Screening Practices Of Primary Care Nurse Practitioners For Domestic Violence

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SCREENING PRACTICES OF PRIMARY CARE NURSE PRACTITIONERS FOR DOMESTIC VIOLENCE

by

AMY BRANYON

A Thesis
Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Science in Nursing in the Division of Nursing
Mississippi University for Women

COLUMBUS, MISSISSIPPI

August 1999
Screening Practices of Primary Care Nurse Practitioners for Domestic Violence

by

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Abstract

Domestic violence is prevalent in our society, affecting 2 million women each year (Butler, 1995). This creates a significant health problem for women, yet research has shown that few health care providers routinely screen for domestic violence. The purpose of this descriptive study was to identify the number of nurse practitioners screening for domestic violence among their clients, identify the methodology used for screening, and identify barriers to screening. The theoretical framework was based on the Health Promotion Model (Pender, 1997). The research questions for this study were as follows: What are the screening practices for domestic violence of nurse practitioners? And what are the barriers to screening for domestic violence by nurse practitioners on a consistent basis? The setting for the study was the state of Mississippi. A sample of nurse practitioners was obtained from the Mississippi Board of Nursing. Self-report questionnaires, created by the researcher, were mailed to the nurse practitioners, with a target sample of 100
returned reports. A descriptive, exploratory design was used. Descriptive statistics including percentages and frequency distributions were used to report the frequency with which nurse practitioners screen for domestic violence and the barriers that prevent screening. A demographic analysis of the respondents was also reported. Nursing implications and recommendations for further research were discussed.
Acknowledgments

In thanks to all those inspiring individuals without whom I could have never completed this research. Most importantly, I would like to thank the loving God who is the author of all good things and the protector of my heart. “Delight yourself in the Lord and He will give you the desires of your heart” (Psalm 37:4).

To my parents, Eugene and Bonnie Branyon, thank you for all the love, encouragement, and patience you have provided throughout my life, but especially in the last 2 years. You are both an inspiration to my life. I love you both more than you will ever know. My successes would have been impossible without you. I have felt your prayers and intercessions, and for that I am eternally grateful.

To my husband, Rodney Bigham, thank you for your love. You are truly a gift from God. Thank you for always reminding me that you love me for who I am, and not what I accomplish. Thank you for being my best friend. I love you more than life.
Thank you to my friends and colleagues, Sueanne Davidson and Philip Fikes, for your encouragement. I cannot tell you how thankful I am for the phone calls and constant reassurance. You are assets to the profession of nursing. I wish you both many successes in your careers. (Yes, you have to read the rest of this thesis!)

To my friend, Kristi Acker, thanks for listening to my woes for the past years. The drive would have been miserable without your comic relief! Next year let’s spend less time in the car and more time on the lake!

To Dr. Melinda Rush, my advisor and committee chairperson, a special thank you for the support, wisdom, and advice you have given in the last year. Thank you to Dr. Lynn Chilton and Lorraine Hamm for agreeing to serve on my research committee. You are all excellent teachers, and I am grateful to have been a part of this program.

To all the members of the MUW class of 1999, may God bless each of you as you use the knowledge gained to help those who are sick and in need. You have been a phenomenal group of people to know and work with.
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Chapter I

The Research Problem

Domestic violence is a growing health problem in the United States, affecting 35-45% of the female population (Erikson & Hart, 1998). It has been estimated that violence from intimates is the largest cause of women’s injury—larger than auto accidents, mugging, and rape combined. The enormous aggregate of domestic violence victims are at risk for immense health consequences. Heise et al. (1994), in assessing the health consequences of domestic violence against women, estimated that in industrialized countries domestic violence takes about 5 healthy years away from women between the ages of 15 and 44 years. Violence contributes to the growing number of dollars spent on health care each year, costing Americans $44 million in medical costs, 40,000 physician visits, and over 100,000 hospital stays annually (Easely, 1996). Of women seen in emergency departments 30 to 35% have symptoms or injuries secondary to battery, though only about 5% are attributed as such (Keller, 1996). Women
frequently experience violence during pregnancy, and some research has suggested that violence may first begin during pregnancy (Casey, 1989).

Physical injuries can include bruises, broken bones, and closed head trauma, as well as miscarriages, permanent or partial loss of hearing or vision, or physical disfigurement. Women in violent relationships experience depression and somatic complaints, such as migraine and nonspecific complaints of abdominal and joint pain. Women living in violent relationships have significantly poorer health than women who do not live in such relationships. The psychological impact of domestic violence can be more debilitating than physical injuries (Keller, 1996). Miller (1990) found that having been in a violent relationship was, for women, the strongest predictor of alcoholism, and women living in an intimate relationship are more likely to attempt suicide.

Establishment of the Problem

Although 87% of clinicians report having received formal education on the topic of domestic violence, 92% underestimate the prevalence by 4 to 1 (Smith, Danis, & Helmick, 1998). Societal norms suggest that intimate
partners, being consenting adults, are responsible for their own experiences. This may explain society’s tolerance of domestic violence in intimate relationships even while it expresses outrage at the abuse of children and elders.

The battering of women crosses all ethnic, religious, and socioeconomic lines and affects 2 million American women each year (Blair, 1996). Twenty to 30% of women are living in abuse situations (Campbell, 1992). Of all homicides against women, 40% are committed by male partners (Campbell, 1992). Although women of all ages are battered, higher percentages occur during pregnancy and in older groups (McFarlane, Parker, Soeken, & Bullock, 1992).

Domestic violence is a major public health issue. Easely (1996) reported that $44 million in medical costs, 40,000 physician visits, and over 100,000 hospital stays per year are attributed to physical violence against women. Easely (1996) estimated that more than 4 million women were beaten by their partners in 1995 and one in four women are projected to be beaten by a man in her lifetime. Domestic violence is the single largest cause of injury to women in the United States and is more common
than injuries due to automobile accidents, muggings, and rape combined (Erikson & Hart, 1998).

Domestic violence differs from other forms of interpersonal violence as family members often return to the same violent environment in which they are at risk for repeated injury. In addition to injuries women receive from assaults, battering has contributed to the development of stress-related conditions, such as depression, post-traumatic stress disorder, substance abuse, chronic pain, irritable bowel syndrome, and sexually related conditions (Erikson & Hart, 1998). Batterers also commonly use economic abuse, isolation, and intimidation to exert power over their partners. Dutton (1992) found that many battered women who fight back against their victimization are typically treated as criminals themselves and given little recognition for their recent history of abuse (Erikson & Hart, 1998).

Significance to Nursing

Nursing practice. Domestic violence is recognized and well documented by the literature as a significant health problem for women. Health care professionals often recognize and treat the physical injuries caused by abuse,
but may neglect the emotional trauma caused to the client.
If a health care professional validates that abuse has occurred, then the ethical and legal concerns become the responsibility of the nurse. These responsibilities may be more than the nurse is prepared to handle. Nurse practitioners are looked to by the public as professionals who provide care to those in need. Every aspect of those needs must be met by the nurse practitioner, including the sensitive aspects of domestic violence.

Nurse practitioners are in a unique position to help victims of domestic violence. Unlike professional nurses in the acute care setting, nurse practitioners follow clients through the health care continuum. Repeated interactions may foster trust between the client and the practitioner, allowing for a more open, sharing relationship. Recognition of abuse begins in the primary care setting. The prevalence of domestic violence documented by the literature alone is reason to screen every women in primary care. Recognition of abuse is the first step in preventing further episodes.

Nursing research. Nursing research has documented the prevalence of abuse, factors that contribute to abuse, and effective screening tools available for nursing
professionals, but little research has documented the nurse practitioner’s role in the early recognition of domestic violence. This study may provide insight to the needs of nursing professionals in primary care who encounter victims of domestic violence.

