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Barriers to Domestic Violence Screening in the Emergency Department

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BARRIERS TO DOMESTIC VIOLENCE SCREENING IN THE EMERGENCY DEPARTMENT

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Abstract

Are you in a relationship in which you're being abused? That is not an easy question to answer or ask. Identification of those who are victims of domestic violence is important to prevent further abuse and injury. The purpose of this non-experimental study was to determine barriers of Emergency Department Registered Nurses screening patients for domestic violence. 33 ED RNs completed a short anonymous questionnaire that was developed by Dr. Mary Lou Moore, Wake Forrest University, Winston-Salem, North Carolina. The most significant barriers to screening identified, were the lack of education on how to ask questions about abuse, language barriers, a personal or familial history of abuse, time issues, and the lack of training to deal with the problem of abuse. Emergency Departments should assess the education and training needs of staff to increase accurate identification of those at risk and in need of resources and protection. Results of this study may be integrated into domestic violence training curriculum.

Introduction

Are you in a relationship in which you're being abused? This is not an easy question to ask or answer. This article will describe the need for Emergency Department (ED) continuing education surrounding domestic violence. Domestic violence victims are often reluctant to disclose abuse. Statistics from the Centers for Disease Control (CDC), (2002), reported that an intimate partner injured 36% of the women who were treated in the ED for violent injuries. Instituting a policy of screening all ED patients for domestic violence increases the likelihood of identifying this at risk patient population. This article also explains how a large urban ED implemented universal screening and developed a violence intervention program. A pilot project using a non-experimental quantitative study method was used to determine the educational needs of the ED Registered Nurses (RN). This pilot project focused on how certain barriers may affect the ED RNs ability to ask screening questions. A model by Mager & Pipe (1997), *Analyzing Performance Problems*, was applied to determine possible reasons for lack of screening for abuse by ED staff. Literature supporting universal screening in the ED and the existence of factors that may pose as barriers to screening for domestic violence is presented.

Scope of the problem

Domestic violence, or a more universal term, intimate partner violence, has been recognized as a national health problem that results not only in physical, but psychological, and economic abuse as well. This abuse also takes the form of forced sexual activity, thus increasing the risk of unplanned pregnancy, and sexually transmitted diseases, including human immunodeficiency virus (Warshaw & Ganley, 1998). Not until the 1970's was there an increased focus on intimate partner abuse by the health community and the public (Humphreys & Campbell, 2004).

Professional standards

Many professional nursing organizations, including the American Association of Colleges of Nursing, American Nurses Association, and the Emergency Nurses Association, published position statements in support of curriculum development, training, and continuing education in domestic violence (Cohn, Salmon, & Stobo, 2002). Despite the existence of domestic violence curriculum, a survey of health care professionals indicated that only approximately 30% of the students recalled ever receiving education about domestic violence (Cohn, et al.). Standards for hospitals, and in particular EDs, regarding establishing policies, procedures, and education on abuse screening, are also required by the Joint Commission on the Accreditation of Healthcare Organization. (Joint Commission on the Accreditation of Healthcare Organizations, 1995).

Definitions

The following definitions were used for the purposes of this pilot project: (a) *Domestic violence* or *abuse*, is defined as a "pattern of assaultive or intimidative behaviors, including physical and psychological, that adults or adolescents use against their intimate partners." (Warshaw & Ganley, 1998, p. 16); (b) *Domestic partner* or *intimate partner* describes a current or former spouse, boyfriend, girlfriend with whom the individual has had an intimate relationship; (c) *Registered Nurse,* is a professional licensed nurse; and (d) *Emergency Department* is a specialized area of the hospital that provides care and treatment to patients of all ages and conditions that present to the department for care. Intimate partner violence has been recommended as the preferred term by the CDC (2003). Domestic violence or abuse and intimate partner violence or abuse are used synonymously in this article.

Background

A search of the literature using MEDLINE, CINAHL, Biomedical Reference Collection, Nursing and Allied Health Collection databases from 1995-2003 was conducted. Key terms used in the literature search included: domestic violence, intimate partner abuse, domestic violence screening, spousal abuse, and emergency department.

