DOMESTIC VIOLENCE SCREENING

BY NURSES

IN THE PRIMARY CARE SETTING

BY

KAREN HETZEL

A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE

REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

IN

NURSING

UNIVERSITY OF RHODE ISLAND

2004

DOCTOR OF PHILOSOPHY DISSERTATION

OF

KAREN HETZEL

UNIVERSITY OF RHODE ISLAND

2004

Abstract

Domestic violence is one of the most important health care issues in the United States. One of every four women is a victim of domestic violence each year and thirty-one percent of women have a lifetime prevalence of domestic violence. Since most women receive their health care in primary care settings, nurses can play a critical role in decreasing the cycle of violence through screening and intervention.

Although the research literature on domestic violence is voluminous, little is known about nursing practice related to routine screening of women for domestic violence or intervention with identified victims in primary care settings. This study examined the impact of an educational program on changes in nursing practice in a pediatric primary care setting. A survey of thirty-five nurses in primary care practices in southeastern Massachusetts and two focus groups of nurses from diverse practice settings, provided information about the knowledge needed by nurses to effectively screen for domestic violence as well as the barriers to and facilitators for domestic violence screening and intervention in their settings.

Data from the survey and focus groups were used to inform the development of an educational program adapted from two well established programs, The Physician's for a Violent-Free Society (PVS) Assessment Response Course and Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) Universal Screening for Domestic Violence. The program was delivered to 5 nurses in a pediatric primary care practice over a period of 3 days. Following the intervention (the educational program) the nurses were interviewed to evaluate the effect of the program on changes in nursing practice related to screening for domestic violence and

intervening with identified victims. All five nurses reported the adoption of routine screening for domestic violence in their practice combined with the placement and use of environmental facilitators. As a result of the educational program, the nurses were more knowledgeable about domestic violence, more alert to cues and signs of domestic violence, and better equipped to screen and intervene with their female patients. The environment had become more conducive to screening for domestic violence with awareness posters and literature placed in waiting areas and a chart prompt to routinely ask about domestic violence.

The findings of this research point to the short-term benefits of a comprehensive educational program on changes in nursing practice in primary care settings related to domestic violence screening. Implications for future research, nursing knowledge development, nursing practice and education were discussed.

Acknowledgments

The completion of this dissertation was possible through the assistance of many individuals in my life. It is difficult to begin to thank all of them but I will try my best to include everyone that helped me to achieve this impressive goal. First, I am grateful to those who participated in this study, survey respondents, focus group participants and intervention participants. Without all of their valuable input and time, this study would not have been possible. They have all contributed to making a difference in nursing practice and patient care.

My dissertation committee members contributed in countless ways to guide me through this arduous, but ultimately gratifying process. Dr. Ginette Ferszt, my major professor and most significant contributor was a source of infinite knowledge, insight and advice. She was the key to fulfillment of this dissertation. Dr. Judy Van Wyk similarly provided her expert knowledge of methods as well as her expertise in family violence. Dr. Peter Maynard was one of my initial advocates for this study as he observed my passion for domestic violence awareness in his course. His motivational words and time invigorated my pursuits. Dr. Mary Sullivan and Dr. Diane Martin, who joined the committee later in the study, were valuable contributors as well with their unique perspectives and suggestions that helped bring this study to fruition. I will always be grateful to my committee as they were invaluable to my goal attainment.

I am thankful to the faculty and staff of the University of Rhode Island who provided me knowledge, support and resources to complete my work. In particular, I would like to acknowledge Dr. Margaret McGrath, who began the dissertation process with me, providing me with inspiration, guidance and support to finish this study. My

classmates at the University of Rhode Island were an unending source of encouragement and knowledge, especially Nancy Blasdell, Ph.D.(c), R.N. and John Aflague Ph.D.,APRN,B.C. I will always feel their presence with me in academia and in friendship. My gratitude is also extended to the faculty and students of Simmons College for their support of my endeavor. They were a driving force behind my quest. HUGS II of Easton was another source of inspiration to complete this study.

This pursuit would have never been feasible without the enduring support and love of my husband, Tom. The sacrifices made by him and my three children, Matthew, Benjamin and Andrew were many, but they knew the end result was important to me and therefore, worthwhile. My parents, siblings, friends, coworkers and in-laws, especially my mother-in-law, Theresa Hetzel (who responded to the original draft of my questionnaire), were thoughtful and patient as I progressed through my charge. Each of them contributed to my success by listening, understanding and having faith in my abilities. They were truly an inspiration for me to continue at stressful times during this challenging process. I would also like to thank my research assistant, Sarah Twomey who was available at a moment's notice and made a significant contribution to the data collection and its completion.

The financial assistance of the Massachusetts Nursing Foundation, Sigma Theta Tau, Theta-at- Large and Delta Epsilon Chapters and the Nursing Foundation of Rhode Island made it possible to complete this study and my coursework. I am thankful to all of them for their generosity.

Finally, yet most importantly, this research is dedicated to the women and children who have experienced domestic violence in their lives.

TABLE OF CONTENTS

List of Tables

List of Figures

CHAPTER I

Statement of the Problem

Introduction

In the United States 31% of women are victims of domestic violence at some time in their lives (Dearwater et al., 1998). Despite this high prevalence, domestic violence often goes undetected in primary care settings as well as in other health care environments. The number of domestic violence victims is larger when one considers the many other women who may be affected by the experiences of family members, friends, neighbors, and co-workers. Thus, domestic violence is a public health problem, a criminal justice problem and a women's health issue (Campbell, Harris, & Lee, 1995; Harshbarger, 1995; Haywood & Haile-Mariam, 1999).

The physical and mental health effects of domestic violence on victims have been researched extensively, paving the way for healthcare professionals to respond to victims (Bergman, Brismar, & Nordin, 1992; Campbell & Lewandowski, 1997; McCauley, Kern, D., Kolodner, K., Dill, L., Schroeder, A., DeChant, H., Ryden, J. Bass, E. & Derogatis, L 1995; Plichta, 1997). However, few health care professionals regularly incorporate domestic violence screening into their assessment procedures with at most, 9-10% of patients being asked routinely in primary care settings (Rodriquez et al., 1999; Sugg, Thompson, Thompson, Maiuro, & Rivara, 1999). Given the prevalence of domestic violence, every female client that nurses encounter needs to be screened (Paluzzi, 2002).

Justification and Significance of the Problem

Domestic violence has negative health consequences comparable to cancer, hypertension and diabetes. In women, the incidence of domestic violence is substantially higher than diabetes (3%), breast cancer (23%), and hypertension (23%) (USDHHS, 1997). Domestic violence is prevalent among all racial and ethnic minority groups and is not exclusive to one socio-economic stratum. According to the Commonwealth Fund 1998 Survey of Women's Health, 8% of women received counseling by their primary care provider about safety and violence in the home, whereas 49% received counseling on exercise, and 29% on smoking (1999).

Healthy People 2000 included a set of objectives under health promotion and disease prevention relating to violence and abusive behavior. These objectives, *7.1b:* "reduce homicides among spouses aged 15-34 to no more than 1.4 per household", *7.5:* "reduce physical abuse directed at women by male partners to no more than 27 per 1,000 couples" and *7.12:* "extend protocols for routinely identifying, treating and properly referring... victims of spouse abuse to at least 90 percent of hospital emergency departments", speak to this critical public health problem (USDHHS, 1997, p.83). In 1994, the Violence Against Women Act (VAWA) was passed by Congress. An office was created to promote awareness of domestic violence among the public, train professionals, and conduct research on intimate partner violence. More programs were added in 2000 supporting statewide efforts to ending domestic violence (Paluzzi, 2002).

Health care professionals encounter the consequences of domestic violence in everyday clinical practice. Battered women are frequently treated in health care

settings. Health care professionals may be the only "helping" professional they encounter. Women experiencing domestic violence are often seen for gynecological concerns, prenatal care, at pediatric visits for their children, and during their own health management, creating opportunities for identification and intervention by primary care providers. Battered women also present with obvious domestic violence related injuries such as fractures, bruising, burns, and abrasions. In addition, in primary care, they present with other less recognizable domestic violence related problems such as somatic complaints, depression, anxiety, insomnia, abdominal pain, headaches, sexually transmitted diseases, unintended pregnancy, miscarriage, eating disorders, and alcohol and drug addiction (Alpert, 1995; Chez, 1994; McCauley et al. 1995; McNutt, L., Carlson, B., Rose, I., & Robinson, D., 2002; Rodriguez, Bauer, McLoughlin, & Grumbach, 1999). Most often, these less obvious signs of domestic violence are not pursued as possible consequences of a beating. In many circumstances, the visible signs are overlooked or not followed up. Often, victims are treated symptomatically for their illnesses and injuries and return home, only to be abused again. Battering, most often increases in frequency and severity over time, which makes identification and intervention key to preventing further health problems and possibly death.

The key factors that influence health care providers' assessment of domestic violence are extensively reported throughout the health care literature. Despite numerous endorsements from professional healthcare organizations and mandates for screening in emergency departments, studies suggest that domestic violence screening is not done in most outpatient settings (Bullock, McFarlane, Bateman, & Miller, 1989;

Elliott & Johnson, 1995; Rodriguez et al., 1999; Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000).

Provider inquiry appears to be one of the most compelling determinants of communication with patients about domestic violence (Rodriguez, Sheldon, Bauer & Perez-Stable, 2001). Anecdotal experiences, by nurses in various outpatient settings, suggest that domestic violence victims will discuss their battering experience if asked about it in a direct, empathic and non-judgmental manner.

Many factors are identified in the literature as to why screening and subsequent identification of and intervention with domestic violence victims is not performed or performed consistently. The barriers identified by health care professionals include: lack of training, time constraints, knowledge of resources available for victims, lack of privacy, fear of offending victims or low confidence in asking questions, personal history of exposure to abuse, frustration related to the futility of the healthcare system's response, fear of repercussions of mandatory reporting laws, cultural differences and language barriers. Perceived patient-related barriers include: fear of retaliation, shame, accessing care due to perpetrator's prevention, socioeconomic factors, lack of disclosure, fear of police involvement and lack of follow-up on referrals (Kimberg, 2001; Rodriguez et al. 1999; Sugg, Thompson, Thompson, Maiuro & Rivara, 1999; Tilden, Schmidt, Limandri, Chioda, Garland, & Loveless, 1994).

Many factors influence assessment of domestic violence by health care professionals across disciplines and settings. Domestic violence victims do not have a set of characteristics that identify them. These victims often present with common health care problems or injuries. Despite mandatory protocols and training in hospitals

and clinics, providers "... still have difficulty integrating routine inquiry about domestic violence into daily practice" (Warshaw & Alpert, 1999, p.620). Only inquiring about abuse when there is suspicion is not sufficient. A missed opportunity to screen may place the woman (and her children) in danger of further abuse or even death. In actuality, screening for domestic violence is no different than screening for safe sex practices, or healthy eating and exercise. In order to screen effectively, health care professionals must have the knowledge and resources to help patients with their options. Providers must realize the act of screening is itself an intervention, no matter what the health concern. Screening conveys to the patient that domestic violence is not acceptable, that help is available and that the provider cares about the patient's safety.

The most common barriers to screening for domestic violence stem from a lack of knowledge about domestic violence and how to respond to victims. Other deterrents such as privacy, time constraints, denial that domestic violence exists, fear of offending patients and lack of comfort asking about abuse can also be attributed to insufficient education and practice utilizing the acquired knowledge. If providers are educated about the cycle of violence, its prevalence, the process of leaving, community resources and how screening can be incorporated into the health care history, the barriers will gradually diminish.

Studies on barriers to screening and intervening with domestic violence victims are abundant. However, studies that focus on facilitators to screening are less prevalent. The need for education is identified as the priority. Education that begins in schools of nursing, medicine, psychology and other social services and continues throughout the careers of nurses, doctors, psychologists, social workers and other

health care professionals can change what is needed for sustained domestic violence screening practice (Kimberg, 2001).

Education is not the only facilitator or tool that is needed to influence the incorporation of routine screening by health care professionals in practice settings. Chart prompts, routine screening questions included on assessment forms, and protocols are other facilitators that enhance screening. Posters and buttons that address domestic violence create an atmosphere that provides a safe environment for victims to disclose, or know that they can get help when they are ready. Larger scale facilitators include on-site counseling programs, development of community outreach programs and on-site "champions." These facilitators have not been widely evaluated as to their success. However, several programs such as WomanKind in Minnesota and AWAKE (Advocacy for Women and Kids in Emergencies) in Boston have demonstrated positive outcomes as a result of increasing identification and referrals of domestic violence victims (Freund, Bak, & Blackhall, 1996; FVPF, 1999; Ganley, A., Fazio, J., Hyman, A., James, L.,& Ruiz-Contreras, A., 1998; Hadley & Short, 2000; Kimberg, 2001; Nudelman, Durborow, Grambs, & Letellier, 1997).

In 1990, Bohn suggested that health care providers treating women could address domestic violence by intervening on three levels: primary, secondary and tertiary. Primary interventions include political activism with regard to ending insurance discrimination, welfare reform, encouraging healthy images of women, and domestic violence awareness campaign participation. Recommended secondary interventions focused on screening and treatment, such as routinely asking about domestic violence, providing nonjudgmental support to identified victims, and

overcoming acknowledged barriers to assessment. Tertiary interventions were directed at accurate documentation of identified victims, knowledge of resources and referrals and awareness of batterer's programs.

Research Plan

The purpose of this study was to examine the impact of an educational program on nurses' routine screening of female patients for domestic violence in primary care settings. The research questions were:

1. What are the barriers identified in primary care settings by nurses that prevent them from effectively screening for domestic violence?

2. What facilitates effective screening for domestic violence by nurses in the environment of primary care settings?

3. What is the impact of a domestic violence educational program intervention delivered to nurses in primary care settings on decreasing the barriers identified by the nurses to screening for domestic violence?

4. Does a domestic violence educational program intervention increase the identification and intervention of domestic violence by nurses in a primary care setting as compared to pre intervention conditions?

A combined approach of qualitative and quantitative inquiry addressed the above questions. In Stage One, a 20 item survey developed by this researcher, was distributed to nurses working in primary care settings in an area of southeastern Massachusetts. The settings included practices in family and internal medicine, pediatrics and obstetrics-gynecology. This survey served to assess the nurses' learning needs and perceived barriers to and facilitators for effective screening for domestic

violence of female patients in primary care settings. The survey included an invitation for the nurses to attend a focus group to discuss domestic violence issues in ambulatory care nursing. In Stage Two, focus groups were utilized to explore the nurses' identification of barriers to and facilitators for screening, as well as interventions with victims in their clinical practice.

The data from the surveys and focus groups provided the foundation for Stage Three. In this stage, a program adapted from two existing domestic violence education programs was modified for the outpatient primary care setting. One of the sites, where the nurses who participated in the survey and focus groups practiced, was selected to receive the program. In Stage Four, the modified domestic violence education program was delivered to five nurses in a pediatric practice. The program specifically aimed at developing strategies that facilitate routine and continuous screening for domestic violence and intervention with identified victims in primary care. The results of the focus group discussions were incorporated in the intervention. In Stage Five, individual interviews with each nurse participant were completed following the delivery of the program, to assess if they were incorporating routine screening of female patients in their practice.

The conceptual framework for this study utilized the Theory of Reasoned Action and the Theory of Planned Behavior. Fishbein and Ajzen (1975) developed the Theory of Reasoned Action (TRA) to explain how behavior under volitional control is effected by personal and social factors, in other words how individuals make decisions to carry out certain behaviors. Intention to perform behavior is jointly influenced by two components, attitude toward the behavior and subjective norm. The Theory of

Planned Behavior (TPB) is an extension of the TRA, adding a third component, perceived behavioral control which speaks to an individual's belief that he/she possesses the skills/opportunities to perform a behavior (Ajzen, 1985).

The TRA and the TPB have been used to test its utility in a variety of health-related behaviors such as consumer screening practices, contraceptive behavior, and weight loss (Adler, Kegeles, Irwin, & Wibbelsman, 1990; Hill, Gardner, & Rassaby, 1985; Schifter & Ajzen, 1985). Since the theories have a cognitive orientation and decision-making as a key factor in healthcare delivery, they been also been used to predict healthcare professional behavior (Laschinger & Goldenberg, 1993; Millstein, 1996; Taylor, Montano, & Koepsell, 1994). This study was based on the assumption that nurses in the primary care setting, receiving an educational program on domestic violence, would be able to or would include routine domestic violence screening (intention and behavior) into their daily practice, once the barriers and facilitators to screening were identified (attitudes, beliefs, and subjective norm).

Significance of the Study to Nursing

With the prevalence of violence against women in our society continuing at alarming rates, each woman must be approached in the health care setting as a potential victim of abuse. Nurses in primary care settings are in a unique environment to participate in domestic violence intervention. Assessment of domestic violence may not only save a woman's life or help her to obtain the assistance she needs, but could also help end the cycle of violence in the woman's family for future generations. Often, nurses in primary care have a long-standing relationship with their patients, where trust between the patient and the nurse has developed. In the context of this

relationship, patients may be more comfortable disclosing a domestic violence situation, setting the stage for nurses to provide safe and effective intervention.

As nurses, we have an ethical and professional obligation to assess patients for domestic violence and offer intervention. "No woman deserves to hurt", (FVPF, Get Help section). Even if a woman has a negative response to screening, the message is clear from the nurse, 'I care about your safety.' It may deepen a relationship with a patient, leaving the door open for future disclosure of domestic violence.

CHAPTER II

Review of the Literature

Background

Domestic violence is pervasive in our society, affecting every race, social class, ethnic and religious group. In the United States, violence among family members or intimate partners occurs more frequently than with strangers (Strauss & Gelles, 1990). There are many definitions of domestic violence. For the purposes of this study, domestic violence is defined as "a pattern of coercive behavior designed to exert power and control over a person in an intimate relationship through the use of intimidating, threatening, harmful, or harassing behavior"(Meuer, Seymour, & Wallace, 2000). The most common form of domestic violence is violence perpetrated on women by men (Greenfield, Rand, & Craven, 1998). Although this author acknowledges the seriousness of violence in same gender relationships and violence inflicted on men by women, the focus of this study is on its most common form.

Literature Review

The research literature on domestic violence and the complexity of factors that influence its recognition and intervention in health care settings is voluminous. Empirical studies on this topic include health care professionals' assessment of domestic violence in various outpatient settings, barriers to domestic violence screening, and perceived patient related barriers. More extensively examined are educational strategies, types of domestic violence screening tools, the ability of screening to improve outcomes, implementation of screening policies, and mandatory reporting of domestic violence.

This chapter reviews the literature on domestic violence related to barriers to screening, screening tools, and educational programs. Evidence from intervention studies to improve outcomes is presented. Implementation of screening policies and issues regarding mandatory reporting are reviewed as well. Finally, the theoretical framework, TRA & TPB is described as it applies to this study.

Mandatory Reporting of Domestic Violence

Ethical issues contribute to health care providers' assessment of domestic violence and help perpetuate ambivalence toward screening in health care settings. One of the more recent dilemmas with domestic violence is the issue of mandatory reporting laws, which have passed in six states. Plainly stated, these laws require health care providers to report acts of presumed domestic violence to local law enforcement or another specified state agency. Many more states have laws that are not specific to domestic violence but allude to it. The supporters of these laws believe they will help enhance patient safety by improving legal intervention and increasing documentation. These advocates assume that laws will create more effective responses to victims and give health care providers the notion that they are contributing to the demise of domestic violence (FVPF, 1997; Glass & Campbell, 1998; Hyman, Schillinger, & Lo, 1995; Rodriguez, Craig, Mooney, & Bauer, 1998).

Opponents of mandatory reporting laws identify a number of problems with the laws: (1) Victims may not seek needed treatment if they do not want law enforcement involved, (2) Immigrant women in particular may fear deportation if they seek help and it is reported, (3) Opponents who support victim autonomy believe that competent adult women can make their own decisions with regard to their safety, (4)

Children's safety may be compromised if a report is made without consideration of their particular needs, (5) Mandatory reporting can undermine provider-patient confidentiality, (6) Reporting could possibly be biased and inconsistent, (7) Opponents believe there is no guarantee that law enforcement will increase women's safety, (8) If safety planning – a major intervention with domestic violence victims is not done prior to reporting, the woman could be at an even higher risk for violence than she was prior to the encounter with her provider, and (9) With these laws in effect, providers may not want to know if their patient is a victim and experience ambivalence with regard to screening, as they would have to report a positive finding. As a result, the victim continues in the violent relationship (FVPF, 1997; Glass & Campbell, 1998; Hyman et al. 1995; Rodriguez et al. 1998). In essence, mandatory reporting becomes another barrier to domestic violence screening and intervention by health care professionals.