Nursing theory. This research study is guided by the principles of the Health Promotion Model (Pender, 1987). This model focuses on the person’s belief in the benefit of health-promoting behaviors. The study assumes that once a victim is identified through screening, the nurse practitioner may empower the client to make decisions that promote health. The client, however, must make the decision to use the knowledge provided by the nurse practitioner and to choose health-promoting behaviors. The study may further the use of the Health Promotion Model in the screening and treatment of victims of domestic violence.

Nursing education. The prevalence of domestic violence suggests that nursing professionals will encounter domestic abuse some time during their career. The topic of abuse should be included in all nursing curricula. Education regarding abuse will increase the comfort level for screening and treating victims of abuse.
Increasing knowledge and awareness of domestic violence and the impact on the victim’s health may increase the attentiveness of nurse practitioners in the primary care setting.

Theoretical Framework

The theoretical framework for this study was Pender’s (1987) Health Belief Model. This model attempts to explain participation in health-promoting behaviors, such as screening for domestic violence in the presence of a cue to action. The model proposes cognitive-perceptual factors which influence the individual to engage in health-promoting behavior. Cognitive-perceptual factors included in the model are importance of health, perceived control of health, perceived health status, perceived benefits of health-promoting behaviors, and perceived barriers to health-promoting behaviors. Within the model’s framework, all of these perceptions are integrated to lead to the likelihood of action, which, in the context of this study, would be the nurse practitioner’s screening of clients for domestic violence. Ongoing self-assessment by the nurse practitioner can lead to more effective intervention in the lives of victims of domestic violence.
Importance of health. The nurse practitioner’s perception of the importance of the health state can greatly impact screening practices. This perception could be a barrier to the screening of clients if the practitioner does not perceive the abuse situation to impact the client’s health.

Perceived control of health. The practitioner’s perception of the social situation can prevent screening. If the practitioner perceives that nothing can be done to change the abuse situation and that the health of the client cannot be impacted, screening will be a low priority for the nurse practitioner. The perception of the practitioner of his or her ability to impact the client’s health or the abuse situation can motivate or discourage screening.

Perceived health status. Nurse practitioners may perceive the abused state of health for a client to be a normal state on the wellness-illness continuum. If domestic violence is perceived as normal for some clients, screening for the presence of abuse may be viewed as unnecessary.

Perceived benefits of health-promoting behavior. Can the client benefit from routine screening for domestic
violence? Can health be promoted by routine screening for domestic violence? Many nurse practitioners may answer no to both of these questions if past experiences have left them feeling that time is wasted when attempting to promote health in an environment that does not value health.

Perceived barriers to health-promoting behavior. The practitioner’s belief that the screening activity is difficult may influence his or her decision regarding participation. A stimulus, or cue to action, is needed to trigger appropriate action within this model. These cues are perceptions of the individual and may be internal or external experiences. Individual perceptions are the basis for internal cues, such as memories of past experiences with victims of domestic violence. Interpersonal interactions, assessments, and communication are external cues, such as the visible trauma to a victim of domestic violence. Depending on the practitioner’s other perceptions of abuse, these cues may promote or inhibit screening of the client for domestic violence.

The focus of the Health Promotion Model is to understand motivational factors that lead to health-promoting behaviors. While Pender formulated her model for
the analysis of health-promoting behaviors of clients, the model can appropriately be applied to analysis of health-promoting behaviors of nurse practitioners. Health promotion and disease prevention are the “business” of nurse practitioners. Screening for domestic violence will greatly impact the health of women of all ages.

Assumptions

The assumptions surrounding this study were as follows:

1. Nurse practitioners perceive domestic violence to be a threat to the health of female clients.

2. Nurse practitioners are qualified to screen for domestic violence.

3. Women who experience domestic violence may utilize nurse practitioners as their health care provider.

Statement of the Problem

The prevalence of domestic violence is astounding. Victims of domestic violence may seek care from the nurse practitioner for primary interventions and for the injuries sustained from an abuser. This places nurse practitioners in a unique position to promote the health of these clients. Identifying the problem of abuse is the
first step in preventing further abuse. Research suggests that nurse practitioners do not routinely screen for domestic violence (Easely, 1996). The problem addressed in this study was whether nurse practitioners in the state of Mississippi screen for domestic violence. Barriers that prevent routine screening were also explored.

Research Questions

The following research questions guided this study:

1. What are the screening practices for domestic violence of nurse practitioners?

2. What are the barriers to screening for domestic violence on a consistent basis?

Definition of Terms

To better explain the problem statement for this study, the following definitions are given:

Screening practices: Theoretical definition: the assessment of a client by a health care practitioner for physical disease process. Screening may include physical assessment, diagnostic, and laboratory testing on a routine schedule (Branch, Crouch, & Talerico, 1998).

Operational definition: assessment of a client by a nurse practitioner for domestic violence, including, but not
limited to, physical assessment, interpersonal actions, and psychological assessment, as defined by the Screening Practices Survey.

**Domestic violence:** Theoretical definition: Domestic violence is any act by an intimate partner which causes physical, emotional, or psychological harm to another person (Pinkowish, 1997). Operational definition: any act by an intimate partner upon a woman aged 21 years or older that inflicts physical harm or emotional harm. Manifestations may include physical trauma, somatic complaints of illness, or psychological disorders.

**Nurse practitioner:** Theoretical definition: A nurse practitioner is defined by the American Academy Colleges of Nursing as an advanced practice nurse who has completed an accredited program and has passed a certification exam in family or adult health. Operational definition: a registered nurse who has completed an accredited program and obtained certification in his or her specialty area, licensed by the state of Mississippi, practicing in a primary care area, and treating adult women aged 21 years or older.

**Barriers:** Theoretical definition: Taber's Cyclopedic Medical Dictionary defines a barrier as an obstacle,
impediment, obstruction, boundary, or separation (Thomas, 1993, p. 205). Operational definition: Barriers will be defined as any impediment to the continued assessment for domestic violence by the nurse practitioner as listed on the Screening Practices Survey.

Summary

Domestic violence has a significant effect on the health of American women. Nurse practitioners are in a unique position to assess for and intervene in the domestic abuse situation, but do not consistently do so because of a variety of reasons. Assessment for domestic violence should be consistent and ongoing in order to be effective. This chapter provided an introduction into the research problem by exploring the concept of domestic violence and the role of the nurse practitioner in assessing for domestic violence in the primary care setting.

In Chapter II, a review of the literature supporting this study will be discussed. The method for empiricalization of the study will be discussed in Chapter III. A presentation of the findings will be discussed in Chapter IV. Finally, in Chapter V, findings from the
research will be interpreted and conclusions drawn from the interpretations will be presented with implications for nursing discussed.
Chapter II

Review of the Literature

In reviewing the literature related to the issues surrounding the care of the domestic violence victim, significant research was found which evaluated the prevalence and effects of domestic violence on the client. However, little research was found which addressed the screening practices of practitioners for domestic violence.

Waller, Hohenhaus, and Stern (1996) found that the number of patients treated in their department for domestic violence was far below the national average. The researchers suspected that patients were presenting for treatment but were not being identified. The researchers sought to investigate the problem and design, develop, and validate a protocol for the purpose of identifying victims of domestic violence. The problem statement was that victims of domestic violence are not properly assessed and consequently are not referred for follow-up and counseling. Domestic violence was defined as any act
causing physical harm to a woman by a significant other. The category of woman was defined as a female aged 16 years or older who presented to the department during the study period. The term screening was defined as a two-part assessment by the nurses. The conceptual framework was derived from Levine’s Conservation Model.

Using a two-part screening tool, the nurses assessed patients as they presented for treatment (N = 114). If the patient was suspected to be a victim of violence at the first component of screening, a more in-depth assessment was done in a private setting.

