to battering in pregnancy. This researcher modified McClure's model to describe the health promoting behaviors of a health care provider who deals with domestic violence in the primary care setting and the use of referral resources. This study described the major variables of knowledge, assessment practices, barriers, and the use of referral resources as they pertained to a provider in a primary health care setting. This study also explored the relationships between these variables such as the connection between knowledge and assessment practices, barriers and assessment practices, and the impact these connections have on the use of referral resources. Figure 2 highlights the application of these research variables to the HBM.

METHODS

Sample

A non-probability convenience sample of physicians and advanced practice nurses providing primary care in the tri-county area of Saginaw, Midland, and Bay City, Michigan were used for this descriptive study. The names and addresses of the health care providers were obtained from area hospital roster lists, local telephone books, health insurance provider directories, the Mid-Michigan Advanced Practice Network member list, and the Michigan Nurse's Association list. Practice settings included private and group practices, hospital owned practices, clinics, and health maintenance organizations. Areas of practice comprised

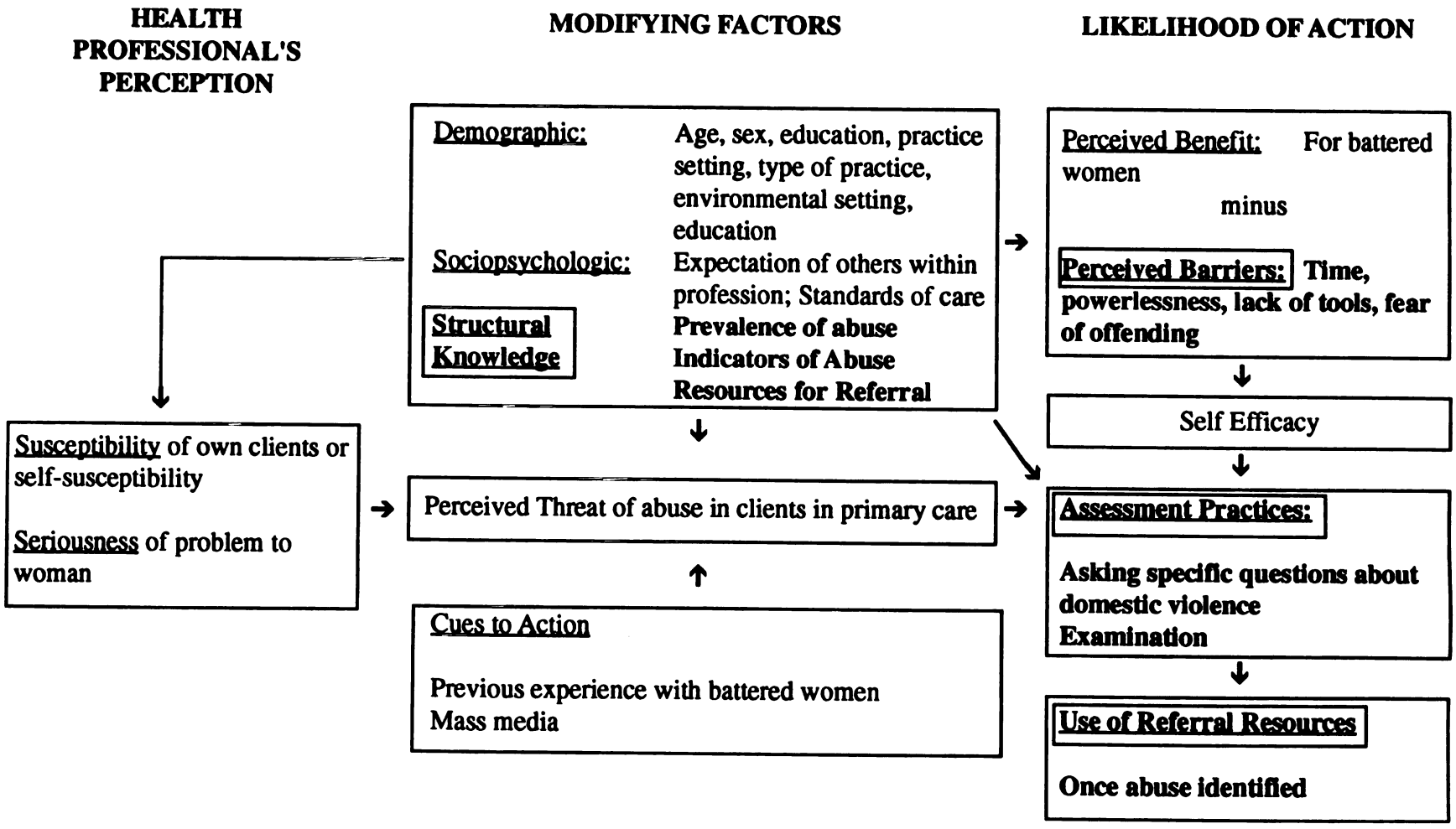

Figure 2. (Adapted from McClure, 1993). Domestic violence in primary care. Application of research variables to the Health Belief Model.

family practice, internal medicine, and obstetrics and gynecology.

Each physician name and specialty was identified on the hospital roster listing, as well as, under specific headings in the telephone book. Based on the identification of physician specialty, the target population was comprised of 128 family practice physicians, 38 obstetricians and gynecologists, and 45 internal medicine specialists, for a total physician number of 213. The Advanced Practice Network member listing was used in conjunction with the Michigan Nurse's Association listing of APNs in the tri-county area. The identification of names of APNs and the type of practice setting came from one of the four officers of the Advanced Practice Network. APNs whose specialty was not known for certain were sent a survey. The phonebook was also used to locate additional APNs whose name and area of practice was listed with the collaborating physician name and specialty. A total of 38 APNs were identified, bringing the total number of targeted health professionals to 251.

Data Collection Procedure and Recording

The information gathered for the study was based on a one-time, cross sectional survey. A cover letter was sent along with the questionnaire describing the purpose of the study and instructions to the providers regarding completion of the survey and its timely return (see Appendix A). In addition, a second cover letter, which was written by two local emergency room physicians emphasizing the importance

of participating in the study and completing the survey, was also included in the initial mailing (see Appendix B).

The survey instrument and the two cover letters were sent to the identified physicians and advanced practice nurses providing primary care to women in the Saginaw, Midland, and Bay City, Michigan area. To help facilitate the return of a completed survey, a self-addressed, stamped envelope was included. A deadline of two weeks was given and a postcard was sent one week after the initial mailing as a reminder to complete and return the survey or as a thank you to those that had already done so. As each survey was returned, it was numbered consecutively.

Protection of Human Subjects

The survey consisted of no identifying characteristics to protect anonymity and assure confidentiality. Receipt of a completed survey was interpreted as acceptance to participate in the study. Participants had the opportunity to receive the results of the study by returning a self-addressed, stamped postcard separate from the completed survey. In addition, approval for the research was granted from UCRIHS at MSU (#97-191, see Appendix C).

