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INTIMATE PARTNER VIOLENCE SCREENING IN RETAIL HEALTH CLINICS:
THE VIEWS OF THE FAMILY NURSE PRACTITIONERS.

by

Suzanne Herrera Phipps

Dissertation

Submitted to the faculty of

Olivet Nazarene University

School of Graduate and Continuing Studies

Partial Fulfillment of the Requirements for

the Degree of

Doctor of Education

in

Ethical Leadership

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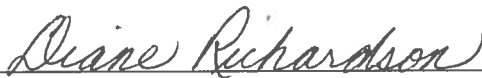
INTIMATE PARTNER VIOLENCE SCREENING IN RETAIL-HEALTH CLINICS.

THE VIEWS OF THE FAMILY NURSE PRACTITIONERS

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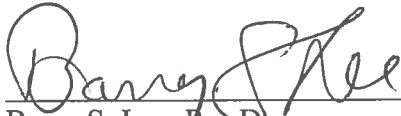
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Dissertation



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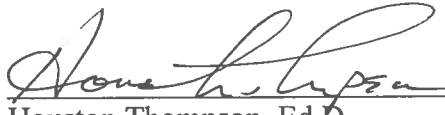
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Dr. Houston Thompson, thank you for this life-changing program, and for recognizing the possibilities a learner can achieve.

To those who work effortlessly to end Intimate Partner Violence.

DEDICATION

I dedicate this work to my husband, Dr. Lemuel Bryan Phipps,
my parents, Mr. & Mrs. Hector R. Herrera, my brother and his family, Mr. & Mrs. Davin
R. Herrera, Elizette I. Herrera, Davin R. Herrera, Jr., Tristin R. Herrera, and Ivelisse T.
Herrera, and my little brother, Rev. Hector R. Herrera, Jr.

Without their prayers, encouragements, patience, support, understanding, and
love, this rigorous journey would not have been made possible. They keep me grounded
and have taught me to always be kind to others. Thank You and Love You All!

ABSTRACT

Intimate partner violence (IPV) affects all women regardless of socioeconomic, race, or religion. More than one in three adult women in the U.S. have experienced rape, physical violence, and/or stalking by an intimate partner at least once in their lifetime. Aside from deaths and obvious physical injuries on a patient, IPV is associated with a number of adverse health outcomes. Retail health clinics (RHCs) are a new gateway to access healthcare and have the potential to see millions of patients per year. Family Nurse Practitioners (FNPs) are employed in RHCs, and patients have reported to be satisfied with the healthcare delivered by RHC FNPs. FNPs in RHCs are in a prime position to screen for IPV in RHCs. The purpose of this study was to explore the 65 RHC FNPs views on IPV knowledge, barriers, and roles on IPV screening based on a validated questionnaire. The results revealed 36 FNPs who reported *yes* to IPV training had statistically significant more IPV knowledge than those 25 FNPs who reported *no* to violence training. There was a statistically significant negative correlation found between the total scores for barrier statements and the total scores for statements about screening for IPV. Nine FNPs who reported a battered woman in a year knew their roles in IPV significantly more than the 47 FNPs who did not report a battered women in a year. The conclusion is that the most ethical practice is for FNPs in RHCs to screen patients for IPV.

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CHAPTER I

INTRODUCTION

According to the Centers for Disease Control and Prevention (2014), intimate partner violence (IPV) is a serious, preventable public health concern. Injury and violence prevention are listed among the Healthy People 2020 Topics and Objectives (United States Department of Health and Human Services, 2013). One of the most common forms of violence is performed by a husband, boyfriend, or intimate partner against a woman. The health burden of IPV is overwhelming and this burden is borne by women at the hands of men (World Health Organization, 2002). There are four main forms of IPV: physical, sexual, threats of physical or sexual, or psychological/emotional (Saltzman, Fanslow, McMahon; Shelley, 2002).

Intimate partner violence varies in frequency and severity (Centers for Disease Control and Prevention, 2014). IPV can occur on a continuum, ranging from a single episode to chronic, severe violence. IPV can result in a lifetime of harmful effects on individuals, families, and communities. Recognition and prevention of IPV are the goals of public health (Centers for Disease Control and Prevention, 2014).

Black et al. (2011) conducted the National Intimate Partner and Sexual Violence Survey (NISVS), and reported that more than one in three adult women in the U.S. have experienced rape, physical violence, and/or stalking by an intimate partner at least once in their lifetime. Approximately one in four women has lived through severe physical violence such as getting hit with a fist, beaten, or slammed against an object by an

intimate partner at some point in their lifetime. Most females experienced IPV before they were 25 years of age. According to NIPSVS, one in five Black and White non-Hispanic women and one in seven Hispanic women in the U.S. have experienced rape at some point in their lifetime. Approximately four out of every 10 women of American Indian or Alaska Native race/ethnicity, and one in two multiracial non-Hispanic women have experienced abuse such as rape, physical violence, and/or stalking, by an intimate partner in their lifetime (Black et al.). In 2010 IPV resulted in 1,336 deaths, 276 or 82% of these deaths were females (Centers for Disease Control and Prevention, 2012).

IPV occurs in heterosexual, gay or lesbian, or bisexual relationship (Black et al. 2011). In the U.S. more than one in four males have experienced rape, physical violence, and/or stalking at least once in their lifetime. Nearly half of American Indian, Alaska Native, and almost four out of every 10 Black and multiracial non-Hispanic men have reported IPV during their lifetime (Black et al.).

In their lifetime, one in eight lesbian women and nearly half of lesbian women have been raped. Four out of 10 gay men and nearly half bisexual men have reported sexual violence outside of rape during their lifetime (Walters, Chen, & Breiding, 2013). For the purposes of this paper, the main focus of IPV is abuse inflicted upon women by men.

Intimate partner violence has devastating effects on one's physical and mental health (Black et al., 2011). Of the women who experienced IPV, nearly three in 10 women's lives were affected in the areas of being fearful, such as being concerned for their safety, needing healthcare services, experiencing physical injury, contacting a crisis hotline, needing housing and victim's advocate and legal services, and missing at least

one day of work or school. There are health consequences reported by patients of IPV. Patients who were victims of IPV experienced ailments such as frequent headaches, chronic pain, sleeping difficulties, asthma, irritable bowel syndrome, and diabetes more than women who were not victims of IPV (Black et al.).

The findings of the NIPSVS study spotlighted the burden that IPV takes on women, men, and children and society as a whole (Black et al., 2011). In order to decrease the total number, prevention efforts should start early in promoting strong, healthy, and respectful relationships in the home and community. As to community, the nation's social structures must create a climate that supports IPV screening through updating and enforcing policies. As to the home, the key message is to promote prevention efforts early on starting with fostering healthy family relationships (Black et al.).

According to NIPSVS, along with prevention efforts, patients of IPV need coordinated services to ensure healing and prevent re-exposure to IPV (Black et al., 2011). The healthcare system's response to IPV must be strengthened and better coordinated to assist patients of IPV in reaching services and resources. One way to strengthen the response to patients of IPV is to increase IPV training of healthcare providers (HCPs) (Black et al.). HCPs lack the training to screen for IPV (Minsky-Kelly, Hamberger, Wolff, & Wolff, 2005).

For over a decade, Futures Without Violence (2004) has recommended routine assessment for IPV, and other national organizations, such as the American Nurses Association (ANA), have taken similar positions. Despite the recommendation to screen for IPV, IPV continues to be a health problem of enormous proportions. Houry et al.

(2008) identified that among patients who disclosed IPV, their partner did not harm them. Other patients who disclosed IPV did not retaliate as a result of screening. In fact, many patients contacted community services for help.

Since 2000 retail health clinics (RHCs) have emerged as a way for patients to access healthcare. Most RHCs are staffed by Family Nurse Practitioners (FNPs), and in some states Physician Assistants (PAs); Convenient Care Association, 2013). Potentially, patients accessing RHCs are missing the opportunity to be screened for IPV. IPV screening is lacking in a patient's medical record in RHCs (C. Franco, L. Tucco, M. Crang, and P. Singh, personal communications, February 8, 2014). During a patient's office visit, there are IPV validated assessment tools that can be integrated while taking his or her social history, such as during tobacco, alcohol, and drug use screening (Futures Without Violence, 2004). RHC FNPs are in prime position to reach out to patients (Hunter, Weber, Morreale, & Wall, 2008). They can assist in identification of IPV patients in RHCs, and offer patients support services such as social and legal referrals.

Statement of the Problem

There is little to no research exploring the views of FNPs in RHCs regarding screening for IPV. The purpose of this study was to determine whether RHC FNPs are prepared to screen for IPV in order to provide information to IPV patients. More specifically, this study explored the views on how much knowledge FNPs have regarding IPV, investigated what barrier(s) they would encounter with IPV screening, and explored FNP views of their role in IPV screening all based on their responses to a validated questionnaire.

Background

FNPs are mandatory reporters required to report elder and child abuse. In Illinois, however, while healthcare professionals, and thus FNPs who work in RHCs, are obligated to offer services to IPV patients according to the Illinois Domestic Violence Act of 1986. They are only required to report IPV when a firearm or criminal offense occurs within the intimate partner relationship.

Article IV: Health Care Providers (750 ILCS 60/401) (from Ch. 40, par. 2314 1)

Sec. 401:

Any person who is licensed, certified or otherwise authorized by the law of this State to administer health care in the ordinary course of business or practice of a profession shall offer to a person suspected to be a victim of abuse immediate and adequate information regarding services available to victims of abuse. Any person who is licensed, certified or otherwise authorized by the law of this State to administer health care in the ordinary course of business, or practice of a profession and who in good faith offers to a person suspected to be a victim of abuse information regarding services available to victims of abuse shall not be civilly liable for any act or omission of the agency providing those services to the victims of abuse or for the inadequacy of those services provided by the agency. (Illinois Coalition Against Domestic Violence, 2009, p. 36)

The mandatory reporting of IPV is as follows:

20 ILCS 2630/3.2 requires any person conducting or operating a medical facility, or any physician or nurse, to report treatment of injuries to local law enforcement when it reasonably appears that the person requesting treatment has suffered from

an injury caused by the discharge of a firearm or sustained in the commission of, or as the victim of, a criminal offense. (Futures Without Violence, 2010, p. 23)

A logical extension of the FNP's services, then, would be to allow them to offer information regarding services available to victims of abuse and report all instances of IPV, not only IPV that occurs under the circumstances of firearms and criminal offense. The FNP's potential to serve to victims of IPV has not been fully realized.

Risk Factors

There are risk factors for IPV; however, no one is immune to the act of abuse. IPV occurs in all walks of life. IPV can occur in urban, suburban, rural, and remote communities, in all social classes, and in all ethnic and religious groups. Though there are risk factors mentioned, there is no such thing as a typical IPV patient (Fox-Bartels, 2008); therefore, women aged 18-64 years old, regardless of healthcare settings should be screened for IPV (Futures Without Violence, 2004).

According to the CDC (2013), there are several risk factors that may increase the likelihood of IPV. A combination of individual, relational, community, and societal factors contribute to the risk of experiencing IPV. The individual risk factors include the following:

low self-esteem, low income, low academic achievement, young age, aggressive or delinquent behavior as a youth, heavy alcohol and drug use, depression, anger and hostility, antisocial personality traits, borderline personality traits, prior history of being physically abusive, having few friends and being isolated from other people, unemployment, emotional dependence and insecurity, belief in strict gender roles (e.g., male dominance and aggression in relationships), desire

for power and control in relationships, perpetrating psychological aggression, being a victim of physical or psychological abuse (consistently one of the strongest predictors of perpetration), history of experiencing poor parenting as a child, history of experiencing physical discipline as a child. (Centers for Disease Control and Prevention, 2013, para. 1)

Relationship factors include the following: “Marital conflict-fights, tension, and other struggles, marital instability-divorces or separations, dominance and control of the relationship by one partner over the other, economic stress, unhealthy family relationships and interactions” (Centers for Disease Control and Prevention, 2013, para 1).

Community and societal factors include the following:

Poverty and associated factors (e.g., overcrowding), low social capital-lack of institutions, relationships, and norms that shape a community's social interactions, weak community sanctions against IPV (e.g., unwillingness of neighbors to intervene in situations where they witness violence), and traditional gender norms (e.g., women should stay at home, not enter workforce, and be submissive; men support the family and make the decisions). (Centers for Disease Control and Prevention, 2013, para 1)

Costs

The economic burden of IPV is substantial. Since 2003 the effects of IPV were \$8.3 billion each year. The cost is because of medical, mental, and lost productivity (Centers for Disease Control and Prevention, 2003). Even after the

cessation of IPV, patients' healthcare costs can extend beyond many years after the abuse (Centers for Disease Control and Prevention).

Snow-Jones et al. (2006) compared healthcare costs between 185 women who reported physical, sexual, and/or emotional abuse and 198 never-abused women. The authors noted that in 2003, IPV healthcare costs had reached \$4.1 billion. In particular, the costs were related to hospitalizations, higher utilization of clinic and mental health services, and out-of-plan referrals. The authors sampled women who were well-educated and well-insured in their study (Snow-Jones et al.).

Snow-Jones et al. (2006) found that abused women exceeded healthcare costs by \$1,700 over a three-year period. Healthcare costs for women who had experienced physical, sexual, and/or emotional abuse were associated with neurological symptoms, injuries, and mental healthcare. The authors concluded that IPV elevates healthcare costs whether women had experienced a recent one-time abuse incident or whether they had experienced a history of chronic abuse (Snow-Jones et al.).

Bonomi, Anderson, Rivara, and Thompson (2009) acknowledged the need for additional studies concerning the relationship between healthcare utilization and costs based on both the type and timing of IPV. The authors defined the types of IPV as either physical or non-physical, and defined the timing of IPV as ongoing, recent, or remote. The authors aimed to estimate healthcare utilization and cost concerning the type of IPV women faced based on the timing of when their abuse occurred. The authors conducted a quantitative study and randomly sampled 3,333 women utilizing telephone surveys (Bonomi, et al.).

Bonomi, Anderson, Rivara, et al. (2009) found that regardless of the type of IPV, either physical or non-physical, abused women used mental health services more than never-abused women. Women who experienced ongoing or current IPV, either physical or non-physical, had the highest use of mental health services. The authors noted that women who experienced IPV in the past five years (recent) or more than five years ago (remote) also utilized mental health services. The authors pointed out that women continued to seek mental health services years after the abuse had stopped. Also, the authors found that abused women utilized emergency rooms (ERs), hospital outpatient clinics, primary care visits, pharmacy, and specialty services more than non-abused women. The authors mentioned that abused women utilized healthcare services most often when the abuse was ongoing (Bonomi, Anderson, Rivara, et al.).

Bonomi, Anderson, Rivara, et al. (2009) determined as far as cost was concerned, abused women who had ongoing, physical abuse had higher healthcare costs compared with never-abused women in the areas of primary care, pharmacy, specialty, laboratory, and radiology. Also, women who had ongoing or recent, non-physical abuse had higher total healthcare costs compared with never-abused women. Women with recent non-physical abuse had higher costs in the areas of pharmacy, specialty, and radiology compared with never-abused women. Also, the authors found that the total annual health care costs were the highest for ongoing and recent physical IPV as well as recent, non-physical IPV (Bonomi, Anderson, Rivara, et al.).

Bonomi, Anderson, Rivara, et al. (2009) figured out that the healthcare costs and utilization patterns of physically abused women were the highest when the abuse was ongoing, because women were seeking care for immediate injuries and health problems

associated with IPV. On the other hand, non-physically abused women may take longer to seek healthcare services instead of immediately. The authors mentioned that the participants reported the duration of their non-physical abuse was seven and a half years and 11 years for physical abuse (Bonomi, Anderson, Rivara, et al.).

Bonomi, Anderson, Rivara, et al. (2009) stated that compared with other studies, their participants were older, had higher income levels, and were more highly educated; therefore, the findings of their study cannot be generalized. The authors showed a relationship between healthcare utilization and costs determined by the type and timing of IPV (Bonomi, Anderson, Rivara, et al.).

Consequences

Aside from deaths and obvious physical injuries on a patient, IPV is associated with a number of adverse health outcomes (Black et al., 2011). The health consequences involve reproductive, mental, and social health, and can have negative effects on health behaviors such as smoking, alcohol, or use of drugs. There are immediate and long-term health outcomes as a result of IPV (World Health Organization, 2002). Bonomi, Anderson, Reid, et al. (2009) indicated that little is known about what type of medical and psychological manifestations women who were recently abused had when they went to various clinics. The authors conducted a telephone survey of 3,568 women, who were randomly sampled, to assess past-year IPV experience. The authors investigated common medical and psychological diagnoses between recently abused women and never-abused women (Bonomi, Anderson, Rivara, et al., 2009).

Bonomi, Anderson, Reid, et al (2009) found that women with past-year IPV had more medical and psychological disorders experience compared with never abused

women. The authors reported some of the following issues that the abused women faced: substance use, family and social problems, depression, degenerative joint disease, low back pain, menstrual disorders, and vaginitis or vulvitis or cervicitis. The authors stated that abused women had a three-fold increased risk of having a sexually transmitted infection, a two-fold increased risk of having lacerations, acute respiratory tract infections, gastroesophageal reflux disease, chest and abdominal pain, urinary tract infections, headaches, and contusions/abrasions (Bonomi, Anderson, Rivara, et al., 2009).

Coker, Smith, Berthea, King, and McKeown (2000) sought to determine the physical health consequences of psychological forms of IPV. A total of 1,152 women participated in a cross-sectional survey. The authors found that out of the 1,152 women, 620 experienced partner violence at some point in their life. Also, of the 1,152 women, 156 experienced psychological IPV without physical IPV. Women who lived through psychological IPV reported poor physical and mental health. The psychological IPV contributed to adverse health outcomes such as disability, arthritis, chronic pain, migraines, stomach ulcers, and pelvic pain (Coker et al.).

Coker, Smith, Berthea, King, and McKeown (2000) concluded that psychological IPV produced negative health outcomes. The authors recommended that HCPs screen for psychological IPV along with physical and sexual IPV. The authors mentioned that HCPs intervening at any point during a patient's IPV experience may be beneficial for healing because the effects of IPV persist even after a relationship ends.

Perceptions of nurses

Natan and Rais (2010) sought to examine the effects of nurses' knowledge, department routines, and attitudes concerning the identification of battered women. Natan

and Rais mentioned that in their study physicians or nurses, in spite of the women's wish to be screened for IPV by their HCP and willingness to disclose IPV to their HCP, they did not identify most battered women. The authors mentioned that previous studies had revealed the following nurses' attitudes toward screening for IPV: "discomfort, frustration, missing skills, embarrassment, inability to find a remedy, fear of losing control, denial, guilt, and lack of awareness" (p. 113). Also, the authors indicated that previous studies had found that nurses felt that screening for IPV was an invasion of privacy, IPV situations were too complex to treat, screening for IPV would not promote change in the home, and the feeling of suppressing the problem is much easier to do than to cope with IPV disclosure (Natan & Rais).

Natan and Rais (2010) performed a descriptive, quantitative study. The authors used a convenience sample of 100 nurses and distributed questionnaires to them. The questionnaires assisted the authors in examining the barriers that the nurses faced when screening for IPV. The authors found a positive correlation between nurses' knowledge, department routines, and attitudes when screening women for abuse. The authors found the facts that the nurses were aware of domestic violence, and that the nurses understood the need to identify IPV; however, the authors also noted that the nurses' knowledge of IPV was not implemented in their daily practice (Natan & Rais).

