CE 2.5 HOURS
Continuing Education
ORIGINAL RESEARCH

Intimate Partner Violence: The Knowledge, Attitudes, Beliefs, and Behaviors of Rural Health Care Providers

While this study's findings are largely encouraging, troubling knowledge and practice gaps persist.

Intimate partner violence (IPV)—defined by the Centers for Disease Control and Prevention as the "physical, sexual, or psychological harm by a current or former partner or spouse"[1]—continues to be a pervasive health and social problem in the United States, affecting about one in three women during her lifetime.[2] Such violence has devastating effects on women and families, including serious physical and mental health problems, economic hardship, and decreased quality of life.[3-6] (Although men can also be victims, women are disproportionately targeted; this article focuses on women.)

Nurses and other health care providers can have a positive impact on the lives of women who experience IPV. Studies have found that interactions with providers can influence a woman's perception of herself and her situation, as well as her decision making around leaving the abusive relationship.[7,8] Yet among providers, lack of knowledge, negative attitudes and beliefs, and low IPV screening rates are common.[9-11]

Problems with the responses of health care providers may be magnified in the rural setting, where women face particular challenges. Studies have consistently found that factors such as limited availability and access to resources, lack of formal and informal support, isolation, patriarchal attitudes, economic stress, and privacy issues exacerbate IPV in rural settings.[12-17] Though a large body of research exists regarding providers' IPV-related knowledge, attitudes, beliefs, and behaviors, little is known in this regard that's specific to rural providers. Given the unique challenges faced by women in the rural setting, it's important to understand the perceptions of rural providers regarding IPV, available resources, and appropriate responses. Also, IPV has been receiving more attention recently, both in the general news media[18-21] and by health care organizations seeking to meet Joint Commission standards for IPV screening,[22] and this may have further influenced providers' knowledge, attitudes, beliefs, and behaviors. To learn more, we conducted a study to determine the current IPV-related knowledge, attitudes, beliefs, and behaviors of health care providers in the rural setting.

BACKGROUND

Women who experience IPV often describe unsatisfactory and detrimental interactions with health care providers, as characterized by lack of help; disbelief

ABSTRACT

Background: Intimate partner violence (IPV) continues to be a pervasive health and social problem in the United States with serious short- and long-term consequences. Women in rural areas face particular challenges. Health care providers can play an important role in the lives of women who experience IPV; yet among providers, lack of knowledge, negative attitudes and beliefs, and low rates of screening are common.

Objective: Though a large body of research exists regarding health care providers' IPV-related knowledge, attitudes, beliefs, and behaviors, little is known specifically with regard to rural providers. Given the challenges faced by rural women and the potential influence of their providers, it's important to understand rural providers' IPV-related knowledge, attitudes, beliefs, and behaviors. We conducted a study to learn more.

Methods: Health care providers working in a large rural health network were asked to complete electronic surveys that examined their IPV-related knowledge, attitudes, beliefs, and behaviors. Descriptive and correlational statistical analyses of the data were conducted.

Results: A total of 93 health care providers returned completed surveys. In general the respondents demonstrated good overall knowledge, judicious attitudes, and beliefs congruent with the available evidence related to IPV. Of concern were their knowledge and practice gaps regarding the prevalence of IPV, the higher risk of injury faced by women who leave their abusers, the ability of women to make appropriate choices about their situations, and what actions to take when someone discloses abuse.

Conclusion: The results of this study were encouraging with regard to the IPV-related knowledge, attitudes, beliefs, and behaviors of rural health care providers. But the findings also indicated important knowledge and practice gaps. Preparing providers to deliver compassionate, effective care to women who experience IPV is essential for the health and well-being of women and their families.

Keywords: domestic violence, intimate partner violence, rural population

or victim blaming; failure to address safety concerns; breaches of confidentiality; or angry, insensitive, or condescending attitudes.[8, 17, 23] This is supported by studies in which nurses have expressed feelings of frustration, anger, and helplessness in dealing with IPV.[24, 25] Furthermore, there is evidence that some providers don't think that addressing IPV should be part of the clinician's role, and are reluctant to spend time and other resources in doing so.[26, 27]

Yet there is strong evidence to counter the belief that asking patients about IPV is futile and a waste of time. Victims have reported that they would discuss their experience with a health care provider if they were asked respectfully and treated in a nonjudgmental way.[23, 28] Moreover, study findings have suggested that women will utilize resources, often successfully, when offered.[7, 29] Indeed, Chang and colleagues found that expressions of concern and support from a health care provider were instrumental in changing how abused women saw themselves, leading them to "strive for safety and a better situation."[7]

The United States Preventive Services Task Force (USPSTF),[30, 31] the Institute of Medicine (now the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine),[32] and most major nursing and medical organizations recommend universal screening for IPV in health care settings.[33-37] Despite this, routine screening for IPV remains underused, with studies reporting screening rates ranging from 7% to 39%.[9, 29, 38, 39] Health care providers have identified a number of barriers to screening, including providers' discomfort in asking women about IPV, providers' knowledge deficits, and system problems.[11, 40-43] Providers' discomfort appears to be related both to their feeling that they don't know how to ask and to their concerns about how their questions will be received by the women being asked. Lack of knowledge includes familiarity with local resources and how or where to refer women who disclose abuse and an understanding of legal issues.[11, 27, 41, 44]

METHODS

Design. This study used a descriptive survey of health care providers working in clinics in a rural setting. We used the definition of *rural* provided by the U.S. Office of Management and Budget (OMB), which is used by the Office of Rural Health Policy to determine eligibility for rural health grants.[45-47] According to the OMB, an area is considered rural if it does not contain any core urbanized areas or "clusters." (Core urbanized areas or clusters are defined as "a Census Bureau delineated urbanized area of at least 50,000 population or a Census Bureau delineated urban cluster of at least 10,000 population."[47])

The study was conducted in three counties covering 4,378 square miles in the Adirondack Mountains region of northeastern New York State. According to the U.S. Census Bureau, more than 90% of the residents in the study region are white.[48] The median ages in the three counties are 45, 46, and 52 years; 88% to 91% of residents older than 25 years have at least a high school diploma and 24% to 28% have at least a bachelor's degree. Between 2010 and 2014, across the three counties, the median annual household income ranged from $50,322 to $56,601.