Waller et al. (1996) found that eight women screened positive at Part I. Two of the eight were confirmed to be victims of domestic violence at Part II. Another two patients were identified as victims of domestic violence that screened negative at Part I, for a total of four confirmed cases of domestic violence during the 2-week study period, or 3.5% of women screened. Six false positives at Part I and two false negatives at Part II were identified, yielding a Part I screening sensitivity of 50% and a specificity of 95%. The Part I screening appeared to be highly specific rather than highly sensitive, the opposite of the authors’ intent.
Qualitative interviews with the staff after the study revealed several barriers to the validation of the study. Although the staff had training about domestic violence prior to the implementation of the study, efforts failed to meet the learners' needs. The staff expressed concerns with the time constraints in processing patients. The prevalence of domestic violence also was an issue for the nursing staff. The nurses stated that they did not believe domestic violence was an issue in their community and felt that screening every patient was unnecessary. Nurses in this acute care setting were hindered from screening by lack of time, lack of education regarding how to approach the subject of domestic violence with a patient, and the belief that screening was not routinely necessary because the prevalence of violent acts was not significant. This study supports the researcher's belief that screening for domestic violence is not a priority for primary care providers.

Just as Waller et al. (1996) perceived the assessment of domestic violence in the emergent care setting to be inadequate, the researcher for this study perceived assessment and detection of domestic violence in the primary care setting to be inadequate. The Waller study
focused on registered nurses in an emergent department, while the current study focused on a primary setting.

Barriers to screening and knowledge level about domestic violence were also evaluated in a study by Varvaro and Gesmond (1997). The purpose of the study was to assess the response of house staff to an education program on domestic violence against women. Approximately one fourth of physicians report having received training on the assessment of and intervention in domestic violence. The research study consisted of the following five questions:

1. What training topics did the house staff rate as most important and relevant to their practice?
2. What topics did the house staff rate as most useful to their day-to-day practice?
3. What were the house staff attitudes and beliefs before training?
4. Did the method of training on domestic violence influence the house staff's attitudes and beliefs?
5. What were the house staff's perceptions in terms of sociodemographic variables?

The house staff was defined as a resident, intern, or medical student assigned to the emergency department for a
clinical rotation in the emergency department. Domestic violence was defined as violence against a woman by a significant or intimate other.

The study was designed as an exploratory, descriptive study. A three-group pretest and posttest were used. Approximately one third (n = 11) of the house staff received testing and no education, one third (n = 13) received lecture only, and one third (n = 13) received lecture plus a pocket-sized training manual on domestic violence. The sample consisted of a nonrandom group of medical students, interns, and residents assigned to an emergency department rotation of an urban, Level I trauma center. The sample ranged in age from 25 to 40 years with a mean age of 28 years.

The following instruments were used for data collection: (a) Importance of Training Topics for Domestic Violence Questionnaire, (b) Usefulness of Training Topics for Domestic Violence, (c) Inventory of Beliefs About Wife Beating, and (d) Self-Efficacy Scale for Battered Women-Professional Version. The training was scheduled so that initial pretesting and training occurred during the house staff member's first 8 days of the emergency department rotation. Posttesting occurred during the last 2 weeks of
the rotation. The training was based on a review of the literature and the first author's 16 years experience in domestic violence counseling. Training sessions were one hour in length. Data described in the article were collected in a 3-month period.

Analysis of the data revealed that the topics on domestic violence against women that the house staff rated as most important, relevant, and useful in their day-to-day practice were awareness of the problem, referral as an intervention, documentation of abuse, and references/resources. Attitudes held by those after training included an increased confidence in the self-efficacy behaviors of women who are abused by others, an increased need in the assessment, treatment, and referral of victims of domestic violence, and an increased belief that help should be given to all women who are abused. Very little variation was noted among participants with regard to sociodemographic status. The major conclusion of the study was that the house staff had a positive response to the training on domestic violence against women.

This study by Varvaro and Gesmond (1997) evaluated house staff perceptions of barriers to the assessment of domestic violence. The current study sought to identify
barriers to screening for domestic violence in the primary care setting.

In a similar study, Smith et al. (1998) proposed that assessment for domestic violence is not universal in the health care setting. Smith et al. sought to investigate the factors associated with screening behaviors of doctors and nurses in outpatient clinics, believing that numerous factors prevented appropriate assessment and intervention. The purpose of the study was to identify the factors preventing screening, report the findings, and discuss the implications for practice. The PRECEDE-PROCEDE framework for conceptualizing behavior change was utilized for the study’s data collection and analysis. Descriptive, bivariate (chi-square and t test), and multiple linear regression were used to report the data. Battering was defined as a process where an individual in a relationship feels vulnerable, powerless, or entrapped as a result of physical, psychological, sexual, or moral force.

The setting of the study was outpatient clinics affiliated with a major university teaching hospital in the Southeast. Smith et al. (1998) sent questionnaires to 272 physicians and 77 nurses surveying screening behavior related to domestic violence. About half (51%) of
outpatient physicians and 20% of nurses returned the survey. A Likert scale assessing frequency of assessment for domestic violence and professional preparation for assessment and treatment was used. Predisposing, enabling, and reinforcing factors associated with screening were investigated.

A review of the literature prior to the study implementation revealed predisposing factors included knowledge regarding domestic violence, attitudes about physician responsibility, and beliefs about appropriate behavior. The participants in the study, as a group, had received exposure to education in the area of domestic violence. A lack of knowledge of legal issues (70% of respondents) and referral sources (58%) of respondents were identified as significant predisposing factors. Seventy-two percent disagreed that the victim shares responsibility for abuse behavior, and 98% disagreed that it is sometimes acceptable to use physical force. A majority (97%) believed residency programs should provide training. While both believed that responsibility regarding assessment should be shared (81%), nurses were more likely than physicians to believe that responsibility is shared.
Enabling factors were identified as the clinician’s perception of competency regarding screening and treatment and the elimination of obstacles to screening. While a majority of clinicians felt prepared to ask women about abuse (65%), document injuries (60%), and refer to community resources (57%), physicians were significantly more likely to feel prepared to treat battered women ($t = 2.07, p = .0035$). Obstacles identified included a lack of time (85%), no initiative from the patient (82%), patient unwilling to disclose abuse (92%), and having to deal with legal issues (81%). Physicians felt more pressured by time ($t = 2.05, p = .04$) than nurses, while nurses felt more intimidated by legal issues ($t = -3.90, p = .0001$).

Reinforcing factors were those identified as possibly having an impact on future screening behavior of clinicians. One reinforcing factor was identified as follows: Eighty-three percent agreed that asking about abuse helps the clinician be a more effective care-giver. Factors that negatively enforce screening behavior were also identified. Asking about abuse which consumes time that is spent in a nonreimbursable activity was identified by 53.2% of respondents. Feeling uncomfortable asking about abuse was identified by 53.4%, and frustration about
effecting change in a patient’s life was identified by 60.3% of respondents.

Smith et al. (1998) concluded that physicians and nurses were informed about the importance of domestic violence as a health concern. Assessment for battering was not limited to women with injuries. At least two thirds of clinicians were screening at some level of thoroughness. Although obstacles were identified, none were related to screening behavior in the final multiple regression analysis. Reinforcing factors was not found to be significant in relation to screening behavior.

This study by Smith et al. (1998) assessed the clinician’s perception of enabling factors for screening. This researcher sought to identify and eliminate obstacles to screening for domestic violence.

In a study by Gagan (1998), the screening practices of nurse practitioners were assessed using written vignettes. The purpose of the study was to identify diagnosis and intervention accuracy, variables that influenced this accuracy, and barriers that impede performance accuracy of adult nurse practitioners and family nurse practitioners. Subjects were active members of the American Academy of Nurse Practitioners who were
employed at the time of the survey. The names were selected randomly from a computer composite of names. The sample number was 500. Two measures were developed: the Nurse Practitioner Survey and the Nurse Practitioner Performance Tool. A total of 118 adult nurse practitioners (ANPs) and family nurse practitioners (FNPs) completed and returned the mailed surveys from across the United States. Bandura's Social Cognitive Learning Theory was the theoretical framework for the study.