Barriers to Screening and Intervening for Domestic Violence

Sugg and Inui (1992) utilized an ethnographic approach to uncover barriers that might influence physicians from intervening with domestic violence victims in a large urban health maintenance organization. They interviewed thirty-eight primary care physicians over 6 months for 1 hour regarding how they managed domestic violence cases. The image of Pandora's box being opened is a good metaphor for describing their reaction to inquiring about domestic violence with their patients. Identification with their patients was a major theme expressed by the physicians. A strong fear of offending patients when asking about domestic violence and how it would jeopardize the physician-patient relationship was expressed. Feelings of

powerlessness in the physicians' inability to 'fix it' and having appropriate interventions for patients were also shared by the physicians. The constraint of time was identified by most physicians as the major deterrent for asking their patients about domestic violence. Two physicians stated they were very comfortable with inquiring about domestic violence. The authors concluded with recommendations for educational programs that include facts about domestic violence and strategies for intervention.

Tilden, Schmidt, Limandri, Chioda, Garland, and Loveless (1994) surveyed six different health care disciplines (dental hygienists, dentists, nurses, physicians, psychologists and social workers) with 1,588 response identified factors that influence assessment and management of family violence. A significant number (33%) did not have any education on domestic violence, and a large number did not believe abuse existed in their practices. A substantial number of these professionals did not see themselves as responsible for intervening or for reporting abuse (child or elder). They reported low confidence in the system's ability to respond effectively and yet expressed a desire for mandatory reporting of spouse abuse.

Rodriquez et al. (1999) conducted a study of 400 primary care physicians (of 582 eligible) utilizing questionnaires. Seventy-nine percent of physicians stated they often, or always, asked about abuse when a physical injury was apparent. However, these same physicians only routinely asked women about domestic violence in 9% of patient visits and in 10% of their new patients. The barriers identified by the physicians included lack of training, time, and resources available for victims. Perceived patient-related barriers included fear of retaliation, lack of disclosure, fear

of police involvement, and lack of follow-up on referrals. Mutual barriers identified by physicians and patients included lack of privacy, cultural differences, and language barriers.

In a similar study of 206 providers (physicians, physician assistants, nurse practitioners, nurses and medical assistants), Sugg, Thompson, Thompson, Maiuro, and Rivara (1999) found that 10% of the clinicians had never identified an abused person and that the clinicians believed domestic violence in their practice was rare. Fearing offending patients by asking about domestic violence, lack of confidence in inquiring, lack of strategies to assist victims, and lack of access to referrals were identified as barriers to screening and intervening.

Ellis (1999) studied 40 nurses employed at a Level I trauma center utilizing a survey to ascertain the most common barriers to screening for domestic violence in that setting. Lack of privacy and time constraints were the most frequently cited barriers to screening. Forty-five percent of the nurses stated they screened routinely, but only 8.8% of the charts (from the retrospective record review done prior to the survey) had documented domestic violence screening. The nurses stated that more in-service programs and availability of resources/referrals would better prepare them to screen for domestic violence and intervene with women who identified themselves as victims.

Screening Tools for Domestic Violence

Statistics provided by Campbell (1986) indicate that 1000 women are killed each year in the United States by their husbands. Campbell (1986) designed a clinical and research instrument to help assess the danger of homicide in battered women. The

Danger Assessment (DA) tool was developed as part of the author's doctoral dissertation and used with an initial sample of 79 battered women. It was intended to be used in conjunction with the nurse's assessment of battered women in all health care settings. The tool has two components: (1) severity rating scale for each domestic violence incident in the past year; and (2) a15-item section of yes/no questions of risk factors for lethality potential. Questions regarding the abuser's possession of firearms, increased nature of physical abuse, abuser's drug/alcohol use and abuser's methods of control are included also in this section. After administering the tool, the nurse discusses options that the patient may want to pursue. In this study, the author utilized Orem's conceptual framework to enhance patient self-care and empower women. The need for victims to utilize informed decision-making is highlighted, referring back to the nurse's responsibility to warn victims as well as to assess for violence.

Helton, McFarlane, and Anderson (1987), together with other members of the Nursing Research Consortium on Violence and Abuse (NRCVA), developed the *Abuse Assessment Screen* (AAS). This screening tool has five questions which measure the frequency and severity of abuse. It has been used in several studies and found to be effective if used correctly (Soeken, McFarlane, Parker, & Lominack, 1998). Using a sample of 1203 pregnant women, responses to the AAS and three other established domestic violence scales' results were compared. Agreement between scales ranged from 96-100% for reliability and validity. The AAS was found to be a reliable and valid tool to detect abuse.

With the hope that assessment would become a universal practice, Hoff and Rosenbaum (1994) developed an instrument for victimization assessment utilizing a

5-point scale measuring the degree of trauma. The items were rated on a scale from 'no experience' to prolonged or life-threatening abuse. Further reliability and validity studies were suggested by the authors, who also implied the need for nurses and other disciplines to become educated in the role that victimization plays in the health of patients.

The addition of a single question to a health history form was found to be efficacious to improve domestic violence detection in a primary care setting (Freund, Bak, & Blackhall, 1996). The question, 'At any time has a partner hit you, kicked you or otherwise physically hurt you' was added to a self-administered written health history form and given to female patients on initial visits in a primary care setting (p. 44). Since this tool only refers to physical abuse and is not verbally administered, it has limitations. However, detection rates using the form improved as compared to discretionary inquiry alone. Identification of domestic violence rose from 0% with discretionary inquiry to 11.6% with the addition of the single question on the health history form.

Healthy People 2000 influenced Haywood and Haile-Mariam (1999) to study the problem of domestic violence in the emergency department. One of the objectives in *Healthy People 2000* is to become more efficient in the identification and treatment of domestic violence victims. They looked at the scope of the problem, its prevalence, identification, screening, assessment, intervention and documentation. The authors developed a screening tool, adapted from Campbell's *Danger Assessment* (1986) and safety planning measures, to be utilized in the emergency department as well as other in other clinical departments. In addition to adding two more questions to the yes/no

section of Campbell's *Danger Assessment*, the authors also added items related to safety measures for women while in abusive relationships and after leaving the relationship.

Gerard (2000) presented statistics of emergency department noncompliance with the Healthy People 2000 objectives to screen and intervene for domestic violence, such as less than 30% of emergency departments being compliant with screening and 50% of female homicide victims being seen in an emergency department prior to being killed. As a result of these statistics, the author proposes stepping up efforts to promote identification of and intervention with victims. The domestic violence screening tool of the Massachusetts Medical Society, *RADAR* is introduced as potentially helpful to emergency room staff. The acronym letters stand for: *R* – routinely screen all female patients over age 14, *A* – ask direct questions, *D* – document your findings, *A* – assess patient safety and that of her children and *R* – review options and referrals (p. 54-56).

Domestic Violence Educational Strategies

Henderson and Ericksen (1994) spoke to the confusion of the nurse's role with domestic violence victims, and elucidated how nurses can have a significant impact on the lives of this population. The authors reviewed literature written by nurse researchers in the field of domestic violence who emphasized how nurses miss a unique opportunity to intervene with victims. They inferred that nurses encounter victims in all clinical settings and that intervention for these victims needed to improve. The nurse's role of empowering patients and promoting patient autonomy is part of the nurse's moral obligation. Empowerment is the essence of advocacy and is

included in the professional nurse's code of ethics. Since many nurses have myths about domestic violence, promoting awareness was found to be essential. Accordingly, the authors proposed the need for nurses to reframe their approaches and not be fearful of the results of intervention. The authors recommended administrative support for nurses through the development of intervention protocols, zero tolerance of violence, and programs for nurses who may be victims themselves. Education for nursing students was identified by the authors as a critical component that needs to be included in nursing curriculums.

Using data from a previous study of 1,521 clinicians from six health care disciplines, Limandri and Tilden (1996) further explored factors that influence nurses' assessment of and intervention with victims. Nine nurses were interviewed using an interview guide with 14 questions. In order to explore how the nurses assessed for domestic violence and intervened with identified victims, the nurses were asked to describe how they responded to a past situation of suspected abuse. The 'case' that each nurse discussed indicated a lack of knowledge about domestic violence. The nurses recommended educational programs to increase their level of comfort in working with this population as well as provide them with the necessary knowledge base to help them be more effective in their practice. Frustration was also expressed by the nurses with regard to the inadequacies of the protective system. Lastly, conflicting roles with physicians was cited as an obstacle to intervention. Who should report, despite nurses doing the documentation, was identified as a conflict. The boundaries between the nurses' personal and professional role within the community were seen as blurred due to the overlap of the roles' responsibilities. The authors concluded changes

in institutional, legislative and organizational policies were necessary to enlighten health care professionals about domestic violence.

In their study, Coeling and Harmon (1997) found that providers who participated in a domestic violence educational presentation went through a series of stages before they developed a level of comfort to ask patients about domestic violence. Initially, providers would forget to ask, then they would give excuses for not asking, followed by a need to ask because of 'mandates.' Finding ways to ask questions, using their own style, ensued with an increasing level of comfort. The providers also accepted personal responsibility for asking patients about domestic violence.

Moore, Zaccaro, and Parsons (1998) compared education, attitudes. and practices of perinatal nurses at three different practice sites. Just over half of the 275 nurses in the study had some education on domestic violence. Thirty-one percent had experienced domestic violence in their family, with 26% of them stating that personal experience encouraged them to identify victims in their practice. Lack of domestic violence education and not having time to fully evaluate patients were identified as issues that need further attention. Public health nurses were the most likely to screen for domestic violence. These nurses also followed up on their clients and provided them with educational material and referrals. Office and hospital based nurses screened less often due to fear of offending patients. Also, they did not believe that domestic violence was a serious problem. The authors implied that nursing education changed practice (the public health nurses having the most education in this study) and

together with comprehensive protocols, intervention for domestic violence victims would be reinforced.

The Physicians for a Violent-Free Society (PVS) in collaboration with Allina Hospitals and Clinics, United Behavioral Health, and the Family Violence Prevention Fund produced the Abuse Assessment Course: Systems Approach to Partner Violence Across the Life Span. This program was designed to be a 'train the trainer' course, encouraging problem-solving among health care providers. It includes an important track that "provides strategies and tools for developing and implementing clinical protocols for abuse assessment" (PVS, 2002, flyer). This track is valuable to the continuation of domestic violence screening and intervention after the training has been completed. It assists providers to incorporate domestic violence screening into their daily practice, as part of a comprehensive health care response.

The Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) Universal Screening for Domestic Violence (2003) is another novel educational program on domestic violence. The AWHONN program is a slide and script presentation package for health professionals. It is a multifaceted presentation in CD-ROM format that includes a slide show and speaker's script, participant handouts, the Abuse Assessment Screen in English and Spanish, the Danger Assessment Tool, and a list of resources that includes Web sites and abuse help lines. Although the primary target audience are nurses and advanced practice nurses, it is applicable to all healthcare providers. The information is very comprehensive and is presented in a way that is understandable and applicable across disciplines.

Waalen et al.(2000) reviewed 24 studies that focused on barriers to screening for domestic violence in clinical settings and environmental facilitators that increased screening. They determined that education on domestic violence was not enough to increase screening and intervention. In the studies that described provider use of strategies, similar to the Precede/Proceed model described by Thompson et al. (2000), they saw more changes in their behavior similar to that of providers screening for other preventive health problems such as smoking cessation, and cancer and cholesterol screening. Also, studies that had a domestic violence advocate on site (in addition to the educational program) had higher rates of identification of victims.

Improving Outcomes by Screening for Domestic Violence

Tilden and Shepherd (1987) examined emergency room nursing staff identification of battered women in a large metropolitan hospital. They utilized a quasi-experimental time-series design to collect data from patient records before and after a protocol was introduced to the nursing staff of 22 registered nurses. Patient records were reviewed prior to the use of a protocol based on Flitcraft's (1977) *Classification of Battered Women.* Coding in this classification includes four categories: positive for spouse battery, probable for spouse battery, suggestive for spouse battery and negative for spouse battery. The protocol consisted of an interview component and a staff education program. The interview included opening questions, abuse description questions, resources, current plans, and a nursing management plan individualized around the responses to the questions. The staff education program included family violence and crisis intervention theory, goals, realistic outcomes, resources available in the community, legal issues and mock interviews. After all the nursing staff received both components of the protocol, patient record reviews were

conducted again (in the same manner as before the protocol) to determine if there was an increase frequency of identification of domestic violence. Identification of battering significantly increased post interview/education compared to the pre-treatment rate. Although the authors identified possible threats to the validity of the study, such as seasonal factors, staff attrition and history (8 months between data collection) limiting the findings to the clinical setting the study was important because it demonstrated how education awareness of staff nurses improved domestic violence identification.

McLeer and Anwar (1989) studied the emergency department staff of a large hospital similar to the Tilden and Shepherd study. They utilized Flitcraft's *Classification of Battered Women* (1977) to retrospectively review records of female trauma victims and then trained the triage nurses in the emergency department on a protocol that enhanced identification of battered women. The protocol included questions to elicit a trauma history and direct questions about battering. If a victim was found to be positive for battering, available community resources were identified. One year later, the records were retrospectively reviewed and classified. The percentage of victims positively identified increased by 24.5% indicating that increasing staff awareness of domestic violence improved identification of battered women in their emergency department with the use of this protocol.

Rittmayer and Roux (1999) using a grounded theory approach, interviewed 13 obstetricians/gynecologists regarding their diagnoses and interactions with patients who were domestic violence victims. A double bind conflict arose among the physicians, that of being remiss about not diagnosing domestic violence, and not improving a patient's condition if the diagnosis was made. A three stage process to

resolve 'the need to fix it' became the intervention for the physicians. The stages included trying to successfully address domestic abuse, rationalizing failure and dealing with the diagnosis. Each stage had steps to address the physicians' lack of education regarding domestic violence, its screening and intervention. The process illustrated how the need to fix it, shifted to recognizing domestic violence, offering options, and respecting patients' choices. Awareness and social reform became the focus of the participants. The underlying issue regarding lack of domestic violence education became clear in the study.

Parker, B., McFarlane, J., Soeken, K., Silva, C., and Reel, S. (1999) designed an intervention study to prevent further abuse of pregnant women. Two groups were recruited using women's positive answers to one of the Abuse Assessment Screen (AAS) questions. The women were at various stages of their pregnancies in the intervention group while the comparison group were recruited within the first 8 weeks following delivery. The comparison group of 67 women were administered two instruments that measure severity of abuse (Index of Spouse Abuse and Severity of Violence Against Women Scales) at entry, 6 months and 1 year post-delivery. They were also given a wallet-sized card with community resources. The intervention group of 132 women received three counseling sessions. The two instruments were administered to the intervention group three more times than the comparison group at two months and at two evenly spaced times during the pregnancy. The data was analyzed using repeated multivariate analysis of variance (MANOVA). Women in the comparison group experienced more ongoing abuse than the women in the intervention group at 6 months and 1 year. However the findings were not statistically

significant. Both groups experienced less abuse than they had prior to the study, underscoring the importance of assessment of domestic violence in all settings.

Cole (2000) cited a 21% decrease in violence against women based on the US Department of Justice reports from 1993 through 1998. He suggested that the decrease was partly related to screening for domestic violence. Colleagues at a workshop sponsored by the Center for Disease Control suggested that screening in and of itself is not harmful and has potential value as in mammography. It was recommended that patients be screened for domestic violence in primary care settings even though scientifically based evidence for screening protocols of domestic violence is not yet available.

Thompson et al. (2000) examined the effects of an intensive domestic violence educational program at five primary care clinics in a large health maintenance organization. A variety of health care professionals from adult practices were included in the study. An educational session, incorporating skill training and environmental enhancements, was utilized in the Precede/ Proceed planning model to create a change in practice to screen for domestic violence. The Precede/Proceed model "focuses on changing practitioner predisposing factors... enabling factors... and reinforcing factors" (Thompson et al. 2000, p 255). The authors found a significant change pattern in their staff who employed cost-effective methods to screening for domestic violence. These methods included having domestic violence questions on health questionnaires, placing domestic violence awareness posters in the clinical areas and domestic violence brochures in restrooms.

Implementing Policies to Screen for Domestic Violence

Taylor and Campbell (1992) recommend the use of a written policy and protocol in health care settings to increase identification and subsequent intervention with victims of domestic violence. To support their recommendation, they cite numerous studies of statistical information acknowledging the need for policies and protocols to aid in continued screening and intervention with female patients. The authors also cited studies describing ongoing domestic violence educational programs for health care providers. Twelve comprehensive protocols are offered as suggestions for varied health care settings such as emergency rooms and hospitals. The authors remind the reader of the 1992 Joint Commission for the Accreditation of Health Care Organizations' mandate for hospitals and emergency rooms to develop policy and procedures for domestic violence identification and treatment in their institutions. Despite this mandate, routine assessment is still not common in many hospitals and emergency rooms (Wiist & McFarlane, 1999).

A protocol of systematic assessments during the prenatal care of pregnant adolescents resulted in increased reporting of domestic violence compared with routine prenatal assessment (Covington, D., Dalton, V. Diehl, S. Wright, M., & Piner, M., 1997). Maternity care coordinators were trained to utilize the systematic assessment protocol at three times during the adolescents' pregnancies. The protocol consisted of five questions designed from the AAS (Abuse Assessment Screen). Consistency with the use of a written protocol, asking direct questions about behaviors, using non-stigmatizing words, not naming the abuser and the use of multiple assessments were all factors that contributed to increased identification of

victims versus solely using the routine prenatal assessment tool. Although the limitations of the study does not allow for generalizability to other adolescent populations, the findings indicate that the multiple assessments were significant in increasing reports of violence (Covington et al. 1997).

Another study incorporating an abuse assessment protocol into prenatal care visits at public health clinics was conducted by Wiist and McFarlane (1999). The protocol consisted of a staff domestic violence training, the AAS being included in the charts and an on-site counselor for referral of all abused women. Three sites were utilized, one of which was used for comparison only. The authors discovered that integrating the protocol resulted in increased assessment and referral of pregnant domestic violence victims, as well as increased documentation in patient charts. They recommend abuse assessment protocols be incorporated into routine maternity care.

McNutt, Carlson, Rose and Robinson (2002) focused their study on the use of a screening and intervention protocol in the primary care setting. Two sites of a health maintenance organization (HMO) were used, one as a control site and the other as the intervention site. The intervention site had the standard components of the control site as well as more domestic violence education for staff, a protocol for screening and intervention, and an on-site counselor. Sticker prompts were placed in female patient charts to serve as reminders for the staff to screen. In addition, domestic violence materials were placed in examination rooms and rest rooms. They found increased domestic violence screening and more domestic violence materials taken from their examination rooms at the interview site compared to the control site. Screening alone is not enough to detect and intervene with domestic violence victims

(FVPF, 1999). Environmental enhancements (posters, brochures, palm cards and prompts) appear to increase screening as in other studies (Covington et al. 1997; McCaw, Berman, Syme & Hunkeler, 2001; Thompson et al. 2000). Although domestic violence education is profoundly important, ongoing in-service education, environmental enhancements, support for the staff and a referral source preferably on-site (even a domestic violence 'champion' on staff), appear to be what is needed for a successful system protocol.

Theoretical Framework of the Study

Fishbein and Ajzen's (1975, 1980) Theory of Reasoned Action and Ajzen's (1985) Theory of Planned Behavior was the conceptual framework for this study. Fishbein and Ajzen (1975) developed the Theory of Reasoned Action (TRA) to explain how behavior under volitional control is effected by personal and social factors. The authors not only wanted to predict an individual's behavior but to understand it as well. The theory is based on several assumptions. Ajzen and Fishbein (1980) make the assumption that "human beings are usually quite rational and make systematic use of the information available to them" (p.5). Furthermore, they assume that "most actions of social relevance are under volitional control" (p.5). Their theory views "a person's intention to perform (or not perform) a behavior as the immediate determinant of the action" (p.5). In other words, intention is a prerequisite for subsequent action of a person.

There are two determinants of a person's intention in the TRA, attitude toward the behavior and subjective norm. Attitude toward the behavior refers to an individual's judgment of performing the behavior as positive or negative. For

example, if asked to make a donation to a particular charitable cause, some would have a favorable attitude and some would not. The second determinant, subjective norm, refers to an individual's perception of the social pressures placed on the individual to perform or not perform a given behavior. Using the previous example, if others believe that it is important to make a donation to the charitable cause or to the contrary that it is not important, the action taken will be reflected in the subjective norm of the individual (Ajzen & Fishbein, 1980). Knowledge of the relative weights of each of the determinants of intentions increases the descriptive value of the theory. One determinant may have more weight than another, even though the attitudes and subjective norms may be the same between individuals, depending on their situation.