Natan and Rais (2010) found that out of the 100 nurses, 44 had not received training on IPV. When the nurses were asked about departmental norms, 47 of the nurses stated that there were no policies in place that required IPV screening, while 53 nurses stated that they had departmental policies requiring IPV screening. When the authors asked the nurses about intentional and actual behavior toward screening for IPV, 37.5 of

the nurses agreed that they should screen for IPV, 26 of the other nurses slightly agreed that nurses should screen for IPV, and the remaining of 36 nurses said that they should not screen for IPV. The authors did find, however, that 60 of the nurses indicated that they would screen for IPV in the future (Natan & Rais).

Natan and Rais (2010) pointed out that the nurses in their study did not feel that asking patients about abuse was insulting to patients, and the nurses felt that screening for IPV was an important part of a nurse's job. The nurses in the study stated that they were equipped to screen and identify IPV. The nurses also felt that abuse is a crucial medical problem and that abused women did not cause the abuse inflicted upon them. The authors concluded that despite the nurses' beliefs in their abilities surrounding IPV their beliefs were not being implemented daily.

Natan and Rais (2010) commented that if nurses had positive attitudes and high levels of knowledge concerning IPV and if nursing departments made routine IPV screening mandatory, then there would be a higher chance that more abused women will be identified. The authors suggested that in all patients—HCP encounters, there should be a designated area in a patient's medical chart for documenting about IPV. Another important suggestion the authors highlighted was the need for organizations as a whole to create an atmosphere that encourages IPV screening and openness about abuse. Natan and Rais pointed out that if IPV is viewed as important as other health issues such as preventing infections, health promotion, and quality of care, then IPV screening could become a routine in nursing practice.

Nurses who intervened in an IPV dispute were more likely to provide higher quality of care to their patients (Christofides & Silo, 2005). Nurses do feel like screening

for IPV is their role (Natan & Rais, 2010). With proper training, they can feel confident to screen their patients for IPV.

Perceptions of patients

Usta, Antoun, Ambuel, and Khawaja (2012) mentioned that IPV is prevalent among women accessing primary health care services. The authors mentioned that IPV has negative effects on women's health; however, physicians are not screening for IPV. The authors noted that abused women face poorer physical and mental health, require more hospitalizations, greater use of outpatient services, and less preventative care than their non-abused counterparts. The authors mentioned that previous studies have found that women were in favor of universal screening for IPV.

Usta, Antoun, Ambuel, and Khawaja (2012) conducted a phenomenological, qualitative study utilizing focus groups. The authors explored abused women's attitudes towards how the health care system manages IPV. Also, the abused women were asked about expectations they had about the health care system's meeting the needs of IPV patients.

During the study, Usta et al. (2012) implemented an IPV protocol in selected primary care centers to ensure that all women were screened for IPV, and the authors provided an IPV hotline number for women who disclosed IPV. A total of 72 women participated in the focus groups. The 72 women discussed the following topics: opinions, attitudes, and expectations regarding the involvement of primary health care in the management of IPV, opinions about screening for IPV utilizing the Hurt, Insulted, Threatened with harm, and Screamed at them (HITS) questionnaire, perceived barriers

that the health care system faced when screening for IPV, and any suggested solutions for the barriers that the health care system encounters.

Usta et al. (2012) found out that the 72 women from the focus groups encouraged the health care system to be involved in the management of IPV. The women told the authors that disclosing IPV to their HCPs was considered to be a socially acceptable way to break the out of the IPV silence. Most women mentioned that they were enthusiastic about the healthcare system addressing the IPV problem. The women considered health care clinics as a better place to talk about IPV instead of talking to their families or neighbors about their IPV problems. After the women talked about IPV to their HCPs, the women expected to feel encouraged, supported, and relieved by their HCP.

Usta et al. (2012) were told by the women that they expected their HCPs to be open, ready to listen, unhurried, and to respect their confidentiality. Some women suggested that screening for IPV should occur during the first office visit, while others suggested that screening for IPV should occur after building rapport between the HCP and patient. Instead of neglecting to ask about the injuries and bruises, several women expressed to the authors that HCPs should inquiry about injuries and bruises. Most of the women expressed feeling comfortable with either a female or male HCP when discussing IPV.

Usta et al. (2012) pointed out that the women expected their HCPs to be thorough and competent and to provide emotional and material support upon disclosing IPV. The women requested receiving respect for autonomy from their HCP in deciding what she will do about her IPV relationship. In addition, the women valued having follow-up care after disclosing IPV to their HCP. Also, the women expressed that they would like to

receive support from the rest of the health care team, such as nurses and social workers, in the form of listening, counseling, and raising awareness of IPV. Another suggestion that the women made to the authors was mass media and community awareness campaigns that would highlight family relationships discussing IPV.

Zink, Elder, Jacobson, and Klostermann (2004) sought to determine what patients preferred regarding how their physicians identified and managed their IPV experience while their children were present. The authors conducted a retrospective interview of 32 women. The women were asked about their IPV experience and healthcare encounters, and a theme evolved. That is women preferred help during their healthcare encounters even while their children were present. The authors determined that the participants in their study wanted their physicians to screen them routinely for IPV regardless of IPV symptoms and even while their children were present. The participants indicated to the authors that screening for IPV can capture women in the early phases of IPV victimization. Also, the participants encouraged the physicians to be mindful of clues a patient may give about IPV. The participants told the authors that when IPV victims are ready to disclose, physicians should affirm and document the abuse, be knowledgeable about local resources, and educate patients on the health consequences of abuse.

Benefits

MacMillan et al. (2009) sought to determine whether IPV screening reduces violence or improves health outcomes in women. The authors conducted a randomized control trial. A screening group of 3,271 women completed a self-questionnaire called the Woman Abuse Screening Tool (WAST). The women who had a positive IPV screen were

interviewed at baseline and every six months until 18 months concerning IPV re-exposure, quality of life, health outcomes, and potential harms of screening for IPV.

MacMillan et al. (2009) found that the women who were screened for IPV experienced fewer IPV reoccurrences, posttraumatic stress disorder symptoms, alcohol problems, depression, and improved quality of life. The authors pointed out that of the screened women, no one was harmed. The authors recommended that evaluating services after women with IPV have been identified be a priority.

McCloskey et al. (2006) conducted a study that if a patient would leave an abusive relationship would health outcomes improve? Also, the patient's HCP gave the patient interventions after the patient disclosed IPV. The authors interviewed 132 abused women who both disclosed IPV and received IPV interventions 12 months earlier.

McCloskey et al. (2006) found that 58 out of 144 of the abused women left their abusive relationship. Of the 58 abused women who left their abusive partners, 32 received IPV interventions such as advocacy pair-up, women's shelter, or restraining orders. The abused women mentioned that talking to their HCP about IPV increased their likelihood of utilizing an intervention, leaving their abusive partners after having knowledge of interventions, and reporting better physical health compared with women who stayed in abusive relationships. The authors concluded that HCPs can play an active role in delivering IPV services to women in need. The authors noted that the determining factor of whether or not an abused woman accessed IPV services is how her HCP responded to her disclosure of IPV.

McFarlane, Groff, O'Brien, and Watson (2006) noted that despite the global recognition that IPV is associated with morbidity and mortality, there is a lack of

evidence-based treatment in primary care settings. The authors conducted a randomized controlled trial to determine safety behaviors, use of community resources, and the extent of violence following two interventions. The authors utilized two interventions, which were the distribution of a wallet-sized referral card and a 20-minute nurse case manager session. The study participants were 361 abused women who were positive for IPV 12 months earlier.

McFarlane et al. (2006) measured the outcomes of the two interventions 24 months later. The authors found that the women in both groups reported fewer threats of abuse, assaults, danger risks for homicide, and events of work harassment. Also, the authors found that both groups of women continued to engage in safety behaviors 24 months after the two interventions. Another finding was that the use of community resources declined between both groups. The authors concluded that simple interventions, such as screening for IPV, the distribution of wallet-sized referral cards and 20-minute nurse sessions have the potential to interrupt and prevent IPV.

Wathen, Jamieson, and MacMillian (2008) aimed to determine the accuracy of screening methods that correctly identify women experiencing IPV and how IPV is associated with certain presenting factors. The authors conducted a randomized controlled trial to determine the effectiveness of screening for 5,607 women in IPV relationships. The first group was given two screening questionnaires administered before and after a visit with their HCP. The second group was given the same two screening questionnaires only after their HCP visit. The authors found that administering both questionnaires identified IPV regardless of timing when the women took the questionnaires.

Wathen et al. (2008) pointed out that HCPs need to be in tune with other symptoms besides physical symptoms. The authors particularly highlighted women of IPV who present with mental health symptoms. The authors stated that IPV women do visit their primary care providers (PCPs) and the IPV women often have mental health symptoms, but their PCPs miss the opportunity to identify IPV and begin treatment among these patients.

Wilson et al. (2001) sought to determine how often PCPs miss the opportunity to screen for IPV and provide services to patients experiencing IPV during a healthcare visit. A convenience sample of 149 IPV female patients were interviewed concerning the last time they saw their PCP and if their PCP asked them about IPV. Of the 149 patients, 128 of them saw their PCP within the past year, but only 36 of the 128 patients were screened for IPV. Out of the 128 patients, 103 of them received their annual preventative women visit or prenatal care, five patients reported injuries cause by their partner, and 14 patients had mental health concerns.

Wilson et al. (2001) pointed out that because abused women seek out healthcare services more than non-abused women, the application of universal IPV screening has the potential to identify IPV. The authors noted that in their study, and other studies as well, the low rates of screening were the outcome of abused women who were having difficulty disclosing IPV to their PCPs. The authors suggested that nurse practitioners be in a prime position to screen for IPV.

Screening

Coker et al. (2007) aimed to determine the frequency of IPV screening and service interventions administered by nurses. The authors screened 3,664 women at risk-

women for IPV. Out of the 3,664 women, 939 experienced IPV within the past five years. There were 3,008 women who reported past and current IPV relationships. Out of the 3,008 women, 399 were actively in an IPV relationship. Of the women who ever experienced IPV, 616 out of 3,664 experienced both assault and psychological battering. Out of 3008 women who were actively experiencing assault and psychological battering, 2,556 reported that violence was a problem in their relationship. Coker et al., found that IPV screening was feasible and acceptable to women patients. The authors also found that women reported current IPV exposure and that IPV was a problem in their relationship. The authors demonstrated in their study that IPV screening is important to implement in clinical areas to reduce the prevalence of IPV.

Thurston et al. (2007) conducted a mixed-methods study in order to determine IPV rates in an urgent care clinic after implementation of a universal IPV screening protocol 12 months earlier. The authors conducted IPV training for nurses regarding screening guidelines, the nurses' roles, and explanation of the IPV screening procedures. Also, the authors sought to determine contextual factors that might influence screening practices.

Thurston et al. (2007) found that the IPV screening rates in their study were considerably higher and were maintained longer than those reported in other studies. The authors determined that the leadership of monitoring and documenting IPV rates was the key to maintaining higher than average IPV rates. The authors pointed out that screening all patients for IPV in urgent care settings may improve overall IPV screening rates and public education.

Barriers

Colarossi, Breitbart, and Betancourt (2010) found that the barriers to IPV screening included lack of time, training, and referral resources. The licensed providers such as social workers and advanced practice clinicians reported fewer barriers than the unlicensed providers such as healthcare assistants. Both the licensed and unlicensed providers reported that IPV appeared to be helpful for patients. Licensed providers reported having more positive attitudes toward IPV screening and felt more prepared for screening compared with the unlicensed providers.

Colarossi et al. (2010) pointed out that some providers were frustrated with the patients' unwillingness to utilize referrals to social services after IPV disclosure. Also, the providers were concerned that IPV screening took too much time away from other more important healthcare matters of the patients. For example, addressing current violence is more important than asking about past violence or testing for sexually transmitted infections should take precedence over IPV screening. Another opinion that evolved from the focus group was that licensed providers should conduct IPV screening instead of unlicensed providers. The unlicensed providers expressed that they were not prepared about how to respond to a patient that disclosed IPV.

Gerber, Leiter, Hermann, and Bor (2005) examined both PCPs documentation and attitudes when patients disclosed IPV through a waiting room questionnaire. The authors found that out of the 90 charts that were reviewed, 65 of the charts had documentation of IPV; however, only six of those charts mentioned a referral and safety plan. Also, the authors found that PCPs were most likely to give referrals and safety plans to patients who had mood or anxiety disorders, feared for their safety, and were from low-income

households. The PCPs agreed that screening for IPV was their role; however, the PCPs admitted that they needed more confidence about how to manage IPV.

Gerber et al. (2005) concluded that mandatory screening of IPV while patients were in the waiting room did not result in an increase of referrals or safety planning by PCPs. The PCPs expressed that they lacked the confidence and time to address IPV. The PCPs admitted that they needed more IPV training and staff support in order to deal with IPV.

Jaffee, Epling, Grant, Ghandour, and Callendar (2005) examined barriers of IPV screening among obstetricians/gynecologists, family physicians, and internists. Because IPV causes approximately 2 million injuries and 1,300 deaths per year, women seek healthcare frequently, but not all HCPs screen for IPV. The authors wanted to tailor IPV training to address the barriers encountered by the HCPs.

Jaffe et al. (2005) conducted a cross-sectional survey of 143 HCPs. The authors found that if the HCP was male, there were more barriers encountered. On the other hand, fewer barriers were perceived when the HCP was an obstetrician/gynecologist, and had been in practice for five to 10 years. The authors concluded that more HCP training needs to be in place for physicians to be able to recognize IPV. Also, the need for on-going IPV training during an HCP's career was mentioned. Most importantly, the authors determined that their findings supported the need for better practice protocols in order to encourage routine IPV screening.

Universal screening

Because of the dire health consequences and substantial cost of IPV, as a result of IPV on a person, family, and society as a whole (Bonomi, Anderson, Rivara, 2009; Coker

et al. 2000; Liebschutz, Battaglia, Finley, & Averbuch, 2008; Snow-Jones et. al, 2006), professional health organizations have promoted universal screening of IPV. Here are the supporting organizations of universal screening of IPV: Futures Without Violence, the American Medical Association (AMA), American College of Obstetricians and Gynecologists (ACOG), American Academy of Family Physicians (AAFP), American Psychological Association (APA), American Nurses Association (ANA), American Academy of Pediatrics (AAP), the Joint Commission on the Accreditation of Health Care Organizations (JC), and the Institute of Medicine (IOM) (Futures Without Violence, 2004). Despite the efforts of the professional health organizations, IPV screening does not occur in all healthcare settings (Futures Without Violence). An HCP not asking about IPV, could be considered unacceptable practice (Fox-Bartels, 2008).

Screening Tools

Numerous validated screening tools are utilized in various settings. For example, ERs can be found using the Partner Violence Screen (PVS) screening tool. The screening tools can be administered to the patient via either computer-based, written self-completed methods or a face-to-face method with verbal questioning by the HCP (MacMillan et al., 2009). The healthcare setting, and patient preference would determine which screening tool would be best to utilize (Chang et al., 2012). Because there is growing recognition that IPV has a connection with other risk factors, IPV screening has been integrated in routine inquiry of psychosocial issues such a tobacco and weight control (Futures Without Violence, 2004).

Following is a screening tool example from the PVS:

Purpose: A brief screening instrument for use in emergency departments or other urgent care settings.

Instructions: Interview the patient alone and ask questions directly.

1. Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?
2. Do you feel safe in your current relationship?
3. Is there a partner from a previous relationship who is making you feel unsafe now? (Feldhaus, et al., 1997, para. 1).

Retail Health Clinics

In 2000 RHCs were developed in retail-based locations that provided patients with accessible, affordable, and quality healthcare. There are approximately 1500 RHCs in 40 states, and RHCs have served over 20 million patients (Convenient Care Association, 2013). RHCs are predicted to double in locations by 2015 to 2000 clinics (Stempniak, 2013). Potentially, RHCs can see 10.8 million visits a year. An overall healthcare spending of \$800 million annually can be saved. In Illinois there are 105 RHCs (Urgent Care Locations, 2014). With the shortage of primary care physicians expected to worsen in 2014 and beyond, patients are increasingly turning to RHCs for their basic health needs. Under the Affordable Care Act (ACA) (2010), the consumer demand for healthcare is expected to intensify with millions of previously uninsured Americans soon to be eligible for healthcare coverage, and RHCs have the capability to capture these patients (Stempniak). RHCs emerged because of the response to political, social, and economic pressure on the American healthcare industry to provide consumer-

driven demand for accessible, low-cost, and convenient healthcare. Patient demands include patients without health insurance, those who have high co-payments, those who have health saving accounts that have high deductibles, patients without PCPs, those who cannot schedule a timely appointment with their PCPs, and those not needing emergency room services (Hunter, et al., 2008).

Hunter et al. (2008) analyzed data from patient satisfaction surveys from two RHCs. The purpose of the surveys was to evaluate patient satisfaction with care delivered by FNPs, patterns, and preferences. Hunter et al. utilized a descriptive design to gather data from 456 surveys. The authors' study suggested that RHCs are providing satisfactory services to patients.

Ahmed and Fincham (2010) sought to estimate how many patients utilized RHCs. The authors conducted a telephone survey of 383 participants. The participants were asked the following questions: Would you seek healthcare for a minor illness? Would you prefer to see a physician or nurse practitioner? Would you wait one day or more for care? And would you pay \$75 or \$95?

Ahmed and Fincham (2010) found that patients were attracted to the cost savings and convenience aspects offered by RHCs. Because of the cost saving and wait time attributes, patients will continue to seek care in RHCs. The authors concluded that appointment time is a major determinant of seeking healthcare for minor illnesses. The study participants reported being very satisfied or satisfied with the care they received from nurse practitioners at RHCs. The study participants also expressed that they would continue to seek care at RHCs again. Also, the authors determined that RHCs will continue grow.

Thygeson, Van Vorst, Maciosek, and Solberg (2008) conducted a study obtaining data from a computer database concerning common health conditions diagnosed in either RHCs, physician's offices, urgent cares (UCs), or ERs, and the cost of the visits. The authors utilized a total of 628,513 episodes of care in their study. The authors pointed out that RHCs offer convenience, accessibility, short wait-times, low cost, and transparent pricing.

Thygeson et al. (2008) found that the five main conditions seen in RHCs were pink eye, ear infections, sore throats, sinus infections, and bladder infections. Also, the authors found that patients spent \$51 less in RHCs than when they received care in an UC, \$55 less than when they were seen in a physician's office, and \$279 less than when they went to the ER. Another finding in their study was that females were most likely to seek care in RHCs than other healthcare sites.

Wang, Ryan, McGlynn, and Mehrotra (2010) conducted 61 interviews of patients who sought care at RHCs. The authors pointed out that little was known about patient experiences in RHCs. Also, the authors were interested in knowing why patients sought care at RHCs and, if RHCs were not available, then where would the patient seek healthcare.

Wang et al. (2010) found out that patients went to RHCs because of the RHC's convenient location, fixed, transparent pricing, and satisfaction with the care they received. The participants of the study who had PCPs sought care in RHCs because their PCP was unavailable in a timely manner. The participants would have gone to the ER if RHCs were not available. The authors concluded that RHCs are responding to the patients' need of affordable, convenient, and consumer-centered care.

Millions of patients access RHCs yearly, and the number of patients being seen at RHCs is only expected to increase even more by 2015 (Stempniak, 2013). FNP's at RHCs have the opportunity to screen for IPV so no patients are missed. Based on Futures Without Violence the recommendations of universal screening of IPV, RHCs should be included (Futures Without Violence, 2004). Because patients have reported to be satisfied with the care delivered by RHC FNP's (Hunter et. al, 2008), RHC FNP's can successfully assist with IPV screening.