Setting. The survey participants all worked at regional health care centers that are part of an extensive, community-based, nonprofit network that provides care to a large underserved population. These centers provide urgent and primary adult and pediatric care to local residents and, during the summer and winter tourist seasons, to a large transient population. The network provides comprehensive services through both scheduled appointments and walk-in visits, offering diagnostic evaluations (including laboratory and radiologic testing); specialty care (including cardiology, orthopedics, mental health, obstetrics and gynecology, gastroenterology, otolaryngology, podiatry, and urology); physical therapy; nutritional and dietary counseling; and dentistry. Providers see more than 60,000 patients annually, covering about 260,000 patient visits. Many of these patients are uninsured, have limited financial resources, or lack access to care because of other constraints (such as lack of transportation).

Sample. The sample population was a convenience sample of health care providers currently working for the health care network. There are approximately 200 providers in this network at any given time. Inclusion criteria were being an NP, RN, or LPN; or a physician, doctor of osteopathy, physician assistant (PA), social worker, psychologist, or psychiatrist; and providing care in one or more of the health centers serving the region. There were no exclusion criteria.

We received ethical approval from the institutional review board (IRB) of New York University. The health care network did not have an IRB. Onsite permission for the study was provided by the network's chief medical officer, executive staff, and nursing leadership.

Recruitment and consent. In April 2013, a facilitator at the health care network sent an advance notice of the study to all providers via intranet e-mail three days before the survey link was made available. The next e-mail provided a direct link to the survey questionnaire, which was conducted via Qualtrics. Reminder e-mails were sent at one and four weeks after the survey was first made available, and these reminders also contained direct links to the survey. A final e-mail thanking respondents and reminding nonrespondents to participate was sent seven weeks after the survey was first sent.

The first page of the survey included a statement indicating that completion of the survey implied informed consent. The first page also stated the study's purpose, gave background information about the researchers, and explained how the study would be carried out and how results would be used. The survey was anonymous and there were no expected risks to the respondents. No incentive was offered.

Instrument. Data collection began in April 2013 and ended in June 2013. We used a modified version of a survey developed and tested by Maiuro and colleagues that measures health care providers' knowledge, attitudes, beliefs, and self-reported behaviors about IPV.[49] The tool was originally developed and tested with NPs, physicians, PAs, and medical assistants and demonstrated good internal reliability and good criterion-related concurrent validity.

Our modified version covered six domains: "perceived self-efficacy," "system support," "blame victim" (meaning attitudes of blaming the victim), "professional role resistance/fear of offending patient," "victim/provider safety," and "frequency of IPV inquiry." The original instrument also included a section containing questions related to batterers; we omitted this section as not relevant to our survey. We also added 10 knowledge questions, taken from the Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS),[50] that assess areas of knowledge not included in Maiuro and colleagues' instrument. The PREMIS was tested initially with physicians and then with a group of medical, nursing, social work, and dental students, and demonstrated good reliability in both instances.[50, 51]

Our survey thus consisted of a total of 41 items covering the categories of knowledge, attitudes, beliefs, and behaviors (questions were not grouped by category on the survey). It began with three background questions aimed at gauging the respondents' knowledge about the prevalence of IPV in the area served by the network, the existence of a written IPV policy within the network, and the number of new IPV diagnoses the provider had identified in the past year. Thirteen questions assessed the providers' knowledge about IPV; these included two questions answerable using a 5-point Likert-type scale and 10 true or false statements, as well as a question about mandatory reporting. Six questions measured attitudes and were answerable using a 5-point Likert-type scale. Eleven questions assessed beliefs and were answerable using a 5-point Likert-type scale. For both the attitude and belief questions, mean scores above 2.5 reflected more favorable or objective attitudes or beliefs while those below 2.5 indicated less favorable or objective attitudes or beliefs. Eight questions assessed providers' behaviors and sense of self-efficacy. Six of these were answerable via a 5-point Likert-type scale. One asked respondents to rate how often they asked about IPV when patients presented with certain conditions, six

of which are known to be associated with IPV and one that is not. And one asked respondents how confident they felt asking about certain topics as part of the medical history. Mean scores above 2.5 in this category indicated greater self-efficacy or behaviors more congruent with best practice in diagnosing and managing IPV in clinical practice.

We also included two open-ended questions regarding health care providers' perceptions of local barriers to women seeking and obtaining help, and their perceptions about prevailing community views of IPV and women who experience IPV. Results of these open-ended questions are reported elsewhere.

Data analysis. We performed descriptive and correlational statistical analyses of the survey data using IBM SPSS Statistics for Windows, version 21, software. The descriptive analysis included frequency distribution, dispersion, and measures of central tendency, followed by correlational analyses. As noted above, after data collection was complete, we divided the survey questions into categories of knowledge, attitudes, beliefs, and behaviors, with a subsection under behaviors that focused on self-efficacy. There was no global score.