The Nurse Practitioner Survey and the Nurse Practitioner Performance Tool were mailed to the participants. The Nurse Practitioner Survey contained questions concerning demographic data for each of the practitioners, including age, number of years practicing in their specialty, and education regarding domestic violence. The Nurse Practitioner Performance Tool contained 10 written vignettes designed to evaluate adult nurse practitioner and family nurse practitioner performance when addressing suspected cases of domestic violence. Five vignettes served as controls and included routine health problems. The other five contained indicators of domestic violence. The indicators were derived from theories of aggression and family violence.
The reliability and validity of the tools were tested in a pilot study. Consistency of diagnosis and intervention formulation across the 10 vignettes were evaluated using Cronbach's alpha coefficients for total diagnosis (TDX), total intervention formulations (TINT), and total violence diagnosis (TVDX).

Research Question 1 addressed the performance accuracy of adult nurse practitioners and family nurse practitioners in formulating accurate and acceptable diagnoses for potential cases of violence. The results show that overall the participants had higher levels for formulating accurate diagnoses than formulating acceptable interventions.

Research Question 2 addressed the relationship of adult nurse practitioner and family nurse practitioner characteristics to diagnosis and intervention performance accuracy. A significant effect in the analysis of variance was noted ($p = 0$). Three variables were identified as having a significant effect. These variables included having taken a college course on domestic violence (improved by 0.44 diagnoses), pursuing a professional interest in domestic violence (0.45 diagnoses), and with every year increase in experience domestic violence
diagnosis performance improved 0.03 diagnoses. Professional interest in domestic violence improved the TVIN score by 2.20 interventions, while professional experience improved this score by 2.14 interventions. Variables that produced no effect included type of nurse practitioner certification or attending a continuing education workshop on domestic violence in the last year.

The study produced results that were expected and validates that additional education and professional interest in the patient involved in domestic violence improves assessment, diagnosis (identification), and intervention. Gagan (1998) believes strongly that the variables related to formal knowledge acquisition, as well as knowledge acquired through experience, play a vital role in domestic violence performance. The researcher of the current study was seeking to validate a correlation between formal education and professional interest in domestic violence.

Knowledge and experience about domestic violence and practitioners' performance in assessing for violence. In a study by Caralis and Musialowski (1997) at a Veterans Affairs Outpatient Medical Center, women were interviewed about their experiences with domestic violence and their
attitudes and expectations regarding medical care. A total of 406 participants were interviewed by trained professionals using a standardized 50-item questionnaire. The survey included questions about personal experiences with domestic violence and preferences and expectations about physician screening for domestic violence and treatment of victims.

The mean age of the study participants was 50.4 years. Forty percent reported emotional or physical abuse by a partner at some time during their lives. Seven percent were in an abusive relationship at the time. Most of the women believed that physicians should routinely screen for domestic violence in the patients; 85% agreed and 50% strongly agreed that routine screening for domestic violence should be incorporated into medical practice. Only 12% of the total group stated that their physicians had inquired about domestic violence, although 23% of the women who had been abused reported that physicians or nurses asked them about abuse. Sixty-eight percent of the women strongly agreed that they would admit to experiencing domestic violence if their physicians had asked them about it. Twenty percent of the victims said that their physicians, even when informed about abuse, did
nothing with the information. The majority of the women believed that physicians should provide information concerning community and legal resources if violence affects their patients and should assist patients in finding protective services.

Caralis and Musialowski (1997) concluded that women expect physicians to address the issue of domestic violence. They also expected physicians and other health care professionals to take an active role in providing services for victims and perpetrators of abuse. Women recognize that physicians and other professionals can work together to coordinate the range of community services that are available to victims of domestic violence. The current research sought to evaluate perceptions of nurse practitioners regarding responsibility for screening and assessment and compare to the expectations of women clients.

Summary

In conclusion, the review of the literature addressed research which focused on the problem of domestic violence and the need for continued assessment. The lack of recognition of abuse by all health care professionals was
evident. Each study recommended that screening be made routine for the health care professional. Waller et al. (1996) identified that the number of patients treated in the emergency department was far below the national average due to a deficit in accurately screening for and identifying victims. Time constraints and comfort level were identified as barriers to screening. Varvaro and Gesmond (1997) also identified barriers to screening and found knowledge level, lack of formal training in abuse situations, and lack of knowledge as barriers. In a similar study, Smith et al. (1998) proposed that screening for domestic violence was not universal and postulated that numerous factors interfered with screening. Factors identified included attitudes about physician responsibility, perceived competency regarding screening and treatment, lack of time, and legal implications. Gagan found that screening accuracy improved with knowledge level and professional experience with domestic violence. Caralis et al. (1997) found that women are open to inquiries about domestic violence and expect help from their health care professionals when faced with the issue of domestic violence.
The information obtained in the review of literature verifies the need for continued screening for domestic violence among health care professionals. Little information exists about the screening practices of nurse practitioners on the subject of domestic violence. This study will attempt to validate the screening practices and the barriers to screening of nurse practitioners in the state of Mississippi.
Chapter III

The Method

The purpose of this study was to assess the screening practices and the barriers to screening for domestic violence by primary care nurse practitioners in the state of Mississippi. The empiricalization of the study is discussed in this chapter. The study design is explained, and the setting, population, and sample are defined.

Design of the Study

A descriptive, exploratory design was utilized for this research study. A questionnaire format was used to collect data about the screening practices of nurse practitioners in the state of Mississippi. Descriptive research designs included data collection through face-to-face interview, telephone interview, or questionnaire (Polit & Hungler, 1995).

Variables. The variable of interest for this study was the screening practices of nurse practitioners for domestic violence and the barriers they identified as
significant to their practice. Controlled variables included the geographic location of the study and the professional certification of the subjects. Many other variables may have affected subjects' responses, including level of professional experience with domestic violence, formal education in the area of domestic violence, and personal life experiences with domestic violence.

Setting, Population, and Sample

The setting for the study was primary care practices in the state of Mississippi. Nurse practitioners have a broad scope of practices in the state of Mississippi and are widely available for client care in both urban and rural areas. The researcher was interested in the practices of those professionals working in the geographic area around her.

The population consisted of all nurse practitioners currently listed with the Mississippi Board of Nursing. Questionnaires were mailed to 250 nurse practitioners registered with the Board of Nursing. A convenience sample was utilized and included 142 participants who returned the designated questionnaire and met the inclusion criteria. Inclusion criteria were state as a certified
nurse practitioner or certified nurse midwife working in a primary care area in Mississippi who care for women aged 21 years or older.

Method of Data Collection

Instrumentation. The instruments used for data collection and recording were the Demographic Survey (see Appendix A) and the Screening Practices Survey (see Appendix B). Both questionnaires were developed by the researcher. The Demographic Survey was designed to provide in-depth information about the participant’s professional credentials and assure that any responses included in the study were from participants who met the inclusion criteria. The Screening Practices Survey was developed to provide information pertinent to the study.

The Demographic Survey contained a total of seven questions. Questions 1-3 inquired about the participant’s age, gender, and number of years experience as a nurse practitioner or certified nurse midwife. Question 4 asks the respondent to identify his or her area or specialty practice. Question 5 asks about the area of certification of the respondent. Questions 6 and 7 inquire about the
highest level of formal education of the participant has completed.

The Screening Practices Survey contains eight questions, with a short section at the end of the survey for the participant to share their thoughts about the subject of domestic violence in narrative form. Question 1 asks for information about the respondent’s level of education regarding domestic violence. Question 2 asks the practitioner to estimate the number of clients he or she treats annually who may have been victims of domestic violence. Level of comfort with discussing domestic violence is asked in Question 3, while Question 4 asks about level of knowledge about community resources. Question 5 asks about specific barriers to screening for domestic violence and lists responses that may be checked, but also has a fill-in-the-blank response. Question 6 asks about the frequency with which the respondent screens for domestic violence, and Question 7 inquires about the tools the provider may use to collect information from clients about domestic violence. Question 8 asks if the respondent has ever been a victim of domestic violence. Question 9 asks for a narrative response about the participant’s perception of the role of the nurse practitioner in the
comprehensive care of the client who has been the victim of domestic violence.