Research Questions

There were three research questions that prompted this study:

1. What is the relationship between how much knowledge RHC FNP's have regarding IPV and the strength of Agreement Rating Scale scores?
2. What is the relationship between the stated barriers for RHC FNP's regarding IPV screening and the strength of Agreement Rating Scale scores?
3. What is the relationship between the stated role for RHC FNP's regarding IPV screening and the strength of Agreement Rating Scale scores?

The goal of this study is to gain knowledge from these questions. RHC FNP's will be given a validated questionnaire addressing their views of IPV screening. The validated questionnaire by Natan and Rais (2010) utilized an agreement rating scale score, 1-6. The higher numbers equal stronger agreements with the statement—with 1 equaling strongly disagree and 6 strongly agree.

Description of Terms

Due to the nature of the topic of IPV, IPV is a form of violence that is performed by a husband, boyfriend, or intimate partner against a woman (World Health

Organization, 2002). An attempt was made to provide clear, thorough, and concise definitions of terms related to IPV. In order to provide an understanding of the study, the definition of terms are presented.

Disclose/Disclosure. To open up, to expose to view, to make known or public (Merriam-Webster, 2014).

Family Nurse Practitioners (FNPs). FNPs are also referred to as mid-level providers. Family is a specialty area (American Academy of Nurse Practitioners, 2014).

All NPs must complete a master's or doctoral degree program, and have advanced clinical training beyond their initial professional registered nurse preparation.

Didactic and clinical courses prepare nurses with specialized knowledge and clinical competency to practice in primary care, acute care and long-term health care settings (American Academy of Nurse Practitioners, 2014, para. 2).

To be recognized as expert HCPs and ensure the highest quality of care, NPs undergo rigorous national certification, periodic peer review, clinical outcome evaluations, and adhere to a code for ethical practices. Self-directed continued learning and professional development is also essential to maintaining clinical competency. Additionally, to promote quality health care and improve clinical outcomes, NPs lead and participate in both professional and lay health care forums, conduct research and apply findings to clinical practice. (American Academy of Nurse Practitioners, para. 3)

NPs are licensed in all states and the District of Columbia, and practice under the rules and regulations of the state in which they are licensed. They provide high-quality care in rural, urban and suburban communities, in many types of settings

including clinics, hospitals, ERs, urgent care sites, private physician or NP practices, nursing homes, schools, colleges, and public health departments.

(American Academy of Nurse Practitioners, 2014, para. 4)

Autonomously and in collaboration with health care professionals and other individuals, NPs provide a full range of primary, acute and specialty health care services, including: Ordering, performing and interpreting diagnostic tests such as lab work and x-rays, diagnosing and treating acute and chronic conditions such as diabetes, high blood pressure, infections, and injuries, prescribing medications and other treatments, managing patients' overall care, counseling, educating patients on disease prevention and positive health and lifestyle choices (American Academy of Nurse Practitioners, 2014, para. 5)

Healthcare Providers (HCPs). Health care providers are involved in primary care, nursing care, drug and specialty care (Vorvick, 2012). At times, the terms HCPs and PCPs are used interchangeably.

IPV or Domestic Violence. Throughout this paper, IPV will be used. “IPV describes physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy” (Centers for Disease Control and Prevention, 2013, para. 1). “IPV can vary in frequency and severity. It occurs on a continuum, ranging from one hit that may or may not impact the victim to chronic, severe battering” (Centers for Disease Control and Prevention, 2013, para. 2).

Physical violence. The intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to,

scratching; pushing; shoving; throwing; grabbing; biting; choking; shaking; slapping; punching; burning; use of a weapon; and use of restraints or one's body, size, or strength against another person. (Saltzman et al., 2002, para. 3)

Primary care providers. A primary care provider (PCP) is a person you may see first for checkups and health problems. If you have a health care plan, find out what type of practitioner can serve as your PCP. The term *generalist* often refers to medical doctors (MDs) and doctors of osteopathic medicine (DOs) who specialize in internal medicine, family practice, or pediatrics. OB/GYNs are doctors who specialize in obstetrics and gynecology, including women's health care, wellness, and prenatal care. Many women use an OB/GYN as their primary care provider. Nurse Practitioners (NPs) are nurses with graduate training. They can serve as a primary care provider in family medicine (FNP), pediatrics (PNP), adult care (ANP), or geriatrics (GNP). Others are trained to address women's health care (common concerns and routine screenings) and family planning. NPs can prescribe medications. A physician assistant (PA) can provide a wide range of services in collaboration with an MD or a DO. (Vorvick, 2012, para. 1)

Psychological/emotional violence. Involves trauma to the victim caused by acts, threats of acts, or coercive tactics. Psychological/emotional abuse can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other basic resources. It is considered psychological/emotional violence when there has been prior physical or sexual violence

or prior threat of physical or sexual violence. In addition, stalking is often included among the types of IPV. (Saltzman et al., 2002, para. 3)

Retail Health Clinics (RHC) or Convenient Care Clinics (CCC). RHCs will be used throughout this paper. In 2000 the first in-store medical clinic opened in St. Paul/Minneapolis, Minnesota. There has been a rapid increase of RHCs that provide quick, inexpensive, and convenient healthcare (Hunter et al., 2008). The RHCs offer a limited menu of non-emergent, routine, and preventative services to patients 18 months and older on a walk-in basis. Some common conditions treated at RHCs include, but are not limited to, allergic reactions, upper respiratory infections, allergic rhinitis, sinusitis, bronchitis, strep throat, otitis media, influenza, insect bites, urinary tract infections, and conjunctivitis. Also, patients can receive routine immunizations, pregnancy testing, school, sports, or work-related physicals. Available to patients are routine screenings for diabetes, tuberculosis, and hypertension (Hunter et al.).

Health care services are provided by FNP's and in some instance PAs. FNP's and PAs have the education to diagnose common acute health problems, order diagnostic tests, prescribe medications, and refer patients needing higher level of care. Cost of the services may range from \$40-\$60 per visit. Patient request services that are not available in RHCs are referred to PCPs, UCs, or ERs. Most of the clinics utilize computerized medical records that may facilitate the transfer of patient information to their PCP. Clinic sizes are generally small ranging from 400 to 600 square feet, including a waiting room, one to two exam rooms, and a restroom. Most of the clinics are open daily including weekends and open until late evening (Hunter et al., 2008).

Risk factors. Any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease or injury. Some examples of the more important risk factors are underweight, unsafe sex, high blood pressure, tobacco and alcohol consumption, and unsafe water, sanitation and hygiene. (World Health Organization, 2014, para. 1)

Screening. “The concept of screening in the medical model usually involves use of a standardized clinical test to detect disease in asymptomatic patients” (Futures Without Violence, 2004, pp. 7-8).

Sexual violence. Divided into three categories: 1. use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed; 2. attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act, e.g., because of illness, disability, or the influence of alcohol or other drugs, or because of intimidation or pressure; and 3. abusive sexual contact (Saltzman et al. 2002, para. 3).

Threats of physical or sexual violence. “Uses words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm” (Saltzman et al., 2002, para. 3).

Significance of the Study

The researcher supported the recommendation of universal screening of IPV (Futures Without Violence, 2004). With the idea that RHCs, a new gateway to healthcare and where millions of patients are accessing healthcare (Stempniak, 2013), IPV screening has a place. By screening for IPV in RHCs, IPV patients will have the opportunity to be

identified and receive appropriate resources. The results of this study unfolded views of the RHCs FNP's regarding IPV and determine what support structures they need to comfortably screen for IPV in the RHC settings.

Family nurse practitioners employed in RHCs are the main audience for this initiative. In addition to FNP's, RHCs' leadership teams, stakeholders, policy makers, anti-violence organizations, educators including nursing, medicine, social work, and counseling are the target audiences as well because they can properly support the training of IPV screening to FNP's employed in RHCs and offer community resources. All parties involved can make a positive contribution to the knowledge of IPV screening in RHCs by FNP's.

Ideally, IPV extensive education should begin in nursing school to prepare nurses for IPV patients. Beccaria, et al. (2013) suggested that nursing students need more education in nursing interventions about learning how to address the emotional needs of an IPV patient. Ross, Hoff, and Cout-Wakulczyk (1998) recommended that schools of nursing are in need of increased, systemic curriculum addressing violence against women and children. Also, students need experience with patients who have faced violence in their lives. Additionally, faculty needs to share resources and develop strategies with other schools of nursing to gain expertise in violence studies.

Process to Accomplish

A nonexperimental, descriptive, quantitative study was conducted utilizing an online questionnaire that was completed by FNP's employed at RHCs to address their views, barriers, and knowledge on IPV screening. A cross-sectional survey was performed utilizing a validated questionnaire from Natan and Rais (2010) (see Appendix

A) and was adapted (see Appendix B) and aimed to address each research question presented for a period of time. The researcher received permission to utilize and adapt the questionnaire (see Appendix C). Both descriptive and inferential statistical analyses were conducted in this study.

Population and Sample

The population for this study was in Illinois (IL) FNPs who work in RHCs. Homogeneity of the population was important; therefore, only RHC FNPs were studied (Robson, 2011). The results of this study attempted to generalize the findings to RHC FNPs. The sample was drawn from FNPs who work full-time, part-time, or as needed (pro re nata or PRN) in RHCs across IL. Identifying information such as work status was addressed in the questionnaire. One-hundred RHC FNPs was the goal sample size. The researcher would like to achieve at least a 60-to -75% response rate (Robson). Out of 100 questionnaires distributed, at least 60 should be completed.

Measures

An adapted questionnaire from the Natan and Rais, 2010 was utilized. The questionnaire's reliability was Cronbach $\alpha = 0.85$, and contained content validity. The questionnaire was comprised of 46 statements. Section I of the questionnaire consisted of four items requesting demographic information, e.g., gender, ethnicity, age, and area of residence. Section II continued with 7 demographic information items regarding professional education, four items, and employment, three items. Section III contained violence-training questions, three items. Section IV contained 19 items that dealt with views and knowledge about violence. For example, one of the statements indicated that the FNP would lose his/her patient's trust if he/she asked the patient questions about

violence. The FNP would respond on a scale of one, strongly disagree, to six, strongly agree. Section V contained nine items that dealt with FNP roles taken during IPV disclosure. A statement involved an FNP giving a patient of IPV phone numbers for counseling and support services. The FNP would respond on a scale of one, strongly disagree, to six, strongly agree. Section VI contained four items that dealt with IPV situations. Of the four questions, two of them required a nominal response, and the other two require a multiple-choice response.

Research Question 1 was best addressed with Sections II, III, and IV statements. Research Question 2 was best addressed with Section IV statements. Research Question 3 was best addressed with Section V statements.

Procedures

Survey Monkey®, an online questionnaire, was utilized to collect data. To assist with sample size, two groups were approached. First, with permission from a state professional organization, a SurveyMonkey® link was e-mailed to its members, inviting only FNPs who work in RHCs to participate in the study. Second, a convenience sample of FNPs from RHCs was obtained. They were sent the SurveyMonkey® link to their work e-mail, and the link was also available for 30 days. After 30 days, the SurveyMonkey® link via e-mail was deactivated. Once the FNP opened the link to begin the questionnaire, informed consent was obtained. The cover letter thanked the FNPs for their participation and indicated to the FNP participants that they were anonymous, that their answers were confidential, that they could stop answering the questionnaire at any time without consequences, and that they could contact the researcher with any questions, comments, or concerns.

In order to increase the rate of return, the researcher distributed the questionnaire during a low-peak time, such as non-holiday and vacation times, to both groups of FNPs. The Executive Director (ED) of the state professional organization e-mailed all members on behalf of the researcher. The ED was given the cover letter from the researcher to utilize for the body of the e-mail. The e-mail included a brief message from the researcher inviting only FNPs who currently work in RHCs to participate in a study regarding views of RHC FNPs to IPV screening. The e-mail indicated that RHC FNPs' participation would promote knowledge regarding views their views about IPV screening. The researcher e-mailed the cover letter, and included in the SurveyMonkey® link to her personal FNP contacts that are employed at RHCs. To promote a higher response rate, a follow-up e-mail was sent to both groups on days 14, 21, and 27 from the start of the collection period by both the ED and researcher. The questionnaire took approximately 10-15 minutes to complete.

Descriptive analyses such as central tendency, i.e., mean, median, mode, variability, and standard deviations were conducted on the ratings as a function of the demographics and responses to categorical questions. These analyses provided tabular depictions of the data gathered from the questionnaire. The inferential statistical analyses utilized to determine the relationships between the variables from the questionnaire were independent samples *t*-tests and Pearson product moment correlation.

Research Question 1: What is the relationship between how much knowledge RHC FNPs have regarding IPV and the strength of agreement rating scale scores? Some of the questionnaire statements that assisted in answering this research question are as follows: The FNP would be harming his/her patient if she/he asked the patient about

violence; the FNP believed that his/her patients do not suffer from violence; the FNP believed that there is no way to identify violence; and the FNP believed that violence is not a medical condition.

Variables

There were different statements about FNPs' knowledge, which served as an independent variable. These statements were rated and the rating scores, reflecting how strongly the nurse's knowledge was suited to IPV. IPV training served as independent variables in some of the analyses. The number of months an FNP was employed and knowledge statements served as the X and Y variables.

Data

Ratings on the questionnaire, as well as demographic items on the survey, provided the data set used to address this question (e.g. gender, age, IPV training, work status, knowledge statements on questionnaire). The FNPs participants were asked to rate their strength of agreement with a series of statements on a scale of one, strongly disagree, to six, strongly agree, which were designed to assess their beliefs about FNPs knowledge of screening for IPV in RHCs. The lower scores on the knowledge statements signified IPV knowledge.

Analyses

Descriptive statistical analyses such as mean ratings for different methods for addressing IPV were used. Also, inferential analyses were conducted to determine which IPV knowledge would be seen as best suited for use in RHCs. An independent t-test was conducted with the specific statements regarding knowledge of IPV. Pearson product

moment correlation was used to determine if there was a relationship between time of employment and knowledge statements.

Research Question 2: What is the relationship among the stated barriers for RHC FNP's regarding IPV screening and the strength of agreement rating scale scores? Some of the questionnaire statements that assisted answering this research question is as follows: The FNP agreed that he/she does not have enough time to make a violence assessment in the clinic; the FNP agreed that he/she does not have training in violence cases; and the FNP agreed that upper-class women are not involved in IPV situations.

Variables

The participants were given a number of statements about possible barriers to be overcome were asked to rate the extent to which each item listed would be a barrier or how difficult the barrier might be to overcome. These statements were rated and the rating scores, reflected how strongly the nurse's barriers was suited to IPV screening.

Data

Ratings on questionnaire items regarding possible barriers were measured compared to screening statements. The FNP's participants were asked to rate their strength of agreement with a series of statements on a scale of one, strongly disagree, to six, strongly agree, which were designed to assess their barriers about FNP's role of screening for IPV in RHCs. The lower the scores on the barrier and screening statements indicated fewer barriers to IPV screening.

Analyses

Inferential analyses were conducted to determine which IPV barrier statements would be encountered in RHCs. Pearson product moment correlation was used to determine if there was a relationship between barrier and screening statements. Research Question 3:

What is the relationship between the stated roles for FNP's at RHCs regarding IPV screening and the strength of agreement rating scale scores? Some of the questionnaire statements that assisted answering this research question were: The FNP agreed that IPV should be documented in the medical records; the FNP agreed that he/she should inform an abused woman about counseling and support services; and the FNP agreed that giving support to an abused woman who is not at fault for IPV should be done.

Variables

FNP roles served as an independent variable because FNP's may serve in different roles in the RHCs. Some FNP's work full-time, part-time, or as needed. Others may have leadership positions or could be taking on projects within the clinic. Some FNP's have worked in RHCs for more or less than one year. Other FNP's may have worked in other healthcare settings before working in RHCs. The FNP's beliefs toward IPV screening as indexed by their rating scores served as the dependent variable.

Data

The FNP's participants were asked to rate their strength of agreement with a series of statements on a scale of one, strongly disagree, to six, strongly agree, which were designed to assess their beliefs about FNP's role of screening for IPV in RHCs. The higher scores on the role statement signified that the FNP owned the IPV screening role.

Analyses

Both descriptive statistical analyses and inferential statistical analyses were conducted on these data gathered from the questionnaire. An independent samples t-test was conducted to determine if there was a difference in the average scores between groups of one or more variables. Such that FNP's who reported having identified a battered woman or no identification of a battered woman was the between subjects independent variable (IV), and the mean score of the six FNP IPV role statements was the continuous dependent variable (DV). The two groups were only being tested once.

Summary

The researcher sought to explore the views that RHC FNP's have regarding the screening of IPV. The views were captured utilizing a validated questionnaire and having the questionnaire available online for the FNP's to access. In the sections to follow, the researcher presented the investigations of previous researchers done on this topic and the need for this particular study.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

The intent of the Literature Review is to summarize what is already known about IPV screening in various healthcare settings. One phenomenon that the literature revealed was that the healthcare utilization rates of IPV in various healthcare settings exceeded those that rates for patients who do not have a history of IPV (Prosman, Lo Fo Wong, Bulte, & Lagro-Janssen, 2012; Rivara et al., 2007). More specifically, with the presence and growing number of RHCs, and the millions of patients accessing these clinics for healthcare, RHC FNP's are in an prime position to capture IPV patients and screen them for IPV in order to provide early detection, management, and referral to community resources. Gerlock, Grimesey, Pisciotto, and Harel (2011) also found that regardless of the healthcare setting a patient presents to, she should be screened for IPV and be given the appropriate resources by her health care provider (HCP).

There are long-term effects of IPV on women including high rates of adverse physical, social, emotional, and mental health outcomes. Furthermore, it is not only women who are affected by IPV, but IPV jeopardizes families and families at all levels of socioeconomic status (Rhodes, 2012). Because IPV patients utilize healthcare at high rates (Prosman et al., 2012; Rivara et al., 2007), HCPs regardless of their healthcare setting should have the chance to provide early identification, intervention, and secondary

prevention of IPV. Despite that numerous health organizations have endorsed universal screening of IPV, HCPs have consistently failed to provide IPV initiatives (Rhodes, 2012). Screening for IPV may increase women's awareness that IPV is a legitimate health concern and help them recognize and label their current or future IPV experience (Chamberlain & Perham-Hester, 2002). Having compassionate, nonjudgmental HCPs available to practice/implement IPV screening will encourage women to take advantage of this help if and when they are prepared to disclose (Renker, 2008).

Since the emersion of RHCs across the country in 2000, millions of patients have accessed RHCs for their health needs (Convenient Care Association, 2013; Stempniak, 2013). Regardless of economic status, sexual orientation, or ethnic/racial groups, IPV affects both men and women (Black et al., 2011). Futures Without Violence (2004) recommends IPV screening in all healthcare settings, and RHCs pose no exception to their recommendation. RHCs are staffed with FNPs, FNPs are in a prime position to identify IPV, and they can offer much needed community resources to IPV patients.

The following section of the Literature Review addressed the three research questions in this study. The evidence provided supports the need for IPV screening in RHCs. Most importantly the Literature Review addressed the research regarding HCPs views on their knowledge of IPV, barriers that HCPs encounter when screening for IPV, and what are the roles that HCPs should play surrounding IPV. The last section of the Literature Review provided research in regards to removing barriers of IPV screening and looks at the possibility of incorporating and implementing IPV screening in RHCs based on the evidence available.

Healthcare Utilization

According to the Centers for Disease Control and Prevention (2003),

The costs of intimate partner rape, physical assault, and stalking exceed \$5.8 billion each year, nearly \$4.1 billion of which is for direct medical and mental health care services. The total costs of IPV also include nearly \$0.9 billion in lost productivity from paid work and household chores for victims of nonfatal IPV and \$0.9 billion in lifetime earnings lost by victims of IPV homicide. The largest proportion of the costs is derived from physical assault victimization because that type of IPV is the most prevalent. The largest component of IPV-related costs is health care, which accounts for more than two-thirds of the total costs. (p. 8)

IPV patients enter the healthcare system more than their counterparts (Rivara et al., 2007). Because IPV affects all walks of life, and because RHCs are a new and convenient gateway to healthcare for patients to access, there is a possibility that IPV patients are passing through RHCs. RHC FNP's are in a prime position to capture patients who have a history of IPV.

