A Comparison of Domestic Violence Screening, Attitudes, and Knowledge Base

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The project and manuscript have been successfully completed and meet the standards of the School of Nursing at San Jose State University. The project demonstrates the application of professional knowledge, clinical expertise, and scholarly thinking. An abstract of the project and two copies of the manuscript are attached.

Please submit this form to the Graduate Coordinator. Attach the abstract, two copies of the manuscript, and documentation of submission to the journal.
SAN JOSE STATE UNIVERSITY  
SCHOOL OF NURSING  
MASTER'S PROGRAM PROJECT OPTION (PLAN B)  
PROJECT ADVISOR APPLICATION

Prepare a short paper (3-5 double spaced pages) which addresses each of the following. Turn it in to the Graduate Coordinator by May 10 or December 10 of the semester before implementation of the project.

1. Succinct statement of problem and significance of the problem (1-2 pages);

2. Category of project, (A-G on Plan B information sheet) e.g., implementing and evaluating a health program or completion of a needs assessment;

3. Purpose statement (one sentence);

4. Detailed description of the project including each of the following, if relevant.
   a. subjects or clients;
   b. test materials, questionnaires, surveys, or other materials to be used (attach a copy of each);
   c. the intervention, implementation, or what the subjects or clients will be required to do;
   d. data collection procedures;
   e. procedures to protect subjects confidentiality;
   f. data analysis procedures.

5. Agency permission letter, if relevant.

6. Title and format guidelines for authors from the professional journal for which your manuscript will be written.
SAN JOSE STATE UNIVERSITY
SCHOOL OF NURSING

MASTER'S PROGRAM PROJECT OPTION (PLAN B)
PROJECT SIGNATURE FORM

STUDENT NAME

SEPTEMBER ENROLLED
Spring 1999

TITLE OF PROJECT
A Comparison of Domestic Violence: Screening, Attitudes, and Knowledge Base.

The project and manuscript have been successfully completed and meet the standards of the School of Nursing at San Jose State University. The project demonstrates the application of professional knowledge, clinical expertise, and scholarly thinking. An abstract of the project and two copies of the manuscript are attached.

Mareena Marone, R.N., M.S.N., F.N.P.  5-17-99
ADVISOR SIGNATURE  DATE

Please submit this form to the Graduate Coordinator. Attach the abstract, two copies of the manuscript, and documentation of submission to the journal.

DATE
A Comparison of Domestic Violence Screening, Attitudes, and Knowledge Base

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Abstract

Objective: To compare advanced practice nurses' (APNs) and physicians' (MDs) domestic violence screening behaviors, perceived obstacles, and knowledge base so as to determine the efficacy of the collaborative practice model of care.

Design: The survey questionnaires were the "Nurse Practitioners' Experience with Partner Abuse in Alaska" and the "Physicians' Experience with Partner Abuse in Alaska". Significant differences were evaluated by using one-way analysis of variance (ANOVA).

Setting: Two 200-300 bed urban HMO medical centers.

Participants: Thirty-five providers (23 MDs and 12 APNs) with the mean age of 40, and with 8 years clinical practice in California.

Results: Of total providers, 47% estimated domestic violence occurred in < 5% of patients. APNs exhibited better screening at initial visits, regular, and annual exams. MDs exhibited better screening when patients present injured. Frustration and resource availability were identified as obstacles to screening. MDs considered a patient's right to privacy important.

Conclusions: Domestic violence incidence is underestimated. APNs exhibited better primary and secondary prevention. MDs exhibited better tertiary care. Frustration and resource availability are difficult for nurses, privacy issues difficult for MDs. Collaborative practice would combine the strengths of both professions providing appropriate domestic violence care.
Callouts

Page 6: The true incidence of domestic violence is unknown. Reluctance to report abuse at the hands of an intimate partner makes any statement of domestic violence frequency, at best, an approximation. With universal screening this hidden population of victims could be offered appropriate care and services.

Page 16: This lethal disorder of women, domestic violence, deserves the same rate of screening as even less threatening disorders. These same providers would never suspect hypertension, cervical cancer, or AIDS and then send the patient home without the appropriate follow-up and referrals.