Instrument

Permission was obtained from Bonnie McClure, RN, CS, MSN, to use a survey tool developed by McClure and Meierhenry (1995) for a similar research study (Appendix D). According to McClure (1993), the tool was developed based on content from the Conflict Tactics Scale (CTS) (Straus, 1979)

and the Abuse Assessment Screen (AAS) (McFarlane et al., 1992). Questions 1-10 comprise demographic data about the respondents, such as profession, age, sex, years in practice, clinical practice setting, and educational background. Question one was altered for this study to include the advanced practice nurse and degree achieved. Question 10 was added to this study to include educational information derived from reading published material on domestic violence. Questions 11-13 referred to knowledge regarding the prevalence of domestic violence and knowledge of signs and symptoms and reported behaviors that are possible indicators of domestic violence. Questions 12 and 13 describe possible indicators of abuse and were altered from the original survey. Question 12 listed eleven possible signs and symptoms of abuse. *Broken bone, bruises, black eye* and *lacerations* were all included in the original survey. The additional 7 signs and symptoms were added for this study. Question 13 described ten behaviors as possible indicators of abuse, all of which were included in the original survey; however, the words, *report of,* were removed for this study. Knowledge of possible referral resources in the community was addressed in question 14, and previous use of such referral resources was identified in question 15. An additional resource, counseling services, was added to the original survey as a potential source for referral. The assessment practices of providers were covered in questions 16-27 and question 30. Possible

barriers to assessing about domestic violence were added to the questionnaire and were examined in questions 28, 29 and 31-33. Lastly, room for reactions or comments was provided at the end (see Appendix E for complete survey).

According to McClure, the instrument was reviewed by two nationally recognized experts in the field of "battering in women" and was determined to have content validity. A pilot group of five health care professionals established readability. Since the barrier questions were added to the questionnaire for this study, an emergency room physician, who has worked extensively with domestic violence victims, reviewed those questions for content validity.

Operational Definitions

Assessment practices. Assessment practices regarding domestic violence were measured in questions 16-27 and question 30. These questions evaluated a primary health care provider's (PHCP) frequency in asking female patients about domestic violence during initial visit and each following annual visit; the frequency with which questions were included on a history form that female patient completes; the frequency in which the PHCP verbally asked about domestic violence; the frequency in which the PHCP verbally asked female patients if, in the last year, they have been hit, slapped, kicked, or otherwise physically hurt by someone; and lastly, the frequency in which the PHCP verbally asked female patients if, within the last year,

they have been afraid of their partner or anyone close to them.

Knowledge. Providers' knowledge of domestic violence was measured in questions 11-14. These questions asked primary health care providers about the prevalence of domestic violence, indicators of domestic violence, as well as, awareness of referral resources in the community, such as: a 24 hour crisis line, police force, prosecuting attorney's office, legal aid, shelter/safehouse, counseling service, or others not listed. In addition, respondents were also asked to identify the resource used by name.

Barrier. Barriers to assessing for domestic violence were measured in questions 28, 29 and 31-33. Potential impediments to assessment were evaluated by a primary health care provider's response to such statements as, *Time constraints of a busy practice prevent you from assessing for domestic violence, You consider domestic violence a private matter and therefore do not ask about abuse for fear it may offend her, "Normal" men and women do not engage in domestic violence, Primary care providers do not have the necessary tools to help victims of domestic violence,* and lastly, There's nothing I, as a health care provider, can do about domestic violence.

Use of referral resources. Previous use of referral resources was measured by a primary health care provider's positive response to past referral to a 24 hour crisis line, police force, prosecuting attorney's office, legal aid, a

shelter or safehouse, a counseling service, or a resource not described. In addition, the respondent was asked once again to provide the name of the resource utilized. This was evaluated in question 14.

Scoring and Data Summarizing Procedures

The overall knowledge level of the provider with regards to domestic violence was evaluated in four questions and scored on a cumulative point system ranging from 0-47. In addition, each sub-component score was calculated based on assigned points. Knowledge of the prevalence of domestic violence was given a total value of 10 points. Zero for a response of less than 6%, 1 for a response of 6-10% or >26%, 5 for 11-15% or 21-25%, and 10 for the correct response of 16-20%. Recognition of possible signs and symptoms of domestic violence was assigned one point for each one identified and one point for any additional signs and symptoms added by the respondent in the comment section for a grand total of 12 points. Similarly, the recognition of reported abusive behaviors as potential indicators of domestic violence was assigned one point for each behavior selected and an additional point for behaviors identified by the survey participant in the comment area, for a total of 11 points. A single question evaluated knowledge of referral resources in the community. Responses were either "yes" or "no" to indicate awareness. One point was given for each "yes" response and an additional point was given if the provider included the name of the resource. Space was

provided to include additional resources used by the provider. Points were assigned to those responses confined to the subset available in all three communities so that knowledge was measured not availability of resources. Therefore, points were not assigned to any additional responses and a grand total of 12 points were possible.

A single question analyzed the previous use of those same local referral resources. Each "yes" response indicated previous use of the resource and was assigned a single point. An additional point was awarded if the name of the resource was included, regardless if it was previously mentioned, allowing for the fact that many of the resources listed provide multiple services. A "no" response indicated no prior use of the resource. Space was provided to include additional resources used as referrals by the provider. A total of six possible resources were identified and a range of 0-12 points were possible.

Eleven assessment questions addressed the provider's approximate frequency in screening women for abuse, the frequency in using specific questioning techniques, and the frequency in considering specific exam findings as indicators of abuse. A Likert scale of 1 "Never" to 5 "Always" was used and then the mean of all responses was used to generate a cumulative score for assessment practices. The range of this score was 1-5 corresponding with the Likert scale.

The five barrier questions were evaluated on two separate Likert scales. Two questions were scored as mentioned above on a scale of 1 "Never" to 5 "Always," and three questions were scored on a scale of 1 "Strongly Disagree" to 5 "Strongly Agree." The overall barrier score consisted of the mean across the five response items, allowing for a possible range of the scale score from 1 to 5. The higher the number, the stronger the barriers in deterring assessment practices for domestic violence.

Data Analysis

Frequency statistics were used to describe the sample with regard to type of primary care provider, age, sex, clinical setting, type of practice, years in practice, and educational background. Correlation statistics were utilized to determine relationships between *assessment practices*, *knowledge*, *barriers*, and *use of referral resources*. Group differences between nurses and physicians in all primary care settings regarding *assessment practices*, *knowledge*, *barriers*, and the *use of referral resources* were assessed on the basis of independent t-tests. Factorial analysis of variance was used to determine whether differences between physicians and nurses remained after taking into account the effects of age, sex, and practice setting and which was the strongest predictor of the outcome variables, *use of referral resources* and *assessment practice*. Accepted levels of significance were .05 for all statistical tests.

Information was processed and statistically analyzed through the use of SPSS.

RESULTS

Demographic Characteristics

Of 251 surveys mailed, 84 were returned for a total response rate of 33%. The physician group returned only 49 of 213 surveys mailed for a response rate of 23% and the APNs returned 25 or 38 surveys mailed for a higher rating of 66%. Ten respondents were omitted; one practiced in a long term care facility, one in pediatrics, and one in an acute care setting; and six physician questionnaires and one APN questionnaire were received after data analysis had begun leaving a final sample total of 74.

Table 1 describes the subjects by profession and type of health care provider. The sample consisted of 49 physicians (66%), 40 with a medical degree (MD) and 9 with a degree in osteopathy (DO), and 25 advanced practice nurses (34%). Of the advanced practice nurses (APNs), 22 were certified practitioners--15 with master's degrees, 5 with bachelor's, and 2 with associate degrees. Three were not certified, 2 at the master's level and one at the baccalaureate level. Fifty-one percent were male and 49% were female, as shown in Table 2. The age distribution as well as the number of years in practice is highlighted in Table 3. The mean age of the providers was 46 and the average number of years practicing in the current specialty was 14.

Table 1.