Another assumption of the TRA follows that attitudes are a function of beliefs. A favorable attitude toward the performance of a behavior will most likely develop from a person who believes in a positive outcome from the behavior, with the opposite being true as well, believing in a negative outcome will stem from an unfavorable attitude toward a behavior. Behavioral beliefs underlie a person's attitude toward a behavior while normative beliefs are those that an individual acquires from specific individuals or groups toward a behavior (Ajzen & Fishbein, 1980).

The influence that external variables may have on a person's beliefs or the relative importance of attitudes and norms in the TRA need to be addressed. Ajzen and Fishbein's theory regards external variables as only having indirect effects on behavior. In the TRA, there is no necessary relation to a given behavior or any consistent effect of external variables. External variables are factors that include personality characteristics, demographic data and attitudes toward targets. The TRA

recognizes their importance but does not consider their effects on individual behaviors but rather, on behavioral categories. Behavioral categories are defined as a class of actions without specificity (Ajzen & Fishbein, 1980). A diagram of Ajzen and Fishbein's model of the TRA is displayed in Figure 1.

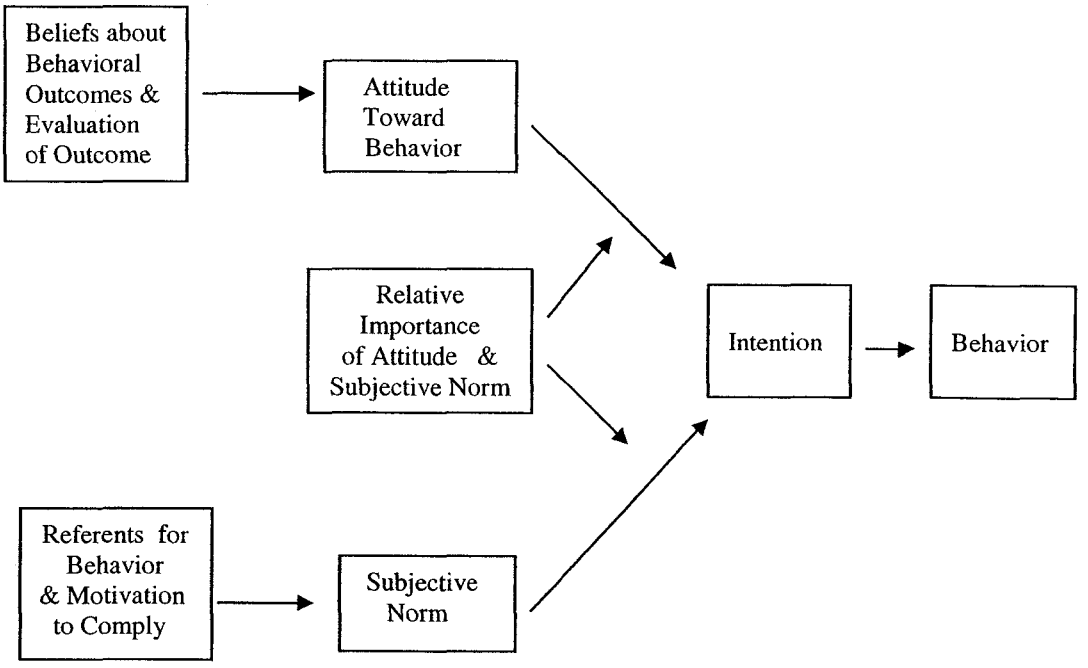

Figure 1
Ajzen & Fishbein's Theory of Reasoned Action (1980)

The Theory of Planned Behavior (TPB) was developed as an extension of the TRA by Ajzen (1985). An exogenous variable, that of perceived behavioral control was added to the TRA, which has effects on intention and behavior, both directly and indirectly. Perceived behavioral control is assumed to indirectly have motivational implications on intentions. The direct effect is on behavior reflected by the individual's belief of actual control on the performance of the behavior. The underlying assumption is that if resources and opportunities to perform a given behavior are present, the individual will have perceived behavioral control. Perceived

behavioral control needs to be distinguished from the volitional control of the TRA. Volitional control is when an individual can decide at will to perform or not to perform a behavior, whereas perceived behavioral control are associated with resources and opportunities present for a given behavior to be performed (Ajzen, 1985; Ajzen & Madden, 1985; Madden, Ellen, & Ajzen, 1992). A diagram of the TPB is displayed in Figure 2.

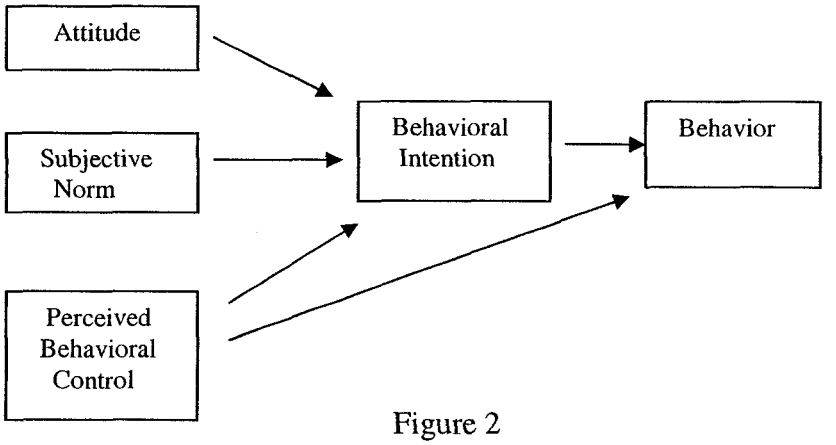

Figure 2
Ajzen's Theory of Planned Behavior (1985)

Both the TRA and the TPB have been tested and used to predict intention and behavior in a variety of settings such as college student class attendance, weight loss, contraceptive use, compliance behavior and cancer screening (Ajzen & Madden, 1986; Barling & Moore, 1996; Davidson & Morrison, 1983; Schifter & Ajzen, 1985). Of particular interest to the researcher is a study done regarding domestic violence prevention utilizing the TRA. Nabi, Southwell, and Hornik (2002) utilized a survey of 1250 adults regarding their beliefs about domestic violence and the correlation with their intentions to act regarding a domestic violence situation, as part of an evaluation of a domestic violence prevention initiative. The authors believed that efforts to stop

violence were comparable to other health behaviors where the act of performing a behavior was related to personal beliefs and social norms. Beliefs about domestic violence were found to be predictive of intentions to act, but not predictive of the actual behaviors. Despite their findings, Nabi et al. (2002) suggest communication campaigns will ultimately effect behaviors to help end domestic violence.

The TRA and TPB was used in two studies predicting physician behavior regarding use of screening mammography (Taylor, Montano, & Koepsell, 1994), and delivery of preventive services for adolescent transmission of HIV and other sexually transmitted diseases (Millstein, 1996). In another study utilizing the TRA, Laschinger and Goldenberg (1993), focused on nurses' prediction of intended care for HIV positive patients. These authors found that nurses' attitudes and subjective norms were significant predictors with regard to their intentions to provide care for HIV positive patients. The personal beliefs about the consequences of caring for such patients with reference to self, family and friends determined those who intended to care for the patients and those who did not. These beliefs were at odds with the subjective norm of the expectations of caring for HIV positive patients as a professional nurse. The researchers recommended teaching interventions for nurses and nursing students targeting not only the course of the illness and transmission, but also feelings, attitudes, beliefs and behavioral intentions about HIV-related topics (Laschinger & Goldenberg, 1993).

The results of these last three studies suggests that the TRA and TPB have relevance for studying the behavior of health care professionals and testing interventions to change their practices with patients. A substantive knowledge base for

understanding phenomenon of universal health problems including HIV, cancer, and domestic violence, as well as understanding the attitudes, subjective norms and intentions of professionals providing care for patients with these illnesses/problems, may provide the impetus for change in clinical practice.

Viewing domestic violence as a health care concern along with other illnesses such cancer and diabetes (that are routinely screened for by health care providers in primary care) will be a major step in addressing this serious health problem. Through an understanding of nurses' beliefs and social influences that underlie their decision to screen women for domestic violence and intervene with identified victims, we will be closer to knowing how to assist nurses to be more effective in their practice with this population.

Conclusions

The review of the literature on domestic violence laid the foundation for this study. The literature strongly indicates that appropriate screening for domestic violence and intervention with victims in primary care settings will help to prevent and end this major health problem. Nurses are in a unique position to help create change in the lives of female victims and their families. As one can see from the literature, there is more than enough data to support screening for domestic violence in any setting. Although many studies have been completed on screening and intervention practices, there is a paucity of research that focus on nursing practice with this population. In addition, no studies have been done utilizing the TRA/TPB to examine nursing practice related to domestic violence. By examining nurses' attitudes, beliefs and behavioral intentions, a teaching intervention for domestic violence screening and

intervention can be tailored for nurses resulting in routinization of a possible life-saving plan for women.

CHAPTER III

Methodology

The purpose of this study was to examine the impact of an educational program on nurses' routine screening of female patients for domestic violence in primary care settings. Utilizing the framework of Ajzen and Fishbein's TRA and Ajzen's TPB, the research questions were:

1. What are the barriers identified in primary care settings by nurses that prevent them from effectively screening for domestic violence?

2. What facilitates effective screening for domestic violence by nurses in the environment of primary care settings?

3. What is the impact of a domestic violence educational program intervention delivered to nurses in primary care settings on decreasing the barriers identified by the nurses to screening for domestic violence?

4. Does a domestic violence educational program intervention increase the identification and intervention of domestic violence by nurses in a primary care setting as compared to pre intervention conditions?

Overview of the Stages

This study occurred in five stages. Stage One included the distribution of a survey to nurses in primary care settings to assess learning needs regarding domestic violence screening and intervention. Focus groups were held in Stage Two to identify the barriers and facilitators to domestic violence screening and intervention by nurses in the primary care setting. The data gathered from the surveys and focus groups informed the intervention in Stage Three.

Stage Three was comprised of the development of an intervention – a domestic violence educational program for nurses in primary care settings. The data from the surveys and focus groups were incorporated into a program and adapted for nurses practicing in primary care settings. In Stage Four, the researcher delivered the program to five nurses in a pediatric primary care setting. In Stage Five, individual interviews with each nurse participant were completed, following the delivery of the program, to assess if they were incorporating routine screening of female patients in their practice.

Stage One

Survey methodology

Survey methodology is an appropriate way of gathering data that is capable of producing high quality information for its intended users. Accurate assessments of social facts (such as demographic data) as well as personal attitudes and beliefs from participants can be obtained from survey results that are close to true population value (Dillman, 1978). Optimum balance is of utmost importance when designing a survey. The Total Design Method (TDM) for surveys developed by Dillman (1978), utilizes a theory of response behavior and ensuring the implementation of the survey as designed. Response behavior refers to obtaining completed and accurate surveys from a representative sample of the population under study. Ensuring that the survey is implemented as designed deals with following through with administration of the survey as planned. Dillman (1978) recommends the TDM as a means and a guide to improved success particularly with mail and telephone surveys.

In order for a quality survey to yield accurate results, four potential sources of error must be monitored. Since only a sample of a population is usually surveyed,

sampling error often occurs. Use of statistical tables can quantify the error, as well as increasing the sample size. Coverage error occurs when the sampling frame is not a subset of the target population for the study. If questions are not answered accurately or precisely, measurement error can occur. Nonresponse error refers to a lack of significant number of respondents and their differences to the responders (Dillman, 1978).

In Stage One, the TDM method was used as a guide. This author designed a 20-item partially close- ended survey to assess the learning needs and perceived barriers and facilitators to effective screening for domestic violence of female patients by nurses in primary care settings (Appendix A). In particular, the nurses in this study were employed in 10 primary care practices in the southeastern Massachusetts area. The survey was distributed to approximately 35 nurses. The confidential surveys were returned by mail to this researcher in a self-addressed stamped envelope that accompanied the survey. Upon receipt of the completed surveys, the data was coded and entered for analysis. A reminder flyer to return the surveys was distributed to the nurses' practice settings two weeks after the survey was initially distributed (Appendix A). The data from the surveys served two purposes, it established a baseline of the participants' knowledge of domestic violence and served as a guide for the direction of the focus groups in Stage Two. The results of these two stages were incorporated into the development of the intervention, that is, the educational program. At the bottom of the survey, the nurses were informed of focus group meetings that would occur, on issues in ambulatory nursing practice related to domestic violence, for which they would receive a small stipend and a light dinner.

Stage Two

Focus group methodology

Focus groups have been acknowledged as a valuable and regularly used method of collecting data in both qualitative and quantitative research. First credited to Merton and his colleagues in the mid-1940's, focus group interviews were originally developed to study the wider fields of the human experience in communications research and propaganda analysis (Carey, 1994; Merton, Fiske, & Kendall, 1956). According to Morgan (1988), they have been used in conjunction with surveys as feedback from an administered questionnaire and as a follow-up to analysis. "As a method of qualitative research, focus groups are another alternative to individual interviews and participant observation that may provide access to less easily obtained forms of data" (Morgan, 1988, p.15). Carey (1994) notes focus group are quite compatible in settings where complex clinical issues are best researched using qualitative methodology.

Merton & et al. (1956) distinguished focused interviews, the original name of focus groups, from other types of interviews with four distinctive characteristics:

- The subjects interviewed have been involved in a *particular situation.*
- The researcher has done some provisional *content analysis* that leads the researcher to a set of hypotheses for the particular situation.
- An *interview guide* is established as a result of the analysis, providing for major areas of inquiry and criteria of relevance for interview data.
- The focus of the interview is on the subjective experiences of the subjects to gain *their definitions of the situation* in which they were involved (p.3).

Merton et al. (1956) originally began the focused interview as an adjunct to experimental research citing it as a "useful near-substitute for such a series of experiments {enabling}...the experimenter to arrive at plausible hypotheses concerning the significant items to which subjects responded" (p.7). The possibility of answering specific questions that may generate data for interpretation of results that were not anticipated was another benefit Merton and his colleagues suggested for utilizing the focused interview (1956).

There are four criteria to effective focused interviews: range, specificity, depth and personal context (Merton et al.,1956). Range, being the extent of relevant data provided by the interview, includes anticipated and unanticipated responses and interrelations between responses. Use of questions that are unstructured, transitional and mutational at various stages of the interview can produce range. Specificity refers to narrowing the gap of subjects' perceptions and reports of the situation, which the interviewer tries to elicit through linking reported responses to the specific situation. Depth seeks affective responses beyond one-dimensional reports. A depth-continuum is established in each interview. Through use of flexible interview styles, retrospection, reference to feelings and comparing situations, higher levels of depth can be reached.

The last criterion, personal context refers to the attributes and experiences of the subjects, which have contributed to their responses. Identification, controlled projection and paralleling of experiences will bring about personal context, which is essential for understanding unanticipated responses (Merton et al.,1956). When these four criteria are met, "rich details of complex experiences and the reasoning

behind... {the members} actions, beliefs, perceptions and attitudes" may become known to the researcher (Carey, 1994, p.123).

The present day focus group has evolved from the original 'focused interviews' as described by Merton and his colleagues to semi-structured group sessions, moderated by a group leader in an informal setting, with the aim of gathering information on a selected topic (Carey, 1994; Merton et al.,1956). In this study, the aim of the qualitative focus group interview was to explore the knowledge that nurses had about domestic violence (if any) and the interventions they utilized (if any) with domestic violence victims in their practice setting. In addition, specific questions were included related to strategies that would help the nurses, who had limited or no knowledge of domestic violence, with routine screening and intervening.

Barriers and facilitators for domestic violence screening that the nurses encountered in their practice settings would also be pursued by the researcher/facilitator in the focus groups. This identification of the barriers and facilitators of domestic violence screening in primary care settings would not only provide the researcher with valuable data to answer the research questions in the study, but also essential information for the intervention (educational program) in the subsequent stages of the study.

Focus groups in market research is grounded in the positivist tradition. Participants' emphasis is based on the individual's view, even though it is expressed in groups with the focus on consumption not production (Cunningham-Burley, Kerr, & Pavis, 1999). In social science research, focus groups are viewed as socially

constructed with the data dependent on the social context of the focus group. Active involvement of the participants is encouraged.

Focus group methodology as a research tool provides useful information to the researcher that can be both advantageous and limiting. "Focus groups are valid if they are used carefully for a problem that is suitable for focus group inquiry" (Krueger, 1994, p.31.) The major advantage to using focus groups is its social orientation. The influence of group members on each other is natural occurring in real life rather than the controlled experiment in a laboratory. As inhibitions are reduced, and the researcher gets at the participants' attitudes and experiences, deeper meaning is developed. The facilitator can probe to explore and clarify the unanticipated issues that arise. Other advantages of this approach are its high face validity, flexibility and relatively low cost. Focus groups can be done more quickly than using other methods, such as individual interviews and/or participant observation. In addition, the results are often more easily understood (Krueger, 1994; Morgan, 1988).

There are several limitations to focus groups. There is less control with participants in focus groups than with individual interviews. Each focus group is unique. The environment must be conducive to interaction. The facilitator must keep the discussion focused. Also, the facilitator must be carefully trained to know how and when to ask different types of questions, as well as when to probe, pause, and move on. Focus groups are difficult to assemble. Finding the right time, a convenient location, and accommodating participants' schedules is often more difficult than anticipated. Since attention must be given to interpreting the data within the group context, analysis can be challenging (Krueger, 1994; Morgan, 1988). Carey and Smith

(1994) point out the possibility of censoring and conforming among group members, which also speaks to the need to analyze the data in the group context.

Unlike brainstorming that is used to solve problems, or Delphic processes to develop a consensus or make decisions for an action plan, focus groups seek to gather information about participants' perceptions, feelings, and ways of thinking. Often focus groups are utilized for the purpose of a needs assessment, prior to expending large amounts of time, effort and funding on a larger scale program of research. In their study, Halloran and Grimes (1995) utilized focus groups to assess the learning needs of nurses caring for patients with HIV/AIDS in order to develop an educational program for nurses caring for this population. This study utilized focus groups for a similar purpose, that is, to explore the participants' attitudes, perceptions, feelings, and knowledge about domestic violence, and to examine barriers and facilitators to screening for and intervening with victims of domestic violence.

Planning of the focus groups for the study. In order to best meet the four criteria described by Merton et al. (1956), detailed planning of the structuring, implementation, and data collection of focus groups, must occur. Structuring focus groups entails several essential issues. First, an environment must be selected that is conducive to focus groups. The environment must be one that is convenient to the participants and comfortable, both physically and emotionally. The room should be quiet, private and free from interruptions (Kitzinger & Barbour, 1999). Merton et al. (1956) recommend a circular seating pattern around a table with the researcher /facilitator seated within the group.

Audiotape recording of the groups is recommended and can be accomplished

with high quality equipment that is multidirectional so that all participants can be heard on tape during transcription. Recording the groups "provides far richer research access to the discussion" (Kitzinger & Barbour, 1999, p.15) and provides a record of the session. A research assistant/observer is also recommended to take notes during the sessions regarding the seating arrangement, body language, and other details that audio-recording equipment cannot obtain. These field notes may supplement the transcripts of the sessions and can be quite useful during analysis (Krueger, 1994). In this study, this researcher facilitated the focus groups, and the research assistant/observer was seated outside the group taking observational notes as described by Schatzman and Strauss (1973).

Selecting the number of focus groups to be conducted depends on the research question, population subgroups, time and resource limitations. The more homogeneous the group, the less number of focus groups needed. The number of focus groups needed is reached when the research question(s) is (are) answered adequately.

The size of focus groups varies from three to fifteen participants (Carey, 1994; Kitzinger & Barbour, 1999; Krueger, 1994). For sociological studies, the ideal number is five or six participants (Kitzinger & Barbour, 1999). Composition of the group is a perennial problem for focus group research. Homogeneity of the participants is often most productive, but heterogeneity can be illuminating as well (Kitzinger, 1994). Working with people who know each other can be an advantage as they may be more comfortable to discuss the research issues as "the naturally occurring group is one of the most important contexts in which ideas are formed" (Kitzinger & Barbour, 1999, p.9). It is not essential however to utilize participants known to each other for a

successful focus group. Homogeneity can occur through other factors such as employment position, practice environment, or experience with the research issue. Qualitative sampling in focus groups is generally employed, as statistical representativeness is not the aim of most focus group research (Kuzel, 1992).

Focus groups in this study were not designed to test hypotheses, but rather to explore the experiences, insights and perspectives of the participants with regard to domestic violence issues. The focus groups for this study were designed with several assumptions. First, group or team settings are well-known to nurses who normally function in a group or team model within their work environment – arranging assignments for the day, attending patient or educational conferences and staff meetings, where members participate in discussion. Outside of the work place, many nurses are active in school advisory councils, places of worship, sports and community organizations, and they are comfortable in those settings. Second, group thoughts and ideas may generate more thoughtful and complex responses regarding the nurses' needs to be able to incorporate routine screening for and intervening with victims of domestic violence. In addition, individual participation can be enhanced in a group setting as the participants have an opportunity to reflect on the comments of others (Carey, 1994).