Statistical analysis began with recoding of inversely worded Likert-type scale questions so that all higher numbers represented more favorable attributes or beliefs. Responses were then summed and a mean value calculated for each item as well as for each category (knowledge, attitudes, beliefs, and behaviors). Crosstabulation was done to determine if there were any associations among responses to individual items or categories. Testing for normal distribution was conducted using Q-Q plots and histograms. Data for the demographic characteristics of age, sex, ethnicity, practice roles, and years in practice were not normally distributed; thus we could not perform statistical analyses based on those variables to look at differences among the various groups.

Table 1. Participant Demographics

Variable	n	%
Sex		
Female	75	85
Male	13	15
Age, years		
18–29	12	13
30–39	20	22
40–49	20	22
50–59	26	29
≥ 60	11	12
Race/ethnicity[a]		
White	86	99
Other	1	1
Current role/profession		
RN	17	20
LPN	23	28
NP	7	8
Physician	13	16
Physician assistant	14	17
Unlicensed assistive personnel	4	5
Other	5	6
No. years in practice		
< 3	19	22
3–5	20	23
6–10	12	14
11–15	8	9
> 15	28	32

[a]All other categories of race/ethnicity = 0.
Because not all respondents answered all questions, the total n for a given variable may not sum to 93. Because of rounding, total % may not sum to 100.

RESULTS

Sample. One hundred and eight health care providers responded to the survey; of these, 93 surveys were completed and included in the analysis, for a response rate of about 47%. Of those respondents who identified their professional role, 56% identified as nursing staff (NPs, RNs, and LPNs), 33% as medical staff (physicians and PAs), 5% as unlicensed assistive personnel, and 6% as other. A majority of respondents were female (85%), white (99%), and between 30 and 59 years of age (74%). Of the 52 providers who identified their area of specialization, family practice and primary care were the most represented areas (19 and 11 respondents, respectively), followed by urgent care (7 respondents). For more on participant demographics, see Table 1.

Background information. Respondents were asked about IPV prevalence in the health care network service area, and were given five choices ranging from "very rare (1/1,000)" to "very common (150/1,000)." Most respondents answered either that IPV was "somewhat common (50/1,000)" (45%) or that it was "rare (10/1,000)" (31%). Only one respondent thought IPV was "very common (150/1,000)."

A majority of respondents (53%) reported making one to five new diagnoses of IPV within the past year. Thirty-two percent reported making no new diagnoses; 11% reported making six to 10 new diagnoses; and 3% reported making 11 to 20. Only one respondent reported identifying 21 or more new diagnoses. There was a weak positive correlation ($r = 0.281$; $P = 0.006$) between respondents' answers regarding prevalence and the number of new diagnoses they reported making within the past year.

A majority of respondents (68%) weren't sure whether the health care network had written guidelines for the detection and management of IPV. Another 21% thought that it did, while 11% thought that it did not.

Table 2. Knowledge: Likert-Type Scale Items

Survey Item	n	Mean	SD
IPV tends to become more frequent and severe over time.	93	4.06	0.91
Most victims report the abuse to their health care provider.	92	4.02	0.61

IPV = intimate partner violence.

Knowledge. In general, a high proportion of respondents answered most knowledge questions correctly. There was some variation with regard to individual questions (for details, see Tables 2 and 3). The only statistically significant correlation was a weak negative correlation ($r = –0.276$, $P = 0.011$) between responses indicating that there could be good reasons for not leaving an abusive relationship and the number of new IPV diagnoses the provider reported making within the past year.

With regard to mandatory reporting and IPV, the question with the highest percentage of incorrect answers was related to reporting when children are involved. Only 3% of respondents answered correctly that they were not mandated to do so. Most respondents (85%) thought that if a child witnessed IPV, and even if that child wasn't in immediate danger, they were mandated to report this to child protective services; while 11% didn't know. (Laws pertaining to mandated reporting of IPV vary from state to state. Some states mandate reporting of a child witnessing IPV, but New York State is not one of them.)

In answering the remaining questions on what providers are required by New York State law to report, a large majority of respondents answered correctly that reporting is mandatory when IPV occurs in adolescents (n = 75; 90%) or when a knife or gun is used (n = 65; 78%). A smaller majority answered correctly that reporting is mandatory when IPV occurs in people over the age of 65 years (n = 57; 69%). About half of the respondents incorrectly answered that reporting is mandatory when IPV occurs in people ages 18 to 65 years (n = 40; 48%) or when a bone is broken (n = 47; 57%).

Of the knowledge questions, the true–false item "Alcohol consumption is the greatest single predictor of the likelihood of IPV" had the highest percentage of respondents who answered "don't know" (40%).

Table 3. Knowledge: True–False Items

Survey Item	True	False	Don't Know	n	% Correct
Alcohol consumption is the greatest single predictor of the likelihood of IPV.	30√	23	36	89	34
There are good reasons for not leaving an abusive relationship.	35√	49	5	89	39
When asking patients about IPV, you should use the words "abused" or "battered."	9	61√	18	88	69
Being supportive of a patient's choice to remain in a violent relationship would condone abuse.	21	53√	15	89	60
Victims of IPV are able to make appropriate choices about how to handle their situation.	14√	59	15	88	16
Health care providers should not pressure patients to acknowledge that they are living in an abusive situation.	37√	30	20	87	43
Victims of IPV are at greater risk of injury when they leave the relationship.	48√	28	12	88	55
Strangulation injuries are rare in cases of IPV.	1	62√	24	87	71
Allowing partners or friends to be present during a patient's history and physical exam ensures safety for an IPV victim.	3	74√	11	88	84
Even if a child is not in immediate danger, providers are mandated to report an instance of a child witnessing IPV to Child Protective Services.	75	3√	10	88	3

IPV = intimate partner violence. √ indicates correct response.

Those who answered true (the correct answer) or false were divided fairly evenly (34% and 26%, respectively).