Distribution of Sample by Professional and type of Health Care Provider

Variable	Number of Subjects	Percentage
Profession		
Physician	49	66.2
Nurse	25	34.8
TOTAL	74	100.0
Type of Health Care Provider		
MD	40	54.1
DO	9	12.2
AND & Certified	2	2.7
BSN	1	1.4
BSN & Certified	5	6.8
MSN	2	2.7
MSN & Certified	15	20.3
TOTAL	74	100.0

Table 2.

Distribution of Sample by Sex

Variable	Number of Subjects	Percentage
Sex		
Male	38	51.4
Female	36	48.6
Total	74	100.0

Table 3.

Distribution of Sample by Age and Number of Years in Current Specialty

Variable	Mean	SD	Mode	Median	Minimum	Maximum
Age	45.8	10.4	33	44	32	73
Years in Current Specialty	14.2	10.1	20	13	1	40

Sixty-nine percent of the providers practiced in private offices, 22% in clinics or hospitals, 3% in health maintenance organizations, and 7% in other. Fifty-three percent were in family practice, 39% in obstetrics and gynecology, and 8% in internal medicine (see Table 4).

In regard to the educational background of the study participants, 81% (48% of the nurses and 35% of the physicians) reported having read published literature or journal articles on domestic violence within the last year, 39% (92% of the nurses and 75% of the physicians) had attended an educational program, and 43% (72% of the nurses and 29% of the physicians) had received specific training during their formal education (see Table 5).

Instrument/Measures

Knowledge was to be measured by four factors. The first component of knowledge was that of prevalence of domestic violence. It was determined, however, through the use of item correlation statistics that prevalence scores did not correlate with the other three knowledge indicators. It was therefore deemed an unreliable indicator of knowledge and discarded. The signs and symptoms and behaviors responses were highly correlated and thus were combined together as a single measure of knowledge. Reliability analysis produced a Cronbach's alpha of .79. The second measure of knowledge was knowledge of referral resources. Reliability analysis produced a Cronbach's alpha of .69 for this scale. A correlation coefficient of .41 indicated that

Table 4.

Distribution of Sample by Clinic, Practice, and Environmental Settings

Variable	Number of Subjects	Percentage
Clinic Setting		
Private Office	51	68.9
Clinic	16	21.6
HMO	2	2.7
Other	5	6.8
Total	74	100.0
Practice Setting		
Family Practice	39	52.7
Internal Medicine	6	2.7
OB/GYN	29	39.2
Total	74	100.0
Environmental Setting		
Urban	33	45.8
Suburban	24	32.4
Rural	14	18.9
All	1	1.4
Missing	2	2.7
Total	74	100.0

Table 5.

Distribution of Sample based on Educational Background regarding Domestic Violence

Variable	Group Total	Group Percent	Physician Total	Physician Percent	APN Total	APN %
Attend Educational Program						
NO	45	60.8	32	65.3	13	52.0
YES	29	39.2	7	34.7	12	48.0
Total	74	100.0	49	100.0	25	100.0
Read Literature or Journal Articles						
NO	14	18.9	12	24.5	2	8.0
YES	60	81.1	37	75.5	23	92.0
Total	74	100.0	49	100.0	25	100.0
Formal Education						
NO	42	56.8	35	71.4	7	28.0
YES	32	43.2	14	28.6	18	72.0
Total	74	100.0	49	100.0	25	100.0

those who were aware of community resources are not necessarily aware of signs and symptoms or behaviors indicative of abuse. Therefore, these two scales were kept apart as separate knowledge dimensions.

Missing data was considered "no" responses for interpretation of knowledge of referral resources and use of referral resources.

Linear regressions were used to predict missing responses with regard to assessment practices, except where missing data reflected a "not applicable" response. A factor analysis of the eleven responses did not indicate a distinct enough pattern to warrant two separate scales--one evaluating screening practices and a second describing exam practices. However, a single question, *During an examination of a woman, do you consider abuse when seeing injuries that do not match their cause?* showed a low inter-item correlation with the rest of the items at .18; therefore, this item was removed. A reliability analysis was completed on the remaining 10 items and a Cronbach's alpha of .90 was achieved.

A reliability analysis on the use of referral resources revealed a Cronbach's alpha of .55. This low score was to be expected since many providers may rely on only one or two resources in the community thereby not utilizing all that were listed.

The barrier scale factor analysis indicated a low item total correlation (.19) regarding the statement, *"Normal"*

men and women do not engage in domestic violence." The remaining items were .36 or higher. As a result, the *"Normal"* question was omitted leaving the remaining four items and increasing the Cronbach's alpha from .58 to .68.

Other Findings

Frequency statistics were used to describe the sample's response to the question, *To the best of your knowledge, how frequently does domestic violence occur?* The 16-20% range received the highest response (27%), which was the correct response based on current literature findings. Slightly less than 2% of the sample selected 0-5% and over 31% of the sample thought the prevalence of domestic violence was 21% or higher. Nearly 10% or 7 of the respondents did not answer the question, some of whom added comments such as, *"of what?" and "vague."*

As for indicators of abuse, a sub-component of the knowledge scale, all of the participants acknowledged *bruises, black eye,* and *threats of harm to the woman* as suspect for abuse. *Insomnia, abdominal pain,* and *partner jealousy* received the lowest responses of 89% each. The remaining signs and symptoms and behaviors received response rates of 92-99%. Of a possible 23 points, the mean sample score was 20.6 with a SD of 2.1, indicating that most subjects had a high level of knowledge related to indicators of abuse.

The total possible points for *knowledge of* and *use of referral resources* was 12. Omission of a "yes" or "no"

response was taken for a "no" and scored accordingly. The mean sample score for *knowledge of referral resources* was 6.1 with a SD of 2.9. The mean sample score for *use of referral resources* was lower at 3.3 with a SD of 2.4. Knowledge of a shelter or safehouse received the greatest response with 35% of the sample simply acknowledging the existence of such a resource and an additional 57% of the sample identifying one by name, for a total of 92%. Likewise, referral to a shelter or safehouse also received the highest response rate, 41% of the sample indicated prior referral to a shelter or safehouse and an additional 27% of the sample identified the referral resource used by name, for a total of 68%. These figures are represented in Table 6.

The mean scores for each of the eleven assessment questions are shown in Table 7. The overall mean across all eleven assessment score items for the sample was 2.77 with a SD of .77 (2=rarely and 3=sometimes), indicating that the sample rarely to sometimes assessed for domestic violence.

The overall mean barrier score was 1.8. Providers indicated that the potential barrier of *time constraints* rarely to sometimes (2=rarely and 3=sometimes) interfered with assessing for domestic violence and either disagreed with or were uncertain (2=disagree and 3=uncertain) regarding the premise that *"normal" men and women do not engage in domestic violence*. Each of these statements received a mean score of 2.6. Subjects disagreed with the

Table 6.

Sample Distribution of Knowledge of and Prior Use of Referral Resources

Resource	Knowledge of Frequency	Knowledge of Percent	Use of Frequency	Use of Percent
24 Hour Crisis Line				
No	18	24.3	47	63.5
Yes	31	41.9	18	24.3
Name	25	33.8	9	12.2
Total	74	100.0	74	100.0
Police Force				
No	22	29.7	53	71.6
Yes	24	32.4	14	18.9
Name	28	37.8	7	9.5
Total	74	100.0	74	100.0
Prosecuting Attorney				
No	36	48.6	68	91.9
Yes	27	36.5	5	6.8
Name	11	14.9	1	1.4
Total	74	100.0	74	100.0
Legal Aid				
No	42	56.8	67	90.5
Yes	25	33.8	4	5.4
Name	7	9.5	3	4.1
Total	74	100.0	74	100.0
Shelter or Safehouse				
No	6	8.1	24	32.4
Yes	26	35.1	30	40.5
Name	42	56.8	20	27.0
Total	74	100.0	74	100.0
Counseling				
No	18	24.3	28	37.8
Yes	21	28.4	19	25.7
Name	35	47.3	27	36.5
Total	74	100.0	74	100.0

Table 7.