Page 20: The collaborative practice model, would incorporate medical, nursing, and patient directed input containing the ingredients necessary to empower the women and their children that are affected by domestic violence.
A Comparison of Domestic Violence Screening,
Attitudes, and Knowledge Base

Collaborative practice has been suggested as an appropriate model for the care of women and children affected by domestic violence. Previous studies have examined the screening behaviors and attitudes of either physicians or nurses, few studies have compared screening behaviors between professionals. It would be expected that of all the available medical providers, those caring for women exclusively would have the best domestic violence screening attitudes and behaviors. The objective of this survey is to examine the screening behaviors, perceived obstacles to screening, and knowledge base of advanced practice nurses (APNs) and physicians (MDs), thereby providing the information needed for effective program planning and promotion of the collaborative practice model.

Background

Prevalence

Prevalence rates for domestic violence have been described as low as one million to as high as 4 million women per year (Bachman & Saltzman, 1995; Commission on Domestic Violence, 1998; Easley, 1996; Warshaw, Ganley, & Salber, 1995). In a large meta-analysis of thirteen studies, Gazmararian et al. (1996) described an overall rate of domestic violence at any time in the past as
Reluctance to report abuse at the hands of an intimate partner makes any statement of domestic violence frequency, at best, an approximation. Hidden from incidence rates and numbers are many more women and their children trapped in abusive environments. Often, they are reluctant to report violent incidents because of fear, shame, depression, or guilt. With universal screening this hidden population of victims could be offered appropriate care and services.

Screening Behaviors and Obstacles

Routine health screening is a common occurrence in the primary care setting. Domestic violence has a higher prevalence rate in the general population than hypertension, hypercholesterolemia, glucose intolerance of pregnancy, cervical cancer, gonorrhea, syphilis, and AIDS (Chescheir, 1996). "Experts predict that abuse can be reduced by up to 75 percent if identification and intervention are offered in primary care settings" (McFarlane & Gondolf, 1998, p. 22).

Even though domestic violence has good clinical outcomes with intervention, universal screening does not routinely occur even with high risk women. Sugg & Inui (1992) described physicians' reluctance to screen for domestic violence as a "fear of opening a Pandora's box" (p. 3158). Physicians in previous
48 studies have expressed discomfort with areas traditionally defined
49 as private and difficulty with domestic violence assessment due to
50 a close identification with the patient. They were concerned about
51 the lack of time within the clinical setting and expressed
52 frustration because they felt they could not do anything about the
53 patients’ problems (Sugg & Inui, 1992; Parsons et al., 1995).
54 Returning the decision-making power and control to the
55 victim is at the core of domestic violence treatment. Physicians,
56 as problem-solvers, can become frustrated by their perceived
57 powerlessness and lack of control when managing cases of domestic
58 violence. By validating, advising, and listening, physicians can
59 avoid the pitfall of rescuing patients and allow them to regain
60 the sense of control needed to achieve desired life changes
61 (Gremillion & Kanof, 1995).

**Conceptual Framework**

Collaborative practice, as suggested by both Parsons et al.
64 (1995) and Gremillion and Kanof (1995), is a model that would
65 ensure both routine screening and sensitive, appropriate care for
66 families suffering the effects of violence in their homes.
67 Collaboration would allow the patient to receive the benefits of
68 treatment and care from both the perspective of medicine and
69 nursing.

The "Circle of Caring" as described by Dunphy and Winland-
71 Brown (1998) contains the essence of collaborative practice. The
broadened database, holistic approach, and incorporation of the patient’s response to the meaning of their experiences would empower victims of domestic violence. This model of care is unique because the clinical outcomes are evaluated based on the patient’s and the family’s perception of improvement. Within this collaborative practice model of care, the woman is given the respect to be considered an expert on her own condition.

Methodology

Definitions

For the purposes of this survey, domestic violence is defined as actual or threatened physical, sexual, or emotional abuse of an individual 16 years or older, by someone with whom they have or have had an intimate or romantic relationship. Screening for domestic violence is defined as asking patients direct, specific questions about domestic violence (Warshaw, et al., 1995). Victims of domestic violence will be referred to as women due to the 90% to 95% incidence of intimate partner abuse directed towards females.