Prosman et al. (2012) conducted a case control study on the healthcare utilization of abused women compared with non-abused women. Prosman et al. found that abused women visited their HCPs almost twice as often as non-abused women. The abused women saw their HCPs for social, substance abuse, and reproductive health problems. IPV patients were significantly more often referred to mental healthcare and had more additional diagnostic testing done than their counterparts. The authors also found that abused women were prescribed antidepressants at a rate of 4.1 times more than non-

abused women (Prosman et al.).

Klap, Tang, Wells, Starks, and Rodriguez (2007) mentioned that patients with a history of IPV were frequently encountered in healthcare settings. The authors mentioned that IPV is a risk factor for physical and mental health issues. Klap et al. sought to determine national rates of IPV screening, predictors of screening, and to identify what type of healthcare settings screen for IPV.

Klap et al. (2007) conducted a telephone survey of 4,821 women over the age of 18. The authors asked the participants if their HCP had ever screened them for IPV. Out of the 4,821 surveyed, 337 women had been screened for IPV by their HCP in primary care settings. Most of the women had been screened for IPV in primary care settings. The second most common area where women had been screened for IPV was in mental health settings (Klap et al.).

Klap et al. (2007) found that IPV rates of screening were low in their study. The authors recommended that HCPs receive training to screen for IPV. Also, they emphasized the importance of raising IPV awareness and the health consequences of IPV to HCPs (Klap et al.).

Through a longitudinal cohort study, Rivara et al. (2007) sought to compare healthcare utilization and medical care costs between women with and without a history of IPV. Telephone interviews were conducted on 3,333 women who were aged 18-64. A total of 1,546 women reported IPV in their lifetime. Of these women, 1,345 women reported that IPV had ceased on an average of 16 years before the researchers had interviewed them on the phone. The authors found that compared with women without an IPV history healthcare utilization was higher among women with IPV history. The

healthcare services included office visits to primary and specialty care providers, emergency and urgent cares, acute hospitalizations, behavioral health, home care, laboratory, radiological, and pharmaceutical. Healthcare utilization did decrease overtime; however, healthcare utilization was 20% higher with those who had a history of IPV that ceased after five years. The annual total healthcare costs were 19% higher in women with a history of IPV compared with women without a history of IPV. The annual total healthcare cost was \$439.00 per woman with a history of IPV (Rivara et al.).

Due to the effects of IPV, IPV patients have high rates of healthcare utilization (Bonomi, Anderson, Rivara, & Thompson, 2009; Snow-Jones, et al., 2006). Since the emergence of RHCs, millions of patients are tapping into their services. The chances of an FNP encountering a female patient with a history of IPV in an RHC setting are likely. RHC FNPs have abundant opportunities to identify and intervene early, and provide secondary prevention (Rhodes, 2012).

Views and Knowledge

Knowing the HCPs views and knowledge about IPV can determine the barriers to screening and thus why IPV screening rates are low. The barriers to screening should be addressed so that more research can be done to tackle the issues. Also, what HCPs are encountering in their practice that hinders them from screening for IPV should be addressed so that more research can be done to tackle these issues.

DeBoer, Kothari, Kothari, Koestner, and Rohs (2013) aimed to identify hospital-based nurses' perceived attitudes and barriers regarding IPV screening. DeBoer et al. conducted a cross-sectional survey study using both web-based and hard copy versions of

the surveys. There were 156 nurses who completed the survey, and 129 of the nurses reported taking care of less than two IPV patients in the last year (DeBoer et al.).

DeBoer et al. (2013) found that the majority of the 126 nurses agreed with the statement that they have enough time to screen for IPV. Out of the 156 nurses, 93 of them agreed that their work environment provides them the opportunity to screen their patients for IPV. There were 143 nurses who agreed that all patients needed to be screened for IPV regardless of obvious injuries. Nurses were split regarding being adequately trained to recognize the signs and symptoms of IPV. There were 87 nurses who agreed that they were adequately trained to recognize the signs and symptoms of IPV, and 68 nurses who disagreed that they were adequately trained to recognize the signs and symptoms of IPV. Out of the 156 nurses, 148 of them agreed with the statement that it was their business if the patient was a victim of IPV. Also, 140 out of 156 nurses, felt that IPV screening was an important part of nursing practice. Finally, of the 156 nurses, 120 agreed that they felt comfortable screening for IPV (DeBoer et al.).

DeBoer et al. (2013) concluded that nurses do feel that screening for IPV is important, that it is their responsibility, and that they encountered few work environment barriers to screen for IPV. However, in the DeBoer et al. study, 129 out of 156 nurses reported taking care of two or less IPV patients within the last year. The reality is that the prevalence of IPV is close to 16% in a hospital setting, and in the DeBoer et al. study, 71 nurses reported taking care of no IPV patients within the last year. The authors therefore recommended the importance of improving the identification and management of IPV patients.

Being aware of HCPs' perspectives regarding IPV and disclosure is important. Taylor, Bradbury-Jones, and Duncan (2013) conducted a qualitative study that utilized a Critical Incident Technique (CIT) that explored HCPs' beliefs regarding IPV and disclosure. Also, the authors investigated women's beliefs regarding IPV and IPV disclosure. The study used a theoretical model called the Common Sense Model of Self-Regulation of Health and Illness (CSM). The model is generally used to explore the links between cognitive illness and health behaviors. In the Taylor et al. study, the CSM attempted to explain how HCPs' beliefs about the identity and controllability of IPV and how their beliefs shapes their approaches and responses to IPV disclosure. In the study, 29 HCPs and 14 women participated. The CSM had five elements that were utilized to explore the relationship between HCPs beliefs regarding IPV as a chronic medical condition and perspectives of women who experienced IPV. The five elements are as follows:

(a) identity, the label or name given to a condition, (b) cause, ideas about perceived causes of a condition, (c) timeline, beliefs about how long the condition will last, (d) consequences, perceptions regarding the consequences and impact of a condition, and (e) curability/controllability, beliefs about the extent to which a condition can be cured or controlled. (Taylor et al., 2013, p. 490)

First, identity was categorized as types of abuse and sociocultural bias (Taylor et al., 2013). Second, cause was based on associated factors and context such as alcohol and drug use, social isolation, mental health, and pregnancy. Also, cause was considered self-inflicted because IPV was the women's fault by choosing the wrong partner or the woman contributed the violent atmosphere. Third, timeline meant readiness to disclose

during a discrete event, previous concealment, or disclosure as a process. Also, timeline meant manifestation or nature of abuse such as a one-time or chronic event. Fourth, consequences involved several issues. Fifth, curability was based on locus of control performed by the HCP or the woman. The severity of abuse ranged from a life-threatening event or having long-term impact on health. Consequences for women resulted in homelessness and remaining with the perpetrator. The consequences for children were being unsafe and also being protected. The consequences for HCPs were the following: feeling shocked at women's choices, hopelessness, frustration and concern. The Taylor et al. study uncovered the beliefs that HCPs and women of IPV held by using the CSM as a way to view IPV through social phenomena.

Ramsay et al. (2012) aimed at studying the selected United Kingdom (UK) HCPs' level of knowledge, attitudes, and clinical skills in IPV screening. The authors conducted a prospective observational cohort in 48 practices by administering the Physician Readiness to Manage Intimate Partner Violence Study (PREMIS). The survey addressed five sections, responder profile, background including perceived preparation and knowledge, actual knowledge, opinions, and practice issues (Ramsay et al.).

Ramsay et al. (2012) surveyed 272 clinicians, 111 reported postgraduate IPV training, and 76 reported medical or nursing school IPV training lectures. The clinicians reported only having basic knowledge of IPV, but expressed interest in engaging with IPV patients. The clinicians felt ill-equipped to both screen for IPV (79) and to make appropriate referrals (65). Of the clinicians, 109 never or seldom screened for IPV. Then two-hundred eighteen clinicians stated that they did not have an adequate knowledge of local resources. Physicians reported that they were better prepared and more

knowledgeable than nurses. Also, physicians identified a higher number of IPV patients than nurses (Ramsay et al.).

Ramsay et al. (2012) concluded that clinicians' attitudes toward IPV screening were positive. However, the clinicians only had basic knowledge of IPV. The authors recommended that clinicians be trained more on the assessment and intervention of IPV. They further recommended that clinicians be aware of local IPV services (Ramsay et al.).

Lazenbatt, Taylor, and Cree (2009) sought to compare and contrast how midwives working in either a hospital or community-based setting addressed IPV by evaluating their views on IPV, their role in IPV, screening for IPV, and barriers, internal and external, they encountered when screening for IPV in pregnant patients. Lazenbatt et al. conducted a postal survey questionnaire of 983 midwives, 488 midwives completed the questionnaire.

Lazenbatt et al. (2009) found that both group of midwives underestimated the prevalence of IPV. The midwives reported a lack of confidence, education, and training that hindered them from screening their pregnant patients for IPV. The perceived roles in responding and screening for IPV of the 488 midwives were the following: role in responding to IPV, 360 hospital compared with 88 community midwives; screening all pregnant patients for IPV, 202 versus 52, respectively; inquiring about IPV, 84 versus 51, respectively; confidence in addressing IPV, 60 versus 25, respectively; confidence in the identification of IPV, 82 versus 26, respectively. The most common barrier encountered by midwives who had difficulty speaking to pregnant women in private was the patient's own reluctance to leave the partner (Lazenbatt et al.).

Rhodes et al. (2007) conducted a randomized, controlled trial of a self-administered, computer-based health risk assessment tool from June 2001—December 2002. The tool generated health recommendations for patients and alerted health risks to patients including IPV. The trial occurred in two diverse emergency departments. The female patients ranged from 18-65 years old and came to the emergency room for non-emergent medical reasons (Rhodes et al.).

Rhodes et al. (2007) found 77 IPV disclosures out of 293 conversations. Out of the 77 IPV disclosures, 24 of the charts had the IPV disclosures documented in their patient charts. Another finding was that out of the 77 IPV disclosures, 45 of the patients were assessed for their safety at home, 29 patients were shown empathy by the HCP, and only 19 patients were given referrals (Rhodes et al.).

Rhodes et al. (2007) recommended focusing on the use of different communications styles HCPs use because certain types of communication styles can facilitate patient disclosure of IPV. Another recommendation was that further education is needed to improve the HCPs response to IPV disclosures (Rhodes et al.).

Even though patients are reluctant to disclose IPV, they do want to discuss the issue with their HCP (Spangaro, Zwi, Poulos, & Man, 2010). Spangaro et al. stated that previous studies have focused on IPV screening on women in IPV advocacy services who typically have not experienced IPV. In order to obtain a more representative sample, Spangaro et al. conducted a cross-sectional survey of women who were screened six months prior to determine the proportion of both IPV women who disclosed IPV the first time they were screened and those who did not disclose and their reasoning for not

disclosing. The authors reported 122 women who disclosed IPV six months earlier, and 241 women did not disclose IPV at that time (Spangaro et al.).

Spangaro et al. (2010) found that out of 120 women, 27 disclosed IPV for the first time to any person. Of those who did not disclose IPV at the time of screening, 34 out of 240 disclosed IPV six months later. The women stated that they did not disclose IPV for several reasons. Some women felt that the abuse did not appear serious enough to discuss the abuse with their HCP. Also, some women feared that their partner would find out about the IPV disclosure. Another reason was that the women did not feel comfortable with the HCP who was conducting the IPV screening (Spangaro et al.).

Being aware of the views and knowledge of both HCPs and patients can only guide in the interventions needed to feel confident to screen for IPV and to decrease barriers to IPV screening. Nurses felt that it was their responsibility and part of their nursing practice to screen for IPV (DeBoer et al., 2013). Patients want their HCPs to ask them about their situation at home (Spangaro et al., 2010). Knowing nurses' and patients' views regarding IPV screening can support this endeavor in RHCs.

Barriers

Research has shown common barriers that HCPs face that disable them from engaging in IPV screening (Parsons et al., 1995). The common barriers that have been reported are as follows: lack of provider education, lack of time, lack of effective interventions, patients non-disclosing, and fear of offending the patient (Parsons et al.; Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000). The low disclosure rates are a direct result of HCPs hesitating to screen for IPV (Renker, 2008; Waalen et al.).

Addressing these known barriers can support women of IPV so that they will be identified and given the resources that they need to begin the healing process.

Spangaro, Poulos, and Zwi (2011) utilized focus groups with HCPs screening for IPV in order to understand both challenges and enablers of screening and to apply this to a model of how health policies become standardized in practice. There were 10 focus groups totaling 48 participants. Spangaro et al. found three main challenges to implementing screening. They were, difficulty establishing privacy, establishing trust with patients and then having to call child protective services, and patients not taking the HCPs referrals and staying with their abusive partner. The authors uncovered five enabling themes to screening: “(a) scripted questions, (b) training, (c) access to referral services, (d) familiarity, and (e) women’s favorable reactions” (Spangaro et al., p. 134). Despite the challenges of screening, the HCPs indicated that the screening had become routine for them in their practice and allowed the HCPs to gain confidence in screening.

Spangaro et al. (2011) utilized the normalization process theory by Carl May. The normalization process theory was made to understand how complex health interventions could become routinized in practice. May (2006) named four elements which were: (a) interactional workability, defined as the impact on the worker-patient interaction; (b) relational integration, defined as how work is understood by networks of people around it including patients and other health professionals and whether it increases accountability or confidence; (c) skill set workability, defined as fits with existing role definitions of health professionals; and (d) contextual integration, defined as the organizational sponsorship and control of the work (p. 139).

The four enablers found in this study aligned with May's elements of routinization. First, the scripted questions and the patient's favorable responses aligned with interactional workability. Second, the IPV training and referrals aligned well with relational integration. Third, the skill set workability was achieved by inserting the screening tool in already existing assessment tools. Fourth, the contextual integration matched the statewide policy for annual monitoring and formal process for implementation of the screening (Spangaro et al., 2011).

Jonassen and Mazor (2003) aimed at identifying potential barriers that new medical residents faced when screening for IPV. The authors indicated that in order for IPV to occur, certain factors must be present such as patient attributes, physician training, competence, and patient comfort. Previous studies had reported that the IPV curriculum physicians received in medical school was inadequate. The authors pointed out that inadequate educational preparation concerning IPV plays a role in the low frequency of physicians screening for IPV (Jonassen & Mazor).

Jonassen and Mazor (2003) administered a questionnaire to medical residents depicting patient scenarios. The residents were more likely to screen for IPV when a patient had the two following characteristics: young-aged female and patient bruising. Male residents were less likely to screen for IPV compared with female residents. The authors recommended improving medical education programs promoting the routine of IPV screening (Jonassen & Mazor, 2003).

Parsons et al. (1995) sought to determine the screening behaviors of obstetrician-gynecologist (OB/GYNE) and the barriers they encountered with IPV screening. Parsons et al. developed a questionnaire to capture the attitudes and current screening practices of

OB/GYNs of IPV. A randomly selected sample of 6,568 OB/GYNs were mailed the survey, and 962 returned the survey. There were 746 male and 215 female respondents. Male OB/GYNs were less likely to screen than female OB/GYNs. Of the male physicians, 253 of them indicated that they had had no training in abuse. The male OB/GYNs who stated they had had training were more likely to screen for IPV (Parsons et al.).

Parsons et al. (1995) found that the most common barrier reported in screening for IPV was lack of education. Out of the 961 respondents, 442 indicated that abuse was not a problem found in their patients, 377 mentioned that they had lack of time to confront abuse, and 329 were frustrated that they could not help the IPV patient. The authors concluded that the majority of OB/GYNs do not screen their patients for IPV. Parsons et al. recommended that in order for IPV screening to be universal and to overcome the stated barriers, educational tools, and training materials are needed. Because of barriers that HCPs encounter, screening rates for IPV is low (Renker, 2008; Waalen et al., 2000). Addressing the known barriers that both HCPs and patients encounter in healthcare settings could help guide interventions to make IPV screening possible in RHCs.

Health Care Providers' Roles

In the fiscal year 2014, there are 178,302 active Registered Nurses, according to the Illinois Department of Financial and Professional Regulation (2014). As of August 7, 2014, there are 9,102 active Advanced Practice Nurses (APNs) and of those APNs, there were 5,885 Certified Nurse Practitioners (CNPs). Because nurses are the largest group of HCPs, their manpower enables them to perform IPV screening and to detect, and manage

IPV (Daniel & Milligan, 2013). With the presence of RHCs, FNP's are readily accessible, and patients are satisfied with their care (Hunter et al., 2008).

In Chapter One, the Natan and Rais (2010) study found that nurses felt IPV screening was an important role for them. The following discussion shows supporting evidence regarding the HCP role in IPV screening. One of the most important messages to take away from the following section is that HCPs need to be knowledgeable about community resources in order to help IPV patients.

The American Nurses Association (2000) published a position paper on violence against women that supported universal screening of IPV, routine assessment of IPV, and documentation for all victims in any healthcare setting, including the offices and clinics where FNP's work (Ward & Wood, 2009; Wilson, Lane, & Gillespie, 2006).

The American Nurses Association's position paper regarding violence against women is as follows:

The ANA supports education of nurses, healthcare providers and women in skills necessary for prevention of violence against women; assessment of women in healthcare institutions and community settings; and research on violence against women. ANA believes there is a critical need for attention to and increased awareness of the problems of violence against women by all healthcare providers in order to reduce immediate and long-term physical and psychological injuries that are associated with this crime. Through knowledge and clinical skills, nurses can engage in the assessment, intervention and prevention of sexual assault and domestic violence. Further, ANA supports a coordinated, interdisciplinary community-based focus using Healthy People 2010 objectives and other research

that promote surveillance, prevention and intervention for violent behavior as priority issues for the nation. (ANA, 2000, para. 1)

Safety plan.

After a patient decides to disclose IPV, the FNP would need to do an assessment of the patient's immediate safety and implement a safety plan (Futures Without Violence, 2004; Ward & Wood, 2009). A good safety plan may include having extra keys, clothing, money, and important documents, such as driver's license, birth certificate, passport, car insurance and title, available and having the patient provide family and friends with a pre-arranged signal to inform them that she is in trouble or having any other pre-arranged way to keep her from becoming a victim again. Also, the safety plan should include the IPV hotline numbers and websites, and local shelters. Other safety information can include IPV victim advocates and mental health providers contact numbers. FNPs must ensure that the patient keeps all information regarding her safety plan away from the abuser: danger may be inflicted upon the patient if her partner is aware that she is trying to escape or if she has reported the relationship (Futures Without Violence; Ward & Wood).

Patients that have experienced IPV desire to have their HCPs to inquire about family conflict, listen to their story, and provide needed information and referrals (Burge, Schneider, Ivy, & Catala, 2005; Ward & Wood, 2009). FNPs are in a prime position to reassure a patient that they will provide help regardless of the patient's decision to stay or not stay in the relationship (Coker, 2007; Ward & Wood). The FNPs role does not include determining what is best for a patient, but instead the FNPs role is to offer the available options and provide then necessary support in making decisions. By having the

patient break the cycle of IPV, restores and enables the patient to restore and gain control of her life back (Goff, Shelton, Byrd, & Parcel, 2003; Futures Without Violence, 2004; Ward & Wood).

Documentation.