Attitudes. Most of the answers reflected positive attitudes toward IPV victims: the overall mean score for attitudes was 4.02 out of 5. The item with the lowest mean score (3.51) was the statement "The victim's passive-dependent personality often leads to abuse." The items with the highest mean scores were the statements "The victim has often done something to bring about violence in the relationship" (4.37; no respondents agreed with this statement); "When it comes to IPV, it usually 'takes two to tango'" (4.25); and "A victim must be getting something out of the abusive relationship, or else she/he would leave" (4.15). (See Table 4. Results were coded to reflect the desired responses to questions; thus higher mean values reflect more congruency with accepted attitudes.) There were no statistically significant correlations between any of the attitude questions and the number of new IPV diagnoses respondents reported identifying within the past year.

Beliefs. The overall mean score was 4.01 out of 5. The item with the lowest mean score (3.11) was the statement "The role of the health care provider is limited in being able to help victims of IPV." The items with the highest mean scores (4.31 in each case) were the statements "The victim often does something (consciously or subconsciously) to contribute to the violence," "Asking patients about IPV is an invasion of their privacy," and "It is demeaning to patients to ask them about abuse." (See Table 5. Results were coded to reflect the desired responses to questions; thus higher mean values reflect more congruency with accepted beliefs.)

Table 4. Attitudes

Survey Item	n	Mean	SD
A victim must be getting something out of the abusive relationship, or else she/he would leave.	93	4.15	1.01
Victims of abuse could leave the relationship if they wanted to.	92	3.87	0.99
When it comes to IPV, it usually "takes two to tango."	93	4.25	0.72
I have patients whose personalities cause them to be abused.	92	3.95	0.94
The victim's passive-dependent personality often leads to abuse.	91	3.51	0.91
The victim has often done something to bring about violence in the relationship.	92	4.37	0.62

IPV = intimate partner violence.
Results were coded to reflect the desired responses to questions; thus higher mean values reflect more congruency with accepted attitudes.

There was a weak positive correlation ($r = 0.214$; $P = 0.049$) between responses agreeing with the statement "By specifically asking about IPV, providers greatly increase their ability to identify victims" and the number of new diagnoses the provider reported making within the past year. A weak negative correlation ($r = -0.211$; $P = 0.049$) was found between responses agreeing with the statement "Asking patients about IPV is an invasion of their privacy" and the number of new diagnoses of IPV the provider reported making within the past year.

Table 5. Beliefs

Survey Item	n	Mean	SD
By specifically asking about IPV, providers greatly increase their ability to identify victims.	92	3.89	0.82
The role of the health care provider is limited in being able to help victims of IPV.	93	3.11	1.14
The victim often does something (consciously or subconsciously) to contribute to the violence.	92	4.31	0.88
There is nothing I can do to help the victim because she/he is unlikely to leave the relationship.	93	4.07	0.73
It is not my place to interfere with how a couple chooses to resolve conflicts.	92	4.14	0.94
Asking patients about IPV is an invasion of their privacy.	91	4.31	0.61
If patients do not reveal abuse to me, then they feel it is none of my business.	93	3.96	0.75
It is demeaning to patients to ask them about abuse.	93	4.31	0.61
If I ask non-abused patients about IPV they will get angry.	93	4.11	0.70
I think that investigating the underlying cause of a patient's injury is part of medical care.	92	4.18	0.78
I can recognize victims of IPV by the way they behave.	91	3.71	0.83

IPV = intimate partner violence.
Results were coded to reflect the desired responses to questions; thus higher mean values reflect more congruency with accepted beliefs.

Table 6. Practice Behaviors

Survey Item	n	Mean	SD
I don't have time to ask about IPV in my practice.	90	3.94	0.84
The best approach to questioning about IPV is to routinely ask all patients.	92	3.98	1.00
I'm concerned I will offend the patient if I ask about IPV.	91	3.90	0.91

IPV = intimate partner violence.

Behaviors included both actual practice behaviors and perceived self-efficacy in managing patients with IPV. Practice behaviors were assessed with four items (see Tables 6 and 7). These were answerable using a Likert-type scale ranging from 1 to 5, with higher scores indicating behaviors more congruent with best practice. Respondents indicated a degree of agreement or disagreement with the statements "I don't have time to ask about IPV in my practice," "The best approach to questioning about IPV is to routinely ask all patients," and "I'm concerned I will offend the patient if I ask about IPV." The mean score for responses to each question was 3.94, 3.98, and 3.90, respectively.

The fourth question asked respondents to indicate how often they asked about IPV when patients presented with any of seven conditions within the past three months. These conditions included injuries, chronic pelvic pain, irritable bowel syndrome (IBS), headaches, depression/anxiety, hypertension, and eating disorders; all except hypertension are known to be associated with IPV. A mean score of 4 or above indicated that respondents routinely asked such patients about IPV. When hypertension was removed from the summation, the overall mean score was 2.29. For individual conditions, mean scores ranged from a low of 1.78 for IBS to a high of 2.83 for injuries, indicating that the respondents did not routinely screen for IPV in patients with these conditions. There were no statistically significant correlations between any of these variables and the number of new IPV diagnoses respondents reported making.

Four survey items assessed respondents' self-efficacy when addressing IPV (see Tables 8 and 9). Three Likert-type scale statements assessed their confidence in asking about IPV and responding to patients who are victims. The overall mean score for these questions was 3.52, indicating a moderate level of confidence. The fourth item asked respondents how confident they felt in asking patients about smoking, alcohol use, illegal drug use, sexual orientation, emotional abuse, physical abuse, and use or possession of firearms as part of the medical history. Emotional and physical abuse received the lowest scores (3.93 and 3.96, respectively) while the highest score was for smoking (4.98) followed by alcohol use (4.82).