Questions 1, 3, 4, 5, and 8 provide information about the barriers in screening for domestic violence. Questions 6 and 7 asks for specific screening practices of the respondent. Questions 2 and 9 request additional information. To establish face validity, the tools were reviewed by a panel of four expert researchers and nurse practitioners. Construct validity was established by administering the tool to a class of 31 nurse practitioner students.

Procedures. Institutional approval from the Mississippi University for Women’s Committee on the Use of Human Subjects in Experimentation was obtained prior to beginning research (see Appendix C). The participants were mailed a questionnaire packet containing the Demographic Survey and the Screening Practices Survey, a cover letter explaining the research and information for contacting the researcher (see Appendix D), and a stamped, self-addressed envelope. The participants were guaranteed confidentiality and were informed that voluntary completion and mailing of the survey implied their consent to participate. The
research covered a 6-week time period from April 21, 1999, to June 2, 1999.

Methods of Data Analysis

The sample characteristics were measured using descriptive statistics. Current nurse practitioner screening practices were analyzed using frequencies and percentages. Content analysis of responses to the open-ended Question 9 was conducted, and the information was included in the text of the final chapters.

Summary

In this chapter, the empiricalization of this research study of nurse practitioner screening practices and barriers to screening for domestic violence in the primary care setting was described. The design of this study, the variables, and the setting, population, and sample were reviewed. The instrument, methods of data collection, and methods of data analysis were explained. The research findings will be presented in Chapter IV, and a discussion of the findings and conclusions drawn from the research will follow in Chapter V.
Chapter IV

The Findings

The purpose of this study was to determine the screening practices of primary care nurse practitioners for domestic violence. This descriptive study was implemented using a researcher-designed instrument, the Screening Practices Survey. A questionnaire was mailed to nurse practitioners in Mississippi to assess demographic information, screening practices, and barriers to screening for domestic violence on a consistent basis. Data were analyzed using frequency distributions, percentages, and content analysis. The findings from the study are presented in this chapter.

Description of the Sample

The population selected by the researcher was family nurse practitioners certified in the state of Mississippi. A total of 250 surveys were mailed to nurse practitioners in Mississippi who were certified in family practice. One hundred forty-two nurse practitioners (57%) responded to
the survey. All respondents listed a primary care area treating women aged 21 years and older as the area of practice. No surveys were discarded from the study, and all data were calculated for the study totals.

The sample consisted of 125 (88%) women and 17 (12%) men for a total of 142 respondents. The mean age of the respondents was 45 years, with a range from 27 to 56 years. Of the sample, 125 (88%) were in a family practice. Eight (6%) were in a practice for women and children, and 6 (4%) were in a college health setting. All respondents answered these questions.

The respondents were asked to indicate the number of years in the nurse practitioner role. The years of practice ranged from 6 months to 20 years. Twenty-four percent of the sample had less than 2 years experience as a nurse practitioner. Forty-eight percent had 2 to 5 years experience as a nurse practitioner. Eight percent had 5 to 10 years experience, while the remainder (20%) had 10 to 20 years practice experience.

The majority (64%) of nurse practitioners held a Master of Science in Nursing degree as the highest level of education obtained. Twenty percent listed a master’s degree and a post-master’s certificate as the level of
education achieved. Ten respondents listed a doctorate in a field other than nursing as their educational level, while 2 participants listed certification as nurse midwives in addition to certification as family nurse practitioners.

The majority (87%) of nurse practitioners received information about domestic violence while in a degree program, including formal education at the bachelor and master's level. Participants also learned about domestic violence through recorded in-service programs (11%), journal articles (5%), and individual research in the area as means of acquisition of information about domestic violence (2%). One respondent stated she had participated in research about domestic violence, and another identified the police department personnel as a source of information about abuse.

The respondents were asked what percentage of women they treated annually had been victims of domestic violence. The answers varied widely from less than 1% to 60%. One respondent answered < 1%, and 25 respondents answered 5%. The most frequent response was 10%, answered by 113 of respondents. Two respondents estimated treating 30% of their client population as victims of domestic
violence. One respondent answered 60% to this question. Eight practitioners reported that they could not estimate the number of women affected by domestic violence.

The participants were questioned about their level of comfort in discussing domestic violence with their clients. The vast majority (72%) identified feeling comfortable or very comfortable discussing domestic violence with their clients. This percentage was divided equally, with 36% for each response. Sixteen percent felt somewhat comfortable with the topic of domestic violence. The remainder of respondents identified feeling “not comfortable at all” when discussing domestic violence. In Question 4 of the Screening Practices Survey, the nurse practitioner was asked, “How would you describe your level of knowledge regarding community services available for victims of domestic violence?” Sixteen percent identified feeling very knowledgeable. A near majority of respondents (48%) felt knowledgeable about community resources. Nearly one fourth of respondents (25%) identified feeling only somewhat knowledgeable. Twelve respondents (8.5%) chose not to answer Question 4.
Results of Data Analysis

Two research questions guided this study. Question 1 is as follows: What are the screening practices for domestic violence of nurse practitioners? Two questions, Questions 6 and 7 on the Screening Practices Survey, addressed this research question. Question 6, “Please indicate your current screening practices for domestic violence,” specifically answered the question. The results indicated 88% of the nurse practitioners reported always or often screening for abuse when a client is injured, but only 15% reported always or often screening when clients present for somatic complaints, at the initial visit, or at each visit. Ten percent of respondents identified screening clients with physical injuries sometimes. The remaining 2% stated they rarely screened clients for domestic violence who present with physical injuries. Twenty percent of practitioners sometimes screen for domestic violence when clients present with somatic complaints, at the initial clinic visit, or at each visit. The overwhelming majority (65%) rarely screened for domestic violence on a routine basis. One practitioner stated, “I rely on my experience and intuition to let me know when to ask about domestic violence rather than a set
This respondent, however, reported sometimes screening for domestic violence in clients with physical injuries and rarely screening for domestic violence at other times indicated on the survey. Results of Questions 6 are listed in Table 1.

Table 1

<table>
<thead>
<tr>
<th>Screening practice</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>With physical injuries</strong></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>21.0</td>
</tr>
<tr>
<td>Often</td>
<td>67.0</td>
</tr>
<tr>
<td>Sometimes</td>
<td>10.0</td>
</tr>
<tr>
<td>Rarely</td>
<td>2.0</td>
</tr>
<tr>
<td><strong>With somatic symptoms</strong></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>1.0</td>
</tr>
<tr>
<td>Often</td>
<td>2.0</td>
</tr>
<tr>
<td>Sometimes</td>
<td>11.0</td>
</tr>
<tr>
<td>Rarely</td>
<td>7.0</td>
</tr>
<tr>
<td><strong>Once, at first visit</strong></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>2.0</td>
</tr>
<tr>
<td>Often</td>
<td>5.0</td>
</tr>
<tr>
<td>Sometimes</td>
<td>8.0</td>
</tr>
<tr>
<td>Rarely</td>
<td>48.0</td>
</tr>
</tbody>
</table>

(table continues)
Table 1 (continued)

<table>
<thead>
<tr>
<th>Screening practice</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>At each visit</td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>0.0</td>
</tr>
<tr>
<td>Often</td>
<td>4.0</td>
</tr>
<tr>
<td>Sometimes</td>
<td>1.0</td>
</tr>
<tr>
<td>Rarely</td>
<td>8.0</td>
</tr>
</tbody>
</table>

Question 7, "What tools do you use in assessing for domestic violence?" sought to identify the most common methodology used in domestic violence screening. Verbal communication was identified as the most common screening tool. Ninety percent of respondents utilized verbal assessment techniques exclusively. Written instruments were used in addition to verbal screening by 6% of practitioners. No respondents identified using a computer questionnaire as a screening tool. No other screening tools were identified on the Screening Practices Survey by any respondents.