In cases of IPV, documentation provides an important record that may help the patient in various ways (Ward & Wood, 2009). Also, documentation facilitates the communication between HCPs dealing with the IPV case, including previous episodes of abuse. Documentation can help the patient recognize and acknowledge abuse and showcase the abuse escalation over a period of time (Griffin & Moss, 2002; Rudman, 2000; Ward & Wood).

FNPs must include a thorough history. The history should include information regarding past health and social histories. Social history should capture sexual history including sexually transmitted infections, and sexual assault, and tobacco, alcohol, and drug use should be documented in the patient's record (Ward & Wood, 2009).

The documentation of subjective data should be included as well. An accurate depiction of the IPV incident should include the patient's own words using quotation marks. If the patient mentions any names, then include the name as well. Documenting the time of the IPV occurrence as well as when the FNP saw the patient should be included in the patient's record. The FNP should include the patient's demeanor and appearance and any reported threats and psychological abuse perpetrated by the abuser (Rudman, 2000; Ward & Wood, 2009).

Pertinent physical exam findings should be documented (Ward & Wood, 2009). A body map is an accurate way to depict any areas of injury. If necessary and accessible,

with a patient's signed consent photographs may be taken of any injuries. If photographs of the patient's injuries are taken, then the patient's and the photographer's identification must be included in the patient's record. Body parts as well as any measurements should be included on the photographs to help clarify the subject of the photograph. There are photographic principles to follow when taking photographs of injuries, which are beyond the grasp of this paper (Ward & Wood).

If there were any laboratory tests, radiography, and/or other diagnostic tests that were ordered, then those tests and results should be found in the patient's record (Ward & Wood, 2009). If the FNP made any referrals to local shelters or victim advocate, then that must be documented. A risk assessment needs to be completed if a patient has disclosed IPV (Futures Without Violence, 2004; Rudman, 2000; Ward & Wood).

Mandatory Reporting.

In Chapter One, the Illinois' requirements for IPV were mentioned. FNPs should be aware of IPV reporting guidelines in states in where they practice (Ward & Wood, 2009). A synopsis of current state statutes and reporting guidelines are available, and state statute numbers are listed (Durborow, Lizdas, O'Flaherty, & Marjavi 2010; Futures Without Violence, n.d.). Supporting mandatory reporting laws provide these four benefits: (a) facilitates of prosecuting the perpetrators, (b) helps identify victims, (c) promotes intervention, and (d) improves data collection (May, 2004; Ward & Wood). In contrast, mandatory reporting laws can certainly put the victim in danger and violates the patient's right to make her own decision (Ward & Wood). The responsibility of the patient's safety then becomes that of the HCP's, who in turn, relies on law enforcement and the courts to provide safety for the patient.

Referrals.

The identification of IPV provides no benefit without a sufficient referral system in place (Ward & Wood, 2009). The patient who disclosed IPV needs assistance on what services are available. There are numerous resources the FNP's can access in order to take action against IPV. First, FNP's should become familiar and establish relationships with local domestic violence shelters. These shelters have numerous resources that can help the IPV patient. Most centers offer a 24-hour hotline, advocacy within the community, as well as temporary shelter for patients and their children if there are safety concerns about them returning home. Advocacy within the community can include legal aid such as restraining orders; housing, mental health, and dental referrals; drug and alcohol programs including support groups; and accessing local and government assistance programs (Ward & Wood).

Another referral option for FNP's to be aware of are local sexual assault centers (Ward & Wood, 2009). If an IPV patient has been sexually assaulted, then they can be taken care of by counselors, support groups, and victim advocates, and they can receive a thorough physical exam and testing. FNP's need to be cognizant of the fact that they need to give patients referrals for services that she can access discretely so that her safety is not compromised. If the patient's abuser discovers her disclosure, then she can be in imminent danger, and the FNP needs to have a discussion with the patient regarding the safest action for her situation (Ward & Wood).

There are resources that can be found online, and this section will highlight the most popular and helpful. The National Coalition Against Domestic Violence (NCADV) contains public policy information and local IPV contacts (Ward & Wood, 2009). The

National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization contains usable screening tools, safety plans, discharge instructions, and script prompts. Other useful tools that can be easily placed in the waiting, exam, and rest rooms are posters, safety cards, pamphlets, and the pregnancy wheel. Generally, this information has steps outlined that women can take to protect herself and her children. Also, this information provides the National Domestic Violence Hotline (Ward & Wood).

IPV patients should also have legal information readily available (Ward & Wood, 2009). The website womenslaw.org provides easy-to-understand legal information. There is information regarding restraining orders, court forms, sheriff office locations, and other legal information (Ward & Wood).

Brykczynski, Crane, Medina, and Pedraza (2009) conducted a qualitative study of experiences that APNs had with women who had experienced IPV. Brykczynski et al. utilized face-to-face interviews with 10 APNs concerning the ways APNs support and help women of IPV. The authors sought to promote more understanding of IPV and stimulate changes in education, practice, research, and health policy (Brykczynski et al., 2009).

Brykczynski et al. (2009) found that APNs experience both challenges and successes when taking care of women living with IPV. The authors depicted several major themes that had emerged: receptivity, promoting safety, the cycle of violence both relapsing and celebrating success, pattern recognition, turning points, sense of the situation, universality, commitment, stigma, and mind-body separation. The authors concluded that APNs have a wealth of clinical knowledge concerning patient situations

that can set the foundation for the development of interventions for healing, facilitating women's survival, and preventing further abuse (Brykczynski et al.).

IPV is not limited to any economic status, ethnic background, and educational levels (Ward & Wood, 2009). IPV may result in damaging health consequences for patients. In many cases, the damage will result in long-term health consequences.

Although FNPs may not have the capabilities to eradicate IPV, being aware of the subtle signs of IPV, screening every patient, and providing the appropriate community resources (Ward & Wood) can be lifesaving actions for one patient at a time.

Implementation

With all the various types of IPV screening methods, which one(s) would support IPV screening in RHCs? Being familiar with the evidence, will be the guide what to avoid when trying to implement IPV screening in RHCs. Factors such as maintain confidentiality and FNP, staff, and patient safety are important considerations in choosing the best IPV screening method.

Gillum, Sun, and Woods (2009) noted that IPV has been linked to adverse physical and mental health consequences. The authors reported results from a randomized control trial pilot study that was designed to assess the effect of IPV women engaging in safety-promoting behaviors to avoid these adverse consequences. A total of 41 women participated in the study. Twenty-one women were in the intervention group. They received both on-site and telephone counseling over a three-month time frame. The 20 women in the control group received educational brochures and a listing of community resources (Gillum et al.).

Gillum et al. (2009) determined that the intervention group engaged in 3.47 more safety-promoting behaviors, such as hiding an extra set of car keys or having an extra bank account compared with the control group. Gillum et al. also mentioned that there are high rates of IPV victims seeking care in healthcare settings. The authors highlighted that medical clinics can positively impact a patient experiencing violence by routinely screening for IPV and having on-site interventions. The authors suggested that on-site interventions have the potential to identify and increase safety in IPV patients. Gillum et al. concluded that their study provides a model for implementing a low-level intervention that provided benefits for women of IPV. Medical clinics have the opportunity to screen for IPV and to provide intervention services to those patients experiencing IPV (Gillum et al.), which are positively impacts the IPV patients.

Hewitt, Bhavsar, and Phelan (2011) hypothesized that linking an IPV screening tool with an alcohol abuse-screening tool would result in higher rates of IPV disclosure. Hewitt et al. conducted a prospective study on 125 patients. Of the 125 patients, 14 women disclosed IPV, and four out of 14 women were admitted for IPV injuries.

Hewitt et al. (2011) found that asking IPV screening questions along with asking, alcohol abuse-screening questions, i.e., using both screenings tool together resulted in higher rates of IPV detection. Regardless of why the patient was seeking health services, the authors pointed out that linking the two screening tools has the potential to improve IPV detection. Hewitt et al. study encourages the use of both screening tools that may be beneficial in RHCs.

O'Campo, Kirst, Tsamis, Chambers, and Ahmad (2011) generated evidence from performing a realist-informed systematic review. O'Campo et al. were interested in re-

evaluating the evidence on program mechanism of universal screening for IPV and disclosure. O'Campo et al. reviewed scholarly articles from January 1990 to July 2010 and used 23 articles for their study. They identified 17 programs that took a comprehensive approach, such as the incorporation of multiple program components and institutional support. More specifically, there were four programs that appeared to increase provider self-efficacy for screening, which included institutional support, effective screening protocols, initial and ongoing training, and immediate access and referrals to onsite and/or offsite support services. O'Campo et al. concluded that a multi-comprehensive IPV screening program approach supports building provider self-efficacy for screening.

Grafton, Wright, Gutmanis, and Ralyea (2006) performed a yearlong investigation of professional development strategy on public health nurses (PHN) to improve their IPV documentation among low-risk postpartum women. The strategy involved workshops and small group work. Grafton et al. conducted a retrospective chart audit of cross-sectional data one year before the implementation of the Routine Universal Comprehensive Screening (RUCS) Program. The authors found that before the implementation of the RUCS program there was only 0.8% of the charts had included IPV screening. After the implementation of the RUCS program IPV screening increased by 20.5%. Grafton et al. concluded that policy changes involving IPV screening could be improved when specific expectations and documentation notifications are in place. Also, new policies can be effective when they are combined with existing programs and infrastructure; therefore, facilitating the long-term success of new initiatives (Grafton et al.).

Earlier in this section of the Literature Review, three main issues were discussed: views and knowledge of HCPs, barriers encountered in healthcare settings, and roles of HCPs surrounding IPV. By being aware of these issues, one can guide the implementation of IPV screening in RHCs. Being knowledgeable of various implementation strategies will guide RHCs.

Screening Methods

Various screening methods have been utilized in certain healthcare settings. Being knowledgeable of certain screening methods, may contribute to supporting the most effective screening method(s) in RHCs. When RHCs begin screening for IPV, then identifying the most optimal screening methods are vital to the detection and management of IPV.

Renker (2008) sought to determine whether computer assisted self-interviewing (CASI) screening for IPV would increase both HCP IPV screening and patient disclosure rates of the patients. The CASI included but was not limited to desktop, kiosk, laptop computers, and handheld devices, which have video and audio capabilities to those who may need them. Renker performed a review that compared computer screening with face-to-face and written methods. The author found that the prevalence of IPV was captured 16-19% with CASI versus less than 1% to 11.2% with written or interview methods. Renker found that women favored CASI screening compared with other approaches. Renker also found that HCPs supported CASI screening initially but concluded that the research on long-term outcomes of CASI screening as well as its use in various healthcare settings is limited. CASI IPV screening may address the barriers of HCPs

screening for IPV, patients reluctance to disclose IPV, and facilitate institutions' goals of screening for IPV (Renker).

Chen et al. (2007) undertook a study that compared three ways of IPV screening by administering a brief questionnaire by one of three methods; by self-administration, medical staff, or physician interviews. The authors conducted a randomized control trial of the three methods of administering the questionnaire. There were 523 women that were eligible to participate in the study (Chen et al.).

Chen et al. (2007) found that both the patients and clinicians were comfortable with the screening questions as well as the method of administration. The average time spent for IPV screening was 4.4 minutes. The authors concluded that patient self-administered IPV screening was as effective as the clinic interview in regards to rates of disclosure, comfort and the time spent to screen for IPV (Chen et al.).

MacMillan et al. (2009) sought to determine the optimal method for screening IPV in a healthcare setting. Even though some professional organizations have recommended IPV screening in healthcare settings, MacMillan et al. pointed out that there was limited information regarding the accuracy, acceptability, and completeness of different IPV screening methods and instruments (MacMillan et al.).

MacMillan et al. (2009) conducted a randomized control trial in two of each emergency rooms, family practice clinics, and women's health clinics. There were 2461 women who participated in one of three screening methods. The three screening methods conducted were face-to-face interviews with a physician or a nurse, a written questionnaire, and a computer-based self-completed questionnaire. The authors randomly administered two screening instruments called the Partner Violence Screen (PVS) and the

Woman Abuse Screening Tool (WAST) during the methods. The PVS and WAST were compared against the criterion standard of the Composite Abuse Scale (CAS). The CAS questionnaire was completed after each method (MacMillan et al.).

MacMillan et al. (2009) found that regardless of the instrument, the patients preferred the self-completed approaches to IPV screening as opposed to the face-to-face screening. MacMillan et al. found out that written screenings on the WAST had the fewest missing answers to the questions. However, the prevalence of IPV was reported fewer times on the written WAST screenings compared with the face-to-face interviews and computer screenings (MacMillan et al.).

MacMillan et al. (2009) conducted a useful study in the area of what method would be most preferred for IPV screening by patients in various healthcare settings. Because of the sample size of 2,461 women, the authors' findings were important to consider for both clinical implications and research on IPV. The authors found that the written screening method produced the least amount of missing data so that written screening may be the method of choice in other healthcare settings unlike what was previously found on the written WAST screening (MacMillan et al.).

There are various IPV screening methods available such as face-to-face, written, and computer-based (Chen et al., 2007; MacMillian et al., 2009; Renker, 2008). Based on the studies presented, anyone of these screening methods could be utilized in a RHC setting. Future studies would need to be conducted in order to determine what type(s) of screening methods would be most effective in RHC settings.

Training

One of the most named barriers to IPV screening was lack of IPV training (Parsons et al., 1995; Waalen et al., 2000). Identifying barriers will only support HCPs to feel confident in screening for IPV. Training is recommended to begin in nursing and medical schools in order to prepare HCPs in practice (Beccaria et al., 2013; Ross, et al., 1998). Institutions where IPV screening occurs need to provide on-going education (Parsons et al., 1995).

Chapin, Coleman, & Varner (2011) mentioned that the strongest predictor of a HCP to screen for IPV and provide community referrals is the individual's practitioner commitment to screening and referring. In order for IPV screening and referrals, the HCP has to be dedicated, knowledgeable, and confident in their abilities or self-efficacy. Chapin et al. performed a post-test survey on a convenience sample of 320 nurses and medical students who participated in an IPV training program that was provided by a domestic violence shelter.

The Chapin et al. (2011) study used posttest surveys to measure the five following areas: self-efficacy, usefulness of screening, accessibility of services, understanding the obstacles faced by IPV patients, and the level of knowledge regarding local IPV services. The authors reported the following: as both as knowledge of services and understanding of obstacles increased, self-efficacy increased; medical personnel reported that they were confident in screening for IPV; self-efficacy was not reflected on how medical students and nurses felt regarding their current screening; if it was in fact useful to identify IPV patients, then correlation between self-efficacy and the accessibility of IPV services was not significant (Chapin et al.).

Chapin et al. 2011 concluded that the IPV training by a domestic violence shelter better prepared the medical students and nurses in regards to knowledge of services available to IPV patients and obstacles faced by IPV patients. Therefore the knowledge of services and obstacles were both related to self-efficacy. Chapin et al. suggested that partnerships between medical schools or hospital systems with non-profit domestic violence centers might provide cost-effective IPV training.

Hamberger et al. (2004) evaluated the effectiveness of training on the attitudes and self-efficacy of 752 HCPs toward identifying and helping IPV patients. The authors conducted a three-hour IPV training session with the HCPs. They were interested in determining whether increased self-efficacy of HCPs was related to being able to screen and help IPV patients.

Hamberger et al. (2004) tested four hypotheses during pre-and post-training and at a six-month follow-up. The first hypothesis was supported that training would increase self-ratings of efficacy to identify and help IPV patients, was supported. The second hypothesis was supported that training would increase endorsement of healthcare settings that served as an area where IPV patients can receive support, was supported. The third hypothesis was also supported that training would increase comfort in making referrals to community resources was also supported. Finally, the fourth hypothesis, was also supported that prior training in IPV or prior experience aiding a patient of IPV provided little changes to attitudes and self-efficacy of HCPs, was also supported. All four hypotheses were supported. Also, the authors found that extensive training, such as eight-hour long sessions, may not be necessary. Hamberger et al. suggested that HCPs who

have prior IPV experiences could build on their knowledge to develop shorter training models.

Based on the evidence, lack of training of HCPs appeared to be one of the most mentioned barriers to IPV screening (Jonassen & Mazor, 2003; Parsons et al., 1995; Waalen et al., 2000). The recommendation was to begin IPV education and training in medical and nursing curriculum in order to better prepare students for practice (Beccaria et al., 2013; Ross, et al., 1998). Also, on-going education to HCPs was recommended to better equip HCPs with information and confidence to screen for IPV (Chapin et al., 2011; Hamberger et al., 2004). In order to support FNPs in RHCs regarding IPV screening, on-going training would need to be implemented.

Non-Beneficial

Although numerous professional health organizations have recommended IPV screening of asymptomatic women by HCPs, others such as the World Health Organization (WHO), the Canadian Task Force, and the United Kingdom's (UKs) Health Technology Assessment Programme have disagreed with such recommendation (Jewkes, 2013). They have disagreed because of insufficient evidence supporting the IPV screening of asymptomatic women (Jewkes).

The WHO has issued guidelines regarding IPV to help HCPs screen, treat, and support patients of IPV (Eggerston, 2013). Despite WHO stating that "violence against women is a major public health and human rights concern, with intimate partner violence and sexual violence among the most pervasive forms of violence against women" (World Health Organization, 2013, p. 20), it discourages universal IPV screening. The change to previous guidelines was based on the fact that IPV screening has not produced better

outcomes for women of IPV. Instead the guidelines are asking HCPs to screen for IPV when patients have conditions that could be caused or complicated by IPV. Some of the conditions to keep in mind are the following: anxiety, depression, posttraumatic stress disorder, sleep disorders, suicidality or other forms of self-harm, alcohol and other substance abuse. Eggerston identified certain conditions that could be consistent/associated with IPV, such as unexplained reproductive or gastrointestinal.

Hegarty et al. (2013) conducted a cluster, randomized control trials to determine whether brief counseling from IPV-trained doctors would increase women's quality of life (QOL), safety planning and behavior, and mental health. The authors randomly allocated 52 doctors and 272 women to either a 30-minute counseling session, or intervention group, or standard care, or control group. Hegarty et al. detected that after a 12-month follow-up, there was no difference in QOL, safety planning and behavior or mental health. The authors concluded that even though no improvements in QOL were found, counseling did reduce depressive symptoms, and no adverse effects were recorded.

Klevens et al. (2012) sought to determine the effects of computerized IPV screening. The first group was screened plus they were given IPV resources if they tested positive for IPV; the second group was only given a list of IPV resources and were not screened for IPV, and the control group were not screened nor were given IPV resources, but they were given a list of general resources. The authors conducted a three-group blinded randomized control trial on 2,708 women, and 2,364 women participated in a one-year follow-up. Klevens et al. found that there were no significant differences among all three groups in QOL indicators such as mental and physical health components, days

unable to work or complete household tasks, number of hospitalizations, emergency room, or ambulatory, proportion who contacted a victim agency, or recurrence of IPV.

Despite the new WHO guidelines, HCPs cannot ignore the growing rate of violence in the US and around the world (World Health Organization, 2013). The fundamental message is to train HCPs beginning in their education as well as continuing education after they complete medical or nursing schools (World Health Organization, 2013). The researcher of this current study believes that if we already screen patients for smoking, alcohol use, and other medical conditions that are not obvious what makes screening for violence any different? The effects of violence can last many years after the violence has occurred in a patient's life (Daniel & Milligan, 2013), so they too are not obvious.

Summary

Despite what type of healthcare setting a patient chooses to visit, IPV screening should be incorporated during the patient visit (Futures Without Violence, 2004). The health consequences that can burden a patient from the infliction of IPV can linger long after the violence has ended (Campbell, 2002). Many effects of IPV, especially after the cessation of IPV, may not be obvious to an HCP (Daniel & Milligan, 2013; Ward & Wood, 2009).