Participants & Setting

A survey was mailed to a convenience sample of 102 women’s health care providers, consisting of 69 (68%) MDs and 33 (32%) APNs, working in Santa Clara County, California. The sample was obtained from the roster of providers at two 200-300 bed medical centers, located in a large urban area. These two facilities
belong to a large nationally known HMO, each serving 200,000 to 250,000 members. The medical centers provide care to an ethnically diverse population of 16-23% Hispanic; 61% Caucasian; 9%-11% Asian; and 2%-3% African American (B. Freygang, personal communication, March 16, 1999).

Survey Instrument

The survey instruments used were the “Nurse Practitioners’ Experience with Partner Abuse in Alaska” and the “Physicians’ Experience with Partner Abuse in Alaska”, developed by the Alaska Domestic Violence Project, Section of Maternal Child and Family Health (Warshaw, et al., 1995). Except for the identified provider, these questionnaires are identical. The instrument was developed as an Alaska statewide needs assessment of health care providers and had been validated and successfully used to develop training and resources. Permission for use of the tool was obtained from the Alaska Domestic Violence Project.

Procedure

After university and institutional Human Subjects Review Board approval, all participants were mailed a cover letter, explaining the purpose of the study, appropriate copies of the survey, and a stamped return addressed envelope with request for return in two weeks. The questionnaires were anonymous and the return of the questionnaire constituted informed consent to participate.
The data was analyzed on an IBM computer workstation by the computer program SPSS 7.5 for Windows (Norusis, 1997).

Demographic data was compiled in frequencies, ranges, medians, and means. The qualitative data was evaluated for significant differences between APNs and MDs using one-way analysis of variance (ANOVA), with an $F$ value of $>1$ indicating a significant difference between samples. An alpha level of 0.05 was used for all statistical tests. The data was also described by comparing means, medians, ranges, and frequencies.

**Results**

**Demographics**

Of the 35 (34%) questionnaires returned, 23 (66%) were from MDs and 12 (34%) were from APNs. The majority of both groups of respondents were female (77%), with a mean age of 41 years old. The median age for the APNs was 8 years older than that of the MDs. (see Table 1)

**The Practice Environment**

All the respondents, except one APN, are currently in clinical practice in California and work in women’s health. They averaged 12 years post training and had an average of 8 years of clinical practice in California. Ninety-seven percent of the total respondents work in obstetrics and gynecology and a large percentage (69%) reported treating more than 30 female patients, age 16 years or older, per week.
Screening Beliefs and Behaviors

Even though almost half (47%) of the providers believed that less than 5% of their patients had been abused, over 1/3 of the APNs indicated they believed that greater than 15% of their patient population had been abused. Eighteen percent of these nurses, compared to only 8% of the MDs, indicated the belief that more than 25% of their patients had been abused. (see Table 2)

Ninety-one percent of the total respondents replied yes to ever asking female patients direct, specific questions about abuse. A difference was noted between providers with 100% of the APNs as compared to 86% of the MDs answering yes to this question.

More APNs (80%) than MDs (40%) indicated often or always screening for domestic violence during initial visits, regular, and annual exams. More MDs (95%) than APNs (81%) indicated often or always screening when the patients presented with an injury. Table 3 documents there was no statistical difference in screening behaviors when the provider suspected abuse, during the first prenatal visit, or during follow-up prenatal visits.

Treatment Options

There were no statistical differences noted between the provider’s use of various resources when caring for domestic violence victims. The majority of providers indicated always referring patients to shelters or safe houses (54%), providing
them with information on community resources (77%), and referring
patients for counseling (75%).

Obstacles to Screening

Table 4 documents the obstacles to screening for domestic violence, two of which exhibited significant differences between MDs and APNs. The obstacle "it is frustrating to identify domestic violence because I can do little to help" was not felt to be a barrier by the physicians. Significantly more MDs (48%) than APNs (30%) indicated this barrier as not important ($p = .04$). The response to a lack of resources being an obstacle to effective domestic violence screening was also significant ($p = .004$).