There was a weak negative correlation between responses agreeing with the statement "I don't have time to ask about IPV in my practice" and the number of new IPV diagnoses a provider reported making within the past year ($r = -0.231$, $P = 0.031$). There were weak positive correlations between the number of new IPV diagnoses providers reported making within the past year and both responses agreeing with the statement "If I find a patient who is a victim, I know what to do" ($r = 0.231$, $P = 0.03$) and responses agreeing with the statement "There are strategies I can use to help victims of IPV change their situations" ($r = 0.243$, $P = 0.023$).

DISCUSSION

In general, survey respondents demonstrated good overall knowledge about IPV, judicious attitudes toward victims, and beliefs congruent with the available

Table 7. Practice Behaviors: 'In the Past Three Months, When Seeing Someone with the Following Conditions, How Often Have You Asked Them About the Possibility of IPV?'

Condition	n	Never	Seldom	Sometimes	Nearly Always	Always	Mean
Injuries	69	13	15	22	9	10	2.83
Chronic pelvic pain	57	22	14	12	5	4	2.21
Irritable bowel syndrome	65	35	13	14	2	1	1.78
Headaches	72	33	18	16	3	2	1.93
Depression/anxiety	73	20	17	17	11	8	2.59
Hypertension	69	45	10	9	4	1	1.64
Eating disorders	64	23	13	15	4	9	2.42

IPV = intimate partner violence.

evidence relevant to IPV. This result is in contrast to those of earlier studies, which consistently found that health care providers lacked knowledge about IPV; continued to believe common myths about IPV; and had attitudes about IPV that were characterized by frustration, condescension, anger, and helplessness.[9, 11, 38, 39, 52] One recent study of 200 medical students and surgical residents used a modified survey instrument that, like ours, was based on the one developed by Maiuro and colleagues.[10] The researchers found that respondents had "multiple misperceptions about IPV" and expressed discomfort with the subject, although most felt that identification of victims was an important part of their practice.

In our study, areas where respondents' knowledge was lacking included the prevalence of IPV, the higher risk of injury faced by women who leave their abusers, the ability of women to make appropriate choices about their situations, and what actions to take if someone discloses abuse. The overall prevalence of IPV in this country has been estimated at 36%[2]; thus the best answer to our question regarding prevalence in the network service area is "very common." Yet only one respondent chose that answer; most chose "somewhat common" (45%), followed by "rare" (31%). This is consistent with previous study findings indicating a lack of recognition regarding the extent of IPV.[42, 53] This knowledge gap is important because it may affect screening behaviors. In our study, there was a weak association ($r = 0.281$; $P = 0.006$) between respondents' answers regarding prevalence and the number of new diagnoses they reported making within the past year. It stands to reason that providers will screen more frequently for problems they believe are common than for those they believe are uncommon, so ensuring that providers have accurate information about IPV prevalence has important implications for screening rates.

Only about half of the respondents knew that women are at a greater risk for injury after they leave an abusive relationship. Indeed, the risk of femicide has been estimated at three to five times greater when women leave such relationships.[54] It's essential that providers be aware of this when they counsel women—especially when encouraging them to leave. Findings from a recent qualitative study that examined discussions women had about IPV with their health care providers suggest that this knowledge gap may be common.[8] In that study, 71% of the participants who disclosed IPV reported that their provider wanted them to leave the relationship, yet only 31% reported that their provider talked to them about safety planning. Understanding the risks that women who leave their abusers face might also help allay some of the frustration and anger providers feel when women don't leave, allowing them to better support those patients.

Table 8. Self-Efficacy

Survey Item	n	Mean	SD
If I find a patient who is a victim, I know what to do.	93	3.54	0.97
I know how to ask about the possibility of IPV.	92	3.55	0.98
There are strategies I can use to help victims of IPV change their situations.	91	3.48	0.77

IPV = intimate partner violence.

Very few respondents (16%) thought that women are able to make appropriate choices about how to handle their situation. But research indicates that women are often "impressive predictors of their own risk" and may assess their risk more accurately than some risk assessment tools.[54] Moreover, it's widely recognized that most abused women are actively engaged in protecting themselves and their children.[7, 55-59] The belief that women can't make appropriate choices is not merely inaccurate; it also disempowers women and replicates the patriarchal attitudes that abused women are trying to escape.

Respondents reported only a moderate level of confidence in both their ability to know what to do when someone discloses abuse (mean score, 3.54) and in having strategies to help women (mean score, 3.48). Lack of knowledge about what to do when someone discloses abuse is one of the primary reasons providers are uncomfortable asking about IPV.[43] This can result in a failure to provide services. In one study that looked at IPV across medical specialties, only 62% of women who disclosed IPV to a provider received help in obtaining services.[60] Such results are of concern, given the risks inherent in disclosure to a woman's safety and the importance of resources to her decision to leave an abusive relationship.[23, 26, 57, 61, 62]

Table 9. Self-Efficacy: 'How Confident Do You Feel Asking About the Following Topics as Part of the Medical History?'

Topic	n	Mean	SD
Smoking	91	4.98	0.61
Alcohol use	91	4.82	0.68
Illegal drug use	91	4.77	0.78
Sexual orientation	90	4.03	1.35
Emotional abuse	91	3.93	1.30
Physical abuse	90	3.96	1.28
Use/possession of firearms	91	4.12	1.40

Most respondents (85%) believed that they are mandated to report IPV when a child witnesses IPV, even if the child is in no immediate danger. In New York State, where these providers practice, this is not the case. And almost half of the respondents mistakenly thought they are mandated to report IPV when it occurs in people ages 18 to 65 years or in cases when a bone is broken. As noted above, some states do mandate that health care providers report IPV, but the conditions requiring such reporting vary across states.