Incidence of domestic violence

A hallmark study conducted by Goldberg and Tomlanovich, in 1984, determined that one in four women seeking care for any reason in the ED has been a victim of domestic violence. Abbott, Johnson, Koziol-McLaine, and Lowenstein (1995) determined that 77% of women who have been seen in the ED for non-trauma complaints have been victims of domestic violence, but found that only 13% of these patients had been screened for domestic violence. A more recent study by Larkin, Hyman, Mathias, D'Amico, & MacLeod (1999), found one in five patients who were in the ED reported exposure to domestic violence. The Bureau of Justice compared women and men and estimated that women make up 85% of those abused (Rand & Strom, 1997). In 1998 there were five times more women than men who were victimized by a domestic partner (Rennison & Welchans, 2000). Gerard (2000) found that 35% of ED patients may be victims of domestic violence, and that 95% of them were women. In addition to physical and psychological trauma, death may also be a result of domestic violence as statistics indicate that 11% of all homicides were committed by a domestic partner (Rennison & Welchans).

Domestic violence affecting pregnant women and children

A cross-cultural study of African American, Hispanic, and White women found a risk for domestic violence during pregnancy. One in six pregnant women reported abuse when screened for domestic violence by their obstetrician (McFarlane, Parker, & Soeken, 1996). There was a

delay in prenatal care and increased risk for low birth weight of infants for those women who reported abuse (McFarlane, et al.). Maternal weight gain was also less in those women in domestic violence relationships and was most significant in the Caucasian women, thus further placing the health of the fetus as risk (McFarlane, et al.). Abused pregnant women are also at risk for miscarriage, premature labor, and fetal injury (Warshaw & Ganley, 1998). Because the ED treats all patients presenting for care, this includes pregnant women. Women who have been screened for domestic violence in the pediatric setting have reported domestic abuse 40% of the time (Erickson, Teresa, & Siegel, 2001). Children in families in which domestic violence occurs frequently suffer from sleep and psychological disorders, problems in school, and from abuse themselves (Hill & Siegel, 2001). Clearly, domestic violence has detrimental effects on the entire family unit. Early identification of individuals who are victims of domestic violence may assist in preventing further psychological and physical injury.

Barriers to screening

One of the most common barriers to screening for domestic violence is the lack of education and instruction in asking domestic violence screening questions (Heinzer & Krimm, 2002; Cohn, et al., 2002). Other barriers to screening identified in EDs include the lack of privacy and time limitations for staff (Ellis, 1999). Previous research has also discovered that many nurses have a personal or familial history of violence, as seen by Moore, Zaccaro, & Parsons (1998) in 31% of their sample of perinatal nurses. Another barrier identified by obstetricians screening for domestic violence is the inability to "fix" the problem once identified (Parsons, Zaccaro, Wells, & Stovall, 1995). The lack of adequate referral sources was identified as a common barrier for other health care professionals (Hill & Siegal, 2001).

Universal screening

Unique to the ED is the treatment of men and women of all ages, socio-economic backgrounds, and ethnicities, for an unending variety of illnesses and injuries. An ED visit may be the domestic violence survivor's only contact with healthcare providers who may be able to provide intervention to end the cycle of abuse. Symptoms of domestic violence may not be an obvious bruise or injury. Medical complaints may be related to stress and present as dizziness, shortness of breath, and palpitations (Koss, 1993). Universal screening of all patients seen in Emergency Departments is recommended because the verbal chief complaints of the patient, demographic data, or physical indicators cannot be used to determine those who are victims of domestic violence (Muelleman, Lenaghan, & Pakieser, 1998). Ideally, through universal screening, those being abused could be identified before there is obvious physical evidence of violence. A study by Datner, et al.(2002) found that 35% of patients in the ED positively responded to domestic violence screening questions, but only 4% were documented in the medical records. Ellis (1999) performed a chart review of almost 300 ED medical records from a large urban medical center, and found only 8.8% of the charts had evidence that domestic violence screening was performed. This result was in conflict with a questionnaire survey done by Ellis, in which 45% of the RNs in the ED self reported that they routinely screened their patients for domestic violence. Krimm and Heinzer (2002) reported, in another single site study, that patients in the ED were not consistently screened for domestic violence and that documentation of screening was not always evident. These studies indicate that many patients are not being screened for domestic violence in Emergency Departments. With this failure to identify victims recurrent abuse and future health problems loom for those being abused (Glass, Dearwater, & Campbell, 2001).