Distribution of Sample Response to Assessment Questions

Assessment Questions	Mean*	SD	Minimum	Maximum	N
1) Screen for domestic violence during initial intake history.	3.0	1.2	1.0	5.0	74
2) Screen for domestic violence during annual visits.	2.8	1.0	1.0	5.0	74
3) Include question about domestic violence on intake history form patient completes	2.1	1.4	1.0	5.0	74
4) Verbally ask about battering	2.9	1.0	1.0	5.0	74
5) Verbally ask about being hit, kicked, slapped, or physically hurt by someone.	2.3	1.1	1.0	5.0	74
6) Verbally ask about being forced into sexual activities.	2.2	1.0	1.0	5.0	74
7) Verbally ask about being afraid of partner or someone close.	2.2	1.0	1.0	5.0	74
8) Consider abuse when injuries do not match cause.	4.1	.90	2.0	5.0	74
9) Consider abuse when see depression, withdrawal, or lack of eye contact.	3.5	1.0	1.0	5.0	74
10) Consider abuse when male partner will not leave woman	3.9	1.0	1.0	5.0	71
11) Consider abuse when office visits frequently missed.	2.7	.92	1.0	5.0	72

*the higher the number the greater the frequency of assessing for domestic violence

beliefs that *primary care providers do not have the necessary tools to help victims of domestic violence* and *there is nothing I, as a health care provider, can do about domestic violence* with mean scores of 1.9 and 1.4 respectively (1.0=strongly disagree and 2.0=disagree). In addition, participants rarely to never felt domestic violence was a private matter declining to ask out of fear of offending. This received a mean score of 1.5 (see Table 8).

Table 8.

Sample Distribution regarding Barriers to Assessing for Domestic Violence

Barrier Questions/Statements	Mean*	SD	Median	Mode	Valid N
1) Time constraints of a busy practice prevent assessing for domestic violence.	2.6	.96	3.0	3.0	72
2) Domestic abuse is considered a private matter and questions are not asked out of fear of offense.	1.4	.87	1.0	1.0	72
3) It is a belief that "Normal" men and women do not engage in domestic violence	2.6	1.5	2.0	2.0	72
4) It is a belief that primary health care providers do not have the necessary tools to help victims of domestic violence.	1.9	.86	2.0	2.0	72
5) It is a belief that primary health care providers can do nothing about domestic violence.	1.5	.60	1.0	1.0	72

*The higher the number the greater the strength/frequency of barrier.

Research Questions

Descriptive statistics were used to answer the following research question:

1. *To what extent do primary health care providers verbally and physically assess for domestic violence?* The overall mean assessment score for the sample was 2.77 with a SD of .72 indicating that the primary health care providers in this sample *rarely* to *sometimes* assessed for domestic violence.

The Pearson Product Moment Correlation was used for describing relationships among the major study variables and to answer the following research questions:

2. *Is there a relationship between knowledge regarding domestic violence and the assessment practices of primary health care providers?* The knowledge of specific signs and symptoms and certain behavior patterns as possible indicators of the presence of domestic violence had a moderate relationship (r=.31) with the frequency of assessing for domestic violence, which was significant (p=.006). The component of knowledge related to the awareness of referral resources did not have a significant relationship with assessment practices (r=.18, p=.12).
3. *Is there a relationship between barriers identified and the assessment practices of primary health care providers regarding domestic violence?* There was a negative correlation between barriers and assessment practices (r=-.39, p=.001). Healthcare providers in this sample who had higher barrier scores were less likely to assess for domestic violence.
4. *Is there a relationship between assessment practices of primary health care providers and the use of referral resources?* There was no correlation between assessment practices of the primary health care providers in this sample and their corresponding use of referral resources (r=.18, p=.13).

Independent t-tests were employed initially to answer the remaining research questions. Mean assessment score differences between physicians and nurses was the only comparison to reach statistical significance (t=-4.01, p=.000). The advanced practice nurse mean assessment score was .65 higher than that of the physician mean assessment score. Factorial analysis of variance was then applied to examine if mean knowledge, assessment, referral, and barrier scores differed between advanced practice nurses and physicians after controlling for the effects of sex, type of practice setting, and years of practice. Practice setting for these comparisons were narrowed to two groups, one which included the family practice and internal medicine groups combined, and the other, the ob/gyn. Years of practice were used versus age as it represented one more case and there was a high correlation between the two .81. The following questions were answered.

5. *Is there a difference between advanced practice nurses and physicians regarding assessment practices for domestic violence?* There was not a statistically significant difference in mean assessment scores between physicians and advanced practice nurses (p=.17). There was, however, a statistically significant difference in mean assessment scores between males and females (p=.005). The female adjusted mean assessment score (2.85) was .16 higher than the male adjusted mean assessment score (2.69).

There was also a statistically significant difference between the family practice/internal medicine mean scores and the obstetrics/gynecology providers' mean scores. The ob/gyn providers' mean assessment scores (3.02) were .41 higher than the family practice/internal medicine providers' mean assessment scores (2.61). In addition, *years in practice* had a negative effect (raw regression coefficient -.014) and was almost statistically significant (p=.08).

6. *Is there a difference between advanced practice nurses and physicians regarding knowledge of domestic violence*? Regarding knowledge of signs and symptoms and behaviors associated with domestic violence, there was not a statistically significant difference between mean knowledge scores of physicians and APNs (p=.90). Similar findings were present regarding knowledge related to referral resources. The mean difference between the two professional groups was not significant (p=.93). There was, however, a statistically significant difference in mean knowledge scores of signs and symptoms and behaviors between males and females (p=.02). The adjusted female mean was 1.07 higher than the adjusted male mean.

7. *Is there a difference between advanced practice nurses and physicians regarding barriers to domestic violence assessment?* There was not a statistically significant difference in mean barrier scores between physicians

and advanced practice nurses (p=.38). *Years in practice,* although accounting for less than 10% of the variation, had a statistically significant positive effect on barrier score (raw regression coefficient=.017, p=.01).

8. *Is there a difference between advanced practice nurses and physicians regarding use of referral resources?* There was no statistically significant difference in mean referral scores for physicians and advanced practice nurses.

Interpretation of Findings

Much can be said about the findings in this study related to the Health Belief Model (HBM) and the literature. The HBM was used in this research as a means to describe a primary health care provider's health promoting behaviors as they relate to the likelihood to assess for domestic violence and use referral resources. By examining modifying factors and possible impediments to take action, the HBM was also used to explain the relationships among the variables of knowledge, barriers, assessment practices, and use of referral resources. This study did not, however, attempt to evaluate all components of the HBM, such as a health care provider's perceived susceptibility or seriousness of own clients in relation to domestic violence, the providers perceived threat of abuse in clients in primary care, cues to action, or a provider's perceived benefit for assessing for domestic violence.