In this study, nurses from outpatient pediatric settings, general internal medicine/family practices and obstetrical/gynecological practices in the southeastern Massachusetts area were the selected population for the focus groups. Participants were recruited by the invitation accompanying the end of the survey, as well as informational flyers posted where they were employed. Participants called the phone

number provided and were given the location and time when the focus group would occur. They were also informed about what to anticipate from attending the group (consent form, number of group participants, brief overview of content, and amount of stipend for attendance).

All the participants were working in an outpatient primary care setting, spoke English and had an interest in domestic violence. Every effort was made to have a diverse sample and include nurses with varied demographic backgrounds. Despite these efforts diversity of participants was not accomplished. The participants for both groups had at least six years of clinical experience and were familiar with each other's practices in the health care community of southeastern Massachusetts

The focus groups were scheduled between December, 2003 and March, 2004. Each group occurred in a comfortable conference room in a middle school in southeastern Massachusetts. This location was selected because it was convenient to all of the practices from which the participants were sought.

When the prospective participants contacted the researcher, they were given information about the study design, its benefits, risks and assurance of confidentiality. Any questions they had were answered, and an invitation letter if they agreed to participate was mailed to them (Appendix B). Written informed consent from each participant was obtained prior to the start of each focus group as per the University of Rhode Island's Office of Compliance guidelines (Appendix C). The participants were asked to fill out a short confidential demographic data sheet to be used for descriptive statistics in the analytic phase (Appendix D).

This researcher, who has been a psychiatric clinical nurse specialist for 20

years was the facilitator for the focus groups. She has continuously worked in either inpatient or outpatient psychiatric settings where groups were/are facilitated by the researcher on a regular basis. Being well versed in group therapy was beneficial to the researcher's role as facilitator of the focus groups. Group dynamics, being a core element for successful focus groups and therapy groups was well within the researcher's realm of experience.

This researcher also has a wealth of clinical experience working with victims of domestic violence, individually and in the community. Many victims of domestic violence are patients in her therapy practice and have required intervention at various levels of care. In the community, she belongs to a grassroots organization, HUGS II (Help Us Get Safe, II) which provides domestic violence victim services and community-wide violence prevention programs.

Once the focus groups were planned, the implementation of the groups occurred. The groups lasted for two hours. The research assistant (Appendix E) was present to take supplemental field notes during each group, record the seating arrangement, assume responsibility for the recording equipment, and observe for any behaviors that could not be reflected on the audiotape. A light meal was served prior to each session. An interview guide with the ground rules of the group and a group of core questions prepared by the researcher to assist with stimulating discussion among the participants, was read before each session began (Appendix F). Members of the researcher's dissertation committee were consulted about the contents of the interview guide. The initial question, used as an ice breaker, was designed to include all

participants into the discussion. The subsequent questions were generally open-ended relating to the topic of interest.

The facilitator was responsible for the groups' interaction by keeping the discussion on track and encouraging input from all the participants. During each group, the facilitator listened carefully, validated each participant's response and probed for more information when needed. Probing to gain greater understanding of the participant's statements as well as taking careful notes was of great value during analysis of the groups.

After each focus group ended, the researcher/facilitator and research assistant checked the tapes to make sure the group was recorded correctly. A debriefing session about the group took place and was also recorded. A brief summary of the key points elicited from the groups, as well as preliminary ideas about the group, were helpful in the subsequent analysis. All tapes and notes were coded to protect the participants' confidentiality. The tapes were copied with the original sent to a transcriptionist. The researcher/facilitator listened to the backup copy to compare with Merton's criteria for an effective focused interviews, and reviewed notes while waiting for the transcript of the original copy. Data from each focus group was compared and contrasted after both groups were completed.

In this study, the original intent was to have three focus groups with 5 or more members in each group. Several attempts were made to achieve this goal. It became extremely difficult to gather 5 or more nurses at the same time and place due to work schedules, child care coverage, and the weather. The time of year, December was another factor that inhibited getting the focus groups started. Times to hold the groups

were made available for weeknights and Saturday mornings. Dinner or breakfast was available as well as a stipend for attendance. On two occasions, nurses that had agreed to participate in the groups, at the last minute were unable to attend for reasons of child care, illness and an injury sustained earlier in the day. Groups were postponed until January, when one group did occur with three members. The February group was cancelled as only one participant attended. The third group occurred in March with two members in attendance. The nurses that did participate in the two groups were from diverse primary care practices including pediatrics, family, internal medicine and obstetrics/gynecology. Although these groups were small, data collected from both groups were rich and sufficiently answered research questions, number one and two. The core dissertation committee validated that the data collection was completed for the focus groups in Stage Two.

Analysis of the Focus Group Data. Plans for analysis reflect the intent of the focus groups. Learning the experiences, insights and perspectives of these nurses, as well as their needs to adopt domestic violence screening into their daily practice, was the intent of the groups. With these intentions in mind, the transcripts were read multiple times to identify prominent themes. The research assistant also reviewed the transcripts. Each focus group transcript was reviewed prior to the next group. The transcripts were coded and the data was organized by the researcher utilizing the researcher's interview guide for structure. This data was supplemented with the observational notes that included nonverbal communication, gestures and behaviors that occurred in the groups. All of the data was interpreted in the context of the focus groups themselves as well as the individual level and in a comparison of the individual

and group level as recommended by Carey and Smith (1994). The prominent themes of the focus group helped guide the researcher with the development of the domestic violence educational program in Stage Three.

Stage Three

The Development of the Intervention: A Domestic Violence Educational Program

The themes from the surveys and the focus groups were utilized to modify two established domestic violence educational programs, The Physician's for a Violent-Free Society (PVS) Assessment Response Course (2002), and The Association of Women's Health, Obstetric, and the Neonatal Nurses (AWHONN) Universal Screening for Domestic Violence (2003). The PVS Abuse Assessment Course was created by a group of national multi-disciplinary and multi-specialty health care providers, educators and researchers with domestic violence experience. Its purpose is to provide domestic violence educators and advocates instructional material that is, "comprehensive yet succinct and flexible...for health care professionals in academic and private settings...that will help participants gain competencies in responding to family violence" (PVS, 2002, p.1).

The program, on CD-ROM format, has three tracks that can be modified for specific audiences, time constraints, and speaker style and experience. Hard copies of the material to be presented may be printed to maximize the benefit of the course. The PVS program's first track includes the background, screening, clinical management, forensic recognition and documentation, and medical legal issues regarding domestic violence. The second track includes strategies and tools for integrating family violence into academic and private health care settings including utilizing environmental

facilitators. The last track provides enabling tools that can help promote system change in the health care setting to develop and implement clinical protocols for abuse assessment.

The AWHONN program is a slide and script presentation package for health professionals. It is a multifaceted presentation in CD-ROM format that includes a slide show and speaker's script, participant handouts, the Abuse Assessment Screen in English and Spanish, the Danger Assessment Tool, and a list of resources that includes web sites and abuse help lines. According to Santa-Donato, a member of the AWHONN board of directors, "The package includes everything that a healthcare provider needs to prepare and deliver a lecture about the subject of domestic violence," (AWHONN, 2003, p.1). Written by a nursing professor, well known in the field of domestic violence, Jacquelyn Campbell, PhD, RN and a women's health nurse practitioner, Kathleen Furniss, RNC, MSN for a primary target audience of nurses and advanced practice nurses, the information in this package is very comprehensive and is presented in a way that is understandable and applicable across disciplines. For the purposes of this study, the researcher utilized participant handouts, the Abuse Assessment Screen and the list of resources on the web in response to the data from the surveys and focus groups. The contents of the researcher's educational program can be found in Chapter IV.

Stage Four

Domestic Violence Education Program for Nurses in a Primary Care Setting

Setting and participants. The educational program was delivered to one site, selected from all the practices that had the survey distributed in Stage One.

Nurses/nurse practitioners from a large pediatric practice in southeastern Massachusetts, enthusiastically agreed to participate in the domestic violence educational program. This practice was chosen as it had the largest number of nurse providers from all the practices who participated in the survey. The researcher decided to choose a larger practice, as the benefits of a successful program would reach a larger patient population. It was anticipated that the six nurses would attend the educational program (the intervention). Four registered nurses and one nurse practitioner were in attendance. The second nurse practitioner went out on an earlier than expected maternity leave, and therefore could not attend the program.

The program was provided in three segments, each lasting one hour, over a three day time span at no cost to the participants. Each day, the program was held in a conference room at the participants' practice setting. Lunch was provided by this researcher as well as all the necessary written materials for the program. Educational strategies included didactic presentation, a video, role plays, and question and answer periods. After the program was completed, environmental facilitators including domestic violence awareness posters for examination rooms, domestic violence awareness buttons for the nurses, laminated practitioner reference cards, a stamp prompt for charts, and palm cards for the restrooms were given to the practice setting at no cost. In addition, each nurse received 2.2 continuing education credits for their participation in the program.

Stage Five

Post Intervention Interviews

Two weeks after the completion of the educational program, the five nurse participants were individually interviewed by the research assistant in their practice setting, utilizing a semi structured interview guide (Appendix G). In the post intervention interviews, the nurse participants were asked several questions related to domestic violence screening and other practice changes.

Wake (1986) modeled a questionnaire after Ajzen and Fishbein to measure practice change intention to determine if a relationship exists with effectiveness between continuing nursing education and practice improvement. Some of the interview questions for this study were modeled after Wake's questionnaire (1986) to determine the impact of an educational program (the intervention) on practice changes by nurses regarding domestic violence screening and intervention.

Final Analysis of the Data

With Fishbein and Ajzen's Theories of Reasoned Action and Planned Behavior (Fishbein & Ajzen, 1975; Ajzen & Fishbein, 1980; Ajzen, 1985) as the conceptual framework of the study, this researcher looked for intention and change in behavior. Specifically, the researcher looked for the intentions and changes among the nurses and their practices, who received the educational program intervention (which included the environmental facilitators). Attitude, subjective norm and perceived behavioral control determine intention. Intention is a valid indicator of educational intervention (Ajzen & Fishbein, 1980). If the educational program (the intervention) had an impact on intention, then the behavior, change in nursing practice (specifically,

routine screening for domestic violence) may follow. The impact of the environmental facilitators on the behavior (change in nursing practice – routine screening for domestic violence) was also assessed.

Descriptive statistics were used to summarize the demographic data of the participants obtained from the surveys and the focus groups. The barriers and facilitators identified by the nurses in outpatient primary care practice settings who participated in the focus groups were summarized. Analysis of the semi-structured interviews included identification of themes that described how the nurses' practice had changed (or not changed) in employing routine screening of female patients for domestic violence. Comparing similar themes from each nurse and examining how they related to their practices before and after the intervention was valuable to this study and possible subsequent studies.

Changes in the environment were noted by the research assistant when she returned to the practice setting for the post interviews of the nurse participants. The research assistant looked for domestic violence awareness posters on the walls of the waiting room, conference room and examination rooms. The presence of the resource list in the examination rooms, the domestic violence reference cards and awareness buttons on the nurses' lab coats and the literature in the patient waiting area with other pamphlets were noted by the research assistant as well.

Trustworthiness

Establishing trustworthiness is an intrical component of the research process. Trustworthiness in a qualitative study speaks to the results having met the criterions of credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985).

Credibility is demonstrated when the findings reflect the experiences of the participants. Activities such as prolonged engagement, persistent observation, triangulation, peer debriefing and member checks increase the likelihood that the findings will be credible. The criterion of dependability is met if the results are credible, similar to validity and reliability in a quantitative study. Transferability, (or fittingness) demonstrates the results of a study may have meaning to another group of similar subjects and is met most often through thick description. The last criterion, confirmability is established through the audit trail provided by the researcher throughout the study. The audit trail includes all raw data, field notes, process notes, instruments and any other materials utilized in the study to answer the research questions. The audit trail is quite helpful to the researcher when the research report is being synthesized and produced (Lincoln & Guba, 1985).

A variety of checks and balances were used in this study to establish trustworthiness of the data in this study. After the focus groups and the educational program, the researcher reflected about each of the experiences and wrote journal entries about each of them. At the end of each focus group, the research assistant provided a short summary of the content to the group members, inviting additions or corrections from the members. The researcher and research assistant debriefed after each focus group to discuss overall impressions, notable quotes, key ideas or insights presented and the research assistant's field notes.

Numerous problems can occur in the transcriptions. Transcriptions depend on the quality of the recording and the skill and accuracy of the transcriber. To maintain trustworthiness with the transcriptions, the focus group tapes were copied and the

original was sent for transcribing. The transcriber was experienced with focus group transcription and had references from other doctoral students. The researcher reviewed the transcripts several times both individually, and with the research assistant to identify themes, and noted 100% inter-rater agreement between them. The research assistant was a master's prepared school adjustment counselor with ample group experience as well as a strong familiarity with domestic violence issues. In addition, the researcher spoke with her major professor after each focus group to obtain constructive feedback for future groups and ensure credibility of the findings.

The researcher followed the educational program content as planned including all the program categories identified in Chapter IV. The time frame agreed upon with the participants was adhered to for the completion of the educational program. The individual post intervention interviews were conducted by the research assistant with each participant in a private office at the practice setting to maintain the participants' confidentiality. The same interview guide was utilized for each participant, the results of which were transcribed on to a disk by the research assistant. An audit trail was maintained throughout the entire data collection and analysis of the study with all materials being stored properly.

Human Subjects Protection

Approval from the Institutional Review Board on Human Subjects at the University of Rhode Island was obtained on November 13, 2003. The study was explained fully to each participant with the opportunity to ask questions of the researcher before any stage took place. The researcher explained to each participant that their participation was voluntary and that they had the right to withdraw from the

study for any reason and at any time. Focus groups and the educational program did not begin until each participant's informed consent was obtained and signed with each participant receiving their own copy (Appendix C). All records, including tapes, notes and transcriptions, are coded and will be kept in a locked cabinet at the researcher's office and then destroyed by the researcher after three years per University of Rhode Island guidelines.

CHAPTER IV

Results

The results of this study illustrate the effect of a domestic violence educational program (the intervention) on the beliefs, attitudes, and behaviors of four nurses and one nurse practitioner in a primary pediatric care practice in southeastern Massachusetts. The survey and focus groups informed the intervention by identifying the barriers to and facilitators for domestic violence screening in primary care settings. As a result of the intervention, three nurses and one nurse practitioner identified improved changes in their practice.

Stage One

The Survey

Approximately thirty-five surveys were distributed to nurses at ten primary care practices in southeastern Massachusetts. Selection criteria were: the practice site must have nurses and/or nurse practitioners on staff who were able to read and speak English. The practice settings included pediatrics, family practice, internal medicine and obstetrics/gynecology. The selected practices were familiar to this researcher from her own clinical practice. The survey, developed by this researcher, included demographic questions and ten questions about domestic violence screening practices (Appendix A). Twenty-two completed surveys, a 63% return rate, were returned by mail within three weeks.

Survey Sample Demographics

All 22 participants were white females. Eighty-two percent had an annual household income of at least $60,000. Demographic data of the survey participants is found in Table 1.

Table 1. Demographic Data from Stage 1 Survey Respondents (N = 22)

	n/total	%
Age		
26-35 yrs. old	5/22	23
36-50 yrs. old	10/22	45
51+ yrs. old	7/22	32
Years as practicing nurse		
< 5 yrs.	2/22	9
6-10 yrs.	6/22	27
11-15 yrs.	3/22	14
16-25 yrs.	5/22	23
> 25 yrs.	6/22	27
Years in present position		
<3 yrs.	5/22	23
3-7 yrs.	7/22	32
8-15 yrs.	5/22	23
16- 25 yrs.	5/22	23
Marital Status		
Single	2/22	9
Married	19/22	86
Separated	1/22	5
Highest nursing education		
RNCS/NP	9/22	41
BS	2/22	9
Midwife	3/22	14
LPN	4/22	18
Diploma	2/22	9
AD	2/22	9
Type of Setting		
Pediatric	11/22	50
Internal Medicine	5/22	23
OB/Gyn	4/22	18
Family	2/22	9

Survey Results

All of the 22 participants in the survey had direct patient contact on a daily basis at their practice setting. Their interactions with patients varied from taking vital

signs, completing initial histories, performing physical examinations, asking screening questions (such as using seatbelts, regular exercise, eating healthy), providing follow-up visits and drawing blood. When asked if they ever suspected a female patient(s) to be a victim of domestic violence, 68% percent of the participants had suspected at least two female patients who might have been victims. Fifty-five percent of participants had had the opportunity to screen female patients about past or present domestic violence. Of the participants who screened for domestic violence, 79% had a female patient(s) who screened positive. Seventy-three percent of the participants, who had had the opportunity to screen, were able to intervene with patients who screened positive. All of those who intervened provided phone numbers of counselors, shelters and hotlines. Two participants began a safety plan with their patient and gave the patient educational literature on domestic violence in addition to the interventions provided above.

Only 18% of participants could estimate the percentage of victims of domestic violence in their practices. They estimated that 1- 5% of their female patients were victims. Thirty-six percent of participants were told by a female patient(s) that they were victim(s) of domestic violence without being asked. Of the participants who were told by the patient(s), 75% intervened by giving phone numbers of shelters and counselors to the victims and 25% did not intervene at all.

Forty-five percent of participants worked in practice settings presently or in the past, where screening measures for domestic violence were in place. These facilities included community health centers, a long-term care facility, emergency departments in hospitals, an urgent care unit, an inpatient psychiatric unit, a family planning clinic,

an inpatient obstetrical unit, outpatient obstetrical-gynecological offices and a midwifery practice. Fourteen out of twenty two participants had a bachelor's degree. Only 50% of participants had domestic violence content in their nursing curriculums. Thirty-two percent of participants had attended a continuing education program on domestic violence or read about it in a professional journal or in another medium (television program, self-directed learning tool). Seventy-three percent of participants who had domestic violence content either during their nursing program or afterward, acknowledged that the information influenced their practice.

The participants were asked to identify what information they needed in order to routinely screen their female patients for domestic violence. The following suggestions were offered: signs and symptoms of domestic violence; asking the right screening questions, the who, how, where, when of asking screening questions; being knowledgeable of the local resources (referrals for shelters and counselors); knowing the outcomes for those who get help, having an office protocol for domestic violence screening, and identification of children and teenagers at risk who witness domestic violence.

Summary of Survey Data

Data from 22 respondents were reviewed for analysis. The data analysis informed the researcher's intervention, the domestic violence educational program. The data was tabulated utilizing percentages for each answered question on the survey. Categories were made for questions that had open-ended responses with percentages for each category compiled. The survey data supplemented the content of two

domestic violence educational programs previously reviewed by this researcher (PVS' & AWOHNN's programs).

From the responses to questions #11 through #16 on the survey, the researcher was able to glean useful information to supplement the two established programs in order to provide a comprehensive intervention program to a particular primary care setting. While many nurses had suspected a female patient may be a victim of domestic violence, they did not always ask these patients if they were victims, nor did they have enough resource and referral information to intervene with the women who screened positive.

Survey question #20 generated the most data about what the nurses specifically needed to know in order to screen their female patients for domestic violence. All of the nurses who responded to the survey worked in primary care and fourteen of twenty-two respondents (64 %) specifically listed the need for information about resources and referrals. Half of the participants cited that knowledge of the screening process itself was important. Knowing what to look for, such as signs and symptoms of domestic violence, was mentioned by seven of the twenty-two (32%) respondents. Information related to these three questions were incorporated into Stages 3 and 4.

Stage Two

The Focus Groups

The Process. After the surveys were returned and the data analyzed, focus groups were initiated. The intent of the focus groups was to supplement the survey data. They produced some additional data expressed in the nurses' own voices regarding barriers to and facilitators for domestic violence screening and intervention

in their practice settings. The focus group data also helped to reinforce the validity of the survey data. Being an area where little was known about the phenomenon of interest, this data was relevant to the development of the content of the domestic violence educational program conducted in the next phase of the research.

Recruitment for the focus group initiated with an invitation attached at the end of the survey. Selection criteria for the focus groups included: being a nurse currently in practice in a primary care setting with direct patient contact, and the ability to understand and speak English. Several nurses and nurse practitioners called this researcher and inquired about attending a focus group. Flyers were posted at each practice site where the surveys were distributed. The focus groups were scheduled during December, 2003 through March, 2004.