Violence intervention

The effectiveness of ED domestic violence intervention has been demonstrated in a study conducted in a large urban hospital by Krasnoff and Moscati (2002). Women who were identified as domestic violence victims were provided case management and after follow-up over half of the women who received intervention perceived themselves as no longer at risk for domestic violence. Studies have also indicated that identification rates and intervention has increased after healthcare provider education (Humphreys & Campbell, 2004). With the cost of treatment alone for those who are victims of domestic violence estimated to be $1.8 billion in the United States, this health care problem should not be overlooked (Warshaw & Ganley, 1998).

Universal screening for domestic violence in the study setting

The concept of universal screening for domestic violence was implemented at the facility for this study in 1998, for all patients over the age of 12 years seen in the ED. This also coincided with the development of a facility-wide violence intervention service for those experiencing violence or abuse. ED nursing staff at this facility received training on screening patients for domestic violence at the time the program was implemented. New staff members also received domestic violence education and training during their orientation period in the ED. All healthcare professionals were required to assess for domestic violence, but in the ED the RNs generally spend more time than the physician with the patient, providing the opportunity to screen for domestic violence.

Violence intervention program

California law Penal Code Section 11160 also requires health care providers to report domestic violence to the police (California Health Care Association, 2000). Studies have shown

that identification rates for domestic violence increased with more widespread screening by healthcare professionals (Thompson, et al, 2000; Garcia-Moreno, 2002).

At the facility in which the research was conducted a Violence Intervention Program (VIP) was developed in 1989, which was staffed by on-call Registered Nurses (RN) 24 hours a day, who responded within 45 minutes of being called by the Emergency Department. This nurse's role was to assist patients who had been identified as possible or probable victims of violence. Accurate identification of individuals who are subjected to abuse and referred to intervention could result in decreased injury, illness, and death in this patient population, although the activity in a busy ED is not a friendly environment in which to perform the sometimes-delicate line of questioning about domestic violence. Unfortunately in 2003, due to County and State budget shortfalls, important programs, including the Violence Intervention Program were eliminated.

Conceptual Framework

This research was based on Mager and Pipes' model (1997), *Analyzing Performance Problems*, to establish the need for further domestic violence training in the ED. This model indicates that one must recognize that there is a performance problem, and then, following a series of 12 steps, determine how to solve the identified problem. The next step in the process is to determine if the performance discrepancy is important, and if this discrepancy involves a skill deficiency. If a skill discrepancy is identified, the other questions that must be asked are, (a) Could this skill be performed in the past?, (b) Is this skill used often?, and (c) Do the subjects have the capacity to perform the skill ? (Mager & Pipe). Mager and Pipe's analysis continues to describe that if there is not a skill discrepancy, one must determine whether the performance is punishing, non-performance rewarding, does the performance matter, and finally if there are

obstacles to performance. This model, in which Mager and Pipe describe a process of identifying and solving problems in human performance, was applied to investigate the possible reasons for a lack of screening ED patients for domestic violence by the RN staff. In answering the questions if the performance of screening for domestic violence matters, the literature indicated that screening for domestic violence is important to prevent the continued risk of abuse and injury. Analysis of the research responses determined the importance of domestic violence to the ED RN's. All of the ED RN staff previously received basic training about how to screen for domestic violence, indicating that a skill level did exist at one time. Although Mager and Pipe's model was not intended specifically for use in nursing, it was very useful to determine what obstacles in screening for domestic violence may exist for this ED nursing population.

Purpose

The purpose of this pilot project, using a non-experimental quantitative methodology, was to determine beliefs and attitudes of ED RNs when universally screening patients for domestic violence. Factors, beliefs and attitudes of ED RNs were assessed to determine the existence of potential barriers to effective screening for domestic violence. This study examined the research question, "What are the factors or perceived attitudes of ED RNs that may pose as barriers when screening patients for domestic violence?" The results of this project could be used for the development of an educational program in domestic violence.

Methods

Setting

A large urban public hospital ED, level one trauma center, with an approximate daily census of over 160 patients, was the setting for this study. Approximately 60 full or part-time ED RNs, who screened patients for domestic violence, were employed in the ED of the facility.