Modifying factors, as described by Kozier et al. (1992), affect a person's perceptions and influence their decision to take preventive actions. These factors include demographic variables, sociopsychological variables, structural variables, and cues to action. Based on this study and the participants involved, the structural variable knowledge was moderately correlated with the likelihood to assess for domestic violence. However, it depended on the type of knowledge. Participants who had a greater working knowledge of signs, symptoms, and behaviors associated with abuse were more likely to assess for domestic violence. The participants in this sample who were more knowledgeable about resources in the community were not necessarily more inclined to assess. This finding, in part, conflicts with the literature, which often cites a lack of knowledge as a reason for not assessing for domestic violence. The high knowledge scores related to signs, symptoms, and behaviors may be due to the way in which these indicators were presented in the survey lending to ease of recognition and therefore artificially skewing the scores.

The component of the HBM, *likelihood of action*, is affected by negative aspects involved in initiating health promoting behaviors (Janz & Becker, 1984). In this sample, certain identified barriers did inhibit the health care provider's likelihood to assess for domestic violence. Those primary care providers who had higher barrier scores were less likely to assess for domestic violence. Although

this study demonstrated a moderate relationship, moderately correlated (.39), this finding is highly supported by the current literature, which cites that health care providers are negatively influenced by certain barriers thereby impeding assessment practices related to domestic violence.

Further utilizing the HBM component, *likelihood of action*, it was presumed that one action may be directly related to another action. It seemed apparent by this researcher that the use of referral resources would be directly influenced by the frequency of assessment practices. The proposed existence of this relationship was not supported by this study, nor is it substantiated in the literature. There was no relationship between assessment practices of the primary health care providers and corresponding use of referral resources. It is unclear if this was a result of a poor scale for use of referral resources or merely a sample effect.

When analyzing the data to determine any differences between advanced practice nurses and physicians with regard to assessment practices, barriers, knowledge, and use of referral resources, some interesting findings emerged. First and foremost, it was noted that there were no significant differences between advanced practice nurses and physicians across all research variables. What apparent differences did arise in one-way comparisons seemingly to indicate that the APNs assessed more frequently was

obliterated once the sample was controlled for by other variables in a multivariate analysis.

A consistently important control variable was the demographic variable of sex. Differences in gender played a key role in many of the relationships. Females assessed for domestic violence more frequently than males and had higher knowledge scores related to signs, symptoms, and behaviors than did males and each of these findings was statistically significant. Although females tended to be more knowledgeable about referral resources, have fewer barriers and use referral resources more frequently than men, this was not a significant finding and could be due more in part to sample effect. Much of the one-way effect regarding provider type differences is explained by the fact that all of the nurses in the sample were female. The differences associated with gender have been supported in the literature (Parsons et al., 1995) and unsubstantiated (McClure, 1993). This may be due in part that most victims are female and most perpetrators are male.

Practice setting, another demographic variable, also had a strong positive relationship to the research variables. A statistically significant finding was those providers practicing in ob/gyn offices were more likely to assess for domestic violence than those in family practice and internal medicine practices combined. On average, ob/gyn providers were also noted to have higher knowledge scores related to signs, symptoms, and behaviors associated

with abuse as well as knowledge of sources for referral. They also scored higher on use of referral resources and lower in relation to barrier scores. These findings were an observed effect in the sample and were not statistically significant. Furthermore, there is no published literature supporting this finding, in fact, McClure, (1993) found that family practice physicians had higher mean scores in both assessment practices and use of referral resources.

Years of practice, which correlated highly positive with age (.81), was a significant indicator of barriers. The more number of years in practice, the greater the barriers to assessing for domestic violence. This may be due in part to developing certain practice patterns over the years that may not have included the screening and assessing for domestic violence. Providers may have become in the "habit" of not inquiring, and find it difficult or awkward to begin. This is not substantiated by the literature, and like many of the findings, needs further research to determine.

Discussion

Methodological Assumptions and Limitations

This research was not conducted without limitations and assumptions. First of all, a non-probability convenience sample was used thereby inhibiting generalizability of the findings. Second, a survey was mailed to participants in the study to collect information on assessment practices, which may result in self-selection bias as well as a poor

survey response rate. These results may be reflected in the lower response rate for physicians possibly indicating that only the most concerned physicians responded. A second survey was not mailed, only a reminder card. A second survey may have increased response rates. Third, a survey tool that has not been well established was used to measure the variables of knowledge, assessment, and use of referrals. The prevalence question was omitted from the survey as it was often taken as vague or ambiguous. This left only two measurements of knowledge. There was little variation in the knowledge scores of signs, symptoms, and behaviors which may limit correlations. And lastly, the barrier question regarding "normal" men and women was omitted from the survey also due to ambiguity, thereby, leaving only four statements which measured barriers. In addition, the barrier scale received a somewhat low Cronbach's alpha of .68.

This research was conducted under three main assumptions, 1) Self report accurately reflects practice techniques, 2) Health care providers completing the survey are representative of health care providers in general, and 3) Standards of care regarding domestic violence guide ob/gyn assessment practices.

Implications of Results for Existing Literature

This research adds to the limited existing body of literature about domestic violence in the primary care setting. It also is the only study related to domestic

violence that compares assessment patterns, knowledge, and barriers between advanced practice nurses and physicians in various primary care settings. It is one of a very few studies that examines barriers and use of referral resources as they relate to domestic violence.

Implications for Advanced Practice Nursing

Implications for advanced practice nursing are many. As advanced practice nurses continue to emerge as effective primary care providers who are able to provide quality, cost-effective care, APNs will need to be acutely involved in the many important issues confronting the public as a whole. As a means to stay involved and address the issue of domestic violence, APNs need to develop and incorporate into practice specific measures to impact the problem of violence in America. Some of these methods include the dissemination of information regarding domestic violence, the incorporation of assessment techniques into practice, and the development of strategies to identify and address barriers to assessment practices.

The nursing profession takes pride in its ability to educate and teach. One of the first steps in disseminating information regarding domestic violence is through educating the educators. Information about domestic violence must be incorporated into all nursing programs at both the undergraduate and graduate levels. Information must include, but must not be limited to, the prevalence of domestic violence in the United States, an overview of

common characteristics of the abused woman and the batterer, the cycle of abuse and possible indicators, assessment techniques, and community resources available for referral.

Once armed with this information, advanced practice nurses can then spread their knowledge by presenting continuing education seminars or conferences for other primary health care providers. To further increase providers' awareness about domestic violence, actual case scenarios, video presentations, or real victims of abuse could be incorporated into these educational programs; and, to promote the use of referral resources, representatives from various community agencies could discuss goals and services each provide. Written resource materials could also be distributed.

In a less formal way, APNs can disseminate information about domestic violence to peers, colleagues, and physician counterparts alike. APNs can raise the issue of the prevalence of domestic violence in the practice area. By presenting and discussing domestic violence cases and describing presenting signs and symptoms, distinguishing characteristics, behaviors, and how intervention was handled can serve to educate others.

In addition to primary health care providers, APNs can also conduct presentations and lectures to other health care professionals, i.e., hospital and office staff, social workers, mental health workers, etc., as well as, to public officials, community leaders, and the community at large to

enhance their knowledge and understanding of domestic violence. Education in the schools and community in general can promote the awareness of the issue of domestic violence. Increasing the public's awareness of domestic violence through the use of radio and television ads, lectures in schools and township halls, as well as political activity to further raise public consciousness that domestic violence is a social problem in an attempt to stop the desensitization of Americans to violence.