Eighty-two percent of the MDs indicated this obstacle as less than neutral or not important compared to 60% of the APNs.

The remainder of the obstacles to domestic violence did not demonstrate statistical differences. As a whole these providers felt that time constraints were important, although none of the providers indicated as very important the belief that their attention should be focused on other health problems of a higher priority. Direct questioning about domestic violence was not seen as being too confrontational for patients. Both groups of providers felt that language barriers and different cultural beliefs and values were moderately important obstacles to screening for domestic violence. (see Table 4)
One physician wrote in "right of privacy", and indicated this obstacle as moderately important. This same physician strongly agreed with the statement "patients have a right to privacy about family matters like domestic violence".

**Attitudes About Domestic Violence**

Table 5 documents the provider attitudes about screening for domestic violence, two of which exhibit significant differences between MDs and APNs. The statement that patients have a right to privacy about family matters such as domestic violence, was considered important by 52% of the MDs compared to 27% of the APNs ($p = .07$). A large percentage (64%) of the APNs somewhat or strongly agreed with the statement that patients would deny domestic violence if questioned ($p = .07$).

The issue of sufficient resources in the community to assist domestic violence victims approached statistical significance ($p = .33$). Forty-four percent of the MDs somewhat agreed with this statement as compared to 40% of the APNs somewhat disagreeing.

The remaining options indicated agreement among the providers. Both groups of providers indicated they felt comfortable asking female patients direct questions and believed that they could help a patient being abused by her partner. They also indicated that they have as much responsibility dealing with domestic violence as they do to deal with other clinical problems. (see Table 5)
Domestic Violence Knowledge Base

Forty-six percent of the APNs indicated that they had had no training on domestic violence within the past two years. Fifty-two percent of the MDs reported two to three or more classes within the past two years. Eighty-five percent of the total sample (100% of the APNs) desired training on domestic violence. Legal issues and referral options were the top two priorities for classes.

Discussion

Perceived Prevalence

Almost half of the respondents indicated that the suspected domestic violence rate in their patient population was under 5%. This is lower than most documented incidence rates (Dearwater et al., 1998, Garzmaraian et al., 1996). It is noteworthy that over 1/3 of the APNs indicated the higher incidence rates for their population. One would wonder if this was an over estimation, or if the nature of the nurse-patient relationship allowed more patients to confide their domestic violence histories.

Screening Behaviors

The question that asked if the MD or the APN "ever screened for domestic violence" obtained a high positive total response (97%). This question asked if they ever screened for domestic violence: This would indicate that a small percentage (0.3%) of this self selected group (n = 35) never screened. These providers
did not consider domestic violence a significant enough risk to
their patient’s health to warrant screening and intervention.
Horan et al. (1998) documented a 27% routine screening rate
for physicians during the initial visit. In this survey there was
an improved rate of 40% of the physicians indicating always or
often screening for domestic violence during the initial visit.
The APNs, however, exhibited much better screening rates. Twice as
many APNs (80%) indicated they often or always screened for
domestic violence during initial visits. These nurses considered
domestic violence screening to be a routine part of the health
maintenance evaluation, thus allowing for both primary and
secondary prevention to occur for domestic violence as it
routinely occurs for other threats to a women’s health.
More MDs (85%) than APNs (63%) indicated they always
inquired about domestic violence when the patient presented with
an injury. This finding was supported by Horan et al. (1998) who
concluded that even though physicians possess a good understanding
of domestic violence, they did not screen on a routine basis but
only when a suspicion was triggered. It is unclear, however, why
APNs, so good at the practice of primary and secondary prevention,
seem not to do as well providing their patients with tertiary
preventative care.
When the providers suspected abuse, 86% indicated they
always screened for domestic violence. This is not acceptable.
This lethal disorder of women, domestic violence, deserves the same rate of screening as even less threatening disorders. These same providers would never suspect hypertension, cervical cancer, or AIDS and then send the patient home without the appropriate follow-up and referrals.