Sample

Prior to initiating the study, approval was obtained from appropriate investigation review boards to ensure human subjects protection. Thirty three ED RNs were recruited by the researcher by use of signs displayed in the ED. Staff members were assured that their responses were anonymous and confidential. Furthermore, staff were informed that if the results were published that there would be no direct reference to individuals in the ED. An informed consent form was signed by those who agreed to participate in this project. Findings from the study cannot be generalized due to the limitations, which include the use of a modified tool, a single site convenience sample, and a small sample size.

Instrument

A short anonymous questionnaire containing 3 components was used as a screening tool. The instrument was developed and tested by Dr. Mary Lou Moore, Wake Forrest University, Winston-Salem, North Carolina. Written permission was obtained to modify the questionnaire for use in the ED. The first component consisted of 18 statements used in the tool to determine beliefs and attitudes about screening for domestic violence. These statements were rated on a Likert type scale from one to five, where one is equivalent to strong disagreement, two is equivalent to disagreement, and three is equivalent to being uncertain, four is equivalent to agreement, and five is equivalent to strong agreement with the statement. The second component consisted of demographic information collected about the ED RNs. The third component was comprised of two questions with a *yes* or *no* answer concerning routine and selected screening of patients. An additional question was added to the statements to determine if there were any problems encountered relating to language barriers in domestic violence screening. Pilot testing the questionnaire was accomplished by a review from nursing colleagues, which also included a

masters prepared forensic nurse educator. The questionnaire was then distributed to all ED RNs during staff meetings. A total of 33 questionnaires were completed and deposited in a locked box. An additional locked box was used for the signed informed consent form to ensure anonymity. The locked boxes were then stored in a locked file cabinet to which only the researcher had access.

Results

Demographics

Data were analyzed using non-parametric methods of analysis. Of the 33 RNs who completed the questionnaire, 29 were female and 4 of the respondents were male. Seventy two percent of the subjects were between the ages of 40-59 years of age, 21% were younger than 40 years, and 6% were older than 60 years. By ethnicity, 49% were Caucasian, 21% Filipino, 12% Hispanic, 9% Asian-non-Filipino, and 6 % described themselves belonging to other ethnic groups. Fifty seven percent of the RNs were educated at the baccalaureate level, 24% possessed an associate degree, and 6% had completed a diploma program in nursing. Thirty nine percent reported 21 or more years of nursing experience, 24% had been a nurse for at least 16 years, 21% with 6 to 15 years, and 15% with less than 6 years. (see Table 1).

Statement responses

Eighty seven percent of the participants expressed an interest in receiving training on how to ask questions about abuse. The highest ranking potential barrier to domestic violence screening (76%) was the existence of language barriers making it difficult to talk about abuse. Additional barriers included a personal or familial history of abuse (39%), and a lack of training to deal with the problem of abuse (33%). Twenty nine percent reported that time issues impacted the respondent's ability to screen for abuse. Conflicting results were obtained regarding

questions about routine screening. Only 51% of the RNs indicated that they routinely screened all patients for abuse, but also responded to a separate question that they screened selected patients (74%). This finding may indicate that the RNs screen selected patients with more obvious signs of abuse, but only universally screen all patients 51% of the time (see Table 2). Further investigation is needed to determine the significance of the discrepancy of these findings. This may indicate that when there is an obvious cue to abuse, such as a bruise or injury, the RN is more likely to selectively screen these patients. Self reported results indicated that the ED RN's believed abuse is a problem in the ED population (91%), the victims do not bring on the abuse themselves (91%), it is appropriate to inquire about abuse (88%), physical contact is not expected in families (85%), abuse is just not a lower socioeconomic group phenomena (86%), abuse is a medical problem (88%), and abuse is an important issue to verify (88%). (See Table 2 and Table 3).

Discussion

Demographics of the participants indicated an educated, older, and ethnically diverse population of ED nurses. More than half of the RNs in the study were educated at the Baccalaureate level. This may increase screening behaviors, because most Baccalaureate programs now include curriculum in family violence (Cohn, et al., 2002). It is also noteworthy that the majority of the RNs have been practicing nursing for more than 16 years, and thus may not have been exposed to family violence education in nursing school.