Advanced practice nurses can also assist in the identification and assessment process of domestic violence. APNs can create and institute policies and standards of practice that incorporate specific assessment techniques into practice. By presenting to colleagues and peers examples of different direct questioning techniques, by requiring that specific questions be included on all intake assessment forms, and by mandating that on initial visit, each annual visit, and any subsequent visit suspicious for abuse these questions be asked, domestic violence victims will be more readily identified. Advanced practice nurses can also create helpful reminders encouraging routine inquiry, such as reminder forms, stickers or stamps in charts; posters in clinical areas that remind clinicians what to ask and what to do; and pocket-sized protocols with written descriptions of identification, assessment, and intervention techniques and strategies, examples of specific questions, and referral resources and phone numbers;

Advanced practice nurses can establish training and intervention programs assisting professionals in the assessment and identification process. Through the use of educational tools, videos, and role playing professionals can acquire creative ideas and necessary skills to feel comfortable inquiring about abuse. Lastly, APNs can develop outcome measures to evaluate knowledge and assessment practice of providers, the effectiveness of provider response, and success of intervention for domestic violence victims.

One of the most difficult areas for advanced practice nurses to impact regarding domestic violence is that of barriers. Many primary care providers, as well as other members of the multidisciplinary health care team, have preconceived ideas and misconceptions surrounding the issue of domestic violence. Advanced practice nurses can help colleagues recognize possible barriers to assessing for domestic violence by discussing attitudes and beliefs about abuse. In addition, many of the health care professionals have also established certain practice habits that are difficult to alter and change. This author believes that by incorporating many of the strategies listed above to raise the knowledge level and understanding regarding domestic violence and to arm professionals with the necessary tools to assist victims, many of these barriers can be obliterated.

Implications for Future Research

Since the issue of domestic violence is relatively "new" in the literature, further research involving all aspects of the subject is greatly needed. Research studies like this one needs to be repeated so that ways to best increase knowledge and assessment practices can be identified. In addition, barriers need to be further described and analyzed so that techniques can be devised to address potential impediments to assessing for domestic violence.

Future research should continue to include APN's, especially male APN's, and APN's from other practice and geographical areas. In addition, research could be conducted with one's own practice site to assess for prevalence of domestic violence before and after the introduction of a protocol designed for assessing for domestic violence.

Lastly, research needs to be conducted not only at the identification and intervention levels but also the prevention level. Determining effective methods at dealing with power and control issues as well as societal and culture norms and values and the way in which violence is viewed in the United States are the means to the beginning of the end of domestic violence.

LIST OF REFERENCES

LIST OF REFERENCES

American Academy of Family Physicians Commission On Special Issues and Clinical Interests (1994). Family Violence: An AAFP white paper. American Family Physician, 50(8), 1636-1646.

Alpert, E. (1995). Violence in intimate relationships and the practicing internist: New "disease" or new agenda? American College of Physicians, 123(10), 774-781.

American College of Obstetricians and Gynecologists (ACOG) (1995). Domestic violence: ACOG Technical Bulletin. Washington, DC: American College of Obstetricians and Gynecologists.

American Medical Association (1994). Diagnostic and Treatment Guidelines on Domestic Violence. Chicago, IL: American Medical Association.

Analysis by the Center for the Study and Prevention of Violence, Institute for Behavioral Science, at the University of Colorado at Boulder, Colorado. The data used to calculate this percentage came from the FBI's 1988-91 Uniform Crime Reports (UCR).

Bohn, D.K. (1990). Domestic violence and pregnancy: Implications for practice. Journal of Nurse-Midwifery, 35(2), 86-98.

Bokunewicz, B. & Copel, L. (1992). Attitudes of emergency nurses before and after a 60-minute educational presentation on partner abuse. Journal of Emergency Nursing, 18(1), 24-27.

Brown, J.B., Lent, B., & Sas, G. (1993). Identifying and treating wife abuse. The Journal of Family Practice, 36(2), 185-191.

Bullock, L., McFarlane, J., Bateman, L., & Miller, V. (1989). The prevalence and characteristics of battered women in a primary care setting. Nurse Practitioner, 14(6), 49-54.

Carpenito, L. J. (1983). Nursing Diagnosis Application to Clinical Practice. Philadelphia, PA: J.B. Lippincott Company.

Chambliss, L.R., Bay, C., & Jones III, R.F. (1995). Domestic violence: An educational imperative? American Journal of Obstetrics and Gynecology, 172(3), 1035-1038.

Chez, R.A. & Jones, R.F. (1995). The battered woman. American Journal of Obstetrics and Gynecology, 173(3), 677-679.

Collins, W. & World Publishing Co., Inc. (1990). The Pocket Webster School & Office Dictionary. New York, NY: Simon & Schuster Inc.

Council on Scientific Affairs, American Medical Association (1992). Violence against women, relevance for medical practitioners. Journal of American Medical Association, 267(23), 3184-3189.

deLahunta, E.A. (1995). Hidden trauma: The mostly missed diagnosis of domestic violence. Journal of Emergency Nursing, 13(1), 74-76.

deLahunta, E.A. & Tulsky, A.A., (1996). Personal exposure of faculty and medical students to family violence. Journal of American Medical Association, 275(24), 1903-1906.

Donaldson, M., Yordy, K., & Vanselow, N. (Eds.). (1994). Defining Primary Care: An interim Report. Washington, D. C.: National Academy Press.

Easley, M. (1996). Domestic violence. Annals of Emergency Medicine, 27(6), 762-763.

Douglas, H. (1991). Assessing violent couples. Families in Society, 72(9), 525-535.

Friedman, L.S., Samet, J.H., Roberts, M.S., Hudlin, M., & Hans, P. (1992). Inquiry about victimization experiences a survey of patient preferences and physicians practices. Archives of Internal Medicine, 152, 1186-1190.

Ganley, A.L. (1996). Improving The Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers. San Francisco, CA: Family Violence Prevention Fund.

Gremillion, D.H. & Kanof, E.P. (1996). Overcoming barriers to physician involvement in identifying and referring victims of domestic violence. Annals of Emergency Medicine, 27(6), 769-773.

Hamberger, L.K., Saunders, D.G., & Hovey, M. (1992). Prevalence of domestic violence in community practice and rate of physician inquiry. Family Medicine, 24(4), 283-287.

Hardy, M.E. & Conway, M.E. (1988). Role Theory, Perspectives for Health Professionals. Norwalk, CT: Appleton & Lange.

Helton, A. (1987). Protocol of care for the battered woman. White Plains, NY: March of Dimes Birth Defects Foundation.

Janz, N. & Becker, M. (1984). The health belief model: A decade later. Health Education Quarterly, 11(1), 1-47.

Kassebaum, D.G. & Anderson, M.B. (1995). Proceedings of AAMC's consensus conference on the education of medical students about family violence and abuse. Academic Medicine, 70(11), 961-963.

Kozier, B., Erb, G., & Blais, K. (1992). Concepts and Issues in Nursing Practice. Redwood City, CA: Addison-Wesley Nursing.

Kurz, D. (1987). Emergency department responses to battered women: Resistance to medicalization. Social Problems, 34, 69-81.

Limandri, B.J. & Tilden, V.P. (1996). Nurses' reasoning in the assessment of family violence. Image: Journal of Nursing Scholarship, 28(3), 247-252.

