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

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**SAN JOSE STATE UNIVERSITY
SCHOOL OF NURSING**

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

STUDENT NAME

Terry Garoner RN

SEMESTER 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.

Sharon Wake
ADVISOR SIGNATURE

5/19/99
DATE

_____
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.

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.

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Marcia Morone RNE, MSN, FNP
ADVISOR SIGNATURE

5-17-99
DATE

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.

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

24 9.7% to 29.7%. Yet, the true incidence of domestic violence is
25 unknown.

26 Reluctance to report abuse at the hands of an intimate
27 partner makes any statement of domestic violence frequency, at
28 best, an approximation. Hidden from incidence rates and numbers
29 are many more women and their children trapped in abusive
30 environments. Often, they are reluctant to report violent
31 incidents because of fear, shame, depression, or guilt. With
32 universal screening this hidden population of victims could be
33 offered appropriate care and services.

34 Screening Behaviors and Obstacles

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

43 Even though domestic violence has good clinical outcomes
44 with intervention, universal screening does not routinely occur
45 even with high risk women. Sugg & Inui (1992) described
46 physicians' reluctance to screen for domestic violence as a "fear
47 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).

62   Conceptual Framework

63   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.

70   The "Circle of Caring" as described by Dunphy and Winland-
71 Brown (1998) contains the essence of collaborative practice. The

72 broadened database, holistic approach, and incorporation of the
73 patient's response to the meaning of their experiences would
74 empower victims of domestic violence. This model of care is unique
75 because the clinical outcomes are evaluated based on the patient's
76 and the family's perception of improvement. Within this
77 collaborative practice model of care, the woman is given the
78 respect to be considered an expert on her own condition.

79 Methodology

80 Definitions

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

90 Participants & Setting

91 A survey was mailed to a convenience sample of 102 women's
92 health care providers, consisting of 69 (68%) MDs and 33 (32%)
93 APNs, working in Santa Clara County, California. The sample was
94 obtained from the roster of providers at two 200-300 bed medical
95 centers, located in a large urban area. These two facilities

96 belong to a large nationally known HMO, each serving 200,000 to
97 250,000 members. The medical centers provide care to an ethnically
98 diverse population of 16-23% Hispanic; 61% Caucasian; 9%-11%
99 Asian; and 2%-3% African American (B. Freygang, personal
100 communication, March 16, 1999).

101 Survey Instrument

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

112 Procedure

113   After university and institutional Human Subjects Review
114 Board approval, all participants were mailed a cover letter,
115 explaining the purpose of the study, appropriate copies of the
116 survey, and a stamped return addressed envelope with request for
117 return in two weeks. The questionnaires were anonymous and the
118 return of the questionnaire constituted informed consent to
119 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.

129 Results

130 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)

136 The Practice Environment

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

144 Screening Beliefs and Behaviors

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

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

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

162 Treatment Options

163   There were no statistical differences noted between the
164 provider's use of various resources when caring for domestic
165 violence victims. The majority of providers indicated always
166 referring patients to shelters or safe houses (54%), providing

167 them with information on community resources (77%), and referring
168 patients for counseling (75%).

169 Obstacles to Screening

170 Table 4 documents the obstacles to screening for domestic
171 violence, two of which exhibited significant differences between
172 MDs and APNs. The obstacle "it is frustrating to identify domestic
173 violence because I can do little to help" was not felt to be a
174 barrier by the physicians. Significantly more MDs (48%) than APNs
175 (30%) indicated this barrier as not important ($p = .04$). The
176 response to a lack of resources being an obstacle to effective
177 domestic violence screening was also significant ($p = .004$).

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

180 The remainder of the obstacles to domestic violence did not
181 demonstrate statistical differences. As a whole these providers
182 felt that time constraints were important, although none of the
183 providers indicated as very important the belief that their
184 attention should be focused on other health problems of a higher
185 priority. Direct questioning about domestic violence was not seen
186 as being too confrontational for patients. Both groups of
187 providers felt that language barriers and different cultural
188 beliefs and values were moderately important obstacles to
189 screening for domestic violence. (see Table 4)

190   One physician wrote in "right of privacy", and indicated
191   this obstacle as moderately important. This same physician
192   strongly agreed with the statement "patients have a right to
193   privacy about family matters like domestic violence".

194   Attitudes About Domestic Violence

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

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

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

214 Domestic Violence Knowledge Base

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

221 Discussion

222 Perceived Prevalence

223   Almost half of the respondents indicated that the suspected
224 domestic violence rate in their patient population was under 5%.
225 This is lower than most documented incidence rates (Dearwater et
226 al., 1998, Garzmaranian et al., 1996). It is noteworthy that over
227 1/3 of the APNs indicated the higher incidence rates for their
228 population. One would wonder if this was an over estimation, or if
229 the nature of the nurse-patient relationship allowed more patients
230 to confide their domestic violence histories.