Both groups of providers described low screening rates at prenatal visits. A domestic violence rate during pregnancy of 4%-8% and documented perinatal morbidity and mortality warrants an improvement in screening behaviors for both groups of providers. Many patients report repeated abuse warranting routine domestic violence screening during each trimester (Gazmararian et al., 1996; King & Ryan, 1996; McFarlane & Gondolf, 1998).

Obstacles, Beliefs, and Behaviors

Time constraints. Within these busy clinical practices both the APNs and the physicians felt that time constraints were of moderate importance as barriers. This was similar to the majority of the physicians in the article by Sugg & Inui (1992) who stated that time constraints were a major deterrent to domestic violence screening. Yet, even though time constraints were an obstacle, they still indicated that when prioritizing their care, other health problems did not take a higher priority.

Resources. A larger percentage of MDs (52%) compared to APNs (30%) believed there were sufficient resources within the community, they did not perceive the lack of resources to be an
obstacle to domestic violence screening. The nurse’s concern about
the availability of resources may have been due to the fact that
46% of the APNs had reported having no education on domestic
violence within the past two years and requested additional
training with referral options as a high priority.

Providers. On the whole, these providers displayed comfort
approaching victims of domestic violence. They were unlike the
physicians in the earlier studies, who described feelings of
frustration, discomfort, and helplessness when screening domestic
violence victims (Sugg & Inui, 1992; Parsons et al., 1995). They
exhibited a greater similarity to the physicians described in the
article by Horan et al. (1998), over half of whom reported feeling
confident about their domestic violence screening skills.

These providers indicated that they felt comfortable asking
female patients direct screening questions and they felt empowered
to help these women and their families. The providers differed
only in their feelings of frustration. Although, as a whole, the
feelings of frustration and helplessness when dealing with
domestic violence victims was not considered important as an
obstacle. APNs appear to have more concern about feelings of
frustration and helplessness affecting their screening. All
providers felt strongly that they had as much responsibility to
care for domestic violence victims as they did for any other
clinical problem.
Patients. In 1999, Caucasians will cease to be the majority in Santa Clara County (Cha & McLaughlin, 1999). These providers serve an ethnically diverse and varied population; thus, it would not be unexpected that language barriers and different cultural beliefs and practices might be considered a barrier to domestic violence screening. Exhibiting a certain cultural competency, only a little over 1/3 of these providers considered different cultural beliefs and values as an important barrier to domestic violence screening. A larger percentage (41%) of the providers believed language barriers to be a moderately important obstacle.

Considering the diversity of this particular patient population, and the difficulty providers have discussing this sensitive subject with even English speaking patients, this percentage is lower than anticipated. It is suggested that culturally sensitive domestic violence screening be emphasized in training programs.

Although these providers did not perceive direct questioning about domestic violence to be to confrontational, over half (55%) of the APNs believe that patients will deny domestic violence if asked. This is an expected finding, given the social constraints and feelings of guilt and shame that surround domestic violence (Warshaw, et al. 1995). It may take repeated nonjudgemental and empathic questioning for the women to gain the trust needed to disclose abuse.
A family's right to privacy about domestic violence is a difficult issue. The majority of the MDs (52%) indicate agreeing with this statement. The fear of offending patients was noted as an obstacle to screening by both Sugg & Inui (1992) and Horan et al. (1998). Yet, King and Ryan (1996) noted that the patients rarely are offended by the personal nature of this question.

The damage done to children who witness domestic violence, the cost to society, and the potential lethality make the question of honoring a family's right to privacy a difficult ethical issue. Most women want the violence to stop and are unsure how to accomplish this end. To protect a family's right to privacy might mean withholding resource, support, and counseling information that a victim so desperately needs. Questions of a personal nature are asked of patients at every health encounter. When one examines the potential morbidity and mortality when protecting privacy becomes an obstacle to effective screening, one might ask exactly whose privacy are we maintaining, the woman's or the abuser's.

Limitations of Study

This study had several limitations that would make its findings difficult to generalize to all APNs and MDs. The total sample size was small, only 23 MDs and 12 APNs. Also, the return rate for the questionnaire could have been improved with follow-up mailings. This study was conducted on a convenience sample of
providers only in California. Different outcomes may occur from a
larger sample obtained from different areas of the country.