McCauley, J., Kern, D.E., Kolodner, K., Dill, L., Schroeder, A.F., DeChant, H.K., Ryden, J., Bass, E.B., & Derogatis, B. (1995). The "battering syndrome:" Prevalence and clinical characteristics of domestic violence in primary care internal medicine practices. Annals of Internal Medicine 123(10), 737-746.

McClure, B.M. (1993). Knowledge and assessment practices of health professionals in primary care related to battering in pregnancy. Unpublished thesis.

McClure, B.M. (1996). Domestic violence: The role of the health care professional. Michigan Family Review, 2(1), 63-75.

McClure, B.M., & Meierhenry, M. (1995). Domestic violence: Knowledge and practices of physicians in primary care. Unpublished research.

McFarlane, J., Christoffel, K., Bateman, L., Miller, V., & Bullock, L. (1991). Assessing for abuse: Self report versus nurse interview. Public Health Nursing, 8(4), 245-250.

McFarlane, J., Parker, B., Soeken, K., & Bullock, L. (1992). Assessing for abuse during pregnancy severity and frequency of injuries and associated entry into prenatal care, Journal of American Medical Association, 267(23), 3176-3178.

McLeer, S.V., Anwar, R.A., Herman, S., & Maquiling, K. (1989). Education is not enough: A systems failure in protecting battered women. Annals of Emergency Medicine, 18(6), 651-653.

Melvin, S.Y. & Brunton, S.A. (1995). Domestic violence: The physician's role. Hospital Practice, 30(10), 45-53.

Mezey, M.D. & McGivern, D.O. (Eds.). (1993). Nurses, Nurse Practitioners: Evolution to Advanced Practice. New York, New York: Springer Publishing Company, Inc.

Mikhail, B. (1981). The health belief model: A review and critical evaluation of the model, research , and practice. Advances in Nursing Science, 4, 65-82.

Novello, A.C., Rosenberg, M., Saltzman, L., & Shosky, J. (1992). From the Surgeon General, US Public Health Service: A medical response to domestic violence. Journal of American Medical Association, 267(23), 3132.

Neufeld, B. (1996). SAFE questions: Overcoming barriers to the detection of domestic violence. American Family Physician, 53(8), 2575-2580.

Parsons, L.H., Zaccaro, D., Wells, B., & Stovall, T.G. (1995). Methods of and attitudes toward screening obstetrics and gynecology patients for domestic violence. American Journal of Obstetrics and Gynecology, 173(2), 381-387.

Pender, N.J. (1987). Health Promotion in Nursing Practice. East Norwalk, CT: Appleton & Lange.

Randall, T. (1990). Domestic violence intervention calls for more than treating injuries. Journal of American Medical Association, 264(8), 939-940.

Randall, T. (1990). Domestic violence begets other problems of which physicians must be aware to be effective. Journal of American Medical Association, 264(8), 940-942.

Rodriguez, M.A., Quiroga, A., & Bauer, H.M. (1996). Breaking the silence battered women's perspectives on medical care. Archives of Family Medicine, 5, 153-158.

Safriet, B. (1992). Health care dollars and regulatory sense: The role of advanced practice nursing. Yale Journal on Regulation, 9(2), 417-487.

Silver, H.K. (1977). The essentials of primary health care. Journal of Family Practice, 4(1), 151.

Smikle, C.B., Satin, A.J., Dellinger, C.L., & Hankins, G.D.V. (1995). Physical and sexual abuse: A middle-class concern? Journal of Reproductive Medicine, 40(5), 347-350.

Starfield, B. (1992). Primary Care: Concept, Evaluation, and Policy. Oxford, New York: Oxford University Press.

Straus, M. & Gelles, R. (1990). Physical Violence in American Families: Risk Factors and Adaptations to Violence in 8145 Families. New Brunswick, NJ: Transaction Publications.

Straus, M., Gelles, R., & Steinmetz, S. (1980). Behind closed doors: A survey of family violence in America. New York, NY: Doubleday.

Warshaw, D. (1989). Limitations of the medical model in the care of battered women. Gender Society, 3, 506-517.

APPENDIX A

Letter of Explanation by Researcher

March 31, 1997

Dear Health Professional:

This letter is to request approximately five minutes of your time to complete a survey on domestic violence. The information will be utilized to complete a descriptive study examining the knowledge and assessment practices of health professionals providing primary care to women in the Saginaw, Bay, and Midland areas.

You indicate your voluntary agreement to participate by completing and returning this questionnaire. Although not required, it is encouraged that you answer all questions. All results will be treated with strict confidence, and all participants in the study will remain anonymous in any report of research findings. If you would like a copy of the survey results, please write your name and address on the enclosed postcard and mail it separately from the survey so your response will remain anonymous.

Please return your completed questionnaire by **April 15**. If you have any questions or concerns, you may contact me at 517-754-0819. Your time and honesty in completing this survey are truly appreciated.

Sincerely,

Deborah K. Johnson

Deborah K. Johnson, R. N., B. S. N.
MSU College of Nursing
Graduate Program-Family C. N. S.

APPENDIX B

Letter of Explanation by Emergency Department Physicians

March 24, 1997

Dear Survey Participant:

Put simply, domestic violence is a problem. However, the extent and severity of the problem are still uncertain. What we are discovering is that there are many degrees of understanding regarding domestic violence, just as there are victims.

Currently we are implementing domestic violence screening tools in the Emergency Department which is being mandated by JCAHO for 1997. Victims of domestic violence don't just seek emergency care though, they need yearly exams, deliver babies and have other illness for which they need treatment.

The enclosed survey is an opportunity for you to help us collect information about your perception of the problem and your current practice in primary care. Please return the survey to further the understanding of current trends in the Tri-city area so that we might direct further educational activities to address the needs of all health professionals concerned.

Thank for your time.
Sincerely,

Kathleen Cowling, D.O., ABEM
Attending Emergency Physician
St. Lukes Hospital, Saginaw

Mary J. Wagner, M.D. FACEP
Assistant Program Director
SCHI Emergency Medicine

APPENDIX C

UCRIHS Approval Letter

MICHIGAN STATE
UNIVERSITY

March 31, 1997

TO: Linda Beth Tiedje
A-230 Life Sciences Building

RE: IRB#: 97-191
TITLE: PORTRAIT OF AN ABUSED WOMAN: DO PRIMARY HEALTH CARE PROVIDERS RECOGNIZE HER?
REVISION REQUESTED: N/A
CATEGORY: 1-C
APPROVAL DATE: 03/31/97

The University Committee on Research Involving Human Subjects'(UCRIHS) review of this project is complete. I am pleased to advise that the rights and welfare of the human subjects appear to be adequately protected and methods to obtain informed consent are appropriate. Therefore, the UCRIHS approved this project and any revisions listed above.

RENEWAL: UCRIHS approval is valid for one calendar year, beginning with the approval date shown above. Investigators planning to continue a project beyond one year must use the green renewal form (enclosed with the original approval letter or when a project is renewed) to seek updated certification. There is a maximum of four such expedited renewals possible. Investigators wishing to continue a project beyond that time need to submit it again for complete review.

REVISIONS: UCRIHS must review any changes in procedures involving human subjects, prior to initiation of the change. If this is done at the time of renewal, please use the green renewal form. To revise an approved protocol at any other time during the year, send your written request to the UCRIHS Chair, requesting revised approval and referencing the project's IRB # and title. Include in your request a description of the change and any revised instruments, consent forms or advertisements that are applicable.