Overall the data indicated that the ED RN's recognized that abuse is a problem in the ED population and are concerned about domestic violence. This is consistent with the premise that nurses recognized a concern for this population as a part of their nursing practice. The results of universal screening reported as 51% is comparable to the results obtained by Ellis in another

study of ED RNs. Lack of education as a barrier is also consistent with previous research (Heinzer & Krimm, 2002; Cohn, et al., 2002), although an important finding from this pilot study was the wish to know how to specifically ask about domestic violence. Although ED nurses exhibit expert critical thinking skills in triage and the overall management of ED patients, these findings suggest a desire for more task-oriented techniques for screening for abuse. The lack of time indicated by one third of the nurses as a potential barrier to screening is similar to Ellis'(1999) findings in which 25% of the RNs indicated that time restricted the violence assessment. In a very busy ED, it is not surprising that time impacts screening for domestic violence, when more apparently urgent physical issues demand more immediate attention of the nurses.

The desire of the RNs to learn more provided a wonderful opportunity for educating these nurses who already have the mind-set to learn more about how to ask questions when screening for domestic violence. There is also an opportunity for further research to develop evidenced based standards for training and frequency of continuing education for effective domestic violence screening. A useful source for a synthesis of information on education and training of healthcare personnel in familial violence may be found in the book by Cohn, et al., (2002).

Finding a personal history of violence or in the respondent's close family is also consistent with previous research studies, although the implications of personal violence and its impact on screening for domestic violence is unknown (Moore, et al.,1998). An additional barrier that has been identified includes the challenge of screening patients who speak a foreign language, despite access to translators at the facility in which the research was conducted. The conceptual framework of Mager and Pipe indicates that training needs must first be met to improve the performance. This model could be used to gain a better level of understanding of the

needs for education and training in other EDs. In response to this research, an additional hour-long continuing education presentation on domestic violence and screening was provided to the ED nurses at this facility.

Implications for research and practice

Similar surveys could be performed in Emergency Departments to determine if there is a need for further education and training. Perhaps, lack of time barriers may be eased somewhat with the new ED RN staffing ratio requirements that were signed into California law in 2003, as Assembly Bill 394, and set to be implemented in 2004. This new law requires a minimum, and specific, nurse to patient staffing ratios for acute care facilities (California Nurses Association, 2003). The ED staffing ratios will be 1 RN to 4 patients, which is in contrast to the current ratio that may be 1:5, or up to 1:8, at times in this busy ED. Future research could determine if a change in staffing ratios increases the amount of time the RN has available to screen for abuse, and thus potentially increase the identification of those who are being abused. Another difficult task is that of addressing the aspect of diversity and providing trained translators to assist in the screening of ED patients for domestic violence. Translators provide expert language skills, but their training and knowledge in family violence issues may greatly vary or be non-existent. An opportunity exists to investigate the effectiveness and accuracy of translation concerning domestic violence issues. Further investigation may also determine that despite the RNs utilization of critical thinking skills in the ED, the desire may exist for more task oriented questioning techniques when screening for domestic violence. Staff developers and educators in the hospital setting may have the opportunity to utilize multiple media, such as computerized information tools, for training RNs to ask questions about abuse.

The impact of domestic violence on families and the healthcare system warrants continued investigation into evidence based curriculum, education and training methods for ED RNs and health care professionals. Domestic violence training must take into account the possible barriers of beliefs or attitudes, language barriers, the limited amount of time spent with patients, as well as the possible effects of previous experience with personal violence. This study provides beginning information that others can build on to investigate these issues in future research. The results of this study also provide valuable information to integrate into a domestic violence training curriculum.

References

Abbott, J., Johnson, R., Koziol-McLaine, J., & Lowenstein, S. R. (1995). Domestic violence against women: Incidence and prevalence in an emergency department population. *Journal of the American Medical Association, 273,* 1763-1776.

California Health Care Association. (2000). Assault and abuse reporting. *California Consent Manual.* Sacramento, CA: California Health Care Association.