Most respondents reported feeling moderately comfortable asking about IPV when taking a history. But when given a list of specific topics, they were the least comfortable asking about emotional and physical abuse. They were more comfortable asking about other potentially sensitive topics, including illegal drug use, sexual orientation, and use or possession of firearms. This finding is consistent with those of other studies showing that health care providers (including physicians, RNs, NPs, LPNs, and nurse midwives) were more comfortable asking about alcohol use, smoking, illegal drug use, firearms, and sexual orientation than about IPV.[42, 52]

The belief that women can't make appropriate choices disempowers women.

An encouraging finding of our study was that, for both attitudes and beliefs, the overall mean scores were high (4.02 and 4.01, respectively), indicating strong positivity. This is in contrast to results from earlier studies, which often found that health care providers had negative attitudes and beliefs.[25, 26, 63-65] Our finding may be one result of the aforementioned increased attention to IPV, both in the news media[18-21] and through IPV-related educational campaigns (such as the National Coalition Against Domestic Violence's Take a Stand [www.ncadv.org/takeastand] and NoMore.org's campaigns [http://nomore.org/about], among others); or to increased efforts by health care organizations to screen women for IPV in order to meet Joint Commission standards.[22] It may also be a reflection of the kind of person who chooses to practice in an underserved area, for generally lower monetary rewards and less prestige.

Limitations. This study was conducted with a sample of health care providers who choose to work in an underserved rural area; they may not be representative of providers in general. Furthermore, we used a small convenience sample from one rural (albeit large) health care network from one region of New York State; the survey results may not be generalizable to other populations or regions of the country. With one exception, the respondents self-identified as white; thus our findings may not reflect the knowledge, attitudes, beliefs, and behaviors of a more diverse population. Because we modified the survey instrument developed by Maiuro and colleagues by adding 10 items from the PREMIS, there may be issues with its reliability and validity. Also, the original instruments were tested among practicing physicians; practicing NPs; and nursing, medical, social work, and dental students; our study sample represented a number of different health care roles.

PRACTICE IMPLICATIONS

Our study found that most respondents didn't know whether their facility had a formal, written policy on IPV (at the time of the study, the health care network did not). Developing an IPV policy that states clear goals and outlines procedures for managing these patients may reduce providers' discomfort and increase the identification of IPV victims and their subsequent referral to appropriate services. Health care organizations must also communicate such policies to staff during orientation programs and through continuing education.

Knowledge deficits persist, and it's vital that health care organizations provide IPV-related education for all staff, particularly with regard to the complexity of IPV, the decision-making process involved in leaving an abuser, and the possible consequences a woman faces in doing so. Such education must begin well before licensure and employment, as part of the curricula of all medical and nursing programs. The World Health Organization (WHO) strongly recommends that all health care providers receive "training at prequalification level in first-line support for women who have experienced intimate partner violence and sexual assault," and in-service education for all those who provide care to women.[66] Integrating IPV-related education into the curricula will yield nurses and physicians who recognize the importance of screening and who have the knowledge and skills to care for people affected by IPV.

Broadening the scope of education to include IPV will also serve to familiarize providers with the applicable state regulations about mandated reporting. In our study, this was the area in which respondents showed the greatest knowledge deficit. Mandated reporting of IPV by health care providers is not recommended by the WHO; nor do many women who experience IPV support it.[66] Providers should offer to report an IPV episode—and should respect the woman's decision either way. Safety must always be the first priority. Regardless of whether the woman chooses to report or not, accurate documentation of the episode in the medical record, including photographs of any visible injuries, is imperative.

The laws regarding mandated reporting differ from state to state, and this is problematic. It makes the "official" approach to IPV seem arbitrary, confuses providers, and complicates care. Varying IPV policies and regulations at state and local levels also make it easier for local organizational influence and individual bias to operate within the judicial system. The creation of a clear national policy on IPV would help curtail such practices, as well as increase public awareness and promote funding for research.

Given that interactions with health care providers can significantly alter the lives of women who are experiencing abuse,[7,8] having an accurate understanding of providers' current attitudes and beliefs is crucial. Further research in other settings (including urban settings) and geographic areas and with more racially and ethnically diverse samples will help to determine whether the more positive findings in this study reflect an overall shift in providers' attitudes and beliefs.

Future research must also focus on interventions that will improve providers' ability to identify women who are experiencing IPV and to manage their care. In particular, research that develops and tests interventions in both educational and practice settings is needed to ensure that providers have the requisite knowledge and resources. Studies of the effectiveness of strategies aimed at increasing providers' comfort and skills in screening for and responding to IPV are also warranted.

Individual providers must examine their own IPV-related knowledge, attitudes, beliefs, and resultant behaviors. They must take responsibility for obtaining information about available resources and for educating themselves about what to do when a woman discloses abuse. Those in leadership positions should make sure that all staff are educated about IPV and are familiar with the organization's IPV-related policies, and should offer all necessary support. Information about such policies and local resources, including shelters, social services, law enforcement, and advocacy groups, should be easily accessible to all staff (for example, via the organization's intranet).

CONCLUSION

The results of this study were largely encouraging with regard to the IPV-related knowledge, attitudes, beliefs, and behaviors of health care providers. But there were still troubling knowledge and practice gaps. Preparing providers such that they can deliver compassionate, effective care to women who experience IPV is crucial for the health and well-being of women and families, regardless of where they live. ▼

For three additional continuing nursing education activities on intimate partner violence, go to www.nursingcenter.com/ce.