The second research question was as follows: "What are the barriers to screening for domestic violence on a consistent basis?" Question 5 on the Screening Practices Survey addressed this issue. Three issues were identified
most frequently as barriers to screening: (a) lack of
time, (b) the perception that the client was not open to
an inquiry about domestic violence, and (c) the client’s
lack of initiative in seeking help had an equal number of
responses. Each was listed by 11% of the respondents. The
most frequent response was “lack of client disclosure once
an inquiry was made.” This response was listed by 13% of
the nurse practitioners responding. Other barriers
identified were lack of privacy (2%), lack of appropriate
resources for victims (4%), and the nurse practitioner’s
level of comfort with discussing domestic violence (2%).
Two practitioners wrote in responses to the question about
barriers to screening. One respondent identified frequent
client denial of abuse as a barrier, while another
identified client fear of retaliation by the offender if
abuse was disclosed.

Additional Findings

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

Question 9 on the Screening Practices Survey asked
respondents about their perceptions of the role of the
nurse practitioner in the comprehensive care of the client who has been a victim of domestic violence. Twenty-four participants commented on this question. When content analysis of these responses was performed, two common themes emerged. One theme was the responsibility of the nurse practitioner in the assessment and treatment of clients who have been abused. Many of the respondents identified the assessment, diagnosis, and treatment of the victim of domestic violence as priorities of care. Appropriate referral for counseling or shelter was also identified by respondents. Some of the written responses reflecting this theme were as follows:

**Domestic violence is extremely prevalent in Mississippi. The NP is often the only person that can identify, assess, treat, and/or refer women to appropriate resources. The NP should follow up on the patient once the referral is made. The NP, in my opinion, has a professional and ethical responsibility to seek out domestic violence rather than ignore it. Often, the NP is the only place an abuse person has to turn and their cries are often silent! We should also not forget that domestic violence always affects children either directly or indirectly.**

...  

The role of the NP is different according to practice site. All legal systems should be alike — consistent with implementation of persecution. I find that in rural health domestic violence is almost considered normal. My patients are ignorant to the fact that this is not acceptable
and life is more than being someone’s punching bag or verbal abuse recipient. This ignorance is due to financial constraints, low self-esteem, and learned poor behavior. I am always challenged to make a difference.

... The NP has a moral and legal obligation to assess, discuss, and report domestic violence. The NP must become familiar with resources available for victims of domestic violence. You cannot adequately care for a patient if you ignore this vital part of the history.

... Obviously, assessment and documentation of the injuries is important. It is very important to establish a rapport with the patient. In my full-time position in a large downtown ED, the police always file a report. The police and I discuss domestic violence with the patient, who almost always refuses to press charges. We give them written information about their rights and also provide a list of community resources, including shelters with phone numbers where they can get help for themselves and their children. We strongly encourage the patient to get out of the abuse situation.

The second theme identified the presence of barriers to screening. Respondents identified barriers that included lack of client disclosure and inadequate referral sources. Some of the responses related to the theme of barriers to screening included:

If I take time to ask, about one-fourth of patients will tell me the truth about what has happened or what is happening. The rest just accept it as a part of life.
If I ask about abuse, but have no solutions to offer the patient for the problem situation, the patient perceives that I am just being nosy. The patient does not always understand the impact that abuse has on health. Sometimes I feel the same way. Why should I ask (about abuse) if I have no where to send them?

Summary

In Chapter IV the data collected and analyzed for this study were presented. Demographic characteristics of the participants were examined. Descriptive statistics used to answer the research questions were presented. The findings verified that nurse practitioners do not screen for domestic violence in the primary care setting on a routine basis. The results from the Screening Practices Survey indicate that nurse practitioners tend to underestimate the number of women affected by domestic violence each year. Barriers to screening for domestic violence were identified and included lack of time, lack of disclosure once an inquiry was made, and the perception that the client was not open to an inquiry. The following chapter contains a summary and discussion of the data described in this chapter.
Chapter V
The Outcomes

Domestic violence is prevalent in our society, affecting 2 million women each year (Butler, 1995). This violence creates a significant health problem for women, yet research has shown that few health care providers screen for domestic violence. The purpose of this study was to identify the domestic violence screening practices of nurse practitioners in primary care settings in Mississippi. Identification of the common screening methodology and any barriers to screening was also integral to the study’s purpose.

This study was conducted using a self-report questionnaire, created by the researcher. The surveys were mailed to the participants. A convenience sample was chosen from the 500 nurse practitioners certified in family practice with the Mississippi Board of Nursing. A total of 250 questionnaires were mailed. The sample was selected randomly by choosing every other name from the
alphabetical list, and 142 questionnaires were returned within the designated time frame for the study.

Summary and Discussion of the Findings

Participants for this study included certified family nurse practitioners in the state of Mississippi who were currently practicing in a setting where women aged 21 years and older were being treated. Some participants held certifications in both family practice and midwifery. The majority of the respondents were female, with a mean age of 45 years. Twenty-four percent of the study participants had less than 2 years experience in the advanced practice role, while 48% had less than 5 years experience. Examination of other demographic data revealed that none of the respondents answered "yes" to the question, "Have you ever been the victim of domestic abuse?" Current research estimates reflect that one in eight women is affected by domestic violence. Since none of the respondents in the current study answered "yes" to the question about personal abuse history, this sample of respondents could be atypical. Another explanation could be that the practitioners do not recognize abuse in their
own lives. A third explanation could be that the respondents did not answer the question truthfully.

All of the participants had some level of formal education regarding domestic violence. The knowledge level and perceptions about screening for domestic violence were revealed in the responses to the survey. Question 2 on the survey asked participants what percentage of clients seen each year did they estimate had been victims of abuse. Researchers estimate that 35% of American women are affected by domestic violence each year (Butler, 1995), yet only 10% of those surveyed for the current study estimated that at least 35% of their clients were affected annually. Ninety percent of respondents estimated that 10% of women in their practice had been affected by some form of abuse. This finding most likely represents a significant underestimation of the number of women injured or abused each year, a mistake made by about 92% of primary care clinicians in the United States (Smith et al., 1998). Practitioners may not recognize the signs of abuse in clients who present with somatic complaints rather than physical injuries. This under-representation may have been influenced by the fact that none of the 142 nurse practitioners reported being victims of domestic
violence. If they had no personal experience or did not recognize the abuse in their own lives, they may not have been able to detect domestic violence in their clients.

Two research questions guided this study. The first question asked, "What are the screening practices for domestic violence for nurse practitioners?" Descriptive statistics indicated that 88% of the nurse practitioners surveyed always or often screen for domestic violence when a client is injured, but only 15% always or often screen when clients present for somatic complaints, for the initial visit, or at each visit. Research has shown that, although women do not willingly offer information about an abusive situation, they want to be asked about it (Butler, 1995). Based on the findings of this research, health care professionals should ask questions about the presence of abuse in the lives of their clients on a routine basis. Few studies in the literature were found that explain why health care providers were not screening on a routine basis. Yet, identification of abuse, especially in the beginning stages, may prevent acute and long-term problems for the client. Screening requires asking about a woman's intimate relationships in a nonjudgmental fashion (Butler, 1995). Nurse practitioners should screen for violence
early in their relationships with clients in order to open the door to healing and transformation.

The most common screening tool identified was verbal assessment. Ninety percent of participants in this study utilized verbal assessment techniques exclusively. Written survey instruments were used in addition to verbal screening tools by only 6% of practitioners. Nurse practitioners should be equipped with good listening and communication skills to effectively reach clients who are victims of domestic violence. If only 15% of practitioners are routinely screening and they are using verbal screening techniques, the importance of good communication skills is critical. Waller et al. (1996) concluded that nurses generally did a poor job of screening for domestic violence. The complication of the previous and current findings indicate a need for nursing scientists to develop valid and reliable clinical and research instruments for domestic violence screening. The current researcher, along with Caralis and Musialowski (1997), Smith et al. (1998), Varvaro and Gesmond (1997), and Waller et al. (1996), assert that a firm educational foundation upon which to base history and screening practices regarding domestic
violence would facilitate more accurate and assertive screenings by all health care providers.