IPV patients access the healthcare system more times than their counterparts (Prosman et al., 2012; Rivara et al., 2007). HCPs have the capability to identify IPV and to distribute community resources (Rhodes, 2012). Even after 20 years of research supporting IPV screening, changes in health care information technology (HIT), and organizational and healthcare delivery models, IPV screening is not universal yet

(Rhodes). Despite the research indicating that HCPs lack the confidence, knowledge, and time to screen for IPV (Parsons et al., 1995; Waalen et al., 2000), the use of electronic medical records can be a quick, effective and low-cost way that patients can be screened for IPV (Renker, 2008; Rhodes) in RHCs.

Irrespective of the circumstances, health-care providers who come into contact with women facing violence need to be able to recognize signs of it and respond appropriately and safely. Individuals who have been exposed to violence require comprehensive, gender-sensitive health-care services that address the physical and mental health consequences of their experience and aid their recovery from what is a traumatic event (World Health Organization, 2013, p. 20).

Conclusion

Chapter II Literature Review presented research surrounding IPV screening. The researcher would like to point out that what RHC FNP's know regarding IPV, what barriers they face regarding IPV screening, as well as what they feel their roles regarding IPV screening should include could support the implementation of IPV screening in RHCs. The following section will describe the Methodology of this study. A nonexperimental, descriptive, quantitative study was conducted utilizing an online questionnaire that was completed by FNP's employed at RHCs to address their views, barriers, and knowledge on IPV screening. A cross-sectional survey was performed utilizing a validated questionnaire from Natan and Rais (2010) (see Appendix A for original questionnaire) was adapted (see Appendix B for modified questionnaire) and aimed to address each research question presented for a period of time.

CHAPTER III

METHODOLOGY

Introduction

According to the Centers for Disease Control and Prevention, one in three adult women have experienced intimate partner violence (IPV) at least once in their lifetime (Black et al., 2011). As a result of IPV, there are negative effects on one's physical and mental health (Black et al.). Some of the negative effects that IPV patients have manifest themselves as are acute respiratory tract infections and urinary tract infections (Bonomi, Anderson, Reid, et al., 2009), which are commonly treated in Retail Health Clinics (RHCs) (Thygeson, et al., 2008). RHCs are a recent wave of access to healthcare (Convenient Care Association, 2013).

Patients have reported being satisfied with care delivered by Family Nurse Practitioners (FNPs) in RHCs (Hunter, et al., 2008). RHCs have the potential to see 10.8 million patients in a given year (Stempniak, 2013). RHCs have the capacity to capture IPV patients because patients have reported being satisfied with the healthcare they have received in RHCs by FNPs, which may assist with IPV screening.

Because of the dire health consequences of IPV (Coker et al., 2000; Liebschutz, Battaglia, Finley, & Averbuch, 2008) and the substantial costs

(Bonomi, Anderson, Rivara, & Thompson, 2009; Snow-Jones et. al., 2006) required of individuals, family, and society at large, professional health organizations have promoted universal screening of IPV (Futures Without Violence, 2004). Despite the efforts of these organizations, IPV screening does not occur in all healthcare settings. An HCP not to ask about IPV could be considered unacceptable practice (Fox-Bartels, 2008). Chapter III focuses on the following: (a) research design, (b) population, (c) data collection, (d) analytical methods, and (e) limitations of this research study.

There are three research questions that were addressed in this study. The goal of the study was to gain insight on FNP's views on IPV knowledge, barriers, and roles based on their FNP responses to a reliable and valid questionnaire. The following three research questions are as follows:

1. What is the relationship between how much knowledge RHC FNP's have regarding IPV and the strength of Agreement Rating Scale scores?
2. What is the relationship between the stated barriers for RHC FNP's regarding IPV screening and the strength of Agreement Rating Scale scores?
3. What is the relationship between the stated role of RHC FNP's regarding IPV screening and the strength of Agreement Rating Scale scores?

Research Design

A nonexperimental, descriptive, quantitative study was conducted utilizing an online questionnaire that was completed by FNP's employed at RHCs that addressed their knowledge, barriers, and roles on IPV screening. A cross-sectional method utilizing a

group of participants at one point in time (Salkind, 2012) was performed using an adapted questionnaire from Natan and Rais (2010). The questionnaire was available for a time period of 30 days in order to minimize the cost and the dropout rate (Salkind). This study had aspects of both correlational and quasi-experimental methodologies. In the correlational study, the researcher looked at similarities in questionnaire statements among the natural groups, RHC FNPs, while in the quasi-experimental study the researcher looked at differences in questionnaire statements among natural groups, RHC FNPs (Salkind).

Convenience sampling, or participants who were readily available, participated in the online questionnaire (Leedy & Ormrod, 2013). The adapted questionnaire had a reliability of Cronbach's alpha of 0.75, and had established content validity with 13 FNP peers of the researcher.

The goal of research question one was aimed to find out how much IPV knowledge the RHC FNP had based on eight IPV knowledge statements that were based on violence training and the duration of employment. Research question one was best addressed with a question from Section III, IPV Training, and statements from Section IV, Views and Knowledge of IPV, of the questionnaire. The validated questionnaire by Natan and Rais (2010) utilized an agreement rating scale score, 1-6, measuring how strongly the FNPs knowledge was suited to IPV (Section IV). The higher numbers equal stronger agreements with the statement—with 1 equaling strongly disagree and 6 strongly agree. Preferably, the FNPs should respond to lower numbers, 1-3 meaning disagree and thereby indicating having knowledge of IPV. The researcher was interested in the mean scores from the IPV knowledge statements and whether an FNP has had violence training

or not. The following illustrates a statement found in Section III, IPV Training that was utilized to address research question one:

13. Have you been trained on the subject of violence? (Yes or No response)

The following illustrates eight statements found in Section IV, Views and Knowledge of IPV that were utilized to address research question one:

1. I'd be harming the patient if I asked her about violence.
3. My patients do not suffer from violence.
7. I have not yet dealt with a violence assessment situation.
12. It's none of my business if the woman is a victim of violence.
14. Some women bring the violence on themselves.
15. Violence is not a medical condition.
16. There are more important problems to deal with than violence.
17. A small amount of physical violence exists in every normal family.

Research question one was also addressed utilizing the duration of time an FNP was employed in an RHC with the eight Section IV, Views and Knowledge of IPV, statements mentioned above. The researcher sought to investigate whether there was a relationship between time employed as an RHC FNP and IPV Knowledge.

The purpose of research question two was to investigate whether there was a relationship between the mean barrier scores as an FNP in RHC and mean scores of IPV screenings performed on every woman patient. Research question two was best addressed with Section IV Views and Knowledge of IPV statements.

The validated questionnaire by Natan and Rais (2010) utilized an agreement rating scale score, 1-6, that measured how strongly the FNP encountered barriers to IPV

(Section IV). The higher numbers equal stronger agreements with the statement—with 1 equaling strongly disagree and 6 strongly agree. Preferably, the FNP's should respond to lower numbers for 3 statements, 6, 10, and 18; thereby indicating low barriers to IPV screening. For statements 2 and 19, higher scores, 4-6, would indicate that screening for IPV is occurring. Ideally, scores for statements 6, 10, and 18 should be from 1-3, meaning disagree with the statements, and the scores for statements 2 and 19 should be 4-6 meaning agree with the statements. The researcher was interested in the total scores among the five barrier statements. Also, the researcher was interested to find out if there was relationship among the screening statement: A test to identify the victim of violence is a clinic routine performed on every woman and the total scores among the five barrier statements.

The following illustrates three barrier statements and three screening statements found in Section IV, Views and Knowledge of IPV and one screening statement that were utilized to address research question two:

- 6. I don't have enough time to make a violence assessment.
- 10. I am qualified and trained in treating medical problems, not cases of violence.
- 18. I don't have time to ask about violence.
- 4. I intend to ask my patients questions about violence.
- 19. I check for and identify women who are victims of violence.
- 2. A test to identify the victim of violence is a clinic routine performed on every woman.

The purpose of research question three was to determine what the roles of RHC FNP's were when dealing with IPV screening and that if that would be reflective of the

number of identified IPV patients. Research question three was best addressed with Sections VI, Identifying IPV. The validated questionnaire by Natan and Rais (2010) defined FNP's roles within the statements asked to the RHC FNPs. The questionnaire utilized an agreement rating scale, 1-6, reflecting how strongly the FNPs viewed their role in IPV screening (Section VI). The higher numbers, 4-6, equal stronger agreements with the statement—with 1 equaling strongly disagree and 6 strongly agree. Preferably, the FNPs would respond to higher numbers, 4-6 meaning agree; thereby indicating the statement is reflective of their role to screen for IPV. The researcher was interested in the mean scores of certain role statements and how many patients of IPV were identified. The following illustrates six statements found in Section V, Role of an FNP in IPV, that were utilized to analyze research question three:

2. Informing an abused woman of counseling and support services.
3. Documenting IPV in medical records.
4. Giving an abused woman phone numbers for counseling and support services.
5. Giving support to a woman who is not a fault for the violence.
6. Inquiring whether the woman is in mortal danger.
7. Inquiring whether her children are in mortal danger.

The following question is an example of what was found in Section IV, Identifying IPV, and that was utilized to analyze research question three in the past year: How many battered women have you identified?

Population

The population of interest was Illinois FNPs who are employed in RHCs.

The sample was captured via two ways (a) members from a state professional organization and (b) contacting an RHC manager to reach RHC FNPs. The sample included FNPs who work full-time, part-time, or as needed (pro re nata, or PRN) in RHCs across Illinois. Identifying information such as work status and city of residence was addressed in the questionnaire. Demographics included in this research study were gender, ethnicity, age, doctoral degree, non-nursing degrees, and work status, and they can be found on Tables 1-6 below:

Table 1

Gender

Gender	Frequency (<i>n</i>)	Valid Percentage (%) (100%)
Females	62	95.4
Males	2	3.1
No response	1	1.5

^a*n*=65

Table 2

Ethnicity

Ethnicity	Frequency (<i>n</i>)	Valid Percentage (%) (100%)
Asian or Pacific Islander	5	7.7
Black or African American	3.5	9.2
Hispanic or Latino	1	1.5
White or Caucasian	48	73.8
Prefer not to answer	5	7.7
^a <i>n</i> =65		

Table 3

Age Range

Age Range	Frequency (<i>n</i>)	Valid Percentage (%) (100%)
<hr/>		
25-30	8	12.3
31-35	13	20.0
36-40	6	9.2
41-45	7	10.8
46-50	7	10.8
51-55	14	21.5
56-60	6	9.2
61-65	1	1.5
over 65	1	1.5
Prefer not to answer	2	3.1
<hr/>		

^a*n*=65

Table 4

Doctoral Degrees

Doctoral Degrees	Frequency (<i>n</i>)	Valid Percentage (%)
		(100%)
No	59	90.8
Yes	6	9.2

^a*n*=65

Table 5

Non-Nursing Degrees

Non-Nursing Degrees	Frequency (<i>n</i>)	Valid Percentage (%)
		(100%)
No	51	78.5
Yes	14	21.5

^a*n*=65

Table 6

Working Status

Working Status	Frequency (<i>n</i>)	Valid Percentage (%) (100%)
Full-Time	47	27.6
Part-Time	7	4.1
As needed	11	6.5

^a*n*=65

A convenience sample produced 156 respondents. Participants who did not work in RHCs, who did not specify if they worked in RHCs, and those who were not currently employed in RHCs were not included in the study. The total number of participants was 65.

Data Collection

To collect the data, Survey Monkey®, an online questionnaire, was utilized. To assist with the sample size, two groups were approached. First, with permission from a state, professional organization, a SurveyMonkey® link was e-mailed to the members. The link was available for 30 days inviting only FNPs who work in RHCs to participate in the study. Second, a practice manager at one of the RHCs was asked to e-mail the link to FNPs working in the RHCs. The manager was sent the SurveyMonkey link to their employee e-mail, and the link was also available for 30 days. For both groups, the body of the e-mail included the purpose of the study, which was to gather views of RHC FNPs views of IPV screening, how their participation would promote knowledge regarding

RHC FNPs about IPV screening, thanking the FNPs for their participation, indicated to the FNP participants that they were anonymous, that their answers were confidential, that they could stop answering the questionnaire at any time without consequences, and that they could contact the researcher with any questions, comments, or concerns. Once the FNP participants opened the link to begin the questionnaire, informed consent was obtained. The questionnaire took approximately less than 15 minutes to complete.

In order to increase the chance of return rates, the researcher distributed the questionnaire during a low-peak time such as non-holiday and vacation times to both groups of FNPs (Leedy & Ormrod, 2013). The Executive Director (ED) of the state, professional organization, and an RHC practice manager e-mailed all members and employees on behalf of the researcher. To promote a higher response rate, follow-up e-mails were sent to the state, professional group indicating that the online questionnaire remained available for two weeks, one week, and three days. A follow-up e-mail was given to the practice manager to remind the participants that 10 days remained to complete the online questionnaire.

Analytical Methods

In an attempt to analyze the three research questions, this study was both a quasi-experimental and correlational. Research question one was sought to find out if there was relationship between how much IPV knowledge do RHC FNPs have and the strength of Agreement Rating Scale scores. The researcher utilized the statistical method of the *t*-test for independent samples. The researcher sought to find out if there was a difference in the average scores between groups of one or more variables. The FNPs who reported having yes/no to violence training was

between subjects independent variable and the mean score of the eight IPV knowledge statements was the continuous dependent variable. The two groups were only being tested once. The following are the eight IPV Knowledge statements:

1. I'd be harming the patient if I asked her about violence.
3. My patients do not suffer from violence.
7. I have not yet dealt with a violence assessment situation.
12. It's none of my business if the woman is a victim of violence.
14. Some women bring the violence on themselves.
15. Violence is not a medical condition.
16. There are more important problems to deal with than violence.
17. A small amount of physical violence exists in every normal family.

In the second component of research question one the researcher sought to determine if there was a relationship between the number of years an FNP has been employed in an RHC (X variable) and having IPV knowledge (Y variable). The statistical method utilized for research question two was the Pearson product-moment correlation. The researcher sought to assess a linear relationship among continuous variables such that the X variable was the total score for number of months an FNP has been employed with a RHC, and the Y variable was total score for the eight IPV Knowledge statements.

The researcher was interested in knowing if there was a relationship between the stated barriers for RHC FNPs regarding IPV screening and the strength of Agreement Rating Scale scores. The statistical method utilized was the Pearson product-moment correlation. The researcher sought to determine if there is a relationship between three

statement barriers (X variable) and two IPV screening statements on every woman patient (Y variable). The researcher sought to assess a linear relationship among continuous variables such that the X variable was the total score for three barrier statements below:

6. I don't have enough time to make a violence assessment.
10. I am qualified and trained in treating medical problems, not cases of violence.
18. I don't have time to ask about violence.

The three barrier statements represent the Y variable and the X total score for two statements about screening for IPV below:

4. I intend to ask my patients questions about violence.
19. I check for and identify women who are victims of violence.

Also, the researcher was interested to find out if there was correlation among the screening statement:

2. A test to identify the victim of violence is a clinic routine performed on every woman and the total scores among the five barrier statements.

For research question three, the researcher sought to find out if there was a relationship between the stated roles for RHC FNP's regarding IPV screening and the strength of Agreement Rating Scale scores. The statistical method utilized was the *t*-test for independent samples. The researcher was looking to find if there was a difference in the average scores between groups of one or more variables such that FNP's who reported having identified a battered woman or no identification of a battered woman was the between subjects IV, and the mean score of the six FNP IPV role statements was the continuous DV. The two groups were only being tested once. The following are the six role statements and is the Y variable:

2. Informing an abused woman of counseling and support services.
3. Documenting IPV in medical records.
4. Giving an abused woman phone numbers for counseling and support services.
5. Giving support to a woman who is not a fault for the violence.
6. Inquiring whether the woman is in mortal danger.
7. Inquiring whether her children are in mortal danger.

The X variable of one role statements in the past year: How many battered women have you identified?

Limitations

Because this study faced numerous limitations, generalizing the findings to RHC FNPs should be treated with caution. The process concentrated only on Illinois RHCs as IPV screening views, which views may differ from state to state. Because the questionnaire links were e-mailed, there was a possibility that the e-mail went into spam inbox, therefore not reaching the intended participant. Because participants may receive numerous e-mail, there was a possibility that the e-mail was deleted. Participants may have changed their e-mails; they therefore, did not receive the e-mail link, and were unable to participate.

In regards to procedures, the questionnaires were e-mailed, and not in form of a face-to-face interview; therefore, if the participant did not understand the statement, the researcher was not present to clarify the meaning of the statement. Then the statements were being answered based solely on the participants' interpretation of the statement. Also, the timing of when the

participant took the questionnaire matters. If the participant was at work, she/he may have encountered distractions as far as working in a busy clinic during flu season, or if a customer approached the FNP in the clinic inquiring about the location of certain over-the-counter products. This could result in the FNP abandoning the questionnaire.

In looking at the design of the study, the questionnaire consisted of eight pages and 47 statements, so there is possibility that the participants were faced with fatigue and caused them not to complete the questionnaire. Because a convenience sample was utilized, there was a chance that the questionnaire did not capture those participants who may have good insight such as a new member to the professional organization or a new employee.

This study encountered some threats to internal validity. The questionnaires were circulating during heavy National Football League media surrounding IPV; therefore, events could influence the internal validity of history while the FNPs were taking the questionnaire. Because of the small sample size, low return rate, only two males having responded to the questionnaire, and the many others reasons highlighted in this section, generalizing the findings should be done with caution.

Summary

Chapter III focused on the following: (a) research design, (b) population, (c) data collection, (d) analytical methods, and (e) limitations of this research study in order to analyze the three research questions of interest. Chapter III was utilized to bring forward the views of RHC FNPs views on IPV knowledge,

barriers, and roles. The findings of this research study may shed some light on how IPV screening in RHCs can be made available so patients can receive the community resources they need.

CHAPTER IV

FINDINGS AND CONCLUSIONS

Introduction

IPV is not limited to any economic status, ethnic background, or educational level (Ward & Wood, 2009). In many cases, the damage will result in long-term health consequences. IPV may result in damaging health consequences for patients. In many cases, the damage will result in long-term health consequences. Although FNP's may not have the capabilities to eradicate IPV, having IPV awareness of subtle signs of IPV, screening every patient, and providing the appropriate community resources (Ward & Wood) can be lifesaving actions for one patient at a time. Even though patients are generally reluctant to disclose their experience with IPV, they do want to discuss the issue with their healthcare provider (HCP) (Spangaro, et al., 2010).

Chapin, et al. (2011) mentioned that the strongest predictor of an HCP to screen for IPV and provide community referrals is the individual's practitioner commitment to screening and referring. In order for an HCP to screen for IPV and then make a referral to services, the HCP has to be dedicated, knowledgeable, and confident in his/her abilities or self-efficacy (Chapin, et al.).

The goal of the study was to gain insight into FNP's who work in retail health clinics (RHCs) and their IPV knowledge and the barriers they face and the roles they play in IPV patients' care. The three research questions addressed in this study follow:

1. What is the relationship between how much knowledge RHC FNP's have regarding IPV and the strength of Agreement Rating Scale scores?
2. What is the relationship between the stated barriers for RHC FNP's regarding IPV screening and the strength of Agreement Rating Scale scores?
3. What is the relationship between the stated role for RHC FNP's regarding IPV screening and the strength of Agreement Rating Scale scores?