Karen Roush is an assistant professor of nursing at Lehman College, Bronx, NY, as well as a former clinical managing editor at AJN. *Ann Kurth is a professor at and dean of the Yale School of Nursing, New Haven, CT. At the time of this study, she was a professor at and executive director of New York University (NYU) College of Nursing Global, as well as associate dean for research at NYU's Global Institute of Public Health, both in New York City. Contact author: Karen Roush, roushkm@gmail.com.* *The authors and planners have disclosed no potential conflicts of interest, financial or otherwise.*

REFERENCES

1. Centers for Disease Control and Prevention. *Intimate partner violence*. 2015. http://www.cdc.gov/violenceprevention/intimatepartnerviolence.
2. Black MC, et al. *National intimate partner and sexual violence survey: 2010 summary report*. Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2011 Nov. http://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf.
3. Bonomi AE, et al. Medical and psychosocial diagnoses in women with a history of intimate partner violence. *Arch Intern Med* 2009;169(18):1692-7.
4. Campbell J, et al. Intimate partner violence and physical health consequences. *Arch Intern Med* 2002;162(10):1157-63.
5. Rees S, et al. Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function. *JAMA* 2011;306(5):513-21.
6. Zlotnick C, et al. Intimate partner violence and long-term psychosocial functioning in a national sample of American women. *J Interpers Violence* 2006;21(2):262-75.
7. Chang JC, et al. Understanding turning points in intimate partner violence: factors and circumstances leading women victims toward change. *J Womens Health (Larchmt)* 2010;19(2):251-9.
8. Morse DS, et al. "They told me to leave": how health care providers address intimate partner violence. *J Am Board Fam Med* 2012;25(3):333-42.
9. Klap R, et al. Screening for domestic violence among adult women in the United States. *J Gen Intern Med* 2007;22(5):579-84.
10. Sprague S, et al. Perceptions of intimate partner violence: a cross sectional survey of surgical residents and medical students. *J Inj Violence Res* 2013;5(1):1-10.
11. Yonaka L, et al. Barriers to screening for domestic violence in the emergency department. *J Contin Educ Nurs* 2007;38(1):37-45.
12. Bosch K, Schumm WR. Accessibility to resources: helping rural women in abusive partner relationships become free from abuse. *J Sex Marital Ther* 2004;30(5):357-70.
13. Davis K, et al. Narrative accounts of tracking the rural domestic violence survivors' journey: a feminist approach. *Health Care Women Int* 2001;22(4):333-47.
14. Eastman BJ, Bunch SG. Providing services to survivors of domestic violence: a comparison of rural and urban service provider perceptions. *J Interpers Violence* 2007;22(4):465-73.
15. Few AL. The voices of black and white rural battered women in domestic violence shelters. *Fam Relat* 2005;54(4):488-500.
16. Logan TK, et al. Protective orders in rural and urban areas: a multiple perspective study. *Violence Against Women* 2005;11(7):876-911.
17. Riddell T, et al. Strategies used by rural women to stop, avoid, or escape from intimate partner violence. *Health Care Women Int* 2009;30(1-2):134-59.
18. Blum R. Yankees closer Chapman agrees to accept 30-game suspension. *ABC News* 2016 Mar 2. http://abcnews.go.com/Sports/wireStory/yankees-closer-chapman-agrees-accept-30-game-suspension-37317410.
19. Caldwell LA. Domestic violence: the next front in gun-control. *CNN* 2014 Jul 30. http://www.cnn.com/2014/07/30/politics/domestic-violence-and-guns.
20. Seitz MZ. HBO's documentary about domestic violence is difficult to experience, essential to watch. *Vulture (New York Magazine)* 2014 Oct 20. http://www.vulture.com/2014/10/tv-review-hbo-private-violence-essential.html.