California Nurses Association. (2003). *Fact Sheet on RN Staffing Ratio Law*. Retrieved December 2, 2003, from http://www.calnurse.org/finalrat/7103factsheet.html

Centers for Disease Control. (2003). National center for injury prevention and control, division of violence prevention. Retrieved November 9, 2003, from http://www.cdc.gov/ncipc/dvp/dvam.htm

Cohn, R., Salmon, M. E., & Stobo, J. D. (Eds.). (2002). *Confronting chronic neglect: The education and training of health professionals on family violence*. Washington, DC: National Academy Press.

Datner, E. M., Baren, J. M., Sites, F. D., Schears, R. M., Shofer, F. S., & Hollander, J. E. (2002). Universal screening for domestic violence. *Academic Emergency Medicine, (9),* 512-513.

Ellis, J. M. (1999). Barriers to effective screening for domestic violence by registered nurses in the emergency department. *Critical Care Nursing Quarterly, 22,* 27-41. Retrieved October 4, 2002, from Ovid database.

Erickson, M. J., Teresa, D., & Siegal, R. M. (2001). Barriers to domestic violence screening in the pediatric setting. *Pediatrics, 108.* Retrieved November 6, 2002, from http://web2.epnet.som/citation

Garcia-Moreno, C. (2002). Dilemmas and opportunities for an appropriate health-service response to violence against women. *Lancet, 359*, 1509-1514.

Gerard, M. (2000). Domestic violence: How to screen & intervene. *RN, 63,* 52-56.

Glass, N., Dearwater, S., & Campbell, J. (2001). Intimate partner violence screening and intervention: Data from eleven Pennsylvania and California community hospital emergency departments. *Journal of Emergency Nursing, 27*, 141-149.

Goldberg, W.G., & Tomlanovich, M. C. (1984). Domestic violence victims in the emergency department: New findings. *Journal of the American Medical Association, 251,* 3259-3264.

Heinzer, M. M., & Krimm, J. R. (2002). Barriers to screening for domestic violence in an emergency department. *Holistic Nurse Practitioner, 16,* 24-33.

Hill, M. J. & Siegel, R. M. (2001). Barriers to domestic violence screening in the pediatric setting. *Pediatrics, 108.* Retrieved November 6, 2002, from http://web2.epnet/ciation.asp

Humphreys, J., & Campbell, J. C. (Eds.). (2004). *Family violence and nursing practice.* Philadelphia: Lippincott, Williams, and Wilkins.

Joint Commission on the Accreditation of Healthcare Organizations. 1995. *1996 Accreditation Manual for Hospitals* (pp. 39-50). Oakbrook Terrace, IL: Author.

Koss, M. P., (1993). The impact of crime victimizations on women's medical use. *Journal of Women's Health, 2,* 67-71.

Krasnoff, M. & Moscati, R. (2002). Domestic violence screening and referral can be effective. *Annals of Emergency Medicine, 40,* 485-492.

Krimm, J, & Heinzer, M. M. (2002). Domestic violence screening in the emergency department of an urban hospital. *Journal of the National Medical Association, 94,* 484-491.

Larkin, G. L., Hyman, K. B., Mathias, S. R., D'Amico, F., & MacLeod, B. A. (1999). Universal screening for intimate partner violence in the emergency department: Importance of patient and provider factors. *Annals of Emergency Medicine, 33,* 669-675.

McFarlane, J., Parker, B., & Soeken, K. (1996). Abuse during pregnancy: Associations with maternal health and infant birth weight. *Nursing Research, 45,* 37-42. Retrieved October 19, 2002, from Ovid database.

Mager, R. E., & Pipe, P. (1997). *Analyzing Performance Problems.* Belmont, CA: David S. Lake

Moore, M. L., Zaccaro, D., & Parsons, L. H. (1998). Attitudes and practices of registered nurses toward women who have experience abuse/domestic violence. *American Journal of Obstetric, Gynecologic, and Neonatal Nursing, 27,* 175-182.

Muelleman, R. L, Lenaghan, P. A., & Pakieser, R. A. (1998). Nonbattering presentations to the ED of women in physically abusive relationships. *American Journal of Emergency Medicine, 16,* 128-131.

Parsons, L. H., Zaccaro, D., & Wells, B., & Stovall, T. G. (1995). Methods of and attitudes toward screening obstetrics and gynecology patients for domestic violence. *American Journal of Obstetrics and Gynecology, 173,* 381-385.