Coordinating the date and time that participants could attend was more difficult than anticipated. Each focus group was conducted in a conference room at a local middle school convenient to all participants. The room was arranged prior to the start of each session. The participants were seated around an oval table with the researcher placed within the group. The sessions were audiotaped and the tapes were then kept in a locked file cabinet to ensure confidentiality. The recording equipment was placed on the table utilizing a multi-directional microphone to assure that all participants' voices were audible and clear. Dinner was served prior to the start of each focus group session.

This researcher, who was also the facilitator, had an assistant who was responsible for the audiotaping, recording observational notes, and providing a summary to the facilitator at the end of the session. The summary included the

assistant's overall impressions, notable quotes, and any key ideas or insights from the group.

Written informed consent was obtained with a copy of the informed consent given to each participant prior to the beginning of each focus group (Appendix C). This researcher discussed the purpose, method and risks associated with the research. Protection of participants' privacy and confidentiality was emphasized as well as their participation being voluntary. The researcher/facilitator utilized an interview guide that was read prior to the start of each group that had been approved by the researcher's committee members. The interview guide included ground rules for the group and several core questions to stimulate discussion (Appendix F). Each session was conducted in the same manner.

Each session started after all the informed consents were obtained. The interview guide was read by the researcher/facilitator and the discussion began. Each focus group was two hours in length. At the end of each session, the participants were given a small stipend and were thanked for their time. Two participants asked to donate their stipends to a domestic violence shelter or another local domestic violence resource. All participants wanted to know the outcomes of the focus groups and information about the next phases of the research. They all appeared to be acutely aware of the need for domestic violence screening and intervention in their respective settings. This researcher communicated to the participants that they would be informed of the findings as it pertained to their practice settings. They were thanked for their eagerness to be part of a potential change in nursing with regard to domestic violence screening and intervention in the primary care setting.

Focus Group #1 Analysis

The first group occurred in mid-January, 2004. At that time, three nurses were in attendance. A fourth nurse, who had intended to participate became ill and was unable to attend. The three remaining participants consisted of two pediatric nurse practitioners and one pediatric registered nurse from two similar pediatric practices. The participants were all female, married, white, between 33 and 51 years of age, with a minimum of six years of clinical experience. They were a purposefully homogeneous group of nurses. Of note, the participant who could not come to the group was a pediatric nurse practitioner with a similar demographic background as the participants, but worked in a middle school. After written informed consent was obtained and the interview guide read, the discussion began. The discussion moved freely from one speaker to the next in response to the core questions. With the researcher's probing, more details emerged.

The initial core question was considered 'an icebreaker' and asked about a typical day in their practice setting. Both of the pediatric settings where the three participants were employed had very similar patient populations with regard to ages (birth – 22 years old), ethnicity (White, Black, Hispanic, & Asian) and a mixed socio-economic background (lowest to highest levels). Both practices accepted similar types of health insurance (HMO's, indemnity plans, Medicaid) and were located in the same city in southeastern Massachusetts. One practice was a larger practice with four doctors, two nurse practitioners, and a physician's assistant as providers, while the other practice had two doctors and two nurse practitioners as providers. Each practice had nurses and medical assistants on staff, in addition to their support staff.

The next two core questions were designed according to the research questions regarding barriers and facilitators in the participants' practice settings. Themes developed from the findings of the group related to the first two research questions. To maintain confidentiality, the participants are identified in Focus Group #1 as Participant A, Participant B, and Participant C.

Findings related to the research questions in Focus Group #1

Research Question #1. What are the barriers identified in primary care settings by nurses that prevent them from effectively screening for domestic violence? In Focus Group # 1, the participants identified several barriers in their settings that prevented them from effectively screening for domestic violence. Participant A, a nurse practitioner, spoke of "just not knowing what are the best services and how I can relay that information (regarding domestic violence services) in a confidential way to my patient". She was unaware of the local resources and what places were the "best" to send a patient. She identified this as a barrier to screening in her practice setting. Participant B, also a nurse practitioner, agreed with her stating "Resources, where do you go? What do you do?" Time was also a barrier in Participant A's practice. Knowing that " if the patient (or patient's mother in the pediatric setting) responds with a yes (to a screening question about domestic violence), I am opening Pandora's Box". The other two participants echoed this same barrier occurring in their practice. However, when a visit is going over the allotted time, they utilize other providers.

> I just come out of the exam room and say, ___ (other provider's name who is free at the time), I'm running behind. Can you get my next patient started or alert her/him that I am about 15 minutes late? Most often, it's not a problem, but we all have those days when time is not on our side. We can't always have as much time as we like to and other staff aren't always available (Participant B).

Participant C, a registered nurse, identified language as a barrier. "There aren't interpreters in a private practice office too often." Participant B also responded with "Maybe some of the doctors like to think they can speak another language, but in reality they really don't speak it fluently." Having a male provider was a barrier that Participant C also raised. "...they (female patients) don't want to open up to a man because it's a man, that's put them where they are perhaps...having access to a female provider, I think helps."

Lack of social supports and denial on the part of patients were acknowledged as barriers by Participant B:

> These women have no family. They're isolated...I find if they don't have a lot of social supports, it's very difficult to get them out of a situation or is it apathy? ...I (patient) can make him change. It will get better...

The themes from Focus Group #1, relating to the first research question, (barriers to effective domestic violence screening) were divided into two categories: provider barriers and nurses' perceived patient barriers. Provider barriers were:

- Being unaware of the local domestic violence resources

- Inability to provide information to the patient on domestic violence resources
- Time availability to screen and intervene for domestic violence
- Language barriers between patient and provider
- Lack of social supports for patients with domestic violence issues

Perceived patient barriers were:

- Female patients with domestic violence issues may not be able to be open with male providers
- Patient's denial that they are in abusive relationships

The barriers identified by the participants were similar to the answers to question #20 in the survey conducted prior to Focus Group #1, except for the language barrier and the two perceived patient barriers, lack of openness with male providers and denial that abuse is existing in the relationship. However, perceived patient barriers had been found by the researcher in the domestic violence literature. The focus groups raised the importance of perceived patient barriers, therefore supporting the value of the focus groups as a supplement to the survey. This information enriched the domestic violence educational program, provided in a later stage of this research.

Research Question #2. What facilitates effective screening for domestic violence by nurses in the environment of primary care settings? In Focus Group #1, the participants were able to identify environmental facilitators for effective screening of domestic violence in primary care settings. Participant B identified "the supportive team" where she worked as being a strength in her setting. The conferring between providers about particular patient families that were of concern to them led providers to "write subtle notes in an area of the chart not released with the medical record". The

provider that saw the family on subsequent visits would be aware of potential safety issues in the home with regard to domestic violence, and would then review its status. If a child was injured, the note by the provider in the main body of the chart would include documentation of notification to the Department of Social Services. This is consistent with the mandatory child abuse federal and state reporting laws

Participant C commented on the use of a history form completed by patients in her practice, where there was the question, "Have you ever been abused?" Participant C continued, "It allows them the anonymity of not having to talk about it right away... and the provider to let them know they can talk about it when they are able to. But it is only on the initial patient history form." Participant B suggested that the question about abuse be incorporated into their check-off stamp for physical exams in their practice.

All of the participants gave several suggestions that could be incorporated in practice settings: an acronym that helped them to remember screening questions, palm cards with domestic violence information, and resources for patients available in the rest rooms at the practice settings. Accessible information in the waiting room with all the other educational pamphlets about asthma, AIDS, and toilet training was also proposed as an environmental facilitator. Awareness posters or informational sheets on the walls of the examination rooms for patients to read while waiting for providers instead of old magazines was the final suggestion by the participants for environmental facilitators.

The themes from Focus Group #1 related to the second research question on facilitators for effective domestic violence screening in the environment of the primary

care setting were divided into existing facilitators and proposed facilitators. The existing facilitators were:

- A supportive team of providers and staff
- Having the abuse questions on the history form (& then incorporate it into the chart for routine screening)

Proposed facilitators were:

- Palm cards with domestic violence resources in rest rooms
- Educational pamphlets on domestic violence with the other educational materials in the waiting room
- Awareness posters in the examination rooms or informational sheets on the walls to read while waiting for the provider in the exam rooms (as is done with Attention Deficit Disorder, immunization schedules, and bike safety)

As with the barriers to screening, the survey did not directly ask about the facilitators for domestic violence screening in the environment. Question #20 in the survey did yield some responses: having appropriate pamphlets in the waiting room, and a protocol for providers to utilize for screening that would enhance practice settings' environments. Both the existing and proposed facilitators identified in Focus Group #1 were themes that were able to be incorporated into the researcher's educational program in phase two of the research.

Focus Group # 2 Analysis

Scheduling the second focus group was a difficult task. Numerous attempts were made to schedule the groups at convenient times and locations. However, only one participant came to the group scheduled in February. In March, 2004, four participants volunteered for a focus group. Approximately two hours before the group, one participant was unable to attend due to childcare coverage. Another

participant had fallen on ice earlier that day, broke her arm, and was too uncomfortable to sit for a group. This researcher contacted her major professor. The core dissertation committee approved conducting the group with only two participants.

The two participants were both nurse practitioners, one worked in a family medical practice and the other in an obstetrical-gynecological practice. The participants were female, married, and white, between 45 and 47 years old, with 15-25 years of nursing experience. They were a purposefully homogeneous group of nurses. One nurse practitioner, who was unable to come to the group, was a woman's health and adolescent health nurse practitioner with the same demographic background as the two participants present for the group. The other nurse practitioner that broke her arm worked in the same practice with the obstetrical-gynecological nurse practitioner participant and had a similar demographic background.

As in the first focus group, after written informed consent was obtained and the interview guide read, the discussion began. The discussion progressed well from one speaker to the next in response to the core questions. As with the first focus group, with this researcher's probing, more details emerged. The 'icebreaker' (initial core question) was asked regarding a typical day in the two participants' practice settings. Both of the practice settings where the participants were employed had very similar patient populations with regard to ages (adolescents - elder adult) and ethnicity (Caucasian, Black, Hispanic, & Asian). The socio-economic background of the patients was somewhat different as the family practice had a more affluent group while the obstetrical-gynecological practice had a more middle class clientele. Both practices accepted similar types of health insurance (HMO's, indemnity plans,

Medicaid) and were located in two different cities in southeastern Massachusetts, but similar in population size. The family practice was a larger practice with five doctors and one nurse practitioner as providers, while the obstetrical-gynecological practice had one doctor and two nurse practitioners as providers. Each practice also had nurses and medical assistants on staff, as well as their support staff. Similarly to the first focus group, themes emerged relating to the first two research questions regarding the possible barriers and facilitators in the participants' practice settings. To maintain confidentiality, the participants in Focus Group #2 were identified as Participant D and Participant E.

Findings related to the research questions in Focus Group #2

Research Question #1. What are the barriers identified in primary care settings by nurses that prevent them from effectively screening for domestic violence? The participants in this focus group identified several barriers in their settings that prevented them from screening as well as screening effectively for domestic violence. Participant D identified her employer as not being supportive of her:

> I'm always opening Pandora's box...the box has to be opened somewhere...I know you then have to pick up the pieces... we have to talk... it takes time and I am not letting her (the patient) go until I know she is safe...

Participant E brought up her 'time constraints' with patients resulting in not knowing the patients' psychiatric history before a gynecological exam, stating, "It's important to know what their psych history is because they may see you as an abuser also...time does not always allow a review of the chart and she may not have been

seeing me regularly..." Participant D spoke of an abuse question being on the physical form. If it was not there she said, "I don't know that I would ask about it (domestic violence)".

The need for privacy in order to screen patients was identified by Participant D. Her current practice setting did provide for privacy, but in a previous practice, there were problems with the physical layout. Participant E identified a lack of resources and referrals that were readily available for patients when they disclose abuse ..."you have to have a list of things that you can offer them... It's not like in our mothers' day when they were probably given a Valium prescription...Local affordable female counselors, lawyers and safe shelters are what's needed..." Participant D echoed the need for safe shelter referrals..."sometimes a patient will come back and tell me horror stories about the shelter they stayed at...it makes me very hesitant to refer to that shelter again."

Identified barriers to effective domestic violence screening in the primary care setting were:

- Lack of support from non-nurse colleagues
- Time constraints to screen and to know the patient's history
- Lack of an easily accessible list of domestic violence resources and referrals for patients that are safe
- Abuse questions not on the physical exam form
- Lack of privacy with regard to the physical layout of the setting

One barrier was raised in Focus Group #2 that was similar to the answer to question #20 from the survey regarding important information to know about domestic violence. Resources and referrals were frequently noted as needed information

regarding domestic violence (from the answer to question #20) on the survey and were also discussed in Focus Group #2. Time constraints, lack of support of colleagues, privacy issues, and the abuse questions not being on a form were not mentioned in any of the survey responses but were identified in the review of the literature found in Chapter II. All of these themes were able to be incorporated by the researcher into phase two of the research.

Research Question #2. What facilitates effective screening for domestic violence by nurses in the environment of primary care settings? The participants were able to identify facilitators in the environment in their primary care settings for effective screening of domestic violence. Participant E identified educational literature (not resources) about domestic violence being in the rest rooms in her practice setting as a facilitator, in addition to having many female providers (and all support staff being women). "Abused women, I think are more likely to trust a female provider than a male...they can feel more free about things," added Participant E. Participant D agreed with Participant E about female providers being helpful to patients with abuse issues.

Participant D had her own list of domestic violence counselors and attorneys that she utilized for patients who revealed their abuse situations to her. This participant also felt having the questions about abuse on the physical exam form was a facilitator for her to ask about domestic violence, at least on an initial visit with her patients. She was quoted earlier regarding the lack of knowledge about 'what would happen' if the abuse questions were not on the form.

When asked about additional ideas they may have, the two participants expressed concern about their own coworkers experiencing domestic violence. Both participants were exposed in the past to a nurse (in Participant E's experience) and a medical assistant (in Participant D's experience) that they worked with each day, as being victims of domestic violence. Each participant felt that it was important as providers to be aware that domestic violence can strike providers just as breast cancer and diabetes.

The identified facilitators in the environment for effective screening of domestic violence were:

- Educational literature about domestic violence available in rest rooms
- Female providers for female patients
- Abuse questions on the physical form
- A list of resources and referrals for help with domestic violence that are reliable and easily accessible
- Awareness of coworkers' experiencing domestic violence

The facilitators identified in focus group # 2 were included in the researcher's intervention program. Although the issue of female provider availability was not part of the main content areas, it was discussed during the educational program. Participant E's practice setting had three male providers and three female providers, while Participant D worked with all female providers.

Inter-Focus Group Analysis

Two focus groups were conducted in this research study. Although the initial intent was to have three focus groups, the committee agreed with this researcher that knowledge saturation had occurred within the two groups. The purpose of the focus

groups was to enlighten this researcher as to the barriers to and facilitators for domestic violence screening in the primary care setting by nurses, in order to best inform the development of the educational program to be delivered to nurses in a primary care practice. The focus group data supplemented the content of two already established domestic violence educational programs that the researcher utilized for the intervention, which were discussed in Chapter III and in the survey analysis. The data from the focus groups was added to the development of the intervention in order to adapt it specifically to the primary care setting, thereby enhancing the content.

In both focus groups, time availability to screen female patients for domestic violence was seen as a barrier. Some practices had more time with patients than other practices and some of the participants did not mind if their schedule was running late. However, they all acknowledged that time, especially for a positive screen was a problem. Upon further probing, time for a positive screen meant finding appropriate resources and referrals for the patient, and creating a safety plan. Not having a list of easily accessible referrals and resources or knowing local resources and referrals was seen as another barrier by participants in both focus groups. This multifaceted barrier was addressed through the development (by the researcher) of a detailed, current and exhaustive list of referrals and resources in southeastern Massachusetts that could be utilized with a positive (or possible) screen, and the inclusion of role playing in the educational program.

Language barriers between patients and providers was raised in Focus Group #1. With further inquiry this barrier was somewhat related to the lack of knowledge of resources and referrals. Information on resources and referrals, and environmental

facilitators in English, Spanish, Vietnamese, & Russian, were provided in the educational program. An agency's hotline number that had interpreters available in 40 languages was also provided on the resource list developed by this researcher.

The lack of the questions being on the form was seen as a barrier in the practices of three participants. Two other participants stated that the questions were already on the physical exam forms in their practices, and saw this as a facilitator. Another environmental facilitator, a chart stamp prompt for domestic violence screening, alleviated the problem of not having the abuse question on the pre-printed physical exam forms already in use in the practices. Lack of support of non-nurse colleagues was identified as a barrier in one focus group. This barrier was addressed in the educational program in the area of common misconceptions, prevalence of domestic violence and medical-legal aspects.

The barriers, lack of social supports and the patient's own denial (that she was in an abusive relationship), were seen as most difficult by the focus group participants. It was this researcher's belief that as the participants became more knowledgeable of the dynamics of domestic violence, local resources, and routinely screened their female patients, these barriers would decrease over time. Providers would become more experienced and more understanding of these patients' circumstances.

Not having female providers for all female patients and the lack of privacy in the physical layout in one of the practice settings were difficult barriers as they were part of the infrastructure. However, in the groups themselves, participants gave suggestions about what could be done in those instances (i.e., make follow-up

appointments with a female provider, utilizing exam rooms furthest away from the office and lunchroom areas).

Many of the facilitators raised in both focus groups became the key to resolving the barriers. Having abuse questions on the history forms, use of palm cards in rest rooms, domestic violence educational pamphlets in the waiting area, domestic violence awareness posters or information sheets in the exam rooms, and a list of local domestic violence resources and referrals were all facilitators that could remedy some of the barriers raised in the focus groups and were included in the intervention.

Stages Three and Four

The Development of a Domestic Violence Educational Program and The Domestic Violence Educational Program for Nurses in a Primary Care Setting

One practice setting was chosen as the site for the intervention to occur. Nurses in the chosen setting had to be willing to have the program at their workplace during their lunch hour for three consecutive days with all the nurses participating on each day. This researcher decided to start by choosing a larger practice, as the benefits of a successful program would reach a larger patient population. Two nurse practitioners and four nurses in a large pediatric practice were invited to participate in the program. This practice also had four pediatricians and a physician's assistant on staff and an office support team of nine members. The pediatric practice nursing staff agreed to three one-hour lunch sessions on three consecutive days at the practice site. Lunch and continuing education credits were to be provided to the nurses and nurse practitioners. The dates were set for April, 2004, with four nurses and one nurse practitioner planning to attend. The second nurse practitioner went on maternity leave unexpectedly before the program could occur.

The program began with obtaining written informed consent from each participant (Appendix C). On the first day, the participants were each given a packet of information on the domestic violence intervention program designed by this researcher, which included the needs, suggestions and concerns from the surveys and focus groups. The design of the program was based on the content of the PVS (Physician's for a Violent-Free Society, 2002) Abuse Assessment Response Course and the AWOHNN (Association of Women's Health, Obstetric, and Neonatal Nurses, 2003) Universal Screening for Domestic Violence, 2nd edition, and adapted for the pediatric setting. Both programs permitted reproduction of their content for educational purposes of health care professionals in various settings.

The content of the program was presented in a multi-media format, accompanied by a 17-paged packet for each participant. The packet content included eleven subheadings: 1) Definition of Domestic Violence, 2) Prevalence of Domestic Violence, 3) Dynamics of Domestic Violence, 4) Impact on Health & Children, 5) Common Misconceptions, 6) Barriers to Responding, 7) Common Presentations, 8) Screening Techniques & Guidelines including Role Playing, 9) Clinical Management with Referrals & Resources, 10) Documentation and 11) Medical-Legal Aspects.

Within each subheading, the content specific to the area was reviewed in detail. Themes from the survey and focus groups were included under several subheadings as appropriate. On the third day, the environmental facilitators were given to the participants. Educational strategies included didactic presentation, a video, role plays, and question and answer periods.

The theme 'lack of support of non-nurse colleagues' was included under the

subheadings, Prevalence and Dynamics of Domestic Violence and Common Misconceptions. Coworkers may render their support when they are made aware by their nurse participant colleagues of the cycle of domestic violence, its prevalence, and stages of change experienced by victims before they are able to leave the abusive relationship. Also under Dynamics denial that abuse may exist among female patients was discussed.

Under Screening Techniques and Guidelines, time availability as well as asking the right screening questions (who, how, when, where) were discussed and practiced in active role playing between participants. Under Clinical Management. Safety Planning, topics included: a list of easily accessible current local (and national) resources and referrals, resources for interpreters for non-English speaking patients, and how to obtain assistance with social supports in the community. Information related to special populations such as domestic violence among co-workers and among immigrants was integrated.