21. Willis D. Domestic violence in The Times: from civil unrest to spouse abuse. *New York Times* 2014 Sep 10. http://www.nytimes.com/2014/09/11/upshot/domestic-violence-in-the-times-from-civil-unrest-to-spouse-abuse.html.
22. Joint Commission. Accreditation participation requirements. In: *Accreditation program: hospital*. Oakbrook Terrace, IL; 2009. p. APR.1-APR.9. http://canainc.org/compendium/pdfs/D%201.%20JC%20Standards%202010.pdf.
23. Dienemann J, et al. Survivor preferences for response to IPV disclosure. *Clin Nurs Res* 2005;14(3):215-33; discussion 234-7.
24. Davis RE, Harsh KE. Confronting barriers to universal screening for domestic violence. *J Prof Nurs* 2001;17(6):313-20.
25. Henderson A. Factors influencing nurses' responses to abused women: what they say they do and why they say they do it. *J Interpers Violence* 2001;16(12):1284-306.
26. Dowd MD, et al. Mothers' and health care providers' perspectives on screening for intimate partner violence in a pediatric emergency department. *Arch Pediatr Adolesc Med* 2002;156(8):794-9.
27. Furniss K, et al. Nurses and barriers to screening for intimate partner violence. *MCN Am J Matern Child Nurs* 2007;32(4):238-43.
28. Zeitler MS, et al. Attitudes about intimate partner violence screening among an ethnically diverse sample of young women. *J Adolesc Health* 2006;39(1):119 e1-e8.
29. Krasnoff M, Moscati R. Domestic violence screening and referral can be effective. *Ann Emerg Med* 2002;40(5):485-92.
30. Nelson HD, et al. Screening women for intimate partner violence: a systematic review to update the U.S. Preventive Services Task Force recommendation. *Ann Intern Med* 2012;156(11):796-808, W-279–W-282.
31. U.S. Preventive Services Task Force. Screening for family and intimate partner violence: recommendation statement. *Ann Fam Med* 2004;2(2):156-60.
32. Committee on Preventive Services for Women, Board on Population Health and Public Health Practice, Institute of Medicine of the National Academies. *Clinical preventive services for women: closing the gaps*. Washington, DC: National Academies Press; 2011. http://www.nap.edu/catalog/13181/clinical-preventive-services-for-women-closing-the-gaps.
33. American College of Emergency Physicians. *Clinical and practice management: domestic family violence*. Irving, TX; 2007/2013. http://www.acep.org/Clinical---Practice-Management/Domestic-Family-Violence.
34. American College of Obstetricians and Gynecologists. ACOG Committee Opinion No. 518: intimate partner violence. *Obstet Gynecol* 2012;119(2 Pt 1):412-7.
35. Association of Women's Health, Obstetric, and Neonatal Nurses. AWHONN position statement. Intimate partner violence. *J Obstet Gynecol Neonatal Nurs* 2015;44(3):405-8.
36. Council of International Neonatal Nurses (COINN). *Position statement on routine screening for intimate partner violence*. Yardley, PA; 2010 Jan. http://coinnurses.org/wp-content/uploads/2013/06/Position_Stat_Intimate_Partner_Violence.pdf.
37. Emergency Nurses Association; the International Association of Forensic Nurses. *Joint position statement: intimate partner violence*. Des Plaines, IL; Elkridge, MD; 2013. https://www.ena.org/SiteCollectionDocuments/Position%20Statements/Joint/IPV.pdf.
38. Kramer A, et al. Prevalence of intimate partner violence and health implications for women using emergency departments and primary care clinics. *Womens Health Issues* 2004;14(1):19-29.
39. Thurston WE, et al. Implementation of universal screening for domestic violence in an urgent care community health center. *Health Promot Pract* 2009;10(4):517-26.
40. Davis JW, et al. Victims of domestic violence on the trauma service: unrecognized and underreported. *J Trauma* 2003;54(2):352-5.
41. Schoening AM, et al. Effect of an intimate partner violence educational program on the attitudes of nurses. *J Obstet Gynecol Neonatal Nurs* 2004;33(5):572-9.
42. Sugg NK, et al. Domestic violence and primary care. Attitudes, practices, and beliefs. *Arch Fam Med* 1999;8(4):301-6.
43. Todahl J, Walters E. Universal screening for intimate partner violence: a systematic review. *J Marital Fam Ther* 2011;37(3):355-69.
44. Sundborg EM, et al. Nurses' preparedness to care for women exposed to intimate partner violence: a quantitative study in primary health care. *BMC Nurs* 2012;11:1.
45. Health Resources and Services Administration. *Defining rural population*. 2015. http://www.hrsa.gov/ruralhealth/aboutus/definition.html.
46. Health Resources and Services Administration. *Rural health grants eligibility analyzer: about geographic eligibility for rural health grant programs*. n.d. http://datawarehouse.hrsa.gov/RuralAdvisor/RuralHealthAdvisor.aspx.
47. Office of Management and Budget. 2010 standards for delineating metropolitan and micropolitan statistical areas; notice. Washington, DC: Federal Register 2010 37246-7.
48. U.S. Census Bureau. *QuickFacts: United States*. n.d. http://www.census.gov/quickfacts/table/PST045215/00.
49. Maiuro RD, et al. Development of a health care provider survey for domestic violence: psychometric properties. *Am J Prev Med* 2000;19(4):245-52.
50. Short LM, et al. A tool for measuring physician readiness to manage intimate partner violence. *Am J Prev Med* 2006;30(2):173-80.
51. Connor PD, et al. Psychometric properties of an intimate partner violence tool for health care students. *J Interpers Violence* 2011;26(5):1012-35.
52. Herzig K, et al. Comparing prenatal providers' approaches to four different risks: alcohol, tobacco, drugs, and domestic violence. *Women Health* 2006;43(3):83-101.
53. Sprague S, et al. Barriers to screening for intimate partner violence. *Women Health* 2012;52(6):587-605.
54. Roehl J, et al. *Intimate partner violence risk assessment validation study, final report*. Washington, DC: U.S. Department of Justice; 2005 May. https://www.ncjrs.gov/pdffiles1/nij/grants/209731.pdf.
55. Anderson DK, Saunders DG. Leaving an abusive partner: an empirical review of predictors, the process of leaving, and psychological well-being. *Trauma Violence Abuse* 2003;4(2):163-91.
56. Enander V, Holmberg C. Why does she leave? The leaving process(es) of battered women. *Health Care Women Int* 2008;29(3):200-26.
57. Koepsell JK, et al. Factors that influence battered women to leave their abusive relationships. *Violence Vict* 2006;21(2):131-47.
58. Moe AM. Silenced voices and structured survival: battered women's help seeking. *Violence Against Women* 2007;13(7):676-99.
59. Moe AM. Battered women, children, and the end of abusive relationships. *Affilia* 2009;24(3):244-56.
60. McCloskey LA, et al. Intimate partner violence and patient screening across medical specialties. *Acad Emerg Med* 2005;12(8):712-22.
61. Bell M, et al. Variations in help-seeking, battered women's relationship course, emotional well-being, and experiences of abuse over time. *Psychol Women Q* 2009;33(2):149-62.
62. Feder GS, et al. Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. *Arch Intern Med* 2006;166(1):22-37.
63. Bhandari M, et al. (Mis)perceptions about intimate partner violence in women presenting for orthopaedic care: a survey of Canadian orthopaedic surgeons. *J Bone Joint Surg Am* 2008;90(7):1590-7.
64. Robinson R. Myths and stereotypes: how registered nurses screen for intimate partner violence. *J Emerg Nurs* 2010;36(6):572-6.
65. Woodtli MA. Domestic violence and the nursing curriculum: tuning in and tuning up. *J Nurs Educ* 2000;39(4):173-82.
66. World Health Organization. *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva; 2013. http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf?ua=1.