Rand, R. & Strom, L. (1997). *Violence related injuries treated in hospital emergency departments.* Bureau of Justice Statistics Special Report, United States Department of Justice. Retrieved October 17, 2002, from www.ojp.usdoj.gov/bjs.

Rennison, C.M., & Welchans, S. (2000). Intimate partner violence. *U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics Special Report,*

Retrieved October 4, 2002, from http://www.ojp.usdoj.gov/bjs/pub/pdf/ipv.pdf

Thompson, R., S., Rivara, F. P., Thompson, D. C., Barlow, W. E., Sugg, N. K., Maiuro, R. D., & Rubanowice, D. M. (2000). Identification and management of domestic violence: A randomized trial. *American Journal of Preventive Medicine, 19*, 253-263.

Warshaw, C., & Ganley, A. (1998). *Improving the health care response to violence: A resource manual for health care providers* (pp. 1-15). San Francisco: Family Violence Prevention Fund.

TABLE 1
Demographics of Respondents (n = 33)

	n (%)
Gender	
Female	29 (88)
Male	4 (12)
Age	
20-29	12 (12)
30-39	3 (9)
40-49	13 (39)
50-59	11 (33)
>60	2 (6)
Ethnicity	
Filipino	7 (22)
Asian-non Filipino	3 (9)
Caucasian	16 (50)
Hispanic	4 (12)
Other	2 (6)
Education	
Diploma	2 (6)
Associate Degree - Nursing	8 (24)
BSN	19 (57)
Years of Nursing practice	
Less than 2 years	2 (6)
2-3 years	1 (3)
4-5 years	2 (6)
6-10 years	4 (12)
11-15 years	3 (9)
16-20 years	8 (24)
21 or more years	13 (39)

TABLE 2

Emergency Department RN Response to Statement About Domestic Violence

	Mean
Middle and upper class patients are unlikely to be victims of abuse	1.36
Abuse is not a problem in my patient population	1.48
It is not a medical problem	1.55
Some people bring this on themselves - I cannot hope to change them	1.55
It is none of my business - it is a private issue	1.58
Some physical contact may be expected in families - I see not reason to interfere	1.73
Even if a patient tells me she is abused, there is no way to verify it is true	1.76
There are too many other important problems to ask about	1.94
I screen selected patients, especially those in lower socioeconomic situations	2.16
I believe I may offend my patients if I ask about abuse	2.3
I have a history of abuse in myself or in my close family	2.45
I am not trained to deal with the problem of abuse	2.55
I do no have time to ask about abuse	2.55
I feel more qualified to deal with concrete physical problems than psychological issues	2.85
I intend to institute the screening for abuse, but have not done so	2.91
I am concerned about domestic violence and screen all of my patients	3.45
Language barriers make it difficult to talk about abuse	3.88
I would like some training in how to ask questions about abuse	4.19

1 = Strongly agree, 2 = Disagree, 3 = Uncertain , 4 = agree, 5 = strongly agree

TABLE 3

Registered Nurses disagreed with the following statements	n Percent
Middle and upper class patients are unlikely to be victims of abuse	30 (91)
Abuse is not a problem in my patient population	30 (91)
It is not a medical problem	29 (88)
Some people bring this on themselves - I cannot hope to change them	30 (91)
It is none of my business - it is a private issue	29 (88)
Some physical contact may be expected in families - I see not reason to interfere	28 (85)
Even if a patient tells me she is abused, there is no way to verify it is true	29 (88)
There are too many other important problems to ask about	26 (76)
I screen selected patients, especially those in lower socioeconomic situations	21 (66)
I believe I may offend my patients if I ask about abuse	21 (63)
I have a history of abuse in myself or in my close family	20 (60)
I am not trained to deal with the problem of abuse	19 (33)
I do no have time to ask about abuse	21 (64)
I feel more qualified to deal with concrete physical problems than psychological issues	14 (42)
I intend to institute the screening for abuse, but have not done so	12 (36)
I am concerned about domestic violence and screen all of my patients	17 (36)
Language barriers make it difficult to talk about abuse	6 (34)
I would like some training in how to ask questions about abuse	1 (3)

n = 33