Findings

Research Question 1

In research question one, the researcher was interested in finding out if there was a relationship between how much IPV knowledge RHC FNP's have and the strength of Agreement Rating Scale scores. In order to analyze this research question, the mean IPV knowledge scores among eight IPV statements were recorded with those FNP's who reported *yes* or *no* to IPV training. As illustrated in Table 7, the mean scores and standard deviations of IPV knowledge statements were calculated based on the responses to violence training. A validated questionnaire by Natan and Rais (2010) utilized an Agreement Rating Scale scores, 1-6, measuring how strongly the FNP's' knowledge was suited to IPV, with 1 equaling strongly disagree and 6 strongly agree. The knowledge statements reflect low-to-no knowledge of IPV views. Preferably, the FNP should respond to lower numbers, 1-3, therefore, indicating having knowledge of IPV. Internal consistency of the eight-item IPV knowledge scale was calculated. Coefficient alpha for the scale was .70, indicating a fair degree of internal consistency among the eight items in the scale. The means of the individual items ranged from 1.24-3.69, with a mean on the

total score of 14.62 ($SD = 5.62$) (see Table 7). Overall, the participants' responses on the scale indicated that they had a fairly high degree of IPV knowledge.

Table 7

Mean Scores and Standard Deviations of Intimate Partner Violence Knowledge Statement Responses

Statements	Mean	SD	n
1. I'd be harming the patient if I asked her about violence.	1.24	0.6	62
3. My patients do not suffer from violence.	2.18	1.19	62
7. I have not yet dealt with a violence assessment situation.	3.69	1.93	62
12. It's none of my business if the woman is a victim of violence.	1.35	1.01	62
14. Some women bring the violence on themselves.	1.47	1.20	62
15. Violence is not a medical condition.	1.71	1.41	62
16. There are more important problems to deal with than violence.	1.55	1.15	62
17. A small amount of physical violence exists in every normal family.	1.44	1.00	62

^a $n=62$

As a result, the 36 FNPs who reported *yes* to IPV training ($M = 12.92$, $SD = 5.15$) had statistically significant more IPV knowledge than those 25 FNPs who reported *no* to violence training ($M = 17.16$, $SD = 5.41$), $t(60) = -3.12$, $p = 0.003$, $d = 0.81$.

Related to the second component of research question one the researcher sought to determine if there was a relationship between the number of months an FNP had been employed in an RHCs and having IPV knowledge. Figure 1 illustrates the number of months an FNP has been employed in an RHC. The researcher sought to assess a linear relationship between two continuous variables: the mean number of months a FNP had

been employed in an RHC and his/her mean score for the eight IPV knowledge statements. The results reveal that there was no correlation found between the time employed as an FNP in RHC and IPV knowledge, $r(62) = -0.05, p = 0.73$.

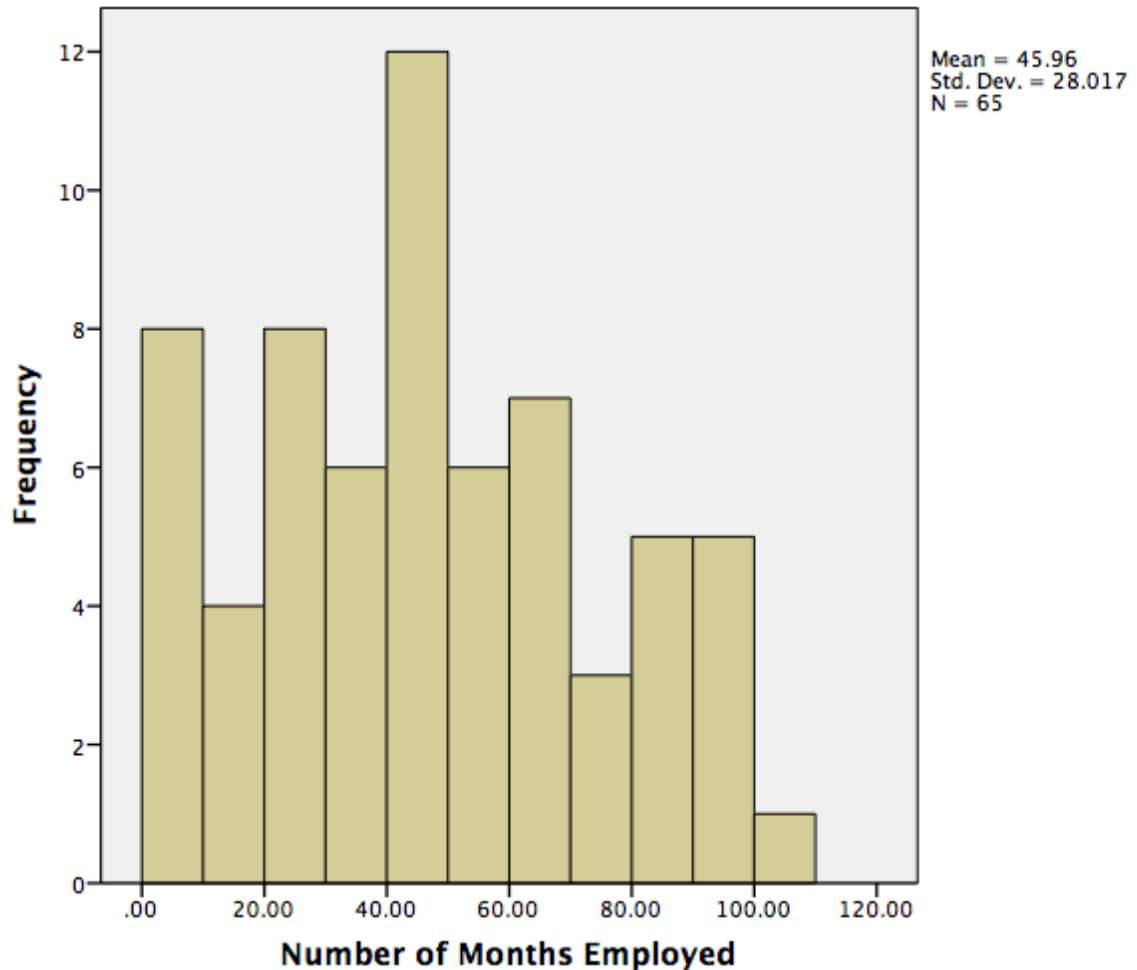


Figure 1 Time employed as an FNP in a RHC

Research Question 2

For research question two, the researcher was interested in knowing if there was relationship between the stated barriers for RHC FNP's regarding IPV screening and the strength of Agreement Rating Scale scores. The researcher sought to determine if there was a relationship between three statement barriers and two IPV screening statements

that assess whether screenings are performed on every woman patient. The researcher sought to assess a linear relationship among continuous variables. Table 8 and Table 9 illustrate the descriptive statistics for the statements of interest.

A validated questionnaire by Natan and Rais (2010) utilized an Agreement Rating Scale scores, 1-6, reflecting the different categories of barriers—with 1 equaling strongly disagree and 6 strongly agree. The barrier statements reflect time, training, intent, and routine screening barriers of IPV. Preferably, the FNP's would respond to lower numbers, 1-3, thereby, indicating encountering fewer or no barriers to screen for IPV.

Internal consistency of the three barrier statements and two statements about screening for IPV was calculated. Coefficient alpha for the scale was 0.74 and .83, indicating a fair and good degree of internal consistency, respectively. For the three barrier statements, the means of the individual items ranged from 2.42-3.11, with a mean on total score of 8.11 ($SD=3.82$) (see Table 8). For the two screening statements, the means of the individual items ranged from 2.61-2.73 ($SD=2.74$) (see Table 9). Overall, the participants' responses on the scale indicated that they encountered low degrees of barriers to screen for IPV and the participants were not screening for IPV.

Table 8

Mean Scores of Intimate Partner Violence Screening Barrier Statements

Statements	<i>M</i>	<i>SD</i>	<i>n</i>
6. I don't have enough time to make a violence assessment.	3.12	1.68	65
10. I am qualified and trained in treating medical problems, not cases of violence.	2.58	1.50	64
18. I don't have time to ask about violence.	2.42	1.63	64

^a*n*=64

Table 9

Mean Scores of Intimate Partner Violence Screening Statements

Statements	<i>M</i>	<i>SD</i>	<i>n</i>
4. I intend to ask my patients questions about violence.	2.73	2.50	64
19. I check for and identify women who are victims of violence.	2.61	1.47	64

^a*n*=64

There was a statistically significant negative correlation found between the total scores for three barrier statements and the total scores for two statements about screening for IPV, $r(62) = -.29, p = 0.02$ (see Table 10).

Also, the total barriers scores were compared against one screening statement: A test to identify the victim of violence is a clinic routine performed on every woman. The response to this statement may differ from the two IPV screening statements because it can be viewed as either a routine clinical task or as holding personal relevance to the FNP. The researcher sought to assess if there was a linear relationship between two continuous variables: the total scores on barrier statements and the screening statement

score. There was a statistically significant correlation found between the total scores for three barrier statements and the total score of the screening statement, $r(62) = 0.37$ $p = 0.003$ (see Table 10).

Table 10

Reliabilities, Means, Standard Deviations, and Correlations for All Variables

Variable	1	2	3
1. Barriers Total	1.0		
2. IPV Screening	-.29*	1.0	
3. Identify	.37**	-.13	1.0
Reliability	.74	.83	N/A
Mean	8.11	5.34	N/A
Standard Deviation	3.89	2.74	N/A

Note. All tests are two-tailed.

^a $n=63$

* $p < .05$

** $p < .01$

Research Question 3

For research question three, the researcher sought to find out if there was a relationship between the stated roles for RHC FNP's regarding IPV screening and the strength of Agreement Rating Scale scores. The researcher sought to determine if there was a difference between FNP's who reported an IPV patient and those who did not report an IPV patient based on their indicated IPV role statements (Table 11).

A validated questionnaire by Natan and Rais (2010) utilized an Agreement Rating Scale scores, 1-6, reflecting how strongly the FNPs viewed their role in IPV screening, with 1 equaling strongly disagree and 6 strongly agree. The role statements support the FNPs' role in IPV screening. Preferably, the FNPs would respond to higher numbers such as 4 or higher, thereby, indicating the statement is reflective of their role to screen for IPV.

The internal consistency of the six-item FNP role statement scale was calculated. Coefficient alpha for the scale was .95, indicating an excellent degree of internal consistency among the six items in the scale. The means of the individual items ranged from 4.15-5.2, with a mean on the total score of 29.29 ($SD = 8.78$) (see Table 11). Overall, the participants' responses on the scale indicated that they had a fairly high degree of IPV roles.

Table 11

Mean Scores of FNP IPV Role Statements

Statements	<i>n</i>	<i>Mean</i>	<i>SD</i>
2. Informing an abused woman of counseling and support services.	59	4.73	1.63
3. Documenting IPV in medical records.	59	4.15	1.89
4. Giving an abused woman phone numbers for counseling and support services.	59	5.22	1.40
5. Giving support to a woman who is not a fault for the violence.	59	5.00	1.63
6. Inquiring whether the woman is in mortal danger.	58	5.03	1.57
7. Inquiring whether her children are in mortal danger.	59	5.07	1.59

^a*n*=59

As a result, the nine FNPs who reported a battered women in a year ($M = 33.89$, $SD = 4.31$) knew their roles in IPV significantly more ($M = 28.64$, $SD = 8.95$) than the 47 FNPs who did not report a battered women in a year, $t(24) = 2.70$, $p = .012$, $d = 0.97$.

Conclusions

The study sought to determine whether RHC FNPs were prepared to screen for IPV in order to provide information to IPV patients. More specifically, this study was designed to explore how much knowledge do FNPs have regarding IPV, to investigate what barrier(s) FNPs would encounter with IPV screening, and to seek out the FNP views of their role in IPV screening. Some of the findings of this study were consistent with what was found in the review of the literature.

Research Question 1

The goal of research question one was to find out how much IPV knowledge did RHC FNP had based on eight IPV knowledge statements that were based on violence training and the duration of employment. This research found that those FNPs who had violence training turned out to have more IPV knowledge compared with those FNPs who reported no prior IPV training. Also, this research study determined that the duration of employment in a RHC was not related to IPV knowledge. The responses to the eight IPV knowledge statements listed below indicated that the FNPs had knowledge of IPV:

1. I'd be harming the patient if I asked her about violence.
3. My patients do not suffer from violence.
7. I have not yet dealt with a violence assessment situation.
12. It's none of my business if the woman is a victim of violence.

14. Some women bring the violence on themselves.
15. Violence is not a medical condition.
16. There are more important problems to deal with than violence.
17. A small amount of physical violence exists in every normal family.

The median scores for these IPV knowledge statements were 1-2, disagreed, except for statement 7, which received a median score of 4, agreed. The responses meant that the RHC FNP's reported having IPV knowledge yet had not encountered violence assessment situations. If FNP's are knowledgeable about IPV because they have had violence training, then why are patients not being routinely screened?

Patients are not being routinely screened because the reality is that IPV varies in frequency and severity (Centers for Disease Control and Prevention, 2014). IPV can occur on a continuum, ranging from a single episode to chronic, severe violence. IPV can result in a lifetime of harmful effects on individuals, families, and communities. Recognition and prevention of IPV are the goals of public health (Centers for Disease Control and Prevention, 2014).

Black et al. (2011) conducted the National Intimate Partner and Sexual Violence Survey (NISVS), and they reported that more than one in three adult women in the U.S. have experienced rape, physical violence, and/or stalking by an intimate partner at least once in their lifetime. There are health consequences reported by patients of IPV. Patients who were victims of IPV experienced ailments such as frequent headaches, chronic pain, sleeping difficulties, asthma, irritable bowel syndrome, and diabetes more than women who were not victims of IPV (Black et al.). Since 2000, RHCs have emerged as a way for patients to access healthcare (Convenient Care Association, 2013). Potentially, RHCs can

see 10.8 million visits a year (Stempniak, 2013). Most likely, patients accessing RHCs are missing the opportunity to be screened for IPV.

Although this study found, that FNP's have IPV knowledge, the literature reflected different findings. Minsky-Kelly, et al. (2005) found that HCPs lack the training to screen for IPV. Gerber et al. (2005) found that PCPs admitted that they needed more IPV training and staff support in order to deal with IPV. Lack of IPV training of HCPs appeared to be one of the most mentioned barriers to IPV screening (Jonassen & Mazor, 2003; Parsons et al., 1995; Waalen et al., 2000;). Ramsay et al. (2012) surveyed 272 clinicians: 111 reported postgraduate IPV training, and 76 reported medical or nursing school IPV lectures. Clinicians reported only having basic knowledge of IPV, but they expressed interest in engaging with IPV patients. Clinicians felt ill equipped to both screen for IPV (79) and to make appropriate referrals (65). Of the 272 clinicians, 109 never or seldom screened for IPV, and 218 stated that they did not have an adequate knowledge of local resources. Ramsay et al. concluded that clinicians' attitudes toward IPV screening were positive. However, the clinicians had only basic knowledge of IPV. The authors recommended that clinicians needed more training on the assessment and intervention of IPV. They further recommended that clinicians must be aware of local IPV services (Ramsay et al.).

Research Question 2

The researcher sought to determine what types of barriers RHC FNP's were encountering and that if those barriers that would be reflective in IPV screenings performed on every woman patient. Below are listed the three barrier statements followed by the two statements about screening for IPV:

- 6. I don't have enough time to make a violence assessment.
- 10. I am qualified and trained in treating medical problems, not cases of violence.
- 18. I don't have time to ask about violence.
- 4. I intend to ask my patients questions about violence.
- 19. I check for and identify women who are victims of violence.

The median scores for these statements 6, 10, and 18 were 2-3, disagreed. The median scores for statements 4 and 19 were 1-2, disagreed. The responses meant that the RHC FNP's reported having no barriers, yet they had not routinely screened for IPV. For the screening statement, "A test to identify the victim of violence is a clinic routine performed on every woman," may have had either clinical routine or personal relevance. If FNP's are not encountering barriers to screening for IPV, then why are patients not being routinely screened?

The findings of this study supported what was found in the review of the literature. DeBoer et al. (2013) found that the majority of the nurses, or 126 nurses, agreed with the statement that they have enough time to screen for IPV. Out of the 156 nurses, 93 of them agreed that their work environment provides them the opportunity to screen their patients for IPV. DeBoer et al. found that there were 143 nurses who agreed that all patients needed to be screened for IPV regardless of obvious injuries.

Contrary to this study and the DeBoer et al., study, other studies found that the common barriers that have been reported in the literature are as follows: lack of provider education, lack of time, lack of effective interventions, patients non-disclosing, and fear of offending the patient (Parsons et al., 1995; Waalen et al., 2000). The low disclosure

rates are a direct result of HCPs hesitating to screen for IPV (Renker, 2008; Waalen et al.). Gerber et al. (2005) found that PCPs expressed that they lacked the confidence and time to address IPV. Colarossi et al. (2010) found that the barriers to IPV screening included lack of time, training, and referral resources.

Research Question 3

The researcher wanted to determine what RHC FNP's role were during IPV screening and that if that would be reflective in the number of identified IPV patients.

Below are six role statements:

2. Informing an abused woman of counseling and support services.
3. Documenting IPV in medical records.
4. Giving an abused woman phone numbers for counseling and support services.
5. Giving support to a woman who is not a fault for the violence.
6. Inquiring whether the woman is in mortal danger.
7. Inquiring whether her children are in mortal danger.

The six role statements were compared with the responses to the statement: In the past year, how many battered women have you identified? The median scores for the role statements were 5-6, agreed, and the median scores for the identification of battered women statement was 0. The responses meant the RHC FNP's agreed with the roles in IPV, yet they had not identified an IPV patient. If FNP's know their roles for IPV, then why are IPV patients not being identified?

The findings of this study are consistent with what was found in the review of the literature. Natan and Rais's (2010) study found that nurses felt IPV screening was an

important role for them. DeBoer et al. (2013) found that 140 out of 156 nurses felt that IPV screening was an important part of nursing practice. The statement regarding nurses feeling comfortable screening for IPV resulted in 120 out of 156 nurses agreeing. DeBoer et al. concluded that nurses do feel that IPV screening is important and that it is their responsibility and that they encountered few work environment barriers to screen for IPV. However, in the DeBoer et al. study 129 out of 156 nurses reported taking care of two or fewer IPV patients within the last year. DeBoer et al. also reported that out of the 156 nurses, 148 of them agreed with the statement that it was their business if the patient was a victim of IPV (DeBoer et al.). Natan and Rais (2010) pointed out that the nurses in their study did not feel that asking patients about abuse was insulting to patients, and the nurses felt that screening for IPV was an important part of a nurse's job. The nurses in the study stated that they were equipped to screen and identify IPV. The nurses also felt that abuse is a crucial medical problem, and that abused women did not cause the abuse inflicted upon them. Natan and Rais concluded that despite the nurses' beliefs in their abilities surrounding IPV their beliefs were not being implemented daily.

Implications and Recommendations

The impact of this study is that since the emergence of RHCs across the country in 2000 millions of patients have accessed RHCs for their health needs (Convenient Care Association, 2013; Stempniak, 2013). Based on the review of current literature and the findings of this researcher's study, this means that many RHC patients could be IPV patients. Black et al. (2011) conducted the NIPSVS, and they reported that more than one in three adult women in the U.S. have experienced rape, physical violence, and/or stalking by an intimate partner at least once in their lifetime. This means the HCPs in

RHCs are not capturing patients that may be in need of IPV information. As FNPs responsibility is to practice due diligence for patients safety and wellness. For an FNP or an HCP not to ask about IPV, could be considered unacceptable practice (Fox-Bartels, 2008).