231 Screening Behaviors

232   The question that asked if the MD or the APN "ever screened
233 for domestic violence" obtained a high positive total response
234 (97%). This question asked if they ever screened for domestic
235 violence: This would indicate that a small percentage (0.3%) of
236 this self selected group ($n = 35$) never screened. These providers

237 did not consider domestic violence a significant enough risk to
238 their patient's health to warrant screening and intervention.

239 Horan et al. (1998) documented a 27% routine screening rate
240 for physicians during the initial visit. In this survey there was
241 an improved rate of 40% of the physicians indicating always or
242 often screening for domestic violence during the initial visit.
243 The APNs, however, exhibited much better screening rates. Twice as
244 many APNs (80%) indicated they often or always screened for
245 domestic violence during initial visits. These nurses considered
246 domestic violence screening to be a routine part of the health
247 maintenance evaluation, thus allowing for both primary and
248 secondary prevention to occur for domestic violence as it
249 routinely occurs for other threats to a women's health.

250 More MDs (85%) than APNs (63%) indicated they always
251 inquired about domestic violence when the patient presented with
252 an injury. This finding was supported by Horan et al. (1998) who
253 concluded that even though physicians possess a good understanding
254 of domestic violence, they did not screen on a routine basis but
255 only when a suspicion was triggered. It is unclear, however, why
256 APNs, so good at the practice of primary and secondary prevention,
257 seem not to do as well providing their patients with tertiary
258 preventative care.

259 When the providers suspected abuse, 86% indicated they
260 always screened for domestic violence. This is not acceptable.

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

266 Both groups of providers described low screening rates at
267 prenatal visits. A domestic violence rate during pregnancy of 4%-
268 8% and documented perinatal morbidity and mortality warrants an
269 improvement in screening behaviors for both groups of providers.
270 Many patients report repeated abuse warranting routine domestic
271 violence screening during each trimester (Gazmararian et al.,
272 1996; King & Ryan, 1996; McFarlane & Gondolf, 1998).

273 Obstacles, Beliefs, and Behaviors

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

282 Resources. A larger percentage of MDs (52%) compared to APNs
283 (30%) believed there were sufficient resources within the
284 community, they did not perceive the lack of resources to be an

285 obstacle to domestic violence screening. The nurse's concern about
286 the availability of resources may have been due to the fact that
287 46% of the APNs had reported having no education on domestic
288 violence within the past two years and requested additional
289 training with referral options as a high priority.

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

298   These providers indicated that they felt comfortable asking
299 female patients direct screening questions and they felt empowered
300 to help these women and their families. The providers differed
301 only in their feelings of frustration. Although, as a whole, the
302 feelings of frustration and helplessness when dealing with
303 domestic violence victims was not considered important as an
304 obstacle. APNs appear to have more concern about feelings of
305 frustration and helplessness affecting their screening. All
306 providers felt strongly that they had as much responsibility to
307 care for domestic violence victims as they did for any other
308 clinical problem.

309   Patients. In 1999, Caucasians will cease to be the majority
310 in Santa Clara County (Cha & McLaughlin, 1999). These providers
311 serve an ethnically diverse and varied population; thus, it would
312 not be unexpected that language barriers and different cultural
313 beliefs and practices might be considered a barrier to domestic
314 violence screening. Exhibiting a certain cultural competency, only
315 a little over 1/3 of these providers considered different cultural
316 beliefs and values as an important barrier to domestic violence
317 screening. A larger percentage (41%) of the providers believed
318 language barriers to be a moderately important obstacle.
319 Considering the diversity of this particular patient population,
320 and the difficulty providers have discussing this sensitive
321 subject with even English speaking patients, this percentage is
322 lower than anticipated. It is suggested that culturally sensitive
323 domestic violence screening be emphasized in training programs.

324   Although these providers did not perceive direct questioning
325 about domestic violence to be too confrontational, over half (55%)
326 of the APNs believe that patients will deny domestic violence if
327 asked. This is an expected finding, given the social constraints
328 and feelings of guilt and shame that surround domestic violence
329 (Warshaw, et al. 1995). It may take repeated nonjudgmental and
330 empathic questioning for the women to gain the trust needed to
331 disclose abuse.

332 A family's right to privacy about domestic violence is a
333 difficult issue. The majority of the MDs (52%) indicate agreeing
334 with this statement. The fear of offending patients was noted as
335 an obstacle to screening by both Sugg & Inui (1992) and Horan et
336 al. (1998). Yet, King and Ryan (1996) noted that the patients
337 rarely are offended by the personal nature of this question.

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

349 Limitations of Study

350 This study had several limitations that would make its
351 findings difficult to generalize to all APNs and MDs. The total
352 sample size was small, only 23 MDs and 12 APNs. Also, the return
353 rate for the questionnaire could have been improved with follow-up
354 mailings. This study was conducted on a convenience sample of

355 providers only in California. Different outcomes may occur from a
356 larger sample obtained from different areas of the country.

357 Conclusion and Implications

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

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Table 1.