On the last day of the program, the environmental facilitators were given to the participants. These facilitators included domestic violence awareness posters, domestic violence palm cards, domestic violence buttons, domestic violence literature, a stamp prompt for charting, and practitioner reference cards. Suggestions from the focus groups addressing environmental facilitators were: the stamp prompt in the medical record for domestic violence to remind nurses to ask the patient about domestic violence, the educational literature in the waiting areas, the palm cards for the restrooms and the posters in the exam rooms. The palm cards, literature and posters were available in other languages (Spanish, Vietnamese & Russian) to address

the issue of language barriers. In addition to the above environmental facilitators, many pamphlets and flyers from the local domestic violence counseling centers, shelters, advocacy programs, and the health resource center were supplied to the practice site by the researcher.

All five participants were actively engaged during the program. They asked appropriate questions for clarification or for more details on particular subject areas. They were quite engaged with the researcher as well as each other, with regard to experiences they had had with victims of domestic violence in their past. The participants felt much more knowledgeable at the end of the program as evidenced by their role plays (as victims and nurses) and their comments.

The role plays were quite dynamic. The nurses were actively involved in practicing different potential situations that might occur in their practice. This researcher was surprised to see the how quickly the nurses had absorbed the material presented in the program and act out the scenarios without hesitation. The nurses were supportive of each other as they took on roles of the screening nurse, colleague-nurse, potential victim and potential victim's child. They acknowledged that practicing screening techniques and reviewing interventions for a positive/probable screen with fellow nurses had increased their confidence and level of comfort to screen with their patients.

Some of their comments during the program indicated they were surprised by the statistics of lifetime prevalence of domestic violence and the potential lethality of a given situation. The participants were also unaware of the increased danger a victim and her children when she/they decide to leave, the increased risk when a victim is

pregnant, and how the incidence of violence and homicide increases with domestic violence. At the end of program, the participants shared their gratitude with the researcher for both the educational program and the environmental facilitators. They verbalized that they were more comfortable with their knowledge of domestic violence and consequently felt better prepared to screen and intervene with their female patients.

Stage Five

The Post Intervention Interviews

After the intervention (the domestic violence educational program) was completed, the five participants at the selected pediatric practice site were individually interviewed two weeks later by the research assistant. The research assistant utilized the Post-Intervention Interview Guide designed by this researcher (Appendix G). Each participant was interviewed in an office at the practice site, where privacy was ensured for the entire interview. Each interview lasted one half hour and occurred just before or during office hours. The answers were then transcribed onto a disk for the researcher to analyze.

All of the participants were female, white, married and had an annual total household income of $80,000 or more. Each participant had completed the survey distributed by this researcher in Stage One. In addition, two of the participants had attended the focus group led by the researcher in January 2004. To ensure confidentiality of the participants, they will be identified by using the names of Judy, Sally, Nancy, Kathy and Terry.

Judy was a registered nurse with an associate degree who had worked at her present position for eighteen years in the pediatric practice. She stated that the educational program increased her knowledge of domestic violence as well as her level of comfort in screening her patients. Judy identified several changes in her practice as a result of this program. She now screens for domestic violence with all female patients. Her level of comfort in following up with identified victims of domestic violence has increased. She now feels better prepared to intervene with patients who screen positive by being able to discuss options with them and provide them with resource information. Judy also stated that she and her colleagues were now more alert to cues and signs of domestic violence. This practice setting had some environmental facilitators in place after the educational program (domestic violence awareness posters on the walls and domestic violence pamphlets in patient areas).

Sally, the second participant, was an associate degree prepared registered nurse who had been working in her current position for eight years. She stated she had not changed her practice to screen for domestic violence as she "always had practices in place to screen for it". She did comment that her awareness of the importance of screening female patients had been increased. She stated that she "was not looking as hard as I am now" since the educational program. Sally believed that the posters that were up on the walls in the waiting room facilitated domestic violence screening.

Nancy, the third participant, was a master's prepared nurse and certified as a pediatric nurse practitioner. She had been a nurse practitioner in this practice for seven years. Since the educational program, Nancy incorporated screening for all of her female patients. She noted that the patients were very receptive and the nurses had a

positive response to this change in her practice. Nancy believed that having posters and pamphlets visible and available had facilitated domestic violence screening. This was a major change in this setting.

Kathy, the fourth participant, was a diploma prepared registered nurse who had worked in her position at the pediatric practice for seventeen and a half years. Since the educational program, she had changed her practice to include screening for domestic violence stating, "I ask more appropriate questions in regards to domestic violence". Specifically, the program made her more aware of the immensity of the problem and the warning signs of domestic violence. Kathy also stated that she was more comfortable discussing this issue with her patients commenting, "It is a more open issue". As a result of being able to converse as a group of nurses about warning signs during the educational program, Kathy believes that the nurses in her practice are much more informed about domestic violence and are committed to make changes in their practice.

Terry, the last participant that was interviewed, was a bachelor's prepared registered nurse who had only been working at the pediatric practice for one year. She had been working on a psychiatric inpatient unit for eight years prior to this position. Terry also stated that her practice had changed and now includes domestic violence screening. She became more informed by the program and developed greater sensitivity for looking at cues, "I have tuned into how mom's look, cues that are given. I'm more comfortable and receptive to asking questions about domestic violence." Since she was able to share her experiences as a psychiatric nurse with her colleagues during the educational program, she believes the nursing staff are now more open with

each other. "We talk more and share what we know ". Terry believes that the posters in the waiting room and the rest room are positive environmental facilitators. "It shows we are accepting and nonjudgmental to patients."

At the post interviews, all participants stated that none of their female patients had told them that they were victims of domestic violence and all had a negative screen.

Analysis of the Findings from the Post Intervention Interviews

The findings concerning the third and fourth research questions regarding the impact of the intervention were examined by the researcher in reference to the theoretical framework of the study, Fishbein and Ajzen's Theory of Reasoned Action (TRA) and Ajzen's Theory of Planned Behavior (TPB). The post intervention interview findings were utilized to evaluate the impact of the intervention. Research Question #3 is addressed first, followed by Research Question #4.

Research Question #3. What is the impact of a domestic violence educational program intervention delivered to nurses in primary care settings on decreasing the barriers identified by the nurses to screening for domestic violence? In the TRA, there are two determinants of a person's intention to change behavior, attitude toward the behavior and subjective norm. Data gathered from the post intervention interviews indicated a positive change in all five of the participants' attitude toward screening for domestic violence. Most of the barriers to screening, identified in the surveys and focus groups, were incorporated in the intervention by this researcher. The identified barriers to screening including lack of knowledge of the local domestic violence resources, screening techniques, written materials to provide patients, language

barriers and time needed to screen were decreased. Comments from the participants such as, "You don't know unless you ask..." "It has heightened my awareness... You leave the door open"... "I ask more appropriate questions" were interpreted as positive in attitude toward changes regarding screening for domestic violence.

All participants felt more knowledgeable about domestic violence and were more aware of the prevalence and incidence after they participated in the program. As a result, their beliefs about screening had changed. One of the assumptions of the TRA is that attitudes are a function of beliefs. The favorable attitude of the participants toward screening for domestic violence was interpreted by this researcher as a change in their beliefs regarding the outcome of the behavior of screening.

One participant described an increase in her level of comfort in being able to talk to female patients about domestic violence. Another participant stated that "knowledge of the high incidence rate" contributed to a change in her practice. She now asks, female patients over 14 years old and their mothers, about domestic violence during their annual physical exams.

Four participants ardently verbalized their intentions to incorporate their knowledge of domestic violence and interventions into their practice to this researcher at the intervention program, and to the research assistant in the post intervention interviews. One participant stated that she "always had practices in place to screen for domestic violence." However, she did indicate that she did have a heightened awareness of the importance of screening as a result of the educational program.

In the post intervention interviews, subjective norm, the other determinant of a person's intention in the TRA, was addressed by asking the effect of changing the

participants' practice to screen for domestic violence on patients and the other nurses in the practice. Two participants spoke of the effect screening had on patients in their practice. One participant noted that she believed her patients would be receptive to screening since she could now provide counseling and resource information for assistance. One participant said it was "too early to tell" if there was an effect on patients, but she was routinely screening patients.

Four participants stated that screening patients for domestic violence had a positive impact on the other nurses in their practice. Three participants stated that their colleagues were more knowledgeable and alert to cues and signs of domestic violence. Cues and signs such as bathing suit injuries, spotty alopecia and delays in seeking care were new to the participants. Another participant stated that she and the other nurses shared their experiences with victims more often than before routine screening began. The positive effects on each other of, changing their practice to screen for domestic violence, speaks to the determinant of subjective norm and intention in the TRA.

Research Question #4. Does a domestic violence educational program intervention increase the identification and intervention of domestic violence by nurses in a primary care setting as compared to pre intervention conditions? At the time of the post intervention interviews, the nurses were screening for domestic violence but no women screened positive or probable. However, it was clear from the interview findings that the participants had incorporated the knowledge provided in the educational program into changes in their practice setting. Four participants stated in the post intervention interviews that they had changed their practice to incorporate routine screening for domestic violence.

The participants made changes in their environment that would be more conducive to screening for domestic violence issues. The posters, buttons, palm cards and educational pamphlets about domestic violence were viewed by the participants as additional facilitators in the environment for screening and intervention. During the interviews at the practice site, the research assistant noted posters in the waiting area and some examination rooms, and saw domestic violence pamphlets with the other educational materials on display in patient areas.

One of the participants was delegated by the others to speak with the support staff to stamp the patient progress note forms with the domestic violence prompt. All of the participants indicated that the prompt in the chart would be a helpful reminder to screen for domestic violence. The palm cards were not in the rest rooms at the time of the interviews, as the participants wanted the cards in a plastic box on the wall, so they would not get damaged. A box was ordered for the cards. The resource list from the intervention program was being copied for all of the examination rooms.

As an aside, this researcher went to this setting with one of her children four weeks after the intervention and noticed domestic violence awareness posters on the walls in the waiting area, domestic violence literature with the other educational pamphlets in the waiting area, and the resource lists in the examination rooms. This again indicated substantial changes had been maintained one month after the program.

In the TPB, the exogenous variable of perceived behavioral control assumes that if resources and opportunities to perform a given behavior are present, the individual will have perceived behavioral control, which effects intention and behavior. In this study, the educational program provided knowledge about domestic

violence that was necessary for routine screening. The resources included a list of local agencies that provide counseling, support and legal assistance and the environmental facilitators.

Role playing during the educational program provided opportunities to practice routine screening and intervening with female patients who screened positive. This educational strategy served to increase the nurses' level of comfort in screening and intervening. Based on the statements of the participants during the educational program, it was clear that all five nurses had the intention to change their behavior. Data from the post interviews noted that a change in behavior related to screening for domestic violence had occurred. Since none of the patients screened positive for domestic violence prior to the post interviews, the nurses did not have the opportunity to intervene. However, given the positive changes that had already occurred and the stated increased level of confidence in being able to intervene, this researcher believes that intervening will occur when patients do screen positive.

Using the figures for the TRA and TPB illustrates the results of the study. Figure 3 depicts the TRA and Figure 4 depicts the TPB for this study (p.89).

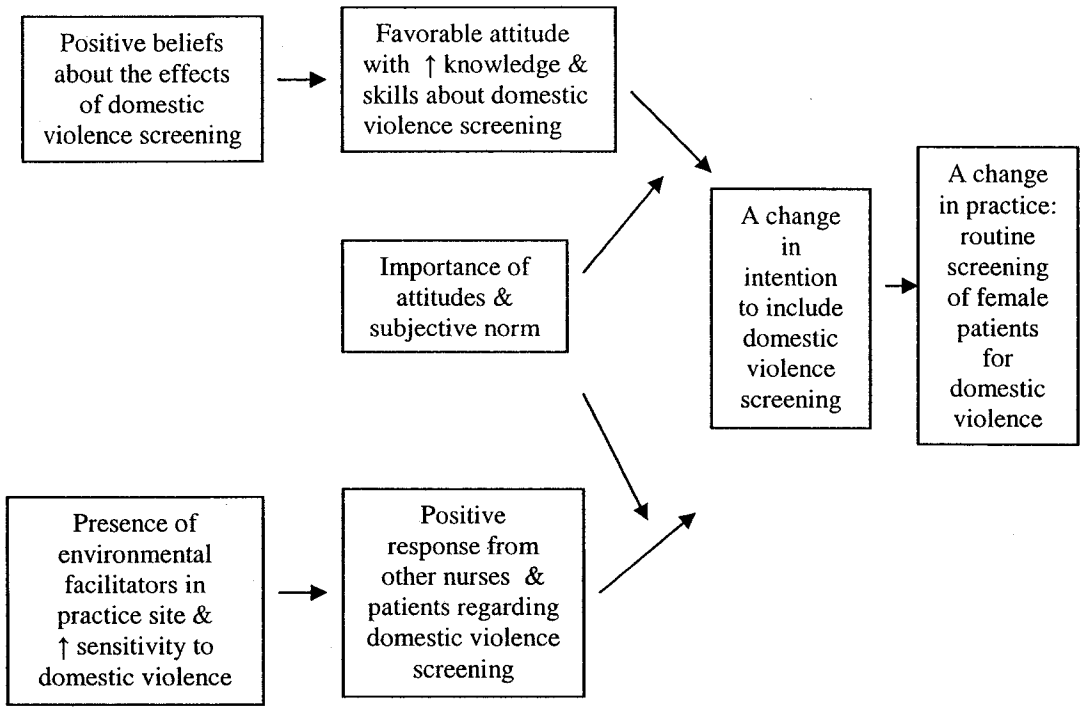

Figure 3 - Results of the study utilizing TRA framework

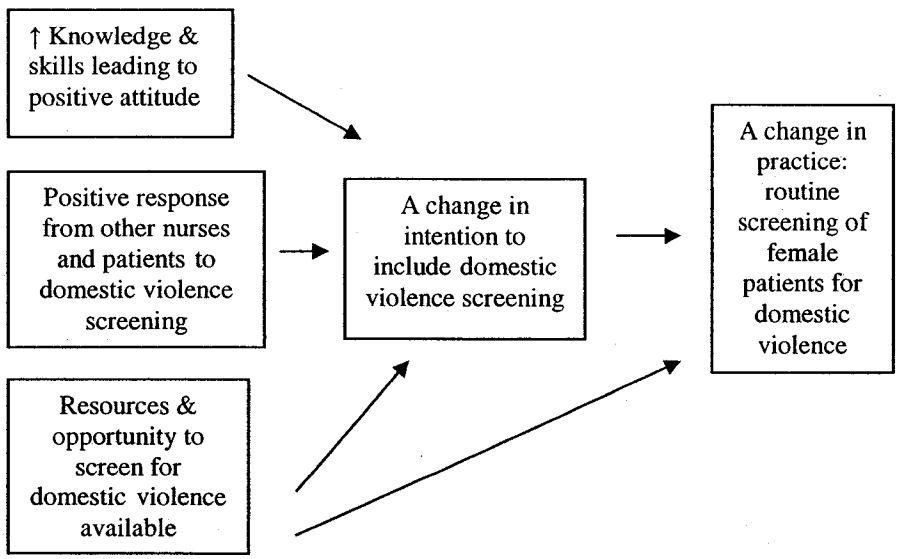

Figure 4 - Results of the study using the TPB framework

CHAPTER V

Conclusions and Implications

Main Findings

This study explored the effects of a domestic violence educational program on outpatient primary care nurses' practice. Five stages were undertaken to complete this study. In Stage One, surveys were distributed to 35 nurses in primary care practice settings to ascertain their knowledge of domestic violence and their domestic violence screening practices. Data from the surveys provided important information that nurses need to have in order to effectively screen for domestic violence with their female patients. This information included signs and symptoms of domestic violence, asking the right screening questions, techniques of asking screening questions, knowledge of the local resources and referrals such as shelters and counselors, domestic violence protocols for the office setting, outcomes for those who receive help and effects of child and adolescent exposure to domestic violence in the home.

In Stage Two, focus groups were utilized to explore nurses' identification of barriers to and facilitators for screening in the primary care setting, and interventions utilized with victims in their clinical practice. The barriers identified in the focus groups were: lack of knowledge of local resources and referrals, time to screen female patients for domestic violence, language barriers between patients and providers, lack of domestic violence screening questions on examination forms, lack of support from non-nurse colleagues, the patients' denial of being in an abusive relationship, having male providers, and lack of privacy in the practice setting. The facilitators identified in the focus groups were: having abuse questions on the history forms, having domestic

violence educational pamphlets in the waiting area, having domestic violence awareness posters or information sheets in the exam rooms, the use of palm cards in rest rooms and having a list of local domestic violence resources and referrals.

In Stage Three, two existing domestic violence programs were modified using the data from the surveys and focus groups to create a domestic violence education program (the intervention) tailored for nurses in an outpatient primary care setting. In Stage Four, five nurses in a pediatric primary care setting in southeastern Massachusetts participated in this modified educational program (the intervention). The program was conducted over a three-day period for a total of four hours. In Stage Five, the nurses were interviewed, two weeks after the intervention, to determine if they had made changes in their clinical practice as a result of the program. The five participants had a change in intention, leading to a change in their screening practices.

From the perspective of the Theory of Reasoned Action, (Fishbein & Ajzen, 1975; Ajzen & Fishbein, 1980) changes in the nurses' attitudes and in the subjective norm (positive responses from other nurses and patients in their practice setting regarding domestic violence screening and intervention) paved the way for the change in intention and subsequently, in practice. The additional variable of perceived behavioral control in the Theory of Planned Behavior (having the resources and opportunity to screen for domestic violence available to the nurse participants) also emerged, contributing to the nurses' changes in intention and practice.

Methodological Implications

The survey and focus groups proved to be very fruitful. The survey served several purposes: it provided a baseline of nurses' knowledge of domestic violence in

primary care settings, a nursing needs assessment for screening and intervention in primary care settings, and a guide for the direction of the focus groups. The focus groups complemented the survey data by providing 'rich details' of the barriers to and facilitators for domestic violence screening and intervention by nurses in primary care settings. Providing the opportunity for groups of nurses from a variety of primary care practice settings to discuss their experiences with patients regarding domestic violence contributed valuable information that was incorporated in the educational program. It also reinforced the survey data.

Although the use of the survey and focus groups were advantageous, several problems occurred. The return rate of the survey was moderate at 63%, (n = 22). While 63% return rate is good for mail surveys, if a larger sample of nurses were initially mailed the survey, a larger sample may have been obtained. A larger sample may have increased the frequency of responses for the results and/or revealed other areas of need by nurses to screen for domestic violence. Given the final sample of 22, the generalization of the study results are limited. However, the repetition of topics revealed in the focus groups lend support to the survey findings.

The focus groups were more difficult to arrange than anticipated. In retrospect, the time of year when they were to begin (December) was a deterrent to getting the groups started. The prospective focus group participants had varied hours of availability and many responsibilities outside of their employment. Three confirmed participants were unable to attend at the last minute causing the cancellation of one group and a small participation in another group.

To achieve a level of homogeneity in the focus groups, this researcher had to find participants who were employed in outpatient primary care settings and were willing to commit to a discussion on domestic violence issues. It was difficult to reach the ideal number of three groups, each with five participants, and to have diversity among participants. The group effect within the data had to be identified in the analysis to limit concerns of bias, conflict, and inequitable participation. This researcher/facilitator's experience and skill conducting the focus groups limited these potential difficulties. In each of the focus groups, the response by the participants was very positive.

The educational program was evaluated by the nurse participants on feedback forms (required for continuing education credit from AWHONN) as highly effective. Comments from the participants under the section, 'Other Comments and Suggestions' included "comprehensive... a peek at reality... increased my awareness.... good information". One participant suggested extending the program another hour. Negotiating a longer time allotment for future programs will be given consideration. In preparation for incorporating screening into their practice, the role playing segment of the program was viewed as valuable by the nurses as they began to become comfortable with the screening process and utilization of the resource and referral list. " It helped to practice using this new information (domestic violence program) on each other (nurses) first, before we use it with patients... it was fun to be an actress, too."

The post intervention interviews were conducted utilizing a semi-structured guide approved by the researcher's major professor. The research assistant completed the interviews at the practice site before or during office hours. The participants chose

to meet at their practice setting, rather than another convenient location. Although privacy was ensured for the participants, they may have been rushed by their need to start or return to their work responsibilities. This could have interfered with elaborating on their responses to the interview questions.

Future Directions for Nursing Knowledge Development and Research

To this researcher's knowledge, this is the first study that has explored screening practices for domestic violence by nurses in primary care practices. The barriers to and facilitators for domestic violence screening and intervention by nurses were also discovered. The results of this study indicate a positive impact of an educational program on the screening practices of nurses in primary care settings in the short-term. It will be important to know whether the improvement in domestic violence screening can be maintained for longer periods of time (6 months, 1 year), and how the program participants did when they had a positive case of domestic violence with a female patient.