Conclusion and Implications

This population of providers exhibit a belief that domestic
violence is an important clinical problem. The APNs more
frequently indicated screening for domestic violence during
initial visits, routine, and annual exams (i.e. primary and
secondary prevention). The MDs more frequently indicated screening
for domestic violence when a patient presents with an injury (i.e.
tertiary prevention). The collaborative practice model, would
incorporate medical, nursing, and patient directed input (Dunphy &
Winland-Brown, 1998). This model of care contains the ingredients
necessary to empower these women to make the decisions that would
hopefully allow them to free both themselves and their children
from domestic violence.
References


Table 1.

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>Gender</th>
<th>Mean</th>
<th>Median</th>
<th>Age range</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
<td></td>
<td>male</td>
<td>female</td>
<td></td>
</tr>
<tr>
<td>MD</td>
<td>23</td>
<td>30%</td>
<td>70%</td>
<td>40</td>
<td>36</td>
</tr>
<tr>
<td>APN</td>
<td>12</td>
<td>8%</td>
<td>92%</td>
<td>41</td>
<td>44</td>
</tr>
<tr>
<td>Total providers</td>
<td>35</td>
<td>23%</td>
<td>77%</td>
<td>44</td>
<td>40</td>
</tr>
</tbody>
</table>

Note. MD = physician APN = advanced practice nurse
Table 2.

<table>
<thead>
<tr>
<th>Group</th>
<th>&lt; 5%</th>
<th>5-10%</th>
<th>11-15%</th>
<th>16-20%</th>
<th>21-25%</th>
<th>&gt; 25%</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD</td>
<td>44%</td>
<td>48%</td>
<td>4%</td>
<td>--</td>
<td>--</td>
<td>4%</td>
</tr>
<tr>
<td>APN</td>
<td>55%</td>
<td>9%</td>
<td>--</td>
<td>18%</td>
<td>--</td>
<td>18%</td>
</tr>
<tr>
<td>Total providers</td>
<td>47%</td>
<td>35%</td>
<td>3%</td>
<td>6%</td>
<td>--</td>
<td>9%</td>
</tr>
</tbody>
</table>

*\(E(1,32) = 2.01, p = .17\)

**Note.** Dashes indicate no respondents chose available option. Asterisks indicate ANOVA with \(E > 1.0\) = significant difference. MD = physician APN = advanced practice nurse
Table 3.

<table>
<thead>
<tr>
<th>Circumstance</th>
<th>Never</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
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<tr>
<td></td>
<td>MD</td>
<td>APN</td>
<td>MD</td>
<td>APN</td>
</tr>
<tr>
<td>Initial visit</td>
<td>10%</td>
<td>10%</td>
<td>50%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*E(1,28) = 1.57, R = .22</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual exam</td>
<td>10%</td>
<td>--</td>
<td>35%</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*E(1,28) = 1.57, R = .20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st prenatal</td>
<td>24%</td>
<td>20%</td>
<td>18%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*E(1,25) = 0.01, R = .89</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up prenatal</td>
<td>22%</td>
<td>30%</td>
<td>68%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*E(1,26) = 0.02, R = .88</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presents with injury</td>
<td>5%</td>
<td>18%</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*E(1,29) = 1.96, R = .17</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D.V. suspected</td>
<td>--</td>
<td>--</td>
<td>7%</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*E(1,20) = 0.15, R = .7</td>
<td></td>
<td></td>
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</tbody>
</table>

Note. Dashes indicate no respondents chose available option. Asterisks indicate ANOVA with $E > 1.0 = \text{significant difference. MD = physician APN = advanced practice nurse, D.V. = domestic violence.}$
Table 4.