Sample Demographics

Group	n	<u>Gender</u>		<u>Mean</u>	<u>Median</u>	<u>Age</u>
		<u>male</u>	<u>female</u>	<u>age</u>	<u>age</u>	<u>range</u>
MD	23	30%	70%	40	36	28-61
APN	12	8%	92%	41	44	37-55
Total providers	35	23%	77%	44	40	28-61

Note. MD = physician APN = advanced practice nurse

Table 2.

Incidence of Provider Suspected Abuse

Group	< 5%	5-10%	11-15%	16-20%	21-25%	> 25%
MD	44%	48%	4%	--	--	4%
APN	55%	9%	--	18%	--	18%
Total providers	47%	35%	3%	6%	--	9%

* $F(1,32) = 2.01, p = .17$

Note. Dashes indicate no respondents chose available option. Asterisks indicate ANOVA with $F > 1.0$ = significant difference. MD = physician APN = advanced practice nurse

Table 3.

Circumstance	<u>Screening Circumstances</u>							
	<u>Never</u>		<u>Sometimes</u>		<u>Often</u>		<u>Always</u>	
	<u>MD</u>	<u>APN</u>	<u>MD</u>	<u>APN</u>	<u>MD</u>	<u>APN</u>	<u>MD</u>	<u>APN</u>
Initial visit	10%	10%	50%	10%	10%	40%	30%	40%
* $F(1,28) = 1.57, p = .22$								
Annual exam	10%	--	35%	20%	20%	30%	35%	50%
* $F(1,28) = 1.57, p = .20$								
1st prenatal	24%	20%	18%	10%	18%	50%	41%	20%
* $F(1,25) = 0.01, p = .89$								
Follow-up prenatal	22%	30%	68%	50%	6%	20%	6%	--
* $F(1,26) = 0.02, p = .88$								
Presents with injury	5%	18%	--	--	10%	18%	85%	63%
* $F(1,29) = 1.96, p = .17$								
D.V. suspected	--	--	7%	--	7%	13%	86%	88%
* $F(1,20) = 0.15, p = .7$								

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 4.

<u>Obstacles to Screening</u>										
Obstacles	<u>Not</u>		<u>Less</u>		<u>Neutral</u>		<u>Slightly</u>		<u>Very</u>	
	<u>Important</u>		<u>Important</u>				<u>Important</u>		<u>Important</u>	
	<u>MD</u>	<u>APN</u>	<u>MD</u>	<u>APN</u>	<u>MD</u>	<u>APN</u>	<u>MD</u>	<u>APN</u>	<u>MD</u>	<u>APN</u>
Time constraints	13%	27%	22%	--	39%	9%	22%	55%	4%	9%
* $F(1,32) = 0.64, p = .43$										
Other problems higher priority	35%	30%	44%	20%	13%	40%	9%	10%	--	--
* $F(1,31) = 0.88, p = .36$										
Frustration due to feelings of helplessness	48%	30%	39%	30%	13%	20%	--	10%	--	10%
* $F(1,31) = 4.38, p = .04$										
Lack of resources	52%	30%	30%	30%	17%	20%	--	10%	--	10%
* $F(1,32) = 9.36, p = .004$										
Screening too confrontational	43%	36%	17%	18%	22%	9%	13%	27%	4%	9%
$F(1,32) = 0.57, p = .46$										
Language barriers	22%	9%	13%	18%	22%	36%	35%	27%	9%	9%
* $F(1,32) = 0.08, p = .76$										
Cultural beliefs	36%	18%	14%	18%	14%	27%	27%	27%	9%	9%
* $F(1,31) = 0.37, p = .55$										

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

Attitudes	<u>Not</u>		<u>Less</u>		<u>Neutral</u>		<u>Slightly</u>		<u>Very</u>	
	<u>Important</u>		<u>Important</u>				<u>Important</u>		<u>Important</u>	
	<u>MD</u>	<u>APN</u>	<u>MD</u>	<u>APN</u>	<u>MD</u>	<u>APN</u>	<u>MD</u>	<u>APN</u>	<u>MD</u>	<u>APN</u>
Sufficient resources	4%	--	9%	40%	26%	20%	44%	20%	17%	20%
* $F(1,31) = 0.97, p = .33$										
Feel can help	--	--	4%	--	13%	--	44%	72%	39%	27%
* $F(1,32) = 0.13, p = .72$										
Comfortable with direct question	--	--	17%	9%	4%	9%	43%	46%	35%	36%
* $F(1,32) = 0.13, p = .72$										
Right to privacy	17%	27%	13%	36%	17%	9%	22%	27%	30%	--
* $F(1,32) = 3.62, p = .07$										
Patients will deny if asked	4%	--	48%	18%	17%	18%	22%	55%	8%	9%
* $F(1,32) = 3.42, p = .07$										
Responsibility equal to other problems	4%	--	--	--	9%	9%	17%	36%	70%	55%
* $F(1,32) = .005, p = .94$										

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.