The second research question stated, "What are the barriers to screening for domestic violence on a consistent basis?" Researchers have postulated that lack of comfort with the subject of domestic violence, lack of knowledge and formal training about abuse, and the lack of appropriate resources for victims of domestic abuse are barriers to screening for domestic violence (Butler, 1995; Varvaro & Gesmond, 1997). A variety of barriers also were identified in the current study.

Lack of time to adequately assess each client was listed by 11% of respondents. Screening should take place at a time when the interviewer can appear unhurried, and in an environment where confidentiality can be assured. In an effort to appear productive, nurse practitioners may feel pressured to treat as many clients in a day as possible, thereby preventing accurate assessment for domestic violence. Nurse practitioners should use creativity to allow more time to adequately assess victims of domestic violence. Schedules could be rearranged, clients could be asked to return for another visit when time is more available, or other duties the nurse
practitioner performs could be delegated when appropriate to allow more time for verbal interaction with the client.

Another 11% of the participants stated that their perception of the client not being open to inquiry about abuse served as a deterrent for screening. Other practitioners stated that once an inquiry was made, the majority of clients did not disclose an abuse history, even though the practitioner had a high degree of suspicion. An additional 11% stated that the client’s lack of initiative in seeking help for an abusive situation was a deterrent. These variables pose problems for practitioners who attempt to screen appropriately. If a health care provider feels that asking questions about abuse yields no tangible result, then the frequency of assessment is likely to diminish, resulting in poor screening practices. One respondent stated, “If I take time to ask, about one fourth of clients will tell me the truth about what has happened or what is happening. The rest just accept it as a part of life.” Again, good communication techniques and active listening skills are vital tools for the nurse practitioner. These components must be present in the verbal interaction to facilitate effective intervention in cases of abuse. The practitioner
must possess a high degree of suspicion and also be aware of nonverbal cues the client may be expressing.

A few nurse practitioners in the current sample (11%) believed that potential legal involvement by the health care provider prevented frequent inquiries. Earlier researchers have documented frequent omissions of assessment regarding abuse from the history and physical documentation in hospital charts (Gremellion & Kanof, 1996). The premise for the lack of assessment is that if one does not ask about domestic violence, then one does not identify a problem. If abuse is not identified as a problem, then it does not have to be solved. This author suggests that it is not necessarily the responsibility of the nurse practitioner to solve the problem of domestic violence. However, by presenting as a member of the health care team, the nurse practitioner accepts a responsibility to provide care to the clients encountered, including accurate assessment, diagnosis, treatment, and education about the client’s condition. By screening for domestic violence on a routine basis, the nurse practitioner is in good faith meeting his or her responsibility. Communication with the client about abuse is in itself a therapeutic intervention, as is treatment of any
associated injuries and appropriate referral to a counselor or shelter. Fear of a legal entanglement might be less prevalent if the nurse practitioner understood his or her responsibility in the care of the victims of domestic violence.

Lack of appropriate resources when referring a client for help in an abuse situation was identified by 13% of respondents as a barrier to screening. One respondent asked,

If I ask about abuse, but have no solutions to offer the patient for the problem situation, the patient perceives that I am just being nosy. The patient does not always understand the impact that abuse has on health. Sometimes I feel the same way. Why should I ask (about abuse) if I have no where to send them?

Smith et al. (1998) reported that over 60% of doctors and nurses cited frustration about being unable to change a client’s life as a deterrent to screening. This frustration on the part of the current respondents also was substantiated to some extent by Caralis and Musialowski (1997), who concluded that the majority of women believed health care providers should provide information concerning community resources and legal resources and should assist clients in finding protective services. Knowledge level regarding community resources
was assessed in Question 4 of the screening tool. Sixty-four percent of respondents felt "very knowledgeable" or "knowledgeable" about community resources available for domestic violence.

Regardless of the public’s expectations and perceptions, the nurse practitioner should be aware that referral to another organization is not the only way to assist the victim of domestic violence. Many interventions can be provided by the nurse practitioner that are therapeutic, including therapeutic communication. Health promotion is always a therapeutic intervention provided by the nurse practitioner, including protection against pregnancy and sexually transmitted diseases. However, all nurse practitioners should establish a referral system for domestic violence just as they would for all disease processes that need further treatment. Even when formal referral sources are not locally available, the nurse practitioner can refer the client to a counselor, friend, clergy member, or even another person who has experienced abuse for support.

Level of comfort with screening for domestic violence was assessed in Question 3 of the Screening Practices Survey. The majority of respondents held a Master of
Science in Nursing degree (64%), including formal education about domestic violence in their education. The comfort level with discussing domestic violence was high. The vast majority (72%) reported feeling very comfortable or comfortable with discussing domestic violence with their clients. Contrary to the previous research (Smith et al., 1998; Waller et al., 1996), lack of comfort was not identified in the current study as a barrier to screening. This encouraging finding indicates that nurse practitioners hold the potential, as well as the responsibility, to be leaders in the area of screening and intervention for domestic violence.

Additional findings of the research study included respondents’ perceptions about the role of the nurse practitioner in assessing for domestic violence. Responses indicated that practitioners are aware that domestic violence is a problem, but sometimes feel helpless in preventing the effects of abuse. Education, assessment, documentation, treatment, and appropriate referral were all listed as responsibilities of the nurse practitioner. One respondent stated the nurse practitioner was identified as the only person in the health care arena who can significantly impact the affects of domestic violence.
Other identified barriers included lack of consistency in the legal system when abusers are reported and the perception by many clients in the rural setting that abuse is a normal part of life. Many nurse practitioners perceive that women affected by violence are often made victims by the medical and legal systems and by the communities in which they live. This researcher has observed firsthand that the adage “she must have deserved it” is prominent in rural communities and in the hearts of many women who are abused. Nurse practitioners have the opportunity to become advocates for these women by providing education about the effects of domestic violence on the physical and emotional health of those involved.

Conclusions

The current researcher concluded that nurse practitioners do not routinely assess for domestic violence in primary care settings. With national statistics as a reference, participants most likely underestimated the prevalence of abuse among women in the primary care setting. Participants expressed a substantial level of comfort with discussing domestic violence with their clients and also expressed confidence in regard to
their knowledge about community resources available for victims of domestic violence. Although routine screening for all clients is rarely conducted, nurse practitioners in Mississippi do screen clients with physical injuries the majority of the time.

There are many barriers to screening for domestic violence. Lack of time and resources were identified as barriers. The client's lack of initiative in seeking help and lack of disclosure about abuse also were barriers. Failure to accept responsibility on the part of the health care provider is a barrier that must be overcome for domestic violence to be adequately identified. Communication techniques must be straightforward and specific in all interactions. Attention to detail and nonverbal communication are essential in order to thoroughly assess for the problem of domestic violence. Education of health care providers, as well as victims and the general public, may be a critical element in the solution.

Limitations

This study had limited external validity. The population is from the state of Mississippi, so results
may not be generalized to other settings. The sample was chosen for convenience from a list from the Mississippi Board of Nursing rather than through formal randomization.

There are certain limitations associated with survey research. Information from surveys tends to be superficial. Surveys rarely probe into the complexities of human behavior and feelings. Survey results cannot establish cause-and-effect relationships, and variables cannot be controlled by the researcher (Polit & Hungler, 1995).

**Implications for Nursing**

This study brought to light several implications for nursing. Implications related to practice, research, and theory are discussed.