**Obstacles to Screening**

<table>
<thead>
<tr>
<th>Obstacles</th>
<th>Not Important</th>
<th>Less Important</th>
<th>Neutral</th>
<th>Slightly Important</th>
<th>Very Important</th>
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</thead>
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<tr>
<td></td>
<td>MD</td>
<td>APN</td>
<td>MD</td>
<td>APN</td>
<td>MD</td>
</tr>
<tr>
<td>Time constraints</td>
<td>13%</td>
<td>27%</td>
<td>22%</td>
<td>--</td>
<td>39%</td>
</tr>
<tr>
<td><em>F</em>&lt;sub&gt;1,32&lt;/sub&gt; = 0.64, <em>p</em> = .43</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other problems higher priority</td>
<td>35%</td>
<td>30%</td>
<td>44%</td>
<td>20%</td>
<td>13%</td>
</tr>
<tr>
<td><em>F</em>&lt;sub&gt;1,31&lt;/sub&gt; = 0.88, <em>p</em> = .36</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frustration due to feelings of helplessness</td>
<td>48%</td>
<td>30%</td>
<td>39%</td>
<td>30%</td>
<td>13%</td>
</tr>
<tr>
<td><em>F</em>&lt;sub&gt;1,31&lt;/sub&gt; = 4.38, <em>p</em> = .04</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of resources</td>
<td>52%</td>
<td>30%</td>
<td>30%</td>
<td>30%</td>
<td>17%</td>
</tr>
<tr>
<td><em>F</em>&lt;sub&gt;1,32&lt;/sub&gt; = 9.36, <em>p</em> = .004</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening too confrontational</td>
<td>43%</td>
<td>36%</td>
<td>17%</td>
<td>18%</td>
<td>22%</td>
</tr>
<tr>
<td><em>F</em>&lt;sub&gt;1,32&lt;/sub&gt; = 0.57, <em>p</em> = .46</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Language barriers</td>
<td>22%</td>
<td>9%</td>
<td>13%</td>
<td>18%</td>
<td>22%</td>
</tr>
<tr>
<td><em>F</em>&lt;sub&gt;1,32&lt;/sub&gt; = 0.08, <em>p</em> = .76</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural beliefs</td>
<td>36%</td>
<td>18%</td>
<td>14%</td>
<td>18%</td>
<td>14%</td>
</tr>
<tr>
<td><em>F</em>&lt;sub&gt;1,31&lt;/sub&gt; = 0.37, <em>p</em> = .55</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note.** Dashes indicate no respondents chose available option. Asterisks indicate ANOVA with *F* > 1.0 = significant difference. MD = physician APN = advanced practice nurse, D.V. = domestic violence.
### Table 5.

#### Attitudes About Domestic Violence

<table>
<thead>
<tr>
<th>Attitudes</th>
<th>Not Important</th>
<th>Not Important</th>
<th>Neutral Important</th>
<th>Slightly Important</th>
<th>Very Important</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MD</td>
<td>APN</td>
<td>MD</td>
<td>APN</td>
<td>MD</td>
</tr>
<tr>
<td>Sufficient resources</td>
<td>4%</td>
<td>--</td>
<td>9%</td>
<td>--</td>
<td>40%</td>
</tr>
<tr>
<td><em>F</em>(1,31) = 0.97, p = .33</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feel can help</td>
<td>--</td>
<td>--</td>
<td>4%</td>
<td>--</td>
<td>13%</td>
</tr>
<tr>
<td><em>F</em>(1,32) = 0.13, p = .72</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comfortable with direct question</td>
<td>--</td>
<td>--</td>
<td>17%</td>
<td>9%</td>
<td>4%</td>
</tr>
<tr>
<td><em>F</em>(1,32) = 0.13, p = .72</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Right to privacy</td>
<td>17%</td>
<td>27%</td>
<td>13%</td>
<td>36%</td>
<td>17%</td>
</tr>
<tr>
<td><em>F</em>(1,32) = 3.62, p = .07</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients will deny if asked</td>
<td>4%</td>
<td>--</td>
<td>48%</td>
<td>18%</td>
<td>17%</td>
</tr>
<tr>
<td><em>F</em>(1,32) = 3.42, p = .07</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsibility equal to other problems</td>
<td>4%</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>9%</td>
</tr>
<tr>
<td><em>F</em>(1,32) = .005, p = .94</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note.** Dashes indicate no respondents chose available option. Asterisks indicate ANOVA with *F* > 1.0 = significant difference. MD = physician APN = advanced practice nurse, D.V. = domestic violence.