To date, nursing research has made a significant contribution to the field of domestic violence in the following areas: the effects of domestic violence on women and their children (physical, psychological, and behavioral), abuse during pregnancy (low birth weight, incidence, and late prenatal care), use of screening tools (AAS, the Index of Souse Abuse, and the Danger Assessment instrument), interventions (access to health care, support groups, and counseling), nurses' helpfulness with domestic violence victims (approaches, responses, and professional preferences by victims) and the cultural influences on battering (beating vs. battering and sensitivity with specific populations), (Abbott, Loziol-McLain, & Lowenstein, 1995; Campbell, 1986;

Campbell, Campbell, King, Parker, & Ryan, 1994; Campbell, Kub, Belknap, & Templin, 1997; Hamilton & Coates, 1993; Heise, Pitanguy, & Germain, 1994; Henderson, Sampselle, Mayes, & Oakley, 1992; McCauley et al., 1995; Parker & McFarlane, 1991; Plichta, 1997; Soeken et al., 1998; Tilden, Schmidt, Limandri, Chioda, Garland & Loveless, 1994).

The findings of this study support the need for future research in several areas. Replication of this study with different practice settings would expose more nurses to domestic violence issues with their patient populations and heighten their awareness to this aspect of nursing assessment. Interviews following the educational program at later time points, such as 6 weeks, may provide information about the continuous impact of an educational program and any further needs nurses may have discovered in regard to screening and intervention. Studies that examine intervention practices may assist nurses to be more comfortable using their resources and referrals for domestic violence victims. Knowing the outcome of utilizing particular resources may be an effective catalyst for nurses to adopt routine screening practices. Outcome studies of identified victims by nurses in the primary care setting may further assist nurses with the understanding of the importance of routine screening and intervention.

The findings of this study contribute to the practice domain in Kim's typology of nursing knowledge (1987, 2000). Nursing assessment and enactment are concepts in the practice domain. Screening and intervention of domestic violence illustrate these concepts. Developing a theoretical link between nurses' assessment of patients for domestic violence, and their subsequent interventions, may lead to a middle range theory of nursing assessment.

Implications for Nursing Practice

Violence towards women remains alarmingly high. Two of five women have experienced some type of abuse or violence in their lifetime. It is estimated that between one to three million women per year are victims of domestic violence (Commonwealth Fund, 1999). As a result, it is likely that nurses in primary care settings will be in a position to screen for domestic violence and provide critical interventions for women who screen positive or probable.

On the primary prevention level, nurses can routinely screen all female patients over 14 years old. At the secondary prevention level, nurses can educate patients about domestic violence and leave the door open for those patients who are not ready to disclose their abusive relationship. Finally at the tertiary level, when a victim answers positively to domestic violence screening, the nurse can intervene by creating a safety plan, and providing information about resources and referrals.

Nurses are in a unique position to screen for domestic violence and intervene with victims. Providing thorough assessments of the whole patient that includes domestic violence screening along with the other types of screening that are routinely performed, such as smoking habits, sleeping and eating habits, exercise routines, stress level, seat belt usage, mammography and pap smears, lets women know that their safety is as important as any other aspect of their life to nursing and other health care providers. It is important for nurses to recognize that domestic violence victims can appear in any practice setting and no setting is immune to it.

Implications for Nursing Education

This study points to the necessity of educating nursing students and practicing nurses in all practice settings about domestic violence. When asked about domestic violence education on the survey in Stage One, only 50% of the sample had domestic violence content in their curricula and 32% had attended a domestic violence continuing education program. Seventy three percent of nurses who had received education about domestic violence acknowledged that it influenced their practice.

Nurses can have a significant role in decreasing the negative sequalae of domestic violence. Given the high incidence of domestic violence, nursing faculty need to include content related to domestic violence in undergraduate curricula. With this knowledge, combined with practical experiences in clinical settings, nurses' confidence and comfort to screen for and intervene with victims may increase.

This study explored the effect of a domestic violence educational program (the intervention) on the screening practices of five nurses in a pediatric primary care setting. The findings demonstrated positive outcomes in the screening practices of the nurses following the intervention. Future research examining the long-term impact of an educational program on nursing practice is recommended.

As more nurses become committed to screening for domestic violence, more victims will find the support and assistance they need to eventually end the cycle of violence in their lives. In turn, the negative sequalae of domestic violence will decrease and future generations may be spared.

APPENDICES

Appendix A

University of Rhode Island
College of Nursing
Kingston, RI 02881

November , 2003

Dear Nurse Participant:

As you know, domestic violence is a recognized public health problem in the United States with 31% of women being victims at some point in their lives. As a practicing psychiatric clinical nurse specialist for 19 years, I have seen many women and children who have been exposed to domestic violence directly as victims, or indirectly as witnesses to domestic violence. As a result of these experiences, I have chosen to become active in helping to stop domestic violence. I am presently pursuing my doctorate in nursing and for my dissertation, I have selected domestic violence screening in primary care settings as my focus.

Enclosed please find a brief questionnaire that is being distributed to a small sample of nurses in outpatient primary care practices of southeastern Massachusetts. It concerns issues related to nursing practice and domestic violence screening of female patients in primary care settings. Your input will be very valuable to an educational program being modified for the outpatient primary care setting. This program will assist nurses to develop a better understanding of domestic violence as well as explore ways that they can be helpful in responding to the needs of these women.

In order to improve the care of this underserved population, I need your help. It is important that each questionnaire is completed and returned in the envelope provided. You may be assured of complete confidentiality. Your name will not appear on the questionnaire. The completion of this questionnaire indicates your consent.

I would be happy to answer any questions you may have about this study. Please feel free to call me at 508-427-6911, option #2. Please note that your participation in this research project is voluntary. Thank you very much for your assistance.

Sincerely,

Karen Hetzel, R.N.,C.S.
Principal Investigator

Appendix A continued

University of Rhode Island
College of Nursing
Kingston, RI 02881

Nurses in Primary Care Practice and Domestic Violence

Please answer the following initial questions about yourself. All information will be utilized for comparisons only and not for identification. Please check the appropriate space for each item.

1. Age: <25 yrs___ 26-35 yrs___ 36-50 yrs___ >51 yrs____

2. Gender: F___ M___

3. Race: African-American/Black____ Native American____ White____
Asian-American____ Other_____ (please specify)

4. Marital status: Single ___ Married __ Divorced ___Widowed __

5. Yearly Total Household Income: <$10,000 ____
(all members of household) $10,000 -- 19,999 ____
$20,000 – 39,999 ____
$40,000 – 59,999 ____
$60,000 – 79,999 ____
$80,000 or more ____

6. Highest Nursing Degree Completed:
LPN__ Diploma__ AD__ BSN __ MSN__
NP__ RN,CS__ Midwife__

7. Years as a practicing nurse: <5 yrs___ 6-10 yrs___ 11-15 yrs__
16-25 yrs___ >25 yrs___

8. Type of practice at present position: Pediatrics ____ Family Practice ____
Internal Medicine_____ OB/GYN____ Other_____ (please specify)

9. Length of time employed in present position: ___yrs. ___mos.

10. Can you please describe your responsibilities regarding patient assessment ? (ex. taking vital signs, asking screening questions such as smoking or alcohol use, taking an initial history)

Please continue to next page>>>>

Domestic violence is defined as violent or controlling behavior by a person toward an intimate partner. It can take the form of physical assault, sexual assault, emotional attacks or economic control. Approximately 95% of domestic violence victims are women. With this definition in mind, please answer the following questions.

11. Is it possible for you to estimate what percentage of female patients in the practice where you are currently employed, are victims of domestic violence ?

yes_____ no____

11a. **If yes, please specify percentage_____%**

12. As you reflect on your practice, about how many female patients have you suspected were/are victims of domestic violence in your practice setting ?

_____ **(please specify number)**

13. About how many female patients in your practice setting have **told** you that they were victims of domestic violence without being asked ?

_____ **(please specify number)**

14. Have you had the opportunity to ever ask female patients about any past or present-day violence in their lives in your practice setting ?

yes_____ no_____

14a. **If yes, please specify number**_____

15. How many female patients that you asked about violence, past or present, in their lives ? **(please specify number in each option)**

____ screened positive (patient acknowledged being a victim)
____ screened negative (no suspicion of patient being a victim)
____ screened possible (patient does not acknowledge being a victim, but patient injuries/history suggest abuse)

16. Have you had the opportunity to intervene with those victims that screened positive or possible ? yes_____ no_____

16a. **If yes, what interventions did you provide ?**

17. Have you ever worked anywhere, where screening measures for domestic violence were in place? yes ____ no ____

17a. **If yes, please specify type of facility(s) & practice area(s)**

Next page>>>>

18. In your nursing program(s), did you have any domestic violence education in the curriculum ? yes____ no_____

18a. **If yes, please describe specific content**

19. Have you ever attended a continuing education program on domestic violence ? yes____ no_____

19a. **If yes, please describe specific content**

19b. Did this information influence your practice ? yes_____ no_____

19c. **If yes, please describe how**

20. From your point of view, what information related to domestic violence is important for you to know ?

* * * * * * * * * * * * * * * * * *

Please keep the information below for future reference

A small stipend and light dinner will be provided to those nurses who attend a focus group meeting. If you are interested in attending a focus group meeting (1-1½ hour duration) to discuss issues in ambulatory care nursing practice related to domestic violence, please call XXX-XXX-XXXX (press option #2) to register.

Thank you for your time to complete this survey.

Appendix A Continued

University of Rhode Island
College of Nursing
Kingston, RI 02881

December , 2003

Two weeks ago, a brief questionnaire about your experience with patients and domestic violence was brought to your practice. A small sample of nurses in the southeastern Massachusetts area were selected to participate in the survey of which your practice was chosen.

If you have already completed and returned your questionnaire to me, please accept my sincere thanks. If not, please do so today. I am especially grateful for your help because I believe your responses will assist me to design a useful educational program for nurses in outpatient primary care settings on domestic violence screening.

If you did not receive a questionnaire, or it was misplaced, please call me at XXX-XXX-XXXX and press option 2 if the secretary is not in, and I will get another one in the mail to you today. Please remember, your participation is voluntary.

With sincere thanks,

Karen Hetzel, R.N.,C.S.
Principal Investigator

Appendix B

University of Rhode Island
College of Nursing
Kingston, RI 02881

January , 2003

Participant Name/Address

Thank you for accepting the invitation to attend the domestic violence and ambulatory care discussion at the Olmsted School in North Easton on January .The Olmsted School is located at 101 Lothrop Street. The directions are enclosed I would like you to be my guest for a light dinner which will be begin at 6:00pm. The discussion will follow the meal and end at 8:00pm.

Since I am talking to a limited number of people, the success and quality of our discussion is based on the participation of the people who attend. Because you have accepted my invitation, your attendance at the session is anticipated and will contribute to making the research project a success.

You will be participating with a group of nurses from the southeastern Massachusetts area who work in outpatient primary care settings. We will be discussing issues of domestic violence and the female patient population in your practice setting. Your contributions based on your experiences as a nurse practicing in an outpatient setting with female patients, will be of tremendous assistance to me. At the conclusion of the session, I will be giving you $20.00 to cover your expenses for attending.

If for some reason you find you are not able to attend, please call me to let me know as soon as possible. My phone number is XXX-XXX-XXXX option #2. Please note that your participation is voluntary. You may contact me for any concerns that you may have about this study, or you may contact the office of the Vice Provost for Graduate Studies, Research and Outreach at the University of Rhode Island, Kingston, RI, telephone: (401) 874-4328.

I look forward to seeing you on January .

Sincerely,

Karen Hetzel, R.N.,C.S.

Appendix C

The University of Rhode Island
College of Nursing
Kingston, RI 02881

Domestic Violence Screening by Nurses in the Primary Care Setting

CONSENT FORM FOR RESEARCH

You have been asked to take part in a research project described below. The researcher, Karen Hetzel, R.N.,C.S. will describe the project to you in detail. You should feel free to ask any questions. If you have more questions later, Karen Hetzel, the person mainly responsible for this study, XXX-XXX-XXXX will discuss them with you.

Description of the project:
You have been asked to take part in a study that will look at screening patients for domestic violence in the primary care setting. Because domestic violence is so prevalent in our society, it is important to understand how nurses in primary care settings can adopt routine screening measures for domestic violence into their practice.

What will be done:
If you decide to participate in this study this is what will happen: The researcher will ask you to participate in a focus group with several other nurses. If you agree to participate in this study, Karen will meet with you at a pre-arranged time for a period of no more than two hours. At the focus group, Karen will ask you to respond to specific questions and talk about your experiences with female patients with regard to domestic violence issues. The group will take place at a convenient location such as a hospital or clinic conference room. Karen will ask your permission to tape record the session as it will help her to have an exact copy of the things that are said. In the next phase of the study, you may be asked to participate with other nurses in an educational intervention program on domestic violence at no cost to you. The program will be conducted by Karen with lunch provided, at your work site. A post program interview with a research assistant will follow, at a time convenient for you.

Risks or discomforts:
There are no known physical or emotional risks or discomforts involved if you decide to participate in the study. Your participation in this study will not affect your position at your employment in any way. There is a chance that you might be emotionally upset when recalling an experience with a patient. If this occurs you can contact the researcher for assistance.

Benefits of this study:
Although there will be no direct benefit to you for taking part in this study, the researcher may learn more about screening for domestic violence in the primary care

setting. This knowledge has implications for nursing practice with patients who may be or are victims of domestic violence.

Confidentiality:
Your participation in this study is confidential. The information that you provide will be used for research purposes only, including teaching and publication. You will not be identified by name. All study records, including notes and transcribed focus groups, will not identify you by name and will be kept in a locked file cabinet in the researcher's office for three years. Since audio-tapes have intrinsic value for future research, they will be kept in a locked file cabinet in the researcher's office for three years. Your name will not appear on the audio-tape label. You will be identified by a number assigned by the researcher. This number will appear on the audio-tape label and on the typed interview transcript. The list of names and assigned numbers will be kept in a locked file cabinet separate from the audio-tapes and transcripts. All members of the focus group will be asked to keep confidential all the information shared in the group.

Decision to quit at any time:
The decision to take part in this study is up to you. You do not have to participate. If you decide to take part in this study you can quit at any time. Whatever you decide will in no way penalize you. If you wish to quit, simply inform Karen Hetzel, R.N.C.S. at XXX-XXX-XXXX of your decision.

Rights and complaints:
If you are not satisfied with the way this study is performed, you may discuss your complaints with Karen Hetzel R.N.,C.S. or with her major professor, Margaret McGrath, DNSc, RN, University of Rhode Island College of Nursing, at (401) 874-5326, anonymously if you choose. In addition, you may contact the office of the Vice Provost for Graduate Studies, Research and Outreach, 70 Lower College Road, Suite 2, University of Rhode Island, Kingston, RI, telephone: (401) 874-4328.

You have read the Consent Form. Your questions have been answered. Your signature on this form means that you understand the information and you agree to participate in this study.

_____	_____
Signature of Participant	Signature of Researcher
_____	_____
Typed/Printed Name	Typed/Printed Name
_____	_____
Date	Date

Appendix D

Focus Group Demographic Data Sheet

(To be given to focus group participants before group starts)

To further help with the study, please answer the following questions about yourself. All information will be utilized for comparisons only and not for identification.

1. Age: <25 yrs___ 26-35 yrs___ 36-50 yrs___ >51 yrs____

2. Gender: F___ M___

3. Race: African-American/Black____ Native American____ White____
Asian-American____ Other_____(please specify)

4. Marital status: Single ___ Married ___ Divorced ___ Widowed ___

5. Yearly Total Household Income: <$10,000 ____ $40,000 – 59,999____
(all members of household) $10,000 - 19,999 ____ $60,000 – 79,999____
$20,000 – 39,999 ____ $80,000 or more ____

6. Highest Nursing Degree Completed:
LPN__ Diploma__ AD__ BSN __ MSN__ NP__
RN,CS__ CNM__

7. Years as a practicing nurse: <5 yrs___ 6-10 yrs___ 11-15 yrs___ 16-25 yrs___
>25 yrs___

8. Type of practice at present position: Pediatrics _____ Family Practice _____
Internal Medicine_____ OB/GYN_____
Other_____(please specify)

9. Length of time employed in present position: ___yrs. ___mos.

Thank you for your time to complete this form.

Appendix E

Job Description of Research Assistant

- Together with the principal investigator, arrange for the food and beverages for each focus group session.
- Arrange the room for seating at the focus groups.
- Together with the principal investigator, be responsible for the equipment for the focus groups – ensure that needed equipment is available, set up and working. This includes recorders, microphone, tapes, handouts, name tents, markers, etc.
- Welcome participants as they arrive for the focus groups– make participants feel welcome and comfortable.
- Sit in a designated location – outside the circle, opposite the moderator and closest to the door.
- Take observational notes throughout entire focus groups.
- Operate recording equipment during the focus groups– be familiar with the tape recorder. Turn over or insert another tape as quietly as possible. Label the cassette tapes.
- Do not participate in the discussion at the focus groups – talk only if invited by the moderator. Control your non-verbal actions no matter how strongly you feel about an issue.
- Provide a brief oral summary of responses to the group (no longer than three minutes) at the end of each session, inviting additions or corrections from the group.
- Hand out honorariums and thank participants when they leave focus groups.
- Debrief after each focus group session – give an oral summary to the principal investigator, discuss overall impressions, notable quotes, key ideas or insights presented, and diagram the seating arrangement. Record all debriefing for later analysis.
- Provide feedback on focus group analysis and reports upon reading them.
- Assist with post interviews of participants of the domestic violence intervention education program provided by the researcher.

Appendix F

Interview guide

Introduction to be read before each focus group

Good evening and welcome to our session. Thank you for taking the time to join this discussion of domestic violence screening in the primary care setting. My name is Karen Hetzel and I am conducting this research because of my involvement with experiences of women who have been victims of domestic violence over the last 11 years. What is of particular interest to me is how nurses in primary care settings such as yourselves, caring for female patients can adopt screening for domestic violence into your everyday practice. Also, I am conducting this research to complete my doctorate from the University of Rhode Island. Prior to today and also as a part of my dissertation research, you may have replied to a survey that was distributed to you about awareness of domestic violence in your particular setting. I have received some important data from the responses thus far. My dilemma is how to provide nurses with the educational information needed as well as the resources available, so nurses can include routine screening of their female patients for domestic violence into their daily practice. Assisting me today is XXXXX XXXXXX , a XXXXXX from XXXXXX.

You are specifically invited to discuss your experiences with female patients that you encounter in your daily practice and how to address domestic violence issues with them. For about the next hour and a half, we will discuss what would be of help to you in order to screen your patients routinely for domestic violence. You are the key to my success of my work in domestic violence.

Before we begin this discussion, I want to review a few ground rules for the focus group.

1. You have each read and signed a consent form that ensures that I will keep the contents of this discussion confidential.
2. I am asking that all group members keep confidential anything that is said within the focus group. In this way, all group members can feel safe to share information that they might not share if they felt it would be discussed outside of this group.
3. You should feel free to say anything you need to say regarding the topic we are discussing within the focus group.
4. The focus group will be taped so it is important that everyone speak up, respect each others' comments, and only one person should talk at a time. It will be difficult to listen to the tape, if more than one person speaks at the same time and valuable comments may be missed. Please refrain from having side conversations.
5. The discussion will focus on the needs nurses have in primary care settings, in order to routinely screen their female patients for domestic violence
6. We will be on a first name basis tonight, however, the reports that will be written later will use no names and the content will be entirely anonymous.

7. The session is not a social support group. Its purpose is meant to talk about your professional experiences and not personal experiences related to the topic. If you have personal experiences that you would like to share with me, I'd be happy to talk with you after the session.
8. The purpose of this session is to assist me in identifying the needs you have in order to routinely screen your female patients for domestic violence. Identifying specific needs in your setting will help me prepare a domestic violence education and intervention program for nurses in your settings. I will ask you to be very honest and open about your needs and concerns regarding domestic violence screening.
9. Your contributions are critical to my research. Each one of you possesses the information and knowledge that I need to prepare an educational program that will help nurses adopt domestic violence screening into their daily practice. Without your participation, I would be unable to provide such a program tailored to the needs of your settings. You are the key to that success.
10. Let's begin the session.

Core Focus Group Questions

- I'd like to begin by asking each of you to briefly describe what a typical day in your practice setting is like for you.
- In your practice, have you ever suspected a patient was a victim of domestic violence? What was the reason you suspected? How did you respond?
- Do you see any barriers in providing care for identified or suspected victims in your setting? What are the most difficult parts?
- Are there any particular strengths in your setting in screening for domestic violence?
- Imagine a situation where a female patient reveals to you that she was a victim of domestic violence. What do you think is the most important thing you could say or do for this patient?
- Do you have any ideas as to what might better prepare you to assess and intervene with domestic violence victims?

Appendix G

Domestic Violence Screening By Nurses In The Primary Care Setting

Post Intervention Interview Guide
Please have participant answer all the following questions.