PROBLEMS/ CHANGES: Should either of the following arise during the course of the work, investigators must notify UCRIHS promptly: (1) problems (unexpected side effects, complaints, etc.) involving human subjects or (2) changes in the research environment or new information indicating greater risk to the human subjects than existed when the protocol was previously reviewed and approved.

If we can be of any future help, please do not hesitate to contact us at (517)355-2180 or FAX (517)432-1171.

Sincerely,

David E. Wright, Ph.D.
UCRIHS Chair

DEW:bed

cc: Deborah K. Johnson

OFFICE OF
RESEARCH AND GRADUATE STUDIES

University Committee on Research Involving Human Subjects (UCRIHS)

Michigan State University
246 Administration Building
East Lansing, Michigan
48824-1046

517/355-2180
FAX 517/432-1171

APPENDIX D

Permission to Use Survey Tool Letter

August 6, 1996

Deborah K. Johnson
3584 Hanchett St.
Saginaw, MI. 48604

Dear Deborah,

Per your request, I have enclosed two surveys I have developed and used in research related to domestic violence and the knowledge and assessment practices of health professionals. The first survey entitled, "Survey: Battering in Pregnancy" was used in 1993 for my thesis and was mailed to physicians and nurses within the Mid Michigan area. The second survey, "Domestic Violence: Knowledge and Assessment Practices" was used in 1995 by myself (primary investigator) and Mary Meierhenry, M.D. in research conducted with 600 physicians practicing in internal medicine, ob/gyn, and family practice within the state of Michigan. In citing authors of the survey, please remember to include M. Meierhenry with the second survey.

Let me know if I can be of further assistance to you. I look forward to receiving the results of your research. Much success as you embark on this major project!

Truly,

Bonnie McClure

Bonnie McClure, RN,CS, MSN
517 483-2097 (W)
517 655-6139 (H)

P.S. I have enclosed an article recently published.

APPENDIX E

Survey: Domestic Violence: Knowledge and Assessment Practice

SURVEY
Domestic Violence: Knowledge and Assessment Practices

For the following, please check the appropriate space or enter the data which applies to you and your practice specialty.

1. Physician (check one): ___MD ___DO
   Advanced Practice Nurse (check all that apply): ___ADN ___BSN ___MSN ___Certified

2. Date of Birth: ___Month ___Day ___Year

3. Sex: ___M ___F

4. Clinical Setting (check one):
   ___ Private Office
   ___ Clinic (hospital or government funded)
   ___ Health Maintenance Organization
   ___ Other, please specify_____

5. Type of Practice (check the one which best describes your primary focus):
   ___ Family Practice
   ___ Internal Medicine
   ___ OB/GYN

6. Environmental Setting of your Practice (check one):
   ___ Urban Community
   ___ Suburban
   ___ Rural Community

7. Years in Current Specialty (round to nearest year): ___.

8. Have you attended an educational program on Domestic Violence within the last year?
   ___Yes ___No

9. Have you read any literature or journal articles on Domestic Violence within the last year?
   ___Yes ___No

10. During your formal education, did you receive specific training related to Domestic Violence?
    ___Yes ___No

For the following questions, please answer as honestly as possible.

11. To the best of your knowledge, how frequently does domestic violence occur? (check one):
___0-5% ___6-10% ___11-15% ___16-20% ___21-25% ___26% or >

12. Based on your knowledge, which signs and symptoms would you consider possible indicators of domestic violence? (check all you consider appropriate):

___ Broken bone
___ Bruises
___ Depression
___ Headaches
___ Abdominal pain
___ Excessive drinking by patient or partner
___ Black eye
___ Lacerations
___ Insomnia
___ Anxiety
___ Suicidal thoughts

Other indicators of abuse (please list)_____

13. Based on your knowledge, which of the following reports of behavior would you consider possible indicators of abuse? (check all you consider appropriate):

___ forced sexual contact
___ threats of harm to the woman
___ verbal degradation
___ partner jealousy
___ physical isolation
___ slapping
___ threats of harm to the children
___ choking
___ punching
___ kicking

Other indicators of abuse (please list)_____

14. To your knowledge, which of the following community resources are available for the referral of abused women. (Check yes or no to each source listed and identify at least one specific name where indicated.)

	YES	NO
24 Hour Crisis Line (Name)_____	____	____
Police Force (Name)_____	____	____
Prosecuting Attorney's Office_____	____	____
Legal Aid (Name)_____	____	____
Shelter/Safehouse (Name)_____	____	____
Counseling Service (Name)_____	____	____
Other Please Identify)_____	____	____

15. To which of the following local community resources have you referred an abused woman. (Check yes or no to each source listed and identify those used by name.)

	YES	NO
24 Hour Crisis Line (Name)_____	____	____
Police Force (Name)_____	____	____
Prosecuting Attorney's Office_____	____	____
Legal Aid (Name)_____	____	____
Shelter/Safehouse (Name)_____	____	____
Counseling Service (Name)_____	____	____
Other Please Identify)_____	____	____

For the following questions, please circle a number on a scale of 1 (NEVER) to 5 (ALWAYS), which most accurately describes **your assessment practice** for domestic violence.

	Never	Rarely	Sometimes	Often	Always
16. During an initial intake history, how often do you screen women for battering?	1	2	3	4	5
17. During annual visits with an established patient, how often do you screen women for battering?	1	2	3	4	5
18. Do you include a question(s) related to battering on a history form which the patient completes?	1	2	3	4	5
19. Do you verbally ask women about battering?	1	2	3	4	5
20. Do you verbally ask women, *Within the last year, have you been hit, kicked, slapped, or otherwise physically hurt by someone?*	1	2	3	4	5
21. Do you verbally ask women, *Within the last year has anyone forced you to have sexually activities?*	1	2	3	4	5
22. Do you verbally ask women, *Within the last year have you been afraid of your partner or anyone close to you?*	1	2	3	4	5

23. If you routinely inquire about battering and the question is not listed, what question(s) do you use?

_____

_____

_____

For the following questions and statements, please circle a number on a scale of 1 (NEVER) to 5 (ALWAYS), which most accurately describes **your practice**.

	Never	Rarely	Sometimes	Often	Always
24. During an examination of a woman, do you consider abuse when seeing *injuries that do not match their cause?*	1	2	3	4	5
25. During an examination of a woman, do you consider abuse when seeing *depression, withdrawl, or lack of eye contact?*	1	2	3	4	5
26. During an examination of a woman, do you consider abuse when *office visits have been frequently missed?*	1	2	3	4	5
27. During an examination of a woman, do you consider abuse when a male partner will not leave the woman unattended?	1	2	3	4	5
28. Time constraints of a busy practice prevent you from assessing for domestic violence.	1	2	3	4	5
29. You consider domestic violence a private matter and therefore do not ask about abuse for fear it will offend her.	1	2	3	4	5

30. Other practices you use to assess for domestic violence (please list).

_____

_____

_____

For the following statements, please circle a number on a scale of 1 (Strongly Disagree) to 5 (Strongly Agree), which most accurately describes **your beliefs** about domestic violence.

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
31. *"Normal" men and women do not engage in domestic violence.*	1	2	3	4	5
32. *Primary care providers do not have the necessary tools to help victims of domestic violence .*	1	2	3	4	5
33. *There is nothing I, as a Health Care Provider, can do about domestic violence.*	1	2	3	4	5

I am interested in your reaction/comments; please feel free to share personal observations or experiences with abused clients below.

Thank you for completing this survey. Please be sure you read all five pages. If you would like copies of the results, please complete and return the enclosed postcard separate from your survey.