**Nursing practice.** The roles of the nurse practitioner as a health care provider are diverse, including those of educator, manager, and advocate. Within these roles, the practitioner has a commitment to treat the whole person. When practicing, according to Pender’s Health Promotion Model (Pender, 1987), the practitioner must include every aspect of the client’s life in management along the wellness-illness continuum. Findings from this study imply
the need for a commitment to promoting improvement or enhancing quality of life through intervention. The need for specific questioning about abuse at every interaction with the client is implicated. A high degree of suspicion must be maintained to detect possible victims of abuse. In order for each client interaction to be achievement of a higher level of wellness, nurse practitioners must put aside violence-related fears and frustrations and focus on true and open communication with clients.

Nursing research. The prevalence of domestic violence and its effects have been well-documented in the literature. Findings from this study indicate nurse practitioners in primary care settings do not screen for domestic violence on a consistent basis. Barriers to screening have been postulated, but more research is needed to determine why nurse practitioners do not screen in a routine manner. Nursing research aimed toward the development of valid and reliable clinical questionnaires and research instruments with which to assess domestic violence also is implicated.

Nursing theory. Research is the foundation of nursing theory. The theoretical framework that guided this research was the Health Promotion Model (Pender, 1987).
This nursing model focuses on the willingness of the client to take control of his or her lifestyle in order to promote healthy lifestyle changes. Behavior that does not promote wellness must be recognized and accepted as inappropriate before changes can be made. It is the nurse practitioner’s responsibility to enable the client in recognizing behavior that does not promote health. It is then the client’s responsibility to make the lifestyle changes necessary to continue on the wellness continuum. By assisting clients in the recognition of abuse as aberrant or inappropriate behavior, the nurse practitioner is modeling Pender’s Health Promotion theory. The results of this study did not substantiate the frequent use of this theory as nurse practitioners did not routinely screen for domestic violence. Nurse practitioners should incorporate health promotion into every client interaction.

Nursing education. Screening for domestic violence on a routine basis in the primary care setting promotes health of every client. Education regarding domestic violence enhances the practitioner’s understanding of the importance of assessing for and intervening in abuse situations. Comfort, screening accuracy, and appropriate
referral are all enhanced with educational instruction. Content on domestic violence should be included in all areas of nursing curricula including formal education and continuing education.

Recommendations

Based on the findings of the research study, the following recommendations are made:

Nursing practice.

1. Screening for domestic violence should occur in all interactions with women in the primary care setting.

2. Each practitioner should assess and recognize his or her personal barriers to holistic assessment for domestic violence and seek ways to overcome these barriers.

3. Pender’s Health Promotion Model should be utilized as a framework for care when screening women in primary care settings for domestic violence.

Nursing research.

1. Replication of the study in different geographic locations.
2. Implementation of a qualitative study to determine why nurse practitioners do not screen for domestic violence.

3. Replication of the study to refine the Screening Practices Survey.

4. Implementation of a study to determine nurse practitioner’s perception of his or her impact on the outcome of an abuse situation where appropriate screening has occurred.

Nursing education

1. Publication of the study to promote awareness of the need for screening for domestic violence by primary care nurse practitioners.

2. Increased content regarding domestic violence within the curricula of the schools of nursing and in-service education programs.
REFERENCES
References


APPENDIX A

DEMOGRAPHIC SURVEY
Demographic Survey

1. What is your age? ____________

2. What is your sex?
   ____ Male
   ____ Female

3. How many years have you practiced as a nurse practitioner or nurse midwife? ______________

4. What is your area of specialty practice?
   ____ Clinic--Primary Care Family
   ____ Clinic--Primary Care Pediatric
   ____ Clinic--Urgent Care
   ____ Clinic--School Based
   ____ Emergency Department
   ____ Hospital--Acute Care
   ____ Long-Term Care or Nursing Home
   ____ Other (please specify):____________________

5. What is your area of certification?
   ____ Family Practice
   ____ Adult
   ____ Other (please specify):____________________

6. What is your level of education? (Check all that apply)
   ____ BSN
   ____ MSN
   ____ Certificate Practitioner Program
   ____ Doctorate in Nursing
   ____ Other doctorate (please specify):____________
   ____ Other degree (please specify):______________

7. What is your level of nurse practitioner education? (Check all that apply)
   ____ Certificate Practitioner Program
   ____ MSN
   ____ Post-Master’s Degree
APPENDIX B

SCREENING PRACTICES SURVEY
Screening Practices Survey

1. What level of education have you received regarding domestic violence? (Check all that apply)
   ___ Formal education in a BSN program
   ___ Formal education in an MSN program
   ___ Formal education in a certificate program
   ___ Inservice programs
   ___ Read journal articles
   ___ Other (please specify): _______________________

2. What percentage of women 21 years or older that you see annually do you ESTIMATE have been victims of domestic violence?________________________________________________

3. How comfortable do you feel discussing domestic violence with your patients?
   ___ Very comfortable
   ___ Comfortable
   ___ Somewhat comfortable
   ___ Not comfortable at all

4. How would you describe your level of knowledge regarding community services available for victims of domestic violence?
   ___ Very knowledgeable
   ___ Knowledgeable
   ___ Somewhat knowledgeable
   ___ Not knowledgeable at all

5. What do you perceive as reasons for not screening for domestic violence? (Check all that apply)
   ___ Lack of time
   ___ Lack of privacy
   ___ Perception that the client is not open to an inquiry
   ___ Lack of client disclosure once an inquiry is made
   ___ Lack of appropriate resources for victims if violence is identified
   ___ Legal implications
   ___ Your lack of comfort with discussing domestic violence
   ___ Domestic violence is not prevalent among your patient population.
   ___ Physician preceptor does not want you to screen.
6. Please describe your current screening practices for domestic violence using the following scale:

<table>
<thead>
<tr>
<th>Screen women patients</th>
<th>Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. with physical injuries</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>b. with other symptoms</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>c. once, at first visit</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
<tr>
<td>d. at each visit</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
<td>_____</td>
</tr>
</tbody>
</table>

7. What tools do you use in assessing for domestic violence?
   (Check all that apply)
   ____ Written surveys or questionnaires
   ____ Verbal screening tools
   ____ Computer questionnaire
   ____ Others (please specify):

8. Have you ever been a victim of domestic violence?
   ____ Yes
   ____ No
   ____ Unsure

9. What is your perception of the role of the nurse practitioner in the comprehensive care of a client who has been a victim of domestic violence?

Thank you for your time and participation.
APPENDIX C

APPROVAL OF THE COMMITTEE ON USE OF HUMAN SUBJECTS IN EXPERIMENTATION OF MISSISSIPPI UNIVERSITY FOR WOMEN
March 22, 1999

Ms. Amy Louise Branyon  
c/o Graduate Program in Nursing  
Campus

Dear Ms. Branyon:

I am pleased to inform you that the members of the Committee on Human Subjects in Experimentation have approved your proposed research as submitted.

I wish you much success in your research.

Sincerely,

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

SK: wr

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

Where Excellence is a Tradition
APPENDIX D

COVER LETTER
May 24, 1999

904 Windsong Drive
Northport, AL 35476
(205) 339-5534

Dear Nurse Practitioner,

My name is Amy Branyon and I am a nurse practitioner student in the graduate program at Mississippi University for Women in Columbus, Mississippi. I am conducting a research study to investigate the screening practices of nurse practitioners for domestic violence. Research has shown domestic violence to be a threat to the health of primary care patients and may be prevalent in as many as 30% of women treated in primary care. I wish to identify the screening practices of nurse practitioners and identify the barriers to screening for domestic violence in primary care settings.

I am writing to request your participation in this study. Enclosed is a Demographic Survey and a Screening Practices Survey that will give me the information needed for the study. I expect it to require only 10 to 15 minutes of your time. Your participation will be greatly appreciated.

All responses will be anonymous and confidential. By returning the survey, your consent for participation in the study will be implied. I have enclosed a self-addressed, stamped envelope for your convenience. Again, your participation will be greatly appreciated.

Sincerely,

Amy Branyon, RN, BSN