1. Age: <25 yrs___ 25-35 yrs___ 36-50 yrs___ >50 yrs____

2. Gender: F___ M___

3. Race: African-American/Black____ Native American____ White____
Asian-American_____ Other_____ (please specify)

4. Marital status: Single ___ Married ___ Divorced ___ Widowed ___

5. Yearly Total Household Income <$10,000 ____ $40,000 – 59,999___
(all members of household) $10,000 - 19,999 ____ $60,000 – 79,999___
$20,000 – 39,999 ____ $80,000 or more___

6. Highest Nursing Degree Completed:
LPN__ Diploma__ AD__ BSN__ MSN__ NP__ RN,CS__ Midwife__

7. Years as a practicing nurse: <5 yrs___ 6-10 yrs___ 11-15 yrs___
16-25 yrs___ >25 yrs ___

8. Type of practice at present position: Pediatrics _____
Any Other_____ (please specify)

9. Length of time employed in present position: ___ yrs. ___ mos.

10. Did you complete and return the questionnaire given by the researcher,
Karen Hetzel ? yes____ no_____

11. Did you attend a focus group facilitated by Karen Hetzel ?
yes____ no_____

12. Did you attend the domestic violence education program led by Karen Hetzel ?
yes____ no_____

13. Have you changed your practice to include domestic violence screening of female patients since the educational program? yes_____ no_____
If yes, how ? If no Skip to # 20.

14. What specifically has helped you to change your practice to include domestic violence screening ?

15. How has changing your practice to screen for domestic violence affected patients ? In what ways ?

16. How has changing your practice to screen for domestic violence affected you ? In what ways ?

17. How has changing your practice to screen for domestic violence affected the other nurses in your setting ? In what ways ?

18. Since the educational program how many female patients that you asked about violence past or present, in their lives ? (please specify a number in each option)

_____ screened positive (patient acknowledged being a victim)
_____ screened negative (no suspicion of patient being a victim)
_____ screened possible (patient does not acknowledge being a victim but patient injuries/history suggest abuse)

19. Have you had the opportunity to intervene with those victims that screened positive or possible ? yes_____ no_____
If yes, what interventions did you provide ?

20. Since the educational program, how does the physical environment in your practice setting facilitate domestic violence screening of female patients ?

21. Since the educational program, have any female patients **told** you they were/are a victim of domestic violence ? yes_____ no_____
If yes, describe that experience.

22. (Skip if already has changed practice) Do you intend to change your practice to include domestic violence screening ? yes_____ no_____ If yes, when ?
If no, do you have other needs to make this change in practice ?
What are they ?

BIBLIOGRAPHY

Abbott, J., Loziol-McLain, J., & Lowenstein, S. (1995). Domestic violence against women: incidence and prevalence in an emergency department population. *Journal of the American Medical Association, 273*,(22), 1763-1767.

Adler, N., Kegeles, S., Irwin, C., & Wibbelsman, C. (1990). Adolescent contraceptive behavior: An assessment of decision process. *Journal of Pediatrics, 116*, 463-471.

Ajzen, I. (1985). From intentions to actions. In J. Kuhl & J. Beckman (Eds.), *Action Control from Cognition to Behavior* (pp. 11-39). NY: Springer-Verlag.

Ajzen, I. & Fishbein, M. (1980). *Understanding Attitudes and Predicting Social Behavior.* Englewood Cliffs, NJ: Prentice Hall.

Ajzen, I. & Madden, T. (1986). Prediction of goal-directed behavior: Attitudes, intentions, and perceived behavioral control. *Journal of Experimental Social Psychology, 22*, 453-474.

Alpert, E. (1995). Violence in intimate partner relationships and the practicing internist. *Annals of Internal Medicine, 123*(10), 774-780.

Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN). (2003). *Universal Screening for Domestic Violence, 2nd Edition.* CD-ROM.

Barling, N. & Moore, S. (1996). Prediction of cervical cancer screening using the theory of reasoned action. *Psychological Reports, 79*, 77-78.

Bergman, B., Brismar, B., & Nordin, C. (1992). Utilization of medical care by abused women. *British Medical Journal, 305*, 27-28.

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

Bullock, L., McFarlane, J., Bateman, L., & Miller, V. (1989). The prevalence and characteristics of battered women in a primary care setting. *Nurse Practitioner, 14*(6), 49-56.

Campbell, D., Campbell, J., King, C., Parker, B., & Ryan, J. (1994). The reliability and factor structure of the Index of Spouse Abuse with African-American battered women. *Violence and Victims, 9*, 259-274.

Campbell, D. & Stanley, J. (1963). *Experimental and Quasi-experimental Designs for Research.* Chicago: Rand McNally College Publishing Co.

Campbell, J. (1986). Nursing assessment for risk of homicide with battered women. *Advances in Nursing Science, 8*(4), 36-51.

Campbell, J., Harris, M., & Lee, R. (1995). Violence research: An overview. *Scholarly Inquiry for Nursing Practice, 9*(2), 104-125.

Campbell, J. Kub, J., Belknap, R., & Templin, T. (1997). Predictors of depression in battered women. *Violence Against Women, 3*,(3), 271-293.

Campbell, J. & Lewandowski, L. (1997). Mental and physical effects of intimate partner violence on women and children. *Psychiatric Clinics of North Amerıca, 20*, 353-374.

Carey, M. (1994). The group effect in focus groups: Planning, implementing and interpreting focus group research. In Morse, J. (Ed.), *Critical Issues in Qualitative Research Methods* (pp. 225-241). Thousand Oaks: Sage Publications.

Carey, M. & Smith, M. (1994). Capturing the group effect in focus groups. *Qualitative Health Research. 4*(1), 123-127.

Chez, N. (1994). Helping victims of domestic violence. *American Journal of Nursing, 94*(7), 33-37.

Coeling, H. & Harmon, G. (1997). Learning to ask about violence. *Women's Health Issues, 7*(4), 263-268.

Cole, T. (2000). Is domestic violence screening helpful? *Journal of the American Medical Association, 284*(5), 551-553.

Commonwealth Fund 1998 Survey of Women's Health. (1999). New York: Commonwealth Fund.

Covington, D. Dalton, V. Diehl, S. Wright, M., & Piner, M. (1997). Improving detection of violence among pregnant adolescents. *Journal of Adolescent Health, 21*(1), 18-24.

Cunningham-Burley, S., Kerr, A., & Pavis, S. (1999). Theorizing subjects and subject matter in focus group research. In Barbour, R. & Kitzinger, J. (Eds.), *Developing Focus Group Research* (pp. 186-199). Thousand Oaks: Sage Publications.

Davidson, A. & Morrison, D. (1983). Predicting contraceptive behavior from attitudes. *Journal of Personality and Social Psychology, 45*, 997-1009.

Dearwater, S., Coben, J., Campbell, J., Nah, G., Glass, N., McLoughlin, E., & Bekemeier, B. (1998). Prevalence of Intimate Partner Abuse in Women Treated at Community Hospital Emergency Departments. *Journal of the American Medical Association, 280* (5), 433-438.

Dillman, D. (1978). *Mail and Telephone Surveys, The Total Design Method.* New York: John Wiley & Sons.

Elliott, B. & Johnson, M. (1995). Domestic violence in a primary care setting. *Archives of Family Medicine, 4*, 113-119.

Ellis, J. (1999). Barriers to effective screening for domestic violence by registered nurses in the emergency department. *Critical Care Nursing Quarterly, 22*(1), 27-41.

Family Violence Prevention Fund Resource Center. (1999) San Francisco: Family Violence Prevention Fund (FVPF).

Family Violence Prevention Fund (FVPF). Resources. (n.d). Retrieved December 1, 1999, from http://www.endabuse.org/resources/gethelp/html.

Fishbein, M. & Ajzen, I. (1975). *Belief, Attitude, Intention and Behavior. An Introduction to Theory and Research.* Reading, MA: Addison-Wesley.

Flitcraft, A. (1977*). Battered Women: An Emergency Room Epidemiology, MD Thesis.* New Haven, CT: Yale School of Medicine.

Freund, K. Bak, S., & Blackhall, L. (1996). Identifying domestic violence in primary care practice. *Journal of General Internal Medicine, 11*, 44-46.

Ganley, A. Fazio, J., Hyman, A., James, L., & Ruiz-Contreras, A. (1998). *Improving Health Care Response to Domestic Violence: A Trainer's Manual for Health Care Providers.* San Francisco: Family Violence Prevention Fund.

Gerard, M. (2000). Domestic violence: How to screen & intervene. *RN, 63*(12), 52-58.

Glass, N. & Campbell, J. (1998). Mandatory reporting of intimate partner violence by health care professionals: A policy review. *Nursing Outlook, 46*, 279-283.

Greenfield, L., Rand, M., Craven, D., Klaus, P., Perkins, C., Ringel, C., Warchol, G., Maston, C., & Fox, J.(1998). *US Department of Justice: Violence by Intimates.* Washington, DC: US Department of Justice.

Hadley, S. & Short, L. (2000). Evaluation of WomanKind: An integrated model of 24-Hour health care response to intimate partner violence. Presented at the *National Conference on Health Care and Domestic Violence.* San Francisco, CA:10-13-00.

Halloran, J. & Grimes, D. (1995). Application of the focus group methodology to educational program development. *Qualitative Health Research, 5*(4), 444-53.

Hamilton, B. & Coates, J. (1993). Perceived helpfulness and use of professional services by abused women. *Journal of Family Violence, 8*, 313-324.

Harshbarger, S. (1995). *Diagnosis: Domestic Violence.* Newton: Lifecycle Productions.

Haywood, Y. & Haile-Mariam, T. (1999). Violence against women. *Emergency Medicine Clinics of North America, 17*(3), 603-615.

Heise, L., Pitanguy, J., & Germain, A. (1994). *Violence against women: The hidden health burden.* (World Bank Discussion Paper No. 255). Washington, DC: World Bank.

Helton, A., McFarlane, J., & Anderson, E. (1987). Battered and pregnant: A prevalence study. *American Journal of Public Health, 77*, 1337-1339.

Henderson, A. & Ericksen, J. (1994). Enhancing nurses' effectiveness with abused women. *Journal of Psychosocial Nursing, 32*(6), 11-15.

Henderson, D., Sampselle, C., Mayes, J., & Oakley, D. (1992). Toward culturally sensitive research in a multicultural society. *Health Care for Women International, 13*, 339-350.

Hill, D., Gardner, G., & Rassaby, J. (1985). Factors predisposing women to take precautions against breast and cervix cancer. *Journal of Applied Social Psychology, 15*, 59-79.

Hoff, L. & Rosenbaum, L. (1994). A victimization assessment tool: Instrument development and clinical implications. *Journal of Advanced Nursing, 20*, 627-634.

Hyman, A., Schillinger, D., & Lo, B. (1995). Laws mandating reporting of domestic violence. *Journal of the American Medical Association, 273*(22), 1781-1787.

Jones, A., Gielen, A., Campbell, J., Schollenberger, J., Dienemann, J., Kub, J., O'Campo, P., & Wynne, E. (1999). Annual and lifetime prevalence of partner abuse in a sample of female HMO enrollees. *Women's Health Issues, 9*, 295-305.

Kim, H.S. (1987). Structuring the nursing knowledge system: A typology of four domains. *Scholarly Inquiry for Nursing Practice*, 1(2), 99-110.

Kim, H. S. (2000). *The Nature of Theoretical Thinking in Nursing.* (2nd. ed.). New York, NY: Springer Publishing Company.

Kimberg, L. (2001). Addressing intimate partner violence in primary care practice. *Medscape Womens' Health e Journal, 6*(1). Retrieved January 31, 2003, from http://www.medscape.com/viewarticle/408937

King, M.C. & Ryan, J. (1982). Abused women: Dispelling myths and encouraging intervention. *Nurse Practitioner, 14*(5), 47-58.

Kitzinger, J. (1994). The methodology of focus groups. *Sociology of Health and Illness, 16*(1), 103-121.

Kitzinger, J. & Barbour, R. (1999). The challenge and promise of focus groups. In Barbour, R. & Kitzinger, J. (Eds.), *Developing Focus Group Research* (pp. 1-20). Thousand Oaks: Sage Publications.

Krueger, R. (1994). *Focus Groups: A Practical Guide for Applied Research.* Thousand Oaks: Sage Publications.

Kuzel, A. (1992). Sampling in qualitative inquiry. In Crabtree, B. & Miller, W. (Eds.), *Doing Qualitative Research* (pp. 31-44). Newbury Park, CA: Sage Publications.

Laschinger, H. & Goldenberg, D. (1993). Attitudes of practicing nurses as predictors of intended care behaviors with persons who are HIV positive: Testing the Ajzen-Fishbein theory of reasoned action. *Research in Nursing & Health, 16*, 441-450.

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

Lincoln, Y. & Guba, E. (1985). *Naturalistic Inquiry.* Newbury Park, CA: Sage Publications.

Madden, T., Ellen, P., & Ajzen, I. (1992). A comparison of the theory of planned behavior and the theory of reasoned action. *Personality and Social Psychology Bulletin, 18*(1), 3-9.

McCauley, J., Kern, D., Kolodner, K., Dill, L., Schroeder, A., DeChant, H., Ryden, J. Bass, E.. & Derogatis, L. (1995). The battering syndrome: Prevalence and clinical characteristics of domestic violence in primary care internal medicine practices. *Annals of Internal Medicine, 123*(10), 774-781.

McCaw, B., Berman, W., Syme, L., & Hunkeler, E. (2001). Beyond screening for domestic violence, A systems model approach in a managed care setting. *American Journal of Preventive Medicine, 21* (3), 170-176.

McLeer, S. & Anwar, R. (1989). A study of battered women presenting in an emergency department. *American Journal of Public Health, 79*(1), 65-66.

McNutt, L. Carlson, B., Rose, I., & Robinson, D. (2002). Partner violence in the busy primary care environment. *American Journal of Preventive Medicine, 22*(2), 84-91.

Merton, R., Fiske, M.,& Kendall, P. (1956). *The Focused Interview*. Glencoe, IL: The Free Press.

Meuer, T., Seymour, A., & Wallace, H. (2000). Domestic violence. In Seymour, A., Murray, M., Sigmon, J., Hook, M., Edmunds, C. & Gaboury, M. *2000 National Victim Assistance Academy*, http://www.ojp.usdoj.gov/ovc/assist/nvaa2000/academy/welcome.html {accessed May 20, 2003}.

Millstein, S. (1996) Utility of the theories of reasoned action and planned behavior for predicting physician behavior. *Health Psychology, 15*(5), 398-402.

Moore, M., Zaccaro, D. & Parsons, L. (1998). Attitudes and practices of registered nurses toward women who have experienced abuse/violence. *Journal of Obstetrical Gynecological Neonatal Nursing, 27*(2), 175-182.

Morgan, D. (1988). *Focus Groups as Qualitative Research*. Thousand Oaks: Sage Publications.

Nabi, R., Southwell., B., & Hornik, R. (2002). Predicting intentions versus predicting behaviors: Domestic violence prevention from a theory of reasoned action perspective. *Health Communications, 14*(4), 429-449.

Nudelman, J., Durborow, N., Grambs, M., & Letellier, P. (1997). *Best Practices: Innovative Domestic Violence Programs in Health Care Settings*. San Francisco: Family Violence Prevention Fund.

Paluzzi, P. (2002). Violence against women: Are we doing enough? *Journal of Midwifery & Women's Health, 47*(5), 303-304.

Parker, B & McFarlane, J. (1991). Nursing assessment of the battered pregnant woman. *Maternity Child Nursing Journal, 16*, 161-164.

Parker, B., McFarlane, J., Soeken, K., Silva, C., & Reel, S. (1999). Testing an intervention to prevent further abuse to pregnant women. *Research in Nursing & Health, 22*, 59-66.

Physicians for a Violent-Free Society (PVS). (2002). *Abuse Assessment Response Course*. CD-ROM.

Plichta, S. (1997). Violence, health and the use of health services. In M. Falik & K. Collins (eds.), *Women's Health: The Commonwealth Fund Survey* (pp. 237-272). Baltimore: Johns Hopkins University Press.

Rittmayer, J. & Roux, G. (1999). Relinquishing the need to fix it: Medical intervention with domestic abuse. *Qualitative Health Research, 9*(2), 166-181.

Rodriguez, M., Bauer, H., McLoughlin, E., & Grumbach, K. (1999). Screening and intervention for intimate partner abuse. *Journal of the American Medical Association, 282*(5), 468-474.

Rodriguez, M. Craig, A., Mooney, D., & Bauer, H. (1998). Patient attitudes about mandatory reporting of domestic violence. *Western Journal of Medicine, 169*, 337-341.

Rodriguez, M., Sheldon, W., Bauer, H., & Perez-Stable, E. (2001). Factors associated with disclosure of intimate partner abuse to clinicians. *Journal of Family Practice, 50*, 338-344.

Ryan, J. & King, C. (1998). Woman abuse: Educational strategies to change nursing practice. In J. Campbell (Ed.), *Empowering Survivors of Abuse* (pp. 45-60). Thousand Oaks: Sage Publications.

Schatzman, L. & Strauss, A. (1973). *Field Research*. Englewood Cliffs, NJ: Prentice Hall.

Schifter, D. & Ajzen, I. (1985). Intention, perceived control and weight loss: An application of the theory of planned behavior. *Journal of Personality and* Social Psychology, 49(3), 843-851.

Soeken, K., McFarlane, J., Parker, B., & Lominack, M. (1998). The Abuse Assessment Screen: A Clinical Instrument to Measure Frequency, Severity, and Perpetrator of Abuse. In Campbell, J. (Ed.), *Empowering Survivors of Abuse* (pp. 195-203). Thousand Oaks: Sage Publications.

Stewart, D. & Shamdasani, P. (1999). Focus group research. In Bickman, L. & Rog, D. (Eds.), *Handbook of Applied Social Research Methods* (pp. 509-526). Thousand Oaks: Sage Publications.

Stillman, F. (1992). Focus group research: An overview. In Becker, D., Hill, D., Lackson, J., Levine, D., Stillman, F. & Weiss, S. (Eds.), *Health Behavior Research in Minority Populations* (pp.168-175). Bethesda, MD: United States Department Health Human Services.

Strauss, M. & Gelles, R. (Eds.). (1990). *Physical Violence in American Families*. New Brunswick, NJ: Transaction Publishing.

Sugg, N. & Inui, T. (1992). Primary care physicians' response to domestic violence. *Journal of the American Medical Association, 267*(23), 3157-3160.

Sugg, N., Thompson, R., Thompson, D., Maiuro, R., & Rivara, F. (1999). Domestic violence and primary care. *Archives of Family Medicine, 8*, 301-306.

Taylor, W. & Campbell, J. (1992). Treatment protocols for battered women. *Response, 81*(14), 16-21.

Taylor, V. Montano, D., & Koepsell, T. (1994). Use of screening mammography by general internists. *Cancer Detection and Prevention, 18*, 455-462.

Thompson, R., Meyer, B., Smith-DiJulio, K., Caplow, M., Maiuro, R., Thompson, D., Sugg, N., & Rivara, F. (1998). A training program to improve domestic violence identification and management in primary care. *Violence & Victims, 13*(4), 395-410.

Thompson, R., Rivara, F., Thompson, D., Barlow, W., Sugg, N., Maiuro, R., & Rubanowice, D. (2000). Identification and management of domestic violence. *American Journal of Preventive Medicine, 19*(4), 253-263.

Tilden, V., Schmidt, T., Limandri, B., Chioda, G., Garland, M., & Loveless, P. (1994). Factors that influence clinicians' assessment and management of family violence. *American Journal of Public Health, 84*(4), 628-633.

Tilden, V. & Shepherd, P. (1987). Increasing the rate of identification of battered women in an emergency department: Use of a nursing protocol. *Research in Nursing & Health, 10*, 209-215.

United States Department of Health & Human Services (USDHHS). (1997). *Healthy People 2000*. Washington, DC: US Government Printing Office.

Waalen, J. Goodwin, M., Spitz, A., Petersen, R., & Saltzman, L. (2000). Screening for intimate partner violence by health care providers. *American Journal of Preventive Medicine, 19*(4), 230-237.

Wake, M. (1986). A Study of Instruction and Nurses' Intentions to Change Practice (Doctoral dissertation, University of Wisconsin, 1986). *Dissertation Abstracts International*, A: 47-05, p.1576.

Warshaw, C. & Alpert, E. (1999). Integrating routine inquiry about domestic violence into daily practice. *Annals of Internal Medicine, 131*(8), 619-620.

Wiist, W. & McFarlane, J. (1999). The effectiveness of an abuse assessment protocol in public health clinics. *American Journal of Public Health, 89*(8), 1217-1221.