Usta et al. (2012) found that the 72 women from the focus groups encouraged the health care system to be involved in the management of IPV. The women told the authors that disclosing IPV to their HCPs was considered to be a socially acceptable way to break the out of the IPV silence. Most women mentioned that they were enthusiastic about the health system addressing the IPV problem. The women considered health care clinics as a better place to talk about IPV instead of talking to their families or neighbors about their IPV problems. After the women talked about IPV to their HCPs, the women expected to feel encouraged, supported, and relieved by their HCP. In this study, FNPs report having IPV knowledge. Usta found that patients sought to be screened. So then what are FNPs waiting for to screen for IPV?

Because there is growing recognition that IPV has a connection with other risk factors, IPV screening has been integrated in routine inquiry of psychosocial issues such as tobacco and weight control (Futures Without Violence, 2004). Numerous validated screening tools are utilized in various settings. For example, ERs can be found using the Partner Violence Screen (PVS) screening tool. The screening tools can be administered to the patient via either computer-based, written self-completed methods or a face-to-face method with verbal questioning by the HCP (MacMillan et al., 2009).

Following is a screening tool example from the PVS:

Purpose: A brief screening instrument for use in emergency departments or other urgent care settings. Instructions: Interview the patient alone and ask questions directly.

1. Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?
2. Do you feel safe in your current relationship?
3. Is there a partner from a previous relationship who is making you feel unsafe now? (Feldhaus, et al., 1997, para. 1).

IPV should be treated as any other medical conditions. IPV screening can be incorporated in the patient's medical record as such as social screening inquires of drugs, alcohol, tobacco, sexual practices, caffeine use, and exercise habits. Routine social screenings have been taught to nurses throughout nursing school, and IPV screening should not be treated differently.

Spangaro et al. (2011) utilized the normalization process theory by Carl May. The normalization process theory was initiated to understand how complex health interventions could become routinized in practice. May (2006) named four elements of the routinization process:

- (a) interactional workability, defined as the impact on the worker-patient interaction;
- (b) relational integration, defined as how work is understood by networks of people around it including patients and other health professionals and whether it increases accountability or confidence;
- (c) skill set workability, defined

as fits with existing role definitions of health professionals; and (d) contextual integration, defined as the organizational sponsorship and control of the work. (p. 139)

The four enablers or obstacles to IPV screening found in this study aligned with May's elements of routinization. First, the scripted questions and the patient's favorable responses aligned with interactional workability. Second, the IPV training and referrals aligned well with relational integration. Third, the skill set workability was achieved by inserting the screening tool in already existing assessment tools. Fourth, the contextual integration matched the statewide policy for annual monitoring and formal process for implementation of the screening (Spangaro et al., 2011).

In order for FNP's to screen for IPV confidently, training should begin in nursing school. FNP's learn about tobacco, alcohol, and drug screening in nursing school and are accustomed to screening because FNP's were educated early on which builds the FNP's confidence to screen for these issues. Because FNP's learn about tobacco, alcohol, and drug screening early on in nursing school, they are thus accustomed to and confident in screening for these issues. Because IPV patients may not present to RHCs with obvious signs and symptoms, patients need to be routinely screened. This study demonstrated that FNP's who have IPV knowledge reported no barriers and felt that IPV screening was part of their role. However, a disconnect was found in the identification and screening of IPV patients. In order for IPV patients not to be missed, the focus should be on routine IPV screening should be standard operating procedure.

In agreement with the aforementioned research, starting extensive IPV training in nursing school would improve FNP's' confidence in screening and providing services.

Extensive training should include courses instead of just a lecture in a class. Training is recommended to begin in nursing and medical schools in order to prepare HCPs in practice (Beccaria et al., 2013; Ross, et al., 1998). Beccaria et al. suggested that nursing students need more education in nursing interventions about learning how to address the emotional needs of an IPV patient. Ross et al. recommended that schools of nursing are in need of increased, systemic curricula addressing violence against women and children. Also, students need experience with patients who have faced violence in their lives. Additionally, faculty members need to share resources and develop strategies with other schools of nursing to gain expertise in IPV studies (Ross et al.).

Woodtli (2000) found several studies, which indicated that nurses are inadequately prepared by their education to deliver sensitive, high quality, and effective nursing care to patients who have survived domestic violence. Woodtli conducted a qualitative study that sought to identify then describe the essential knowledge and skill that nurses require in order to deliver competent and sensitive nursing care to patients of DV. The author mentioned that nurse educators would need to recognize a student's readiness to learn about DV as a precursor for the student to learn effectively about DV. Woodtli recommended that inclusion of violence-related content in nursing curricula should be a priority to prepare nurses for professional practice. Also, on-going education to HCPs was recommended to better equip HCPs with information and confidence to screen for IPV (Chapin et al., 2011; Hamberger et al., 2004). In order to support RHC FNP's regarding IPV screening, then on-going training would need to be implemented. Institutions where IPV screening occurs need to provide on-going education (Parsons et al., 1995).

Organizations may reach out to third parties to conduct IPV trainings. Organizations may get in touch with IPV researchers such as the nearby universities. Organizations may use FNP's employed in their own organization who are passionate about IPV and who may conduct on-going education to FNP's. FNP's need to feel confident on what steps to take when a patient discloses and training would need to include how to handle a patient's IPV disclosure. Based on this study, FNP's can begin to start to screen for IPV in RHCs once there is an established screening method, whether the method is face-to-face, written, or computer. Future studies would need to be conducted in order to determine what type(s) of screening methods would be most effective in RHC settings. Screening methods would include either face-to-face, written, or computer IPV screenings. The screening tools can be administered to the patient via either computer-based, written self-completed methods, or face-to-face method with verbal questioning by the HCP (MacMillan et al., 2009). The healthcare setting and patient preference that would determine which screening tool would be best to utilize (Chang et al., 2012). Future studies may involve qualitative studies of RHC FNP's about their views on knowledge, barriers, and roles in different RHCs as well as other states. Studies may involve interviewing RHC patients about their views of IPV screening. Studies may determine what screening method in the RHC would best suit patient privacy and needs.

Because of the damage that IPV has on one's health (Coker et al., 2000; Liebschutz, et al., 2008;), and the substantial costs (Bonomi, Anderson, Rivara, & Thompson, 2009; Snow-Jones et al., 2006), incurred of individuals, family and society at large, professional healthcare organizations have promoted universal screening of IPV (Futures Without Violence, 2004). Despite the efforts of these organizations, IPV

screening does not occur in all healthcare settings. In particular, RHCs have been exempt from IPV screening. Because of the booming emergence of RHCs, RHCs should not be an exception to performing IPV screening. In fact, FNP performing IPV screening at RHCs should actually be the rule. Because IPV is a major public health concern and the number of patients accessing RHCs is growing, RHC FNPs are in a prime position to capture IPV patients.

With the shortage of primary care physicians expected to worsen in 2016 and beyond, patients are increasingly turning to RHCs for their basic healthcare needs. With the passage of the Affordable Care Act (ACA) (2010), millions of Americans are now eligible for healthcare coverage. Because RHCs are on the new gateway to healthcare, they have the capability to capture these new patients (Stempniak, 2013). An HCP not asking about IPV could be considered unacceptable practice (Fox-Bartels, 2008). The only conclusion one can reach here is that the most ethical practice is for RHC FNPs to screen patients for IPV and this ethical responsibility should be conferred upon the FNP by an act of the legislature should be mandated by law. RHC FNPs should be mandated by law to screen for IPV.

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Appendix A
Original Survey Questionnaire

1. Gender: 1. Male 2. Female
2. Country of birth: 1. Israel 2. Former Soviet Union 3. Ethiopia 4. Other:

3. Ethnicity: 1. Arab 2. European Jew 3. Sephardic (Oriental) Jew 4. Other:

4. Age: _____
5. How long ago did you complete your nursing degree?
 - a. 0-2 years
 - b. 2-5 years
 - c. 5-10 years
 - d. More than 10 years ago
6. What kind of training do you have?
 - a. Practical nurse
 - b. Registered nurse
 - c. Registered nurse with a bachelor's degree
 - d. Registered nurse with a master's degree
 - e. Registered nurse with a doctorate
7. Where do you work?
 - a. In hospitals
 - b. In the community
8. For how long have you been working in your present position?
 - a. Less than a year
 - b. 1-2 years

- c. 2-5 years
- d. 5-10 years
- e. More than 10 years

9. Have you been trained on the subject of violence? 1. No 2. Yes

Where did you receive your training?

10. While studying nursing 1. No 2. Yes

11. In a post-basic nursing course 1. No 2. Yes

12. In a private course 1. No 2. Yes

13. During service-learning 1. No 2. Yes

14. While studying for a postgraduate degree 1. No 2. Yes

15. Do you have experience treating women staying in a battered women's shelter?

1. No 2. Yes

Please circle the number that best represents how much you agree with the statement:

	Statement	Highly disagree	Disagree	Disagree somewhat	Agree somewhat	Agree	Highly agree
16	I'd be harming the patient if I asked her about violence	1	2	3	4	5	6
17	A test to identify the victim of violence is a departmental routine performed on every woman	1	2	3	4	5	6
18	My patients do not suffer from violence	1	2	3	4	5	6
19	I intend to ask my patients questions about violence	1	2	3	4	5	6
20	I would lose the patient's trust if I asked her questions about violence	1	2	3	4	5	6
21	I don't have enough time to make a violence assessment	1	2	3	4	5	6
22	I have not yet dealt with a violence assessment situation	1	2	3	4	5	6
23	I'm frustrated that I can't do anything about the violence	1	2	3	4	5	6
24	There is no way to identify violence	1	2	3	4	5	6
25	I am qualified and trained in treating medical problems, not cases of violence	1	2	3	4	5	6
26	Violence does not affect pregnancy	1	2	3	4	5	6
27	It's none of my business if the woman is a victim of violence	1	2	3	4	5	6
28	Upper-class women are not victims of violence	1	2	3	4	5	6
29	Some women bring the violence on themselves	1	2	3	4	5	6
30	Violence is not a medical condition	1	2	3	4	5	6
31	There are more important problems to deal with than violence	1	2	3	4	5	6
32	A small amount of physical violence exists in every normal family	1	2	3	4	5	6
33	I don't have time to ask about violence	1	2	3	4	5	6
34	I check for and identify women who are victims of violence	1	2	3	4	5	6

In the following list of activities, circle the number that represents the extent to which you agree to take these measures while treating a battered woman:

	Statement	Highly disagree	Disagree	Disagree somewhat	Agree somewhat	Agree	Highly agree
35	Collect data from previous hospitalizations to check for proof of violent injuries	1	2	3	4	5	6
36	Informing a battered woman of counseling and support services	1	2	3	4	5	6
37	Documenting in medical records	1	2	3	4	5	6
38	Giving a battered woman phone numbers for counseling and support services	1	2	3	4	5	6
39	Giving support to a woman who is not at fault for the violence	1	2	3	4	5	6
40	Inquiring whether the woman is in mortal danger	1	2	3	4	5	6
41	Inquiring whether her children are in mortal danger	1	2	3	4	5	6
42	Scheduling follow-up appointments						
43	Calling a social worker for follow-up						

44. What is the estimated number of cases a year in which patients in your ward report incidents of violence? _____

45. In the past year, how many battered women have you identified? _____

46. What are you obligated to do when a woman reports that she has been the victim of violence, but refuses to tell anyone?

- a. Quickly inform the police
- b. Inform the social worker

- c. Inform her of counseling and support services
- d. I am not allowed to take action

47. While examining an Ethiopian woman you identify her as the victim of violence.

The woman confirms this and claims that her children are also badly abused by her husband, but asks you not to tell anyone. What do you do?

- a. inform the social worker or the police
- b. only inform counseling and support services
- c. I won't threaten her life and won't report this

Appendix B

Modified Survey Questionnaire

Modified Survey Questionnaire

Section I (Demographics)

1. Gender: __Male __ Female
2. Ethnicity: _____Caucasian_____Asian
_____Hispanic/Latino_____African-American
3. Age: ____
4. What town or city do you live in? _____

Section II (Education & Work Experience)

5. How long ago did you complete your bachelors of nursing degree? _____
6. How long ago did you complete your masters of nursing degree? _____
7. What kind of specialty training do you have?
____ Family
____ Adult
____ Pediatrics
____ Mental Health
____ Emergency
____ Administration
____ Education
____ Other
8. Do you have a doctoral degree? __Yes __No
9. Do you have another degree in addition to nursing?

____Yes If so, what____ ____ No

10. At which retail-health location do you work?

☐ CVS/Pharmacy

☐ Hospital

☐ Jewel-Osco

☐ Target

☐ Walgreens

☐ Wal-mart

☐ Other

11. For how long have you been working in your present position?

Years Months

12. In your current position, do you work ☐ Full-time ☐ Part-time

☐ As needed/PRN

Section III (IPV Training)

13. Have you been trained on the subject of violence?

☐ Yes (if yes, go to question 13) ☐ No

14. Where did you receive your training? (pick all that apply)

☐ While studying nursing

☐ In a private course

☐ During online learning

☐ While studying for a postgraduate degree

☐ Other

15. Do you have experience treating women staying in an abused women's shelter?

☐ Yes ☐ No

Section IV (Views and Knowledge of IPV)

Please indicate the number that best represents how much you agree with the statement.

Note that higher numbers equal stronger agreement with the statement,

with 1 equaling strongly disagree and 6 strongly agree.

	Statement	Strongly disagree	Disagree	Disagree somewhat	Agree somewhat	Agree	Strongly agree
16	I'd be harming the patient if I asked her about violence	1	2	3	4	5	6
17	A test to identify the victim of violence is a clinic routine performed on every woman	1	2	3	4	5	6
18	My patients do not suffer from violence	1	2	3	4	5	6
19	I intend to ask my patients questions about violence	1	2	3	4	5	6
20	I would lose the patient's trust if I asked her questions about violence	1	2	3	4	5	6
21	I don't have enough time to make a violence assessment	1	2	3	4	5	6
22	I have not yet dealt with a violence assessment situation	1	2	3	4	5	6
23	I'm frustrated that I can't do anything about the violence	1	2	3	4	5	6
24	There is no way to identify violence	1	2	3	4	5	6
25	I am qualified and trained in treating medical problems, not cases of violence	1	2	3	4	5	6
26	Violence does not affect pregnancy	1	2	3	4	5	6
27	It's none of my business if the woman is a victim of violence	1	2	3	4	5	6
28	Upper-class women are not victims of violence	1	2	3	4	5	6

29	Some women bring the violence on themselves	1	2	3	4	5	6
30	Violence is not a medical condition	1	2	3	4	5	6
31	There are more important problems to deal with than violence	1	2	3	4	5	6
32	A small amount of physical violence exists in every normal family	1	2	3	4	5	6
33	I don't have time to ask about violence	1	2	3	4	5	6
34	I check for and identify women who are victims of violence	1	2	3	4	5	6

Section V (Role of an FNP in IPV)

In the following list of activities, indicate the number that represents the extent to which you agree to take these measures while treating an abused woman. Note that higher numbers equal stronger agreement with the statement, with 1 equaling strongly disagree and 6 strongly agree.

	Statement	Strongly disagree	Disagree	Disagree somewhat	Agree somewhat	Agree	Strongly agree
35	Collect data from previous hospitalizations to check for proof of violent injuries	1	2	3	4	5	6
36	Informing an abused woman of counseling and support services	1	2	3	4	5	6
37	Documenting IPV in medical records	1	2	3	4	5	6
38	Giving an abused woman phone numbers for counseling and support services	1	2	3	4	5	6
39	Giving support to a woman who is not at fault for the violence	1	2	3	4	5	6
40	Inquiring whether the woman is in mortal danger	1	2	3	4	5	6
41	Inquiring whether her children are in mortal danger	1	2	3	4	5	6

42	Scheduling follow-up appointments for an IPV patient	1	2	3	4	5	6
43	Calling a social worker for follow-up on an IPV patient	1	2	3	4	5	6

Section VI (Identifying IPV)

44. What is the estimated number of cases a year in which patients in your clinic report incidents of violence? _____

45. In the past year, how many battered women have you identified? _____

46. What are you obligated to do when a woman reports that she has been the victim of violence, but she refuses to tell anyone?

- a. Quickly inform the police.
- b. Inform a social worker.
- c. Inform her of counseling and support services.
- d. I am not allowed to take action.

47. While examining a patient you identify her as the victim of violence. The woman confirms this and claims that her children are also badly abused by her husband, but asks you not to tell anyone. What do you do?

- a. Inform a social worker or the police.
- b. Inform counseling and support services.
- c. I won't threaten her life so I won't report this and follow her request.
- d. I give her phone numbers to call.

Your participation in completing this questionnaire is greatly appreciated!

Appendix C
Permission Letter

Permission Letter

From: To: Subject: Date:

Attachments:

OeBoer Mican Suzanne Herrera

RE: Permission to Utilize Questionnaire Sunday, October 27, 2013 7:48:27 AM image002.ong
image004.png
image006.png

Suzanne-

Thank you so much for your interest in using our questionnaire for your dissertation. absolutely want you to utilize it if the questionnaire would be beneficial to your project.

The way we contacted Ms. Natan was through her e-mail address provided in her publication, and that address is meraav@hy.health.gov.il. Just so you know, she /lives and works in Israel, so we had to have someone translate the original questionnaire for us---it was originally in Hebrew. I would have to dig to find the original translation, but I would do that for you if that would help.

Thanks again for your inquiry, and I wish you the best of luck on your journey to your doctoral degree.

Mican DeBoer, BSN, RN, CEN I Trauma Program Manager

Trauma and Surgical Specialties IMSB 005 I1535 Gull Road IKalamazoo, MI 49048
Office (269) 226-5668 IFax (269) 226-7878 IPager (269) 513-2705

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From: Suzanne Herrera [mailto:sherrera@olivet.edu]
Sent: Thursday, October 24, 2013 10:44 PM
To: DeBoer, Mican

Subject: Permission to Utilize

Questionnaire

Dear Mican I. eBoer:

Thank you so much for your research concerning Domestic Violence.

In your article, What are Barriers to Nurses Screening for Intimate Partner Violence? You adapted a questionnaire from Natan. I would like to utilize the questions used in your research.

Would I be able to use your questionnaire in my dissertation titled: "Where is Intimate Partner Screening in Retail-Health Clinics?" (power point attached for your viewing).

Would you have Natan contact

information? Hope to hear back from

you shortly.

Fro Suzanne Herrera
m:
To: ~~1"1nn1m p~~
Subje RE: Permission to Utilize
ct: Questionnaire Tuesday,
Date: October 29, 2013 9:38:06
PM

Thank you very much Dr. Ben Natan!

Would you be able to send me your original

questionnaire? Most gratefully,

Suzanne Herrera
Cohort VIII
Class of 2016

From: Merav Ben Natan [mailto:meraav@hy.health.gov.il]
Sent: Sunday, October 27, 2013 12:00 AM
To: Suzanne Herrera
Subject: RE: Permission to Utilize Questionnaire

Yes you can use my
questionnaire Sincerely
Dr Merav Ben Natan

From: Suzanne Herrera [mailto:sherrera@olivet.edu]
Sent: Friday, October 25, 2013 5:30 AM
To: Merav Ben Natan
Subject: Permission to Utilize Questionnaire

Dear Dr. Merav Ben Natan:

Thank you so much for your research concerning Domestic Violence.

In your article, Knowledge and Attitudes of Nurses Regarding Domestic Violence and Their Effect on the Identification of Battered Women, you adapted a questionnaire from Parsons.

Would I be able to use your questionnaire in my dissertation titled: "Where is Intimate Partner Screening in Retail-Health Clinics?" (power point attached for your viewing).

Would you also have Parsons contact information? Hope to hear back from you shortly.

Most gratefully,

Suzanne Herrera, APN,
FNP-BC Family Nurse
Practitioner
Doctor of Education,
candidate Olivet Nazarene
University Bourbonnais,
Illinois